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Building Citizenship: An Experiential Awareness Intervention for Mental Health Professionals

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Abstract

This article presents the first structured implementation of the citizenship framework as a professional training and awareness intervention for mental health professionals. The programme aims to promote critical reflection on practice and support a shift from symptom-focused models towards an understanding of mental health grounded in full citizenship. It combines four hours of theoretical and reflective content introducing the citizenship framework and its five dimensions of rights, responsibilities, roles, resources, and relationships with four hours of experiential learning. This experiential component employed an adaptation of the fixed-role technique and the as if philosophy, encouraging participants to reimagine their daily practice by envisioning themselves working within citizenship-oriented services. Participants represented a wide range of mental health disciplines, spanning clinical, psychosocial and social care professions and bringing considerable professional experience. Qualitative analyses of reflective group work and facilitator documentation of experiential activities provide preliminary insights into how professionals understood and enacted citizenship principles. Within the intervention, participants collaboratively constructed an enhanced awareness of citizenship, questioned symptom-centred assumptions, experimented with collaborative and relational practices, and identified both personal dilemmas and structural barriers that limit its everyday application. The article outlines the design and delivery of the initiative, situates it within constructivist approaches to professional development, and discusses its implications for advancing citizenship-informed mental health care.

Keywords*: as if philosophy, citizenship, experiential learning, fixed-role technique, professional training*

Building Citizenship: An Experiential Awareness Intervention for Mental Health Professionals

The consolidation of the rights-based framework in mental health policy embodied in the Americans with Disabilities Act (National Council on Disability, 1990) and the United Nations' Convention on the Rights of Persons with Disabilities (United Nations, 2006), has prompted a re-examination of how mental health interventions are designed and delivered. In that context, over the past two decades the concept of citizenship has emerged as a transformative framework in mental health theory and practice. The citizenship framework (Rowe, 2015) highlights the social, political, and relational dimensions of wellbeing, understanding it as emerging through relational processes and shared meanings within social and civic contexts, while building upon the principles of the recovery model and extending beyond its emphasis on personal growth amid psychosocial distress (Rowe & Davidson, 2016).

Citizenship was initially defined as the extent of individuals' engagement with five foundational dimensions, referred to as the '5Rs': rights, responsibilities, roles, resources, and relationships (Rowe, 1999; Rowe & Baranoski, 2000). Building on this concept, the citizenship framework emerged from community-based participatory research aimed at integrating social justice principles within mental health practice (Rowe & Pelletier, 2012a). According to the model, to achieve full membership in society, individuals must be guaranteed access to effective rights and corresponding responsibilities as community members. Simultaneously, they require knowledge and practical skills to access resources and must be enabled to develop roles and relationships within their communities (Rowe & Pelletier, 2012b). Therefore, understanding mental health as citizenship does not imply ignoring symptoms but rather recognising that a person enjoying mental health is one who uses their rights and respects those of others,

takes on responsibilities effectively but realistically according to their abilities, exercises roles considering both their preferences and needs as well as those of their community, obtains and manages resources autonomously, and establishes relationships of mutual support and complicity with others without distinction of age, ethnicity, gender, social class, or other characteristics (Eiroa-Orosa, 2019). Mental health challenges can seriously affect all these processes, but the fundamental principle is that all mental health services should maintain full citizenship of service users as their goal, whether or not complete symptom remission is achieved.

Various international research and intervention projects have emerged from the citizenship framework. The pioneer Citizens Project used citizenship as a framework for opening opportunities for social participation to members of stigmatised groups (Clayton et al., 2013; Rowe et al., 2009). Rather than viewing individuals with mental health challenges as problems to be addressed through others' intervention, participants were positioned first as students and later as citizens. They were recognised as experts on their own problems and difficulties, able to identify solutions and to learn how to become valued members of the community. A randomised clinical trial comparing the citizenship intervention to usual care demonstrated that it successfully reduced substance use and increased quality of life for participants, although it was also associated with a slight increase in symptomatology, an expected trade-off when formerly withdrawn individuals are supported to re-engage with the demands and opportunities of community life (Clayton et al., 2013).

Beyond its grounding in social justice and rights-based approaches, the citizenship framework is also consistent with a constructivist orientation to psychological theory and practice. It conceptualises identity, wellbeing, and recovery as emergent constructions developed through social participation and reciprocal meaning-making rather than as

static individual traits. From this perspective, becoming a citizen is an active process of (re)constructing one's sense of self and agency within a shared social world. This view aligns with constructivist emphases on the co-creation of personal meaning (Mahoney, 2003; Neimeyer, 2009), narrative identity (McAdams, 2001), and the situated nature of knowledge and experience (Gergen, 2009). The framework therefore resonates with constructivist understandings of psychological change as a process of developing new narratives and positions within relational contexts (Neimeyer et al., 2006; Neimeyer & Mahoney, 1995).

Consistent with the significant role training programmes played in disseminating the recovery model (Eiroa-Orosa & García-Mieres, 2019; Jackson-Blott et al., 2019; Mabe et al., 2016; Sreeram et al., 2021), our research and outreach group is currently implementing educational interventions for mental health professionals as an outreach strategy (Eiroa-Orosa, 2023). In keeping with the constructivist orientation of the citizenship framework, the present initiative employed reflective and experiential learning methods designed to facilitate professionals' reconstruction of their own meanings related to citizenship and mental health practice.

This article describes the first educational implementation of the citizenship framework within a broader research programme aimed at demonstrating how mental health is tied to citizenship and helping professionals understand wellbeing and distress in the context of social rights and responsibilities. The initiative sought to introduce the citizenship framework to mental health professionals and promote reflection and practice transformation consistent with its principles. The intervention combined a theoretical introduction to the framework with reflective group work and constructivist experiential methods, specifically employing a novel procedure based on the fixed-role technique (Kelly, 1955; Neimeyer et al., 2003) and the psychotherapeutic applications (Watzlawick,

1977; Watzlawick et al., 1974) of the ‘as if’ philosophy (Vaihinger, 1911) to facilitate professional meaning reconstruction.

Method

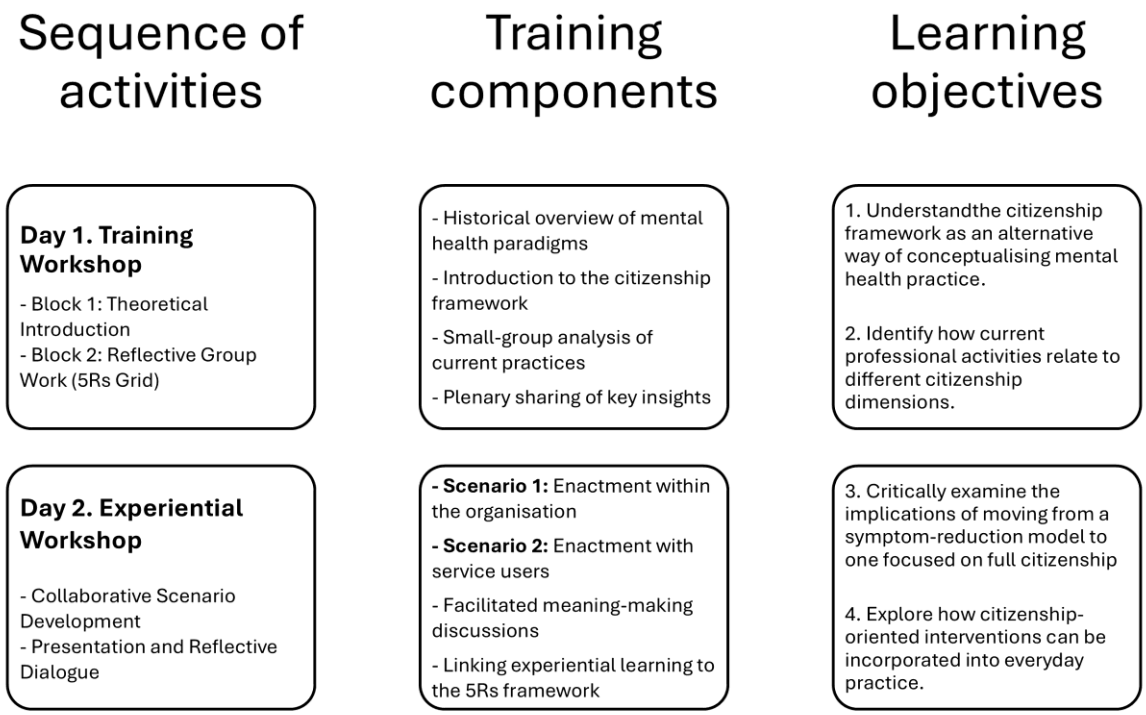
Development of the training and awareness intervention

Prior to the development of the training content, a participatory co-design process was implemented to ensure contextual relevance and participant engagement. Two structured co-design workshops were organised during the spring of 2024 with the participation of key actors representing diverse perspectives within the mental health ecosystem, including people with lived experience of mental health challenges, relatives, and mental health professionals from multiple disciplines and service settings. The first workshop included two mental health activists, two technicians from an anti-stigma campaign, and three mental health professionals (a clinical psychologist, a social worker, and a consulting psychiatrist), and lasted 1.5 hours. The second workshop included three mental health activists, a technician from a mental health federation, and a consulting psychiatrist, and lasted 1 hour.

These workshops identified priority themes, perceived barriers to citizenship implementation, and contextual specificities of the local mental health system. Insights generated through these participatory workshops directly informed the structure and content of the training initiative, ensuring that both theoretical and experiential components were contextually grounded and responsive to the lived experiences of participants. Building on these findings, the citizenship-based awareness intervention was developed to translate the co-designed priorities into a structured educational programme for mental health professionals.

Figure 1

Sequence of activities, training components and learning objectives addressed



The citizenship-based experiential awareness intervention

The intervention is delivered through two sessions with a one-week interval. Each edition includes a 4-hour training and 5Rs reflective group work and a 4-hour experiential workshop, totalling eight hours across the two-week period (see figure 1). Its learning objectives are: (1) to understand the citizenship framework as an alternative way of conceptualising mental health practice, (2) to identify how current professional activities relate to different citizenship dimensions, (3) to critically examine the implications of moving from a symptom-reduction model to one focused on full citizenship, and (4) to explore how citizenship-oriented interventions can be incorporated into everyday practice. The dual-component design was intentionally structured to integrate the conceptual foundations of the citizenship framework with constructivist methods and epistemology described below. The intervention design drew upon established principles for mental health social marketing campaigns, including the Targeted, Local, Credible, Continuous Contact (TLC3) principles (Corrigan, 2011), which were adapted to focus specifically on professional beliefs and practice transformation.

Training Workshop

The theoretical and reflective contents, delivered during the first four-hour session, aim to introduce participants to the conceptual and ethical foundations of the citizenship framework while promoting critical reflection on prevailing professional practices. This session is organised into two interconnected blocks. The pedagogical contents of the session follow.

Theoretical Introduction.

The opening block provides contextual grounding by tracing the evolution of mental health care across multiple historical periods and geographical contexts, emphasising the sociopolitical factors that shaped professional practices prior to the

emergence of consumers and survivors' movements. Presentation of the Vermont Longitudinal Study (Harding et al., 1987a, 1987b), which provided scientific foundation for the recovery model (Anthony, 1993) and was subsequently incorporated into U.S. federal policy (Satcher, 2000), illustrates how recovery became established as a guiding principle within mental health service systems. The discussion concludes with a systematic introduction to the theoretical structure of the citizenship framework as articulated by Rowe and colleagues (Rowe, 2015; Rowe et al., 2001). Two audiovisual resources further illustrate the relational and ecological dimensions of the citizenship framework (Yale Program for Recovery and Community Health [PRCH], 2020b, 2020a). The first video (PRCH, 2020b), recounts Jim's story, whose return to the street after securing housing led Rowe and his outreach team to question the implicit promises of belonging and social membership within traditional services. This reflection prompted Rowe and his team to consider the identities that services help people to build, ultimately shaping the citizenship framework. The second (PRCH, 2020a), presents the foundational elements of the citizenship framework and shows how the 5Rs can be applied in everyday practice.

Reflective group work using the 5Rs grid.

The second block transitions to an applied focus, engaging participants in structured small-group reflection facilitated by the 5Rs reflection grid (Eiroa-Orosa, 2019), a structured tool guiding a systematic examination of professional practices across each citizenship dimension. Participants are organised into small working groups (typically 4–6 members per group), with attention given to achieving homogeneous composition whenever possible, meaning that participants are grouped from the same team or working within the same service setting, to facilitate an in-depth analysis of each mental health service. Printed copies of the grid are provided to each participant.

Working groups are tasked with identifying aspects of their current daily professional practice that already align with the 5Rs framework, as well as areas requiring strengthening or modification to better support citizenship. Groups are explicitly instructed to generate concrete, context-specific examples from their own services. Each group designates a spokesperson who documents reflections and subsequently shares key insights with the larger group through a plenary presentation. Groups utilise provided materials (such as whiteboards or flipcharts) to create a collaborative table of citizenship-promoting and citizenship-limiting practices across represented services (see table 1). The exercise promotes plenary discussions by identifying patterns across groups, highlighting particularly innovative existing practices, and supporting constructive problem-solving around identified barriers.

The session concludes with an invitation for participants to identify one citizenship dimension requiring strengthening within their services, thereby laying the foundation for experiential work to be undertaken during the second session.

Experiential Workshop

The central experiential component employed a method developed specifically for this training, adapted from a pedagogical version of the fixed-role technique (Neimeyer et al., 2003) and the psychotherapeutic applications (Watzlawick, 1977; Watzlawick et al., 1974) of the ‘as if’ philosophy (Vaihinger, 1911). This method invites participants to temporarily adopt and enact alternative professional roles that embody new ways of thinking, feeling, and relating, enabling them to explore how citizenship-oriented practices could operate in real contexts.

Table 1

Structured Reflection Grid Based on Rowe's 5Rs

		Elements to highlight (parts of the programme that we believe already deal with this dimension of citizenship)	**Elements of reflection** (parts of the programme 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 being able to take on responsibilities in an effective but realistic way according to their abilities?		
Roles	Are there elements that help people 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 get and manage resources by themselves?		
Relationships	Are there elements that help people establish relationships of mutual support and complicity with other people regardless of age, ethnicity, gender, social class, or any other characteristic?		

Building on situations identified during the previous week's 5Rs grid analysis, each group develops two short scenarios. The first scenario involves professionals enacting discussions with colleagues and/or managers, exploring how citizenship-oriented practices could be introduced within their organisations. The second scenario focuses on the application of these practices in interactions with service users, emphasising relational dynamics and collaborative engagement. In both scenarios, participants reimagine situations as transform contexts in which citizenship principles are fully operationalised, acting according to useful fictions to explore realities not yet established.

Scenarios are presented to the other participants, creating a safe and reflective space framed as exploratory hypotheses rather than prescriptive instructions. This approach reduces defensiveness and fosters curiosity towards alternative ways of working. Each exercise is followed by facilitated integration of meaning, connecting experiential engagement with the theoretical frameworks introduced during the training and enabling co-construction of insights through group dialogue. Experiential learning is explicitly linked to theoretical concepts, reinforcing connections between the citizenship framework's five dimensions and participants' direct experiences during the exercises.

Participants

The intervention has been implemented throughout 2025 across six editions in five mental health provider organisations in Catalonia, Spain. The first author, a psychologist with training in constructivist psychotherapy and qualitative thematic analysis, conducted the first edition and the first session of the second. The second author, a social educator and medical anthropologist trained in socioconstructivism, and experiential methods conducted the remaining sessions.

The intervention was delivered to professionals from multidisciplinary mental health teams across public inpatient and outpatient services. Recruitment occurred via institutional channels, with participating organisations issuing invitations to their staff. Across the six editions, 146 professionals registered for the activity, of whom 93 attended the training and provided informed consent to participate in the evaluation. The group was predominantly female (86%) and included 20 psychologists, 18 social workers, 13 social integration professionals, 10 social educators, 9 nurses, 9 psychiatrists, 8 occupational therapists, 3 nursing assistants, 2 administrative staff, and 1 leisure support worker. On average, they had 15 years of professional experience (SD = 9.6). Each training session accommodated between 10 and 24 participants. Ethical approval for the study was granted by the University of Barcelona institutional review board (IRB: 00003099).

Data collection and analysis

In addition to a randomised wait-list controlled quantitative evaluation currently underway (Eiroa-Orosa, 2023), three complementary qualitative data collection and analysis methods were employed by both authors to provide a preliminary evaluation of the intervention's implementation. First, photographs of the whiteboards and flipcharts containing the completed 5Rs grids from all groups in the six editions of the programme were reviewed to identify and classify content. In addition, audio recordings of the dialogues that took place during the 5Rs grid presentations in the reflective group work sessions from the first two editions of the training were analysed using reflexive thematic analysis (Braun & Clarke, 2006, 2019), enabling the identification of patterns across the five dimensions of citizenship. These two editions were purposefully selected as the first implementations of the intervention and because they took place in markedly different settings (a psychosocial rehabilitation and residential programme and a mental health care

complex including outpatient and inpatient services) providing complementary perspectives on how the activity unfolded in contrasting organisational environments. Although the 5Rs of citizenship provided the overarching conceptual framework for the intervention and analysis, no predefined theoretical coding frame was imposed. Instead, we conducted an inductive analysis of participants' reflections to gain an initial exploratory understanding of how professionals engaged with the intervention.

Second, detailed facilitator notes from all six experiential workshops were examined. The sessions were not audio or video recorded because the study focused on preliminary implementation rather than exhaustive audiovisual analysis and recording improvised role-play activities would have raised additional ethical and data-protection complexities while potentially reducing participants' spontaneity. Each workshop was therefore documented in real time by the respective facilitator of each edition. Notes were expanded immediately after each session and subsequently reviewed and discussed between the two authors. This process captured emergent relational dynamics, shifts in language and non-verbal communication, and specific examples of how participants enacted citizenship-oriented practices. However, given the reliance on facilitator notes, these insights are interpreted as exploratory.

Results

Analysis of reflective group work sessions

Analysis of photographs of 5Rs grids elaborated during the reflective group work across the six editions identified a range of existing practices aligned with the citizenship dimensions. Commonly reported strengths included participatory structures such as assemblies, councils, and individual meetings that fostered communication, consent, and some degree of decision-making; access to information on rights and responsibilities (e.g., informed consent forms, advance directives, and satisfaction surveys); opportunities

to assume meaningful roles within the service and the wider community (e.g., through volunteering, sport, and family involvement); support for autonomous resource management through social work; and relational opportunities via peer interactions and community activities. However, professionals consistently highlighted areas for improvement, emphasising the need to address limitations imposed by institutional regulations or large community living arrangements that restrict rights; deepen user involvement in goal-setting and recovery planning; enhance empowerment and valued roles beyond a service user identity (e.g., peer support or leadership in activities); reduce paternalistic tendencies and overprotection; and strengthen responsibilities and community networks to counteract dependence and self-stigma.

Thematic analysis of the transcribed recordings from the reflective group work sessions of the first two training editions identified several codes, organised into four main themes: Agency, Dependence, Professional Involvement, and System Limitations. These themes and their associated codes capture professionals' reflections on existing practices, potential improvements, and barriers for citizenship-based practices (see table 2 for definitions and frequencies).

Agency

Professionals consistently described agency as a core goal of practice, encompassing the interrelated codes of autonomy, right to decide, participation, roles, responsibility, and sharing experiences. Agency was framed not as an individual attribute but as a process enabled or constrained by service structures, professional practices, and relational contexts.

Autonomy was described as extending beyond the provision of options to the active creation of conditions in which service users could shape their own care and life projects. Professionals emphasised the importance of involving service users from the

outset, particularly in defining goals and priorities. As one participant reflected, ‘we had considered giving them pre-written objectives once the team had agreed on them but letting them set the goals themselves would make them much more involved with the whole team.’ Autonomy was therefore linked to ownership of the process rather than compliance with predefined objectives and was understood as something developed through ongoing practice.

The *right to decide* was closely connected to autonomy and was evident in professionals’ emphasis on supporting service users to evaluate risks, make informed choices, and manage personal matters. Participants described efforts to ensure that interventions and goals were shaped around service users’ own projects and preferences, rather than imposed by teams, stressing that ‘the objectives have to be things the person sets for themselves, not things that we require of them.’ Decision-making was framed as voluntary, particularly in intensive or residential settings, with professionals highlighting the importance of making clear that involvement was ‘not obligatory.’ Support for decision-making included access to therapeutic and community resources, harm reduction approaches, advance decision-making initiatives, and everyday choices related to housing, medication, and service dynamics.

Participation was described as a key mechanism through which autonomy and decision-making were enacted in relational contexts. Professionals frequently referred to assemblies and group spaces as central settings in which service users could express preferences, communicate needs, and engage in dialogue about service-related issues. One participant described the assembly as ‘one of the most direct ways’ for service users to exercise participation and communicate their interests or concerns. Group-based formats were repeatedly emphasised, with one professional noting that ‘almost the whole intervention is done in groups,’ highlighting the collective dimension of participation. At

the same time, professionals stressed that participation should not be limited to assemblies alone. As one participant reflected, ‘when we think about collective decision-making, the first thing that comes to mind is an assembly, and that’s fine, but there can be other strategies,’ including more individual or less demanding forms of involvement when group participation was not feasible.

Roles were described as extending across both service-based and community contexts, positioning service users in a range of social roles beyond their identity as ‘patients’. Within services, professionals highlighted practices in which peers shared their experiences with others at earlier stages of care, for example by ‘explaining their experience to people who are just starting the process.’ These practices framed experiential knowledge as a shared resource and reinforced mutual recognition. Professionals also referred to roles enacted beyond the service, such as being neighbours, volunteers, or participants in community or sport activities, as well as opportunities to experiment with new roles. At the same time, role enactment was described as relational and sometimes unequal, with one participant noting that ‘there are sometimes hierarchies among service users that affect the rights of others,’ highlighting the need for professional facilitation to ensure reciprocity and respect.

Responsibility was repeatedly linked to decision-making and participation, with professionals emphasising that increased agency involved assuming accountability for personal choices and their consequences. As one participant noted, ‘having more decision-making power also means they take responsibility for aspects of their life, such as treatment or finances.’ Responsibility was further described through practices such as therapeutic agreements, shared care planning, and negotiated rules of coexistence, particularly in residential contexts, where professionals emphasised the need to balance

individual rights with respect for others. Supporting responsibility was framed as an ongoing process requiring accompaniment, rather than a one-time transfer of control.

Finally, *sharing experiences* was described as both a precondition for and an outcome of agency, particularly within group settings. Professionals highlighted the value of creating spaces in which service users could exchange experiences, reflect collectively, and support one another, especially during difficult moments. As one participant explained, these spaces allowed service users 'to share with other peers and see what could change or make the stay easier.' Sharing experiences was therefore understood as a relational practice that reinforced participation and mutual learning. Despite these efforts, professionals acknowledged that opportunities for sharing experiences were largely concentrated within services, with more limited extension into community settings.

Dependence

This theme captured forms of dependence that limited service users' agency and was structured around three interrelated codes: coercion, lack of self-care, and infantilisation. Professionals frequently linked these dynamics to acute distress states, institutional arrangements, and well-intentioned but restrictive practices.

Coercion was most evident in involuntary contexts, particularly in acute units, where clinical severity constrained participation and decision-making. As one professional explained,

> When a person is involuntary, in a manic or psychotic episode, the only interaction you have is about basic needs, like leaving or smoking, they are unable to participate in an assembly or take part in decisions at that moment.

Several participants stressed that this limitation was often temporary, noting that participation could increase as symptoms stabilised, yet during acute phases citizenship practices were perceived as clinically unfeasible or even risky.

Professionals described a *lack of self-care* emerging through habituated dependence on services, in which prolonged support reduced initiative and motivation for autonomy. In supported housing and long-term programmes, staff reflected on how some service users had become accustomed to professionals managing everyday decisions, making transitions towards greater independence difficult: 'people get used to being in that position where you choose what they wear, what they eat, or their daily routine, and then it's very hard for them to transition.' This dependence was sometimes linked to demotivation or the absence of personal goals, particularly among service users with long trajectories within services, reinforcing passivity rather than self-management.

Infantilisation further reinforced dependence through paternalistic assumptions about competence, even when service users retained significant abilities. Professionals acknowledged that deciding on service users' behalf, often justified by concerns for safety or treatment adherence, could undermine empowerment and self-worth: 'assuming you must make all decisions for them affects their sense of agency and self-esteem.' Overprotection was described as embedded in everyday practices, such as organising all activities or outings for service users, which, while intended to provide care, limited opportunities to exercise responsibility and choice. Several participants reflected critically on this tension, emphasising the need to reduce paternalism and recognise preserved capacities, balancing protection with the gradual restoration of decision-making and participation.

Professional Involvement

This theme captured professionals' active role in enabling service users' citizenship and autonomy, encompassing six interrelated codes: support, rights-based work, confidence, professional engagement, diversity, and public awareness. Across services, professionals positioned themselves not merely as providers of care, but as key

relational and structural facilitators of agency, whose practices could either expand or restrict service users' opportunities to exercise rights and participate meaningfully.

Support was the most prominent code and was described as a continuous, process-oriented form of accompaniment across different stages of recovery. Professionals emphasised guiding service users through transitions between acute care, residential settings, and community-based programmes, adapting the level of support while actively working to avoid fostering dependence. This accompaniment included practical assistance, emotional support, and mediation with other systems, with the explicit aim of enabling service users to sustain autonomy in complex and sometimes contradictory institutional contexts. As one participant noted, support involved 'being there throughout the whole process, not doing things for them, but helping them to be able to do them on their own.' Professionals frequently described support as relational rather than directive, requiring time, flexibility, and attentiveness to individual rhythms and capacities.

Rights-based work emerged as a central professional responsibility, particularly through the provision of information about service users' legal and social rights. Participants highlighted the importance of communicating rights universally, rather than selectively filtering information based on professional assumptions about service users' capacities. One professional reflected critically that 'we decide what to communicate depending on what we think, when perhaps we should provide information indiscriminately,' acknowledging how gatekeeping information could undermine citizenship. Rights-based practices included explaining contractual conditions, informing service users about mechanisms such as advance decision-making, and facilitating access to legal advice or advocacy services. These practices were framed as essential for enabling informed choice and reducing asymmetries of power between professionals and service users.

Confidence captured professionals' trust in service users' capacities and their willingness to tolerate uncertainty and risk. Participants described deliberately allowing space for service users to make decisions, including the possibility of mistakes, as a sign of respect and a necessary condition for reducing dependence. Trusting service users' abilities was framed as an active professional stance, requiring restraint, reflection, and resistance to overprotective impulses. As one participant expressed, 'allowing them to take responsibility, even if mistakes are possible, shows respect for their capacity and encourages inclusion.'

Professional engagement referred to staff members' active involvement beyond routine tasks, including anti-stigma actions, advocacy within organisations, and critical reflection on institutional norms. Participants described themselves as key resources in promoting citizenship, often navigating tensions between their own values and the constraints imposed by organisational or regulatory frameworks. Engagement included questioning over-institutionalisation, negotiating flexibility within rigid systems, and creating opportunities for participation even when formal structures were limited. This reflexive stance was evident in professionals' willingness to examine their own practices and the potential unintended consequences of well-intentioned interventions.

Promoting *diversity* was described as both an ethical commitment and a practical strategy for inclusion. Professionals highlighted efforts to recognise and accommodate cultural, gender, sexual, and functional diversity within services, for example through symbolic visibility, adaptation of physical spaces, and the creation of safer environments for expression. Diversity work was often described as transversal, requiring continuous reflection rather than isolated initiatives. Participants noted that recognising diversity helped service users feel acknowledged as full subjects rather than homogenised recipients of care.

Finally, *public awareness* extended professional involvement beyond the immediate service, focusing on educating other professionals, community organisations, and employment services. Participants emphasised that fostering inclusion required changes not only within mental health services but also in the broader social environment. As one professional stated, 'people working in employment support need a deeper understanding and acceptance of those with mental health problems, because this facilitates integration and successful participation in the community.'

System Limitations

This theme captured structural conditions that constrained the enactment of agency and citizenship, articulated through three interrelated codes: structural constraints, lack of resources, and housing constraints. Across accounts, professionals described how system-level arrangements shaped the boundaries of both service users' rights and professionals' capacity to support participatory and autonomy-oriented practices.

Structural constraints referred to institutional rules, therapeutic contracts, and administrative procedures that restricted choice and decision-making. Professionals frequently described tensions between rights-based principles and organisational frameworks, noting that the exercise of rights was often conditional on institutional compatibility. As one participant explained, 'we had doubts about explaining a right because it might conflict with the therapeutic contract or the way the service operates,' highlighting how transparency about rights could generate expectations that services were structurally unable to fulfil. These constraints were described as embedded features of the system rather than isolated practices, leading professionals to reflect that 'the system itself ends up limiting what service users can do.' Such accounts illustrated how agency was negotiated within narrow institutional margins, despite explicit professional commitment to participation and empowerment.

A *lack of resources* further constrained the implementation of citizenship-oriented practices. Participants referred to persistent shortages in staffing, funding, time, and service availability, which limited the feasibility of participatory initiatives and individualised support. Even when professionals expressed strong motivation to promote autonomy, they emphasised that structural capacity was insufficient to sustain meaningful change. As one professional stated, 'without sufficient resources, it is impossible to implement changes that truly allow users to exercise autonomy and participate fully in the community,' while another noted that 'many changes simply cannot be implemented because we lack the resources to do so.' Resource limitations were thus framed as systemic barriers rather than a lack of professional engagement, reinforcing the perception that institutional conditions shaped what could realistically be achieved in practice.

Housing constraints illustrated how access to essential resources was contingent on compliance with restrictive conditions. In supported housing and residential programmes, professionals described how entry into the resource often required service users to relinquish certain freedoms, particularly during periods of crisis. As one participant observed, 'people give up some of their rights to access the resource; once inside, they must follow rules, such as admission during decompensation, which limits their freedom.' These constraints were described as structurally imposed rather than individually negotiated, generating ongoing tensions between protection, care, and the exercise of citizenship. While housing was recognised as central to stability and recovery, professionals highlighted how the conditions attached to access could undermine autonomy and decision-making over time.

Table 2

Themes, codes, definitions, and frequencies derived from thematic analysis of reflective group work sessions

Code	Definition	Frequency
Agency		**104**
Autonomy	Core aspects of user independence, self-management, and fostering personal initiative in daily life and recovery processes, including spaces and tools for users to develop as citizens (e.g., assemblies for expressing preferences).	26
Right to decide	Emphasis on service users' rights and capacity to make informed, free choices about treatment, living arrangements, risks, and personal matters.	21
Participation	Involvement of service users in decision-making processes, activities, and service governance, such as assemblies, goal setting, or contributing to service-level decisions.	16
Roles	Adoption and exercise of valued social positions within the service and broader community.	16
Responsibility	Service users assuming duties and accountability in coexistence, personal goals, risk evaluation, and community interactions.	15
Sharing experiences	Creating spaces to share experiences, communicate needs, preferences, or interests with the group, and exchange knowledge or skills with peers.	10
Dependence		**29**
Coercion	Involuntary aspects of care, particularly in acute settings, where clinical states or institutional procedures limit service users' ability to exercise rights or participate.	19
Lack of self-care	Disengagement or habituation to dependence on staff, reducing service users' initiative and motivation for autonomy or self-management.	6
Infantilisation	Paternalistic practices where professionals decide for users, treating them as incapable, affecting empowerment and reinforcing unequal power dynamics.	4
Professional involvement		**66**
Support	Accompanying service users throughout the recovery process towards full community integration, including ongoing professional actions to promote autonomy.	38
Rights-based work	Providing comprehensive, indiscriminate information about service users' rights to empower citizenship and decision-making.	8
Confidence	Trusting service users' capacities, allowing space for development and risk-taking to reduce dependence and encourage inclusion.	6
Professional engagement	Active staff involvement in fostering citizenship, such as anti-stigma actions or viewing themselves as key resources in the process.	5

Code	Definition	Frequency
Diversity	Promoting visibility and acceptance of diversity to create inclusive spaces and reciprocal relationships without distinctions.	5
Public awareness	Efforts to raise understanding and acceptance among professionals, employment services, and the public to reduce stigma and facilitate community integration.	4
System limitations		**57**
Structural constraints	Institutional rules, procedures, therapeutic contracts, or norms that restrict service users' rights, choices, or autonomy.	39
Lack of Resources	Shortages in staffing, funding, infrastructure, or time that hinder implementation of participatory or citizenship-oriented changes.	14
Housing constraints	Requirements in supported housing programmes where users renounce certain rights or freedoms to access basic needs (e.g., involuntary admissions during crisis).	4

Experiential Workshop analysis

Emerging Scenarios and Practices

Across training sites, participants represented and discussed a wide range of scenarios reflecting the operationalisation of citizenship principles in daily professional contexts. Commonly emerging practices included the introduction of former service users or peer support workers into teams, proposals for new activities where service users could pursue hobbies or share skills, co-construction of individual recovery plans, greater service user participation in assemblies and policy meetings (including co-leadership of assemblies). Several groups portrayed service users taking on valued community roles such as volunteering, mentoring, or teaching. Institutional innovations were also frequently represented, such as debates on allowing greater autonomy in areas like sexual relationships within residential settings (with alternatives proposed), open-door policies in acute inpatient units, and greater interdisciplinary collaboration across hospital and community-based resources. In several enactments, professionals depicted transitions from asking service users to commit to an individual recovery plan to co-constructing such plans jointly, often in team meetings where service user preferences and risks were openly discussed. Some grooups also portrayed stronger coordination with community assets, including neighbourhood associations and non-health-related initiatives, as well as direct proposals to service users for community involvement or autonomous projects.

Relational and Communicative Shifts

Observable communication patterns were among the most salient outcomes of the experiential workshops. In scenes depicting interactions between professionals and service users, participants adopted a relaxed posture, used a gentle tone of voice, and displayed attentive nonverbal behaviour while enacting citizenship-oriented roles. Many groups observed these

behaviours with interest, using them as opportunities to explore implicit beliefs about service users and professional authority. Verbal communication in citizenship-oriented enactments was characterised using inclusive and collaborative language using open-ended, dialogical questions ('what options do you see?' 'How do you imagine these alternatives could work?'), particularly evident in individual interviews or flat meetings where professionals transparently shared team doubts while recognising service user initiative, motivated participation in new projects, or jointly explored alternatives to restricted requests (e.g., sexual needs or absences from activities). Listening behaviour was evident. Professionals attended closely to service user's interpretations, priorities, and values, validating decisions even when differing from professional views and emphasising shared responsibility. Nonverbal expressions, including open body posture and sustained eye contact, reinforced attitudes of availability and mutual recognition.

Structural and Epistemological Tensions

Participants identified contextual and conceptual challenges that constrained full implementation of citizenship principles. Some professionals with a stronger biomedical orientation initially interpreted the 5Rs within the limits of clinical recovery, focusing mainly on treatment adherence. Group dialogue helped broaden this view, situating citizenship beyond the therapeutic frame and extending it into community and civic life. However, discussions showed that professionals may sometimes integrate citizenship terminology without challenging the pathologising discourse that underpins traditional models. Regarding the *Resources* dimension, several enactments highlighted structural inequalities that limit service users' autonomy in identifying and managing community resources. Professionals often assumed primary responsibility for tasks such as applying for disability benefits, which reflects paternalistic dynamics reinforced by systemic constraints. Participants also discussed territorial disparities

across Catalonia, noting that services are heavily concentrated in metropolitan areas, while rural areas face reduced access and public transport barriers. A further limitation concerned self-stigma among some service users, who were described as reluctant to engage in decision-making processes due to internalised notions of incapacity. Family members were also sometimes perceived as ambivalent allies, either reinforcing protective attitudes or expressing discomfort with greater service user autonomy.

Discussion

This study explored the first structured implementation of a citizenship based experiential awareness intervention for mental health professionals. The qualitative findings, derived from reflective group discussions and experiential workshop observations, reveal both the potential of the citizenship framework to reshape professional practice and the structural, relational, and conceptual challenges that limit its full enactment. The results from the two components offer complementary insights. The reflective group work illuminated how professionals conceptualised and critiqued current practices in relation to the five dimensions of citizenship. In contrast, the experiential workshop demonstrated how professionals could provisionally inhabit and experiment with new relational positions consistent with citizenship principles.

The reflective group work surfaced four interrelated areas of professional concern, each mapping onto core tensions within the citizenship framework. First, professionals consistently identified agency as a central yet often constrained goal of mental health practice. This aligns with literature positioning agency as fundamental to citizenship-oriented care (Ball & Eiroa-Orosa, 2024) and reflects the framework's emphasis on rights, responsibilities, and relational belonging (Rowe, 2015). Second, participants concurrently acknowledged forms of dependence that limited agency, particularly in acute or long-term residential settings. These were articulated through

coercion, infantilisation, and a perceived lack of self-care among service users, echoing prior research that citizenship enactment varies with clinical status and situational power dynamics (Ponce et al., 2016). Third, discussions highlighted professional involvement as a key facilitative process. Professionals described their role as supporters, rights informants, and advocates who build confidence and public awareness. This evidence echoes previous research suggesting that such proactive involvement reduces dependency and fosters social participation (Hamer & Finlayson, 2015), and is most effective when aligned with service users preferences, thereby supporting authentic citizenship experiences (Harper et al., 2017). Finally, these facilitative efforts were described as operating within significant system limitations, including structural constraints, resource shortages, and restrictive housing policies. These barriers are consistent with research highlighting how systemic factors undermine professional efforts and service users' community membership (MacIntyre et al., 2022), often reinforcing dependence despite policy intentions (Ponce et al., 2016).

The experiential workshop provided a distinct, process-oriented perspective, moving from conceptual reflection to embodied experimentation. Within the reflective and hypothetical space created by the as if philosophy, professionals temporarily adopted new relational postures (Watzlawick, 1977). They practiced using collaborative language, employed open nonverbal communication, and engaged in dialogical questioning. These observable shifts enacted what might be termed citizenship in practice. Unlike the reflective discussions, which often focused on identifying systemic barriers, the enactments revealed how professionals might relationally navigate these barriers (Kelly, 1955; Neimeyer et al., 2003). For instance, professionals experimented with co-constructing recovery plans alongside service users or facilitating peer-led assemblies. This provisional trying on of alternative professional positions aligns with

constructivist principles of meaning making and identity reconstruction through experiential action (Mahoney, 2003; Neimeyer, 2009). Our experiential workshop operationalised the five dimensions of citizenship and demonstrated how professionals can act as catalysts of connection with other community members, aligning with constructivist principles that emphasise experiential reconstruction of professional identities (Karjagdi Çolak et al., 2025).

Taken together, these complementary data sources suggest that while experiential and reflective methods can help professionals imagine and rehearse citizenship-oriented practice, lasting transformation requires addressing both individual meaning-making and structural constraints. The intervention exposed a core tension, which can be understood through the lens of implicit or implicative dilemmas (Feixas et al., 2009). Professionals in the workshops grappled with the challenge of integrating new citizenship ideals, such as fostering autonomy and mutual decision-making, with deeply ingrained aspects of their existing professional identity and institutional responsibilities. For example, a recurring dilemma involved the tension between promoting a service user's right to decide and the professional's perceived duty to mitigate clinical risk and ensure safety. Another common conflict arose between valuing open participation and navigating the rigid constraints of institutional rules and resource limitations. These were not merely practical obstacles but represented cognitive and ethical conflicts where pursuing a desired change in practice implicated a threat to another valued aspect of the professional role, such as their sense of expertise, control, or fiduciary responsibility. These identity-related cognitive conflicts resonate with literature on professional development, which highlights that negotiating such relational and ethical dilemmas is central to shaping a reflective and adaptable professional identity (Binyamin, 2018; Monrouxe & Rees, 2017). Recognising and explicitly addressing these dilemmas may therefore be a necessary step in supporting sustainable shifts towards citizenship-

oriented practice, as it allows professionals to critically examine assumptions and reconcile competing values without feeling their core professional identity is undermined.

The findings also illuminate broader structural and epistemological tensions that mediate the integration of the citizenship framework. The analysis revealed that some professionals initially approached the 5Rs from a biomedical epistemology, translating social processes like relationships or roles into clinical or behavioural targets. This reflects the documented difficulty of moving beyond explanatory systems that locate suffering primarily within individual pathology rather than relational or structural contexts (Mezzina, 2014; Slade et al., 2014). Furthermore, participants identified self-stigma among service users and ambivalence from family members as significant obstacles. Both phenomena can be interpreted as consequences of dominant deficit-based discourses, which position people with mental health challenges as dependent and perpetuate internalised barriers to full participation (Corrigan et al., 2012). Similarly, the resources dimension exposed how systemic and territorial inequalities fundamentally constrain citizenship, underscoring that its realisation cannot be sustained without structural justice and equitable access to community assets (Clayton et al., 2020; Harper et al., 2017; Tew et al., 2012).

At a systemic level, the results point to the need for policies that enable the material conditions of citizenship. This includes equitable resource distribution across territories, institutional openness to user leadership, and flexible professional frameworks that prioritise belonging and participation (Ponce & Rowe, 2018). This requires extending citizenship work beyond professional training to include service users, relatives, and policy makers in sustained processes of co-construction and public dialogue. Future implementations could integrate iterative follow-ups and peer reflection groups to consolidate learning and monitor institutional transformation over time, building on evidence that sustained educational interventions enhance

recovery-oriented practice (Eiroa-Orosa & García-Mieres, 2019; Sreeram et al., 2021). Further research should also examine the sustainability of these transformations and their impact on service users' lived experiences of citizenship, potentially through longitudinal designs that track changes in 5Rs enactment and service user outcomes.

Several limitations must be considered when interpreting these findings. First, participating centres self-selected into the intervention, which may limit the generalisability of results to settings with less initial interest in innovation. Second, the qualitative thematic analysis was based on recordings from only the first two editions of the reflective group work activities. Additionally, the absence of audiovisual recordings for experiential workshops reduces the depth of analysis and auditability for those components. While detailed notes were taken, they cannot capture the full nuance of interactions, tone, and non-verbal communication present in verbatim transcripts. Third, due to data protection requirements, we could not collect identifiable professional details alongside specific contributions during group discussions. This prevented analysis of potential disciplinary patterns in how themes were articulated. Fourth, as a preliminary implementation study, the analysis did not aim for thematic saturation or employ formal qualitative rigor criteria such as member checking. Finally, the facilitators were also the primary analysts for the experiential notes, introducing the potential for interpretive bias, although this was mitigated through collaborative review. These limitations underscore that the findings should be viewed as exploratory insights from an initial implementation of the intervention.

Conclusions

This study suggests that constructivist experiential learning may offer a useful pathway for translating the citizenship framework into mental health practice. It supports professionals as they reconstruct meanings, explore new relational positions, and envision care grounded in rights,

participation, and mutuality. The experiential activity created a reflective space in which professionals tentatively experimented with collaborative language and responsive postures, engaging with service users as potential partners. These provisional shifts hint that citizenship-oriented practice could begin with a rethinking of the assumptions guiding mental health work. At the same time, the findings caution that such personal and relational explorations are inevitably constrained by structural inequalities, resource limitations, and institutional cultures that often prioritise biomedical interpretations. Consequently, realising citizenship likely requires not only shifts in professional understanding but also broader organisational and policy reforms to ensure equitable access to the rights, responsibilities, roles, resources, and relationships that define full membership in society. In this light, citizenship may be understood not as a definitive endpoint of recovery, but as an ongoing, co-constructed framework for reimagining mental health systems in ways that foster collective belonging.

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