

## **Citizenship as mental health. A study protocol for a randomised trial of awareness interventions for mental health professionals.**

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### **Abstract**

**Purpose** – The purpose of this study is to demonstrate how mental health is tied to citizenship, and to help professionals understand mental health in the context of social rights and responsibilities, to move towards a right-based practice.

**Design/methodology/approach** – The purpose of this study is to demonstrate how mental health is tied to citizenship, and to help professionals understand mental health in the context of social rights and responsibilities, to move towards right-based practice.

**Findings** – The author will use thematic analysis for qualitative data and multilevel mixed-effects linear models to evaluate the effect of the awareness interventions.

**Social implications** – The results of the project will enable conversations between mental health professionals, relatives and service users that might help them understand mental health as part of citizenship.

**Originality/value** – To the best of the author’s knowledge, this will be the first controlled study of standardised citizenship-based awareness interventions for mental health professionals.

**Keywords** *Awareness, Citizenship, Mental Health, Participatory Research, Randomised Controlled Trial.*

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## **Introduction**

Since the 1960s, mental health care systems have undergone a series of changes that have involved the transition from a disease-based to a patient-centred model. Starting with deinstitutionalisation, replacing long-stay psychiatric hospitals with community mental health services, new paradigms have been created which seek to replace paternalistic approaches with cooperation and shared decision-making. These changes were proposed on the basis that psychosocial distress not only cause symptoms but also significant social limitations (Anthony, 1993), including stigma (Goffman and Guinsberg, 1963). These new paradigms were supported by scientific evidence which promoted the view that total symptom remission is possible even from the conditions considered to be the most severe such as psychosis or bipolar disorder (Harding *et al.*, 1987a, 1987b), but it is also possible to live meaningful lives despite the possible residual effects of a mental health condition (Davidson, 2016).

### ***The Citizenship framework***

After the path of alliance between people with physical and psychosocial disabilities initiated by the Americans with Disabilities Act (National Council on Disability, 1990), the United Nations enacted the Convention on the Rights of Persons with Disabilities, which places the person at the centre as a subject of rights and recognises their autonomy (United Nations General Assembly, 2006). In parallel to this wider framework, the Citizenship framework emerged in the field of mental health and social inclusion and has been recently begun to be applied worldwide (Eiroa-Orosa and Rowe, 2017).

Citizenship has been a complex social concept for centuries in terms of the degree to which a person is part of society and can influence it (Rowe, 2014; Rowe *et al.*, 2001). Within this idea, it has also become the leitmotif of a professional and academic movement that, similar to the Recovery model, seeks to improve the living conditions of people experiencing psychosocial distress by fully exercising their rights (Rowe *et al.*, 2009). The strengths and limitations of outreach work, including the finding that helping people get material resources does not, in itself, lead to their full community membership, led a group of scholars and practitioners based at the Yale Programme for Recovery and Community Health to develop the theoretical framework of Citizenship (Rowe and Pelletier, 2012).

We can define citizenship as a measure of the strength of the connection of people with five dimensions (five Rs in English): rights; responsibilities; the roles and resources that society offers them; and relationships, which involve close bonds, supportive social networks, and community living (rights, responsibilities, roles, resources and relationships; Rowe, 1999; Rowe *et al.*, 2001, 2009; Rowe and Pelletier, 2012). Thus, to achieve the goal of full membership in society, people

must be guaranteed access to effective rights and the corresponding responsibilities as members of society. At the same time people need to have the knowledge and practical skills to access resources and need to be able to develop roles and relationships in the community (Rowe and Pelletier, 2012). According to this model, within clinical mental health services contexts, therapeutic success should not be based simply on symptomatic alleviation, but on being able to encourage people to exercise their rights, assume their responsibilities and develop new roles in society, while being able to relate to significant others and manage resources (Eiroa-Orosa, 2018). Thus, understanding mental health as citizenship should not imply ignoring symptoms. It should however imply that the following can contribute to improved mental health (Eiroa-Orosa, 2019):

- Be more aware of their rights and learn strategies to exercise them assertively and respectfully.
- Take responsibilities effectively according to their capabilities, assessing risks without imposing boundaries.
- 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.
- Establish relationships of mutual support and complicity with other people without distinction of age, ethnicity, gender, social class or any other feature.

Of course, psychosocial distress can seriously affect all these 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 and difficulties.

Although models such as Recovery and the Citizenship framework share values and goals, Citizenship explicitly emphasise socio-contextual dimensions, such as the importance of social justice and advocacy (Ponce and Rowe, 2018; Rowe and Davidson, 2016). Thus, the citizenship framework highlights barriers to citizenship and the challenges of social inclusion for marginalised groups within society (Cogan *et al.*, 2021). From the point of view of psychosocial intervention objectives, in the same way that the Recovery model proposed to change the approach of reducing symptoms to the autonomous construction of a community life project even with possible limitations (Anthony, 1993), the Citizenship framework adds the five dimensions mentioned above. As can be inferred, these dimensions are collectively affected during social turmoil periods such as the pandemic, but more incisively among people experiencing psychosocial distress and/or different forms of social exclusion.

The use of Citizenship as a framework rooted in collaborative work with and among people affected by psychosocial distress is related to other similar conceptualisations. A meeting point between all these conceptualisations is that Citizenship should be thought as negotiated and enacted rather than given (Stevenson *et al.*, 2015). For example, Barnes, Auburn, and Lea (2004) link Citizenship with the dynamics of membership and its legitimacy. They show how the entitlements associated with the category citizen are embedded in the dynamics of inclusion and exclusion of rights. Continuing with the idea of Citizenship as the legitimation of rights entitlement and adding a transformative dimension, Renedo and Marston (2014) developed the concept of participatory Citizenship in the context of patient and public involvement in the healthcare system. They propose a dynamic view of Citizenship involving the participation of different actors in negotiating and acting on their rights and responsibilities as health service users and drivers of change.

### ***The Citizenship movement***

During the last few years, an international platform, the International Recovery and Citizenship Collective (IRCC), coordinated by the Yale University Program for Recovery and Community Health, has attempted to spread the Citizenship framework. Its main activity has been unifying efforts to achieve the full citizenship of all people regardless of their sexual, ethnic or social condition and the promotion of mental health at all levels, but with special attention to people at risk of social exclusion and victims of stigma for having been diagnosed of a mental disorder. This network is made up of more than one hundred researchers, service users, family members and mental health professionals from more than 10 territories [the main ones being Australia, Brazil, Catalonia (Spain), Scotland (United Kingdom), Connecticut (United States), France, Hong Kong, New Zealand, Norway, and Quebec]. Its members combine activism and social transformation with projects participated by people affected by psychosocial distress combined with an intense academic activity. The objective of the network is to transform the practice of the professions in the field of mental health and social inclusion, as well as the vision at the population level. The proposal consists of moving from a paradigm in which a set of symptoms is treated, to one in which citizenship is promoted as a global concept. Under this point of view, an intervention that is effective in terms of symptomatic relief but reduces the connection of a person with the five Rs should not be considered effective overall. This should apply to psychosocial, psychotherapeutic, and psychopharmacological interventions. The IRCC focuses on two-way learning and policy exchange, service delivery, workforce and other innovations in mental health and addictions designed to promote recovery, citizenship and the development and transformation of the healthcare system. Among the various activities organized by this group, the annual organisation of an international symposium should be highlighted.

The first Citizenship intervention was the Citizens Project (Rowe *et al.*, 2007, 2009), implemented at the Yale Program for Recovery and Community Health. The concept of Citizenship (Rowe *et al.*, 2001) was used as a framework (Pelletier *et al.*, 2009) for opening up opportunities for social participation to members of stigmatized groups. In this programme, rather than viewing individuals experiencing psychosocial distress as problems to be addressed through the intervention of others, participants were considered “students” and “citizens” (Rowe, 2015). Hence, they were viewed as experts on many of their own problems and difficulties, on identifying solutions to them, and who were capable of learning not only how to remain stable in terms of symptoms and disruptions, but to see themselves as and take actions to become valued members of their communities. Citizens Project participants were persons affected by psychosocial distress including, for many, the dual problem of substance misuse and previous criminal charges. A randomized clinical trial comparing the Citizenship intervention to usual care for the target group showed that it successfully reduced alcohol and other substance use, and increased quality of life for participants (Clayton *et al.*, 2013). Following this study, participatory action research methods including peers as researchers were employed to develop an individual measure of Citizenship (Rowe *et al.*, 2012). The 46-item measure was 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 already been psychometrically validated (O’Connell *et al.*, 2017), and used to evaluate community engagement programmes (Georghiades and Eiroa-Orosa, 2019; Ponce and Rowe, 2018). Recently, the participatory process has been replicated in other socio-cultural contexts such as Scotland (Cogan *et al.*, 2022; MacIntyre *et al.*, 2021) and Norway (Nesse *et al.*, 2021).

In the same way that training programmes played a very important role in the dissemination of the Recovery framework (Eiroa-Orosa and García-Mieres, 2019; Jackson-Blott *et al.*, 2019), the citizenship movement is fostering public discussions and implementing awareness interventions for health professionals as outreach strategies (Eiroa-Orosa, 2019; Eiroa-Orosa and Rowe, 2017). Similarly, a brief version of the citizenship measure has been used to stimulate dialogues with stakeholders on the relevance of the framework in public mental health care (Ponce *et al.*, 2016). For all these reasons, with this project we intend not only to help implement the citizenship framework in a new socio-cultural context such as Spain, but also to design training and awareness interventions for mental health professionals within the citizenship framework.

## **Objectives**

### ***General objective***

The main objective of this project is to help professionals understand mental health in the context of social rights and responsibilities, to move towards a rights-based mental health practice by means of integrating the citizenship framework in routine mental health care.

### ***Specific objectives***

- a) Explore the concept of citizenship together with service users', relatives' and professionals' organisations.
- b) Develop a manual with an awareness methodology that can be scaled to other territories and specific health professionals target groups.
- c) Implement awareness interventions with mental health professionals.
  - 1) Implement a prospective double-blind cluster-wait-list-randomized-controlled trial experimental design to evaluate the impact of these awareness interventions.
  - 2) Measure the degree of change in beliefs and attitudes through the statistical significance and effect size of the score differences between intervention and control groups.
  - 3) Explore together with participants the specific intervention components that are more or less useful.

## **Hypotheses**

The main hypotheses of the project are that:

*H1.* The concept of citizenship is an adequate tool to transform professionals' vision of mental health towards a rights-based mental health system.

*H2.* An awareness intervention that uses the concept of Citizenship as the main component is capable of changing professionals' beliefs, attitudes, and behaviours towards a rights-based mental health system.

## **Procedure**

### ***Focus groups and in depth-interviews***

Focus groups will be carried out with the objective of exploring the possibilities of implementing the citizenship framework in the Spanish mental healthcare system. We will carry out 20 focus groups, five in each target population subgroup (adult mental health service users, youth mental health service users, relatives of service users and professionals) based on the methodological recommendations by Guest and colleagues (2017). Each group will be made up of between six and ten people. Additionally, we will offer the possibility of carrying out individual interviews in the case of people who feel more comfortable with this format or do not have availability to join

the focus groups. These activities will be recorded with the prior informed consent of the participants. Once these recordings have been transcribed, a qualitative analysis of the topics covered in the debates will be carried out. Specifically, a thematic analysis (Braun and Clarke, 2006) of the strengths and weaknesses of the possible implementation of the Citizenship framework in the mental healthcare system will be carried out, highlighting the needs and challenges detected. In the case of the focus groups carried out with professionals, special questions will be asked to explore the possibilities of the citizenship framework to transform professional beliefs, attitudes, and behaviours. Additionally, within mental health service users' and relatives' focus groups, citizenship statements, i.e., any sentence that refer to the conceptualisation of citizenship will be extracted from the transcripts.

### *Awareness intervention*

The intervention will aim to raise awareness toward the need to consider the full citizenship of all mental health service users. The methodology will be based on the TLC3 principles (targeted, local, credible, continuous contact ) as described by Corrigan (2011) and thus will be carried out by activists with experience of a mental health diagnosis. The content of the awareness interventions will include both theoretical and practical content, aimed at improving professional care, to promote the participation of mental health service users in decisions related to their treatment and the exercise of their rights. This will be done always combining the viewpoint of service users with the therapeutic framework from which professionals act. The concrete content of the interventions and the implementation manual will be developed in the context of the execution of the present project. We offer, in a preliminary way, its basic structure. Tentatively, the intervention will consist of three parts: a 4-hour training session, a 4-hour participative workshop, and a self-directed activity carried out by the participants but supported by the organisers.

### *Co-creation process*

As commented above, the results of the analysis of the focus groups carried out with professionals will be used to generate content for the awareness intervention. Once the manual of the intervention will be ready, a committee will be created in which representatives of mental health service users, relatives, and professional organisations will be present. At least two meetings and a content prioritisation activity will be carried out through a spreadsheet distributed by email.

### *Preliminary contents of the awareness intervention*

During the training session, the socio-political background of the citizenship framework will be explained. The origin of the framework will be explored, through the stories of people who, although are helped through community intervention or mental health programmes, achieving

goals such as housing or symptomatic remission, are not able to accomplish full community membership. In the participatory workshop, among other activities, the grid elaborated by our research group (Eiroa-Orosa, 2019) will be used to carry out a reflective activity on mental health intervention programmes through the citizenship framework. Participants will be given a  $2 \times 5$  grid whose rows refer to the five Rs of rights, responsibilities, roles, resources, and relationships. The two columns will refer to the elements that the participants thought their programs already included in reference to each R and those that still needed improvement to be able to address them.

#### *Intervention evaluation*

The intervention will be evaluated through a prospective double-blind wait-list-randomized-controlled trial experimental design. There will be two intervention arms: active and waiting list. The design is double blind since neither the participants nor the evaluators will know which centres have been evaluated as case or control. Only the organisers of the intervention will have this information. The names of the centres taking part in the study will be kept confidential to keep evaluation blindness.

Upon enrolment, each centre will be included in a randomisation table with a fixed number of wait-list control, and intervention sites. In this way, each centre has the same possibilities of belonging to the experimental or to the control conditions. Once the centre is randomised, professionals will receive a registration questionnaire, which will include the baseline assessment. It will be composed by sociodemographic (including gender, age, and educational level) and professional (profession category) information + beliefs and attitudes scales (see instruments below). The centres included in the experimental group will access the course immediately, while the centres included in the control group will wait, giving time to carry out the follow-up assessments within the intervention group before beginning the course. This will allow us to know the impact that the intervention has had on the experimental compared to the control group, who will not have received the intervention but, for ethical reasons and to maximize the impact of our interventions, will do so afterwards. Figure 1 shows a flow diagram of the design.

#### *Participants*

Considering effect sizes of similar interventions evaluated using the same evaluation design (Eiroa-Orosa *et al.*, 2021; Rubio-Valera *et al.*, 2018), the number of participants has been estimated according to the following calculation of statistical power. Accepting an alpha risk of .05 and a beta risk of .2 in a two-sided test, 100 subjects are necessary in each group (control and experimental) to recognize as statistically significant difference greater than or equal to 0.4 standard deviations, being the correlation coefficient between the initial and final measurement



0.5. Thus, the awareness intervention will be implemented in mental health centres comprising 200 professionals. If possible, we consider carrying out more awareness activities that allow us to collect enough sample to carry out sub-group analyses (e.g. the effect of the intervention by gender). The recipients will be all professionals working in mental health settings: administrative officers, nurses, occupational therapists, psychiatrists, psychologists, social workers, etc.

*Instruments*

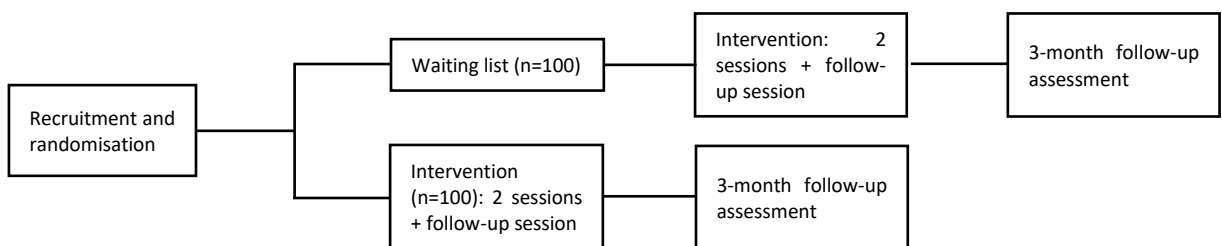
These instruments will be administered to participating professionals together with socio-demographic data before the first intervention session is held, and before the follow-up session and three months after it.

The *Reported and Intended Behaviour Scale* (RIBS; Evans-Lacko et al., 2011) is a widely used measure of behavioural discrimination at the population level. The scale has two parts, one that refers to past experiences and another that refers to willingness to share spaces with diagnosed people. The reliability of the instrument is  $\alpha = .85$ .

The professionals' *Beliefs and Attitudes towards Mental Health Service users' rights* scale (BAMHS; Eiroa-Orosa & Limiñana-Bravo, 2019) has been developed by our group for this project. In preliminary analyses carried out within cross-sectional studies, we have found four subscales: justification beliefs ( $\alpha = .70$ ), coercion ( $\alpha = .65$ ), paternalism ( $\alpha = .71$ ) and discrimination ( $\alpha = .65$ ) with good global reliability ( $\alpha = .87$ ).

Figure 1.

Flow diagram of the evaluation design



*Statistical analyses*

Baseline comparability between groups (including sociodemographic and professional data and scale scores) will be assessed using  $\chi^2$  tests or Fisher's exact tests for categorical data and Student's t test for continuous data. All the participants will be included in the analysis in the group to which they were randomised irrespective of whether they have missing data. To deal

with missing information due to dropouts, we will use multiple imputations with chained equations. To evaluate the differences between groups before the follow-up session (1 month after baseline) and the 3-months follow-up assessment, we will use multilevel mixed-effects linear models using sociodemographic and professional variables and baseline outcome scores as covariates in the models.

#### *Exploration of the usefulness of intervention components*

In the same way as in the case of training, the exploration of the successful elements will be done through qualitative data collection techniques. Open fields will be offered in the follow-up questionnaires to allow participating professionals to give their opinion. In addition, interviews will be conducted with key actors (4 activists, 6 people in charge of the coordination of training, 6 managers of the centres, and 6+6 professionals with small and large effect of the intervention). Given the need to group contents that can be useful in an improvement for the future large-scale implementation of these interventions, the analysis methodology will be thematic (Braun and Clarke, 2006).

#### **Conclusion**

This will be the first controlled study of standardised citizenship-based awareness interventions for mental health professionals. This is a promising framework for the reflection within and transformation of mental health services. Reflecting on these concepts within the post pandemic context are fundamental steps to implement this framework internationally.

The results of the project will serve to justify citizenship as mental health projects at the local and international levels. This is a very important aspect in a context of scarce resources. As it can be seen, this project has a great power of social impact. The current shortcomings of mental health care causes delays and resistance to the use of services contributing to increase distress as many people delay seeking help due to fear of stigma and discrimination. For this reason, we believe that it is essential to carry out the project in close collaboration with stakeholders to ensure its social impact.

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