

“If You Can’t Follow, You’re Out.” The Perspectives of People with Mental Health Problems on Citizenship

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Abstract The new paradigm of ‘community care’ promotes the integration of people with mental health problems in society. This reconversion in social care risks to remain limited to a ‘physical’ level of integration. As the voices of people in vulnerable situations are largely absent in today’s debates about citizenship, the present study used photovoice to investigate how people with mental health problems ($n = 16$) and co-occurring drug dependence ($n = 14/16$) perceive ‘being a citizen’ in everyday life. A thematic analysis of the verbal data and the selected pictures led to seven themes. These themes illustrate the complex, dual reality of living with mental health problems; the strengths, capacities and hope of people, but also the various obstacles they are confronted with in relation to the broader society. These findings imply an urgent need for an alternative, inclusive view on citizenship and according policy actions.

Keywords Photovoice · Citizenship · Inclusion · Mental health problems

Introduction

Since the worldwide development of deinstitutionalization, mental health care policies are increasingly committed to reduce care in large institutes and provide care and support in the community instead (Davis et al. 2012; Ware

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et al. 2007). This new paradigm of ‘community care’ aims at supporting people in their daily environment and facilitating their integration in society (Mandiberg 2012; Townley et al. 2013; Yanos et al. 2012). In particular the involvement of the local community, for example through local, community-based organizations (outreach projects, organized peer support, etc.), is a key element in this new paradigm (Rowe et al. 2001). Although this new care paradigm promotes the integration of people with mental health problems in society, several authors have pointed at the risk that this reconversion in social care remains limited to a ‘physical’ level of integration (‘being present’) but does not contribute to ‘inclusive’ citizenship (‘being part’) (Cummins and Lau 2003; Lister 2007a, b; Prince and Prince 2002; Ware et al. 2007). It has been widely emphasized that being merely physical part of the community (e.g. living in a house in the community, care workers providing support at home), without ‘belonging’ and being socially connected, can never lead to ‘full citizenship’ (Lister 2007a; Townley et al. 2013; Ware et al. 2007). In this paper, we define citizenship, according to Lister as *“being part of the mainstream of society, which involves participation in the social, economic, political, civic and cultural spheres”* (Lister 2004, p.165). Participation is central to this definition, which indicates *“how citizenship represents a practice involving agency, as well as a status carrying rights and responsibilities”* (Lister 2004, p. 166). Such a conceptualization of citizenship is opposed to ideas that define citizenship *as a status*, something you can achieve by adapting to a particular standard of citizenship (Lister 2007a; Lawy and Biesta 2006). This results in a normative form of citizenship, in which the ‘dominant’ majority often perceives minority groups not adhering to ‘their’ frame of reference, as deviant and sees this as a justified reason to exclude them (process of ‘othering’) (Chamberlin 1997; Roets et al. 2012).

An important debate in the field of community care and support for people with mental health problems from the outlook of citizenship is the way ‘vulnerability’ is conceived. From a citizenship-as-status-perspective, vulnerability is considered as a personal trait that functions in a process of ‘othering’, resulting in excluding certain groups of people (Brown 2012). Consequently, people with a vulnerability such as people with mental health problems are deprived of choice, self-determination and recognition and they are often regarded as ‘non-citizens’ or ‘second class citizens’ (Chen 2011). Opposing is a view on inclusive citizenship where vulnerability is considered as a situation in which *“(…) structural ‘causes’ of people’s varying degrees of fragility and need, engendering a society-wide and blame-avoiding rationing of resources”* (Brown 2012, p. 48) are emphasized. People with a certain vulnerability such as people with mental health problems are defined as people who run a risk to be socially excluded or whose rights are violated by care policy and structures, and/or the society (Vettenburg et al. 2013; Rowe and Baranoski 2011). Essential is that vulnerability is no personal characteristic, but always originates from the

interaction between an individual and his/her social context or societal institutions (Vettenburg et al. 2013). A basic assumption is that individuals and societal groups are ‘societally vulnerable’ “*when they derive little benefit from their contacts with societal institutions and additionally are mainly and recurrently confronted with the negative effects of these institutions*” (Vettenburg et al. 2013, p. 445). In contacts with societal institutions such as education systems, labour market and the criminal justice system, people with mental health problems mainly and recurrently experience negative effects, what often leads to exclusion, discrimination and stigmatization (Clayton et al. 2013; Davis et al. 2012; Prince and Prince 2002; Rowe and Baranoski 2011).

Today’s debates about citizenship mainly take place in an ‘empirical void’ (Lister et al. 2005) wherein the voices of the citizens themselves are largely absent (Kabeer 2005). In particular, we do not know what citizenship means to people in a situation of social vulnerability, such as people with mental health problems (Kabeer 2005). In order to listen to the voices of citizens in vulnerable situations on citizenship we formulated the following research question: “How do people with mental health problems experience and perceive ‘being a citizen’ in their everyday life?” The study adopts a bottom-up and strengths-based approach and starts from the narratives of people with mental health problems, with a focus on people’s capacities and abilities, without neglecting the disabilities and problems they face (Boyle and Harris 2009; Coare and Johnston 2003; Saleebey 1996; Jouffret-Roustide 2009).

Method

In the present study, photovoice was used to investigate perspectives of people with mental health problems on citizenship. Photovoice is a participatory action based method that is adaptable to different populations whose voice has been marginalized (Catalani and Minkler 2009; Mizock et al. 2014; Wang 1999). It has previously proven to be a valuable method to capture the narratives of people with mental health problems (Cabassa et al. 2013; Mizock et al. 2014). Photovoice involves giving cameras to people in order to record and reflect their personal and community strengths and concerns (Wang 1999). It fits in seamlessly with our research question, as “*photovoice is all about point-of-viewness: it sets out to capture and convey the point of view of the person holding the camera*” (Booth and Booth 2011, p. 432). The method also aims to promote critical dialogue and knowledge about personal and community issues through group discussions of photographs and wants to reach policymakers through individual and community action (Wang 1999). The latter is grounded in the idea that policies based on the integration of local knowledge, skills and resources within the populations concerned will more effectively contribute to healthful public policy (Wang 1999).

Sampling and Data-Collection

This study was set up in collaboration with two low-threshold centers for people with mental health problems: ‘Villa Voortman’ and ‘Poco Loco’, located in the city of Ghent, Belgium. Both centers organize low threshold, outpatient support with a focus on encounters with other visitors with similar experiences. ‘Villa Voortman’ receives people with a dual diagnosis (mental health problems and drug dependence), ‘Poco Loco’ receives people with a broad range of mental health problems and has no specific focus on drug dependence. Approachable non-residential care, participation, maximal responsibility, and contribution of visitors are of major importance for the daily functioning of both centres (Bryssink 2014; Van den Steen 2007). Visitors can participate in or organize a variety of activities (e.g. music, art, poetry, cooking, and excursions). Both centers also work towards creating connections between visitors and the local neighborhood, through moments of encounter in and outside the center. The research project was presented to the visitors of both centers during a ‘visitor meeting’. Afterwards, the research team individually informed potential participants about the research design, aims and ethics (e.g., anonymity and confidentiality, ability to redraw at any time without consequence). Informed consents were obtained from nineteen participants and each participant received a digital camera, which they could keep after the project. Three participants dropped out at the start of the research process, because of different reasons (i.e. loss of camera, physical illness, hospitalization). The final participant group ($n = 16$) consisted of eleven men and five women, with a mean age of 42 years old. Four participants were visitors of ‘Poco Loco’, the other twelve were visitors of ‘Villa Voortman’. All participants had mental health problems, all but two were also drug dependent at the time of the research ($n = 11$) or had a history of drug dependence ($n = 3$). The majority of the participants were people with a dual diagnosis. Ethical approval for the study was obtained from the Ethics Committee of the Faculty of Psychology and Educational Sciences at Ghent University (2014/06).

Weekly group sessions were organized with two successive groups of respectively 10 and 6 participants over a period of ten months (April 2014 – February 2015). The first session with each group of participants started with an open discussion (brainstorm) about the question: “Which themes do you associate with the concept ‘inclusive citizenship’?” The themes elicited by the participants during the meeting were clustered by the research team, inspired by existing literature on citizenship (Kabeer 2005; Rowe et al. 2001), and confirmed as meaningful by the participants during a member-check. The following themes were distinguished: ‘important people in my life’, ‘important places in my life’, ‘rights and obligations’, ‘social roles’, ‘material goods’ and ‘what needs to change to feel included in the society’. Each week one of the themes elicited by the participants was selected and everyone was asked to take pictures in between sessions about how they experienced that theme in their daily life and to select three pictures to share in the next group session. The researchers stimulated a group discussion by paying attention to personal meaning and the differences and similarities between participants. In addition

to the group sessions, individual interviews were organized with the participants to deepen the researchers' understanding about the participants' pictures and the stories behind and the participants' experiences on specific topics, which were included in a topic list; the impact of the mental health problem and/or drug dependence in their daily life, positive and/or negative experiences related to citizenship, aspirations for the future on different life-domains (drug dependence, social relations, work,...) and experiences with different forms of professional care. The main goal of the individual interviews was to get more in-depth information on the themes that were gathered during the group sessions, but also to reach participants who were less comfortable to express themselves in the group sessions or who were harder to reach. With the participants' consent, all collected data were digitally recorded.

Analysis

A thematical analysis on all qualitative data; the group sessions, the individual interviews, and the pictures, was performed. After a verbatim transcription of the data, using NVivo9, all distinctive steps of thematic analysis as described by Braun and Clarke (2006) were followed to analyze all qualitative data (familiarizing with the data, generating initial codes, searching for themes, reviewing themes; defining and naming themes). The same tree of codes was used for all data. Four of the authors were involved in this process, in order to increase inter-rater reliability, they went independently through all steps with all data. In a meeting with all authors, inconsistencies were discussed and a consensus was reached. In addition, in the phase of defining and naming themes, member-checks were performed with almost all participants: the themes, the according personal pictures of the participant and a summary of what he/she had said related to each theme, was presented to the participants. Each participant was asked to make clarifications or corrections if he/she thought this was necessary. Participants were also explicitly asked if their pictures corresponded with the defined themes and the meaning behind the themes and they could also make suggestions about the name and content of each theme. These procedures lead to the distinction of seven overarching themes, all carrying a complex duality (e.g. peace and quiet vs. social isolation). The results' section reports about each theme and the corresponding duality.

Results

The thematic analysis revealed seven themes that describe seven different dualities: 'vulnerability vs. singularity', 'peace and quiet vs. social isolation', 'medication and drugs: need vs. burden', 'psychiatry: support vs. control and confrontation', 'labeling: surety vs. blockade', 'people with shared experiences: connectedness vs. liberation' and 'a meaningful life and future perspectives: hope vs. hopelessness'.

Vulnerability vs. Singularity



Mental health problems make participants unique, yet also vulnerable. Due to their mental health problems or drug dependence, participants often have a certain

susceptibility to emotions and impressions that makes them, in a positive way, feel different compared to others (e.g. more creative and empathic).

“It’s weird sometimes. I am weird. I know it. But I don’t want to change that, because I think that everybody is different, so why can’t I be different too? It makes me special. [...] I am even so special that it cannot be repaired [laughs].”
(Woman with a dual diagnosis, 32 years old)

The experienced vulnerability is often a reflection of a less positive or difficult personal history. Most participants faced intergenerational traumatic experiences such as physical or sexual violence or the loss of a loved one. Despite these difficulties, many participants express a large loyalty towards their family; they refer to beautiful memories and wish to restore relationships.

“My parents divorced when I was fourteen. I had no official home anymore. I’ve lived in a foster home, in a youth care institution, I’ve been in the army. You’re like a street-dog. You miss your family, you miss your mother and your father. And the older you become, the worse it gets. It’s horrible. Because of having children myself and experiencing how important that is.” (Man with a dual diagnosis, 46 years old)

At the same time, participants are often frustrated because they feel that this history, wherein their vulnerability is rooted, tends to be neglected in the context of different societal institutions they are confronted with (i.e. juridical authorities, school, health care), and because people they meet in the local community (i.e. in public places) behave merely stigmatizing and discriminative towards them. Especially the confrontation with a society that is reluctant towards being ‘different’, rather than the mental health problems as such, are experienced as the most problematic.

“That’s what the big problem is: some people get no opportunities in their developmental process because of stigma or bullying. That’s terrible, but society pays no attention. It starts in school already: everything according to the standards and you have to be fast enough to follow. If you can’t follow, you’re out.” (Man with mental health problems and a history of drug dependence, 34 years old)

The vulnerability, that makes them singular, also creates a fragility for ups and downs in life and the feeling to have little grip on the own life course.

“You are like a little fish, losing his way in the strong current. [Sighs] So, sometimes, I let it go and then...I am like a falling leave, blown by the wind. Or a plastic bag on the highway, dangling from here to there.” (Man with a dual diagnosis, 46 years old)

Peace and Quiet vs. Social Isolation



Regular moments of peace and quiet are considered necessary and treasured in participants' daily lives, but can also evoke social isolation. Participants experience today's society as fast and demanding and in order to cope, they often feel the urge to be alone. Many participants talk about the value of an own quiet place, usually their home, as a safe haven.

"The night calms me, it calms me really well. I can feed me with the night. It's really a time to reflect and come close to myself. When I was home [stays in prison now], I used to sleep during the day and wake up at night. [...] It's more quiet then and that gives me the space to generate new creative stimuli in my head, positive stimuli. [It helps me] to think clearer and more positive and to stand still." (Woman with a dual diagnosis, 32 years old)

Several participants experienced longer periods of homelessness, wherein they felt fundamentally unsafe and separated from society. This period caused a lot of mental unrest. Participants value having their own house, because it adds structure and peace to their lives.

Searching for peace, however, often leads to feelings of loneliness and isolation. Participants often lack a social network apart from their network in the local low threshold center. Outside working hours, when participants are not supported by a formal network, they are often confronted with emptiness.

"When I see three guys cycling and having fun, while I have difficulties to build a social network, it gnaws at my self-esteem. Actually, it gnaws at the

fact that I don't belong to a network.” (Woman with mental health problems, 38 years old)

Medication and Drugs: Need vs. Burden



Medication and drugs are often experienced as needed and at the same time as a burden to feel part of society. Drug use is often a way to find the needed peace of mind and to cope with mental health problems and the experienced pressure in society. It helps to face personal barriers and to make contact and feel connected with others.

“I started using to belong to the group, because I felt like an outsider. I just wanted to feel part of society.” (Man with a dual diagnosis, 32 years old)

A major disadvantage is that it often leads to social isolation and feelings of loneliness. Furthermore, some participants also perceive drugs as the main reason of their mental health problems. As drug use intensifies, many participants long for a life without dependence.

“Drugs cause my isolation; heroin makes me socially isolated. Because I don't go out anymore, I'm just sitting on my own. And especially because heroin inhibits me in everything. In any case, there's always something positive about it too, otherwise I wouldn't keep on using. It always brings some peace when you are upset”. (Man with a dual diagnosis, 44 years old)

Almost all participants use medication, in order to diminish drug use or to control mental health problems. Living without medication seems for many participants almost impossible. At the same time, they are confronted with physical and psychological side effects of medication use. Several participants also question the frequent prescription of medication in psychiatry.

“Sedation worked in the beginning, to calm down. The first time I had to go to psychiatry, it worked well to use medication for three weeks. I had a break and got new insights and points of view and it was all more bearable. But then they keep on giving you the medication, off course, and then something else happens and they give you more and more, ...Actually, it's the same as dope.” (Man with a dual diagnosis, 30 years old)

Psychiatry: Support vs. Control and Confrontation



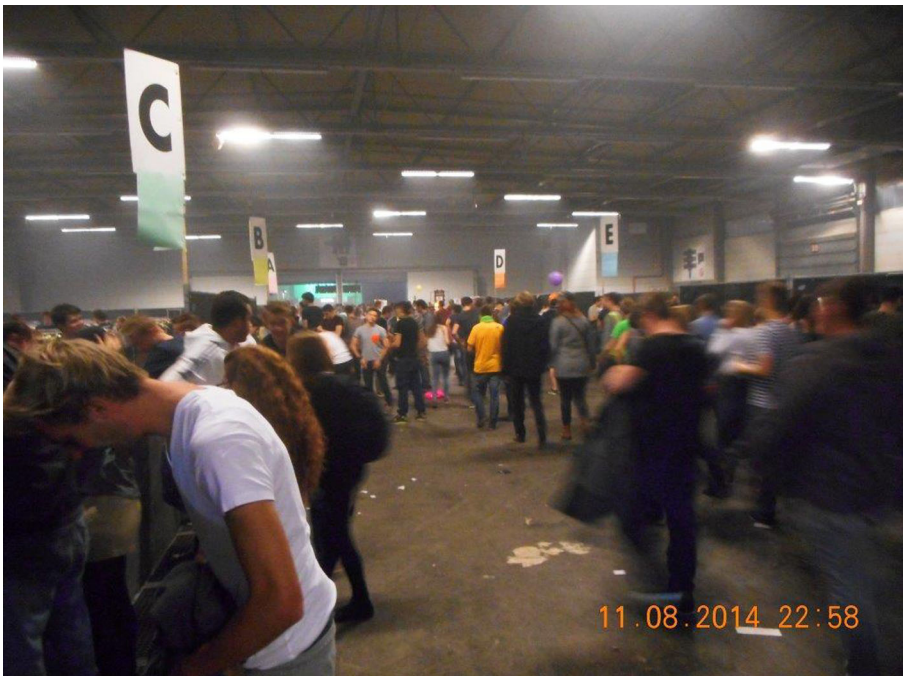
Experiences related to the psychiatric institution were predominant in the participants' stories. For some participants, the psychiatric institution symbolizes a safe haven, away from society, providing highly needed tranquility and support in times of crisis. Most participants, however, make primarily negative associations with the institution. Especially in cases of forced psychiatric hospitalization, participants experienced that they didn't receive the support they needed, and were treated with little attention or respect for them as an individual with own capacities and strengths. Some participants even told to be treated inhumane during these hospitalizations.

“In psychiatry you’re not really a citizen. You’re a number. Why? Psychiatry is a kind of factory, I guess? People come and go. [...] I wasted a lot of time in psychiatry. Off course, I was lying abed the whole time, for months, that’s not a way to progress.” (Man with a dual diagnosis, 60 years old)

Being confronted with the need for professional care and support in general evokes mixed feelings. On the one hand, it enlarges people’s possibilities and in some cases it is even needed to lead a dignified life. It sometimes results in trustful relationships with professionals based on openness and respect. On the other hand, it is often very confronting to need professional care and support. The dependence on professionals often leads to feeling oppressed and weak.

“It’s such a huge difference, how it was as an eighteen-nineteen year old, to work and live alone. And now as woman of 34, without a job and with a disablement grant and with a [compulsory] financial administrator. I mean: your life is taken away from you. Every second of it. It started five years ago and I’m still stuck with it. It’s terrible. It makes you doubt about yourself, it makes you super small. This is what they mean with it: you’re not able to do anything, you can’t do anything on your own, you constantly need support. They want to tell you that if you’re not in psychiatry, you won’t make it.” (Woman with a dual diagnosis, 34 years old)

Labeling: Surety vs. Blockade



Participants often receive a label, explicitly (e.g. diagnosis) or implicitly (e.g. scum). A label is sometimes experienced as supporting and relieving:

“Those labels [explicit labels, here Autism Spectrum Disorder] aren’t wrong, you know. If I don’t feel OK, I now know why. I feel less vulnerable because of that and I’m grateful that they told me: “That’s the reason”. In the past I didn’t know: I cried for nothing, was irritable and so on. When I feel like that now, I know exactly: “Look, I have the answer””. (Man with mental health problems and a history of drug dependence, 56 years old).

Some participants, however, do not agree with the diagnostic label they got and experience it as a blockade, that hinders to take their place in society as the citizen they want to be, because it determines how people perceive and assess them and evaluate their capacities. Furthermore, participants testify that they are implicitly labeled and seen as scum; lazy and unreliable. And they are only seen as a psychiatric patient or an (ex-)drug-addict, without being valued in other roles they take up in life, such as parent or artist.

“People see us a garbage. They seldom see us as human beings. But not every junk steals elderly women’s purses.” (Man with a dual diagnosis, 60 years old)

People with Shared Experiences: Connectedness vs. Liberation



All participants stress the importance of feeling connected to others but at the same time long to liberate themselves from being solely connected to peers. Participants usually feel most connected to other people with similar mental health problems; other ‘visitors’ in the low threshold centers or people they met during a hospitalization. These people experience similar (difficult) life situations and related feelings, which facilitates giving emotional support, mutual learning from situations and contributing to others’ well-being. Peer support and peer work is valued positively by a number of participants.

“These people [other visitors in low threshold center] hear voices too, it’s the same for them. That’s a different type of people. We share certain factors in life. Yes, we can count on each other and accept each other. Because of our so-called disability, we actually belong to each other. They’re my idols.” (Woman with a dual diagnosis, 48 years old s)

Low threshold centers have an important role in their experienced citizenship, because they function as a kind of social laboratory; a place where people feel safe, where they can show their vulnerabilities and develop themselves amidst people with shared experiences and where they can experiment and fail without being accused by the broader society.

“I see people take a lot of responsibilities in the low threshold centre, as long as there is the openness that you can try everything and that it is ok to fail. Under these preconditions you see amazing results.” (Man with a dual diagnosis, 34 years old)

That way, these centers can pull people out of social isolation and function as a passageway to the broader society. Participants often strongly long to broaden their networks beyond the social network of peers. One reason is that being with people with shared experiences often confronts them with their own vulnerabilities and can trigger negative thoughts or relapse in excessive drug-use.

“It used to be a drive-in at my place, everybody knew where I lived. Going along with people with shared experience is OK, but you need to make sure that you are not being abused.” (Woman with a dual diagnosis, 48 years old.)

In reality, integration in the broader society is often difficult because of experiences of stigmatization and discrimination, resulting in the risk that people keep treading on the spot in the low threshold centers and not expanding their social networks.

A Meaningful Life and Future Perspectives: Hope vs. Hopelessness



Participants' thoughts about the future navigate between hope and hopelessness. Relationships, education, work, art, religion and many small things in life give participants hope and make their lives meaningful. Art can help to express emotions and thoughts and can be a way to share experiences with the broader society by making the inner visible to others. Education and work make people feel part of society; they have the feeling to contribute, they can show what they can, develop themselves and make social contacts. However, participants are confronted with high demands of the labor market and the idea that regular work might not be possible for them now or in the future often has a negative impact on their self-worth. When participants reflect on the future, they share diverse stories. Some participants lost all hope for the future:

“I am tired of fighting. (...) Just day by day and if it's my last day, well than it's my last one. No perspectives, no dreams, no wishes or aspirations. (...) Otherwise it's too difficult for me. I don't dare to look at the future. It's all too late for me. (...) (Woman with a dual diagnosis, 34 years old)

Central in the stories is the process of accepting the own vulnerabilities and searching for new meaning in life, that can be turned into future perspectives worth fighting for. Most common is the aspiration to build up a 'normal' life, as a 'regular citizen': to have an own family, a relationship, an own house and work; what they often have missed themselves in the past. These targets are crucial for participants in order to

feel like a full member of society, but appear to be very difficult to realize because of their vulnerabilities and experiences of stigmatization and discrimination.

“I’m getting older and I want to give my [future] child what I’ve never got from my father. That’s the last wish I have. Just unconditional love and support when he needs it.” (Man with a dual diagnosis, 44 years old)

Discussion

Photovoice generated pictures and verbal data that illustrate how people with mental health problems perceive ‘being a citizen’ in their everyday live. Thematic analysis of the verbal data and the related pictures resulted in the identification of seven themes. Dominant in all themes are the various obstacles people with mental health problems are confronted with in relation to the broader society. These obstacles point at the current dominance of a normative form of citizenship (Chamberlin 1997; Roets et al. 2012). Participants experience a large reluctance in the broader society towards ‘being different’, which is even more problematic for them than their mental health problems as such (Mizock et al. 2014). This social exclusion often starts early in the participants’ lives (i.e. at school) and continues and intensifies throughout different life stages and related social contexts (i.e. at work, in the neighborhood, ...) (Hamer et al. 2014). Participants’ narratives show that explicit and implicit labeling reinforces stigmatization and the feeling not to be valued in important social roles other than those referring to their problems or vulnerabilities (such as being a parent or (potential) employee) (Borg and Kristiansen 2014; Mezzina et al. 2006). According to the participants’ experiences, professional care contributes to these exclusion processes as it is often standardized and the own personality, strengths and needs of clients tend to be neglected (Lasalvia et al. 2012). It is clear that these detrimental social experiences negatively impact on people’s mental health and make them even more vulnerable (Hamer et al. 2014). These processes clearly illustrate how vulnerability is no personal trait, in contrast, it develops in interaction between a person and his/her context (Brown 2012; Vettenburg et al. 2013).

Besides these negative experiences, the present study also illustrates that people with mental health problems are unique people with many strengths, capacities, ambitions and hope who long to build sustainable connections with others and who have much to offer to society (Borg and Kristiansen 2014; Mizock et al. 2014). Altogether, this implies an urgent need for an alternative view on citizenship. In an inclusive citizenship perspective, people with mental health problems are seen as full citizens, who can participate and contribute to a society wherein they are not only physically but also socially part (Lister 2004; Kabeer 2005; Townley et al. 2013; Ware et al. 2007).

Implications

The development towards an inclusive citizenship perspective has many implications for policy and practice. In the context of the new paradigm of ‘community care’ (Mandiberg 2012; Townley et al. 2013; Yanos et al. 2012), policies, as they are primarily responsible for guaranteeing social support for every citizen, should invest

in qualitative basic institutions, available for all, that approach clients in an integrative, holistic way; with attention for all life domains and people's personal and social context. These institutions can help to decrease stigmatization, and can function as a connector between people with mental health problems, their social network and the local community (Lasalvia et al. 2012; Mezzina et al. 2006). To support these connections, listening to the voices of people with mental health problems and using their experience-based knowledge, is strongly recommended (Kabeer 2005; Lister et al. 2005). Future photovoice-projects, in research as well as in practice, could be a powerful manner to further capture and convey the point of view of people with mental health problems (Booth and Booth 2011). The results of the photovoice-project reported in this article, were for example also integrated in an exhibition that was set up as awareness campaign in different organizations in the broad field of mental health services and society in general (e.g. art galleries, cultural centres,...). By doing so, the results of the project and the experiences of the participants promote awareness and initiate critical dialogue on inclusive citizenship, starting from a strengths-based perspective. The experience-based knowledge gained from photovoice-projects can thus be used to contribute to the support of (other) people in vulnerable living situations, by making the daily lifeworld and concerns of those people comprehensible for professionals in social service delivery while having attention for the risk of structural exclusion of this target group (Borg et al. 2009). When working with experience-based knowledge it is however crucial to always keep in mind the dynamicity of experiences; experiences differ between people and also 'in' people, as they can change over time. Support should thus always be collaborative, adjusted to the situation and experience of each individual client and his/her questions in relation to support. Participants' stories have also illustrated the value of social laboratories (i.e. the low threshold centers), where every person can search for connections with the broader society at their own pace (Mezzina et al. 2006). Socio-artistic and -cultural activities can facilitate participation in society and offer a way to express oneself creatively, to grow and be good at something. But without changes in the level of implicit labeling, stigmatization and discrimination that people with mental health problems are confronted with, moving towards the broader society seems out of the question and people risk to be stuck in the social laboratories. Consequently, there is a high need for sensitization campaigns about the reality of living with mental health problems, the difficulties to be accepted as a full co-citizen and the value of a diverse society. As experiences of discrimination can start in childhood, it is necessary to start sensitization at a young age (Skre et al. 2013).

Limitations and Future Research

Investing time to develop a trusting relationship, collecting data over a period of several weeks and including member-checks with participants, were strategies that helped to establish validity in the present study. Future research could increase validity through following participants over longer periods of time (Vervliet et al. 2014) and through intensifying the level of involvement of participants in all research stages, as full-fledged co-researchers (Catalani and Minkler 2009; Mizock et al. 2014; Schneider 2012). Moreover, the latter strategy would push the voices of people in vulnerable situations even more to the forefront, what can promote taking social action and

reaching policy-makers (Wang 1999). Furthermore, the findings of this study may not be generalizable, given the small sample size and the specific group of individuals included in the study. An in-depth comparison of results between visitors of the two low-threshold centers (with different profiles) was no specific aim of this study and this would have been difficult, because more visitors of ‘Villa Voortman’ (with a dual diagnosis) than visitors of ‘Poco Loco’ (with mental health problems, no dual diagnosis) participated in the study. Future research could strive towards a more equal distribution of participants between services, to make comparison possible.

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Compliance with Ethical Standards

Disclosure of Potential Conflicts of Interest None.

Research Involving Human Participants and/or Animals NA

Informed Consent Informed consents were obtained from all participants.

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