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INSIDE THE CITY WALLS: MENTAL HEALTH SERVICE USERS’ JOURNEYS TOWARDS FULL CITIZENSHIP

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A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy in Health Science
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ABSTRACT

This study was undertaken at a time when mental health service users were lobbying to be treated as full citizens with the same participation, rights and responsibilities as other citizens. It explores mental health service users’ understandings of citizenship and whether the recovery approach helps or hinders their journey towards full citizenship. The study uses Isin’s (1999, 2002, 2008b) conceptual framework of citizenship to interpret data from in-depth individual and focus group interviews with 17 service users and 12 key stakeholders. Isin’s conceptual framework focuses on the social, civil and political dimensions of citizenship.

The overarching finding was that service users experience conditional citizenship, which includes barriers and restraints to their participation and to the rights and responsibilities that others in society enjoy. Conditional citizenship results from labelling which has its genesis in the bio-medical model, the predominant treatment approach used in mental health services. The labelling of service users leads to stigma and discrimination in wider society and results in service users being Othered. In an attempt to blend in with the rest of society service users shape their behaviour through self-surveillance and self-policing to mitigate risk to themselves and others. Additionally in an attempt to be accepted they engage in practices of inclusion. These practices include self-disclosing about their illness, working in education and leadership roles to bring about acceptance of those with mental illness, and the expansion of the prevailing behavioural norms. For service users, deeper, existential and spiritual connections with others is essential for their sense of belonging. In some cases they make a claim for their full rights by engaging in acts of citizenship such as private and public practices of responsible subversion.

The findings from this study have important implications for the recovery approach that should ideally underpin mental health service delivery. The thesis concludes by outlining recommendations for nursing practice, nursing education and policy.
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TABLE OF CONTENTS

ABSTRACT ................................................................................................................................. III
ACKNOWLEDGEMENTS ........................................................................................................ IV
CHAPTER ONE: INTRODUCTION ............................................................................................ 1
  Research focus ....................................................................................................................... 3
    Research questions and aims ............................................................................................... 3
    Philosophical approach to the study .................................................................................... 4
  Research method ................................................................................................................... 4
  Structure of the thesis ........................................................................................................... 4
CHAPTER TWO: BACKGROUND ............................................................................................... 6
  Political context .................................................................................................................. 6
    Historical aspects .............................................................................................................. 6
    Mental health reforms ....................................................................................................... 7
  Civil context .......................................................................................................................... 9
    Human rights .................................................................................................................... 9
    The Mental Health Act ...................................................................................................... 10
    The impact of the Act on service users ............................................................................. 12
  Social context ..................................................................................................................... 14
    Mental illness and mental health ....................................................................................... 14
    The bio-medical model ...................................................................................................... 15
    De-institutionalisation ...................................................................................................... 16
    The recovery approach .................................................................................................... 17
  Conclusion ............................................................................................................................ 19
CHAPTER THREE: LITERATURE REVIEW ................................................................................ 20
  A brief history of citizenship .................................................................................................. 21
    Modern democratic citizenship ......................................................................................... 21
  General research studies ..................................................................................................... 24
  Ethnicity ................................................................................................................................ 26
  Lesbians and gays ................................................................................................................ 29
    Hetero-normativity ............................................................................................................ 29
    Politics of normalisation ................................................................................................... 30
    Intimate citizenship .......................................................................................................... 31
  Disability ............................................................................................................................... 32
  Service users ....................................................................................................................... 34
  Stigma and discrimination ................................................................................................. 40
The politics of inclusion and exclusion..........................................................43
Conclusion ........................................................................................................45

CHAPTER FOUR: THEORETICAL FRAMEWORK .............................................46
Extent ..................................................................................................................46
Content ...............................................................................................................51
Depth ..................................................................................................................55
Acts ...................................................................................................................59
Conclusion .........................................................................................................61

CHAPTER FIVE: RESEARCH METHODS ........................................................62
Aims of the study................................................................................................62
Methodological approach ...............................................................................62
Philosophical underpinnings .........................................................................63
Qualitative interviews....................................................................................64
    Recruitment ..................................................................................................64
    The sample ...................................................................................................65
    Interview schedule .......................................................................................66
    Interview questions ......................................................................................66
    Interview process .........................................................................................67
    Transcription of interviews ........................................................................68
Data analysis.....................................................................................................68
Reflexivity ..........................................................................................................71
Ethical considerations.....................................................................................72
Conclusion ........................................................................................................73

CHAPTER SIX: EXTENT OF CITIZENSHIP ....................................................74
The rules and norms of exclusion and inclusion ........................................75
    Written and unwritten rules .....................................................................75
    Norms ..........................................................................................................76
Exclusion ..........................................................................................................77
    Diagnosis of mental illness ......................................................................77
    Being trustworthy .......................................................................................81
    Transgressing the rules and norms ..........................................................82
Being included as a citizen ............................................................................85
    Shaping behaviour ......................................................................................86
    The practices of inclusion .........................................................................92
    Educating others .........................................................................................94
    Being different from others .................................................................96
    Subverting and bending the rules and norms ...........................................98
<table>
<thead>
<tr>
<th>Chapter Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conclusion</td>
<td>99</td>
</tr>
<tr>
<td>CHAPTER SEVEN: CONTENT OF CITIZENSHIP</td>
<td>101</td>
</tr>
<tr>
<td>The continuum of citizenship</td>
<td>101</td>
</tr>
<tr>
<td>The rights of being a citizen</td>
<td>103</td>
</tr>
<tr>
<td>Civil rights</td>
<td>105</td>
</tr>
<tr>
<td>The Mental Health Act</td>
<td>108</td>
</tr>
<tr>
<td>Political rights</td>
<td>112</td>
</tr>
<tr>
<td>The state of abject-hood</td>
<td>113</td>
</tr>
<tr>
<td>Social rights</td>
<td>115</td>
</tr>
<tr>
<td>The responsibilities of being a citizen</td>
<td>117</td>
</tr>
<tr>
<td>Being a responsible citizen</td>
<td>117</td>
</tr>
<tr>
<td>Making a contribution</td>
<td>118</td>
</tr>
<tr>
<td>Personal responsibility</td>
<td>120</td>
</tr>
<tr>
<td>The responsibility of the mental health system</td>
<td>123</td>
</tr>
<tr>
<td>Conclusion</td>
<td>126</td>
</tr>
<tr>
<td>CHAPTER EIGHT: DEPTH OF CITIZENSHIP</td>
<td>128</td>
</tr>
<tr>
<td>The thickness of belonging</td>
<td>128</td>
</tr>
<tr>
<td>Ethnicity and nationalism</td>
<td>128</td>
</tr>
<tr>
<td>Being connected</td>
<td>131</td>
</tr>
<tr>
<td>Solidarity</td>
<td>132</td>
</tr>
<tr>
<td>A deeper meaning</td>
<td>136</td>
</tr>
<tr>
<td>Thinness of belonging</td>
<td>141</td>
</tr>
<tr>
<td>Being disconnected</td>
<td>143</td>
</tr>
<tr>
<td>Conclusion</td>
<td>148</td>
</tr>
<tr>
<td>CHAPTER NINE: ACTS OF CITIZENSHIP</td>
<td>150</td>
</tr>
<tr>
<td>Individual acts</td>
<td>150</td>
</tr>
<tr>
<td>Acts by others</td>
<td>158</td>
</tr>
<tr>
<td>Conclusion</td>
<td>164</td>
</tr>
<tr>
<td>CHAPTER TEN: DISCUSSION</td>
<td>166</td>
</tr>
<tr>
<td>Conditional citizenship</td>
<td>166</td>
</tr>
<tr>
<td>The bio-medical model</td>
<td>168</td>
</tr>
<tr>
<td>Being Othered</td>
<td>171</td>
</tr>
<tr>
<td>Being trustworthy</td>
<td>172</td>
</tr>
<tr>
<td>Being competent</td>
<td>174</td>
</tr>
<tr>
<td>The journey to becoming an insider</td>
<td>178</td>
</tr>
<tr>
<td>Shaping of behaviour</td>
<td>178</td>
</tr>
<tr>
<td>Practices of inclusion</td>
<td>179</td>
</tr>
</tbody>
</table>
CHAPTER ONE: INTRODUCTION

Citizenship is a legal status that carries the distinct advantages of rights, liberty, protection and the ability to participate in the democratic processes of the state (Isin, 2002). Historically, these rights and responsibilities were limited to the citizens who lived within the city walls. Those who did not meet the criteria to be citizens, such as, slaves and the freedmen of the Greek polis\(^1\), or the serfs of the Roman empire, were regarded as non-citizens, and excluded from the city (Hindess, 2004; Isin, 2002).

Modern nation states continue to exclude people from the status of citizenship. Asylum seekers and refugees, for example, have to meet certain conditions before they are able to claim this status. Equally, other minority groups who are de jure citizens do not feel that they are treated as full citizens by society, or indeed able to exercise the same rights and responsibilities as other members of society. A number of minority groups, including people with physical and intellectual disabilities (Marks, 2001; Meekosha & Dowse, 1997; Walmsley, 1993, 2000) and lesbians and gays\(^2\) (Cooper, 2006; Isin & Wood, 1999; McGhee, 2004; D. Richardson, 1998, 2000; Seidman, 2002) have made legitimate claims for their full rights and entitlements. Increasingly, people who have been diagnosed as mentally ill\(^3\) (Barnes & Bowl, 2001; Barnes & Shardlow, 1997; Sayce, 2000) have expressed concerns that they do not feel that they are treated as full citizens, and have argued for recognition as fully participating members of society with the “same rights and opportunities as other citizens” (Mental Health Commission, 2004b, p. 8).

\(^1\) Polis is defined here as the city, a city-state and also a body of citizens.

\(^2\) Semp (2011) uses the term *queer* to denote same-sex attracted people in the broadest sense, and to signify that many do not identify with the common terms of lesbian, gay, bisexual, taka’tapui (Māori term for a devoted partner of the same sex) and fa’afafine (Samoan males who have a strong female gender orientation). In this study I will use the terms lesbians and gays to denote same-sex groups, as the literature on citizenship reports primarily on these two identities.

\(^3\) There are a variety of terms used to describe the phenomenon of mental disorder such as mental illness, insanity or madness. These terms are contested constructs (Barnes & Bowl, 2001; Perring, 2009) and can vary in meaning depending on the context and the moral, legal and social judgements within which these terms are constructed. The majority of the participants in this study used the term mental illness, and therefore this term will be used throughout the thesis.
The aim of the study is to explore the understanding and meaning of citizenship for mental health service users and whether the recovery approach helps or hinders their journey towards full citizenship. The study was conducted within New Zealand. Qualitative research methods were used for the study. Data were gathered using individual interviews with service users, public servants and a focus group with mental health nurses. Data were also generated from a variety of other sources, for example service users’ narratives (Lapsley, Nikora, & Black, 2002) publicly available strategic health documents and other reports (Mental Health Commission, 1998, 2001).

This is the first research study to explore the understanding and meaning of citizenship for service users. My interest in this topic stems from my many years of supporting service users on their journeys of recovery within my clinical practice. I have also been involved in co-facilitating workshops on the recovery competencies (Mental Health Commission, 2001) for mental health workers in collaboration with an experience-based expert. Over the decade of teaching recovery competencies, I recognised an increasing concern within the service user movement that the term recovery had been co-opted by mental health professionals. Their main concern was that the recovery philosophy had become a model, something that one does to service users, rather than the professional’s responsibility to provide an environment within which service users could flourish and regain their place within society. As the term citizenship began to emerge within service user discourses, it appeared that this was being used to highlight their goal to be autonomous and participating members of society; the exact principles ideally embedded within the recovery approach. A review of the citizenship literature revealed that there were no empirical studies that focused specifically on service users’ understanding of citizenship, hence the opportunity to explore this area. The increasing use of citizenship discourses within the current government and service user literature led to this research study.

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4 There is an on-going debate about the best term to use when referring to people living with mental illness. The terms mental health consumer, service user, psychiatric survivor and, in New Zealand, tangata whaiora (person seeking wellness) are used interchangeably. I have chosen to use service user as the majority of the participants used this term.

5 Data collection and profile of the participants interviewed will be discussed in more detail in chapter five.

6 The nomenclature experienced-based expert (EBE) denotes a person who is using their experience of mental illness to raise awareness of the impact of the illness on a person’s life. The roles of the EBE can be found in many settings, commonly in the education field (Schneebeli, O’Brien, Lampshire, & Hamer, 2010) and peer support roles.
Chapter one presents the research focus for this study. It provides a brief overview of the analytical framework used to interpret the data and the research methods. An outline of the structure of the thesis concludes the chapter.

**Research focus**

O’Grady (2005) argued that transparency about the author, or in this case, the researcher’s motivation informing their topic of exploration, helps to avoid any assumptions of neutrality or impartiality. As a lesbian, I have experienced stigma, discrimination and the fear of rejection from other members of society as someone outside of the norm (Kristeva, 1991; Krummer-Nrvo, 2002; Krummer-Nrvo & Benjamin, 2010; Lister, 2004). Even so, I continue to enjoy the many benefits of citizenship that living in the democratic state of New Zealand provides. For this I have to thank the lesbian and gay movement which, in the latter half of the past century fought for the right to no longer be labelled as mentally ill, and progressively claimed the majority of rights and responsibilities as other members of society. Because of this experience I hope to walk alongside the service user-participants in this study and give voice to their lived experience of being stigmatised and marginalised.

**Research questions and aims**

The aim of this research was to explore what citizenship meant to mental health service users. The overarching question for the participants in this study was “What is your understanding of citizenship”? Supplementary questions such as “What does citizenship mean to you, and to other service users that you have represented?” and “What contribution have nurses made on your journey towards citizenship?” were also asked in order to provide a more in depth understanding (see interview questions in appendix three).

The thesis will make an important contribution on two levels. Firstly, it contributes to the professional literature by offering a socio-political analysis that provides an alternative way of understanding service users’ experiences of their social worlds. Secondly, the thesis provides a fuller understanding of the experiences of citizenship for service users, thereby, contributing to current debates about citizenship.

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7 The professional literature refers to research studies, theory and clinical practice publications for a range of health professionals of all disciplines.
Philosophical approach to the study

This study takes a critical constructivist approach (Ackermann, 2004; Charmaz, 2000; Kincheloe, 1991), meaning that it is concerned with the way participants construct their world, and how the social, political and historical context influences their ways of knowing. This approach, combined with current socio-political perspectives on mental illness, provides a way of understanding why service users continue to feel that they are not fully participating members of society at a time when they are lobbying for full citizenship status (Mental Health Commission, 2004b).

This thesis borrows concepts from the disciplines of sociology and political science. Isin and his colleagues (Isin, 1999, 2002, 2008c; Isin & Nielsen, 2008b; Isin & Wood, 1999) have developed a theoretical approach to citizenship that goes beyond traditional approaches and captures the issues of social justice, exclusion and the right to full citizenship for marginalized groups. Isin’s (1999, 2002, 2008b) conceptual framework is used to analyse and interpret the data generated from interviews with the participants in this study.

Research method

This study takes a qualitative approach, and Isin’s (1999, 2002, 2008b) conceptual framework was used to analyse the data. Data were collected through individual interviews, a focus group, the reading of service users’ narratives and government documents relevant to the research question. Seventeen service user advisors were recruited and interviewed. All had current or past roles as service user representatives and peer support workers. Five public servants were also interviewed. The focus group consisted of seven mental health nurses currently practising in mental health settings. Analysis of the data was undertaken using the framework approach developed by social policy researchers Ritchie and Spencer (1994).

Structure of the thesis

Following this introductory chapter, chapter two explores the background to the study. Chapter three examines the theoretical and professional literature, with the aim of reviewing the current thinking about citizenship, its relevance to service users and their claims for full citizenship. Chapter four presents the theory of citizenship and sets the scene for the use of the framework approach to interpret the data.

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8 Discussed in more detail in chapter four.
Chapter five discusses the research strategies used to collect and analyse the data and outlines the methodological and ethical issues experienced while conducting this research. Chapters six, seven, eight and nine present the research findings from the study. Chapter six is focused on the extent to which the participants feel excluded or included, and the actions they have taken to re-claim their right to be included as full citizens. Chapter seven focuses on the rights and responsibilities of being a citizen. Chapter eight focuses on the sense of belonging and connection where it is shown that service users’ sense of belonging is determined by the thickness or thinness of the social relationships they have with their co-citizens. Based on the emerging theory of acts of citizenship, chapter nine reports the acts that the participants have undertaken to make a claim for their right to be treated as full citizens (Isin & Nielsen, 2008b).

Chapters ten and eleven conclude the thesis. Chapter ten draws the findings of the study together, discussing them in light of current literature and the research question for the study. The contribution of this study to existing research in this area is also highlighted. The chapter also considers the theoretical and practical significance of the research. Chapter eleven concludes the thesis and makes recommendations for future research in the area of service users’ journeys to citizenship.
CHAPTER TWO: BACKGROUND

This chapter provides the context in which the research was undertaken. It does this using the following headings: the political, civil and social contexts.

Political context

Historical aspects

Citizenship in New Zealand has been shaped by the colonization of Māori and the country, and the state’s founding document, the Treaty of Waitangi\(^9\) (Treaty). Māori have been recognized as tangata whenua (n.d.), the indigenous people of Aotearoa/New Zealand (2000). The Treaty is a unique constitutional document enshrining the guiding principles of protection, participation, partnership and tino rangitiratanga or self-determination of Māori alongside non-Māori or Pākehā.

New Zealand society has also been shaped by western liberalism (Cameron, 2000), which brought an emphasis on the protection of a person’s autonomy in their social and political affairs. As first citizens (2002) Māori were accorded the status of British subjects, however, the liberalist focus of the state led to a somewhat ambiguous and semi-autonomous self-governance, where full citizenship was based narrowly on being male and having ownership of property. This political arrangement ran counter to the communal view that traditional Māori held of whanaungatanga\(^10\) and usufruct\(^11\) (n.d.).

Pearson (2002) has also suggested that the Marshallian model of citizenship (Marshall, 1950) did not fully account for the politics and practices of indigenous peoples, creating a tension

\(^9\) The Treaty of Waitangi, signed in 1840, is New Zealand's founding document. The Treaty is a broad statement of principles on which the British and Māori made a political contract to found a nation-state and build a government in New Zealand. The Treaty has three articles: that Māori cede the sovereignty of New Zealand to Britain; Māori give the Crown an exclusive right to buy lands they wished to sell, and, in return, Māori were guaranteed full rights of ownership of their lands, forests, fisheries and other possessions; and Māori would have the rights and privileges of British subjects.

\(^10\) Māori word meaning relationship, kinship, sense of family connection, a relationship through shared experiences and working together which provides people with a sense of belonging. It develops as a result of kinship rights and obligations, which also serve to strengthen each member of the kin group. It also extends to others to whom one develops a close familial, friendship or reciprocal relationship.

\(^11\) The legal right to use and enjoy the fruits or the profits of something belonging to another.
between collective versus liberal understandings of rights. Turner (2001a) has argued that the white settler societies have failed in their policies of assimilation and/or multiculturalism, resulting in the social deprivation of aboriginal communities. Although Turner has stated that New Zealand is the exception, given that the Treaty represents a constitutional framework, he questions whether aboriginal people can or should “be treated as citizens of the nation-state, or whether their political aspirations are better served by other legal means and political structures” (p. 206). As Humpage (2006, 2008) has argued, the majority of Māori are still unable to realize their constitutional claims and continue to experience second class citizenship with regard to health, education and political participation.

In 1948, the British Nationality and New Zealand Citizenship Act (British Nationality and New Zealand Citizenship Act) was passed into law. This meant that all residents by birth, and those from other Commonwealth countries, became New Zealand citizens simply by registering on arrival in the country. New Zealand citizens were still British subjects, until the Citizenship Act (Citizenship Act) removed the nomenclature from the New Zealand passport.

The development of health services in New Zealand has also influenced the citizenship status of service users. The Lunatics Ordinance 1846 made a condition for lunatics to be held indefinitely within an asylum or prison. In recognition of the place of families in the care of lunatics, there was a provision made for those certified to be placed in the care of a relative or friend. According to Parr (2008), twentieth century institutional care continued to restrict the individual’s freedom and liberty, although there was a benign approach to therapy, such as industrial work or horticultural activities. These activities, which Parr (2007) termed a type of social citizenship, were a form of domestication and preparation to serve the state, for example, in times of war. Parr contended that the promise of a return to society remained unfulfilled for the majority of service users, who continued to be denied their basic human right of liberty and citizenship as a result of their “spatial and medical categorisation” (p. 557).

Mental health reforms
In New Zealand, several inquiries into the deaths and maltreatment of those incarcerated in the psychiatric institutions (Mason, 1988) led to the Mason Inquiry and subsequent report (Mason, Johnston, & Crowe, 1996). As a result, radical changes to service delivery heralded
a stronger consumer voice, and the establishment of the Mental Health Commission. The Commission’s primary role was to monitor the implementation of the recommendations from the Mason report, and to establish service direction from the Commission’s first publication *The Blueprint for Mental Health Services in New Zealand: How Things Need to Be (The Blueprint)* (Mental Health Commission, 1998). The Blueprint signalled the era of recovery, concerns about the impact of stigma and discrimination, and highlighted the mental health workers’ responsibility to recognize that people with mental illness have the same rights and responsibilities as other citizens.

In tandem, the strategic document *Moving Forward* (Ministry of Health, 1997) presented the Government’s major priority for improving outcomes for the three percent of adults and five percent of children and young people with severe mental disorder. Despite a change of government, a commitment was made to continue to implement the goals of *The New Zealand Health Strategy* (Ministry of Health, 2000) to improve things for people with mental health problems, such as full access to education and housing, and to reduce stigma and discrimination. The new Labour-led Government made a commitment to continue to implement the goals of the Blueprint, to place a greater focus on recovery, and improve coordination between the health sector and other social service sectors to ensure that service users would be treated fairly, and with respect and dignity.

Following publication of the Blueprint, Mary O’Hagan, one of three Mental Health Commissioners, authored the *Recovery Competencies for Mental Health Workers in New Zealand* (Mental Health Commission, 2001). This document focused on the right to full citizenship for service users. A subsequent publication by the Commission on service user participation (Mental Health Commission, 2002) highlighted the term citizenship, and the recognition by the Commission that service users should have the same rights and be treated the same as other citizens.

2014 stated that service users want to be “fully participating members, with the same rights and opportunities as other citizens” (p. 8).

Civil context

*Human rights*


More recently, human rights for service users have been enshrined within the Convention on the Rights of People with Disabilities (United Nations High Commissioner for Human Rights, 2006). The document defines persons with disabilities as those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others. The Convention’s purpose is to:

Promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity (Article 1).

The ideal of people enjoying equal civil and political freedom can only be achieved if the conditions that support such rights have been created within the state. However, the legal status of these instruments varies between countries (Bell, 2003). The declarations, principles, guidelines, standard rules and recommendations have no binding legal effect, but have a moral force and provide practical guidance to states, in their conduct, statutes and protocols (The International Council on Human Rights Policy, 2006).

Universal human rights apply to a citizen regardless of whether their place of residence is in other nation states. According to Gledhill (2008), though human rights do not have a binding legal effect, New Zealand’s judicial system is obligated to construe domestic legislation
consistently with the human rights and freedoms enshrined in the New Zealand Bill of Rights (1990). Citizenship rights, however, are a specific interpretation and concretisation of the more abstract and universal human rights (Lister, 2004), and make a moral and ethical claim on the duty of other citizens to realise these rights for the marginalised (Isin & Wood, 1999; Lister, 2004).

Ranciere (2004) argued that when citizens are subjected to repression, or similar conditions of existence then their human rights can appear diminished or “empty” (p. 307). People with disabilities have experienced diminished human rights (Marks, 2001; Walmsley, 1991). Marks (2001, p. 169) contended that people with disabilities have “de facto” citizenship because their claims to civil, political and social rights are stalled by barriers such as stigma and discrimination, and professional gate-keeping of resources by those in authority. It appears, therefore, that service users may not always be regarded as de jure citizens with full rights. This is apparent in the way that service users are reported to be the most disadvantaged members of society (Diesfeld et al., 2008; Human Rights Commission, 2004). For example, violations of their rights constitute 24 percent of complaints to the Human Rights Commission (2004), largely as a result of the structural and institutional barriers associated with having a mental illness.

Operating at the macro-level is an increasing focus on risk within the territorial borders of nation states (Beck, 1999; Isin, 2004; Nyers, 2008b; N. Rose, 2005). This is reinforced at the micro-level by media representations of the mentally ill that continue the myth of dangerousness (McKenna, Thom, & Simpson, 2007). Consequently mental health services have become risk-averse environments, and the care of the mentally ill has become dominated by risk-management often at the expense of the therapeutic relationship (Hazelton, 1997b, 1999; N. Rose, 1998; Sawyer, 2005). Risk management has increased the legal control of service users through the use of the Mental Health Compulsory Assessment and Treatment Act (the Mental Health Act) (Mental Health (Compulsory Assessment and Treatment) Act, 1992).

The Mental Health Act
The Act mandates the detention and compulsory treatment of the mentally ill in hospital or in the community. As Bell (2003) stated, the Act and its subsequent amendments were designed
to give force to notions of rights contained in various international covenants, rather than the paternalistic approach of the previous 1969 Act. The 1992 Act promoted patient (sic) autonomy and the concept of the least restrictive intervention. The 1992 Act’s definition of mental disorder eschewed diagnostic labels, instead focusing on danger to self and others, and one’s capacity for self-care (Bell, 2003). The Act obliges the state and its agents to provide health and social services to its citizens, as well as making a broad range of treatment options available. Legal safeguards are also in place such as access to Section 16, the district inspector, the mental health review tribunal and the role of the duly authorised officer.

Bell (2003) and Winick (2003) argued that the law governing the care of the mentally ill contains two principal powers. Firstly, police powers to protect society from those who are dangerous and, secondly, parens patriae or the powers to protect the best interests of citizens whose illness deprives them of the ability to make rational decisions. O’Brien argued that the Act imposes a sort of “legal patient-hood” (A. O’Brien, personal communication, 6 June, 2011) or a status of less-than-full citizenship, but without the array of rights (Health and Disability Commission, 1996) that would normally be accorded to patients in most (but not all) health contexts.

Perlin (2003a) described certain universalities that mould mental health law, these are the importance of personal autonomy and the balance between medical, psycho-social-

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12 The Mental Health Act (Mental Health (Compulsory Assessment and Treatment) Act, 1992) defines Mental Disorder as “an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it: (a) Poses a serious danger to the health or safety of that person or of others; or (b) Seriously diminishes the capacity of that person to take care of himself or herself”.

13 Section 16 is a review of the patient’s condition by the Judge. The Judge must take into account the proposed course of assessment and treatment, and the patient's views on these matters, and consult with the responsible clinician concerning the patient's condition. If the Judge is satisfied that the patient is fit to be released from compulsory status, the Judge shall order that the patient be released from that status forthwith (Mental Health (Compulsory Assessment and Treatment) Act, 1992).

14 Section 76 requires a patient to attend a clinical review. The district inspector must communicate with the patient to find out whether the patient wants an application to be made to the Review Tribunal for a review of their condition.

15 The principal function of a Review Tribunal is to consider whether the person is fit to be released or not released from a compulsory treatment order, see Brookbanks (2006) for further discussion and critique of the review tribunal.

16 The duly authorised officers are specialist mental health professionals (the majority are mental health nurses). The role is to provide expert information and advice on the mental health needs and services that may be required by people who are experiencing mental health difficulties and, where appropriate, to facilitate the assessment of a person or proposed patient (sic) (Ministry of Health, 2003).

17 The state, acting as parens patriae (n.d.) can make decisions regarding mental health treatment on behalf of one who is mentally incompetent to make the decision on their own behalf, but the extent of the state's intrusion is limited to reasonable and necessary treatment.

18 For example, tuberculosis is a notifiable disease; it is highly contagious and can be lethal. Treatment may take many months or years to complete. Some people with tuberculous refuse to accept treatment, therefore they can be detained by a physician to undertake enforced treatment. This happens on rare occasions, as most people have the opportunity to discuss the risk and shared responsibility is negotiated between patient and the system. This is less coercive.
behavioural models and the legal system. While the intent and wording of the Act reflects commitment to rights, this commitment may not be realised if the practice of the law is prejudicial or lawyers do not advocate for the rights of their client, or that their perspective be put forward fully. Following the seminal work by Birnbaum (1960), Perlin (2000a, p. 684) contended that “sanism”, which he described as “irrational prejudice of the same quality and character as other prejudices, such as racism, sexism, homophobia and ethnic bigotry” continues to permeate mental health law. According to Perlin, sanist lawyers trivialise their clients’ problems and question their competence and credibility, impairing the lawyers’ advocacy efforts. Pre-textuality (Perlin, 2000b) also contributes to sanist assumptions in that lawyers’ myths, stereotypes and biased views of the mentally ill perpetuate the acceptance of psychiatric evidence that can be regarded as intellectually dishonest.

If the rights of service users are to be curtailed, then the principle of reciprocity means there must also be benefit for them. Reciprocity is the justification for the curtailment of a person’s freedom. The principle of reciprocity (Hatfield & Antcliff, 2001; G. Richardson, 2003), is concerned with the balance of the state’s restriction on the liberty or autonomy of the citizen, and in return, its responsibility to provide an adequate treatment system. The notion of therapeutic jurisprudence (Winick, 2003) suggests that the law can be a therapeutic agent by advocating and reducing the curtailment of the civil liberty of the mentally ill when assessing a person for compulsory treatment. However, given these legal precepts, the Act continues to have a profound influence on the liberty and rights of service users as autonomous citizens, and is a form of civil commitment in the absence of any crime (Winick, 2003).

Service users appear to regularly have their competence to be the bearer of rights, and their autonomy as citizens consistently questioned. Winick (2003) suggested that better therapeutic and non-coercive access to treatment under a voluntary system should be explored, and this assertion is echoed in the work of Pilgrim (2005) and Pilgrim and Rogers (2005a). The relationship between the Act, and the era of recovery with its inherent principle of autonomy, continues to be in conflict, and the use of the law prolongs the many interruptions in the life of service users and their ability to participate in society.

*The impact of the Act on service users*

Stevens (2003) gave a compelling account of her experience of involuntary containment and treatment. She suggested that psychiatry understood mental disorder as a disease of the brain
(Bracken & Thomas, 2001; A. Morgan, 2008) and completely separate from the human being. Her initial and subsequent involuntary treatment in the hospital, therefore, was more about suppressing her distress, by heavily medicating her, rather than bringing relief and calm to the turmoil she was experiencing at that time. Decisions about involuntary treatment led to irreparable breakdowns in her family relationships.

Stevens (2003) also described how the longer term effects of being subject to involuntary treatment dehumanised her as a statistic. She now had the label and stigma of psychiatric patient, and as she was removed from society she could no longer participate as she had no place within it. Stevens explained that people who are detained by law in a psychiatric hospital have very few rights\(^{19}\). One cannot, for example, claim the right to refuse or change one’s mind about the treatment on offer (Health and Disability Commission, 1996).

Service users who are detained under the Act lose the right to vote\(^{20}\) or enter into legal contracts. Stevens explained that when compulsorily detained it is hard for service users to assert their rights, and thus they need the advocacy of others, for example, mental health nurses. More recently, the Mental Health Commission (n.d.) has promoted the option of advance directives. Advance directives are usually completed by people who have long-term conditions and set out their treatment preferences during an episode of illness when they are unable to decide or communicate these at that time. Advance directives, in part, protect the service user’s right to choice of treatment, however, as the Commission states, there is no law that specifically allows advance directives, and they can be overridden if the person is subject to the Mental Health (Compulsory Assessment and Treatment) Act (1992).

Compulsion and coercion through the use of the law represents an intrusion on the rights and liberties of an individual (Barnes & Bowl, 2001; Barnes, Bowl, & Fisher, 1990; Bell, 2003; Sayce, 2000). It is a form of social control and regulation of the lifestyle of citizens (Bartlett, 2003; Bell, 2003). Hatfield and Antcliff (2001) contended that if governments promoted social policies that attend to economic inequalities and social exclusion of service users,

\(^{19}\) See Mackenzie and Shirlaw (2002).

\(^{20}\) Section 80: (c) of the NZ Electoral Act (Electoral Act, 1993) disqualifies the following persons from voting: A person who is detained in a hospital under the Mental Health (Compulsory Assessment and Treatment) Act 1992 or in a secure facility under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.
rather than containing risk and rationing resources for mental health care, they may reduce the need for compulsory treatment.

Social context

Mental illness and mental health
The European Commission\(^{21}\) (2005) has made a clear statement on the importance of mental health for the individual and society to flourish:

> For citizens, mental health is a resource which enables them to realise their intellectual and emotional potential, and to find and fulfill their roles in social, school and working life. For societies, good mental health of citizens contributes to prosperity, solidarity and social justice. In contrast, mental ill health imposes manifold costs, losses and burdens on citizens, and societal systems (p. 4).

At a macro level optimal mental health is of social, public health and economic importance. The World Health Organization (2001, p. 6) has cited the economic consequences of mental ill-health on lost productivity and the cost of treatment for those affected. Further, the World Health Organization has reported that four of the ten leading causes of disability worldwide are neuropsychiatric disorders which account for 30.8% of total disability and 12.3% of the total burden of disease, and this latter figure is expected to rise to 15% by the year 2020.

Johnstone (2001) has contended that members of society have a moral responsibility to come to the aid of those who have been diagnosed with a mental illness and to safeguard their rights, promote social justice and subvert the stigma of difference. However, there is a misunderstanding by many in society about the experience of mental illness. Mental illness is dynamic and episodic, and is experienced as a state of flux in response to both internal and external factors. Mental distress is derived not only from biological roots, but also from early traumatic experiences and the direct effects of mental health care in environments that perpetuate neglect, invalidation and abuse (Briere & Zaidi, 1989; Brown & Anderson, 1991; Deegan, 1990; Randal et al., 2009).

Many service users have reported that they can be both “ill and well” (Borg & Kristiansen, 2004, p. 496). The phenomenon of mental illness therefore, can be viewed as a fluidity of experience, rather than a fixed or irreversible state of ill-health. Fluidity of mental illness can

\(^{21}\) The European Commission is the executive body of the European Union, representing the 27 member states.
blur the boundaries between a person’s inner life of creativity, desire and passion and the despair and anguish of mental distress they may be experiencing.

*The bio-medical model*

The notion of biological roots of mental illness and the bio-medical approach to treatment have been contested (Hopton, 2006; Hughes, 2009; Read & Harré, 2001; Rogers & Pilgrim, 2003; Thomas, Bracken, Cutler, May, & Yasmeen, 2005). Shah and Mountain (2007) argued that the biological component is an essential part of the broader bio-psycho-social approach to psychiatric illnesses. Shah and Mountain rigorously challenged those who regard the psychiatrist as a “unidimensional pharmacologist” (p. 376), with a narrow focus of treatment limited to prescribing psychiatric medication. In contrast, users of services have strongly argued that the bio-medical approach is underpinned by psychiatric orthodoxy which has traditionally emphasised “professional boundaries, scientific objectivity, technological solutions to emotional problems, treatments with quick ‘results’, standardisation of diagnosis and treatments... [and] central [to the] role of medically trained psychiatrists” (Beresford & Wallcraft, 1997, p. 80).

Other critics (Habibis, 2005; Hazelton & Clinton, 2001; Henderson, 2008) have argued that the dominant approach to service delivery views the person and their distress through the lens of the bio-medical model, an ideology that ascribes the genesis of mental illness to a predominantly neurobiological cause (Bracken & Thomas, 2001; Read, Mosher, & Bentall, 2004). Biological dominance can overlook fundamental factors and structural inequalities such as gender, socio-economic status, cultural and religious differences, stigma and discrimination (Mortensen, 2008; O’Grady, 2005; Ussher, 2000). Further, biological dominance, though not intentionally, can exclude the meaning that each person ascribes to their unique experience (Crowe, 2006). This is of particular concern in the New Zealand context where there are specific cultural approaches to mental health care incorporated into the assessment, appropriate diagnosis and planning of care to assist in the healing required for tangata whaiora and service users from Pacific nations.

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22 Te Whare Tapa Wha (Durie, 1994) is one model of Māori health, based on the strong foundations of the symbol of the wharenui, or meeting house, illustrating the four dimensions of Māori well-being. The Fonofale model (Pulotu-Endemann, 2009) incorporates the metaphor of a Samoan house with the foundation or the floor, three posts and roof encapsulating the philosophy of holism and continuity.
A broader view of the healthy and the unhealthy body and mind is essential (Crawford, 1994). According to Crawford, health and illness are constructed sociologically and illness and/or disease are tainted with the Otherness\(^{24}\) of the mentally unhealthy. The frightening portrayals within the media of people with a mental illness have become a “natural alibi” (Crawford, 1994, p. 1361) to strengthen the defences by some in society against those with dangerous identities who, they perceive, do not possess personal discipline and therefore pose a threat to the “steadiness” of life.

Through many years of clinical practice, I have taken the position that the experience of mental illness is not solely rooted in biology, rather, a larger part of the psychological distress is a response to the person’s vulnerability (Randal et al., 2009). The bio-medical model is underpinned by an implicit assumption that mental illness is a permanent impairment that may require treatment over a lifetime, and that service users can be perceived as personally flawed, dangerous, a risk to others or at least different from the rest of the general population (Beresford & Wilson, 2002; Hazelton, 1999). This appears to still be the case in the post-deinstitutionalisation era.

**De-institutionalisation**

Institutionalisation was the era of containment and control of those with dangerous identities, with many of the large hospitals being described as worse than prisons or concentration camps (Goffman, 1961). Weinstein (1994) argued that Goffman’s (1961) work was repeatedly drawn on during the 1960s and 1970s by the critics of mental hospitals. Such criticism gave momentum to the deinstitutionalisation movement because of the violations of human rights and the anti-therapeutic consequences of hospital treatment. According to Weinstein, the negative effects of labelling had a detrimental impact on service users’ sense of self-worth, and the loss or curtailment of their legal rights.

\(^{24}\) Isin (2002) uses a lower case ‘o’ in other in his essay on citizenship. In his 2008 work on acts of citizenship, he uses the upper case ‘O’, specifically with reference to the work of Bakhtin (1993). Lister (2004, p. 101) has offered the distinction between other with a lower case ‘o’ and a capitalised ‘O’. The capital ‘O’ denotes its symbolic weight and that Othering is not a static state, but an on-going process perpetuated by the way the dominant group in society treat those perceived as different, creating the demarcation between “us” and “them”. As Lister’s distinction resonates with the experiences of the participants in this study, I have chosen to use Other throughout the thesis.
The period of de-institutionalisation and closure of the large psychiatric hospitals in New Zealand occurred during significant change in the political landscape. There was a move away from the welfare state to neo-liberalism. Henderson (2005) examined the key documents from the Australian National Mental Health Strategy (Australian Health Ministers, 1992b) to explore the extent that they reflect neo-liberal ideals. She found that neo-liberalism has framed health policy in three important aspects: (1) the role of economics and the market informing governance, (2) the diminishing role of the state in the provision of health and welfare services and (3) a growing reliance upon self-responsibility for one’s health and well-being. The essence of neo-liberal government is, therefore, self-governance (M. Dean, 1999; N. Rose, 1993) encouraging the individual to make socially responsible decisions and undertake activities to maintain and care for themselves.

Hazelton (1997a) has argued that in the post-institutional era the political discourse of the state has rendered some service users as passive citizens who are vulnerable and in need of protection, and reflected in the legally mandated restrictions that curtail service users’ liberty and rights. Concerns about vulnerability and passivity have perpetuated a paternalistic approach to care within the community. Paternalism has resulted in a maintenance paradigm of care, increasing service users’ dependence on services, increasing the frequency of crises, and introducing the notion of the revolving door of frequent hospital admissions. In response, the service user movement in New Zealand began to lobby for changes, heralding the recovery approach.

The recovery approach

The Blueprint defined recovery as the ability to live well in the presence or absence of one’s mental illness. This definition was purposefully a broad one as the experience of recovery is different for everyone. Service users have also argued that recovery has, at its heart, the belief that all people have the potential to have a life worth living. Deegan (1988) and Anthony (1993) have been influential commentators on recovery, suggesting that there are many personal definitions and accounts of recovery journeys. Some shared concepts include: the capacity to have hope; development of new purpose and meaning; and living with the reality that you can be “ill and well” at the same time (Borg & Kristiansen, 2004, p. 496).
The recovery competencies\textsuperscript{25} (Mental Health Commission, 2001) are an essential part of the delivery of mental health services within this country. Central to recovery are the precepts of hope, self-determination, personal responsibility, personal agency, social connectedness and relationships, self-advocacy, education, a broader range of treatment options and the equality of service users in the health services, and in society (Mental Health Commission, 2001; O'Hagan, 2010; Onken, Craig, Ridgway, Ralph, & Cook, 2007).

Davidson (2008) proposed that the focus on recovery and social inclusion has overlooked or minimized the impact of oppression, and that the recovery movement emerged as a response to precisely these forces. One of the core assumptions held by some mental health professionals is that serious mental illnesses are associated with risk and that the person is required to be rid of their mental illness prior to being in recovery. Davidson asserted that it is “precisely when the illness will not go away that people most need to exercise their right to full citizenship and inclusion in community life” (p. 305). As more and more service users recovered and developed their lives beyond the illness, there was a growing realisation that the illness was not degenerative or unremitting, suggesting that the chronic nature of the perceived illness was the legacy of social stigma, rather than the effects of the mental illness \textit{per se} (Schep-Hughes & Lovell, 1986).

Recovery means moving from the sole identity as a mental patient to that of citizen. Perkins (2011) contended that a recovery environment supports service users to be experts in their own self-care. Mental health professionals are no longer the only experts with total control; rather, service users are making decisions and accessing their opportunities. Perkins asserted that the notion of recovery supersedes the jargon of participation and social inclusion to mean doing what other citizens do. As citizens, service users are no longer marginalised and have the same opportunities and rights as other members of society. Perkins used Churchill’s famous phrase “on tap, but not on top” (Churchill, 1964) p. 127 to portray how mental health professionals should perceive their role. Likewise, as one respondent reported “if we have

\textsuperscript{25} There are ten competencies for the mental health worker: to have an understanding of recovery within the bi-cultural context of New Zealand; to recognise and support the personal resourcefulness of service users; to understand and accommodate the diverse views on mental illness, treatments, services and recovery; to have the skills to develop good relationships with service users; to understand and know how to reduce discrimination and social exclusion; to acknowledge the different cultures in New Zealand; to have comprehensive knowledge of community services and resources; to have knowledge of the service user movement and support their participation in services; and to have knowledge of family/whanau perspectives (Mental Health Commission, 2001).
mental health professionals on our side, understanding what the inequalities are and how they affect us, this will strengthen our demands to be truly equal as citizens” (British Psychological Society, 2008, p. 12).

Perkins (2011) further asserted that mental health nurses need to become coaches to service users by moving away from the dominance of a problem-based therapy approach to one that increases each person’s resourcefulness. In summary, when mental health professionals use the recovery approach they will demonstrate the following to service users. Demonstrate their hope in the service users ability to recover; listen to service users and treat them with respect; involve service users in decisions about treatment and care; and support service users to manage their own mental health problems (Mental Health Commission, Fact Sheet, 2011).

The introduction of the recovery approach was an attempt to address the realisation of full citizenship for service users, yet there are few evaluation studies on the outcomes of the recovery approach (Dornan, Dumont, Onken, Ralph, & Ridgway, 2002; Onken et al., 2007), and very little discussion of how the recovery paradigm can help or hinder the service user’s journey towards full citizenship. There is growing interest in the next phase of the recovery approach, with some commentators advocating for the adoption of the principles embedded in the social model of disability (Beresford, 2002, 2005). A social model of madness promises service users the benefits of greater inclusion and participation in the body of citizenship, providing that mental health professionals also understand and support this change in paradigm (Dickerson, 2006; Perkins, 2011).

**Conclusion**

This chapter has presented the background to the study and the political, civil and social contexts that have shaped service users’ experiences of citizenship in New Zealand. The significant changes to mental health service delivery, treatments and the legal aspects that impinge on service users’ human rights and citizenship rights have also been discussed. The future direction of mental health care has been briefly highlighted, including the importance that service users have placed on the implementation of the recovery approach as a means of realising their full citizenship status. It appears, however, that current mental health services have not implemented practices that fully support service users’ full citizenship, hence the importance of this study.
CHAPTER THREE: LITERATURE REVIEW

This chapter reviews the current literature on the topic of citizenship. The initial literature search on the topic had two main objectives: to establish the scope of the scholarship within the citizenship literature, and to assist in the development of a theoretical framework or methodology to support my research. A literature search was conducted using the following data bases: Psychinfo, Medline, CINAHL, ERIC, Social Work Abstracts, AB Inform, ProQuest, International Political Science Abstract, Hein Online, ProQuest Dissertations and Theses, Google Scholar and Scopus. The following key terms and words were used: citizenship, citizen, mental illness, rights, responsibilities, psychiatric patient, psychiatric disability, mental disorders, psychiatric nursing, inclusion and belonging. Specific journals, for example Citizenship Studies, were also searched. The search had an extended time frame as many of the seminal authors were retrieved from the 1950s to the current date. Reading of the literature helped to develop and refine my topic, and as the study progressed, the search vocabulary was updated. For example, Othering was added as a search term in order to broaden my knowledge of the field. An electronic alert system was set up to keep abreast of the emerging literature.

Lister (2007) contended that there is an avalanche of articles and books on the topic of citizenship, and the initial search yielded a broad number of publications on the general topic of citizenship. Of significance were the few empirical studies that were retrieved, none of which to date related specifically to mental health service users and their understandings of citizenship. A lack of scholarly work in this area justified the importance of my research topic.

A critical review of the literature revealed journeys towards full citizenship by other marginalised groups, which had some parallels for service users. These parallel journeys are used as a framework to illuminate similar struggles that service users have encountered on their journey towards recognition and acceptance as full citizens. This chapter explores the following main areas: the history and general concepts of citizenship; the empirical studies on the general understandings of citizenship; the parallels between mental health service users and other minorities including ethnic groups, lesbians and gays and people with physical and
intellectual disability. Literature pertaining to mental health reforms will also be reviewed. The chapter concludes with a review of the literature on stigma and discrimination and the politics of inclusion and exclusion. The available empirical or theoretical literature relevant to each section is presented, highlighting the main questions that were addressed by the authors, the issues and debates on citizenship and the resulting gaps in knowledge that emerged from the findings.

**A brief history of citizenship**

Hartley (2010) explained that the term citizenship was first recorded in England in 1611, translated from the French word *citoyen* (citizen). Isin (2002) described citizenship as an association amongst citizens, strangers, outsiders and aliens. Other scholars have argued that citizenship is a status and a practice (Kymlicka, 1995; Lawy & Biesta, 2006; Lister, Smith, Middleton, & Cox, 2003; Morrow, 2004; Oldfield, 1990a, 1990b). Citizenship provides the political status as subject which confers a bundle of rights, and in return it is expected that the person will take on the responsibilities, obligations and duties required of citizens (Bellamy, 2008; Isin, 2008c).

Currently discussed in these descriptions of citizenship are the struggles for recognition and inclusion, and the degrees of equality and the fair distribution of resources within the body of citizenship. Turner (1993) suggested that citizens are expected to be competent, successful, self-reliant and enterprising individuals. Lister (1990a), taking a feminist perspective, warned that this universal understanding of citizenship is exclusive. People who do not measure up to the above norms are disqualified from the ranks of citizenship. She asserted that the notion of the active and able-bodied citizen does not take into account the disabling effects on the autonomy and human agency of people who are marginalized because of their difference from the norm. Historically, groups such as lesbians and gays, people with serious mental health problems or people with physical and intellectual disabilities have been excluded. This is an example of how citizenship can, paradoxically, be an exclusionary practice (Crick, 2000; Isin & Nielsen, 2008b).

*Modern democratic citizenship*

Twenty-first century understandings of citizenship have been profoundly influenced by the seminal work of T. H. Marshall (1950) and his sociological essay on citizenship constructed
in the aftermath of post-war Britain of the 1950s. Marshall’s (1950) three elements of the political, civil and social rights of citizenship continue to be the standard criteria that define citizenship. Turner (2001a) and Isin (2000) explain the three components of civil, political and social rights of citizenship as follows: the civil rights protect the individual’s freedom of speech and association, ownership of property and the right to equal justice; political rights ensure the individual’s participation in the exercise of political power and the right to vote; social rights ensure the individual’s share in economic welfare, security and the right to live one’s life as a full human being. Inherent in these rights is the provision of the basic requirements of personal agency, dignity, the absence of coercion, and shelter, food, and health (Bellamy, 2008).

Though Marshall (1950) laid a strong foundation, his masculinisation of citizenship has been of concern for some (Lister, 2001, 2003). Lister (1998) argued that Marshall’s (1950) view did not fully address the gender, ethnic and racial aspects of citizenship, in particular the implications for women and the disadvantaged in society (Lister, 1997, 2003; Pateman, 1988; Young, 1990, 2002). This view is further supported by Peled (2008) who argued that although citizenship has some universalising aspects, the Marshallian (Marshall, 1950) view has homogenized and solidified the “fault lines” (p. 95) of class, race and gender within the social structures of the community. Citizenship, therefore is both unifying (inclusive) and divisive (exclusive) for some members of society.

Isin (2008c) suggested that contemporary views of citizenship now offer a much broader conceptualisation from both a sociological and political perspective. A diversity of categories of citizenship has emerged, such as cultural citizenship (Kymlicka, 1995), consumer citizenship (J. Clarke, Newman, Smith, Vidler, & Westmarland, 2007), sexual citizenship (Lister, 2002; D. Richardson, 2000) and intimate citizenship (Plummer, 1995, 2003). This contribution to the literature of citizenship has in part attempted to redress the lack of gendered and ethnocentric perspectives of citizenship.

Other authors have highlighted the exclusionary aspects of citizenship, related to the diversity of ethnic groupings and issues of inequality and exclusion faced by migrants, asylum seekers and refugees (Isin & Wood, 1999; Joppke, 2007; Kymlicka, 1995; Ong et al., 1996; Squire, 2009; Stevenson, 2001; Turner, 2001b). Yet few have discussed the exclusionary aspects of
citizenship for service users. A number of authors have attempted to address this by expanding the notion of cultural to include people with mental and intellectual disability (Lister, 1993; Marks, 2001; Meekosha, 2006), and lesbians and gays (Lister, 2002; D. Richardson, 1998). Overall, each contributor has enriched the general theories of citizenship by addressing the socio-political aspects such as the politics of inclusion and exclusion, social justice, and the civil, political, social and human rights for those citizens who are marginalized in society.

Isin (2008c) and Nyers (2008b) noted that the focus of the citizenship literature has primarily been on issues of rights and the legal aspects of citizenship. Bellamy (2008) has warned that broadening the meaning of citizenship to include the aspect of human relationships may detract from the distinctly political task of being a citizen. However, an emerging body of work on the social aspects and the importance of the relationships that citizens have with each other has been proposed (Conover, 1995; Isin, Brodie, Juteau, & Stasiulis, 2008; Kershaw, 2008; Twine, 1994).

Such scholarship has advanced the understanding of citizenship towards a more inclusive and less rights-based practice in an attempt to restore the balance between rights and responsibilities (Allman & Beaty, 2002). The notion that citizenship can be a holistic practice (Faulks, 2000; Heater, 2004) that embodies a “sense” (Conover, 1995, p. 135) or a feeling of what it means to be a citizen is based on the ontological view that citizenship can be a social process of relationships and the shared life that all citizens have in common (Oldfield, 1990a, 1990b). This notion emphasises the importance of a sense of belonging, solidarity and social cohesion that is required for citizens to flourish.

The influence by the above scholars and political thinkers support Hoffman’s (2004, p. 138) contention that citizenship is a “momentum concept”. Hoffman argued that static concepts such as patriarchy or violence are barriers to emancipation and inclusive citizenship. Whereas momentum concepts such as freedom and equality, are part of the human condition, and require constant re-working in order to provide social justice for those who are marginalized and oppressed.
In summary, citizenship connotes a person’s membership of the citizenship club (Bellamy, 2008) and the opportunity to participate in the community’s political, civic, economic and social processes. In return for this allegiance and solidarity to the state and one’s community, the person is able to have the freedom and autonomy to pursue their goals and desires. Service users, however, continue to lobby for full citizenship, because their liberty and autonomy is constrained by power structures, such as the use of the Mental Health Act (Barnes & Bowl, 2001; Chamberlin, 1998; Sayce, 2000) and the impact of stigma and discrimination (Mezzina et al., 2006).

**General research studies**

In the last two decades, neo-liberal governments have been concerned about the threat to the quality of citizenship highlighted by increased migration and assimilation of other cultures, the undermining of communities, and the decline of civic engagement by incumbent citizens (Lister, 2003). In response, political theorists have been challenged by successive governments to investigate the decline of citizenship (Conover, Crewe, & Searing, 1991).

Conover, Crewe, and Searing (1991) argued that much of the theoretical debate about citizenship is conducted within an empirical void, and in response to this challenge, they conducted a qualitative study with over 200 people in the United States of America (US) and England to explore their conceptions of their rights, duties and civic responsibilities within liberal-democratic states. Conover et al. found that the meaning of citizenship is far more complex and ambiguous than the general views in the citizenship debates. The findings reported that the roles constructed by citizens blend the liberal and communitarian assumptions of citizenship that underpin the content and language of rights. The authors also highlighted the emotional attachment associated with being a citizen, which Conover (1995) later theorised as a sense of citizenship, encompassing the legal, psychological and behavioural elements. Importantly, Conover et al. reported that participants were identified as falling into two types of citizen identities, the independent or the “I” identities, and the interdependent or the “we” identities. The latter have higher sensitivity to the desires and interests of other members of society. Older people, racial minorities and women have more interdependent selves than independent types such as young people, men and whites.

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26 These are discussed in more detail in chapter four.
Although Conover et al.’s (1991) study is somewhat dated, few authors since have attempted to fill the empirical void of how citizens themselves understand citizenship. Almost a decade later, Lister et al. (2003), used a three year longitudinal study with 110 people 16 to 23 years of age in the United Kingdom (UK), to explore how young people negotiate their transition to becoming full citizens. Lister et al. found that young people take their relationships with wider society seriously and are a highly responsible group. This was in contrast to the UK government’s impression that young people give primacy to their rights as citizens, rather than to their responsibilities. Lister et al. reported that young people place a high premium on constructive social participation in their community, citing this as the essence of good citizenship. This finding is in contrast to Conover et al. (1991) and their claim that younger people have an independent citizen identity, and fewer ties to the collective. Lister et al. also found that the young people conveyed a predominantly communitarian model of citizenship. They concluded that young people had taken on board the political messages of the state, demonstrated by their active citizenship and the ascendance of responsibilities over rights.

Lister et al.’s (2003) findings demonstrated that Marshall’s (1950) classic definition of citizenship, which bestows equal social status on all members of the community, is not apparent within a society that values an economic independence model of citizenship and in turn reinforces class divisions. Lister et al. (2003) suggested that these findings point to how everyday understandings of “lived citizenship” (p. 251) have both inclusionary and exclusionary implications.

The findings of Conover et al. (1991) and Lister et al. (2003) have implications for service users. First, if the notion of citizenship is concerned with constructive social participation, this assumes one is socially accepted as a full participant in society. As Peterson, Pere, Sheehan and Surgenor (2007) found in their New Zealand study on stigma and discrimination, many service users are excluded from the usual activities associated with social membership.

Continuing the theme of younger people’s views of citizenship, Howard and Gill (2001) explored how thinking globally impacted on the taken-for-granted notions of national identity and belonging. This study was conducted in response to increased immigration and the arrival of refugees within Australian borders, prompting the question by the state of what it means to
be an Australian citizen. Howard and Gill (2001) conducted a qualitative study using focus group interviews with 28 Australian children from seven to 12 years of age. The aim of the study was to explore participants’ perceptions of their identity as global citizens or as Australian citizens. The findings from Howard and Gill’s (2001) research has relevance for service users. They found that in order to be recognised as a member of the nation state, one must possess the required symbolic and stereotypical markers of the collective, and follow the norms.

The findings from the above research, support Tarcow’s (2002) assertion that the majority of people do not focus solely on the rights and privileges of citizenship. As Conover et al. (1991) reported the meaning of citizenship is far more complex and ambiguous than the theoretical propositions suggest. The authors’ finding that citizenship is something that one feels, or lives, are a new development in the citizenship literature. The above studies have explored the understanding of citizenship from the perspective of a heterogeneous group of adults and younger people; they do not represent the experiences of service users and other marginalised groups.

**Ethnicity**

Nagel and Staeheli (2004) contended that citizenship can be viewed as both formal and substantive. Formal citizenship refers to one’s legal status, such as a visa or passport, whereas substantive citizenship is one’s ability to realise the rights and privileges of societal membership. Nagel and Staeheli conducted a qualitative study with 40 participants, to examine the narratives of Arab activists in the US and their views of assimilation and belonging as Arab Americans. The aim of the study was to explore whether Arab Americans realise substantive citizenship within a political backdrop of assimilation strategies in post-nine-eleven US. Nagel and Staeheli reported that these political events have stereotyped the identities of Arabs as untrustworthy and they are often regarded as dangerous terrorists, prompting Arab American activists to promote Arabs as normal citizens.

The authors found that it fell to the participants to change their behaviour in order to be assimilated. This was achieved by blending with the host society to escape the negative stereotypes associated with being Arab. Participants were expected to learn the customs, thinking and behaviour of the American-way. In response, the activist Arabs went to great
lengths to offer images of success, such as Arab Americans who were celebrities or sports people, to reduce the stigma, avoid systematic exclusions and the marginalisation of the “us” and “them” distinction (p. 489).

Nagel and Staeheli (2005) reported that Arabs were neither regarded officially as a protected class or included in affirmative action policies of assimilation, nor classified ethnically as other. As one respondent reported, this ambiguity led to them being considered a minority and “kind of lost in between” (p. 493). The authors concluded that the participants wanted to be regarded as “the same, but different”.

People with mental illness are equally marginalised and stigmatised because of their perceived dangerousness and threat to the safety of other members of society (Angermeyer, Matschinger, & Corrigan, 2004; Hazelton, 1999). Corrigan (2005a) noted that such perceptions have an impact on service users who try to pass as normal and attempt to blend into society to avoid further stigma and prejudice. This supports Nagel and Staeheli’s (2005) findings that, equally, service users experience social exclusion and restrictions on their rights and privileges and full participation in society. Service users may have formal citizenship status as de jure citizens, yet the realisation of substantive citizenship are questionable. Given the degree of exclusion that service users have reported (D. Peterson, Pere, Sheehan, & Surgenor, 2007), it is possible that service users also experience an ambiguous social status of either full citizenship or the status of denizenship with restricted rights and privileges.

Pinson (2008) conducted a study to explore 20 young Palestinian/Arab Israeli Muslim students’ understandings of citizenship. Data were gathered through individual semi-structured interviews and focus groups. Similar to Nagel and Staeheli (2005), Pinson (2008) found that there were themes of sameness and blending in emerging in the data. Participants reported two notions of inclusion and exclusion. One based on equal rights, and the other based on sameness. The participants also recognised a thin sense of civic belonging based on equal rights, and alternatively a thick notion of national belonging. Some participants

27 Nagel and Staeheli (2004) describe denizenship as long-term residency without naturalisation. According to Bellamy (2008) denizenship provides some rights of citizenship, but this is selective and depends on the nation state, for example for the right to vote and access to affordable health care.
reported a sense of the collective “we”, whereas other respondents described feeling like tourists or others. This latter finding also reflects the work by Lister et al. (2003).

Ho (2009) investigated the emotional aspects of citizenship. She retrospectively analysed data from 43 Singaporean migrants living in London (Ho, 2008) and found that the participants had a strong emotional attachment to their sense of citizenship within their original nation-state. They used metaphors such as home or belonging to refer to it. Ho argued that their sense of exclusion in their current communities was based on racism and led to feelings of abjection and resentment. Ho concluded that the articulation of claims for political and social recognition is integral to being emotionally involved as a citizen, and increases participants’ sense of belonging and emotional agency.

The presence of racism alienates and marginalises minority groups, leading to isolation and abject-hood when individual rights are suspended or denied (Isin & Rygiel, 2007). Lister (2004) likewise asserted that people in poverty experience the same prejudicial treatment, reducing their personal, political and citizenship agency. Ho’s (2009) study contributes the notion of emotional agency as a key factor required of active citizens.

Saeidi (2010) interviewed 150 wives and daughters of Iranian martyrs from the Iran-Iraq war, to explore how they express their individual autonomy and political thought in the face of the state’s expectations. Saeidi used Isin’s theory of acts of citizenship (Isin, 2008b) to interpret the data. Saeidi (2010) found that far from being passive, the women had engaged in active roles during the war and subsequently, had gained confidence to express their autonomy in political thought and action in post-war Iran. By engaging in acts of citizenship the women challenged the state’s perceptions of widowhood and citizens. Saeidi concluded that the women’s dissatisfaction with the cultural norms galvanised them to establish a new order of the current customs of child custody and gender roles expected of war widows. The women became creative participants in transforming the Islamic republic into a more pluralistic state through asserting their self-determined citizenship status. This is the first published empirical study that has used Isin’s (Isin, 2008b) theory of acts of citizenship as a conceptual framework. Saeidi’s (2010) findings have some parallels for service users. First, engaging in acts of citizenship facilitates personal transformation and increase the confidence of the actors. Second, Saeidi concurred with Lister et al. (2003) that citizenship is a relational
process, developed through everyday experiences; and third, acts of citizenship can create new social norms in both the public and private arenas. Saeidi (2010) concluded that when people engage in acts of citizenship they create a self-identified citizenship status which challenges the state’s monopoly on classifying who has political membership.

This section has reviewed a small number of current empirical studies that have specifically explored different perspectives of citizenship with a range of ethnic groups. The findings revealed that notions of belonging were predicated on being part of the “we” collective, or alternatively regarded as the other, or the stranger or for some, being lost in between. Although service users have not been the focus of these studies, findings suggest that stigma and discrimination, racism and sanism (Birnbaum, 1960; Perlin, 2000a, 2003b) have similar effects on an individual’s ability to realise their substantive citizenship and participate meaningfully in society. Minority ethnic groups have campaigned for legislative changes to political, civil and social rights to ensure their citizenship (Joppke, 1999, 2007; Kymlicka, 1995; Nagel & Staeheli, 2004, 2005; Pakulski, 1997). The following section will review the literature of another minority group, lesbians and gays, and draw parallels with service users.

**Lesbians and gays**

Sexual minorities have campaigned to have the same rights and responsibilities as other citizens, however the literature search did not locate any current empirical studies that have investigated the understanding of citizenship for this group. This section will present the current debates and present the parallel journey towards full citizenship by lesbians and gays and service users.

**Hetero-normativity**

Several authors have argued that the heterosexual and normal view of citizenship is constructed in terms of whiteness, traditional gender roles, property and wealth, monogamy, the nuclear family structure and able-bodiedness (J. Clarke, 2004; D. Richardson, 1998; Vitulli, 2010). Queer theorists (Sedgwick, 1990; Seidman, 2002; Spargo, 1999) explained that understandings of normal sexuality lie within a frame of hetero-normativity, a concept that represents punitive rules (social, familial, and legal) that force individuals to conform to hegemonic heterosexual standards of identity (Jackson, 2006; Rich, 1980; Westerstahl & Bjorkelund, 2003). The pressure to conform in order to be included has forced some lesbians
and gays to mimic the hetero-normative gender, sexual, and family structures, which in turn strengthen hetero-normativity and the privilege of heterosexuality (Vitulli, 2010).

Constructions of hetero-normativity and normalcy provide a parallel for service users, who are unable, or prevented from, reaching the norms of the ideal citizen. For example, the notion of “ableism” perpetuates the exclusion of people with physical and mental disabilities (Diesfeld et al., 2008, p. 436). Service users are often perceived as being unstable, and their conduct regarded as odd or eccentric and not conforming to society’s expectations (Gill, 2009). Within the bio-medical model, the conduct of service users is viewed through a diagnostic framework, such as the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) which provides a normative set of standards by which all different types of behaviour are at risk of being regarded as mental illness. Like hetero-normativity, psycho-normativity constructs normal and acceptable conduct, thoughts and feelings expected of stable and predictable members of society. Anything that wavers from these norms is labelled as psycho-pathological, undermining the multi-factorial influences that result in psychological distress (Read et al., 2004). Beresford (2004, p. 248) contended that a new body of knowledge of mental distress is required to counter the “unhelpful medicalised individual understanding” of a person’s situation and experience, which results in the denial of their political, social and civil rights of citizenship.

*Politics of normalisation*

During the crisis of the HIV/AIDS epidemic late last century, homophobia initially increased, and then turned to an acceptance and tolerance of gays. Interestingly the outcome of safe-sex education at this time prompted a re-emphasis on sex as a practice, and sexuality as an identity (Spargo, 1999). Queer politics values difference and promotes a broader definition of normality, arguing that sexuality is a spectrum of human experience, rather than a straight/queer binary. Given this, the effects of hetero-normativity are still present for lesbians and gays.

Richardson (2004) contended that to be fully integrated into society one must appear to be normal. Richardson (2005, p. 393) explained that it is perhaps understandable that some lesbians and gays will “disavow their difference and desire normalcy” or at least to be understood as “normal”, to achieve equality with heterosexuals. Richardson (2007) argued further that normalising politics are at the basis of the equal rights agenda. She contended that
the notion of the “other” (1998, p. 84) is perpetuated by binaries such as the hetero/homosexual or normal/abnormal. Likewise the sane/insane or biology/environment binaries also apply to service users. Such concepts shape how perceptions of otherness are constructed, and who is deserving and tolerated in society (Shotter, 1993).

Richardson (2007) suggested that normalcy is a relatively unexplored concept, and argued that normal is associated with “a fixed, coherent and stable understanding” of a person’s identity. A “plural, provisional and situated” (p. 469) view of identity would loosen the rigid boundaries of society’s perception of normal. The service user movement is beginning to pursue an inclusion and equal rights agenda (Lakeman, McGowan, & Walsh, 2007), however unless service users achieve the normalisation of their identity, they will continue to be othered. For this to happen members of society need to change their perceptions of mental illness, moving from a view of “deviancy”, sickness and difference as a condition that people embody, to the understanding that the experience of mental distress is the “phenomenological character” of their vulnerability (Turner, 2006, p. 101).

**Intimate citizenship**

Plummer’s earlier study on sexual diversity led him to develop his concept of intimate citizenship (2003) which has challenged the hollow perspective of citizenship. He proposed that bringing the often hidden, and misunderstood diversity and uniqueness of human beings into the public sphere, would create commonly shared values and assumptions. Intimate citizenship brings a shared morality and the acceptance of difference within society. Plummer asserted that the older approaches to citizenship have to be reworked. Lesbians and gays have gained a fuller understanding of the inner self, free to express their wishes, wants and desires and the right to remain different (Phelan, 2001). Like lesbians and gays, service users also have the desires and wishes for acceptance, equality, and freedom to express their difference without being alienated (Sayce, 2000).

The ethnic studies too revealed how migrants were pursuing their collective power to change society’s attitudes towards minority groups. The lesbian and gay literature offers a much broader critique of how power structures, such as hetero-normativity, continue to privilege the notion of the ideal citizen, and are less tolerant of those who waver from the norm.
Another important observation is that majority of the authors reviewed identify as lesbian or gay and therefore are able to speak from the position of the excluded (Kabeer, 2005).

This section has reviewed the key debates in the literature regarding lesbians and gays and citizenship and discussed parallels between these two groups. For example, Richardson’s (2007) notion of identity as fluid offers another parallel to explain how mental illness can equally be regarded as dynamic, episodic and often experienced as a state of flux. The binaries of hetero/homosexual and normal/abnormal have highlighted that service users also have an ambiguous citizenship status, compounded by their segregation, isolation and exclusion as part of their treatment (Beresford & Wilson, 2002). These experiences have also been reported for people with physical and intellectual disabilities.

**Disability**

Gilbert, Cochrane, and Greenwell (2005) explored the understandings of citizenship of professionals working in the services for people with learning disabilities. The authors interviewed 17 participants from 14 organisations providing residential care for this group. The authors found that there was no coherent idea of citizenship, and that the role of the professionals was to move the residents along a continuum of self-management, whilst anticipating and managing the risks involved. The focus on risk led to subjecting residents to segregation, surveillance and coercive technologies by professionals. Other key findings were that participation in society was dependent on the residents complying with the prevailing norms, and engaging in self-forming activities, such as paying attention to one’s physical appearance and developing relationships with others.

Other commentators on citizenship for people with physical and intellectual disabilities argue that this group have been excluded from participating as full citizens. Walmsley’s (1991) seminal essay on citizenship and the learning disabled provided a historical context to describe the journey to full citizenship for this group. Walmsley contended that it was evident that people with learning disabilities can develop the skills required for active participation, but there are many socio-structural and ideological barriers that place constraints on their ability to exercise full citizenship. For example, similar to service users resident in mental hospitals, the learning disabled were not entitled to exercise their right to vote. Walmsley (1991) illustrated the parallels between people with learning disability and women, claiming
that the latter are likewise economically dependent, often confined to the private world of the family, they take on informal and unrecognised roles as carers, and are regarded as second class citizens. Walmsley concluded that future debates on citizenship must end the segregation and dehumanisation of people with learning disabilities, and fashion a pluralistic society that incorporates and values its members.

Meekosha and Dowse (1997) concurred with Walmsley’s claim that socio-structural barriers exist, contending that the construction of able-bodiedness as a marker of the ideal citizen is a major hurdle to participating in society. Marks (2001) concurred, citing that the continuation of an ablist focussed environment has contributed to the loss of civil rights for disabled people. Marks (2001) argued for an extension of citizenship to include the right to en-dignified representation to ensure the full cultural citizenship rights of the disabled. Similar to the findings by Gilbert et al. (2005), Marks (2001) argued that the disabled are portrayed as isolated and disengaged members of society.

Likewise Sherry (2004) posited that disabled people have been “queered” through the various cultural processes of “enfreakment” (p. 781) which has perpetuated society’s fears and anxieties around Otherness. Being Othered has denied disabled people their rights as citizens, particularly sexual citizenship rights because of the perception that they are unfit to be parents. Sherry illuminated the high rates of violence, stigma and discrimination towards people with disability by members of society. He concluded that the representations of disability perpetuate the notion of the damaged Other, rather than focusing on the disabling nature of the social and cultural environment. Similar to Sherry, a commentary by Hughes (2009) highlights how the Disabled People’s Movement has embraced both the biological aspects of disability and the social model of the disabling society. By rejecting the notion of “cure” the social model of disability has emerged as a sociological critique of the factors that contribute to the social disabling of people with disability, perpetuating their exclusion, discrimination and social oppression.

The social model of disability (Beresford, 2005; Beresford, Nettle, & Perring, 2010) challenges the power structures that perpetuate the oppression of people with disabilities, particularly the discriminatory ethos of ableism (Diesfeld et al., 2008). Diesfeld et al. and McLean (2005) suggested that a social constructivist approach to disability has revealed the
oppression of the disabled, sustained by the language, attitudes and cognitive constructions which shape society’s understanding of disability. Thomson (1997) concurred, asserting that disability is regarded as a bodily inadequacy to be compensated for with pity and goodwill, rather than focusing on systemic changes based on civil rights. Thomson also presents a constructionist argument explaining that disability is not a bodily insufficiency but arises from the interaction of physical differences within the environment. She argued that strategic constructionism can challenge power structures by de-stigmatising the disabled body, rendering “difference” as relative and eliminating the privileging of “so-called normalcy” (p. 23). Thomson (1997) does not include intellectual disability or service users in her thesis however she argued that political equity can be attained by casting disability as difference, rather than deviance, deficit or bodily insufficiency.

In summary, the above literature has highlighted that people with disability have struggled to gain recognition and acceptance of their difference and identity as citizens. In parallel with the commentaries on hetero-normativity, the above authors have offered a deeper analysis of how power structures, such as ableism have created barriers to substantive citizenship for the disabled. There is however no empirical research to date that has reported on whether these findings are relevant to service users’ claims for full citizenship. The literature that reported the connection between citizenship and the mentally ill will be presented in the following section.

Service users
The literature search yielded no studies of service users’ understandings of citizenship. The following section will first report on the empirical studies that have revealed a link between citizenship and service users. This will be followed by a review of conceptual literature on the topic.

Rowe, Kloos, Chinman, Davidson, and Boyle-Cross (2001) reported a citizenship project to advance a community integration agenda for mentally ill homeless persons. The main finding was that social problems were given precedence over biological problems. The strength of this study is the use of a citizenship framework to underpin service delivery. The framework had a primary focus on the rights and responsibilities of citizenship, highlighting that the acquisition of housing and resources for homeless people increased their sense of
membership and belonging in wider society. The citizenship framework changed the perceptions of the outreach workers, who began to regard service users as political subjects rather than patients. These perceptions increased the beliefs that service users could undertake their rights and responsibilities regardless of their social and economic hardship, and diagnosis of severe mental illness. A weakness is that data were obtained through participant observation and outreach workers’ accounts, rather than exploring the narratives of the homeless mentally ill and their understandings of citizenship. The finding that the homeless mentally ill experienced non-citizenship or second class citizenship, echoes the results from the study by Lister et al. (2003), that found when people are economically and socially disadvantaged it changes their social status.

Overt racism and lack of advocacy by mental health professionals to support service users’ rights was reported by Pierre (2000). Qualitative interviews with black British service users revealed that participants were unable to exercise their rights as citizens when subject to the Mental Health Act. Pierre’s finding that racism is a barrier to service users’ rights of citizenship highlighted the concerns that other commentators have raised of similar structural impediments such as hetero-normativity, homophobia and ableism.

Pols (2006) conducted a study within a psychiatric rehabilitation unit in the Netherlands, observing psychiatric nursing care and the washing practices of patients (sic). Pols employed a sociological and anthropological analysis of the practice of washing, emphasising that the ritual of cleaning is embedded in culturally specific forms of social order. Thus Pols used washing of the person as a metaphor for service users’ claims to an esteemed place within the social order as citizens.

There are two specific findings of interest in this current study. First, Pols (2006) contended that patients within the rehabilitation centres are ambiguously seen as citizens or citizens-to-be, and that the role of the psychiatric nurses was to teach service users to be active citizens. Second, Pols coined the term “relational citizenship” (p. 100) which extends the notion of the teaching component of the development of citizenship. Relational citizenship appears to be a constructive partnership between the nurse and the patient which emulates the sociability required for active citizenship, and the acquisition of negotiation skills and the mutual accommodation of each other. Similar skills for citizenship have also been proposed by Isin
et al. (2008), and Conover et al. (1991). They reported that interdependence between citizens created a holistic form of citizenship. Likewise, Gilbert et al.’s (2005) finding of self-forming activities, such as taking care of one’s physical appearance concurs with Pols’(2006) findings. Pols concluded by contending that the notion of relational citizenship signals greater opportunities for nurses and patients to engage in two-sided political action and the responsibilities they have towards each other as citizens.

Brannelly (2004, 2006) examined the ways citizenship was or was not upheld for people with dementia, and how the levels of their participation in care was facilitated by practitioners. Fifty older people in England were observed over a 14 month period, and interviews were conducted with eight community psychiatric nurses and seven social workers. Data were collected through observation of people with dementia, practitioners and lay carers, and interviews with practitioners. Data were analysed using Tronto’s (1993) integrity of care framework, taken from the wider feminist political argument of an ethic of care (Gilligan, 1982).

Brannelly (2006) offered a citizenship framework to contextualise her interpretation of the findings. She reported that practitioners primarily worked with the principles of citizenship, such as rights and autonomy, but they found it difficult to sustain these when legal restrictions were imposed on the people with dementia. Significantly, given these ethical dilemmas in care, practitioners were able to discourage the use of compulsory detention under the Mental Health Act. Brannelly concluded that the adoption in practice of an ethic of care strengthened the opportunity for increased participation and inclusion of older people with dementia. A weakness of the study is that Brannelly did not interview the older people to ascertain their understandings of citizenship; however two distinct observations were made. First, the oldest olds in the study contemplated their citizenship in terms of having fought for freedoms and now wishing to realise their entitlements to health and social care. Second, the baby boomers in the group were well established rights campaigners and willing to challenge what the welfare state had to offer if it was iniquitous with what other service users received.

Brannelly (Gilmour & Brannelly, 2010) expanded her citizenship framework further to include the notion of the subaltern and personhood. The authors made further
recommendations for changes in nursing practice, such as the need to acknowledge the power differential between service users and nurses perpetuated by the dominance of the biomedical model. Concurring with Rowe et al. (2001), Brannelly and Gilmour contended that the use of a citizenship framework for practice increased visibility, voice and inclusion for older persons.

The findings from this study are relevant for mental health professionals and the care of service users. On-going debates in mental health law and its impact on clinical practice centre on service users’ competence and capacity (Chamberlin, 1998; Link & Phelan, 2006; Read & Harré, 2001). Such debates inform practitioners’ decisions to use compulsory detention and treatment that jeopardises the rights and responsibilities of service users. Brannelly’s (2006) findings address in part, the gap in current mental health practice, particularly the notion of attentiveness which is an empowering process that reaffirms agency and protects the person’s citizenship.

The above studies have highlighted that the importance of rights, the ability to participate in society and to undertake one’s responsibilities are important elements of active citizenship for service users. These aspects of citizenship were explored by Ware, Hopper, Tugenberg, Dickey, and Fisher (2007) in their investigation of the social integration of service users. Ware et al. (2007) conducted a study in the US with 56 adults with psychiatric disorders to address the persisting problem of social exclusion and to redefine the notion of the social integration of service users. The findings pointed to a new definition of social integration, describing this as a process that unfolds over time and through which service users develop and exercise their capacities for connectedness and citizenship.

Ware et al. (2007) concluded that the citizenship rights of people with psychosis have been restricted on the grounds of mental incompetence, reducing their status to second class citizens and exempting them from social and personal responsibilities. Brannelly (2006) also reported that Sweeting and Gilhooly’s (1997) notion of “social death” (p. 94) and loss of personhood reduced the capacity of people with dementia to be active social citizens. A consistent gap in the studies reported so far is that none of the research has explored service users’ understandings of citizenship.
Mezzina et al. (2006) interviewed 12 service users in four northern hemisphere countries to gain insights into their journeys of recovery from serious mental illness. Key findings from the study included: the need to be accepted and to accept oneself as a normal person who exists beyond the psychosis; stigma and discrimination and impact on maintaining a meaningful social role and reduce the opportunity to have positive relationships outside of the formal mental health system; a sense of belonging and participation as a first step to recovery and overcoming self-stigma; and regaining social status leading to a sense of “being accepted just as you are” (p. 51). These findings led Mezzina et al. to draw a link between recovery journeys and citizenship concluding that citizenship is more than a legal status. The finding of social relatedness concurs with Ware et al. (2007) who found that the importance of social relationships is essential for the exercising of citizenship by service users.

In summary, the above studies reported the emerging themes of stigma, discrimination and social exclusion and the impact of these on service users’ ability to be active citizens. During their investigations, the authors made unexpected links to the notion of citizenship as a vital component of recovering from a serious mental illness. The following studies will report on how health reforms and changes in policy direction in the delivery of mental health service can impact on service users’ status as citizens.

Morrow (2004) and Hazelton (1997a, 1999) focussed their research on the analysis of mental health reforms and changes in state policy. Morrow conducted interviews with mental health providers, administrators and advocates in British Columbia, Ontario and Quebec. The aim of the study was to seek informants’ perspectives on the key reforms in mental health, the philosophy that guides the mental health system, the involvement of service users in service delivery decisions and the impact of cost containment. Morrow reported on the dominance of the bio-medical model and the channelling of available resources towards bio-medical interventions. She argued that policy is not only driven by the way mental health/illness is understood but that it is intimately connected with economic decision making. The example she provided was how reformist ideas of user participation, mutual aid and self-help models are compromised during restructuring processes and budget restraint. She argued further that these models are tolerated providing they do not challenge the dominance of bio-psychiatry.
In a similar vein, neo-liberal agendas in health care in New Zealand have centred on cost containment versus appropriate treatment for service users. Hazelton’s (1997a) doctoral thesis has led to a substantial body of work focusing on the processes of deinstitutionalisation, government reforms and the implementation of mental health policy within Australia (Australian Health Ministers, 1992a, 1998). The aim of the study was to examine how the discourses from recent social justice reforms impacted on mental health professionals’ practice. Hazelton (1997a) reported that the participants regarded patients as dangerous, vulnerable, and a risk to self and others. The discourses of power and risk management led to interventions that were coercive and surveillance practices that were highly directive and prescriptive. Participants reported tensions in clinical decisions between psychiatric medicine and mental health nursing. These tensions led nurses to frame both patients and management in contrary, hostile, alien and resentful terms, perpetuating an “us/them” distinction. These had a direct impact on patient’s rights when containment and surveillance technologies increased.

Hazelton (1997a) also found that many participants did not acquiesce to policy directives, instead they engaged in a form of “enacted policy” (p. 287) by modifying, resisting, ignoring and undermining new policy directives. Those professionals who responded positively to such reforms did so by being more guarded and secretive about their practice. Such subversive practice was an attempt to avoid the conflict of clinical decisions within the interdisciplinary power relationships, particularly between mental health nurses and psychiatrists. It was perpetuated by the dominance of a bio-medical discourse. Hazelton (1999, 2005) and Hazelton and Clinton’s (Hazelton & Clinton, 2001, 2004) on-going research has focussed on whether closure of the large mental hospitals has improved citizenship participation and the protection of human rights for service users. Hazelton (1999, 2005) reports that while policy makers have focused on improvements to mental health services, little attention has been paid to improving rehabilitation, housing and the support services required for life in the community as participating citizens.

This finding concurs with Gilbert et al. (2005) who also emphasised the importance of the social aspects of citizenship beyond psycho-social support currently offered in their services. Developing meaningful social relationships with members of society who do not have contact with mental health services increase service users’ sense of belonging and acceptance. Of
concern is Hazelton’s (1999) finding of the emergence of risk management as the dominant discourse in mental health services, which he described as the “hardening” (p. 233) of the institutional end of the mental health spectrum and a paradoxical response to liberalising reforms (Hazelton, 2005; Hazelton & Clinton, 2001). Other commentators have shared his concerns. For example Sawyer (2005) argued that the impact of deinstitutionalisation has resulted in a shift from a therapeutic consciousness which has centred on home-based treatment, to a risk consciousness with the focus on risk protocols.

In summary, this section has reviewed the empirical studies that have focused on the link between citizenship and service users. The studies reported several key aspects that determine whether service users can be active citizens within society. First, the increase in the management of risk has impacted on service users’ liberty and ability to participate fully. Mental health professionals’ concerns about risk at times denied service users their full rights as citizens. The use of Foucauldian discourse analysis (Gilbert et al., 2005; Hazelton, 1997b, 1999, 2005) has made an important contribution to the literature by exposing power structures such as the dominance of the bio-medical approach and the power of health professions and their control of the conduct of service users impinging on their ability to attain substantial citizenship. Likewise stigma and discrimination impinge on service users’ citizenship.

**Stigma and discrimination**

There is a vast literature on stigma and discrimination, for example Corrigan (2005b) cites the completion of 60 research projects by 20 researchers on the topic in the last decade alone. Few of the existing studies have linked stigma and discrimination to citizenship (Gilmour & Brannelly, 2010; Mezzina et al., 2006). A full review of the literature therefore is beyond the scope of this current study. Given this, the aim of this section is to locate stigma and discrimination within the context of this current study by giving a brief overview of the effects that these have on service users’ ability to conduct their lives with minimal restrictions on their liberty.

Even with a plethora of literature, Green (2009) and Deacon (2006) contended that a clearly defined and shared understanding of stigma should not be assumed. Seminal work by Link (1987) and associates (Link, Cullen, Frank, & Wozniak, 1987; Link & Phelan, 2006; Link,
Struening, Dohrenwend, Cullen, & Shrout, 1989; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001) has built an increasing body of knowledge about the concept of stigma and discrimination. Link and Phelan (2001) contended that stigma is a “mark” (p. 365) or an attribute that links a person to undesirable characteristics or stereotypes associated with social disgrace (Goffman, 1963). Stigma associated with the mentally ill usually relates to their characteristics, specifically behaviour that is contrary to the social norms. Link and Phelan (2001) contended that social norms are based on a shared belief that “a person should behave in a certain way at a certain time” (p. 365). When service users contravene these norms it results in the perception that service users no longer meet the social and cultural ideals of society (Green, 2009).

Link and Phelan (2001, p. 367) apply the term stigma when the following interrelated elements of labelling, stereotyping, separation, status loss, and discrimination co-occur “in a power situation that allows the components of stigma to unfold”. The power differential constructs the impassable barrier between the “us” and “them” (Fine, 1994; Krummer-Nevo & Benjamin, 2010; Lister, 2004; Schwalbe et al., 2000) and the distinctions between the healthy self and the unhealthy other (Crawford, 1994).

Green (2009) and Deacon (2006) argued that labelling theory has become a useful explanatory framework to account for the stigmatisation of people who are devalued. The process of labelling links difference to deviance and subsequently the negative stereotypes unfold; according to Scheff (1974, p. 445) being mentally ill is synonymous with “deviancy” and service users are viewed as sick, childlike and unable to take responsibility (Scheff, 1968, 2006). Link (1987) and Link, Struening, Dohrenwend, Cullen, and Shrout (1989) proposed a modified labelling perspective which claimed that even if labelling does not directly perpetuate mental disorder, it can lead to negative outcomes when service users internalise negative stereotypical attitudes. Markowitz (2005) concurred, suggesting that labelling leads to sustained illness, impacting on service users’ life satisfaction, poor social outcomes and self-concept, and their expectation that they will be devalued and discriminated against by others. The impact of stigma and discrimination on service users, and self-stigma (D. Peterson, Barnes, & Duncan, 2008) constrains their return to a meaningful social role through work and/or positive relationships outside of the formal mental health system (Davidson et al., 2005; Mezzina et al., 2006).
Link and Phelan (2001) argued that stigma is based on social, economic and political power. Such prejudice and subsequent discrimination are based on the misrecognition (Fraser, 2000; Isin et al., 2008) of another human being, resulting in inequalities, marginalisation and oppression. Patterns of institutional inequality are evident between social groups, which perpetuates a “pathology of the oppressed” (Kennedy, 1970, p. 441). Patterns of oppression also occur in institutions, such as mental health services and the education and employment arenas (Sayce, 2000). Sociological commentaries on the effects of stigma and discrimination and their subsequent impact on service user’s rights have been posited by Pilgrim and Rogers (Pilgrim, 2008; Pilgrim & Rogers, 1993, 2005a, 2005b; Rogers & Pilgrim, 1989, 2003). Their body of work has consistently used a human rights framework to critique citizenship and illuminate the particular forms of oppression experienced by service users.

Deacon’s (2006) research has focused on HIV/AIDS and contends that the power structures that maintain stigma cannot remain unchallenged because they perpetuate the myth that people are somehow individually responsible for reducing stigma by changing themselves to appear normal. These myths also locate the problem within the person, who feels blamed and ashamed. Rather, the responsibility for change needs to be placed firmly at the feet of those who do the discriminating (Sayce, 1998). These findings will have consequences for mental health professionals who represent the fourth of the seven most stigmatising groups that service users will encounter (D. Peterson et al., 2007).

In New Zealand, the Like Minds-Like Mine campaign (Ministry of Health, 2007b) has been central in reducing stigma and discrimination within society. The portrayal of celebrities with experience of mental illness may have added a certain prestige to the campaign; however, it prompted the service user movement to question the media representations which promulgated certain ideals of the body, lifestyles, possessions and relationships. The use of celebrities promotes an ideology of self-critique and subordination to the norm (Weber, 2009). Such media ideals can lead to obsession with self-improvement and individuation, which become the normative view of the citizen. Service users challenged this projection of

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28 John Kirwan (Kirwan & Thomson, 2010) has been an excellent role model in demonstrating how society can change its perceptions of mental illness. It could be argued that John was a model citizen; a famous All Black, sports celebrity and the ideal of the Kiwi male, yet his disclosure of his mental illness has helped many, particularly the silent majority of depressed males, to also come out about their experiences of depression.
celebrity status because it was an unrealistic and unachievable ideal and risked increasing service users’ sense of Otherness.

Pilgrim and Rogers (2005a) critiqued an anti-stigma campaign by the Royal College of Psychiatrists in the United Kingdom (1998), concluding that de-stigmatization campaigns implemented within a dominant bio-medical orthodoxy continued to serve the “governmental need to reinforce powers of surveillance and control in community settings” (p. 2554). Though the Like Minds-Like Mine campaign was designed to reduce the fearful attitudes of the general public about meeting someone with a mental illness (Mental Health Commission, 2005b; Ministry of Health, 2007b), the health system still subjects people with a mental illness to an inordinate amount of excessive power and control using coercive strategies such as seclusion and restraint (O'Hagan, Divis, & Long, 2008) which perpetuates their demoralisation and social exclusion.

When service users are excluded geographically and psychologically from their communities this further increases stigma of the self (D. Peterson et al., 2008), and by others through covert and overt discrimination. Now viewed as “sick, non-rational and dependent” (Barnes & Bowl, 2001, p. 128) by those professions who also lay claim to being advocates for service users (Hopton, 1994), users are less able to assert their political rights or voice. Bowl (1996) warned that mental health services and the legislation that protects the vulnerable can be influenced by societal pressures to contain risk, at the expense of the rights of the service users. A focus on risk reduces the interactions between the nurse and the service user to issues of power and control, which place the nurse in a conflicted position of being the advocate on behalf of and for service users. Hopton (1994) further warned that mental health nurses who believe that they hear the voice of service users should strive to join service users in the struggle against the dominance of psychiatric orthodoxy.

The politics of inclusion and exclusion

Over the last decade, one of the many attempts to reverse the stigma and discrimination experienced by service users has been the adoption of a focus on social exclusion (Social Exclusion Unit, 2001) with the aim of increasing their participation and building society’s capacity to integrate service users as “full contributing and valued citizens” (British Psychological Society, 2008, p. 1).
A number of scholars have commented on the importance of a social inclusion approach within mental health services and in wider society (Repper & Perkins, 2003; Repper & Perkins, 2004; Sayce, 2000). Contrary to this body of work, others are critical of the notion of social inclusion (Berry, Gerry, Hayward, & Chandler, 2010; Guzofski, 2007; C. Morgan, Burns, Fitzpatrick, Pinfold, & Priebe, 2007), contending that there is an urgent need for more conceptual and methodological work on the notion of social inclusion (C. Morgan et al., 2007). Berry et al. (2010) also asserted that mental health professionals inadvertently contribute to the social exclusion of service users, through “iatrogenic stigma, confused agendas and restrictive practices” (p. 418). Clearly the emphasis needs to be on tackling the iatrogenic stigma within the mental health profession, as well as wider society. The inclusion of a citizenship framework within clinical practice may also increase social inclusion for service users.

Lister (2004) provides a broader understanding of social exclusion and inclusion. She argued that the concept of social exclusion has become more a political than a sociological concept, and has multiple meanings. Silver (1994) has suggested three typologies of causes of exclusion: solidarity, specialisation and monopoly. Exclusions based on the breakdown of the bonds of solidarity between citizens’ places the emphasis on the state to reintegrate the excluded. Exclusions based on specialisation or social differentiation, place the emphasis on the individual citizens responsibility to be included through the exchange of their rights and obligations. Exclusion that arises from the interplay between class, status and political power serves the interests of the included, who have a monopoly over the excluded.

Lister (2004) contended that social exclusion is regarded as divisive, and the term has been rejected in favour of the more aspirational politics of social inclusion. The premise of inclusion is based on social integration, primarily through paid work. When rights to citizenship are contingent on obligations however, then individuals who cannot consistently meet this contract for citizenship are devalued and marginalised. Sayce (1998, 2003) described social exclusion as a vicious circle of impoverishment that leads to limited or non-existent social networks, status, difficulties in establishing a family, repeated rejections and lack of hope for the future. Conversely, Sayce defined social inclusion as a virtuous circle of improved social and economic rights, new opportunities, reduced impact of disability and
recovery of one’s status and meaning. Social inclusion also means having support and reasonable adjustments, so that service users can be included in employment, and social networks, and have friendships, intimate relationships and participation in civic life. Finally, Sayce contended that social inclusion must be given a greater emphasis in mental health policy and must become a therapeutic goal in the practice of mental health clinicians. Mental health professionals also need to increase their partnerships with the service users’ movement.

**Conclusion**

This chapter has presented a review of the current research, conceptual literature and theoretical debates on the topic of citizenship. Common themes outlined in this chapter were the importance of the legal or formal status of citizenship, protection of rights and the persons’ social relatedness and connection to members of society.

Though there is considerable conceptual literature on citizenship, there is no empirical research that has focussed on service users’ understandings of citizenship, or their perceptions of the barriers that are placed on their ability to be accepted as full citizens. This is a major gap in the literature and therefore justifies the importance of this current study. Drawing parallels between other minority groups and service users also highlighted significant gaps in the literature regarding the power structures that present similar barriers to service users. Because the studies and commentaries on service users were located within the professional mental health literature, a broader socio-political analysis of the barriers to their full citizenship was limited. It is apparent that the concept of citizenship and the recognition of the right to social justice, privileges and protection for service users is not well understood, yet it is regarded as a strategic imperative for recovery from serious mental health problems and future wellbeing (Mental Health Advocacy Coalition, 2008; Mental Health Commission, 2004b, 2007).

This study will meet a number of gaps identified in this literature review. It will do this by addressing the understanding and meaning of citizenship for service users which will be strengthened by the use of a defined and appropriate conceptual framework. This conceptual framework will be presented in the following chapter.
CHAPTER FOUR: THEORETICAL FRAMEWORK

This chapter presents the theoretical underpinning of the study and Isin’s conceptual framework (1999, 2002, 2008b) used to analyse and interpret the data. Isin has developed a theoretical approach to citizenship that goes beyond traditional approaches and captures the issues of social justice, exclusion and the rights to full citizenship for marginalized groups. Following a discussion about the general principles of the approach, the conceptual framework will be discussed under the four dimensions: extent, content, depth and acts. As will be discussed below, the acts dimension has been a later development.

Isin’s conceptual framework is informed by a critical constructivist approach\(^{29}\) (Isin & Wood, 1999; Rorty, 1991). According to Isin and Wood (1999) and Kincheloe (2005), critical constructivist researchers aim to produce a much thicker and more detailed analysis of participants’ social, political, economic and cultural worlds. This approach also allows for a critical analysis of the power structures that privilege some people and marginalise others. Drawing on this approach, Isin and Wood (1999) also adopted an ethos of pluralism, or multiple modes of identity (Connolly, 1995, 2002) in their conceptualisation of citizenship. They argued that this radical view of citizenship recognises diverse identities and provides a platform to question the relevance of Marshall’s (1950) concept of citizenship.

Isin’s (1999) emerging conceptual framework describes three dimensions of citizenship: extent, content and depth. The next three sections of chapter four will describe these dimensions in depth. Subsequent work by Isin and colleagues has developed these dimensions further (Faulks, 2000; Isin, 2000, 2002, 2008b; Isin & Turner, 2002a) to include a theory of acts of citizenship to explain how citizens move from subjects to political actors (Isin, 2008b). This recent development will also be discussed.

**Extent**

Isin (Isin, 1999, 2002) contended that the extent of citizenship relates to the criteria of inclusion, later defined as the rules and norms of inclusion and exclusion. The notion of

\(^{29}\) According to Ackermann (2004) Piaget argued that constructivism is the notion that knowledge and one’s experiences of the world are both construed and interpreted through action.
inclusion within the body of citizens suggests that a person is required to meet a pre-defined set of criteria. There are three modes or legal principles (Isin, 2009; Joppke, 2007) of eligibility for citizenship: *Jus sanguinis*, which refers to those citizens who are related by blood, cultural or ethnic identity; *jus soli*, citizenship that is inherited by place of birth regardless of parentage; and *jus domicile*, citizenship which is acquired by naturalisation within another nation-state other than one’s place of birth. Some people reside in different nation states as denizens, long term residents who have some of the benefits of citizenship but are denied the majority of rights, such as voting (Bellamy, 2008; Turner, 2000).

Isin’s (2002) extensive study of the genealogies of citizenship has highlighted how different groups have constituted themselves as citizens in different historical contexts. Isin suggested that the criteria for citizenship are dependent on several factors. These are: one’s legal status; the competence to undertake one’s responsibilities, obligations and duties; possessing a set of virtues; and following the rules and norms. Being recognised, and recognising others as deserving of the privileges of citizenship, is also criteria for membership. In return, citizens expect to have the liberty and freedom to enjoy their lives and have equality with their co-citizens.

Isin (2008c) argued that citizenship has increasingly been determined by social behaviours, rather than civil or political affiliations. This suggests that citizens are active agents within their social relationships and environments. This “enactment” (Isin et al., 2008, p. 7) of citizenship is described as the art of being with others, which involves negotiating different situations and identities, articulating oneself as distinct yet similar to others and asking questions of justice.

Isin (2009) posited that the citizen-insider qualifies for membership because they have adopted society’s rules and norms. These rules and norms are founded in conventions, rituals and routines that socialise individuals into a set of practices and relationships with each other (Turner, 1993). As such, these “ground rules” (Calhoun, 2003, p. 548) of membership are based on sharing a common culture, speaking the same language and having

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30 Isin’s dimension of the extent of citizenship is informed by the work of Bourdieu (1990, 1991) and the notion of *habitus*, defined as the schemas of perception, action and discourse which generate the ideal standards of conduct, attitudes, beliefs and characteristics of social groups.
the same referents or symbols. The “persona” (Isin, 2009, p. 372) of the citizen is, therefore, constantly being developed within the social processes of citizenship.

Isin (2000) argued that the extent of one’s political power as a citizen is nestled within the patterns of inclusions and exclusions within the city. Isin proposed that the city is a “difference machine” (p. 1); a composite idea inspired by other metonyms such as “abstract machines” (Deleuze & Guattari, 1988); “diagrams” (Foucault, 1977), “figurations” (Elias & Scotson, 2008) and “fields” (Bourdieu, 1984). According to Isin (2002), the city is a crucial condition of citizenship. The space that is objectified as the city is constituted by the dialogical encounters of groups who assemble themselves, mobilise various forms of capital and make claims for their rights to be of the city. The city, therefore, is not a container where differences encounter each other, the city “generates differences and assembles identities” (Isin, 2002, p. 283). The idea of a difference machine is at once both creative and controversial (Elden, 2005; Staeheli, 2005) because it suggests that exclusion is a necessary process in the struggles for inclusion by groups who do not fit with the ideal standard.

Isin (2000) contended that those contained in institutions such as prisons and mental asylums lack certain attributes of citizens. This is a rare reference by Isin to service users, and within this context it is possible to draw conclusions that historically service users have experienced profound inequality and exclusion from full citizenship. This argument adds weight to Isin’s view that the degree of inclusion or exclusion as a citizen is determined by social behaviours dictated by the rules and norms of society. The city, in this respect, is also the space of discipline through its institutions, such as hospitals, prisons and asylums. Those who do not follow the rules and norms become subject to discipline and control by the state. Currently, the city still imposes law and order on those who are deemed to transgress the rules and norms of citizenship, and who are identified as the unruly and dangerous strangers and outsiders or aliens.

Isin (2002) argued that the state of Otherness is a condition of citizenship. Isin contended that the “closure theories” (p. 4) of citizenship define the space of privilege for the few. He argued that this theory excludes the subtle aspect that the constitution of the immanent Other

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31 The immanent Other is the essential, opposite category required to maintain the belief of those in the dominant group that they are the powerful and privileged insiders.
historically women and slaves, are the essential categories required to define the privileged status of the citizen. Influenced by Elias and Scotson (1965, 2008) and Wirth (1964), Isin concludes that when the power differentials between dominated and dominant groups are small enough, the dominated pose a possible threat to the dominant. In response, the dominant (“us”) constitute the dominated as objects of difference (“them”). These technologies and alienating and agonistic strategies of citizenship (Isin, 2002), control and dominate all citizens through the governmental structures within the city. Those individuals who are perceived as not following the rules and norms are then identified as outsiders, aliens and strangers (p. 49). Isin used the configuration of the “established and outsider” principle (Elias & Scotson, 2008, p. xiii) to explicate how the dominant group ascribed superior human qualities to themselves to not only exclude the members of the dominated group but also prevent them from having contact with each other.

Wirth (1964) qualified this by contending that minority groups are then held in low esteem and become objects of hate, ridicule and violence, which leads to them becoming further socially isolated and spatially segregated. This is also supported by Squire (2009) in her thesis on asylum seekers. Squire argued that asylum seekers have been excluded based on the unfounded fear, hatred and mistrust of this group by others in society and are considered to be outsiders and aliens.

Isin (2002) contended that domination is fundamental to being political. Wirth (1964) argued that when disadvantaged groups become articulate and conscious of their deprivation and see themselves as worthy of their rights, “they become a political force to be reckoned with” (p. 246). Therefore, when strangers or outsiders constitute themselves as being political, they overturn the misrecognised images ascribed to them by the dominant group (Isin, 2002; Isin et al., 2008).

Isin’s (2002) argument on the control and domination of social groups has been shaped by the work of Foucault (1977; 1988). Following Foucault, Isin and Wood (1999) contended that the structures of power, control and surveillance by the state are the technologies of citizenship which ensure a disciplined and conforming community, as well as regulating those citizens who may make demands upon the state. Isin (2002) argued that exclusion is maintained by the above technologies and the important notion of alterity. Alterity is implicit in the struggle
for inclusion as a citizen. In its simplest form, alterity refers to the small and often imperceptible changes made to the whole. In a philosophical sense, alterity (n.d.) is understood to be “the quality or state of being radically alien to the conscious self or a particular cultural orientation”. The state of alterity brings a quality to one’s experience, described as an intuitive or a visual representation of the experience of being Other. According to Elias (2008), the logics of alterity embody differentiation and distinction. Alterity is a strategy of exclusion, but also a strategy of recognition, incorporation and affiliation. The notion of alterity and Othering are, therefore, important aspects of the dimension of extent and the struggles for the status of citizenship by those who are excluded and marginalised.

The city is composed of many different kinds of people, prompting Aristotle (1995, p. 1261) to declare that “the city cannot be composed of those who are like one another”. In doing this, Aristotle set the platform for the value of mutual respect for difference and inclusive citizenship. Isin and colleagues have highlighted how the inclusion-exclusion binary and the acceptance of difference operate. This illustrated the ethos of pluralism, which Isin et al. (2008) and Isin and Wood (1999) proposed results in the recognition of the unique and differentiated rights of all marginalised groups.

Furthermore, Isin (2009) asserted that citizenship, as a concept, is in a state of flux. Citizenship traditionally has been based on the civil, political and social rights and the social processes that embody how subjects enact themselves as citizens. According to Isin, citizenship as an institution can be “both domination and empowerment, separately or simultaneously” (p. 369). He concluded that citizenship is not a fixed and immutable concept and contended that there are essential differences between citizenship and membership. The latter governs conduct within social groups, whereas the former requires the individual to master the “modes and forms of conduct” appropriate for an insider (Isin, 2009, p. 372). This repositioning of the identity of the citizen conceptualises the individual as the “person” who has the status within the law and the “persona” (2009, p. 372), one who has adopted the rules and norms, and is thus assimilated, integrated and incorporated by others.

Marginalised groups have challenged the universalistic view of citizenship by lobbying for recognition of their different identities within the body of citizenship. Isin et al. (2008)
suggested that misrecognition of identities occurred through the social relations and social processes that underlie the formation and definition of social groups (majorities and minorities). For example, groups such as women, ethnicities, and gay and disabled people, have been misrecognised when compared with the universal figure of the citizen, perceived as the able-bodied, adult, white, heterosexual and male figure (J. Clarke, 2004). The latter groups have become politically active and have challenged the social conditions of oppression and their subordination. Isin et al. (2008) contended that such activism, for example, by people with physical disabilities, has brought the normative assumption of able-bodiedness into light as a means of exclusion. Despite his attention to the exclusion and Othering of the latter groups, Isin’s conceptual framework does not go far enough to explain the implications that the politics of inclusion or exclusion and misrecognition have for service users. Fraser (1997, 2000) argued that when groups are socially constructed as the Other, this can create mal-distribution of their rights and entitlements and misrecognition of their identity, which weakens their democratic participation and ability to make meaningful contributions to society.

In summary, the extent of citizenship relates to the ability to live in harmony and to be free to pursue ones goals within a framework of governance that treats citizens with impartiality and equality. The technologies of exclusion and inclusion feature strongly within the extent of citizenship. Citizenship is an identity within a city whereby dominant agents constitute the characteristics of the virtuous, good and superior insider thereby differentiating themselves from the strangers, aliens and outsiders. The extent of citizenship focuses on the sites of contestation, resistance and struggle that various social groups engage in to identify the structures that prohibit their attainment of full citizenship. Central to Isin’s (2002) thesis is the importance of the city. Being a citizen means being a political actor within the city as, he asserted, there is no political being outside of the city. The rights and responsibilities, or content, of being a citizen are also an important aspect of citizenship and will be discussed in the following section.

**Content**

The content of citizenship is defined as the rights and responsibilities of citizens. Citizenship is a legal status requiring one to be a competent member of the polity (Isin, 2002; Isin & Wood, 1999). Isin and Wood further described content as both a set of practices (cultural,
symbolic and economic) and a bundle of rights and duties (civil, political, and social) which constitute the status and practice of citizenship. The status of citizenship enables citizens to take part in the democratic processes of the state to both rule and be ruled on an equal basis (Isin & Wood, 1999). However, Isin (2008c) and Isin and Wood (1999) have contended that in modern neo-liberal democracies there has been a greater emphasis on the rights of the individual citizen, rather than the responsibilities of citizenship, though there is evidence of a resurgence of the latter (Allman, 2002; Allman & Beaty, 2002; Tarcow, 2002).

The understanding of the benefits and burdens of citizenship as rights and responsibilities are embedded in the three traditions of citizenship: liberalism, civic republicanism and communitarianism (Isin & Turner, 2002a). Liberal citizenship places emphasis on rights and freedom; however it does emphasise the moral qualities and responsibility by citizens to not abuse this freedom. Civic republicanism emphasises civic virtues and the responsible practise/duties of citizenship (Dagger, 2002; Oldfield, 1990a). The communitarian tradition emphasises the politics of the common good and a cohesive and just society. Communitarianism also embodies the moral voice of the community which calls to all citizens to carry out their responsibilities or face the consequence of drifting towards individualism and anomie (Delanty, 2002).

Marshall’s (1950) sociological essay on citizenship was based on entitlements and had little to say about duties and obligations. Turner (2001a) argued that Marshall’s minimal emphasis on the responsibilities of citizenship envisaged a passive citizenry, and in the last two decades democratic neo-liberal governments have reprised the emphasis on the responsibilities and obligations to encourage an active citizenry (J. Clarke, 2004; Peled, 2008). The discourse on rights and responsibilities has its foundation in the notion of liberty (Berlin, 1969) and the right to individual self-determination, recognition and the assertion of self and personal agency (Isin & Wood, 1999). Isin and colleagues (2008b) have given some attention to the meaning of responsibility as a citizen, a position informed by Bakhtin (1990), Levinas (1998) and Derrida (1997), and they concluded that responsibility also has an ethical quality of obligation and answerability not only to the state, but for each other32.

32 Discussed further in the acts of citizenship section in this chapter.
The concept of citizenship presumes that its members have the autonomy and resources to perform these responsibilities, duties and obligations as well as participate as political agents. Not all members of society, however, ascribe to the dominant view of the active citizen who is a successful, self-reliant and enterprising individual. Lister (2004) argued that individuals whose choices and actions are constrained by social and political structures may not be able to be the authors of their own biographies because they may find themselves in a subordinate position where they are perceived as unsuccessful and un-enterprising. As a consequence, the subordinated are excluded from the ranks of citizenship (Lister, 2003), exemplifying that citizenship is an exclusionary practice (Crick, 2000). Interpreting citizenship as a “uniform” (Turner, 2001a, p. 191) concept, therefore, does not take into account the fluid nature of citizens’ abilities, capacities and social status. Barton (1993) and Marks (2001), for example, have reported that people with physical disabilities have experienced denial of their rights and entitlements as citizens. Likewise, service users are constrained by the social structures that perpetuate their stigma and discrimination, and the constraints of the Mental Health Act on their liberty and ability to participate as active citizens.

In the traditional view of citizenship, access to economic capital (the ownership of property or status symbols) was the mark of the citizen. However, Isin (1999) and Isin and Wood (1999) proposed that Bourdieu’s (1986) forms of capital, such as social (collaborating and joining with others), cultural (upbringing and educational qualifications) and symbolic (reputation, prestige and status) are equally important. These forms of capital enhance citizens’ power, influence and the means to live life to the full.

Isin and Turner (2007, p. 9) and Turner (2008, p. 134) have proposed that citizenship entitlements located within liberal capitalism can be best described as “contributory rights”, defined as the claims against society in return for the contributions that citizens make. Turner (2001a, p. 189) argued, however, that the contributions were based on the “three pillars” of citizenship: work, public service (such as military duty) and reproduction. This view constructs the social identities of people as “worker-citizens”, “warrior-citizens” and “parent-citizens”. Some minority groups, he explained, are excluded from these identities thereby curtailing their ability to contribute as citizens. For example, lesbians and gays have been excluded because of the hetero-normative dominance of the military, the family, and discrimination in the workforce (D. Richardson, 1998, 2004, 2005). Service users are
excluded on a similar basis, mainly due to the stigma and discrimination they encounter in these institutions, which places restrictions on their ability to make a contribution as citizens.

Isin (1999) argued that globalization redefined the concept of the city and the image of the citizen. This work was influenced by the view of Castells (2000), who asserted that the global city has a primary focus on the production and consumption of goods. Sassen (1996) suggested that the city has become the new site of dual class structure and group conflicts. This has led to the rise of a “new class” (Isin, 1999, p. 272) of mainly professionals and an underclass disproportionately represented by immigrants. Lister (1990a, 1990b, 1993) contended that women, the disabled and the poor have been disqualified from citizenship on this basis. It can be argued that service users are also a disqualified group.

Historically, social rights were separated from the rights of citizenship (Isin & Wood, 1999) meaning that socially disadvantaged groups, such as women and the poor, were cared for in the state’s workhouses or charitable alms houses provided they gave up their civil and political rights of citizenship. Many who were classified as insane were grouped with those who did not have financial means and thus deemed unproductive and unemployable, living in the lunatic wards in the workhouses and later warehoused in the large asylums (Barham, 1992).

Though Marshall’s (1950) model of citizenship attempted to restore the inclusion of social rights and welfare for the disadvantaged, Isin and Wood (1999) have continued to question whether the institution of citizenship masks various forms of inequalities and denial of rights for some marginalised groups. Isin and Wood (1999) argued that groups, who have become radicalised, such as African Americans and women, won the right to claim their full rights of citizenship and an effective share of power within society. This “politics of recognition” (1999, p. 31) enables marginalised groups to escape their experiences of disrespect and alienation. If one is recognised as a citizen, then one is entitled to the rights and the responsibilities of a citizen.

The notion that citizenship does not have an “ideal type” (Isin & Wood, 1999, p. 5) has relevance for the cultural diversity of the polity. There has been debate about the positive and
negative aspects of the diversity of groups and their demands for citizenship rights. Kymlicka (1995) contended that such diversity beyond ethnicity or race requires special representation rights. However, the fundamental argument is that if society could remove the disadvantages that oppressed groups experience in the first instance, then this would eliminate the need for these rights. Chamberlin (1998) and Sayce (2000) contended that service users equally would wish to have the barriers that disadvantage them removed, so that their group rights would be acknowledged and protected in a similar way.

In summary, the content of citizenship has highlighted how enacting one’s rights and responsibilities are important criteria for those who seek membership of the citizenship club and recognised as active participants in society. In the following section, the depth of citizenship, defined as the thickness or thinness of belonging, will be discussed.

**Depth**

Isin and Wood (1999) maintained that discussions about citizenship regularly spill over into the notion of identity, belonging, solidarity and recognition. Rather than viewing citizenship as a uniform concept, Isin and Wood proposed that there is a rich tapestry of different identities within the citizenry, such as women (Lister, 2001, 2003); lesbians and gays (Lister, 2002; Plummer, 2003; D. Richardson, 1998, 2000); indigenous groups (Humpage, 2006, 2008; Pearson, 2002, 2005) and migrants, refugees and asylum seekers (Kymlicka, 1995; Penninx, 2004; Squire, 2009).

Identity is concerned with the similarity and dialogical recognition of one’s other, and is thus a relational process. Group identity determines who is and who is not a citizen through the process of identifying in each other certain attributes that establish “resemblance and affinity” (Isin & Wood, 1999, p. 19). Tully (2000) suggested that a sense of belonging is engendered more by engagement in the struggles to gain recognition, than by the end-state of the actual form of recognition. He suggested that the struggles themselves constitute the public displays of the intolerability of the present form of recognition and that these displays constitute another, more desirable form. Isin (2002) contended further that the patterns of inclusions and exclusions create the social struggles which, in turn, create the different identities of citizens. The thickness of identity is dependent, therefore, on how the individual is comprehended and accommodated by others in society (Isin & Turner, 2002a).
A thinner sense of belonging emanates from the historical roots of citizenship, particularly the Roman figure of the republican citizen who had the right to dominate other subjects (strangers, outsiders) and abjects (aliens) (Isin, 2002). In contrast, the modern communitarian or cosmopolitan traditions of citizenship have a much stronger focus on shared civic identity and common values, which create a thicker sense of belonging, solidarity and togetherness (Kostakopoulou, 2006).

In pre-modern times, solidarity was based on permanent, emotional and solid tribal affinities (Turner, 1999). Modern societies, in contrast, are organised around the “market place and anonymous strangers” (Turner, 1999, p. 141). The influence of the market place and consumerism has had an impact on belonging, solidarity and loyalty. Citizens disconnect from each other by being highly mobile and subject to modern types of media and communication (Hartley, 2010). This can be starkly compared to tribal mediums of communication based on oral and ritualistic traditions which helped sustain a strong connection between citizens.

Isin (2000) posited that the global city is the space within which the very meaning of citizenship is made and transformed. Isin argued that globalisation has engendered new political groups who seek to expand modern civil, political and social rights. This has been illustrated in the struggles of women for pay equity and lesbians and gays who have fought for their claim to the rights extended to heterosexuals. The various claims of each group strained the boundaries of citizenship. Minority groups struggle to retain their difference and, at the same time, make their claims to equivalent rights and inclusion within the dominant group. According to Isin and Turner (2002b), citizenship is, therefore, always in a state of flux and can hinder or ease the domination of one social group over another. Likewise, Lister (2007) asserted that citizenship must be continuously reworked to realise its egalitarian and anti-hierarchical potential to support marginalized groups, such as service users, who are struggling for social justice.

Isin (2009, p. 369) argued that rather than asking “who is the citizen?” it is best to ask “what makes the citizen?” This shifts the focus from fixed and immutable identities to the sites of struggle where new identities of citizens are developed. Rather than being defined solely by
the person’s disability (Isin & Wood, 1999), members of new social movements, such as service users, can assert their evolving identity and make their claim for the right to belong as full citizens. Isin (2000) contended that the city is a space that provides a glimpse of the flows and fleeting images of the struggles of its citizens. Even though it is a site of struggle, Isin portrays the city in sentimental terms as a place that teaches “humility and care” (p. 19) to its inhabitants, and cultivates good citizenship so that groups can govern themselves.

These sentiments add weight to the importance that a sense of belonging, solidarity and social cohesion has for citizens and their ability to flourish. A commitment to the responsibility towards others is an example of the ethic of care (Gilligan, 1982; Plummer, 2003; Tronto, 1993). Other scholars (Barnes & Brannelly, 2008; Brannelly, 2006; Sevenhuijsen, 1998) have also argued that the role of care, relationality and interdependence needs to be acknowledged as part of the social processes of citizenship. The vocabulary of humility, care, and other moral concepts of attentiveness, responsibility, competence, responsiveness, trust and asymmetrical reciprocity echoes Connolly’s (1995, p. 142) “warm words” derived from his ethos of pluralism. Such sentiments connote a deeper sense of being a citizen, and a sense that citizenship has the quality of being something that one lives, rather than a legal status alone (Bellamy, 2008; P. B. Clarke, 1996; Isin, 2000).

Isin and colleagues (Isin, 2008c; Isin & Turner, 2007; Nyers, 2008a) have increasingly been inspired by Heidegger (1962), claiming that being a citizen is both ontic (contingent everyday facts), and ontological (the necessary existential conditions). Isin (2002) uses Heidegger’s philosophy to make a distinction between politics, expressed as everyday activities, and the existential process of how beings become political. Isin argued earlier that citizenship is concerned with the other and the Other. Isin suggested that being in the world is being-with-another. Being concerned with the other can express itself as tolerance or intolerance, difference or indifference, constituting the solidaristic, agonistic and alienating strategies of citizenship. Isin (2008b, p. 19) described the latter strategies as follows: solidaristic: actions towards the other that are generous, magnanimous, beneficent, hospitable, accommodating, understanding and loving. Agonistic are competitive, resistant, combative and adverse; alienating are vengeful, revengeful, malevolent, malicious, hostile and hateful. In so doing, the citizen responds to the other as another citizen, or as the Other; the outsider, stranger or alien. In other words, Isin claims that being a citizen is a process that one lives.
Other scholars have also been interested in the ontological aspects of citizenship. Conover (1995) suggested that the psychological meaning of citizenship constitutes a framework of beliefs that shape the way citizens relate to the state and their co-citizens. Conover calls this the “sense of citizenship” (1995, p. 134). Beliefs about one’s identity as a citizen, argued Conover, provide the key motivation and emotional energy for the practice of citizenship. Conover (1995) argued further that this deeper sharing of the common good is exemplified by the communitarian tradition of citizenship, whereby citizens hold beliefs about the communal “we identities” (p. 137) rather than the “I identities” (p. 138) held by the liberal tradition (Taylor, 1989). Dean (1995) further supported this view and warned that the repressive and exclusive aspects of citizenship can create the “us” and “them” binary (p. 115).

Dean (1995) offers two types of solidarity: affectional solidarity and conventional solidarity. Conventional solidarity grows out of the common interests and concerns that citizen’s hold, whereas affectional solidarity grows out of the intimate relationships of love and friendship, mutual care and concern. Dean’s notion of affectional solidarity is inspired by Benhabib and Cornell’s (1987, p. 87) view that the other “feels recognised and confirmed as a concrete other, an individual being, with specific needs, talents and capacities”. Such aspects of belonging and solidarity augment Isin’s (2008b) argument that citizenship is a lived experience and a holistic practice.

In summary, Isin and colleagues argued that citizenship is both a legal institution and something that one lives. The depth of one’s belonging is also concerned with the ethical, political and aesthetic focus on the social processes of being a citizen (Isin, 2008c; Isin & Turner, 2007). Isin has proposed that how one’s identity is accommodated and understood by others in society can render the person as an outsider, stranger or alien, or insider and citizen. Citizens struggle to continually shape their identity as insiders, mediated through the norms, practices and meanings inherent within society. Such struggles are conducted by active citizens who make the claims for their rights and responsibilities, often in the face of alienating and agonistic strategies of citizenship. The making of a claim for justice is the concern of the theory of acts of citizenship (Isin, 2008b; Isin & Nielsen, 2008b) which will be discussed in the following section.
Acts

Isin (2009) argued that citizenship is not a fixed state, rather it is a fluid institution that both dominates and empowers subjects. He argued that citizenship is in a state of flux wherein the outsider, stranger or alien continually redefine their person (law) and their persona (norm) in order to acquire the status of the insider. According to Isin (2008b) and Isin and Nielsen (2008b), acts of citizenship transform the person from political subject to political actor, and claimant of justice, in the face of the injustices of having one’s rights, responsibilities and entitlements of citizenship suspended or denied.

As discussed above, citizenship is dialogical, and relies upon the social processes of relating to others (Isin & Wood, 1999). Therefore, acts of citizenship are fundamental ways of being with each other, and are located within the solidaristic, agonistic or alienating social processes of being a citizen. Acts of citizenship involve acts of courage, bravery, indignation and/or righteousness. Acts create a rupture in the habitus (Bourdieu, 1998; Isin, 2008b), described as the internalised and embodied ways of thought and conduct constituted by the usual customs, routines, habits and particular practices in which citizens engage.

Isin (2005, 2008b) argued that an act is interpreted as political when it constitutes the subject as a claimant of justice. Acts can take many forms, he suggests, such as dissent, resistance, affirmation or withdrawal. Isin (2008a) and Nyers (2008b) proposed three important principles that constitute acts of citizenship. Firstly, people move from subjects to political actors (or activists) through the scenes that they create which are neither inclusionary nor exclusionary, but can be interpreted as such through their consequences and effects. Secondly, acts produce actors who become answerable to justice against injustice, but finding an explicit motive or rationale for the action is not of paramount concern. Thirdly, acts can happen without being founded in law or responsibility. To become responsible, it would seem that acts of irresponsibility must be undertaken.

Citizenship involves orientations (motives), strategies (manoeuvres) and technologies (techniques) (Isin, 2008b, p. 37) which determine the rational, unintentional actions and routinized ways of how individuals conduct themselves. Social actions such as voting, paying taxes or enlisting in the army are the actions of citizens but do not constitute acts of citizenship because these social actions are already established (Isin, 2009).
Being constituted as a claimant of justice requires three related activities: making the claim (solidaristic, alienating, agonistic); articulating the claim (orientations, strategies, technologies) and making and articulating it from a position (citizen, stranger, outsider or alien). Isin contended that citizens, outsiders, aliens or strangers become political actors when they break with the routine practices of citizenship by creating a rupture in the “already written script” (Isin, 2008b, p. 38) that others in society follow. Thus an act creates the “rupture in the given” (p. 25) and creates a new beginning. The capacity to act as that “being” is the act of being political (2009, p. 380). The act, therefore, is the “expression for the need to be heard” (Reinach, 1983, p. 20). The act hails the other and constitutes the “two-sided answerability” (Bakhtin, 1993, p. 3) which evokes the “responsible-other” (Lavoie, De Koninck, & Blondeau, 2006, p. 239; Lévinas, 1998, p. 159).

Isin’s concept of acts has been influenced by Ware (1973) who posited that unlike actions that produce observable physical changes over a finite time, an act is different in that it does not possess “spatio-temporal coordinates” (p. 414). In contrast, Isin (2008b) argued that acts do have a spatio-temporal quality and “accrete over time” (p. 24). This suggests that one can be answerable to the other without necessarily being in the same geographical location. Equally important to Isin’s (2008b, p. 25) argument is that acts of citizenship require “accomplishments” and “completion” (R. Ware, 1973, p. 414).

Acts of subversion and resistance emerge in all aspects of struggles for citizenship within the city. Acts are the moments of “justice seeking answerability” (Isin, 2008b, p. 36) when the alienating and agonistic technologies and strategies of citizenship have rendered the individual as Other and outsider. Therefore, acts set the scene to subvert and destabilise the social processes that are degrading and diminishing of citizens’ rights.

For example, during the Nazi occupation of the Netherlands in World War II, the yellow Star of David was imposed on the Jewish citizenry as a symbol of their dehumanisation. The Dutch citizens’ knew the star was meant to create a barrier between themselves and their

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33 This refers to space and time. Temporality is not linear time; it is a succession of moments in a person’s history. Temporality has a qualitative dimension, which creates a story and is evident when there is new self-understanding or emergence of new knowledge as the person reinterprets the past (Benner & Wrubel, 1989, p. 64)
Jewish fellow citizens. As a form of resistance to this violation of their rights, Queen Wilhelmina pinned a piece of yellow cloth to her own lapel. Other Dutch citizens were similarly inspired to pin yellow cloth or paper to their lapels (Friedman, 2004) as a sign of solidarity with their peers. This is an example of a solidaristic act of citizenship. In such profound circumstances, the act gave hope to the Jewish community because they were recognised as human beings, and as citizens.

According to Wells (2008) an act can “clear the way” (p. 76) for new rules and ways of being, forging the way forward for a citizenship “yet to come” (Isin & Nielsen, 2008a, p. 4) for those who are marginalised and oppressed. This brings into existence the possibility of full citizenship for strangers and outsiders (Isin & Nielsen, 2008a). Acts provide the platform for all people to call into question the injustices towards those who are excluded. These political acts are the practice of the making of citizens (Isin, 2008b).

In summary, the theory of acts of citizenship posits that individuals can transcend from subjects to political actors. Acts of citizenship disrupt the universal rules that can be oppressive and supportive of the on-going injustices and unethical treatment of those rendered as outsiders.

Conclusion
Over a decade ago, Isin (2000) warned that the conceptual and analytical tools that had been inherited from the nineteenth century sociological, political, philosophical and economic traditions may not be adequate for the task of understanding the rights, responsibilities and entitlements of citizenship within modern democratic processes. The era of globalization, argued Isin, would ultimately change how citizenship was configured. It would require a rethinking of the understanding of citizenship beyond the confines of the city as the sole container of citizen rights. Isin argued that citizenship is not just a legal status; it is a social process of recognition, redistribution and the resourcing of all members of society. The following chapter will address how Isin’s conceptual framework was utilised to analyse and interpret the data for this thesis.
CHAPTER FIVE: RESEARCH METHODS

This chapter outlines the philosophical underpinnings of the research and describes the methods used to collect and analyse the data. The ethical issues associated with the research are also considered. The decision making processes undertaken during the research process are also presented.

Aims of the study
The main purpose of the study was to answer the research question, “What are mental health service users’ understandings of citizenship”? This research question arose from my acknowledgement of concerns from within the service user movement that recovery had been co-opted by mental health professionals. These concerns describe how recovery has become something mental health professionals do to service users. Rather, recovery is a philosophy of care that places the responsibility on mental health professionals to provide an environment within which service users can flourish and regain their place as full citizens within society. These concerns prompted the secondary part to the research question, “Does the recovery approach help or hinder the service users’ journey to full citizenship”? By answering this research question, the study aims to contribute to current theoretical and clinical knowledge of the barriers to full citizenship for service users. The study also highlights implications and recommendations for nursing practice, nursing education, mental health policy and further research.

Methodological approach

One of the key philosophical debates in qualitative research is how to study the social world (Snape & Spencer, 2003). Snape and Spencer argued that a positivist view claims that an external reality exists independently of people’s beliefs and understandings about the world. A postmodernist view asserts that there are no absolute truths, instead there are only different interpretations formed through language which interprets one’s reality, and how these realities are socially constructed (Freedman & Combs, 1996; Walker, 2006). This study aims to explore how the participants interpret and construct their reality by using a qualitative approach. This approach was chosen because it allows for an exploration of the participants’ understandings of citizenship and whether they perceive the recovery approach to be helping
or hindering their journey towards full citizenship. Data were collected through individual interviews with 17 service users, five public servants and one focus group with seven nurses, and readings of service users’ narratives as well as government documents relevant to the research questions. Isin’s (1999, 2002, 2008b) conceptual framework was used to analyse the data.

**Philosophical underpinnings**

This study is informed by a critical constructivist approach (Isin & Wood, 1999; Rorty, 1991). According to Isin and Wood (1999) and Kincheloe (2005), critical constructivist researchers aim to produce a much thicker, more detailed and complex view of participants’ social, political, economic and cultural worlds. This approach is also focused on exploring the power structures that privilege some people and marginalise others. The critical constructivist approach ensures that the process of analysis allows for the dialogical nature of participants’ perceptions and their constructions of citizenship to emerge.

According to Finnemore and Sikkink (2001) critical constructivism is founded on critical social theory, which was informed by scholars such as Giddens (1984), Habermas (1984), Foucault (1972) and Goffman (1971). Finnemore and Sikkink further argued that critical constructivists believe that certain powerful groups, such as professional bodies, play a privileged role in the process of the social construction of a common set of norms, world views and social structures, and that the role of the researcher is to “unmask” structures of domination (p. 398).

The critical constructivist approach framed the position I took as the researcher during the interviews with the participants and the subsequent analysis of the data (Miles & Huberman, 1994). The approach allowed for an exploration of participants’ perceptions and analysis of the nature of the power structures inherent in their narratives of citizenship, recovery and the role that of mental health nurses have in their journeys towards full citizenship. As Diesfeld and Freckelton (2003) contended, the narratives of service users can reveal subjugated knowledge that can challenge the dominance of the unitary knowledge of the most empowered, such as mental health clinicians.
The critical constructivist approach requires researchers to attend to the power structures that exist within the research process. According to Mills, Bonner, and Francis (2006) power imbalances between the researcher and participant can be attended to by taking a more reflexive stance on the research process and considering the practical aspects of planning for the interviews. In this study, reflexivity was attended to by prior reading of the critical constructivist approach, taking field notes during and after the interview and keeping a reflexive journal. The reflection on the underlying assumptions of the research enabled me to listen andanalyse the participant’s stories as openly as possible. This required a non-judgemental stance towards the participants and relied on my ability to resist the urge to assign values to participants’ responses.

Practical strategies were also used during the research process to help move the researcher and participants towards a more equal sharing of power (Mills et al., 2006; Seibold, 2000). For example, I scheduled the interviews at a time and place chosen by the participants and facilitated an open flow of conversation within the interview, sharing my understanding of the participants’ key points as they emerged. I shared personal details about myself and answered questions from the participants about the research process during and after the interviews. Taking a flexible approach during the interview allowed the participants to take power over the flow, content and direction of the conversation which helped them to gain greater insight into their own worlds (Mills et al., 2006). This increased the sense of reciprocity and enabled a mutual construction of their stories.

Qualitative interviews

Recruitment
A purposive sample of service user advisors, public servants from government agencies and mental health nurses was recruited for the research. The service user advisors were recruited to provide their personal experiences as users of mental health services as well as the experiences of the service users they had represented. Leaders of consumer network organisations were contacted to seek their support in recruiting possible participants. They were provided with participant information sheets (see appendix one) which they circulated within their networks. The aim was to recruit up to 20 service user advisors and peer support workers, 17 people responded and all agreed to take part in the study.
The public servants were recruited to provide their views on how current and future service development and policy direction could help service users on their journey to full citizenship. These participants included key people from the Ministry of Health, the Mental Health Commission, the Human Rights Commission, the Disability Rights Commission and international leaders in mental health service development. Each person was contacted directly to seek their consent to participate in the study. All were resident in New Zealand, apart from one person who lived in the United Kingdom.

On the completion of data collection I also facilitated a focus group interview with seven mental health nurses\textsuperscript{34} who were recruited through the New Zealand College of Mental Health Nurses\textsuperscript{35} (the College). This group of informants were recruited to assist in the analysis of the study’s findings. The group interview followed the same question format as the individual interviews and included a discussion about the emerging findings from the service users’ data. It was decided to recruit nurses who were attending the inaugural College conference in 2007. Permission was sought from the Chairperson of the College research board, and once granted the Chairperson of each Branch forwarded the advertisement to the College members. Of the nine people that replied, seven agreed to take part in the focus group. The focus group was scheduled to occur on the evening of the second day of the conference at the home of a PhD student who lived near the conference venue.

\textit{The sample}

The first group of participants consisted of 17 service user advisors, 13 women and four men. The age range was from early 20s to late 60s and one woman identified as New Zealand Māori\textsuperscript{36}. All of the service user participants had been diagnosed at an earlier stage of their lives with a serious mental illness and a number had experienced admissions to psychiatric institutions, some for lengthy periods of their lives (more than six months). Most of these participants were in paid employment and many had current or past roles as service user representatives and peer support workers. Of the five public servants, two were women and one identified as New Zealand Māori. All were over the age of 45 years. The focus group

\textsuperscript{34} This group will be identified as nurse in the findings chapters.
\textsuperscript{35} This is one of two professional bodies for mental health nurses in New Zealand.
\textsuperscript{36} The Māori participants disclosed their cultural identity during the interviews.
consisted of seven mental health nurses currently practising in mental health settings. Six of the group were women, two of whom identified as New Zealand Māori. The age range was from the late 20s to the late 50s.

*Interview schedule*

The interviews were semi-structured and the questions were open-ended. This ensured that the researcher was able to obtain the specific information required to answer the research question and at the same time enabled the participants to provide further information from their own experiences and views on the subject. Within constructivist approaches the meanings of participants’ stories are developed through a conversational style of the interview, leading the respondents to new insights about their world. Thus, the researcher plays an active role in the development and interpretation of the data (Legard, Keegan, & Ward, 2003). This was facilitated in this study by the use of periodic summaries, clarifications and further probing questions (Minichiello, Madison, Hays, Courtney, & St John, 1999).

*Interview questions*

The preparation of the interview questions (see appendix three) was influenced by the initial reading of the literature on citizenship and centred on the main aims of the study. Four main themes were explored:

- The understandings of citizenship and what it means for the participants and the people that they have represented in their roles as consumer advisors/representatives
- Whether the recovery approach helped or hindered service users’ journeys towards full citizenship
- The contribution that mental health nurses have made to service users’ journeys towards full citizenship
- What changes, if any, could be made to future mental health policy to better support service users’ journeys towards full citizenship

At the conclusion of the first two interviews the respondents suggested that participants should be able to provide their personal definition of recovery prior to answering questions

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37 This theme was explored with the participants who were public servants.
around theme two. In response, the supplementary question “What is your definition of recovery?” was added to the interview format.

*Interview process*

The individual interviews were conducted face-to-face at a geographical location of the participants’ choice. Two interviews were conducted over the phone for the convenience of the participants. Field notes were completed after each interview as part of the audit trail (Miles & Huberman, 1994; Watt, 2007). Each interview was digitally recorded and lasted approximately one hour. All participants signed a consent form (see appendix two) prior to the commencement of the interview and any questions related to the participant information sheet (see appendix one) were answered.

A similar process was adhered to in the focus group. The second supervisor for the research study attended the focus group to take field notes, whilst I took the role of the group facilitator. The appropriate practical preparation for a successful focus group interview was attended to (Carey, 1995; Kitzinger & Barbour, 1999), this included arranging the chairs in a U-shape around a table and supplying refreshments during the group session (Côté-Arsenault & Morrison-Beedy, 1999). The group interview was 90 minutes in duration.

Due to the sensitive nature of the research topic it was important to ensure that each participant felt comfortable during the interview process. I have had many years of experience in interviewing and was therefore able to put the participants at ease and respond appropriately in the event of any discomfort that arose during the interviews. Skilled questioning and summarising, the use of a conversational style and seeking feedback during and at the end of the interview, ensured the comfort of the participants. Some of the service user advisor participants commented that they found the interview process therapeutic, providing them with the opportunity to reflect positively on their personal journeys of recovery.

Undertaking research with vulnerable groups has not been widely discussed in the literature (Flaskerud & Winslow, 1998; Hamer, McCallin, & Garrett, 2009; Moore & Miller, 1999). Kidd and Finlayson (2006) presented a salient account of the ethical responsibility of researchers when researching sensitive topics with a vulnerable population. Researchers
using the narratives of participants need to be aware of, and acknowledge, their emotional responses, and how these reactions could affect the quality of the research. It was during this first level of analysis of the data that I experienced my own intense emotional responses. These were triggered by the participants’ stories of both courage and success, but also their grief related to not being regarded as full citizens by others in society. In particular, the themes of powerlessness, exclusion and some of the participants’ Utopian accounts of a society free of prejudice and stigma were profoundly moving for me. This highlighted the importance of keeping a personal journal to document my emotional reactions, as well as the need to debrief with peers and thesis supervisors.

Transcription of interviews
All 20 interviews and the focus group were transcribed by me. The last four interviews were transcribed by an experienced transcriber who had signed a confidentiality agreement (appendix four). I read all the transcripts and erased any identifying material, such as people’s names and geographical locations. The participants either chose pseudonyms or were allocated them by the researcher. The participants were given the choice of receiving paper and/or electronic copies of their transcripts to check for accuracy. One service user returned his transcript with changes to the data that he believed, with hindsight, could identify a service user and a clinician he had discussed. Two participants added new data which were mainly for clarification.

Data analysis
Analysis of the data was undertaken using the framework approach developed by Ritchie and Spencer (1994). This approach has gained popularity for analysing qualitative data derived from applied research within health care settings (Smith & Firth, 2011). Though the framework approach is similar to thematic analysis, the latter has been criticised for lacking transparency on how the themes are developed (Attride-Stirling, 2001). In contrast, the framework approach requires the researcher to work with structured topic guides to elicit, manage and explore data in-depth, whilst simultaneously maintaining a transparent and effective audit trail (Smith & Firth, 2011).

38 Four participants wanted to use their own names, a request honoured by the researcher.
The topic guides used in the data analysis in this study were derived from the conceptual framework. The rationale for choosing Isin’s conceptual framework was based on the compatibility between my philosophical position of constructivism and the critical constructivist approach to research used by Isin at the Centre for Citizenship, Identity and Governance (CCIG) in the United Kingdom. As discussed in the previous chapter, Isin’s conceptual framework has three themes (extent, content and depth) and sub-themes (rules, norms, rights, responsibilities, belonging and acts of citizenship).

The framework approach (Ritchie & Spencer, 1994) provides a series of interconnected stages that help to guide the process of analysis. These are familiarisation, developing the thematic framework, indexing, charting and mapping, and interpretation of the data. Though the framework approach provides interconnected stages, it is not a linear approach, rather it provides a scaffold that guides the iterative process of analysis (Smith & Firth, 2011). The approach has the advantages of preventing the data from being fragmented and maintains the coherence of the emerging themes resulting in a conceptual map of the data (Ritchie & Lewis, 2003; Smith & Firth, 2011).

I began the familiarisation phase during the interviews, when transcribing the data and through the initial readings of the transcripts. This process gave me the opportunity to form some “hunches” (Ritchie & Spencer, 1994, p. 178) about key issues and emergent themes. I then immersed myself in the data (Ritchie & Spencer, 1994; Smith & Firth, 2011) by printing a copy of each interview and reading the transcripts multiple times. The familiarisation phase not only helped me gain an overview of the richness, depth and diversity of the data, it also enabled me to begin the process of abstraction and conceptualisation.

A thematic framework progressively developed using a data coding system that identified the key words or phrases that corresponded with the themes and sub-themes within Isin’s conceptual framework. The indexing and annotating of the textual data was completed by

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39 See chapter three for more detail on this conceptual framework of citizenship.
40 CCIG promotes critical and interdisciplinary research and openness to various theoretical and empirical approaches and methods, including discourse analysis, postcolonial theory, psychoanalysis and cultural studies. It is critical in that it highlights the conditions of the existence and emergence of oppression and marginalization associated with particular social, political and cultural arrangements. CCIG also supports reflexive approaches to the conduct of social science research and knowledge production.
making margin notes of the themes. Each theme was then allocated a different colour and transcripts were cut and grouped accordingly. I then charted the textual data by rearranging the quotes under the themes and sub-themes from the thematic framework on to flip-charts, one for each dimension - extent, content and depth. This involved making numerous judgements of the meaning and significance of the textual data as many of the quotes contained a number of different themes. The mapping of the data to the three dimensions, extent, content and depth is an integral component of the deductive nature of the framework approach (Pope, Ziebland, & Mays, 2000). At this point I showed the emerging themes to two research colleagues so that I could check-out the beginning synthesis of the themes, and to guard against being over-immersed in the data (Smith & Firth, 2011).

The final step was the interpretation of the data as a whole. All of the data was interpreted and guided by the questions in the interview format. While the research question has been addressed through the analysis of the three themes, not all the data was included. Firstly, I chose not to include the data related to the question “What is your definition of recovery?” as this was not the main aim of the study. Secondly, only a small amount of data from the focus group participants mapped on to the three themes and therefore is not fully represented in the findings. This additional data will be used for future publications.

To ensure rigour in the study I used both manual and electronic (NVivo) approaches to data analysis. The transcripts were imported into NVivo and I replicated the coding according to the themes and sub-themes identified in the manual analysis. Memos were made regarding decision-making around each theme which NVivo then linked to the relevant pieces of text in the different transcripts.

The subsequent development of Isin’s conceptual framework that included the acts of citizenship (Isin & Nielsen, 2008b) prompted a retrospective analysis of the data, and the fourth theme, acts of citizenship was included in the final analysis. The findings are presented in the following four chapters under the headings: extent, content, depth and acts of citizenship.
**Reflexivity**

Reflexivity in research is concerned with ensuring the confirmability (reliability) and dependability (validity) of the findings (Lewis & Ritchie, 2003). This was ensured by attending to the audit trail (Miles & Huberman, 1994; Watt, 2007) in order to provide transparency of the research process. The audit trail consisted of member checking, confirming results with the participants, peer debriefing, personal journaling and keeping all copies of the data analysis and important documentation to ensure the trustworthiness of the study.

The structure of the framework approach to data analysis also allowed for transparency and it is customary to involve other researchers, key informants or experts in the research process to ensure confirmability and dependability of the findings. The indexing and annotating of the textual data made the process of analysis visible to others. I met with my supervisor and a doctoral peer to appraise the process of analysis and interpretation of the data. This also gave me the opportunity to check-out the basis of my initial assumptions, and the discussion led to further abstraction and contextualising of the findings. Member-checks were also undertaken with the participants to assist with the accuracy of the descriptions, explanations and interpretations emerging from the analysis. This consisted of sending a brief overview of the key points from the initial findings to all participants via an email. Five participants responded by return email to confirm that the findings were representative of their understanding of citizenship.

As the analysis deepened, I met face-to-face with five of the participants to refine the conceptualisations that were emerging, for example, the connection between recovery planning and self-surveillance. These meetings further strengthened “face validity” (Patton, 2002, p. 561) as all five acknowledged that these findings rang-true with their understanding of their world. This also increased the interpersonal authenticity between us.

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41 I followed the format suggested by Wolf (2003) to complete the audit trail using the following three parts. Part one relates to the raw data which included copies of: field notes, transcribed interviews, extra material from the participants such as material on recovery, newspaper articles and excerpts from their personal reading material. Part two covers analysis and interpretation, this included: coding, theoretical notes, flip-chart paper, grouping of quotes, notes on the emerging concepts and themes, extra field notes on the hypotheses and patterns as they emerged. Part three encompasses findings or the synthesised material, for example, my interpretations, drafts and final versions of the narratives, journal entries during writing and rewriting of the analysis chapters, the continuum of citizenship and preparation of the final thesis.
Peer review was another important step in the audit trail. I attended bi-annual supervision days with a doctoral peer group which allowed for critical discussion on the progress of the study and the emerging findings. I also presented at three doctoral schools facilitated by the School of Nursing at The University of Auckland and at conferences that took place in Vancouver (Hamer, 2008), Auckland (Hamer, 2009b), Athens and Copenhagen. Finally, I also visited the CCIG in 2009 to meet with Professor Isin and his colleagues. This visit enabled me to discuss my research study and present my early findings at a CCIG seminar day (Hamer, 2009a). Through discussions with Professor Isin I was able to deepen my theoretical analysis and to explore further his conceptual framework. This was similar to a member-check in that it ensured my interpretation of his framework rang-true for him as the author.

Attending to issues of culture (Strickland, 1999; Strickland, Walsh, & Cooper, 2006) was important for this study, specifically in relation to my responsibilities to the Māori participants (Health Research Council of New Zealand, 2010). I sought external guidance on the cultural implications of the data analysis by consulting with two senior Māori leaders within a mental health service to discuss the emerging findings.

In order to further protect the integrity and rigour of the study, I also kept a reflective journal to document how my own assumptions and processes as the researcher may be impacting the inquiry. As discussed above, note taking at every stage of the research project helped me to record and explore my thoughts and feelings and take stock of my assumptions and biases as they emerged (Higginbottom, 1998). Journaling became part of the field work of the study, and my self-reflections added to the interpretation of the data and evaluation of the progress of the research.

**Ethical considerations**

During the preparation phase of this study, attention was given to all the ethical issues that could arise. In the first instance, ethical approval was sought and granted from The University

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42 The 4th International conference on Interdisciplinary Social Sciences, Athens, Greece, 8-11 July 2009.

43 The 16th International Symposium for the Psychological Treatments of the Schizophrenias and other Psychoses (ISPS), Copenhagen, 15-23 June 2009.

44 For example, I discussed the Māori participants’ view of citizenship being “enforced” and secondary to their notions of citizenship.
of Auckland Human Ethics Committee\textsuperscript{45}. Issues of informed consent and confidentiality of the participants and their data were paramount. All participants were fully informed and knowledgeable about the study and signed consent forms before the interviews were undertaken (see appendix two). The participant information sheets included an explanation of the risks and benefits involved, recognised the need for confidentiality and participants were given the opportunity to check their transcripts before data analysis. The participants were also informed that electronic data would be stored on a password protected computer and any hard copies of data kept safe in a locked cabinet for six years, after which they would then be destroyed.

**Conclusion**

This chapter has discussed the data collection and data analysis processes used in this study. This included a description of the use of the qualitative research methods of semi-structured interviews and a focus group. Description of the participants and recruitment was also presented, along with a discussion of the data analysis and ethical considerations. The findings of the study will be discussed in the following four chapters which cover the extent, content, depth, and acts of citizenship.

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\textsuperscript{45} Approved by The University of Auckland human participants ethics committee on 19 July 2006 for 3 years from December 1st 2006 to December 1st 2009 reference number 2006/216. See appendix five for confirmation letter.
CHAPTER SIX: EXTENT OF CITIZENSHIP

The next four chapters present the findings from the data. The first three, chapters five to seven, examine the data using the conceptual framework by Isin (2002, 2008b): the extent, content and depth of citizenship. In the fourth chapter, the theory of acts of citizenship, proposed by Isin and Nielsen (2008b), will be used to interpret acts of citizenship reported in the participants data.

Chapters six and seven report the interpretation of the findings from the participants’ responses to the first three interview questions “What is your understanding of citizenship?”, “What does citizenship mean to you?’ and “What does citizenship mean to other service users that you have represented?”46 Quotes from the data are presented and identified using pseudonyms to maintain anonymity47.

Throughout the chapters, illustrative examples from the data are used to support the findings, followed by interpretive comments and a more in-depth analysis drawing on the theory of citizenship provided by the conceptual framework. Other literature is incorporated, where required, to further expand the analysis.

This current chapter presents in three sections the participants’ understandings of how written and unwritten rules and norms can determine their inclusion and/or exclusion as citizens. The first section will define the rules and norms. Next, the second section uncovers the participants’ experiences of how the rules and norms have served to exclude them. The third section reports on how the participants shaped their behaviour in order to adopt the norms. Finally, the chapter concludes with a discussion on how the participants challenged and expanded the boundaries and expectations of the norms in order to be included as citizens.

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46 Chapter eight and nine report the data in response to the remaining questions.
47 For ease of reading please assume that all quotes are from the participants who identify as service users. All other quotes from the participants will be identified as PS for the public servants. The participants from the focus group will be identified by nurse.
The rules and norms of exclusion and inclusion

Written and unwritten rules

The participants discussed their perceptions of why societies need to have rules and norms, indicating that they saw the acceptance and adoption of both written and unwritten rules to be an important part of citizenship:

Citizenship is a collection of both written and unwritten rules... [And] protocols [that determine] the way that we should... conduct and behave ourselves within a community. The object being that we have a functional, respectful and thriving community. (Lola)

The rules of society are written, the laws and things like that, not hurting people not appearing naked in the street [laughs]. (Ann)

While some of the rules of society are clear cut, such as the laws of what is right and wrong, to guide the conduct of citizens, there are also:

Unspoken things like being polite, being respectful, becoming involved, doing your bit towards the community, or the place where you belong. There are a whole pile of un-written things like which side of the street you walk on... it’s like this unwritten thing that someone starts doing and everyone starts following it. As a baby, I had this real temptation to go against it [laughs] and to not fit in all the time. (Ann)

They are just customs, based on something someone has told you. (Nurse)

Conversely, the adoption of the rules may be guided by values such as the demonstration of respect and consideration between co-citizens; for example, giving up one’s seat on the bus for an older person:

Being a citizen [means] being mindful and respectful [of others], because we have our rules and they are sometimes social rules.... There are also rules that you just know because you’re a citizen, they’re cultural aren’t they, [you learn them] growing up. (Jo)

Jo did not differentiate between written and unwritten rules and described the rules and norms as being “open” rather than a prescribed list of how one is expected to conduct oneself. Jo suggested that these “social” rules are given and accepted and often unquestioned ways of being.

Lorraine suggested that being a true citizen:

[Is] really a bit like the first and second commandments in the Bible, to love God and to love others. And with love comes respect and so we would respect others, and respect the laws... they are there to protect us. So we ostensibly should be law abiding citizens doing that stuff, and caring about others and respecting the authorities that are in place in the country, and respecting other peoples’ views when they are different from ours. (Lorraine)
Lorraine explained that the rules are in place to guide how we conduct ourselves as part of a collective, such as showing respect and care for others, living by religious codes and the acceptance of other views and opinions that may differ from her own.

**Norms**

Norms are derived from conventions, rituals and routines that socialize a group into a set of beliefs and practices (Turner, 1993) which incline the members of the group to act in a particular way (Isin & Wood, 1999). According to Bolton (2008), norms are based on the similarities between group members, rather than their differences, which can raise issues for people who want to be different:

In a paradigm of citizenship [it is about] getting a core of expectation... about similarity if you like. So you know “we should all behave in a certain way, we should all adopt certain norms and so on...” and that can become slightly oppressive. Depends how/who defines what those common values, norms and behaviours are. (Sally, PS)

Who gets to say what is normal? [I am an] expressive, creative person who has spent my entire life not put in a box. Act normal, for whom? Heaven help me from normal! (Maria)

Choosing to be different was important for some participants, but one of the defining aspects of mental illness is the perception of a loss of this choice. Being different by choice, as Maria described above, is not the same as the experience Lola reports of being mentally ill:

How to train the mind? It is so difficult to harness, it has an entity of its own that I can’t control. [There is] an internal battle of the mismatch between what I have to act on the outside and what internally my mind is doing to me. (Lola)

Lola’s actions are, therefore, affected by her inability to control her mind and she is then judged as not adhering to the norms or appearing normal. Lola has to make an extra effort and maintain her stamina to show that she can adopt the norms. Mostly Lola is not overwhelmed or all-consumed by the mental illness and has moments when she thinks “oh my God, I am acting just like a real person”.

Norms provide a shared understanding between members of the dominant group, but can also be based on rigid expectations of behaviour. These expectations can suppress a person’s unique identity and differences and box people into rigid categories that are based on cultural stereotypes. This can lead to the exclusion of those who are perceived as not conforming, or who waver from the norm:
We had rituals in the [psychiatric] institution and they are dependable and reliable, out here there are still rituals, but I don’t know them, you constantly watch others to emulate, then there are consequences if you get it wrong... if you don’t comply by certain codes of conduct. So I feel sensitive to the rejection that I may have experienced as a consequence of not adhering to particular codes. (Lola)

Codes (n.d.) are cryptic cultural symbols shared by the dominant group. This suggests that, at times, service users may find it hard to decipher these codes and behave accordingly, particularly when they are regularly excluded from the group. This exclusion may lead others to perceive that the service user may not fully demonstrate the conduct that society has determined as normal.

In sum, the participants in this study reported that adopting the rules and norms was important for their inclusion in society. Isin (2009) has contended that the individual is required to adopt the rules and norms of society in order to be accepted as a full citizen. Participants explained that they tried hard to conform, yet they continued to feel excluded from the dominant group. This will be discussed in the following section.

**Exclusion**

*Diagnosis of mental illness*

When others in society were aware that the participants had a diagnosis of mental illness, they were excluded from many activities such as:

Being invited to the neighbourhood party, getting a job or being invited to be part of a group of parents who baby-sit for one another, or being able to get a hire purchase on something you want to buy. So there are many layers [of citizenship that] can be affected, that are different for every person depending on the resources that they already have, and the relationships in the community. (Jean)

Jean explained that service users are frequently excluded from the taken-for-granted activities that other citizens enjoy. These exclusions can leave some service users feeling devastated and, as Jean emphasised, “amputated” from their communities. Such exclusions impact on service users’ economic, financial and social spheres, depleting their resources and resulting in loss of social status.

The diagnosis of mental illness alters participants’ identity which then excludes them from the usual social activities or the roles expected of a citizen, such as being a parent:
There were a lot of assumptions made about me based on the fact that I did not take up the conventional role of mother... and not being sick. If I had had cancer and not able to tend to the children, and been in hospital, that would have been acceptable. But because I was experiencing mental illness the assumption was that it was self-inflicted [and] self-indulgent, which was excluding. (Lola)

If I look at my own journey, I would say that there were many times when I would not have felt worthy of being a citizen. I’m bi-polar [diagnosed after] my first child was born... eventually my husband met another lady and so in the end I had to make a decision to give him custody of my children, that was a very big kind of no-no in 1974, people didn’t do that. I still know it was the right thing to do for them, but it has never stopped being painful or difficult… it’s a fracturing of a relationship… but none of [my children] have a mental illness and they are all functioning human beings. (Lorraine)

When Lola and Lorraine were labelled with a mental illness, they were no longer regarded by others in society as fit to fulfil the conventional role of mother. This placed conditions on their parenting, such as emotionally painful voluntary or enforced separations and loss of custody of their children. Lola was derided as being self-indulgent and was expected to “pull herself together for the sake of the children” without the support and compassion of her neighbours. Lola suggested that if she had had a medical condition such as cancer, then the response from her community may have been different.

Zara also experienced other people’s doubts about her ability to parent her child once she was diagnosed with a mental illness:

Part of the journey through the psychiatric system [is] the act of being labelled and being separated [and] marginalized from the community and given drugs... Concurrently with that is the sense of internalized shame, that somehow I am different, that I don’t make the grade. What I have had denied me is my ability to be a custodial parent. (Zara)

In contemporary mental health services the bio-medical approach, which privileges a neurobiological origin of mental distress, dominates treatment. This psychiatric universalism (Bracken, 1998) ignores environmental factors such as lack of support, economic status, gender stereotypes and stigma and discrimination. Being labelled mentally ill provides a limited understanding of the distress or dissent expressed by service users, and simplifies the complex reactions and feelings experienced by many.

Ann had a different experience when she had her baby:

After I had my son I thought I was on TV all the time and I didn’t ever tell anyone because it never occurred to me that it was a mental illness. And I was quite crazy especially for that year, they wanted to hospitalize me and [my husband] refused... and I will be forever grateful
to my darling ex-husband for that, because I just know where I would have ended up... my life [would have] been interrupted... The less interrupted we make a life, the better (Ann).

Ann described a year of horror with her mental illness after the birth of her first baby. The initial support of her husband meant she avoided going into the psychiatric institution where, she notes, she would have become “immeasurably dependent”. Continuing her part-time employment and having minimal interruptions in caring for her baby during this time of crisis helped her to retain her sense of identity and retain some stability in her life. Ann believes that having less interruption reduced the impact on her social status; however a subsequent admission into the psychiatric unit, resulted in her status being changed when the negative attributes of the label mentally ill were ascribed to her identity. Ann noticed the change in her social status, and her subsequent exclusions from the taken for granted activities of being a citizen.

Isin (2002) argued that historically, women, the poor and refugees were constituted as problematized beings and not only excluded from citizenship but also constituted as its immanent Other. Isin contended that the focus of Otherness is a dialogical condition of citizenship and its alterity, which simultaneously provides the space of privilege for those constituted as the insiders and citizens, whilst excluding the outsiders and strangers. Though Isin does not focus on the mentally ill, the alienating and agonistic strategies of exclusion are evident for participants who have reported being regarded as unfit mothers. Montgomery (2005) has also argued that women who are mothers and have a serious mental illness have few community supports, regarded as “unfit mothers” (p. 226) and are Othered and excluded. Swain and Cameron (1999, p. 75) have contended that those with disabilities are often regarded as not making “enough effort” to conform to the behavioural norms. Lack of understanding by some in society of what it is like to experience a mental illness constitutes an agonistic strategy of citizenship which serves to further exclude and Other service users.

Receiving a psychiatric diagnosis and being labelled as mentally ill can have a major impact on a persons’ identity:

[Mental illness] strips you... robs you of [your] identity. If citizenship is about anything [it is] about identity; it identifies you. (Lola)

48 The solidaristic, agonistic and alienating strategies and technologies of citizenship were discussed in chapter four, the theory of citizenship.
As a result of being labelled mentally ill:

[Service users become] the objects of pity or charity, victims of discrimination or victims of “your condition”. (Sally, PS)

Being labelled mentally ill objectified the participants as different from the normal others and rendered them as the powerless “victims” of their illness, reinforcing the myth that mental illness is an unusual health “condition” with enduring symptoms that will be suffered for life. As discussed (Swain & Cameron, 1999), the medical discourse of illness and impairment creates the cultural stereotype that the person lacks the attributes to be fully human, resulting in the assumption that treatment, rehabilitation or pity, is the appropriate response to a person’s impairment (Sayce, 2003). This stereotypical view of the service user alters the persons’ identity and they become the unwitting sufferers who lack the competence or intelligence (Link & Phelan, 2006) to change their circumstances, and therefore are often viewed as lacking the moral fibre to be treated as full citizens. As a consequence, the subsequent strategies of citizenship such as discrimination and exclusions by others in society, place service users at a social disadvantage which increases their burden of illness or disability (Link & Phelan, 2006).

This section has presented the participants’ experiences of being labelled mentally ill and the subsequent loss of their social status as full citizens. Isin (2002) has argued that when the dominant group perceives a member to have undesirable qualities then they are excluded as the outsider. However it is not just being treated as outsiders that concerned the participants, but the impact of being labelled mentally ill and the negative effects on their status and identity as citizens.

Rowe (1999) and Ware, Hopper, Tugenberg, Dickey, and Fisher (2007) have suggested that the mentally ill have marginal status as citizens because their rights and responsibilities have traditionally been restricted on the grounds of mental incompetence. Doubts about competence have also lead to reservations about the participants’ trustworthiness.

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49 The link between competence and the Mental Health Act is discussed in more detail in chapter seven: the rights and responsibilities of being a citizen.
**Being trustworthy**

Being labelled also led to others in society regarding them as untrustworthy and therefore excluded:

> Somehow you’re given this persona, that because you have got the label of schizophrenia, or manic depression or personality disorder that somehow you are not quite to be trusted. (Zara)

> “She’s had a mental illness, oh I wonder if we can trust her”, it’s like people with a mental illness can’t be trusted, can’t be relied upon, can’t be given responsibility. (Maria)

Zara explained that she was excluded from her right to be a parent by the family court because she was no longer trustworthy as a parent. Though not made overt, Maria also felt she was no longer trusted by her colleagues, and was excluded from taking up the responsibilities assigned the role, which she had proved to be extremely competent in, prior to her illness. Although her colleagues were attempting to be kind and protect her by diverting the mail to someone else on the committee, Maria believed that it was less to do with protection and more about “we don’t want her reading our letters”, therefore no longer trusting her to process the committee’s sensitive information.

When labelled mentally ill, the “persona” (Isin, 2009, p. 372) and status of the participants changed from the privileged insider, to them becoming the undesirable Other who is untrustworthy, unreliable and irresponsible. This finding points to society’s misperception that service users are a potential threat to the cohesion of society because of their unconventional, eccentric or deviant (Scheff, 1999) behaviour, and no longer meet the required norms of citizens:

> Mental illness isn’t contagious. What is it about mental illness that people are so scared of? I think possibly the media’s had a big play in that; people with mental illness have been portrayed as dangerous, uncontrollable, need to be controlled. They are perceived as loose cannons which we know is not the truth... but people watch the news, and it gets good press. (Jo)

As well as being regarded as untrustworthy (Link & Phelan, 2006), being labelled mentally ill is also coupled with notions of unpredictability and dangerousness (Angermeyer et al., 2004), and deviance (Scheff, 1999) because service users are perceived as having transgressed the behavioural norms of society.
Transgressing the rules and norms

When a person is perceived as contravening or transgressing the boundaries of the behavioural norms, they can be excluded because they have:

- Broken the social rules [and then] become one of “them”, an outsider [and others think] “then what’s to stop you breaking all the other rules”? (Phil, PS)
- I suppose it is inevitable that if a person has transgressed, or crossed the boundaries or the codes of good or reasonable behaviour, then there is a backlash; a personal backlash [or] a media backlash. (Zara)

Phil made the comparison between mental illness and the “gay men’s disease”, HIV. He explained that society’s fear was based on the belief that gay men had transgressed the norms of the natural heterosexual orientation, and had become one of “them”, the unhealthy and threatening outsider. Likewise, service users share similar stigma associated with being labelled with an illness that is essentially misunderstood and associated with criminality and mistrust.

When a person becomes one of “them” they are excluded from many aspects of society. When Wayne was admitted to the psychiatric institution his social status changed, and rather than being one of “us” and a member of the dominant group, he became “suddenly one of “them”, and “them” to me [meant] I was suddenly a loony”. Lorraine also explained that being one of them led to service users feeling “downtrodden” by members of the dominant group, and feeling “unworthy” of being a citizen. Internalising such negative feelings associated with the stigma is discussed by Peterson, Barnes, and Duncan (2008) and Watson and Corrigan (2001). Such stigma undermines the service user’s personal agency as a citizen.

The media “backlash” and biased reporting further strengthens the perception by society that service users have transgressed the norms and further label them as dangerous and unpredictable members of society. It is inevitable that at times citizens will waver from the behavioural norms, but the participants claimed that wider society is less tolerant of service users, resulting in a higher degree of surveillance and scrutiny of their behaviour:

- People with serious mental illness are perceived as crossing those lines earlier and more dramatically, when it shouldn’t be any different. (Maria)
- If I say No to something [my son] wants to do, he’ll say “oh mum, you’re being manic, or are you down at the moment?” That really angers me, because I want that freedom to say No without being questioned. If I crack a joke he’ll say “Oh careful mum... have a sit down, have a rest”. He casts aspersions on my behaviour and relates it back to my mental illness. (Zoe)
The power of the label continues to redefine Zoe’s identity as the deviant Other and at risk from the effects of her symptoms. Consequently, when Zoe was acting appropriately in her role as a parent, she was again unwittingly cast as the “mental patient” by her son, and her social status was diminished.

Isin (2008b) contended that the predominant focus of neo-liberal citizenship is concerned with conduct, discipline and rule. This predominant focus has become the way people develop certain habits in their bodies, develop certain behaviours and follow certain rules. Consequently, as Isin argued, the state values routine over rupture, order over disorder and habit over deviation within the social and political conduct of citizens. When service users are perceived to have transgressed these orderly practices, they are cast as the outsiders, and are excluded and socially isolated from other people in their communities:

I didn’t feel part of the community or society. I isolated myself for so long that my mother was the only other person in my life. (Beth)

Because I spent a lot of my time in institutions I certainly felt [there] were some of the repercussions against me, of not being able to fulfill my role... [This led to a] sense of isolation and that sense of being excluded. (Lola)

Even though Beth and Lola live in the community, they reported that they continued to experience exclusions, either self-imposed or imposed by others, which isolated and separated them from the rest of society. This is, in part, due to the long term effects of being institutionalised which enforced the service users’ isolation from society. The legacy of such incarceration has had a negative effect on the participant’s sense of self resulting in the loss of social status and autonomy:

[The service users] that I talk to feel like they have been banned from citizenship, that they cannot be part of it or not wanted to be part of it... they’re so damaged that they shouldn’t be part of it. (Ann)

They are so dependent “I am just waiting for my nurse to come once a week to give me my jab, and I see my psychiatrist once a month or once every 3 months”. The big fear for some people is being discharged [they think] “I will be left and I will be isolated again” because they won’t have the mental health services connection, and so [they] go back around the revolving door. (Beth)

Being labelled mentally ill changed the participants’ identity from the trustworthy and competent insider, to one who is damaged, and as Hazelton (1997a) found, vulnerable and dependent on the psychiatric experts. This dependency makes it harder to restore one’s status as an autonomous citizen. Isin (2002) contends that isolation and alienation is a technology of
citizenship, and the strategies of incarceration or sequestration of the undesirable members of society within institutions serves to maintain the identity and the dominance of the privileged insiders. This suggests that the power and control of the asylum has now been transferred to the community, heralding an era of the “new institutionalism” (Hazelton, 1999, p. 224; Morrall & Hazelton, 2000) which continues to exercise the somewhat invisible and restrictive social and psychological control over the aberrant and the mentally ill. The participants have reported that their continued exclusion from society has placed conditions on their status as citizens. It appears that the participants in this study continue to be alienated from their communities because the label of being mentally ill perpetuates their identity as the docile and compliant users of services. Similar to other risky populations, service users have become isolated and self-policing subjects (Foucault, 1977).

When service users are denied the basic human need of acceptance and inclusion by others (Maslow, 1943, 1998) this can have a profound effect on their general well-being:

You have to be strong, articulate [and] resilient enough to take the knocks, rejections and exclusions and not [have] full citizenship, its hard work and exhausting, a battle [and you need] the strength and stamina to fight [these] pretty serious battles. (Maria)

Exclusions and rejections take their toll on a person. Coupled with intermittent episodes of mental distress, service users are exhausted and depleted, which affects their ability to sustain their social networks.

Participants reported that they want to be citizens with the same rights and entitlements as others in society. Yet data reports that service users find themselves in a paradoxical space of the assumed protection of their legal rights, embedded within their status as a citizen, while at the same time regarded as legally incompetent and disenfranchised.

While Isin and Wood (1999) have not studied service users’ experiences of exclusion, their notion of the “psychological borderlands” (p. 18) can provide an explanation of service users’ continuing sense of being outsiders. According to Isin and Wood, the psychological borderland is a liminal space whereby the “subaltern” (p. 17) is constituted as different from both the insider and outsider. This hybridisation of identity may account for why service users are separated from the privileged normal categories of those who are deemed as full citizens “of and within the city” (Isin & Rygiel, 2007, p. 194).
In other words, when service users are trapped in the borderland it re-trenches their marginalised experience and further identifies them as the subalterns, and their conduct is articulated as the “pathologies” of non-citizens (Isin & Wood, 1999, p. 11). Likewise, early proponents of labelling theory (Gove, 1970; Link et al., 1989; Scheff, 1974) argued that when a person’s behaviour is pathologised and deemed as inappropriate behaviour, any attempts by the person to act in an appropriate fashion is normalised by others as inappropriate. This can heighten others’ perceived fear of the danger that service users pose (Link et al., 1989). The identity of service users is then perpetuated as being one of “them” (J. Dean, 1995; Elias & Scotson, 1965; Isin & Wood, 1999) and they continue to be excluded.

In summary, when the participants in this study were labelled as mentally ill, they were regarded as not meeting the shared understanding of what is regarded as normal, and perceived as the abnormal or deviant Other and excluded. In response to the narrow and rigid behavioural norms, the participants engaged in practices that would increase their inclusion.

**Being included as a citizen**

All of the participants in this study expected to be included in society as a:

[A] Full and equal participant in every aspect of social relations, an equal participant in everything [with] no exceptions.... That means you are just accepted as a normal, equal citizen. (Peter)

Either you’re a citizen or you’re a foreigner. So we are all citizens. [Citizenship] just means belonging to the country, being a citizen of the country, [it is] that straightforward. (Wayne)

This unequivocal and straightforward view meant that service users should not be subject to exclusions based on having a label of being mentally ill, and that citizenship should be inclusive of anyone who has the legal right to be a member of the nation state. Nagel and Staeheli (2005) contended that the public opinion of “one is assimilated or not” and “one is a citizen or not” (p. 489) has prompted marginalised groups to challenge this all-or-nothing conditional citizenship. The authors argued that citizenship is fluid rather than fixed, and multiple rather than singular. Nagel and Staeheli reported that participants in their study enacted politics of sameness and politics of difference to challenge this conditional view of citizenship. This was achieved by blending with their new communities rather than giving up completely their cultural behaviours and characteristics. Service users however, report that to
be included and assimilated, without any exceptions placed on one’s citizenship, appears to be something that other citizens take for granted.

Some participants were cautious about the use of the word inclusion:

I don’t like inclusion... the inclusion club, a bit like the “normal” thing; you can come in when you have made yourself normal or sorted yourself out... Inclusiveness and being excluded [is] another example of the “them and us”, which one are you? I think there is just an “us” we are all human, we should relate to others on the basis of their humanity first... I don’t like talk of inclusion, you have to pass a test, and who sets the test? (Maria)

Social inclusion... a lot of us don’t really like that [term] much. “Participation in society”... that puts the person who’s being included in a passive role, and it becomes a choice of the excluders whether to let them in or not. (Mary)

The term “inclusion” can put the responsibility on the person to demonstrate ones worthiness to be included, rather than placing the focus on the social and cultural processes inherent within the dominant group that serve to exclude service users. Maria was also concerned that people had to pass a “test” to determine whether they can be a member of the citizenship club. Isin and Turner (2007) argued that when governments set the test for eligibility for citizenship, this assesses whether the person will undermine the traditional political loyalty to the state and its power base. The participants however, suggest that the test of a person’s eligibility for membership excludes the range of diversity within humanity. To increase their sense of inclusion in the community, the participants shaped their behaviour in order to be regarded as normal citizens.

*Shaping behaviour*

Some participants, depending on their social situation, chose to hide their diagnosis or history of mental illness. Lola shaped her behaviour by having to:

Lie and be evasive [because others give me]... the covert message that [I’m] not alright, I am not accepted or I am accepted by proxy. What makes me acceptable is how I am acting, not who I am. It is citizenship with conditions... provisional, like I have an L plate on. (Lola)

After being diagnosed with a mental illness Lola realised that other people began to treat her differently. On a surface level her co-citizens gave her the impression that she was included as if she was a citizen, but this was conditional on how she acted or shaped her behaviour. This was at the expense of being her true self. Lola felt that her citizen status was temporary, and easily lost if she did not pass the test of being normal. This state of conditional
citizenship also impacted on her social status and identity, and she felt that she was a “proxy” and a substitute for the real thing.

Being closeted was another way of shaping one’s behaviour:

I was in the closet about my mental illness until the 1990s... then I met all these mad people and [accepted myself as] a psychiatric survivor⁵⁰... I worked through my internal stigma about that. I was a closet [psychiatric] survivor, but I wasn’t a closet dyke, that was easy to come out. But coming out for somebody who had just been in hospital, it was hard. (Priscilla)

In order to be accepted by the wider community, Priscilla was “out” about being a lesbian but remained closeted about her mental illness for many years. Priscilla suggested that the stigma and discrimination associated with the label of being mentally ill has much worse consequences than disclosing that one is homosexual. This may be indicative of the increased acceptance of lesbians and gays within society being directly related to the equality legislation which protects the rights and status of such diverse citizens.

Other participants faced the dilemma of staying in the closet about their illness experiences or taking the risk to be out:

[At a job interview] you have to explain that five year gap. You can’t really lie to an employer and say you were doing something else… because if you lie and they find out, it’s instant dismissal so you’re… screwed if you reveal and screwed if you don’t. You’re probably not going to get the job that is equal to your qualifications if you reveal you have a mental illness… And if you don’t reveal and you have a mental illness, then you become unwell [and] you’re really screwed… in some sense you are denied full participation because of the discrimination and the stigma. (Peter)

There is [an] invisible barrier... and the potential to be outed, do I tell or not? Do I want to be outed, [and] what are the consequences of telling? (Lola)

I think full citizenship, on a more human level, involves being a valued member of society in whatever form that might take and that is quite often the first one to go [when you are open about your illness]. Assumptions begin to be made about what kind of responsibility you could take. Decisions tend to be made on your behalf without your consultation. That’s what I call overlooking or bypassing, sidelining is a better word. I felt as if some of my rights as a person had been taken away from me. That is a price that service users pay for disclosing what kind of illness they have and where they have been. [The price is not] being included. (Maria)

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⁵⁰ Priscilla joined the psychiatric survivor movement which began in New Zealand at the time of the closure of the large psychiatric institutions on the mid 1980s. The movement adopted the term survivor to express the collective view that many had survived a regime of treatment and incarceration that was for many users, a punishing and spirit breaking experience. The evolution of the movement has led them to change the name to the psychiatric consumer movement.
Lola and Maria described the dilemma of whether to transcend the “invisible barrier” and break from the contained world of the closet, and self-subjugation, or be out and risk the possible conditions that would be placed on their status as citizens because of the label of being mentally ill. The consequences were being devalued, overlooked and side-lined as people, rather than accepted for who they are.

Although shaping of behaviour was a short-term solution that served to protect the participants from hurtful exclusions, it had negative consequences. Isin and Wood (1999) have argued that for lesbians and gays the closet can be both a shelter from prejudice, and a form of containment. The participants in this study reported that when they were closeted they were contained and unable to fully participate as citizens, and when they were out they continued to be overlooked and side-lined, and unable to participate in society.

When participants shaped their behaviour by being closeted or passing, this helped to neutralise the stigma associated with the label of being mentally ill. This finding is also supported by Thomson (1997) who argued that closeting is a way of managing the adjustment of being regarded as different from the “normates”\(^5\) (p. 13) and also serves to make those that stigmatise comfortable. Closeting enables the service users to safely negotiate their relationships with their co-citizens, which Isin and colleagues (Isin et al., 2008) have argued, is an important element of being a citizen. The participants reported, however, that when they felt excluded they could not sustain or deepen their relationships with others.

Closeting and passing can unfortunately be a form of self-betrayal when service users accommodate the limitations on their status, and the associated personal distress, to ensure the comfort of the stigmatising others:

[Closeting results in] a perpetual sadness and grief because you have to deny part of yourself... You don’t invite the madness, but there is no provision for it in our society.... But still that inner conflict... and self-doubt, “am I denying myself and choosing to conform to be accepted”? What I am saying is that I don’t want to be noticed... I am solely focused on myself passing. (Lola)

\(^5\) The term normate has been coined by Thomson (1997, p. 8) to describe the social figure through which people can represent themselves as definitive human beings. According to Thomson, the normate is the constructed identity, by way of cultural capital and bodily configurations that can step into a position of authority and wield the power that this grants them.
Lola described having to contain her “madness” because society is not accepting of the expressions of mental distress. The consequence of passing as normal denies a large part of her identity and sense of self because the label of being mentally ill is a constant reminder to others that Lola is the deviant Other. Lola qualified her explanation by suggesting that not being noticed equated with being a citizen, rather than being noticed purely for her mental illness and excluded.

The consequences of being out about the mental illness may mean that others perceive service users as posing a risk:

> For me it means risk; it’s “do you take a risk with this person”? An employer or anyone... Because of the mental illness, you are a risk to take on because of the potential of having another break, so it is [about] understanding that risk, and living with that risk, but also understanding that giving someone the chance can also minimize that risk. (Peter)

Service users take the risk of increasing or decreasing their symptoms of mental illness depending on whether they came out or not:

> [Then service users] are not meeting their potential because they are not allowed to reach their full potential... if you’re constantly being put down, you get anxious, stressed and depressed; you’re going to get unwell, but if you are allowed to go up that ladder, that opportunity [minimizes those symptoms]. (Peter)

Shaping behaviour is a strategy of avoiding an increase of their symptoms of mental illness. When the participants hide their identity, however, this prevents others from getting to know the real person, or their ability to demonstrate that they can be fully participating citizens in their communities.

Participants reported that shaping their behaviour was a way of meeting the perception of being normal. Lola reported that when she undertakes the ordinary, everyday things that other citizens take for granted, this helped her feel more included:

> Sometimes I forget that I am mentally ill, or have a mental illness. I don’t forget in terms of my frailties, but I forget the label. If you dare to forget then something will remind you.... but [I think] do I have to be a service user all the time? Can I be other things as well? Just doing ordinary things such as going to work, or shopping at the supermarket... acting like an ordinary person. (Lola)

Isin (2002) and Turner (2001a) argued that it is the everyday activities and gestures of hospitality in which citizens engage that increases their sense of inclusion and ability to participate in society. The participants in this study, however, cannot take for granted that
they will be fully included within wider society when they have to tolerate the constraints of
the closet. Conforming at all times brings a personal cost to service users as others place
much higher expectations on them to prove that they are worthy of being included as citizens.

Isin (2009) argued that members of society are expected to adopt the norms of being a citizen
in order to be included, and this is achieved by emulating others within the dominant group in
order to take on the persona of the citizen. The participants reported, however, that they have
to undertake a higher degree of self-scrutiny and self-surveillance to ensure that they are
perceived as adopting and accommodating the behavioural norms. Isin further suggested that
the institutions for the discipline of strangers and outsiders have been transformed into new
modes of control and surveillance, an argument that would support Hazelton (1999) and
Morrall and Hazelton’s (2000) findings of new institutional practices of surveillance within
the community. These new modes of control and surveillance of service users are, for
example, community treatment orders52 and monitoring by a psychiatrist when taking a
restricted medication such as Clozapine53.

Brysk and Shafir (2004) warned that when a person becomes the victim of their own
surveillance, this hinders their autonomy and ability to live as freely as possible without fear
of the oppressive practices which lead to the suspension, withholding and disregarding of
their citizenship rights. Likewise the participants in this study reported restrictions and
conditions on their rights and entitlements as citizens, due to being labelled mentally ill and
regarded as untrustworthy and incompetent members of society.

Shaping behaviour did however help some participants to find their place or niche in society,
where they experienced an increased sense of being included:

        We are all equal citizens, but it’s finding your own niche and where you are comfortable...
        where in society you fit. (Beth)

Brent found inclusion through his church:

52 The Mental Health Act was discussed in chapter two.
53 Clozapine is an anti-psychotic medication used in treatment resistant schizophrenia, and can only be
    prescribed by a medical specialist who practices solely within the scope of psychiatry.
54 The participants’ rights and entitlements will be discussed in chapter seven, the content of citizenship
I’m a person now from being a non-person, everyone is on mutual territory and we’re all equal, and all part of the community, we’ve got citizenship there [at the church]. (Brent)

However, when these participants found their niche in society, and conducted their daily lives as if they were citizens, they still came up against the stigma and discrimination associated with the label of being mentally ill.

In summary, the participants in this study reported that they shaped their behaviour to pass as normal citizens and insiders. Isin (2000) made a rare reference to the plight of the mentally ill in his comparison with those regarded as strangers and outsiders, such as lesbians and gays and people with disabilities. Isin (2000, p. 283) argued that the “city” determines the spaces for the discipline of the outsiders, such as prisons and mental hospitals, which impose law and order on those who are deemed to transgress the rules and norms. He argued that, similarly, when the mentally ill are perceived to be lacking certain attributes required for the persona of the ideal citizen, they become marginalised and experience profound inequalities and exclusions from full citizenship.

Likewise, the participants in this study reported that they have had to work hard to adopt the behaviours dictated by the rules and norms of society in order to be included. This was achieved by hiding their illness and shaping their behaviour. In contrast, members of the disability movement have embraced their impairments as part of their valid social identities, rather than an imposed oppressive social category. This has been achieved by rejecting the tyranny of the normal (Donley & Buckley, 1996; O’Grady, 2005; Thomson, 1997). The majority of participants in this study reported that the label mentally ill is an oppressive and marginalising social category which has placed conditions on their status as citizens. The participants’ desires to be accepted for whom they are, challenges society’s perceptions of what constitutes a normal citizen. Similar to those with physical disabilities, the participants reported that they have attempted to challenge this social category by loosening and expanding the rigid criteria of who is included as an insider.

Isin’s conceptual framework has been informed by the work of Lister (1997, 2002, 2003). Lister (2004) proposed four types of agency and resistance undertaken by people in poverty which can provide a useful parallel with service users. The first two stages of agency/resistance are the use of personal resilience and resourcefulness to get over the
hurdles and keep up the fight to keep going. Similarly, the participants in this study reported that shaping their behaviour was a form of personal resistance to keep going in the face of being Othered. The added dimension of the service users’ recovery journey also produced the planning and the actions associated with getting out of the negative experiences associated with being labelled mentally ill. Participants also engaged in the third stage of agency/resistance by the subversion of the norms and rejection of the negative labelling, and this was achieved by engaging in practices of inclusion.

The practices of inclusion

Participants’ efforts to be like others by espousing the behavioural norms, required hard work and a significant amount of energy. Even so, the participants still felt that they were excluded because the prevailing norms were too rigid or inflexible. There were many examples in the data of how the participants challenged and pushed the boundaries within the health care system and within society to increase the likelihood that they and other service users would be included.

Recovering from serious mental illness was in itself a practice of inclusion. Zara described how she began to feel included as an equal again when she worked on her own internal process of becoming more real by “uncovering the past, recovering what has been lost and discovering a stronger more authentic self”. Zara felt this helped her begin to reclaim her status as a citizen:

One way I have regained my citizenship is through therapy for the past nine years for my childhood trauma. I have regained an internal sense of worth as a first class citizen... I don’t sacrifice or squander my resources on others as much... so I am rebuilding my city walls. I am no longer hiding behind a mask.... I feel equal with people; I’m no longer less than or more than. (Zara)

The analogy of “re-building” her “city walls” indicates a solid foundation which supports her sense of personal agency, essential for the practice of citizenship (Isin & Wood, 1999). Reclaiming her life again was a rejection of the internal and external negative attributes associated with being labelled mentally ill, and Zara began to increasingly feel as if she was a “first class citizen” and the equal of others.

The younger generation of service users is challenging the mental health system to change their practices by holding a resilience-based and inclusive approach to treatment:
The younger generation, who are newer into the services [and] have not had that custodial view or paternalistic approach, expect to be much more engaged, expect to be much more consulted. They actually have much higher expectations. But they also expect more of themselves. (Lola)

I guess it is just thinking in terms of the history of mental illness… with that kind of deinstitutionalization, and mental health systems still kind of sucked. A recovery approach came out and people were changing the way they think about consumers, and how consumers think of themselves, and now we seem to be in a new era. [Young people] are thinking about other things [rather than the recovery approach] like well-being or resilience or whanau ora or… whatever. (Gillian)

Younger service users are loosening the traditional norms of how service users are treated within the mental health system. They want to remain as active members of society rather than incarcerated in institutions for what can sometimes amount to a considerable length of time. They want to stay at work or school, or have care in their homes to maintain a stronger connection to their communities, rather than experience the “revolving door” (S. Clarke, 2007, p. 14) of continuous re-entry into the psychiatric institutions. Younger service users are also questioning whether the recovery approach is relevant to their experiences of mental distress because recovery is associated with having to overcome an enduring and longstanding mental illness. Adopting the notion of resilience represents the impermanence of being mentally ill and is a direct challenge to the negative attributes associated with the label.

The majority of participants in this study have been or are currently service user advisors or peer support workers. By being open about their own experiences and successes in their recovery journeys, the participants are role models for their peers, and their employers. This practice of inclusion has demonstrated that service users can be trustworthy and competent members of the workforce, which has begun to loosen and expand the norms, and create space for the inclusion of other service users.

Participants also used the medium of education to increase society’s awareness and acceptance of people with mental illness to encourage their inclusion as full citizens with the same rights and responsibilities as others.

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55 He Korowai Oranga (Māori Health Strategy) (Ministry of Health, 2002b) defines Whānau Ora as Māori families being supported to achieve their maximum health and well-being.
Educating others

Zoe explained that she spent eight years as a “mad” woman before she was given any information about her diagnosis of manic depression. Being labelled as mentally ill changed her persona. Family and friends treated her differently as they were bewildered, confused and grieving for the loss of Zoe as the person that they knew before. Because they had little understanding of the diagnosis, they made assumptions about her:

[The] word manic does not mean maniac or low life. [My family thought] “What’s happened to Zoe, she used to be really intelligent, what’s happened to her”? Yeah I had to educate them. (Zoe)

Expanding the knowledge of others became an important part of Zoe’s re-connection and inclusion within her family and her community. This practice of inclusion began in the hospital with the nurse who sat for many hours educating Zoe about how she could manage the symptoms. Zoe then felt she was “free to blossom, come out of that cocoon and fly like a butterfly”. The nurses’ practice of inclusion modelled acceptance and equality for Zoe, which she in turn modelled for her family through educating and raising their understanding of mental distress beyond the negative attributes of the label.

Gillian engaged in practices of inclusion through the workshops that she facilitated with younger people and their families. These offer a counter-narrative to the bio-medical explanation of mental distress and normalised their experiences:

[In the workshops] I am talking about having a mental illness or experiencing mental distress, and it just doesn’t kind of register with them “I am not mentally ill cause I am not crazy” or “I’m not like those people in the news” that the media sensationalises. They see it as more like a glitch in their life or “some problems that I have” or “some problems that my parents have” or “everybody else has” [laughs]… Resilience is more applicable for young people in terms of they have all these natural resources that are there, supports [like] friends, family or they like playing their guitar and that kind of means that young people can utilize those to bounce back. It’s not permanent state. (Gillian)

Modelling to others in society that mental illness is not a permanent limitation or a barrier to one’s citizenship, is a practice of inclusion:

Citizenship means autonomy, being allowed to make decisions that directly have a bearing on the possibilities that can happen for me. My [education provider] has been wonderful and has given me a scholarship to do my studies [as a peer support worker]. (Brent)

[Some people] go on to peer support because it’s a way to use their experience of mental illness, so in one sense mental illness is actually a qualification to do something that is beneficial to the community. (Peter)
Having their autonomy restored, after a mental illness, increased the participants’ ability to engage in education and employment.

Other participants also reported the value of educating others and raising their awareness of mental illness within their communities as one way towards feeling included:

Awareness is the first thing, from awareness you get knowledge; hopefully from knowledge you get understanding and then comes the acceptance. And that is all we want. (Wayne)

The importance of awareness, knowledge and understanding can break down the negative attributes associated with the label of being mentally ill. In his role as an educator and peer supporter, Wayne is able to challenge the public to re-think the negative label of being a “loony” and to regard the person with mental illness with a human face, someone who is just like us - a parent, a partner, a work colleague and a friend. Wayne adopted the maxim “know me, before you judge me” (Ministry of Health, 2007b, p. 21) which encapsulated the importance that even though service users may be perceived by their co-citizens as being different, they still have the right to be accepted and included. Acceptance means not being pressured to fit within the prevailing behavioural norms, or as Donley and Buckley (1996) argued, to stay out of sight.

Isin (, 1999, 2002) and Isin and Wood (1999) contended that forms of capital (social, cultural, economic and symbolic) are the assets that enhance a citizen’s power, influence and the means to exist. The participants reported that collaborating and joining with others is an important aspect of building their social capital. Gaining further educational qualifications is a form of cultural capital. The enhancement of the service user’s reputation, prestige and status based on their “qualification” of the experience of mental illness, is a form of symbolic capital.

According to Isin (1999, 2002), the acquisition of capital requires time to accumulate, and is generated through the enactment of the rituals, rules, norms and the institutions within which capital is reproduced and grown. The findings report that when participants are perceived as not adopting the rules and norms of being a citizen, then they are excluded from the social space within which such assets are generated. Service users then lose their strategic position within the social space that identifies them as political agents.
**Being different from others**

Some participants actively promoted their difference as a means of challenging the behavioural norms:

It’s about the choice [of] how I live... that’s incredibly important to me, and I might choose to be slightly on the margins of citizenship... well on the margins of what’s considered normal [and still] have full citizenship. (Mary)

Many members of the community have chosen to live on the margins of society, such as the bohemians, poets and artists and other eccentric, creative and individualistic people who do not want to be part of the mainstream of society. People who live on the margins follow their own personal and social norms which can break from the standard mould by pushing the edges of what is accepted as the norm. Participants reported that they also want to be free to express their differences and make choices about how they live their lives without any expectations or conditions on their status as citizens.

When diversity is valued within communities, this can challenge and re-write the definition of what is normal:

We don’t do eccentric people well... we should celebrate them... if you are looking at the textures of life; they are the bumpy bits that make it really beautiful and interesting. How boring the world would be without them. Citizenship [is] not about all being the same and all adhering to everything all the time, we should just “be” somehow. (Ann)

Society is not made up of a homogenous group of individuals; rather eccentricity is part of the human fabric of life. Isin and Wood (1999) argued that the notion of citizenship connotes a diverse and pluralistic view of identity, compared to the traditional universalistic understanding of citizenship and the expectation of conformity to the prevailing norms. Ann’s desire for society to accept that people can just “be” suggests that individuals can express their differences, and at the same time be accepted as equal citizens. Isin (2008b) would concur with this finding by arguing that the practice of citizenship requires individuals to be with others of their own kind, and with those who are differentiated as “another kind of other” (p. 35). Service users hope for the possibility of the recognition of their difference as another valued Other. It is through the practices of inclusion that participants are actively re-drawing the boundaries of who should be accepted as citizens.

As mentioned above, being accepted for who one is, was important for the participants in this study. Lola explained how important it was to “accept yourself, but there is something about
being accepted by others”. An inclusive society accepts and accommodates the differences and diversity of its members:

It’s not actually about being mentally ill, it’s actually about fundamentally being different… and wanting different things. (Lola)

Depends how/who defines what those common values, norms and behaviours are. However at best, citizenship can be genuinely about accommodating difference. (Sally, PS)

Lola argued that being different from others can be pathologised as being mentally ill when one’s behaviour wavers from the norm. Likewise, Sally was sceptical about who determines exactly what the norm is, and that unless society accommodates difference then service users will continue to be excluded.

Isin (2002) argued that the city is a “difference machine” (p. 49) which renders the Other as the stranger or outsider. According to Isin, solidarity within the dominant group maintains the social capital to define their otherness as the virtuous and superior others, whilst casting a shadow on other groups that lack these attributes. The power differential between the insiders and Others is compounded when the insiders attribute characteristics to the Other that are associated with inferiority or disgrace. The participants reported that the negative attributes associated with being labelled mentally ill also created a power differential that resulted in them being Othered. As Isin asserts, groups cannot then mount resistance or a counterforce to being Othered which places the group within a field of forces that maintains their inferiority and oppression:

There is still this kind of bubble around them. Some of it is imposed by them; some of it is imposed by society. [It is] largely invisible, but... it exists all the time and you never know when it’s going to come up and hit you on the nose. I think real citizenship is beyond the bubble, and that’s a very hard place to go. (Maria)

The “bubble” represented the day to day world that service users inhabit, where they feel as if they are citizens, until they encounter the pervasive stigma and discrimination from others in their communities. The stigma is also internalised, resulting in service users continuing to be closeted and isolating themselves.

The metaphor of the bubble suggests a force field which impedes the service user’s ability to move towards their goal of claiming full citizenship. The bubble has become an in-between space or “zone of in-distinction” (Agamben, 2000, p. 40); an ambiguous grey zone where individuals are neither fully excluded nor fully recognised as citizens (Walters, 2008). Many
service users exist within the grey zones as the outsiders who are perceived as the untrustworthy and incompetent Other. In order to reclaim their rights and responsibilities as citizens, they have to break through the invisible barrier. Maria argued that full inclusion as a citizen is just beyond this invisible barrier, and a place that embraces diversity and difference. Engaging in the practices of inclusion is one form of resistance by service users to break from the containment of the bubble and achieve real citizenship.

The participants in this study have explained how the practices of inclusion occur on a macro level which has enhanced the opportunities to take their place as full citizens. Some participants also suggested that the practices of inclusion can happen at a micro or institutional level, and this was achieved by subverting or bending the rules and norms.

**Subverting and bending the rules and norms**

When Maria was first admitted to the psychiatric unit she was so anxious that she was unable to eat with others in the dining room at designated meal times, preferring to eat her food in her room:

> My family described [that] the nurses that were the most helpful to them were the ones willing to slightly bend the rules where necessary... Some staff [were adamant] “no, these are the rules” [others were] willing to bend the rules, adapt and look at my best interests and my families best interests. (Maria)

A number of staff rigidly adhered to the rules and would not allow Maria to eat in the privacy of her room, which compromised Maria’s recovery. Other nurses on the unit were more flexible and responsibly subverted (Hutchinson, 1990) the unit rules, which Maria regarded as an act of inclusion and the safeguarding of her rights.

Priscilla explained that she bent the rules in order to increase the sense of inclusion for her peers who she perceived to have the same rights as other citizens. Priscilla was a peer support worker for a non-government organisation. She was concerned that the rigidity of the rules incorporated within their residential rehabilitation unit policies was preventing her peers from accessing service user movement documentation (Mental Health Commission, 2004b) to enhance their recovery from mental illness:

> I love my role as a support worker because I do bend the rules a little and I know the policy… and to me policy is there to be bent. Not broken, don’t break it, just bend it and be careful how you bend it; so you don’t get your hand hit too hard... I thought that was the Kiwi culture
[if we go back to the idea of] citizenship... and getting away from the “us and them” syndrome... So I do bend the rules a little. (Priscilla)

Priscilla strongly believed that the way policy is interpreted and implemented by some services is too rigid and restrictive. Bending the rules to fit the service user rather than the needs of the service was part of her strategy to safeguard the rights of her peers.

As a nation, New Zealand is internationally renowned for its “Kiwi culture” of being a compassionate, humanitarian and inclusive group of citizens involved in many humanitarian activities in other parts of the world. Priscilla suggests that these same philanthropic principles are not necessarily applied to all groups within our own society; particularly service users. This can be described as “telescopic philanthropy” (von Heyking, 2002, p. 34) whereby members of a nation state focus their attention outwards to other nations rather than always attending to the rights of vulnerable groups and individuals at home. Priscilla used her own experiences of being excluded to change the outcomes for the service users she was advocating for, with the aim of increasing their inclusion in wider society.

In summary, many participants engaged in the practices of inclusion in an attempt to challenge and break down the rigidity of the rules and norms that determine who is included or excluded. By engaging in the practices of inclusion, the participants are creating a new site of struggle to contest such exclusive notions of citizenship. Following Lister’s (2004) stages of agency/resistance, the participants have demonstrated the subversion of the norms and the rejection of the negative label through their practices of inclusion. Such practices have provided representations of service users as autonomous, active and hardworking members of the community, who can simultaneously adapt and resist the realities of labelling and exclusion.

**Conclusion**

Participants reported that being accepted as an equal and included as an insider was contingent on their ability to adopt the rules and norms of society. Being regarded as a full citizen by others was dependent on the participants appearing to be the somewhat elusive normal citizen. At times, participants felt as if they were citizens, a fragile status experienced within the grey zone of the bubble. Consequently this placed conditions and barriers on their status as citizens. When participants were perceived as not adhering to the rules and norms, then others in society questioned their trustworthiness and competence to fulfil their rights.
and responsibilities as citizens. Being subject to the Mental Health Act also reinforced the label that they had a permanent impairment and were a potential risk to themselves and/or others in the community.

In response to these exclusions, participants shaped their behaviour by passing as a normal citizen, or became closeted in order to be accepted, though participants had to increase their self-surveillance to make sure they appeared normal. Participants moved from the oppressive practices of shaping behaviour to the practices of inclusion in an attempt to break down the social barriers that have marginalised and ostracised them. This was achieved by challenging and expanding the prevailing behavioural norms.

Isin’s dimension of the extent of citizenship has provided some understanding of how service users are excluded. Service users are regarded by some members of society as not possessing the persona of the insider because they are perceived as not following the rules and norms. What his conceptual framework does not account for, however, is how participants shaped their behaviour in order to be accepted in society. These findings expand Isin’s conceptual framework by contributing the views of service users as a marginalised group who are lobbying to be recognised as full citizens. The participants wanted to be accepted for who they are, without giving up or denying their differences. In the following chapter: the content of citizenship, the findings of the participants’ understanding of their rights and responsibilities as citizens will be presented.
CHAPTER SEVEN: CONTENT OF CITIZENSHIP

The previous chapter reported on the findings of the rules and norms of exclusion and inclusion. This chapter explores the content of citizenship, the second of the three dimensions of Isin and colleagues’ conceptual framework. It focuses on the rights and responsibilities of citizens.

In the first part of this chapter the participants’ general understanding of their rights and responsibilities is presented. This is followed by a discussion of the importance participants place on their basic human rights and the civil, political and social rights of citizenship. The second part of the chapter reports the participants’ understandings of their responsibilities as citizens, such as making a contribution to society; taking personal responsibility; their perceptions of the health sector; and society’s responsibilities towards them.

The continuum of citizenship

Ann used the image of a continuum to explain her understanding of her rights and responsibilities as a citizen:

I think [citizenship] is a continuum, and there is the negative end and the positive end, and I think that a lot of where you think you are on that citizenship continuum depends on... your feelings of that time. So you don’t have that citizenship as of right, we also lose some rights around [not having] that sense of being part of a bigger collective. (Ann)

The negative pole of the continuum encompassed Ann’s feelings of being “broken” and “shattered into lots of pieces”. Ann’s contact with the mental health system increased the negative attributes she experienced of being labelled mentally ill and the perception of her body as broken and having a spoiled identity (Goffman, 1963). The associated stigma and discrimination by others in society resulted in Ann losing more of her rights, and feeling that she no longer enjoyed full citizenship status “as of right” and she was thus disenfranchised.

The continuum evoked a journey to becoming a full citizen, and that citizenship is not a static state. Whilst Isin and Wood (1999) have described citizenship as a fluid status, Ann extends this understanding further by not only evoking a sense of fluidity but also momentum, and an unpredictability when trying to maintain her status as a full citizen. Ann’s description suggests that citizenship status is not a static state for her, but a subjective state depending on
how she feels internally, and the way others in society respond to her as a service user. Ann explained that the citizenship continuum is paralleled by a recovery continuum. As she progressed on her journey of recovery she moved towards the positive pole of the citizenship continuum, and at times felt “whole” and “part of the bigger collective”, with more opportunity to exercise her full rights and responsibilities as a citizen. Ann, however, qualified this by explaining that it was impossible to stay at the positive end of the continuum for too long when service users have experienced conditions being placed on their citizenship.

Jean also explained that having the full rights of citizenship was also dependent on being part of the bigger collective:

Citizenship is membership of a group, community or society with all the associated rights, responsibilities, privileges and protection. (Jean)

Feeling part of the group of citizens can provide a form of “protection” for those who are vulnerable in society.

A number of participants explained that their rights and responsibilities carried equal importance:

Citizenship has something to do with having the full rights and responsibilities of a human being within society. It’s got something to do with my own understanding or notion of privileges, and that’s aligned to rights, however it is balanced by the notion of responsibilities as well. (Zara)

In contrast, Zara and Jean suggested that even though they had the legal status of other citizens, they could not take for granted that they would have the same privileges and rights. Priscilla differentiated between the rights and responsibilities she has when she is receiving care within the mental health services, and the more general rights and responsibilities she has as a citizen:

As service users we have rights and responsibilities, as citizens we have our rights and responsibilities too. (Priscilla)

The patients’ charter\(^56\) supports the rights of people seeking health care such as the right to respect and receive dignified treatment and the right to be informed. The charter also expects that patients will uphold their responsibilities such as engaging in treatment plans and using

\(^{56}\) For more information see The Health and Disability Commission (1996) code of rights.
the health services responsibly. When Priscilla is not a consumer of health services she suggested that she should still be afforded the same rights and responsibilities as all other citizens within society.

The image of the service user’s fluidity of movement along the continuum echoes Isin and Wood’s (1999) contention that the concept of citizenship is multidimensional and plural, rather than fixed, unitary and homogenous. This radical understanding of citizenship (Mouffe, 1992, 2001) reduces and eliminates the inequalities of its members, increases access to resources and protects the rights of minority groups. The participants in this study wanted to be part of the assemblage of plural identities, however their experience of being labelled as mentally ill placed conditions on their rights and responsibilities as citizens. The following section will report the participants’ understanding of their rights, beginning with their human rights, followed by their perceptions of the civil, political and social rights of being a citizen.

**The rights of being a citizen**

In accordance with the Universal Declaration of Human Rights (UN), the International Covenant on Civil and Political Rights (ICCPR) recognised the inherent dignity and the equal and inalienable rights of all members of the human family as the foundation of freedom and justice. Likewise, the participants regarded these basic human rights as an essential part of being a citizen:

[It is] incredibly important [that] their human rights are adhered to... New Zealand ratified UNCROC in 1993, [which] says young people have the right to know what their rights are, and they also have the right to be involved in decisions that affect them. (Gillian)

[Human rights] only gets you to the floor level, and that’s great, [for example] you shouldn’t be incarcerated without fair process. Of course that’s very important in any society, but [citizenship] is talking about something a bit more than that, you might expect mental health consumers to be able to do anything, raise kids, be Prime Minister, to do whatever they will. (Sally, PS)

[Citizenship is]... the right to be treated as a human being, all your rights; if you’re not a citizen then you don’t have [citizenship] rights. You’ve got to have human rights but you don’t have rights to treatment, schooling all the normal rights that we would have as citizens. (Priscilla)

[You have] The UN Convention [on Human] rights [and as well] you’ve got civil, political, social, economic and cultural [rights]. So [citizenship] is about the expression of all those rights. (Mary)

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The basic human rights of service users must be adhered to, particularly by mental health professionals, as these provide a platform that ensures their dignity, respect and protection from exploitation and unfair detention, for example, in a psychiatric unit.

The participants in this study understood that there was a difference between the inalienable human rights of the individual and the specific rights of being a citizen. For example, Priscilla explained that a person is entitled to the protection of their human rights regardless of their place of residence in other nation states. The ideal of people enjoying civil and political freedom can only be achieved, however, if the conditions that support such rights have been created within the state. According to Gledhill (2008), in New Zealand there is an interpretative obligation on the state’s judicial system to construe domestic legislation consistently with the rights and freedoms of the New Zealand Bill of Rights (1990). Although the Bill of Rights Act does partially domesticate the ICCPR, the Convention on the Rights of People with Disabilities (2006) is not domesticated. Coupled with the high degree of sanism, the rights of service users are further stalled when they are treated differently within the legal system (Birnbaum, 1960; Perlin, 2003b) because of the fear and apprehension of the mentally ill demonstrated by their legal representatives.

The participants reported that though human rights are vital, they are different to the rights of citizenship. Isin and Turner (2007), Ranciere (2004) and Turner (2006) have argued that in contrast to human rights, citizenship rights are granted through belonging to a particular state which is then responsible to ensure that all members’ rights are upheld. These rights include the right to work and to vote, and in New Zealand the right to affordable and appropriate health care. Whereas citizenship rights are a specific interpretation and concretisation of the more abstract and universal human rights (Lister, 2004), Isin and Wood (1999) and Lister (2004) contend human rights imply a moral and ethical claim on the duties of other citizens to realise these rights for the marginalised.

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58 New Zealand is a signatory to the United Nations charter on the declaration of human rights (UN), and the ICCPR. New Zealand passed the Bill of Rights Act in 1990 to affirm the state’s commitment to this covenant in order to protect and promote the human rights and fundamental freedoms in New Zealand citizens. While the ICCPR is ostensibly binding as a matter of international law, New Zealand has not fully incorporated the ICCPR and the CRPD into domestic law (Gledhill, 2008).
Participants’ reported, however, that the rights inherent within their universal entitlement do not guarantee that they can enjoy the same level of citizenship rights as other people, such as access to adequate physical health care, reasonable housing and employment, once they have been labelled mentally ill. As Isin and Wood (1999) stated, the UN charter on human rights is a dated document and cannot be relied upon to ensure membership to the “Homo sapiens club” (p. 69) for marginalised groups. Participants argued that they must have equal rights of citizenship in order to safeguard their ability to pursue their own interests and have the same opportunities that other citizens enjoy. As for other citizens, service users expect to be able to follow their goals, such as pursuing a career free of discrimination related to their health status. Though Isin and colleagues have argued that rights consist of concrete legal entitlements, Lister (2004, p. 159) argued further that rights also have a “symbolic resonance” for those who are marginalised, such as the right to dream of a better life.

In the following section, the participants’ understanding of their rights of citizenship will be presented under the headings of the civil, political and the social rights of being a citizen.

**Civil rights**

Participants wanted to be accorded the same freedom and equality inherent within civil rights:

>Citizenship is] the right to relate freely with who you meet in [the] community, to feel free to be yourself and express yourself. (Maria)

I think that we get the goodies of being citizens of the country and have the freedom to have the cloak of all that citizenship means. So it’s like a cloak or umbrella of protection really. We have protection; and we have access to the courts of law and if we have issues we have a means of addressing those rights, and so we don’t have to be down trodden in this country. (Lorraine)

The cloak of protection Lorraine described is important for service users who, as vulnerable members of society, need to have the protection from prejudice and discrimination. Along with these protections is the right to have freedom of speech and thought, and the freedom to meet with other like-minded people.

Civil rights also provide protection for those who want to openly express their difference:

You can be quite different to a lot of other people and yet still possess these rights... there’s an immense amount of diversity that’s more accepted, but of course people with so called “psychiatric disabilities” [will] be one of the last cabs off the rank to claim a place in the diverse society. (Mary)
Mary suggested that service users are still unable to have the same protections as other marginalized groups such as people with disabilities and lesbians and gays. While others in society appear to be accepting of the latter groups, as discussed in the previous chapter, service users have to, at times, shape their behaviour and undertake increased self-policing in order to claim the same social status and equalities enjoyed by others in society.

Sally explained that if service users are to exercise their civil rights and speak freely about their illness then they must be supported by fairer “media representations and opportunities to be open in public life”. As discussed in chapter six, speaking out and educating others about mental illness is a practice of inclusion. Sally, however, cautioned that service users may be impeded from exercising their civil right when their freedom to be and express themselves is sullied by sensationalised media representations of the mentally ill.

Angermeyer and Matschinger (2003) and Angermeyer, Matschinger and Corrigan (2004) also reported that service users are represented in a negative light when reports in the media reinforce their actions and opinions as outlandish or eccentric and in stark difference to the prevailing norm. These negative representations perpetuate the stereotype of those labelled as mentally ill. The media thus becomes a form of external discipline and control over service users, which contributes to their exclusion from “public life”, impeding the many opportunities to exercise their rights as citizens.

Isin and Wood (1999) have highlighted the intersection between gender identities and citizenship, claiming that women and lesbians and gays have historically struggled to secure equal civil rights as citizens. However, Isin’s conceptual framework does not fully explain the struggle that service users are engaged in as a marginalised group. Service users similarly remain oppressed, silenced, and unable to fully exercise their civil rights when they continue to be subjected to stigma and discrimination by others in society.

A parallel can be drawn between the sexual identity of gay men with HIV/AIDS and service users, particularly the association of disease, identity and not meeting the ideal concept of the citizen who possesses the competent mind and body (Isin & Wood, 1999; Yingling, 1997).
Lola explained that the label of being mentally ill robbed her of her identity as a competent citizen:

[When] I am robbed of my identity [and seen] as a dependent, sickly, incompetent and incapable person, the leap seems too great to be an independent, capable, competent healthy person, it just seems in some ways too big an ask. (Lola)

The disease focus of the bio-medical model resulted in Lola being labelled mentally ill and not only rendered her powerless, it also raised doubts for others about her competence to participate as a citizen.

The right to freedom and self-determination is not guaranteed. As Maria explained in chapter six, when service users are labelled as mentally ill they are no longer trusted. Maria explained that increased monitoring of service users by others in society continues to place conditions on their civil rights as citizens:

They are trying to edit them, limit them... [It is] conditional. [Citizenship is] like pregnancy; you either are, or you’re not. You can have freedom, if citizenship is about freedom, only this far but no further, and who gets to say, or draw where the line is? [Real citizenship] status would be unrestricted. I can do anything I want to do within the law and moral compass, legal compass and a socially acceptable compass, all [the] things that others take for granted. People with serious mental illness are perceived crossing those lines earlier and more dramatically when it shouldn’t be any different, [because] someone could just be eccentric... I think from a consumer’s point of view it puts a fear or curbs their ability to express themselves freely, and express opinions. (Maria)

Service users cannot take for granted that they have the same degree of freedom and ability to be self-determining when others place restrictions and conditions on their civil rights as citizens. Maria suggested that being untrustworthy was linked to the perception that service users were not fully competent to take on the rights and responsibilities of citizenship. Service users are thus fearful of expressing who they are because others see this as a symptom of being mentally ill.

Peter also agreed that there were increased restrictions on service users’ civil rights, particularly because of the labelling and doubts about their competence to be fully functioning citizens. This led to a double standard, especially if a crime had been committed:
You are denied parts of citizenship when there is stigma and discrimination that’s specifically aimed at people with mental illness. A good example of that recently was Mark Burton[^59], [being] sacked from [his job at] the zoo because of his history, and he’s quite well, he’s not going to hurt anyone. [There] are bad people, and he’s just mad, so that’s a very good example where you are actually discriminated against, more because you have a mental illness, but are actually quite safe. Whereas a convicted murderer, who has so willingly killed in a criminal way, gets privileged treatment, and the person with mental illness is discriminated against. (Peter)

Peter encapsulated the double standard that exists in society between people who have been labelled as mentally ill, and those who have knowingly broken the law. While prisoners may have their rights withheld or suspended during their incarceration, Peter suggested that, unlike service users, prisoners assume their rights and privileges as citizens when integrating back into their communities. According to Uggen, Manza, and Thompson (2006, p. 305) many “hardened” criminals become decent citizens when they have the full restoration of their citizenship rights. In contrast, ex-convicts, who have a mental illness, face a wall of resistance to being integrated back into their communities (Draine, Wolff, Jacoby, Hartwell, & Duclos, 2005). Peter suggested that like criminals, service users are also trying to integrate back into their communities. The double standard places conditions on their rights and closes down any opportunities to demonstrate that they can be trustworthy and competent citizens.

**The Mental Health Act**

Enforced treatment through the use of the Mental Health Act[^60] can also place restrictions and conditions on the civil rights of service users. When a person is compulsorily detained under the Act their autonomy and freedom to make decisions as a citizen are diminished and the participants experienced many injustices and conditions on their civil rights:

I’ve never been put under the Act but certainly worked for enough people that have, and there are still huge injustices that go on; and you know the equality issues are just appalling… You can even get your [drivers] license taken off you, you have to take medication, [and] you cannot be free if they decide that you are too unsafe... where else can you do that? (Ann)

I think the current mental health legislation is discriminatory by its very nature. I would go for legislation that says that if anybody who has got the capacity to make decisions they should be able to make them, and so if, you know, someone understands and is able to make choices... and if they don’t want to take psychiatric treatment then it shouldn’t be possible to make them take it. But that begs a million questions about how you define capacity, what the power relationships are in defining it and so on. But I think it’s fairer than saying “because you’ve got a diagnosis of mental illness, even though you have got capacity, I can still make

[^59]: Mark Burton was found not guilty by reason of insanity and detained as a special patient in a forensic unit. Part of his rehabilitation involved working at a zoo. This was reported in a local newspaper and Burton was subsequently asked to leave this position.

[^60]: The impact that the Mental Health Act has on a person is discussed more fully in chapter two.
you take this treatment”. Like, that seems to me to be totally unjust. So I think that treats people differently in a discriminatory way. It also, of course, damages trust. (Sally, PS)

The use of the Act suspends, and at times denies, the rights of service users. It also interrupts their ability to enact their responsibilities as a citizen and jeopardizes their social status. Being subject to the Act also creates the lack of trust between service users and mental health professionals (Vassilev & Pilgrim, 2007). Though the psychiatric consumer movement acknowledges that service users, at times, require security and asylum to safeguard their rights, Sally and Ann have suggested that a fairer, more just and less coercive approach to mental health legislation is required. This would need to be balanced with the protection of the rights of the wider citizenry.

Ann gave an example of how her psychiatrist questioned her competence to make informed decisions about her wellbeing and safety when she was under the Act:

We lose so much when we get put under the Act, those citizenship rights; and you only get put under the Act with the prediction that you are going to do a certain thing. And you know, the irony of it used to amuse me, because when [I was] raving about something, my psychiatrist would say “oh you can’t read people’s minds, you can’t know what that person is thinking”. But they do apparently, and they have all this power to do this. (Ann)

Ann highlighted the power that her psychiatrist had to detain her under the Act at any stage in her treatment. Ann noted the irony that he would base any decision about her competence to manage her own life by “reading” her, rather than listening to her explanation of mental distress. In further discussion Ann concluded that her judgement about her safety and risk status were invalid, irrational and a symptom of her illness, whereas the psychiatrist’s explanatory framework was rational and valid. Service users have often raised concerns about feeling unheard by psychiatrists (Beresford & Wallcraft, 1997), which has resulted in them being prescribed more medication. Beresford and Wallcraft reported that service users are concerned that once they are labelled mentally ill psychiatrists appear not to listen to them anymore.

When the explanatory framework of the service user differs from that of the mental health professional, then the service user can be regarded as not fully competent and lacking insight into their illness (Diesfeld & Sjöström, 2007; Hamilton & Roper, 2006). The assumptions that the participants were not competent to have a valid opinion or insight about their illness was evident:
[There was] one particular nurse... she was a bit like Nurse Ratchet from One Flew over the Cuckoo’s Nest. She was very dictatorial.... She used to teach some of the mental illness classes in the ward, you know, where patients learned about how to deal with their mental illness and all the symptoms. She was terrifying… people [would] put up their hands and say “I’ve got this symptom” and she would say “No, that doesn’t fit into it, you haven’t got that symptom”. (Ann)

I kept saying “could you please give me a sleeping pill that’s safe for pregnancy? I’m not psychotic”. It was like somehow because of my prior history and having this fat file that all they could think about was the old [me], and I hadn’t been on medication for 3 years and I didn’t want to go back [to an antipsychotic]. They had already got the idea [and were] suspicious about my capacity to be a mother, given my mental health history. (Zara)

In these examples, participants’ explanations or understandings of their distress was invalidated by mental health professionals when the discourses of the bio-medical model and the person’s own lived experience of distress was conflicted. People that have been labelled mentally ill are more likely to be monitored and, at times, dependent on mental health professionals. Isin and Wood (1999) and Isin (2002) argued that power and control is vested in the professions who represent the new bourgeoisie, and are regarded as “professional-citizens” (Isin & Wood, 1999, p. 103). Further, a sphere of power and dependency has been created within society, and subsequently, citizens now rely on the language of professionals to interpret their world. When the world of the service user is constructed through the language of psychiatric professionals, this can reinforce the label of being mentally ill, and subsequently service users are regarded as incompetent and lacking insight (Hamilton & Roper, 2006).

In their focus on migrants, refugees, and children, Isin (2004), Hindess (2004) and Stasiulis (2002) argued that citizens are required to have the legal capacity, rationality, moral autonomy and self-control to be accepted as citizens. Their thesis does not fully account for the fluctuating nature of mental illness and the impact that this has on service users’ capacity to fulfil their rights and responsibilities as citizens. This is further compounded by being labelled mentally ill by psychiatric professionals and others in society. Rose (1996, 2005) recognised that people who are regarded as insane or intellectually disabled are deemed as incompetent and excluded from their full rights of citizenship, however, he did not take into account the effects of being labelled with a mental illness. Green (2009) and Anspach (1979) contended that the bio-medical model holds assumptions that the mentally ill are at the mercy of their distortions and that their perceived powerlessness and irrationality is a symptom of their mental disorder. The professionals’ assumptions that powerlessness is associated with mental illness, rather than a response to the denial of one’s civil rights as a citizen,
perpetuates the stereotype that those who have been labelled mentally ill are unable to demonstrate a similar level of conscious, rational and goal directed actions (Anspach, 1979) expected of normal citizens.

Civil rights ostensibly grant protection from stigma, prejudice, racism and other attitudinal barriers that impinge upon one’s freedom, but it is clear from the data that service users are excluded from this protection. When Zara was diagnosed with a mental illness she experienced prejudice from other citizens. She explained that the discrimination and intolerance impacted on her civil rights, particularly the right to have custody of her child:

What I have had denied me is my ability to be a custodial parent. I have had that removed from me recently, and going to court reminded me about all the prejudices that the community has [which] were played out in the court room. (Zara)

This was a heart-breaking experience for Zara. It could be argued that Perlin’s (2000b) notion of pretextuality was in force in the court room. Although Zara presented evidence of activities that constituted her as a responsible parent (for example, attending parenting classes) to the assessing mental health clinician, this was not included in the report or allowed as evidence in court. Zara believed that her evidence was ignored because of preconceived assumptions about her inability to parent. Zara was deemed a potential risk because she was labelled mentally ill, and consequently the state assumed custody of her child.

Isin (2004) argued that the neo-liberal practice of citizenship governs its citizens through the notion of risk. Citizens who are perceived as disrupting the social order, such as single mothers on benefits (Lister, 2004), are marginalised and excluded from society and their rights of citizenship become conditional. This can lead to a state of “confusion and chronic discontent” (Isin, 2004, p. 233). Equally, when service users experience the interruptions and suspensions of their rights, this can further exacerbate their existing fragile state of mind and powerlessness. At times, service users may not be able to fulfil their full rights and responsibilities, but this should not be construed as the service user’s inability to enact their political rights as a citizen as discussed in the following section.
Political rights

Political rights provide citizens with the power to determine how the democratic processes of the state will run, and include the right to vote and the right to access one’s political representatives:

You have a lot of rights as a citizen of New Zealand... [And] although it might be a difficult process; you could approach and have an interview... with the leader of the country [and] make your views known to the highest in the land. (Lorraine)

It’s the right to participate fully.... the right to go to our members of parliament, which is a place that is ours, and to which we all have a right to be. (Phil, PS)

The majority of citizens may take their political power for granted, but this appears to be different for some service users. For example, Phil described how a small group of service user representatives were invited to attend the launch of the de-stigmatization campaign (Ministry of Health, 2007b) at Parliament. After the launch the service users spoke to Phil and stated: “we didn’t know we had the right to be here”. Phil was shocked and upset by this statement as he understood that:

[The right to be at Parliament is] the core of citizenship; the right to participate and to participate fully [and] to not be excluded from anything. (Phil)

This demonstrated that though some service users have a good understanding of their political rights, the effects of being labelled mentally ill can lead others to believe that they do not possess their political rights as citizens because:

[You are] dependent, and have very low self-esteem, you see yourself in that sort of... that illness role, you don’t really see yourself as having all the same rights and responsibilities as “normal” citizens. (Peter)

Many participants have had lengthy hospitalisations and some have felt dependent on health professionals, resulting in reduced confidence and low self-esteem associated with self-stigma (D. Peterson et al., 2008). When people lack this personal agency then they are unable to exercise their capacity for successful action at a political level (Isin & Wood, 1999; Lister, 2004). The perception of being powerless to exercise one’s political rights has previously been described as the state of abject-hood, whereby one’s rights are often dismissed, overlooked or suspended (Isin & Rygiel, 2007). This will be discussed in the following section.
The state of abject-hood

The participants’ narratives described a sense of powerlessness, alienation and lack of personal agency to assert their rights of citizenship. For example, Zoe had many experiences where she felt “useless and worthless” or a “non-entity”. After Brent was labelled as mentally ill he felt he was a “non-person”. When Wayne had his first admission into the psychiatric institution he felt that he was in “a big, deep, dark hole”, and Beth described the sense of “living in [a] void”. Jo and Ann described being “broken” and “damaged” and therefore “banned” from being citizens. These narratives reflected the negative pole of the continuum of citizenship, previously described in chapter five, which is consistent with a state of abject-hood and the lack of recognition as the bearer of rights as a citizen:

[Service users] lose their voice because they become, not so much invisible but unrecognized as needing a voice, undervalued, often passed over. (Maria)

When a service user is labelled mentally ill, this changes their perceptions of their social status and can silence their political voice. A nurse in the focus group explained how she supported a service user to exercise her political rights as a citizen:

I worked with somebody last year who approached me and said “I have this form for jury service what shall I do?” and I said it is entirely up to you... and she said “Well, I feel like signing and saying “I can’t do it because I have a mental illness” and I said it is your duty as a New Zealander to do jury service and she said “you know you’re the first person that has said that to me”, so she said “OK I am going to do it” and she did it successfully, she did it for a week and she got paid for it, and she was absolutely delighted and she felt like she had served her duty and [was] responsible like everybody else. And I think, as nurses we’ve really got a role to play in encouraging people [to be] fully functioning citizens... just because they have got a mental illness does not stop them from fulfilling their role as a citizen. (Nurse)

A number of participants have overcome their experience of abject-hood by becoming members of the psychiatric consumer movement61. Participants reported that they are moving on from shaping their behaviour in order to survive within a stigmatising and discriminating world, to getting organised through their practices of inclusion and rallying together as a social movement. The movement has rallied service users to exercise their political right to bring about change within the mental health system. This has led in recent years to a larger number of service user representatives being consulted on the development of strategic documents that guide mental health policy in New Zealand. As Priscilla explained, the document62 Our Lives in 2014 (Mental Health Commission, 2004b), authored by a group of

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61 This was discussed in chapter six.
62 This document is discussed in chapter two.
service user representatives sent a strong message to the sector that service users want “equal rights, like every other citizen”.

The participants regarded voting as an important political right that increases their sense of personal agency and gives them a voice in the democratic processes of the state:

I have the right to vote and I exercise that vote, I haven’t always been a voter; I like it, I like having my say on how I want the country to run and who I want running it. Often I hear people bitching about the government and [I say to them] “well did you vote?” “No”. “Well how can you have an opinion”? I don’t think it should be compulsory, I think it should be a right and people should choose… [These are our] rights as a citizen… [And I] have the right to have a civil union now that it’s law in New Zealand. (Priscilla)

Citizenship is very prized in many countries and… I see it as an entitlement... and to vote, to make one’s views known in a very practical way by voting for the person or the government that you choose or want to have. (Lorraine)

Priscilla described how she strongly encourages her peers to continue to vote and express their political opinions, but at times there may be obstacles preventing them from doing so. Although being sectioned under the Act does not deny service users the right to vote, they still rely upon the mental health service where they are detained to provide the opportunity to vote at election time. Repeated admissions to psychiatric institutions can also mean that service users do not have stable housing and maintain their registration as a voter on the electoral roll. These are two examples of structural disadvantages that interrupt the service users’ ability to exercise their political rights as a citizen.

Isin and Wood (1999) questioned whether the institution of citizenship still masks various forms of inequalities and denials of rights, based on the conflict between citizenship and different forms of identities. Service users as citizens have not been fully represented in the citizenship literature. Isin and Wood contend, however, that other radicalised groups, such as black power and the women’s movement, have won the right to an effective share in the total power of society, through the “politics of recognition” (p. 31). In so doing, they are now accepted as legitimate members of society and have escaped the abject state of anomie and alienation. Lister (2004), suggested that for people in poverty the nexus of their personal and political agency, voice and rights has been pivotal for them to reclaim their power as citizens. Likewise, service users are beginning to emerge as a new social movement, creating new sites of struggle for recognition of their voice and contesting their right to be recognised as
full citizens (Barnes & Bowl, 2001). In the following section, the participant’s understanding of the social rights of being a citizen will be presented.

Social rights

The participants demonstrated a broad understanding of their social rights of citizenship. They suggested they include:

- Basic rights; like access to accommodation, employment and insurance. (Maria)
- Having a job; having stable accommodation. (Zara)
- [Having the] rights and opportunities, particularly around employment, education [and] housing. (Sally, PS)
- Having the same rights [to] jobs, educational opportunities... The same kind of things as everybody else. (Gillian)

Generally, the participants’ understanding of their social rights of citizenship included the basic needs of welfare, housing and financial protection through insurance. This represents the common social platform upon which all citizens are assured the benefits and protections by the state (Dahrendorf, 1976; Isin & Turner, 2007). In addition to these common expectations of social rights, the participants in this study stressed the importance of having friends, intimate relationships and expressing their spirituality as part of their social rights as citizens. This deeper sense of one’s social rights is not fully accounted for by Isin and colleagues in their work with refugees and other marginalised groups.

Employment was also regarded as an important social right as a citizen. Participants reported being excluded from employment when their employers failed to make reasonable adjustments to accommodate them in the workplace:

In order for people to reach their full potential, if they have a mental illness, and using the example of getting a job or developing a career, then it needs a change in the way employers think about mental illness. They have to recognize that sometimes people are going to be unwell, that they perhaps need extra support [and] are susceptible to things like stress.... and society has to adapt slightly so that people with mental illness can reach their full potential. (Peter)

We have just had a case of a woman who lost her job in the prison service who, because they did not make reasonable adjustments for her. She had depression, she is about to win the biggest ever compensation claim for lost earnings... Now compensation [and] money isn’t the only thing, but it sends a signal [to employers] that says “actually you can’t do this, you can’t just fire someone when they have got depression, sorry but you can’t!” So we have done simple things, like when we put up materials to employers saying “this is good practice in
making adjustments for people”... We are constantly trying because we know that the employers are not thinking about people with mental health problems. (Sally, PS)

Sally explained further that employers have a rather narrow view of reasonable adjustments, and focus on physical changes to the work environment, such as widening the doors for better wheelchair access. This lack of understanding leads to discrimination in the workplace and places conditions on the service users’ social rights.

Some participants faced other inequalities:

I struggle with the fact that [the premium] on my life insurance is three times what other people’s is and that has nothing to do with the fact that I smoke and I am overweight, it was purely on my [psychiatric] diagnosis… that is inequity. (Ann)

Once Ann was labelled mentally ill, this increased her insurance risk (Ericson & Haggerty, 1997), whereas Ann believed she was more at risk from her physical state of being overweight and a smoker. This is another double standard, as Ann was unable to have equal and fair access to insurance cover that other citizens take for granted. Johnstone (2001) reported similar difficulties that an accomplished academic encountered when refused income protection insurance based on her diagnosis of depression. The refusal was based on company policy to decline anyone with depression, rather than contacting the woman’s general practitioner or psychotherapist to assess her current, and low risk, condition. Insurance companies focus on the risk associated with the label of mental illness, and are more likely to protect the rights of their shareholders, rather than the rights of service users.

The right to reasonable and accessible health care is also a social right. Ann sought emergency treatment for a physical problem, but was treated differently once the staff knew she had the label of being mentally ill:

[For example] you go to A&E63 for a normal physical thing and on your file your mental health status comes up and they treat you differently, they don’t hear your physical thing anymore. (Ann)

People who have mental illness are often denied adequate health care for a physical problem because health professionals do not take their physical complaint seriously. Ann was able to remonstrate with the staff and did receive the care she needed. Some service users may not be

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63 The accident and emergency room in a general hospital.
sufficiently confident to make the same claims for their social right to healthcare, and in some extreme cases, this can result in poor outcomes for service users:

Why are we just accepting that if you have a diagnosis of schizophrenia you die young? We shouldn’t just accept it. People who are equal citizens should expect to get the same level of health care [as others] that is adapted to your needs and opportunities. (Sally, PS)

The notion of citizenship has raised the expectation of equal and accessible health care for all, including service users. Currently service users can expect to have a much shorter life expectancy than their co-citizens (Handiside, 2004; Robson & Bragg, 2008; Robson & Gray, 2007), and this is related to the long term effects of their psychiatric medication and discrimination by health professionals. Twine (1994) has argued that such restrictions on one’s social rights to health and welfare can lead to social exclusion and the impairment of the development of the social self. Societal messages of low worth as well as stigmatisation damages service users’ self-identity subsequently affecting their health behaviour which leads to higher health risks.

The participants in this study regarded the social rights of being a citizen to include equal access to health care, stable accommodation, financial security and meaningful relationships. Participants also reported that their rights as a citizen have to be balanced with their responsibilities, duties and obligations, and this will be discussed in the final part of this chapter.

The responsibilities of being a citizen
This section will present the findings under the headings of being a responsible citizen, making a contribution, the importance of personal responsibility and the health sector and society’s responsibilities towards service users.

Being a responsible citizen
For the participants their responsibilities as citizens are important:

[With] the rights of being a citizen come the responsibilities, so we ostensibly should be law abiding citizens... caring about others and respecting the authorities that are in place in the country, and respecting other people’s views when they are different from ours. (Lorraine)

Citizenship is viewed in terms of the web or network of both reciprocal relationships and contributions... it’s not only about rights as in demanding rights, it is about reciprocity based on equality, substantive equality. (Sally, PS)
The participants reported that the notion of reciprocity and making a contribution to society are part of the responsibilities of being a citizen. Isin and Turner (2007) explained that an appreciation of one’s entitlement to the rights of citizenship in turn entices the citizen to demonstrate their responsibility, through the notion of reciprocity. This is an active process of giving and taking:

[I have] something to offer, something to contribute, and in that process I will receive something... that is part of my privilege of living in a community, in a country. And I need to exercise my responsibility as a citizen, not sit and wait for the world to come to me. There are lots of contributions that [service users] receive from citizens, helping them re-establish so they can live well, and stay healthy and [in return] contribute [back to their communities]. (Polly)

Polly explained that contrary to the assumptions inherent in the label of being mentally ill, service users have a great deal to contribute to their communities. Polly’s view of her reciprocal relationships with others in her community evoked a sense of connection and commitment to the common good of the community. Participants reported that they wanted others to recognise that they have something to offer to society, and can undertake their responsibilities as citizens. Polly expressed her sense of privilege, satisfaction and pride in her ability to be able to give back to her community. Reciprocity increased her sense of entitlement, acceptance and sense of belonging with others.

Isin and Wood (1999) recognised in their early work that citizenship is a reciprocal relationship between the citizen’s right to have the freedom to live their life unhindered, and at the same time take responsibility for the society that provides such liberty. Isin and Turner (2007) developed this principle of reciprocity further contending that this give and take, often covertly, fosters the citizens’ education in civic culture, creating pride in the society to which they belong and therefore increasing their commitment to defending its democratic institutions. Linking this assertion to the “ethic of participation” (Faulks, 2000, p. 165) citizenship can be reconceptualised as a holistic idea of an active rather than passive status that promotes equality and a personal sense of virtue and in return citizens reap the rewards of substantive citizenship, that is, full access to civil, political and social rights.

Making a contribution
Several of the participants explained that being a responsible citizen meant making a contribution to family, friends and the wider community as a “contributing member of society” (Jo):
To bring my kids up in a responsible, thoughtful way and those responsibilities go to all sorts of things... [Citizenship is] being involved... it is an obligation to be part of it. (Greg, PS)

[Citizenship] is the responsibility to participate in those systems that you feel comfortable with, and because of that I think we all have to take on some role and burden for making society better. (Fran, PS)

Greg and Fran understood their role as citizens as being responsible and thoughtful members of society. Their position also reflected the importance of the balance of claiming their rights as citizens and their obligations and duties to others. Isin and Turner (2007) stated that this cycle of effort, reward and virtue invigorates citizens to become active, and in so doing, promotes democratic virtues. When the “ordinary man and woman” (Isin & Turner, 2007, p. 16) become actively involved in the democratic spaces that cultivate citizens this increases opportunities for the protection of the citizenship rights of the more vulnerable members of society. Fran epitomizes the moral voice which calls to citizens to carry out their responsibilities, or risk society drifting towards individualism and anomie (Delanty, 2002).

As discussed already some service users may, at times, be perceived by society as not capable of taking on their full responsibilities as citizens in order to contribute, or they doubt their own ability to do so because of the effects of being labelled mentally ill. Service users have to manage the delicate balance between the recurrent symptoms of an illness, and at the same time be seen by society as valued, active and responsible citizens.

While Isin (2008b) and colleagues have offered a generic understanding of the responsibilities of citizenship, their conceptual framework does not fully explain what this means for service users. Isin argued that citizenship presumes that members of society have the autonomy, freedom and resources to perform these responsibilities and participate as political agents, through access to economic, social, cultural and symbolic capital. This assertion is not supported by the findings in this study, as once labeled mentally ill, service users experience a thinner form of social capital because they often are excluded from collaborating and joining with others in their community, face restricted access to education and employment, and lose their reputation, prestige and status as citizens. Without full access to these forms of social capital, service users cannot enhance their power, influence and the resources required to have the life they would choose. Service users thus become passive recipients, rather than active agents. In the following section, how the participants took
personal responsibility to maintain themselves as active and participating citizens will be presented.

**Personal responsibility**

Being a responsible citizen requires a person to demonstrate their commitment to meet their obligations and duties. Jo explained that she was “responsible for herself” as a citizen. Lorraine also regarded personal responsibility as important for citizenship, “I think to be a true citizen we have to be responsible to ourselves and to those around us”. The participants’ emphasis on taking personal responsibility suggested that being a citizen is an active rather than a passive process.

For several participants, the journey of recovery from their mental illness helped them to develop some of the individual qualities which enabled them to take personal responsibility as active participants in their communities:

> There was something about being responsible, being proactive, and being in control, being able to do something rather than nothing, that made a huge difference. (Lola)

Lola described the similarity between citizenship and some of the principles of recovery (Mental Health Commission, 2001) such as personal responsibility, autonomy and having meaning and purpose and the hope of a better life, rather than being a passive and dependent recipient of care.

For the majority of service users, reclaiming their lives after an episode of mental illness requires them to make a commitment to their journey of recovery. Recovery requires a high degree of self-reflection:

> Because you get into this recovery cycle and it's very self-absorbing [because] I’m doing all this to look after myself... Being in recovery is all about you [laughs]. Well maybe citizenship is one step above that, where you are actually contributing to society, outside of yourself. (Jo)

Jo suggested that recovery is vital however it is just the first step on the continuum to reclaim one’s identity as a citizen. Once she began making a contribution to her community again, Jo became less consumed by her illness and more confident. This process of personal agency she called “taking herself for granted”.

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64 The concept of recovery is discussed in more detail in chapter two.
Some participants reported that growing up and being more mature were essential qualities of responsible citizens:

In my hot-headed younger days of being a bit of a radical it was like “I have all these rights and no responsibilities” but it is something I have grown into... people come to an awareness that they have responsibilities as well as rights. (Priscilla)

I always maintain my wellness. Once I got on top of [my illness] and once I was on the right drugs and had insight [I] realized that I had a choice and [the] responsibility to look after myself. I was grown up, I was an adult, growing up is a really important part of citizenship. You are making the decisions that are important to look after yourself. (Moley)

Priscilla described how she has moved from being a “hot-headed” radical to being more mature and more measured in her actions as a citizen. This maturity has helped Priscilla to appreciate that being a citizen is a balance of rights and the responsibilities and obligations towards others in her community.

Peter explained that it is in the “late teens [when] you really develop as a citizen” and it is in these formative years that young adults develop the capabilities of civic engagement (Lister et al., 2003). Moley, however, had these formative years interrupted by a mental illness:

I grew up full of alcohol and drugs and boys being stupid. It takes a while to let go of that and realize [that] I can’t live like that. I can’t do drugs. It took me 4 or 5 years to give up marijuana. Marijuana would just send me off on a paranoid trip all the time, so it’s the responsibility thing. And the looking after yourself as an individual and not doing what everyone is doing around you. (Moley)

Moley explained that “growing up” helped him develop the maturity and ability to be self-reflective and become personally responsible to maintain his wellness. He also argued that having gained “insight” about what contributed to and maintained his mental illness was important to restore his personal responsibility. Once he gained an understanding of his vulnerabilities that maintained a vicious cycle of illness (Randal et al., 2009) he was able to reclaim personal responsibility and build his resilience and personal agency.

Polly explained that taking personal responsibility was an important step in managing her symptoms, rather than the symptoms managing her:

Personal responsibility [is important]. [You have to learn to] know your triggers... early warning signs... your support people. [So] you know what to do if you look down the road one day and you see a crisis coming like a big truck “uh oh, lets ring somebody” and what [you have to] do to get over it. (Polly)
Other participants gave examples of how they took personal responsibility by engaging in mutual support:

We talk about self-management and taking responsibility for our own journeys and steering a course where we avoid the next altered state... we don’t talk about other people managing us, we take ownership of our lives [and] take responsibility. (Zara)

Zara and her peers have exercised their personal responsibility and autonomy as citizens by taking “ownership” of their wellness.

Mary explained that she, however, had concerns about the term self-responsibility:

I try not to use the word self-responsibility. I try to use the word resourcefulness; because I think once we start talking about self-responsibility you’re really getting into this moral dimension. (Mary)

The notion of self or personal responsibility suggests that the person has complete self-control and self-mastery. White and Hunt (2000, p. 102) have argued that the latter are regarded as the desired attributes of one who has the “moral fibre” to be a “worthy” and “good” citizen. Such rigid expectations can be exclusive of those who cannot consistently reach this ideal. Mary juxtaposed the concept of self-responsibility with resourcefulness, which connotes the practical state of ingenuity and inventiveness of many service users.

Isin (2008c) and Isin and Wood (1999) argued that modern neo-liberal democracies place a greater emphasis on the rights rather than the responsibilities of citizenship. In contrast, the participants in this study placed a higher degree of importance on the latter, particularly personal responsibility. Such an emphasis could be due to the development of their personal agency on their journey of recovery. Alternatively, such a high degree of focus on personal responsibility could be an artefact of the heightened self-surveillance and self-policing that service users have to undertake in order to be included as normal citizens.

Responsibility has an ethical quality of obligation and answerability to each other. Democratic neo-liberal governments have recently reprised the emphasis on the responsibilities and obligations of being a citizen (J. Clarke, 2004; Peled, 2008). Isin (2000) contended that the global city is the space within which the very meaning of citizenship is

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65 Discussed in more detail in chapter nine.
made and transformed. He argued that the city is a complex, diverse and mysterious construct that teaches “humility and care” (p. 19) to its citizens. This responsibility and ethic of care towards the self and others has been noted by other scholars as an important part of the social processes of active citizenship (Barnes & Brannelly, 2008; Brannelly, 2006; Sevenhuijsen, 1998, 2000, 2003).

The participants in this study reported that mutual and reciprocal responsibilities were also expected within the state institutions that they had contact with. How such institutions, namely the mental health system, supported service users to be full citizens will be discussed in the following section.

The responsibility of the mental health system
Ann explained that the mutual and reciprocal responsibilities between her and the mental health system were based on the fundamental principle of trust:

   It is definitely around trust, because I could trust them to actually know what was right for me at a time that I couldn’t. (Ann)

When Ann was in a mental health crisis she felt she had temporarily lost her ability to be totally responsible for herself. Surrendering her responsibility also meant giving up her autonomy. Though this left her feeling vulnerable Ann was able to place her trust in the mental health professionals to take care of her when she was unable to do so.

In contrast, participants felt that sometimes the system takes over their lives and removes the opportunity for them to demonstrate that they can be responsible people. The bio-medical approach to treatment also places restrictions on the choice of treatment options that were available:

   The basic principle is not [to have] people run your life for you. Being allowed to make choices, being allowed to fail is an important one. And the external... dimension, is having a system that allows you to do that. So the conditions have to be there [so] that you’re not the captive of the services, because they do have this tendency to capture-and-keep. And not allow people to take risks, not give people choices. (Peter)

Mutual responsibility builds trust and engenders the reciprocal relationships of give and take, which fosters service users’ sense of autonomy, even when subject to compulsory treatment. Mental health law also promotes the principle of reciprocity (Eastman, 1994; G. Richardson,
2003), particularly the obligation of the mental health professionals to provide choices and appropriate services that involve the least restrictive care.

Jean suggested that if service users are to have full citizenship then mental health professionals had a responsibility to take a much broader view than the bio-medical model to advance their current understanding of mental health and illness:

> I do think that we need to look far more systemically and take far more collective responsibility, and that will both advance our current understanding of mental health issues as well as start looking at what some of our society’s needs are and will continue to be. (Jean)

Jean explained that the health system cannot work in isolation from other statutory agencies, such as Housing⁶⁶ or Work and Income⁶⁷ which support the welfare of service users. As suggested by Mortensen (2008), a more cohesive and systemic view is required in the hope that working across systems will achieve shared goals and better service responses for users:

> I think citizenship is a helpful construction because it places obligations on the state and other institutions, employers and so on, without making individuals who may experience exclusion passive in the process. But nor does it just focus on the individual and what the individual needs to do with support, which is one of the risks of recovery... if you take recovery on its own. I think citizenship works with policy makers [because citizenship] is all about reciprocity. People can take more charge of their lives... and the more that services users say “I want to do things, but you know these barriers have got to be removed, I need this support” then you’ve got a much better chance of making real tangible progress. (Sally, PS)

When agencies work together, share the responsibility to support service users and remove the barriers to their social and economic rights, then this can disassemble the negative attributes associated with the label of being mentally ill. The bio-medical model is also a barrier to full citizenship for many service users because it does not place an acceptable focus on the environmental factors that result in poorer mental health:

> Many women, as a result of domestic violence, get diagnosed with [mental health disorders] and the notion of recovery says that they are the problem... and so the whole system absolves itself of responsibility by saying “well, you know, you are the problem, get better, you are sick” and so they don’t have to actually look at what the causes of the issue are. (Jean)

Jean explained the strong correlation between early childhood trauma and the development of mental illness (Read & Haslam, 2004; Read et al., 2004). A bio-medical view of the person’s

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⁶⁶ Housing New Zealand is the New Zealand government’s main advisor on housing, and services related to housing.

⁶⁷ Work and Income provides financial assistance and employment services throughout New Zealand. The agency is a single point of contact for New Zealanders needing job search support, financial assistance and in-work support.
problems means that the system may abdicate its responsibility to uphold and protect the rights and wellbeing of the person by viewing such violations of their rights as the private troubles of the individual who is in need of treatment (deSwaan, 1990).

Other participants spoke of the importance of the mental health system working collectively to promote and accept the opinions and wisdom of service users. For example, service users were asked to give their vision for the future of mental health and addictions services in the strategic document, *Te Tahuahu* 68, however most of what they argued for was not included in the final copy:

[The Ministry of Health official] said to us that a lot of this couldn’t be implemented into Te Tahuahu because of the [service user] language [so] they had to put it in different [clinical] language. It’s like “put it in different language and you lose the essence of it”. Put it in government lingo, it’s not graspable [by service users]. This is what service users were saying, this is what we want and it’s so damn simple. It is gate-keeping. (Priscilla)

Priscilla was concerned that the system did not uphold its reciprocal responsibility to ensure that service user views were incorporated into the document. The report privileged the clinical language, underpinned by the bio-medical discourse, rather than service users’ discourses of recovery and citizenship rights. The subjugation of this knowledge served to perpetuate the “medicalization” (Epstein, 2003, p. 160) of the identities of those who are marginalised.

A paternalistic approach by the system can absolve the service user from their responsibility:

[There is] a reluctance [to support our] rights and responsibilities, because people think we are not capable. [This is] paternalistic “we can’t trust you with that responsibility”.... [Service users then] start to absolve their responsibility... by default they accept [their serious mental illness] as a permanent limitation. It can be a relief in some cases “I don’t have to worry about that” or “someone else will take care of that” or “everyone knows I can’t take responsibility for that”. (Maria)

Priscilla explained that many staff within the system do not expect service users to take responsibility because they think “*Oh, but they are unwell, we’ll let it ride*”. This paternalistic stance reinforces the negative attributes associated with the label of being mentally ill, and lowers the social status of service users.

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In sum, the participants have reported that although personal responsibility is important for citizenship, this can also be augmented by the collective responsibility between service users and the statutory agencies, particularly the provision of health and welfare services. The participants expected that the system would reciprocate and engage in upholding its responsibility to safeguard and uphold the rights and responsibilities of service users.

**Conclusion**

The participants expressed a broad understanding of the importance of balancing their rights and responsibilities as citizens. Similar to Mortensen (2008), participants found themselves in a paradoxical position of having the legal status of citizens, yet, as the data showed, they did not enjoy the substantive nature of citizenship and unconditional access to their civil, political and social rights as citizens when labelled mentally ill. The image of the continuum of citizenship helped to provide a fuller understanding of the world that service users inhabit as the outsiders. The negative pole of this continuum evoked the metaphor of the bubble as the space of abject-hood and alienation where the rights of service users are interrupted, suspended or denied. This in-between space is the ambiguous grey zone (see chapter six) where individuals are neither fully excluded nor fully recognised as citizens (Walters, 2008), and this has placed conditions on service users’ citizenship.

Participants reported the need to take a higher degree of personal responsibility, perpetuating their self-surveillance and self-policing to prove their worthiness as insiders. These findings concur with those reported in chapter six, that service users have to continually demonstrate that they are trustworthy and competent members of society.

Isin’s dimension of the content of citizenship has provided some understanding of how service users’ rights and responsibilities can be interrupted or denied. Isin’s commentary on other marginalised groups, such as lesbians and gays and women, provided an interesting parallel to illuminate that service users are also lobbying to reclaim their full rights as citizens.

What his conceptual framework does not account for is the impact that labelling has on service users’ legal status, particularly the use of the Mental Health Act and compulsory treatment. The subsequent suspension of their rights and responsibilities, and the conditions
that this places on their status is one aspect of citizenship that theorists have not explored fully. Isin’s conceptual framework does, however, help to illuminate the emphasis that participants placed on the balancing of their rights and responsibilities, and their notion of reciprocity. These findings will expand Isin’s conceptual framework by contributing the views of service users as a marginalised group who are lobbying to be recognised as full citizens.

To conclude, the emerging findings illustrate how participants regard citizenship as both a legal status and a practice (Isin et al., 2008; Lister et al., 2003; Morrow, 2004; Oldfield, 1990b). The participants’ practice as citizens, such as shaping behaviour and the practices of inclusion69 can be further extended to include the reciprocal relationships that enhanced their ability to enact their rights and responsibilities as citizens. These findings illustrate further how service users are progressing on the continuum to become insiders. In the following chapter, the finding that a sense of belonging was important for the participants’ journey towards full citizenship will be presented.

69 See chapter six, the extent of citizenship.
CHAPTER EIGHT: DEPTH OF CITIZENSHIP

In chapters six and seven, the findings generated from the participants’ responses to the first three questions in the interview schedule were presented. This chapter presents the participants’ understandings of the importance of a sense of belonging and connection. These findings were generated from the responses to the questions: “How has the recovery approach helped or hindered your journey towards full citizenship?” and “What contributions have mental health nurses made on your journey towards full citizenship?” The findings are presented using Isin’s third dimension of his conceptual framework, the depth of citizenship, which he has defined as the thickness or thinness of belonging.

The first section of the chapter focuses on the thickness of belonging and includes the macro levels, such as ethnicity and nationalism. The micro level refers to the deeper sense of belonging experienced by the participants, created through their sense of connection, spirituality and solidarity.

The thickness of belonging

Ethnicity and nationalism

Participants explained that their culture and/or ethnicity increased their sense of belonging:

Being Māori and being part of the hapu, iwi, whanau\textsuperscript{70} structure, citizenship would be a secondary thing for me... [My priority is] wanting to belong... to my hapu, iwi and my turangawaewae... and with that comes automatic citizenship. So I have never questioned it. If you belong then you feel part of something, you are a member, having earned the right to be one. It is the internal sense of belonging. (Priscilla)

Priscilla distinguished between her status as Māori and tangata whenua\textsuperscript{71} and the sense of belonging to her tribal group, and her status as a citizen of New Zealand. Māori have a strong sense of tribal affiliation and connection through their blood-lines, which is sustained by the rituals and customs of the tribe. Priscilla described an internal sense of belonging, derived

\textsuperscript{70} Hapu: kinship group, clan, tribe, sub tribe, section of a large kinship group. Iwi: extended kinship group, tribe, nation, people, and race, often refers to a large group of people descended from a common ancestor. Whanau: extended family, family group, a familiar term of address to a number of people. Turangawaewae: literally translated as ‘a place to stand’, where Māori feel especially empowered and connected, a foundation, a place in the world, a home (n.d.).

\textsuperscript{71} Tangata whenua is translated as first people of the land.
from whanaungatanga\textsuperscript{72} the active participation in the affairs of her whanau (n.d.), hapu (n.d.) and iwi (n.d.). Through this deeper sense of belonging, Priscilla has gained the emotional, physical and spiritual sustenance required for her health and wellbeing. This is coupled with the unconditional acceptance of her identity as a lesbian and as a service user by others in her cultural group.

Isin and Turner (2007) proposed a sociologically-informed definition of citizenship that emphasises “norms, practices, meanings and identity” (p. 4), as opposed to legal rules. This creates an assemblage of different forms of belonging and understandings of citizenship. Isin et al. (2008) contended that the recognition gained through one’s social practices as a citizen is essential for inclusive citizenship. Priscilla described the important social and cultural practices within her tribe which has created a thicker sense of belonging for her. Kabeer (2005) and Lister (2007) have suggested that this is a horizontal view of citizenship, whereby citizens gain their sense of belonging and recognition from identifying with others and acting in unity as a group.

This suggests that the identity as Māori has primacy, the title of citizen being secondary:

[Citizenship is] that nation-hood stuff and it’s that local stuff, and I think the nationhood stuff is the big picture... as for me I don’t see myself as citizen of New Zealand, you know as a fully functioning citizen of New Zealand, with the same rights as other people... it’s probably the Māori thing, it’s more around it’s enforced, [and] we really have no choice. So I don’t feel like I am really a New Zealander, but I do feel that I am part of the country. (Nurse)

This Māori nurse felt that citizenship was enforced upon Māori. That it is a concept and status associated with the colonial notion of subject. This is in stark contrast to the notion of being tangata whenua and the affiliations to both the tribe and the land. Although Isin and Wood (1999) have addressed in part how the legal and social aspects of citizenship may be constructed for indigenous groups, such as Māori, a much fuller understanding is proposed by Pearson (2002). Pearson has argued that Māori have “double citizenship” (p. 1000) as aboriginal “people in place” with existing socio-economic and political status as the first people of a nation. Being aboriginal provided a legal and political relationship between the state-colonizers and the non-state people. The Treaty of Waitangi\textsuperscript{73} upholds the obligation of the state to ensure that Māori have protection, participation, partnership and tino

\textsuperscript{72} Explained in chapter two.
\textsuperscript{73} The Treaty of Waitangi (TOW) is discussed more fully in chapter two.
rangatirityaŋa as first people. Through this agreement Māori also gained the automatic legal status as citizens. The nurse acknowledged the importance of fulfilling her rights and responsibilities as a resident of New Zealand but strongly felt that Māori do not enjoy the same rights and entitlements that other Pākehā citizens may take for granted. However, for Māori, being regarded as citizens has not fully delivered on their guaranteed rights and entitlements (Humpage, 2006) as first people of the land.

Zoe had a different perspective on her sense of belonging as a citizen:

> Citizenship to me means belonging to a particular country... I’ve mixed with a lot of Māori people who perceive that they don’t have the same feeling of belonging to New Zealand; they belong to the Māori race. I’m sure that goes for a lot of ethnicities... they wouldn’t have the same feeling of belonging to New Zealand. You see I don’t see myself being Pākehā, I see myself as being a New Zealander [and] belonging to New Zealand. (Zoe)

Zoe strongly identified as a New Zealander, eschewing her status as Pākehā which connotes one’s colonial heritage and a stronger sense of allegiance and belonging to the Sovereign and the commonwealth. In contrast to Priscilla, Zoe explained that a sense of belonging as a citizen is derived from her relationship to the country and her identity as a New Zealander.

Isin and Wood (1999) asserted that ethnic (*jus sanguinis*) and civic (*jus soli*) understandings of nationhood determine the individual’s sense of belonging as a citizen. The affiliation that the citizen has with the state has been described as the vertical view of citizenship (Kabeer, 2005; Lister, 2007). Participants have reported that their sense of belonging is determined by both horizontal and vertical understandings of citizenship. From their standpoint as the excluded, participants argued that regardless of how their status as a citizen has been conferred, being recognised as an insider, rather than Other, is paramount.

Ann’s perspective encompassed an even wider view of her sense of belonging:

> I think that probably everybody has a different view of citizenship, and a lot of that depends on where you come from. I know the Māori collective views are different... they work as a collective; they make decisions always as a collective. I actually quite like it, but I’m not sure I could buy into it. There is no “I” in it. I love the connection and I think most of us in the Pākehā world need to solidify those, particularly whānau relationships, and things like that.

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74 Self-determination and sovereignty.

75 In 1950 (British Nationality and New Zealand Citizenship Act) the status of ‘British subject’ on a New Zealand passport was changed to citizen of New Zealand.

76 *Jus sanguinis* is a legal principle that ascribes citizenship to those who are related by blood; *jus soli* ascribes citizenship to those people who are residing within a given set of borders.
But the loss of “I” is too much. I think there has to be a balance between the “I”, and belonging and being connected to the world. (Ann)

Ann explained that Māori tribal affiliations are strengthened by the collective ‘we’ rather than the individualistic “I”, suggesting that Pākehā can place more emphasis on the individualistic view of citizenship. Ann believed a balance of the “I” and the “we” is important, further suggesting that the principles underpinning the emphasis on family/whanau and collective decision making between the health professional and Pākehā service users would be an added advantage. Ann’s descriptions resonate with the liberal and communitarian traditions of citizenship (Isin & Turner, 2002a; Isin & Wood, 1999). A deeper sharing of the common good is exemplified by the communitarian tradition, embodying the communal “we” identities, rather than the “I” identities held within the liberal tradition (Conover, 1995).

Participants emphasised the unique cultural aspects within Aotearoa/New Zealand, the value placed on connections with family/whanau, a place to call home, and the importance of making meaning though their connections to others. Isin (2008a) argued that it is within the city that the life of its citizens is organised and rendered meaningful. He contended that it is through the city, rather than where the city is located, that citizens develop their individuality and their sociality. It is through these virtual forms of relationships, rituals, symbols and representations within the city that inclusion and belonging and democratic engagement is engendered. A sense of connection was also important for participants to develop their sociality and feel that they belonged to the collective.

Being connected

Having a sense of connection led to a thicker sense of belonging:

My understanding of citizenship is about being connected [and] belonging to a community... to do things that everyone else does, [and] that I have right to be here and... Participate in this world in the ways that I like to do. (Ann)

[Citizenship] is the direct connection between the community, the natural environment... and the involvement with the people that you are connected with. And I feel a bond to all of those communities. (Fran, PS)

Ann regarded a sense of connection and belonging as essential for maintaining her right as a citizen to take part in the democratic processes of the state. Fran placed importance on the bonds of attachment and union with his co-citizens, which provided him with a sense of connection and acknowledgment from which he derived his identity as a citizen.
Connection also suggested one’s responsibility towards others which increased the sense of belonging. This was supported by Lola:

You can’t be a citizen on your own, so I think that connectedness is the thing that is the most important... the connectedness, and sense of responsibility to others. (Lola)

Citizens cannot exist alone. Participants have conveyed a deeper, more existential meaning of citizenship, constituting a framework of beliefs that shape the way citizens relate to each other and the state. This finding suggests that citizenship is something that one lives (Lister, 2007) through belonging to the collective. Isin and colleagues (Isin et al., 2008; Isin & Turner, 2007; Isin & Wood, 1999) asserted that citizenship is much deeper than the legal status. Substantive citizenship (Isin, 2008a) is cultivated by the intensification of social relationships underpinned by loyalty, virtue and civism (good citizenship). According to Isin, citizenship is social in the deeper sense that citizens understand themselves as co-dependent entities that co-exist with others. As Isin and Turner (2007) and Conover (1995) argued, when citizens feel connected it increases their motivation and emotional energy to practice citizenship.

However, participants reported that when they have been labelled mentally ill, they are excluded and marginalised, and they experience social inequalities. These agonistic and alienating strategies of citizenship perpetuated the identity of service users as the immanent Other and the outsider. Hence, participants worked hard to stay connected through practices of inclusion which have engendered and strengthened their social networks, and enhanced their sense of solidarity with their co-citizens.

**Solidarity**

Participants actively sought networks with their peers or joined with religious groups and other community groups to increase their sense of solidarity and belonging:

[Since] de-institutionalization [service users] have formed their own little networks within each community, so in a way they have citizenship... they are not isolating themselves. They go round and have a cup of tea at Joe Blogg’s place and [someone] will make a banana cake... I see it all the time, and that’s citizenship, because there is a sense of belonging. (Beth)

Beth explained that the psychiatric institution was often the only community that many service users had. Because of the geographical and social isolation many were unable to have

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77 The responsibilities of being a citizen have been discussed in chapter seven.
regular contact with their families, friends and social and employment networks. When care was moved to the community service users began to meet with their own networks for emotional and material support, which developed a pattern of reciprocity. Such expressions of solidarity between service users were a positive step on the continuum towards being an insider and a full citizen. The sharing of the “banana cake” embodied the practices of domesticity and hospitality, representing the fundamental aspects of what it means to be a citizen (Isin, 2002).

Within this domestic space of care (Hill Collins, 2000; Kershaw, 2008, 2010), marginalised groups meet to learn and express the power of self-definition, to value and respect each other, and develop as self-reliant and independent citizens. Kershaw (2008) further expands Isin et al.’s (2008) assertion of the social aspect of citizenship, contending that demonstrations of care for each other are forms of resistance which defy the expectations of the prevailing practices, norms and values within the dominant group. Likewise, service users created domestic spaces as a survival strategy to adapt to, and resist the realities of their exclusion, while simultaneously undercutting their Othering (Krummer-Nevo & Benjamin, 2010; Lister, 2004). Buttressed by these social resources, service users’ increased their social capital, fostered restoration of their civic engagement and deepened their sense of solidarity and belonging.

Some participants joined other peer groups within their community. Brent felt he belonged again when he joined his local church78. Zara also derived great benefit from joining a peer group of people who did not have the label of mentally ill:

I get so much from attending my [AA] fellowship meetings79 learning this richness of experience from people who are anaesthetists or journalists.... Benefit can come from aligning [myself] with so called normal members of the community who are also committed to their own recovery, so that you get the benefit of people who are functional. (Zara)

Zara benefited from socialising with other citizens who she regarded had the social status of successful and respected citizens. The positive attributes associated with being a functional and normal member of society was in stark contrast to being labelled mentally ill. Courtesy stigma, or stigma by association, can work both negatively and positively (Green, 2009;

78 This was reported in chapter six.
79 Zara attended the alcoholics anonymous (AA) group which is a support network based on fellowship and the 12 steps to recovery from addiction.
Scambler, 1998, 2004). In Zara’s example, the benefit she gained was the sense of solidarity within a group which helped her escape the identity of the abnormal and pathological Other:

I wanted to discover a non-pathological base of the sense of myself... [Which] has transformed [because self] is not a concrete definition, it is a fluid evolution. (Zara)

Whilst in the group, Zara experienced life at the positive pole of the citizenship continuum, and felt she was a normal citizen and an insider. Zara reversed the negative effects of labelling and stigma by associating with the insiders. This was a normalising experience which provided Zara with a sense of solidarity and a thicker sense of belonging to a collective. According to Ware et al. (2007), service users increase their sense of connectedness when they identify with larger groups, particularly those groups that are not defined by their experiences of mental illness. Zara still had a sense of loyalty to her service user peers, but the role as activist in that group had taken its toll on her own mental health. Zara continued the “fluid evolution” of her self-identity through her affiliation and solidarity with similar groups who looked beyond her label of being mentally ill and accepted and embraced her for who she was.

The notion that the identity as a citizen is fluid is argued by Isin and Wood (1999), contending that recognition and belonging inevitably spill into issues of identity and the new proliferation of lifestyles. Isin (2009) posited that rather than asking who is the citizen? it is best to ask what makes the citizen? This shifts the focus from fixed and immutable identities, to the sites of struggle where new identities of citizens are developed. This has been evidenced by people with disability (Green, 2009; Marks, 2001; Meekosha & Dowse, 1997) and lesbians and gays (D. Richardson, 1998, 2000) who have gained recognition of their identity and lifestyle as citizens. Rather than being defined solely by the person’s disability (Isin & Wood, 1999), members of new social movements, such as service users, can assert their evolving identity and make their claim for their right to belong as full citizens.

Some participants expressed their gratitude for the actions of others which helped them to redefine their identity beyond the label of mentally ill, and increased their sense of solidarity. Since the closure of the large psychiatric hospitals, Lola has experienced a change in the way some mental health nurses have engaged with her:

They are much more likely to talk about everyday things so that they actually include me in their world... The covert message that I get is that “we are in this together, your struggle is my
struggle” and that’s different to how it used to be. Before it used to feel like the problem was distinctly mine, and only mine. (Lola)

When the nurses talked about everyday things Lola felt she was on an equal footing with them. The self-disclosures by the nurses validated and normalised Lola’s own experiences as a woman and a parent. She no longer felt she was totally responsible for her problems. This is in stark contrast to the bio-medical model which claims that mental illness originates from the neurobiology of the person. These inclusive gestures provided a thicker sense of solidarity and belonging and strengthened the social interrelatedness between Lola and the nurses. This blurred the previous institutional boundaries that maintained the impassable barrier between the “us and them”.

Beth reported that more mental health nurses are breaking down the barrier of us and them:

Nurses are coming out of the closet in the sense of “my family member has bi-polar” [and] a couple of nurses have come to me and told me that they have been through depression. So they know exactly what it’s like... They are not just medicating, they are looking at the whole person. (Beth)

Beth explained that when the nurses are out about their own experiences of mental illness she regarded this as a show of solidarity and connectedness with service users and an inclusive and solidaristic strategy of citizenship (Isin, 2002). Such demonstrations of solidarity begin to disassemble the negative attributes associated with the label mentally ill. The nurses no longer hold a dominant view of the bio-medical understanding of mental distress, and take into account the whole person. This compassionate understanding places service users on the “same page” as the nurses:

They reminded me of who I was and... [And] where I could be... They didn’t give up on me. That was a biggy, because I wanted to throw in the towel several times. They celebrated with me the gains [I had made], they listened to me... and they also repeated the same messages over, and over, and over again. I’d say “I’ll be alright won’t I”? And they would say “Yes, of course you will, you always are”. (Ann)

Ann was suicidal on many occasions and ready to give up on her life, however, the nurses continued to show their solidarity and loyalty by not giving up on her. When the nurses took the very important step of reminding Ann of whom she was: a mother, a wife, and an employee, this was a show of solidarity. Isin (2008b) described this as being-with-one-another as citizens. This inclusive strategy parallels the vital element of being-with, which is at the heart of the recovery philosophy (Deegan, 2005; Randal et al., 2009). When the nurses made such a commitment, this intensified the social relatedness, and Ann was able to move
closer to the positive pole of the citizenship continuum as an insider and part of the collective.

When others demonstrated their solidarity towards the participants, through their deeds or words, this increased their sense of belonging and created a new orientation between the health professional and the service user:

[Recovery is] like doing an apprenticeship on how to be a human being... [Learning] the skills and attributes that I may need [to be a citizen]... with someone [the nurse] who is kind and caring, which is semi-parental, but also someone who will set me straight as well; who is trustworthy. [This] reflects the real world, so I can take what I am doing with the nurse into my experience with friends, acquaintances etc., it seems much more transferable, which is more real. (Lola)

The conversations between Lola and the nurses modelled a range of skills that are required for civic engagement. These actions of others constituted the dialogical relatedness which is inherent in the social and symbolic practices of the making of citizens (Isin, 2008b; Isin et al., 2008; Isin & Wood, 1999). Focussing on the pathology associated with the label of mentally ill, located the service users as the object and outsider. Alternatively when the nurses were trustworthy, caring, and open about their own experiences, this stance located service users as insiders and citizens. Pols (2006, p. 100) defined this as “relational citizenship” which creates a much deeper sense of equality and belonging. These findings suggest that there is a deeper dialogical and spiritual aspect of what it means to be a citizen.

A deeper meaning
Participants explained that there was a deeper sense of meaning and purpose to being a citizen:

Being allowed to belong, being allowed to attend, being accepted... sometimes very human basic needs like that. (Maria)

Essentially, citizenship is the sense of being entitled to be here, that there is some sort of greater purpose and meaning to human existence, and that we all contribute something. (Lola)

Greg explained that his understanding of citizenship goes deeper than his legal status:

Citizenship really connotes a far deeper issue of not only belonging, but belonging to a community... and perhaps a commitment to the common good... I think there is sort of a veneer of citizenship, but I think there is a deeper issue of citizenship which may not go to the legal definition; it might go to the spiritual definition. (Greg, PS)
Greg described the legal status of citizen as a “veneer”, and for the more vulnerable and marginalised members of society this could create a façade, or the appearance that they are full citizens. The veneer suggests one’s citizenship is a thin or brittle mantle of rights and responsibilities. When citizenship is viewed purely as a legal status, this can be at the expense of the necessary basic human needs associated with the concept. Isin et al. (2008) argued that citizenship is much more than a legal status. They contended that the enactment of citizenship is constituted by the social and dialogical struggles of citizens. As Lola reported above, learning the art of being with others and being able to negotiate different situations and identities is an essential part of being a citizen. In other words, citizens are engaging in various resistance practices (Isin, 2008b) and increasing their social and political networks. When service users feel a bond with their co-citizens this increases their sense of belonging, their social and political capital, and re-affirms their identities beyond the label as mentally ill.

A deeper spiritual and existential understanding of citizenship goes to the intimate core of what it means to be a citizen:

When you experience mental illness... 99% of [your] spirit is crushed and demolished.... the nurses and support people need to... be mindful that anything they do is not damaging to the person’s spirit. Spirituality is having a meaning in your life. When you have a meaning then you have spirit, and then you have self-respect, self-belief and self-worth. (Wayne)

The experience of mental illness crushed Wayne’s spirit. He found himself in the “big, deep dark hole” of the institution, without any personal understanding of what was happening to his mental state. Over a period of 12 months Wayne lost his relationship, his house and his business, as a result of being labelled mentally ill. This was spirit-breaking for Wayne, and he lost all sense of meaning and purpose in life. During this profound time of his spiritual emergency, Wayne recalled the comforting words of his family and the support of a particular nurse and peer support worker who helped him on his journey to recovery. He was also inspired by the personal account of mental illness by Leibrich (2002).

Isin and Wood (1999) and Lister (2004) argued that agency characterises individuals as autonomous, purposive and creative actors, capable of a degree of choice. Agency is also important to the person’s self-identity and sense of self-esteem. When Wayne was able to

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80 Wayne spoke about his experience of being in a big, deep dark hole in the section on abject-hood in chapter seven, the content of citizenship.
exercise his personal agency, even in the face of such adversity, this helped him escape the abject space, restoring his sense of belonging. Isin and colleagues, however, do not account for the importance that the participants have placed on the spiritual component which was vital for Wayne to regain his personal agency, and continue his journey towards being an insider. Such frameworks of meaning are essential for the shaping of one’s identity and bring a deeper sense of belonging as a citizen (Calhoun, 2003). However, a narrow focus on the neurobiological origins of mental illness means that the important aspects of spirituality are minimised (Leibrich, 2002; Mental Health Foundation, 2008).

Many participants used sentiments to describe the depth of their belonging. Some participants regarded the notions of love and caring as essential attributes of being a citizen:

If all that we contribute [as a citizen] is that we love our cat, or love our kids, or love our parents, then that is enough. [To be able to] love is sufficient to have warranted someone’s existence. And people may not leave a great mark in history in terms of doing anything wonderful, but they have contributed something by caring about somebody else in some stage of their lives. (Lola)

Brent also talked about the importance of “aroha” and being nurtured as a person who had experienced mental illness. The attributes of caring and loving were essential for Maria’s journey towards full citizenship:

Rather than “clinical practice”, “medication”, “therapy”, you know all these “tools” that [health professionals] see as being so important... [It was] someone who will listen, someone who will get to know me, someone who will treat me tenderly, and that’s all around compassion. And you cannot teach that. I think people have that or they don’t. (Maria)

The compassion shown to Maria was a demonstration of kindness and caring. Being treated “tenderly” was a display of love and the cherishing of another, which has been described as agape or clinical caritas (Stickley & Freshwater, 2002; J. Watson, 1998). Many health professionals place greater priority and importance on the technical skills, at the expense of caring skills (Naisbitt, Naisbitt, & Philips, 1999; E. H. Peterson, 1994). Some health professionals are uncomfortable with showing such depth of feeling or do not have the personal attributes to develop this depth within the therapeutic relationship with service users.

Ann explained that many of the nurses she met chose the role because they had compassion for people with serious mental health problems. She explained, however, that:

81 Māori for unconditional love and support and regard for others.
Sometimes with the professionalisation of those things [nurses] are taught to [have very strong] boundaries. So rather than access that compassion and use it in an effective way, they kind of shut it off, because it is hard to measure or work out how you do that without, you know, forming a warm relationship with someone; which can feel very unprofessional. (Ann)

It is important for health professionals to have ethical and moral boundaries within therapeutic relationships with service users. Ann suggested that when these boundaries are extremely rigid they do not allow nurses to develop a warm relationship or show their depth of compassion to the service user. The depth of such relationships is based on the human to human connection. Isin (2002) has argued that professional-citizens maintain a web of power. Service users can be trapped in this web, lose their personal power and agency and become passive and dependent subjects. When these relationships are devoid of the personal touch, and the human to human connection this perpetuates the Othering of service users.

Isin (2000) evoked similar sentiments about citizenship, arguing that the city is a complex, diverse and mysterious construct that teaches “humility and care” (p. 19) to its citizens. Participants, however, argued that within the mental health services a deeper connection of concern for the wellbeing of others has often been regarded as a breach of the boundaries within the professional-client relationship (Kidd & Lampshire, 2010; Stickley & Freshwater, 2002). Yet for participants, these connections appeared vital for their recovery journey. An ethic of care (Barnes & Brannelly, 2008; Brannelly, 2006; Sevenhuijsen, 1998, 2000, 2003) can complement the clinical relationships and deepen a sense of belonging for service users.

A sense of meaning and the significance of one’s place in the world is also an important part of reclaiming one’s identity and increasing the sense of belonging as a citizen. Some people have been so consumed by their illness that they feel that they cannot rise above it:

A lot of it is to do with their past, the way that they have been abused, and their family situation, and they have switched off somewhere. As you move on and learn about what goes on for you, what makes you tick, [your] relationships improve with family and friends, and a sense of empowerment comes. And we can understand the meaning of citizenship from an empowered place. (Lorraine)

There needs to be more awareness that often people... are enacting or playing out their own distress from ancient injustices that they have been on the receiving end of. And somehow the full story doesn’t get to the public which would... activate their sense of compassion and understanding and empathy [towards service users, and] that doesn’t get conveyed. (Zara)

Zara argued that a trauma focus can broaden the understanding and meaning of mental distress by others in society and bring a higher degree of compassion and empathy towards
service users. Lorraine suggested that many service users who have experienced trauma and abuse have literally “switched-off” their lives. This has resulted in service users losing their sense of identity and their personal and political power as citizens.

Isin (1999) asserted that the question of citizenship is intimately connected with the question of meaning. He further posited that if one’s rights as a citizen are suspended or denied then this leads to the state of “confusion and chronic discontent” (Isin, 2004, p. 233). Likewise, Hoggett (2001, p. 47) contended that when individuals experience a “collapse of agency” this leads to depression or anxiety. He argued that social agencies must be prepared to confront the real experiences of powerlessness and psychic injury which result from injustice and oppression. Participants’ reported that mental health professionals must also acknowledge the injustices that service users have experienced. Increasing a socio-political view of the effects of past and current injustices and violations of the rights of service users, within current clinical practice, will break down the negative attributes associated with the label mentally ill and undermine their Othering.

The journey of recovery from illness has given many people the ability to once again switch-on their lives, by increasing their strengths and resilience. As their personal agency increases, service users begin to exercise what Lister (2004) defined as political and citizenship agency and restoring their power as political actors. This brings a sense of entitlement, equality and belonging to the collective.

When service users are validated as people this conveys the belief by others that they are worthy of the rights and entitlements of citizenship, reducing their discontent and further deepening a sense of belonging:

One of the things that have been so good for me is just being here [at work]. Being believed in, and having my skills and talents and knowledge validated, which is not something I had in my family. (Jo)

Jo explained that the social connections with colleagues at her workplace validated her capabilities as a person. This lifted her spirits and increased her sense of personal power and autonomy, which enabled her to be self-governing in how she wanted to live her life. Jo referred to Maslow’s hierarchy of needs (Maslow, 1943, 1998) as a way to explain this personal sense of self-esteem and validation by others. Maslow’s (1943) seminal work
described the importance of “belongingness” (p. 380) which he defined as a basic need gained from the respect, love and affection from others. Importantly, once belongingness has been satisfied, one can reach the higher-order goal of self-actualization, or the desire for self-fulfilment. If human beings are unable to reach these goals this can lead to discontent and restlessness.

The “warm words” (Connolly, 1995, p. 142) and sentiments used by the participants to describe their understanding of citizenship suggested that there is a feeling associated with being a citizen, particularly when one can take part in the social relationships that create the bonds within a community. Isin and Turner (2002a) asserted that the depth of citizenship is also concerned with how the thickness of members’ identities should be accommodated and comprehended. Participants have reported that once they were labelled mentally ill, society’s lack of understanding and prejudice meant that they were no longer accommodated as members of the group and were Othered. Hence, service users no longer felt that they were citizens when social distancing impeded the “affectional solidarity” (J. Dean, 1995, p. 115) cultivated by the intimate relationships (Plummer, 2003) of love and friendship between citizens. When service users experienced emotional affirmation from their co-citizens this created the bonds of mutual care and concern for each other and provided a thicker sense of belonging.

Isin and Turner (2002a) have warned, however, that there is a “Utopian” (p. 8) image of citizenship which can raise the expectations that a sense of belonging between citizens will result in a world free of irrational prejudice. As argued in chapter six, the stigma and prejudice (Perlin, 2003b) and social distancing (Baumann, 2007) experienced by service users throughout their lives, leads to exclusion, disconnection and severing of the bonds with their co-citizens. This results in a thinner sense of belonging.

**Thinness of belonging**

Ann suggested that there have been many times when she has felt that she did not belong, resulting in a personal sense of failure as a citizen:

In general I think people want to be part of something greater and want to have a sense of connection and belonging, and want that feeling of citizenship with all the gifts that appear to come with it and all the responsibilities as well. But they often feel like there are barriers in their way because sometimes it appears you have to be perfect to belong there... [The gifts
Ann explained that service users want to feel part of something greater, rather than being isolated and disconnected individuals. Service users, however, have to work harder to be “perfect” before they can belong to the citizenship club, and claim the gifts associated with the privileged position of being an insider. Many service users do not have a deeper sense of connection belonging when there are many conditions and barriers placed on their citizenship.

The secondary effects of being labelled mentally ill can lead service users to conclude that they are not as good as the next person because they are:

Broken, you feel like you are shattered into lots of pieces and you try and put them all back together; so you’re not whole either... It’s your feelings that are broken, or your mind that is broken. (Ann)

This profound sense of being “broken” suggested that the mind and the body cannot be restored to its whole. If the helper holds a reductionist or materialistic view of the service user as the damaged object, this diminishes the personal experience and meaning associated with mental distress and the impact on the person:

Because of this illness view, you’re treating the person’s symptoms. If you take the more recovery view you’re... responding to a person who has lost their place within their own self [and] within their world. (Mary)

Having a mental illness affects one’s sense of belonging and the ability to exercise agency and self-determination. When the mental health professional responds only to the symptoms of the illness, restoration of the existential aspect of the person will not be completed perpetuating the person’s distress. The person is thus cast as the problematised being, lacking the desired attributes to be accommodated as a full citizen and subsequently constituted as the immanent Other (Isin, 2002). As a number of the participants have reported, gaining and retaining a sense of self can be perceived as a form of resistance against the process of Othering, which Lister (2004) argued, enhances the individual’s dignity and encourages agency in the face of indifference and disrespect by others in society.

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82 The meaning of the immanent Other was discussed in chapter four.
Isin (2005) contended that there are ontological conditions in which people develop and practice as citizens. Individuals can be the proactive and engaged insiders, or alternatively, alienated strangers and outsiders. Likewise, Lister (2004) asserted that the subjectivities and identities of citizens create a sense of being and belonging. Nevertheless, rigid and ascribed social categories, such as being labeled mentally ill, can impinge on the individual’s subjectivity and as reported, render service users as strangers and outsiders.

A fluid understanding of self-identity, however, allows for a “categorical identity” (Lister, 2004, p. 150) which provides the basis for the individual’s sense of belonging and sameness with others. According to Lister, categorical identity contributes to an ontological identity, a unique sense of self, being and being a member of the collective. This further supports the argument that less clinical and more human relationships between health professionals and service users will augment the recovery of the self. It is through these relationships that service users can engender a stronger sense of self, a subjective understanding of their mental distress and the ability to exercise their agency. However, when there are conditions placed on service users’ citizenship this diminishes their sense of belonging and leads to a sense of being disconnected.

**Being disconnected**

Isolation from others led to a thinner sense of belonging as a citizen:

> I think the most debilitating thing for everyone with mental illness [is] isolation, because that’s the first thing you automatically do... you isolate yourself [and] you don’t belong to society. (Beth)

Isolation from others served as a protective mechanism, but Beth’s sense of belonging and connection with others in her community diminished. Many service users are isolated and experience a poverty of meaningful relationships and connections with others and this can be a terrifying experience:

> When I am in the grip of the worst type of episode... I do not feel connected to the world... or to anybody, and that is what I grieve for. I want that [connection] and I am just behind this glass and I can’t get it. And lots of people feel like that... And so connection is really important. That’s about being human, and again it is that citizenship and belonging... being alone is the most terrifying thing sometimes. So citizenship for me is important. (Ann)

Episodes of illness can last for days and sometimes weeks. When Ann was in the grip of her distress her sense of disconnection severed the stabilising bonds that she held with others. Ann grieved for the loss of connection increasing her mental distress and chronic discontent.
Ann’s terrifying experience inferred an overwhelming powerlessness, aloneness and even abandonment. The analogy of the “glass” evoked the impassable barrier between the “us and them”. When Ann is Othered, she longs for the dialogical relatedness or compassion and connection to bring her back from this abject space.

The treatment for a mental illness can also contribute to disconnection and disrupt the dialogical practices of being a citizen. Zara described the debilitating effects of her psychiatric medication:

I spent a large part of each fortnight in bed sedated because of the [side effects of the] medication that I have no power to change, so that’s an immediate barrier to my citizenship.

(Zara)

Zara’s medication was an injectable form of a major tranquilliser, something she had no control over, and she felt an overwhelming sense of powerlessness to change her situation. She spent long periods in her bed at home, alone, isolated and disconnected from others. This created a barrier to taking an active role as a parent and as a citizen. Isin et al. (2008) contended that citizenship is a regime of governing the population. Inherent within the social practices of citizenship is the means for the state to sort people into citizens and non-citizens (Rygiel, 2008). According to Isin and colleagues, the state’s bio-politics of regulation values the biological capital of people that secures the health of the state. Chen (2008) further argued that state racism has become a strategy for sorting people into categories according to their biological capital. State sanism can also sort the normal from the abnormal citizens by investing its power within the profession of psychiatry as its agent of social control of the risky and deviant members of society. In this way, the use of psychiatric medication creates the docile and compliant body of risky subjects, lowering their biological capital and thus Othered. These technologies of power and control (Foucault, 1991; Hazelton, 1999; Isin, 2002; D. Rose, 2000) place conditions on service users’ status and no longer guarantees them their rights as citizens.

Zara wanted to have psychotherapy rather than medication alone, but felt that there was a disconnect between what clinicians regarded as therapeutic and her own understanding of what would be appropriate treatment for her and her peers:

I have been supporting a person who is long time member of the psychiatric system [who] I met in a back-ward in 1990 when I was a [consumer] advocate. For years I tried to get him into counselling and nobody would allow him to go, they had already made judgments about
his ego fragility, and yet they [were] prepared to forcibly inject him and shut him in a small room, so what about his ego fragility for that? (Zara)

Zara argued that disconnection from others is not only a personal experience it is also perpetuated by the alienating and agonistic strategies within the institutions that reduced service users’ sense of belonging as insiders. Zara’s situation changed\(^\text{83}\) and she overcame her predominantly isolated and drugged existence by accessing talking therapy outside of the mental health system, where she felt nurtured, respected and her dignity was restored:

The system likes to hang on to its own and not allow fresh ideas or different services to come in. [Mental health professionals] assume that because people are angry and non-responsive to so called “therapeutic interventions” within the mental health system that they are not going to be responsive to a cooperative, respectful, loving, sensitive, empathetic kind of dynamic in a different service. (Zara)

Zara’s account highlights the subtle exercise of power and social control by the continuing institutional practices within the community setting (Hazelton, 1999). According to Hazelton the emerging themes of safety and risk management in the era of the new institutions has led psychiatric personnel to continue monitoring, shaping and directing conduct “under the guise of therapy” (p. 225). As reported earlier, Zara was subject to control through her therapy of high doses of tranquillising medication. As a result of her lobbying for herself and her peer, Zara was likely to have been regarded as uncooperative or difficult and reduced to an object of care by the health professionals, perpetuating the “us/them” distinction (Hazelton, 1999).

The findings from this study illuminate the impact that this asylum mentality has on the service users’ status as citizens and their sense of belonging. Zara was able to undertake psychotherapy when she exercised her agency and sourced the funding from a government agency. She noticed immediately the difference between the combative and adversarial approach of the mental health system in comparison to the compassionate and cooperative approach of the external agency.

As Isin and Turner (2002a) asserted, the depth of citizenship is concerned with how the thickness of members’ identities should be accommodated and comprehended. In the above examples the identity of service users is rendered as Other through the lens of the bio-medical model which dominates treatment. Participants’ requests for access to alternative treatment, such as psychotherapy were not accommodated, because they were perceived to be the

\(^{83}\) Discussed in chapter nine, acts of citizenship.
incomprehensible Other who is *non compos mentis*\(^8\) (Morrall & Hazelton, 2000), thus their opinions were disregarded.

Service users reported that they feel as if they are citizens, until they come up against the invisible barrier of the bubble and the effects of the alienating and agonistic strategies that perpetuate their labelling and Othering. Having to endure such conditions on their status as citizens reinforces the importance that participants have placed on the deeper sense of belonging, and the emphasis on being able to stay connected so that they can sustain dialogical relationships with others.

In contrast, Beth explained that some service users are fearful of making a recovery from their illness as this means that they will have to disconnect from the mental health services:

> [The] ultimate fear is that they wouldn’t have the sense of belonging once again... it’s a circle... it really is. (Beth)

Beth argued that even though the focus of mental health services is now on the delivery of care in the community, some service users continued to be caught in a vicious circle (Deegan, 2005; Randal et al., 2009) and the revolving door of treatment within the psychiatric services (S. Clarke, 2007; Hazelton, 2005). Beth suggested that many service users have been in the mental health system for so long that they gain their only sense of identity and belonging from this association. This appears to be a paradox for service users. On the one hand, the continued reliance upon the services as the only source of contact and support gave service users a sense of belonging. On the other hand, the continued dependence on the psychiatric experts perpetuated their disconnection from wider society. The paradox reinforces the stereotype that service users are dependent and passive users of care (Hazelton, 2005). It also perpetuates their exclusion and marginalisation, resulting in a thinner sense of belonging to the collective. As a consequence, the opportunity to establish their identity as a citizen, rather than as a patient, is impeded.

Beth suggested that a sense of belonging equally applied to mental health nurses:

> It’s not just about me [and my citizenship], what about the nurses? I’m talking about the newer [nurses] who are listening to the old war-horses. They need to stand up and say “where

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\(^8\) Not of sound mind.
do I belong, how do I belong in this recovery [approach]?” and “how can I practice this, without the older [nurses] feeling threatened?” They don’t have citizenship in that sense. (Beth)

Beth’s construction of citizenship correlated with the freedom and the self-determination to live by her values and beliefs, supported by a like-minded group of people with whom she feels she belongs. Beth explained that this notion of citizenship equally applied to newer mental health nurses. When their value system, compatible with the recovery approach, challenged the dominant “asylum mentality” (Barker & Buchanan-Barker, 2005, p. 26) of the older nurses, the new nurses were silenced, subordinated and subject to stigma and discrimination by their colleagues.

Zara agreed that the older nurses were “hardening up” the new nurses who were challenging the institutional rules and norms:

I am interested in the rules and norms, in my family they had some rules that “I am a nuisance and should never be there in first place” and not to challenge the rules... And the system mirrors that, “don’t make a complaint” [and] “you are the problem”. Nurses define their identity by the difference from the Other who is the client... Citizenship [is] a means to prepare service users to engage with society at large... [We] need to loosen the system so that we can engage in a critical thinking environment... If nurses are encouraged [to develop] ethics, nurses can be empowered to be autonomous... and can defend ethically if called to account. (Zara)

Beth and Zara suggested that mental health nurses have the collective power to change the system, provided that they act in an ethical way. It seems that the alienating and agonistic strategies within the mental health system impact on the nurses and create a disconnect and a lack of solidarity and belonging to the professional collective. The nurses cannot undertake the radical changes that service users wish for, because they too have experienced the collapse of their personal, political and citizenship agency.

Likewise, Isin (2008a) argued that when citizens co-exist it presupposes and engenders solidarity, as well as conflict and competition. Beth cast the new nurses as citizens who were attempting to assimilate into the existing norms, rituals and patterns of being within the virtual “city” of their workplace. When the new orientations of recovery and the solidaristic strategies of the nurses challenged the often agonistic and alienating strategies of the mental health system, they too were Othered and excluded from the body of professional-citizens (Isin, 2002). Ward (2011) also reported that mental health nurses are vulnerable to being marginalised and silenced, however, a strong sense of belonging with like-minded colleagues
helped them remain positive and able to continue to advocate for the service users in their care.

**Conclusion**

Participants reported that a deeper sense of belonging is essential for their practice and status as citizens. Belonging was experienced at a macro and micro level. At a macro level, a deeper sense of belonging arose from the participants’ ethnic or racial blood-lines or their affiliation to their country. At a micro level, belonging was deepened when participants felt a connection and solidarity with their co-citizens, vitally important for their physical and mental health. When these connections were not evident this resulted in a thinner sense of belonging.

Participants emphasised the importance of the relational and dialogical elements of citizenship. When mental health nurses expressed genuine compassion, tenderness and kindness towards the participants, this increased their sense of solidarity. When mental health professionals consistently affirmed the participants’ personal value and dignity, this restored their identity beyond the label of being mentally ill, and increased their social status as insiders and equal citizens.

Isin’s dimension of the depth of citizenship has illustrated the importance that participants placed on their sense of belonging. The notion that if one is not accommodated, or one’s identity not comprehended by those in the dominant group, has also provided an understanding of why service users become the immanent Other and are excluded. His dimension also illuminated the importance that participants’ placed on the social and relational aspect of citizenship which increased their sense of belonging to the collective. In this way they were able to participate more fully as citizens, cultivated by the intensification of social relationships that were underpinned by solidarity and loyalty, leading to substantive citizenship.

Though his conceptual framework offered an alternative sociological view of how pathology plays a role in the lives of people whose rights have been denied or suspended, Isin does not fully explain the deeper spiritual aspects that the participants described as the depth of their experience and feeling of citizenship. The participants have constructed a deeper, more
existential meaning of citizenship, and explained how at times they were dependent on others to help them shape their practice as citizens.

To conclude, a sense of belonging was predicated on a collective sense of identity, recognition and solidarity which created the thick or thin sense of belonging as a citizen. In the following chapter, data will be presented to show how the participants and others made a claim for the rights of service users to be included as full citizens by engaging in acts of citizenship.
CHAPTER NINE: ACTS OF CITIZENSHIP

The previous three findings chapters presented the data using Isin’s three dimensions of citizenship: extent, content and depth. In this findings chapter, the theory of acts of citizenship (Isin & Nielsen, 2008b) is used as a conceptual framework to interpret the acts reported in the data.

As reported in chapter six, shaping of behaviour was a form of personal resistance to keep going in the face of being Othered. Participants’ also demonstrated agency/resistance (Lister, 2004) by engaging in the practices of inclusion which subverted the norms and rejected the negative attributes associated with the label of mentally ill. Given these strategies of inclusion, many participants still felt that they were not perceived as having the same rights and responsibilities as other citizens. A number of the participants did not sit back or succumb to the many exclusions and subsequent conditions placed on their citizenship status. In response, some participants and others made a claim for the rights that they and their peers are entitled to, by engaging in acts of citizenship (Isin & Nielsen, 2008b). These acts will be presented under the headings of individual acts by participants, and acts undertaken by others.

Individual acts

According to Isin (2008) subjects become political actors and activist citizens through engaging in acts of citizenship which make a claim for justice in the face of injustice. The following is a good example of a creative act of solidarity by a service user on behalf of his peers. The intention of the act was to orientate others towards the injustices experienced by the group, and to highlight the agonistic and alienating relationships which perpetuated their Othering by the health professionals.

A number of the participants had been incarcerated in psychiatric institutions, some for lengthy periods of time. It is common for the mental health units to be locked, restricting the freedom of service users, particularly those who have chosen to be admitted as voluntary

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85 The theory of acts of citizenship was discussed in chapter four.
patients. Being locked up can make some service users feel secure, however for others it is a humiliating and frightening experience when their liberty and autonomy are suspended.

Moley was admitted to a locked psychiatric unit and he noticed that the nurses treated him and his peers in an undignified and disrespectful way. The nurses seemed detached from the service users, they no longer took any interest in their daily activities, or engaged in conversations to help them to overcome their mental distress. This alienating, and at times, hostile environment led Moley and his peers to feel excluded and Othered. In response to being Othered, Moley’s peer undertook a spontaneous act to expose the injustices of having their rights as service users (and as citizens) suspended and restricted:

When we were in the lock-up we had to line up every hour for a cigarette... we’d go outside and [the nurses] wouldn’t watch you. They’d go into their office for the mundane routine... I remember a guy got a key... and locked the entire [group of] nurses in and took off [laughs] and they didn’t know what to do, they were all locked in with us, the weirdo’s! (Moley)

The man’s intention was for the nurses to experience first-hand what he and his peers were subjected to, a loss of control and rendered as the objects of treatment. When the nurses were locked in their office they were in a position of powerlessness, and momentarily, became one of them.

This was a solidaristic act of citizenship, and a form of resistance against the dehumanising and disrespectful treatment within the unit. The act also illuminates this man’s ability to be critical of the institutional structures that perpetuated being Othered. Isin (2002) asserted that individuals or groups struggle to mount resistance or a counterforce to being Othered when they find themselves within a field of forces that maintains their inferiority and oppression, as was the case for Moley and the other service users. This man was exercising his personal, political and citizenship agency to reverse the hierarchical power relationship between the group of service users and the nurses.

In this example, the service user transcended from being the passive object of care, to become an activist citizen. The act ruptured the usual practices and rituals within the unit. The nurses had followed existing scripts that did not foster inclusion, diversity and tolerance of service users. Their rituals and practices had evoked the notion of the Panopticon (Bentham & Bozovic, 1995), whereby the nurses spent more of their time in the nurses office, resorting to
observing and monitoring the activities of the service users from a central area. As Hazelton (1999) argued, the need for nurses to provide a more secure and controlled environment for patients has often resulted in the loss of the range of interpersonal skills and the absence of a therapeutic milieu. The unit environment thus became an abject space\(^{86}\) that relegated service users to the subaltern\(^{87}\) (Isin & Rygiel, 2007; Isin & Wood, 1999). Before the act Moley and his peers had been the dominated and controlled subjects unable to exercise their rights as “patients”\(^{88}\) and as citizens.

According to Isin (2008b), an act of citizenship ruptures the habits, practices and conduct within institutions and social relationships, and its essence is the expression of one party’s desire to be heard by another. However, through the lens of the bio-medical model, this man would be perceived as transgressing the cultural institutional rules and norms of how service users are required to conduct themselves within a locked ward. From within the hospital this man’s conduct would be pathologised, and he would be perceived as acting-out (Hazelton, 1999; Roughton, 1993). In contrast, using Isin and Nielsen’s (2008b) conceptual framework, his conduct could be interpreted as an act of solidarity with his peers, which served to overturn the agonistic and alienating strategies within the unit. The act sent a signal to the nurses of the service users’ desires to be treated with respect, dignity, and compassion:

> We’re not monsters. We’re not children. We are here to learn... and don’t treat people with mental illness like we don’t know, we are actually quite aware and quite in tune... We are here to learn (about our illness)... [Or] we can’t learn from our mistakes or [how] to take responsibility. (Moley)

Post-liberal institutional structures within the mental health system were designed to promote service users’ freedom of movement and expression, and offer the least restrictive environments (Hazelton & Clinton, 2001). Whereas in Moley’s example, it appears that the nurses have perpetuated the asylum system of care that placed an emphasis on a custodial role, rather than a therapist role. Hazelton and Clinton argued that service users have become caught up in this conflicting professional role, and are marginalised and even “demonized”, and their opinions are often dismissed as irrational and invalid (p. 97).

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\(^{86}\) The participants’ experiences of abject-hood are discussed in chapter seven, the content of citizenship.

\(^{87}\) The subaltern is discussed in chapter six, the extent of citizenship.

\(^{88}\) See the Health and Disability Commission, Code of Rights for Patients.
According to the principles that guide acts of citizenship, finding an explicit motive or rationale for the act is not of paramount concern. Isin (2008b) posited that subjects can undertake political acts without directly articulating their reasons for acting in such a way. Isin (2008b) and Nyers (2008b) contended that acts can happen without being founded in law or responsibility. The service user who locked up the nurses may be perceived by many as being irresponsible, however, following Isin and Nyers assertion, this was a practice of resistance which implicitly asked the question of the nurses to demonstrate responsibility towards the service users. The men wanted their plea for dignity and respect to be heard by the nurses. The instigator wanted the nurses to be answerable for the injustices that they, the service users, experienced. The act of solidarity towards his peers was an example of how this man transcended from a passive subject to an activist citizen through exercising his agency, which in turn encouraged collective agency within his peer group.

Isin (2008b) argued that the tension between responsibility and answerability produces acts as ruptures in given habits, rituals and practices. Isin posited that responsibility invokes the immediate or the identifiable intention of the act, whereas answerability orientates the act towards the Other, who is the stranger or the outsider or alien. The above example of an act highlighted the responsibility that the nurses need to take, to acknowledge the lack of therapeutic interventions for the service users they care for. The act hailed the nurses to be answerable towards the men and regard them as insiders rather than Other.

The tension between responsibility and answerability creates the rupture or new beginnings that reveal to the actors their own being-in-the-world. In other words, the performance of the thoughts, feelings, words and practical deeds in the moment of the act reveals to the self that the experience is “mine” (Isin, 2008b, p. 31). Though Isin does not further elaborate on the revealing of the self, it can be argued that this revelation creates the rupture of the institutional rules and norms, whereby the subject recognises the self as the actor, capable of exercising his/her own personal and political agency. Lister (2004) expanded this notion, suggesting that individuals whose choices and actions are constrained by social and political structures may not be able to be the authors of their own biographies when in a subordinate position. She suggested that in order to escape this subordinate position, actors use strategic and citizenship agency, and come to believe that they can act. Citizenship agency involves acts of defiance or trying to effect wider change within such social and political structures by
getting back at or getting organised\textsuperscript{89}. When Moley’s peer locked the nurses in the office this was a symbolic act intended to get back at those who were treating the group of service users as objects. It was also a creative and diverse way of responding to being Othered that helped others in his peer group to get organised.

If acts are to be a force for change, then they require “accomplishments” (Isin, 2008b, p. 25). The accomplishment for Moley was that the act revealed to him the institutional structures that engendered a collapse of agency for both his peers and the nurses:

The [nurses] I didn’t like the most were the ones who did not say anything, they were neutral all the time. Not helpful really, sometimes I’d see nurses hide away. They don’t know how to operate, they don’t know how to relate or [are] burnt out, or they are in the wrong job, or not passionate enough or they’ve got their own paranoia or their own fears, or their own lack of ability. They need to have people in there who run the [patients’ ward] meetings, and organise things. It’s not what the nurses are doing wrong; it’s what the patients are not doing for themselves. [The nurses think] “Oh, I have to look after them” or “You can’t do that, you may hurt yourself”... [The] good nurses are the ones that know how to push people, know how to push the buttons at the right time and are going for a good result. But not the ones that want to get home at the end of the day as soon as possible “I want to make the day as cruisy as possible” or “He’s crazy, lock him up, he’s being a problem”. (Moley)

How people understand their situation shapes their response to it (Lister, 2004). The process of Othering frequently damages the person’s self-esteem and sense of self, resulting in self-blaming and a sense that change is not possible. Moley also reflected on how the act highlighted the vulnerability of the nurses and the service users. The institutional technologies of control and coercion were not invincible, and the service user’s “cunning plan” (Moley) exposed the vulnerability of everyone in the unit which placed the nurses and the service users at further risk.

Moley’s reflections on what he perceived as barriers to the therapeutic environment helped him understand what Lister (2004) has posited are the micro-politics of the institution and the micro-processes of the power relationships. These barriers created the collapse of agency of both parties within the milieu of the locked unit, and such reflection revealed to Moley how the environment can affect the actions of others. He was able to get organised and draw on his resourcefulness to continue on his recovery journey, and he began to exercise his own personal, political and citizenship agency. This change of perspective helped him to

\textsuperscript{89} The stages of agency were also explained in the section on \textit{shaping behaviour} in chapter six.
relinquish his agonistic stance towards nurses, and engage in a solidaristic relationship with a nurse in the community when he was discharged, which bolstered his recovery:

The ones who teach you things are pretty good. I had a really good nurse and remember going to her and talk about my problems and stuff, she was quite hard to me “you’re not doing anything Moley, what do you expect. Do something” [I was angry] but I sort of listened to her... And she was right. And after that I always respected her and she always looked after me, she had a soft touch, and if I ever needed anything she would always look after me. She taught me something. (Moley)

Isin and Nielsen (2008a) contended that acts of citizenship do not necessarily have to be momentous public displays, such as street demonstrations against state authorities. Acts are everyday deeds that rupture the socio-historical patterns, create new possibilities, claim rights, impose obligations and shift the status of individuals and/or groups.

Acts of citizenship also involve the practice of the making of citizens (Isin, 2008b). In the following example of an individual act of citizenship, Beth demonstrated how she made a claim for service users to be recognised as members of the dominant group of citizens, rather than regarded as Other and outsiders. Beth reported that she had found her niche within society when she began working as a consumer advisor at a local community mental health service. This position helped restore her sense of belonging and inclusion as a citizen. Beth, however, was still aware of the stigma towards people labelled mentally ill and she encountered this when visiting the garage next to her workplace:

I went to [the garage] to get the tyre fixed and this [mechanic] is a local guy and says “where do you work?” I just said “I work at the [community mental health centre], because I am not going to say I”m a consumer, and he just says “Oh, those nutters”! (Beth)

There was an obvious paradox within this scene which Beth reflected on. From the mechanic’s perspective, Beth appeared to be a normal person, yet she was also one of the “nutters” that he was insulting. Though Beth was affronted, she waited until the job had been done and then admonished him:

So I waited till he’d fixed my tyre, then I let him have it. I’ll never go there again, and I said “I’ll tell everyone I know not to come to you, you discriminate”. But that sort of thing is still [happening] and that’s why I think for us to have citizenship we have to be prepared to say “we are a consumer” and a lot of people won’t say that… for the fear of just exactly what I have explained. (Beth)
Whilst she waited for the job to be completed, Beth reflected on the power that stigma and discrimination has had over herself and her peers. The mechanic’s bigoted response prompted Beth’s act of defiance, demonstrated by her agonistic and combative rejoinder. If she had disclosed that she was a “nutter”, Beth would have been at risk of being Othered by the mechanic, which would have lessened the impact of her rejoinder. In this scene, remaining closeted was a strategic form of shaping behaviour which enhanced her agency. Rather than taking a passive stance, Beth engaged her citizenship agency by getting back at (Lister, 2004) the mechanic’s embodiment of the alienating and agonistic strategies of citizenship which exclude and Other service users.

The accomplishment from this act of citizenship was three fold. First, Beth’s act of defiance was a show of solidarity with her peers and an opportunity to highlight to the mechanic his offensive conduct and attitudes. Second, she turned the label on to him as a bigot who stigmatises the mentally ill. Third, the act of defiance revealed to Beth that she has many choices as a consumer of everyday products and services, which reinforced her sense of economic power and choice that she can wield as a discerning citizen by undercutting his business. The act of admonishing the mechanic implicitly asked the question of him to consider his future responsibility towards others, by reminding him of his prejudiced and discriminatory words and actions.

Isin (2002) argued that it is through the everyday struggles and battles within the life of the city that individuals negotiate their claims to their status as citizens. The participants in this study reported that such negotiations of social relationships often occur within adverse conditions of profound stigma, bigotry and prejudice towards people with mental illness, which Perlin (2003b) contended is more invisible and insidious than racism or sexism. As a “citizen in the making” (Isin & Nielsen, 2008a), Beth demonstrated her resistance to such prejudice by engaging in this political act, demonstrating her dignity and courage to continue making the claim for service users to have the right to be included.

Brent, a peer support worker, described an occasion when he made a claim for the rights of a service user in a rehabilitation unit. The service user had spent many years within residential psychiatric units, and was now ready to integrate back into his community. In the following
example, the assumptions and beliefs held by the psychiatrist responsible for the care of this man were at the root of the denial of the service user’s right to talking therapy:

[The client] started drinking, and when any of those guys drink or take drugs they go straight back to [the] forensic unit. [The resident clients]... voted on what the first priority was for this client. Rather than send him back, every one of them voted on psychotherapy... [They wanted to] give him another chance. [But] The psychiatrist wanted to send him back to forensic unit. I challenged [the psychiatrist]; I pulled out the UN convention on the rights of disabled people and their rights to counselling [but] he said if anything goes wrong [then his] job is in jeopardy. And I said “yes I am hearing you, but you’ve got to cut him some slack”. (Brent)

Brent engaged in an act of solidarity to make a claim for the right of the service user to access counselling as part of his treatment, rather than following the institutional pattern of readmission to the forensic unit. In this scene, Brent not only made a claim for the rights of people with serious mental health problems to have psychotherapy, he also challenged and questioned the rigidity of the rules that the psychiatrist was adhering too.

Institutional sanism holds assumptions that the mental illness renders a person incompetent and that such illnesses result in the person engaging in unpredictable and violent behaviour (Perlin, 2003b). The psychiatrist may have been erring on the side of caution, or protecting his professional role, however, his refusal also suggests that the psychiatrist regarded the man as the incompetent and untrustworthy Other, unable to benefit from or be worthy of psychotherapy. Brent challenged these sanist assumptions and beliefs, perpetuated by the biomedical view of mental distress, and challenged the psychiatrist to give this man another chance, but the man’s right to appropriate treatment was denied.

Isin (2008b) argued that acts of citizenship are associated with Otherness. In this scene, the “arena of othering” (Krumner-Nevo, 2002, p. 303) was created, whereby two social images, the psychiatrist and the service user, interacted. In social terms, the psychiatrist was more powerful than the service user who was deemed as the inferior social image. He was now Othered and less-than. This increased the perception that the service user would not benefit from such a treatment that would normally be recommended for other citizens who had not been ascribed the label of serious mental illness.
Brent had previously described himself as a “non-person”\(^{90}\) until he began his journey on the continuum to full citizenship. When Brent challenged the decision of the psychiatrist, he transcended from the perceived object and Other to become a citizen in the making by asking his question of justice, in the face of an injustice (Isin, 2008). Brent’s solidaristic act not only made a claim for the service user’s rights under the UN convention on the rights of disabled people (United Nations High Commissioner for Human Rights, 1975), his act also created a sense of the possible citizenship “yet to come” (Isin & Nielsen, 2008a, p. 4) for this service user and his peers.

When others engaged in acts of citizenship on behalf of service users this had an impact on their successful journey towards full citizenship. The acts by others will be presented in the following section.

**Acts by others**

The participants reported that others engaged in actions that helped them on their journeys towards feeling like they could be accepted once again as full citizens. The following example demonstrates how a solidaristic act of citizenship by a psychiatrist helped Zara transcend the agonistic and alienating relationships that she encountered when seeking help in the first trimester of her pregnancy.

Zara was discharged from her treatment team three years previously. When she became pregnant she had trouble sleeping, so she sought help from the team that she had previously trusted. Zara encountered a hostile response to her request for a prescription for a sedative. Seemingly the crisis nurse was following a set of processes and particular practices associated with the “persona”\(^{91}\) that Zara had acquired through being labelled mentally ill. Zara pleaded for a safe form of medication for pregnancy. Her distress escalated and the nurse followed the usual pattern. Zara was admitted to the psychiatric acute unit, forcibly injected with a tranquillising drug that is contra-indicated in pregnancy, and placed in a locked seclusion\(^{92}\) room. This resulted in Zara being detained in an abject space where she could not enact her rights without the explicit aid of the nursing team.

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\(^{90}\) See chapter seven, the content of citizenship.  
\(^{91}\) See chapter six, the extent of citizenship.  
\(^{92}\) Seclusion is a routine procedure within mental health services that is subject to both ethical and political scrutiny regarding the rights of the service user (Mental Health Commission, 2004c; O’Hagan et al., 2008).
This example of an act of citizenship by another, illuminates the influence that other scholars have had on the development of Isin’s (2008b) theory of acts; for example, Levinas (1998, p. 159) asserted that the introduction of the “third party” is the birth of the question of justice. Zara’s psychiatrist became the third party, and his act of solidarity reversed the alienating and hostile patterns used by the nurses in the acute unit:

I pleaded with him [the psychiatrist] to start addressing my trauma and abuse issues. And he did a 180 degree turn. I was able to form a much stronger and more trusting therapeutic relationship with him... and [he] apologised to me, [because after this episode] he didn’t realise how high the threshold was before I could pick up the phone and ask for help. (Zara)

For some time, Zara had pleaded with the psychiatrist to address her trauma history. When he was aware that Zara was further traumatised by her recent experience, and that her respite care had been withdrawn after she made a complaint, he understood why she could no longer trust the service to respond to her crises. Zara’s desire was to be heard (Isin, 2008b; Reinach, 1983) by the other. Being heard by the psychiatrist transformed his action into an act of citizenship.

An act of citizenship produces actors and their others as equals. When the psychiatrist responded to Zara’s plea, he transcended the usual script of the neurobiological origin of her illness, acknowledging the childhood trauma as the underlying source of Zara’s distress. This rupture was the beginning of both individuals creating a dialogical process that enabled them to be defined in relation to each other as political actors and citizens. Within this scene, the psychiatrist was hailed (Isin, 2008b) and responded to the injustices of the hostile and alienating system that he was also part of. This was achieved when the psychiatrist validated the injustices of Zara’s recent re-traumatisation and answered her claim for justice. The psychiatrist apologised to Zara for what had happened. The power of the apology and the role this had in her healing cannot be underestimated (Allan, Allan, Kaminer, & Stein, 2006; Regehr & Gutheil, 2002). The psychiatrist’s actions changed their relationship by creating new beginnings between them, thereby reversing her Othering and upholding her citizenship-yet-to-come.

Respite facilities are places of care, safety for time-out and used instead of the person being admitted to an acute psychiatric inpatient unit. Respite can be in the person’s own home, motel or other appropriate non-clinical setting with 24 hour clinical support.
The psychiatrist became the “responsible-other” (Lavoie et al., 2006, p. 239). Hostility was now replaced with hospitality (Isin, 2005; Lévinas, 1998). The act also had other accomplishments:

I have a really good nurse that I have come to trust at the centre... I feel a lot more positive about my recovery than I ever did a few years ago... [However] there are some nurses that need to retire! [Laughs] (Zara)

For the psychiatrist, the accomplishment was the change in his conduct which will benefit other service users who can place their trust in him to be able to safely disclose their trauma histories.

In the following example of an act, Lola, who was employed as a consumer advisor, described how a nurse within a rehabilitation unit subverted the customs, routines, habits and particular practices to ensure that a young man’s right to the entitlements that other citizens enjoy was upheld. A recent visit by Laurie Curtis (1998) and subsequent training in the recovery approach had inspired some staff in the rehabilitation unit’s clinical team. Some staff remained actively resistant, while others took a passive role, creating an environment of mistrust. One nurse embraced recovery with enthusiasm. She felt confident and keen to utilise the recovery principles in her practice. This was to be tested when she was chosen to work with a new client to the service, a 22 year old man who had been hearing voices from the age of 18. The voices constantly tormented him with sexual references to children. The young man was a gentle, softly spoken person who seldom made eye contact when speaking. He was admitted to the rehabilitation centre after being discharged from an acute unit after a psychotic episode. He was very heavily medicated and isolative. He was visited by his family infrequently and seemed to prefer their absence.

The nurse was the introduction of the third party (Isin, 2008b) who asked the question of justice for this young man. Her act of solidarity was the invitation to Lola, the consumer advisor on the unit, to speak to this young man about his voices. This approach had never before been undertaken in the unit and it ruptured the usual rules and practices. After getting to know this young man, Lola felt completely confident that the voices were mendacious and trying to control him. For the first time, someone had offered an alternative view and he felt that he had someone he could trust.
The nurse had been endeavouring to work with him towards his goal of becoming a teacher, but had met with strong opposition from the clinical team who were totally focused on the risk he posed to others in society. Even though the young man had stated and demonstrated that he had no sexual attraction to children, staff based this assertion purely on the content of his voices.

Under the premise of physical exercise, the nurse enrolled this young man at a gymnasium which was situated within the local tertiary institution, and he was allowed to go if escorted by the nurse. After a few months other residents started to attend and there was no longer a need to escort him. The staffs’ anxiety slowly started to dissipate. At this point the nurse encouraged him to enrol in a short course and the staff agreed but only on the condition that she attend as well. The young man never missed a class and did well, further reducing the anxiety of the staff. He eventually enrolled at a university, left the unit and lived independently. This young man has since married, and is working as a mathematics teacher in a high school.

At all times the nurse acted responsibly when she engaged in a solidaristic act of citizenship. She subverted the institutional norms and rules by becoming the activist citizen, resisting the agonistic strategies perpetuated by the majority of the clinical team. The nurse created a scene that transformed the young man from the passive object of care, to becoming a citizen in the making.

Isin (2008b) argued that creative ruptures and breaks take different forms. The nurse’s act of citizenship began with the invitation to Lola, subverting the rule that the psychiatric professional is the expert. From that moment, the act took on a “virtual existence” (Isin, 2008b, p. 36) and subsequent actions by the nurse led to the act accreting over time, until the accomplishment of the man’s independent living was reached. The act weakened the institutional intransigence to change the patterns of being, which denied the right of the young man to have the same entitlements and opportunities as other citizens.

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94 Isin (2008b) argued that acts have a spatio-temporal quality which refers to space and time. Benner and Wrubel (1989) expand this notion contending that temporality is not linear time, rather a succession of moments in a person’s history. Temporality has a qualitative dimension, which creates a story and is evident when there is new self-understanding or emergence of new knowledge as the person reinterprets the past.
Isin (2008b) posited that acts always concern others and the Other. The nurse’s act of citizenship opened the possibility for this young man’s citizenship-yet-to-come, and concurrently, increased the personal, political and citizenship agency of both he and Lola. Isin argued that acts of subversion are required to break the rules. The nurse chose to act responsibly by subverting the current rules in the unit as the majority of staff was actively ignoring the policy requiring them to work in a recovery-focused way.

The difficulty in implementing new policy has been reported by Hazelton (1999) and Hazelton and Clinton (2001), who argued that some professionals actively undermine or modify new policy directions by becoming more guarded and secretive about their practice. In this example, the secrecy and subversive practice of the nurse was an act of resistance with the intent of supporting the agency of the service user. By taking such action, however, she risked being Othered by her colleagues, but was willing to take such a professional risk based on her sound clinical expertise. When the young man started becoming independent and his voices abated, his agency, self-identity and self-esteem were restored. Other staff then began to engage in recovery practice to emulate this success.

Over the last two decades, I have engaged in acts of citizenship. I employed two of the participants as educators within the mental health system and the tertiary sector, based on their qualification of having a serious mental health problem. These participants reported that when their potential was recognised and they were invited to join teams of mental health professionals and academics, the benefits for them at a personal level were enormous.

Such solidaristic acts of citizenship signalled to the mental health sector that service users are vital actors in the preparation of the health workforce and can directly influence the delivery of user-informed services. The sanctioned role of the experienced-based expert not only effected a change on a personal level for the participants, it also raised the expectations of the whole sector that service users have the right to be part of the workforce (Hatcher et al., 2005). Employing service users in the workforce is also a strategy to target stigma and

95 Maria also gave an example of the acts of subversion by the nursing staff that ‘bent’ the rules so that she could eat whilst in the acute mental health unit (chapter six, the extent of citizenship).
discrimination by increasing the contact (A. C. Watson & Corrigan, 2006) that others have with service users by providing images of success.

In this current decade I have continued to lobby for the continuing employment of service users in the clinical and tertiary education institutions. The act of employing service users subverts the already written scripts within such institutions and has challenged the privileged position of the professional as the expert.

Acts of citizenship restore the personal, political and citizenship agency of service users enabling them to continue to undertake acts of defiance or effect wider change within institutions. For example, Ann reported that it was in her nature to go “against the flow” by not following the rules and norms expected of citizens. Ann became a member of the service user movement and in the early years of activism she lobbied for the rights of her peers:

A lot of the time, the consumer stuff we have done has been very exclusionary and very… siloed, because that’s what mental health services are like.... We are getting better and more mature about this stuff... I think there was a time when we had to close ranks, kick down doors and shout and yell. I think we are at different stage now [and we are] starting to form partnerships and collaboration [with the services]. (Ann)

The metaphorical image of Ann’s description illuminates the acts of defiance by the service user movement to draw attention to the injustices that service users experience within the mental health system and to effect wider change within other institutions. Ann noted that the service user group has since moved from an adversarial and agonistic stance to a position of solidarity through the development of partnerships and collaboration with leaders in the mental health services. When service users lobbied the Ministry of Health and other government representatives it restored their sense of identity and confidence, and claimed recognition of their citizenship-yet-to-come as worthy of participating in political life.

Like other social movements, such as African American civil rights, the feminist movement, or physical disability, service users have also become organised and taken up the struggle to be claim-making subjects through acts of citizenship. Isin (2008b) argued that acts of citizenship occur regularly within the public domain, particularly cultural, or carnivalesque
practices of resistance. Cultural acts can begin to change the attitudes and perspectives of mental illness by the public, and reduce the degree to which people stigmatise and discriminate against service users. When the public are exposed to the images of success and courage through service users’ cultural achievements, such as theatre, radio and television, music and gatherings, this exposure and personal contact with service users can be more effective than standard education programmes on mental illness (A. C. Watson & Corrigan, 2006). These represent the many sites of resistance through which service users constitute themselves as beings-with-claims (Isin 2008), further disassembling the negative attributes of the label and stereotypes and undermining the Othering of service users.

Conclusion

The acts of citizenship have given voice to those who are vulnerable members of society and are Othered and marginalised. It was through acts of citizenship that the participants were able to have their plea for recognition as full citizens realised. The acts have highlighted that there is a new site of struggle within the everyday experiences of the lives of service users and their supporters. These acts challenged the rituals, customs and habits that maintain the status quo of power and gate-keeping of access to resources within the mental health system. For example, acts occurred in the clinical setting, in the participants’ consumer advocacy roles, as peer supporters and educators and as consultants on the development of policies in mental health service delivery. Through acts of citizenship service users are claiming back their power to secure their civil, political and social rights of citizenship. Service users have transcended from the object and Other to become political actors who are recognised and accepted as the bearers of the same rights and responsibilities as other citizens.

The acts were also calls to others to respond to injustices. This extends the importance that participants placed on the notion of reciprocity between citizens. As described, the citizen is enticed (Isin & Turner, 2007) to take responsibility for others in return for the enjoyment of their rights. When citizens engage in acts of citizenship they are “robbed of their irresponsibility” (E. F. Isin, personal communication, June 11, 2009) and become responsible

98 See the Rethink project at www.rethinkgrant.co.nz.
100 Mad Pride festival at www.mentalhealth.org.nz.
101 The Nutter’s Conference at www.lighthousetrust.co.nz.
102 Discussed in chapter seven, the content of citizenship.
to themselves and answerable to the Other by asking questions of justice. In so doing, the status of the service user is recognised as the insider.

The accomplishments of the acts demonstrated a personal transcendence within the participants which enabled them to engage their personal, political and citizenship agency. When the participants recognised the micro-politics of the alienating and agonistic strategies of citizens and the injustices and violations of their rights, the associated stigma and discrimination was revealed to them. The accomplishments of the act restored service users to a powerful position as political actors rather than victims, strangers or outsiders. Isin’s theory of acts of citizenship has provided a useful filter within which to capture the actions of participants as political acts, rather than the sanist view (Perlin, 2003b) that such actions are symptoms of their mental illness. This provides an ontological understanding of how service users are living and performing their practise as citizens.

Isin (2008b) has subsequently argued that the dimensions of citizenship: extent, content and depth, are an ontic understanding of citizenship in that the actors are already produced through the routinised scripts, rules, norms and patterns of being. Acts, however, produce actors that did not exist before. They are formed through the dynamic social processes through which beings come into being. By using Isin’s conceptual framework to interpret the data in this study, the first three findings chapters of extent, content and depth have highlighted that service users are ensnared within such scripts which render them as the subordinated and subjugated objects unable to experience their full sense of being. Acts of citizenship, however, have illustrated that as a social group, service users are enacting themselves as political actors by navigating the solidaristic, agonistic and alienating modes of being with each other.

Isin (Isin) argued that the virtual city is the ontological space where people’s difference is recognised and accepted, where people are supported to participate and exercise their rights and responsibilities, and in turn, feel a sense of belonging to the collective. Service users have demonstrated, through acts of citizenship that they have the same rights to be of the city as political actors possessing the personal, political and citizenship agency to take their place alongside their co-citizens.
CHAPTER TEN: DISCUSSION

There are minimal studies that focus on people’s understandings of citizenship. This research constitutes the first New Zealand study to explore the understandings of citizenship by mental health service users. This study provides an in-depth exploration and interpretation of how the participants have journeyed towards becoming full citizens, using Isin’s (Isin, 1999, 2002, 2008b) conceptual framework of citizenship. Isin provides a unique perspective for this study, enabling an exploration of the participants’ experiences of citizenship. The study, using in-depth interviews and a focus group to comprehensively explore the participants’ experiences, makes an original contribution to knowledge in the field of citizenship. It also has practical implications for the nursing profession and these will be addressed in chapter eleven.

As stated in chapter two, concerns have been raised by some commentators that the recovery approach has been medicalised by health professionals (Joyce, 2007; Pilgrim, 2008), because of the dominance of the bio-medical model. These concerns led to the main aim of this research: to explore service users’ understandings of citizenship, and whether the recovery approach helps or hinders their journey towards being full citizens.

Borrowing concepts from the disciplines of sociology and political science, Isin’s conceptual framework has provided a lens to analyse, interpret the data, and provide a fuller understanding of the topic. This approach, combined with the current socio-political perspectives on mental illness, has provided a way of understanding why service users do not feel that they are accepted as insiders at a time when they are lobbying for full citizenship status (Mental Health Commission, 2004b). The findings from this study are discussed in the following section.

**Conditional citizenship**

The overarching finding, and an important contribution to knowledge, is the discovery that service users experience *conditional citizenship*. Conditional citizenship results from labelling which has its genesis in the bio-medical model. The labelling in turn leads to *Othering* and in an attempt to escape the oppressive power experienced through Othering,
service users shape their behaviour to blend in with the rest of society. However, a further step is needed in the journey to being accepted as an insider and this involves practices of inclusion whereby service users challenge the oppressive practices of stigma and discrimination within society. Along the journey to becoming an insider, they are seeking a sense of belonging which is vital for restoring their sense of full citizenship. In some cases service users went even further and engaged in acts of citizenship to make a claim for their full rights of citizenship. Each of these italicised interlinking components represents a continuum of the service users’ journey towards full citizenship. This journey to becoming an insider is represented diagrammatically (see figure 1) below and each step is discussed in more detail in the following section.

As mentioned above, the overarching finding in this study was that the participants do not experience the same citizenship status as the general population due to labelling imposed through the bio-medical model and the resulting constraints and barriers others have placed on them. For those who have received a diagnosis of mental illness, even if it was many years earlier, the experience of being treated as though they are constantly unwell has placed limitations on their ability to participate fully in society. In other words, the participants often experience conditional citizenship.

In contrast, people who have an enduring physical illness or a physical or intellectual disability are accepted for who they are without any conditions placed on their status as citizens. People with physical disabilities (Marks, 2001; Meekosha, 2006; Meekosha & Dowse, 1997), including the Deaf103 and the blind (Emery, 2009; Peters, 2000), have developed political solidarity, pride and group identity through collective action. Such actions have ensured that their differences are not obstacles to fulfilling their obligations and duties and enjoying their rights as full citizens. For this group of people, many of the physical barriers to full participation in society have been removed. This demonstrates the accommodation of difference by the rest of society for the range of people with physical disabilities. Similar accommodations have been made for people with physical illness and intellectual disabilities. The accommodation of difference has decreased the physical and

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103 Emery (2009) notes that the term ‘Deaf’ (with a capital ‘D’) follows the convention to define people who regard themselves as part of a linguistic minority group, and distinguishes from those who use a lower case ‘d’ and consider their deafness to be an audio-logical condition and who normally choose/prefer to lip-read and speak.
attitudinal barriers within society that had, in the past, placed restrictions on the social status of some of the individuals within these groups. This has increased their participation in society thereby ensuring they have the civil, political and social rights enjoyed by those with full citizenship.

Other minority groups such as lesbians and gays and ethnic groups (Isin & Wood, 1999; Joppke, 1999, 2007; D. Richardson, 1998) have also campaigned for legislative changes to the political, civil and social rights that ensure their citizenship. In New Zealand, for example, lesbians and gays have similar entitlements to heterosexuals, such as the right to a civil union. Both groups also have legal protection against hate crime, discrimination and harassment based on their sexual orientation or cultural beliefs and practices\(^{104}\) (Human Rights Act, 1993; Kaplan, 2008).

In the last two decades a number of service user groups in New Zealand have engaged in comparable collective action. The participants in this study, however, reported that their perceived difference and continuing lack of acceptance by others in society, still places many conditions on their status as citizens. Rather than continuing to experience conditional citizenship, they stated they would like the same visibility, representation, and the least restrictions on how they live their lives. They reported that the label of mental illness should not be seen as a permanent impediment to their ability to enact their full status as citizens. As the following section illustrates, the dominance of the bio-medical model impedes the ability of service users to move beyond conditional citizenship.

*The bio-medical model*

The majority of the participants in this study reported that the bio-medical model dominated the treatment they had experienced within the mental health services. They described how the labelling, created through diagnostic procedures aligned to this model, can lead to them being perceived as personally flawed, dangerous, a risk to others or at least different from the rest of the “normal” members of society. This process clearly locates the problem within the individual. Participants stated that there was a tacit understanding that the cause of their

\(^{104}\) For the first time, on June 18, 2011, the United Nations endorsed the rights of gay, lesbian and transgender people highlighting the violations and abuses of their human rights.
illness was due to an internal and unstable aspect of their neurobiology and their treatment was prescribed accordingly (Beresford, 2004; Read & Harré, 2001).

It is important to note that the participants reported that they do not always want to conform to the tyranny of the normal (Donley & Buckley, 1996; O'Grady, 2005; Thomson, 1997). The majority of participants in this study reported that the label mentally ill is an oppressive and marginalising social category which has placed conditions on their status as citizens. They want to be accepted as people who are sometimes eccentric, and in parallel with members of the disability movement, service users want to embrace their vulnerabilities as part of their identities, rather than the imposed oppressive category of an illness.

The impact that such labelling can have on the social exclusion of service users, and therefore their status as citizens, was overwhelmingly illustrated in this study. As Link et al., (1987) found, some of the participants reported that some in society often regarded them as transgressors of the behavioural norms of society and thus deviant or abnormal (Scheff, 1999). Discriminatory behaviours by members of society were described by participants where they had lost the legal right to parent their children or restrictions had been placed on their current employment. Overall, it was shown that being labelled mentally ill devalued participants’ social identity and status, often leading to a loss of personal agency. Similar to earlier research by Link (1987), the participants in this study reported that these exclusions impacted negatively on them, leaving them feeling like a “non-person”, “useless”, “damaged” and “broken”. This is a very concerning finding given that this can lead to a vicious cycle where negative outcomes perpetuate further mental distress (Link & Phelan, 2006; Randal et al., 2009). Further to these previous studies, this study found the bio-medical model, with its focus on internal neurobiological deficits, contributed to the labelling.

As Hazelton (1997, 1999) found, labelling can result in mental health professionals becoming less collaborative and increasingly paternalistic in their relationships with service users. This in turn can lead to inequitable actions by mental health nurses who engage in highly directive and prescriptive practices in their interactions with those they care for. These practices significantly reduce service users’ personal agency and participation in the determination of their treatment plans. The critical constructivist approach that underpins this study has revealed the structure of power and control vested in the professionals. Service users rely on
the language of professionals to interpret their world at a time when they are in extreme states of mental distress. For some service users this can result in being caught in a negative sphere of power and dependency, which in turn can marginalise them.

As mentioned above, the dominance of the bio-medical model in the treatment of service users is focused on the damaged body. This means that mental health professionals keep their focus mainly on the service users’ illness, rather than the impact that mental distress may have on their ability to live independent and fulfilling lives that other citizens take for granted. The participants in this study provided examples of mental health professionals with such a focus, and stated that this resulted in conditions being placed on their rights. These included: being denied access to talking therapies; being overly-medicated and the barriers this placed on their ability to take part in their communities; and difficulties in accessing appropriate physical health care.

Isin’s conceptual framework provided a parallel with other marginalised groups such as migrants, refugees and asylum seekers. His notion of abject-hood and the zone of indistinction described how members of these groups are incapacitated and unable to make their claims for their rights (Agamben, 2000; Isin & Rygiel, 2007). The zone of indistinction has become an in-between space or an ambiguous grey zone where individuals are neither fully excluded nor fully recognised as citizens (Walters, 2008). Likewise, Hazelton and Clinton (2001, p. 99) also contended that service users can feel “as if” they are citizens in a kind of “no-man’s land”.

Isin’s conceptual framework does not account for the effects of the bio-medical model on service users’ status as citizens. Despite this limitation, using his conceptual framework has revealed important findings that will contribute a socio-political analysis to the professional literature. As reported in chapter three, there is a substantial body of research and commentary on being labelled mentally ill. However, none of the studies have explored the service users’ perspective on the impact that being labelled has on their status as citizens, and this current empirical study will extend the knowledge in this area.
The finding that service users are neither fully excluded nor fully recognised as citizens once they have been labelled mentally ill has a significant impact on their social status. Once labelled, service users become the Other and thus find themselves in the grey zone of indistinction. Service users then lose their strategic position within the social space and are no longer recognised by others in society as active political agents and full citizens. The loss of their role and status places conditions on their ability to generate economic, political, symbolic and social capital, which is accumulated by engaging in the social relationships with members of society. Also of concern is the finding that mental health professionals working within the bio-medical model can unwittingly perpetuate the service users’ mental distress. Now regarded as the stranger or the outsider, service users are Othered. The following section will discuss the participants’ experiences of being Othered and regarded as untrustworthy and incompetent.

**Being Othered**

The labelling discussed above resulted in the participants being Othered and thus excluded by the majority in society. Otherness is a dialogical condition of citizenship and its alterity (Isin, 2002). A contribution from this study is the extension of Isin’s notion of the immanent Other. Once the negative characteristics and stereotypes associated with the label of mental illness are ascribed to service users, their identity as an insider is subtly altered and they become the feared outsiders or strangers.

The change in identity serves the function of highlighting the dichotomy of the normal/abnormal binary, against which the members of the dominant group recognise themselves as normal and the insiders. The identity of service users is then transformed to the immanent Other: the essential, opposite category required to maintain the belief of those in the dominant group that they are the powerful and privileged insiders. This study has revealed the underlying power structure of the established and the outsider principle (Elias & Scotson, 2008) which has not been previously researched in the area of citizenship for service users. This contribution to knowledge provides a conceptual understanding of why the stigma and discrimination of service users is perpetuated, and explains why social inclusion policies continue to fail.
Whilst some scholars (Beresford & Wilson, 2002; Maccallum, 2002; Montgomery, 2005; Scott & Wilson, 2011) have provided commentary on the Othering of service users, this study has provided empirical evidence that Othering places conditions on participants’ status as citizens. As cited above, being the outsider results in the state of abject-hood for service users, accompanied with a sense of shame which results in the lowering of their self-esteem and personal agency. The combination of these factors – having conditions placed on one’s citizenship, and being Othered or being in a state of abject-hood – leads to the loss of one’s social status.

In summary, when labelled mentally ill, the “persona” (Isin, 2009, p. 372) and status of the participants changed from the privileged insider, to them becoming the undesirable Other who is untrustworthy, unreliable and irresponsible. The findings in this study indicate that when service users are constructed as the Other, this leads to the mis-recognition of their identity, which has consequences for their ability to exercise their rights and access to their entitlements. Mis-recognition also weakens their democratic participation and ability to make meaningful contributions to society (Fraser, 2000; Fraser & Honneth, 2003; Isin & Wood, 1999). Isin, however, has not empirically explored the impact that mis-recognition has on individuals. Chapter seven reported that labelling and Othering places conditions on service users’ rights and responsibilities, and likewise, chapter eight described the impact that labelling and Othering have on service users’ identity and sense of belonging. The empirical findings from this study not only make an important contribution to knowledge but also expand Isin’s theory.

The concept of Othering provides a richer understanding of why the participants in this study came to experience conditional citizenship. As mentioned above, the study also found that Othering leads to doubts being raised about service users’ trustworthiness and competence.

*Being trustworthy*

The process of Othering, which results from the bio-medical model, often meant that participants were not trusted because they were perceived to be unpredictable, unreliable and sometimes dangerous. This study found that being Othered meant that participants were not recognised as having the same desirable qualities as the members of the dominant group, and therefore posed a threat to the social order.
Being trustworthy is an important element of citizenship (Dagger, 1997; Drover, 2000; Heater, 1999; Isin & Wood, 1999). People are required to have a degree of trust in their co-citizens to co-operatively fulfil their required duties and obligations. The participants in this study, however, reported not being trusted to parent their children, to be reliable employees, to drive their cars safely, or to babysit their neighbours’ children.

Mental health professionals contribute to this experience of untrustworthiness. At times, they do not trust service users to take personal responsibility in terms of making decisions, or managing conflict. This is of major concern as placing one’s trust in service users is an integral aspect of their recovery journey. Service users need to be trusted to manage their difficulties (Davidson et al., 2005) which, in turn, increases their resilience and resourcefulness. Mental health professionals need to create an environment that demonstrates trust to enhance collaboration and sharing of power when planning treatment (Borg & Kristiansen, 2004). The participants in this study reported that when trust is not evident between mental health professionals and themselves, they are prevented from taking full responsibility for life’s challenges. For example, participants wanted to be able to make decisions about their employment, changes of lifestyle or to manage their personal difficulties.

The participants reported that being perceived as untrustworthy is based on society’s view that they have transgressed the norms. Isin (2008b) contended that the predominant focus of neo-liberal citizenship is concerned with conduct, discipline and rules. Consequently the state values routine over rupture, order over disorder and habit over deviation within the social and political conduct of citizens. What it doesn’t account for is the temporary nature of some citizen’s waver from these orderly practices and consequently being cast as the outsiders, and having conditions placed on their citizenship.

Isin (2004) contended that the expectation of the neo-liberal view of the ideal citizen is an individual who can be self-contained and self-controlled. This conceptualisation does not account for the impact that labelling and the recurrent symptoms of mental illness can have on a person’s status as a citizen. Crawford (1994) theorised that members of society become threatened by the abnormal behaviour that transgresses society’s behavioural norms. The
participants in this study similarly felt that once they were labelled as mentally ill then they were regarded as abnormal and permanent transgressors, and no longer trusted. A key contribution of this study was the finding that when people are labelled as mentally ill and consequently untrustworthy, their competence to be self-controlled and predictable citizens is consistently questioned.

Being competent

In addition the participants reported that their competence, which is associated with rationality and reason, was doubted when they were labelled mentally ill. Several of the participants reported that there is a double-standard within society. They explained that there is one standard for the “normals” which is more tolerant and less restrictive of their behaviour, and another, more restrictive and less tolerant standard that is based on the perception that service users are incompetent. This double-standard resulted in a number of the participants feeling that they had to be “perfect” to meet the standards for a competent citizen.

Chamberlin (1998), also a user of mental health services, also argued that people with mental illness are deemed as the “incompetents” (p. 407). She argued that this results in mental health professionals taking a paternalistic stance towards service users because of the assumption that they need to be protected from their own shortcomings. Other scholars have argued that when a person is labelled as mentally ill, others in society tend to discriminate in terms of perceiving them to be incompetent and intellectually slow (Link & Phelan, 2006; Read & Harré, 2001). This supports the notion of the double-standard described by the participants in the current study because the majority of people in society, who are regarded as competent, continue to make irrational or incompetent decisions with impunity. For example, vast numbers of people in society continue to smoke cigarettes, not exercise sufficiently, drive too fast, and/or drink heavily despite the known risks. In contrast, the participants were shown to be subjected to more vigilant scrutiny that identified any eccentricities. These eccentricities are then attributed to the actions of an incompetent person from whom others require protection and that they themselves must be protected from. This close scrutiny was a core aspect of the participants’ experiences of conditional citizenship because it restricted their freedom to be themselves.
The paternalistic response from mental health professionals also absolved a number of participants from taking personal responsibility in their treatment planning, and/or they were discouraged from having a career or children. Implicit in the participants’ examples of the coercive practices of the health professionals are the negative assumptions inherent in the ideology of the bio-medical model which dictates mental illness is a permanent impairment; that service users are not competent and that they cannot be held responsible for their actions. Read and Harré (2001) reported that because mental illness is considered to be caused by faulty brain functioning, service users are more likely to be absolved of their responsibility in terms of treatment. Such negative assumptions perpetuate the identity of service users as the outsiders.

In contrast, Rowe et al. (2001) reported that when health professionals used a citizenship framework to underpin their practice they regarded service users as political subjects rather than patients, and assumed that service users could enjoy their rights and undertake their responsibilities, regardless of their social and economic hardship and diagnosis of severe mental illness. The findings from this study suggest such a framework should underpin mental health professionals’ practice.

Most concerning, a key finding from this study, was that participants were often placed in a position where they had little hope of living in a way that most citizens take for granted. Ann (chapter eight) explained that the rights of citizenship should not be solely concerned with the tangible things, such as voting. The rights of citizenship, she suggested, are also the “gifts” or the “ethereal” things that one experiences, such as the right to dream of a better life. This finding supports the work of Isin et al. (2008) and Lister (2004) who argued that the rights of citizenship include more than the political and civil rights, they also include more intangible aspects.

When doubts about the competence of an individual are coupled with the professional’s determination that the person lacks insight into their illness and/or the implications of their illness, further conditions are placed on their rights and responsibilities of citizenship. The participants described instances where they were regarded as lacking insight into their illness. This occurred when their explanations of distress did not accord with the professionals’ biomedical explanatory framework of illness (Beck-Sander, 1998). Similar to Hamilton and
Roper’s (2006) observations, once the participants were regarded as incompetent and lacking insight, they reported that any subsequent commentary on their care and treatment was considered invalid and was mistrusted.

Invalidating the service users’ narratives of their distress can be described as epistemic injustice (Coady, 2010; Fricker, 2006, 2007) which is a form of prejudice that gives less credibility and belief to the testimony of a person, even though the speaker deserves to be believed. Epistemic injustice is founded in prejudice, ignorance and doubts about the credibility of the speaker. Coady (2010) contended that epistemic injustice is widespread and systematic, constituting a form of oppression that afflicts those with “relatively little social power, particularly the poor, members of racial minorities, women, and gays and lesbians” (p. 110). This study has reported that, equally, the labelling and prejudice experienced by the service users caused an unjust lowering of the mental health professionals’ degree of belief in the testimonies of service users because of their perception that they are incompetent and lacking insight. The notion of epistemic injustice has recently had some attention by Lakeman (2010) who has proposed that mental health nurses should place importance on listening to service users’ narratives of the experiences of mental illness. However, this study is the first to locate epistemic injustice as an element of the power that professionals hold over service users, perpetuating their oppression and placing conditions on their ability to realise their full citizenship status.

Epistemic injustice supports the privileging of the bio-medical explanation of mental distress and legitimises the professional’s therapeutic aim of the need for treatment. Diesfeld and Sjöström (2007) contended that the determination that the person lacks insight can be a means of ensuring that service users comply with such treatment. Service users’ requirement to comply with treatment results in increased monitoring (Hamilton & Roper, 2006) and regular visits to outpatient clinics (Crowe & Carlyle, 2003) because of the perceived risk to themselves or to public safety (Beresford & Wilson, 2002; N. Rose, 1998).

Other types of control and compliance with treatment are enforced by the Mental Health Act. Enforcement of such control and compliance leads to further injustices and inequalities because of the suspension or denial of service users’ full rights as citizens. Both Chamberlin (1998) and Stevens (2003) contend that service users are deprived of their liberty when
detained against their will, often indefinitely, and are required to take psychiatric medication. When subject to the Mental Health Act conditions are also placed on service users’ right to get married, enter into legal contracts, work in their chosen professions and have custody of their children. Though Chamberlin’s and Steven’s commentary concurs with the empirical findings in this study, they do not consider the impact of these conditions on services users’ citizenship.

People with a physical illness\textsuperscript{105} expect to be fully informed of the range of treatments or alternatives that are available, and have the right to decline some treatment options. In contrast, the choices and negotiations about treatment can be limited when a person is subject to the Mental Health Act. The Act gives the health professional the power to force the service user to comply with prescribed treatment. The enforcement of treatment poses an ethical and moral dilemma for mental health professionals. On the one hand, there will be times when a service user is so vulnerable that their right to safety and protection must be sustained by the state’s obligation of \textit{parens patriae}\textsuperscript{106}. On the other hand, members of the public expect mental health professionals to safeguard them from the mentally ill. Mental health professionals have the dilemma of protecting both the service user and the public, and at the same time placing the least restrictions on the service users’ liberty. The participants in this study argued that until a kinder and less restrictive alternative to the Mental Health Act is found, it will continue to place conditions on their status as citizens.

In summary, a key contribution of this study is the finding that the perceptions that service users are not trustworthy and competent places conditions on their status as citizens. Similarly, being subject to the Mental Health Act further reinforces the label that service users are mentally ill, and heightens the public’s perception that service users are the dangerous outsiders. This results in restrictive approaches to their care and this in turn impinges on their rights as citizens.

The participants demonstrated that for the majority of the time they can be reliable and trustworthy members of society. This study has shown that the labelling resulting from their

\textsuperscript{105} There is an exception for people who have tuberculosis as public health law can be used to enforce them to take their medication under direct observation by a health professional, or compulsorily detain them in a treatment facility.

\textsuperscript{106} This was discussed in chapter two.
diagnoses, and the subsequent paternalistic care received, interrupts their confidence to make
reasoned decisions and exercise constructive choices about how they want to live their lives.
Some scholars have concurred that beliefs about service users’ incompetence has
implications for their status as citizens, however, this current study makes clear linkages
between the underlying assumptions of the bio-medical model, the labelling of service users,
the determination of incompetence and the conditional citizenship experienced by the
participants. These findings expand the existing knowledge about citizenship (Isin, 2008b,
2009) by focussing on the notion of conditional citizenship.

The journey to becoming an insider
The study also found that the participants in this study had a strong desire to move beyond
the conditional citizenship they had been experiencing, and be accepted as insiders. They
found that this was not an easy task, as on their journey to becoming an insider they had to
shape their behaviour and carry out practices of inclusion to assimilate and integrate into
society. For the first time, this study has detailed the journey to citizenship as reported by
mental health service users.

Shaping of behaviour
In an attempt to appear as competent and normal members of the dominant group,
participants shaped their behaviour by adopting the rules and norms of inclusion (Isin, 2002,
2009; Isin & Wood, 1999). In particular, they shaped their behaviour by being closeted and
secretive about their diagnosis of mental illness, or passing as normal in an attempt to appear
as insiders. A small number of participants also shaped their behaviour by being solitary and
isolated to shield themselves from emotionally painful rejections and exclusions by some in
society.

Shaping of behaviour became an oppressive function of self-protection and resulted in service
users engaging in a high degree of self-monitoring, thus becoming, as Foucault (Foucault,
service users engage in self-surveillance to emulate the characteristics of an ideal citizen who
monitors, regulates and manages their health behaviours. Rose (2007) argued that the
responsibility to manage one’s mental disorder befalls the patient (sic) who must comply with
the treatment directed by an expert. Halperin (1995) and Roberts (2006), in their more
general citizenship studies have labelled this process as the “responsibilisation” of citizens. The findings from this study (chapter seven) indicated that service users have become responsibilised and that the bio-medical model has had a major impact on this process.

Isin’s conceptual framework has provided a useful understanding of marginalisation but he does not explain how vulnerable groups engage in strategies to escape this Othering. This gap in his conceptual framework can be informed by Lister’s (2004) work with people living in poverty, another marginalised group. Lister proposed four types of agency and resistance undertaken by people in poverty to overcome the on-going process of Othering. The first two stages include the use of personal resilience and resourcefulness to get over the hurdles and keep up the fight. The third stage is to escape the oppression, and the fourth is to get organised either as individuals or as a group to effect wider change. Likewise, Lister’s typology accounts for service users’ attempts to overcome Othering by shaping their behaviour.

Participants in this study wanted to move beyond the grey zones of in-distinction, and the oppressive practices of shaping their behaviour (closeting, passing and isolating the self from others). Lister (2004) described the third stage of agency and resistance as getting out, and the participants in this study engaged in practices of inclusion to get out of and escape the negative experiences associated with being labelled mentally ill, and continue their journey along the continuum towards being an insider.

*Practices of inclusion*

The practices of inclusion, both individual and group endeavours reported by the majority of participants, challenged their co-citizens to broaden the boundaries of accepted behavioural norms. For some this resulted in their inclusion in the dominant group without them having to continue the oppressive practices of shaping their behaviour. In short, the participants in this study wanted to be accepted without giving up or denying their difference.

The practices of inclusion described by participants included the process of coming out about their illness experiences, speaking at recovery seminars, lecturing in tertiary education institutions, occupying leadership positions within government departments and being political. A large number of participants have been actively involved in the inception of the
service user movement, have been consultants for mental health policy documents, and involved in the design and implementation of the de-stigmatisation campaign for the Like Minds, Like Mine project (Ministry of Health, 2007b). This study extends Isin’s conceptual framework by offering an understanding of how the participants engaged in practices of inclusion to continue on the continuum to becoming insiders and full citizens. Engaging in practices that promote their inclusion re-locates service users from the grey zone of indistinction to the political life of the city (Isin, 2000). A key contribution of this study is that where individuals and groups in society have been Othered they can actively undertake practices of inclusion to overcome their isolation and be accepted as insiders.

A sense of belonging
The participants explained that feeling like an insider was contingent on them having a deeper sense of belonging at a more micro level in society. This deeper sense of belonging was fostered within their web of meaningful social relationships with others in their communities. The importance of a sense of belonging was particularly evident for Māori participants, who reported that their cultural affiliations created a web of relationships which facilitated a thicker sense of belonging. The cultural practices of manaakitanga (n.d.) and whanaungatanga (n.d.) provide a deep, somewhat spiritual sense of solidarity, connection and equality with their peers. Equally, the majority of non-Māori participants described a deeper spiritual core associated with being accepted as an insider and full citizen by members of society.

While Isin’s macro approach to the depth of citizenship has predominantly focused on one’s identity, loyalty and sense of belonging to the nation state, the participants in this study emphasised the importance of their more micro level relationships and their spirituality. For them this was a deeper sense of belonging, an existential experience. Isin et al. (2008) have since re-cast the notion of the social in citizenship studies in an attempt to redress how citizenship has increasingly been determined by social behaviours, rather than by civil and political affiliations alone.

Where other scholars (Carney, 2008; Kymlicka, 1995; 2003; Oldfield, 1990a) have reported that citizenship has a relational and active element, this study reports the experiences of service users’ practices of citizenship with other members of society. Whilst Isin (2008c) and
others (Isin & Turner, 2007; Lister et al., 2003; Nyers, 2008a) have recognised there is a social aspect to citizenship and Connolly (1995), Conover (1995), Dean (1995), Plummer (2003) and Ho (2009) have highlighted the subjective experience or feeling of being a citizen, this study illustrates the connection between such depth of feeling and a sense of belonging for service users. For example, the participants expressed their sense of belonging as contingent on relationships that foster spirituality, love, compassion, tenderness, respect and dignity. These warm words echo Aristotle’s ethics (Pakaluk, 1999) of philia (fond appreciation of the other) and agape (brotherly love), associated historically with citizenship.

Likewise, within mental health services, a sense of belonging for the participants was also dependent on the quality of the relationships that the participants had with mental health professionals. For example, a thicker sense of belonging was experienced by some participants when mental health nurses expressed genuine compassion, tenderness and kindness towards them. This approach also increased the participants’ sense of solidarity with those caring for them. Alternatively participants experienced a thinner sense of belonging when their treatment was based on assumptions of danger, risk, and being Othered.

To summarise this section, this study proposes that a sense of belonging at the micro level, rather than the macro level, is important for the service users’ self-esteem and self-worth. At times, when the participants did not have a sense that they belonged as an insider, they engaged in acts of citizenship.

*Acts of citizenship*

An important contribution of this study is recognising acts of citizenship that have helped the participants’ journey on the continuum by claiming their status as insiders. Acts of citizenship described by the participants revolved around making a claim for their right to be included and recognised as full citizens.

The majority of the participants have journeyed on the continuum towards being included as an insider by developing responsible roles that have restored their status as political actors, a key element of citizenship. Many participants were able to pursue further education and employment or exercise their political will in their roles as leaders in the service user movement. In spite of these political activities, the findings of this study illustrate that service
users continue to experience conditional citizenship when their rights and responsibilities are suspended or denied. To reclaim the rights enjoyed by other citizens, the participants’ at times engaged in acts of citizenship (Isin, 2008b) in response to the unjust and unwarranted prejudicial treatment that they encountered. The reported acts of citizenship occurred within the mental health system in order to break from the habits, practices and conduct promulgated by those using the bio-medical model to diagnose and treat service users.

The traditional patterns, habits and the health professionals’ conduct within the mental health institutions can render the service user as Other and silence their voices. This finding correlated with Wells (2004) who argued that the dominance of a biological aetiology of distress silences those service users who try to speak out about the injustices from their past which are now perpetuated by an unjust system. The acts reported in this study demonstrate the political efficacy of service users, derived from their deeper sense of belonging and sameness with others in society. The acts of citizenship by service users provide an extension of Lister’s (2004) theory of poverty by revealing the strategies used by service users to get back at or get organised to effect wider change within the social and political structures that place conditions on their citizenship.

Acts of citizenship are the voice/action narratives (Krumer-Nevo & Benjamin, 2010) which challenge the bio-medical constructs that label the service user as incompetent or intellectually inferior. The plea by Wells (2004) that service users must be heard supports acts of citizenship as the demonstration of political and citizenship agency to counter the epistemic injustice within the mental health system. A core argument of this thesis is that mental health professionals need to respond to such acts by hearing and believing the narratives of service users. The analysis of acts of citizenship in this study expands current theories of why some service users continue to be silenced and subordinated by revealing that acts of citizenship by service users create the political space to allow the subaltern to speak (Gilmour & Brannelly, 2010; Isin & Wood, 1999).

As discussed above, the bio-medical model has labelled service users as the incompetent and “deviant” Other. Through the lens of the bio-medical model the actions of service users, such as forms of resistance, protest and subversion could be interpreted as deviant and behavioural symptoms of their illness. The theoretical concept of acts of citizenship has provided an
alternative lens to interpret such acts by service users as them re-claiming their status as citizens by challenging the injustices inherent within the system.

Isin and colleagues have argued that acts of citizenship produce citizens. This study has illustrated that the participants accomplished their transcendence from subjects to citizens and insiders through acts of citizenship. These included locking the nurses in the office, claiming the right of their peers to access talking therapy and subverting the rules in the psychiatric units. These acts illuminated the participants’ ability to be critical of the social structures that perpetuated their Othering.

Whilst Isin and Nielsen (2008b) have proposed an extension of their theory to include acts of citizenship, there is only one relevant published study (Saeidi, 2010). This is the first empirical study that reports on the acts of citizenship that service users have engaged in to claim their full rights of citizenship. The acts challenged the bio-medical narratives and the negative attributes associated with being labelled mentally ill. The acts were a form of social protest that illuminated their voices and their insider knowledge. This finding provides an empirical base for the theorising of acts of citizenship and makes a crucial contribution to professional knowledge. In the following section, the contributions that this study makes to the theory of citizenship, proposed by Isin and colleagues, is discussed.
FIGURE 1. THE JOURNEY TO BECOMING AN INSIDER AND A CITIZEN

CONTINUUM OF CITIZENSHIP
JOURNEY OF RECOVERY
JOURNEY OF CITIZENSHIP

GREY ZONE
LABELLING
OTHERING

ZONE OF INCLUSION
PRACTICES OF INCLUSION
SENSE OF BELONGING
ACTS OF CITIZENSHIP

OUTSIDER
INSIDER

BIO MEDICAL MODEL

SHAPING OF BEHAVIOUR

PRACTICES OF INCLUSION

SENSE OF BELONGING

ACTS OF CITIZENSHIP

CONTINUUM OF CITIZENSHIP
**The recovery approach**

While the recovery approach introduced by service users was a philosophical approach to living with mental illness, the participants reported its co-option within the bio-medical model has resulted in it hindering service users’ journeys towards full citizenship. They recognised that if it had remained as a philosophical approach to clinical practice it would have had the potential to reduce the labelling that they experienced and hence facilitate their journeys. Further it would have promoted their rights in terms of participating in their treatment plans and being treated as partners in their recovery. In addition it would have supported service users to work towards living a life of their choice with minimal restrictions as enjoyed by other members of society.

As a result of the recovery approach being co-opted by mental health professionals who are committed to the bio-medical model, it has served as a reinforcement of mental illness being due to deficits within individuals rather than recognising the social and environmental factors impacting on people. The deficit focus reinforces the need for self-surveillance and self-monitoring to mitigate risk to self and others.

**Contributions to theory**

This is the first study to use the conceptual framework by Isin and colleagues. While the theory was developed using data from predominantly migrants, refugees and asylum seekers, this study expands the theory by applying the dimensions to another marginalised group, mental health service users. The findings in this study support Isin’s contentions in terms of the extent, content and depth as well as the acts of citizenship.

The findings extend the dimension of the extent of citizenship by demonstrating that the participants adopted the rules and norms of inclusion and exclusion by shaping behaviour and engaging in practices of inclusion to further expand the rules and norms of citizenship. Isin’s second dimension, the content of citizenship highlighted that the participants’ practised their rights and responsibilities and extended the dimension with the finding that participants’ became responsibilised in order to be included as insiders.
The findings extend the third dimension, the depth of citizenship, reporting that participants’ experienced a deeper existential sense of belonging, including spirituality, than had been described within the conceptual framework. While Isin et al. (2008) extended this dimension, he still does not go as far as including spirituality as a core aspect of belonging. This study specifically explored the participants’ experiences of acts of citizenship which support his contentions and therefore provides an empirical basis for Isin and colleagues’ later theoretical development, the acts of citizenship.

The findings extend Isin’s contention of risk and how citizens are governed by the state, through the legal aspects of mental health care, particularly the use of the Mental Health Act, and the conditions placed on participants’ citizenship. His contention that the legal status is required for the qualification as a citizen is extended by the in-depth exploration of the relationship between competence and citizenship.

**Conclusion**

This chapter has synthesised the findings from the research, related them to Isin’s conceptual framework of citizenship and has drawn on other literature where necessary to provide a deeper understanding. It has also drawn comparisons with other marginalised groups and it has highlighted the contributions to existing knowledge on citizenship.

The overarching finding was that service users experience *conditional citizenship*, this results from labelling which has its genesis in the biomedical model and the labelling in turn leads to *Othering*. To blend in with the rest of society service users *shape their behaviour* and in a further attempt to be accepted they engage in *practices of inclusion*. For service users a *sense of belonging* is important for full citizenship and in some cases to make a claim for their full rights they engage in *acts of citizenship*. Chapter eleven concludes the thesis and makes recommendations for nurses’ clinical practice and education, policy and further research.

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107 Discussed more fully in chapter four.
CHAPTER ELEVEN: CONCLUSION

This final chapter concludes the thesis by revisiting the research question, discussing the strengths and limitations of the study, addressing the implications for nursing practice, and making recommendations for clinical practice, nursing education, policy and further research.

This research is the first study that has explored in depth service users’ understandings of citizenship, and whether the recovery approach helps or hinders their journey to becoming full citizens. The findings demonstrate that service users experience conditional citizenship due to the labelling that results from them being diagnosed and treated within the bio-medical model and the consequent barriers and constraints that are placed on their citizenship status. Conditional citizenship prevents service users from enjoying the full rights and responsibilities that others in society can expect, including the important reciprocal social relationships that foster a deeper sense of belonging within society.

Strengths and limitations of the research

The strengths of this study are fourfold. Firstly, this is the first study to interview service users to gain their understanding of citizenship. Secondly, using a qualitative approach to the study allowed for deeper exploration of the research question to elicit a multi-faceted understanding of what citizenship means to service users. Thirdly, the use of Isin’s conceptual framework to underpin the work provided an opportunity to explore a deeper understanding of citizenship that focuses on the social, as well as the civil and political dimensions. And the fourth strength is the contribution to Isin’s conceptual framework.

The 17 service user participants in this study were purposively sampled to include only those who were currently symptom free. These participants also brought their own experiences as users of mental health services and through their positions as advisors and peer support workers they were able to contribute from the experiences of those they represent. The other 12 participants, mental health nurses and public servants, brought both practice and policy experiences to the research.
The use of a critical constructivist approach to the study has provided two important contributions to knowledge. Firstly, the approach has identified the power structures within society that place barriers on service users. Secondly, the study has unmasked how service users are cognisant of the micro-politics of the health and social service institutions and the micro-processes of the power relationships within those institutions that place conditions on their citizenship.

The findings from this study provide evidence to underpin Isin’s conceptual framework and extend his dimensions of citizenship by applying the dimensions to another marginalised group: mental health service users. It provides empirical evidence that shows that service users experience conditional citizenship due to labelling. To be included they are required to take on a greater degree of responsibility than others in society to mitigate risk to themselves and others; they stressed a deeper, more existential sense of belonging is required for acceptance; and they provided examples of service users making claims for their rights through agonistic acts and acts of solidarity with others.

Using a specific framework to underpin the study could be perceived as a limitation in terms of narrowing the focus of the analysis, but as stated above, I believe the use of Isin’s conceptual framework has provided an opportunity to gain a deeper understanding of the topic.

**Implications for nurses’ clinical practice**

From a personal reflection, the findings from this study have provided me with a broader political analysis of my academic and clinical practice as a registered nurse. This study has expanded my understanding of how the practices of mental health professionals, informed by the dominance of the biomedical model, and some psychotherapeutic approaches, can place significant conditions on service users’ status as citizens.

If we are to truly change practice that maintains the status of citizens for service users, then we must turn the mirror on ourselves and face the important finding that as a profession, mental health nurses are equally complicit in the oppressive practices of service users.
There is hope; working within a citizenship paradigm would capture the new narratives of both the profession and service users which would prevent the subjugation of knowledge and wisdom of both parties. It is time to stop privileging the clinical language and psychiatric universalism, and take the professional risk of joining with service users to promote their discourses of recovery and citizenship rights. Mental health nurses need to consider how they can best use their political power in a constructive, citizenship-based way to walk alongside service users on their journeys towards full citizenship.

Nurses need to move beyond the dominance of the bio-medical model and become aware of the social and environmental impacts on service users’ mental health. They need to perceive service users as citizens with the full rights and responsibilities of others in society. Even when service users are subject to compulsory treatment under the Mental Health Act nurses should still respect service users’ rights to participate in their treatment plans and place the least restrictions on their status as citizens.

Nurses also need to be aware of the impact of labelling on service users, the resulting stigma and discrimination and how these impact on their rights and responsibilities as citizens. This broader awareness would bring a political focus to their practice enabling them to recognise the power structures that perpetuate the Othering of service users. This would in turn bring an awareness of the sanism, sexism, racism and homophobia that currently perpetuates the vicious circle of mental distress and the revolving door of admission and treatment. It is imperative that mental health nurses incorporate the recovery competencies, designed to ensure a recovery approach, into their practice. Despite their inclusion in nursing curricula over the last 12 years, the participants reported that nurses are not translating the philosophy into practice. Initially, practising according to the recovery competencies would involve adopting a strengths and resourcefulness-based therapeutic approach which would incorporate resolution of the shame and demoralisation associated with being labelled mentally ill.

Using Isin’s conceptual framework it could be argued that it is in nurses’ interest to maintain the Othering of service users, to distance them, as this enables the nurses to retain their privileged position within the dominant group as insiders. The bio-medical model perpetuates this positioning.
Participants reported that they want mental health nurses to move beyond their current understandings of their role as advocates and undertake political deeds that would see them speak out and break the silence that surrounds the injustices that service users continue to experience. As discussed above, currently the majority of mental health nurses are not aware of their privileged position and the power that they have over service users to be able to do this. As stated above, by embracing the recovery philosophy they would be more likely to recognise the imbalance and make the changes.

As advocates for service users, mental health nurses need to openly demonstrate practices that support the rights of service users and challenge the dominance of the bio-medical model. It is not sufficient for a few nurses to engage in private acts of responsible subversion as these do not model new ways of working.

**Recommendations**

The following section makes recommendations for practice, nurses’ education, policy and future research.

**Recommendations for practice**

- Nurses need to move beyond the dominance of the bio-medical model and become aware of the social and environmental impacts on service users’ mental health.

- Nurses need to be aware of the impact of labelling on service users, the resulting stigma and discrimination and how these impact on their rights and responsibilities as citizens.

- Mental health nurses need to incorporate the recovery competencies into their practice and adopt a strengths and resourcefulness-based therapeutic approach which incorporates resolution of the shame and demoralisation associated with being labelled mentally ill.

- Mental health nurses need to move beyond their current understandings of their role as advocates and undertake political deeds that would see them speak out and break the silence that surrounds the injustices that service users continue to experience.
• Mental health nurses need to openly demonstrate practices that support the rights of service users and challenge the dominance of the bio-medical model.

• Mental health nurses should establish supervision and mentoring relationships with service users to increase their knowledge and skills to work more effectively as partners.

• As mental health nurses are integrally involved in the administration of the Mental Health Act they need to be aware of the limitations the Act places on service users’ rights as citizens and actively support the least restrictive and ethically sound options for their treatment, and protect their basic human rights.

Education
• Nursing programmes need to include citizenship studies to raise awareness of service users’ human and citizenship rights, and an analysis of the power structures within health services and wider society.

• Nursing programmes need to include increased emphasis on the impact the Mental Health Act has on service users’ citizenship rights, the concept of therapeutic jurisprudence, and the principle of reciprocity that underpins mental health law. This would support fairer and less restrictive approaches to compulsory treatment.

• The document *Our Lives in 2014* (Mental Health Commission, 2004b) should provide the guiding principles for the teaching of mental health nursing practice.

Policy
• Implementation of the recommendation for an increase in mental health Nurse Practitioner™ roles (Hamer, Finlayson, Thom, Hughes, & Tomkins, 2006, p. 62) should be supported by employers and professional bodies to facilitate new ways of working with service users.

• Programmes to understand the impact of stigma and discrimination should be mandatory within health and social services.
Recommendations for future research

- Research needs to be undertaken into the implications of conditional citizenship on service users’ access to physical health services, education, welfare, housing and employment.

- Further research using Isin’s conceptual framework is required to underpin its theoretical development and provide a deeper understanding of marginalised groups’ experiences of citizenship.

- Further research is required on acts of citizenship that are undertaken by nurses to support service users in their claims for their rights.

- Further research is needed on how health professionals are contributing and perpetuating social exclusion and mental distress of service users and the impact this is having on their status as citizens.

Conclusion

This study has illuminated the barriers and constraints that have placed conditions on service users’ status as citizens and insiders. The study drew on data generated from qualitative research methods, and used a conceptual framework (Isin, 2002, 2008c) to extend contemporary understandings of citizenship which will make a contribution to current knowledge on citizenship and the recovery approach in mental health service delivery. This study also has major implications for the profession of mental health nursing and clinical practice.

It is evident that service users work hard to reclaim their status as full citizens. Many of the participants in this study gave examples of how they have re-claimed and re-built their personal “city walls” on their recovery journey, and have demonstrated their trustworthiness and commitment in taking on their rights and responsibilities as citizens.
APPENDIX ONE: PARTICIPANT INFORMATION SHEET

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PARTICIPANT INFORMATION SHEET FOR INDIVIDUAL INTERVIEWS

Mental health service users as citizens in a recovery paradigm: The implications for mental health nursing practice.

My name is Helen P Hamer and I am a Senior Lecturer at the School of Nursing at the University of Auckland, and Nurse Consultant in Auckland District Health Board mental health services. I am a doctoral candidate undertaking a qualitative research study. The principal supervisor for the project is Dr Mary Finlayson who is an Associate Professor in the School of Nursing at the University.

The above study is aimed at exploring the journey towards full participation in society for service users who are recovering from mental illness, and the implications for mental health nursing practice. I hope to generate knowledge about our understanding of full participation as citizens and whether recovery focused services help or hinder the journey towards citizenship. An anticipated outcome of the study is that the findings may influence the future education and practice of nurses and others working in mental health settings.

I invite you to volunteer to be interviewed by myself in a face-to-face interview. The interview will take place in a setting that is convenient for you, at a time that suits you. You will be interviewed once, and then there may be a follow up discussion once you have read the transcripts. This will require us to have contact over a period of approximately 2 months.

I have many years experience of interviewing and working with groups. I will ask you to talk about the journey towards citizenship from your perspective. With your permission I will tape the interview, using an audiotape. You can ask for the tape to be turned off at any stage during the interview. The interview will last approximately one hour. Once the tape has been transcribed I will offer it to you to review. This will enable you to amend or withdraw the information you have provided before the final data is written up.
I will use an experienced transcriber and this person will sign a confidentiality form to confirm that they will not disclose the content of the information that you have given. The transcriber will protect your files using a password, and destroy any records once they have forwarded copies to me. To ensure anonymity, pseudonyms will be used on the tapes and you will not be identified in the thesis or any publications resulting from this research.

I will guarantee safe storage of all tapes and written information in a locked cabinet within the University of Auckland premises. My computer files will be password protected for this purpose. My supervisor and I will be the only people to see the data as it is collected. After the study is completed all tapes can be returned to you or stored by the researcher for six years, then all written and taped material will be destroyed.

The aim of the study is to explore the journey towards citizenship within the recovery paradigm. Taking part in this study will give you the opportunity to share your ideas and knowledge about this topic. However, taking time to reflect on your own personal experience may mean you experience pleasant or unpleasant reactions. I will be able to identify and minimize any possible psychological stress that may arise in the discussion and if necessary will provide guidance for obtaining support for you. In addition the contact details for the Health Advocacy Trust are provided below.

You can withdraw from the study at any time and withdraw any information you have provided up until November 2007. If you have any further questions about the research, and/or have decided that you would like to be a participant then please contact me at the address on the letterhead. If you have questions or concerns about the research that you do not wish to direct to me, then please contact my supervisor associate Professor Mary Finlayson (details below).

If you agree to take part in this study you will be asked to sign the consent form attached before the interview. You will be offered a summary of the findings on completion of this study. If you have any queries regarding this study please do not hesitate to contact me (details above) or my supervisor Associate Professor Mary Finlayson or Head of School, Associate Professor Judy Kilpatrick (details below)

If you have any queries or concerns about your rights as a participant in this study you may contact the Chair of the University of Auckland Human Participants Ethics Committee at 373-7599 ext. 87830.

Assoc Prof Mary Finlayson  Assoc Prof Judy Kilpatrick
(09) 373 7599 ext. 88508  (09) 373 7599 ext. 82897
m.finlayson@auckland.ac.nz  j.kilpatrick@auckland.ac.nz

Health and Disability Advocate, telephone 0800 555 050, Northland to Franklin.
Thank you for taking the time to read this information sheet

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 19 July 2006 for 3 years from December 1st 2006 to December 1st 2009. Reference Number 2006/216
APPENDIX TWO: PARTICIPANT CONSENT FORM

Helen P Hamer, RN, MN (Hons)
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CONSENT FORM FOR INDIVIDUAL INTERVIEW PARTICIPANTS

Title of Project: Mental health service users as citizens in a recovery paradigm:
The implications for mental health nursing practice.

Principal Investigator: Helen P Hamer: Senior Lecturer/Nurse Consultant

This study is aimed at exploring the journey towards full participation in society for service
users who are recovering from mental illness, and the implications for mental health nursing
practice

- I have read the participant information sheet and had the details of the study explained
to me. My questions have been answered to my satisfaction, and I understand that I
may ask further questions at any time.
- I understand that this consent form will be kept separate from the data in a locked
cabinet at the University of Auckland for 6 years and then destroyed.
- I understand that my participation in this study is voluntary. I have the right to
withdraw from the study at any time and to withdraw any information I have
contributed up until November 2007.
- I agree to the interview being audio taped.
- I understand that I have the right to ask for the audiotape to be turned off at any time
during the interview.
- I understand that anonymity will be assured in any publications and presentations
resulting from this research.
- I agree to take part in this research.

Signed…………………………………………Name…………………………………………
Date……………………………………

I wish to receive a summary of the research findings: YES/NO

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS
ETHICS COMMITTEE ON 19 July 2006 for 3 years from December 1st 2006 to December
1st 2009. Reference Number 2006/216
APPENDIX THREE: INTERVIEW QUESTIONS

Q1 What is your understanding/view of citizenship?

Q2 What does citizenship mean to the people you represent?

Q3 What is your definition of recovery?

Q4 Do you think the recovery approach assists service users on their journeys towards citizenship?

Q5 How may the recovery approach hinder their journeys toward citizenship?

Q6 What contribution do you think mental health nurses make to service users’ journeys towards citizenship?

INTERVIEW SCHEDULE FOR FOCUS GROUP INTERVIEWS WITH MENTAL HEALTH NURSES

Q1 What is your understanding/view of citizenship?

Q2 What does citizenship mean to the service users that you work with?

Q3 What is your definition of recovery?

Q4 Do you think the recovery approach assists them on their journeys towards citizenship?

Q5 How may the recovery approach hinder their journeys towards citizenship?

Q6 What contribution do you think you make in your role as a mental health nurse in service users’ journeys towards citizenship?

INTERVIEW SCHEDULE FOR INDIVIDUAL INTERVIEWS WITH KEY STAKEHOLDERS

Q1 What is your understanding/view of citizenship?

Q2 What does being a citizen mean to you as an individual?
Q3 What contribution do you think you make in your role as a policy maker in service users’ journeys towards citizenship?

Q4 What is your definition of recovery?

Q5 Do you think the recovery approach assists service users on their journey towards citizenship?

Q6 How may the recovery approach hinder their journey towards citizenship?

Q7 How does current mental health policy assist/hinder the service users’ journeys towards citizenship?

Q8 How could future mental health policy contribute to mental health service users’ journeys toward citizenship?

Extra Q:

Q9 What contribution do you think mental health nurses make to service users’ journeys towards citizenship?
CONFIDENTIALITY AGREEMENT

Title of Project: Mental health service users as citizens in a recovery paradigm: The implications for mental health nursing practice.

Principal Investigator: Helen P Hamer

Name of transcriber: .........................................................

- I will not disclose the content of the information that I have typed.
- I will protect the data files using a password, and destroy any records once they have been forwarded to the researcher Helen P Hamer.

Signed.................................................................

Date.................................................................

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 19 July 2006 for 3 years from December 1st 2006 to December 1st 2009. Reference Number 2006/216
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