

# Citizens defining citizenship: A model grounded in lived experience and its implications for research, policy and practice

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## Funding information

This research was funded by the Scottish  
Recovery Network, Turning Point Scotland  
and the Health and Social Care Alliance.

## Abstract

Citizenship is gaining currency in health and social care internationally as a way of making sense of the lived experiences of people with major life disruptions who face exclusion, marginalisation and discrimination, but the concept is often contested, poorly defined and understood. This paper charts the development of an empirical model of citizenship within Scotland, UK. A mixed-method, community-based participatory research approach using 10 focus groups ( $n = 77$ ), concept-mapping exercises ( $n = 45$ ) and statement clarity and relevant ratings ( $n = 242$ ) was used to develop a model of citizenship that is grounded in the lived experience of participants, which is absent from current conceptualisations of citizenship. Multidimensional scaling and hierarchical cluster analysis revealed five core domains emerging from our work: 'building relationships', 'autonomy and acceptance', 'access to services and supports', 'shared values and social roles' and 'civic rights and responsibilities' representing the personal meanings of citizenship for participants. We argue that the value of this model is that it draws upon the personal understandings and experiences of participants who emphasised the 'banal ordinariness' of its core elements. We suggest that the model makes an original contribution by clearly illustrating the practical applicability of citizenship as a concept; thus, enhancing existing theories of citizenship. Our model highlights the interplay between the relational and structural aspects of citizenship and acknowledges the barriers that marginalised groups face in claiming their citizenship rights. It offers a call to action for policy makers and practitioners to set goals that contribute to the social inclusion of those who have experienced major life disruptions.

## KEYWORDS

citizenship, community-based participatory research, concept mapping, mental health problems, physical health conditions, recovery, social inclusion

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## 1 | INTRODUCTION

Citizenship is a complex and multidimensional concept and can be a lens through which to explore how individuals with different life experiences perceive inclusion or involvement across a variety of health and social care contexts (Rowe, 2015). In this study, we argue that a citizenship-based approach offers a broader framework through which to understand the lived experience of individuals from that of traditional illness-based models (MacIntyre et al., 2019). In the United States, Ponce and Rowe (2018) have argued that citizenship-based practice can offer the opportunity to move beyond a narrow focus on the relationship between individuals and the services they receive to consider the role of the community organisations, civic associations and other structural factors that affect people's physical and mental health, thus promoting their inclusion within society.

This study is based in Scotland, where there is an arguably progressive policy environment particularly receptive to ideas of citizenship and inclusion for individuals and communities experiencing marginalisation (see Mooney et al., 2016). The aim of our work was to understand how people who are self-defined as having mental health problems, experience of the criminal justice system or a long-term physical health condition, as well as those who had not experienced any of these disruptions that define citizenship, adding much-needed empirical evidence to theoretical discussions around citizenship. In this study, we consider how these understandings of citizenship might help inform health and social care policy and practice. We present the theoretical framework that has influenced our work (Rowe et al., 2001; Clayton et al., 2013; Rowe, 2015) before going on to present our methodological approach to developing a citizenship model in Scotland and sharing our key findings. We argue that our work is innovative in adopting a mixed-method, community-based participatory approach to advance our model of citizenship and its utility for people facing life disruptions. This study makes an original contribution to the literature on citizenship by emphasising the practical application of citizenship as a concept acknowledging the importance of ordinary aspects of life that are deemed necessary for achieving citizenship from the perspectives of those who have experienced marginalisation. The study's application to a Scottish context provides important lessons for applying citizenship ideas to inform practice.

## 2 | THEORETICAL FRAMEWORK

Citizenship is a contested concept (Gaille, 1956). Marshall (1950) argued that citizenship is a status that confers individuals with a specific set of universal rights, which are granted to them by the state. Marshall introduced the notion of social rights that provide individuals with resources they need to claim their civil and political rights, potentially leading to greater equality with individuals developing a shared sense of identity that can cut across class divisions (Lawy & Biesta, 2006). Rawls (1971) added the concept of *redistribution*, by which the choices a person can make are not constrained by their

### What is known about this topic?

- Citizenship is a much researched and theorized concept but only recently has been applied to mental health, with a lack of consensus regarding its meaning in this domain.
- People with 'life disruptions' often have difficulty gaining access to their citizenship rights.
- They are often excluded from key dimensions of citizenship.

### What does this paper add?

- Citizenship is conceptualised here as a multi-faceted concept covering a range of domains with a significant focus on relationships, which can be used to understand the experiences of those facing major life disruptions.
- Banal, ordinary (taken for granted) aspects of social life are critical for achieving full citizenship, yet have been overlooked in the literature.
- Citizenship offers a lens through which health and social care practitioners and policy makers can shift their gaze from a largely clinical focus to consider personal, relational and structural aspects of citizenship that contribute to recovery.

socioeconomic position. A fair society, he argued, consists of citizens who hold equal basic rights.

Citizenship with an emphasis on equality, universality and redistribution offers a framework for promoting social inclusion to traditionally excluded persons such as those who have experienced life disruptions. Marshall's concept of citizenship, however, has been criticised for its individualised nature and its emphasis on individual agency at the expense of social, structural and market forces. Indeed, Marshall highlights the 'three pillars of citizenship'—individual contributions via employment, military or public service and parenting (Isin & Turner, 2002)—from which 'life disrupted' groups are often excluded. This exclusion creates tension between formal and substantive effects of citizenship (Prior et al., 1995), where citizens may in theory possess civil, political and social rights but not possess the means to fully access them (Higgins, 1999). Marshall's focus on individual agency has also been criticised as 'papering' over a power struggle between excluded or second-class and 'full' citizens, with the likelihood that the state will favour the interests of the latter, often on the basis of economic reasoning (Hoxsey, 2011).

Conceptualisations of citizenship stemming from a republican or communitarian perspective on the other hand have focused less on individual rights and the relationship between the individual and the state and more on social participation. These conceptions have roots in Tocqueville's theory of associational democracy (Tocqueville, 1994; Isin and Turner, 2007), with an emphasis on voluntary associations and community groups rather than the state. This view

privileges the social contexts and the importance of social networks, where an individual's sense of identity is produced through their social relationships (Sandal, 1998). Yuval-Davis and Werbner (1999) argue that citizenship is no longer understood simply in terms of the formal relationship between the individual and the state but as a total relationship between individual citizens and their responsibilities towards the wider community (see also de Koning et al., 2015).

Rowe et al. (2001) have defined citizenship as a measure of the strength of an individuals' connection to the '5r's' of rights, responsibilities, roles, resources and relationships that link them to society. They acknowledge that people with lived experience of life disruptions face obstacles to making these connections and gaining access to opportunities available to the population in general (Ponce & Rowe, 2018).

Feminist critiques of citizenship acknowledge such power differentials. Lister (1997, 2007) develops the notion of inclusive citizenship and argues that a citizenship framework must highlight rights and obligations while also acknowledging that citizenship is an *active practice* (Lister, 1997). Isin and Turner (2002) have developed a 'social model of citizenship' that emphasises the limitations of frameworks that focus solely on rights or on identity and difference. This view acknowledges and challenges the potentially exclusionary nature of citizenship (see also Mouffe, 1992) and suggest that we must shift our gaze to consider all the spaces in which active citizenship can take place.

We need to understand what citizenship means to people whose claim to citizenship may be difficult to realise, developing both theoretical knowledge and practice on citizenship, given the dominant rhetoric on citizenship is not always reflected in daily lived experience (Kurtz & Hankins, 2005). Indeed, it is argued that what 'ordinary' people think about citizenship is the biggest gap in the literature (Joppke, 2007). This need for empirical work on the lived experience of citizenship (Lister, 2007a), which explores people's everyday interactions and experiences (Hopkins & Blackwood, 2011), is the gap our research seeks to address. Rowe et al. (2012) and Rowe (2015) have provided a basis for this thinking with their work on citizenship and this paper adds to this body of knowledge by undertaking primary research on citizenship within a Scottish context.

### 3 | METHODS

We adopted a community-based participatory research (CBPR) approach which has roots in participatory action research, in which partners contribute expertise and share decision-making throughout the research process (Minkler & Wallerstein, 2003). We employed a mixed-methods approach consisting of a number of phases (see table 1). We received ethical approval for the study from the University Ethics Committee and all participants were required to provide informed consent prior to their participation. NHS ethical approval was not sought for this study as participants were recruited via local community and third-sector organisations and not in their capacity as patients.

#### 3.1 | Preparatory work

The first phase involved recruiting peer researchers (people with lived experience of major life disruptions) and establishing the research team (see MacIntyre et al., 2019, for more detail). Consistent with a growing number of CBPR studies (e.g. Damon et al., 2017; Mosavel et al., 2005), peers were recruited as co-researchers, promoting inclusion and active participation in decision-making throughout the research process (Quinn, 2014). Training in relevant research methods was provided by the research team.

#### 3.2 | Recruitment and sampling

We used a purposive sampling approach in order to recruit participants who had experienced a range of 'life disruptions' and those who had not. Eligibility criteria for the first phase of the research were that individuals had lived experience of one or more of the following life disruptions:

- A diagnosed mental health problem.
- A long-term physical health condition.
- Current or previous experience in the criminal justice system.
- No experience of any of these life disruptions.

We initially recruited participants through a number of community and third-sector settings with further newspaper advertisements to recruit those who self-identified with no experience of life disruption in the last 5 years. Participants for concept-mapping sessions were recruited from interested focus group participants.

#### 3.3 | Generating statement items

Statement items about citizenship were generated through 10 focus group discussions ( $N = 77$  participants) to address one key question— '*What does citizenship mean to you?*'. All focus groups were audio-recorded and transcribed verbatim. Each of the transcripts were read and re-read to identify statement items that related to the concept of citizenship resulting in 708 preliminary statement items. The research team then checked for potential duplication of items in order to reduce the list further. A total of 110 statement items were taken forward to the concept-mapping phase.

#### 3.4 | Sorting, rating and reducing statement items

Participants from each of the focus groups were invited to participate in concept-mapping sessions (Windsor, 2013); a total of 45 of the 77 participants (58%) took part. Each participant ( $N = 45$ ) was given cards detailing statement items about citizenship. Participants were asked to sort the statement items into at least two piles based on those items which they felt shared similarities.

**TABLE 1** Stages of the mixed-methods research process

Stages	Description	Participants/contributors	
1	Preparatory work	Establish research team with people with 'lived experience' of life disrupting events as co-researchers. Developing stakeholder group. Setting up training in research methodology and reflective practice sessions.	Stakeholder group consisting of peer researchers, health and social care professionals, non-government organisations and academics.
2	Recruitment and sampling of research participants	Purposive sampling used to recruit participants with lived experience of 'life disrupting' events through health and social care settings and newspaper advertisements. Participants who did not identify as having had a life-disrupting event were also recruited through newspaper advertisements.	Adults with MHPs, long-term physical health conditions, experience of criminal justice system, substance misuse and adults with no life disruptions (total, <i>n</i> = 77)
3	Generating statement items	Preliminary statement items about citizenship ( <i>n</i> = 708) were generated through 10 focus groups with research participants recruited in stage 2. Following cross checking by the research team, the statement items were reduced ( <i>n</i> = 110).	Participants from stage 2 engaged in the focus groups that were each facilitated by two peer researchers. Items generated through focus groups were extracted from transcripts by two researchers.
4	Sorting rating and reducing statement items	Concept-mapping sessions were held, in which participants were asked to sort statement items ( <i>n</i> = 110) into groups of similarities and then rate them in terms of importance and achievement. A cross-sectional, online survey was administered online using social media and posters advertised in community settings. The survey asked participants to rate statement items in terms of their relevance and clarity as a means of reducing the items further.	Participants with and without lived experience of life-disrupting events engaged in sorting and rating statement items (total, <i>n</i> = 45). Participants with and without life-disrupting events took part in the online survey (total, <i>n</i> = 242)
5	Visual representation through computation of concept maps	Data generated from stage 4 were analysed using multidimensional scaling to develop concept maps to visualise the similarities between statement items using a distance matrix. Hierarchical cluster analysis was adopted to explore cluster solutions and denogram was used to visually represent different cluster arrangements. Workshops involving peers researchers and the advisory group were conducted to decide on the optimal cluster solution for the model of citizenship	Research team generated concept maps. Peers research and members of advisory stakeholder group took part in workshops to decide on cluster model.

(Continues)

TABLE 1 (Continued)

Stages	Description	Participants/contributors	
6	Interpretation of conceptual maps of citizenship	Stakeholder workshops were held to explore the statement items associated with the cluster solution and to name each cluster accordingly. Calculation of coefficient alphas was used to explore the covariance among statement items to establish how closely related a set of statement items are in a cluster.	Peers research and members of advisory stakeholder group took part in workshops to name clusters. Research team conducted calculation of coefficient alphas.
7	Contextualisation of the data	In-depth qualitative analysis using thematic approach was used to contextualise and interpret the concept maps generated in stage 5 with data generated from stage 3. Preliminary themes were cross checked.	Two independent researchers generated the preliminary themes and these were cross checked by the co-researchers.

Participants were then asked to rate each statement item on a 5-point Likert scale regarding the degree of importance and level of achievement of each statement. As we sought to ensure that we captured statement items that were clear and relevant, we developed an online survey recruiting participants through social media, which included all 110 statement items and asked participants ( $n = 242$ ) to rate these in terms of their clarity and relevance. In line with previous work (e.g. Rosas and Kane, 2012), we removed items that >80% of participants found clear or relevant, resulting in 60 statement items.

### 3.5 | Visual representation and interpretation of concept maps

The data generated were entered into SPSS, enabling the data to be visually represented and for statement items to be grouped together using multidimensional scaling. This process created a visual map whereby those statement items most frequently sorted together were displayed as closer together than those sorted together less frequently.

In order to represent the conceptual domains of citizenship we used hierarchical cluster analysis (Everitt, 1980). Ward's algorithm was used as this gave an interpretable solution to how best to partition the multidimensional scaling map into clusters. All hierarchical cluster analysis procedures give as many possible cluster solutions as there are statements. A key task was to decide how many clusters the statements should be grouped into for the final model. The highly interpretative nature of this process meant that an optimal configuration of clusters was not automatically selected. We, therefore, held a series of stakeholder workshops involving peer researchers and the research advisory group to review the different cluster arrangements. Essentially, discretion had to be used in examining different cluster solutions to decide on which made sense both theoretically and practically in developing the conceptual model of citizenship.

### 3.6 | Contextualisation of the data

While concept mapping employs qualitative research techniques, in-depth information can be lost in the structured methods employed in individual concept-mapping sessions which focus only on words or statements on the meaning of citizenship. Consequently, re-contextualising and interpreting the conceptual maps of citizenship through conducting an in-depth thematic analysis (Braun & Clarke, 2006) of the transcripts from the focus group discussions was completed. This involved two team members reading and re-reading the transcripts and generating initial codes focusing on what the participants were saying in relation to their understandings and experiences of citizenship. We identified meaningful extracts and coded them into themes. These themes informed the final decision of naming each of the clusters in the final model of citizenship.

## 4 | FINDINGS

A five-cluster solution was agreed as being the optimal configuration for the conceptual model of citizenship using the approaches described above with clusters names as follows: *building relationships, autonomy and acceptance, access to services and supports, shared values and social roles and civic rights and responsibilities*. These clusters represent the personal meanings and lived experiences of citizenship for participants and are represented visually in Figure 1 below.

## 5 | BUILDING RELATIONSHIPS

The central component of citizenship for our participants concerned building meaningful and reciprocal relationships. This cluster contains items that focus on the development and maintenance of relationships at a micro-level. For example, 'belonging', 'having friends', 'caring

### 5 cluster model

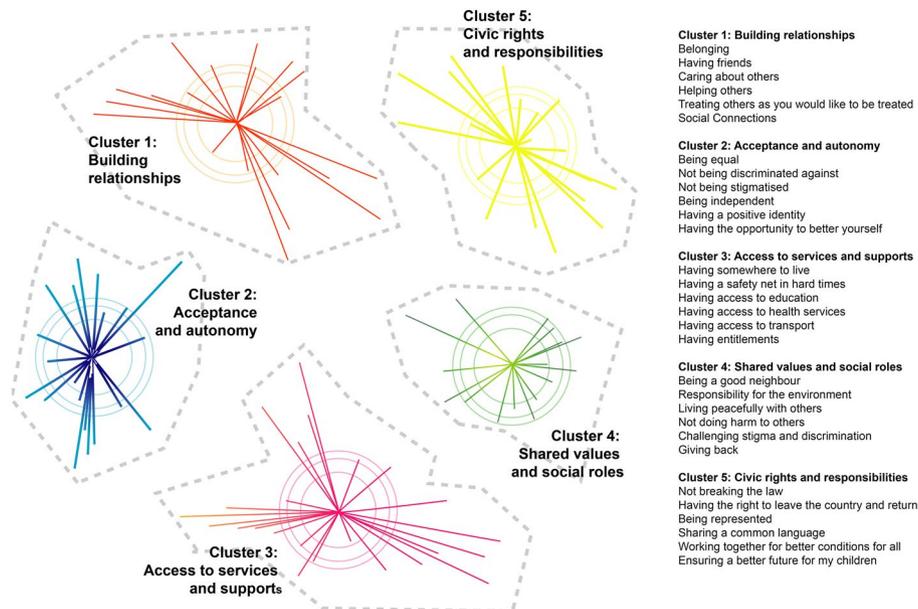


FIGURE 1 Five Cluster Model of Citizenship

about others', 'helping others' and 'treating others like you want to be treated'. These items appear to blur the boundaries between 'rights' and 'responsibilities' seen in traditional theories of citizenship, suggesting our participants did not necessarily conceptualise citizenship in this way. Opportunities to build new relationships, to maintain existing relationships and to repair damaged or broken relationships are particularly important. These statement items were rated as highly important in regard to citizenship by all participants whether or not they had experienced a life disruption. Analysis of focus group transcripts suggested those who had experienced a life disruption placed particularly strong emphasis on relationships (although there was not a statistically significant difference in how these items were rated across life-disrupted and non-life-disrupted groups). Our focus group data suggested that they were seeking to repair ruptures in relationships or replace damaging relationships with new, positive ones. Those with life disruptions also placed special emphasis on building relationships with like-minded people who shared similar experiences. Such relationships offered the opportunity to develop a sense of community and of belonging within a supportive environment:

*Its getting a group of similar minded people, where it might be just from experience and that and how they actually deal with situations. It is taking these and trying to build up people's confidence and giving them hope at the end of it. (James, FG4)*

## 6 | ACCEPTANCE AND AUTONOMY

Participants acknowledged that while they could try to build relationships by treating other people well, these relationships had to be

reciprocal to be meaningful. An important component of this related to gaining acceptance from others and developing autonomy. This cluster of items is best understood in two parts. The first sub-group of statement items includes 'being equal', 'not being discriminated against', 'not being stigmatised' and 'not being judged'. All participants rated these items as highly important to the concept of citizenship. Data from the focus groups suggested that life-disrupted participants had a strong sense of being judged, discriminated against or stigmatised, and felt they were often treated as 'second-class' citizens. This point was emphasised particularly strongly by those with experience of the criminal justice system. Perhaps as a result of this sense of judgement, participants with a life disruption rated items such as 'being accepted', 'feeling safe', 'having hope' and 'having privacy' as important yet difficult to achieve:

*You work on yourself and you don't say I'm an addiction, I'm just [Sarah] and then I...go for a job and they do a PVG and I've got a criminal record...I've built myself up, I'm Sarah, I'm a good citizen...you can't get the job, you've got a record,...so how does that person after all that work... just kicks somebody to the gutter... (Sarah, FG2)*

The second sub-group in this cluster related to autonomy and included items such as 'being independent', 'having a positive identity', 'believing in yourself' and 'having the opportunity to better yourself'. This sub-group initially appeared noticeably different from the other in this cluster; however, we hypothesise that experiencing less stigma and discrimination might make it more likely for individuals to achieve or experience these items. This may help to explain why participants tended to group these two sub-clusters together. Many of our participants experienced a number of barriers in achieving these items.

## 7 | ACCESS TO SERVICES AND SUPPORTS

The third cluster related to the supports and services people need to claim their citizenship rights. It included statement items such as 'having somewhere to live', 'having a safety net in hard times', 'having access to education', 'having access to health services', 'having access to transport' and 'having entitlements'. Our analysis suggested that this was a particularly strong cluster as it remained independent of all other clusters in the different configurations that we tested. Again, all of the participants rated the items included here as highly important to the concept of citizenship regardless of whether or not they had experienced a life disruption. Interestingly, participants also rated these items as highly achievable. This may point to the cultural specificity of the model, as healthcare, for example, is generally free at the point of use in the United Kingdom. Within this cluster, participants acknowledged the differential ability of individuals and groups to gain access to their citizenship rights, with some noting particular barriers such as a lack of information:

But its not easy to know that, or to access it, how are people supposed to know...how easy is it for a normal citizen to find that out... (Joe FG3)

Our focus group data illustrated the value participants placed on support services in gaining access to their citizenship rights. Participants acknowledged that people's access to services was influenced by complex individual, structural and attitudinal factors. Our participants envisaged a society of equal entitlement but they offered caveats to this ideal. For example, those in the prisons group felt that certain entitlements did not apply if someone had committed a particularly serious or dangerous offence. Likewise, a small number of participants in the non-life-disrupted groups appeared to introduce a distinction between deserving and undeserving citizens. Some participants said there was something particularly British about feeling entitled to certain services and opportunities, again highlighting the cultural specificity of the model. This was brought into sharp relief by the small number of participants who had grown up elsewhere and had moved to the United Kingdom as adults where the concept of entitlement was less readily applicable.

A final point related to the impact that budget cuts were having on service provision. This was particularly prominent as the research was carried out at a time of significant public sector austerity measures across the United Kingdom, which participants believed was having a direct impact on their ability to access services.

## 8 | SHARED VALUES AND SOCIAL ROLES

The fourth cluster in our model related to making a contribution via relationships, communities or other networks. It included statement items such as 'looking out for each other', 'being a good neighbour', 'responsibility for the environment', 'volunteering', 'living peacefully with others', 'not doing harm to others', 'challenging stigma and

discrimination', 'recognising that individuals who cannot contribute still have rights' and 'being connected'. In addition, this cluster contained statement items on 'sharing values' and 'sharing values across generations'. Clearly, there was a strong relational component here, although we suggest that this is less concerned with immediate (micro-level) relationships, as in cluster 1, but extends the focus to macro-level relationships that contribute to the greater good. All participants rated these items as important to the concept of citizenship regardless of whether they had experienced a life disruption or not. They also rated these items as achievable, although further analysis of our focus group data suggested that those with a life disruption often felt that they had to be at a particular stage in their own 'recovery journey' before they could begin to make such a contribution:

*When I took ill eight years ago... and now ... I am feeling like I can go back into the community and talk to other people, helping people, going to groups and make other people feel I am supporting them but also...I am helping myself at the same time... (Laura, FG5)*

This cluster shifts the focus somewhat to the obligations that people are perceived to have in order to be a full citizen. Participants across all groups cited everyday acts such as bringing in a neighbour's bin, not dropping litter or contributing to local community or charity organisations by donating to a food bank or volunteering at a local church. Those with life disruptions of all types placed particular emphasis on giving back. What seems clear from our participants' accounts is that giving back often involved recognising the support that one has received as part of one's recovery journey and taking the opportunity to pass this on to others. While this involved a level of altruism, our participants' testimonies suggested that they also benefit from this by having the opportunity to take on valued roles and by becoming more socially connected to others.

## 9 | CIVIC RIGHTS AND RESPONSIBILITIES

The final cluster in our model concerned civic rights and responsibilities and was more closely aligned with the rights and duties commonly associated with legal and political citizenship outlined earlier in the study. This cluster included statement items such as 'not breaking the law', 'paying your taxes', 'having the right to leave the country and return', 'being represented', 'sharing a common language', 'working together for better conditions for all' and 'ensuring a better future for my children'. These items were rated as highly important by all participants. Focus group data did suggest that some non-life-disrupted participants placed more emphasis on these items when defining and discussing citizenship, although they were rated highly by all:

*...the first thing that came to mind was the phrase citizen of the UK on your passport and the legal rights that go with having a passport...so it was a sort of legal, technical*

sense of what the word [citizenship] meant (Lorraine, control group 2).

As before, participants' grouped items primarily concerned with rights (such as the right to leave the country and return) with items primarily concerned with responsibilities (such as not breaking the law). This suggests that the relationship between rights and responsibilities is complex but it does not necessarily follow that not fulfilling one's duties should result in the denial of citizenship rights and the majority of participants did not conceptualise citizenship in this way.

## 10 | DISCUSSION

As set out earlier, Scotland has its own unique political landscape where public spending per head of population is greater than in England and Wales (<https://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN04033>). There has also been a shift towards the integration of health and social care systems to promote better joint working and more holistic care and support. Yet, similar to many other Western countries, health and social care systems in Scotland often take an overly individualised and medicalised approach that does not necessarily take account of the broader social, economic and cultural factors that impact on lived experience. Therefore, we argue that our findings have broader applicability internationally within research, policy and practice.

Our model highlights the multi-faceted nature of citizenship by bringing together a series of inter-related clusters that highlight the key components of citizenship from the perspective of our participants. A key feature of our model is its 'banal ordinariness'. The items that participants identified as being important to citizenship are things that we often take for granted. They are not in and of themselves complicated, although achieving them often involves a complex interaction between an individual and a range of structural factors. They are everyday interactions, relationships, characteristics, attitudes and resources, many of which are affected by the attitudes of others (Ponce et al. (2012), see also Neveu, 2015). This makes an important contribution to our understanding of the concept of citizenship and how it might be applied to make sense of the lived experience of people who have experienced a life disruption or other forms of marginalisation.

For a small minority of participants, there was the view that some of the statement items were not about citizenship, which illustrates the difficulty with citizenship as a concept, as it can mean 'everything and nothing', leading some theorists to question its usefulness. However, Hopkins and Blackwood (2011) argue that much can be gained from exploring people's understanding of how they are positioned by others in every day interactions. Indeed, we argue that it is precisely this focus on these 'ordinary' interactions and relationships that makes citizenship such a useful tool within health and social care settings to understand and tackle the exclusion often faced by those who have experienced life disruptions. This would appear to fit well with Lister's (1997) plea for citizenship to be a call

for action to challenge exclusion and marginalisation as well as a useful theoretical framework.

Our model places great emphasis on the relational aspects of citizenship with participants emphasising the importance of being around like-minded people who offer opportunities for shared experiences, connections and social support where needed. It is argued that people become citizens through particular relations and social spaces (Ware, 2007; Parr, 2006; Pols, 2016). In our study, life-disrupted participants emphasised the need to 'work hard' at relationships, re-building those which had been damaged and developing new positive relationships with others. While those without life disruptions also placed great importance on relationships, data from our focus groups suggested those with life disruptions focused on their *immediate* micro-level relationships with friends, family and their local community, while those without disruptions extended their gaze more widely to broader communities and nation states. Higgins (1999:302) sums this up well by suggesting that 'citizenship is closer to home for those who feel they are on the outskirts of society'. If we begin to understand relationships as the space in which citizenship is enacted, this makes sense given that opportunities for participation in such relationships are likely to be constrained for those who have experienced life disruptions. This is partly a result of stigma and discrimination which makes their ability to return to meaningful social roles more difficult outside of the formal health and social care system (Hamer et al., 2017; Harper et al., 2017).

A sense of belonging underpins each of the clusters in our model. Analysis of our data suggests that belonging and participation are inextricably linked and that people are less likely to participate if they are made to feel like an outsider. Hamer et al. (2017) and Stewart et al. (2017) argue that social integration and a greater sense of belonging are untenable without a willingness of the broader community to 'see a likeness in someone'. We were struck by the powerful testimonies of participants who gave examples of times when they felt the wider community had blocked their citizenship journeys by refusing to accept them or give them a second chance. Harper et al. (2017) suggest that participation at three levels is necessary to promote citizenship—the immediate or micro-level with friends, family and neighbours, the intermediate level in the community with familiar strangers and the macro-level where there is the development of civic consciousness. Our data suggest that the development of communities of peer support plays a crucial role in enabling people to participate at all three levels.

Returning to our theoretical framework, our model overcomes some of the tensions inherent in current debates around citizenship. Questions have been raised around whether the concept of citizenship can ever be truly universal, with some arguing that the promotion of an inclusive agenda will always result in an out-group against which the in-group define themselves (Condor, 2011), and the challenge, therefore, is to promote universality without suppressing difference (Morris, 2005; Mouffe, 1992). We argue that the 'ordinariness' of our model can aid in this task. The model has not been developed to apply to any one group, although our particular focus here is on mental health. Many items identified as highly

important for achieving citizenship were endorsed across all life disruption groups and by non-disrupted participants also. By focusing on everyday interactions and relationships, individuals and groups can identify the areas that are of particular relevance to them at particular times. Indeed, our model acknowledges the differential ability of our participants to achieve particular items, suggesting that some people may need more support in some areas than others. This means that the model can retain its universal appeal while at the same time acknowledging diversity (Higgins, 1999).

## 11 | IMPLICATIONS FOR POLICY AND PRACTICE

Rowe and Baronski (2000) argue that citizenship can be defined as both an individual and collective goal. It provides a framework for understanding what is important in achieving one's place in society (Ponce et al., 2016). We argue that promoting the citizenship rights of an individual will support them to participate in the ways outlined above, thereby promoting empowerment and potentially resulting in greater independence, although we situate this firmly within the context of the collective with Quinn et al. (2019) arguing for a model of collective citizenship. Such a model can contribute to a comprehensive strategy to support people with life disruptions who have experienced marginalisation to achieve fuller citizenship through addressing structural as well as individual challenges through collective agency. This active component is likely to be attractive to policy makers given its potential to empower people to challenge the structural oppression they might have experienced (Kurtz & Hankin, 2005).

We would argue that a citizenship approach, in line with the model developed here, encourages policy makers and practitioners to shift their gaze from a purely clinical focus to consider the personal, relational and structural factors that might impact on a person's health and well-being. Ponce et al., (2016) describe this as a shift from 'programme citizenship' where people's lives are centred on the receipt of health and social care services and interactions with professionals to focus on the development of meaningful social relationships and other activities that are external to services. Implementing this will require a culture shift at both policy and practice levels as despite the influence of the disability and recovery movements, understandings of health and well-being remain heavily influenced by the medical model (Eiroa-Orosa and Rowe, 2017; Davidson et al., 2016; Pelletier et al., 2015).

Concerns have been raised that the onus of 'achieving' citizenship will be placed firmly on the individual in a similar vein to concerns and criticisms of the recovery model (see, e.g. McWade et al., 2016). Indeed, Ponce et al., (2016) in a study on the experiences of clinical practitioners of citizenship in practice in the United States, found that barriers towards adopting 'new practices' included staff prioritising urgent and high-risk needs, heavy workloads and budget constraints, all of which are similar concerns

in Scottish and UK health and social care settings (Stewart and MacIntyre, 2013). For citizenship-based care to be implemented, practitioners working within traditional models need to consider the key principles, processes and practices of a citizenship-based approach; engaging with structural barriers such as housing and employment as well as individual need. Eiroa-Orosa and Rowe (2017) argue that this requires bottom-up (service user led) and top-down change (administrator led). Progress has been made within services that focus on person-centred and trauma-informed care (see, e.g. Ferguson et al., 2014; Levenson, 2020; Reeves, 2015), recognising the importance of social relationships and broader social structures and situating the individual within these contexts. It is essential that people with experience of life-disrupting events continue to be involved in the implementation of citizenship-based practice (Eiroa-Orosa and Rowe, 2017).

## 12 | CONCLUSION

In order to develop an empirical model of citizenship within the Scottish context, we have taken a mixed-method, CBPR approach. We address an important gap set out in the literature that highlights a lack of empirical data on the personal meanings and experiences of citizenship, particularly for those who have been excluded or marginalised. Anonymous and colleagues have made a significant contribution here by providing empirical data from the United States. Our work has been built on this and added new insights, although it has its own limitations. The limitations of focus groups have been discussed in the literature (see, e.g. Gibbs, 1997) and can pose particular challenges when discussing sensitive topics. They also depend on being facilitated by a skilled moderator. We attempted to overcome these barriers with careful training and reflexivity, as well as ensuring that our groups were a safe space for discussion (MacIntyre et al., 2019). We also acknowledge the limitations of using models to inform health and social care practice given the potential to exclude important issues and not provide operational solutions for practitioners (Griffiths et al., 2016). In stages 2 and 3 of this study we have developed a measure of citizenship to be utilised in practice settings, helping to overcome some of these practical concerns. What has emerged from our study is the multi-faceted nature of citizenship and the importance of ordinary aspects such as relationships, belonging and participation that have been identified as necessary for achieving citizenship. This supports the move for policy makers and health and social care practitioners to consider the personal, relational and structural aspects of citizenship and to create health and social care systems and a policy environment that addresses these wider structural issues, moving beyond a purely individual gaze to understand health and well-being in a holistic way. Although developed within a Scottish context, the theoretical innovation emerging from this study has the potential to be replicated with other groups experiencing life disruption in a range of settings and country contexts.

## 13 | AUTHOR STATEMENT

Dr Gillian MacIntyre (corresponding author): conceptualisation, methodology, formal analysis, investigation, writing original draft, writing reviewing and editing, visualisation, supervision, project administration and funding acquisition. Dr Nicola Cogan: conceptualisation, methodology, formal analysis, investigation, writing original draft, writing reviewing and editing, visualisation, supervision and project administration. Dr Ailsa Stewart: conceptualisation, methodology, formal analysis, investigation, writing original draft, writing reviewing and editing, visualisation, supervision, project administration and funding acquisition. Neil Quinn: writing, reviewing and editing and funding acquisition. Dr Maria O'Connell: conceptualisation, methodology and formal analysis. Professor Michael Rowe: conceptualisation, methodology and writing reviewing and editing.

## CONFLICT OF INTEREST

There are no known conflicts of interest for any of the author.

## DATA AVAILABILITY STATEMENT

Anonymised data available on request due to privacy/ethical restrictions.

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**How to cite this article:** MacIntyre G, Cogan N, Stewart A, Quinn N, O'Connell M, Rowe M. Citizens defining citizenship: A model grounded in lived experience and its implications for research, policy and practice. *Health Soc Care Community*. 2021;00:1–11. <https://doi.org/10.1111/hsc.13440>