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# Supporting political rights for people in psychiatric rehabilitation: “Appropriate” political action in medicalized environments

## 1 | INTRODUCTION

There has been a recent surge of interest in recovery, co-production in care and political inclusion for persons with mental health difficulties (Voorberg, Bekkers & Tummers, 2015). This has revealed a need for principles based on robust theoretical and empirical enquiry to guide practices that enhance political participation in institutional settings. This need is likely to be felt in any jurisdiction that has ratified the UNCRPD and therefore the concern is internationally relevant.

The Universal Declaration of Human Rights (UDHR) 1948 constructs widespread political inclusion in elections as a primary method of driving the establishment, implementation and enforcement of human rights. Political rights are therefore of great importance for people with mental health challenges who are at greater risk of their freedoms and rights being violated through state interference in their personal affairs. 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, Protocol 1, Art 3 (1952), also established a right to free and fair elections.

For people with mental health challenges and disabilities, these rights are too often abstract and partial (European Union Agency for Fundamental Rights, 2014). The *United Nations Convention of the Rights for Persons with Disabilities* (UNCRPD) aims to substantiate and extend these rights under Article 29—the right to equal opportunities to participate in public and political life. Article 29 is merely one of several UNCRPD participation rights (e.g. Article 3, 4(3), 8, 12, 19, 21, 22, 24 and 33) that aim to ensure people with disabilities can directly influence decisions that affect their lives. The World Health Organisation (WHO), in guidelines relating to Community-Based Rehabilitation, recommends that Article 29 is implemented

internationally as a mandate to support and encourage engagement with a broad range of political activities (WHO, 2010).

In an analysis of implementation of Article 29 across the EU, the European Union Agency for Fundamental Rights found that in many Member States, a lack of legal capacity automatically excludes many people with mental disabilities from the franchise (European Union Agency for Fundamental Rights, 2014). Such restrictions being directly based on a disability or a proxy such as capacity, contravene the principles of the UNCRPD as interpreted by the CRPD Committee. In many jurisdictions, procedures for persons with disabilities to request support or assistance to vote are inaccessible. 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 violated, there are frequently no obvious routes to redress.

Substantiation of political rights, through the implementation of reasonable accommodation and positive support, is vital to provide equal opportunities for political participation. Further, political inclusion symbolically recognizes people with mental health difficulties as equal citizens and is a practical application of the principles of humanistic, person-centred recovery.

Recent empirical research in which the development and implementation of policies were observed and discussed in interviews concludes that these principles are too often relegated as a secondary concern for mental health practitioners preoccupied with risk aversion (Clubbs Coldron, 2020). In this paper, I seek to identify a number of ethical dilemmas that arise in psychiatric practice centring around the need to reconcile patient autonomy with paternalism and beneficence. It is argued that in the context of advancing political rights for residents of psychiatric rehabilitation facilities, these principles can often be incompatible. The focus of this paper is the implementation of policies aiming to improve and expand political opportunities for people with mental health challenges. Prior to discussing the ethical and practical dilemmas inherent in this practice, a working definition of politics is provided.

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## 2 | A BROAD CONCEPTION OF POLITICS

Contemporary definitions of politics, according to Van der Eijk (2018) can be categorized into two groups. There are “Domain” definitions that rely on identifying an institutionalized political sphere—for example governments, politicians or political parties—associated with large scale and explicit governance and public administration. At any given moment, there is a certain domain or sphere of which you can say *that* is governmental and whatever happens *there* is political. Definitions based in this tradition are referred to in this paper as domain politics or big-P Politics. Van der Eijk points to a second type—“Aspect” definitions—which rely on identifying aspects of behaviour in processes that attempt to resolve conflict relevant to a community as a whole. This category of definitions I refer to as aspect, or small-p, politics.

A definition of politics restricted to big-P politics can result in barriers to the development of political identities and capabilities (Community rehabilitation: CBR Guidelines WHO 2010). For example, in mental health rehabilitation policies of political inclusion may only be implemented to support the right to vote during elections. Participation in the everyday politics of mental health care and treatment may as a result be deemed inappropriate for service users (Clubbs Coldron, 2020). This can be avoided if a broader definition is adopted that includes small-p politics. The WHO CRB guidelines indicate that, in implementing Article 29, what aspect definitions result in more inclusive practices encompassing “interrelationships between people—between men and women, parents and children, people with and without disabilities—and the operation of power at every level of human interaction” (WHO, 2010). For people with mental health challenges who are detained in institutions, this brings into focus the day-to-day processes of conflict and cooperation on matters relevant to the community within the mental health institution of which both staff and residents are a part.

The WHO CBR guidelines are not without some pitfalls from the point of view of people experiencing mental health difficulties. For example, they recommend encouraging activities ranging from “developing thinking about disability or other social issues at the individual or family level, joining disabled people's organizations or other groups and organizations, and campaigning at the local, regional or national level, to the process of formal politics, such as voting, joining a political party, or standing for elections.” Despite the reference to “other social issues,” the WHO focuses on the politics of disability which potentially narrows the field of appropriate political engagement to disability issues, that is, the health services, mental health law and policy, and welfare systems. Engagement with such topics, in practice, appears to depend on embracing the role and identity of the “disabled person.”

Further, the CBR guidelines are based on the premise that people with disabilities have reduced capabilities and opportunities to engage in public and political life. In addition, they assume that political participation is something to be achieved at the later stages of recovery. Therefore, political inclusion is positioned as something that is only attainable following achievement of good health, educational

attainment, employment and the establishment of a settled social and family life. Therefore, political inclusion is potentially subordinated to the principles of functional rehabilitation and treatment. It is also constructed as dependent on psychiatric staff “giving” people with mental health difficulties the opportunity to participate. Although participation 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 may be 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.

Policies aiming to enhance and increase opportunities for political participation are currently being implemented in residential psychiatric rehabilitation in England. My recent ethnographic study of implementation in three institutions (Clubbs Coldron, 2020) indicates that the outcomes are likely to be much more effective when practitioners take the policies as a mandate to support and encourage engagement with a broad range of activities through which people develop and express their opinions on the world and how it is governed. By doing so, they were more likely to open opportunities for meaningful engagement in public and political life. However, it was discovered that such supportive practices also raised difficult ethical and practical dilemmas such as the threat of undue influence and indoctrination, the tension between diagnosis and recognition, and that between necessary coercion and equally necessary respect. It was clear that some principles based on robust theoretical and empirical analysis would be useful in developing a progressive practice.

Before developing such principles into a practical framework, I briefly discuss two key difficulties arising in practice that the principles seek to address. Firstly, that the prioritization of rehabilitation and treatment can be restrictive of political rights and secondly, that both staff and service users are restricted in their opportunities to participate in public and political life through the structures of institutionalized mental health care.

## 3 | AN EXTENSION OF STAFF'S POTENTIAL SPHERE OF CONTROL

Coercion, Enabling, Education and Conciliation are four strategies used by mental health practitioners in their everyday practice to ensure efficient running of services (Perry, Frieh and Wright, 2018). Many service users experience mental health treatment as a process in which they have reduced freedom of choice and action, and where compliance with treatment is achieved by invoking therapeutic goals—that is, coercion is paradoxically justified by the aim of enabling autonomy in the long term as part of treating mental illness. On this basis, mental health institutions are often technocratic rather than democratic in the way power over others is manifested. This is related to the competing aims of institutional efficiency versus provision of humanistic care.

Technocracy is a form of governance based on technical expertise. Comprehensive governance over the lives of people in mental health institutions is legally justified based on qualification in the discipline of psychiatry and psychology. Mental health nurses are seen as experts in themselves as well as implementing the decisions of psychiatrists and psychologists.

It is important to keep in mind that the relationship between service users and providers is complex and is not necessarily dictated by these or any other structures. Staff and service users can “escape” ascribed roles and the principles offered later seek to facilitate that. However, in role performances within the institutional setting certain rituals of interaction are required of staff and service users (Goffman, 2005) and these habits of interaction can restrict opportunities to interact on the basis of explicitly political identities. I found that in several ways described below staff and service users were deprived of opportunities for effective political participation by these structures. These restrictions, it is argued, are related to the individualized notion of autonomy inherent in the neoliberal conception of the citizen as consumer as well as to a conception of power as a resource to be redistributed from the top-down.

In the three institutions observed during UK general and local elections, political education was imposed based on psychiatric expertise. The provision of support and reasonable accommodation to people who have genuine impairments on their capabilities for political expression and action (for example difficulties in processing information or in communicating their will and preferences) intensive support may be justified despite the danger of undue influence being more acute.

However, the imposition of the novel political role was experienced by some service users as an extension of technocratic control and psychiatric surveillance to the political sphere. For example, over the weeks preceding an election a social worker sent a letter offering support for political participation. At the same time, as offering support service users were required to sign over rights of correspondence with the electoral commission causing widespread distrust among the service user community. Other conditions of participation such as requiring an escort to polling stations or compliance with medication created rational reasons for disengagement. Capacity assessment procedures, patronizing educational sessions, social skills interventions and bureaucratic processes constructed the political as a space mainly owned and managed by senior staff members. Psychiatric nurses were seen as complicit in this allocation of responsibility and power.

There is therefore potential for the implementation of policies of political inclusion to feel oppressive and intrusive for service users. Further, because of the way that media and information were restricted for residents, staff became responsible for curating political information and answering political questions. Many staff felt uncomfortable in this role and sought to hide their own opinions or to restrict provision to politically neutral “facts.”

The policy of political inclusion was in some cases interpreted as providing a mandate for staff to manage patient political expression and action so that action was “appropriate.” It also allowed staff to

select service users to provide supported access to political opportunities and to exclude others. Implementers become arbiters of “appropriate” political expression justifying the management of a wide range of political expression and action and can effectively exclude individuals by restricting access to reasonable accommodations.

Thus, in implementing a well-intentioned policy there is a danger that voting may be considered the behaviour of a “good” or “healthy” citizen and imposed coercively as an aspect of best interest or as a therapeutic goal. By contrast, engaging in political conflict, either with mental health staff or other service users, may be defined as non-political and even pathological. On this basis, some forms of political action may be restricted for service users in ways that constitute differential treatment and potential discrimination. Furthermore, the imposition of professional authority in the provision of support for political participation assumes political incompetence on the part of service users. This may be experienced as mis/mal-recognition (Fraser, 1990). Mental health nurses, social workers, psychologists and psychiatrists may on this basis erroneously assume people with mental health difficulties need help. When support is offered on the basis that you must adopt an “acceptable incompetent” role, it can be experienced as a reduction in status for adult citizens. In this way, policy implementation, despite good intentions, can be experienced as an extension of staff’s potential sphere of control under the technocratic governance paradigm of the institution. Staff reluctance to proactively support political action in order to avoid these risks can result in those who genuinely need help and support being denied reasonable accommodations.

An aggravating factor is the degradation of healthcare work associated with technocratic pursuit of “neoliberal efficiencies.” According to McKeown & Carey (2015), it has undermined the capability of nurses to exert influence and involvement at all stages of the nursing process and patient journey. He argues that the lack of control over work pattern, content and intensity leads to alienation for both mental healthcare staff and those they care for. This can have negative impacts upon relationships between staff and service users that undermine the ability to construct oneself as a compassionate, “good” nurse and inhibit the substantive implementation of ideals of autonomy and political inclusion in practice. These are findings that are reflected in my ethnographic research where I found that institutional requirements for efficiency undermined the good intentions of nurses seeking to open opportunities for political engagement (Clubbs Coldron, 2020). This appeared to be particularly acute in private mental health rehabilitation facilities.

#### 4 | A THERAPEUTIC EXPERIENCE

Despite support for political participation potentially being experienced in negative ways, there were also many potential benefits for service users. 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 practised and enhanced. The symbolic recognition of political agency is potentially therapeutic in the sense that it provides a social and political environment in which service users can take pride in their opinions and perspectives. This was the case for some service users who showed increased levels of confidence and self-esteem following the election.

Of course, there were dilemmas posed by this practice. The secrecy of the ballot was compromised when the staff members escorting the group went into polling stations to support service users and found they had to accompany them into the booth to enable them to cast their ballot. In addition, service users' rights to refuse escorts were 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.

Processes of political participation become implicated in the relation between patient and medics. For example, they provide behavioural confirmation of "progress" which staff can record as contributing towards the recovery process. Service users may be praised, and their participation recorded through the official record confirming the "fact" that the individual is a political citizen. Staff may see participation as a sign of increased capabilities and capacities. This process of recognition may be therapeutic as a symbolic expression of increased social standing within the immediate community.

These processes of recognition have the effect of changing how the political environment is experienced for service users. There was evidence that the ritual order of treatment was rendered more flexible to subversion and challenge by both staff and residents giving them greater power in self-definition and greater freedom of expression. The relationships between individual staff members and service users, in interactions based on supporting and enhancing political inclusion, become less reliant on institutionally ascribed identities. This supports the view that the sphere of legitimate political action for service users is usefully extended to both small-p and big-P politics.

## 5 | BENEVOLENCE, AGENCY, POWER AND INDOCTRINATION

The UNCRPD rights are potentially transformative in both symbolic and practical ways. However, obligations to protect and support political rights are addressed to States and this implies a view of progressive reform as a process of top-down power redistribution rather than supporting bottom-up political mobilization. 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 health difficulties through top-down policy reform can work against improvements in political inclusion. In other words, the application of law and policy in the management

of political participation potentially strengthens the role of mental health practitioners in ways that can disempower people in their care and reinforce social exclusion (Rummery, 2006). In short, making mental health workers responsible for supporting political autonomy can institutionalize a form of mis/mal-recognition.

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 (Sandland, 2017: 93–94). However, the good life in mental health institutions is often reduced to recovering one's "mental health." Technical and disciplinary knowledge about mental health is claimed by mental health professions which allows practitioners the power to impose their own concepts of the good life. This can be both benevolent and insidious. Versions of the good life are diverse, may be contradictory and are therefore the basis of much political conflict. At the extreme, some individuals' versions will likely be universally thought misguided and possibly harmful for the individual themselves and others. It should however be acknowledged that allowing experts to determine the boundaries between dangerous version of the good life and acceptable ones is to grant exceptionally broad powers to define political views and action as either disordered or appropriate and thus poses a profound dilemma for practices of political inclusion.

Increased and enhanced political inclusion for people with mental health difficulties can support their autonomous pursuit of the good life in a variety of ways ranging from therapeutic improvements, increasing a sense of empowerment, and better knowledge and information (Felton and Stickley, 2004; McCann, Clark, Baird, & Lu, 2018; Nilsen, Myrhaug, Johansen, Oliver, & Oxman, 2006), to improved social and economic conditions (Crawford Rutter, Manley, Weaver, Bhui, Fulop & Tyrer, 2002). All these factors can contribute to both political inclusion and person-centred recovery. Inclusion also has institutional and reputational benefits in that it potentially supports satisfaction rates, improves health outcomes and strengthens arguments for recommission.

Human rights discourse and practices proposing to advance patient autonomy have been criticized for embracing conceptualizations of the political citizen as consumer and subject (McKeown & Carey, 2015). The introduction of rights to political participation reflects general trends towards corporatization, consumerism and user involvement in mental health discourse (Sandland, 2017). Within a political environment in which such neoliberal conceptions of citizenship and politics are dominant, political action and debate may be associated with the pursuit of bare self-interest. The idea of political engagement as a way of advancing the common good may be de-emphasized. Increased political participation of people with mental health difficulties can mean they are socialized into an individualistic and independent form of citizenship. This can have benefits as well as drawbacks. Re-responsibilization of the individual can be both an extension of freedoms and a way for state agents to avoid their own responsibility for supporting and enhancing inclusion for people with mental health challenges (Tisdall, 2008). Participation rights require people in positions of power and authority to recognize the agency of subjects of that power as well as find ways to exercise

power independently. "Participation" requires more than increased voting and registration rates or tokenistic patient representation in hospital governance.

Debates around child participation and politicization can offer useful insights concerning some of these dilemmas of practice so far identified. In the Convention on the Rights of the Child, children's participation is understood to aim at providing conditions in which people can develop a sense of self-worth, capabilities and confidence (Sandland, 2017). It is also said to lead to "better outcomes, both for young people and for organizations" (Kirby, Lanyon, Cronin, & Sinclair, 2003: 18).

Better participation, in theory, enhances the autonomy of individuals, accountability of institutions, and democracy itself, by creating the conditions in which active citizens can exercise and subvert 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" or good mental health patient and even when autonomy is achieved, subversive contributions may be readily dismissed. Participation is thus dependent on the participant being a governable subject.

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 of the UNCRPD however seek to curtail state influence on the formation of political views. Article 12 for example provides a right to the recognition of legal capacity but also requires undue influence to be policed. In mental health practice, supportive interventions are under scrutiny for undue influence. This made the practitioners I observed so cautious that they distanced themselves from the pedagogical role. This understandable trepidation could have a chilling effect on political socialization for people confined in mental institutions for significant periods. Being seen as vulnerable to influence and excluded from political debate because of this assumption can also be experienced as a mis/mal-recognition of the legal capacity for political citizenship.

At this point, it may be useful to consider the dichotomy between empowerment and indoctrination in the pedagogical process of politicization. The contradictory aims of participatory rights (to both socialize people into a political system of decision-making and also empower the individual to pursue their own version of the good life) create difficulties in evaluating policy implementation in the case of Art.29 UNCRPD—the right to equal opportunities to participate in public and political life. 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 realization is placed on those in functional authority, in technocratic institutions, creating a risk of indoctrinating pedagogies being applied despite good intentions. Restricting political opportunities only to those who are well behaved or who subscribe to a particular worldview is a poor basis for including people in the political process on their own terms.

The taking on of political responsibility for those not able to represent themselves is in some cases justifiable where cognitive

capabilities for forming, communicating and acting on a worldview are absent. But, giving psychiatric professionals the power and responsibility to assess the risk of someone's political views being somehow "ineffective" or "risky" is also a poor starting point for empowerment. In addition, many staff in the mental health rehabilitation appear reluctant to exercise such powers and responsibilities seeing them as outside of the remit of maintaining a safe and therapeutic environment (Clubbs Coldron, 2020).

Article 12 and 29 of the UNCRPD require state parties to operate their mental health systems to both develop the personality, talents, abilities and capacities of service users 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 provide opportunities, and ultimately to teach people how 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. This pedagogical dimension of mental health practice is vital to consider and is much broader than teaching people how to vote. One of the problems of implantation in mental health institutions is that under the doctrine of neoliberal efficiency achieving measurable outcomes such as increasing the voting rate can overtake the more fundamental aim of teaching and socializing people into public and political life more generally.

Humanistic educational theory as advocated by Dewey (2004), and Rosenstock-Huessy, (1970) indicates that the aim of adult citizenship education or "anthrogogies" of citizenship is to teach adults to carefully consider diverse ideas, be self-reflective and empathize with others. Adopting these practices, it is hoped, will encourage students, whether staff or patient, to be reasonable and democratic, to treat others fairly and to be open to reconsidering their own ideas as they seek evidence for use in decision-making processes.

The risk of staff capturing the teaching role and imposing pedagogies of politics and citizenship coercively is that people under their care may be forced to be "free" political agents through top-down policy rather than participating on their own terms. We observed this in the 2017 general election where a service user asked whether he "had to" go and vote and was given the answer in the affirmative (Clubbs Coldron, 2020). Under such policies, freedom can feel very much like coercion. A fundamental dilemma for institutions is that the freedoms "granted" might exceed the boundaries of appropriateness imposed on their exercise. The autonomous subject, educated in the process of mental health rehabilitation to be a political citizen, might exercise this capability to resist an institutionally acceptable 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 politicized



mental health ward" (Sandland, 2017: 96). This notion of power is based on an individualized conception of autonomy that emphasizes the person's capacity for rational thought. This obfuscates the way in which political autonomy is relational, contextual and dependent on identity, self-efficacy and social role. This neoliberal conception of power and autonomy can limit our ability fully to evaluate the risks and benefits of the implementation of participation rights for people with mental health challenges.

Commodified notions of power that see empowerment as a redistribution of resources owned by those in powerful roles and understandings of autonomy as requiring capacities for rational thought (as defined by those in power) can restrict opportunities for people in psychiatric rehabilitation to achieve the greatest degree of political autonomy reasonably possible.

## 5.1 | Autonomy and beneficence

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 all people with mental health challenges are able to "fully" participate in public and political life, partial participation or recognition of their political agency remains a worthy and achievable goal. Making political support dependent on the having the status of some possessing autonomy I argue is the wrong approach as it creates a false binary between having and lacking autonomy. In everyday life, no human being is completely autonomous. 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. We all exercise degrees of autonomy within the physical, economic, social and ethical constraints. Achieving autonomy in one area can reduce autonomy in another. The contemporary understanding of autonomy of individuals, originally used in reference to a form of social organization 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 determination that an individual is lacking in this capacity for autonomy to some degree.

A relational analysis of autonomy offers a conception of autonomy that is more nuanced and that is perhaps more useful in this

context. 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 (MacKenzie and Stoljar, 2000; Sherwin, 1998, Shewn 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. 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. In the next section, I bring together some of these principles in a framework to provide some practical guidance for practitioners in negotiating this thorny issue.

## 5.2 | Appropriate political participation

Appropriate political participation and action for people with disabilities in residential mental health services should not be restricted by the requirement to accept and embrace a disabled identity. Productive political conflict should not automatically be cast as inappropriate political action either. The question of how to make the distinction between appropriate and inappropriate political engagement, on the basis of which principles, and who should decide therefore remains at the heart of the problem of implementation.

In line with the UNCRPD, policies of political inclusion should not result in differential treatment solely based on disability. If a practice would not be acceptable for the general population, then it should not be acceptable for people with mental health challenges. On the other hand, reasonable accommodation of impairment is also required. Mental health practitioners would benefit from clearer guidance in striking an appropriate balance between these contradictory obligations.

On the assumption that the arguments and evidence presented are accepted as tenable I offer below several principles that I think are implied. This provides practical guidance for mental health nurses and service users based on the WHO CBR guidelines (WHO, 2010), the principles underlying the UNCRPD and humanistic education as well as findings from ethnographic fieldwork in mental health

rehabilitation during elections in England (Clubbs Coldron, 2020). On this theoretical basis, supporting political participation may be seen as a process of education, identity formation and role performance.

I hope that the principles developed can serve as a basis for academic debate and practical trial in the variety of real-life situations in different institutions. Academic debate will inevitably help to correct and refine them. But just as these principles were refined and developed in collaboration with service users and practitioners, only similar collaboration, on the basis of further empirical research into attempts to use the principles to guide practice, will enable us to see what is useful in them and what needs to change.

In attempting to distinguish between appropriate and inappropriate political participation, the following questions might fruitfully be asked: What is the context in which the expressions, actions or omissions occur? What are the social relationships between the people involved? What are the potential risks and benefits of political participation for those involved?

The “community as a whole” should be involved in distinguishing between appropriate and inappropriate conduct also. In inpatient rehabilitation settings, this will, as a minimum, include people with lived experience of mental disability, their family and peers, NGOs, Mental health nurses, social workers, advocates, psychologists and psychiatrists.

It should be made clear that the consequence of designating a (potentially) political expression, action or omission as inappropriate is that it can legitimately be suppressed and discouraged. Suppression and avoidance should only be applied in mental health settings where it would be legitimate to take such actions in relation to a person without mental health difficulties. In addition, the consequence of designating a political expression, action or omission as appropriate is that it can legitimately be encouraged as an educational “intervention” or reasonable accommodation. Provision and encouragement should not be applied coercively in mental health settings and may only be imposed where it would be legitimate in relation to a person without mental health difficulties. Encouraging “appropriate” political actions to be pursued as an aspect of recovery should not impose greater expectations on people treated for mental health difficulties than the general population.

The following general principles should underpin the implementation of policies of political inclusion in mental health rehabilitations services. These would help to more deeply embed principles of political inclusion into the everyday life of the institution:

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 to interact with politically engaged others. 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 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-recognized as symptoms of mental illness.
4. Mental health and disability are 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)
5. “Politics” and “power” should not be defined exclusively by professionals but be treated as an essentially contested concept. Politics can be non-exhaustively defined as engaging in processes of conflict and cooperation on matters relevant to the community. One such matter is “what should count as political” and another “what should be counted as a *disordered worldview*”
6. Political inclusion, as a fundamental aim of person-centred recovery, should be prioritized over and above the efficient running of health services.
7. 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. It therefore requires “stepping out” of the doctor patient roles. Political discourse should be conducted between equal citizens.
8. 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.
9. The whole process of mental health treatment incorporates aspects of civic education, and therefore, “treatment” should be applied as a process of dialogical and empowering anthropology (or adult education) where the roles of teacher and student are interchangeable. Political participation should be supported in ways that broadly motivate the pursuit of open-mindedness, that is, the pursuit of truth and understanding with due regard to available evidence and argument.
10. The role of teacher, in the process of educating people on how to engage in politics and influence decisions that affect them, should not be professionalized or institutionalized. Political education, in order to be person-centred must be premised on dialogical and mutual learning, rather than a didactic “banking” approach.

## 6 | CONCLUSIONS

Both staff and service users are restricted in their opportunities to participate in public and political life through the structure and rituals of institutionalized mental health care. 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.

Inclusive political practice in mental health services requires the destabilization of role and identity for both staff and service users and creating spaces in which the law and policy are weakened and challenged rather than reified as immutable. Psychiatric nurses are uniquely placed to develop relationships and environments that support such practices. Interaction between service users and nurses must enable co-construction and signify co-ownership of the rules of appropriate political conduct in the everyday life of the institution. Deconstructing the law, policy and culture governing the relations between staff and service users can encourage creative identity play, mutual dialogical learning and recognition as legitimate political actors.

Creating informal environments in which political identity 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 mental health institutions.

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## CONFLICT OF INTERESTS

The author has no conflict of interests to declare.

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