CITIZENSHIP-BASED CARE: Where it stands and where it might go.

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Abstract

The authors discuss the definition and application in practice of citizenship as a framework for the social inclusion and participation of people with mental illnesses. While noting progress on citizenship practice outside of mental health care (or treatment), they focus on its less-developed application to the latter. The third author, Michael Rowe (Michael), introduces the concept and definition of citizenship that has guided 'citizenship work' and reviews progress to date in practice and evaluation. The co-first authors, Francisco José Eiroa-Orosa (Fran) and Silje Louise Nord-Baade (Silje), discuss their views on the potential for citizenship-based care. The authors then make brief final comments on the state of the field regarding citizenship in mental health care.

Michael

Citizenship, as my colleagues and I have conceptualized and practiced it since the latter 1990s, is defined as the person's, or people's, access to the 5 Rs of rights, responsibilities, roles, resources, and relationships that society offers its members through public institutions and associational life, and a sense of belonging that is validated by others. Passage from exclusion and marginalization requires the involvement of excluded persons themselves, service providers, community members and society as a whole. Additionally, peer support has been integral to the development and implementation of citizenship practices (Rowe, 2015).

While a sense of belonging supports the 5 Rs as well as following from access to them, the Rs have led in the development of citizenship practices and supports. These have included community-level interventions aimed at supporting people's transition from homelessness into housing coupled with public support for and involvement with this transition (Rowe et al., 2001); a community-based, time-limited group intervention based on the 5 Rs (Clayton et al., 2013; Rowe et al., 2007); peer-supported information about and referral to community resources and opportunities within a community mental health center (Bromage et al., 2017); individual, group, community and societal level financial health interventions (Harper et al., 2018); and an ongoing community group focused on mutual support and social advocacy (Quinn et al., 2020).

A notable gap in our 20-year plus implementation and evaluation of citizenship work has been the practice of citizenship-oriented care, or treatment, as practiced in community mental health centers and clinics for persons with serious and disabling psychiatric disorders who cannot afford or gain access to private treatment. One reason for this gap is that citizenship began as a response to the limitations of mental health systems of care (though not as a direct criticism of mental health care): at their best, such systems of care, as we observed through the practice of mental outreach to persons who were homeless with mental illnesses, could provide a wide range of coordinated care and support to their clients including mental health

and substance use treatment, primary and dental care, housing, access to income through employment or disability entitlement programs. They could, in effect, provide 'program citizenship' to their clients with that system of care. What they could not do was provide access to full citizenship for their clients in their communities and society (Rowe, 1999).

Citizenship, then, began with a gaze mainly beyond and outside systems of care, and put the greater part of its program development and evaluation efforts there. This process helped to push forward its community-facing nature and agenda and gave it the advantage of creating new programs rather than integrating them into existing care. This outward focus, however, left a gap in its potential impact in the mental health field, as community mental health centers and clinics, at least in the U.S., are the main sites for providing care and supports to people with mental illnesses.

A number of efforts toward citizenship-based care have taken place, however. These include development and validation of an individual measure of citizenship employing community-based participatory research and concept mapping methods, with peer researchers leading focus groups and persons receiving mental health services nominating the citizenship items that, eventually, became the 46 items of the measure (O'Connell et al., 2017; Rowe et al., 2012). A citizenship tool based on the 5 Rs was developed in collaboration with case managers for use in care planning (Bellamy et al., 2017). Extensive focus groups and discussions have been held with clinical teams at a large community mental health center in the U.S., identifying social, systematic/structural, and clinical aspects of potential citizenship-oriented care, including both team members' support for implementation of citizenship-based care and areas of concern about the prospects of doing so successfully within current systems of care (Clayton et al., 2020; Ponce et al., 2016; Ponce & Rowe, 2018).

Citizenship researchers have identified clinician's 'acts of citizenship' in current mental health care, initiating, hopefully, a 'bottom-up' influence, from individual clinicians to teams to mental health centers as a whole (Hamer et al., 2019). Clinician researchers have argued, with practical examples from research, that mental health professions and direct care providers are well positioned to enact social justice, recovery, and citizenship agendas in public mental health care (Carr & Ponce, 2022). Since 2020, the Yale Program for Recovery and Community Health, in collaboration with the Connecticut Department of Mental Health and Addiction Services, has conducted a Recovering Citizenship Learning Collaborative (RCLC) with thirteen state-operated mental health centers or clinics and two state psychiatric hospitals. This has brought the message and tools of citizenship practice to these agencies, and follow-up technical assistance is under development following the conclusion of the RCLC in early 2023.

Finally, international colleagues have added knowledge and guidance regarding citizenship practice working from the U.S. measure (MacIntyre et al., 2021; Pelletier et al., 2020); the sociological context of psychosocial interventions and transferring principles and practice to different sociocultural contexts (Eiroa-Orosa, 2018b; Eiroa-Orosa & Rowe, 2017); identification by persons experiencing mental health challenges of barriers to citizenship (Cogan et al., 2021), and inclusion of citizenship in national health policy planning (MacIntyre et al., 2019).

Still, citizenship-based care in practice remains a largely undeveloped domain. Silje and Francisco offer their thoughts next on the integration of citizenship in mental health care.

Silje

What helps people cope with mental illness? What motivates and enables people to engage in healthy behaviours, and change or maintain unhealthy behaviours? How do we understand human behaviour when seen in light of its surroundings? How do we build "the good life"? These questions are at the heart of psychology in general and clinical psychology in particular. The answers that these professions supply are complex, but at the level of basic human needs, do they not overlap with the five R's and the need to belong? And

if so, why is it hard to create and practice citizenship-based mental health care?

Citizenship aims to help people thrive in their local communities as fully recognized citizens. It deals with fundamental human needs such as safety and protection, access to desirable resources, and the wish to be acknowledged as a valuable contributor (Rowe, 2015). These needs and values are important components of overall psychological well-being (Boniwell & Tunariu, 2019). In general, with such needs met, people can experience good subjective quality of life, which in turn creates a psychological hardiness when faced with obstacles and negative life events.

Citizenship goals and the general aim for treatment for mental illness might be somewhat of a false distinction. However, in practice, the differences between treatment and "citizenship work" become clearer. They both aim to help people become autonomous and self-sufficient, and they might be working towards much of the same overarching goals, but with different approaches and means. One could argue that treatment might come first for some people to be able to engage in citizenship activities, but at the same time we are telling people it is the job they do in between appointments that matters most. The possible synergetic effects of combining therapeutic approaches with citizenship work building upon each individual needs and challenges, seems to be a good fit, and an obvious one. Both approaches have value. How can we combine the best of two separate, but overlapping approaches?

Every clinician knows the value of healthy relationships, using one's resources and having valued roles. They should know the importance of practicing one's rights as a citizen and having responsibilities. They know the importance of being treated with fairness by receiving the benefits a citizen is entitled to give the needs we must obtain and maintain a decent living standard and experience personal development. And further, you will never hear a psychologist or clinician deny the importance of belonging. The psychologist uses the therapeutic setting to untangle experiences and illness that often relate to the five R's, and the dynamic between individuals and their social contexts are sources of understanding the maintaining mechanisms and possible paths in people's recovery processes. Good care involves values and commitments that reflect citizenship values and principles. If emphasized, supporting people's citizenship' would help their recovery processes, which is criticized for being too focused on the individual, not sufficiently treating the individual as a social being.

Much work can be done in a treatment setting by helping people cope and heal, but also by preparing the individual to explore and gain new and healthy experiences related to building "the good life". But how do clinicians support the individual in real-life settings where the actual building takes place? Traditionally, much responsibility is placed on the individual itself. We expect and hope that the person will take the experience of mastery and safety they have gained in the treatment setting and use it to engage in citizenship acts in their local communities. And people know that engaging in social activities are good for them. But still, this is a challenging task and process for many; for some it is where treatment fails to help, is not sufficient. They may need, or simply may benefit from, having someone, such as a peer, to walk with them while moving from the treatment setting to the community context. Is closing this gap a way to introduce the citizenship approach to mental health care?

A possible source of disconnection from mainstream society in the treatment setting is the uneven relation between the "expert" and the "patient". For some people, this relationship represents the one space they have where they can truly connect with themselves and be acknowledged by someone else. The expert and patient are perceived as fundamentally different. The nature of the relationships that are offered in treatment might be one of the limitations that the citizenship approach can compensate for.

Another limitation of the expert and patient relation is that a treatment relation will, and should for most people, at some point end. Through using and creating opportunities in people's local communities and working on people's resources and self-efficacy while practicing acts of citizenship, the citizenship approach builds upon more permanent structures to help people cope with their lives.

Citizenship can help people create relationships that could last indefinitely. The nature of the relationships that are created through citizenship work are based on equal terms.

Changing systems is challenging even for those with excellent skills and the will to improve what they do. Seeing as every clinician should know the value of belonging and the 5 R's, although they may call them something else, the citizenship approach can help clinicians emphasize these values.

The transition from the treatment setting to everyday life is important. When treatment ends, then what? Or after the session ends, then what? In citizenship-based care, it is my belief that peer workers can and should play a key role in such transitions. A joint process with the person, the clinician, and a peer worker may benefit the person and contribute to their mastery of real life outside the clinical care setting. Such a process could, in fact, be part of the treatment itself, creating a synergistic in which the person benefits from the citizenship approach and treatment at the same time. The clinician could meet the person and the peer worker in selected sessions or have separate meetings (in the clinic or outside of it.)

Such a process might support the treatment process while, at the same time, supporting the person's "citizenship work." It would challenge many clinicians struggling to include peer workers in the mental health field and would acknowledge the use and value of lived experience when facing challenges in one's recovery- and citizenship-process. Finally, it might contribute to minimizing the gap between mental health care and citizenship.

Improving how we work on social inclusion and participation for people with mental illness and/or substance abuse is an ongoing process in Norway. However, the citizenship framework is less explored in this context. Introducing citizenship-based care could be a way to improve our services.

Fran

As commented above, work has been developed on the analysis of the transference of citizenship principles and practice to different sociocultural contexts in the framework of its implementation in Catalonia and the rest of the Spanish state (Eiroa-Orosa & Rowe, 2017). The results of these analyses led us to the conclusion that, to make the implementation of citizenship-based mental health care projects possible, it was necessary to first invest energy in the implementation of peer support as a profession in these territories, in which it has barely been integrated, and so we did (Eiroa-Orosa & Sánchez-Moscona, 2022; Sanchez-Moscona & Eiroa-Orosa, 2021). If, peer support is considered integral to this model (Rowe, 2015) as commented above, our obligation as proponents of the citizenship model in this territory was clear.

In the context of peer support training, the Recovery model is internationally recognized as mainstream, as it is in the transformation of beliefs and attitudes in the rest of the staff towards a rights based mental health care system. The latter was indeed identified as another cornerstone task prior to the possibility of introducing the citizenship model in a conservative mental health care system such as the Spanish one (Eiroa-Orosa & Rowe, 2017). Thus, after performing a comprehensive systematic review and meta-analysis (Eiroa-Orosa & García-Mieres, 2019), we created a training scheme based mainly in the Recovery model and the Convention on the Rights of Persons with Disabilities in which we introduced some brushstrokes of the Citizenship model (Eiroa-Orosa et al., 2021; Limiñana-Bravo & Eiroa-Orosa, 2017). Additionally, we validated an instrument to measure possible changes in beliefs and attitudes of mental health professionals who received the training (Eiroa-Orosa & Limiñana-Bravo, 2019). This was the main work that we carried out in Spain from 2016 until the start of and during the pandemic, thanks to funding received within the Marie Skłodowska-Curie framework.

All this work was carried out with an awareness and understanding of the overlaps and differences between the Recovery and Citizenship models (Rowe & Davidson, 2016). However, for us, basing our work more on the former than the latter allowed us to have more impact on various stakeholders, including policy makers.

We could say that neither practitioners nor academics in Spain in general, nor in Catalonia in particular, were prepared for or interested in the citizenship model beyond its first R. That is, in Spain and internationally there was and still is indeed a very deep debate on the rights of people who use mental health services. However, it is not understood that this debate should involve the rest of the dimensions (i.e. responsibilities, roles, resources, and relationships), beyond whether professionals allow service users to experiment them freely, but not whether the care system should encourage or support them. However, there were many mental health professionals willing to understand the internationally acclaimed Recovery model, both at the individual and organizational providers' levels.

Nevertheless, also during this time, there was a small window of opportunity. In the framework of a collaboration with the master's degree in Community Mental Health at the University of Barcelona I was asked to design an evaluation activity for its Community Rehabilitation module (now called Recovery and Psychosocial Rehabilitation). This opportunity was used to design a reflective activity on mental health care contexts using the Citizenship model (Eiroa-Orosa, 2019). Students were given a 2 × 5 grid whose rows referred to the 5 Rs of rights, responsibilities, roles, resources, and relationships. The two columns referred to the elements that the participants thought their programs already included in reference to each R (left column) and those that still needed improvement to be able to address them (right column). A content analysis of the student's responses showed how reflecting through the citizenship framework on the work that community mental health practitioners carry out could help to extend these ideas.

Fortunately, after the break caused by the pandemic, we have recently received funding for three years for a project called "Citizenship as Mental Health" exclusively based on the Citizenship model. The objective of this project will be threefold: exploring the concept of citizenship together with Spanish mental health service users, relatives and professionals; validating the Citizenship measure (O'Connell et al., 2017; Rowe et al., 2012) within the Spanish context using participatory research methods; and implementing citizenship-based awareness interventions with mental health professionals working in all types of clinical settings. The efficacy of the awareness interventions will be evaluated through a prospective double-blind cluster-wait-list-randomized-controlled trial experimental design (Eiroa-Orosa, 2023).

The idea of understanding citizenship "as" mental health is related to the World Health Organization's concept of mental health[1] that speaks of abilities and contribution to the community rather than symptoms and specific treatments based on clusters of them. Accordingly, our proposal within clinical mental health services, is that therapeutic success should not be simply based on symptomatic alleviation. On the contrary, it should imply understanding that persons who enjoy their mental health are persons who use their rights and respects those of the rest; take responsibilities according to their abilities; exercise roles considering both their preferences and needs as well as those of the rest of the people in their community; obtain and manage resources by themselves; and establish relationships of mutual support and complicity with other people without distinction of age, ethnicity, gender, social class or any other feature (Eiroa-Orosa, 2019). However, understanding mental health as citizenship should not imply ignoring symptoms. Psychopathology can of course seriously affect all citizenship dimensions, but the idea is that all mental health services have as their ultimate goal the full citizenship of their users, whether or not they may totally overcome their symptoms as already proposed in the original Recovery model (Anthony, 1993).

We do not intend to have a position of superiority. We know that many mental health professionals already implement interventions that are compatible with our citizenship model (hence the reflective activity commented above has a column that collects what is already being done). What is perhaps not so clear is which objectives are preferable. For us it is clear, an intervention; be it psychopharmacological, psychotherapeutic or psychosocial; that is effective in terms of symptomatic relief, but reduces the exercise of rights,

1 *According to the Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community.*

the assumption of responsibilities the development of significative roles, and makes service users less able to relate to significant others and manage their resources; it is not an effective mental health intervention. For this reason and to finish with my part, in terms of research design, what we hope is to be able to turn the tables. Instead of treating citizenship dimensions as determinants of "mental health" understood as absence of symptoms, as is already partially the case in some research but without a clear impact on changes in the mental healthcare model, our proposal is to treat citizenship dimensions as the main desired results of any mental health intervention and treat psychopathology as one, among many others, of its determinants.

The Authors

We wish to close with the observation, reflected we hope in this article, that citizenship work and studies seem to have reached a new stage, beyond those of: (1) making the case for the framework itself—that citizenship includes but reaches beyond legal citizenship to include a range of key elements (the 5 Rs) critical to attainment of full membership and a sense of belonging in society, followed by: (2) specific community-based citizenship interventions at the edge of or outside mental health systems of care, to (3) bringing citizenship tools, principles, and approaches into mental health care (treatment). We note that citizenship in community and citizenship in care are equally important and that, over time, making strong distinctions between the two will seem unnecessary. We look forward to taking next steps in practice in our own continuing study and research on citizenship and mental health, and to learning from those of other colleagues.

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