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Hearing Voices:

Anthrogogies of Politics in Psychiatric Rehabilitation

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Benjamin M. Clubbs Coldron

4250742

School of Law

University of Nottingham

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Abstract

In this thesis I investigate how policies aiming to enhance and increase opportunities for political participation for people with mental disabilities are currently being implemented in residential psychiatric rehabilitation. These practices form part of the implementation of the *United Nations Convention of the Rights for Persons with Disabilities* (UNCRPD) Article 29 – the right to equal opportunities to participate in public and political life.

In answering how Article 29 is substantiated, I deconstruct the micro-social interactions relevant to politicisation in psychiatric treatment and the effect policy implementation has on constituted identities and social roles available to service-users and staff. Politicisation refers to the mechanisms by which people become politically aware or engaged to act politically. These mechanisms, in observation, were fundamentally pedagogical. This raises a number of important complexities which inform a theoretical discussion of power, benevolence, indoctrination and empowerment. The phenomenon under investigation is the anthrogogies of politics applied in the course of residential mental health treatment. The implications of this research go far beyond the mental health institution.

The evidence presented in this thesis indicates that ethical and political environments in mental health services, whether imposed by staff or co-produced with service-users, determine exclusions and inclusions in political life through processes of social recognition. Particular roles are naturalised in the mental health treatment process. The doctor patient ‘act’ required within institutional settings can often frustrate attempts to expand and enhance opportunities for service-users and providers to adopt political identities and be recognised respectively as political members of the community.

At one level, this study demonstrates that practices of politicisation face significant challenges when implemented in psychiatric rehabilitation. Many

mental institutions surveyed did not practically implement any positive support for political inclusion. Even in the three pioneering facilities studied there was low uptake of voting rights by service-users who appeared broadly to lack motivation, access to information and resources, and opportunities to engage in political discourse. Staff appeared to accord low priority to political action and expression. They sometimes elevated electoral participation to a characteristic of mentally healthy ways of being and applied didactic pedagogies of citizenship and ethics. Staff and service-users alike appeared to be disempowered and disenfranchised by strict adherence to particular rituals, traditions, identities and roles attached to the mental institution. This demonstrates that implementation of practices of political inclusion often slip back into medicalised practices of assessment and treatment creating rational reasons for disengagement.

At a theoretical level I argue ethical worldviews, in the sense of conceptualisations of what the good life is or should be, influence capabilities to exercise political agency and action. Psychiatric services, in their everyday functions, appear to impose ethical worldviews on service-users. Pedagogical approaches in supporting political inclusion ranged from didactic banking approaches based on rehabilitative intervention, to co-constructivist and dialogical approaches based on humanistic, person-centred recovery. Political empowerment in the former approach is understood as in the gift of staff and practitioners but in the latter as a process of co-construction.

A Foucauldian theory of power and Butlerian theory of co-constructed identity is applied and adapted to the empirical data in an iterative process to understand how policies of political inclusion are implemented. Based on this analysis, as well as engagement with debates in educational philosophy about indoctrination and empowerment in adult education, I conclude that spaces in which law, policy, and institutional ritual are denaturalised facilitates and encourages connectedness, co-production and conflict. Such spaces are in turn productive of political opportunities. Greater opportunities to engage in conflict and cooperation with other members of the community , in spaces where the significance of the law and psychiatric epistemology is reduced, appears vital in the case of people being treated in mental rehabilitation to enable staff and service-users to play at, and develop, political identities and capabilities.

These findings have radical implications for the mental health law, policy and practice and speak to an inherent contradiction at the heart of the UNCRPD. Participation rights such in the UNCRPD attempt to redistribute power from the top down so that people with disabilities can exercise greater agency. This views power as a resource owned by powerful actors and distributed through law. By using legal mechanisms premised on that very conceptualisation of power, and by addressing states and mental health service-providers as the principle actors in stimulating political change, UNCRPD implementation can have the unintended effect of reducing the political agency of people with mental disabilities. By contrast, understanding political inclusion, and by extension mental health care itself, as a process of dialogical education represents a more promising way forward in substantiating participatory rights.

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Chapter 1

1. Anthrogogies of Politics in Psychiatric Rehabilitation

1.1. Introduction

This study critically investigates the implementation of policies of political inclusion in psychiatric rehabilitation. In studying implementation analysis became increasingly focused on the educational strategies used by practitioners to support service-user's participation in public and political life. These strategies are referred to as anthrogogies of politics.

I outline and describe the intricacies of implementation and explore the micro-social processes involved in political interaction in psychiatric services. Foucault and Bourdieu provide some base concepts for analysing human interactions on the basis of power relations and capital in different social fields. Goffmanian dramaturgy and Butlerian co-construction are also applied to tease apart the data and produce detailed theoretical understanding of the processes of politicisation under scrutiny. This theoretical framework was developed after data collection but is introduced early in the thesis to allow the reader a better understanding of the data presented in later chapters.

Using empirical data, I show how English mental health services implement policies of political inclusion. These policies seek to establish equal opportunities to engage in public and political life for people with mental disabilities. In analysing the empirical data, I observe how implementation, when done well, de-emphasise the boundaries between the mental health practitioner and the patient and between the political field and everyday life. I apply a theoretical framework to understand how political roles are supported through anthrogogies of citizenship and ethics and how political identities are constructed, performed and recognised in these contexts.

I clarify how certain social conditions of connectedness and co-construction need to be fulfilled if participants are to be reasonably accommodated to increase equality of opportunities for political participation. If certain conditions are not met, the recognition of persons with mental disabilities as political agents' risks emerging as a fabrication (Goffman, 1974). Where service-users and providers shared a belief in a more comprehensive recovery, in which wider political empowerment was part of the process and not an outcome, practices of political inclusion appeared more effective and had a broader focus. The assumption that equal political participation was not practically attainable, and in any case was of little value, frequently became a barrier to the substantiation of political rights. In addition, the spectre of medicalisation of political expression, based in rituals of assessment and containment, was a source of demotivation and alienation.

Despite a recent surge of interest in recovery, co-production in care, and political inclusion for persons with mental disabilities, social scientists and legal researchers have not yet produced detailed research on the everyday implications of implementation (Fotaki 2011, Tuurnas 2015, Voorberg et al. 2015). Detailed ethnographic study exploring the interactions occurring during implementation of policies of political inclusion in mental institutions are necessary if we are to move beyond abstract theories of political agency and recovery and towards an understanding of its co-production in everyday interactions (Kirkegaard & Andersen, 2018). This thesis is a response to this critical need for knowledge.

In the following chapters I scrutinise positive support, provided to psychiatric patients in mental health rehabilitation facilities in England, to enable equal opportunities for participation in politics. This is front-line implementation of Article 12 and 29 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (2006). The policies implemented in these settings aimed to enhance and increase opportunities for political participation for persons with mental disabilities so they were commensurate with opportunities available to the general population.

In this introductory chapter I provide an overview of the topic by looking at trends emerging from the literature relating to political participation in Britain. I then explain the research focus and questions.

1.2. Mental Disability and Political Participation

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD 2006) requires reasonable accommodations to be made to support the equal opportunities of people with disabilities to participate in public and political life (Art.29). It is the substantive implementation of this right, in the context of residential mental health services, that this thesis concerns.

There have been a number of campaigns, policy initiatives and legislative changes in the UK over recent decades that reflect a commitment to change societal perceptions of mental illness, as well as improve the capabilities and opportunities of people with mental disabilities to participate in political and civic life (Sayce, 2016 ch.3-4; Mckinley & Yiannoullou, 2011). The Electoral Administration Act 2006 and the Representation of the People Act 1983 (amended in 2000) now grant people detained in mental health institutions, and those without mental capacity, a right to vote.

Expansion of political rights has occurred concurrently with policies of 'person-centred care' seeking to increase patient inclusion in care decisions. The participation of service-users in governance and regulation of the mental health systems is identified as a fundamental principle in the WHO Mental Health Action Plan (WHO, 2012). Across Europe, policies are being implemented aiming to positively support public inclusion in health policymaking and implementation. Approaches widely refer to concepts such as 'voice', 'representation' and 'choice' and generally focus on participation in the politics of public health institutions (WHO 2006: 7).

Patient participation in commissioning and implementing health services has become a widespread policy in the UK. In Scotland NHS Boards have duties to involve the public alongside duties to ensure equality of opportunity under the NHS Reform (Scotland) Act 2004 (s.7). Similarly, in Northern Ireland a duty of personal and public involvement in health and social services has been established by the Health and Social Services (Reform) Northern Ireland Act 2009 (s.16-20). This has been accompanied by various policy commitments to '*increase user involvement in the design and delivery of services'* (Heenan 2009: 454).

In England and Wales, the Local Government and Public Involvement in Health Act 2009 (s.221) imposes a duty on public bodies to involve service-users in governance and service provision. The Health and Social Care Act 2012 replaced Primary Care Trusts and Strategic Health Authorities with Clinical Commissioning Groups which have a legal duty to involve service-users in commissioning services (s.26 ss.14U; ss.14Z2). The inclusion in mental health law, policy and practice of people treated in mental health services has been identified as a key area for improvement (Lewis, 2014).

Although a range of forums in the health care sector are being opened up to participation of their 'clients' and 'consumers' the benefits of implementation for people with disabilities remain insubstantial and abstract and assume that health policy is their main political concern. According to Lewis '*There are elements of the current UK mental health policy context which are unfavourable to the progressive development of user involvement, beyond a consumerist approach' (*Lewis 2014: 8.5). An aggravating factor is the degradation of health care work associated with technocratic pursuit of 'neoliberal efficiencies'. According to Mckeown (2015) it has undermined the capability of psychiatric nurses to exert influence and involvement at all stages of the nursing process and patient journey.

Participation in public and political life, for adult citizens, may minimally be understood as casting a ballot in an election every four or five years. Other, and perhaps more transgressive forms of political action and expression may be considered inappropriate even for average citizens, but particularly so for persons with mental disabilities (Walker, 2019). Some forms of political action, when performed by particular actors, may be cast as symptomatic of mental illness and trigger capacity assessments and coercive treatment.

This possibility can render the threshold for what counts as legitimate political participation significantly higher for people with mental disabilities than for the general population. The voices of people with mental disabilities are currently rarely heard directly and when they are, can be delegitimised on the basis that they do not convey 'real' experiences. In medical contexts "inappropriate" political action and expression may be restricted and discouraged for reasons relating to risk and capacity notwithstanding their political rights. By extension, more mundane forms of political participation may also become less appealing as action and expression is put under intense scrutiny creating rational reasons for disengagement.

The substantive implementation of Article 29 of the UNCRPD should expand opportunities for political action for service-users. The data shows however that mental health settings are replete with rules and rituals of interaction which encourage some and discourage other types of political performances. This renders implementation complex. In fact, practices mandated by implementation can have the unintended effect of reducing political agency by imposing educational initiatives that expand psychiatric management of behaviour to the political field.

If we understand politics as being a process of conflict and cooperation, treatment for prolonged periods of time in residential mental health services can create restrictions on the ability and opportunity to construct political identities and worldviews by framing even productive conflict as problematic. Furthermore, the very imposition of psychological interpretations of the personal can reduce opportunities for developing subversive worldviews, political identities and capabilities (Kitzinger, 1993).

Further, researchers such as Bleyen et al. (1998) frame differences between service-user, carer and service-provider perceptions of political inclusion as problematic. They imply that difference and conflict between therapists and their clients are detrimental to the recovery and rehabilitation processes (*Ibid).* Much of the literature assumes that conflict is inimical to the recovery and rehabilitation processes and frame differences in worldviews and opinions between service-user, carer and service-provider as problematic (Tambuyzer & Audenhove, 2013: 676)

Although institutional restrictions on political expression and action may apply to patients and staff in equal measure, it is important at this early stage to consider the corrosive disadvantages faced by people with mental disabilities in trying to contribute to political decisions and debates. Disengagement with electoral participation in the general population is correlated with low socio-economic status (Electoral Commission, 2005; Lijphart, 1997; Whiteley et al 2001; Kessler et al., 1994; Macran et al., 1996; Murali & Oyebode, 2004), low educational attainment, lack of contact with politically engaged peers, and mental and physical disability (Leighley & Vedlitz, 1999). Mental illness is associated with poverty, unemployment, low levels of education and social isolation (Mental Health Foundation 2007: 37-8; Meltzer et al., 2002; Singleton et al. 2000). The literature indicates people with mental disabilities are often affected by a cluster of mutually reinforcing social disadvantages (Wolf and De-Shalit, 2007).

Social influences on behaviour, and idiosyncrasies of personality, interests and perspectives mean that the exercise of political agency and choice are not always conceptually distinguishable from symptoms of a mental disorder or the social causes of disability. This means that arbitration between appropriate and inappropriate political action becomes pertinent. A ‘mistake’ could increase the likelihood of paternalistic or coercive treatment being applied. Diagnostic categories of mental illness may affect this process of mis/mal-recognition but there is no research at present looking at this question in detail.

Studies have shown that supportive practice during elections may increase registration and voting rates (Nash 2002, Keeley et al 2008; Mcintyre et al 2012, Okwerekwu, McKenzie, Yates, Sorrentino, & Friedman 2018, Kelly & Nash 2019). Voting and registration rates, though important, do not take account of the institutional politics occurring in the processes of rehabilitation and recovery - politics with a small p – nor of the anthrogogies of ethics and citizenship that are a prerequisite of successful engagement with politics on a society wide scale. Furthermore, the Article 29 of the UNCRPD requires support to provide equal opportunities to participate in public and political life and voting is merely a small aspect of this social field.

Rights to equal participation in public and political life for people with mental disabilities suffer from a lack of substantive implementation and thus remain obscure, abstract and partial (Rees & Reed, 2016). Rights and policy commitments can slip into rhetorical illusions of inclusion whereby progress is defined as ‘talking about the issue differently’ or ‘changing attitudes’ with no substantive change in practice or behaviour (Thornicroft 2006; Sayce 2016). Nash for example argues that seeing service provision as a means of achieving social inclusion for those with mental illness can relegate it to a principle of treatment compliance (Nash, 2002).

The realisation and importance of service-user's participation in both 'big-p' Politics (electoral participation) and small-p politics (of care and recovery) has been assessed in the literature using a variety of measures: convergence of practitioner and 'consumer' conceptualisations of participation (Anthony and Crawford 2000; Glasby et al. 2003; Lammers & Happell 2003; Lloyd & King 2003); availability and communication of information (Anthony and Crawford 2000; Connor 1999); education for staff and service-users to enhance decision making (Beresford 2007; Connor 1999; Linhorst et al. 2005; Warne and McAndrew 2007) and procedures for involvement in institutional governance for service-users and carers (Cawston and Barbour 2003; Cleary et al. 2006).

These measures capture some aspects of small-p political inclusion. However, there are issues in applying supportive interventions as they broach the line between 'levelling the playing field' and 'differential treatment based on mental disability'. In this thesis I move beyond psy-epistemologies and social care paradigms and consider some insights from political science. This allows us to problematise the assumption that mental incapacity and illness is the cause of political apathy and look at the social barriers to functioning in this context in line with the social model of disability enshrined in the UNCRPD. It is partly for this reason that the question of whether mental health diagnosis is an important factor in political engagement, and if so how, is not a central focus of the analysis.

Power in psychiatric institutions is exercised through a strict hierarchy. Certain professional practitioners exercise power (both epistemological and legal) to reify service-user's identities as disordered and delegitimise their contributions on this basis. They also use power to arbitrate conflict and restrict cooperative activities. Service-users also exercise power in extracting care and resources from staff, sometimes using unusual or antisocial methods. The exercise of, and conceding to, such powers requires explanation.

In the contexts under study the exercise of power appears superficially to depend on The Mental Health Act 1983 and the Mental Capacity Act 2005. As we see in later chapters, these laws grant legal powers to suspend normal rights and responsibilities based on the need to assess and treat mental illness and protect the patient and public from harm. The ascription of role and identity and the construction of worldviews is based on authority derived from psy-epistemologies (Rose 1990). Power in the institution is much more polycentric than this legalistic understanding of power suggests.

The sociology of health and illness can help elucidate two issues relevant to these the exercise of power in mental institutions: the issue of reification and that of narrative power (Brown, 1995; Jutel 2009). This expanding literature examines the way in which diagnostic categories representing behavioural patterns are ascribed and the processes by which they are enforced and internalised.

Gill and Maynard attempt to capture some of the empirical aspects of these processes in their ethnomethodological approach to labelling (1995: 13). Labels and counter-labels are applied and constructed. These in turn influence recognition and reification processes and inform worldviews. However, the effects of labelling in terms of political opportunities are multifarious and contradictory. Labels are applied and policed within institutions and in wider communities in such a variety of ways that labelling theory sometimes suffers from being so general as to be useless in analysing the micro-social interactions under study.

My research indicates much greater complexity than can be grasped by a binary understanding of compliance and deviance defined by powerful actors using labels. Power is exercised by all on all. For example, my observations and interviews demonstrate structural, social, political and personal motivations for adopting certain names for one’s identity and naming other actors and actions. These interacted in both deterministic and agential ways to place actors in particular narratives. Labels may more fruitfully be understood in this context as ways of constructing worldviews. Actors perform such labelled identities with a range of different audiences in mind (Hollin & Pilnik, 2018; 1216). Performance can reconstruct the meaning of a given identity label and labels can be reclaimed. Labels can be both empowering and disempowering depending on context, performance and audience and are ascribed, embraced and subverted by service-users and staff.

Rather than situating our understanding of these processes as an aspect of labelling and deviance theory, it is perhaps more enlightening to understand these processes in terms of role, performance and narrative identity construction (Goffman, 1974; Butler, 1988). Forms of resistance and transgression may provide a way of positing alternative approaches to rehabilitation, recovery and the good life. At the same time labels such as ‘political citizen’ can be ascribed in interaction in ways that expand opportunities and freedoms.

Whilst power may be used to expand opportunities it can also be used to restrict them. In institutions professional actors have the resources to overcome political resistance by defining it in ways that justify coercive control. This can result in implementation of policies of inclusion becoming a form of managed autonomy. People (including staff) are required in law to perform in ‘autonomous’ ways to humanise and personalise the healthcare provided. Psy-epistemology requires service-users to perform as ‘autonomous’ actors to demonstrate recovery. Laws and policies requiring people to act in humanistic and autonomous ways can result in political roles being performed and enforced to demonstrate compliance (Callon and Rabeharisoa 2004: 13).

The centralised management of participation activities in spaces that are not co-owned, (i.e. restricting service-user participation in governance meetings to a single representative on managements terms), ensures that some possibilities for performing autonomy arise in non-threatening areas while other, more risky possibilities are eliminated (Hacking 1995, Hollin, 2017). Transgressive discourses may be co-opted to sustain existing power relations. For example, person-centred approaches, and the social model of disability can have the unintended effect of supporting existing power relations between service-users and practitioners by dressing coercive treatment in the narrative of supporting autonomy (Armstrong 2002, Aspis 1997, Buchanan & Walmsley 2006).

Acts of resistance may be defined as inefficiencies to be dealt with by evidence-based practice and thus delegitimised as political contributions. Acts which attempt to unsettle diagnostic practices in situ may, therefore, ultimately be disregarded. There may be instances where acts of resistance are themselves interpreted as evidence of clinical pathology confirming and legitimising the power of clinicians. This has been observed in the diagnosis of autism whereby resistance and role distancing behaviours are defined as symptoms contributing to diagnosis (Hollin & Pilnik, 2018; 1228).

Mental illness, in legal argument and in the practice of mental health treatment, often refers to everything that mentally ill people do. The way in which mental disorder discursively infects a person's whole identity, so that all actions are seen in terms of their mental health, appears particularly acute for people with personality disorder and schizophrenia. In distinguishing between actions related to personality and those caused by schizophrenia a psychologist providing evidence to the European Court of Human Rights said:

'It is impossible to make any reliable distinction between symptoms... and those which are due to an individual's personality... in the case of a patient known to suffer from schizophrenia, it would be usual to assume that the symptoms were due to the schizophrenic illness.' (Keenan v. the United Kingdom, Application no. 27229/95, (2001) 33 EHRR 38)

Psychiatric distinctions between political and disordered behaviour are therefore problematic because once a categorisation of mental illness is applied any behaviour deemed socially unacceptable can be interpreted as aspects of their mental disorder. This can undermine attempts to present oneself as a political citizen.

Psy-epistemology can also collapse *Bios* (public life and the determination of the good life for human beings to be decided by political conflict and cooperation) into Z*oê* (the private, natural or biological life only included in the polis by its exclusion from politics) by associating mental health with the good life. Agamben (1995) and Snoek argue that:

'Managing the health of citizens is now the central task of politics and simply being alive has become more important than the good life. At the same time simply being alive is not acknowledged as a human life and politics is searching for the bios of the zoê, the form of life, the humanity of the living being… in trying to find the humanity of simply being alive, life becomes stripped of all specific characteristics and loses its value. With this loss of value, life loses its political rights and comes to stand outside politics' (Snoek, 2014: 54-5)

The collision of psychiatric epistemology with democratic conceptualisations of personhood plays out in interactions between staff and service-user in mental health wards in the attempt to include people with mental disabilities in politics. During elections political roles are performed in accordance with certain rules and rituals derived from popular understandings of what political citizenship is. Service-users, in being supported to participate, are thus subjected to, and engage in, anthrogogies of politics. It is how, and on what basis, this educational interaction progresses which is a central focus of the thesis. My findings indicate that this practice often slips back into medicalised rituals of assessment and treatment which can demotivate participation.

Having introduced the general topic of inquiry the remainder of this chapter will outline some more specific themes running through the socio-legal literature on the substantiation of participation rights. Namely the concepts of benevolence, agency, power and indoctrination.

1.3. Benevolence, Agency, Power and Indoctrination

In 2006, the UNCRPD was introduced. It is founded, in part, on the principle of participation for disabled persons in public and political life. Article 3(c) states that participation is one of the general principles of the convention. Article 1 incorporates 'full and effective participation in society on an equal basis with others' into the definition of disability.

Practical realisation of the UNCRPD, and more specifically the right to equal opportunities to participate in public and political life (Art.29 UNCRPD, 2006) implies radical and far reaching changes to the mental health system. Bartlett neatly captures some of the difficulties of attempting to transform practice in line with UNCPRD principles:

'reform does not occur in the abstract, but on the ground, in the context of existing environments and institutions… the issues that arise are not merely geographically and socially specific, but they may also raise issues in fields beyond disability… they may involve human rights situations that are pressing and immediate, where precise requirements of the [UNCRPD] may yet be unclear, and where those charged with reform… may not intuitively support its objectives. The precise direction of reform in such situations may be unclear, and even if clear, may not be politically achievable. Even if politically achievable, such reforms may not be implemented on the ground, through intransigence or hostile incomprehension of people in the system. Approach to reform in these situations is, therefore, complex.' (Bartlett, 2014: 178)

It is an exploration of this complexity, in all it's richness, that my thesis attempts to provide.

The UNCRPD re-affirms a number of human rights for persons with mental disabilities. Obligations are placed on state parties to make reasonable accommodations that reduce barriers to equal participation. In particular Article 12 and 29 UNCRPD create rights for people with disabilities to have reasonable accommodations in place to ensure their inclusion on an equal basis with others, in public and political life. Political citizenship for people with mental disabilities is concerned with influencing both the '*content of social rights and obligations'* *and the 'various social arrangements whereby … benefits are distributed to different sectors of society'* (Turner, 1993: 2–3).

These rights are potentially transformative in both symbolic and practical ways. They are addressed to States and thus reflect a view of progressive change and power redistribution as a process of top-down reform. Rummery's theoretical work on citizenship in the welfare state indicates that the policy focus on developing and improving political capabilities for people with mental disabilities through top down policy reform can work against political inclusion. In other words, that the application of law and policy in the management of political participation potentially strengthens the role of practitioners in ways that can potentially disempower service-users and reinforce social exclusion (Rummery, 2006).

Participation rights are applicable in both the private and political sphere. Social and political rights to participation thus overlap and intersect in complex ways (Sandland, 2017). Sandland argues that participation rights are concerned with providing conditions in which people with disabilities can autonomously form and pursue their version of the good life.

Whilst protection and provision rights are concerned to secure the conditions of possibility for a good and meaningful life, participation rights in the [UN]CRPD are concerned with living that life, and seek to provide appropriately modified, *person-centred, versions of traditional adult civil and political rights to self-determination and involvement in the polis.* (Sandland, 2017: 93-4).

Increased and enhanced political inclusion for people with mental disabilities can support their autonomous pursuit of the good life in a variety of ways: from therapeutic improvements (Gordon 2006; McCann et al. 2018) increasing a sense of empowerment (Felton and Stickley 2004; Frisby 2001), better knowledge and information (Nilsen et al. 2006), to improved social and economic conditions (Crawford et al. 2002). All these factors can potentially contribute to both political inclusion and person-centred recovery. Inclusion also has institutional and reputational benefits in that it supports satisfaction rates, improves health outcomes and strengthens arguments for recommission (Stringer et al. 2008).

Human rights discourse focused on such outcomes can however be criticised for embracing conceptualisations of the political citizen as consumer and subject (Thomas, 2007). The introduction of rights to political participation reflects general trends towards corporatisation, consumerism and user involvement in mental health (Sandland, 2017). Increased political participation of people with mental disabilities means they are associated more and more with self-serving, individualistic and independent citizenship. This can have benefits as well as drawbacks in the form of re-responsibilisation – i.e. direct accountability for one actions (Tisdall, 2008; Sinclair, 2004).

Participation rights require people in positions of power and authority to respect the agency of subjects of that power, with ‘participation’ requiring more than increased voting and registration rates or tokenistic patient representation in hospital governance. As aspects of the thesis concern educational initiatives applied to better support political capabilities, and data collection includes young adults supported to vote for the first time, debates around Article 24 UNCRPD and the United Nations Convention on the Rights of the Child (UNCRC) can offer useful insights. In the UNCRC children’s participation is understood to aim at providing conditions in which they can develop a sense of self-worth, capacities, and confidence (Sandland, 2017). It is also said to mean *'better outcomes, both for young people and for organisations'* (Kirby et al, 2003: 18). Better participation, in theory, enhances the accountability of institutions, and democracy itself, by creating the conditions in which active members of the community can exercise power in ways that hold those in authority to account. However, participation may be premised in practice on performing the identity of a 'good citizen' and even when autonomous participation is achieved subversive contributions may be readily dismissed. Participation is thus dependent on the participant being a governable subject and recognised as an acceptable member of the polis.

Participation rights are constructed in ways intended to help members of the community '*learn how their views… are taken into account and shape the outcome of [decision making] processes'* (United Nations Committee on the Convention on the Rights of the Child (UNCCRC), 2009, para. 3). This *'should not only be a momentary act, but the starting point for an intense exchange… on the development of policies, programmes and measures in all relevant contexts of [their] lives'* (UNCCRC, 2009, para. 13). Participation rights under the UNCRC appear to require radical changes aiming to empower people from the bottom up. Participation rights under the UNCRPD, as the data will show, are implemented in the same way – as a educational intervention.

The application of participation rights appears to incorporate a multiplicity of aims. Some of these aims are contradictory. As we have seen above participation rights aim at the production of political citizens. Other articles however seek to curtail state influence on the formation of political views. Article 12 of the UNCRPD for example requires undue influence to be policed but at the same time requires capacity to be supported. In mental health practice supportive interventions are under scrutiny for undue influence. This can cause practitioners to distance themselves from the educator role and could conceivably have a chilling effect on political socialisation for people confined in mental institutions.

At this point it may be useful to consider the dichotomy between empowerment and indoctrination in the education through which we seek to empower members of the community to become active political agents. Momanu (2012) traces the etymology of the term indoctrination and shows that the previous meaning of the verb to indoctrinate was: to instruct, to provide someone with knowledge, to teach a science (Robert 1957, 1564). When applied to the anthrogogies of politics and citizenship, which involve socialisation into political ideologies, the term undergoes a process of pejoration. According to Momanu's reading (2012) of Robert, the term has come to denote *a set of principles stated as true that aim to guide or govern people's actions* (Robert, 1957: 1564), and indoctrination thus relates to: "*the attempt to make somebody adhere to a doctrine, an opinion, a point of view*" (*Ibid*). In relation to participatory rights the UNCRPD and the MCA 2005 aim to both impose duties to support people's political inclusion and to impose safeguards against undue influence – a form of indoctrination.

The contradictory aims of participatory rights (to both socialise people into a political system and also empower the individual to pursue their own individual version of the good life), creates difficulties in evaluating policy implementation in the case of Art.29 UNCPRD. Positive support from those in authority can superficially increase political participation but may reduce agency by inculcating closed-minded views. In addition, responsibility for substantive realisation is placed on those in functional authority, in authoritarian institutions, creating a risk of indoctrinating pedagogies being applied in spite of good intentions.

Various models have been developed that can help in this regard (Kirby et al., 2003; Storm & Edwards, 2013; Hart, 1992). The main mechanism by which adults gain opportunities to participate in political and civic life on these perspectives is in casting a ballot. Recovery from mental illness under the patient-centred care, shared decision-making, patient participation and recovery models are also presented as emancipatory. However, voting poses practical and social challenges for people detained in mental health rehabilitation and represents only small possibilities for empowerment in their everyday lives. Political empowerment is not something that is only performed on the small and infrequent stage of the polling station. One of the problems encountered in implementation is that political rights are seen as exclusively about voting.

Sandland argues that the substantiation of participation rights in the mental health context can be understood in terms of the tension between autonomy and benevolence: *participation implies agency and, to some extent at least, constitutes the displacement of benevolence—as well as of… power and authority over populations constructed as incapable.* The construction of power as a resource to be redistributed in the realisation of political rights means that arguments for more and better participation are frequently addressed not to people with disabilities but those charged with their care. In this frame the principal actors are not disabled people themselves but beneficent others (Tisdall, 2008). In the discourse, participation for persons with mental disabilities is seen to be dependent on the cooperation of professionals, carers, family and friends and their 'sharing power' (Storm & Edwards, 2013: 317). It is they who must grant power to those under their care and manage its exercise. Thus, the grating of political participation rights is conceived at inception as a top down exercise of power redistribution rather than a bottom up system of political mobilisation.

Whilst the taking on of responsibility for those apparently not able to represent themselves is potentially justifiable, giving a profession the power to assess the risk of someone's political views being somehow 'ineffective' or 'risky' is a poor starting point for empowerment. Such a system endorses a political environment based on the rules of ownership and appropriation. Rather than power being something which can be owned and exchanged, it may alternatively be understood as something which is exercised on all by all (Sandland, 2017; Foucault, 1983: 220). In applying this to anthrogogies of politics it is useful to consider the educational strategies that might be used to support such autonomy.

Taylor (2017: 47) argues that the open-minded agent is "*broadly motivated to pursue truth and understanding, and is specifically motivated to give due regard to available evidence and argument when forming new beliefs and understandings and when maintaining or revising already established beliefs and understandings".* To develop autonomous political agency service-users must adopt the open-minded motive. This requires intellectual modesty but also the courageous and intellectually diligent pursuit of knowledge. This also requires one to embrace the role of student.

This understanding has several implications for the implementation of rights for political participation. Power and authority are not seen in abstract terms but rather as embedded in educational interaction. Power may be understood in terms of 'actions upon actions' and as characteristic of normal human relations (Sandland, 2017).

Article 12 and 29 of the UNCRPD requires state parties to operate their mental health systems so as to both develop the personality, talents, abilities, and capacities of the service-user to their fullest potential, and to prepare them for responsible life in a free society. The aims of policies of political inclusion require mental health practitioners to teach people to become autonomous political citizens. Political citizenship is associated with a shared worldview and a common vision of good governance. It also involves taking responsibility to be both governable and governed.

The risk of imposing anthrogogies of politics, which understand power in the former sense of ownership, is that people are 're-responsibilised' or forced to be free political agents through top down policy. In this approach freedom can feel very much like coercion. An additional issue for institutions is that the freedoms 'granted' exceed the boundaries of appropriateness imposed on their exercise. The autonomous subject, educated in the mental health rehabilitation to be a political citizen, might exercise this capability to resist a given worldview or version of the good life and cease to be governable by mental health practice. '*There are no relations of power without resistances' and resistance 'exists all the more by being in the same place as power; hence, like power, resistance is multiple'* (Foucault, 1980: 142).

Sandland argues that *'notions of power based on ownership or possession, and which see it as alienable, seem inadequate to capture all the competing and conflicting actions and flows which together constitute the operation of power and resistance in the politicised mental health ward'* (Sandland, 2017: 96). This can limit our ability fully to evaluate the risks and benefits of the implementation of rights to political participation.

1.4. Identifying the Research Topic

Having outlined some issues and dilemmas that arise in direct implementation of participation rights for people with mental disabilities, we can begin to see some of complexities that face practitioners in attempting to positively support political participation in the course of mental health treatment. The presence of these philosophical and practical issues, and a lack of empirical investigation into their consequences, justifies taking frontline implementation as the focus of the empirical field work.

Policy implementation is studied in a wide range of disciplines and according to a variety of epistemological approaches (Hill & Hupe, 2014). Pragmatism is required in choosing the right conceptual tools suited to the context in which empirical work will take place (Saetren, 2005).

As a topic of theoretical and empirical inquiry, the political participation of people with mental disabilities is a field which does not respect disciplinary boundaries. This thesis explores how policies of political inclusion are being implemented in mental health services from a socio-legal perspective. The main focus is on the processes and relations inherent in implementation and understanding them in theoretical terms rather than evaluating them on the basis of therapeutic outcomes or voting and registration rates. However, as the research process progressed participants interrogated and evaluated the policy on their own terms and recommendations were co-constructed. This process of inquiry to some extent becomes circular as it in part seeks to model the phenomenon of participation that it purports to interrogate by encouraging participants to engage in open-minded study of the process of politicisation they engage in.

Implementation of a policy of political inclusion for mental health inpatients is a complex undertaking. Some of the policy outcomes are ambiguous. For example, in person-centred and personalised practice the desired outcomes are idiosyncratic to individual service-users who are motivated to political action and expression for a multitude of different reasons. In addition, service-user, service-provider and regulator expectations diverge, and service provision regularly involves coercive practices occurring alongside liberating intervention. Therefore, to base the current research project on whether certain outcome variables were realised entailed choosing a fixed interpretation of the policy aims. This did not seem reasonable in a research project in which I was keen to foreground the voices of service-users and staff who had a more fluid view of policy aims.

The oscillation between broad and narrow definitions of policy outcome is one of the processes of implementation that this thesis seeks to explore, analyse and explain. I wanted to identify some of the environmental and social variables that influence the performance of those implementing the policy and those subject to it. This helped to explain variation in political opportunities available within the network of individuals at the sites in question.

Implementation theory suggests that performances are heavily influenced by the role a performer plays in the organisation and in inter-organisational relations.

Different rules and roles pertain to different situations and environments (Hill & Hupe, 2014). Thus, a staff member, a ward manager and a service-user may all operate in distinct political environments within the same institutional setting. This backdrop allows us to engage with some of the systemic and organisational variables in policy outcome by exposing some of the influences on institutionally ascribed, and personally (co)constructed roles.

1.5. The Research Questions

The practice of providing positive support for political action raises a number of interesting complexities. How does one enhance and support political participation positively through professional services whilst ensuring that undue influence is not applied to voting decisions? How do service-providers and users manage the 'optics' of such an interaction? How does one provide an unbiased and neutral range of political information to sheltered patients in long term residential rehab wards without risking indoctrination? How does the perceived therapeutic or rehabilitative effect of political participation influence practitioner's assessment of patient capacity and risk? How does one reliably distinguish between appropriate political expression and action in the mental health wards and inappropriate or pathological behaviours?

All these questions expose a fundamental tension in psychiatric practice between the use of power to (a) close down risky and dangerous options in order to protect people from unwise decisions, and (b) to expand the range of options available to members of the community to pursue the good life.

Even larger questions may be raised about what this practice says about the epistemological and ontological roots of the current mental health system and democracy itself. What does it say about our approach to political participation for the general citizenry and what are the implications for electoral democracy?

What does it mean for our understandings of personhood, agency, and mental disability? These are questions that cannot be answered in this thesis, but which must be acknowledged as a backdrop for the chapters to come.

In conducting an exploratory research project based on ethnographic methods it was difficult to pinpoint a specific research question that neatly encompasses the entirety of the project undertaken. In addition, ethnographic work is unsuited to the proposing of a specific hypothesis or research question that is then tested or straightforwardly answered. However, I narrowed my topic of inquiry down to the following set of questions.

How are policies aiming to enhance and increase opportunities for political participation of people with mental disabilities being implemented in residential psychiatric rehabilitation; what barriers or difficulties are encountered in achieving that aim; and how might a policy to enhance political participation be more successfully implemented?

In exploring this broad area of inquiry, I found it useful to identify three subsidiary questions which go beyond description towards more comprehensive understanding and evaluation:

1. *On what basis are such policies being implemented?*
2. *What are the principles that underpin the distinction between appropriate and inappropriate political action and expression for people undergoing psychiatric treatment?*
3. *What are the wider implications of practices of political inclusion being implemented in this way?*

The research questions interact to inform a cyclical process of inquiry that moves from exploration towards explanation and back again (Marshall and Rossman, 2006). The study aims to elucidate the conditions which may better advance the rights of people with mental disabilities to participate in politics on an equal basis with others. Whilst I do not offer any definitive answers in relation to how mental health practitioners might fully substantiate the political rights of psychiatric patients; this thesis demonstrates the complexities of policy implementation and suggests some possible routes to further research and progress.

The thesis makes an original contribution to knowledge by presenting rich empirical observations about political inclusion and participation from three sites of implementation. I thereby generate contextualised understandings of how participation of people with mental disabilities has been interpreted and enacted in the everyday lives of people with mental disabilities. In addition, I contribute theoretical and methodological developments building on Foucault (1980), Goffman (1961; 1974), Butler (1988) and Van der Eijk (2017; 2018).

Through an analysis of three strategically selected cases I show how an incongruence of legal, symbolic and social boundaries, and restrictions on co-construction, role and identity can undermine politically inclusive practice. The institutional requirement to entrench social roles within mental health services indicates that symbolic boundaries are continuously reconstructed between mentally disabled political actors and other members of the community. These boundaries mean that actors may be explicitly restricted from, or not be convinced of the value of, political participation (Kirkegaard & Andersen 2018). I also observe aspects of positive practices that inculcate open-minded political agency and seek to describe and explain these differences in theoretical terms.

1.6. The Scope of the Thesis

The research project is concerned with how we are supporting those detained in residential psychiatric care to participate in public and political life. This focus is born out of a concern that people with significant mental disabilities who are institutionalised by the state should attract greater obligations to make opportunities for inclusion in public and political life available and accessible. This is because significant restrictions on such opportunities are likely created by coercive mental health treatment. In addition, policies to support political participation for people with mental disabilities appear to be mainly located in residential rehabilitation facilities. For these reasons, the project concentrates on people with mental disabilities detained in mental health rehab and not the wider community-based services.

This means that the findings are not generalisable to the wider population of people with mental health challenges. However, the conceptualisation of political action and the theorisation of mental health treatment as a process of civic education are transferable to a wider range of contexts. More research is needed to establish the prevalence of policy and practice in community based mental health services seeking to implement the obligations imposed by Article 29 UNCRPD as well as the way psychiatric and mental impairments, in interaction with social barriers such as discrimination and lack of economic opportunities can impact on political participation. Although this is beyond the scope of the current research project it lays some of the theoretical and methodological groundwork for further study in these areas.

Political inclusion therefore is positioned in the thesis as something that is not only attainable following achievement of good health, educational attainment, employment and the establishment of a settled social and family life but something that all human beings do in the course of their everyday lives in seeking influence over decisions that affect them. Political inclusion is not subordinated to the principles of functional rehabilitation and treatment and the language and assumptions of psychiatric practice are not adopted as the lens through which phenomenon are observed. This has important consequences for the data and analysis in the thesis.

The conscious choice was made to avoid constructing political inclusion as dependent on psychiatric staff 'giving' people with mental health difficulties the opportunity to participate. Although participation whilst in treatment may be dependent on the provision of support and reasonable accommodation for those with significant mental impairments, the assumption that this is broadly the case for mental health service-users is unfounded. Political autonomy is not a binary status (i.e. you have it or you don't) but is a matter of degree and increases and decreases according to cognitive function as well as the support offered, and the opportunities presented, in a given context.

For those service-users with significant impairments, increased implementation of policies of political inclusion can support and enhance their development and recovery. Whether or not they will eventually be able to fully participate in public and political life, even partial participation in the politics of their everyday lives remains a worthy goal and people can be involved whether or not they are 'sick' or 'well'.

It is often very difficult for practitioners to support autonomy whilst seeking to manage difficult and significant behavioural and social problems. However, it is also a form of mis/mal-recognition to justify coercive treatment on the basis that an individual is not properly autonomous. In everyday life, no human being is completely autonomous as freedom is a complex characteristic which is not susceptible to easy measurement. If you increase freedom in one area (for example in relation to political action) then freedom in other spheres may be reduced (e.g. freedom to do what you want on election day). In addition, we often can only achieve an enhanced degree of freedom in action and influence in political decisions through our relationships with others and in carving out a role for ourselves as relevant stakeholders. This requires compromise. We all exercise degrees of autonomy within the physical, economic, social and ethical constraints imposed upon us. The contemporary understanding of autonomy of individuals, originally used in reference to a form of social organisation that foregrounds self-governance, has acquired meanings as diverse as liberty, rights, privacy, individual choice, freedom of will, causing one's own behaviour, and being one's own person (Beauchamp & Childress, 2001).

Differing theoretical perspectives offer a range of interpretations of autonomy, however there is little agreement about the nature, scope, or application of autonomy in the psychiatric setting. Those following Kant argue that autonomy is a "freedom of will" (Kant, 1785/1964, p. 97) and takes absolute priority over other ethical principles. Other theorists define autonomy as the capacity to act rationally and do not imply that autonomy has priority over other principles (Beauchamp & Childress, 2001). These theories have the unfortunate consequence of casting people with mental disabilities as lacking autonomy by linking it with the capacity for rational thought. Mental health diagnosis is often a general determination that an individual is lacking in this capacity for autonomy to some degree.

Some theorists therefore adopt a relational analysis of autonomy that offers a conception of autonomy that is more nuanced. Relational autonomy introduces the idea that people are embedded socially and that one's identity is moulded through social relationships and an intricate intersection of gender, race, ethnicity, age, class and health status (Sherwin, 1998 & 2000; MacKenzie and Stoljar, 2000). People can be both constrained by the pragmatics of their ascribed and chosen roles, but this also allows them greater freedoms in other spheres of action. Autonomy is a quality that people possess in variable degrees according to context and social position. It is constantly in flux and not only a characteristic of the individual but of their social situation. An example is that adopting the mental health patient role can restrict a person's freedom of movement and choice in relation to medication, so restricts autonomy in the personal sphere, but could provide access to education, social support and a community of peers that provide opportunities for political action and influence in the public sphere.

On the other side of this coin many people ascribed the role of mental health patient engaging in political action may find that they are dismissed as irrational in both the personal and public spheres. Their worldviews are readily denigrated as fantastical and their proposed solutions as unrealistic. It is clear that the distinction between appropriate and inappropriate political action, within psychiatric rehabilitation, presents significant difficulties for mental health nurses and other psychiatric professions and has wider implications in how residents of such institutions engage in the public sphere. The principles on which this distinction is made require clarification and this is done in the concluding chapter of the thesis.

There are a number of key limitations to the present study and a number of avenues of inquiry that were bracketed off. These limitations should be highlighted, and the areas excluded brought back to light to enable readers to evaluate the quality of findings and identify the areas ripe for further research. Because the practical implementation of policies of political inclusion is relatively rare in England the number of sites and participants was very small. This means that by design the research was contextual and the findings therefore obviously not statistically generalisable. It is also the case that, while I think it would be an extremely fruitful exercise to seek to apply my conclusions beyond the contexts studied, great care and sensitivity would be needed to take full account of the uniqueness of any new sites.

Problems of access and recruitment were overcome by allowing NHS trusts and the private service-provider to self-select participants. This meant that only one responsible clinician (and a rather radical one at that) was involved in the study at the consultation stage. The practice of responsible clinicians in the application of policies of political inclusion is important to consider in further research. In addition, the absence of mental health advocacy in the process of politicisation may be another avenue of inquiry to pursue in the future.

The research was based to some extent on the assumption that greater participation of persons with mental disabilities in politics would be of benefit for themselves, mental health services and for society generally. The research therefore became focused on the benefits of inclusion and participation and how to best implement these principles.

One of the main issues in designing the research method was in finding an appropriate conceptualisation of politics to define the phenomenon under study and to select appropriate research sites. In choosing to adopt a very broad definition of politics (Van der Eijk's aspect definition) I had a conceptual indicator which allowed identification of appropriate practices to study, but that was not so narrow as to exclude the social meanings attributed to politics by the participants themselves. This allowed me to conduct an ethnographic inquiry without imposing a narrow and dogmatic understanding of what politics was in interview and observation. I am however aware that the debate around the nature of politics and power is deep and extensive and that I have only been able to touch the surface.

An appreciative inquiry approach was adopted which meant that the critical edge of the data collection may have been compromised to some extent. In consultation I also perhaps got too close to staff participants and became somewhat of a staff insider. This temporary adoption of staff perspectives, in developing resources and reforming policies at the research sites may have diminished the ability to perceive the negative aspects of policy and implementation. Moving away from this perspective and re-establishing a more balanced view was achieved by withdrawing somewhat from the process of policy reform in the institutions and extensive consultation with service-user participants. I then had to withdraw from these relationships too in order to concentrate on writing up the thesis. I have attempted to convey the diverse perspectives of participants as accurately as possible given the multiple levels of interpretation that occur in the process.

The thesis only considers people with mental illnesses detained in mental health rehabilitation and not the wider community-based services which may be more proactive in this area. This is largely because the barriers to participation are likely to be much more acute in residential services and therefore more accommodation is required in these settings under the UNCRPD principles to equalise opportunities.

Further limitations result from the choice of research questions. The thesis concentrates on exploring examples of positive practice due to issues with gaining access to institutions less proud of their initiatives in this area. I therefore do not present any evidence on what is happening in services less keen on implementing policies of political inclusion. Broader surveys and access to a wider range of institutions is required to present generalisable results. However, many of the findings and insights may be readily transferable to similar contexts so long as careful attention is paid to the similarities and differences between settings. I do not present as much data as I would like on supportive practices for political participation outside of elections either. As we will see, those who are not eligible to vote were often excluded from the remit of the formal policies (but not from Art.29) and so this was a practical restriction rather than one explicitly chosen.

As participating institutions were responsible for recruitment to the research project for reasons related to the assessment of capacity to consent those who were ineligible to vote are not represented in the data collected either. This is because these individuals were not considered beneficiaries of the policies in question by service-providers. This assumption is discussed and criticised in the thesis and recommendations are presented that seek to ameliorate these issues. Broader surveys and research are required so a fuller range of cases and participants can be studied.

The research questions do not seek to test hypothesis relating to the theoretical framework developed. The theoretical framework developed emerged inductively from the data and was an outcome as well as a foundation for theoretical development in the later stages of the project. Therefore, the methods and methodologies were used as a tool for exploration of the diverse issues and dilemmas that practice presents. This in turn was used as a basis for hypothesis generation rather than testing. Despite some minor misgivings we can say with confidence a number of useful insights have been gleaned from the research process.

1.7. Reference Key

Policy documents are referenced by the title of the document the site number and the date when the policy was drafted (e.g. - Voting Rights and Procedure for Inpatients, Site 1, July 2016).

The references to interviews include the site where the data was gathered, the transcript number, the date and the role of the individual in question – (e.g. Site 1, Transcript 1, 2017, WM). Roles are referenced using the following abbreviations:

MHN – Mental Health Nurse

OT - Occupational Therapist

RC – Responsible Clinician

SALT – Speech and Language Therapist

SMHN – Senior Mental Health Nurse

SU – Service-user

SW – Social Worker

WM – Ward Manger

The observation notes are referenced similarly including the site, title of the document and the date at which observation occurred – (e.g. Site 1, Observation Notes, 2017). Consultations with participants to discuss findings and recommendations are referenced by the site, consultation, the date and the role of the individual I talked to – (e.g. Site 2, Consultation, 2018, RC). The research journal is referenced simply by the date at which the entry was made – (Research Journal, Jan 1st 2018)

1.8. Structure of the Thesis

In this introductory chapter I have provided an overview of the topic by looking at trends emerging from the literature relating to political participation. I have also explained the research focus and posed some questions to be explored throughout the thesis.

In the following introductory chapters I elucidate the law and policies on political inclusion of people with mental disabilities (Chapter 2) and present the conceptual framework developed on the basis of the data (Chapter 3). This framework is used as a machine of thought to generate deep understandings of how policy implementation proceeds. I then discuss the context and pragmatics of mental health institutions (Chapter 4) and the methods used to collect data in these settings (Chapter 5).

Armed with knowledge of the law, concepts for analysing processes of politicisation as both a rehabilitative and educational technology, and thorough contextualisation of the setting in which implementation proceeds we move onto description and analysis of how political participation is facilitated and scaffolded in the everyday life of three mental health rehabilitation facilities (Chapters 6-9). I conclude the thesis with a discussion of the benefits, issues and dilemmas that arise from this practice and present my findings, principles and recommendations developed collaboratively with service-users and providers (Chapter 10).

Chapter 2

2. Law and Policy on Participation of Persons with Disabilities in Political and Civic Life

2.1. Introduction

The purpose of this chapter is to elucidate the current legal and policy context from which specific institutional policies spring. It aims to give an account of the wider political, legal, and ethical environments in which current policies of political inclusion are nested. I do this by outlining:

1. The legal restrictions on political participation for people with mental disabilities found in the common law of capacity, the Mental Health Act 1959 and 1983, and in the Representation of the People Act 1983.
2. The distinction between supported and best interests' decisions derived from the Mental Capacity Act 2005.
3. The positive duties to support and enhance political participation for people with mental disabilities derived from the UNCRPD and other International conventions.
4. The safeguards in place to restrict undue influence and indoctrination.

2.2. The Mental Health Act

In previous centuries, even if someone qualified for the franchise based on strict property ownership requirements, those who were deemed to lack mental capacity were deprived of their right to vote. Even when the franchise was extended to a broader range of the population, restrictions on mentally disabled people's ability to participate in elections were practically restricted. Persons with mental disabilities who were institutionalised were prevented from participating in elections due to the exclusion of '*any establishment maintained wholly or mainly for persons suffering from mental disorder'* from being a legitimate place of residence for registration purposes (Representation of the People Act 1929 s.2(3)). The detachment of mentally disabled people from their homes and the added bureaucracy imposed have long been identified as restrictions on political rights (Hale, 1976: 173-5).

There were also traditionally restrictions on the ability of persons with mental disabilities to hold public office. The MHA 1959 created a procedure for ejecting Members of Parliament from the House of Commons on the basis of mental incapacity that results in compulsory detention for over 6 months (MHA 1959 s.137). The Act also made some provision for the removal of barriers to other forms of political participation. Medical institutions and their staff were prohibited from withholding patient mail addressed to Parliamentarians as well as other privileged communication such as that with the court and the hospital administration (MHA 1959 s.36(2)). It therefore appears that some limited opportunities for political action and expression of opinions remained open to inpatients of psychiatric hospitals during this time.

By the 1970s the mental health system and discourses of mental health had changed. Anti-psychiatry, partly in response to the failures and abuses of the old asylum system, was gaining popular sympathy (Laing, 1967). Legislative reform was proposed to update the legal framework to reflect these developments. The

MHA 1959 was also criticised by practitioners for failing to provide a clear process by which mental health practitioners could coercively impose treatment on patients with the mental capacity to refuse.

Studies of institutionalization by Goffman (1961) and Wing & Brown (1970) highlighted the poor quality of life of mental inpatients creating a political and social movement towards community care. In 1961, Enoch Powell gave his renowned ‘water tower’ speech in support of the dissolution of the asylums, and in 1962, the Hospital Plan for England and Wales predicted the closure of half of all mental health beds by 1975 (Ministry of Health, 1962).

Policy makers began to accept the arguments that a new legal framework was required to better regulate the compulsory treatment of mentally disabled people and to better protect their civil and political rights. The Mental Health Act 1983 (MHA 1983) emerged from this reform agenda armed with a new updated nomenclature. This reflected the changing discourse around human rights for people with disabilities. The language of lunatics and idiots was replaced by definitions of mental disorder, impairment and psychopathy.

Under the MHA 1983 persons can compulsorily detained either for treatment or assessment under sections 2 and 3. Thus a range of legal powers is granted to responsible clinicians to treat in absence of consent, and the wide discretion to make sovereign declarations of necessity relating to the need for treatment or assessment, is regulated by law. In order for a person to vote whilst detained under the MHA 1983 they must be able to register. To visit a polling station, service-users also require leave from hospital under s.17. Leave should be planned in advance and agreed in consultation with all relevant persons included in the patient’s care and treatment. Responsible clinicians can also make leave subject to any condition, which he or she considers necessary in the interests of the patient or for the protection of other people.

Significant restrictions on opportunities for political inclusion and participation are created by the law, policy and practices that regulate coercive mental health treatment in the UK. These restrictions are something that appear in various degrees around the world and represent a major stumbling block for practitioners seeking to substantiate the rights underpinning the UNCRPD.

2.3. The Representation of the People Act

Under the Representation of the People Act (RPA) 1983 a person is eligible to vote if he or she:

a. is registered in the register of parliamentary electors for that constituency;
b. is not subject to any legal incapacity to vote (age apart);
c. is either a Commonwealth citizen or a citizen of the Republic of Ireland; and
d. is of voting age (that is, 18 years or over).

Here 'legal incapacity' refers to exclusion from the franchise based on the common law of mental capacity or exclusion based on rules governing the disenfranchisement of convicted offenders (Rees & Reed, 2016). However, the term 'incapacity' can be readily interpreted in practice to refer to mental incapacity under the Mental Capacity Act 2005 discussed later in this chapter.

Compulsory patients deemed to lack capacity are, under the RPA regulations still able to register to vote, but this process is often dependent on family members and cohabitants remembering to put them on the form when it arrives at previous residence as well as being granted leave to return to the constituency or organising a postal vote. Attending a polling station may be logistically difficult if treatment facilities are far from the service-user's home.

There are also potential problems with registering and voting for people detained in mental health facilities that could arise from a failure, in practice, to keep up with patient transfers.

Prior to the amendments to the RPA 1983 in 2000, during the period of twelve months prior to the qualifying date, mental health patients could make a declaration of local connection only if he or she could do so without assistance (unless this was required because of blindness or some other physical incapacity). Therefore, mental incapacity could have been a practical disqualifier for making the declaration. The declaration procedure required inpatients to make a declaration as to their place of residence at the hospital without reasonable accommodation of mental disability. The address of the hospital and the address of the residence they would reside in if not in hospital (or any address in the UK where she or he had previously resided) was required as well as age and citizenship status. People receiving treatment in hospital for mental health challenges could alternatively apply to the registration officer for an absent vote if it could be shown to the officer's satisfaction that the applicant's circumstances were such that he could not reasonably be expected to vote in person (RPA 1985 s.7(1)).

The RPA 1983 was amended in 2000 to change the rule that accommodations of mental capacity should not be made (RPA 1983 7B(2)). Under current law assistance can and should be provided in the declaration processes. After 2000 the eligibility criteria remained the same, but a distinction was drawn between offenders who were detained under the MHA 1983 and convicted persons detained in penal institutions who were to be wholly disenfranchised. Persons prohibited from registering and voting by the RPA 1983 s.3A(1), (2) include only those:

i. detained under s.37, 38, 22, 25A, 27, or 51(5)[1] [MHA 1983];

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[1] i.e. *'Where a person is convicted before the Crown Court of an offence punishable with imprisonment other than an offence the sentence for which is fixed by law, or is convicted by a magistrates' court of an offence punishable on summary conviction with imprisonment, and the person is suffering mental disorder' – MHA 1983*

ii. subject to provisions under the Criminal Procedure (Insanity) Act 1962 and equivalent judgements made by the Court of Appeal (Criminal Division);

iii. or would so be detained if he were not unlawfully at large

Although these prohibitions are potentially justifiable and legitimate in individual circumstances under the European Convention of Human Rights (ECHR) Protocol 1 art.3 (i.e. proportionate), it was decided by the European Court of Human Rights (ECtHR) that such blanket prohibitions on the right to vote may be disproportionate in Hirst v United Kingdom (2006, 22 EHRR 21).

Patients remanded to hospital under sections 35 or 36 under the MHA 1983 or remanded prisoners transferred to hospital (s.28) remain eligible. If those on remand are detained for a length of time significant enough to be regarded as resident at the hospital they can register at the hospital (RPA 1983 s.7A(2), (6)(b) & (c)). This residence rule applies to informal and compulsory patients who are not subject to the criminal diversion procedures outlined above (RPA 1983 s.7(1), (2)). Non-offender informal and compulsory patients may be registered as either in the hospital or somewhere else so long as they can be considered resident there or made a Declaration of Local Connection under ss.7(5), 7A(5)).

Although the reformed registration procedures make voting more accessible for people with mental disabilities, there may remain in practice numerous administrative hurdles, and practical restrictions for inpatients to surmount before being registered and able to vote as there were under the previous regime (Hale, 1976). Although the Declaration of Local Connection no longer requires people with mental disabilities to make the declaration without assistance (RPA 1983 7B(2) the first two policies discussed in Chapter 6 will show that in making declarations of local connection, assistance may remain restricted long after the RPA 2000 changed the law in this regard.

Practical 'hang-ups' from the previous legal regime may remain so long as there is little legal or professional guidance available to practitioners and service-users in accommodating political rights. Guidance and examples of good practice should be more widely available so that perceived or manufactured incapacity for political action or in registering to vote can no longer used to justify exclusion of people with mental disabilities from public and political life.

2.4. The Mental Capacity Act

The Mental Capacity Act 2005 (MHC 2005) codifies, adapts and exists alongside various common law elements of capacity law and policy. Where there is overlap, the provisions contained in the Mental Capacity Act 2005 were intended to be subordinate to the procedures set out in the Mental Health Act 1983 (HL Deb, 25 Jan 2005 Column 1247).

A threshold was created by MHC 2005 to guide practitioners more closely in substitute decision making. The threshold of capacity at which supported decision making is triggered is contextually dependent and incorporates duties to support people in ways that allow them to reach the requisite thresholds in each area.

To be regarded in law as lacking capacity to make *a particular* decision a person must be assessed as unable to: understand the decision; retain the information; weigh and assess the relevant information; and communicate their decision (MCA 2005 s.3). If a person is incapable of making a decision then mental health practitioners are required to support capacity to do so and, if this cannot be achieved, to make that decision themselves in his or her best interests.

The MCA 2005 s.4 requires that in determining what is in a person's best interests, the person making the determination must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him. Donnelly (2009) shows that although frequently applied in practice, the best interests standard is often treated as if its application requires no more than general good will on the part of the decision-maker.

The Act specifically excludes the decision of who to vote for in an election from being subject to replacement decisions on the basis of best interests (MCA s.29). This does not exclude people deemed not to have the decision-making capacity to vote from being supported and facilitated to reach a higher threshold of capacity however. It means that if that threshold cannot be reached a replacement decision cannot legally be made. The Code of Practice points out that no one may vote on behalf of a person who lacks the capacity to do so (Department of Constitutional Affairs, 2007). When the MCA 2005 was first introduced, service-users on civil detention under the MHA 1983 were not subject to any blanket restriction on voting rights. However, mental incapacity to vote could be still be used as a justification for exclusion from public and political life under the common law. This potentially conferred legitimacy on decisions by practitioners to exclude people from positive support to participate in elections on the basis of mental capacity as defined under the Act and this may have become an established ritual in practice around elections. The doubt and lack of recognition implied by the imposition of a capacity assessment in relation to voting also potentially represents a symbolic restriction on the performance of political identities for service-users.

Although capacity assessment of political competencies may be permissible to determine what support and accommodation is required in individual cases, how political capacities are to be fairly assessed, and what the legal consequences of such assessments are remains uncertain. In addition, the potential dangers of mis/mal-recognition of individuals as incapable of political thought and action inherent in assessment procedures should also be highlighted as they could create rational reasons for disengagement with political support practices.

Capacity assessment may in theory still be applied to check whether incapacities are present, and to determine what support is required, but can also constitute an unnecessary and demotivating process that some service-users may consider inappropriate. It could reflect that mistaken belief that people with mental disabilities are by definition incapable of exercising political agency.

Taylor (2015) has argued that although considerable efforts have been made to improve training in how to use the MCA persistent gaps in practitioner knowledge are evident. Willner et al (2011) for example show that although a majority of staff have undertaken MCA training, those who had been trained had the same level of understanding as those who had not. Principled and consistent application is lacking even within specialist staff such as learning disability psychiatrists (Sawhney et al, 2009). Further guidance and training in application of the MCA, including how it applies to supporting political participation, is required (Alonzi et al, 2009).

2.5. The Electoral Administration Act

The earliest example of the common law of capacity in England is the De Prerogativa Regis 1322 or the Royal Prerogative (Andrews et al, 1997: Ch. 8; Baly, 1995; Fry, 1864; McGlynn, 2003 and 2005; Wright & Digby, 1996). The common law, up until 2006, essentially meant that 'persons of unsound mind', could in theory be excluded from voting and standing in elections. Capacity depended on how far an individual understood:

"*in broad terms what he is doing and the effects of doing it (i.e. choosing his representative in Parliament, for no one can appreciate all the effects of a particular voting decision)*" (Hale, 1976: 173-5)

Just prior to the UNCRPD being ratified in the UK, Lord Rix tabled an amendment to the Electoral Administration Act (EAA) 2006 which abolished the common law rule of legal incapacity as an eligibility criterion to register and vote in elections. In doing so he argued that:

> *'Incapacity is an important concept in the law around disabled people's decision making... Yet it has a different meaning in electoral law, for it means legal disqualification from voting, rather than a physical or mental condition which makes voting difficult. For the purposes of this Bill, it seems best to avoid suggestions that disabled people have any kind of incapacity... The changes I propose are of great symbolic and practical importance to people with a learning disability and to other disabled people'* – Lord Rix (HL Deb, 15 May 2006 Column 122)

The EAA 2006 was intended to do away with any vestiges of the common law power to disqualify electors on grounds of mental incapacity. This means assessing capacity to vote should only be permissible if used to identify if, and what, support is required for supported decision making. Even in these circumstances the imposition of capacity assessments could institutionalise a form of mis/mal-recognition of mentally disabled people's political expression and create rational reasons for self-exclusion. Replacement decisions cannot be made in relation to voting and there are various restrictions on undue influence that practitioners must consider. In this way voting decisions are designated a special legal status (alongside decisions as to sex, marriage and permanent medical operations) that requires the agency of the individual to be exercised.

Agency, rather than benevolence, must be prioritised in supporting access to the political field. However, agency does not imply absolute freedom from constraint in thought and action. Whilst all persons with mental disabilities should have an equal right to participate in political and civic life average members of the community are not free to adopt and pursue change anything that they choose.

We all must negotiate contexts, rituals and roles that cast certain actions and expressions as in/appropriate.

Lord Rix, in advocating for the abolition of the common law of capacity, was not arguing that all members of the community should have complete freedom in the formation and pursuit of political worldviews. He merely took aim at the legal language of mental incapacity (particularly the terms ‘idiot’ and ‘lunatic’) as well as the legal disenfranchisement of persons with mental disabilities. The purpose of the abolition of the common law was therefore to discourage the assumption that persons with disabilities should be disqualified from voting:

“existing case law governing people's legal capacity to vote specifically states that "idiots" cannot vote, while "lunatics" can vote only during their lucid moments. [T]his… has important symbolic and practical effects. The symbolic effect is to say to people with learning disabilities and mental health problems that calling them idiots and lunatics is acceptable… The practical effect is that, even today, it is widely and mistakenly believed that people with a learning disability or mental health problems do not possess that most basic of rights in a democracy—the right to vote and have a say in who represents them and governs the country. (HL Deb, 13 Feb 2006: Column 1028)

The EEA 2006 removes a symbol of prejudice and exclusion from the common law, and provides positive recognition that disabled people retain political rights whatever their mental capacity. The EAA 2006 therefore symbolically recognises the enduring political citizenship of persons with mental disabilities. The reform is also of practical importance. The legal presumption of legitimacy for disabled people’s political expression and action explicitly prohibits psychiatric institutions from restricting voting rights on the basis of mental incapacity.

2.6. UN Declaration and The European Convention of Human Rights

The changes in British electoral law documented in previous sections were intended to enhance and support political rights for people with disabilities. These developments were in part a response to international human rights law and the momentum generated by increased participation of minority groups in the political process of drafting these treaties. The Universal Declaration of Human Rights (UDHR) 1948 constructs political inclusion in transparent and open elections as a primary method of driving the establishment, implementation and enforcement of the rights contained. The right to participatory government is therefore of particular importance. The UDHR Article 21 states: *Everyone has the right to take part in the government of his/her country, directly or through freely chosen representatives. The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret ballot or by equivalent free voting procedures.*

The European Convention for the Protection of Human Rights introduced in 1950 and enshrined under Protocol 1, Art 3 (1952) established the right to free and fair elections (although not a specific right to vote) and the right to non-discrimination in the application of ECHR rights on the grounds of protected characteristics. Therefore a lack of positve state support for people treated in mental health rehab to participate in politics was increasingly recognised as discrimnatory.

The principle of non-discrimination in the ECHR jurisprudence was quite limited in the sense that it was infrequently applied and mostly in relation to other articles of the convention. In addition discrimination on the basis of physical or mental disability is consigned to the category of ‘other status’ and had to be infered into the intention of the article. *Glor v Switzerland (13444/04, Unreported April 30, 2009 ECHR, Grand Chamber)* indicates a shift in such limited interpretations and confirms discrimination on the bassi of disability falls within the articles scope. According to this ruling non-discrimination encompasses not only direct discrimination but also discrimination that is indirect or covert. The Glor ruling also indicates that the UNCRPD provisions will directly influence the ECtHR's interpretation of ECHR rights when considering disability discrimination cases (Stravert, 2010).

The right to free and fair elections in the ECHR is not absolute and may be restricted in certain cases. In the case of *W.X.Y.Z. v. Belgium (1975) 2D.R.E.Comm. HR. 110* it was decided by the ECtHR that certain limited groups, and specifically prisoners, could be excluded from elections but that such exclusions could not be arbitrary nor disproportionate. In *Hirst v the United Kingdom (No 2) 74025/01 (2005) ECHR 681* the ECtHR demonstrates how the right to vote is viewed as a privilege that may be revoked on the basis of breach of the social contract.

Citizens can be lawfully disenfranchised, in the ECHR jurisprudence, if this is proportionate and necessary to maintain a fair and representative democracy. On this basis the UK government, until the EAA 2006 restricted voting rights for persons presumed to be incapable of making independent voting decisions (on the basis they are underage or are mental disabled), and those who forfeit some of their civic rights by engaging in criminal behaviour warranting custodial sentences (thus seriously breaching the 'social contract').

This indicates that the principles underpinning political rights in international law have historically been based on ideas of democracy that are inherently exclusive. The Rawlsian idea that only rational citizens should be included in political decisions about the governance of social relations and the nature of society may provide ready philosophical justifications for exclusion of people with mental disabilities. Political inclusion is often seen as a privilege to be earned.

This privilege may be rescinded under the ECHR in order to protect a ‘fair and representative democracy’.

2.7. The United Nations Convention of the Rights of Persons with Disabilities

The role that political inclusion plays in ensuring respect for human rights is enshrined in the Universal Declaration of Human Rights (1948), the European Convention for the Protection of Human Rights (1950), the International Covenant on Civil and Political Rights (1966), the Convention on the Rights of the Child (1989) and many other international human rights documents. The most important for our purposes is however the UNCRPD (2006).

The UNCRPD catalysed and/or confirmed a series of significant changes in English electoral law and represents a paradigm shift away from “medicalised” approaches towards a “social model of disability” in the protection of rights for disabled people (Bartlett, 2014). In a medicalised approach disability is considered primarily a result of physical or mental impairment. Conversely the social model defines disability by the social restrictions that, in interaction with impairment, cause exclusion.

The introduction of the UNCRPD codifies a general shift in mental health discourse over the last few decades away from practices aiming at functional rehabilitation towards recovery based on patient’s conception of the good life (Burns, 2009). In theory both best interests and agency should be supported by mental health services. As we saw in Chapter 1 however, benevolence and agency in this context are prima facie irreconcilable aims if we understand them as embodying a hard distinction between constraint and freedom.

The UK ratified the UNCRPD in 2009. Ratification of the optional protocol by the UK also means that individuals can complain directly to the UNCRPD Committee. The Committee also periodically may make interpretations of the meaning of particular Articles of the Convention.

The Convention on the Rights of Persons with Disabilities adopts the approach that persons with disabilities are not a homogenous group. They are, similar to the population of any country, individuals who are diverse in needs, interests, desires and abilities. Many countries internationally have election law which restricts the right of persons with mental health disabilities to vote. This is a violation of the principles of international human rights law, including the Convention on the Rights of Persons with Disabilities, which take an approach whereby human rights are not dependent on a person's ability to exercise them.

The Convention on the Rights of Persons with Disabilities recognises the right to vote, and in order to equalize the rights for persons with disabilities, places an obligation upon the State to provide assistance to a person with disabilities who wants to vote and needs some help in doing so. Moreover, the Convention calls for equality and non-discrimination in Article 15. Any ban on the right to vote applied to all persons with restricted or limited legal capacity constitutes discrimination on the basis of disability.

The UNCRPD Committee (CCRPD), in general comments, view all persons as requiring support to be free and autonomous. The intention was to break down the distinction in law between 'able' and 'disabled'. This requires a radical reformulation of the law, policy and practice relating to the rights of people with disabilities (Mégret; 2008).

The model embedded in the UNCRPD, requires that practitioners working with persons with mental disabilities give due respect to their '*inherent dignity, individual autonomy… and independence'*. (CCRPD, 2014, para. 4). In short, the UNCRPD requires practitioners to support *'full and effective participation and inclusion in society; respect for difference and acceptance of persons with disabilities as part of human diversity and humanity; equality of opportunity; accessibility… respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.'* (Ibid)

According to the UNCRPD Committee "*Full and effective participation" (art. 3 (c)) in society refers to engaging with all persons, including persons with disabilities, to provide for a sense of belonging to and being part of society. This includes being encouraged and receiving appropriate support, including peer support and support to participate in society, and being free from stigma and feeling safe and respected when expressing oneself in public. [Such inclusion] can also be a transformative tool for social change and promote agency and empowerment of individuals.* (Committee on the Rights of Persons With Disabilities, 2018)

Adult citizens with mental disabilities thus attract a wide variety of rights and/or responsibilities to be included on an equal basis with others in civic and political life and reasonable accommodations must be made to support the exercise of such rights. "Reasonable accommodation" means necessary and appropriate modification and adjustment to ensure persons with disabilities can enjoy, on an equal basis with others, all human rights and fundamental freedoms (UNCRPD, 2006: art. 2). Such reasonable accommodations should not impose a disproportionate or undue burden on public services. In many cases proactive and positive support is needed to ensure opportunities are available and rights are substantiated.

Although the UK Government defines mental disability narrowly under the Equality Act 2010 (requiring a mental health condition to last at least 12 months[2]) the UNCRPD does not define it exhaustively. The chair of the committee drafting the UNCRPD proposed that there be no definition because of the risk that groups

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[2] https://www.gov.uk/definition-of-disability-under-equality-act-2010

would be inadvertently excluded, but the disabled people's organisations present wanted a definition to ensure that states could not adopt unduly narrow interpretations (Bartlett, 2014 and 2012; UNCRPD, 2006: art. 1)

Articles 4, 8, 12, 19, 21, 22, 24, 29 and 33 (Appendix 1) of the UNCRPD are all relevant to State obligations to support persons with mental disabilities to participate in public and political life. This set of rights require states to provide a variety of reasonable accommodations to people with disabilities in exercising their political agency and legal capacity on an equal basis with others.

The central right in the UNCRPD for the purposes of this thesis is contained in Article 29. Article 29 is the right to equal opportunities to participate in political and public life. It guarantees "*to persons with disabilities political rights and the opportunity to enjoy them on an equal basis with others*". In order to achieve this goal, the Article goes on to list specific obligations placed on State Parties to *ensure that persons with disabilities can effectively and fully participate in political and public life on an equal basis with others, directly or through freely chosen representatives, including the right and opportunity for persons with disabilities to vote and be elected, inter alia, by:*

(i) Ensuring that voting procedures, facilities and materials are appropriate, accessible and easy to understand and use;

(ii) Protecting the right of persons with disabilities to vote by secret ballot in elections and public referendums without intimidation, and to stand for elections, to effectively hold office and perform all public functions at all levels of government, facilitating the use of assistive and new technologies where appropriate;

(iii) Guaranteeing the free expression of the will of persons with disabilities as electors and to this end, where necessary, at their request, allowing assistance in voting by a person of their own choice.

There is limited guidance from the UNCRPD Committee in interpreting the duty and how it should be implemented. In short:

“a person’s decision-making ability cannot be a justification for any exclusion of persons with disabilities from exercising their political rights, including the right to vote, the right to stand for election and the right to serve as a member of a jury. States parties have an obligation to protect and promote the right of persons with disabilities to access the support of their choice in voting by secret ballot, and to participate in all elections and referendums without discrimination. The Committee further recommends that States parties guarantee the right of persons with disabilities to stand for election, to hold office effectively and to perform all public functions at all levels of government, with reasonable accommodation and support, where desired, in the exercise of their legal capacity.“ (CCRPD, 2014, para. 48-9).

Around the world many UNCRPD signatories still restrict voting rights on the basis of cognitive disability and mental illness, either directly on the basis of mental capacity or indirectly on the basis of guardianship or detention in hospital (Barclay 2013). Even in countries like the United Kingdom, where mental capacity is no longer a restriction on the right to vote, the behaviour of mental health professionals, family and peers, and of political parties can restrict opportunities for people to meaningfully engaging in public and political life (ibid). In addition those detained in mental health hospitals following criminal conviction can face more extensive sentences than would be served by those without mental disabilities as so face exclusion from the political process for much longer than criminals without mental health challenges.

The European Union has produced two substantial reports on the implementation of the right to political participation for people with mental disabilities. The authors, as with the member states they study, principally interpret Article 29 as requiring that persons with disabilities retain, and can practically exercise, their right to vote.

The latest and most substantial report finds that 'given an accessible and enabling environment, persons with disabilities are active citizens keen to be engaged in the political life of their communities.' Political activity is defined broadly and includes membership of political parties, attending political meetings and contacting elected officials.

Their analysis shows that in the majority of EU Member States, a lack of legal capacity automatically excludes many people with mental disabilities from the franchise. Such restrictions, being directly based on a disability, or a proxy such as assessed 'capacity', contravene the principles of the UNCRPD as interpreted by the CRPD Committee.

In many Member States, procedures for persons with disabilities to request support or assistance to vote are inaccessible and implementation of Article 29 has not provided a mandate to deconstruct these restrictive processes. For people living in institutions disenfranchisement can be caused by the lack of reasonable accommodation and support. When the right to political inclusion on an equal basis with others is not realised there are frequently no obvious routes to redress.

The UK Initial State Reports (CCRPD, 2011; CCRPD, 2017), in reviewing implementation concentrated almost exclusively on numbers of disabled people who are elected representatives and party support for disabled candidates. It is also, as with the vast majority of other state reports from jurisdictions around the world, primarily concerned with accommodation of physical disability. This reflects a narrow interpretation of public and political life as primarily relevant to persons with physical disabilities having the opportunity to cast a ballot in elections.

The state reports from other jurisdictions do shed some light on the Committees interpretation of how Article 29 may be interpreted and implemented by States in relation to persons with mental disabilities. The initial report on the Netherlands notes that:

To safeguard voting by secret ballot without intimidation, as provided for in Article 29(a)(ii), and to ensure the principle of one vote per person, the Kingdom of the Netherlands declares that it will interpret the term ‘assistance’ in Article 29(a)(iii) as assistance only to be effected outside the voting booth, except with regard to assistance required due to a physical disability, in which case assistance may also be permitted inside the voting booth.

Consequently, assistance to persons with mental disabilities in casting a ballot can, in principle, only be provided outside the voting booth. By way of an exception, the Elections Act does permit assistance in the voting booth for voters with physical disabilities. Here the Government of the Netherlands is grappling with the issue of what they term ‘undesirable influencing’. Permitting assistance to persons with mental disabilities inside polling booths, they argue would no longer guarantee that the vote cast actually corresponds to the will of the voter. This is problematic in the sense that it may result in some persons with mental disabilities who want and request assistance in the voting booth, for example those who are unable to read the ballot paper or suffer from anxiety that they will make an error, being functionally excluded.

This endorses the view that assistance in polling booths of persons with physical disabilities can be regarded as not jeopardising the independence of voting, but rather exclusively support the action itself (Committee on the Rights of Persons with Disabilities, 2019a). This seems to be a controversial assumption being based on such a broad and general distinction to make in practice.

The example of illiteracy demonstrates the issue with making a hard distinction between ‘supporting the action itself’ and scaffolding some of the mental capacities behind the act of voting.

The reporters here seem to assume that mental disability automatically means that an individual is vulnerable to undue or ‘undesirable’ influence. This is problematic. As we shall see in further chapters this can be the case, but should not be assumed as a general rule. Many people with mental health challenges are very well equipped to defend themselves from ballot tampering and would be able to identify and make complaints perfectly competently. In addition, the distinction between undesirable and desirable influence in political education is exceptionally difficult for practitioners to make. ‘Normal’ citizens are deemed to be capable of engaging with politically influential discourse without being determined by it and the same respect should be extended to persons with mental disabilities.

Some states have used the argument that people with mental disabilities are uniquely susceptible to undue influence to justify their exclusion from the political process altogether. Hong Kong’s report states that:

A person may only be disqualified from voting if he/she is found by the Court as incapable, by reason of mental incapacity, of managing his or her affairs… This arrangement is to ensure the fairness of the election through reducing the risk of a voter being subject to undue influence or manipulation. (Committee on the Rights of Persons with Disabilities, 2019b).

Other states simply avoid this thorny issue altogether. The state report for New Zealand includes reference to the production of easy read voting instructions for those with learning and intellectual disabilities but does not make any reference to those detained in mental health hospitals with other types of mental health challenges (Committee on the Rights of Persons with Disabilities, 2013).

In addition to Article 29 the right to inclusive education (Art. 24), the right to legal capacity (Art. 12) and the obligation of States parties to consult and actively involve persons with disabilities in UNCRPD implementation (art. 4 (3)) are relevant. The participation of persons with disabilities in the monitoring process (art. 33 (3)) is also relevant to building a wider concept of participation in public and political life based on UNCRPD principles. The articles mentioned, together mean something more than a responsibility to support participation in electoral politics. Taking Article 29 on its own is not enough to understand rights to participation in public and political life and a broader definition of political participation is needed. Careful consideration of what constitutes appropriate support in practical term is also needed.

Article 12 requires persons with mental disabilities to be seen as citizens capable of holding rights and responsibilities. Restricting access to political participation for people found to lack capacity, via an inappropriate conflation of legal and mental capacity, is therefore a violation of convention principles (CCRPD, 2014, para. 15). This is viewed by the CCRPD as discrimination and a violation of the participation rights of disabled persons (CCRPD, 2014, paras. 13, 45).

Legal capacity and mental capacity are distinguished by the CCRPD. Legal capacity refers to a person's capacity to hold rights and responsibilities and to exercise them. Mental capacity refers to the cognitive abilities to make decisions. Article 12 is seen as a prohibiting the use of capacity tests applied on the basis of disability (Sandland 2017). Substitute decision making is relegated to a measure of last resort, if appropriate at all (CCRPD, 2014, para. 13).

The debates around the UNCRPD reflect a general endorsement of the approach taken by the CCRPD (Arstein-Kerslake & Flynn, 2016). However scholars such as Sandland (2017) and Richardson (2012), identify a contradiction: Articles 12(1)–(3) require all persons to be recognised as having legal capacity, but Article 12(4) suggests an inherent vulnerability to manipulation for people with mental disabilities and seeks to safeguard them by reintroducing substitute decision making procedures where necessary.

Although substitute decision making on the basis of mental incapacity appears to contradict UNCRPD principles, article 12(4) requires state parties to provide '*appropriate and effective safeguards to prevent abuse'* when supporting legal capacity, and permits substituted decisions to be made '*Where, after significant efforts have been made, it is not practicable to determine the will and preferences of an individual'.* (CCRPD, 2014, para. 21). Under the MCA 2005 voting decisions are excluded from these processes and this means that some individuals, even if their will and preferences in relation to voting were clear prior to losing mental capacity, may be deprived of the opportunity to participate in elections via proxy votes.

The UNCRPD therefore requires states to make reasonable accommodations to ensure that people with mental disabilities can exercise their right to participate in public and political life on an equal basis with others. The UNCRPD Committee's interpretation of how this should be implemented is limited and has not reived much thought or attention. In their reports States concentrate on removal of legal barriers for persons with physical disabilities, accessible voting guides for persons with intellectual or learning disabilities and use the concept of undesirable influence to avoid the need to grapple with the thorny issue of reasonably accommodating those with mental illness. Political support for people with mental disabilities is often presented as posing a risk of 'undesirable influence' and this may undermine the substantiation of UNCRPD rights in practice.

2.8. Undue Influence and Treatment

As we have seen the UNCRPD in Article 12 requires safeguards to be put in place to prevent abuse of power in supporting decision making capacities. The prohibition of treatment and undue influence in the Representation of the People Act 1983 are an example of such safeguards. The criminal offence of treating a voter for the purpose of enticing her to vote or influencing their voting choice could potentially apply in the case where mental health practitioners encourage inpatients to vote by relaxing sanctions or offering inducements (RPA 1983, s.112). Undue influence is perhaps also a legal constraint on the types of positive support that are appropriate. The RPA 1983 states that:

'*A person shall be guilty of undue influence… if he, directly or indirectly… makes use of or threatens to make use of any force, violence or restraint, or inflicts or threatens to inflict… any temporal or spiritual injury, damage, harm or loss upon or against any person in order to induce or compel that person to vote or refrain from voting… [or] if, by abduction, duress or any fraudulent device or contrivance, he impedes or prevents, or intends to impede or prevent, the free exercise of the franchise of an elector or proxy for an elector, or so compels, induces or prevails upon, or intends so to compel, induce or prevail upon, an elector or proxy for an elector either to vote or to refrain from voting.'* (RPA 1983, s.115)

This clause potentially captures a wide range of behaviour. However, the offence has a relatively high threshold of evidence to establish wrongdoing (Rehman v Khan [2015] EWHC 2168). The concept of harm could readily include practices in mental health facilities intended to encourage or discourage certain voting choices, including the choice whether or not to vote. Threatening to write a negative health report about an involuntary inpatient who refuses to vote (that equates non-participation with poor mental health) could potentially be construed as threatening spiritual damage in court. These are the serious dilemmas practitioners face in managing access to political participation.

If a ballot is cast on the basis of undue influence it is a criminal offence and may be investigated by the police. There are high evidential thresholds and the police generally will only investigate accusations based on the threat of physical force

(College of Policing, 2017). In alleged cases of undue influence, the police are advised to consider the 'political motivation' of the complainant (*Ibid*). The police therefore set a high evidential threshold to establish claims. It is very unlikely that a ballot would be rendered void even if undue influence is established in a particular case. Isolated instances will not usually affect an overall result and judges are likely reluctant to invalidate an election result.

The law is somewhat vague on the matter of undue influence in these circumstances and the Electoral Commission made clear in a consultation response in October 2018, that the law of undue influence requires greater clarity and a revised and more clearly defined offence should be drafted (Electoral Commission, 2018). In later chapters I show that these safeguards and the consequent fear of being accused of undue influence inhibits some practitioners from engaging as equal political citizens with the ser-vice users in their care.

In addition to the apparent legal constraints on the positive support for political participation in the law of undue influence, a range of other factors may affect the exercise of political rights for people treated in residential mental health facilities. These factors might include risk aversion, poor awareness of political rights, a culture of detached professionalism and even stigmatising attitudes towards people with mental disabilities. (Sayce, 2016 p.131)

Positive and engaging support for inpatients of psychiatric institutions may be needed to fulfil positive legal obligations to support equal opportunities for political participation. It is not clear where the line between undue influence and positive and engaging support should be drawn however.

The danger of drafting specific provisions in electoral law for persons with mental health conditions is that undue influence may be policed more rigorously for psychiatric inpatients compared to the general population. This may already be the case due to the assumption that people with mental disabilities are more vulnerable to manipulation. A restrictive system of surveillance that makes participation less attractive does little to support political agency and can restrict politicisation. Psychiatric staff and families of service-users who feel monitored, and self-censure their opinions to avoid accusations of criminal activity when supporting the right to vote, may be unengaging and overly cautious in engaging in political discourse with psychiatric inpatients.

The concept of ‘autonomy’ is vital in the implementation of political rights under Article 29. In engaging political actions and expressions, a person should, in principle, be able to pursue their own conception of the good life and act on their own will and preferences. In the context of a political system in democratic societies however, influence is widespread, and it is not feasible to ask practitioners to constantly police an individual’s exposure and become an arbiter of ‘undesirable’ or ‘desirable’ influence. Freedom and autonomy may often function as a convenient fiction that justify a lack of adequate support and reasonable accommodations.

2.9. Discussion

In outlining the law and policy of political participation for people with disabilities, and approaches to implementation in a variety of different jurisdictions, I have shown by reference to the literature that a number of issues and dilemmas arise when implementation is pursued within medicalised environments and institutions.

In the UK mental incapacity is no longer a legal justification to prevent someone with mental disabilities from voting. The RPA 2000 and the EAA 2006 abolish any vestiges of the common law rules of incapacity to vote and so the right to vote is no longer linked to mental disability or mental capacity although the criterion of ‘legal capacity’ remains. This has the potential to be misinterpreted by psychiatric practitioners as equivalent to mental capacity.

Mental health practitioners retain powers to deny a person permission to go to the polling station on polling day, by refusing MHA 1983 s.17 leave or even by restricting positive support for registration and declarations of local connection. People with mental illness or learning disability may therefore still be prevented from voting indirectly through restricted access to information and by closing down opportunities for politicisation.

The MCA 2005 excludes voting decisions from replacement decision making procedures. It also creates a mental capacity test which, if applied to capabilities to engage in politics, may present rational reasons for disengaging for fear of being subject to such scrutiny and mis/mal-recognition.

Positive support is therefore required to level the playing field, however concerns over the susceptibility of people with 'mental illnesses' to undue influence can provide justifications for a non-committal approach. Discrimination on the basis of protected characteristics is prohibited under both UK and international law (HRA 1998, EA 2010, UNCRPD). However, failure to provide reasonable accommodation in this area carries little consequence and can be justified by reference to lack of autonomy if the general assumption of vulnerability to political manipulation is maintained. Such general and blanket assumptions about people with mental disabilities are unwarranted and potentially discriminatory.

The principles underpinning political rights in international law have historically been based on ideas of democracy that are inherently exclusive. The Rawlsian idea that only rational citizens should be included in political decisions about the governance of social relations and the nature of society may provide ready philosophical justifications for exclusion of people with mental disabilities (Rawls, 1971). Political inclusion is often seen as a privilege to be earned. This privilege may be rescinded under the ECHR in order to protect a 'fair and representative democracy'.

The UNCRPD by contrast unequivocally requires states to make reasonable accommodations to ensure that people with mental disabilities can exercise their right to participate in public and political life on an equal basis with others. The UNCRPD Committee's interpretation of how this should be implemented is limited but in their general comments appear to adopt a wide interpretation. States discuss the removal of legal barriers for persons with physical disabilities, accessible voting guides for persons with intellectual or learning disabilities in state reports. Some use the concept of undesirable influence to avoid the need to grapple with the thorny issue of reasonably accommodating those with mental illness. Political support for people with mental disabilities is often presented as posing a risk of 'undesirable influence' and this may undermine the substantiation of UNCRPD rights in practice.

The concept of ‘autonomy’ is vital in the implementation of political rights under Article 29. In engaging political actions and expressions, a person should, in principle, be able to pursue their own conception of the good life and act on their own will and preferences. In the context of a political system in democratic societies however, influence is widespread, and it is not feasible to ask practitioners to constantly police an individual’s exposure and become an arbiter of ‘undesirable’ or ‘desirable’ influence. Freedom and autonomy may often function as a convenient fiction that justify a lack of adequate support and reasonable accommodation for those in mental health hospitals.

Although the general shift away from benevolent rehabilitation and towards agency-based recovery is a positive step, notions of both rehabilitation and recovery may also be applied in a legalistic way that ultimately disempowers.

Support may thus be premised on stigmatising assumptions. People may be asked to make choices without the freedom, understanding or guidance necessary to make informed autonomous choices (Dzeng et al. 2015). In addition, promotion of political inclusion in the course of coercive mental health treatment may prove difficult for staff who have to manage the optics of such interactions to allay concerns of manipulation and undue influence. There is a potential conflict of interests in allowing practitioners to choose whether and who to support to participate in politics and what types of political issues to promote and discuss. This raises a number of complexities in implementation.

There are a number of contradictory principles and duties inherent in the provision of positive support for political participation:

i. The legal requirement not to deny, and to positively facilitate, political engagement versus the duty of care to avoid real risk.
ii. The tension between facilitation and support (which necessarily implies education and curating information for vulnerable persons) and the duty not to influence or manipulate.

In addition, a choice to not exercise the right to vote is as legitimate and worthy of respect as the right to vote and so the policy of supporting participation rights does not have any clear and measurable outcome. We should not be tempted to take numbers of users voting or not voting as a criterion of success. It should also be borne in mind that voting is only one method of political participation that is relatively infrequent in the everyday lives of citizens. There are numerous other opportunities to engage in public and political life that do not rely on registration and visiting a polling station so even those who do not have the right to vote should attract obligations and reasonable accommodations under the UNCRPD.

These issues are a direct result of legislative, institutional, and cultural context in which there are irreconcilable contradictions between the advancement of patient-directed recovery. The institutional context has traditionally served to contain, normalise and rehabilitate so implementation in medicalised environments raises the issue of undue influence, indoctrination and alienation. These themes will be further developed in later chapters

2.10. Conclusions

In this chapter I described the formation and nature of the current law and policy and applied it to the political participation of inpatients in mental health hospitals in Britain. The legal restrictions on political participation in the common law of capacity the Mental Health Acts 1959; 1983, and the Representation of the People Act 1983 have been abolished and replaced by positive duties to support and enhance political participation for people with mental disabilities. The rights of persons with mental disabilities to participate in political and civic life is broad and premised on a philosophy of individually enforceable right. A number of safeguards have also been imposed to restrict undue influence and indoctrination in the process of supporting political participation.

Under British law capacity to vote and participate in other aspects of public and political life is assumed for members of the community detained in mental health institutions, whether formally or informally. Capacity assessment, if at all applicable to political views and action, is thus relegated to an articulation of what is needed in terms of support to enable individuals to exercise their rights.

Significant restrictions on opportunities for political inclusion and participation are however still possible under the law, policy and practices that regulate coercive mental health treatment in the UK. These restrictions are something that appear in various degrees around the world and represent a major stumbling block for practitioners seeking to substantiate the rights underpinning the UNCRPD.

Citizens can be lawfully disenfranchised, in the ECHR jurisprudence, if this is proportionate and necessary to maintain a fair and representative democracy. On this basis the UK government, until the EAA 2006 restricted voting rights for persons presumed to be incapable of making independent voting decisions (on the basis they are underage or are mental disabled), and those who forfeit some of their civic rights by engaging in criminal behaviour warranting custodial sentences (thus seriously breaching the ‘social contract’).

The EEA 2006 removes a symbol of prejudice and exclusion from the common law and provides positive recognition that disabled people retain political rights whatever their mental capacity. The EAA 2006 therefore symbolically recognises the enduring political citizenship of persons with mental disabilities. The reform is also of practical importance. The legal presumption of legitimacy for disabled people’s political expression and action explicitly prohibits psychiatric institutions from directly restricting voting rights on the basis of mental incapacity.

In the next chapter I move on to outline theoretical and practical approaches inductively developed to answer the question of how the policy of positively supporting political participation is implemented on the ground in mental health institutions. This provides a basis for a more detailed understanding of the way these laws and policies are playing out in the everyday lives of people with mental disabilities.

Chapter 3

3. Theoretical Approaches to Studying Political Participation in Psychiatric Facilities

3.1. Introduction

In this chapter I provide working definitions of political participation as a form of expressive and agential performance and elucidate the social pragmatics in which interactions are labelled as having political characteristics. I suggest theoretical approaches (by no means exhaustive) that may be adopted to theorise the practice of political inclusion in mental health institutions. I use Goffmanian dramaturgy and Butlerian theory of performativity and identity co-construction to aid understanding in these respects.

Prior to data collection I was working primarily with political theories of mobilisation based on individual resources and characteristics (Rosenstone and Hansen, 1993) and the capabilities approach developed by Nussbaum (2011) and Sen (1993). However, after engaging with the fieldwork it became increasingly clear that other theoretical frameworks were required to grasp the phenomenon under study in all their complexity. This chapter presents this conceptual framework. The framework is an outcome of the project largely studied and developed after field work on the basis of emergent themes in the data. Theoretical perspectives derived from the literature were adapted and combined in new ways and applied to novel contexts. This was an iterative process whereby the data presented a number of issues and dilemmas and the literature was then used as a machine of thought to understand these in theoretical terms. I then went back to the data and applied theoretical understandings to the issues arising. This prompted certain adaptations of theory.

In this chapter I first set out two definitions of politics used throughout the thesis. It is important to understand for the purpose of the analysis that I talk about facilitation of politics in both the small-p and big-P senses of the term. Secondly, I outline key concepts used in deconstructing the process of policy implementation. These concepts flow inductively out of the empirical work but also dovetail with existing theory and literature. The empirical work described later is enlightened by the theoretical work presented here and vice versa. For example, the data demonstrates practical applications, modifications and challenges to previously abstract conceptualisations of political identity construction and politicisation in social performance.

3.2. Defining Politics

Politics in western democracies is a concept derived from deep roots in the philosophies of ancient Greece (Whitehead, 1929). Plato believed that political capacity was exercised in the process by which people seek to attain the truth and to use this truth for the rational and virtuous ordering of human affairs. Plato believed that conflicting interests can be harmonized in the political process. Politics on this view is ultimately a question of deciding what is just through ethical dialogue. The best, rational and righteous, political order, according to

Plato, leads to a harmonious unity of society and allows each of its parts to flourish, but not at the expense of others (Plato, 2000: 331d-335a).

According to Plato, Socrates critiqued these democratic principles and argued that politics is not principally about the exercise of democratic freedom through participation in forming and administering the state (Mara 1997: 107-9). He argued that politics is rather about achieving *arête* or excellence in individual lives. Therefore, politics is generally about nourishing good and virtuous human beings (*Ibid*).

Aristotle built on, and critiqued Plato's understanding of politics. He similarly described a process through which human societies produce and enact ideas about the ideal constitution of human affairs. In addition, he defines citizens as persons who participate in forging constitutions of State and in administering that State once constituted. He argued that citizenship will vary according to the constitution and that therefore the search for universal characteristics of citizenship is misguided.

Aristotle significantly introduced the idea that politics is an inherent aspect of human interaction (Aristotle, 1982: 59 1253a1). He emphasised political participation as having intrinsic value for participants themselves (Kymlicka 2002; Oldfield 1990: 6). Failure to participate, according to this view, renders a person '*radically incomplete and stunted'* (Oldfield 1990: 187). Politics on this view is a process by which societies are constituted and participation is a valuable and unique aspect of human life without which we become bestial and savage.

These ancient ideas form a contradictory historical basis for contemporary conceptualisations of politics. These debates are still ongoing. It is assumed by many contemporary theorists, in the Socratic tradition, that politics is primarily a means of achieving a satisfactory private life rather than participation being an end in itself (Kymlicka 2002: 295). Where Plato and Aristotle promoted the sacrifice of private liberty to promote political life, modern political theorists most frequently view politics as a means to protect enjoyment of private lives so long as this doesn't infringe the liberty of others (Ignatieff 1989; Mead 1986; Rawls 1971; Elshtain 1981).

For centuries, ideas about politics and democracy have been interpreted and implemented in multifarious and contradictory ways and no single definition has been sufficient to capture everything that the term politics refers to (Van der Eijk, 2017). This leads us to the argument that politics and citizenship are themselves essentially contested concepts (Gallie, 1955: 169) to be forged through political action and performance.

Van der Eijk argues that: *The common element in the multitude of attempts to clarify what politics entails are insufficient to arrive at a fully encompassing and universally agreed definition* (Van der Eijk, 2017: 13). Politics is thus a complex concept that derives its meaning from multiple components in open social systems. No single operationalised measure of political participation would be able to capture the many reasonable interpretations of the concept.

Contemporary definitions of politics, according to Van der Eijk, can be categorised into two groups; definitions that rely on identifying an institutionalised political sphere associated with government, governance and public administration. At any given moment in time there is a certain domain or sphere which you can say that is governmental affairs and whatever happens there is political. Definitions based in this tradition are henceforth referred to as domain, or big-P, Politics. A second type of definition relies on identifying specific processes in handling, and attempting to resolve conflict, relevant to a community as a whole. This category of definitions may be referred to as aspect, or small-p, politics (Van der Eijk, 2017).

Below I consider the pros and cons of using domain or aspect definitions.

3.2.1. Domain Politics

The domain perspective proposes that politics is exclusively related to a specific context of organisations, institutions, and actors. Politics, on this view, is to be found in particular domains or spheres of action. The domain is usually referred to as government, public administration, or the public sphere. This is the more prevalent ‘everyday’ definition of politics (Van der Eijk, 2017: 5).

The domain perspective locates politics in the sphere of the state and state actors in public institutions. The mental health system, as a state provided service, is arguably such an institution. It is publicly funded and the subject of much governmental law and policy. Mental health professionals may be seen, at least partially, as agents of the state acting to protect citizens from themselves and from the consequences of mental distress. In this context clinicians effectively make sovereign decision as to the suspension of normal rights and responsibilities on the basis of necessity and place citizens in the sphere of mental health law. On the domain perspective this is implementation of political decisions rather than a political process in itself. It is a form of governance.

In the practice of mental health treatment, a particular version of the ‘good life’ is advocated for and perceived to be legitimately imposed upon people with mental disabilities. These practices socialise individuals to internalise beliefs about themselves and the world and the mechanisms by which change is affected. Individual rather than systemic change is recommended. These worldviews inform behaviour by presenting particular roles and actions as natural and others as inappropriate and illegitimate. When these behaviours and beliefs are reinforced and internalised political identities are shaped and pushed towards certain expressive outlets. Mental health treatment educates service-users into a set of political norms. The anthrogogy of politics applied is clothed in a scientific epistemology with the good life redefined as ‘good mental health’. This serves to naturalise political and ethical worldviews.

The domain perspective implies that actors in contexts outside the political sphere cannot act politically. Because mental health treatment is defined as a technocratic space outside of the domain of politics, actors within this space are treated as apolitical until they visit the ballot box. A division is made between matters to be dealt with politically and those to be dealt with on the basis of other decision-making processes.

Politics and the achievement of the good life (*bios)* may be viewed as a democratic space that accords equal importance to each citizens perspectives and opinions. Bare life (or *zoê)* may be viewed as a technocratic space to be dealt with using principles of necessity, or epistemologies that require scientific evidence and/or expertise. Such distinctions draw a line between the public and private spheres which are difficult to reconcile with the systems of participatory rights currently in place.

As I show in subsequent chapters, mental health service-providers are public actors intervening in the private lives of citizens on the basis of perceived necessity and in this process a version of the 'good life' is applied as a definition of mental good-health often through a didactic and authoritarian educative practice. In residential mental health institutions, the bare essentials of social life, i.e. being alive and minimal functioning in the community, are indicators of the good life and can become reified as an embodiment of the good life (*bios).* In many cases the socialisation into ways of ethical living is necessary and positive. However, the paramountcy in this process of psy-professionals applying such processes alongside mental health treatment may be less justifiable. This is because (as I will later argue) political anthrogogy in mental health rehab often seeks to impose a conception of the good life on people who are categorised as incapable of defending and implementing their own interests.

In conclusion domain politics is one of the more prevalent interpretations of what politics consists of but is far too narrow to include all the things that the

UNCRPD is intended to encompass in Art.29. In addition, the mental health system, in implementing policies of political inclusion, has the power to define the field of legitimate political action in ways that restrict opportunities.

3.2.2. Aspect Politics

Aspect definitions rely on identifying common characteristics in processes of handling or resolving conflict. On this view, politics occurs both inside and outside of 'political' institutions. Proponents argue that political behaviour is observable in all aspects of human interaction. The claim is that not everything is political, but that politics is everywhere. Dahl identifies the aspect that defines political behaviour as a persistent pattern of human interaction that involves, to a significant extent, power, rule or authority (Dahl, 1998). Lasswell and Kaplan similarly argue that the central focus of political analysis is on processes that influence the exercise of power whatever the domain (Lasswell & Kaplan 1950). Schattschneider argues that *conflict* is the key process through which power is shaped, associated with certain roles and exercised in a *language of conflict (*Schattschneider, 1960: 1–2). Van der Eijk argues that both conflict and cooperation are equally important. *Conflict is inevitable, and so is cooperation. Together they constitute the basis of politics.* (Van der Eijk, 2017: 27)

Van der Eijk concludes that aspect politics may be defined as the handling and resolution of conflict on matters that must be settled for the community as a whole (Van der Eijk, 2017: 19). The concept of community is a flexible one which may be applied to both small- and large-scale groups bound together by proximity, common institutions and shared social rituals. As we will see later, residential mental health services often form a relatively bounded community and various processes of conflict and cooperation occur between and within the staff and service-user teams. Mental health treatment involves the exercise of coercive power, staff monopoly of discretion to interpret rules, and the authority to apply and make new rules based on necessity. The practices of political participation in elections are interesting therefore because they do not adhere to, and in fact contradict, this mode of governance.

The interactions studied in the field work occur in totalising institutions (Goffman 1961: 15-22; MacKenzie & Porter, 2019). These are institutions that function by separating the components of individuality in ways that tend towards the dispersal of 'individuals' across the whole social field, often in conflictual and contradictory ways. For example, the mental health patient role may be internalised and/or reified by actors as natural rather than political whilst in election cycles patents are encouraged to adopt the role of political citizen.

Van der Eijk's aspect definition of politics allows service-user action and expression to be interpreted as political across various social fields. Using this perspective, we can perceive processes of politicisation in the everyday life of the institution and not exclusively in relation to support to access the vote. In a methodological sense we can also perceive the differences in how participants define the boundaries of the political sphere. Although voting and registration rates are important, they are far from satisfactory indicators of political participation and inclusion more generally. Aspect politics is a broader definition that encompasses the wide range of behaviours that Article 29 is intended to cover. It is therefore a more appropriate working definition to use for the purposes of this research project.

3.2.3. The Definition of Politics

How one defines politics determines what counts as political participation. In mental health law policy and practice, definitional power is claimed by mental health professionals. In this study, political action in domain politics *and* aspect politics are of interest. How implementers define politics is of practical significance in that it effects the uptake of opportunities for political action. This is relevant in answering the research questions posed in Chapter 1.

As aspect politics is broad and encompasses both big-P Politics and small-p politics, I adopt this as the working definition. Therefore, political action is defined as the handling and resolution of conflict on matters that must be settled for the community as a whole whether this process occurs in elections, political institutions or elsewhere (Van der Eijk, 2017: 19).

3.3. Key Concepts

In this section, I consider issues of power, governmentality, democracy and ethics within the context of a mental health rehab ward by adopting an analytical style and conceptual language developed by Goffman (1961; 1963; 1969a; 1969b; 1971; 1974), combining this with Butlerian ideas of co-construction of political identity, agency and ethical worldviews (Butler 1988, 1990, 1993, 1997, 2005 and 2006) and then applying key questions of political analysis provided by Van der Eijk (2017; 2018). In this way I seek to build a set of concepts that allows me to describe the processes of politicisation that were observed and discussed in field work and to convey the richness of human experience. This allows us to understand participants experiences as they described processes of playing at and becoming political citizens and how this is supported through educational practice.

Dramaturgical analysis is premised on the idea that social acts are ‘staged’, whether intentionally or not, and therefore may be fruitfully analysed as theatrical performances. Goffman (1959), used theatrical enactment as a metaphor to understand processes in everyday life and thus “*social life can be understood as a series of performances*” (Brissett and Edgley, 1990: p. 36). According to Hare and

Benford (2015) applying the theatre metaphor focusses analysis on how people perform in collaboration and conflict, and project social roles, in everyday social interaction. In this tradition, dramaturgists such as Burke (1968, 1969) reject the application of dramaturgy as '*mere metaphor'*. Proponents of this approach contend that 'life is but a stage'. In other words, theatrical performance portrays all the elements of ordinary social life. Thus, concepts used in theatre production can used in the production and analysis of the social behaviour more generally.

Even without choosing between these ontological positions, dramaturgical analysis illuminates how people construct reality (Berger and Luckmann, 1966) and sustain role, meaning and narrative (Goffman, 1983). As Edgley argues '*stripped to its essentials, dramaturgy is about the ways in which human beings, in concert with similarly situated others, create meaning in their lives*' (2013: p. 2). This shared understanding of role and common worldview, provides interactants with a shared set of assumptions which act as a foundation on which individual and communal narratives can be build.

In my view, there are important differences between theatrical performances and the dramaturgical performances in everyday life analysed in this thesis. In theatre, there is a clear and sustained distinction between actors and audiences in which audience direction and production of the performance is supressed. By contrast, in everyday life such boundaries are more unstable. One is, in any given interaction, intermittently both actor and audience. In addition, an important audience in everyday action is oneself. A person can, even during performance, be a critical or accepting audience based on the perception of ones 'true' or inner self. I do not mean to argue here that there is in fact a true self which provides a basis for evaluating the authenticity of one's performance but merely to point out that performance has multiple intended audiences one of which is one's internal *sense of self*. Proceeding from this general sociological perspective, I lay out in the following sections the conceptual tools developed to analyse the data following the field work.

3.3.1. The Nature of the Ritual Order

Before discussing Goffman’s conception of the ritual order, Bourdieu's theories of the cultural construction of social hierarchies and power are useful to consider. The concepts of capital, habitus and field are important backdrop to the development of a ritual order. Capital refers to all kinds of resources which allow a person to gain status within a social field and thereby to exercise more power relative to others (Bourdieu 1986). Different types of capital may be distinguished: Cultural capital (knowledge), economic capital (command of resources) and social capital (a network of social relationships of mutual cooperation and recognition) (*Ibid).* Political capital may refer to types of cultural, economic and social capitals relevant to the exercise of power in relations of conflict and cooperating on matters relevant for the community. This allows us to analyse discourse aiming to produce and represent its own importance and credibility in the political field (Bourdieu 1992).

Habitus is similar to what Goffman called the ritual order. Habitus is the performance of culture i.e. the socially constructed rituals of thinking, being and acting, that are associated with particular groups, classes or institutions and which are repeated and subverted by individuals in interaction (Bourdieu 1977, 1990a: 52 - 65, 1990b: 63 and Reay et al. 2001).

The notion of ‘fields’ refers to aspects of social interaction that are structured according to articulated rules of interaction or pragmatics (Bourdieu, 1993). Social fields are characterized by struggles for hierarchy and positive face. They are competitive in that agents compete for the resources and seek to co-construct positive identities with one another and for external audiences (Warde, 2004). The ‘rules’ of engagement may be co-constructed in immediate interaction, codified in a constitution or contained in ritualised orders of interaction (Bourdieu 1990b).

Playing the game well may involve playing by the rules or attempting to subvert them. The power to construct worldviews and realities is symbolic and is distributed according to perceived capabilities for perception and evaluation (Bourdieu, 1992). The arbitration between legitimate and illegitimate participation incorporates conflict and cooperation, on the basis of political capital, in the process of constructing reality (Bourdieu, 1992; 1993; 1996).

The ritual order of an institution is, according to Goffman, a set of social pragmatics pertaining to a particular set of actors, in a particular place and time. Inappropriate conduct is defined as action that breaches pragmatics pertaining to the individual and his place.

In looking at how people interact with ritual orders Goffman argues that we do not engage in rational strategies to enhance our status on the basis of a clear understanding of the current state of play and our position in it. Rather a man might:

'*[insulate] himself by blindness, half-truths, illusions and rationalisations. He makes an adjustment by convincing himself with the tactful support of his intimate circle, that he is what he wants to be and that he would not do to gain his ends what others have done to gain theirs. And as for society, if the person is willing to be subject to informal social control – if he is willing to find out from hints and tactful cues what his place is, and keep it, - then there will be no objection to his furnishing his place at his own discretion…* (Goffman, 1969b, 34).

Therefore, Goffman's *ritual order* is much more specific than Bourdieu's habitus. It is about assimilating a person into an existing social organisation and/or maintaining a place and status inferred from, or ascribed by, their social milieu. It is a mechanism whereby people are rendered governable subjects and is protective of a person's currently ascribed identity:

'To protect this shelter [a person] does not have to work hard, or join a group, or compete with anybody; [a person] needs only to be careful about expressed judgements [they] place [themselves] in a position to witness. Some situations and acts and persons will have to be avoided; others, less threatening, must not be pressed too far. Social life is an uncluttered, orderly thing because the person voluntarily stays away from the places and topics and times where [they are] not wanted and where [they] might be disparaged for going' – (Goffman, 1969: 35)

In the empirical analysis it will be important to consider whether the ritual order of the rehabilitation unit implies to service-users that political environments are places that they 'might be disparaged' for going. If politics is out of bounds for people with mental disabilities, then service-users may very well become complicit in this exclusion to save face and to gain credits in the psychiatric pathway. Likewise, recognition by those in authority, for both service-users and providers, may depend on avoiding political discourse. The structure of the ritual order may mean there is much to be gained from avoiding political identities for both service-users and providers. *"Tortured learning may be associated… with tortured performance of what is learned…" (*Goffman 1963: 21). "*At the same time minor failings or incidental impropriety may… be interpreted as a direct expression of his stigmatised differentness."* (Goffman 1963: 26)

Strauss et al. (1963; Strauss 1985) argue that the hospital is not a fixed object, but a set of relationships that produce the structure that influences interactions (Nugus, 2019). These relationships inform patients' care pathways and the ethical environment in which they develop new roles and identities. Nugus (2019), building on Strauss states that without a comprehensive overview of perspectives, policies, procedures, networks and relationships '*no one knows what the hospital 'is' on any given day'* and it is therefore *'continually being established, renewed, reviewed, revoked [and] revised'* (Strauss et al. 1963: 164 as quoted in Nugus 2019). This means that the rules of appropriate conduct are continually reconstructed and can cause confusion and anxiety if they are destabilised by political praxis.

However, '*organisations are not in a permanent state of flux…[they] are more or less stable at particular points in time'* (Allen 2000: 331) and established hierarchies of mental health hospitals appear to achieve remarkable stability despite this continual reconstruction. Furthermore, collective work practices and institutionally ascribed identities influence, to an extent, individual behaviour (Berger and Luckmann 1967; Carmel 2006). Nugus (2019) argues that institutional power and stability stems from '*specialised knowledge of inpatient doctors'* and is reinforced by formal organisational boundaries.

Institutional power, and by extension political agency, is excercised disproportionately by health professionals, according to a 'dominant institutional logic' that is 'reinforced and routinised in interaction' (Nugus 2019; Scott 1987). Power can be both a dominative and a co-constructed response to service-users voice and the claim to better represent the patient voice and interest can be used by staff to accumulate political capital in relation to other professions (Nugus 2019: 380; Salhani and Coulter, 2009). On this basis the ritual order is not necessarily restrictive of political action but simply provides a systemic framework which directs it and defines it in ways that advance institutional aims.

Goffman argues the ritual order is not premised on principles of participation or justice in social relations but on the principle of maintaining face in the exchange of communications. People who breach or subvert the ritual order in some way, are not always subject to negative sanctions because such breaches may be by-passed, misunderstood or tactfully conveyed. Subversion may also have the effect of changing the ritual order itself.

The main principle of the ritual order is not justice but face, and what the [persons breaching the ritual order] receives is not what he deserves but what will sustain for the moment the line to which he has committed himself". (Goffman, 2005: 44)

Actors in interaction build a context based ritual order by participating in a mutually reinforcing drama of interpersonal interaction. It is the sum of these interpersonal interactions, relating themselves to an imagined ritual order, which can reinforce the benefits of taking particular lines. Members of a community or institution are mobilised to act in accordance with certain lines, roles and faces, in order that they be self-regulating participants in social interaction and that pragmatics of ‘appropriate conduct’ be maintained. The exercise of institutional power and political agency is therefore dependent on service-users colluding in this performance.

I present arguments in later chapters that the way that mental health institutions sustain boundaries of appropriateness based on psychiatric understandings of mentally healthy ways of being (i.e. the ‘good life’). The definition of reality and the drivers of change are thus constructed as the preserve of a few powerful actors with specialised knowledge.

The regulating forces of reputation and maintaining face are compromised by the spoiled identities implied by the institutional ascription of patient identities which are then reified and internalised (Goffman, 1963). The mental health discourse and the ritual order of psychiatric services potentially teaches service-users to be less aware of decisions relating to line and face as they are often told their behaviour is determined by mental illness. At the same time mistakes in performance of line and face gain a special significance and become the focus of interventions. Practitioner decisions relating to line and face are by contrast defined as treatment decisions based on objective observation. Service-users may be taught that the feelings they have attached to their idea of self are potentially erroneous and caused by ‘illness’. They therefore can be socialised in ways that reduce opportunities to perform honourable, dignified, and authoritative identities and be recognised as legitimately inhabiting appropriate political roles. Forms of recognition, necessary for political agency, expression and influence in political and civic life to flourish, are therefore restricted:

The general capacity to be bound by moral rules may well belong to the individual but the particular set of rules which transforms him into a human being derives from requirements established in the ritual organisation of social encounters. (Goffman, 2005, 36)

The negotiation aspects of Strauss' (1963; 1985) theory of organisational structure are useful in understanding Goffman's ritual order and the organisational structure. Strauss' understanding of negotiated orders emphasises the variety and fluidity of influences on individual behaviour. Any ritual order depends on negotiation, and orders change over time due to dynamics of conflict and cooperation (Strauss 1978). Participation in co-constructing ritual orders can therefore help develop political capacities while exclusion can internalise depoliticising tendencies. Yet, ritual orders have relatively stable boundaries. The significance of stable boundaries is that, although they are continually reconstructed, they have concrete consequences (Strauss, 1985).

The ritual order of an institution is, according to Goffman, a set of social pragmatics pertaining to a particular set of actors, in a particular place and time. Inappropriate conduct is defined as action that breaches pragmatics pertaining to the individual and his place. The concept of the ritual order of an institution is therefore a vital concept in understanding how appropriate and inappropriate conduct in relation to political action is defined in the institutions studied.

This section discussed Goffman's concept of ritual order and other theories of organisational structure. I elaborated, following Nugus (2019), on the oft-neglected structural aspects of negotiated order in their occurrence as observable effects in interaction. Paying greater attention to "*the structural aspects of negotiated order makes it possible to discuss structural power and political power derived from formal structure, without assuming that the organisation is a fixed and unchanging entity*" (Nugus 2019: 389). This allows us to observe the way in which anthrogogies of politics are applied under the guise of specialised knowledge and ensures power is exercised only by those adopting certain roles. I now move on to discuss the subject and identity as a co-constructed and malleable entity.

3.3.2. The Subject

Butler conceptualises the ‘subject’, ‘actor’ or ‘agent’ as a discursive construct. The body is not a “mute facticity” (Butler 1990: 129), i.e. a fact of nature. Rather the body is produced by discursive practice. This theoretical approach allows us to perceive the mechanisms by which discourses during mental health treatment can reify the subject as incapable and apolitical or alternatively as a political agent and citizen.

Butler’s work also allows us to perceive dynamics of change within the ethical and political environments in which mental health treatment occurs. Loizidou argues that Butler’s re-reading of Antigone’s claim illuminates the relationship between the ethical, legal and political as an agonistic one (Loizidou 2007). Butler argues that the legacy of Antigone’s defiance to Creon’s law appeared to be lost in the contemporary efforts to recast political opposition as illegitimate if it demonstrates disrespect for law and authority. A misguided aim of political resistance is to seek the legitimacy of the state in the espousal of your worldviews (Butler, 2000: 1-26). Engaging in conflict and cooperation with others in the political environment of the rehab service, in defiance of law policy and institutional pragmatics, present opportunities for agentic and resistant subjectivity that allow for substantive inclusion. It is agonistic relationships between ethics, law and politics which gives rise to the space and conditions for greater participation in the decisions that affect our lives and the lives of those around us (Mouffe, 2013).

The argument that there is no “natural body” that pre-exists its cultural inscription indicates that a political citizen is not something one is, it is something one does, an act, or more precisely, a sequence of acts, a verb rather than a noun, a "doing" rather than a "being" (Butler 1990). Fraser's work on recognition and distribution, and Goffman's work on the practical mechanisms by which doing performs a legitimate identity, provide the additional insight that social recognition of role depends on it being legitimately and competently performed. A socially ascribed identity may not be perceived as 'being' even if it is being acted out. For example, when the actor "*obstinately attempt[s] to employ an unconventional interpretation of the character of his social identity"* (Goffman 1963: 21) The actor may not recognise herself as legitimately inhabiting the role and therefore distance themselves from it in the course of performance. He or she may use stigma for 'secondary gains', as an excuse for ill success (*ibid).*

Butler's thinking in *Indefinite Detention* (2006) on the place of law in relation to the question of how to promote a liveable and viable life, and its relation to the spheres of ethics and politics (Loizidou, 2007), is important. Butler's thinking in light of the works of Foucault, Agamben, Sorel and Benjamin on sovereignty, governmentality and violence, particularly at the moment when law is suspended by the sovereign in a state of emergency (Agamben, 2005) is also relevant in that it suggests that the exercise of diffuse powers through systems of governmentality (in the construction of good subjects) can act simultaneously with sovereign powers to suspend rights in times of necessity (Butler, 2006: 53). *Whereas the suspension of law can… be read as a tactic of governmentality it [also makes] room for the resurgence of sovereignty.* (Butler, 2006: 55).

On this basis a reification of identities based on psychiatric diagnosis places a body in a permanently threatened state of exception in which a very small space for resistance remains. This process is potentially more acute in cases of psychosis, schizophrenia and personality disorder as these service-users are seen as uniquely delusional thus reducing their ability to present their views and opinions as legitimate criticisms of how they are treated. This threatened state of exception is justified by the potential necessity of making replacement decisions due to mental incapacity. Dissent is potentially interpreted and considered not only unintelligible but moreover dangerous, a threat to national security and cohesion (Loizidou, 2007: 125). A threat to the mutual 'act' constructed in performance.

According to Butler agency is found '*within the possibility of a variation on the repetition'*. Therefore, the requirement to '*be'* a given identity in performance *'produces necessary failure'* (Butler 1990: 145). Butler thus considers that bodies come to be resistant and political by engaging with the deconstruction of the norm (Loizidou, 2007). In challenging and subverting the ritual, and ethical order within an institution, conflict and cooperation around what those norms should be can arise and spaces opened up for political participation.

Alternatively, the political and ethical environment might be designed in such a way that challenge and subversion are suppressed and punished as inappropriate conduct. In such circumstances a court trial or tribunal becomes the only legitimate space for resistance, agentic subjectivity being precisely possible through the performative linguistic space that a legal adjudication allows. Applying this to mental health practice the political and ethical environment created can reduce the space for legitimate patient resistance and agential subjectivity to challenging the grounds for detention in mental health tribunals and official complaint procedures. This can function to delegitimise and thus reduce antagonistic or agonistic political relations. The spaces where conflict is permissible may be reduced to complaint through bureaucratic or legal systems. Such systems require competence in the technical language used, are formal, intimidating and require high levels of commitment. In these sorts of environments, playing at political roles becomes much more difficult. Opportunities and capabilities for resistance and agential subjectivity are reduced.

In applying these ideas directly to the mental health rehabilitation facility, I found it necessary to adapt them. As I show in later chapters, although subversion and challenge are useful in developing political identities for service-users, accepting and adapting to the system and ritual order are also functional in expanding opportunities for political participation and inclusion in the everyday politics of the ward. Processes of assimilation and normalisation, associated with rehabilitation and recovery, are potentially functional in expanding some political capabilities. By adopting and utilising the language of psychiatry and mobilising it in defence of their own interests, service-users can accumulate political capital and develop political agency. In this way subscription to the norm provides opportunities for agency.

The constitution of the self, or 'the subject' is a process that occurs in construction between people in interaction. Although subversion and challenge are undoubtedly important in developing a sense of political identity for service-users, accepting, and adapting to the system and ritual order, are also functional in expanding opportunities for political participation. Embracing assigned identities can function to open opportunities for inclusion in the everyday politics of the ward and institution more generally. Processes of assimilation and normalisation, associated with rehabilitation and recovery, are ways of expanding political capabilities also.

When this strategy is translated into wider political environments problems may then arise as people have skills to conform to particular social norms but not to transgress, subvert and change them in accordance with their conception of the good life. Playing the game well, rather than subverting and challenging it, becomes a way of developing political agency in the small politics of the ward but can become a passive identity that gestures towards impotence in wider political processes. Self-exclusion may be a rational choice based on increased risk of mis-recognition whereby transgressive and emotional political performance is seen as indicative of mental ill health (e.g. symptomatic of antisocial personality disorder). The forms of control and coercion applied to people with mental disabilities in institutions means that ethical principles of obedience and compliance may be prioritised over passionate and transgressive expression.

These issues concern processes of recognition which is the subject of the next section.

3.3.3. Recognition

My use of the term recognition comes from Fraser's analyses of recognition/distribution (1990). The term refers to a normative and psychological form of audience feedback. Recognition implies that you accept obligations to treat an actor in a certain way and recognise a specific normative status of the other person. Recognition is also necessary for performers to embrace themselves and their projects as valuable.

Throughout the thesis I also use the terms mis-recognition and mal-recognition. These are slightly more specific applications of the concept. Mal-recognition carries not only the implication of a mistake but also of actual harm – it is a technology of power in that it labels a person or group in a way that identifies them as inferior and justifies practical exclusions. Whereas mis-recognition is more innocent in the sense that it is merely the unreflective use of practices of categorisation. Collective recognition refers to acknowledgement of the agency amongst and between corporations, cultural minorities, political parties, and various other social groups. It is not clear that these relations are best understood within the same conceptual framework as recognition between individual agents – referred to as individual recognition.

Some readings of recognition (e.g. Honneth, 1995; Taylor, 1992) build on Hegelian insights. Ikäheimo (2002a) for example argues that recognition is achieved by treating the 'other' as a person in such a way that they understand and appreciate this treatment. Recognition is a response to personhood, but also constructs it in a self-fulfilling process (Ikäheimo, 2007). Individual recognition of personhood is important in signalling to potential political agents that their contributions will be considered legitimate.

Only persons can be recognised in the Hegelian sense of the term but at the same time we are persons only through being recognized (Hegal, 1984). Charles Taylor argues, recognition of this kind is a '*vital human need*' (Taylor & Gutmann, 1992). He identifies institutionalisation or learned helplessness as an instance of this need remaining unfulfilled. This is related to the 'quest for wholeness' of identity that Lacan discusses in the context of the subject of lack (Ruti, 2008). The ability to convey or perform a coherent and relatively 'whole' identity in social interaction and the ability, and willingness of others to accept that performed identity is fundamental to functional human organisation.

It is often thought that our needs for recognition should be reflected in the structural design of a society. Thompson (2006), in an overview of political theories of recognition concluded that it is recognition that holds the key for determining what is just in a society, and more fundamentally what a good society is. Recognition distinguishes 'deserving' from 'undeserving'. It sorts persons from non-persons and so is an exclusionary concept. The freedom of people to form and join exclusive associations is important in identity formation and associations provide opportunities for mutual recognition and confirmation. It is only through other people 'knowing us' that we come to have a coherent knowledge of ourselves. To know oneself is to be known to others through recognition and identification with broad identity categories. Broader political identities (such as race or religion) are performed and concretised in small social groups. This process is both inclusive and exclusionary in that membership is constructed through the identification of out-groups who don't share the interests and perspectives of members.

Recognition is important for the development of political agency and identity but, in the act of recognition, exclusion is almost always implied because to be recognised as one thing means to have other potential roles and identities excluded. Recognition of one identity can restrict the possibility of performing others. There is also potential for the incompetent performance of the role one is recognised as trying to play.

Personhood plays a fundamental role in politics. Recognition is multi-dimensional and historical. Relationships take different historical forms based on different assumptions about what it is to be a person. These assumptions are based on rituals and norms of performance between teams and individuals in social fields where power is associated with a hierarchy of institutional roles. The assumptions can be challenged, and roles reconfigured as performers tend to be responsive to competent and appropriate acts that represent positive reform.

Honneth's (1995, 129) distinctions between love as emotional support, respect for moral responsibility, and esteem for traits and abilities gives us three forms of recognition that are responsive to different aspects of historically defined personhood. These forms of recognition are, in turn, solidified in the institutional world and form institutionalised recognition frameworks, in the light of which individuals may grant normative statuses to each other (Honneth, 2004).

Recognition in mental health service provision may be restricted to particular types of personhood. Therefore, a quest for recognition entails risks as well as benefits depending on what type of performances are expected. Our individualistic conceptualisation of the classical liberal subject (independent, hardworking and self-sufficient) can impose burdensome responsibilities to embrace roles and perform them appropriately in civic and political life.

3.3.4. Role

It is useful to consider at this point some of the concepts Goffman uses in his conceptualisation of role. In his book *Where the Action Is* (1969) and *Interaction Ritual* (2005) he outlines how important the concept of role is in the social anthropological tradition and teases apart role concepts described in this literature.

A status is a position in some system or pattern of positions. It is related to other positions in the unit through reciprocal ties, through rights and duties that may be binding on actors. Role consists of the activity the actor would engage in were he to act solely in terms of the normative demands upon someone in his position. Role in this normative sense is to be distinguished from role performance or role enactment, which is the actual conduct of a particular individual while on duty in his position. The individual's role enactment occurs largely through a cycle of face-to-face situations with role otherxzs - that is relevant audiences (Goffman 1969).

To understand this way of thinking about role it is useful to outline three key distinctions that Goffman makes which are fundamental to the development of his operationalised concepts.

1. Expressions we give and expressions we give off - The former is the concretely intended and conscious form of expression, as epitomized by verbal communications using language. The latter is the non-verbal, presumably unintentional, form of communication that is not concretely expressed in speech but nevertheless has efficacy in communicating, consciously or unconsciously, some things about the person expressing it. It is important to keep in mind that, while the former is always intentional, the latter does not necessarily have to be unintentional. In fact, people are capable of manipulating the tacit communications they give off in strategic ways.

2. The symmetry vs. the asymmetry of these two modes of expression - Symmetry occurs whenever there is a congruence between what these two modes of expression communicate, asymmetry is whenever these two do not express the same things. Thus, when a student who had been yawning through a lecture, nevertheless says he had enjoyed the talk greatly, there is asymmetry.

Because people are capable of manipulating non-verbal expression to a considerable degree, there is a possibility for a type of game to set in. This may take the form of a cycle of concealment, discovery, false revelation, and rediscovery, all geared to the goal of giving off as advantageous a set of impressions as possible.

3. "Working consensus" - People interpret the social situations they are in as signifying various acts or role relations. There may be consensus, or the interpretations may conflict. "Working consensus" is a type of consensus, which is not an agreement in any absolute sense, but a tentative agreement as to whose claims and definitions are to be honoured in particular circumstances. Also, in accepting other's definitions of social situations, Goffman notes the crucial importance of information people possess initially concerning fellow participants, for all subsequent actions and responses would be based upon this initial knowledge frame. Following this, these frames set a plan for the co-operative social activity that ensues.

Goffman notes that accepted or dominant narratives can acquire moral and imperative character, in that they now guide actors as to role and behaviour. When people subvert or violate these definitions actors may engage in defensive practices to restore the act to a working consensus. This analysis allows us to elucidate the methods people employ to reconcile the discrepancies between their own actions as they are, the social meanings and impressions they desire to give off and the audience interpretation and recognition of these meanings and impressions. This understanding is vital in analysis of processes of politicisation in the context of mental rehabilitation.

3.3.5. Play, Becoming and Engulfment

Schur, described the concept of "role engulfment" as '*the process whereby persons become caught up in the deviant role as a result of others relating to them largely in terms of their spoiled identity'* (1971: 79). This is a form of labelling theory that emphasises the potential for mis/mal-recognition of the line an individual takes. In playing at a role which is consistently mis-recognised a person can eventually come to be engulfed by the pejorative role attributed and even embrace it. This is not a deterministic process but one of co-construction with implications for political identity and agency. Embracing a purported negative label (for example 'mad') is itself a potentially subversive and political act and does not necessarily follow the negative pattern predicted by labelling theory or models of deviancy. Through this process of iterative reification, a role may become dominant in a person's identity narrative and can be used to accumulate political capital as much as it may be used to restrict a person's agency.

Conversely, the individual may themselves embrace the role (or roles) by expressing attachment and commitment. "In describing individual's attachment to role, it is sometimes said that they have committed their self-feelings to it"' (Goffman 1969b: 43) Performance of defining roles or 'master roles' is reified as real compared to other 'played at' roles. Role 'domination' where a particular role comes to dominate all other roles can occur at a particular time or in a particular context but can also be destabilised by role or audience segregation – a capacity to support in the life cycle, calendar cycle or daily cycle a schedule of '*where and what the individual is to be when'* (*Ibid:* 44*)*. Following role engulfment there can be role abandonment where there is detachment from other goals, priorities, and roles. These processes are never final and although playing at can result in substantially becoming (in relation to a particular performance and in the eyes of a particular audience), we are always in the process of re-(and de-) constructing the person that is projected. Thus, role and identity cannot be reified as a fixed point and may be more fruitfully seen as unstable products of contextual interaction.

Playing at different roles is to be distinguished from role engulfment by ascription which is a processes of reification. To become a played at role it must be embraced and recognised in a process of co-construction but it is constantly eroding and shifting (see s.3.3.2). The term 'playing politics' is a shorthand for adopting the role of political agent without political identities being reified as fixed points. That we all are seen as 'playing politics' is not intended to be pejorative of patronising. I simply use the term to indicate that we play a variety of roles in any given political process and engage in a process of experimentation and discovery of what works in the social situation we find ourselves in.

In later chapters I will describe this process of playing at and adopting political identities as an educational practice that allows people to become, in an ephemeral and non-essentialised sense, political citizens in performance.

3.3.6. Role distance

For Goffman, role-distance refers to "actions which effectively convey some disdainful detachment of the performer from a role he is performing" (Goffman, 1961a: 110). He develops his idea after observing children of various ages riding a merry-go-round. A two year-old, he observed, cannot maintain sufficient "role poise" to maintain physical, and hence emotional, security under the multi-directional movement vectors the machine creates; they therefore "*find the prospect too much for them*" (Goffman, 1961a: 106). Three and four-year-olds, however, perform enthusiastically. "*The task of riding a wooden horse is still a challenge, but apparently a manageable one, inflating the rider to his full extent with demonstrations of capacity.*" At three and four, "*the rider throws himself into* *the role in a serious way, playing it with verve and an admitted engagement of all his faculties*" (*Ibid*). Goffman concludes that for this age group "*doing is being, and what was designed as a 'playing at' is stamped with serious realization*" (*Ibid*). This synthesis of doing and being is described as "*embracement*" of the performer's role.

At age five, everything changes again. "*To be a merry-go-round horse rider is now apparently not enough, and this fact must be demonstrated out of dutiful regard for one's own character*" (Goffman, 1961a*:* 107). By five, "*irreverence begins, and the child leans back, stands on the saddle, holds on to the horse's wooden ear, and says by his actions: 'Whatever I am, I'm not just someone who can barely manage to stay on a wooden horse.'* The rider is hence *"apologizing,*" not for *"some minor untoward event that has cropped up during the interaction, but the whole role*" (*Ibid*). "*Whether this skittish behaviour is intentional or unintentional, sincere or affected, correctly appreciated by others present or not, it constitutes a wedge between the individual and his role, between doing and being,*" Goffman concludes (*Ibid* 107/8).

Extending this to adult performance Goffman describes how a surgeon sings limericks while wielding the scalpel so as to assure co-physicians and staff that beneath his professional role lies an well-rounded human being; the waitress smirks to show that beneath her apron lies a yet-unsung poet or stage performer. "Know that I am not who I appear to be" is the message such asymmetry between expression conveys. These behaviours demonstrate the prevalence of role distance in everyday lives: we do not wish to be seen either as locked into - or as failing to live up to - our adult roles. This applied to the roles of doctor and patient in psychiatric facilities as much as anywhere else.

Understanding the real-life aspects of these terms helped to clarify and demystify several important issues encountered in the empirical work presented later in the thesis. In playing political roles, for example, what seemed like role-distancing was interpreted by practitioners as a poor performance and even evidence of declining social function. It made me aware of the way possibly diverse interpretations might operate in context. For example, a behaviour may well constitute a subversive or problematic performance given the expectations of role embracement but if role embracement is defined as healthy and role distancing as unhealthy then the scope for individual agency and choice in political decision making may be reduced.

Persons engaging in role distancing behaviours are not being “dishonest” or “insincere”. Rather, they are holding on to Goffman’s “dutiful regard for [their] own character,” (Goffman, 1961a: 110) as they understand it. Role embracement, after all, may carry with it the perceived threat of identity effacement, as well as of accusations of deceit and hypocrisy. Such critiques of performance portraying “the real” against, by implication, “the false” both mis-state the technical distinction and overstate the moral or ontological one in a process of identity reification. What is potentially necessary, in such cases, is not for the actor to progress into a generic and ill-defined world of “reality” but to regress into the role embracement of the three-year-old. This is neither moral nor ontological. It is rather a matter of rediscovering the art of play.

It is also helpful, in this regard, to recognize that Goffman did not limit himself to placing role embracement and role distance simply as bi-polar performative behaviours but rather as disparate points on a continuum of real-world self-identification, on which we can find discrete gradations of role distance appearing at age five, eight, eleven, and adult years.

As we have seen in previous sections, the playing at and embracement of roles does not occur in a vacuum. Audiences are required, and cooperation and recognition from other actors, and sometimes conflict in the assertion of specific scripts or ascription of roles. These all influence the process intentionally or unintentionally.

The concept of *role distance* is helpful for my studies in that the politicization of psychiatric patients in rehabilitation units involves casting them as ‘political citizens’. This is potentially intimidating for people who are not used to performing that role, especially if previous attempts to influence decisions have, due to their mental health status, been dismissed. Further, the performance of an explicitly political role is full of pitfalls – it is challenging to perform persuasively, often resulting in tricky conflicts or contingent alliances. Long-term performance may be necessary to display authenticity and conviction. These daunting challenges can lead to the adoption of role distancing behaviors whereby an individual in his performance displays a lack of commitment to the role in order to lower expectations.

3.3.7. Face Validity

Every citizen must continuously negotiate a matrix of social encounters with other citizens and it is profoundly important to each person to maintain what Goffman defines as ‘face’ in these interactions. A pattern of verbal and nonverbal communication is used in each encounter (‘acting out a line’) to establish a set of assumptions about the pragmatics of each individual interaction and this is important in forming and expressing a view of oneself to the other participants. These strategies are not necessarily consciously planned (Goffman, 1969). They are an important aspect of contingent identities that emerge in social encounters. For example, if a mental health practitioner is interacting with a service-user and is purporting to support and enhance political participation, he or she will take a certain ‘line’ and this will be influenced by, and in turn influence, the ‘line’ taken by the service-user. Participants in an interaction defined as political will usually assume that these ‘lines’ are freely chosen and taken at the participants’ discretion. Professionals therefore must act upon the impressions that are expressed by service-users as if they were valid.

However, in the context of an interaction between a citizen ascribed the identity of ‘person with mental disorder or disability’ the lines and faces expressed are not necessarily assumed to be an act of free choice or proper discretion. This is what the practice of capacity assessment is premised on. This creates a friction and potential conflict between the line the ‘person with mental disorder or disability’ is attempting to express, and the impression formed by the audience.

Goffman defines face as the positive social value that a person attempts to claim for herself. By taking a particular line in social interaction a certain face is presented in the hope that it will be received, reinterpreted and ‘recognised’ by the person’s audience. If that audience routinely ignores a person’s ‘face value’ and prioritises assumptions about the characteristics of a person’s line on the basis of a written record, then a person can find themselves in a situation where they are unable to effectively express a positive face and this can be a source of frustration and conflict. Such frustration can encourage protest or disengagement which may then be reflected as mental symptomology in the written record. The institutional context can reinforce a cycle of ritualized behavior which is consistently mis/mal-recognised as symptomatic.

Goffman argues that a person tends to experience an immediate emotional response which is triggered by contact with others:

‘*he cathects his face; his feelings become attached to it. If the encounter sustains an image of him that he has long taken for granted, he probably will have few feelings about the matter; If events establish a face for him that is better than he might have expected he is likely to ‘feel good’; if his ordinary expectations are not fulfilled one expects that he will feel bad or feel hurt* ’ (Goffman; 1969: 3).

It is also important that this face should be confirmed by evidence conveyed through impersonal agencies in the situation, i.e. both interpersonally in a medical interaction, *and in the notes and judgements appearing in any written record.* This is referred to by Goffman as 'face validity'. I talk about this in subsequent chapters in terms of valid or legitimate political identities.

Face is not an essential attribute, but a product of the flow of events and interactions engaged in. It becomes manifest only when events and interactions are read and interpreted (recognised). However, institutional settings can narrow the range of choices available in institutional interactions and thus the possibilities for constructing face.

If a mental health inpatient is inducted sufficiently into a social practice or has their role in that social practice recognized in interpersonal interaction *and in the official record* they may be said to possess a positive face in relation to that role. They may respond with feelings of confidence and assurance in performance and in medical notes be said to have improved mental health. Firm in the line he or she is taking and confident in its recognition he or she can participate in that social process with security. Increased levels of confidence may also be achieved if the members of the audience, although feeling a performer is in the wrong face or incompetent, successfully hide these judgements and perform as if they recognise the legitimacy of the role being played.

A person's personal face or identity may be seen as a sensitive possession over which full ownership and control can be a great source of security and pleasure. But a person's face or identity, is not an object to be possessed and worn but a public performance that is never entirely one's own. Because of the need for recognition, both social and political faces are co-constructed with others. Although people may seek to become the sole authors of this process recognition can be withheld or withdrawn.

Positive interpersonal interactions co-construct norms that become a comfortable constraint. As Goffman states: "*approved attributes and their relation to face make of every man their own jailor; this is a fundamental social constraint even though each... may like his cell*" (Goffman 2005: 10). In this way they restrict potential action while also facilitating it by creating a structure in which relations of conflict and cooperation occur according to ritualized norms.

Information about social worth, and mutual evaluations, can be exchanged by subtle bodily communication or explicitly articulated. These communications will be witnessed, and the fact they have been witnesses acknowledged:

“*An unguarded glance, a momentary change of tone of voice an ecological position taken or not taken can drench a talk with judgmental significance.”* – *(*Goffman: 1969: 26*).*

It is not hard to see that this is of particular importance in the institutional setting of psychiatric wards. From a theoretical perspective, in the community established in a totalizing institution, wherever the possibility of spoken interaction arises a system of practices, conventions and procedural rules come into play. These pragmatics of interaction function as a means of guiding and organizing the co-construction of identities. Goffman identifies some general strategies of such interactional encounters:

“a person determines how he ought to conduct himself during an occasion of talk by testing the potential symbolic meaning of his acts against self-images that are being sustained. In doing this, he incidentally subjects his behavior to the expressive order that prevails and contributes to the orderly flow of messages” – (Goffman, 1969: 31)

Goffman identifies useful functions of the ritual order of interaction

“From the point of view of saving face then, it is a good thing that spoken interaction has the conventional organisation given to it; from the point of view of sustaining an orderly flow of messages, it is a good thing that the self has the ritual structure given to it.” – (*Ibid*)

However, I would add some qualifiers to this statement. If the ritual structure given to an interaction becomes distorted in a way to systematically undermine a person's ability to save face, for example being subject to the exclusive interpretation of one party to the interaction (for example the psychiatrist), this can become a barrier to the potential for political expression and participation of the person excluded. As Goffman rightly points out:

> *"Fear over possible loss of his face often prevents a person from initiating contacts in which important information can be transmitted and important relationships established. He may be led to seek the safety of solitude rather than the dangers of social encounters."* (Goffman, 2005: 39)

It is precisely these sorts of processes that might have the potential to discourage and exclude people being treated in rehab units from developing capabilities and skills needed to participate in political processes of conflict and cooperation in matters that must be settled for the community of residents and the polity as a whole. This aspect of institutionalisation can also affect social skills and capabilities more generally.

3.3.8. Teams

People often cooperate in creating a joint impression thus forming a performance team. A performance depends on all members of the team and they have to trust each other to play their parts competently and in a way that communicates the agreed narrative or 'face'. Successful performance may result in a form of collective recognition of the team. The mutually reinforcing needs for individual and collective recognition evoke a special relationship between team members, often characterized by relative equality and informality. This relationship is further supported by the fact that they share information about performance inaccessible to the non-members. The extent of informality between team members may have limits - for instance, though members of one team, they have to play for themselves in the internal conflict and cooperation occurring within the team hierarchy.

It can be advantageous if the audience is unaware of the fact that the performers form a team, for an impression can appear more credible if it comes from seemingly independent sources. These team performances are also made more credible if they occur in the right setting and with the appropriate backdrop – if they are properly staged.

"Frontstage" in the presence of the audience and "backstage" with fellow (or competing) actors operate with different rules of interpersonal engagement. For Goffman, "frontstage" behaviour is how we act when others are noticeably observing. We behave according to certain pragmatics and expectations when we are conscious of an audience. Frontstage behaviour reflects the internalized norms and expectations for our behaviour that are shaped in part by the climate of ideas about values, the particular role we play on stage, and our physical location and appearance. Frontstage performances are often intended as ways to increase or maintain ‘face’ or reputation and can quickly become ritualised and habitual. Frontstage behaviour typically follows a routinized and enforced social script shaped by ‘cultural’ norms.

Backstage behaviour, by contrast, is unobserved. Actors are freed from the restrictions and rules that apply to frontstage behaviour. We are often more relaxed and comfortable when backstage, we can share personal experiences, and we might reveal our emotional reactions more readily. We are not as precious about maintaining a particular ‘face’ required for acceptable frontstage performance. Staff members in a rehabilitation ward may feel that they have to act as an authoritative doctor with patients when frontstage which could in theory rule out overtly ‘political’ actions and expressions, whilst backstage they may be freed from these professional norms.

When we are backstage we can practice certain behaviours or interactions and play at roles in a way that can support more confident performances frontstage. When we are backstage, the climate of ideas about how we should live still exerts influence and we remain aware of frontstage norms and expectations. In our backstage lives we often have a small team with whom we still interact, close family and peers, but with whom inhabit different roles from what is expected when we are frontstage.

The residential rehab ward is sometimes constructed as a backstage area of service-users lives where they can practice behaviours and roles in a way that can support more ‘healthy’ performances when they return to the wider community. In theory, political roles and performances may be played at in the therapeutic environment of the ward with the staff and other service-users as part of a supportive backstage team. Conversely, the ward may be experienced as a frontstage area in which staff and other service-users are particularly inscrutable audiences with various and contradictory expectations.

When a performance typically reserved for one area makes its way into another confusion, embarrassment, and even conflict can ensue. Often actors make great efforts to ensure the backstage and frontstage aspects of their lives remain separate and distinct. In mental health institutions, the way the space and environment is organised into different categories of stage can vary massively. In some facilities staff areas are strictly out of bounds to patients, ensuring a secure backstage area for staff. In others the staff and patient areas may be integrated and porous. Alternatively, the residents might prevent staff from coming into their private rooms to ensure a secure backstage for themselves. These idiosyncratic organisations of space may be dependent on the specific pressures on different services, the ethical environment in which the institution is based, as well as what might be termed institutional culture.

There are of course various stages each with their front and backstage etiquette and specific assumptions on the part of the audience. Each implies distinct roles and rules of performance. We may think of them as exemplifying diverse cultures, or games with different sets of rules. In everyday social life we are likely to be acting on multiple stages simultaneously and mental health practitioners, and service-users are no exception to this. One important audience for practitioners is other professionals, managers and ultimately the regulator. This may be the stage upon which 'professional' identity is cultivated and this professional face may be presented both front and backstage in the hospital setting. A second important audience for practitioners is of course the service-users themselves.

3.4. Processes of Politicisation

By politicisation I refer to processes by which people become politically aware or engaged to 'act politically' and in the capacity of political citizen. These practices form part of the implementation of the *United Nations Convention of the Rights for Persons with Disabilities* article 12 and 29 – the right to equal opportunities to participate in political and civic life.

Playing at political roles or acting politically is, according to the framework presented, the expression of views in interaction with audiences which seek to present the 'face' of a politically engaged citizen by taking certain 'lines' which are recognised as, (or intended to be) explicitly political and as contributions of a political agent acting at their own discretion. I distinguish three fundamental aspects of the politicisation process: Political identities, Political praxis/poeisis, and Recognition/Embracement.

1. Political Identities

Political identity, based upon the arguments explicated in the present chapter, is built upon engaging in conflict and cooperation to influence decisions that should be settled for the community as a whole. In the mental health rehab ward political identity is co-constructed through both resistance and subversion and well as through adherence to, and embracement of the ritual order and ethical norms. It may be built upon a sense of participating through individual acts which seek to change the environment in accordance with a worldview. Such an identity may also be built on cooperation with others in forms of group agency to achieve change – this requires adherence to a specific worldview shared by other adherents, a view of how to change the realities of this world, and the power and agency to achieve such changes in collaboration and conflict with 'the other'.

2. Political *Praxis* and *Poeisis*

Political expression and action are expressed in persons taking certain 'lines' and presenting certain 'faces' in interaction with other political agents and audiences. Political participation requires social recognition of the person's role as political agent. The adoption of resistance strategies rather than 'acceptance' or 'embracement' of the role does not necessarily deprive expressions and acts of their political character. Political participation can thus incorporate both praxis (actions that aim at changing the world in accordance with worldviews) and poeisis (gestures symbolically performing political agency and inclusion).

3. Recognition and Embracement

For action on the part of service-users to be effective in decision making and in instigating the formation of political identities their aim to influence decisions that affect their lives needs to be recognised by practitioners and other audiences as located explicitly in the political sphere or as having the characteristics of legitimate political action. The exercise of power must be directed towards acts that increase agency rather than those that restrict action according to principles of capacity and necessity.

At the same time, it needs to be acknowledged that the use of narratives of illness can be useful in the political sphere in terms of being granted access to resources by gatekeepers. Narratives of illness and the mentally disabled identity are also potentially useful in stimulating self-directed processes of recovery (Ersfjord 2018). The literature emphasises the risks involved in stimulating and reinforcing the adoption of the psychiatric and medicalised narratives which inscribe social and political problems into the body and mind of the individual. The dangers highlighted include the risk that patients adopt unhealthy self-monitoring strategies and reify their lack of agency and responsibility in ways that could conceivably have negative implications for political development (see for example Alexander et al. 2015, Burrows 2017, Powell and Fitzpatrick 2015). Ersfjord (2018) by contrast argues that the adoption of such narratives in rehabilitation should not always be understood as negative or dangerous but can be productive and help people cope with their illness in more self-directed ways for example by transitioning from ‘I am’, to ‘I suffer from’.

3.5. Conclusions

The process of politicisation for service-users involves taking away responsibility in order to provide conditions in which it may be reinstated. This occurs within an ethical environment (a climate of ideas about how people should live) and in a specific political environment (dynamics of conflict and cooperation) in which actors and teams engage in conflict and cooperation according to specific roles, under defined rules of engagement and under a specific regime of resource distribution. This educational process occurs throughout the course of rehabilitation and not only in implementation of policies of political inclusion during elections.

In this chapter I introduced the idea of politics as an essentially contested concept and provided a brief overview of operationalised concepts used throughout the thesis. In constructing a set of conceptual descriptors for the objects under study I have consciously drawn the definition of ‘the political’ broadly. Politics is viewed as an aspect of behaviour that can occur in any social situation and in which cooperation and conflict occurs over matters which must be settled for the community as a whole. The concept of community is one which can be applied to small scale and large-scale polities.

I also outlined a number of concepts (derived principally from the work of Goffman Butler and Fraser) to be utilised in understanding processes of co-construction, reification and exclusion of the political subject and in developing performative agency.

Goffmanian dramaturgy enables us to understand the ethical and political environments that service-users experience during residential mental health treatment and in staff and service-user’s performance of various roles relevant to political engagement. A microsocial understanding of both individuals and networks, it is argued, is necessary to capture a broad picture of policy implementation in all its complexity. Goffman also allows us to view political behaviour as a playing at political roles. For people to adopt and embrace a role (‘becoming’) it is often necessary to be recognised as qualifying for such a role by authoritative others in a process of co-construction. These processes are important for people in constructing political identities and motivating engagement.

In the next chapter I build on these ideas and draw on the literature to develop a theoretically informed view of politicisation processes in the medicalised environments of mental health wards.

Chapter Four

4. The Political Environment

4.1. Introduction

So far, I have set out the legal obligation's incumbent on the state and mental health practitioners in relation to supporting opportunities for political inclusion in the course of mental health treatment on an equal basis with others. I have also set out several theoretical concepts useful in understanding the process of political socialisation and participation.

In the previous chapter we saw that political identities, expression and action can be placed into particular narratives and individuals are assigned and adopt or resist certain roles. In residential psychiatric care these processes are not equivalent to the political experiences of average citizens and so raise issues of differential treatment on the basis of mental disability.

I begin this chapter by applying the dramaturgy of Goffman to the mental health institution to contextualise policy implementation. I then turn to Nancy Fraser and Judith Butler who provide insights into how political identities are constructed and given adequate recognition in the political environment. Finally, I discuss theoretical basis of adult education to both analyse and critique the various ways in which support for political participation might proceed in psychiatric care. At the end of the chapter I introduce and adapt the theory of andragogy as a model of inclusive educational practice which in later chapters is used as a tool of evaluation. As these theoretical discussions were built inductively from the data I use some examples of practices observed.

4.2. Political Roles for Psychiatric Patients

Goffman, as discussed in the previous chapter, provides a number of fundamental concepts that may be used to interrogate the process of policy implementation. The concepts of role, role engulfment and role distance are fundamental to the analysis of how implementation proceeds in practice. The theory of dramaturgy, which Goffman used to tease apart the characteristics and dynamics of social interaction in mental health services, involves the analysis of social groups or 'teams' of individual actors, on a 'stage' with an 'audience'. This presents social interaction as a drama or theatre in which roles and scripts are provided and the drama proceeds on the basis of certain rituals dictated by the pragmatics of the institution as well as guided by the will of actors attempting to present positive 'faces' to their audience. However, Butler's work indicates this theory should be adapted to accommodate performativity, identity (re)formation and destabilisation.

Role engulfment is a process whereby persons become caught up in the deviant role as a result of others relating to them largely in terms of their spoiled identity (Schur, 1971). This is a form of mis(or mal)-recognition. In playing at a role or being consistently mal-recognised a person can 'become' the role attributed in other eyes. Even playing off script can be interpreted in ways that confirm his or her position. Through this process of iterative reification, a role may become dominant in a person's identity narrative through repetition. Butler indicates that none of these identities are necessarily 'real' or authentic and this problematises Goffman's concept of role distance as a way to assert one's 'own' authentic identity whilst performing an inauthentic role.

Role distance can be employed to pre-empt criticism, for example where we do not wish to be seen either as locked into, or as failing to live up to, our adult roles. This applies to the roles of doctor and patient in psychiatric facilities as much as anywhere else.

Persons engaging in role distancing behaviours are not being "dishonest" or "insincere" Rather, they are holding on to Goffman's '*dutiful regard for [their ascribed] character'* (Goffman, 1990). Role embracement, after all, may carry with it the perceived threat of identity effacement, as well as of accusations of deceit and hypocrisy. Critiques of performance pitting "the real" against – by implication - "the false" misstate the technical distinction and overstate the moral or ontological one in a process of reification. What is potentially necessary, in such cases, is not for the actor to progress into a generic and ill-defined world of "reality" but to regress into the role embracement of the three-year-old. This is neither moral nor ontological. It is rather a matter of rediscovering the art of play and destabilising rituals of law and policy in ways that allow them to be reconstructed according to principles of co-construction and co-ownership. It is a political strategy whereby roles can be subverted.

To borrow from theories of theatrical role-play, role distancing may be similar to the concept of *verfremdungseffekt*[3]. Brecht asserts *verfremdungseffekt* is a form of de-familiarisation from the role one is currently performing. To do this whilst sustaining a convincing performance requires long training. It is most effective when based on an understanding of role and its place in wider social and political environments and performances (Brecht & Willett, 1964). Political identity performance is not simply a variant acting technique, but an outgrowth of the

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[3] Translated literally: prefix *ver* = strong; adjective *fremd* = foreign; noun *Effekt* = effect. Because of the historically contested nature of its English translation, I use the German word *Verfremdungseffekt* in place of 'de-familiarisation', 'alienation', or 'estrangement'

normal human process of identity construction and recognition. To embrace such identities requires relearning how to ‘play’ act, and how to present a role while also maintaining a dutiful regard for one’s previous character.

It is also helpful, in this regard, to recognize that Goffman did not limit himself to placing role embracement and role distance simply as absolutely bi-polar performative behaviours but rather as disparate points on a continuum of real-world self-identification (Goffman, 1990). Brechtian on-stage estrangement is also incremental across a continuum ranging from “short” to “long” distance.

Actors, in participating in political practices, must learn to eschew socially desirable role distancing in order to fully embrace, in the Stanislavskian sense of becoming (Crowley & Benedetti, 1998), a character in a wider narrative of political change. The chosen political role must be presented as enduring and strong enough to fit into narratives of alliance and conflict in a political environment. A competent performance requires that “something of oneself” is preserved and performed while simultaneously engaging in rituals of interaction appropriate to the context.

Various opportunities for role adoption and enactment (for example when debaters argue the case for an opinion they disagree with, or a patient writes their own psychological assessment) could encourage playful improvisation which could in turn increase political capabilities. Educational techniques include drama exercises. For example, dramatic scenes may be performed simultaneously to create a playful atmosphere. This could take the form of multiple groups performing scenes in parallel or even doing plays within plays. In such situation’s actors can more fully embrace their played-at roles without the distraction of an audience to whom they feel a need to perform a ‘real’ persona (Cohen, 2004). Worldviews and political messages could be conveyed through art, music, dance or any other medium. Social connections and camaraderie can be nurtured through sport and other collaborative activities. Techniques like these could be used in political education to enthuse and engage service-users.

The long training that Brecht considered necessary to properly perform the *verfremdungseffekt* is best achieved by a full consideration of the root causes of role distance, thereby permitting the actor to develop this capability through disciplined intentionality rather than falling back on simply the "bad acting" caused by ontological insecurity.

Role distancing is not a problem to be reduced. It is a useful capability in political and public life if done with competence and tact. Lack of motivation, lack of confidence in oneself or ones opinions, are potential reasons for falling back on role distancing however. These are problems that might be better addressed using creative role play and engagement with cultural and social activities. Such activities provide opportunities for the natural development of political roles and identities.

4.3. Developing Political Identities Through Resistance and Play

Judith Butler work is relevant to the formation and nature of political identity and builds on, and often adapts and challenges, Foucault's theories on power and resistance so it is worth briefly putting her work into context.

Foucault, in his historical analyses, indicates that resistance to power in itself is often not just pointless but pernicious because power is something that is inherent in human relations and is applied by everyone, on everyone (Foucault, 1977; 2000a). This fits with Cees van der Eijk's contention that political action is inherent in human interaction rather than restricted to particular domains. In some situations, resistance enhances or confirms existing power/knowledge dynamics (Foucault, 1980; 1981; Knights, 2002). As I hope to show in later chapters, a concrete example of this dynamic is the way in which protests by service-users in mental health rehab may be read as mental illness thus confirming their incapacity for political agency.

Foucault’s rejection of grand narratives of progress, in favour of a theory that the exercise of power is constant and polycentric, leaves him according to some critiques (Fraser, 1989) with difficulty in accommodating political mobilisation and change. Foucault can be read as insisting that control is always rendered perfect because resistance must be framed by narratives of those in power. However, if power proliferates far beyond the bounds of the state then cultural hegemony may be subverted in its application. Power is applied by different people for different ends and is not necessarily based on the same technologies and worldviews. In almost every aspect we are *governed* through everyday technologies of power, but we are also *governors* in interpreting and applying these technologies. Power is not necessarily malign and oppressive but merely a medium of human interaction (Foucault, 1980). Likewise, institutions present both threats to, and opportunities for, the exercise of power.

Foucault argues that when those usually spoken for and about by others begin to speak for themselves, they produce a "counter-discourse." Counter-discourses constitute a practical engagement in political struggles (Deleuze and Foucault, 1977). Lazarus (1991) and other critics like Ehrenreich (1992) argue that Foucauldian political theory relies on the idea that truth is a social construction determined by dominant discourses, and that there is no greater Truth. These critics argue that radical politics is unsustainable when Truth becomes obsolete and only a vacillation between competing discourses remain. Truth, on these readings, is assumed to be the foundation of political change. Moreover, it is argued that Foucault assumes a "structural determinism," which leads to a "conception of the subject which is purely epiphenomenal" (Appiah 1991: 67).

Theorists like Butler (1988), and later McKinley (2010) elucidate the concept of ‘performativity’ which provides a complementary framework that avoids this deterministic tendency and thus moves beyond Foucault’s perceived weaknesses. Using Butler’s work on identity we can develop our understanding of the politics of identity within the mental health rehab facilities visited. It is upon these theoretical foundations that we can build a robust analysis of practices of politicisation in mental health services.

According to Butler, identity categories are never merely descriptive, but always normative, and as such, exclusionary. This is not to say that the term ‘mentally disabled’ should not be used as a category of personhood. On the contrary, if disability rights studies presupposes that "mental disability" designates an undesignatable field of differences, one that cannot be totalized or summarized by a descriptive identity category or through medical notes, then the very term becomes a site of permanent openness and resignifiability (Butler, 1995). Identity, as a reified end-in-itself becomes an impossible ideal, that compels a ‘daily mime that can, by definition, never succeed in its effort to approximate that ideal’ (Benhabib et al., 1995: 122). However, opportunities for the formation and recognition of positive agential identities (albeit provisional and incomplete) is a necessary pre-condition for facilitation of equal opportunities for participation in political life.

For Foucault, power operates at the most mundane level of practice. It is in the processes of conflict and cooperation in everyday life that define Van der Eijk’s definition of aspect politics. Power and the processes of political accountability that regulate its exercise, do not only operate at meta levels of ‘the economy’, ‘the state’, or even ‘modes of production’ but in everyday interaction (Fraser, 1989: 18; Hoskin, 1992; Rowlinson & Carter, 2002).

Butler criticises Foucault’s conceptualisation of the relationship between power and resistance. For Foucault, resistance is to exercise power and vice versa. As

Žižek (1999: 252) puts it, 'the very subject who resists these disciplinary measures and tries to elude their grasp is, in his heart of hearts, branded by them, formed by them' (see also, McCarthy, 1994; Sawicki, 1991). Foucault deliberately did not confront this issue as he argued that power is not concentrated in a single set of institutions but proliferates throughout society. Power is not 'contained' in state apparatuses nor 'held' by a class. So a person is both shaped by power but also exercises power and shapes the powers being enacted. For example the power of mental health professionals is provisional and contingent on people accepting that they are patients and recognising the person treating them as a doctor. Therefore, resistance is a push against a particular contextually held power as well as a push against one's own power and one's own identity through counter-discourse.

For Foucault, power does not 'originate' or 'end' and is "*ceaselessly ingenious in its ideological cloaks and insidious practices*" (McKinley, 2010; Clegg et al., 2006). Resisting what Foucault calls 'the rancorous will to knowledge' is necessarily an unequal struggle with ritualised forms of power. Resistance and self-constitution should not therefore be confused with the destruction or redistribution of power (Foucault, 1978; Han, 2002). Whether writing about the prison, the asylum or sexuality, Foucault was interested in the interplay of power and the subject. Power has meaning only where subjects have some degree of freedom, agency, and choice. In 'The Subject and Power', he makes this point explicitly

'Power is exercised only over free subjects, and only insofar as they are free. By this we mean individual or collective subjects who are faced with a field of possibilities in which several ways of behaving, several reactions and diverse comportments may be realised. Where the determining factors saturate the whole there is no relationship of power; slavery is not a power relationship when man is in chains…. Consequently there is no face to face confrontation of power and freedom which is mutually exclusive (freedom disappears everywhere power is exercised), but a much more complicated interplay. In this game freedom may well appear as the condition for the exercise of power (at the same time its precondition,

since freedom must exist for power to be exerted, and also its permanent support, since without the possibility of recalcitrance, power would be equal to physical determination)'. (Foucault, 1982: 790).

Butler offers a radically different version of the power/resistance dichotomy where disciplinary practices open a Pandora's box of discursive alternatives, a diversity of practices that defy restriction. Far from restricting choice and ensnaring resistance, disciplinary practices encourage oppositions that range from small-scale, micro-protests (such as sarcasm and irony) to the public spectacle of riotous disorder (Žižek, 1999).

Butler begins where Foucault and Goffman end (McNay, 1999b). Foucault wrote of the enclosure, normalisation, and control of the clinic, the asylum, and the prison: Goffman of the total institution. They study the regulation of modern individuals through dreary routine. Butler, by contrast, speaks of a life of possibilities outside of institutions, beyond the reach of normalisation, however temporary. The starting point for understanding practices of political inclusion in psychiatric facilities, and the potentiality of newly possible identities this creates, are not to be found in dry institutional information sessions, but in the demonstration of identities that challenge hegemonic understandings of human nature, beauty and value. This depends on creating spaces, discursive and physical, in which law and policy are destabilised (the door of the law closed[4]) and co-owned rules are studied and scrutinised in dialogue. In this way the law and the politics that constitute it may regain significance (Snoek, 2014).

Butler's understanding of identity involves both constructivism and post-structuralism (Bell, 2007; Lovell, 2000). Social constructivism maintains that identity is, at least in part, a reflexive process between the individual and social practice (Haynes, 2006). Here identity becomes obstinate, an exchange between the knowing individual conscious of their limits and the limits of ritualised social

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[4] *See Before the Law by Franz Kafka - https://www.kafka-online.info/before-the-law.html*

practices. In post-structuralist accounts, identity is always – indeed, is only – process. Identity is never fixed or stable, even provisionally, but always becoming.

The insight provided by Butler's work, building on Foucault, is that subjection contains both subjectivity and subjugation (Disch, 1999). Butler attempts to go beyond Foucault's understanding of subjectification as a dialectic of freedom and constraint. It thus allows us to interrogate more deeply the ways in which agency is developed in relations of benevolence in the mental health treatment context.

In interview Foucault attempted to distance himself from a conceptualisation of the subject as a discursive effect, and conceded a lack of emphasis on agency in identity formation (see McNay, 1999a). Foucault's later work on ethics and sexuality are read by McKinley (2010) as an attempt to address agency, autonomy, and time in identity formation (Foucault, 1988).

The subject, on this perspective, '*is not determined by the rules through which it is generated because signification is not a founding act'* (Butler, 1990: 125). The construction of political identity is thus '*a regulated process of repetition that both conceals itself and enforces its rules precisely through the production of substantializing effects'* (*Ibid*). Performativity is thus a pivotal concept. It avoids an understanding of identity construction on the basis of unilateral determinism without casting agency as operating in a vacuum.

Performativity is not to be confused with performance. Performance suggests an actor who consciously follows – or refuses to follow – a script (Kirby, 2006; Scrhift, 1995). The individual is not free to choose an identity. Equally, the individual is not condemned to simply act out a structurally determined identity. Performativity is a process concept that seeks to escape – or at least to reject – the dualism and reconstruct it as a site of introspection and political change. It casts people as active students of themselves and in this way can offer 'ways out' of reification processes and provide space for identity reconstruction on the basis of individual conceptions of the good life (Snoek, 2014). It thus allows us to better understand the way in which capabilities for political agency may be scaffolded through measures that prima facie appear benevolent restrictions on agency and freedom of thought.

Here, Butler is extending Foucault's notion of the productivity of power in that the very possibility of an identity norm (e.g. gender) is at the same time that which allows resistance and subversion. For Butler, identity is enacted through the 'forced reiteration of norms' (Butler, 1993: 2). Butler's insistence on the enactment of identities in everyday life roots political performativity in mundane daily experience. This idea flows out from Foucault's elaboration of the deadening routines of disciplinary lives that can help in theorising the ways in which the ritual order restricts opportunities for political performativity (Chambers & Carver, 2008).

Structural and discursive constraint is constitutive but not exhaustive of the 'performed' nature of political identity. Discourses are performative to the extent that they co-produce what they name. Not all speech acts are, therefore, performative. Performative speech acts can prescribe and prohibit; cajole and command; censure and sanction. In all cases, to be performative, a speech act must categorise an individual, group, behaviour or attitude and, simultaneously, allow others to recognise the difference signified. Butler is a post-structuralist to the extent that she argues that even reiteration presupposes performative agency and may indicate political capabilities. Performativity is the materialisation of norms, a process that is inherently unstable, latent with the possibility of resistance, subversion and transgression. Performativity refers both to the fragility and the stubborn consistency of identity narratives and thus gives us ways of restructuring discourse to increase opportunities for political performativity in all contexts including mental health rehab.

If I have understood Butler correctly, she understands all identities as socially constructed narratives that produce the effects of identity. As McKinlay notes this raises logical problems: '*every performative moment inevitably stimulates analysis that reveals yet another layer of performativity: this is an analysis of infinite regression.*' (2010; 236). The infinite regression of performativity potentially undermines the value of a concept's analytical application and recasts political action and expression as merely gestural (Digeser, 1992). On the basis of Butler's work, identity and difference appear shaky foundations for social or political mobilisation because pointing to difference as part of a social theory or a political strategy reproduces 'the hegemony of binary oppositions' and falls into the trap of reproducing the discourse that it intends to resist.

Butler has responded to these issues:

'I like the moment when the terms don't work. Or where the epistemological uncertainty, the semantic uncertainty of the term is brought into light in the way that makes people think: Well I'm not quite sure that I can use that word anymore, or, I'm not quite sure what I mean when I say X. And that's, I think, a very creative moment, an intellectually interesting moment' (Butler & Rabinow, 2001: 22).

Her theoretical work therefore appears not to be attempting to deconstruct narratives but to destabilise them in ways in which new meanings can be inserted and in which discourses may be re-purposed.

In addition, many political actions and expressions can be viewed as productive and important despite their essential character being 'gestural'. The gesture, as Kafka's literary works reveal, is an important way of initiating real and symbolic changes in political environments (Benjamin 1999; Snoek, 2014). Gestures are actions that can be both *poiesis* (actions that have ends beyond themselves) and *praxis* (actions that are ends in themselves) (Aristotle, 1926: 1140 b 1-5) and political action can be important in both respects for people with disabilities. Political participation is an end in itself in that it symbolises inclusion in the polis of political citizens. Political participation can also have ends beyond itself in the way it shapes decisions and holds decision makers to account.

There are serious difficulties with using Butler's work to elucidate the phenomenon of political identity formation and action. Her work is primarily abstract and does not easily lend itself to contextualisation in real world settings. There is however potential for political performativity to be used as a tool for individuals to study the subtleties of their own, and others, role in the context of the mental health rehabilitation service and how this can restrict or enhance possibilities for political inclusion.

Butler, Agamben and Snoek therefore provide explanations that fill gaps in Foucault's work. This allows us to interrogate the relations between specific forms of power and identity formation in the process of politicisation in a wide variety of contexts including mental health rehabilitation.

4.4. Political Identity and Benevolence

In the services visited the relations between staff and residents were shaped by the ever-present potential for coercive and/or inappropriate behaviours to be identified in the 'other' team. The constant policing of behaviour was conducted on the basis of reified rules which tended to be both discursively immutable and practically unstable. Both staff and residents felt to some extent coerced into behaviours that they resent on the basis of rules which often lost their significance. For example, residents are told to behave in socially acceptable ways according to mental health practitioners' judgement of what is appropriate. But this law often became arbitrary in application. Some residents pursue their goals against the guidance of professionals by asserting rights to self-determination. This may proceed through complaint procedures, micro-protest (e.g. sarcasm or irony), and even non-cooperative, or aggressive behaviour vis-à-vis staff and other residents.

In this thesis such behaviours are defined as potentially performing political gestures. Through such behaviours service-users and providers play at and construct political and agential identities and develop ethical worldviews. A routine response to vignettes relating to service-user political performance in hospital is to shut down such activities through segregation. A potential effect of functional rehabilitation is therefore to encourage the internalisation of the regime of rules imposed by professionals and to undermine capabilities for active political citizenship.

Disputes over the assessment of resident's interests, and the dismissal of certain goals deemed unreasonable, creates conflict. This conflict is often viewed by staff as problematic when initiated or continued by residents and necessary when caused by staff interventions. Staff constructed their duty in terms of resolving these disputes either by separating the combatants or arbitrating the 'facts'. But, if we agree with the argument that conflict is a fundamental aspect of social relations in any situation then intolerance of such conflict may constitute a restrictive rather than supportive practice. Residents may be socialised into political communities where they are systematically denied explicitly political roles.

Conflicts that arise from the problematic behaviour of staff (one example discussed with participants featured a care worker who didn't let residents go for cigarettes when it was raining) tended to be rationalised and justified by reference to service-user behaviour. On the other hand, residents often viewed conflict initiated and continued by staff as expressions of personal dislike, malice or incompetence. Some viewed transgressions of staff as exploitative or as a violation of human rights. Service-user's own problematic behaviour was regularly rationalised and justified by reference to staff or to other residents' behaviours.

Conflictual situations were officially recorded on a resident's record and this was used as justification for, and even obliging, coercive behaviours. The recourse to the use of power was invariably described as necessary to resolve conflict. Power was often used to shut down the possibility of residents choosing risky options rather than as opening up new possibilities.

A reliance on coercive strategies for dealing with conflict could become significant restrictions on resident's ability to develop skills associated with articulating and persuading others in less demanding ways. Such a system of socialisation may produce an over–reliance on conflict as a political strategy of service-users to acquire attention and resources. Conversely the intolerance of conflictual situations on the part of staff might encourage apathy in some residents who associate politics with conflict and conflict with negative consequences such as chemical and physical restraint or extended deprivation of liberty.

There is a significant asymmetry in available resources (including abstract resources such as power) available to staff and those available to patients. In Nancy Fraser's terms there is a problem of both distribution and recognition (Fraser, 1990). Staff at Site 1 and 3, in the political environment of the ward, were made responsible for making decisions about the distribution of resources and this concomitantly reduces the power of residents to pursue their goals and interests in a self-directed way. Political expression and action may be managed and controlled by staff through the distribution or restriction of resources such as staff escorts or transport. Some staff at Site 1 were frustrated that hospital managers were restricting their ability to distribute resources for recreation purposes and so managers had much more power in terms of the distribution of financial resources. However, staff at all three sites had power over where to dedicate their time and attention. At Site 1 I observed scarce resources being rationed on the basis of 'good' behaviour.

In addition to this asymmetry there was a difference in the importance attached to each conflict and this varied across the sites. For staff members each conflict occurring on their watch was a risk to their established credentials and a challenge to their authority. Therefore, dealing with such situations became important in his or her everyday practice. A staff member's ability to resolve conflict quickly is an important criterion when it comes to their status in the organisation. There are consequences for staff if they do not quickly resolve conflict and a strong sense of professional accountability for pragmatically inappropriate behaviour.

For residents by contrast the importance of a given conflict has a much lower threshold of potential importance. The consequences of a conflict might result in a change of future circumstances based on their propensity to aggressive behaviour, however, because they are not personally accountable to others on a mental health ward (because behaviour is constructed as the result of mental health rather than choice, and the community is ephemeral), these consequences may be experienced as abstract. If someone has been told a mental illness is in fact responsible for their more problematic acts, then the consequences of such acts may have reduced import. In addition, there may be some perceived benefits for residents in seeding conflict in focusing attention on their needs, in retribution, or simply in asserting some power through micro protest.

The political environment of the institutions studied is one in which a class of citizens, possessing the right to equal participation in communal and political decisions, are separated from normal society by an ascribed mental health status and through relocation to long stay residential facilities. Service-users are given little choice in the design and management of their separated communities and conflicts are arbitrated on the basis whether it is the citizen or their illness making such demands.

If a resident wanted to gain immediate political capital in this sort of environment two strategies were pertinent: compliance or challenge. Both strategies are achieved through performative gestures which constitute forms of political agency. Part of the restriction of opportunities for political participation is manifested in the way mental health discourses and treatment practices absolves residents of social accountability for the way they exercise power through such gestures. This reduced the importance of developing skills to negotiate conflict in a more articulate and respectful way.

Adapting political environments through pedagogy means legitimising residents exercise of power in negotiating conflict. In this modelling of, and playing at, political identities participation in political processes and dialogue may become more appealing for service-users. Learning the language of political gesture and action appears most beneficial to service-users when the pedagogical approach had features of mutual learning.

Narratives are important in orientating us to be able to adopt appropriate roles and identities in particular contexts. According to neo-Aristotelians such as MacIntyre (1981; 1984) and Nussbaum (1995) humans are story-telling animals who learn and develop political and moral agency by engaging with the stories of others. D'Olimpio (2018) argues that political agents use rational emotions to empathise with others and to engage in moral ways (i.e. appropriately) with them. D’Olimpio and other educational theorists (GIVE REFS) advocate engagement with and creation of narrative art (i.e. plays, novels and films) as an opportunity to imaginatively and sympathetically explore diverse characters and scenarios in the safe spaces created by fictional worlds. In the process D'Olimpio’s (2018) argues students’ political education might usefully develop from engaging with practical philosophy, a praxis, taught and learned in the context of what she calls a ‘Community of Inquiry’ (CoI) where narrative artworks can provide useful stimulus material to engage students in processes of politicisation and motivate philosophical dialogue and the formation of good habits. In a similar vein, by practising what Nussbaum calls a ‘loving attitude’, both staff and service-users in mental health rehabilitation might develop identities and capabilities that lead to forms of practical wisdom or *phronesis.* Practitioners implementing policies of political inclusion could draw on this literature in ways that open up more diverse opportunities to engage in appropriate political action and be recognised as political agents.

4.5. The Anthrogogical Approach

In the mental health rehabilitation centres under study, political education and support was provided to adult service-users. In order to build on, and apply Freirian approaches to education, it is important to consider the theory of adult education or ‘andragogy’. Andragogy seeks to develop a more targeted discipline of adult specific education useful in the implementation of policies of political inclusion.

Freire discussed the political education of oppressed citizens under the heading of ‘pedagogy of the oppressed’. The etymology of pedagogy is originally derived from the Greek paidagogos ‘*slave who escorts boys to school and generally supervises them*,’ and later from ‘*a teacher*,’ and ‘*pais* (genitive paidos) meaning ‘*child’*. Thus, pedagogy originally meant leading children, although the meaning is somewhat broader in modern usage denoting educational theory and practice more generally. Constructing political education as a form of pedagogy in mental health services is potentially infantilising and poses the danger of reinforcing the hierarchical relationship between teacher and student. The term andragogy helps to focus theoretical and practical development onto adult education in healthcare settings. However even andragogy is not without problematic connotations. Andragogy (‘*andro’* – meaning man, male or masculine) refers exclusively to teaching men. I therefore use the neologism, anthrogogy to denote leading or teaching adult citizens whatever their gender.

The perspectives on andragogy (or anthrogogy) as a discipline are varied. Savicevic (1991, 1999). Comparing differences of perspective between several European countries, identified five distinct approaches:

1. Anthrogogy as a sub-discipline of pedagogy.
2. Anthrogogy as an integrative science, with disciplines such as sociology and psychology being unified.
3. Anthrogogy as a pragmatic and practical field, focusing on managing the behaviour of teachers and learners in adult education.
4. Anthrogogy as a field of research belonging to established sciences such as sociology, psychology, and anthropology.
5. Anthrogogy as an independent scientific discipline with its own scientific structure, specific fields of research, and a system of sub-disciplines.

A full discussion of the numerous theories of andragogy is beyond the scope of this thesis, but, in this section I introduce and adapt the theory of andragogy as a model of inclusive educational practice which in later chapters is used as a tool of evaluation

Adult educational theory can be separated into three discrete paradigms: Behaviourism, Cognitivism and Constructivism. Behaviourism, advocated by people like Watson and BF Skinner is premised on five key concepts: 1) contiguity; 2) reinforcement, 3) stimulus-response, 4) operant conditioning; and 5) contingency. Adult learning is a process, according to behaviourists, of creating external conditions that reinforce ‘correct’, and/or discourage ‘incorrect’, behaviours. Conditions in which learning becomes possible, in this paradigm, involve those in authority providing external social and material reinforcement. This advocates a highly structured situation in which teachers condition students to behaviour in the correct manner. Correct behaviours are dictated to students by teachers. Learner’s mistakes are problematised as inappropriate and antithetical to the learning experience. Mistakes must be avoided and students must be guided through simple to complex tasks, step by step.

This approach is dehumanising in that it treats people like objects to be shaped or animals to be trained by a master using positive and negative reinforcement.

This ignores people’s idiosyncratic worldviews, their perspectives and the need for adults to have social status and recognised as independent agents.

Cognitivist approaches to education, by contrast, seek to interpret cognitive processes, such as reasoning, in mechanical terms using concepts such as information handling and organisation (Legendre, 2005). Key concepts in the cognitivist approach focus on 1) Procedural (know how) and non-procedural knowledge, 2) Short and long-term memory, 3) Knowledge transfer, 4) Metacognition 5) Cognitive dissonance and; 6) Simple to complex learning sequences. Cognitivists see learning as an internal processes that responds to external conditions. The students representations, strategies, and procedures are considered and the curriculum adapted to these internal structures. Cognitive conflict, or problem situations create situations conducive to discovery and motivate open minded exploration. Within this process, mistakes become a central source of knowledge, because they generate cognitive conflict. The educational processes is iterative going from complexity to simple to complex again.

This approach has also been criticised in application for treating adult learners as machines equivalent to computers. This obscured the contexts and relations of power operating in the educational processes. Responding to such criticisms cognitivists like Bruner (1996, 2009) whilst accepting the parallel between human and computational learning processes, insists, that the mind of an individual always operates in a specific cultural setting which has an influence both on the subjective production of meanings and the internal organisation of information.

Bandura (1977, 1994) expanded the cognitivist approach by integrating the social perspective in his analysis of learning processes. Learning is explained by internal processes, but the emphasis is on social mediation so is contextualised. The focus for Bandura is on cognitive processes, social interaction processes, and acknowledgeable results. Here the forces that drive learning include both social and cognitive conflict, problem situations and the notion of proximal development zone. The proximal development zone refers indicates that open situations permitting discovery and exploration are conducive to open-minded learning. Within this framework a learner's mistakes are a source of learning, because they generate cognitive conflict and social confrontations, interactive regulations are a place where ideas can be articulated and challenged productively.

Three humanistic variants of the cognitivist approach may also be considered useful for evaluating policy implementation and in identifying fruitful lines of inquiry in developing policies of participation in mental health settings. In analysis I concentrate on humanistic approaches as they are specific to human relations and context based requiring a focus on the human being in social interaction. This escapes the danger or universalised application being assimilated into 'machine organisations' in ways that reduce opportunities to perform political identities and exercise various types of agency outside the ritual order.

Andragogy based on classical humanism, draws on the teachings of Plato and Socrates. "Know yourself" is a foundational principle. Education in this tradition places focus on inculcating capacities for reason, character, and self-knowledge (Thorpe, Edwards & Hanson, 1993).

Rosenstock-Huessy posits a different approach to humanistic andragogy in which experience and dialogue are foregrounded over formal and logical reason (1970). The dialogical approach is called by some authors 'dialogical humanism'. The adult is to be engaged in moral dialogue to allow satisfactory ways of living to be identified articulated and justified to others. Rosenstock-Huessy (*Ibid*) argued the construction of narratives about both past and the future, and the inner and outer lifeworld becomes possible through this subtle interplay of ideas. This approach aligns with the reformed approach at Site 1 as well as some aspects of practice observed at site 2.

The third perspective on humanistic andragogy was developed by Knowles (Knowles, 1970, 1980). Knowles, posits a more individualistic approach which omits any emphasis on social and political transformation as a goal. Wain (1987) dubbed this a form of romantic humanism in reference to the humanistic psychology of the 1960s, with the theories of Maslow (1943; 1954) and Rogers (1959; 1961) as an important basis for his thinking.

Loeng argues that Knowles theories are '*not about the human being meeting something "greater" than himself/herself in order to develop'* but are rather '*aimed more at individual needs and the self-sufficiency of the individual'* (2018: 11). This form of adult education is about personal development in absence of any grander social and political perspective. Due to these individualistic tendencies, and the apparent need for a grand narrative/worldview in motivating political action, Rosenstock-Huessy's approach appears a more appropriate basis for the development of a modern political anthrogogy of citizenship.

Despite his individualising tendencies, Knowles provides some useful practical assumptions that might assist in the implementation of policies of political inclusion (1970; 1980). These inform strategies aimed at motivating adults to engage in self-directed educational activities:

- As people mature self-concepts move from that of a dependent to a self-directed learner.
- Adults accumulate vast experience that becomes a fruitful resource for self-directed learning.
- Adults' motivation to learn is dependent on enhancing and developing their social roles.
- Adult perspectives shift from one based on postponed application of knowledge to immediacy of application.
- Adults' orientation toward learning shifts from subject centeredness to problem centeredness.

This indicates that educational initiatives that are presented as a form of didactic schooling, whereby individuals learn from a teacher as they did in childhood, are inadequate in constructing empowering educational practices for adults.

It is useful to also consider the concept of Bildung. Bildung, reflects a process of engagement and self-criticism when facing different and often alien perspectives, in the process of constructing and reconstructing the self. It is a dialectic, between the possible and what appears unattainable, in a given professional or social culture. The relationship between self and the world is a necessary opposition that generates interplay. Bildung does not come from gaining competencies as we saw in the discussion of self-mastery, but rather grows out of an inner process of formation and cultivation (Gadamer, 2001, 2003). The endpoint of this processes is an appreciation of the constant process of self-formation and cultivation.

Bildung invites a dialogical approach to the different calls of system and profession being made on the practitioner. Developing practice becomes a dialogical response to power being exerted on the practitioner and informs progressive development. Applying these principles of dialogical self-formation may help us better understand the ways in which rights to participation in public and political life can be supported in more person-centred ways.

One central methodology advocated by educationalists is building a Community of Inquiry (CoI). The CoI is based on democratic, student-led discussions where the teacher acts as a facilitator instead of being the one source of all knowledge (Cam, 1995). This models the idea of interchangeable teacher and pupil roles. Once these more inclusive political environments are built the boundaries of appropriateness in political action and expression are potentially changed.

The CoI is built up with the use of tailored narratives (appropriate for the ‘pupils’ context and capabilities) or other stimulus texts which is then discussed in the group by following the interests and perspectives of all the interactants (rather than being directed by the teacher). *The CoI is arranged in a circle with chairs* *facing inwards so that students can listen to and speak with each other, rather than aiming their dialogue solely towards the teacher standing at the front of the classroom.* (D'Olimpio & Teschers, 2016) The role of the teacher is adapted as the teacher facilitates discussion rather than managing and evaluating students' contributions. They follow where the conversation leads without a specific outcome in mind (Kennedy, 2015).

The trained facilitator encourages critically reflective thinking and open-mindedness as interactants engage in political debate and build upon or challenge their own worldviews and those of others (Sharp, 2007). Lipman defines critical thinking as '*thinking that (1) facilitates judgment because it (2) relies on criteria, (3) is self-correcting, and (4) is sensitive to context'* (Lipman, 1991, p. 116).

However, critical thinking is not sufficient to enable people to fully engage in public and political life. Laurance Splitter and Ann Sharp highlight "caring" and "creative" thinking as equally important skills that political agents should be capable of utilising in shaping and changing the world (Lipman, 1991; Splitter & Sharp, 1995). In this way the critical thinker will not just know what the right thing to do is; they will also know how to go about accomplishing that action while being sensitive to the context and others involved in the situation. It is this contextual application of knowledge and the transferable thinking skills that form the basis of appropriate political action and expression (Sharp, 2007, p. 13).

Three main practical implications could be derived from the anthrogogical approach to political education:

a. priority should be given to the development of meaning and understanding rather than to behavioural training,
b. those temporarily adopting the role of teacher in supporting political participation should presume that learners' actions and reactions are rational, considering how learners give meaning to their reality,

c. learners' errors and unexpected responses should be interpreted as opportunities to know how they are grasping reality. (Legendre, 2005, p. 290, translated by Pätzold, H. (2011). Learning and Teaching in Adult Education: Contemporary Theories. Verlag Barbara Budrich.)

Lave and Wenger (1991) similarly see the learning processes as "participation in communities of practices". They situate knowledge acquisition in the context of everyday experience and of their specific participation in social and political processes. Using an anthropological perspective, Lave and Wenger observed and conceptualised how people develop and mobilise knowledge in relation to a specific context. Observing learning processes as a form of participation in communities of action, they find that people's internal recognition of themselves as competent actors, and external recognition of these performed identities as legitimate is conducive to learning and participation more generally.

Lave and Wenger (1991) conceptualise the dynamic relations between the actors and the social world as a process of conflict and cooperation in constructing knowledge. This is based on four assumptions that: a) knowledge always undergoes construction and transformation, b) learning is an integral aspect of human activity, c) what is learned is always problematic, and d) acquisition of knowledge is not simply a matter of absorbing it, it requires personal search for pertinence and then mobilisation of such knowledge in the immediate context. The learning process, therefore, always takes place in "situated activities". The construction of professional and personal identities within a community of practice is therefore not a passive process of socialisation, but an active and interactive one (Wenger, 1998).

4.6. Conclusions

The idea of political mobilisation in this thesis is shaped by Foucault's (1980, 1982) claims that power is distributed in complex, contradictory and 'micro-capillary' ways. I have established that every interaction where power is exercised contains potential for role-distancing and counter-discourse, or alternatively role embracement and assimilation. Both strategies provide opportunities for political agency. Role distancing and other forms of micro-protest evident in the conflictual relations that sometime flare between staff and residents of mental health wards support the idea of hidden political agencies inherent in processes of conflict and cooperation. Conflict, far from being an aspect of the human condition that can be 'treated' out of existence, is an inevitable and healthy aspect of social interaction. The power of gesture is important as political performativity and by extension identity includes aspects of both praxis and poeisis.

The principled foundations of inclusive political environments on mental health wards is therefore to be found in ideas of political performativity and mutual learning in the Freireian and Anthrogogical models. Conflictual political inclusion of people with mental disabilities already exists, in dialogical processes of identity play, reformation and recognition but these processes can be recast as incorporating gestures that indicate political action and expression as appropriate and acceptable. While moments of resistance to, and assimilation with the ritual order and institutional norms are often fragmented, chaotic and random, they reflect agency of persons with mental disabilities to influence their political environments in defining appropriate and inappropriate political participation. This supports the idea that 'service-user empowerment' in both the politics of the institution as well as in the political community at large, are vital in broadening opportunities for inclusion.

Inclusive political practice in mental rehabilitation thus requires the destabilisation of role and identity for both staff and service-users and 'closing the door of the law' i.e. creating spaces in which the law and policy are suspended and so participants in interaction must construct and co-own rules of appropriate interaction. An educationalist approach based on the theory and practice of political anthrogogy may be one way of evaluating implementation of these principles. By creating spaces in which creative identity play, and mutual dialogical learning can occur, and where Law and policy are de-naturalised, new significance may be attributed to law and policy as social constructs. In turn this could help motivate participation in the Law's interpretation and application. If the door of the Law is closed rules can be (re/co)constructed in ways that allow the Law to regain its significance.

Chapter Five

5. Methodologies and Methods

5.1. Introduction

Epistemological approaches and associated research methods can quickly become problems in the field, raising unforeseen practical, moral or political questions as the process unfolds (Marshall and Rossman, 2006). From the outset, the research methodology and methods chosen should as far as possible be appropriate tools for interrogating the research questions at hand (Punch 1998). For this reason I sought in previous chapters to elucidate what Denzin and Lincoln call the 'the paradigmatic lens through which relevant phenomena are perceived and understood' (Denzin and Lincoln 2003: 368). Denzin and Lincoln (*Ibid*) define an appropriate methodology as the one most likely to produce the richest data and that which can best be considered in relation to the relevant literature

They pose four questions that I kept in mind as I designed my research:

1) How does the research design seek to interact with the paradigmatic lens through which relevant phenomenon are perceived and understood?
2) How will these materials allow the researcher to speak to the problems of praxis and change?
3) Who or what will be studied and how will the research interact with the academic and professional construction of the object?
4) What methods or research tools will be used for collecting and analysing empirical materials? (Ibid)

In establishing the rationale for the choice of research methods I drew on examples from other research. Maconochie's ethnographic study of children's participation in the governance of Sure Start centres (Maconochie, 2013) was one of the main inspirations for the methods used. I also consulted an advisory committee including experts by experience, established academics in the field such as Redley, and practitioner researchers such as Khwaja and Clarke.

Previous research concerning the implementation of policies of political inclusion has focused on measuring the number of persons with mental health problems registering on the electoral register and voting in elections prior to, and after implementation (Keeley et al 2008; McIntyre et al 2012). This suggested the aim of policies of political inclusion was increased voting and registration rates. This approach may reflect the requirements of governmental decision makers for statistically representative measures of policy efficiency and success but does not necessarily address the benefits of such policies for real persons with mental disabilities. In contrast there is relatively little research that deploys a more detailed ethnographic approach to the implementation of such policies in secondary mental health facilities.

I have identified a need for detailed, rich, contextual data to adequately explore the as yet unanticipated issues and dilemmas surrounding practical support offered to psychiatric patients in exercising political rights. In order to inform an inquiry into how the new policies of inclusion are introduced, and the effect they have on staff and patients in treatment of significant mental disabilities, data regarding the diversity of experiences, contextual pragmatics developed between staff and residents, and the opportunities available for political action were identified as relevant in mental health rehabilitation (see Chapter 2).

Mason asserts that to deal with this type of data the analysis must be grounded:

in a philosophical position which is broadly interpretivist in the sense that it is concerned with how the social world is interpreted and understood, experienced or produced… (Mason 1996: 4)

Denzin and Lincoln (2003) also point to the fact that humanist research is multi-method and by implication generates data that is both diverse and detailed.

A philosophy of knowledge that foregrounds both pragmatism and interdisciplinarity is appropriate for an exploratory study seeking to produce rich and detailed data in a socio-legal field which engages social and medical epistemologies, political science, philosophy, sociology and legal theory. Bourdieu advocated an epistemological approach that reflected these pragmatic principles called methodological polytheism, which I propose to adopt (Bourdieu & Wacquant 1992).

In this research I am attempting to describe, and analyse theoretically, real life instances of political participation being supported in mental health rehabilitation. An appropriate method was therefore to observe people in the setting in which they live and participate in their day to day activities in and around elections. I also needed to understand individual perspectives and narratives and that meant talking to people in a fairly unstructured, flexible and open-ended way. Further, the study of how policies of political participation are implemented in mental institutions means examining interactions in naturally occurring settings by means of methods which capture their social meanings and ordinary activities (Brewer, 2000). Broadly speaking this study can therefore be described as ethnographic (Burgess, 1982; 1984; Atkinson & Hammersley, 1998).

Ethnographic research usually involves the researcher directly participating in the setting, if not also the activities, in order to collect data in a systematic manner. Researchers in the field of education such as Maconochie (2013: 72), James and Prout (1997: 9) argue that ethnography and field observation are particularly useful methods. They provide participants a more direct voice and participation in the production of data. This is not possible through experimental or survey styles of research. Ethnographic approaches enable participants' capabilities and voices to be respected because they control what they do, when and with whom (Tudge & Hogan, 2005).

In applying these methodologies, the researcher should be careful not to impose meaning on actions but to describe the meaning attributed to them by participants. This is part of the reason why I chose such a broad and encompassing definition of politics in order to capture the diversity of meanings it had for participants.

Although some aspects of human behaviour are easily quantifiable (such as the registration or voting rates) other aspects are less so (e.g. symbolic, personal or communal benefits of greater political engagement) (McLeod 2003). Therefore, in-depth ethnographic and micro-sociological approaches, in combination with survey data and documentary analysis, were initially chosen as appropriate

The chosen research methods were therefore:

a) By the researcher on the researcher
    - Research Journal

b) By the researcher on publicly available data
    - Analysis of CQC survey data
    - Analysis of policy documents

c) By the researcher with participants
    - field observation and semi-structured interviews at hospital sites;
    - consultation and joint consideration of future practice.

These methods were designed with the intention of enabling me to collect a considerable range of policy documents and to gain knowledge of and access to and appropriate sites for the field study. In this way I hoped to generate a detailed and rich dataset which would give me a comprehensive understanding of the issues and dilemmas arising from the practices in question. In the event, as I go on to describe in the following sub-sections, the survey did not deliver the range of documents needed, nor a nationally representative picture of policy implementation so the main method was the field study in three sites.

5.2. Research Methods

5.2.1. Survey

The survey was to enable me to collect a range of policy documents and to gain knowledge of and facilitate access to appropriate sites for the field study. It was not, and was never intended to be, nationally representative.

The sample of wards in the study was constructed using a convenience sampling technique of mental health wards in England and Wales i.e. the wards the CQC happened to be inspecting during the summer of 2017. Specialist mental health care is provided by both NHS trusts and independent mental health providers in England and Wales. In 2017, there were 54 NHS trusts and 221 independent mental health locations providing such services consisting of a total of 764 specialist wards (Care Quality Commission, 2017). In the survey conducted the CQC completed 68 inspections over a three-month period at which the survey questions were asked.

The CQC inspections were Mental Health Act monitoring visits. These visits can be conducted on each ward of any hospital that detains patients under the MHA on a 18 – 24 month cycle. The CQC prioritise visits within this timescale based on types of ward and acuity of patients, locally-known risks, previous visit findings and the frequency of admission to the ward type. These criteria determine the basic visit schedule for each individual ward (Care Quality Commission, 2020). The basic schedule is flexible however and visits might be pulled forward if the

CQC has a particular concern. This means that the sample of survey participants were to some extent randomly distributed across services that are rated good, requires improvement, and inadequate. It was of course, by no means a random sample. Self-selection bias, i.e. wards with written policies being more likely to respond, was limited. All wards visited responded to the survey questions but only four policy documents were collected.

CQC inspectors during these visits asked two questions of the respondents. The questions were:

1. *Is there a policy on inpatient voting rights applicable to the ward? (such a policy might, for example, require inpatient wards to provide timely written guidance to both staff and patients on eligibility criteria, voting rights and the process of registration before elections, and require that staff discuss practicalities of registration and voting with inpatients as part of their care plans). If yes, please request a copy of the policy to return with this form.*
2. *Have patients likely to be resident on the ward in June 2016 been helped to participate in the EU referendum? (such help might include help with registration, or advice or support about practicalities in voting in the referendum, or providing access to referendum campaign materials on the ward). If yes, please give brief details in the space below.*

The data from the survey was analysed using descriptive statistics but also analysing the sparse data for indications of substantive practices of political inclusion, even in absence of written policies. This information was also triangulated with other contextual data on the type of ward and treatment being provided. The sample was not randomised and responses were inevitably influenced by the context of a regulatory inspection; however, the findings serve to build a preliminary picture of the state of practice at present relating to implementation of policies of political inclusion and was particularly important in identifying cases for further study.

5.2.2. Document Analysis

The three policy frameworks gathered through the initial survey all declared the aim of increasing and enhancing opportunities to exercise the right to vote for mental health service-users'. This, it was implied, was sufficient to protect the right to effectively and fully participate in political and public life on an equal basis with others (Art. 29 UNCRPD). The policies were sourced from five distinct institutions although sites 2 and 3 were covered by the same NHS Trust-wide policy:

1. A private mental health hospital (Site 1)
2. Open rehabilitation facility (Sites 2)
3. Closed rehabilitation facility (Site 3)
4. A medium secure mental health facility (Site 4)
5. An elderly person's ward (Site 5)

A document analysis of the four policy documents was conducted following the survey. This was conducted using both thematic and comparative analysis. Thematic analysis is used as "*a method for identifying, analysing and reporting patterns (themes) within data*" (Braun & Clarke, 2006: 79). Thematic analysis provides a detailed, and nuanced account of data (Braun & Clarke, 2006).

Thematic analysis can be conducted within a constructionist paradigm, by which the policy texts are seen as constructing particular realities for persons charged with implementation and for those intended to benefit (*Ibid*). The policies were texts created to be seen, read, interpreted, and acted on. They were therefore analysed with such uses, and intended audiences in mind (Krippendorff, 2019). Inductive thematic analysis was useful as there were no previous studies dealing with the policies in question, and therefore the themes are derived directly from the text data (Hsieh & Shannon, 2005).

5.2.3. Case Study Selection

I applied for and received ethical approval from the East Midlands - Nottingham 1 NHS Research Ethics Committee (17/EM/0165) to conduct the field work at five potential sites. I acquired institutional approval to access three; one under the jurisdiction of the third policy discussed (s.5.2.3) and two under the jurisdiction of the NHS policy discussed last (s.5.2.4).

The research sites consisted of a private mental health hospital (site 1) and two NHS run rehabilitation services (site 2 and site 3) identified by the research officers at the relevant trust. All three sites were implementing policies of political inclusion. Observations occurred during general and local elections between 2017-2018. An elderly peoples ward and a medium secure facility (discussed in chapter 6) did not grant access. Being self-selected this skewed the data towards sites which were enthusiastic about facilitation of political rights.

Site 1 was a closed rehabilitation service providing mental health treatment in excess of 70 service-users. The facility was separated into staff areas and wards which were organised to enhance surveillance capabilities of staff. Staff and patient areas were strictly segregated. There were hatches through which medications were distributed.

The service-users here tended to have long-term mental health problems. Many had been hospitalised for significant periods of time. The facility had medium and low security wards and number of people detained at the site were under s.37/41 orders. Many of the people were detained under s.3 MHA 1983 and were constructed as high-risk. Staff wore alarms at all times, and doors were always locked. The four service-user participants at the site had a range of mental health diagnoses including learning disability and personality and anxiety disorders. The service-users I talked to and observed had little experience of voting prior to data collection. Three of the participants had been in institutions their whole adult lives.

I liaised with the social worker at this site who was in charge of policy implementation and who nominated staff and service-users for observations and interviews. I observed a visit to the polling station and information sessions based on supporting capacity and interviewed the social worker, a mental health nurse, a speech and language therapist, an occupational therapist and a ward manager as well as the four service-users. During the observation of morning governance meetings, I distributed consent forms and information sheets to all attendees and, prior to interviews and observations, presented information sheets and took informed consent despite this also being completed prior to my arrival.

Site 2 and 3 were both operating in large cities and had capacity for treating between 12-18 service-users. I liaised with the policy drafters initially to identify these two sites which may have meant that services were chosen specifically to demonstrate the benefits of the policy. This self-selection was necessary to gain access.

Site 2 was a community based open rehabilitation facility and was structured like a house. They had a kitchen and communal dining area for both staff and service-users to eat together and the rooms were not on closed wards. Alarms were not used, and service-users were frequently granted leave from the hospital to visit local shops or even just to go for a walk. Many were there informally. Staff areas were porous to service-users. Service-users were constructed as low risk and progressing towards recovery and step-down services. The service-users here were diagnosed with a range of mental disorders from psychosis and paranoid schizophrenia to personality disorder, anxiety disorder and depression. I liaised directly with the general manager of the facility who selected and recruited staff members for participation in the study and who subsequently identified and recruited service-users subject to the policy. I interviewed three service-users, two mental health nurses, an occupational therapist and the ward manager. I also observed a mental health nurse escorting one service-user to the polling station. Ethnographic data collection took a week at this facility.

Site 3 was a locked rehabilitation facility structured in a similar way to Site 1. Many of the service-users were detained under s.3 MHA 1983. Six service-users were detained under 37/41. The facility was used as a step down from medium secure or low secure units. Here I only attended for a single day and interviewed the ward manager, a nurse who had escorted a service-user to the polling station and the service-user who had been escorted. No observation was conducted as on polling day observations were done at Site 2.

The duration of ethnographic field work was 10 days at Site 1, 7 days at Site 2 and 1 day at Site 3 so was relatively short for conducting the detailed inquiry proposed. The brevity of the field work was necessary to keep disruption of the day to day services to a minimum and was largely dictated by the ward managers granting access. In compliance with the requirements of the NHS research ethics committee and with the University of Nottingham School of Law code of ethics I used consent forms and information sheets for each aspect of the research and deferred to responsible clinicians at the sites to conduct capacity assessments for participation in the study. The recruitment strategy was essentially based on a ‘snowball’ sampling method. Ward managers/policy champions were recruited first. Through this first contact willing and appropriate staff and clinicians on the ward were identified and recruited for interviews and observations. Front line staff then conducted capacity assessments and distributed information sheets and consent forms to recruit service-user participants. The inclusion criteria were as follows:

Staff:

- The participant must be employed within a mental health service currently implementing policies designed to increase political participation.
- The participant must be involved in the interpretation or implementation of the relevant policies.

Service-users:

- Participants must be eligible to vote in the UK.
- Participants must be in contact with secondary mental health services implementing policies of political inclusion

The restriction of participants to those who were eligible to vote had important implications as it meant that the sample of participants was skewed to those who already had important political rights recognised. As discussed in previous chapters the right to participate in political and public life is a broad one and is not restricted to casting a ballot in elections and therefore reasonable accommodations and support for people with mental disabilities should also be extended to the excluded group of service-users. As the research recruitment process was delegated to the staff members implementing the policy, and implementation was restricted to those who were eligible to vote this resulted in the sample being restricted to this population. Further research should however be designed explicitly to include these service-users who were excluded in order to capture the opportunities and restrictions on political participation pertaining to all service-users.

In data collection, focus was placed on the practical implementation of policies of political inclusion and involved observation of wards in the run up to, and on polling day of general election and local elections between 2017 and 2018.

I conducted two observations of practice on a polling day: one during a General Election with 4 participants and the second during local elections with 2 participants. In accordance with the ethical approval observations were conducted only on interactions between individuals who had read information sheets and returned consent forms. This included attending morning governance meetings, visiting wards, eating lunch with participants and being taken on tours around the facilities with a minder. Ethnographic observations at Site 3 lasted only a day so the scope of data collection was more limited. On each day of observation, I went through the information sheet again with participants to review continued willingness to participate and capacity. In total 22 people participated in the observations and interviews.

5.2.4. Observation

Observation of practice was a primary technique of data collection. As well as formal observation of policy implementation, the general workings of the mental health hospital was a focus. The information produced in this process forms a dataset on which to base analysis of micro sociological processes situated in wider social systems.

Observations drew on visual and audible data as well as other non-verbal cues to try and understand phenomena (Bowling, 2002). I also took the opportunity to read as much of the media content available on the ward including internal magazines/newsletters, posters and photos that were available to visitors. This method produced detailed information regarding the duration, frequency, consequences and nature of behaviours and discourses relevant to the policy implementation. The observation was structured in collaboration with the policy coordinators after an initial visit prior to the data collection. I allowed the policy coordinators to direct me to locations in which the relevant practices would occur. Rather than actively imposing a structure on the policy coordinators I wanted to take a passive role in observing the policy implementation. This theoretically allowed the relevance of many behaviours and discourses to emerge more naturally

(Duxbury et al, 2010). Knowing that the aim of the project was to support the realisation of participatory rights for patients inevitably influenced the way in which the hospital staff presented their practices. In order to reduce this influence, I avoided any prescriptions for practice in my communications with the participants prior to the data collection and attempted to be a small and unobtrusive presence. This was not always successful.

In addition to visual audible and other data I collected some information on the diagnoses of service-user participants. However, the laws and policies being implemented were not conditional on capacity or the nature of impairment and so practices studied did not divide service-users into diagnostic groups and adapt practice on this basis.. Although reasonable accommodations presumably should be tailored to specific service-users' circumstances and conditions diagnosis specific such approaches were not observed in any of the three sites. Instead general educational approaches were adopted.

Although it does nothing to weaken the imperative of UNCRPD policy for all, the different practical issues of behaviour accompanying an individual's diagnosis or the level of severity of a collective of service-users in a ward creates a context which has a direct impact on the way implementation is pursued. Therefore, the relation of diagnosis to implementation is an urgent topic for future research. This thesis can only make limited contribution to that issue.

A second reason why the diagnoses are not emphasised in the analysis is because there was a small range of diagnoses (limited to learning disabilities, personality disorder, anxiety, depression, schizophrenia and psychosis), little detail of patients medical histories, and idiosyncratic combinations and manifestations of symptoms. The decision was made not to write the thesis as an exploration of how particular mental health conditions affect and impact on political capabilities. This is because a social model is adopted in the UNCRPD which places focus on the environmental restrictions rather than underlying impairments.

Of course, there are real practical difficulties in enhancing political participation that may be attributed to different diagnoses. For this reason, I explicitly acknowledge, explain and discuss the behavioural presentations of service-users that do have impact on institutional and practitioner policy and behaviour where possible. However, it is not just individual diagnoses, but the collective severity of behavioural presentations of service-users gathered in different wards according to levels of risk, that impacts politicisation. An example of this was the different conceptualisations of appropriateness at the more secure sites (hatches, strictly separate areas for staff and service-users etc) compared to other more 'relaxed' sites. Given the limitations of assessing the impact of diagnosis on political inclusion within the current project, a future research agenda should include finding, studying, appreciatively critiquing, celebrating, explaining and disseminating good practices that seek to overcome some of the restrictions inherent in certain psychological and psychiatric ailments.

In asking questions of participants during the participatory observation (Bergold & Thomas 2012) I adopted the role of an 'acceptable Incompetent' in that I assumed a 'naive stance' giving verbal and non-verbal cues to signal to the participant that I was a sympathetic listener. This is an important aspect of appreciative inquiry as real or perceived social, or even clinical judgments of the content of the communications between researcher and participant will, in the context of a CQC regulated mental health hospital, potentially change the emerging and constructed discourses significantly. Judgment implied in verbal and non-verbal ways can indicate a certain meaning to the interaction (i.e. as an inspection rather than a non-judgemental interaction). Therefore, the importance of empathy, complicity and accumulation of shared experience – i.e. co-construction - was foregrounded in accordance with participatory action research principles.

5.2.5. Semi Structured Interviews

After gathering observation data interviews with staff and residents were conducted in order to better understand their experiences of implementing, and being subject to, the policy in question. Both these sources of data allowed an analysis to be conducted on performativity, power dynamics, the impact of organisational structures and the relationships between residents and staff.

The chronological sequence of data collection meant that the interview responses, which relied on individual's articulation of their experiences, is potentially subject to the effect of a triple hermeneutic (Green & Thorogood 2004). Increasing the specificity of interviews to participants own experience was important. Participation in policy implementation introduced proximity and this meant that experiences conveyed by participants were distorted less by spatial and temporal distance. As reality was transformed into participant experience, then into linguistic symbols in interview to be interpreted by the researcher, it was necessary to take account of the number of such conversions and translations. This process can introduce mutations of meaning subsequently amplified by the research process.

The study included interviews with service-users, ward managers, therapists, social workers, psychologists, care assistants and mental health nurses. I also engaged in consultation with a social worker, a responsible clinician and a service-user after data collection. Half of the interview participants were service-users.

If a participant appeared uncomfortable or anxious during data collection they were asked if they wanted to continue. In one instance an interview was terminated after 6 minutes due to the service-user stating he had said everything he wanted to say.

Interviews with ward managers were conducted to explore the nature of specific policies and their implementation. Information sheets were read and consent forms filled in at the start of each interview. I electronically recorded interviews and transcribed the data in anonymised form. All transcripts and observation notes were coded and analysed using NVivo 12. Interviews with staff and practitioners were utilised to access retrospective accounts of professional practice on the ward and to discuss issues and dilemmas in implementation. Accounts of the purported facilitation of political participation was explored with service-users.

Ethnographic research based in the humanist tradition traditionally uses face to face audio recorded interviews with participants as a primary method of data collection. Researchers using an interpretative phenomenological approach in accordance with critical realist epistemologies find the data that interviews produce is invaluable in accessing the lived experiences of participants, and not just the surface 'reality' of phenomenon. Fontana & Frey (2000) note that the formal rigid approach of the structured interview has given way to the more informal approach of the semi-structured or unstructured interview in the postmodern era. My own decision to use semi-structured interviews as a tool for data collection in this project was influenced by the existing relationship built up with the participants during the course of the observations. This made formal and structured interviews inappropriate and restrictive of more open and free-flowing discussion.

Relatively open-ended interviews were a useful method to use in this investigation as they were a means of accessing attitudes and values that are difficult to ascertain from observation, fixed choice questionnaires and even structured interviews. Such a technique also allowed for depth and complexity to emerge. Approaches to interviewing, encouraging reciprocity, support and understanding by allowing the participant a view of the researcher's personality and experience potentially allowed me to explore voices and experiences more comprehensively. However, the contention that this gives access to previously inaccessible and unheard voices is problematic as 'voice' does not necessarily equate to 'experience' (Kitzinger & Kitzinger, 2010). The discussions, dilemmas and issues arising from these interviews were co-constructed and the ascription of authenticity should be avoided.

Interviews with staff members reflected a slightly more structured interview technique with the direct use of vignettes (see Appendix 4). In addition, questions asked specifically about practices intended to increase opportunities to participate in politics, the language and intention of the policy behind such practices and the ways in which the practice could be improved. Potential participants for these interviews were selected by the policy coordinator in run up to the observations during elections.

Following Koslander & Arvidsson, (2007) an interpretative phenomenographic approach was used in the interview process and analysis of emergent themes. Phenomenography is a technique developed over the past 30 years based on research on learning processes in higher education. It has since been utilised widely in research relating to health care and nursing (Fridlund & Hildingh, 2000). Phenomenography is essentially critical realist in that it accepts there is a reality independent of human constructions of it but that this can only be accessed through constructing it in a way that is relevant and cognisable to people. Phenomenography distinguishes between reality - the first-order perspective; and what it is conceived to be - the second-order perspective (Marton, 1981). The approach focusses on the underlying patterns in the variability of conceptions and is particularly useful for my purposes as it enables the elucidation of variation in the way relationships and contexts are interpreted and acted upon on the basis of the principles of the new policy of political inclusion. These conceptions may represent something axiomatic or implicit, that has not previously been reflected on by participants so has potential to be a positive and fruitful experience (Marton & Booth, 1997).

Kvale (1996) argues that the construction of interview schedules in terms of the content and sequence of questions are key elements to consider in securing a rich body of data. In structuring three interview schedules used in the research (one for resident participants, and the other two for clinical staff and management), the notion of the interview as a process was foremost in my mind. In this, participants are taken through a sequence of interactions with the researcher that progress the conversation from introduction, to the main part of the interview and finally to a close. The specific way in which I adapted this for my own purposes is outlined in table 3.3. below:

Table 3.3. Interview schedule summaries

- Ward managers/clinical staff
    - Hypothetical vignettes exploring practical responses to political actions of residents
    - Questions exploring the embedding of political education into everyday mental health practices
    - Questions exploring the restrictions on the staffs' realisation of the policy aims
    - Questions exploring the benefits of the policy
    - Questions exploring the boundaries between appropriate and inappropriate support for residents' political expression
    - Open ended question leading to closure

- Residents
    - Introduction, information about the research, myself as a researcher and ethical issues
    - Biographical questions about the participant – e.g. tell me a little about yourself, are you generally interested in politics are you a political person? – what did you do before you were in this hospital?
    - Questions exploring the experience of receiving support for political participation

  - Questions exploring previous political actions undertaken
  - Questions exploring what residents want in relation to the policy
  - Questions relating to the development of political identity
  - Open ended questions leading to closure

Although the structures detailed in table 3.3 do reflect some of the characteristics of the modernist interview by employing chronological sequences in part, the scope of the questions went beyond an assumption and concern with the political participation of people being treated in mental health facilities and into other aspects of identity and their relationship with social, political and professional contexts and pragmatics.

Thematic analysis of the interview schedules was conducted by firstly familiarising myself with data then transcribing it, whilst at the same time noting down initial themes and interesting points. I then proceeded to generating initial codes again systematically noting down interesting or surprising features across the entire data set, and collating data relevant to each code using NVivo (Braun & Clarke, 2006).

In defining and naming themes I collated codes into headings. I then re-read the data reviewing where they tended to emerge, their prevalence and character. This allowed me to test whether each theme worked in relation to the coded extracts and the entire data set (Vaismoradi, Turunen & Bondas, 2013; Braun & Clarke, 2006).

In writing the thesis, a final analysis of data occurred, whereby quotes and extracts were related back of the relevance to the research question and links were made with relevant aspects of the literature.

In the last phase of the project practice was evaluated in terms of ethical and legal obligations and analysed using sociological and legal concepts in collaboration with three research participants and the advisory committee. I then fed findings back to the service-providers in site specific reports and engaged in constructive dialogue to develop ideas and principles to inform practical reforms on the basis of more robust theoretical understanding of the educational dimensions of policy implementation.

5.3. Critical reflexivity

Because the focus of this research project is on the human experience in implementation, a strictly positivist conception of validity of knowledge is inappropriate (Richardson 2000). The qualitative methodology chosen is potentially open to criticism that it does not sufficiently guard against too readily jumping to conclusions on the basis of prejudice, going beyond the evidence or in ruling out alternative perspectives.

It is the case that I bring to the task of research my own set of values and prejudices including a desire to ensure that the implementation of the policy of political inclusion has positive implications for the lives of the people meant to benefit. This unavoidable personal positioning means that continued vigilance was required in relations with participants in fieldwork, in the interpretation and analysis and in drawing conclusions.

An example of the application of critical reflexivity appears in the research journal:

[Following the consultation and development of resources at Sites 2/3] I… got too close to the staff perspective and this is distorting my analysis. I have ended up reducing the conclusions to what can be done to make policy implementation easier for staff and losing focus on the ways practice might be changed to improve opportunities for service-users. (Research Journal, Dec 2nd, 2018)

Having observed myself adopting the staff perspective I discussed it with my supervisors and took the counter measure of stepping away from consultation work with staff. I countered this by consulting with service-users one of whom developed a blog about the political inclusion of service-users during treatment.

Maintaining sense of critical reflexivity allowed me to deal with some of the methodological issues cited above. The research journal was essential in observing and dealing with the effect of my presence and positionality during data collection and throughout analysis and write up.

5.4. Appreciative Enquiry

The social skills and discursive strategies that made trusting and respectful relationships possible with service-users, staff and managers involved conducting data collection as an appreciative inquiry. The Appreciative Inquiry (AI) approach, has four distinct phases; discovery, dreaming, designing and destiny (Reed, 2007).

‘Discovery’ is the start of the inquiry and is concerned with identifying best experiences rather than commencing from a problem focus. Although this phase aims at best experience, it inevitably also gathers information about experiences that are not ‘best’.

‘Dreaming’ moves the inquiry on and changes the focus; it asks research participants to imagine how the subject under inquiry (for example, staff’s response to a resident with extreme political views) might be improved. Using this as a rough model enabled me to design interview schedules in ways that allowed staff to link their ‘best’ experience to how things may be further enhanced thereby highlighting elements and issues which are important to the research participant.

‘Designing’ involves the research participant in identifying practices, relationships and processes which might be necessary to support the ideas outlined in dreaming and articulated as ‘best’ in discovery. The final phase of AI is ‘Destiny’ and concentrates on what is needed to maintain and sustain the changes that have been dreamed about and designed.

Chapter Six

6. Policies of Political Inclusion in Mental Health Services

6.1 Introduction

The purposes of the survey were to enable me to collect a range of policy documents and to gain knowledge of and facilitate access to appropriate sites for the field study. As explained earlier it was not, and was not intended to be, nationally representative. All 68 institutions surveyed answered the two questions but only a small proportion (four) gave the inspectors a written policy document. Although this was not the 'range' of documents I had hoped for, it still proved useful to analyse them and the responses as they suggested themes to focus on in interviews and observation and in addition questions for a research agenda beyond the thesis. In this chapter I present and integrated analysis of the survey data and policy documents and discuss the import of five significant themes.

1. Inclusivity and Mental Health Status
2. The Conceptualisation of Politics
3. Conditionality of Political Inclusion
4. Influence and Vulnerability to Manipulation
5. Supportive Practices
6. Inclusion in Policy Implementation

6.2. Policy Analysis

6.2.1. Inclusivity and Mental Health Status

In the initial survey we received three comprehensive written policies from the initial survey. This works out as 4.41% of the 68 respondent wards being able to provide a written policy on supporting political participation.

One category of response was to say that implementing such a policy, even if there was one, would not be feasible due to issues with capacity and high turnover. Seven responses included references to capacity in relation to voting and registration forms or the patient's ability to pass assessments on whether they granted leave to make a vote. One respondent stated that such a policy was inapplicable because the patients on the ward were '*women with dementia'* implying that both gender and the fact of dementia, a degenerative condition, are relevant in determining people's eligibility to vote. This implies that in the case of dementia, where service-user's mental disabilities are seen as chronic, enduring and irreversible, political inclusivity is given low priority. This may be because the service-users are not seen as progressing towards a state of recovery.

Another response from the survey simply read '*Patients do not have capacity'*. This indicates that in institutions dealing with people with diagnoses associated with enduring and significant capacity issues, political inclusivity is also accorded very low priority. It may be that, in some institutions, the majority of people lack *legal* capacity in the sense of being ineligible to vote. However, *mental* capacity is no reason for exclusion. Reasonable accommodations should be made for all people with mental disabilities who are eligible to vote and even those who are ineligible require accommodation to participate in public life. Only when it is reasonable to take no action whatsoever to support that capacity, is such a strategy permissible according to UK law and policy (see Chapter 3). Under the current legal regime simply citing a lack of capacity is not enough. The point at which it is reasonable to do nothing is something that has not, at the time of writing, been tested in the courts. Neither is it a subject that has seen much popular, academic or political debate.

There were a variety of survey response referencing practices in place that support and facilitate political participation. The most frequently reported practice was discussion and debate of political issues in community meetings. Twelve responses referred to such meetings as places where the patients could make requests of staff for specific support or simply engage in political debate with others by discussing current affairs. Of the twelve responses in this vein, ten came from low to medium secure acute/PICU (psychiatric intensive care units) wards, one from locked neuropsychiatry and one from an eating disorders unit.

Nine respondents alluded to the provision of information sources useful for the assessment of politicians, ideas and events relevant to political discourse, including posters reminding people to get registered and encouraging them to do so. These again generally originated from Acute/PICU wards, low and medium secure rehab clinics and services aimed at older people. Five respondents referred to a policy to register all patients. Again, these were from rehabilitation facilities, low secure general facilities and Acute/PICU. Four respondents stated that providers had offered general support for registration and had provided access to the internet to facilitate this. These responses came from Acute/PICU, locked neuropsychiatry, and open/locked rehab clinics. Four of the responses stated that the provider had facilitated leave for service-users to visit polling stations. These responses were from acute/PICU, low secure, and rehabilitation wards.

The concentration of practices of political inclusion in low secure and acute settings indicates that people with diagnoses of more short term, acute mental illnesses are seen as more likely to benefit from political inclusivity than those whose recovery is seen as more uncertain.

As already emphasised, we cannot draw any reliable generalisations from the survey data. However, it allows us to identify some important questions about the whole of the national system that need to be addressed in a future nationally representative survey. Firstly, how widely are formal policies of political inclusion being implemented across England and Wales? Secondly, how prevalent is informal support for political participation? Thirdly, does the likelihood of implementation (formal or informal) vary with diagnosis (e.g. in rehabilitation services, Acute/PICU wards, low and medium secure rehab clinics, services aimed at older people or in high secure settings)?

The question of the effect of diagnosis on the practical implementation of policy that the analysis of the survey highlights was also directly relevant to the analysis of the subsequent observations and interviews. Another relevant theme to emerge from the survey analysis is that cognitive or mental capacity, (and to some extent perhaps gender and age also) are deemed relevant considerations in whether policies of political support and inclusion are in fact implemented.

This indicates a significant tendency in the mental health services surveyed to assume that political and public engagement is a low priority, and inappropriate for people with more severe mental disabilities and that many people detained in mental health facilities simply lack the necessary capacities. Indeed, this tendency is also evident in the written policies discussed in the next section. In general, the fact that policy implementation appeared more widespread in less secure settings indicates that political inclusivity is dependent not so much on diagnosis per se, but on how far along the road to recovery a particular group of service-users are.

The assumption that people in more secure settings are less able to engage in politics in problematic as social and behavioural problems withing a cohort of patients detained in such settings will vary widely. Indeed, the breadth of capabilities within diagnostic groupings will vary as much as in the general population as security will be dependent on risk. These assumptions can potentially create the conditions of a self-fulfilling prophecy whereby reasonable accommodations and support are not provided rendering public and political engagement more difficult and inaccessible.

6.2.2. The Conceptualisation of Politics.

One respondent to the initial survey stated they were aware of the general institutional policy and the law but that patients on the high secure ward were not eligible to vote due to criminal convictions. This was used as a justification for the lack of policies on facilitation of inclusion in public and political life.

Across all the policy documents analysed there was an exclusive focus on voting in national and local elections as the sole expression of political agency for service-users. The survey results and the policy documents provided reflect a restrictive view of what implementation of Article 29 UNCRPD (the right to participation in public and political life), and by extension the substantiation of the principle of equal political inclusion, means in practice.

Two examples illustrate this conceptualisation. On the 11th of May 2016 a MHAR visited a medium secure facility (Site 4). Staff there provided the inspector with a set of policy documents dated 1st of October 2015. The policy opens with a set of eligibility criteria for 'inclusion in the electoral register' based on criteria in the RPA 1983. This indicates that the policy drafters' conceptualisation of political action is focused exclusively on electoral participation. This means that the policy of political inclusion is readily interpreted as applying only to those who are eligible to vote. This was common across all the policies that were gathered through the initial survey.

In the mental health ward for older people with mental disabilities (site 5) visited on the 27 May 2016 the MHAR was provided with a comprehensive policy, written in 2013, designed to guide clinicians through the process of supporting patients to vote. The stated aim of the policy was political inclusivity and to ensure that inpatients can exercise their right to vote. The document lists the eligibility criteria for registration under the RPA 1983 as well as the additional criterion that they should be:

"*citizens [who] are not subject to mental incapacity.*" (Site 5, Voting Rights and Procedure for Inpatients, August 2013)

The RPA 1983 includes the criterion of *legal* incapacity. This is a legal concept quite distinct from mental incapacity. The elision of these two concepts is significant in that it contradicts the intention of the Electoral Administration Act 2009, which sought to abolish common law (mental) incapacity to vote and creates an exclusion that contradicts international law under the UNCRPD. If the law is interpreted this way even in a small percentage of mental health wards then it would represent a significant and illegitimate restriction on many peoples right to political participation in the UK.

The above interpretation was not common across all the documents. The first section of the policy document in force at site 1 for example, (a privately run closed rehabilitation service providing mental health treatment to around 80 service-users) states that

"Being a psychiatric in-patient does not inherently change an individual's right to vote… [they] have the same right to vote as anyone else" – (Site 1, Voting Rights and Procedure for Inpatients, July 2016)

Although a more accurate representation of the law, we can see that the conceptualisation of politics at site 1 is also restricted to the service-users right to vote which again is much narrower than the rights and obligations imposed under article 29 of the UNCRPD.

The policy covering site 2 and 3 also explicitly places the right to vote at the centre of political and civic life and the substantive aspects of the policy deal exclusively with protocols and procedures designed to enhance and support opportunities to register on the electoral roll and cast a ballot in elections. However, the policy characterises desired practice as that which will support *“equality and responsibility”* and *“provide a political voice for people with mental health problems”.* (Sites 2/3, Voting Rights for Service-users Policy, October 2015). This is a much broader and more inclusive interpretation of what inclusion and participating in public and political life might mean. This broader interpretation may be related to the fact that sites 2 and 3 were part of a trust which was actively implementing a ‘human rights based approach’ to mental health care. In addition, site 2 was a community-based rehabilitation facility with a humanistic and holistic approach to treatment.

In more secure institutions dealing with people with more significant mental disorders and impairments there was a greater concern with containment and risk aversion. These priorities meant that such settings were likely to be less adaptable to facilitating sometimes disruptive political action as an aspect of everyday interaction. Thus, the narrow focus on electoral participation may function to limit obligations, and the expectations of service-users.

6.2.3. Conditionality of Political Inclusion

As already noted the survey data indicated that a number of institutions see political inclusion as conditional on capacity. The policy documents also indicate that a number of other conditions may be attached to reasonable accommodations being made. Some of the sites used the ability to complete a declaration of local connection without assistance, or the capacity to appoint a proxy, as a condition of participation and support. This may significantly limit political opportunities for service-users and arguably goes against the spirit of the EAA 2006 which was intended to abolish the common law relating to mental capacity to vote.

The policy at site 4 for example, when outlining eligibility criteria to vote, states that this includes the ability to make a declaration. The declaration of local connection is merely a decision as to where the individual wants to register to vote at the mental health hospital (if she can be considered resident there) or their home address. It is not a complicated decision and should not pose a significant difficulty for individuals in contact with secondary mental health services providing they receive the necessary support and accommodations. Further, a declaration of local connection should only apply to those with no possible residence other than the mental hospital where they are receiving treatment. This policy at site 4, however, appears to apply the capacity assessment to make a declaration to all patients as a general rule.

The people designated by the policy as the adjudicators of capacity to make a declaration are 'Attesters'. According to the policy this role is taken on by the Ward Consultant Psychiatrist or Nominated Deputies and the Ward Managers or Nominated Deputies. Attesters are authorised, under the policy, to:

"*decide which service-users/patients… [have] the capacity to understand and complete the Declaration Form.*" (Site 4, Service-user/Patient Voting: Forensic and High Support Services, November 2013)

Further the policy states that the "*declaration should be made without assistance.*" The policy goes on to explain that the prohibition on making reasonable accommodations only applies to mental disability, as it *'does not preclude assistance necessitated by physical handicap or blindness'*. (*Ibid*)

The now repealed provision of the MHA 1983, (making eligibility conditional on the individual's ability to make a declaration without assistance) provides a possible explanation for this exclusion. This does however directly contravene the spirit of both the UNCRPD and the EAA 2006.

The policy at site 4 further requires the creation of a register of those with capacity to vote each year:

"The Ward Voting Form should be completed with a √ against names of the service-user/patients considered to have the capacity to register and vote, or an X against those they consider not capable." (*Ibid*)

The go ahead from a responsible clinician in terms of mental capacity precedes the patient being given the choice of a postal, proxy or in person vote. The list is compiled once a year which makes it difficult to include those with frequent fluctuation in capacity or for wards with high turnover.

The policy imposes obligations on Attesters to encourage all eligible service-users/patients to make a declaration if they are able to do so. It also encourages Ward managers to check the completed declaration forms to ensure they are filled out correctly before sending them back to the medical records office. There is perhaps some limited recognition here of the duty to assist people to fill out the forms on the basis of mental incapacities. Some administrative tasks are taken care of by hospital staff and therefore some of the burden is removed from those services users/patients deemed by Attester to be fit to vote.

Although the policy for site 4 claims that their policy and procedures do not significantly disadvantage any individuals or groups on the basis of their protected characteristics the textual evidence suggests that it has great potential to do so and is not compliant with current domestic legislation nor our international policy commitments.

The introduction of the criteria to be capable of making a declaration of local connection over and above the requirements made of other citizens, indicates that the implementers' role is constructed as an arbitrator of mental capacity to vote. By requiring capacity to make a declaration of local connection, in addition to the capacity to vote mental health professionals are exercising the power to decide who may and who may not vote on the basis of mental capacity. Under current legislation mental health practitioners or attesters do not have the power to decide whether the person has capacity to vote or not. The law is clear that people with mental disabilities have that right irrespective of psychiatric assessments. Capacity should therefore be presumed to be present in all cases, and where it is suspected to be compromised by cognitive impairment an assessment may be made only to determine reasonable accommodations, and not in order to restrict participation. It is the staff and attesters' duty to make reasonable accommodations to support and facilitate the individual's ability to register and make a declaration if they are not capable of the decision at the outset.

The document at Site 4 goes on to define incapacity thus:

"Incapacity here refers to… the ability to understand what voting means, retain information relating to it, weigh up in the balance whether to vote and who to vote for and communicate their decision." (*Ibid*)

In addition to demonstrating that they have capacity service-users must also satisfy clinicians that the provision of support to vote is 'appropriate' under the policy at site 4. Responsible Clinicians are only required to authorise Section 17 leave to allow patients to vote, and Advocates to provide support and accompany patients to vote or arrange a postal or proxy vote, when it is appropriate (Ibid).

The wording of the document strongly indicates that the role of these practitioners is to support patient's inclusion in the electoral process by authorising leave and having advocates accompany and help individuals when they actually go out to polling stations or make arrangements to vote in accordance with the EAA 2006 amendments. However, the text also grants discretion to both clinicians and advocates to either facilitate or restrict any given patient's right to vote on the basis of perceived risk. Given the lack of oversight there is a real possibility that this discretion could be applied arbitrarily or on the basis of reducing liabilities.

This criterion of appropriateness presumably incorporates considerations of the public interest and risk to the patient and others but may also refer back to the eligibility criteria of which mental capacity is a key component. Ward managers and nurses are to provide support '*as necessary'* which is a vague term that could be interpreted in a number of ways depending on what aspects of the ward's practice are prioritised.

Conditions attached to the exercise of political rights are common across the policy documents although they are not always as explicit as the policy at site 4. The way that the policy document at Site 1 distinguishes between patients who are voluntary (and thus '*not subject to any restrictions'*) from *involuntary* patients implies that some restrictions on *involuntary* patient's right to vote are potentially necessary and compliant with the policy. This is despite the fact that detained patients *'have the same right to vote as anyone else'.* (Site 1, Voting Rights and Procedure for Inpatients, July 2016).

Making support for political participation conditional on something like taking medication may conceivably result in lower, and poorer quality engagement. In some circumstances it may be perfectly reasonable for someone to refuse mind altering medication prior to casting a ballot.

The policy at sites 2/3, under the definition of capacity, outlines who is included and who is excluded from practices of support mandated by the policy. Those detained under s.37 are excluded (Sites 2/3, Voting Rights for Service-users Policy, October 2015). This indicates that those inpatients who are detained in hospital having been convicted of a criminal offence by the courts attract no reasonable accommodations. Rights to political inclusion are often conditional on not breaking the social contract through serious criminal activity. However, people detained in hospital following criminal conviction may stay for much longer periods than a normal sentence for the same crime and therefore the restriction on voting rights may be in force for much longer. There is a larger question for national policy here about whether this is un-justified differential treatment based on disability.

In any case Article 29 encompasses much more than the right to vote. People on s.37 orders are disenfranchised and therefore policy makes see them as legitimately excluded from *all* spheres of civic and political life. This is in keeping with a narrow interpretation of politics as something that only concerns official political institutions of state. Just because an individual does not have the right to vote it should not mean they are legitimately excluded from public and political life more generally.

The policy details at length the law relating to patients' right to engage in politics. Specifically, it identifies that *"all patients on civil sections (part 2) of the MHA and prisoners remanded to hospital under the MHA on Sections 35, 36 or 48 of the MHA are entitled to vote*" (*Ibid*). Authority for applying the eligibility criterion based on incapacity is identified as originating from the Mental Capacity Act 2005 which only mentions voting decisions so as to exclude them from replacement decision making procedures. The Electoral Administration Act 2006 is not referenced.

The categories of offenders who are legally incapable of voting under the RPA 1983 s.3A provisions are detailed comprehensively. The document then goes on to explain that, although entitled, in order for patients to exercise their vote, they must be included on the Electoral Register. The named nurse should: *"wherever possible help a patient to contact the Electoral Registration Officer at their local council to ensure that they are included on the Register."* (*Ibid*)

The procedure includes the administration of a declaration of local connection to be administered only if the individual has no place of residence. A process is detailed in which nurses are implicitly expected to facilitate such patients to make such a declaration. The declaration of local connection procedure is therefore applied to the population of patients intended by the Act.

In terms of eligibility the policy explains that

"[The right to vote] may be exercised... if the RC has authorised the patient to leave the hospital on Section 17 leave." (*Ibid*).

The policy rightly states that *'all patients on civil sections (Part 2) of the MHA and prisoners remanded to hospital under the MHA on Sections 35, 36 or 48 of the MHA are entitled to vote'* (*Ibid*), but hospital staff are still granted discretion to exclude some patients due to mental capacity. In the context of patients subject to legal compulsion under the MHA 1983 a responsible clinician or advocate can in practice prevent a patient form voting by restricting s.17 leave.

Despite these problems the policy captures some of the legal principles operationalised in the UNCRPD. For example, it states that "*where it seems helpful and appropriate [staff] should provide any necessary help to facilitate the patient to exercise their vote.*" (*Ibid*). The policy also includes specific duties such as:

"*Assisting the patient in making arrangements for a postal or proxy vote by contacting the Electoral Registration Officer for their area. Helping with arrangements for a patient to vote in person, including provision of an escort where necessary."* (*Ibid*).

The implementation process is detailed briefly and includes posting information on patient's legal rights on the Intranet site, ward managers briefing the staff at team meetings and an awareness campaign to advertise the policy in the Trust newsletter and elsewhere.

The analysis of these documents raises significant issues and questions to be addressed. It is clear from these policy documents that formalised practices of ‘political inclusion’ interpret politics narrowly in ways that reduce the obligations for reasonable accommodation significantly, are still largely dominated by notions of exclusion and containment, and have significant conditions attached. This raises the question of how to substantiate rights political inclusion in ways that directly benefit people in residential mental health treatment, where most other aspects of practice remain steadfastly geared towards the assessment and treatment of mental incapacity and reducing the risk individuals pose.

6.2.4. Influence and Vulnerability to Manipulation

The policy covering sites 2 and 3, and by extension every site commissioned by the NHS Trust in question, was broadly similar in structure to that found at Site 1. (Sites 2/3, Voting Rights for Service-users Policy, October 2015). After explaining the purpose and scope of the policy the document it goes on to define ‘Eligibility to Vote’ (in the terms of the amended Representation of the People Act 1983), ‘Capacity’ and ‘Proxy Vote’. The definition of capacity appears to be particularly important:

“A lack of mental capacity is not a legal incapacity to vote…… Regardless of capacity, the decision of an elector of whether and how to vote at an election must be made by the elector themselves, and not by any other person on their behalf. Those who may be a carer of a person or who make other decisions on behalf of a person may not make decisions on voting.” (*Ibid*)

The caution inherent in this definition suggests that policy drafters assume that a lack of capacity indicates a particular vulnerability attributed to service-users in falling prey to persons who might want to unduly influence a voting decision. This assumption may be warranted in some cases but interventions to prevent undue influence must be proportionate and based on individual cases.

As we saw in Chapter 2 the MCA provides no mechanism to make a best interests replacement decision regarding voting for a person lacking capacity, and no such power exists elsewhere in law (MCA 2005 S.29). It is unclear under the present law how a voting decision can legitimately be scaffolded in the same way as other decisions particularly in light of the legal safeguards and professional caution over political influence in any form. The implication that voting decisions should be made independently of outside influence should not be construed as prohibiting engagement in political discourse with peers. In fact, the concept of relational autonomy indicates that social encounters with influential others is essential in substantiating political agency.

The second section of the policy document at site 1 requires practitioners to make a distinction between those patients who are entitled to vote *and* have no impairments on their capacity to do so, and those who have a condition that impairs their capacity to vote. The practical procedure prescribed in the latter case is as follows:

"These individuals should be asked if they want to register to vote/want to vote and additional support offered to support them doing so. If they require assistance, they must be allowed to express their own intention of how they cast their vote" (Site 1, Voting Rights and Procedure for Inpatients, July 2016)

This reinforces the assumption that if an individual cannot *express their own intention of how they cast their vote* then they are vulnerable to influence. In these cases, practitioner may be entitled to relinquish support in the basis that they want to protect the individual's autonomy. This may create the kind of exclusions based on mental capacity in practice that the Electoral Administration Act 2006 was intended to abolish.

In these cases, the policy also offers a note of caution which hints at some of the issues and dilemmas that practitioners face in implementation:

"It is important that a staff member, advocate, relative or carer does not influence their voting choice." (*Ibid*)

This aspect of practice raises a number of important issues. Influence is central to political processes. It is the currency of political interactions and the expression of political power and capital. Between fellow citizens, exercising influence on one another is fundamental in politicisation and in the practice of politics itself. There is rarely a sharp distinction between undue and acceptable influence in such relations. Indeed, influence over the voting choice is often an explicit aim of political discourse between individuals and certainly between political parties and the public. Despite the centrality of the practice of influence, such action is prohibited in the policy between the service-users and staff, advocates, relatives or carers.

A political party is an agent that is explicitly designed to influence and is subject to regulations in electoral law concerning the funds that can be allocated to this endeavour. But a staff member, advocate, relative or carers has power over a vulnerable adult and so, the policy drafters seem to assume, does not have the same legitimacy to influence. Indeed, it may be regarded as prima facie undue influence and against in the interests of the vulnerable adult. But arguments and evidence presented in this thesis will support the conclusion that this should not be a general rule.

People in the general polity are constructed as capable of dealing with attempts by parties, parents and relatives to influence them in their opinions. But the policy constructs people with mental disabilities as vulnerable to influence from these sources and thus seeks to protect service-users from influential interactions. This appears disproportionate and restrictive of political socialisation where influence is appropriately exercised. I return to this important issue in the following chapters.

The last phrase defined by the policy at sites 2/3 is 'vote by proxy'. According to the policy, if a resident wants to vote by proxy rather than by post or in person, they could be restricted on the basis of mental capacity. Mental capacity is required to designate an appropriate person to act on their behalf. However, if a person detained in hospital deems that a vote by proxy is the most appropriate method they can effectively be denied the vote on the basis of capacity. As noted before, this is a restriction that is not applied to persons without mental disabilities and highlights a disparity. If mental incapacity is not a reason to deny the legitimacy of a vote cast in person, and if the appointment of a proxy is treated in law as a *voting decision,* then it follows logically that the appointment of a proxy should not be a decision that can be denied on the basis of mental incapacity.

"A person must have capacity to appoint or to continue to have a proxy, as that can be taken to be a decision on voting." (Sites 2/3, Voting Rights for Service-users Policy, October 2015)

This point of law was omitted from the policy at site 1. The process of applying for vote by proxy appears to be one that is not often used by service-users and, as we shall see in subsequent chapters, was not utilised by any research participants.

6.2.5. Supportive Practices

The survey data indicates a number of supportive practices across a range of institutions. These include:

- discussion and debate of political issues in community meetings,
- the provision of information sources useful for the assessment of politicians, ideas and events relevant to political discourse

- posters reminding people to get registered and encouraging them to do so;
- automatically registering all patients to the electoral roll
- general support for registration
- access to the internet for registration purposes

The policy documents also provide evidence of supportive practices. The first substantive section of the policy at sites 2/3 details the procedures by which service-users may be supported to register to vote:

"The [HCP] should... discuss registration with a service-user and where necessary support the service-user to contact the Electoral Registration Officer." (*Ibid*)

The outcomes of these policies were that at Site 2, four service-users voted out of 11 residents at the site. One was escorted by a mental health nurse and the other three went on unescorted leave with family members to vote. At site 3 one service-user out of the sixteen had been escorted to the polling station by a mental health nurse and the ward manager said that another had been transported on a mini-bus to the polling station.

The policy at site 2/3 states that ward managers and nurses have a duty *to provide support as necessary to facilitate patients on their ward in exercising their right to vote* (*Ibid*). Responsible Clinicians are also required to authorise s.17 leave to allow patients to vote *when appropriate* and advocates are given the role of providing support and company to patients when going out to vote or helping to arrange a postal or proxy vote.

The policies aim to ensure that inpatients can exercise their right to vote provided that they fulfil certain criteria, including the need to be registered in a particular constituency:

“A person is entitled to vote if at the time they are a resident in the area concerned are on the electoral register and are not subject to any incapacity to vote.” (*Ibid*)

Travelling a large distance from the hospital may be impractical for individuals and may be an unreasonable demand on hospital resources. Postal or proxy votes are a good solution to this problem but are not always practical or desirable and require extra forms to be returned to the electoral office.

Problems arising from out of area placements are covered by the policy in the following terms:

“the named nurse should wherever possible help a patient to contact the Electoral Registration Officer at their local council to ensure that they are included on the Register” (*Ibid*)

The policy then spells out in detail the procedure used when a person has been resident at the hospital for a significant period or where they have no other fixed address:

“The use of a psychiatric hospital address for the purposes of registration is permitted so long as the period of time that the patient is in hospital is sufficient for them to be regarded as resident.” (*Ibid*)

In addition to providing detailed guidance on how staff should support service-users to navigate bureaucratic procedures relating to registration and declarations of local connection, the policy provides some practical advice to nurses:

“Where it seems helpful and appropriate the patient’s allocated nurse should provide any necessary help to facilitate the patient to exercise their vote. This could include: Assisting the patient in making arrangements for a postal or proxy vote... Helping with arrangements for a patient to vote in person, including provision of an escort where necessary.” (*Ibid*)

This is not an exhaustive list and gives practitioners a great deal of discretion in determining the situations in which it is *helpful and appropriate* to provide *any necessary help* to facilitate the person in casting their ballot.

Support was constructed in the policy at Site 1 most often as an individual intervention. More expansive practices such as engaging service-user's family and peers as a group to engage in political events and issues was not covered in any of the policies. This suggests that the practice of political support was formally approached as a *professional* responsibility.

Further comparison of the policies for site 1 and that for sites 2 and 3 highlights some significant issues for further discussion. In the policy document for Site 1, the responsible staff member supporting the service-user in the act of voting is designated as '*the patient's allocated nurse'* (Site 1, Voting Rights and Procedure for Inpatients, July 2016). while in the second policy document, they designate a broader range of staff roles – "*named nurse/Case Manager/Care Coordinator"* (Sites 2/3, Voting Rights for Service-users Policy, October 2015)

A second important difference is in the practical suggestions made to staff members. The Site 1 policy suggests arranging postal or proxy votes by contacting the local Electoral Registration Officer or assistance in making arrangements to vote in person. The policy for Sites 2/3, having covered these two points, also requires:

> *"Responsible Clinician to provide section 17 leave for eligible inpatients. Inpatients who have a residence outside the hospital can choose to vote by proxy or by postal voting. This might be practical where it is unlikely the patient will be able to return to their local area to vote on the day of the poll."* (*Ibid*)

The imperative implied in this phrasing ("*to provide section 17"*) seems to be a strong requirement. A resident asking for leave to cast their vote should be facilitated in this by responsible clinicians making s.17 determinations. This indicates a differentiation in thresholds of risk applied in the case of patients requesting leave to vote.

The effect of the recognition of political agency on general practices of risk reduction will be analysed in more detail in subsequent chapters where it will be important to note how the assessment of risk, and the thresholds at which acceptable risk is set, are changed and adapted in the context of granting s.17.

6.2.6. Inclusion in Policy Implementation

In its later sections, the policy document at Site 1 sets out the procedure for implementation. This section aims to facilitate the uptake of the policy and staff adherence. The document was posted on the institution's shared drive so it was accessible to all staff. Staff were also required to read copies and sign them declaring they understand the policy.

The policy is also '*To be discussed at Carers meetings and copies shared with Advocates…… and implementation will be discussed and reviewed at the Local Corporate Clinical Governance meetings"* – (Site 1, Voting Rights and Procedure for Inpatients, July 2016). The policy finally details monitoring arrangements to review policy implementation:

"The operation of this policy will be kept under review, particularly at election times…. Issues will be raised at local and corporate Clinical Governance meetings." (*Ibid*)

There are no arrangements or requirements to include inpatients, service-users, or persons with mental health challenges in the review process specified although a single patient representative was meant to be present at Governance meetings. This means that monitoring and evaluation of policy implementation potentially lacks direct accountability to the persons it is intending to empower. The design of policies and practices of implementation would benefit from embedding to participatory ethos in every stage. This could, for example, be derived from strategies such as ‘evidence based participatory design’ (Donetto, Pierri,, Tsianakas, Vicki, & Glenn. 2015).

A significant point of departure between the policies at site 1 and sites 2/3 was the inclusion, at sites 2 and 3, of a consultation process whereby the policy would be reviewed by:

“All interested parties, national and trust level, including service-user groups, advocacy service, MIND, MENCAP, to be consulted on policy before finalisation”.
– (Sites 2/3, Voting Rights for Service-users Policy, October 2015)

The policy, therefore, requires service-users, and representatives of the population of people with mental disabilities, to be included in the review process. This indicates an intention to embed democratic values deeply into the ethical environment of the institution.

6.3. The Policy Principles

In the following sections I discuss in more detail what can be understood about the aims and principles underlying the policies and some possible consequences of their adoption.

6.3.1. Appropriateness

One of the explicit aims across the four policies was to allow inpatients to exercise their right to vote more freely. However, support was often dependent on political participation being appropriate and adhering to institutional norms and expectations. Inpatients and other service-users have the right, but not necessarily the opportunity or capability when undergoing treatment, to participate in political and civic life on equal terms with average citizens. This is partly a result of the pragmatics of appropriate political action being assessed and policed in accordance with psychiatric norms rather than norms governing the actions of ‘mentally healthy’ people.

Because of this requirement, the right to participate in public and political life, including but not restricted to the right to vote, is subject to significant conditions relating to good behaviour, medication compliance, escorts, institutional efficiency and safety. These are not requirements placed on the general population who are perhaps given a much wider margin of appreciation when engaging in political activities before containment measures are considered.

Article 29 of the UNCRPD is much broader than the right to vote but as we have seen, the policies discovered only provide an explicit mandate for mental health practitioners to support and enhance opportunities for certain patients to vote in elections and only under certain conditions. The restriction of appropriate political activity to meekly casting a ballot is problematic as political participation should not be a conditional right dependent on good behaviour, taking medication or any other factor that does not apply equally to other citizens without mental health difficulties.

In mental health rehabilitation, performance of social role by patients attracts intensive scrutiny and symptoms of mental illness may be discovered in poor or inappropriate performance. Therefore, the support of political rights may be interpreted by staff as just another social sphere in which mental health treatment can be applied to (re)socialise or educate an individual into particular ethical, political and social norms. Using these justifications, significant conditions may be attached to the political inclusion of people with mental disabilities and reasonable accommodation or support may be withdrawn for what is considered by mental health professionals as inappropriate conduct. This poses the question for practitioners: What norms of action and expression are sufficiently uncontroversial to be taken as the desired outcomes of a (coercive) medical and, ultimately, educational intervention? Encouraging registration and voting is sufficiently "neutral" to satisfy this criterion but allowing people to challenge decisions within the institution or to attend political party meetings or protests may be seen as encouraging these activities and thus subjecting people to undue influence. As we have seen, some of the policies explicitly discourage influential interaction between HCPs and service-users. That political discourse between staff and patients is readily interpreted as undue influence and beyond the scope of staff responsibilities can have a stultifying effect of the adoption of political identities generally. This is particularly restrictive when the majority of a person's time and social interaction occurs in the mental health institution.

It is clear from the principles of the UNCRPD that the threshold at which political action and expression will be deemed inappropriate for people with mental disabilities should be set at exactly the same level as applied to persons without mental disabilities. Conditions attached to the perceived privilege of political participation, and the policing of participation on the basis of obscure rules of appropriateness, can create rational reasons for disengagement and can mis/mal-recognise the political actions of people with mental disabilities as evidence of disorder or illness. This is a significant problem underlying the policy documents and the practices they imply.

6.3.2. Equality of Opportunity

We can see from the analysis of the policies above that there is an implicit assumption that people with mental disabilities and disorders lack political agency. This is reflected in the fact that equality of opportunity to participate in civic and political life for people with mental disabilities as compared to the general population is conspicuously absent as an explicitly stated policy outcome. A single reference to equality of opportunity appears at the end of the first written policy but is not constructed in the terms required by Article 29 of the UNCRPD:

"This Policy should be carried out irrespective of race, gender, disability, orientation." – (Site 1, Voting Rights and Procedure for Inpatients, July 2016)

The comparator used to measure equality here appears to be equality of opportunity *within* the cohort of inpatients and not equality between the general polity and citizens with mental health challenges. This means that even very low registration and voting rates in a hospital can be presented as advancing egalitarian principles.

Rather than starting from an assumption of incapacity policies may be made more inclusive by explicitly endorsing the assumption that every person, whether in a mental health facility or not, has capacity to participate in political and public life so long as the context and circumstance are designed in ways that reduce boundaries and increase opportunities.

Equality of opportunities to participate in politics cannot be advanced if we simply assume that impairments preclude this possibility. No person, whether diagnosed with a mental disorder or not, should not be treated as incapable just because their opinions, actions or omissions may seem unwise or against their own or other people's interests. Even if someone appears to lack the skills or knowledge necessary to make political decisions, and even if someone is denied the right to vote, they still have the right to public and political life on an equal basis with others and to pursue their own interests and perspectives.

Political influence is the currency of politics and is not something that should be avoided in interactions between health care professionals and service-users.

Political participation should not be a conditional right dependent on good behaviour, taking medication or any other factor that does not apply equally to other citizens without mental disabilities.

6.3.3. Awareness Raising

Raising professional and service-user awareness of political rights, and in relation to political issues and developments generally, was an explicit aim of the policy of political inclusion covering sites 2 and 3. The policy in operation at the second and third sites stated that its aim was:

"to ensure that [NHS Foundation Trust] service-users are aware of their legal right to vote…"

And went on to detail

"the responsibilities of [NHS Foundation Trust] employees to support service-users in the uptake of this right " – (Voting Rights for Service-users Policy, Data collection sites 2/3, October 2015)

Policies sought to raise the awareness of professionals by requiring regular training, *("Service line leads to ensure all staff undertake education/awareness training on voting rights of service-users"* (*Ibid*) and all staff to be given the policy as required reading. *("This policy is essential reading for the following groups of staff: All staff groups."* (*Ibid*)

Lack of awareness on the part of staff and patients was cited on numerous occasions by research participants to explain the lack of participation among service-users. In all three facilities I encountered staff and service-users who were surprised that persons detained in mental health rehabilitation facilities were able to register and cast a ballot despite policies to raise awareness. Here is an illustrative example:

"An occupational therapist I spoke to was really surprised that the patients at the centre even had the right to vote and was worried they would 'muck up his vote' (Site 1, Observation Notes, 2017)

This demonstrates that lack of awareness, combined with stigmatising attitudes remains a reality within the very institutions charged with supporting and enhancing opportunities for service-users to engage in politics.

The policy assumes that service-providers are well placed to raise awareness about political rights and provide information regarding general political issues and developments. This assumption should be problematized as the political engagement of staff in rehabilitation facilities is as diverse as in any other group with some likely to be politically apathetic, and/or inexperienced in engaging in political practices themselves. A mental health support worker, responsible clinician or social worker should not be assumed to possess greater political capabilities or enthusiasm than service-users. For example, the social worker in charge of administrating the policy in Site 1 was not going to vote (Site 1, Observation notes, 2017) and many of the nurses or support workers had never voted themselves:

"*You've got unqualifieds who are eager and enthusiastic but young and a lot of them…… [have] never voted……*" – (Site 1, Transcript 7, 2018, SW)

As we have seen, avoiding *influencing* service-users was a policy priority and policy implementers therefore often limited politicisation practices to the provision of logistical support to cast a ballot, and bureaucratic support to register on the electoral roll and in this way avoided difficult cases. There was a sense in the first closed institution (Site 1) that making service-users aware of their political rights, and providing access to political information, could result in some inpatients making unreasonable demands and causing disruption. The social worker in charge of implementation stated:

"many of the other wards were too dangerous and disrupted to disturb due to the fact that one [ward] was brand new and the patients were 'settling in' and 15 others had a 'forensic past'." – (Site 1, Observation notes, General Election 2017)

This implied that one of the prerogatives of those implementing the policy is to limit the explanation of voting rights and other political information, to those who can, in the view of staff, qualify for and 'safely' perform the role of the political agent. If political agency was attributed to 'unsettled' patients and they were recognised by staff as having valid opinions, then the process of institutionalisation and progress of treatment may be undermined according to this logic.

The policy of raising political awareness was sometimes subordinated to the staff need to prevent and reduce conflict. This was illustrated in the instance of the service-user who had failed to register in time. She had said to hospital staff that she wanted to vote but, because her polling card had been sent to a different mental health hospital as a result of her recent transfer, she could not be registered in the local constituency in time. The staff had ruled out traveling to the other constituency to vote (it is unclear why – possibly on the basis of risk and cost) and a postal vote could not be arranged as the deadline had passed.

"one of our ladies was still… registered at her old address … and consequently didn't get a polling card…… we believe it was sent to her previous address, we don't even know if she was registered or anything…" – (Site 1, Transcript 5, 2017)

The service-user was told she couldn't vote and was excluded from information sessions on the electoral system and party manifestoes. She remained under the impression that the election had been cancelled due to a terrorist incident. None of the staff had corrected this mistaken belief. (*No, I would have liked to have* *posted but listen I heard they stopped the vote because of [a terrorist] incident is that correct?* – Site 1, Transcript 1, 2017)

The staff believed they had made an error in not contacting the previous hospital for details on her registration in good time.

"we believe her card had been sent to [location around 60 miles away] and when we tried registering her for a postal vote that had been missed as well and I think that's remiss of the staff" (Site 1, Transcript 5, 2017)

I formed the impression that one of the reasons for not fully informing the patient was embarrassment at making a mistake. The restriction of information avoided potential conflict between staff and the service-user but also prevented her from making complaints and holding those responsible to account:

"…… complaints are often scoffed at. At the meeting [staff talked] about one of my participants [and] reference was made to her making complaints…… many rolled their eyes and some smirked…… "– (Observation notes, General Election 2017)

In this way the political opportunities available to services users in influencing institutional governance can be systematically restricted in order to reduce service-provider accountability and to make staff's lives easier. Under such circumstance's alienation and disenchantment with small-p politics may be encouraged and seeds of distrust in authorities and politicians in national institutions sown.

In sum, although awareness raising is an explicit aim of the policy covering Site 2 and 3, information on political rights and information relevant to the determination of particular electoral events was restricted to certain classes of inpatient deemed competent and manageable. The policy of inclusion is generally subordinate to saving face and avoiding conflict; the principle of political inclusion applied more or less exclusively to electoral politics (i.e. political processes in political institutions of state); and increased opportunities for participation and influence over institutional politics were not outcomes envisioned in the policy documents. This functioned to protect the status and role of the institutions and staff.

Having looked at awareness raising, I now want to discuss the way in which staff members used the policy as a performative demonstration of improving professional practice.

6.3.4. Human Rights-Based Approach

In addition to raising awareness of mental health and facilitating the exercise of human rights, a third aim became evident in the course of observations and interviews**:** the fulfilment of professional standards and bureaucratic requirements that demonstrate improvements of professional practice for outsiders and regulators. This process was described variously as a human rights-based approach, recovery-based treatment or person-centred, holistic, humanistic care. Such fulfilment establishes the organisation's credentials for progressive practice and provides a record of policy implementation that influences regulatory assessment and commissioning. One senior staff member stated this in stark terms as noted in my observation notes.:

"[a senior member of staff] *said that the development of a patient's political agency with a view to recovery was not really an explicit aim of the policy but it might help indirectly. The aim of the policy (and all policies) in the words of the SALT was as a shield against the criticism of regulators and assessors."* – (Site 1, Observation Notes, 2017)

Psychiatric rehabilitation facilities are required by regulators and assessors to apply rehabilitative treatment which is associated with normalisation, containment, and risk reduction. These requirements may be contrasted with person-centred recovery which provides service-users greater responsibility to take decisions and therefore opportunities to take risks. There is therefore a fundamental contradiction between the aims of policies of political inclusion, which is recovery orientated and the aims of normal everyday practice which is based on rehabilitation.

By supporting service-users to participate in political processes such as registration and voting, an organisation can collect numerical evidence that demonstrates practice is moving towards a rights-based approach. This can occur within a rehabilitative paradigm but not without some distortion or narrowing of the concept of equal participation. The above quote suggests that implementation in some cases may be partially motivated by the managerial necessity to gain positive evaluations in Care Quality Commission (CQC) inspections and in commissioning processes. Prioritising aims related to evidence collection and bureaucratic fulfilment channel resources towards enhanced recording practices and lip-service. But practices promoting connectedness and co-construction are not easily recorded and the very act of measurement can distort the process.

Records of which service-users did and did not express an interest in voting can be straightforwardly presented as evidence of the level of political inclusion, but they do not in themselves generate enhanced and sustained service-user experiences of support and can encourage a superficial rather than reflective practice - *"the evidence is there, it's on the paper…… it's all documented on their notes…"* – (Site 3, Transcript 8, 2018, WM). In fact, keeping such records can engender further alienation.

In the services studied the first engagement practitioners had with the policy was during the electoral cycles in which data collection took place. The central management for the NHS foundation trust contacted individual ward managers shortly prior to elections in their constituency to remind them that certain categories of patient had the right to vote.

This meant that local elections happening outside a hospital constituency, for which ‘out-of-area patients’ might be eligible could easily be missed. In addition, participation in political events and processes occurring outside of elections are in danger of falling outside of the policy remit.

The information distributed to ward managers stated that both detained and voluntary patients generally had the right to vote. The documents further detailed the categories of *excluded* patients i.e. those on s.37 detentions. As managers were focused on the numbers of people registering and voting as evidence of the efficacy of the policy, those on s.37/41 orders (offenders detained in mental health hospitals) did not receive the same support as inpatients identified as having the right to vote.

As discussed in Chapter 2 the Representation of the People Act (RPA) disenfranchises those who are convicted and detained in a penal institution and offenders detained in mental health hospitals on s.37/41 orders. It does not exclude them from the right to participate on an equal basis in political and civic life under the UNCRPD but simply bars them from a particular aspect of political and civic life – namely elections.

Persons sent for mental health treatment following a criminal conviction face greater barriers to political participation than similar offenders who are sent to prison. Under s.41 of the MHA 1983 the Secretary of State can prevent the discharge of a person detained in hospital under s.37 indefinitely. These orders can maintain effect for sustained periods of time, sometimes much longer than a typical sentence for the crime. This discrepancy potentially constitutes unequal and discriminatory treatment of persons with mental health disabilities as they may be disenfranchised much longer than non-disabled criminals for similar offences.

During the course of my observation of Site 1 I noted that there had previously been a visit from a local MP which did not include meeting service-users. This demonstrates this assumption of incapacity is widespread in our political culture and not limited to the mental health institution.

"In the staff newsletter it says the hospital was praised by the local MP during a recent visit... The MP had not met any of the patients. He was shown around by the CEO..." (Site 1, Observation Notes, 2017)

The MPs visit in 2016, and the way in which the staff newsletter describes it, are revealing of a specific way in which MP's and the policy implementers construct the political agency of service-users as best represented by those charged with their care. Although the MP's visit did not occur in the context of an election or referendum campaign (it was a few months after the EU referendum) the conduct of the visit was reported in the format of a factory visit in which the politician enters a place of work and discusses ways in which they can support the productive enterprise.

This reflects an underlying theme revealed in analysis of the ethnographic data that practitioners saw the benefit of (and therefore a motivation for) their institution's policy of political participation in raising the profile of mental health issues in the national political discourse and the strengthening of the case for greater investment in, and use of, mental health services. Paying lip service to a human rights-based approach, whilst making little effort to implement it in ways that have concrete benefits for service-users is a consequence of this mindset.

"2: I think it would be a really good exercise to meet local candidates…… it would be extremely good for the local candidates because I mean …… I seriously doubt how much knowledge or experience politicians have" – (Site 1, Transcript 2, 2017)

6.4. Conclusions

The findings from the general survey conducted by the CQC show the majority of mental health wards surveyed had no official policy mandating practices of political inclusion. A higher proportion of wards had substantive, but informal, practices relevant to supporting service-users participate in public and political life in the discussion of current affairs in community meetings. Policies of political participation are most common on acute/PICU, low and medium secure facilities indicating that the categorisation of patients according to diagnostic criteria or proximity to recovery is a relevant factor in determining the level of political inclusivity.

Although formal policies on political inclusion are rare of the three received all made participation conditional. Two (although one indirectly) made inclusion conditional on mental capacity which excludes people from political life on the basis of mental disability. This is a potential violation of the UNCRPD. All the formal policies aimed to support participation only for those eligible for and interested in voting: an unduly restrictive interpretation of the right to participate in political and public life.

The intention of the policies appears to be to suspend medicalised practices of treatment and rehabilitation during elections which are the key focus of implementation of policies of political inclusion. During elections practices are mandated on the basis of human rights-based principles.

The formal texts are however defensive and orientated to service-provider liability reduction which reduces the potential benefits service-users may gain from implementation. For example, the policies seek to avoid accusations of anybody over-influencing the voting decisions of service-users. Despite the aim of the policies being to increase active involvement in political decision-making, service-users are allocated a passive role in developing political capabilities, designing political interventions to change the world, and in the implementation and evaluation of the policies of inclusion themselves.

Decisions regarding who can exercise political rights, and when, were based on ideas about the nature of politics and assumptions of political incapacity associated with mental disability. In this way there appears to be a slippage from human rights based principles back to the psychiatric principles of assessment, treatment and containment. Because the policy defines the realm of the *political* in a restrictive ‘domain’ sense (concentrating on electoral politics) many relevant practices fall outside of the scope of the policies. The logic dictates that if a service-user doesn’t have the right to vote then support for political participation is not required. But, because political rights are reinstated following release from s.37/41 orders, and political rights for mentally disabled people are much broader than access to the franchise, support should perhaps not be withdrawn so readily.

The emphasis on raising awareness about rights to inclusion in electoral politics has potentially far reaching implications. It places responsibility to participate on service-user and reduces expectations and service-providers’ duties of reasonable accommodation to putting up a few posters. The individualisation of political mobilisation in turn provides justifications for exclusion of certain service-users from more proactive supportive services as they can be cast as unmotivated and disengaged. The values underlying the implementation of the policy of political inclusion reflect a selective form of inclusion based on service-users proving they are sufficiently, and appropriately motivated. This is a function of policy being designed by and for mental health staff and institutions rather than by and for service-users.

Because the policy only requires support for service-user participation in electoral politics, the development of capabilities for other types of political action and expression fall outside the policy remit. Further, as discussed in detail in the following chapter, political acts of service-users aiming to influence institutional governance and treatment/care planning decisions can be constructed as inappropriate or even pathological. This functions to protect staff's authority vis-à-vis patients and to reduce responsibility for providing positive support.

Lastly, the performance of duties and responsibilities under the policy has a key audience in hospital management, regulatory assessors the CQC and commissioners. Action under the policy is deemed successful and sufficient if it avoids negative judgement from these audiences. Increasing accountability in decision making within the institutional political environments was not viewed as a policy requirement and inpatients were viewed as passive subjects and not the central audience towards which policy performance was orientated. Participatory design approaches are seen in the literature as a possible alternative. Embedding participatory design approaches into the policy development process could also address issues of disengagement and disillusionment from service-users about politics, democracy and social justice. (Donetto, Pierri,, Tsianakas, Vicki, & Glenn. 2015)

In the next chapter I describe the policy outcomes and analyse the process of it co-construction and subversion of roles in performance.

Chapter Seven

7. Developing Political Capabilities in Psychiatric Rehabilitation

7.1. Introduction

As we have seen in the previous chapter one of the purported aims of mental health services is to ensure service-users will be able to think for themselves and exercise judgement in the political field. This relates in interesting ways to, and often contradicts, the more fundamental aim of safeguarding the individual and others from the risks posed by impaired mental capacities and disordered thought processes. For the purpose of safeguarding people with significant mental disabilities, legal powers are available to practitioners under the MCA 2005 to impose best interest decisions on the basis of mental disability in cases where capacity is absent and cannot be scaffolded.

Political inclusion is constructed in mental health services as exclusively concerning participation in elections through the ballot box. Civic participation, of which voting is an important symbol, is seen as a aspect of self-actualisation above and beyond mere rehabilitation. Rehabilitation is seen either as a wholly separate aim or as contributing indirectly to political participation by providing solid foundations from which electoral participation can spring. In this way coercive treatment finds justification in the advancement of political inclusion in the long term even when suppressing it in the short term. As we will see in the present chapter, this justification is deeply problematic. Often suppression in the short term can create a sense of alienation and reduce self-efficacy that potentially demotivate political engagement in the form of registration and voting rates in both short and long term.

Because political inclusion is seen as an outcome rather than an aspect of treatment resources and professional energy are directed towards assessing risks and benefits of political participation for residents to determine if they are 'ready' (i.e. have progressed sufficiently along a linear path towards recovery). Zoe (bare life) is thus prioritised over, or constructed as prior to, the achievement of Bios (the good life). Once bare life is sufficiently protected then the good life can be pursued. In this way the protection of bare life is constructed by staff as an aspect of the good life and as a fundamental political goal for service-users.

Once capabilities are deemed sufficient (i.e. social skills learnt, and civic responsibility embraced) progress towards rehabilitation and/or recovery can be recorded in medical notes and the scope for autonomous decision making expanded. One aspect of this reintroduction is the provision of support for tentative participation in elections. Participating in political events can function as a test, and if successful as evidence of rehabilitation and recovery. It is seen as a way of demonstrating capabilities to engage appropriately with others. Political inclusion is not always the main aim of taking people to the polling station. People may simply be assessed on their ability to conform to a perceived norm of participation (despite the fact that many 'normal' citizens do not vote). As one ward manager put it*: part of rehab is normalization… showing… how to be in public* (Site 3, Transcript 1, 2018, WM). Support to cast a vote in elections is in danger of becoming a performance of normality for service-users keen, or required, to demonstrate their recovery.

In line with this ritual for categorisation, based in the normal medical practices of mental health services, one aspect of implementation at all three sites was identifying those who was eligible for support. This was done broadly on the basis of whether a given individual was motivated to vote and was eligible to be registered.

Encouraging people to register was an educative practice (i.e. explaining why this was important) but also supporting political participation in the substantive sense of voting was fundamentally educational. People could be socialised into political roles and taught how to be a good citizen through naturalistic engagement with others. Alternatively, they may be herded into polling booths. It was important to understand how these processes were conceived and practised in the course of mental health rehab. The teaching strategies applied by psy-professionals observed ranged from behaviourist or 'banking' approaches, whereby knowledge was distributed from the top down, to being co-produced and co-owned in interactions between equal persons in informal interaction.

I show by reference to the data that mutual learning through dialogue appeared to be more effective in supporting service-users to think for themselves and exercise judgement in the political field. Embedding implementation in humanistic, person-centred and holistic mental health practices allows more contextualised understanding and management of power dynamics between service-users and providers. This in turn facilitates politically inclusive practice. By embedding political inclusion in everyday mental health practice, and finding frequent opportunities to reverse and subvert power dynamics within the patient doctor act, support in forming a view of the good life (bios) can be more open to service-user's worldviews. This can contribute to the protection of bare life through recovery and rehabilitation (zoe) and may be appropriately applied at any stage in the treatment process rather than being conceived of as a pinnacle to be reached only by exceptional or well-behaved individuals.

Before presenting the analysis I provide a bare record of policy implementation at each of the three sites observed. I do this for two reasons, first to give a sense of the effectiveness of the policies in achieving their stated aim of encouraging service-users to register and vote, and to give the reader an overarching narrative of what happened at each of the sites in the hope that this will help comprehension of the microsocial and dramaturgical analysis of the ethnographic data.

7.2. Overt Actions to Implement Policy at Each Site

At Site 1, during the 2017 general election campaign community meetings were used to inform service-users of their rights to political participation, to deliver political information and to support political capacities through political debate. One mental health nurse running these community meetings encouraged them to vote for a particular party and attempted to encourage service-users to exercise their right to vote on the basis of partisan arguments. The social worker sent out a form asking whether residents wanted to vote in the General Election 2017 and whether they wanted support in doing so. On the same form he asked residents to delegate rights of correspondence with the Electoral Commission to the hospital.

Four residents signed the form in the affirmative and three of these individuals were registered on the electoral roll by the social worker. The fourth was not able to be registered due to her being transferred recently form another hospital and missing the registration deadline. The three who wanted to vote were then told to attend information sessions in the week prior, and on the day of the election in which the SALT and a mental health nurse attempted to teach them about the political system and explain party manifestoes. Following these sessions, the three were escorted to the polling station where the SALT and mental health nurse were asked to provide assistance directly in the polling booths. Ward managers looked unfavourably at this practice and argued that support offered should be neutral and free from political bias.

Policy implementation took on a different character following the appointment of a new social worker keen to support political participation outside of elections as well as the right to vote. She organised MP and Mayoral visits to the hospital and a trip to Westminster as well as forums in which the policy of political inclusion could be reviewed quarterly by a group of service-users and staff.

At Site 2 during Local Elections, mental health nurses encouraged service-users to exercise their right to vote in community meetings and in one to ones. Informal political discussion was commonplace in communal lunches at the facility and the relaxed approach to politicisation in the institution allowed practitioners to engage with service-users as political citizens. If the service-users were amenable the mental health nurse attempted to organise family members to accompany the individual to the polling station. Three service-users were therefore accompanied to the polling stations by a father, a mother and a spouse. A fourth service-user was escorted by a mental health nurse with whom he had a good relationship. He declined the invitation to involve his family. He was escorted to the polling station and cast his vote with little or no support from the mental health nurse. She discussed his voting choices with him on the way there and thus provided some social support by being a kind of sounding board.

At Site 3, again during Local Elections, the ward manager conducted a survey of the whole service-user cohort on her ward rounds. She collected information on who was eligible, who wanted to vote, and general comments. Informal discussion was reportedly made available on the wards through mental health nurses who were permitted to discuss such issues but it was deemed inappropriate for clinicians and ward managers to engage in political dialogue with service-users. The ward manager organised a mini-bus on polling day to transport service-users to the relevant polling stations but only one service-user used this service. A second service-user was escorted to the polling station by a mental health nurse having secured s.17 leave.

7.3. Eligibility for Support

Communication of information on voting rights and the inculcation of background political knowledge is preparation for concrete political action. In the following sections I consider the ways in which certain political actions were identified as attracting positive support and the types of service-user identified as suitable recipients.

Practitioner and service-user participants described numerous incidents where inpatients were asked if they were registered to vote, encouraged to register if they were not, and supported to return relevant forms. In relation specifically to registration the support I observed fell broadly into the following kinds and sequence which I elaborate on in subsequent sections.

1. Identification of:
    a. service-users who are eligible to vote;
    b. which eligible service-users were/were not registered;
    c. where service-users were registered;
    d. service-users who wanted to vote and;
    e. the necessity of additional support (e.g. declaration of local connection)
2. Help with the Bureaucracy of Registration:
    a. Supporting service-users to fill in forms
    b. Supporting applications for a vote by post, or by proxy.

7.3.1. Identification

One of the issues encountered by staff in supporting opportunities for political inclusion was the amount of time and effort required to identify the registration status of every inpatient so that appropriate support could be allocated and provided in time for polling day. This process of identification was more difficult in institutions which had a high turnover of service-users where audits had to occur regularly to avoid service-users falling through the cracks. For Site 1, the calling of a snap General Election in June 2017 meant staff had little over 2 months to make preparations and to provide support. In retrospect the fact that implementation of practices occurs only around elections, on a reactionary basis, rather than being embedded into everyday practice was perhaps the real issue. Because of this staff were required to collect a significant amount of information, to organise time and resources appropriately, and provide support based on that information in a short space of time.

The social worker at Site 1 rang the local electoral office to check who was registered to vote and was told that they couldn't disclose the information due to confidentiality issues. They failed to get a service-user, who had expressed an intention to vote and asked for support, registered in time to vote. It was also tactless to send out a letter to all residents in Site 1 asking if they would like to vote because it therefore went to inpatients disenfranchised due to detention under s.37/41 orders.

Individual ward managers or policy implementors determined what was necessary and how the information was to be collected a given ward. Different methods were used across and within the sites studied as different service-users were constructed as requiring different types of approaches. This was not necessarily on the basis of diagnosis but on the basis of service-users progress towards recovery. For example, those in more secure wards service-users were seen as less capable of engaging with political and public life than those who were progressing towards transfer to ‘step-down’ services. One newly established ward at Site 1 was deemed too ‘disrupted’ for any form of implementation at all.

Bureaucratic tasks such as surveying the number of service-users who were eligible and wanted to vote appeared in more secure settings to be prioritised over human interactions in implementation.

I… put everyone’s name down and ask[ed] them prior, do they want to vote… if they want to sign, if they want to comment. (Site 3, Transcript 1, 2018, WM)

Eligibility to vote and registration status were not part of the main survey at Site 3 so were investigated only for the cohort of inpatients identified as wanting to vote (Site 3, Transcript 1, 2018, WM). Being a specialist service catering to many ‘out of area’ service-users identifying the location of registration was particularly important. This type of information was collected directly from service-users. In addition to the survey, registration and voting were also reportedly raised in carers meetings to inform people about their place of residence at the hospital and the implications for re-registration and voting on the day.

At Site 2 staff talked with individual service-users about voting, encouraged them to register and identified their place of residence. In addition, staff sought to liaise directly with family to confirm the location of registration and receipt of voting cards as well as to engage the service-user’s family and peers in the election as part of implementation. Because Site 2 had fewer residents, were located in the service-users’ local community, and had extensive notice of the date of the local elections, a greater level of support could be provided to open opportunities to engage in political and civic life. The service-users were also generally nearing discharge into the community and were older than those at the other 2 sites.

Dividing patients into definitive categories of eligible or ineligible is part of the way institutions seek to impose order in the ward environment. Institutional categorisations become so familiar in the discourse that they are not seen as a "way of ordering," but as "an order [inherent] in the phenomena" (Turner, 1983: 192). The effect of these ordering practices was that service-users were divided into those who would be supported to engage in political and public life and those who would not. Only those who possessed the right to vote and who had stated explicitly that they wanted to vote in a particular election were to be supported to have equal opportunities for political and public inclusion. This is problematic in that the right to political and public inclusion is much broader than a right to vote and it is universal in its application to people with disabilities. All should have reasonable accommodations made and not just those whom it is most convenient to support.

Identification practices were also determined to some extent on the basis of diagnosis. Those with personality disorders appeared to be treated with increased suspicion on the basis that they may use their right to engage in political and public life for apolitical reasons such as cynically acquiring section 17 leave or even simply to cause trouble for staff. One service-user falling into this category was deprived of the opportunity to vote because of a mix up with her registration papers being sent to her previous address and this was not effectively communicated to her. She was left under the impression that the election had not happened which served staffs interests in the sense that she did not make this a point of complaint and conflict. Another service-user with personality disorder at site 3 was given s.17 leave to vote but this was described as a ‘treat’ after having a bad day to appease him. He was also described as using political inclusion as an excuse to acquire leave.

Those with psychosis had their worldviews subjected to increased scrutiny and questioning. Practitioners were wary that the political views of people with psychosis may be informed by unrealistic worldviews or assumptions based on disordered thinking. This resulted in at least two cases in a lack of confidence and self-efficacy in relation to the political actions and opinions. One service-user ended up voting ‘nobody’ and another was left with a great deal of anxiety when the topic of political opinions came up to the point that he was shaking and asked if he could leave.

These differences in political socialisation, being based on mental health diagnosis, could be construed as illegitimate differences of treatment based on mental disability or reasonable accommodations based on individual circumstances. Practitioners need to continuously ask the question whether they are treating people in the same way as they would treat non-disabled people. Would we treat a person without a diagnosis who is espousing a worldview we consider to be untrue in the same way as some service-users were treated? Would we assume a disabled person only has an interest in politics in so far as it affects their health and social care provision? Would we withhold information about whether an election had been cancelled or not simply to avoid difficult questions? Would we subject non-disabled citizens political views to the same degree of scrutiny on whether it was ‘disordered’ or not? It seems to me that we would not as these actions communicate a lack of respect and recognition for these individuals as members of the political community.

7.3.2. Registration

As we noted above at Site 1, in order to identify who wanted to vote a letter was sent to all residents by the social worker months before the election. Out of 80 people at the facility only four formally expressed a wish to vote by responding to the letter. These four were facilitated to be registered on the electoral roll and three of them were registered in time to participate in the General Election 2017. The registration process involved entering the individual’s name on a form sent through by the electoral commission if they had been at the hospital for a long time.

"I got a document through which was from the electoral roll saying who's here…… so I asked people but of course patients change you know" – (Site 1, Transcript 7, 2018, SW)

If an inpatient for whatever reason was not entered on that form to be registered at the hospital, they would be facilitated to register either online or by otherwise contacting the local electoral office. Inpatients with difficulties reading and writing were provided with additional support:

"if someone can't fill out the registration forms, then we help… Say to patients… is there… anything that you would like me to support you with?…" – (Site 1, Transcript 2, 2017, SALT)

This reflected the procedure of registration reported at Site 3 (*"towards the time, [of] the ballot… we'll get a form from the local council. To say who's here and you just update that list"* – Site 3, Transcript 1, 2018, WM). Updating was a relatively simple task which residents could accomplish without a great deal of practical support. However, these processes were still often done by staff members rather than service-users been supported to do it themselves. The declaration of local connection was not required for any of the residents who participated in the study.

The facilitation of service-users to complete the registration process was sometimes complicated by the residential status of inpatients, their placement outside their local constituencies (particularly for local elections), and their transfer between hospitals shortly before electoral events. As discussed previously there were some issues in relation to the registration of persons due to bureaucratic issues.

Even well designed and efficiently implemented systems of support could be frustrated in unpredictable ways. In the course of attempting to get as many residents at the facility registered as possible the social worker at Site 1 encountered resistance and protest from some service-users. *"Some patients were* *apparently hiding their polling cards"* – (Site 1, Observation notes, General Election 2017)

From observation it seemed that the relationship between the social worker and some inpatients was not particularly amicable or trusting. His attempts to support them to get registered were treated with suspicion and seemed to have led some patients to distance themselves from the political roles offered. The quality of relationships between political supporter and supportee appear to be a crucial factor in the level of political participation for service-users.

The power relations in the mental health institutions, whereby staff may become arbiters of appropriate conduct and have the ability to coerce service-users, can undermine the trusting relationships so important in facilitating political inclusion. The consequence of a mental health practitioner designating a political expression, action or omission as inappropriate is that it provides justification for suppression and discouragement. In the context of political education and support such punishment for not participating in the 'correct way' (e.g. registering as an elector and voting) should only be applied where it would be legitimate to do so in relation to a person without mental health difficulties.

In addition, accommodations should be made so that people who are nervous about disclosing personal information and details to authorities are reassured. Alternative methods of participation in public and political life may be suggested and supported if people do not want to vote. Support should be provided by a person of their choosing if possible.

7.4. Educational Support

The term 'playing political roles' refers to the performance of political agency, through expression, gesture or action. For the people observed in rehabilitation, opportunities to play such roles were often restricted to ‘safe’ political environments explicitly designated by staff, where there was little risk of lasting reputational damage to service-users and where staff policed their own communications to reduce their ‘influence’ (see Ch.8). Certain spaces and situations were designed as educational spaces for implementation of policies of political inclusion. This meant that the majority of the environment was retained for medicalised practices. Where playing politics was permitted, it was appropriate for service-users to express political identities. In medicalised environments such conflict would be ‘resolved’ through suppression. After intensive observation it was clear that processes of political socialisation did occur throughout the whole spectrum of environments where rehabilitation took place. When roles are enacted, and identity construction occurs through a cycle of repetition in face-to-face situations, processes of conflict and cooperation on political matters occur. In medicalised environments these processes are heavily managed by technocratic epistemologies of governance. In the spaces where policies of political inclusion were consciously being applied such management was withdrawn on the basis of avoiding political ‘influence’ and to enable more democratic engagement (with mixed success). The conceptual framework outlined in Chapter 3 was developed to scrutinise these processes in a contextualised and detailed manner.

Spaces to play politics were rare at Site 1 and 3 which restricted political permissiveness to specifically designed situations and environments. These in turn were restricted to electoral cycles. In this way opportunities were narrowed and the scope of obligations and expectation for reasonable accommodation effectively reduced.

This contrasted with Site 2 in which the political opportunities were more embedded into everyday practice. Practitioners at Site 2 talked about their practice as holistic, person-centred and humanising. Even in this setting the focus was mostly on voting in elections as the seminal political act. In addition, the ritual performances of individuals and teams in the medicalised environment established particular rules of appropriateness that in turn had negative effects on opportunities for politicisation by promoting passive and submissive political roles. This was alienating and exclusionary for some service-users.

The following discussion makes a distinction between observations of ‘playing politics’ in organised sessions compared to political discussion emerging spontaneously in informal interactions.

7.4.1. Organised play

Staff at all sites were required by the policies to raise awareness of voting rights and at site 2 this extended to encouraging a sense of civic responsibility. The duty to inform service-users of their rights was not necessarily based on a duty to provide conditions that promote inclusion, on the basis of law and policy:

“rights for people with mental health problems… is.. legal binding” – (Site 2, Transcript 6, 2018, WM)

Didactic Education Sessions:

At Site 1 information sessions were organised in which political information was communicated to service-users in a structured way by a speech and language therapist (SALT) who stood at the front of the class to service-users sat in rows. At all three sites community meetings were mentioned as fulfilling this function also, but in a circular seating structure. Both these situations may be described as ‘organised play’ because the practitioner took on the role of teacher with authority to convey and assess ‘correct’ knowledge and appropriate participation. The spatial arrangements were both symbolic and constitutive of power dynamics in the educational interaction. Political information was routinely made available in these forums during the election cycle across the three sites. This positioned staff as curators of political information. Here are two illustrative examples:

“*yeh normally you know we have er newspaper group.”* – (Site 2, Transcript 1, 2018, SMHN)

“we tend to discuss the news on a daily basis in our morning meetings” – (Site 1, Transcript 3, 2017, MHN)

At Site 1 the SALT organised formal information sessions occurring the week prior to, and on the day of the 2017 General Election. The intention was to explain how the political system worked and to introduce party manifestos. The information sessions, and voting itself, were effectively rendered mandatory for the three individuals who had returned a form stating that they wanted to vote. This raised serious questions about whether the service-users were being supported to exercise political autonomy.

The information session prior to the vote was organised as follows:

the SALT proceeded to deliver the easy-read manifesto information as well as information on the political system as a whole and what the process of voting means – (Site 1, Observation Notes, 2017)

The session was organised like a classroom with the SALT at the front and the three young men sat adjacent. The SALT, in the role of teacher proceeded to inform her students of a series of political facts. This was in stark contrast to the dialogue modelled at Site 2:

cross cutting alliances were set up in the conversation with staff seeming genuinely interested in what service-users contributed. (Site 2, Observation Notes, 2018)

Some aspects of the Site 1 information session involved assessment. For example, the students were tested on their understanding of how general elections worked and on their ‘retention’ of facts about politicians and major parties. There were similarities therefore with tests for mental capacity. Mental capacity tests are meaningless for establishing voting eligibility (see chapter 2) but these ‘educational’ tests might easily be interpreted as informal assessments of capacity to vote. Testing for retention and understanding is a commonplace educational practice but while capacity testing may not have been the intention of the practice it might have resonated as such for users or interpreted that way by staff. Because of the effect of the determination of a lack of capacity in many other contexts this could become a real deterrent to participation. Whether or not this was the case the lessons resulted in residents becoming restless and disengaged. They appeared bored by the content delivered. They communicated that boredom with body language and tone which enabled them to demonstrate resistance to being patronised whilst ostensibly cooperating. This can be interpreted as a form of role distancing and may be constructed as an exercise of ‘soft’ political power of resistance.

Senior staff deemed it inappropriate to conduct such formal sessions from a partisan perspective and this was also a source of discomfort for the staff involved across the three sites:

*“Because as far as politics is concerned if we start [encouraging participation] we can influence our own ideas to them, there is a risk of that” – (*Site 2, Transcript 6, 2018, MHN).

“it’s very difficult to speak to somebody about politics without your own political views influencing it” – (Site 1, Transcript 2, 2018, SALT)

In the sessions observed at Site 1, it appeared important for staff to demonstrate neutrality and to avoid being perceived by other members of staff and the researcher as pushing a political agenda. This aversion was not universal. One session organiser stated explicitly she had unsuccessfully encouraged some of the service-users to vote for Labour ("*Despite my encouragement to vote Labour nobody did…*" – Site 1, Transcript 3, 2017, MHN). However, when confronted with vignettes in which conflicts arose due to particular political views being pushed by service-users, she recommended adopting a neutral position to quickly resolve the conflict. This demonstrates a double standard where service-user political influence is seen as inappropriate and potentially dangerous compared to other members of the community. This practice could also have negative implications for future political engagement if interpreted as a punishment.

"I [would] end that discussion and move it on to something more neutral… we would have to risk assess it" – (Site 1, Transcript 3, 2017, MHN)

The ward manager at Site 3, implied that primary nurses could talk in more opinionated ways than clinicians and senior staff members:

"If the clients want to, they can talk to their primary nurse" – (Site 3, Transcript 1, 2018, WM)

This may have been because they considered primary nurses were lower down the institutional hierarchy, had less authority and therefore their influence was thought less problematic. In addition, the doctor and patient roles were perhaps more established between responsible clinicians or ward managers vis-a-vis service-users than they were between service-users and nursing staff and so there was less of a danger of their authority being undermined by politicising the situation.

When two service-users asked, on the day, whether they 'had to' go to the polling station they received a reply in the affirmative. Despite autonomous political inclusion being mandatory for the three men they showed some reluctance, and role distancing in an asymmetry between expressions they gave and those they gave off. Their participation was closely managed by service-providers according to the working consensus that the service-users would comply with directions.

"CM asked very quietly if he was coming out with the SALT who said briskly 'that's right yes.' CM asked 'to go to vote?... I'm not going'. The SALT then asked sceptically 'you're not going?'…… He was unsure of himself and stammered 'I though, you said…' and then trailed off.. SALT replied yes and then moved on... [CM, RS and BB Arriving at the polling station] RS asked 'So do I still have to do all of that?' SALT replied 'Yes you do'" - (Site 1, Observation Notes, 2017)

This demonstrates problems in UNCRPD application more generally. A bottom up political community cannot readily be constructed through the application of top down law and policy addressed to service-providers. To force someone to take on a role as a free agent through top-down enforcement is a contradiction and further does not necessarily work to scaffold individual or relational autonomy.

In mental health rehab commonplace educational practices, applied to processes of politicisation, potentially take on other meanings and significance for both users and staff. If political knowledge is assessed by staff in didactic educational sessions the similarity of the practice to capacity assessment may have a number of restrictive effects on the free expression of political identities. This demonstrates how the moral and political milieu of the mental institution can have a stultifying effect on practices of political inclusion. This is a result of the wide gulf between a situation in which you are free to express opinions about the people, system, and general world around you without restriction, and one in which all your actions and expressions are under scrutiny for signs and symptoms of mental disorder which could be recorded and used against you. It is a problem created by the panopticon of surveillance, the threat of consequences, and the reification of identity through a written record that characterise residential psychiatric care. It seems clear that in such situations healthy political relations are difficult to establish.

Formal inclusion on agenda of community meetings:

Although there was a lack of any direct observation and only a brief time spent at the institution Site 3 appeared to organise sessions dealing with political information also. This reportedly occurred in community meetings and ward rounds but was managed closely because of the fear that political conflict could lead to violence.

"[I] obviously don't mind people discussing their views but it's got to be done in a more acceptable way because this is… a hospital… you know… one argument can lead… to physical assault"– (Site 3, Transcript 1, 2018, WM)

Information about the right to vote was delivered in community meetings at both Sites 1 and 2. At Site 1 the need to explain the patient's right to vote prompted staff to initiate a more detailed discussion about the political parties who were competing for electors' votes.

"we just explained that everybody on our ward at that time had the right to vote and we… explained a little bit about the parties… and then…… every week in the community meeting we went through a different party" – (Site 1, Transcript 3, 2017, MHN)

As described above the subsequent sessions about each political party were conceived in a formal didactic style where facts about each party were delivered to service-users by a member of staff in an organised fashion. This failed to engage many service-users:

I don't know if it was interesting for everybody on the ward… a lot of them then declined [to vote]" – (Site 1, Transcript 3, 2017, MHN)

The didactic transmission of facts was the typical pedagogic approach observed in staff organised information sessions. The interaction was often dominated by technical requirements of social skills training rather than proceeding on a humanistic and person-centred basis. In addition, because staff participants were concerned that some service-users may not have taken in the information on voting rights and therefore staff 'tested' their retention with the associated negative connotations noted earlier. This potentially inhibited discussion and a free flow of ideas. In Butlerian terms the organised structure of the sessions was a repetition of the dominant ritual orders of psychiatric care and consequently gave fewer opportunities for interactants to develop novel and unsubscribed political identities.

The sessions did not result in many of the service-users showing an interest in political discussions or registering to vote. Despite staff's enthusiastic encouragement, registration and intention to vote remained low across the three sites. The delivery of information on voting in community meetings therefore appears on the face of it to have failed to engage many service-users. Very few volunteered for support. The practice may have even prompted some service-users to distance themselves from the political roles they were encouraged to occupy. On the other hand using a survey with neutral written questions during ward rounds ("*Do you want to vote?; Any comment*?" – Site 3, Transcript 1, 2018, WM) as they did at Site 3, appeared no more effective.

This may be construed as a significant failure on the policies own terms. This misses the point to some extent however as the very act of setting up an environment in which political engagement is signalled as formally important, together with the increased opportunities in informal interactions, cumulatively represents a substantive change which might, over time, produce greater uptake of political roles for both staff and service-users. For example, it allowed the staff member previously quoted to volunteer political choices for public and professional scrutiny and this may have been a useful exercise in socialisation into civic and political life whether or not voting/registration rates increased as a result.

The uptake of opportunities to register to vote or to cast a ballot should not be equated with engagement with public and political life more generally. Well-rounded engagement also requires inclusion in the everyday decision-making processes of the institutions in which service-users reside. This might include the mental health service itself as well as workplaces, local councils and communities, political parties, charities, schools, universities and much more. There seemed to be little thought at any of the sites visited as to how the policy of political inclusion might be applied to a broad range of settings. As already noted, the overriding focus was on the uptake of voting rights.

Formal One-to-One Discussions:

Information about voting rights was delivered in some situations on an individual basis rather than in community meetings. Practitioners at Sites 1 and 2 used both community and one-to-one meetings to communicate information on voting rights. This potentially allowed a more in-depth discussion of individual intentions and provided greater opportunities for individuals to ask questions without risking the social judgement of the group. This could facilitate the individuals need to 'save face' and raise opinions they were more uncertain of without risking embarrassment in front of a group of peers. However, it also potentially individualised, and medicalised, the politicisation process reducing opportunities for cross cutting collaboration and conflict.

The SALT at Site 1 stated that communication of rights could occur regularly and might be accompanied by a written reference document detailing political rights. Service-users could keep this document to remind them of the processes by which their political influence might be exerted thus formalising political processes. *"yeh – it's exactly the same as when he's read his rights you know we could hand him a piece of paper with his rights every… month.. "* – (Site 1, Transcript 2, 2017, SALT)

The practice of providing a written reference sheet of rights, with details on voting rights specifically included, was not a current practice. It was a practice that staff at both Sites 1 and 2 thought appropriate for implementation at the next electoral event. '*I think it would be similar to what we do when people come and they are on section we read them their rights and we give them a copy"* – (Site 2, Transcript 6, 2018, MHN). Although this could standardise policy implementation and ensure that everyone is made aware of their voting rights as standard it still insufficient. The distribution of depersonalised written information replacing conversations between staff as service-users could also potentially depersonalise political support and create the impression on the part of staff members that this awareness raising is sufficient accommodation to fulfil their obligations in relation to ensuring equal opportunities resulting in less proactive support being provided.

At Site 3 one-on-one discussion during ward rounds was utilised by some practitioners to collaboratively form 'plans' with service-users to help them organise political actions such as going to a polling station, to vote, or to 'assess' the level of support they needed to access equal opportunities to engage in politics. These assessments were often described as capacity assessments rather than a dialogue producing co-owned outcomes. "W*ell obviously you can do an assessment, if she clearly lacks capacity she's still got the right to vote"* – (Site 3, Transcript 1, 2018, WM).

Often when capacity assessments are implied by the practice of testing political knowledge service-users appeared to engage in role distancing as a result of their capabilities being doubted. This is not an unreasonable reaction when a person with power over you questions your ability to form independent and rational political opinion.

Whether a service-user was averse to being pushed to participate in the election depended on individual circumstances and personality. Being pushed was an effective strategy for at least one service-user who ended up voting and having a positive experience doing so. (*it's okay to push me… they all push me to do stuff so… I don't mind the push.. its good – Site 2, Transcript 5, 2018, SU*). Some practitioners, such as the social worker organising policy implementation at Site 1 during the 2017 general election, sought to avoid any difficulties by communicating rights in formal written letters rather than in person. Again this depersonalises the provision of political support, gives the institution an opportunity to perform the role of progressive mental health service without much effort or resources, and can give the false impression to staff that sufficient accommodations have been made.

Overall we can observe that the provision of organised sessions aiming to raise awareness and educate people with mental health difficulties and disabilities on political matters often fails to engage people, frequently patronises and infantilises adults who want to be recognised as having legitimate opinions and can also allow institutions to control and manage the way politics is defined and engaged in. Sometimes organised sessions function to narrow the scope of politics and its potential relevance to the lives of service-users detained in mental health institutions. Other strategies of formalised and managed political engagement came in the form of one to one interactions in which plans were made for registration and voting, the distribution of formal information letters and allowing service-users to request support to cast a vote, or in the course of ward rounds doing a survey of whether people want to vote and why. These strategies appeared to create restrictive stages upon which the performance of the role of political agent was restricted to managed behaviours. Individuals, in order to receive reasonable accommodations were required to accept and submit to benevolent support which was not always appropriate. For people concerned to increase and enhance their status and to be recognised as having legitimate opinions this created rational reasons for disengagement.

7.4.2. Informal Play

There were a number of informal interactions where political information was exchanged between staff and service-users and between service-users. At Site 1 I observed and participated in a number of informal conversations that performed forms of political expression and action and which modelled a practice of politics for service-users. In the spaces between wards, and outside the hospital building, both staff and service-users felt more able to engage in dialogue about political issues. Within the hospital service-users would regularly undergo assessments and attend meetings with their Responsible Clinician. Coming out of these spaces, heavy with meaning denoting roles and strict rules of interaction, changed political discourse significantly. The effect of the meetings was to reinforce rigid identities and modes of discourse which was heavily regulated.

The space outside of the meetings was productive of a more free and liberated discourse. Political information was requested and shared more readily in these informal spaces observed at Site 1 and 2. Controversial opinions and topics were more easily expressed and raised when the pragmatics were more informal across the three sites.

"Service-user: 'if I voted what changes will it have on where I live on the actual hospital?' we tried to explain that Labour wanted to invest more into the benefits system and most parties wanted to spend money on the NHS but that voting Conservative entailed possible changes to the Mental Health Act" – (Site 1, Observation Notes General election, 2017)

At Site 1 and 2 informal conversations were accorded a place in the practices of political inclusion. Staff in the open rehab ward saw the discussion of politics with service-users as replacing the processes of informal political socialisation usually provided by teachers, parents and/or siblings:

"in some way you're taking the place of those conversations that they had going through school or with parents or with siblings so it's got to be that informal" – (Site 1, Transcript 2, 2017, SALT).

Compared with the didactic and potentially infantilising pedagogy observed at Site 1, many of the organised sessions at Site 2 were more dialogical and accorded service-users legitimacy in directing discussion towards their own interests:

"every morning we have…… discussion groups…… if someone wants to talk about political things we have things on the agenda…… but we also have…… clients who chair the meetings" – (Site 2, Transcript 1, 2018 SMHN)

In this way authoritative roles were 'given' to service-users. Nevertheless, these environments remained monitored, managed and ultimately 'owned' by service-providers. At Site 2, where the spaces in facility were constructed as co-owned, more varied political opportunities were made available. The communication of political information occurred in voluntary activity sessions at Site 2 which were described as service-user led and casual.

"its more sort of casual it's sort of current affairs but really it's more let's sit down and have a coffee and it's a relaxed sort of chatting…… session" – (Site 2, Transcript 3, 2018, OT)

At Site 1 persons and bodies independent of the medical institution were considered by one Ward manager as the only appropriate source of political information. Staff members were viewed as having a considerable amount of influence over those in their care which could be abused. At Site 2 a similar fear of undue influence meant that staff sought first to engage family members or third parties in the process of politicisation.

"we are going and looking for people who are providing information on [politics]…… we bring them in…… they can have a session with service-users" – (Site 2, Transcript 6, 2018, MHN).

There was a wide range of different opinions and approaches observed about sharing personal political opinions across sites. At Site 2, in the context of communal lunches, opportunities to play at and become political persons appeared more widespread: (*"I can discuss [personal political opinions] and I want to give them the benefits if I'm if I am voting… it is good to share"* – Site 2, Transcript 1, 2018, MHN)

The more informal and relaxed the discourse between the parties to a discussion the more engaging it appeared to be for both service-users and for staff. The stage was better set for more democratic discussion between staff and service-user teams in communal eating areas or spaces outside the medicalised spaces of the wards. As soon as there was a change of discourse back to the clinical, rehabilitation or social skills training, political discussion became more uncomfortable and constrained. This effect was explicitly acknowledged by some staff– "*as soon as we get clinical about it.. people will turn off.."* – (Site 1, Transcript 5, 2017, WM). Interactants appeared to sense that mixing the clinical with the political was deemed inappropriate.

Service-users expressed interest in having political conversations with family, friends, other service-users, advocates and political representatives. These were viewed as potential sources of encouragement and recognition. This is in stark contrast to how the educational sessions conducted by the SALT at Site 1 appeared to be viewed. Trusted family members appeared to be a stronger source of political motivation.

I wanted to vote but I wasn't interested in it (Disappointed softer tone) but my auntie has made me change my mind (Site 1, Transcript 1, 2017, SU)

Family socialisation into politics is likely to be less pressurising and less patronising. In addition, the family members may be more empathetic and understanding of the individual's worldview and even share aspects of their views. All this is likely to contribute to a sense of political collaboration. Of course in some cases family engagement may be counterproductive, inappropriate or not practically possible. At Site 2, the community based open facility, was the only facility where substantial effort had been made to liaise with families of residents to provide political support.

if the family want to come we will discuss… if they want to give the service-user [support]… If not we arrange for staff to escort them" (Site 2, Transcript 1, 2018, SMHN)

As we saw in Chapter 5, three service-users were accompanied to the polling stations by family members; one by a father, a second by a mother, and a third with her husband. One service-user was escorted to the polling station by staff, although efforts were made in this case to engage the family to accompany him before-hand. This was declined because: *He said his family didn't talk about politics.*

Enlisting family support was possible at Site 2 because service-users were treated in, or close to, their network of friends and family which is not typically the case. At Site 3 family support was not seen as a viable option. The relationships between family members can of course be fraught and could not always be relied on to provide the kind of support needed. For example, one ward manager said:

"we can take the abuse [inflicted by service-users] because we are trained... but relatives they tend to pull away" (Site 3, Transcript 1, 2018, WM)

The organisation of family and peer support had mixed success in terms of politicisation as it depended on supporters being aware of and engaged in national politics enough to be confident political companions and guides and have enough free time to accompany them to the polling station.

In the case of the man accompanied by his father, limited support was provided in terms of opportunities to discuss political opinions and choices. No help or support was offered in the polling station.

Me: did [your father] help you to cast your vote when you were at the polling station?…….

SU: I was trying to work it out separately" – (Site 2, Transcript 7, 2018, SU)

In the event, the very limited support of his father was not sufficient to overcome his sense of lacking enough information to make a meaningful choice. The staff at Site 2 had not provided any information sessions instead relying on family support. In this case the service-user felt unable to make a confident political choice about who he wanted to represent him in parliament. He understood the way the democratic system worked (*SU: well they may have represented my view if I er actually knew what view they represented* – Site 2, Transcript 7, 2018, SU*)* but felt he did not have any information on the characters, views or platforms of any of the candidates. This resulted in a deep sense of frustration:

"To be honest…. I voted Nobody…. because I didn't know anybody…. I've got no information I've got no details… I've got nothing from the news I've got nothing through the politicians' broadcasts… I had nothing to go upon to my vote" – (Site 2, Transcript 7, 2018, SU)

Many of the residents were keen to construct a positive political identity in informal conversations that would be translated and legitimised by the research process. For the purposes of this section I present the illustrative case of Polly (not her real name). Polly was discouraged from openly expressing a positive identity other than that prescribed by the institution which was limited to attributes associated with normality – one staff member commented that sometimes you couldn't even tell Polly was ill. However, the novel context of the research process provided Polly with an opportunity to express an alternative positive identity. When describing her personal biography, she highlighted her credentials as a singer and an actress as well as her involvement in a youth council at her college. For Polly, creative and cultural activities such as art, music and theatre were important aspects of a positive identity that she wanted to convey. As I was asking her about her history of participating in politics, she clearly thought that these cultural activities were a relevant aspect of her political expression as an independent agent and citizen (Site 1, Transcript 1, 2017, SU).

Providing such opportunities for positive identity creation and assertion are important aspects of political agency and ultimately political participation. Polly conveyed a positive identity to the researcher by discussing other residents in an objectivised medical discourse referring to 'one of our patients' being 'very distressed'. This constructed a distinction between Polly and the other who was constructed as more vulnerable and more dependent than the participant. This appropriation of medical and psychiatric discourse seemed to be a way in which Polly could construct herself as a person with an important role in the institution. She also referred to herself and the management of the hospital as 'we' when discussing improvements in the policy. This collective reference was possible because she had been involved in the monthly governance meeting as a patient representative (although at the time of the interview her involvement had been suspended because she was 'too ill').

'*No but we can make this happen in the future where we talk about elections a bit more in the morning meetings, we could make it happen'* (Site 1, Transcript 1, 2017, SU)

Polly rejected the implication that she needed staff to help her interpret political information and when asked about who she wanted to talk to, identified the local MP.

I would like local MPs to visit the ward…… they could explain, to teach us…yes I would be happy to sit down with an MP" – (Site 1, Transcript 1, 2017, SU)

The three service-users at Site 1 who voted were involved in external cultural and social activities and even work placements. The positive identities exhibited on the reception walls of the hospital included service-users playing a DJ set. Another picture showed the three who voted playing football. In discussion with the SALT and ward manager they stated that only these three male residents had been allowed privileged access to these sessions and it was in fact causing problems with other residents. In this way the selection of persons to be supported in political engagement was viewed as a privilege for well-behaved residents and created a social hierarchy which then became a source of conflict.

When participants had had informal conversations with colleagues about my recommendations (i.e. that political communication between staff and residents become more relaxed and informal) the new social worker at Site 1 said some unqualified staff were eager and enthusiastic about a more relaxed attitude to political discourse. However, more established staff tended to be more reluctant (Site 1, Consultation, 2018, SW).

Placing a focus on collaborative learning through doing, rather than teaching and assessment, could encourage a process or co-constructing and co-owning strategies of political engagement across staff and patient teams. This could have potential in breaking down barriers associated with professionalised and institutionalised roles. During lunch at Site 2 for example I observed:

Two staff members… were in disagreement over Britain's foreign policy…and a service-user agreed with the mental health nurse (Site 2, Observation Notes, 2018)

In this situation a staff member and a service-user were united in their political opinion vis-à-vis another staff member creating opportunities for cross cutting collaboration in the conflict of ideas. Interactants were temporarily ignoring any artificial divides based on institutional roles in this particular performance and this created a stage on which service-users could feel more confident and empowered to advance their own political views. This exemplifies a more humanistic, person-centred and holistic practice of political inclusion.

7.4.3. Pedagogical Approaches

At all three sites efforts were made by staff to explain the nature of the political system as an introduction to the concrete actions of registration and voting. The approach was formalised at Site 1 in organised group sessions which were staged for the three individuals who were going to vote. At Site 2 one-to-one meetings were conducted and at Site 3 it was done briefly during ward rounds.

Staff at Site 1 said that in addition to providing practical support to residents who wanted to vote they also attempted to encourage individuals who had not expressed an interest.

"Trying to encourage everyone who can to vote and trying to make other staff aware of who can and who can't vote" (Site 1, Transcript 3, 2017, MHN)

Staff reported that this process of discussion and encouragement with those who were not planning on participating in the election was a positive experience ("*she couldn't [vote] because we hadn't had a chance to register, I mean it was still positive to discuss everything with her and she'd like to get involved in the next election*" - *Ibid*).

At Site 2 efforts were made to encourage inpatients to vote by explaining the reasons why it would be beneficial:

"I make sure that [service-users are] informed and they exercise the rights…… everybody needs to exercise their rights" (Site 2, Transcript 3, 2018, SMHN)

This approach was often implemented by staff who identified as politically engaged citizens themselves. Historical narratives were communicated which lionised class and identity groups who fought for the right to vote. They often constructed a lack of political engagement as a betrayal or a waste of the efforts of these previous generations: *"women fought to get the vote and working people did…… so how can you not [vote]…"* (Site 1, Transcript 9, 2018, SW). This strategy of using shame as a motivator for action appeared in some cases to be effective and can potentially be effective in helping people identify their conception of the good life (Snoek, 2014).

Another strategy of persuasion was to argue that those who did not exercise their right to vote would be excluded from political influence in other spheres of political and civic life because once they renounce the vote, complaint and contributions in other areas become to some extent delegitimised.

"[if I don't vote] I can't complain if things go wrong… half the countries in the world don't have that right…… a hard fought right you know…" " (Site 1, Transcript 5, 2017)

Persuasive and engaging arguments were used drawing on both personal interests (to have some say in procedures of governance) and group affiliations (loyalty to particular identity groups such as women or people with disabilities) to motivate service-users to exercise political rights. The justification for staff usage of such overtly political strategies was most often based on beliefs in the inherent value of political engagement. These strategies were also justified on the basis of advancing holistic, humanistic and person-centred recovery strategies.

At Site 3 explanation and encouragement was applied in the course of ward rounds and was folded into the process of identification. This appeared to leave little time for the explanation of rights and the political system more generally. The ward manager indicated that encouragement was not appropriate for staff to engage in: *I think, in places like hospitals staff… can only do certain things politically* – (Site 3, Transcript 1, 2018, WM).

Across sites there were some differences in approach based on the diagnosis of a given individual. For example, those with learning disabilities appeared to be encouraged to engage in political issues directly relevant to a disabled political identity. For people with learning disabilities for example, mental health nurses and psychologists focused their educational strategies on particular disability issues such as health and social care and the welfare system. These individuals, all of whom were resident at site 1, were provided with educational sessions and discussion opportunities in which these issues were foregrounded.

As a practitioner at Site 2 put it *"We have to explain to them that [political discussion… should be… done in the appropriate manner"* - (Site 2, Transcript 1, 2018, SMHN). Modelling appropriate political engagement is primarily an educational process. When done well this practice appears to have characteristics of mutual learning (Freire, 1996). Across the three sites practitioners were teaching certain service-users the rules of political engagement and by extension how to be a good citizen. They did this through one to one meetings, community meetings and in the course of political activities such as going to vote. Where implementation was more substantial at Sites 2 and 3, service-users were being taught what 'appropriate' engagement in public and political life entailed. Inclusion in the formation and enforcement on the rules of appropriate political engagement was often restricted for people with mental disabilities. They were often constructed as rule takes rather than rule makers.

An important experience of the ‘resident’ as well as the practitioner in a rehabilitation unit is being under surveillance for performative transgressions, or triumphs, worthy of being entered into the written record. This encourages self-censorship and assessment fatigue as people are conditioned to avoid the pressure and social judgement associated with exercising political agency and challenging rituals and rules of performance.

Me: …… have you ever been assessed to see whether you have the ability to understand?

SU: I’m always assessed [Laughter] – (Site 1, Transcript 1, 2017, SU)

At Site 1 (the closed rehab ward), staff conducted an exercise in which they identified prominent British politicians and told the service-users which party they belonged to. Service-users were then assessed in their ability to name which party a given politician was from. There was a clear right and wrong in such tasks and little room for dialogue on substantive political issues.

“SALT – can you remember any of the parties that you could have voted for? There were five…… (Silence)… any colours? For any of the parties? Purple….” - (Site 1, Observation Notes General Election, 2017)

Great authority is attributed to staff members in a wide variety of areas including politics. This can create a political environment governed by technocratic definitions of right or wrong that are directly influenced by the medicalized ritual order of the institution. The technical skills required to achieve recognition for knowledge about matters relevant to political issues become based on mastery of psychiatric, psychological, social care, and nursing discourse and epistemology.

“you’re used to working within a structure where, actually, things are right or wrong” - (Site 1, Transcript 2, 2017, SALT)

In the political information session at site 1 there was a clear dichotomy between right and wrong. Service-users were assessed on this basis. This is clearly a practice that is not applied to people without mental health challenges and disabilities. It also did not appear all that supportive in allowing the participants to vote.

On numerous occasions practitioners at all three sites refrained from distinguishing between right and wrong in relation to political views which caused frustration and confusion for some service-users who merely wanted a frank discussion with staff members who they trusted. Such arbitration was, in the view of some staff, not appropriately applied to political opinions. Service-users were had a responsibility to make up their own minds and were insulated from influential opinions of staff and other service-users. Here are two illustrative examples from both closed and open facilities:

"it's his opinion and again if he's [capable].. I won't be able to correct him" - (Site 2, Transcript 1, 2018, SMHN)

"SU asked if he had made the right voting decision. The MHN said – 'You're never wrong and you're never right – it's just an opinion'" - (Site 1, Observation Notes, 2017)

These examples show that staff were teaching service-users particular rules of political conduct, themselves based on a hierarchy between fact and opinion that reflects the technocratic governance of the mental health system. The assumption was also made that such basic starting points were appropriate for the three men. Although two participants had learning difficulties, this was not experienced as reasonable accommodation but as patronising differential treatment. In this case the MHN set up a dichotomy between the service-user's voice as 'just' opinion and his pronouncements as neutral truths. This has wide implications for service-users present and future political engagement should they internalise their political opinions and worldviews as inferior to that of trained professionals and experts. It teaches them to be passive and subservient political subjects. This is all the more restrictive when combined with the punishment of conflict through isolation.

A different approach was observed at Site 2 in which substantive political issues were introduced as conversation topics during informal lunches. The dichotomy between staff neutrality and service-user opinion was in this context de-emphasised by the introduction of staff opinions. Here I observed dynamics of conflict and cooperation being set up, cross cutting staff and patient teams, on the basis of substantive issues on both big-P Political issues and small-p politics of personal care.

*[Staff] responded to service-user points in thoughtful ways and kept on including people [staff and service-users] who weren't in the conversation by asking them what they think – (*Site 2, Observation notes, 2018)

At Site 2 staff appeared to model for service-users, and include them in, an intellectual engagement with ethical dilemmas about right and wrong in the public sphere. During a communal lunch they were all permitted space to develop and apply their own ethical perspective on decisions. This was supported through informal discussions around rights and responsibilities:

"for example… drinking… it's a human right. I go out to drink. Don't you… but how can we tell somebody you must not……… because it's not safe for you and… then they will say.. it's not safe for me either. Its not safe for you… so if we get into this discussion then this can take us everywhere and so where would you draw the line?" – (Site 2, Transcript 6, 2018, MHN)

In this way service-users were trusted to engage in political dialogue without being unduly influenced by staff's political opinions. This trust appears crucial in expanding opportunities for both staff and patients to become more involved in politicised discourse and action in the context of mental health institutions.

This sort of interaction is important symbolically in breaking down the boundaries between staff and service-users and facilitates a more wholesome political and social milieu to develop. This humanistic approach was applied irrespective of diagnosis, mental health condition or legal status.

"every individual, doesn't matter [if he] is a detained patient or informal patient… or staff, you have to treat… equally" – (Site 2, Transcript 1, 2018, SMHN)

This democratisation of political discourse across patient and staff boundaries and irrespective of legal or medical status was also discussed at Site 1, but was rarely observed spontaneously within the more risk conscious and security orientated milieu:

"(earnest tone) yeh cos.. everybody has a right to.. vote and has an opinion… and… who am I to say (mock serious tone) actually your suffering from mental illness.. you might vote for the wrong people" (Site 1, Transcript 5, 2017, WM)

Pedagogical practices relating to ethics and public engagement were not just about enhancing cognitive capabilities to decide between right and wrong in the political field or increasing political knowledge. It also involved having confidence to communicate opinions and feelings. A central ethical and political issue that was discussed between staff and service-users concerned paternalism versus agency in the context of treatment. This issue served as a launch pad to initiate political discourse:

"is it good that staff are helping you to vote or… are we being a bit interfering?" (Site 1, Transcript 4, 2017, SALT)

However, such encouragement could also potentially function to reinforce the idea that staff, in managing people's behaviour and restricting their choice and agency, were acting on the basis of a neutral and apolitical assessment of best interests.

The practice of coercion and the practice of supporting agency were seen as overlapping and intermeshed:

"I'm controlling them [but] I'm looking after them. That is what's very tricky… I can be deemed as controlling them or I can be deemed someone who is really looking after their best interest" – (Site 2, Transcript 6, 2018, MHN)

Mental health practitioners were given authority to distinguish between what is right and wrong for service-users whilst at the same time being charged with inculcating abilities for them to think ethically for themselves. This is a contradiction in terms. In a context in which coercion in justified on the basis of advancing best interest, and where staff worldviews are promoted to the status of neutral truth, there is a real risk that this could be experienced as indoctrinating (see chapter 1). In order for people to be provided opportunities participate in politics on an equal basis they must present as 'free thinkers' which paradoxically requires conformity with the norms of such performances. It is clear that this confusing set of contradictions can be daunting and demotivating for service-users and staff.

Relations between teacher and student in adult education or anthrogogy (see chapter 4) are not usually premised on the need for socialisation into the performance of the student role. Teachers in adult education usually justify their role by their utility rather than demanding and policing student compliance. When such demands are made and enforced there is a real risk of infantilising adult service-users. The way that the educational interaction is set up in mental health institutions and the way in which it emerges in relations already latent with expectations and power can create real restrictions on the healthy progress of political socialisation.

Service-users were tentatively involved in discussions around the ethics and politics of treatment, recovery and housing issues as an aspect of their political socialisation. If appropriate political behaviour is to be modelled and taught in these settings without undue influence, practitioners must continually co-construct rules of appropriateness in dialogue with service-users. The dry application of banking pedagogies drawing on the practice of capacity assessment, and the reification of recovery as a key to political participation, was observed to work against the development of political agency. These educational approaches often had the effect of demotivating or even alienating service-users: *'I would like to be part of it again but because of my mental illness I struggle with my thoughts'* (Site 1, Transcript 1, 2017, SU); '*I'm not into politics… It can be a bit boring'* Site 2, Transcript 5, 2018, SU). This alienation may have wider implications in that it may socialise people in ways that make it more likely that they will be apathetic and passive in the future.

In contrast, where staff and service-users were permitted to 'play politics' in situations where roles were less restricted by the ritual order and hierarchy of the institution, opportunities were increased and enhanced.

The role of teacher, in the process of educating people on how to engage in politics and influence decisions that affect them, when professionalised or subordinated to institutional priorities of efficiency, could become disengaging and undermine political opportunities by turning them into another assessment exercise. Political education, in order to be person-centred, must be premised on dialogical and mutual learning, rather than a didactic 'banking' approaches or behaviourist conditioning. Approaches based on humanistic and even cognitivist paradigms appeared much more effective than didactic banking models of education.

7.5. Reasonable Accommodations

As a result of receiving mental health treatment in residential facilities, the costs (in terms of both time and resources) of voting were typically increased.

Consequently, many of the practices observed sought to reduce the cost of voting for inpatients.

A number of logistical issues arise in supporting residents to participate in elections. In closed facilities and for those service-users on involuntary section, s.17 leave (MHA 1983) must be granted in order that they can leave the hospital to vote in person. In specialist facilities with lots of out of area patients the constituency in which a service-user is registered to vote may be far away. Thus, staff may be required to arrange transport. Service-users may be deemed to be a risk to themselves or others and therefore allocated escorts. Lastly, the capacity of service-users to understand the instructions given in polling stations to cast a ballot may be compromised by medications, mental impairments arising from their mental health condition, or the social environment experienced in the polling station due to the behaviour of staff, the public or electoral officials. Therefore, assistance by mental health nurses and therapists was also requested and received in polling booths in accordance with Article 29 (a)(iii) '*Guaranteeing… at their request… assistance in voting by a person of their own choice'*.

7.5.1. Granting Leave

For service-users to get temporary leave from the institution in which they are detained is an important decision for staff and users. The decision process and rationale in making s.17 leave determinations is a place where dilemmas of practice and perspective are brought into sharp relief.

The granting of s.17 leave for the purposes of voting in person was required for inpatients detained under s.3 of the Mental Health Act 1983. The perceived benefits for inpatients participating in the electoral process was an important factor in the consideration of s.17 leave applications. When an inpatient took the line, and presented the face, of a politically engaged citizen such applications were viewed more favourably and the threshold of risk that is apparent to decision makers before they reject such an application is raised. ("*normally we will discuss it…… at an MDT meeting level…… so that.. the leave is approved for them."* – Site 2, Transcript 1, 2018, MHN).

This is a view that was shared by service-users who thought that even if there were risks involved in allowing people leave to vote in person they should facilitate leave as much as possible: *"they should always have the opportunity [to go and vote] even if there are risks"* – (Site 1, Transcript 1, 2017, SU)

This appeared to have been exploited by a service-user and accomplice staff member who wanted to get out of the hospital at Site 3 for reasons other than voting:

"[The named nurse] was saying you know be calm, I've come to take you out… you need a good day…… she used the section seventeen leave to go to the…… Polling station… but it could have been just her way out… using the politician leave. … let's just say the politician leave yeh…" – (Site 3, Transcript 2, 2018, SU)

Decisions relating to the granting of s.17 often had certain conditions attached designed to reduce risk of harm to the resident and others:

"MHN: he's not been self-harming recently. And I don't think there's any reason [to decline s.17 leave]. I think we would put something in place like accompanied leave so… you… go with a person to a particular place and then you leave them for an hour… So it's a compromise" – (Site 1, Transcript 3, 2017, MHN)

Compliance with medication was also a condition of granting leave that was mentioned:

"we're always encouraging compliance with medication as well erm but hopefully if we can see this decline… we would act you know and get some sort of medical

intervention. So that she was settled enough to go out.. So we would probably give some PRN… medication" (Site 1, Transcript 3, 2017, MHN)

Requiring people to vote when under the influence of medication which *settles you down* could affect capacity to make judicious voting decisions. It could also significantly affect the decision as to whether to go to vote at all if such medications become conditions of participation. More research and guidance is urgently required to establish when or if, this is ever appropriate and to ensure that people are not forced to vote under the influence of mind altering medications. Such conditions are a rational basis for declining to vote at all and represent differential treatment on the basis of mental disability..

One ward manager stated that the participation in electoral events and the granting of s.17 leave to vote could in fact have negative consequences for patients' mental health and suggested that the participation in politics 'without purpose' may be detrimental to recovery:

"so we have to make sure that it's not escalating the un-wellness while they're actually doing it for a purpose and they believe that it's going to help them in their recovery" (Site 3, Transcript 1, 2018, WM)

In this way risk has replaced mental capacity as the test for whether political participation will be facilitated. As we will see, voting appeared to be beneficial for all those who participated and there was no evidence that it posed a risk of escalating mental illness. This therefore seems a problematic basis for denying a person the fundamental right to participation in political and public life even if it appears to be exploiting the rules to briefly escape hospital life.

Some practitioners identified the conditionality of successful leave applications as a potential source of restriction of opportunities to vote: (*"I wouldn't particularly want someone coming with me when I was trying to vote"* – (Site 1, Transcript 3, 2018, MHN).

Outright denial of leave to vote appears to require exceptional circumstances but the intensive surveillance that forms conditions of that leave could be a significant restriction in itself and demotivate many from participation.

"we could do something like eyesight so the person could stand at the door and just see them at all times not actually even come in to the hall where the vote is as long as you can see them you got eyes on them" – (Site 1, Transcript 3, 2018, MHN)

When asked about a hypothetical case in which a service-user felt that the provision of staff escort to the polling station was so inappropriate that he refused to vote (either in person or by post) under such circumstances staff invariably responded by saying they would still attempt to negotiate a compromise in which he was escorted and monitored in some way.

In addition, factors such as perceived capacity to vote appeared to be considered relevant in the granting of s.17 leave. Staff retained power to determine whether to allow a person to vote on polling day on the basis of capacity.

if she's got capacity and she's done your first initial assessment – (Site 2, Transcript 2, 2018, WM)

In line with the UNCRPD principles political participation should not be a conditional right dependent on good behaviour, taking medication, accepting a particular ascribed identity, or any other factor that does not apply equally to other citizens without mental health difficulties. It appears these principles are not well understood or implemented in residential mental health institutions.

The lack of guidance in relation to arbitrating s.17 applications for leave to vote (other than the apparent obligation to grant it if possible) has resulted in practitioners seeking to enable voting as far as they possibly can. A high threshold of risk is thus required to justify denial but many conditions are applied which could demotivate participation. In addition, the s.17 leave application appears to be a process in which capacity assessments for voting may creep in.

Under the Guise of s.17 leave decisions, capacity assessments may still be used to deny people with mental disabilities their right to vote. This is a significant issue that may require legislative clarification. Further research is required to investigate the way in which Responsible Clinicians make s.17 determinations where leave is applied for to attend polling stations and other political events. No responsible clinicians were interviewed in the course of this research because they did not identify as being engaged in policy implementation and so were excluded on the basis of the participant eligibility criteria.

7.5.2 Transport

At Site 3, which provided specialist services to a high number of 'out of area' service-users, transport was provided to and from the hospital on the morning and in the afternoon of polling day during the local elections. This potentially allowed a greater number of service-users the opportunity to cast a vote in a nearby constituency to which they have a connection. (*"those on the day who wanted to go we had a… minibus… so … we facilitated them"* – Site 3, Transcript 1, 2018, WM)

This approach differed from Site 1 in which it appears only service-users registered in the local constituency were facilitated to vote in person. This may have been due to practical difficulties in supporting service-users to vote in distant constituencies. The woman who wanted to vote, but ended up being excluded due to admin difficulties, could have been transported to cast a vote in a constituency 60 miles away. This was deemed an unreasonable burden for a hospital with limited resources.

At Site 2, which was based in or near to the service-users' community, transport was provided by the families in their own vehicles, or service-users walked there with their family escorts. In the case of the man whom I observed at site 2, we took the bus. The payment for the bus journeys was arranged by the nurse escort and this was important because as I recorded in my notes:

"The cost of voting seemed quite high in terms of the journey as it would take 3 buses there and 2 buses back…… they said it was normal to get 2 buses to the polling station. This cost £12" (Site 2, Observation notes, 2018)

Because service-users are treated in mental health hospitals that are often far from their place of residence this creates an additional cost in voting for inpatients directly caused by the imposition of mental health treatment. Therefore, it is reasonable to expect some provision to be made in terms of facilitating transport to and from polling stations.

7.5.3. Escorts

In two cases I accompanied service-users and their staff escorts to the polling station. This appeared the default approach in Site 1 and 3. At Site 2 three service-users were escorted to polling stations by family – one by his mother, in one case a father and another by a spouse. The possibility of family support was explored prior to organising staff escorts. In all observed cases of service-users going to vote in person they were escorted, although one service-user reported that he went independently to vote in a local election shortly prior to data collection.

At Site 1 the SALT and a mental health nurse escorted three service-users to the polling station and went into the polling booth with them to support them in casting a ballot:

The SALT, MHN and I stayed by the door and the three men went and handed in their polling cards – there were two officials [who] handed them their ballot papers. The second official… directed them to the polling booths and gave them a quick explanation… B – very quickly to the polling booth but then hesitated and looked to the other two participants who were asking the electoral official for help

The woman attempted to explain to [Service-users] B, C and D but then stopped… and looked over to the SALT. [She] asked 'can you help him?' SALT was surprised and went over – the electoral official said 'it's just that I don't want to get involved if you don't mind'

SALT said 'we weren't sure'

The electoral official said 'no, if you'd like to come check them all I'm more than willing'

SALT asked if they were sure and the other electoral official agreed

B asked why the electoral official couldn't help and she said… 'I would rather some else did if that's okay because I don't want you to be influenced by me' (Site 1, Observation notes, 2017)

In relation to providing support directly in polling stations The Handbook for Polling Station staff states that in all cases the Presiding officer should try to ensure that a person is given appropriate assistance in order to be able to cast their vote*: For example, the elector may need the voting process explained to them by the Presiding Officer, or the elector may request the assistance of a companion.'* (Electoral Commission, 2017: 22)

If the individual requests the assistance of a companion the handbook states that '*a disabled voter may be assisted… with the permission of the Presiding Officer, who must be satisfied that the voter's disabilities would prevent them from voting unaided. The disabled voter's companion can assist up to two [and] must be either* *a close relative (father, mother, brother, sister, spouse, civil partner, son or daughter) or a qualified elector. The voter should ask the permission of the Presiding Officer to be assisted by their companion.'* In my observation it was not the three men who requested assistance by the SALT and MHN but the electoral official, frustrated by their apparent lack of understanding. In addition it was not established whether either the SALT of MHN was a 'qualified elector'.

Another bureaucratic requirement that was ignored was that '*the companion is required by law to complete a simple declaration, 'Declaration to be made by the companion of a voter with disabilities'.* In these cases 't*he Presiding Officer must ensure that they explain the process clearly to both the elector and their companion [and] record the voter's name and elector number, as well as the companion's name and address, on the form 'List of voters with disabilities assisted by companions'.* (Electoral Commission, 2017: 21)

Service-user B had significant support needs being functionally illiterate and requested help directly in the polling booth. He reportedly received no support from electoral officers when he went on unescorted leave to vote in an earlier local election however. This indicates that support is inconsistent and dependent on the competence, patience, and knowledge of electoral officials:

Me: did you ask any of the electoral officials there for help when you went and voted the first time?

SU: nah I just went in and did it – (Site 1, Transcript 2, 2017, SU)

Another issue is the way that rules vis-à-vis support provided by mental health staff were set up and then contradicted. At Site 1, prior to visiting the polling station, staff stated unequivocally that they would not provide support in the polling booths. The three service-users were told to ask electoral officials if they needed help. Once we arrived at the polling station it was clear that the electoral officials were uncomfortable with this because they might be perceived as influencing the vote. They said it was fine however for the SALT and mental health nurse to do so. This was a surprise for both the service-users and providers.

The practical support provided in the polling booths involved reading out the ballot instructions, pointing out the candidate representing the party that the service-user wanted to vote for, and checking that the correct mark had been made before reassuring them it had been done correctly.

"SALT and MHN went around the polling station booths and SALT explained in detail to CM what the sheet said. The [Mental Health Nurse] simply asked and pointed look what's this? Read it and yeh you tick that box that's all you do. When he saw what one had done the MHN burst out laughing and some of the others did as well. He then said 'no no no that's fine" – (Site 1, Observation notes, 2017)

These simple steps facilitated the three service-users to express their political choice of candidate with a degree of confidence. They were all pleased with themselves for voting.

"BB voted and with a huge grin and a bit of pomp and ceremony dunked his ballot paper into the box…… After they had voted all three were exited and were asking lots of questions and the excitable mood was infectious" – (Site 1, Observation notes, 2017)

If persons with mental disabilities are to be reasonably accommodated to participate in elections, then some individuals will require support in the polling booth to identify the correct candidate and to complete the ballot correctly. So long as such support is requested by the person with disabilities, provided by an appropriate person, and documented by the electoral official in accordance with the above regulations then it is acceptable to enter a polling booth to read out instructions and indicate which candidates are which.

However, one of the issues with this provision of support observed at Site 1 in the general election 2017 was that it compromised the secrecy of the ballot. For at least one service-user was particularly important. ("*there was a big kerfuffle about B not wanting to tell C who he was voting for because the rule was that it was meant to be secret." – Ibid).* In the information sessions the secrecy of the ballot had been emphasised ("*Your voting is secret no one can see you.*" *Ibid*)

Although the three men described the act of voting as a positive experience one stated that it was arduous:

"well relatively the only thing that I really learned is that it's really hard work and that you have to keep your vote a secret" - (Site 1, Transcript 6, 2017, SU)

This practice raises issues in relation to the perception of undue influence and the safeguards in place to prevent the manipulation of vulnerable voters. In addition, the way expectations were set up and then contradicted could engender distrust in the voting system. There was no indication of undue influence in this case and the help provided appeared reasonable, but the practice of electoral officials and support staff may give rise to a situation in which problematic influence can be exerted. This is an area ripe for further investigation.

Going to and from the polling station there was a markedly different type of interaction between service-users and staff in communicating political ideas as compared to discourse inside the mental institution. After the vote was cast staff felt a great deal more able to discuss their personal political views with service-users. This was unsurprising as the vote had been cast and undue influence became less of an issue for staff, but even on the way there service-users and staff were much more open in asking questions and discussing how the vote will affect the local area, housing and mental health services. This implies that being in the institution has a profoundly restricting effect on the way in which political discourse can be conducted between staff and service-users.

At Site 2 the observation involved of a man who had voted before. I observed him as he was accompanied by a MHN to the polling station. They talked convivially about how politicians were generally quite corrupt and seemed to make promises that were never delivered prior to the vote. They also discussed openly who he was going to vote for and why. He seemed more interested and knowledgeable about politics than the MHN and said he came from a tribal political family. The MHN said she didn't vote. This demonstrates how service-users can adopt new roles vis-à-vis service-providers in discussing politics. In this instance little practical support was required and the service-user perhaps even taught the MHN some things. He was relaxed and confident at the polling booth also.

he approached the desk and they requested his house number and his name which he provided, the electoral official explained that he had two votes on one section, and one in the other. He went to the booth, marked his ballot and placed it in the box.

This example shows how people in mental health rehab can be perfectly competent, without assistance, to casting a vote. Given that this individual had been diagnosed with psychosis it also shows how mental health professionals can be respectful and even learn from service-users' worldviews without immediately jumping to the conclusion that they are exhibiting 'disordered' thoughts. Service-users can clearly be more knowledgeable about, and involved in, politics than the mental health service-providers who are obliged to give them support in this area.

7.6. Discussion

From these various examples of practice, we can see that political socialisation as well as recovery orientated mental health treatment was applied by some practitioners with the aim of supporting the service-user's *autonomy* in the political field with mixed success. Such practices sat uneasily with often coercive rehabilitative treatment based on behaviourist and/or didactic educational strategies. Treatment and recovery was often viewed as a pre-requisite of the ultimate aim of rehabilitation with each positioned on a linear trajectory. The aim of scaffolding autonomy and the forging of identities and relationships based on political citizenship, were sometimes constructed as secondary to the need for benevolent management of behaviour to enable maximum functionality. Coercive treatment through psychiatric treatment was therefore frequently assimilated into or confused with the aim of advancing agency in the long term.

Individual staff members were sometimes able to find ways out of the hierarchal service-user/provide relationship in spaces outside the institution and in electoral cycles. This sometimes was natural and sometimes stimulated by the need to demonstrate fulfilment of duties to support political inclusion. More humanistic relationships allowed service-users opportunities to perform established political identities and be recognised as competent participants in the community and society at large. With those with less experience of the political process informal settings allowed them more freedom to exercise skills needed and play at political roles.

The way that practices potentially alienated and demotivated many service-users raises serious issues and dilemmas, however. The problematic pedagogical approach to political participation in rehabilitation and recovery needs further elaboration. The first problem arises because practitioners applied two contradictory aims in teaching people to be political and supporting them in the polling booths:

- to enhance the individual agency of service-users to engage politically and;
- to fulfil their duties of care to protect and treat people considered pathologically compromised in their thoughts and behaviour.

Political participation appeared best served by adopting an educational approach based on free-flowing discussion, person-centred interactions, and learning by doing which requires a recognition of the need to recognise and legitimate patients exercise of power over the conditions of their detention. This is about creating opportunities for residence to adopt a valid political faces vis-à-vis the institution and staff members. Motivating political participation and engagement in small-p politics was key to socialising people as political agents with their communities. A hard distinction between the personal, to be governed by technocratic expertise, and the public, to be governed by democratic processes, potentially served to undermine political inclusion in both the short and long term.

Recovery based interventions, at least when the idea was first posited in psychiatric discourse (Hummelvoll, Karlsson & Borg, 2015; McCabe et al., 2018), are intended to facilitate the person in making their own choices and to live the life that they want to lead so long as this doesn't pose a risk of harm. Thus, autonomy always has the caveat that it must be exercised in a way consistent with the autonomy of others. Rawls (1971) argues the ideal society is one in which the most extensive basic liberty is attained but such liberties must be compatible with a similar liberty for others. Put another way gaining autonomy in one social field requires ceding autonomy in another. To be included a person must first be identified as being includable according to psychiatric norms.

The purpose of professionalised rehabilitation was to realign the values of the individual to societal values so that they can be 'included' in society as governable subjects and/or political citizens. Because society and the law places value on 'independent living' and participation these can become evaluative indicators of success in the ritual order of mental health practice and work against the exercise of power in subverting norms by attempting to regulate the process of adapting and applying ethical norms. Services may therefore aim for patients to achieve independence in political thought and political inclusion whether these are the individual's priority or not. Thus, influence on the service-users' worldviews is inherent in the practice of politicisation. Implementation was often about persuading service-users that political inclusion is of inherent value rather than making accommodations. This has consequences for inclusion in, and self-exclusion from, political and civic life as some choose to resist these externally imposed values.

Political expression would potentially symbolise a move towards greater autonomy in choosing values and forming a version of the good life for oneself. Instead increased registration and voting rates, enforced by practitioners, was used to demonstrate the efficacy of the treatments applied and to enhance institutional status.

These problems link in with broad philosophical debates on autonomy and benevolence. On one hand, extreme liberal environments might imply that an autonomous individual is one who chooses their own values based on their own interests and perspectives in complete independence from the social structures around them. Indeed, the MCA 2005 s.4(6) is based on a commitment to achieving patient-centred care that honours where possible the patient's own, reflectively endorsed values, whether or not she has decision-making capacity (Coggan, 2016). As Butler shows us in her discussion of identity co-construction autonomy is never absolute in a social system that frames our actions however (Butler 1988). It is relational. The social structures around us provide pedagogies of citizenship and participation based on particular ethical frameworks. For example, if a service-user chose to completely disregard the interests of others, a 'social skills' intervention might be applied to teach them the "correct" value as dictated by psychiatric practitioners to rehabilitate the individual to be able to function in 'normal' social intercourse. This reifies 'normal' or established practices and thus delegitimates service-users' power to adapt and subvert the fundamental norms but also potentially enables them to engage in mutually empowering relations with others in collaboration.

The liberal justification for psychiatric practice appears incoherent when people under section are effectively being forced to do things that will purportedly enhance their agency. An informed choice of values, rather than deferring to higher authorities, requires awareness of competing sets of values and opportunities to interpret them flexibly. The value of choosing ethical principles for oneself, as and when choice situations arise, is part of a more fundamental set of ethical principles into which someone must already be inducted prior to the choice situation. They must be capable of identifying the good and of developing a sense of justice (Rawls, 1971: 19). These capacities, in policy implementation, were supported through educational support. Practitioners wanted to develop the capacities of service-users to think for themselves on questions of politics, right and wrong, good and bad, but this did not mean that any type of thinking was permissible.

In the development of political roles in the social interaction on the ward, scaffolding by mental health staff can be analysed as constituting five phases. The first phase involves agreement on the idea of receiving support for exercising the right to vote and interactions in which a script is set that is consistent with the ritual order of the institution and the ascribed role of mentally ill person. The second phase involves staging by staff in which they locate appropriate political action and expression or designate an action area in education sessions, individual care planning meetings, community meetings, discussions over lunch or the polling booth. In constructing the action area they prepare resources such as information on parties and on political commitments in manifestos. In the third phase, which often overlaps with the second, actors are recruited to participate in the performance, if they are not already involved in the development of the actable idea, and the actors are trained for their roles. The fourth phase is the period of enactment when the political act is performed. In the final phase, after the performance, new meanings for selves, others, and the situation may be interpreted or assessed by the actors and audience. In the context of the research process, this often took place in interviews.

This process can provide for greater opportunities for those in rehabilitation only if practitioners assume every person has capacity to participate in political and public life so long as the context and circumstance are designed in ways that reduce boundaries and increase opportunities for participation. All practicable steps should be taken to provide opportunities to develop political capabilities and identities and to interact with politically engaged others. We should not ‘give up’ on anyone.

A person in the mental health system should not be treated as incapable just because their opinions, actions or omissions may seem delusional, unwise or against their own or other people’s interests. Even if someone appears to lack the skills or knowledge necessary to make political decisions, and even if someone is denied the right to vote, they still have the right to public and political life and to pursue their own interests and perspectives.

Political participation should not be a conditional right dependent on good behaviour, taking medication, accepting a particular ascribed identity, or any other factor that does not apply equally to other citizens without mental health difficulties.

Political education, in order to be person-centred must also be premised on dialogical and mutual learning, rather than a didactic ‘banking’ approach, behaviourist conditioning. Approaches based on humanistic and even cognitivist approaches appeared much more effective.

7.7. Conclusions

The whole process of mental health treatment incorporates aspects of civic education and therefore ‘treatment’, at least during elections is applied as a process of education or anthrogogy (adult education). Political participation is intended to be supported in ways that broadly motivate the pursuit of open-mindedness, i.e. the pursuit of truth and understanding with due regard to available evidence and argument. However, politically inclusive practice only occurs periodically in and around elections rather than being embedded into everyday practices of treatment and rehabilitation. Thus, the normal medicalised practices and rituals inevitably reassert themselves even in these brief moments of politically inclusive practice during elections.

The ability of service-users in residential rehabilitation facilities to play at political roles and become political citizens is shaped by rehabilitative practices. These practices form pedagogies of ethics and citizenship that impact on political opportunities for both service-users and staff.

Using power to restrict contact with engaged peers and to restrict exposure to humanistic interaction and political discourse with staff members, can create political environments which are highly managed and stultifying. Staff members, because of these professional duties and responsibilities, were careful to avoid voicing personal views and political opinions with service-users and were cautious about permitting political engagement if there was a risk of conflict. However numerous informal spaces still emerged in observation of Site 1 and 2, in which professional oversight of political socialisation was much less pronounced and, in these circumstances, humanistic interaction and political discourse could emerge more organically. This formed a more dialogical style of educational support that could be applied by service-providers to service-users or, in the case where service-providers were politically disengaged, the other way round.

Chapter Eight

8. Roles, Identities and Environments

8.1. Introduction

In this chapter I analyse the ethnographic interview and observation data using the conceptual framework developed in Chapter 3. This involves analysis of the roles, identities and physical arrangements which formed the social field in which performances of political agency occurred, all of which constituted the political environment. By examining roles, identities and environments as they were defended, subverted and/or transformed by policy implementation I analyse how narrative, expressive and agential powers were distributed according to the particular ritual orders of performative interaction and how these powers were directly affected by practices aiming to increase political opportunities. I also evaluate the appropriateness of implementation using the theoretical perspectives developed in previous chapters.

8.2. Changing Roles

Ian Hacking in his book Rewriting the Soul (1995), argues that mental health professionals, in their pastoral role exercise powers that establish new ways of being and can inscribe them with positive meaning (Foucault, 2000a; 2000b). Butler's theory of co-constructive identities shows how novel positive identities can be forged through subversion of the norm (Butler, 1988). New categories of personhood can be empowering. However, they can also constitute a threat to a person's current way of life. The data shows that in implementing policies of political inclusion, the subversion of the norm becomes normatively regulated through an ethics of appropriateness and thus norms attempt to regulate the process of their reconstruction. This can cause restrictions on becoming political agents. In this section I consider how the introduction of new ways of being (the political citizen with mental disabilities and the politically engaged mental health practitioner) affected social discourse and reconstructed the identities of participants in new and surprising ways. As the analysis in this thesis hopes to show regulating and adapting behaviour according to the norms developed in psychiatric rehabilitation can function to restrict political opportunities in the short term. This may arguably be justified by the uncertain promise that such practices might expand opportunities in the long term. Conversely subverting and resisting the role of mental health patient and acceptable incompetent can expand opportunities for political agency in the politics of the institution but also can restrict the opportunities to engage in the politics of the wider community as people are mis/mal-recognised as dangerous or problematic participants in such processes. This can mean people with mental health challenges are readily stigmatised or excluded from political and public life.

8.2.1. Mis/Mal-Recognition

Health practitioners ritually exercise power in relation to service-users. Power is vested in such roles because persons with psychiatric and psychological qualifications are constructed as experts in identifying and implementing the best interests and divining the perspectives of persons with mental disabilities. This relation is manifested in their day to day duties and, of specific relevance to this thesis, their responsibilities to teach service-users skills relevant to political participation and to provide opportunities for political participation. One participant put it in a way that captures both the social and political dimensions of this skill.

social skills [mean] that you… disagree with somebody in an appropriate way and manage yourself as well as not upsetting everybody else. (Site 1, Transcript 2, 2017, SALT)

Professional identity may be characterised as a beneficent carer role in the Goffmanian 'act' between service-provider and user in the mental health setting. This forms an important 'ritual performance'. The institution requires that beneficent carers reduce risk and induce behavioural and attitudinal changes in service-users for the purposes of inducing and evidencing recovery and rehabilitation. This process may be in conflict with, and therefore restrictive of, opportunities to develop identities and capabilities necessary to express political views, to take political action, and to be recognised as behaving as a political citizen.

obviously people are acutely unwell… so those service-users you need to actually erm do a risk assessment and assess their mental health (Site 2, 2018, Transcript 4, OT)

If the patient takes their life the buck stops with the responsible clinician… the psychiatrist has the final say and … the bottom line is medication and containment (Site 1, Transcript 7, 2018, SW)

Coercive treatment and institutionalisation of mental health patients was therefore constructed by staff members as a justifiable restriction on inpatients' ability to cast a vote in elections so long as it is within the norms of the institution. These norms appear inflexible and unresponsive to service-user's wants and needs for recognition. This logic appeared to be applied to service-users across the spectrum of diagnoses although the sample of service-users was so small and the information on diagnoses and symptoms so restricted that it is difficult to make a clear finding on this point.

Despite the emphasis on medication and containment practitioners were keen to stress that it remained a human rights-based approach.

my actions… are justifiable… within reason…. Within expectation, within policy.. you know (speaking quickly) within the human rights… (Site 1, Transcript 5, 2017, WM)

This demonstrates how necessity can function to place people with mental disabilities into a state of exception that even excludes them from the application of laws specifically designed for people with mental disabilities such as UNCRPD Article 29. By creating an exception to the normal application of rights and formalising it as an aspect of law the force of non-law (necessity or ~~law)~~ can be described as 'within' the system of Law.

Restrictions on political agency within the institution were seen by many professionals as a form of collateral damage justified by the more pressing aim of containment and treatment, also required by Law. An example the way in which the state of exception applied to restrict the implementation of policies of political inclusion was evident in the responses to vignettes used in semi-structured interviews. A hypothetical situation was presented to staff in which a political dispute on the Israel/Palestine conflict occurs in a community meeting. Many practitioners argued that the correct response would be to end the conversation and split up the debaters to avoid the risk of causing distress to other patients and escalation of conflict.

[we would] take the two patients that [are arguing about the Israel/Palestine conflict] away from the community meeting to have that discussion… as conflict resolution (Site 1, Transcript 5, 2017, WM)

Constructing political debate as a conflict resolution exercise places pressure on political interaction to be agreeable. This is a norm that is not necessarily applied to politics in other contexts. Staff decisions relating to service-users are often constructed in the discourse as choosing the lesser of two evils – i.e. between coercion or autonomy which carries an increased risk of harm. Staff recognised the potentially restrictive nature of their practices in relation to the political opportunities of service-users. They attempted to resolve the contradiction between agency and treatment by designating some behaviours as appropriate expressions of political agency and others as inappropriate (and outside the sphere of political action protected by the UNCRPD and other legal instruments).

this isn't the appropriate time to be discussing that sort of issue… it's not fair on the other people… if you want to discuss this we should wait till you've calmed down a bit and… meet together with staff to support the discussion… (Site 2, Transcript 3, 2018, OT)

Staff had the power to shut down political discussion and readily used it if they judged that participants were getting too emotive.

if it starts to get aggressive its best to remove people from that situation rather than it (Laughs) escalating (Site 2, Transcript 3, 2018, OT)

the first decision staff make is… whether [the heated political debate in a community meeting is] likely to escalate … a risk assessment of patient safety and patient distress" - (Site 1, Transcript 2, 2017, SALT)

On some occasions this appeared to demotivate participation. This has wider implications too. If a person is socialised to see themselves as a disruptive and incompetent participant in political debate, and has experienced the shame and embarrassment of being removed from a public discussion then they will likely think twice about participating. It is an example of the conflict between the need for safety and order and the need to enhance participation. It is a difficult balance for practitioners to strike. But the threat of removal from the debate creates a situation which potentially mis/mal-recognises individuals with mental health challenges as risky and unstable participants in political processes.

Staff did not relish their role as arbiters of political expression. In describing their experience of implementation, staff expressed confusion and annoyance at a situation in which important decisions regarding a person's effective exclusion from political and civic life were delegated to front line psychiatric staff without appropriate guidance or protocols to help them resolve these conflicting duties.

I mean staff are not unwilling... it's a newish sort of phenomenon and we're all a bit clueless as to what we do – (Site 1, Transcript 2, 2017, SALT)

Because staff were responsible for decisions to restrict a person's choices on the basis of risk, the admission that such choices had a political dimension became difficult to articulate. Policy implementation was experienced as an attribution of personal responsibility for policy outcomes that were difficult to explain under scrutiny. Staff were forced to choose between the lesser of two evils and therefore describing practice as a positive pursuit of person-centred recovery was often implausible. As a result, engaging with implementation was a potential threat to reputation or what Goffman describes as 'face' (i.e. a positive social identity projected in interpersonal interaction). It also had the potential to collapse the doctor patient 'act' by undermining the relevance of psy-epistemology in dividing a person's 'real' interests and recovering their 'real' self from the jaws of mental illness.

Some staff members, in order to reduce reputational threat, avoided responsibility to provide political support. Others assimilated the narrative of human rights-based approaches to treatment thereby creating an apparently neutral technocratic role for themselves 'outside' politics. Support to exercise political rights became part of the service-users 'social care pathway' for upper management at Site 1 and an aspect of service-users 'right to health'. This meant practice could be justified by rehabilitation and normalisation with a view to progressing the individual to step down services. Political inclusion was categorised as treatment and containment which allowed practitioners to justify restriction of political rights on the grounds of risk. It also meant that service-user acceptance of a political role could be used as a measure of rehabilitative progress or decline. From this perspective political socialisation was seen as a conditioning process whereby experts teach their clients how to engage in the proper manner. This form of pedagogy excludes more subversive, bottom up and self-directed learning and engagement. Containment and restriction is reflexive as part of the ritualised norms of the institution.

By supporting political rights (for example by granting s.17 leave or facilitating political debate) staff often anticipated an increased risk of harm based on mental disability. Risk assessment practices often breach the principle of equal treatment with other citizens and can stigmatise people with mental illness as lacking the social and intellectual skills to engage in political processes (Szmukler & Rose, 2013). This has implications for how service-users will understand their role as citizens in the wider community as well as potentially undermining more egalitarian service-user-staff relationships.

Staff who took on the challenge of implementation found that they opened themselves up to criticism from colleagues (*"I think that… [disappointed and disapproving tone] personally I think that should have been handled a lot better than it was* – Site 1, Transcript 5, 2017, WM). Whether practitioners opt for positive support or risk reduction they are open to criticism, negative social judgement and even the potential for legal challenge. This is related to the way in which the adoption of the professional role objectivises political contributions on the basis of expertise and creates a tendency towards technocratic rather than democratic governance. This socialises those in psychiatric rehabilitation into particular types of political role that are not necessarily consistent with ideas of democratic political citizenship.

A common experience of service-users was to be under constant assessment by the staff team, and even other service-users, for performative transgressions. This created a dynamic in which the residents often became increasingly anxious and uncertain as to how his or her views and opinions might be judged and what the social and medical consequences might be. The fact that practitioners were also subject to surveillance by services users and colleagues made them cautious about performing the role of political educator. This motivated role distancing behaviours which in turn communicated that political participation is generally inappropriate. Over many years this is likely to socialise service-users in ways that restrict opportunities for the development of political identities and capabilities conducive to participation in the community. Instead there is the danger that the primary method of influencing the decisions that affect their lives becomes the performance of need through disruptive or disordered behaviours which trigger responses from practitioners. In subverting the norms of psychiatrically defined ‘healthy’ behaviour attention and resources are dedicated to dealing with such behaviours. Alternatively, the adoption of behaviours regarded as ‘healthy’ from the practitioner point of view can create situations in which they are afforded greater and greater influence through step-down procedures.

It was difficult for service-users to understand and assess the effects of these political strategies because communicating information about particular service-users or staff was often done covertly, backstage. The potential for surveillance to be perceived by the service-user team as arbitrary, or even malicious, was greatly increased due to this secrecy. Uncertainty and anxiety about behavioural outcomes became all the more apparent in the context of conversations with new acquaintances (such as the researcher) for whom he or she had even less ability to predict the criteria for successful or appropriate role performance. These processes could be a source of shame and even alienation for service-users.

Me: would you describe yourself as someone who's politically engaged?

(quietly and perhaps a little ashamed or disappointed with this answer) not really no… I don't take a lot of interest. (Site 3, Transcript 1, 2018, WM)

This role distancing could be interpreted as an artefact of the interview methods. Closed, and high pressure questions such as this should not be asked at the start of the interview, however such role distancing was evident also in observations and in following interviews where this question was asked at the end rather than the beginning. Social anxiety about role performance, and thus role distancing, was compounded when roles with unstable and controversial rules and pragmatics, such as the 'political role', were adopted. Expressing a political identity was interpreted by both staff and residents as 'inappropriate' in many situations and for a variety of reasons notwithstanding mental health status. Therefore, they often approached the performance of political roles cautiously and defensively. Many simply avoided the role, at least within the walls of the institution when significant consequences could follow erroneous performance.

Mental Health Nurse – (to [a service-user] after some throw away comment about how boring the political information session was) you're on the ward now so you'll get into big trouble – (Site 1, Observation notes, 2017)

The way in which participants affected distance from the political role indicated that it posed a threat to 'face' in relation to either the staff member audience, the service-user audience, the internal audience (i.e. the performance conflicted with internal worldviews and identity narratives) or the researcher.

I've… asked… who to vote for. Sooo boring (Site 2, Transcript 5, 2018, SU)

Different political performances and lines were taken with different audiences. For example, staff would avoid revealing to service-users who they were voting for whilst service-users were often much more open. This created some discomfort on both sides. Service-providers often sought to allay service-users' concerns about self-perceived inadequacies affecting the performance of political identity by hiding their immediate social judgements (articulated verbally or through body language). By contrast staff were comfortable conveying their misgivings about service-user choices when I interviewed them. These created the sense that the political interactions with service-users were somewhat artificial rather than genuine conversations between two equal members of the polity.

There was uncertainty about the criteria on which political performances were to be judged for residents and how staff practices seeking to support political participation should be evaluated and assessed. Although the rules were uncertain it was clear that conduct was to be policed by staff even in the context of political socialisation within family and peer groups (an explicit feature of the written policy at Site 1). This was supported by the institutionalisation of the individual. A typical feature of the organisational structures observed was the application of rigid rules of appropriate behaviour (relative to 'outside' social and political environments). For example, professionals would refrain from discussing with residents ways of managing behaviour in groups, preferring to discuss these backstage in closed management meetings or between staff members behind closed doors. This systematic exclusion of service-users from these important discussions is em-bedded in the ritual order of the institutions.

In distinguishing between appropriate and inappropriate political participation practitioners carefully took into account the context in which the expressions, actions or omissions occurred. An important consideration was the relationship between the people involved. For example, whether it was between family members and the individual, or the individual and other service-users, or be-tween the individual and staff members. Another was the potential risks and benefits of political participation for those involved. The risk of abusive and unduly influencing relationships was a particular concern in family and peer interactions where the service-user was seen as the potential influencer and abuser. In staff/service-user interactions, there was the additional risk of un-due influence being exerted upon the service-user.

When a service-user engaged and performed the political role, either by contributing a political view or engaging in a political conflict, it was sometimes a negative experience where it resulted in their views being challenged, ridiculed or interpreted as a manifestation of mental illness rather than being recognised as a legitimate contribution. If expression resulted in conflict, it was likely to be viewed as problematic by staff and residents and a risk to mental health. This could be humiliating and induce defensive role distancing behaviours. These factors reduced opportunities to play at, and become, participants in public and political life. Service-users were not recognised as adopting valid or legitimate faces in political discussion and were readily regarded as using it for manipulative purposes. In this way

, the requirement to 'be' a mental health patient in performance 'produces necessary failure' in the performance of political identity (Butler 1990: 145).

Rituals of social intercourse, developed and policed in the context of mental health rehabilitation services, created conditions in which knowledge and capability for performing an explicitly *political* role became a daunting task for residents and staff alike. The prospect of social judgement and sanction for voicing the wrong view, or having that view naturalised as an inherent aspect of your character (for example voicing opinions on immigration and being labelled a racist), induced a great deal of anxiety for some service-user participants as illustrated in one memorable exchange:

Me: so what do you think about politics?..

SU: well I think (voice shaking and goes very quiet) it's okay? – (Site 1, Transcript 6, 2017, SU)

In accordance with the perspective adopted (see Ch.3-4) the performance of a political role requires a player to make assessments of the world around them, identify changes that accord with their interests and perspectives, and then seek to change the world accordingly. There is no single 'correct' way in which this process should be facilitated but there are some prominent epistemologies of governance and/or practices of influence - what Lears (1985) calls cultural hegemonies (Lears 1985) and Bourdieu (1977) doxa - evident in our national political environment.

By an epistemology of governance, I mean a theory of knowledge underpinning governing practices. One prominent example is the 'democratic epistemology of governance' i.e. that opinions and individual experiences measured in national elections are a good way to assimilate diverse interests into a national worldview and thus legitimate governing knowledges informing executive actions or omissions. Another example is that 'scientific' knowledge is the best foundation for good governance and therefore evidence-based knowledge is justifiably dominant in political discourse over and above so called 'subjective' interests. The first might broadly be called democratic the second technocratic.

In the political environment of the mental health rehab unit, a technocratic epistemology of governance was typically adhered to by staff and service-users. Political issues, rather than being decided through processes of conflict and cooperation between people with different perspectives and interests, were often constructed as having correct or 'scientific' answers to be determined by experts. Mere opinion was accorded little value in decision making processes. To seamlessly switch to an approach where the opinions and perspectives of the service-users are relevant to the governance of the relations between staff and users therefore runs counter to the prevailing governing epistemology based on psychiatric knowledge.

This knowledge reified the identity of service-users in ways that compromised their face validity when pursuing political lines and was a significant restriction, over time, of their political inclusion. In Butlerian terms it was a restriction on the possibility of variation on the repetition of the ritual order.

This process of mis-recognition has wide implications. It can discourage people from analysing and articulating their own wants and interests in relation to broader political perspectives. The political and social education inherent in psychiatric rehabilitation can construct aspects of the political in a person's behaviour as individualised problems. Through this process people come to identify their goals as achievable exclusively through self-actualisation rather than through systemic and political change. Rather than disputing the rules of the system in place, residents may directed to increase their capacity to succeed in the system as it is, or simply be encouraged to seek exclusion from the responsibilities imposed by our current economic model.

8.2.2. Professional Roles

The duties under the policy of political inclusion appeared to be viewed by many staff members as an optional extra which only high-flying staff members would engage in. Many adopted a form of *verfremdungseffekt* in the performance of the role attempting to preserve their previous character as authoritative staff member. It provided staff an opportunity to demonstrate their personal and professional commitment to patient rights and for some an opportunity to achieve enhanced status. Rather than institutionalising direct patient involvement the role of political supporter was associated with representing patient views and interests and thus became a source of political capital in institutional decision making.

The ritual order represents a clear, and in some cases legitimate, restriction on opportunities for political expression and action just as it is in many situations outside the mental health service. Specific categories or modes of political participation may be considered socially inappropriate for anyone notwithstanding mental disability in some contexts. The ritual order of the mental health institution, discussed in Chapters 3 and 4, is well established and exerts a powerful influence on behaviour of both staff and residents in the mental health setting. Staff roles were thus moulded in implementation as arbiters of appropriate and inappropriate political action.

The problem of judging service-user's political participation on the basis of appropriateness is that there are a variety of consequences that mental health practitioners can apply which would not be options in the case of someone without mental disabilities. In addition, the threshold at which an act becomes inappropriate appears, for practical reasons already discussed, to be lower for people with mental disabilities compared to the general population and to vary according to the role of the individual within the institution as well as their diagnosis. For example, it appeared from the data that those who were diagnosed with delusional, paranoid or psychotic conditions were subject to more intensive scrutiny in terms of the appropriateness of their political contributions because these conditions were viewed as corrupting and distorting their worldviews which form the basis of political action.

In the political environment of the mental health ward, even appropriate political actions (according to criteria on which people without disabilities would be judged) can be deemed a risk to staff and residents and therefore restricted. Where political action was used to challenge the political system of governance in the hospital itself the efficient running of services was routinely prioritised over the political inclusion of the individual. Political action that would be appropriate for someone without the label of mental disability, was designated inappropriate so as to maintain institutional order or to ensure that progress in medical terms was preserved. One horn of the difficult practical dilemma was routinely chosen.

Consequently, political inclusion - a fundamental aim of person-centred recovery – was routinely de-prioritised.

This is concerning and ways of avoiding this invidious choice need urgently to be sought. A person in mental rehabilitation should, according to the principles of person-centred recovery, have the right to play at, and adopt, different political identities and worldviews and pursue goals to change things in any area of their life without fear that their opinions and actions will be mis-recognised as symptoms of mental illness.

In addition, as we have seen in previous chapters, the nature of politics, mental health treatment and the definition of disability itself are political issues. Political inclusion seeks to ensure opportunities for being involved in big-P Politics (in political institutions and elections) and small-p politics (in the politics of care and containment in the mental health institution) and designating aspects of political action as inappropriate in the spaces where a person undergoing mental health treatment spends a great deal of their time can create substantial restrictions on inclusion in public and political life.

Adjusting our concepts of 'Politics' and 'power' and reconsidering who should get to define them in practice can help. Can we treat them as essentially contested concepts that should not be defined exclusively by professionals. Instead can politics be non-exhaustively defined as engaging in processes of conflict and cooperation on matters relevant to the community as a whole?

How would this work with the thorny problem of what should count as political and what should be counted as a disordered worldview? As already noted staff often experienced political action and expression from service-users as a threat to the ritual order of the institution and more directly a threat to their ability to resolve conflict in service-user/provider performances.

One possible response is to see policies of political inclusion as indicating a requirement to set the threshold between appropriate and inappropriate at the same level as applied to persons without mental disabilities by asking the question, how would I deal with this person's political demands if they were coming from a person not being treated for mental health problems.

But the difficulty in doing this lies deep in the relationship between doctor and *mental health* patient. Health care professionals treating physical conditions must rely on persuasion, using the authority granted by educational qualifications, to gain permission to implement diagnostic and treatment decisions. This is a foundation on which to build mutual trust - a precondition for a relationship in which 'patients' are respected as equal citizens and agents in their own right.

In contrast, the rehabilitation of a person with mental disabilities appears to *require* a person's attitude and worldview to change and consent is unnecessary to impose treatments. In addition it is the case that a patient's actions based on erroneous worldviews can be extremely harmful to themselves and others. The ascription of disordered identity allows doctors to de-legitimate the patient's current worldviews and apply treatment decisions without recourse to persuasion drawing legitimacy for this from professional duty and law. This decision is legitimated further by the evidence of medicalised assessment and recording practices. But, there is a significant lack of accountability in this process which symbolically places a person in a state of exception.

Adapting mental health treatment practices to recognise, support and enhance political agency problematises the foundations of the mental health practitioner's claim to knowledge about the individual's condition. When the discourse moves into the neutral and egalitarian space of political discussion where everyone is entitled to an opinion and no one is wrong or right then the 'patient' doctor relationship is shifted to a citizen to citizen relationship. This enables the patient to be recognised as a person with something to contribute and to negotiate but who may need some teaching and guidance, rather than someone to monitor, manage and tell what to do.

A recognition of the political agency of persons diagnosed with mental illnesses necessitates a shift away from the objectivised knowledge about an individual indicated by psychiatric and psychological epistemologies and technocratic observance of law and policy. To facilitate the co-construction of political participation as an aspect of the good life, spaces must be available where pragmatics of law, policy and professionalism are made more malleable to service-users. The significance of the law is reduced in order that it may regain its significance in people's everyday lives.

The organisational hierarchy in hospitals is structured and justified by the claim to psychiatric knowledge and so the greater recognition of personal experience has potential to destabilise the political environment in ways that undermine the authority of the psy-disciplines. This was perceived by staff research participants as a risk and a threat to the good order of the institution and *therefore* also to patients' functional rehabilitation.

This suggests that practices of politicisation might be more effectively conducted in physical spaces that are not pregnant with medical symbolism and outside of the roles and identities people are required to play within the ritual order of the institution. It also suggests that psy-epistemologies are inadequate to the task of supporting political participation and rather that pedagogy, or in the case of adults, anthrogogy, might provide a better basis for such practices.

8.2.3. Shared Learning Experiences

Many staff described their implementation of the policy as holistic and person-centred.

we are promoting this holistic approach in… voting to… exercising their rights financially… er… emotionally… erm.. socially so it's the whole approach that we have to promote (Site 2, Transcript 6, 2018, MHN)

This positive narrative foregrounded commitment to supporting patient rights but practitioners were aware that it sat uneasily alongside the practices of coercion and containment premised on rehabilitative interventions.

Many of the practitioners had to engage in practices of coercion and containment and manage the mutually coercive relations that are a feature of the ward environment. To counter the perception that mental health professionals were engaging in restrictive practices that undermined human rights and freedoms they presented positive narratives to the researcher and the policy implementation provided experiences from which such narratives could be readily developed.

that's the way forward to try and encourage him to exercise that right and then also feel, again that he's getting well and he's able to make that contribution to society (Site 2, Transcript 4, 2018, WM)

They described implementation as a fulfilling experience because it provided opportunities for them to listen to, and support patients to engage in meaningful political expression and action. This allowed practitioners to construct useful and valuable professional identities based on human rights-based principles and enhance their standing and face.

The staff members who described the role of political supporter as analogous to a parent or teacher found that political interactions with residents became more personable and less reliant on the way doctor patient ascriptions structured social performance. This approach also gave them insight into the way in which institutions restricted politicisation:

your first opinions [are formed by listening to] parents talking about it and then you might talk to your friends... You listen to the news. You actually formulate not only your opinions but your understanding of the whole system... I think for a lot of our patients because they've been in and out of institutions, they've not necessarily had that opportunity to grow in that way (Site 1, Transcript 2, 2017, SALT)

One staff member, citing Paulo Freire, stated that all education is political and described the process of providing political discussion as a joint learning experience in which she and service-users would learn from each other's views and experiences. Although such mutual learning was identified as a model on which to base implementation, in practice staff often felt restricted to a management role rather than seeing themselves as equal participants:

why they want to vote is not my problem... but how I'm going to manage them that is how I would think because my job is basically... managing the situation not touching their choice (Site 2, Transcript 6, 2017, MHN)

As described earlier an MP visited Site 1 prior to data collection in 2017 and reportedly had not talked to residents, interacting only with staff, managers and the owners. In contrast, a social worker organised a later visit by an MP explicitly for the purpose of interacting with and listening to residents following consultation based on my initial findings. The MP, on the second visit, reportedly learned a great deal about what it is like for service-users in the hospital and to live with mental disabilities. This resulted in him inviting a group of residents to parliament. Thus, hearing and recognising voices of people with disabilities as contributions from legitimate members of the community is potentially transformative (Site 1, Consultation, 2018). I have already discussed the importance of narrative for practice in s.4.4.

Influence is the currency of politics and is not something that should be avoided in interactions between health care professionals and service-users. But political discourse is best conducted between equal citizens political support is most effective when offered in the context of egalitarian relationships and in the context of the institutions under study requires ‘stepping out’ of the doctor patient roles. The capacities to engage with others on this basis need to therefore to be supported and environments optimised so that these roles and relationships are encouraged and accessible for both staff and service-users.

8.3. The Political Identity

A helpful aspect of a Goffmanian perspective is that it provides a set of concepts useful in analysing the performance of political roles in the drama of individual interactions. Mental health professionals supporting service-users to engage in political and civic life may, due to institutional pragmatics, briefly separate themselves from their professional identity and role in order to present a personal political identity. This carries the risk of collapsing the doctor patient act and undermining professional authority. Alternatively, the practitioner may engage in political inclusive practice but do so whilst distancing themselves from the political role to preserve a sense of their objective professional identity (performing a *verfremdungseffekt* - Brecht, 2005). Unfortunately, in observation performance often came across as disingenuous to the service-user audience meaning that they distanced themselves. Service-users may also distance themselves from the political identity to avoid criticism for the perspectives and opinions they express.

Some residents sought to deny a disabled identity thereby resisting their status as mental health ‘patients’ or ‘service-users’.

“I don’t class myself as disabled no… I’m still independent” – (Site 1, Transcript 1, 2017, SU)

In contrast, some residents fully accepted and embraced the identity of 'disabled person':

SU: I do have a disability yeh I have learning disability" – (Site 1, Transcript 2, 2017, SU)

If we take the example of a person detained in a mental health hospital for the purposes of treatment and for the safety of themselves and others, and assume that they have a capacity to develop a sense of their goals and interests, then it is useful to ask what are the strategies available to them to pursue these goals and interests?

If you want to gain political capital in this sort of environment two strategies seem pertinent:

1) Compliance with mental health professional's decisions in order to increase the chances that the professional's discretion will be in your favour. In the short term this is potentially an undesirable option as it means deferring gratification and submitting to the will of others. In the long term it can be very positive however as residents progress to the point where they can legitimately exercise their freedom and agency.
2) Challenge and undermine the system by means of protest and conflict. Conflictual behaviour is often immediately supressed and is implicitly discouraged by the threat of prolonged treatment. It is a risky strategy in both the short and the long term. However, in the short term it can be effective to meet certain demands and interests, for example coercing staff into providing some social and material resources by forcefully demonstrating psychiatric need.

The way politics is defined on the ward reduces the salience of systems of accountability in the immediate context. The political environment on the ward may, because of the uneven power relations developed, form an experience that encourages apathy or futile demonstrations of anger (or even attempts to initiate revolutionary conflict). This constitutes a pedagogy of ethics, in the course of political socialisation forming a habitus, that may be transferred to the wider political field. It encourages people to repeat discourses and not to subvert them. This means that political identity is in some ways restricted in the medicalised environment.

8.3.1. Political Identity in Medicalized Environments

In all three facilities a small minority of service-users participated in the general election and the local election so even the exercise of rights to electoral participation appeared rather constipated. This was perhaps due to a lack of awareness, motivation and peer support. However, the social restrictions that influence these factors were little discussed and were rejected by many staff members as a causative factor. To take one example as illustrative - the Speech and Language Therapist at the closed rehab facility identified the restriction as arising directly from psycho-social impairment. This demonstrates the way in which responsibility for exclusion is placed upon the excluded.

because of the mental health problem, you've got that level of you know…… there are some who are really really good and…… But I suppose also by the nature of things cos they're you know… they're not always the most attractive group of people… they're a bit frightening (Site 1, Transcript 2, 2017, SALT)

Here, mental illness and impairment are constructed as naturally causative of political disengagement and exclusion. This effectively displaces responsibility for supporting equal opportunities from staff to patients. Individual characteristics are identified as the main cause of exclusion. The right to participate is, according to many staff members, not undermined by the practice of treatment and detention under the mental health act, (and all the attendant disadvantages this causes) but rather by the way the individual behaves and presents in social situations. This was not discussed as a problem of stigma or mis-recognition in any of the interviews but rather was constructed as a character flaw. Persons with mental health problems who are competent in engaging in political debate are consequently regarded as exceptional and held up as examples of inclusive treatment practice.

Although most staff members placed responsibility for exclusion on the character of service-users, a minority of staff participants did identify systemic restrictions on the exercise of political rights. As noted earlier one staff member at site 2 (the open facility) said that institutional constraints placed upon inpatients' freedom of expression, movement and association was a main cause of lack of engagement with elections.

Defence of patient rights allows staff to perform the role of progressive practitioner and to demonstrate the holistic and virtuous nature of their approach to mental health treatment. This remained an imposed rather than something originating from the discipline and practice of psychiatry.

MHN: it is because of legal rights for certain things so that's what we have to facilitate" – (Site 2, Transcript 1, 2018, MHN)

In common with other participants this interviewee appears to be making a sharp distinction between 'rights-based' practice and medicalised treatment. However, in the facilitation of political rights, a beneficent treatment approach remained hegemonic and dominant in the discourse and in the reification and objectification of identity of service-users. Butlerian strategies of protests against this reification appeared to be ineffective due to the ability of staff to mis-recognise such action and expression as confirmations rather than subversions. This is inherent in the ritual order of interaction which governs staff and service-user performances.

The ward manager in the open facility described practices in which the support for exercising political rights could interact with the professionalised recovery and rehabilitation processes.

"well there is a combination of different things there it… social skills because you're trying to get them back into the community. They're going to get to have to mix with the public…… sooo that's normalisation er therapeutic is about trying to ensure that they are going to exercise their rights make them feel good about themselves…… make them feel valued and make them feel like they have an opportunity to contribute to society and… make them feel like there is a purpose to live." (Site 2, Transcript 2, 2018, WM)

Despite the emphasis on connectedness and co-construction I found that even in the open facility (Site 2) the practice of politicisation was viewed as a professionalised exercise in which service-users were objects rather than active agents in their development. This meant that numerical measures of progress could be produced to evaluate policy implementation as well as restricting the scope of the practice to increasing voting and registration rates. This potentially avoided substantive application of the principles of connectedness and co-construction in the practices of political inclusion.

There was a clear narrative that mental illness inhibited mental capacity to make political choices. This was repeated and internalised by service-users which in turn influenced their perceptions of the pointlessness of participation. One service-user argued acute mental problems made going outside, let alone a trip to the polling station, difficult as a result of anxiety and apprehension. In my observations and interviews, even those professing their incapability were very good at expressing themselves and defending their interests using skills identified by Cees van der Eijk as aspects of political behaviour (2018). For example, the person citing anxiety and apprehension was patient representative in governance meetings and argued forcefully that the private mental health service-provider was exploitative

(*"I don't think they should privatise hospitals… So staff don't take advantage of patients' money and its safer"* - Site 1, Transcript 1, 2017, SU). She also recorded what could be interpreted as a protest song about the experience of the mental health hospital inspired by the film Frozen:

"a kingdom of isolation, and it looks like I'm the queen, the wind is howling like this swirling storm inside, couldn't keep it in, heaven knows I tried. Don't let them in don't let them be, be the good girl you always used to be, conceal don't feel, don't let them know!" (Ibid)

Despite the problems of developing political identities in medicalised and institutionalised environments, the policy meant that a new type of personhood (Hacking 1995) was available to service-users. The policy documents constructed a role of 'politically engaged patient' that previously was not available or a valid or legitimate identity for residents. Therefore, a choice is made available to service-users to adopt, or to play, the novel institutional role of politically engaged patient. Many service-users, and particularly those who were younger and who had been institutionalised early on in their lives, had never performed a political role before and were therefore unsure what the rules of performance were.

The role of politically engaged patient was experienced by some service-users as an imposition. This depended heavily on the sensibilities of the individual people involved, their relationship, their previous experience of political discourse, the staff member's approach to political support and the service-user's status in relation to the recovery process. Service-user engagement in any sort of conflict can be mis/mal recognised as mental illness. This appeared to be particularly acute for those with personality disorders, psychosis and/or schizophrenia. Those with learning difficulties were treated more patiently and sympathetically.

The ascription of a political role caused staff and service-users to engage in role distancing from the ascribed political identity in cases where:

- they had no previous experience of political interaction.
- the institution and staff were viewed by the service-user as not acting in their best interests;
- the individual had a worldview in which the democratic institutions of state are illegitimate and;
- the resident is viewed as acutely ill or dangerous.

Where the resident was resisting staff ascriptions of identity and personhood they engaged in role distancing behaviours. Role distance, as we saw in Chapter 3, is a strategy whereby expectations of a competent performance of role are reduced through bodily and linguistic communications. This allowed residents who did not fully embrace the political role to avoid social judgement and their own internal critique for poor performance or mis/mal-recognition as illustrated by the following comment from service-users: *'Cos of my schizophrenia I wouldn't be able to have a good conversation'* (Site 2, Transcript 7, 2018, SU). Sometimes this created a sense of alienation from and hostility to politics in general, and towards the support offered by staff.

The ascription of the political role was experienced positively as a recognition of political agency in cases:

- where the service-user had embraced previous identity ascriptions (for example identifying as disabled or mentally ill);
- where the service-user/provider relationship was based on greater levels of trust and respect;
- where the service-user had previous experience of political role performance and;
- where they were viewed as nearing recovery.

The availability, and ascription of the political role may be experienced both positively and negatively by service-users depending on their individual circumstances but also depends heavily on the context in which the practice occurs. This means that professionals exercised their discretion carefully in identifying and selecting service-users who they thought would embrace and potentially benefit from the ascription of political identity.

In cases where institutional ascriptions of the political role failed to engage residents in politics, more basic processes of politicisation were required to precede education and encouragement. Organising MP visits, ensuring access to politically engaged others such as family, friends and colleagues, or simply creating environments in which political discussion and information are regularly engaged in and normalised may provide a basis upon which political roles and identities can be constructed by the resident themselves, rather than being ascribed. This was the basis of the reform agenda implemented after data collection at Site 1.

8.3.2. An Extension of Staff's Sphere of Control

Because of the technocratic governance strategy of mental health institutions and the inconsistency between technocratic and democratic governance structures already discussed, the imposition of the novel political role was experienced by some residents as an extension of the sphere of control of staff to the political sphere. Participation being made conditional on good behaviour, capacity assessment procedures, formal and didactic educational practices, social skills interventions and bureaucratic processes indicated that the political sphere was a space primarily owned and managed by staff members.

Consequently, there was potential for implementation to feel oppressive, indoctrinating and to create conflicts of interest. Further, because of the way that media and information was restricted in the institution, staff were privileged with more information which placed them in a clear position of influence when providing political information and answering political questions.

The policy was interpreted by staff as providing a mandate to manage patient political expression and action. It gave discretion to provide supported access or to decline to make reasonable accommodations. Implementers become arbiters of appropriate political expression justifying the management of a wide range of political expression and action. As one staff member put it: *everything's political to some extent but some things are obviously more* (Site 2, Transcript 3, 2018, OT). In this way casting an abstract vote in a general election was seen as more political than railing against a situation in which no suitable housing was available in the local area. One was supported and the other restricted as inappropriate.

Staff, sometimes erroneously, assumed people with mental health challenges needed help. When support is offered on the basis that you must adopt a passively incompetent role it can be experienced as a reduction in status.

Me: would you want one of the staff members to kind of help you read through [party manifestos]…?

SU: No… Other patients might like that though… I don't class myself as disabled…

There is then a need for practitioners to be aware of unexamined assumptions especially given the possible impact of their more powerful position. Engagement with the educational literature and alternative narratives would enable them to be more creative, informal and humanistic in implementation, and to be less defined by the medicalised environment.

More generally, rather than presuming incapacity, practitioners should assume every person has capacity to participate in political and public life so long as the context and circumstance are designed in ways that reduce boundaries and increase opportunities for participation. Taking steps to provide opportunities for service-users and staff to develop political capabilities and identities and to interact with politically engaged others is likely to contribute to achieving recovery as well as fulfilling the obligation to support participation in political and public life. Practitioners should also be aware of the danger of ‘giving up’ on some service-users because of their disabilities and of rationing support to those who are compliant with medication and performing the role of ‘good mental health patient’.

An even more difficult habit to develop (difficult for us all in our everyday lives let alone practitioners in the institutional context) is to abnegate any right to restrict other people’s choices even though we consider them to be wrong. In the context of this study this implies that practitioners should not seek to restrict service-users’ political choices on the grounds of them being incapable just because their opinions, actions or omissions seem to them unwise or against their own or other people’s interests. Further, even if someone appears to lack the skills or knowledge necessary to make political decisions, and even if someone is denied the right to vote, they still have the right to public and political life and to pursue their own interests and perspectives.

8.3.3. A Therapeutic Experience

Despite implementation sometimes being experienced in negative ways there were many cases in which it was experienced much more positively by service-users. Many benefits were identified.

The practice of escorting service-users as a group to the polling stations was experienced as an occasion for positive social bonding both between service-users and between service-users and staff. Because forums where political expression was encouraged allowed people to play at new roles and engage in conflictual and cooperative relations it was experienced as a process of social development where social skills could be practiced and enhanced. In addition, it was an opportunity to eschew socially-desirable role distancing, in order to fully embrace, in the Stanislavskian sense of becoming, the role of political citizen.

Of course, there are also issues with this approach. The secrecy of the ballot was compromised when the staff members escorting the group went into polling booths to support service-users to cast their ballot. In addition, service-users' rights to refuse escorts was undermined by the fact that many would not have been granted section 17 leave without the presence of staff members. This can again provide rational reasons for disengagement and represents differential treatment.

The symbolic recognition of political agency was therapeutic in the sense that it provided a social and political environment in which service-users could take pride in their experiences and perspectives. This reportedly resulted in increased levels of confidence and self-esteem following the election (Site 1, Consultation, 2018). In addition, the transition between playing at the role and becoming a political agent effected by the act of casting a ballot was a source of pride and social esteem.

Me: was it a positive experience coming out and voting or?

SU: yeh… you feel more wanted don't you… cos everyone knows who you are… she underlined it… [my name] was on the piece of paper (Site 2, Transcript 5, 2018, SU)

The process of political participation provided behavioural confirmation of 'progress' which staff could record as contributing to the recovery process. The service-users were aware that their participation was recorded. This record effectively recognised and confirmed the political identity of service-users providing a springboard for further engagement. Staff saw it as a sign of progress in recovery also. This was therapeutic in itself as a symbolic expression of increased social standing within the community of service-users at the facility and a practical step towards more independent living.

These subtle processes of recognition had the effect of changing how the political environment was experienced for certain service-users giving them a greater sense of self-efficacy. The ritual order was, at times, rendered more flexible to subversion and resistance by both staff and residents providing opportunities for self-definition and free expression of perspectives. In other cases, adoption of the ascribed disabled identity (rather than resistance and subversion) provided a basis for building political identities and capabilities also. The Butlerian conception of the development of political agency, primarily through resisting and subverting hegemonic identity norms, might usefully be adapted to allow for 'playing by the rules of the game' as an alternative route to forms of political identity and capability.

Although these positive aspects of adapting to the ascribed identity of the disabled person were evident other service-users did not wish to adopt that identity. One possible response by practitioners to resistance to being placed in this category is that it is deluded. But the evidence and arguments presented here and in later chapters suggests that a more appropriate and ultimately more successful response is to recognise that adults want to acquire a sense of status in social groups and that some people feel that the ascription of disability can negatively affect their status and sense of self.

Political participation is also often constructed as conditional on good behaviour, taking medication, accepting a particular ascribed identity, which are associated with therapeutic success. These are conditions that do not apply equally to other citizens without mental health difficulties.

Although some service-users engaged in the political role for reasons other than exercising influence in political decisions, playing at the role transitioned to 'becoming' and 'being' when the vote was cast. After the vote one service-user for example portrayed himself as being more aware of the world around him and as a responsible political citizen - (*high pitched) everybody has the responsibility to* *vote else you don't know what's happening in the world do you (in a wise tone)* – (Site 1, Transcript 4, 2017, SU). In this way engaging in creative role play was a basis for becoming a political citizen through the symbolic act of casting a ballot.

8.4. Discussion

In mental health settings there is a danger that the concern of staff regarding political rights is experienced and interpreted by service-users as an extension of staff's powers of assessment and behavioural management. Performance of the political role exposed service-users to heightened and inconsistent social judgement as compared to people without mental disabilities. For example, the question of whether a person wanted to vote or not was experienced by some service-users as a threat to face in the Goffmanian sense because they worried that either accepting or rejecting the opportunity risked negative comments in their notes. In this way the politics of care inevitably impacted on political participation more generally.

From the staff perspective, the policy was often interpreted as an inconvenience, perceiving it as a performance required for the maintenance of good public relations - a window dressing exercise rather than a practice relevant to their professional identity - where implementation functioned as an additional demonstration of institutional commitment to patient rights rather than a fundamental aspect of everyday practice. The implementation process was at times stressful and fundamentally disruptive from the institutional perspective as it increase the risk of conflict and inefficiency.

Inclusion in institutional political processes (small p politics) was seen as a greater risk to patients than supporting inclusion in elections. Staff found that the political supporter role provided them with a mandate to manage the service-user's engagement in beneficent ways that undermined agency in the short term.

The role sometimes functioned to allow staff to direct service-users towards 'appropriate' political processes and away from others.

Although the health benefits of participation were rarely constructed as extensive enough to justify coercive practices many staff attempted to resolve the tension between benevolence and agency by attempting to assimilate the roles of political support worker and beneficent carer. Assimilation of the roles was possible by attributing a therapeutic or medical benefit to political inclusion and in this way implementation became a matter of social skills interventions that function to rehabilitate service-users and reintegrate them into the community.

"[political inclusion] is a part of rehabilitating them back into the community …… and I think just making them feel like they have a voice is really important as well – Site 1, Transcript 3, 2017, MHN)

The confluence of medical and political roles was often seen as inappropriate from the service-user perspective. One way of asserting their power to resist was to refuse to exercise their right to vote. Although the assimilation of the political supporter role and the beneficent carer role often facilitated the maintenance of power, it still required staff to recognise the political agency of residents in new and interesting ways. The policy symbolised a shift in practice towards recovery orientated and patient-centred practice, and away from strict application of coercive authority.

Most staff experienced implementation as an opportunity to problematise some of their own assumptions about service-users' capacity for political expression and action and to incorporate the principle of supporting political inclusion into their professional identity. Many staff discovered supporting politicisation in the mental health setting was an intellectual challenge (*"I haven't really thought about [how to distinguish between mental illness and political expression and action], I don't know…. "*– Site 2, Transcript 3, 2018, OT). The thrust of the argument in this thesis implies that the fruitful task of de-fining appropriate and inappropriate or dysfunctional political engagement is one that should not only be confronted by staff. The 'community as a whole' and in particular service-users should also have opportunities to contribute to these judgements. In inpatient rehabilitation settings this could helpfully include people with lived experience of mental disability family, peers and NGOs, mental health nurses, social workers, advocates, psychologists and psychiatrists.

Even where the scope of political inclusion was restricted to electoral politics and the political supporter role was assimilated with the beneficent carer role, it *still* appeared to have transformative potential to reconfigure the professional identities of staff and the passive roles of patients.

Staff members who embraced the role of political supporter found policy implementation allowed them to become more self-reflective and construct a new professional role. They began to view their task as creating supportive political environments for patients and checked the instinct to closely monitor and manage expression and action more often. Rather than policing and assessing inappropriate behaviour, capacities to participate were to be nurtured and encouraged through explorative exercises and discussions. The discourse of political inclusion allowed some staff to enhance their influence in institutional political processes by representing service-user's political interests (for example winning resources for day trips or persuading responsible clinicians to grant s.17 leave). Therefore, the practice provided positive experiences for these staff members which could form the basis of an explicitly political professional identity.

In these cases, the new role was experienced as analogous to an advocate, parent or teacher. Implementation became an educational process in which both practitioners and service-users learned together about each other's subjective experiences, how they would like to change things for the better, and how to make such changes happen in the current political environment of the institution and wider society. Thus, the distinction between staff and patient's as different kinds of political agent was in some cases significantly weakened.

The context of mental rehabilitation in totalising institutions means that practices of politicisation can be have positive and negative in relation to opening opportunities for political engagement. Often, the possibility of engagement in the small-p politics of the institution remained out of bounds, being ringfenced as an arena of professional knowledge. This in turn has wider implications for engagement in big-P politics in the wider community as service-users are socialised to defer to expert knowledge and opinion in preference to their own experiences and worldviews.

Butler's theory of co-constructive identities shows how novel positive identities can be forged through subversion of the norm (Butler, 1988). New categories of personhood can be empowering but can also pose a threat to a person's current way of life and a sense of self. The data shows that in implementing policies of political inclusion, the subversion of the norm becomes normatively regulated through an ethics of appropriateness. These norms are informed by a psychiatric conceptualisation of the good life as one with minimal conflict with others and in which people behaviour according to existing social pragmatics rather than challenge and subvert them. This can create significant restrictions on becoming political agents.

Understanding the real-life aspects of Goffman's concepts can both clarify and demystify several important issues encountered in the empirical work presented in. In playing political roles, for example, role-distanced performance might be interpreted by practitioners as a poor performance and evidence of inadequate social functioning. The behaviour in question may well constitute a subversive or problematic performance given the expectations of role embracement but if role embracement is defined as healthy and role distancing as unhealthy then the scope for autonomy and choice in political identity play may be reduced.

The analysis reveals that regulating and adapting behaviour according to the norms developed in psychiatric rehabilitation can function to restrict political opportunities in the short term. Such restriction is justified by the uncertain promise that such practices might expand agency in the long term. This assumption has been challenged by the finding that the socialisation into technocratic governance structures create alienation and disconnection from the political processes that govern people's lives.

Subverting and resisting the role of mental health patient and acceptable incompetent can expand opportunities for agency in the politics of the institution but also can restrict the opportunities to engage in the politics of the wider community as people are mis/mal-recognised as dangerous or problematic participants in such processes. This can mean people with mental health challenges are readily stigmatised or excluded from political and public life.

8.5. Conclusions

In this chapter I demonstrated, by reference to the interview and observation data at three sites, that the implementation of policies of political inclusion presented a number of issues and dilemmas to staff as well as service-users. It was at times stressful and discussion of politics appeared to be experienced by some as a threat to staff authority and expertise. This was because it can collapse the distinction between political opinions and actions on the one hand, and symptoms of mental disorder on the other. More fundamentally the practice of political inclusion in the 'small' politics of care and recovery presented a challenge to the epistemological foundations of mental health service provision (i.e. superior professional knowledge regarding the individual's lifeworld) and the authority of staff vis-à-vis patients.

As a result, some managers restricted implementation to administrative and logistical support or to neutral or 'non-influential' political interaction. This was a form of cognitive dissonance as the whole raison d'être of rehabilitation is to influence people to live better lives which necessarily involves political influence. In addition, supporting greater political agency in decisions that affects one's life must include medical and institutional decision making most proximate to service-users. Politics should not be constructed as remote, elitists and distant but made as relevant as possible.

These factors mean that during implementation of politically inclusive practice there is a slippage back into the normal medicalised practices and rituals of mental health care. The roles of passive patient and managerial psychiatric professional are normalised and reinforced by the institutional environment and performance of this in interaction becomes a comforting ritual. It is in this way that the good intentions of practitioners are often frustrated and policy outcomes, if measured on the basis of registration and voting rates, remain disappointing.

Some staff experienced the role of political supporter as a continuation of previous carer roles whilst others saw it as a challenge to, or contradiction of, 'normal' practice. Some service-users used the introduction of policies of political inclusion as an opportunity to reflect on the way that power and authority operated in the institutional setting and in the wider polity and thus provided resources and opportunities to disrupt institutional rituals and roles. This disruption in turn had potential to stimulate changes in the political environment of the mental health service for participating service-users and staff. This potential was often then shut down on account of risk and disruption to rehabilitation and recovery.

These findings indicate that a humanistic, person-centred and holistic practice of mental health treatment, that also feature aspects of anthrogogical education and the 'praxis of philosophy' need to be deeply embedded into institution rituals. This would perhaps be more conducive to the types of political opportunities envisioned by both domestic and institutional policy and under the UNCRPD.

The application of principles of political inclusion in mental health services that are more focused on a medicalised and technocratic application of psychiatric and psychological principles, and which construct service-users in the role of passive learners, can end up creating more restrictions on the development of political agency than they open up. This is a complicated and contextual analysis of the phenomenon of political socialisation but such nuance is necessary to more fully substantiate the right to equal opportunities to engage in political and public life for people with mental disabilities.

In the next chapter I analyse in more detail the educational processes intended to enhance and increase service-user capabilities for political participation.

Chapter Nine

9. Practices of Politicisation in Psychiatric Services

9.1. Introduction

In this chapter I will present data and apply dramaturgical and political analysis to analyse the phenomena observed. I use theory to inform this analysis but also use the empirical data to modify and adapt the theoretical approaches described in previous chapters. In some ways the data supports Goffmanian theories on the performance of political roles as well as Butlerian theory on the co-construction of political identities and 'performative agency'. In other ways the data presented contradicts aspects of the literature and theory.

The central argument made in previous chapters is that medicalised practices and rituals of mental health treatment and rehabilitation, which are applied in everyday interactions on the wards, are intended to be suspended during moments of implementation of policies of political inclusion (Ch.6). These moments are constructed as an aspect of person-centred, humanistic and recovery orientated practice and occur periodically in and around elections (Ch.7). However, the normal medicalised practices and rituals are difficult to escape for both practitioners and service-users and inevitably reassert themselves even in these brief moments of politically inclusive practice (Ch.8). It is in this way that the good intentions of practitioners are often frustrated and policy outcomes measured on the basis of registration and voting rates, remain disappointing. In this chapter I analyse these moments of slippage (reverting from recovery orientated practice back to medicalised rehabilitative treatment) and seek to use the data and theory to explain and analyse some possible reasons why this occurs, as well as possible ways out. In doing this I suggest some minor adjustments to Butlerian theory of political identity development arguing that although subversion of norms is important in political conflict, adherence and embracing of norms can function to expand political opportunities also. Both embracement and subversion of social roles can be productive in the process of political anthrogogy.

9.2. The Politics of Recovery and Rehabilitation

The concepts of recovery and rehabilitation discussed in previous chapters (s.6.3.2) is fundamental in justifying current mental health law and policy and underpins modern nursing theory and practice in the UK. Diverse, and often conflicting, definitions of recovery have led to multifarious theoretical and practical approach's to implementation. The policy of political inclusion was interpreted by ward managers as both a therapeutic intervention in rehabilitative practice and an aspect of recovery, but this translated into very different practices in different institutions.

There is a tension between rehabilitative treatment which is associated with normalisation, containment and risk reduction and person-centred recovery which should imply greater responsibility to take decisions and therefore greater risks. In the context of mental health rehabilitation at Site 2, the care pathway was managed closely in order to ensure that service-users didn't present any risks of harm through their 'recovery journey'.

"[It is] very important to take them through their recovery journey in a very safe environment actually" (Site 2, Transcript 6, 2018, WM).

In observation at all three sites, attempts at politization very often failed with numerous service-users resisting attempts made to motivate them to exercise their right to participation. This was perhaps in part because of the assumption that such participation would be closely managed to reduce risk. However, it was more often simply attributed to mental illness and lack of progress in treatment and rehabilitation (see s.8.2.1).

Both formal and informal sessions seeking to facilitate political inclusion presented opportunities to inform people of their rights, to encourage them to register and cast a ballot. However, they also functioned as a way of assessing people's capabilities to engage. They did not appear patient directed nor spontaneous and humanistic interactions. They were rather presented as professional interventions.

"we put a plan in place… and actually find out.. what level of support [they] need" – (Site 2, Transcript 1, 2018, MHN)

When service-users did not want to register to vote or participate in elections the Clinical Team Leader at Site 2 sought to push service-users to get involved as an aspect of holistic treatment (see s.8.2.3).

"Some of them they just – 'No!' – so I have to tell them…… So I told them [the reasons why they should vote] and they said actually 'Yes'" – (Site 2, Transcript 1, 2018, SMHN)

This intervention was justified by the fact that within a holistic treatment approach the social role of political citizen should be encouraged. Capacity assessments were applied to those who wanted to vote and although this was to determine what support was necessary it had the effect of embedding political inclusion in a medicalised understanding of treatment:

"to ensure erm she is aware in terms of you need to assess capacity" – (Site 2, Transcript 4, 2018, WM);

“staff shouldn’t be making the decisions as to whether she shouldn’t vote unless there’s a real capacity issue” – (Site 1, Transcript 2, 2017, SALT)

No capacity assessment was applied to decisions not to vote other than at Site 3. This is in line with an individualistic view of political motivations. It is perhaps deemed rational not to waste time on voting when both staff and patients frequently argued that ‘it won’t make any difference anyway’ or ‘there is no one worth voting for’. By contrast, the ward manager at Site 3 did question service-users who said they did not want to vote. This was an aspect of a checklist criteria developed.

“if they said no you [ask] why? Do you want support?” (Site 3, Transcript 1, 2018, WM)

For many practitioners across all three sites, political participation was constructed as an aspect of rehabilitation in which professional intervention is used to socialise service-users to engage in voting. Such encouragement would not necessarily be a welcome prospect for all service-users. Some practitioners stated that they needed to exercise careful judgement in deciding who to push and when:

“some people… will not give you a lot of room to manoeuvre…… Some people will be very open” – (Site 2, Transcript 6, 2018, MHN)

This judgement may be based on diagnostic criteria. The aims of these practices were often to encourage a holistically conceptualised form of rehabilitation. However such holistic rehabilitation was often seen as an outcome of a process of treatment rather than something to be embedded in everyday life of the institution. In this practice political inclusion is something that may come after successful treatment of mental illness (see appendix 5) rather than something that people with mental disabilities are continuously entitled to and that is therefore embedded in other spheres of life (see appendix 6).

In addition to encouraging people to engage in politics through encouragement, practitioners also sought to develop individual political capabilities. A central aim of political inclusion as rehabilitation was the development of self-efficacy:

"it's the level of confidence…so we…always implore them [and] encourage them" (Site 2, Transcript 1, 2018, SMHN)

Although the development of self-efficacy may be an important aspect of anthrogogical practice and potentially divorced from the medicalised system of treatment, it was often the case that service users were encouraged to embrace their identity as a mentally ill person and be confident in that identity.

Further examples of slippage from politically empowering practice to containment and treatment was found in the way measurement and scaffolding of political capabilities was discussed in governance meetings at Site 1. Policy implementation was subsumed into the program of social skills training required of certain service-user. This allowed rights-based approaches to politicisation to be interpreted as an aspect of, rather than contradictory to, broader objectives of assessment, containment and treatment. Designating politicisation as a social skills intervention made it more amenable to centralised management, measurement and control. Rather than politicisation being an opportunity for all service-users and staff alike to explore political views, roles and actions, individuals were supported in a top down way and often on an individual basis in accordance with institutional goals.

The three individuals at Site 1 who accepted staff support were directed to attend information sessions on this interventionist, top down basis (see 7.4.1). In this way purportedly 'rights-based approaches' tended to slip back into assessment and categorisation practices typical of medicalised approaches. This could have been one reason for many service-users decision not to participate. It was participation on the terms of gatekeepers without much opportunity for individuals or groups to own the terms of their involvement. Staff were thus focused on identifying mistakes in political performances of service-users:

so quite a lot of what I do is… assessing people's… ability to manage… and providing… descriptions for the staff of where their areas of difficulty lay"– (Site 1, Transcript 2, 2017, SALT)

A process of identity reification ascribes a myth of irreconcilable difference and can create conditions in which political identity, expression and action may be discouraged and restricted (Barker & Buchanan-Barker, 2011). Peplau argues that this practice, means people's political opinions and actions may be mal-recognised as aspects of illness rather than the expressed will of an agent and citizen (Peplau, 1995: 2) (see s.8.2.1).

The ritual order of the institution and its reinforcement in day-to-day interaction was identified as a central reason for this difficulty in adopting humanistic, informal and person-centred practices of political inclusion. Processes of institutionalisation both undermined the development of political capabilities and identities in the first instance and meant that service-user's political engagement was monitored and mis/mal-recognised when political action and expression was attempted.

"those three have been in and out of institutions all their life. So they've had very little…. time…. outside living independently…" – (Site 1, Transcript 2, 2017, SALT)

By socialising service-users to internalise an automatic deference to expertise and institutional authority, opportunities to learn how better to think critically, and to develop capabilities for political expression and action, were potentially reduced. In this way the potential for more open anthrogogies of citizenship and ethics was reduced.

“[the] institution makes a big impact… if we are creating routines, we are creating certain things, then we are controlling certain things” – (Site 2, Transcript 6, 2018, OT)

A note in my research diary during my observations of the closed rehabilitation ward during the General Election described how the ritual order of the institution categorised and constructed the patients.

“The language heard… reflected knowledge about the personality and present behaviours of the patients in psychiatric or psychological terms. This… turned patients into objects of knowledge about which expert opinions could be formed. But these ‘knowledges’ were only snapshots and were contingent on the context and relationship with the expert. They were also based on subjective notions about what is a good life and what is good behaviour over which residents had little say.” (Site 1, Observation Notes, 2017)

Butlerian theory would indicate that subversion of and conflict with such institutional ritual orders, are the main ways in which political identities may be developed and co-constructed. However, cooperation with institutional actors and internalisation of the ritual order may also be conducive, for service-users, in this process. Encouraging service-users to engage in perpetual conflicts, challenging norms and ascribed identities, could undermine political inclusion in the long term. Political cooperation with service-providers may be necessary for some members of the community in the short term. For example, performance of their reified institutionalised identities may facilitate cooperative relations and help develop less combative political practices. This could facilitate participation in certain contexts.

The developing practice of politicisation in mental health services constructs care as a social activity focused on growth and development which involves the recognition of both rights and responsibilities. Butlerian forms of subversion places the focus on the rights of individuals and thus encourages combative and conflictual political relations. Cooperative political identities on the other hand, whereby people play their ascribed roles (with potential role distancing) as a way of enhancing their opportunities for recognition, develops political capital on a collaborative basis. This enables them to move from a place of mis-recognition to a situation where they may be recognised as equal members of the polity.

In this section I have described the politics of rehabilitation and recovery as an emerging theme in the implementation of the policies of political inclusion and have discussed the implications of these findings in relation to Butlarian theories of political identity formation and suggested some minor adjustments. In the next section I will analyse the way in which the politicisation of service-users was subject certain responsibilities, placed both on service-users and providers. This was often based on medicalised notions of treatment progress and compliance.

9.3. Rights and Responsibilities for Inpatients

People with mental disabilities have the right to participate in political and public life on equal terms with other citizens. However, the containment and coercion associated with recovery and rehabilitation in the mental health system clearly curtails these rights directly and indirectly in many ways. There are restrictions on access to information and of rights to protest and public assembly for example. These restrictions are based on perceptions of risk but are justified by a human-rights discourse.

Mental health providers, in applying practices that potentially restrict political expression and action, have a duty to make reasonable accommodations to ensure rights to political inclusion are supported in alternative ways. Such accommodations should support rights to health and wellbeing of service-users, as well as the rights to political and civic life. Some practitioners interpreted this as a mandate to push service-users to exercise their rights even if they expressed a contrary wish on the basis that it would help with rehabilitation. The right to participate was thus described as a duty.

“from my point of view, everybody needs to exercise their rights” – (Site 3, Transcript 1, 2018, WM)

Despite requirements to reduce impairments and restrictions on the ability of people with mental disabilities to the exercise of political rights, participation was described in the closed facility as contingent on individuals taking responsibility for themselves: *”you’ve got to take responsibility for yourself because that’s what we aim for”* – (Site 1, Transcript 2, 2017, SALT)

The facilitation of political rights was also frequently considered to be detrimental to rehabilitation (see for example the response to Vignette 2 in Appendix 4 in section 6.2.1). In this way service-providers saw themselves as having a duty to protect certain service-users from the dangers of participation. This logic was used to justify the restriction of political expression and action even in elections. It represents a generalised exclusion from public and political life applied almost exclusively to service users in the mental health system. People with significant and serious mental disabilities or who were deemed acutely ill were assumed to fall into this category as evidenced by the social worker at Site 1 excluding whole wards from inclusive initiatives. Restrictions were contemplated where service-users’ behaviour in political engagement was deemed inappropriate so had a low threshold:

“[the] safety of patients…… whether it’s likely to escalate…… other patients being upset and uncomfortable with it …… that would be the first the first thought I think that would come into staff’s mind” – (Site 1, Transcript 2, 2017, SALT)

Here we see that staff often assume a role in which they impose and police norms of citizenship. They teach individuals to distinguish between appropriate and inappropriate political behaviour and to avoid the latter. An opinion or action being considered beyond the pale because it makes others uncomfortable is an incredibly low threshold for restriction and one that is not typical of other institutional environments. This creates a situation in which conflictual political relations are routinely restricted and supressed as a matter of professional duty. Both staff and service-users are seen as bearing a responsibility to maintain the therapeutic environment. Conflict is thus channelled into complaint procedures and legal challenge. Subversive protest action is discouraged and cooperation with dominant actors becomes a central strategy in gaining influence and political capital. In this way individuals are ‘normalised’ and assimilated into institutionalised worldviews and particular ethical rules are conveyed and internalised.

In this context role distancing behaviours are characterised by political behaviours. For example, disrupting doctor/patient performances become a form of covert protest. Ingratiating oneself with powerful actors, based on performances of obedience, becomes a strategy whereby people can exert greater influence on the co-construction of their identity and in the institutional politics of the hospital. This seems to confirm Butlerian theory in that it reveals empirically mechanisms by which the subject’s development of political identity and ethical perspective is entangled with subversive repetition of prevailing social and political norms. However, Butlerian emphasis on the development of political identity through scepticism, critique, subversion and even rejection of prevailing norms (Butler, 2010) becomes problematic in that these strategies invite greater coercion, isolation and exclusion for people with mental disabilities. Thus, subversion may ultimately hamper the development of political identities in these restrictive medicalised environments.

By narrowing the scope of the policy to voting rights, and emphasising the duty to protect service-users from risky political engagement, many service-users were not supported or encouraged to engage in broader opportunities to play at political roles and become recognised as agents acting in political processes. In the closed facility those who were categorised as ineligible to vote, as '*too disruptive'* or '*unsettled*' were excluded altogether from political information sessions (Site 1, Observation Notes, 2017).

If political identity is performatively constituted as Butlerian theory indicates then it does exist outside of the social performance. This also indicates that political agency is relational. Recognition and effect (i.e. whether we listen to, take account of, and act on people's political action or expression) is a fundamental aspect of political capability and is not inherent in the individual. However, in the case of persons with mental disabilities the performative constitution is undermined by the reification and objectification of (in)capability prior to performance. It is also directly restricted due to assumed risk. There are some aspects of political capability that are inherent in the individual and which can be nurtured. Some contributions appear more recognisable and effective than others independent of the recognition of that performance as they have obviously political aspects. Voting falls into this category. However most of the aspects of a public and political identity appear to be relational.

The psychiatrist, for example, learns what to say, and must speak in codified ways, which means that the codification and ritualization of that discourse precedes and makes possible the subject who speaks (Butler, 2010). The same applies to service-users who can learn what to say to be recognised as 'recovered' and this can constitute recovery. The issue is that even if a service-user learns to competently perform political roles they may still be dismissed as lacking genuine worldviews (schizophrenia or psychosis), being manipulative (personality disorder) or simply as posing a risk of harm or compromising their rehabilitation. They 'play' politics but are not seen as genuinely inhabiting the role in the Stanislavskian sense of becoming (see Ch.4) or through adopting appropriate *verfremdungseffekt*. Of course none of us 'genuinely' inhabit these roles as we all play varous roles in different contexts and with different audiences depending on the face we seek to portray. In the playing, we can only 'become' through recognition but there is no authentic identity underneath. Political participation is in this way a perlocutionary act and not something that springs from the individual in isolation (Austin, 1962).

A series of discursive and non-discursive practices and institutions re-constitute the idea of the political agency as an existing and autonomous reality. But errancy and failure can, and do, undermine these performances. As a result, we recognise that it is these repeated and sometimes errant processes that constitute political agents as 'being' autonomous. Unfortunately, if those processes become too errant under the watchful eye of mental health professionals, the very existence of political agency can be called into question. This potentially has far reaching consequences for political mobilisation of persons with mental disabilities by closing them in to restrictively narrow political domains based on the concept of appropriateness.

To say that there is no singular domain of politics, is not to say that the policy of political inclusion, being viewed as encompassing much more than electoral politics, no longer has an object. It only re-describes that field and affirms that how we describe the field has something to do with how the field finally looks and what we take it to be.

As Callon (1998: 17) has pointed out, theory contributes to the making of the sphere of its application. On this basis the formation of theories of democracy and politics in the implementation of Article 29 can be understood as a political process that circulates, connects, links and (re)constitutes political roles and the dimensions of appropriate participation. Political theory creates a set of methodological assumptions of what the political sphere is and generate a set of processes that fortify those very assumptions in implementing policies of political inclusion. Using this insight, practitioners and service-users may approach the questions of what politics is, what rights and responsibilities are involved in supporting equal political participation and when and where it is appropriate to 'play politics', through an open-minded and dialogical process. These questions should not be unilaterally determined by the staff team. Rights and responsibilities in this field should be a matter of negotiation and determined through a political process.

9.4. Anthrogogy and Indoctrination

Following on from the discussion of political inclusion as an aspect of holistic recovery, and the rights and responsibilities of various actors in securing this outcome, I now want to talk about the related idea of person-centred practice as it applies to anthrogogies of politics.

Person-centred practice draws on a constellation of ideas introduced in disability studies and through the assertion of disability rights in legal and political institutions. Advocates of holistic and person-centred approaches, although they are diverse, generally assume that a person's 'need for nursing' cannot lie in some 'either/or' world of community or hospital, general or specialist service, acute or continuing care, but rather flows across these artificial boundaries, as the person's needs change.

Person-centred practice is an important aspect of recovery in the sense that it promotes the persons capability and opportunity to exercise agency. This is reflected in the frustration that some service-user participants had at the refusal of service-providers to recommend rehousing them in the community. Although housing was the foremost political issue raised by service-users, *("SU asked researcher 'if I voted what changes will it have on where I live…?"* – Site 1, Observation Notes, 2017)*,* their political interests were often described by practitioners in terms of increased funding for services (Site 2, Transcript 4, 2018, WM). This highlights the potential conflict of interests that arise where service providers adopt the role of political advocates.

Within a person-centred practice care "*needs to flow with the person*" (Barker 2001), adapting itself to the person's changing needs. The practices of politicisation suffered from artificial distinctions between staff and patients' political agency, between eligibility to vote and disenfranchisement and between fact and opinion. If we maintain a focus on the needs of the person – for critical, transitional or developmental care – the interdependence of different services, and the person's dependence on peers and family members to meet different needs, becomes apparent.

In the course of describing practices of political socialisation, staff in all the rehabilitation facilities found it necessary to rely on the concept of appropriateness to distinguish between the types of expression and action a staff member should encourage, and those which posed a 'risk' and may be described as symptoms. By doing this they could impose ideas about how people should behave in political interactions. Therefore, an aspect of the role of political supporter was to decide between appropriate and inappropriate political action. This notion was explored and scrutinised rigorously in interviews and many practitioners had difficulty in distinguishing between symptoms of mental ill-health and legitimate political expression. Although the sarcasm at the end of this extract shows the staff member didn't think it was always possible.

3: [to distinguish between political opinions and delusion is] very difficult... we don't know whether or not they're in contact with the secret service do we really (sarcastic tone)– (Site 1, Transcript 3, 2017, MHN)

Staff generally relied on the notion that disciplinary knowledge relating to mental illness (i.e. the definition of 'delusion') allows you to categorise particular expressions and actions as 'outside of the norm' and thus evidence of pathology. This means that different types of mental illness and disability may be seen as a relevant factor for practitioners in identifying suitable service users for political support.

there are extremes as I said – [there are] people with very extreme political views who are absolutely not mentally ill…… but then there are some very strange and extreme political views that come out… of… mental illness…… (Site 1, Transcript 2, 2017, SALT)

This indicates that only 'normal' or common political opinions will be tolerated. Whilst those at either end of the bell curve will be in danger of being classed as mental illness. This is particularly the case for people diagnosed with paranoia, psychosis and personality disorder which influence the process of forming and communicating worldviews. Across the three sites it appeared that practices of political inclusion seemed more difficult where the patient had been diagnosed as having delusional, psychotic or paranoid symptoms.

Another experienced staff member at the open facility went further explaining that disciplinary expertise is not enough: to make a confident distinction. You must have a broad range of direct experiences in dealing with persons with mental illnesses and disorders and crucially you must have spent enough time with the relevant individual to have acquired knowledge about his or her particular opinions and worldviews. Rather than relying on diagnosis or medical records, you must get to '*know the real person'* in order to distinguish between legitimate opinion and symptoms of mental illness. Even with the significant time and commitment spent getting to know the person over a protracted period such judgments are still uncertain. Because this point has significant implications I have reproduced the passage at length:

when I wasn't experienced… I put most of the things as part of their illness…… and also not having to have lots of… direct contact with people… Once this is happening then you will know the person…… and you will know [their opinions]… there are times when… you spend time with people you get to know them… Then you can differentiate…… which one is actually their opinion and which one is part of their *illness but again having said that it's not a black and white thing. I could be completely wrong!* – (Site 2, Transcript 5, 2018, MHN)

The ability to support political expression and action potentially depends on the supporter's ability to distinguish between aspects of the individual's political worldviews and identity that should be cultivated, and those which are disordered and legitimately stigmatised. If we accept the opinion of the experienced member of staff above then, only supporters in long standing, respectful and trusting relationships (where they 'know the person') can make such determinations. This is one reason why the open rehabilitation ward visited relied on family members and spouses to provide political support and socialisation. It may also be one of the reasons that the ward manager at the third facility avoided making such determinations explicit and concentrated on logistical and bureaucratic support.

A range of holistic and person-centred approaches to politicisation and education were observed and discussed in the context of the open rehabilitation ward. Nurses, ward managers and therapists across the three sites described practices of politicisation as generating social pragmatics that emphasize the person's extant resources and capacities for decision making. The various methods observed gave practitioners and service-users a better view of the other person in context as well as the care system. These topics were directly relevant to their experiences. The need for creative and informal spaces to allow opportunities for both staff and service-users to play at, and become, more political was clear. By acknowledging the need for a continuously flexible and reflexive response, the chaotic nature of human behaviour and experience may be recognised and dealt with using social and political practices, as opposed to technocratic but benevolent management (Barker & Ritter, 1996). It must be a dialogue rather than a medical intervention.

Practitioners were engaged in anthrogogies of ethics and citizenship in positively supporting political participation as well as in their medicalised practices. Because this education occurs in a medicalised and technocratically governed institution, the possibility of person-centred anthrogogy is often more difficult. As we saw in Chapter 1 the process of providing positive support to people with mental disabilities to participate fully in public and political life poses the risk of creating indoctrinating systems of education. This was tacitly acknowledged by practitioners keen to avoid 'undue influence'. Indeed, the process of mental health rehabilitation and treatment generally may by subject to the same criticism if we consider that mental health practice is about teaching people to lead 'good' lives through coercion and containment.

Macmillan (1983) has argued that indoctrination in education is inevitable. Because practitioners apply anthrogogies of politics in ways that potentially indoctrinate people into hegemonic political doctrines such as 'democracy' and 'human rights' this process appears benign and legitimate to many. However, the fact that providing positive support for political participation can be viewed as indoctrination has deep implications on whether it can be viewed as advancing agency. Practically it also creates a situation in which practitioners are extremely cautious to engage in politically inclusive education and when they do often affect role distance that reduces the benefits of such initiatives. The issue of indoctrinating tendencies was perhaps one reason that slippage back to more comfortable medicalised acts and rituals was so prevalent during implementation. This allows the political basis of psy-epistemology, that it is based on a very specific and debatable version of the good life, to be effectively hidden.

Macmillan's argument is derived from a reading of Wittgenstein's theory of the world picture or worldview. Wittgenstein likens the worldview to a myth:

> *The propositions describing this world-picture might be part of a kind of mythology. And their role is like that of rules of a game; and the game can be learned purely practically, without learning any explicit rules.* (Wittgenstein: 1972: 15e)

The world-picture, as the basis for a rational debate, must be held with certainty. It provides the basis for effective action in the world and thus forms a foundation for political analysis and action. Garrison (1986) argues that it is possible to radically doubt a world that one continues to occupy, but to do so is to abandon rationality as well as effective action. He argues that to dispute the agreed worldview is to '*court the appearance, at least, of madness'* (*Ibid*: 263).

The teacher/student relationship in being socialised into a doctrine or worldview requires relations of authority (Taylor, 2017; Momanu, 2012). Burdeau (1989) emphasizes the universality of authority and identifies three distinct types of authority:

1. Anonymous authority generated by social, institutional and cultural determinants of behaviour;
2. Personal authority generated within social groups as a recognition of capabilities to influence others and;
3. Functional authority generated by ritual orders and rules of law that invests power in specific roles in an institutional framework.

Indoctrination by those in positions of authority is one of the most efficient methods of constructing governable citizens and is seen as particularly effective when applied to vulnerable populations such as people with mental disabilities and children (Cathala, 1986). This process is potentially very effective in increasing political participation in a superficial sense, but does not necessarily enhance the quality of participation.

Taylor (2017) and Momanu (2012) argue that identification of indoctrination may be based on analysing educational practice in relation to four criteria:

1. Indoctrination as intention: Withe (1972) and Snook (1972) argue that an authority must intend to indoctrinate and the indoctrination must also be functionally successful

2. Indoctrination through contents: Teaching turns into indoctrination when it encourages the transfer of knowledge which has been distorted by and subordinated to a political ideology (Reboul 1977, 55).
3. Indoctrination as method: Teaching may become an indoctrination act when it uses authoritarian methods, regardless of the knowledge transferred and the intentions of the teacher. (Momanu, 2012)
4. Indoctrination as outcome: Teaching that results in the output of closed-mindedness and an imbalance of authority (Taylor, 2017)

I argue that the last two point are most relevant to the current discussion as the ward environment, including education sessions intended to support political inclusion, are based in authoritarian rituals of treatment and containment. In addition, the dominant positivistic epistemologies of psychiatry and psychology can be viewed as encouraging closed-minded ‘students’ who see their problems exclusively through that lens. Momanu (2012) argues that constructivist approaches to education are a way of supporting more open-mindedness in teaching and thus avoiding the problem of indoctrination. She further argues that cognitive conflict (as proposed by Inhelder & Piaget, 1958), allows emphasis to be placed on the non-linear and cumulative process of knowledge co-construction.

In order to avoid any of these optics of indoctrination and to apply more person-centred anthrogogies of politics, a critical approach must be adopted, and lessons learned from debates in education literature.

Momanu (2012) argues, from a constructivist perspective, that productive conflict between teacher and student, in which authority becomes decentralised, enhances the quality of knowledge produced by permitting a wider range of evidence to be considered. Knowledge is co-constructed during the process of conflict which also creates opportunities for collaboration.

Anthrogogies that empower seek to enhance students’ capabilities to engage in knowledge co-production rather than merely communicating readymade truths.

Knowledge construction is not a simple and linear process. Some educationalists advocate a preliminary “deconstruction” (not in the technical Butlerian sense) of the biases and false ideas that act as obstacles to knowledge co-production such as a service-user’s lack of confidence in forming and defending worldviews (Bachelard, 2002). Others argue that base conceptions brought to the educational interaction play an active or even positive role in structuring the conflict upon which co-produced knowledge is built. Knowledge is conceived both as an extension, and as a subversion (Giordan and Vecchi 1987; Giordan 1993; Giordan 1998; Larochelle & Desautels 1992 quoted in Momanu, 2012). This approach complements Butlers ideas on the repetition and subversion processes of identity construction. Under-theorised, but evident in my data, is the process of extension of existing norms and knowledges which can involve embracing and adopting exiting norms rather than subverting them.

The conflict of ideas in knowledge production does not exclude cooperation. Perret-Clermont argues (2000, as quoted in Momanu 2012) that the change of roles between student and teacher to students in dialogue not only leads to the improvement of social relations, but it also makes learning more effective (Momanu, 2012).

The practitioner’s role, in applying anthrogogies of politics, is therefore to mediate the interaction of the service-user with their environment, but not by reducing or managing the problems faced by the service-user in forming a coherent worldview. Managing and reducing the difficulties of forming a coherent worldview by telling service-users how the world is can increase the risk of closed-mindedness and indoctrination.

By involving the service-user in activities that create cognitive conflicts, they can learn capabilities for active knowledge co-production and thus develop a range of political capabilities. If practice is to be person-centred, it cannot take the form of a top down distribution of knowledge not least because psychiatric practitioners are ill-equipped to teach the theory and practice of politics. Agential political capabilities are based in the relational capacity to build and continuously rebuild knowledge and worldviews in collaboration and conflict with others. It is not about rote learning ‘facts’.

Co-constructing knowledge about the world is a political process where each person expresses his/her opinions and develops them in dialogue with the others. Both staff and service-users are thus students who come to the interaction with an appreciation of the importance of engaging with a variety of ideas and perspectives and the will to learn from each other how to articulate opinions. Distance must be engineered between the medical and authoritarian roles and rituals of mental health treatment, and the anthrogogies of ethics, citizenship and politics to prevent slippage back to medicalised and indoctrinating applications.

In the next section I will evaluate the ways in which service-users and staff negotiate conflict within the pragmatics of the psychiatric ward. The way conflict is maligned as disruptive and anti-therapeutic is emblematic of the way in which the norms of rehabilitation overshadow the practices of politicisation and person-centred recovery.

9.5. Redefining Productive Conflict as Political Action

Often slippage back into medicalised rehabilitation practices was triggered by, or justified by the threat of, conflict. Conflict was seen as problematic as it represented a risk of psychological and physical harm as well as evidence of psychiatric deterioration.

Intellectual conflict (if defined politically rather than as a psychiatric matter to be resolved by treatment or a disciplinary matter resolved by containment) is an unavoidable aspect of political action and is therefore something that cannot be resolved and eliminated in the way premised by some psychiatric or psychological paradigms (Van der Eijk, 2017). If political behaviour, and thus conflict, is unavoidable, it makes little sense to try to create apolitical safe spaces for those who are deemed to lack the capacity to competently deal with political conflict and cooperation.

The data indicates that if a wide range of conflicts are deemed inappropriate within the 'therapeutic environment' of mental health institutions political opportunities are dramatically reduced for residents. Enhancing the quality and prevalence of political participation for residents in institutions may demand time and resources and the co-constructing spaces in which residents can engage in diverse forms of productive, political conflict. The risk that such behaviours will be interpreted as symptomatic of mental illness, is a significant pragmatic of the political environment on the ward. It is also the case that some conflicts can do more harm than good. More research is needed to determine whether this is the case, if it is condition specific or influenced by other factors, and what strategies may be useful in ensuring both participation and harm reduction.

Of course, conflict is not always productive or desirable. There are many instances in which conflict (and cooperation) are not political in character because it lacks a social or communal purpose. However one reason to highlight the potentially productive qualities of disruption and conflict is that the demarcation of behaviours, goals and interests as political (rather than dismissed as unreasonable, selfish or pathological) can interrupt and challenge the ritual orders in which the character of someone's behaviour can be deprived of its social and communitarian purpose through a process of separation, individualisation and mis(/mal)-recognition.

When socio-spatial cues organise interactions on the ward in ways that encourage a medicalisation of conflict, support for political inclusion becomes more difficult. This is because it suggests a lack of conflict is the foundation of therapeutic relationships and environments, so opportunities for residents to engage conflicts conducive to political change are consequently discouraged (Gerace et al, 2018). Support for political inclusion that is underpinned by a paradigm that denies the possibility of productive conflict only give the appearance of supporting capacities for meaningful participation (Bovenkamp & Trappenburg 2010). A more engaging form of support thus only becomes possible outside the institutional rituals of conflict resolution.

The arbitration of appropriate political behaviour conveys an anthrogogy of politics which discourages productive conflict. It is based on the categorisation and reification of service-user's worldviews as 'disordered'. Conflict then becomes defined as a manifestation of this disorder. This can imply that good mental health is a state free of conflict and political struggle.

The data gathered indicates that where powers of definition are democratised and continually reconstructed in relationships of both conflict and cooperation, there may be greater opportunities for political inclusion for people with mental disabilities. However, such practices also present challenges in terms of undue influence and indoctrination in contexts of strict hierarchy. The solution is perhaps not to exclude political conflict as inappropriate but to disrupt the hierarchy.

Both staff and service-users should thus be involved in making the distinction between appropriate and inappropriate political conflict. A fully rounded assessment might involve the following considerations:

- The context in which the expressions, actions or omissions occur
- The social relationships between the people involved
- The potential risks and benefits of participation for those involved

The aim of policy implementation through anthrogogies of politics is to encourage people with mental disabilities to think for themselves with a view to becoming reasonable and democratic members of the community. The automatic assumption that people with mental disabilities are incapable at the outset seems to undermine this goal and to reinforce practices of risk aversion and coercive treatment.

The data indicates that people are generally capable of political action whatever their mental health status. Often people in mental rehabilitation are thoughtful and powerful individuals who should have opportunities to engage in productive political conflict without fear of reprisal. The aims of the anthrogogical approach should therefore not be targeted exclusively towards people with mental disabilities but also to the individual, family, friends and the mental health professionals themselves. This elides with the concept of relational rather than individual autonomy discussed in previous chapters.

Anthrogogies of politics involve ethical thinking and therefore require skills that can be attained through engagement with philosophy. Supporters of more universal philosophy education believed that philosophy need not be confined to the domain of the academy, but rather that whatever their circumstances, age or level of impairment, people are capable of critical, creative and caring thinking (Lipman 1976).

9.6. Conclusions

In this chapter I have analysed moments where practices intending to be supportive of political opportunities reverted to medicalised practices of containment and treatment. In doing so I have identified that both subversion and embracement are useful in forming and sustaining political identities. This is based on a minor adjustment to Butlerian theory. I have also shown that the principle of person-centred recovery, when applied to political education in psychiatric rehabilitation, is often not deeply embedded into the ritual order of the mental health institution and can thus be productive of closed-minded thinking.

The application of political education in psychiatric settings by those in positions of authority poses a risk of undue influence and even indoctrination. On the basis of the data gathered I have proposed that introducing a concept of productive political conflict into the ‘therapeutic environment’ of the ward might expand the possibilities of policy implementation to produce enhanced and increased opportunities for more informal and flexible educational relationships. A range of anthrogogical strategies have been posited as possible ways out of the medicalised ritual order of the institution.

Chapter Ten

10. Main Findings, Recommendations and Reflections

10.1. Introduction

In this thesis I have sought to answer the following questions:

How are policies aiming to enhance and increase opportunities for political participation of people with mental disabilities being implemented in residential psychiatric rehabilitation; what barriers or difficulties are encountered in achieving that aim; and how might a policy to enhance political participation be more successfully implemented?

In exploring this broad area of inquiry, I found it useful to identify three subsidiary questions which go beyond description towards more comprehensive understanding and evaluation:

1. *On what basis are such policies being implemented?*
2. *What are the principles that underpin the distinction between appropriate and inappropriate political action and expression for people undergoing psychiatric treatment?*

3. *What are the wider implications of practices of political inclusion being implemented in this way?*

Chapters 6 to 9 provided rich and detailed analysis of how policies were implemented across the three sites. Within these chapters I teased out tentative answers to my main and subsidiary research questions. The following chapter summarises some of the main outcomes of this work and seeks to draw out theoretical and practical insights.

10.2. Main Findings

Mental Health professionals have a duty to reasonably accommodate participation in public and political life throughout mental health treatment (Ch.2). Participation in public and political life, for adult citizens, may minimally be understood as casting a ballot in an election every four or five years but encompasses much broader array of activities in local communities and mental health institutions. Politicisation involves forming and performing political identities through both praxis (actions that aim at changing the world in accordance with worldviews) and poeisis (gestures symbolically performing political agency and inclusion) (s.3.4). Embracing a political identity requires social recognition (s.3.3.3). Mental health treatment incorporates anthrogogies of citizenship and ethics that deeply influence this process (s.4.5). Normal practice, generally restrictive of political identities, was suspended during the run up to elections in brief moments of policy implementation. However, politically inclusive practice within the pragmatics of mental health ward was overwhelmed by the rituals of treatment and containment. This meant many participants experienced discomfort, alienation and engaged in role distancing. Educative practice also presented risks of undue influence and indoctrination within an authoritarian and technocratic system of governance. Given the small number of policy documents received, and problematic survey data, I sought to use ethnographic research methods to elucidate these processes (Ch.5). This was an exploration of complexity rather than an endeavour to test hypothesis derived from theory.

I found that non-electoral, and other transgressive forms of political action and expression are frequently considered inappropriate for persons with mental disabilities (s.6.2.2). Some forms of political action, when performed by particular actors, may be cast as symptomatic of mental illness and trigger rituals of capacity assessment and containment (Ch.8). This was the case even during moments of direct policy implementation. This represented a slippage from politically inclusive practice back into medicalised treatment rituals.

Being a resident of a mental health institution can mean the threshold for what counts as legitimate political action is significantly higher when compared to the general population. This is a prime example of the restricted opportunities for people with disabilities. They are less likely to be recognised as legitimately participating on an equal basis with others (s.7.3). The voices of people with mental disabilities are rarely heard directly and when they are, can be delegitimised on the basis that they do not convey 'real' experiences' (s.7.4). Their worldviews, to be recognised as legitimate, must be corroborated by mental health experts and this can create conflicts of interest when people with mental health difficulties seek to hold mental health institutions to account (s.7.4.2).

In medicalised contexts "inappropriate" political action and expression may be restricted and discouraged for reasons relating to risk and capacity (s.7.4.1). By extension, more mundane forms of political participation may also become less appealing as action and expression is put under intense scrutiny (s.8.3)

The substantive implementation of Article 29 of the UNCRPD should expand opportunities for political action for both service-users and mental health practitioners (Ch.2). The data shows however that mental health settings are replete with rules and rituals of interaction which encourage some and discourage other types of political performances (s.9.6). This renders implementation complex. In fact, practices mandated by implementation, when they slip back into medicalised rituals, can have the unintended effect of reducing political agency by expanding psychiatric management of behaviour into the political field (s.9.4). This can understandably cause alienation.

If we see politics as being a process of conflict and cooperation (s.3.2.3), treatment for prolonged periods of time in residential mental health services can create enduring restrictions on the ability and opportunity to construct political identities and worldviews by framing even productive conflict as problematic individual behaviours (Ch.9). Furthermore, the very imposition of psychological interpretations of the personal can reduce opportunities for developing subversive worldviews, political identities, and capabilities (s.7.3.1. See also Rose, 1990; Kitzinger, 1993).

Boundaries of role and place in the normal drama of the wards create pragmatics that impact on political identity construction and capability for service-users as well as staff. In particular, categorising political action or expression as mental health symptomology can be restrictive of opportunities to play at, and become through recognition, political citizens (s.7.4.). Behaviours can on this basis be forcibly restricted through internalised understandings of ‘appropriate’ political action, separation, escalated treatment interventions and increased coercion (s.9.2-9.3).

Alternatively, power in the institution can be used to expand political opportunities for a select group of service-users who have satisfied psychiatric definitions of progress towards rehabilitation (s.8.2.1). The separation of political conduct into appropriate and inappropriate, was often premised on a view of the political sphere as one full of dangers, particularly for ‘the vulnerable’ (s.9.5). In this way risk has replaced mental capacity as the test for whether political participation will be facilitated (s.7.5.1)

Categorising political behaviour as an aspect of mental health treatment can result in greater control and influence being exerted by professionals over the political development of service-users (s.8.3.2). This can cause both staff and service-users to engage in role distancing behaviours to avoid problems associated with the doctor patient act collapsing (Ch.8). By contrast, in cases where political participation is recognised as an aspect of a person-centred recovery process (rather than a threat) opportunities to play at and become political citizens, and perform as such, were expanded for both staff and service-users alike (Ch.7).

The data presented shows that the attribution of political roles can become (or be experienced as) 'real' through processes of embracement and recognition (s.8.3) but political identity is not necessarily a fixed or enduring object (s.4.3). In addition, the ascription of political identity in mental health treatment can carry a mix of benefits and risks for people in residential care (s.9.3). The supportive role can also present a threat to face for staff and the institution more generally (s.8.2.2.).

The insights that dramaturgy can provide in analysing processes of politicisation are extremely useful in teasing apart the distinctions between political behaviour and behaviour that is inappropriate and seen as beyond the pale in the context of mental health rehabilitation. Dramaturgy also allows practitioners to develop practices to encourage positive development on ethical and political rather than psychiatric grounds thus avoiding ideas of technocratic and authoritarian governance from being internalised as part of the normal practice of politics (s.7.5.).

10.2.1. The Power to Include

In this section I want to outline a central conclusion drawn from this research project. After analysing the law and policy and then observing and discussing it with implementors and subjects, it became clear that the way power is conceptualised as a resource to be distributed from the top down in the substantiation of political rights, makes a problematic foundation for politicisation.

Law and policy, both domestic and international, constructs the enhancement of political opportunities in mental health services as within the power of service-providers (Ch.4 & 6). In studying political participation in mental institutions, I have found that the exercise of power is much more diffuse than the law suggests (s.7.6-7 & 8.4). However, narratives of change, and political power in general, are placed within service-providers remit of control by the very policies that seek to increase political inclusion for service-users (Ch.7-9). This bakes into the policy of political inclusion a form of political exclusion (s.6.2.6).

Politics is power in action, being the main technology used to achieve concrete ends. Power is certainly not unique to the doctor patient relationship, does not flow unidirectionally and is not something to be necessarily avoided within institutions. However, mental health services are built around power being attributed to certain institutional roles and this creates systematic restrictions on the political agency of service-users. Residents of psychiatric institutions are conditioned through mental health treatment and socialised in ways that encourage them to passively comply with decisions of practitioners, experts, family and friends who, they are told, know better. This belief that they cannot ‘know’ the world like people who don’t have their mental illness can demotivate and alienate people with mental disabilities from engaging in both small-p and big-P political processes (s.8.2.1).

Forming and communicating worldviews, and action in changing the world according to what it *should be,* are often mis/mal-recognised as illegitimate actions for someone undergoing treatment. It is often not a valid face for service-users to adopt (s.8.2.1) unless they cross the divide and become a psychiatric practitioner. The narrative of change, through rehabilitation or recovery resolving internal disorder, is positioned as one driven by staff action (s.6.3). These roles are internalised, repeated and resisted in the interplay of actions in the service-user/provider act. The inflexibility of institutional orders and roles, if strictly maintained, stunts the ability of staff and service-users to engage in playful, destabilising, and novel ways of being (Ch.8). In turn this restricts opportunities for politicisation and participation. Playful human interaction in a whole rang of activities such as sport, horticulture, art, music and literature all appear to be important wellsprings for political ideas, identities, and actions (Ch.3). The are also an important source of self-efficacy which is an motivator for political engagement (s.9.2).

A distinction was identified between the formalised pedagogical practice delivered on the wards of the hospital and the informal way in which political information was communicated in more liminal spaces. These arguments led me to conclude that the educational dimension of mental health practice is crucial but that the style of education adopted in supporting political participation was often antithetical to open-minded politicisation (s.8.3). Often the implementation of policies of political inclusion was itself alienating and exclusionary achieving the opposite of what the drafters of the UNCRPD might have envisioned.

The application of radically dialogical anthrogogies of citizenship and ethics better support politicisation than implementation as a policy ‘intervention’ applied as treatment from the top down (s.9.4). Rather than being taught in fixed sessions on the specific topic of ‘politics’, issues and opinions might be discussed in the context of group activities and embedded into everyday practice. A collaborative educative experience might be fostered rather than a hierarchical banking model of political education (s.4.5). If the mutual learning aspects of implementation are emphasised, then this provides a way out of the assumption of staff knowing more about politics than residents. More fundamentally, the aim should not be to deliver a political curriculum, but rather to engage on a regular basis in open and free dialogue on substantive political issues that are relevant to staff and residents (s.8.3.3).

Policies of political participation may instead be viewed as a bottom up activity shaped by humanistic relations. The significance of the law, and the ritual order, may thus be rejuvenated through their de-naturalisation. As in Kafka's parable, to shut the door of the law is to allow space for Law to regain its significance as a political construct (Snoek, 2014).

Successful implementation occurs where practitioners are unafraid to step in and out of the supervisory or care giver role (s.7.3.2) and where service-users are willing to recognise and accept service-providers as individual human beings rather than institutional agents (s.8.2.2). To do this, there needs to be opportunities to develop humanistic relations. Those implementing the policy need to be informed and politically engaged themselves or be willing to learn political skills from service-users and politically engaged others. Both teams need spaces available in which law and policy governing mental health service provision are destabilised in ways that recognise the diffuse nature of power and recognise it as legitimately exercised by all on all (s.8.3.1). Strategies of embedding this type of flexibility in role is something that might be examined in further research as a focus of training for staff and service-users who want to promote similar policies in other hospitals. Policies of political inclusion also need to be co-owned by staff and service-users from the outset rather than be imposed from the top down.

This flexibility does not necessarily exclude the benevolent management of behaviour. Some issues may best be dealt with through a more authoritarian or technocratic practice although this does risk the slippage towards medicalisation of political problems discussed in the previous section.

I merely suggest that by supporting capacities and opportunities for residents to talk about small-p politics such as treatment or care plans through a political discourse, and by weakening the psychiatric claims to exclusive knowledge about service-user identity, we might better realise the right to participation in both electoral and non-electoral politics. By recognising greater agency on the part of service-users in interpreting and dealing with their own social and personal issues people treated in psychiatric rehabilitation may be enabled to develop political capabilities according to their own needs and aspirations in a range of political fields.

Because of the complexity in deciding whether a dispute or issue comes under ‘psychiatric’ or ‘political’ jurisdiction, and because of the monopoly of legitimate force claimed by one side in such conflict, institutions are able to adopt narrow definitions of political action that reduce their obligations and accountability. A potential barrier to the exposure of political conflict is the tendency towards containment of unseemly conflict within the mental health institution (Ch.9). The optics of political conflict undermines the therapeutic and professional image that is required to attract funding as well as presenting a unified institutional ‘face’ to outsiders (s.2.9; Ch.8). This is something that regulators such as the CQC as well as NHS commissioners could consider in evaluation and funding decisions. By raising the acceptable threshold of risk, they might permit more humanistic and person centred care which in turn increases opportunities to engage in public and political life.

The reification of the mentally disabled identity as fundamental to the political affiliations of service-users is embedded in the structure of law and policy on supporting political participation for disabled people. Diagnosis and/or progress towards rehabilitation and recovery become ways of categorising service-users and justifications for exclusion (s.8.2). This is not to say that changing professional practice through top down law and policy in mental health hospitals is always counterproductive. The argument supported by this thesis is rather that more opportunities for residents to disrupt the ascription of the 'patient' role (which is passive and objectified), and the reification of identity as diagnosis, the more the institution might enhance and increase opportunities for political engagement across the full range of political domains. In addition, the more opportunities for staff to disrupt the ascription of a bland role of institutional agent the greater their opportunities to engage in humanistic and recovery orientated practice. These actors both require spaces in which law and policy, and by extension the ritual order of the institution, become more fluid and destabilised.

There was genuine concern that practices of politicisation could be construed as malpractice. The perception that political power is something that can be granted to people with disabilities by service-providers, by transmission of knowledge, generated fears of undue influence that inhibit the enhancement of participation (Ch. 2; s.8.3). There is a potential problem in embedding a policy of political inclusion in the general practice of staff where they are resistant to engage for fear of criticism and reprisal other than at election time. As I have reported, staff feared making 'mistakes' in providing political information, and unduly influencing service-users even during these periods (Ch.7-8).

In addition, staff often felt ignorant about political issues, had never voted themselves, or were disinclined to vote or engage in politics. Many staff had not had opportunities to develop political capacities and identities themselves (s.6.3.3). All of this becomes a problem only if staff are constructed as experts delivering political knowledge to service-users rather than equal participants in political discourse co-constructing political communities in dialogue.

The answer is not to abandon politically inclusive anthrogogies but to conduct them in spaces where hierarchical relations are sufficiently disrupted that knowledge transfer can legitimately occur in both directions. Confidence and competence in participating in political discourse is just as important for the staff implementing policies of political inclusion as it is for residents. Indeed, in some circumstance's residents will be better positioned to support staff political participation than the other way around.

In mental health rehab the threat of soft power and surveillance in the doctor patient nexus, means that indoctrination and undue influence is a real risk. This threat must be explicitly dealt with to allow people to interact in spontaneous political dialogue. Such dialogue was observed between staff and service-users only in places where the rules of interaction could be challenged or subverted without fear. This insight is helpful in designing spaces in which people can experiment with a variety of political identities and strategies.

As rehabilitation is a educational process of socialisation into ethical ways of being, every aspect of mental health treatment is both political and educational (Ch. 4). The aim of person-centred recovery is to allow people to discover and implement their own conceptions of the good life. This requires opportunities for free and open discussion between political equals.

In thinking about how the political environment (as co-constructed between staff and residents on the pathway through the mental health service) might be designed to increase political opportunities it may be useful to identify aspects that more accurately reflect the treatment of citizens in the wider political community. For this to work residents need to have opportunities to subvert roles and challenge social pragmatics and for staff to step out of their institutional roles to form collaborations across the staff patient divide (Ch. 8-9). Productive conflicts must be allowed to play out rather than being resolved by rejection, control or containment (s.9.5). Going outside the physical environment of the hospital appears to be an effective strategy in facilitating the co-construction of political environments where productive conflict can play out. Political debate can be staged in ways that encourage creative engagement on a co-constructed basis (Ch.4).

Although the rhetoric for the NHS and independent hospitals for low secure rehab revolves around recovery and treatment through person-centred practice, the way in which these principles are actually benefiting service-users in the expression of political agency remains difficult to measure and evaluate. In addition, applying policies of political inclusion in high security facilities with patients who have very serious cognitive impairments may present a variety of different challenges not covered in my data. This means drawing wider implementation is a complex undertaking. My findings will not necessarily transfer to radically different contexts and more research is needed on these topics.

In the data, reference is often made to residents who '*will never be able to fully function'* (Site 1, Consultation, 2018, SW*)*. Following consultation on the basis of my findings, practitioners however began to argue more confidently that partial capacities (e.g. articulating wants and needs as well as worldviews) could be supported through a more universal application of the policies of political inclusion. Rather than the practices of support being targeted to specific individuals thought to be receptive, well behaved and who had explicitly signed a form requesting support, the policy of political inclusion began to be applied to a wider set of decisions and situations in the everyday life of service-users following data collection. For example, cultural activities involving a performer and an audience are inevitably highly social. They are events in which certain ritualistic roles are performed by the participants in a temporarily co-constructed power dynamic and thus can be more conducive to political inclusion than formal educational sessions (s.9.4)

In addition, many potent political messages can be conveyed through role play. Much like the construction of a political society in miniature the classroom, or a corporation or the larger imagined community of a nation, the dramatic performance mediates and disrupts the roles of the participants in ways that can be productive of opportunities for new modes of expressing oneself and one's political ideas. Political autonomy can be expressed as the accumulation of cultural and social capital in which the performance of a personally meaningful identity (and the recognition of that identity by an audience) is vitally important. Capabilities for participation should therefore be based on the concept of relational, rather than individual autonomy (Ch. 1).

When you have the epistemological authority to designate what is and is not political then you can exercise the power to delegitimise challenges to your authority and legitimacy. When an institution can prescribe knowledge about your internal experience, legitimate political protest can be portrayed as unreasonable (s.8.2.1). For example, certain political strategies can be readily interpreted as pathological, unhealthy and dangerous. This includes adopting the sick role to coerce others to care for you; making vexatious complaints as a form of protest; aggressive and violent assertions of political ideas; or simply adopting the mannerisms and language of powerful peers.

It can be claimed that the protest action and complaint are based on a misinterpretation of reality and this may be readily generalised by staff and service-users into the political sphere. This delegitimises a person's political identity because they are not recognised as basing arguments on legitimate constructions of the world.

Townsend illustrates how attempts to empower service-users in everyday mental health practice are frustrated by the institutional processes of admission, accountability, decision making, budgeting, risk management, and discharge (Townsend, 1998). Similar processes frustrate the implementation of policies of political participation despite good intentions (Ch. 9).

There is a potential conflict of interest here between the staff's professional duty to the residents and their responsibilities and requirements towards the institution. Greater capability for political agency may mean confronting residents with difficult realities that are easier hidden, an increasing volume of complaints and increasingly demanding patients. Organisationally this requires increasing workloads and staff pay budgets to accommodate and compromise with residents' demands. In addition, it may require less restricted access to electronic devices to open up opportunities for accessing political information and social networks. It may require giving staff more agency and discretion to modify their practices in inclusive ways which can erode hierarchical relations in management. None of these policies would advance institutional efficiency in the sense of risk reduction and containment. They may do precisely the opposite forcing mental health services to become looser and less organised communities rather than tightly bound and totalising institutions.

This medicalisation of complaint, and the restriction of resident's ability to produce and consume cultural and social content outside of the parameters that a mental health hospital deems safe, are potentially significant restrictions on the ability of residents to develop political agency (s.9.3).

This speaks to issues at the heart of implementation of the 'paradigm shift' in mental health practice envisioned by advocates of the UNCRPD (Bartlett, 2014). The difficulty of implementing top down policies of political inclusion in ways that allow law and policies to be challenged, subverted and reconstructed from the bottom up. The approach to participation is premised on a conceptualisation of power as owned by mental health practitioners who are then required by law to concede some of their powers to persons under their care (Sandland, 2017). This thesis has provided empirical evidence that in mental institutions, 'giving' service-users political power is no straightforward task. This is because the premise that power can be owned and distributed is problematic. As Foucault, Goffman and Butler argue, and as I have shown empirically, power simply does not work this way.

10.2.2. Towards a Dialogical Anthrogogy of Politics

One of the most important discoveries in this thesis is that the imperative to enhance the political participation of service-users is often antithetical to, and disrupts, the deep mechanisms of mental health institutions (psy-epistemology; physical environment; manifestations of power; identity performances etc). Disruption was a generative collision of imperatives that created political opportunities for service-users and staff. One understandable response to this otherwise radical challenge to the status quo is to narrowly define the nature of politics to electoral participation, thus excluding the politics of the institution, and to practise a restricted notion of (political) education – didactic and transmissive which replicated and reinforced the institutional hierarchy.

There is a clear alternative path – to define the political much more widely to include an essential aspect of all interactions and to identify a person-centred and respectful system of support. I acknowledge the great difficulty of institutions and professionals moving to adopt educational, rather than psychiatric practice but the need for radical change is already implied by the UNCRPD. In these final sections I will try to outline some theoretical possibilities for best practice building on data gathered.

In consultation with social workers and psychiatrists following data collection Paulo Freire was cited directly as an inspiration for improved practice (s.4.5). The new social worker at Site 1 argued that Freire's ideas could be used to develop a pedagogy of citizenship that could help to empower service-users and increase opportunities for political inclusion.

Freirian practices and theory have significant parallels in the practice of Community based Rehabilitation advocated by the WHO. Freire's 'pedagogy of the oppressed' may be placed into a broader framework of social transformation underpinning the inclusion of institutionalised psychiatric communities in political and civic life. The term "social transformation" here is used in the sense of transforming the identities roles and ritual order of the community of actors within a particular setting rather than on a nationwide scale.

On my reading of Freire, for a pedagogy of citizenship to operate in line with a holistic theory of inclusion or person-centred recovery, rather than a narrow narrative of rehabilitation, a pastiche of approaches is required to identify individual and collective needs for political recognition and to accommodate health struggles in different times and places.

In *The Pedagogy of the Oppressed (1996)* Freire sets up his argument by distinguishing between 'oppressors' and 'oppressed' but then presents the solution as a mutual educational process by which people who identify as being oppressed are given a voice and are listened to. Through such a process liberation is not a gift, and not a self-achievement but a mutual process of discovery. It also appears to require the identification of an 'enemy' in the 'oppressor' and so embraces a form of productive conflict.

Freire also has some interesting things to say on the nature of the oppressor/oppressed distinction:

"The oppressed suffer from a duality which has established itself in their innermost being. They discover that without freedom they cannot exist authentically. Yet although they desire to authentically exist they fear it. They are at one and the same time themselves and the oppressor whose consciousness they have internalized. The conflict lies in the choice between being wholly themselves or divided…… between following prescriptions or having choices; between being spectators or actors; between acting or having the illusion of acting through the action of the oppressors; between speaking out or being silent; castrated in their power to create and re-create, in their power to transform the world. This is the

tragic dilemma of the oppressed which their education must take into account." (Freire, 1996: 31)

To reconcile this with my understanding of Foucauldian power and Butlerian identity construction through performativity the essentialised idea of the authentic self and the divided self requires critique. The conflict, cast by Freire as between a whole self and a divided self, is irreconcilable with the idea of the subject as performed in interaction. However, recognition depends on performance being conducted *as if* the self is wholly inhabiting a particular role in the Stanislavskian sense of becoming (Crowley & Benedetti, 1998) or with competent *verfremdungseffekt.* In preparing oneself for such performances I have argued previously that individuals become reified as lacking capabilities to define their worldviews and interests in ways that are compatible with their perceived and actual roles. To find a way out of this process of reification people must become researchers and students of themselves and of the art of social construction in which they constitute themselves and others. This requires the construction of oneself as an important audience in the performance of identity so that self-reflection can occur. The 'real' identity that one is attempting to be true to in role distancing is thus the identity that is performed for oneself as an internal audience. It is no more or less substantive than the identity performed for external audiences. This provides a potential foundation for the performance and recognition of persons as having power to transform the world – i.e. becoming open-minded independent political agents.

Going back to Freire, he compares the condition of oppressors to that of the oppressed. He argues that similar processes of identity reification apply, and these create restriction on political transformation in very similar ways:

The same is true with respect to the individual oppressor as a person. Discovering himself to be an oppressor may cause considerable anguish, but does not necessarily lead to solidarity with the oppressed. Rationalising his guilt through paternalistic *treatment of the oppressed, all the while holding them fast in a position of dependence will not do. Solidarity requires that one enter into the situation of those with whom one is solidary; it is a radical posture. If what characterises the oppressed is their subordination to the consciousness of the master, as Hegel affirms, true solidarity with the oppressed means fighting at their side to transform the objective reality which has made them these 'beings for another'.* (Freire, 1996: 31-32)

In this way the oppressor is subject to the same reifications of identity as the oppressed and the role of oppressor and oppressed is interchangeable. Therefore, to support political capabilities in situations in which the majority of power is held by one team (the 'oppressors') those with power must deconstruct their own roles and identities and enter into the divided state of identity reconstruction themselves. In mental health rehab this implies that staff must enter spaces in which their legal duties and policy obligations are suspended so they might engage with service-users as equals to engage in politics side by side.

The new social worker at Site 1 made the comparison between staff and residents and Freire's oppressors and oppressed because that provided a basis on which to recast 'patients' as political citizens and staff like herself as attempting to collaborate with them to transform the community for the better. Through a dissolution of previous identities and roles new areas of conflict and cooperation were potentially opened up. A new type of professional personhood - an active participant in a mutual process of learning and political empowerment – became possible so long as staff and residents suspended law and policy and acted on the basis of mutual solidarity.

The oppressor is solidary with the oppressed only when he stops regarding the oppressed as an abstract category and sees them as persons who have been unjustly dealt with, deprived of their voice, cheated in the sale of their labour – when he *stops making pious, sentimental and individualistic gestures and risks the act of love. (Freire, 1996: 32)*

The process of developing solidarity across team boundaries was described by one staff participant as essential in removing barriers to political opportunities for service-users. One staff member at site 2 described the process of building lasting friendships with individuals and knowing the 'person'.

Freirean theory indicates that the challenge for service-providers attempting to open up political opportunities for service-users is to participate equally in activities seeking to 'empower' each other and help build each other's capacity' to exercise greater agency. Rather, through increasing opportunities for meaningful social participation, partnerships can be co-constructed (Rifkin and Pridmore, 2001).

Practices inspired by Freire take various forms. Instrumental approaches view communities as handmaidens of biomedical and behavioural expertise, helping to implement programmes made and owned by managers, doctors or psychologists. Dialogical approaches promote interactions between health professionals and communities as people, facilitating interaction between lay and expert understandings of recovery to create services that resonate with users' understandings of their needs and interests.

Campbell (2014) argues for a critical approach that embeds these efforts within a wider critical or political counter-discourse. Disability rights activists view community mobilisation as a route to collective action to challenge (or 'resist') the social inequalities that place peoples' well-being at risk (Campbell 1997; Campbell & Oliver, 1996). But the requirement to adopt a political identity centred around an acceptance of a radical 'disabled' identity should not become a requirement.

The anthrogogy of politics has become bogged down in essentialist assumptions about community and identity. For practical reasons, educational programmes generally target communities defined by geography, identity, or common institutions assuming that residents share a common motivation to tackle political problems. Yet communities in mental health rehabilitation represent a wide spectrum of age, gender, educational levels and politics, living in varying degrees of cooperation and conflict. Particular groups within the institution have a lot to lose from the empowerment of others. Such groups may actively work to undermine policies of inclusion when they threaten established hierarchies (Gruber & Caffrey, 2006).

The second problem facing the application of anthrogogies of politics in the mental health settings relates to confused assumptions about the potential for political struggle to address the economic and social causes of mental disabilities. Despite evidence that poverty is a key driver of poor health, health projects are often framed by de-contextualised concepts like ‘gender’ or ‘human rights’ conceptualised independently of their intersections with other corrosive disadvantages. An exclusive focus on empowerment through building skills to leverage concession from those in authority or increasing access to the ballot box ignores the consistent finding that *‘across very different contexts, people’s ability to exercise strategic forms of control over their lives is linked to being able to generate regular and independent sources of income’* (Department for International Development, 2011: 2).

Despite Freire’s emphasis on the necessity of equal dialogue between community insiders and supportive outsiders in formulating the goals of joint projects, implementers often impose their own values on communities they seek to mobilise. The same is inevitably the case when service-providers in mental health wards seek to encourage service-users to vote.

Freirean citizenship education in practice may be criticised for the overly linear conceptualisation of social change implicit in ‘planned social change’ approaches. These assume that citizenship education will trigger mobilisation that can lead to health enabling social changes. Eyben (2005) argues that linear planning, supported by instruments of performance management, is poorly equipped to deal with complex social problems, and that it is impossible to predetermine trajectories of change in social systems in constant flux.

Participation, recovery and rehabilitation in mental health services may be improved by aiming to support the independent development of plans to manage individual and collective problems through political action. Anthrogogy is instructive in theorising and articulating some innovative approaches. Educational materials could provide suggestions for immediate application of strategies of social, individual and institutional change as opposed to learning the ‘facts’ about politics. Educational initiatives may in this way become orientated towards dialogical and self-directed learning. The focus, according to these principles, must be primarily 'problem centred' rather than 'topic centred'.

Service-users may in addition require support in developing a sense of self-efficacy. Self-efficacy refers to how confident the patient is about his or her abilities based on feelings of self-confidence and control (Bandura, 1977) Tendencies to perform a given behaviour are influenced by:

- Expectation of outcome (Is it worth it?)
- Expectation of self-efficacy (Can I do it?)

Motivation is highest when service-users are dissatisfied with the current conditions, but it is also vital that service-users believe that they can influence political change, and thus the effort put in will be worth it. Clinicians can potentially enhance self-efficacy by using teaching techniques such as skills mastery and modelling (Habel, 2006).

According to Bandura (1977) a sense of self-efficacy is inculcated most effectively through the mastering of skills. The experience of success increases self-efficacy while experiencing failure reduces self-efficacy. Skills can be anything that the service-user wants to achieve ranging from athletic, culinary, technical or cultural skills and could be organised to bring people together to share political strategies indirectly in the course of doing other activities.

Self-efficacy can be achieved through social prescription and funding for the development of these soft skills. Repeatedly experiencing failure during an initial course of events can be particularly detrimental to the development of self-efficacy. Repeated successes, on the other hand, result in a strong sense of self-efficacy, and subsequent failures are unlikely to diminish the ensuing self-confidence.

Skills mastery may theoretically be scaffolded for service-users by prescribing group activities in which they can develop skills that are useful and relevant to their lives. One of the best ways to foster mastery is to have service-users set goals for themselves in a particular area or for a specific behaviour; this can be written in the form of a contract with oneself and resources and financial or social support provided. Small achievable goals provide direction and incentive for action or change. Goal setting could be personal and self-directed or could be communal and co-constructed but should not be imposed by clinicians.

According to Henry et al. (2009), service-users who believe they have a measure of control over their health are more likely to successfully self-manage their condition than people who believe their health is the service-provider's responsibility or simply down to luck, or fate. Thus, when, service-providers and service-users work collaboratively, service-users and practitioners may experience both a greater sense of control over health outcomes and an increased sense of political agency.

10.2.3. The Principles of Political Participation

At present policy implementation is based on a commitment to human rights (Ch. 6). Those who are not excluded from the right to vote in law are identified as attracting obligations under human rights treaties and are facilitated to participate in elections (s.7.3.1). This reflects a prioritisation of efficiency in the use of institutional resources that means good implementation becomes that which meets obligations with the minimum amount of resources possible. Adherence to this principle means that politics is interpreted narrowly (s.6.2.2), and many service-users are excluded from the benefits of politically inclusive practice (s.7.3). Even when people are identified as eligible and willing to participate, mental health diagnosis can become a way to justify exclusionary practices such as withholding information about elections. For example, a service-user with a diagnosis of personality disorder was left under the impression that the election was cancelled so as to avoid her anger that her registration had not been administered in time by hospital staff. Conflict, even if productive and justified, is seen as anti-therapeutic for people with certain types of diagnosis.

A second principle evident in implementation is a commitment to political autonomy. This is reflected in the obligation to ensure that practice does not unduly influence or indoctrinate service-users into particular worldviews. As I have shown mental health practice already influences service-users to adopt certain worldviews based around ideas of mentally healthy ways of being so this principle appears to be applied inconsistently. In addition, it is based upon an overly individualistic view of political autonomy. A relational concept of autonomy that sees freedom of choice as embedded in social context appears to be a more useful basis for inclusive practice.

A third principle is that of appropriateness. In practice this means that behaviour must be appropriate for the audience and context. When practice slips back into medicalised rituals of assessment political expression and action are often deemed inappropriate and even disorderly to the extent of being classified as aspects of mental illness. Coercive intervention therefore remained a lurking threat in the background of every interaction.

A fourth basis for implementation revolved around the idea of person-centred recovery. This is related to the concept of humanistic and holistic practice and were exemplified by educational approaches and informal socialisation. This appeared conducive to the types of political opportunities envisioned by both domestic and institutional policy and under the UNCRPD. By contrast, application of principles of political inclusion in mental health services that are more focused on a top down, technocratic application of political education, and which construct service-users in the role of passive learners of facts, can end up creating more restrictions on the development of political agency than they opened up.

As noted in previous sections, participation rights should not only be a momentary act, but the starting point for an intense exchange of ideas and worldviews in all relevant contexts of people's lives. It should be dialogical rather than didactic.

The contradictory aims of participatory rights (to both socialise people into a political community and also empower the individual to pursue their independent version of the good life), creates difficulties in policy implementation. Positive support from those in authority can superficially increase political participation but may reduce agency by inculcating closed-minded views. In addition, responsibility for substantive realisation is placed on those in functional authority, in authoritarian institutions, creating a risk of indoctrinating education being applied in spite of good intentions (s.9.4).

Mental health treatment is an application of ideas about what it is to be a good human being, a good citizen and what a good life constitutes. In practice staff socialize service-users into these ideas and into systems and epistemologies of governance (s.7.4 & 8.2). Therefore, practitioners need to be clear in their own minds on what they think about these existential issues and explicit that they apply this in treatment. More democratic and less technocratic approaches to the organisation of services potentially need to be implemented to fully realise the ambitions of the UNCRPD.

People should and can be involved in the decisions that affect their lives and there are innumerable creative and exiting ways this could be enacted. Political engagement, at any level, helps people to engage in their own struggles and claim their own victories but also recognizes their inherent humanity and dignity as equal members of the community. Involving people in the governance of the services they engage in, involving them in the local community and encouraging them to engage in questions about how to improve things for both themselves and for everyone else is an essential aspect of public and political life. Reducing politics to casting a vote in elections every five years is therefore insufficient. Politics must be understood much more broadly if we are to recognise people's dignity, agency and humanity throughout their mental health treatment.

Appropriate political participation and action for people with disabilities in the context of mental health rehabilitation should not be restricted by the requirement for them to accept and embrace a disabled identity on the terms of people in authority. As we saw in the previous section, productive political conflict should not be automatically cast as inappropriate. The question of how to make the distinction between appropriate and inappropriate political engagement, on the basis of which principles, and who should decide remains at the heart of the problem of implementation.

I now want to lay out some of the principles on which such decisions should be based, some ideas for how the process of decision making should be designed and who should be involved in the decision. This provides a basis for mental health service-providers and users to begin to design their own political constitutions for the mini-society that is constructed in each mental health ward. These ideas are based on the theoretical perspectives of constructivist anthrogogical literature, WHO CBR guidelines, the principles underlying the UNCRPD and the MCA 2005, participatory design theory, and the empirical findings from this research project.

How to distinguish between appropriate and inappropriate political participation involves consideration of:

- The context in which the expressions, actions or omissions occur
- The social relationships between the people involved
- The potential risks and benefits of participation for those involved

The following principles should be applied to these questions:

1) Assume every person has capacity to participate in political and public life so long as the context and circumstance are designed in ways that reduce boundaries and increase opportunities for participation. All practicable steps should be taken to provide opportunities to develop political capabilities and identities and interact with politically engaged others in and out of election cycles. We should not ‘give up’ on anyone.
2) A person should not be treated as incapable just because their opinions, actions or omissions may seem unwise or against their own or other people’s interests. Even if someone appears to lack the skills or knowledge necessary to make political decisions, and even if someone is denied the right to vote, they still have the right to public and political life on an equal basis with others and to pursue their own interests and perspectives.
3) A person has the right to play at, and adopt, different political identities and worldviews and pursue goals to change things in any area of their life without fear that their opinions and actions will be mis-recognised as symptoms of mental illness.

4) The threshold at which political action and expression will be deemed inappropriate for people with mental disabilities should be set at exactly the same level as applied to persons without mental disabilities.
5) Disability is political: Political inclusion seeks to ensure opportunities for being involved in big-P Politics (in political institutions and elections) and small-p politics (in the politics of care and containment in the mental health institution)
6) 'Politics' should not be defined exclusively by professionals but be treated as essentially contested concepts. Politics can be non-exhaustively defined as engaging in processes of conflict and cooperation on matters that should be decided by the community as a whole. One such matter is 'what should count as political and what should be counted as a 'disordered worldview'' and people with disabilities should be involved in such a decision from the outset.
7) Political inclusion, as a fundamental aim of person-centred recovery, should be prioritised over and above the efficient running of the mental health institution.
8) Political influence is the currency of politics and is not something that should be avoided in interactions between health care professionals and service-users. Political support must be offered in the context of egalitarian relationships so requires 'stepping out' of the doctor patient roles or the facilitation of contact with politically engaged peers and politicians.
9) Political participation should not be a conditional right dependent on good behaviour, taking medication or any other factor that does not apply equally to others without mental disabilities.
10) The whole process of mental health treatment incorporates aspects of civic education (i.e. how to be a 'good' citizen) and therefore 'treatment' should be applied as a process of dialogical and empowering anthrogogy where the roles of teacher and student are interchangeable. Political education should not proceed as a form of didactic and indoctrinating pedagogy

inculcating closed-minded pupils. Political participation should be supported in ways that broadly motivate the pursuit of open-mindedness, i.e. the pursuit of truth and understanding, and to due regard to available evidence and argument when forming new beliefs and understandings and when maintaining or revising already established beliefs and understandings.

Who should be involved in the decision:

- The ‘community as a whole’. In inpatient rehabilitation settings this will, as a minimum, include:
    - Service-users, People with lived experience of mental disability, family, peers and NGOs
    - Mental health nurses, social workers, advocates, psychologists and psychiatrists
    - People from the local community, local councillors, local MPs, and community leaders

Embedding political inclusion into the design of both policy and practice is vitally important as top down approaches to the implementation of rights participation in political and public life further reinforce the power relations that restrict such rights in the first place. Participation should not be viewed as something to be achieved following recovery and rehabilitation (appendix 5) but as a principle that should be applied throughout mental health treatment (appendix 6). Participatory design should prioritise ‘people’s rights to [participate] in… shaping of the worlds in which they act’. Here participation refers to ‘the fundamental transcendence of the users’ role from being merely informants to being legitimate and acknowledged participants’ (Robertson and Simonsen, 2013: 4–5). For this reason service-users should be involved in policy formation and implementation as equal partners from the outset and not be seen merely as subjects or beneficiaries.

10.2.4 Practical Insights

In this section I want to discuss the practices observed in mental health services, draw out some of the implications of these approaches and use them as a starting point for a frank discussion about what constitutes good practice in this area.

Human rights are a matter of technical law as we saw in Chapter 2. However, the interpretation and substantive implementation, of human rights is a matter of sensitive, empathetic and contextualised practice. Practitioners sometimes engage with the UNCRPD simply because there is a legal obligation to do so. In addition, they risk being subject to legal sanction if they fail to fulfil the obligations. Institutions may therefore adopt policies of political inclusion to attract status and present an acceptably compassionate face to regulators and the public. This is not a good starting point for politically inclusive practice as it positions implementation as a way to advance institutional aims. Rather, such policies should present opportunities for service users to pursue their own objectives even if they contradict institutional goals.

Practitioners should apply the principles of the UNCRPD, and in particular Articles 24 (the right to education) and 29 (the right to participate in political and public life) because they represent an effective way of promoting recovery and rehabilitation as well as preserving people's inherent dignity and agency throughout their mental health treatment.

Political inclusive practice at its best involves providing conditions in psychiatric rehabilitation where people can develop a sense of self-worth, capacities, and confidence. Increased opportunities for political participation, in theory if not always in practice, enhances the accountability of institutions, and democracy itself, by creating the conditions in which active members of the community can exercise power in ways that hold those in authority to account.

Unfortunately, participation in mental health settings is often premised on performing the identity of a ‘good patient’ and even when autonomous participation is achieved subversive contributions may be readily dismissed as symptoms if deemed inappropriate. Participation is thus dependent on the participant being a governable subject and often fails to engender greater accountability. These tendencies should be dealt with at the outset by ensuring that policies are universal, apply to small-p and big-p politics, and that inclusion in both politics and public life is not dependent on the right to vote.

Achieving recovery or ‘good mental health’ is often seen as a prior condition to achieving equal opportunities for inclusion. This could be visualised as a pyramid structure with good mental health as a foundation and political participation as the pinnacle (see Appendix 5). Best practices observed indicate that participation and good mental health should be seen as simultaneous or overlapping goals (see Appendix 6) as they are co-dependent.

A standard response to the question of how to improve implementation of rights is to propose adaptations of law and policy and the adoption of clear protocols and checklists. We might for example consider introducing new regulatory standards of mental health care. If the CQC were to assess mental health services on how they apply the duty to support political capacities and identities then this might mean more efforts and resources are spent in supporting people’s right to vote and to participate outside of elections. This might empower service-providers to allow service-users greater autonomy and to take responsibility for the risks that they might take in exercising these new freedoms.

But, in addition to costs in terms of financial efficiency and reallocation of limited time and resources, there is the danger that allowing residence to take more risks on the basis of individual choice would result in real harm to residents in the hospital’s care. This in turn might provide fuel for scandalising media reports of neglect where things go wrong, even if they are isolated incidents that might be argued a reasonable price to pay for greater autonomy across the board.

Residents may be viewed by various audiences as posing risks to the social order of the institution or even to the fabric of civic society if they are permitted to participate in politics on a more equal basis with others. This is, however, speculation based on the assumption that people with mental disabilities don't have the necessary sensibilities to engage in civil conflict. My data indicates that this is an erroneous assumption. In addition, equal inclusion is what we have committed to in signing up to the UNCRPD. We allow adult members of our community to take the risk of voicing an opinion and acting to advance political causes, whether or not they are deemed to be sufficiently sensible, informed or educated. The same should go for people with mental illnesses and disabilities.

Equal political inclusion, in practice, might require spending a great deal of time listening to, facilitating and accommodating both reasonable and 'bizarre' requests and negotiating satisfactory outcomes with interested parties. This requires taking people with mental disabilities seriously as political agents. This involves looking beyond the bare request (which may be unreasonable or impossible) to the issue, or want, that the request is intended to deal with and supporting opportunities to exercise collective agency with like-minded people. It also requires developing the confidence and opportunity for people in mental health rehabilitation to form worldviews and to seek to argue the case for change in accordance with these views. This a good basis from which political inclusion could flourish. Currently our model of mental health treatment appears to socialise people to be the opposite: passive and compliant subjects. Although this, counter-intuitively also provides opportunities to define oneself by resistance to such socialisation.

A general point to consider is that residents and staff are caught in what might be termed a mutually coercive relationship. By this terminology I do not want to imply malicious or manipulative intention but simply to capture the effects of some of the discursive practices of residents and staff. Through the adoption and maintenance of the sick role residents in effect coerce staff into dedicating time and effort to their wants and needs, and through the adoption of the psychiatric-professional role staff acquire legal duties to act in a paternalistic way toward residents. Finding opportunities to disrupt these mutually coercive roles, by creating contexts in which opinionated discussion between staff and patients can occur without fear of sanction seems to be the right direction of travel towards a more facilitative environment for the development of political capabilities.

There are a number of practical changes that might be made in the system as it is. In the discussion with the SALT regarding the support provided at the polling station it was argued that because the SALT had no explicit protocols in this area she was forced to decide in the agony of the moment whether to support them to vote in the way that they wanted by entering the booth. The alternative was to let the three, who were expecting support, attempt to mark the ballot without guidance and potentially waste their opportunity to meaningfully engage. In this case the SALT decided to provide the support but only after the electoral official had sanctioned it. Appropriate support very much depends on the expectations of the participants.

Both therapist and electoral official have a duty to support persons with disabilities' opportunity to vote, electoral officials even have a duty to encourage this. However, a large degree of discretion is given to the professional in deciding how to implement the rather woolly aims of each policy, and the people who are subject to it have their expectations largely dictated by the people implementing them. This means that there is potentially a reduced chance of holding professionals who abuse this power to account. Although this wide discretion provides an opportunity for a more informal and flexible political socialisation for the residents, it may also provide opportunities for professionals to unduly influence political decisions of others. The relevant regulations already safeguard against this however. A professional providing such a service in the polling booth is restricted to helping two clients (who have requested and need help) and the presiding officer should make a written record of each incident. Fulfilment of these procedures may provide adequate protection.

In addition to the embedding of democratic egalitarian practices, opportunities for the disruption of roles and the development of positive identity narratives, the cultivation of political agency may also be enhanced by providing residents with opportunities to engage in stimulating cultural and social activities outside the hospital. Such opportunities should not be distributed on the basis of good behaviour and privilege but be available to all residents as a matter of course.

One of the main recommendations suggested in consultation following the field work was around awareness raising. Two posters were developed during the research processes in collaboration with participants from Sites 1, 2 and 3. The first poster/leaflet (see Appendix 2) deals with patients' right to inclusion in civic and political life and what that means in terms of mental health staff commitments to service-users. It also provides staff with a space in which to write to important local contacts such as the MP, councillors and a 'hospital champion' of political inclusion.

The second poster/leaflet (see Appendix 2) deals with equal rights to participate in free and fair elections. This deals with practical support in registering and voting as well as facilitating contact with politically engaged peers and access to information and debate. Again, it features spaces for staff to enter local contact details. Both posters feature a staff commitment that reasonable political action and expression will not be assessed for possible symptoms of mental illness and that capacity assessments will not be used as a reason for exclusion.

These resources provide an accessible starting point for staff and service-users to introduce and discuss the practice of politicising psychiatric patients in professional practice with reference to theories of citizenship education and social identity. The posters intend to help raise awareness for mental health service-providers and users to begin implementing the duty to positively support people with mental disabilities to participate in political and civic life on an equal basis with others (Art.29 UNCRPD).

A second suggestion was that site-specific protocols be developed for any institution seeking to implement these policies. These would form a set of rules for political interaction developed in forums using participatory design principles. In this way service-users and staff may co-produce and co-own the outcomes. These 'constitutions' could set out a clear set of principles upon which support for political inclusion may be based. They would need to be reviewed regularly so that new entrants to the institution have opportunities to participate.

To embed the policy of political inclusion more deeply into the discursive practice of staff and residents, as well as for practical reasons (e.g. timely registration on the electoral roll), it was also suggested that discussions on political inclusion could occur at the induction to the hospital or at the care planning stage. At this stage practitioners should considers asking:

1. How the resident might want to be involved in decisions that affect institutional policy and practice,
2. How they might want to be supported to vote in elections and referenda
3. How they might contribute to decisions that affect their lives – e.g. where to live or whether to take a particular medication
4. The care planning should also include:
5. A discussion about how mental health diagnosis does not have to be seen as the defining aspect of any person's identity and an explanation of the various opportunities to explore different roles if they wish to through social and cultural activities

6. A commitment that reasonable political opinions will not be used as evidence of mental disorder and will be heard
7. This care planning guidance developed with participants across Sites 1, 2 and 3 is available in full at appendix 3.

The recommendations proposed here are not solutions to the problem of supporting political participation but merely antecedents to co-constructive processes being born out of such debates and discussions. They should not be viewed as sufficient actions by institutions to fulfil duties of supporting political inclusion.

It is difficult not to be pessimistic about the pusillanimous and even cynical approaches to political inclusion observed in some institutions. It is hard to escape the conclusion that because of the inherent contradiction between coercive treatment and empowerment, only a wholesale de-naturalisation of the system of mental health law and practice will increase the possibility of bottom up political mobilisation. It also perhaps requires a reimagining of our social and mental health support systems.

My findings indicate that involvement of people with disabilities in the design, implementation and monitoring of policies of political inclusion at every stage is necessary so that engagement in public and political life may be on their own terms. Such opportunities are not in the gift of the institutions and services charged with their care. Educational approaches should be dialogical and inculcate open-mindedness rather than didactic and based on a condescending distinction between fact and opinion. This will likely require resources for implementation being provided directly to people with mental disabilities and of course in the experimentation and creative chaos that might ensue, new issues and dilemmas will surely arise. Scandals will occur and new harms will be done. This is, I believe a necessary step to take to fully substantiate the principles of UNCRPD which the UK is committed to implementing.

10.3. Contribution to knowledge

This is the first study to have produced detailed research on the everyday implications of implementation of policies of political participation in the UK mental health system. I have used ethnographic field work to produce rich and detailed data on what occurred during implementation of policies of political inclusion in mental institutions and in analysing and discussing this data moved beyond abstract theories of political agency and towards an understanding of its co-production in everyday interactions.

The thesis has contributed to the conceptual understanding of political participation for people being treated for mental health conditions and also adds to the discussion around how the UNCRPD principles should be implemented more generally. A bottom up approach is likely to model better the co-constructive principles underlying the right to participation. The UNCRPD applies internationally. Given that, this contribution is not restricted to the English context but has international implications.

I have brought to light previously unacknowledged, but key, tensions and dilemmas facing service-users and practitioners wishing to facilitate the participation of residents in secure secondary mental health facilities. The participation dilemmas include cultural dilemmas (conflicting cultural values regarding different types of politics), moral or legal dilemmas (conflicting understandings of residents' rights as they arise in context) and organisational dilemmas (conflicting agendas between the professional ethics, the institutional management and the residents' need for agential recognition). I have shown that, far from residents' participation being a matter of technical practice and implementation of law, the political participation can be complex, messy and risky and therefore its enhancement and constraint is a matter of ethico-political practice that has not previously received adequate attention. There is always a danger, in the context of mental health institutions, of slippage back into medicalised rituals of assessment and coercion in the application of principles of political inclusion. This can present real problems of indoctrination and exclusion

The application of Goffmanian and Foucauldian theorisation of relations in mental institutions is far from a novel approach. I have however added to these modes of theorisation by applying Butlerian concepts. This combination of analytical tools has enabled me to identify deep contradictions in the implementation of this policy that have not previously been recognised sufficiently. This close, theoretically grounded understanding is a considerable contribution to the debate about the implementation of this policy enabling a proper analysis of successes and failures of practice.

I have identified alternative modes of practice that would better enable successful implementation of the policy - not only in the narrow sense of increased voting rates but in the more important sense of becoming a member of the community. I have thereby enabled a clearer understanding of the nature of the radical challenge that this poses for practitioners in implementing these principles in the current system. This has supported the actual development of practice and has already had some impact.

The PhD findings were applied to reforming policy across research sites and in developing protocols for mental health practitioners in supporting service-users to engage in politics. This resulted in a variety of events being organised for the service-users at Site 1 including a trip to Westminster, a meeting with the local MP and a meeting with the local Mayor. I also developed, in collaboration with practitioners and experts by experience, a pair of posters to be used to raise awareness of policies of political inclusion in mental health rehabilitation as well as a care planning guidance so that practitioners consider registration on the electoral register when patients are transferred to residential services. This has been submitted to the Royal College of Psychiatrists so they can potentially implement it as an official nationwide guidance document.

On the basis of the legal research contained in the thesis I have produced a paper for the Journal of Psychiatric and Mental Health Nursing on applying politically inclusive practice in medicalising environments (Clubbs Coldron, 2020). In addition, I have prepared reports for the All Party Parliamentary Group on gambling related harms. This report details the arguments for including experts by experience (those with gambling addiction and their families) directly in policy development and implementation as well as directly in the regulation of the gambling industry through the Gambling Commission. This has resulted in the Gambling Commission making plans to create an in-house committee composed of people with lived experience.

Finally, I have highlighted the educational dimension of implementation, and of psychiatric practice in general. The anthrogogies of politics outlined are heavily influenced by, and sometimes slip back into, the ritual order of the mental institution and this can undermine the good intentions of practitioners. This theoretically grounded link offers powerful new ways of thinking that can aid further research and the development of successful practice.

10.4. Conclusions

Across the UK and Europe policies are being implemented aiming to positively support inclusion in political and public life for persons with disabilities. Approaches widely refer to the inclusion of disabled peoples as ‘voices’ and emphasise participation in the politics of public health institutions and in health and welfare policies (WHO 2006: 7).

Although a range of forums in the health care sector are being opened up to participation of their 'clients' and 'consumers' the benefits of implementation for people with disabilities remain insubstantial and abstract. In mental health there is a widespread assumption that people with mental disabilities by definition lack certain capacities for appropriate political engagement. Policies are made by HCPs intending to facilitate and support political engagement during mental health treatment by facilitating registration and granting leave to vote. Education sessions are organised to teach people the facts and rules of political life. This top down*,* technocratic and *'consumerist approach' (*Lewis 2014: 8.5) can undermine the good intentions of practitioners seeking to implement the principle of political inclusion codified in the UNCRPD. Practices can be alienating and mis/mal-recognising some forms of subversive political actions and expression as mental illness. In this way the 'human-rights based approach' to mental health care often slips back into medicalised rituals of performance on the basis of decisive doctor and passive patient roles.

I have found that both staff and service-users are restricted in their opportunities to participate in public and political life through the structure and rituals of institutionalised mental health care. Policies frequently failed to engage or motivate people to vote or register to vote. In addition education sessions could expand psychiatric management and influence to the political field,

Although reasonable accommodations are required to extend and enhance opportunities, political inclusion of people with mental health difficulties already exists, in dialogical processes of identity play, reformation and recognition. These processes can however be restricted and controlled according to the definition of politics applied by institutions and psychiatric staff. While moments of resistance to, and assimilation with the ritual order and institutional norms are often fragmented, chaotic and random, they reflect agency of persons with mental health difficulties to influence the political environments in which they find themselves. This supports the hope that 'service-user empowerment' in the politics of the institution as well as in the political community at large, are both possible and desirable.

Creating de-medicalised and explicitly political environments, in which identities and worldviews can be experimented with, may lead to greater significance being attributed to law and policy as co-constructions over which people with mental health difficulties have a degree of power and ownership. In turn this could encourage greater opportunities for political participation for both service-users and staff within and outside mental health institutions.

I have shown in this thesis that understanding power as exercised on all by all, is a more fruitful way of analysing participation in politics in psychiatric rehabilitation. This is likely to apply in similar contexts and so potentially has broad implications for both residential and community based mental health services. This analysis leads to the theorising of mental health practice, in its entirety, as embodying a process of political socialisation. In residential institutions this socialisation more often creates exclusion and alienation, than increased and enhanced opportunities for equal participation.

I have posited the application of the anthrogogical approach, based on educational theory, as a possible way to improve practice in this area. When the patient-doctor act collapses, and/or mental health diagnosis is not reified as a fundamental aspect of service-users identities, a wider range of conversation topics, political positions and behaviours become possible for both residents and staff. They are then able to negotiate the emerging conversational dynamic using roles and scripts that are not necessarily derived from institutional ascriptions. Going off-script in this way can develop political capabilities and increase opportunities for participation in both the short and long term. Coercive treatment based on assessment, risk and containment reduce such opportunities.

This understanding may help practitioners and service-users, as well as other stakeholders, design spaces in which law, policy and protocol can be freely questioned. In this way context/person specific adaptations to the law's application may be co-constructed to allow service-users a stake in the rules and rituals that govern their everyday lives. This practice could be improved through engagement with educational theory rather than psychiatric and psychological methods of discipline and treatment. Political opportunities may be better enhanced and increased in the course of providing rehabilitative treatment if environments are adapted to accommodate bottom up conceptions of power, incorporating interchangeable teacher and student roles, rather than relying on the letter of law and policy to redistribute power from the top down as if it were a simple resource.

Achieving enhanced participation for service-users is fraught with real and difficult dilemmas for practitioners especially in the light of the deep and systemic logics of the institution that work against fully meeting the challenge. In addition, challenging behaviours and the real difficulties presented by psychosis, schizophrenia, paranoia and personality disorder must be carefully negotiated. More research is required to establish whether different mental health conditions have a significant effect on the process of politicisation and if so how these subgroups might be best supported to engage. It is therefore inappropriate to consider success or failure as primarily a matter of individual practitioner's actions. However, neither should it be seen as an inevitable result of service-user's illness, incapability or disillusionment. Blame and condemnation of practitioners or service-users has been avoided throughout the thesis as an inappropriate register. This is in line with an appreciative approach to the enquiry.

In suggesting possible reforms and developments of law, policy and practice on the basis of my findings I do not imply that there are clear solutions to the problem of supporting political inclusion in these settings. Politics inevitably involves contextual determinations and choices based on the 'appropriateness' of conflict and cooperation that cannot be captured by universalised law, policy or protocol. Further study on the anthrogogies of ethics and citizenship that shape political worldviews, identity and action for both service-users and staff is therefore an important item for future research agendas. In addition, the embedding of participatory design in the development and implementation of such policies is an area ripe for further research.

The process of supporting political participation in psychiatric rehabilitation has presented a number of complexities. Rather than seeing these complexities as problems to be denied we need to welcome the potential for political dissensus they generate. Dilemmas and conflicts can be used as positive tools for anthrogogical practice and for social and ethical thinking; a way of bringing more egalitarian social relations into the UK mental health service. Issues of discrimination, alienation and indoctrination in politicising practice create uncertainty for practitioners and restrictions for service-users.

The mandate to interact as equal political citizens created opportunities for welcoming difference, valuing diversity and respecting alternative ways of thinking and relating to others. Expansion of policies of political inclusion could in theory provide a valuable avenue of professional and institutional accountability. A great many possibilities and opportunities open up if we are prepared to expose mental health practice to ongoing processes of respectful negotiation, situated ethics and critical reflexivity.

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Health and Social Care Act 2012

Appendix 1:

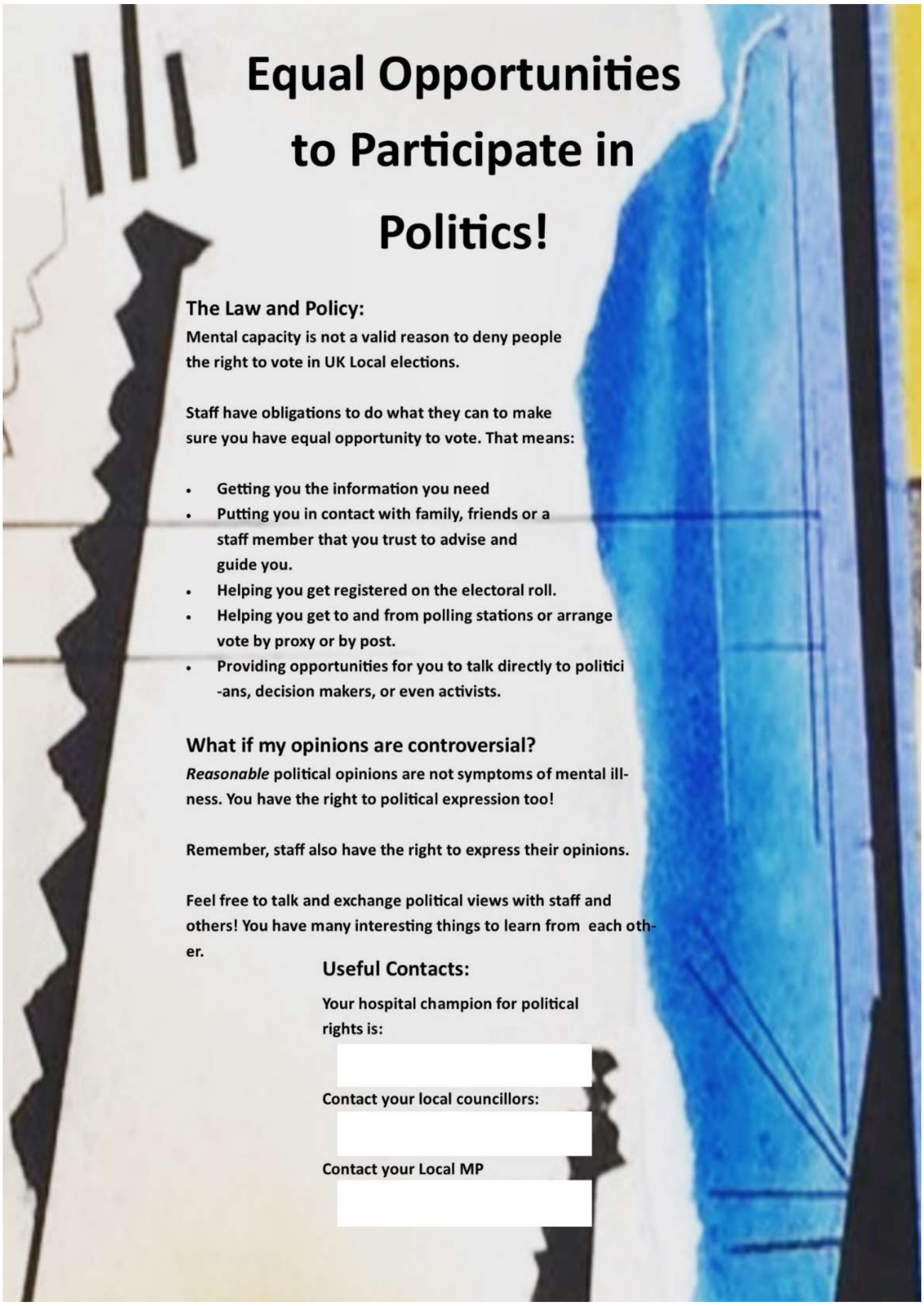
Article 4(3)	States are required to consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations in the development and implementation of the UNCRPD and in other decision-making processes concerning issues relating to persons with disabilities.
Article 8	Requires states to undertake awareness raising to foster respect for the rights and dignity of persons with disabilities and to combat stereotypes, prejudices and harmful practices relating to persons with disabilities.
Article 12	The right to recognition everywhere as persons before the law, legal capacity on an equal basis with others in all aspects of life, and to the support required in exercising legal capacity. State parties are required, in supporting legal capacity, to respect the rights, will and preferences of the person, restrict circumstances in which support represents a conflict of interest and undue influence, are proportional

	and tailored to the person's circumstances.
Article 19	The right to live independently and be included in the community means that States must take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community.
Article 21	The right to freedom of expression and opinion, and access to information requires that States take all appropriate measures to ensure that persons with disabilities can exercise the right to freedom of expression and opinion, including the freedom to seek, receive and impart information and ideas on an equal basis with others and through all forms of communication of their choice.
Article 22	The right to education requires provision of educational services to aid the development of identity, talents and creativity, as well as their mental and physical abilities, to their fullest potential. Reasonable accommodations must be made to allow people with disabilities to participate 'in a free society'. The article also requires states to establish effective individualized support measures which are provided in

	environments that maximize academic and social development. It further specifies that these measures must be ‘consistent with the goal of full inclusion’. Finally it requires states make reasonable accommodations to enable persons with disabilities to learn life and social development skills to facilitate their full and equal participation as members of the community.
Article 24	States are required to recognize the right of persons with disabilities to education and to ensure an inclusive education system at all levels. Education must aim to support the full development of human potential and sense of dignity and self-worth; the development by persons with disabilities of their personality, talents and creativity, as well as their mental and physical abilities, to their fullest potential; and enable effective participation in a free society.
Article 29	States Are required to guarantee persons with disabilities political rights and the opportunity to enjoy them on an equal basis with others. States must ensure that persons with disabilities can effectively and fully participate in

	political and public life on an equal basis with others, directly or through freely chosen representatives. States are also required to actively promote an environment in which persons with disabilities can effectively and fully participate in the conduct of public affairs, without discrimination and on an equal basis with others, and encourage their participation in public affairs. States should encourage participation in non-governmental organizations and associations concerned with the public and political life of the country, and in the activities and administration of political parties. They should also facilitate the formation and participation in organizations of persons with disabilities to represent persons with disabilities at international, national, regional and local levels.
Article 33	In national implementation and monitoring States are required to ensure that civil society, (in particular persons with disabilities and their representative organizations), shall be involved and participate fully in the monitoring process.

Appendix 2



Equal Opportunities to Participate in Politics!

The Law and Policy:

Mental capacity is not a valid reason to deny people the right to vote in UK Local elections.

Staff have obligations to do what they can to make sure you have equal opportunity to vote. That means:

- Getting you the information you need
- Putting you in contact with family, friends or a staff member that you trust to advise and guide you.
- Helping you get registered on the electoral roll.
- Helping you get to and from polling stations or arrange vote by proxy or by post.
- Providing opportunities for you to talk directly to politicians, decision makers, or even activists.

What if my opinions are controversial?

Reasonable political opinions are not symptoms of mental illness. You have the right to political expression too!

Remember, staff also have the right to express their opinions.

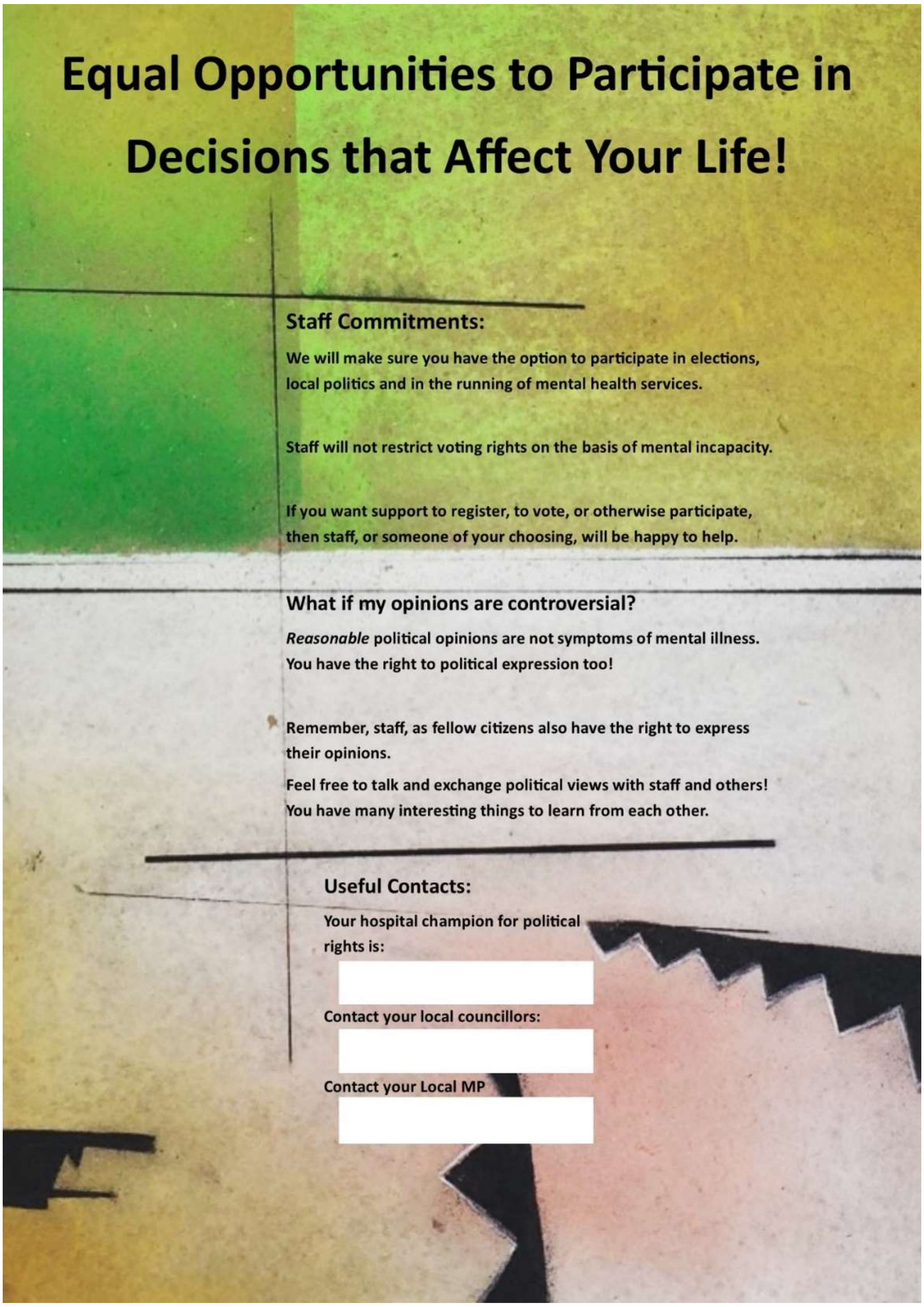
Feel free to talk and exchange political views with staff and others! You have many interesting things to learn from each other.

Useful Contacts:

Your hospital champion for political rights is:

Contact your local councillors:

Contact your Local MP



Equal Opportunities to Participate in Decisions that Affect Your Life!

Staff Commitments:

We will make sure you have the option to participate in elections, local politics and in the running of mental health services.

Staff will not restrict voting rights on the basis of mental incapacity.

If you want support to register, to vote, or otherwise participate, then staff, or someone of your choosing, will be happy to help.

What if my opinions are controversial?

Reasonable political opinions are not symptoms of mental illness. You have the right to political expression too!

Remember, staff, as fellow citizens also have the right to express their opinions.

Feel free to talk and exchange political views with staff and others! You have many interesting things to learn from each other.

Useful Contacts:

Your hospital champion for political rights is:

Contact your local councillors:

Contact your Local MP

Appendix 3

Care Planning Guidance for Staff and Residents of Rehabilitation Services:

Information on Patient Rights:	**Notes:**
You have the right to vote *Certain offenders detained in mental hospitals are disenfranchised: these are those detained, or unlawfully at large, under s37, s38, s44, s51(5), s45A, s46 (now repealed) or s47 MHA; s5(2)(a) CPIA 1964; and s6(2)(a) or 14(2)(a) Criminal Appeal Act 1968.* *Those remanded in custody under s35, s36 or s48 are not disenfranchised.*	
All persons with disabilities, whether mental or physical, have the right to participate in civic and political life the same as any other citizen. *(This right is derived from the UN Convention of the Rights of Persons with Disabilities section 29 and applies to ALL patients)*	

The hospital has responsibilities to make reasonable adjustments so that you have equal opportunities to exercise your rights. To give you Section 17 leave will be facilitated where appropriate so that you can leave the hospital to vote, attend meetings with political representatives or for other reasons related to political action or expression. You can ask for information and support be provided by someone that you trust (family, friends, fellow patients or a staff member).	
You have the right to express your opinions. *(When discussing your views within the hospital you should be respectful and courteous to the views of other patients as well as staff)* Staff will refrain from monitoring or recording reasonable political opinions in medical documents.	
Registration on the Electoral Roll:	

Are you already registered to vote? Where? Would you like to be registered at the hospital so that you can vote in the local constituency?	
Would you like to apply for a postal/online vote? *(Alternatively, would you like to nominate a friend, family member or member of staff to vote on your behalf by proxy?)*	
Contact details for local politicians and councillors:	
If you want to express your views to the person who represents you in parliament, your local MP's contact details are: …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… ……………………………………………………………………	

To express your views regarding local services, planning decisions and other local issues you can contact your local council. The contact details are: …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… If you have any further questions or want to learn more about what you can be involved in, the hospital champion on patient political participation is: …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… ……………………………………………………………………	

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Appendix 4

Staff: Interview schedule

1. INFORMATION SHEET
2. CONSENT FORM

Interview Code: ----------

Confirm that the interviewee is aware that the interview is recorded and is happy to participate

Begin Recording

Demographic data:

Could you tell me a little bit about yourself?

Occupation:

How long have you been working in the mental health trust?

Are you a politically engaged person yourself?

Why is supporting patient's engagement in politics a part of your role here?

This interview will deal with the polices currently in place dealing with patient's opportunity to register for, and to vote in elections should they wish to.

I'm going to give you a few minutes to read through these vignettes, one at a time, and then ask you to discuss how staff should deal with these situations.

Vignettes:

1) A patient is detained under s.3 MHA. She has acute symptoms of bi-polar disorder and is demanding that she be allowed leave to vote in a coming ballot. When this was discussed with her MH advocate it was clear that she had little understanding of the political arguments and is wilfully avoiding thinking about negative consequences of the decision. This reflects the argumentation of a large proportion of voters not diagnosed as mentally ill. She wants to vote but has no concern for the question on the ballot. She simply wants to punish a particular party leader for a perceived slight. She can't fill out the registration forms on her own.
   a. What would be the response of the ward staff?
   b. Postal vote?
   c. How would you use treatment to increase her opportunities?
2) A variety of patients detained under s.2, s.3 of the MHA are discussing an up-coming general election in the community meeting. An individual with paranoid schizophrenia is discussing the Israel/Palestine conflict and a local MPs views on it. He is becoming increasingly passionate and angry. Another patient challenges the narrative being espoused and the meeting becomes increasingly adversarial, loud and gruelling. Some other patients are become uncomfortable and distressed.

a. Basically in a community meeting and a political argument broke out what would be the response?
b. What would be the response of the ward staff?

3) A clinically depressed patient detained under s.3 MHA is adamant that he wants to cast a vote as he wants to feel like he has made a civic contribution. He is experiencing suicidal thoughts but has not been self-harming recently. He does not trust that his postal vote will not be tampered with (on the basis of media reports) and insists on casting his vote in person. He is demanding leave without supervision on the day of the election to cast his vote. He argues that if he is accompanied then he will not be able to cast his vote

a. What would be the response of the ward staff?
b. MAYBE but probably not mention human right litigation

4) The staff have identified 3 patients who are registered and want to vote in the local constituency in a general election. They all have problems with retention and although the manifestos and constitutional structure of elections has been accessibly explained beforehand, when the group arrive at the polling station it is clear that the patients will need help and support to make the decision they seem to have previously preferred.

a. When is it appropriate for clinical staff to accompany patient's into the polling booth and physically direct which box to tick?
b. When is it inappropriate?
c. What information would be needed to make this decision?

I am now going to ask you a few questions about the policy, its implementation and its effects.

Questions:

Ask if they are aware of/familiar with the policy in question.

1. Could you tell me a little about the day-to-day care needs of a typical patient on this ward?
2. How severely would such care needs impact a person's ability to register and vote in elections?

a. The actual act of voting

b. The decision as to who to vote for

3. Do you think voting is a person's civic responsibility?
4. Do you think patients here have a responsibility to vote?
5. Could you give me an overview of how this policy has been implemented so far?

a. What work have you done in supporting patient's political rights since you have been here

b. When did activity in this area first start?

c. What prompted these initiatives?

6. During the last election, did many patients request help in registering to vote or casting a ballot?

a. General election 2017

b. Local elections 2017

7. Could you take me through what support service-users received on the ward to help them cast a ballot during the last election or referendum?

a. What kinds of patients asked for help?

8. Do service-users often communicate a need for support in registering and voting in elections?

a. What types of patient are those who typically make such requests?

b. What help was requested?

c. Why do you think there was so few patients wanting to cast a vote?

9. If a patient is having difficulty fill in the required forms to register to vote what are the practical steps that you would usually follow?

a. Assessment of eligibility?

b. Meet with social worker or Speech and Language therapist?

c. Meet with Mental Health advocate

d. Meeting with care planning team?

10. Are mental capacity assessments necessary?

a. To determine whether providing support is reasonable?

b. To determine what kind of support should be provided?

c. To exclude those who it would be inappropriate to support to participate?

11. What factors would you consider in assessing a patient's mental capacity to vote and register to vote?

a. Mental capacity act?

12. How would you know if a patient was incapable of participating and voting in an election?

13. Do patients that meet those criteria receive any help to support the relevant capacities even if they don't cast a vote?

14. Would you say there is a difference in the way individuals with different disorders are reacting to the support for political engagement?

a. Anxiety disorders

b. Mood disorders

c. Psychotic disorders

d. Eating disorders

e. Learning disabilities – these were the most engaged

15. Would 'extreme' political preferences ever be a factor in assessing a person as mentally ill or incapable?

16. Some mental health patients are not aware of their right to register and vote, or feel that they were in practice restricted in exercising their rights. What are your thoughts on why this is?

17. What difficulties have you encountered in implementing the policy?

a. Distrust between the patient and staff?

b. Time and resources?

18. Do you think it is a worthwhile policy? – in terms of treatment

a. Why?

b. Why not?

19. How important do you think it is that detained patients on mental health wards should be able to cast a vote?
20. Is there anything else that you think I should know?

ENGAGE AND BUILD RAPPOR DON'T JUST ASK QUESTIONS OR IT WONT WORK

Patients: Interview schedule

1. INFORMATION SHEET
2. CONSENT FORM

Interview Code: ----------

Demographic data: Occupation: How frequently have you been in contact with mental health services? What do you think about politics?	

Commence recording **Interview Code:** …………………………………… **Confirm that the interviewee is aware that the interview is recorded and is happy to participate**	

1. Last week we went to the polling station and you cast a vote

a. Why did you want to vote in the election last week?

2. Have you ever voted previously?

a. When did you vote previously?

b. What happened?

3. What support did you receive so that you could vote?

a. Did the staff here help you to register to vote?

b. Were you already registered?

4. Do you think voting is something everyone should do?

5. Was your mental ability to vote assessed at any time before you registered?

6. Who was the main person who helped you to register or vote?

7. What support did they give you?

a. Were you given any information about the vote?

b. Was the vote brought up at community meetings?

c. Were there any events organised?

d. Did you discuss the election with other people on the ward?

8. What help would you want from staff to give you the next time there is an election?

9. Apart from the staff on the ward, is there anyone else, who has helped you to register or vote?

10. Do you mind that staff are encouraging you to vote?

a. Do you feel pressured to vote?

11. Was going out to vote a positive or negative experience?

12. In your view, is there anything about your mental health that would have made it difficult for you to vote?

13. Is there anything about your personal circumstances that would have made it difficult for you to vote?

14. Was there anything that happened on the ward that might have stopped you from voting?

a. Could you explain?

15. When would you say a person should lose the ability to cast a vote?

16. How important do you think it is that detained patients on mental health wards should be able to cast a vote?

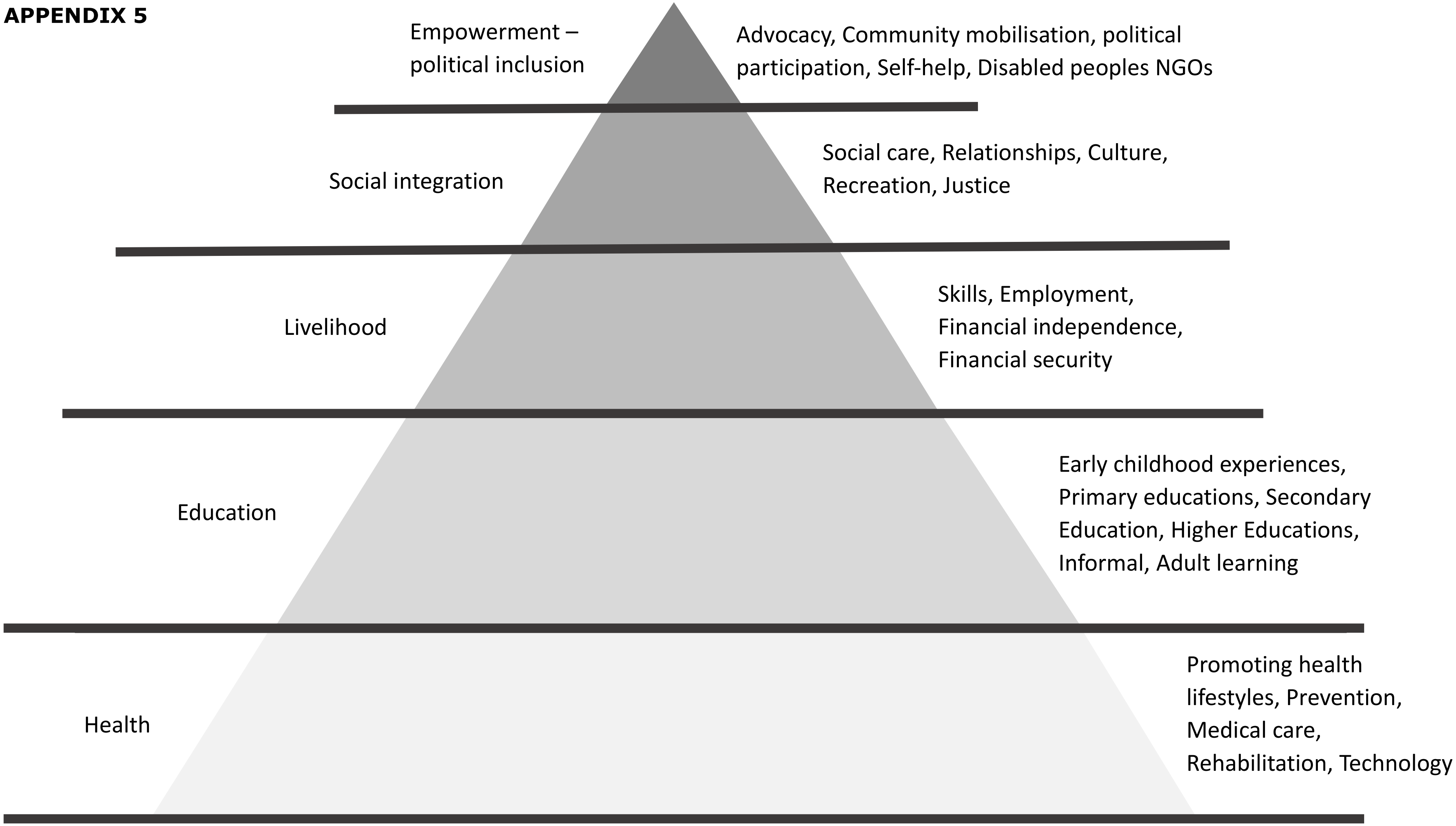
17. Do you identify as a disabled person?

18. What do you think would help you to keep joining in in future elections?

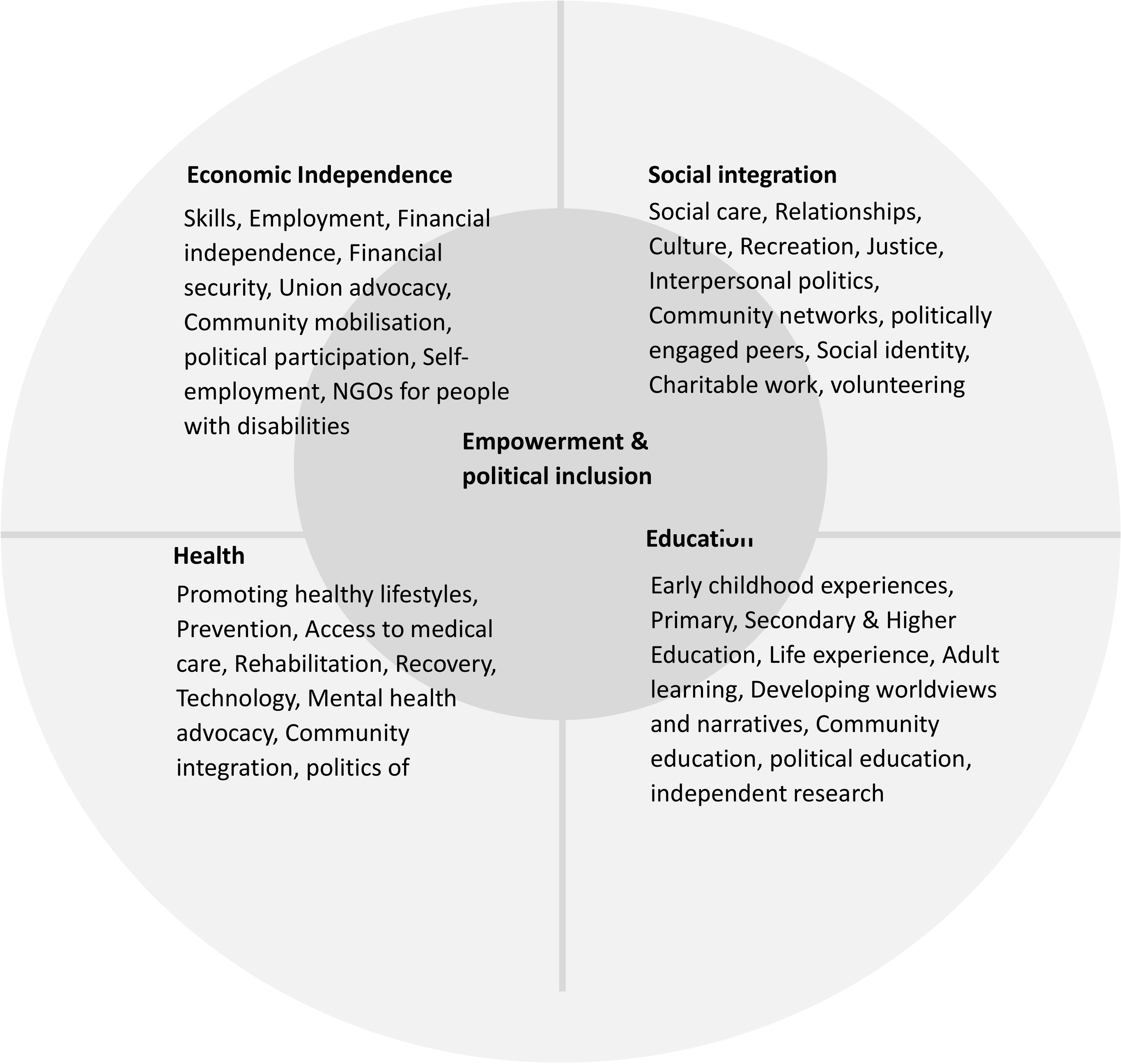
19. Is there a political opinion that you would like to state? – I am recording

20. Is there anything else that you think I should know?

APPENDIX 5


Empowerment – political inclusion
Advocacy, Community mobilisation, political participation, Self-help, Disabled peoples NGOs
Social integration
Social care, Relationships, Culture, Recreation, Justice
Livelihood
Skills, Employment, Financial independence, Financial security
Education
Early childhood experiences, Primary educations, Secondary Education, Higher Educations, Informal, Adult learning
Health
Promoting health lifestyles, Prevention, Medical care, Rehabilitation, Technology

APPENDIX 6



Economic Independence

Skills, Employment, Financial independence, Financial security, Union advocacy, Community mobilisation, political participation, Self-employment, NGOs for people with disabilities

Social integration

Social care, Relationships, Culture, Recreation, Justice, Interpersonal politics, Community networks, politically engaged peers, Social identity, Charitable work, volunteering

Empowerment & political inclusion

Health

Promoting healthy lifestyles, Prevention, Access to medical care, Rehabilitation, Recovery, Technology, Mental health advocacy, Community integration, politics of

Education

Early childhood experiences, Primary, Secondary & Higher Education, Life experience, Adult learning, Developing worldviews and narratives, Community education, political education, independent research