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Analyzing Community Mental Health Programs Through the Citizenship Framework

A Learning Experience

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Abstract

The citizenship framework is an emerging trend in the fields of mental health and social inclusion. After various theoretical developments, instruments have been designed to measure individuals' connection with the various dimensions of citizenship, and interventions have been designed to help practitioners work from this paradigm. In this article I propose a reflective activity developed to help disseminate the citizenship framework among practitioners through the analysis of the programs in which they work. Twenty-seven mental health professionals who were enrolled in a community mental health master's program analyzed community mental health programs using a grid whose 5 rows referred to the 5 Rs (rights, responsibilities, roles, resources, and relationships) that society offers its recognized members, and whose 2 columns referred to the elements that the program already includes in reference to each R and those that need improvement to address them. I analyze how reflecting on the work that community mental health practitioners carry out through the citizenship framework can help to extend its ideas. I then suggest that the citizenship framework should advance the concept that the practice of the various mental health professions is directed at helping service users become full citizens.

Keywords

Citizenship, community mental health, recovery

Introduction

For centuries citizenship has been a complex social concept concerning the degree to which a person is a part of and can influence society (Rowe, 2015; Rowe et al., 2001). Lately it has also become the leitmotiv of a professional and academic movement. Similar to the recovery movement, which has had wide impact on the transformation of services and systems designed for people with mental health problems (Pelletier et al., 2015), the citizenship movement tries to improve the living conditions of people with psychosocial impairments by fully exercising their rights (Rowe et al., 2009). Although both movements share values and objectives, citizenship explicitly emphasizes social-contextual dimensions such as the importance of social justice and advocacy (Ponce & Rowe, 2018; Rowe & Davidson, 2016). Such dimensions might have been eclipsed within the recovery movement by having become mainstream, as well as by mixing elements of personal and clinical recovery (Andresen et al., 2010; Leamy et al., 2011). From a "therapeutic objectives" point of view, in the same way that the recovery movement proposed to change the goal from symptom reduction to autonomous construction of a life project in community, even with possible limitations (Anthony, 1993), the citizenship movement would add a "rights" component. That is, to be able to build a life project in a truly autonomous way, one has to be aware of and able to use the 5 Rs of the citizenship framework—rights, responsibilities, roles, resources, and relationships—proposed by Rowe and colleagues (Rowe, 1999; Rowe & Pelletier, 2012; Rowe et al., 2001, 2009). According to my understanding of the citizenship framework, use of the 5 Rs should be explicit within treatment contexts, so service users are also prepared to exercise them in community contexts. In other words, mental health and social service users should be treated as full citizens regardless of where they are or why they are there.

Making the citizenship framework operational was done initially with a personal measure of citizenship obtained through participatory-action research methods (Rowe et al., 2012). The 46-item measure is divided into seven citizenship domains: personal responsibilities; government and infrastructure, caring for self and others, civil rights, legal rights, choices, and world stewardship or “giving back.” This instrument has been psychometrically validated (O’Connell et al., 2017) and used to evaluate community engagement programs (Georghiades & Eiroa-Orosa, 2019; Ponce & Rowe, 2018). Recently the participatory process has been reproduced in other geographical areas (MacIntyre et al., 2019), so far only in English-speaking regions, but validation processes in other languages are under way.

The citizenship measure is also being developed into a tool to guide clinical practice (i.e., intended to change mental health professionals’ beliefs and attitudes on the process). Bellamy et al. (2017) recently explored its utility for case managers. Accordingly, in the same way that training programs played a very important role in the dissemination of the recovery framework (Eiroa-Orosa & García-Mieres, 2019; Jackson-Blott et al., 2019), the citizenship movement is fostering public discussions and implementing educational interventions for health professionals as outreach strategies (Eiroa-Orosa & Rowe, 2017).

A brief version of the citizenship measure has been used to stimulate dialogues with stakeholders. Ponce et al. (2016) carried discussions on the relevance of the framework into public mental health care. However, to date no research has been performed on the perceptions that mental health professionals have about the degree to which their programs address the 5 Rs. Thus, the objective of this study was to use a qualitative tool that incorporated the the citizenship framework to analyze community mental health professionals’ perceptions of the programs in which they work.

Method

Participants and Procedure

This study was carried out using a convenience sampling strategy. Twenty-seven mental health professionals, who were also students of the Community Mental Health master's in science program at the University of Barcelona, were asked to analyze the mental health programs in which they were involved as staff. This activity was considered the final and compulsory evaluation of the community rehabilitation module of their master's program. The learning methodology was based on experiential learning theories through case studies (Kreber, 2001).

Participants were offered 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; see Appendix for the complete instrument). I chose these two categories with the aim of avoiding resistance from participants, by getting participants to think first about what their programs already include rather than thinking straightaway about limitations.

The participants were instructed on the citizenship framework during a 4-hour lecture using a chronological perspective. The lecture illustrated the evolution of the citizenship framework from the biomedical framework, which focuses mainly on symptomatology, to the recovery framework, which stresses the importance of developing a meaningful life project. Participants learned that the citizenship framework added that people also should be considered full citizens in the context of their recovery (clinical and personal). In other words, it gives the responsibility to mental health professionals to consider only a person who can be considered a full citizen to be what is commonly called a "therapeutic success" (we use this concept to approach the vocabulary that participants handle daily). That is, people may or may not have symptoms, they may or may not have fully developed a life project, but if they can incorporate the 5 Rs, they become owners of their recovery and life projects in general. One month later, the current activity was introduced during a 2-hour lecture. Participants were told that they would be analyzing their programs using the 5 Rs to look for aspects to highlight (already addressed in the program) and other to reflect on (not yet addressed) in each of the Rs. During this second lecture, a trial exercise analyzed one of the programs in which the participants were working using the grid that can be found in the Appendix.

The study was approved by the Bioethics Committee at the University of Barcelona (Institutional Review Board: IRB 00003099).

Analysis

Within a critical-realist ontological stance and a moderately constructivist epistemological position, I performed a theory-based content analysis (Bonoma & Rosenberg, 1978). With Rowe's (2015) framework as background, I created codes as they emerged in the students' accounts of their programs use of the 5 Rs framework. If a particular theme was repeated in another text, I marked it as present for that participant using the categories already created. Using an anonymized system, I introduced categories and occurrences by participant in a spreadsheet to calculate the frequencies of each category within each 5 × 2 grid box (5 Rs × two elements to highlight/reflect on) among all 27 participants. Through the rest of this article, I report both the number and/or percent of the total participants for each characteristic; all percentages are rounded. Only one encoder (the author) participated in the analysis (please see the discussion for a reflection on the limitations this characteristic of the study produced).

Results

Participants’ mean age was 30 years; 22 (81%) of them were women. Eight participants (30%) were nurses, seven (26%) were occupational therapists, six (22%) were psychologists, three (11%) were social workers, and two (7%) were social educators and a psychiatrist. More than a third worked in mental health community rehabilitation centers (n = 11, 41%); others worked in outpatient mental health consultation centers (n = 4, 15%), long-term accommodation services (n = 3, 11%), and addiction treatment services (n = 2, 7%). The remaining seven (26%) worked in a variety of services (including day hospitals, disability, forensics, and research facilities) or did not want to disclose their place of work. In the following sections I describe the codes derived from the theory-based content analysis of participants’ reports. Table 1 offers an overview of categories within each R and by status of each category in the participants’ program (i.e., whether the program highlights it or needs to reflect upon including it).

Table 1. Frequency and Proportion of Categories found in each citizenship dimension

	Elements to highlight			Elements of reflection		
		n	%		n	%
Rights	Information given	21	78	Freedom to choose treatment	9	33
	Freedom to choose treatment characteristics	12	44	Spaces without demand	8	30
	Informed consent/right to information	10	37	More information	7	26
	Group activities	8	30	Informed consent/information	4	15
	Shared decision making/participation	8	30	Shared decision making/participation	4	15
	Bureaucratic support and accompaniment	5	19	Freedom to choose therapist	3	11
	No discrimination	4	15	Staff member in charge	2	7
	Confidentiality	4	15	Support to independent living/empowerment	2	7
	Freedom to choose therapist	2	7	Support and training to staff	1	4
	Support also in relapses	1	4	Skills to use rights	1	4
	Freedom of speech	1	4	Confidentiality	1	4
				Risk of not meeting expectations	1	4
				Gender perspective	1	4
				Self-stigma	1	4
		n	%		n	%
Responsibilities	Responsibility over activities	20	74	Responsibilities over treatment	11	41
	Responsibilities over treatment	10	37	Responsibilities over own life (inside and outside treatment facilities)	6	22
	Responsibility over health and illness	7	26	Responsibilities over resources (less legal custody of economic resources)	4	15
	Shared plans	6	22	Responsibility over health and illness	3	11
	Responsibilities over resources	5	19	Change perspective (sometimes responsibilities are seen as punishment)	2	7
	Competencies model	1	4	Limitations of real life	2	7
	Responsibility of society	1	4	Competencies in each activity	1	4
	Evaluation	1	4	Shared responsibilities with the community	1	4
				Explicit paternalism	1	4
				Ask service users which ones they want to assume	1	4
				Right to be wrong	1	4
				Group responsibility	1	4
		n	%		n	%
Roles	Explicit work on roles	25	93	Community and family roles	13	48
	Community and family roles	19	70	Service user (instead of sick)	5	19
	Empowerment and activism	6	22	Empowerment	5	19
	Caretaker	4	15	Connect roles with activities/take care of all roles	3	11
	Service user (instead of sick)	4	15	Gender	3	11
	Tailored treatment	3	11	P2P	2	7
	Gender	1	4	Work (nonadapted work services)	2	7
				Compulsory elements of intervention	1	4
				Limited time	1	4
				Include service user in role search	1	4
		n	%		n	%
Resources	Information, advice, and connection	22	81	Self-management	15	56
	Accompaniment	7	26	Possible specific group activities	6	22
	Based on capabilities/individualized/needs	5	19	Lack of resources (including time)	3	11
	Personal resources	1	4	Information and advice	2	7
	Public mental health system free of cost	1	4	Include family	2	7

				Not based on capabilities	1	4
				Training to staff	1	4
		n	%		n	%
Relationships	Group activities	21	78	Mixed spaces (people without diagnosis) in the community	12	44
	Mutual support	6	22	Mutual support	5	19
	Mixed spaces (people without diagnosis) in the community	6	22	Sex (accept and support)	5	19
	Sex (accept and support)	6	22	Need to differentiate relational priorities (users vs. professionals)	3	11
	Individualized plan of relational activities	4	15	Peer staff	2	7
	Respect	3	11	Self-management of relationships	2	7
	Gender	2	7	Relations as equals with professionals	2	7
	Family included	2	7	Formality	1	4
	Social skills	1	4	Gender (need for)	1	4
				Need for specialized services	1	4
				Children	1	4
				Intimacy	1	4
				Family	1	4

Note. N = 27.

Rights

Elements to highlight. Strategies for giving information on rights were present in 21 (78%) of the narratives, and there were group information activities in one-third. This information was of a quite varied nature, from documents on very specific procedures (e.g., rights and duties during treatment) to information sessions based on the Convention on the Rights of Persons With Disabilities. Its contents could address the exercise of rights in the treatment center itself (e.g., therapist choice, treatment details), or in the community (e.g., accommodation, work, vote). In this sense, five (19%) reported that in their work centers there was specific bureaucratic support for service users to exercise and claim rights. Twelve (44%) of the participants reported that in their centers service users were free to choose treatment details, 10 (37%) reported that service users were provided informed consent, eight (30%) reported shared decision-making strategies, four (15%) had specific measures for ensuring confidentiality, four (15%) had procedures for ensuring no discrimination, and two (7%) reported that service users were free to choose their therapist.

Additionally, one participant (4%) commented on the importance of receiving support during relapses, and another (4%) noted measures were taken to ensure freedom of speech.

Elements to reflect on. Some of the most commented issues to reflect on had already been mentioned as strengths: freedom to choose treatment details (n = 9, 33%); improving strategies for giving information on rights (n = 8, 30%), informed consent (n = 4, 15%), shared decision-making measures (n = 4, 15%), free therapist choice (n = 3, 11%), and confidentiality (n = 1, 4%). A new and very important theme emerged: the importance of enabling spaces for giving information without or before participants need to demand it (n = 8, 30%). Other aspects mentioned were the importance of having a member of the staff in charge (n = 2, 7%), enhancing support to independent living and empowerment (n = 2, 7%), considering gender issues (n = 1, 4%), supporting and training staff to be able to support others in exercising their rights (n = 1, 4%), and training service users to use their rights (n = 1, 4%). Finally, some participants noted the pending issues of the risk of not meeting expectations (n = 1, 4%) and self-stigma as an obstacle to the exercise of rights (n = 1, 4%).

Responsibilities

Elements to highlight. Seventy-four percent of the participants (n = 20) commented that service users in their programs were given responsibilities over daily life and/or leisure activities. However, the proportion was lower in the cases of treatment (n = 10, 37%), health and illness (n = 7, 26%), and resources (n = 5, 19%). The development of shared plans to promote personal responsibilities was present in six (22%) of the narratives. The use of the competencies framework, the need to inform communities of the importance of shared responsibility with people on recovery, and the importance of evaluation were mentioned by one participant each (n = 3, 11%).

Elements to reflect on. Four categories that were mentioned as strengths were also mentioned as elements to introduce in other programs: responsibilities over treatment (including assisting with meetings; n = 11, 41%), resources (n = 4, 15%), health and illness (n = 3, 11%), and the need to inform communities of the importance of shared responsibility (n = 1, 4%). Enhancing responsibility over one's own life was present in six (n = 22%) of the narratives. Two participants (7%) commented on the importance of changing the perspective of how responsibilities are presented to service users as they might be perceived as punishments. Another two participants (7%) commented that sometimes the "limitations of real life" hamper their ability to grant possibilities to their clients. Issues such as the need to inform service users of the competencies used in each domain, paternalism, asking service users which responsibilities they want to assume, the right to be wrong, and fostering group responsibilities were present in one narrative each (n = 5, 19%).

Roles

Elements to highlight. Most participants (n = 25, 93%) mentioned some explicit work with roles in their programs. Most of them (n = 19, 70% of all participants) were related to community (including work) and family roles. Elements of empowerment and/or activism were present in six (22%) of the narratives, while the importance of switching the sick role for a service user role was commented by four (15%) of the participants. Three participants (11%) mentioned the relation of roles development with tailored (vs. one-size-fits-all) treatments. Only one participant (4%) commented on the importance of addressing gender roles (although, as we will see later, this was also commented in the relationships dimension).

Elements to reflect on. Categories to be improved were very connected with the ones that participants believed were already being addressed. The importance of working further (and sometimes differently) on community and family roles was mentioned by 13 (48%) of the participants. Empowerment (n = 5, 19%), switching from a sick role to a service user role (n = 5, 19%), and gender perspectives (n = 3, 11%) also were repeated. The need to connect roles with activities (n = 3, 11%), tailor adapted work services (n = 2, 7%), include service users in role search (n = 1, 4%), and to defy the acquisition of patient roles within treatment (n = 1, 4%), were mentioned as still pending. Additionally, two participants (n = 2, 7%) commented on the need to introduce workers with lived experience of psychosocial suffering to enhance the work with roles.

Resources

Elements to highlight. The great majority of participants (n = 22, 81%) commented that their programs offered information about, advice on, and connection with different services that facilitated further resources. Seven (26%) of the participants noted the existence of explicit support and accompaniment. Nineteen percent of the narratives (n = 5) included the need to intervene in this regard based on capabilities and adapting to the needs of each person. One participant (4%) commented on the importance of personal resources, and another (4%) on the fact that health and social care is free of cost in the country.

Elements to reflect on. For more than half (n = 15, 56%) of the participants there was a need to enhance self-management of resources. Regarding repeated categories that had appeared as elements to highlight, information, advice, and connection could be improved in two cases (7%), and another participant (4%) mentioned that the work with resources in that person’s program was not based in capabilities. Three (11%) participants mentioned the lack of resources (including time) in the program. Regarding possible improvements, group activities (n = 6, 22%), including the family in the process (n = 2, 7%), and the need to train staff (n = 1, 4%) were mentioned.

Relationships

Elements to highlight. Seventy-eight percent of the participants (n = 21) commented that group activities that could enhance relationships and relational skills were present in their programs. Mutual support (n = 6, 22%), mixed spaces (including people without an explicit diagnosis; n = 6, 22%), acceptance and support of sexual relationships within the program (n = 6, 22%), the existence of an individual plan of relationship enhancement (n = 4, 15%), giving high value to respect (n = 3, 11%), the inclusion of a gender dimension (n = 2, 7%), the involvement of relatives in the process (n = 2, 7%), and specific training in social skills (n = 1, 4%) were mentioned as further elements enhancing this dimension in the participants' programs.

Elements to reflect on. Many issues mentioned as being already addressed were also mentioned as needing further development (sometimes by the same participants). These included the need for mixed spaces (n = 12, 44%), mutual support groups (n = 5, 19%), the acceptance of sexual relationships (n = 5, 19%), and the inclusion of a gender dimension (n = 1, 4%). Sometimes, although these issues were being addressed, they were seen as being addressed in an individualistic way. For instance, one participant (included in the "acceptance of sexual relationships" category; n = 5, 19%) commented that sexual relationships were addressed very individually and just in case the service user made an explicit demand; "maybe we are still afraid of talking about this openly," she commented. Other issues were the need to differentiate relational priorities of service users and professionals (n = 3, 11%), fostering self-management of relationships (n = 2, 7%), inclusion of peer staff (n = 2, 7%), making relationships with staff more horizontal (n = 2, 7%), involving specialized services (n = 1, 4%), avoiding excessive formality (n = 1, 4%), respecting intimacy (n = 1, 4%), and including service users' children (n = 1, 4%) and other relatives (n = 1, 4%) in the recovery process.

Discussion

This study analyzed the contents of 27 personal evaluations of community mental health and social care programs using a methodology specifically designed to promote Rowe's (2015) citizenship framework through analysis, reflection, and critical thinking. The analysis deepens the evidence developed by Bellamy et al. (2017) for guiding case managers' work. I extended this work as a more general reflection on community mental health work using the citizenship framework. The breakthrough for this framework is the introduction of analyses conducted by mental health professionals a month after receiving a lecture on recovery and citizenship. This study thus provides information on how mental health professionals assimilate citizenship-related concepts.

On one hand, many participants believed that mental health programs already include some citizenship components such as information on rights; responsibility over daily activities; explicit work on roles; and information about, advice on, and connection with different services that might facilitate further resources and group activities aimed at improving relational skills. On the other hand, they also think there is much room for improvement. For example, information on rights could be given without having to be explicitly demanded, more responsibilities could be granted (mostly over treatment, one's own life, and resources), community and family roles could be further enhanced, and more support could be given to the self-management of resources. Participants also described a need to create social contact activities in which service users could socialize with other people without the need to disclose psychiatric labels.

We should consider that these are not exhaustive evaluations of these programs, but rather analyses done by a practitioner exploring a specific framework. However, it is clear that the mental health field is in times of transition. For instance, while some participants stressed as strengths the use of shared decision-making instruments, others highlighted it as a possible improvement.

As we have seen, participants of this study were students of a postgraduate program who received a theoretical lecture on the citizenship framework combined with experiential learning through case studies (Kreber, 2001). This allowed them to appropriate the learning process from Kolb's (1984) experiential learning cycle. Namely, participants had their own experience of mental health practice, and the exercise helped them to reflect on that and to carry out an abstract conceptualization based on the citizenship framework. In this way they will be ready for the next phase, that of active experimentation, having received a certain influence from the citizenship framework.

Limitations of the study should also be commented. The study was carried out only with mental health professionals who were asked solely about their views. Testing the same activity by asking mental health professionals about the views of service users, with or without users' participation, would be very interesting. Additionally, although information on specific services and the degree of respect of rights within them is offered, this work cannot be taken as a reliable evaluation. Moreover, all the coding analysis was carried out by just one person, hampering possible reliability analyses. However, this was just a first approach to this methodology of analysis. Participants reported spontaneously with what they thought fit in each of the Rs. It cannot be taken as an evaluation of participants' work centers, but rather as the result of a reflection process. I believe this is essential for disseminating these concepts among mental health professionals, because many of these concepts are not yet associated with professional practice in these contexts.

In conclusion, this work illustrates how working collaboratively with mental health professionals enables them to explore and "learn by analyzing" a new framework based on the exercise of full citizenship.

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Appendix: Tool for the Analysis of Community Mental Health Programs Through the Citizenship Framework

		Elements to Highlight (Parts of the program that we believe already deal with this dimension of citizenship)	Elements of Reflection (Parts of the program that we believe could be modified to deal with this dimension of citizenship more deeply)
Rights	Are there elements that help people to be more aware of their rights and/or learn strategies to exercise them assertively and respectfully?		
Responsibilities	Are there elements that help people to take responsibilities in an effective but realistic way according to their abilities?		
Roles	Are there elements that help people to exercise roles considering both their preferences and needs and those of other people in their family and community?		
Resources	Are there elements that help people to get and manage resources by themselves?		
Relationships	Are there elements that help people to establish relationships of mutual support and complicity with other people regardless of age, ethnicity, gender, social class, or any other characteristic?		