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ORIGINAL PAPER

The Citizenship Project Part II: Impact of a Citizenship Intervention on Clinical and Community Outcomes for Persons with Mental Illness and Criminal Justice Involvement

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Abstract This study assessed the effectiveness of an intervention based on a theoretical framework of citizenship on reducing psychiatric symptoms, alcohol use, and drug use, and increasing quality of life for persons with serious mental illness (SMI) and criminal justice involvement. One-hundred fourteen adults with SMI and a history of criminal justice involvement participated in a 2 × 3 longitudinal randomized controlled trial of a four-month citizenship intervention versus usual services. Linear mixed model analyses were used to assess the intervention's impact on quality of life, symptoms, and substance use. After controlling for baseline covariates, participants in the experimental condition reported significantly increased quality of life, greater satisfaction with and amount of activity, higher satisfaction with work, and reduced alcohol and drug use over time. However, individuals in the experimental condition also reported increased anxiety/depression and agitation at 6 months (but not 12 months) and significantly increased negative symptoms at 12 months. Findings suggest that community-oriented, citizenship interventions for persons with SMI and criminal justice histories may facilitate improved clinical and community outcomes in some domains, but some negative clinical findings suggest the need for post-intervention support for intervention participants. Implications for practice and future research are discussed.

Keywords Mental illness · Citizenship · Criminal justice · Jail diversion · Group support · Community integration

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Introduction

According to the U.S. Department of Justice (DOJ) 24 % of inmates in state prisons and 14 % of inmates in federal prisons have a mental illness and an estimated 15 % of state inmates and 24 % of local inmates meet the criteria for a psychotic disorder (Ditton 1999; DOJ 2006). For such individuals, successful re-integration into the community is often impeded by lack of access to or disqualification from adequate mental and physical health care, housing, and employment (Baillargeon et al. 2010; Draine et al. 2005; Hoge 2007; Roman and Travis 2004). In addition, persons with mental illness and criminal justice histories have high rates of coexisting substance abuse disorders (McNeil et al. 2005) and experiences of trauma including childhood traumas and traumas associated with arrests and incarcerations (Osher and Steadman 2007), which can further challenge their efforts to achieve personal stability and community integration. While a few evidence-based practices—Forensic Assertive Community Treatment, Illness Management and Recovery, and Supported Employment—have been developed or adapted to help meet the specific challenges these individuals face, few interventions that address the multiple day-to-day struggles that individuals with mental illness and criminal justice histories experience have been implemented and evaluated.

Drawing from social science theories that emphasize civic participation as a measure of one's involvement in society (Bellah et al. 1996; Durkheim 1933), the citizenship framework emphasizes the importance of opening up opportunities for participation to members of marginalized groups (Werbner and Yuval-Davis 1999). Citizenship, for the research on which we report in this article, has been defined as a strong connection to the "5 R's" of *rights*, *responsibilities*, *roles*, and *resources* that society offers to

people through public and social institutions, and *relationships* involving close ties, supportive social networks, and associational life in one's community (Rowe and Baranoski 2000; Rowe et al. 2001). Full citizenship requires that people have access to participation in society and perceive others as valuing their participation (Rowe et al. 2001). Persons exiting the criminal justice system who are also diagnosed with mental illness and substance use disorders often face "triple stigmatization," thus threatening their achievement of community and social integration, or citizenship (Hartwell 2004). Given that their life trajectories have been interrupted, and that they face stigmatization and marginalization, special attention to community re-integration for this group is warranted.

In previous work, we have argued that in order to achieve full membership in society, people must attend to both the instrumental aspects of citizenship—acquiring practical knowledge and skills for gaining access to opportunities and resources—and the affective aspects of citizenship—experiencing a sense of membership in a community through relationship-building and role achievement (Rowe et al. 2009). In addition, attention to participation, connectedness, and integration for persons with mental illness are cornerstones of recovery-oriented systems of care in the U.S. Recovery, in the new Federal context, is not limited to an *outcome* of care, to cure, or even to remission. It also refers to a *process* through which people with mental illnesses become and perceive themselves to be full participants in their communities and members of society, even in the face of enduring disability (New Freedom Commission 2003). Citizenship adds to the process-oriented sense of individual recovery a social-contextual emphasis on the elements (rights, responsibilities, roles, resources, and relationships) needed to achieve full membership in democratic society (Rowe et al. 2001).

Zimmerman and Rappaport (1988), in earlier work reported in this journal, integrated literature on citizenship participation with research on perceived control in regard to the concept of psychological empowerment. Their studies, among other findings, revealed the association between higher levels of empowerment and higher levels of community participation. This research, too, resonates with our citizenship intervention research, and may inform future iterations of this work. We see the citizenship framework, which has been applied to the goal of community reintegration for discharged criminal offenders (Uggen et al. 2006), as being particularly relevant to the needs and goals of people who are marginalized by both mental illness and involvement with the criminal justice system.

The Citizenship Project

Derived initially from research on mental health outreach to persons who are homeless (Rowe 1999), the intervention examined in this study—the Citizenship Project—was designed to address the specific community and social inclusion needs of persons with serious mental illness (SMI) and criminal justice histories, as well as to respond to the high rates of criminal recidivism for this population (DOJ 2006). This group includes, but it not limited to, persons receiving jail diversion services. Jail diversion programs emerged in response to concerns that persons with serious mental illness are overrepresented in the criminal justice system. Often, they are arrested and incarcerated for petty crimes related to their mental illness rather than criminal intent and they do not receive adequate treatment in the criminal justice system (Rowe and Baranoski 2000, 2011; Sirotich 2009).

While diversion programs have shown mixed results (Cosden et al. 2003; Frisman et al. 2006), it is believed that linking persons who have a serious mental illness and criminal history with community-based treatment services will reduce police contact and criminal recidivism (Sirotich 2009). Our approach in addressing this concern was to link citizenship-oriented community-based treatment with treatment for previously incarcerated individuals, which may have included jail diversion programming. The citizenship approach represents a view that, important a role as jail diversion and other programs play in diverting people with mental illness from the criminal justice to mental health system, this shift is from one system to another and cannot address the community integration needs of this group (Rowe and Baranoski 2000).

The findings on which we report in this article derive from a *second phase* of analysis of a randomized controlled trial (RCT). In the RCT, individuals with a diagnosis of a serious mental illness and recent history of criminal justice involvement were randomized into either the citizenship intervention or treatment as usual. We hypothesized that individuals in the citizenship intervention would have more positive clinical and other outcomes than those in standard care, even after controlling for baseline sociodemographic and clinical characteristics.

In first-phase analysis, the impact of the citizenship intervention on alcohol and drug use and criminal charges was examined. Results indicated that when controlling for baseline levels of alcohol and drug use, persons who received the citizenship intervention reported decreased alcohol use over time while control group participants showed increased levels of alcohol use over time. Both groups reported decreased drug use across follow up assessment periods, as well as a reduction in new criminal charges (Rowe et al. 2007). While these were substantial findings, given more recent calls to assess an interventions' impact on quality of life (Sirotich 2009), we conducted second-stage analysis, the focus of this article, re-examining first-phase analyses and evaluating additional outcomes—psychiatric symptoms and quality of life.

Methods

Research participants were persons with a SMI who were receiving services at one of two local mental health centers and had a criminal charge in the 2 years prior to enrollment. Participants were randomly assigned to a four-month citizenship intervention or treatment as usual. Treatment as usual consisted primarily of individual or group treatment, medication monitoring, case management, and jail diversion services, as appropriate. The citizenship intervention consisted of three integrated components: individual peer mentor support, an 8-week citizenship class, and an 8-week valued role component.

Peer Mentor Support

Intervention participants were matched with a peer mentor. Working an average of 8 h per week, peer mentors supported participants by helping them to identify goals and set priorities for achieving them, sharing their own coping strategies and lessons learned as people working on their own recovery, and advocating for participants' access to social services, employment, education, and housing. Christens (2011) has conceptualized the relational process of mentorship as an expression of psychological empowerment, as embodied in and practiced by the mentor, that helps facilitate the empowerment of the person being mentored. The peer mentor component of this intervention occurred simultaneously with both the citizenship classes and valued role projects.

Citizenship Classes

The primary objectives of the citizenship class component of the intervention were to enhance participants' problem-solving and other life skills for daily living, their ability to establish social networks based on mutual trust and shared interests, and their knowledge of available community resources. A project director with a background in community advocacy but not in clinical work facilitated twice-weekly 2-h classes of six to ten participants over an 8-week period, in addition to overseeing the project as a whole. Classes were led by both the project director and peer mentor or by a person from the community (e.g. a staff person from the local housing authority) or the service system (e.g. a case manager on aspects of "negotiating" the mental health system) who would teach a class on his or her topic of expertise.

Citizens' classes focused on: negotiating the criminal justice system, assertiveness training and self-advocacy, problem solving and time management, relationship building, entitlement programs and self-help groups, housing in the local community, vocational and educational resources, social integration, and public speaking. Class content consisted of didactic presentations, group discussions, class exercises, and assignments.

Valued Role Projects

Following completion of the class component, participants drew on their life experiences and class learning to design and participate in an 8-week valued roles component that encouraged them to "give back" to the community while, at the same time, teaching community members that they can fulfill valued roles in society. Valued role projects were determined by participants themselves, with input from fellow students (as participants in the project were called) and consultation from the project director and peer mentors.

Some participants developed and completed their valued role projects collaboratively. One cohort, for example, taught a class for police cadets at the local police academy on the experience of being approached on the streets by the police while experiencing symptoms of mental illness. In discussing these experiences with the cadets and engaging in lively discussion with them, they became their teachers. In doing so, they also educated the cadets on the capabilities of persons with mental illness.

Other individuals opted design and complete individual valued role projects individually. One woman decided to cook Thanksgiving dinner for her family. Such a project might raise questions as to its connection to community, but this student saw her family as part of her community, one in which she had been seen as, and learned to see herself as, someone who could only receive, not give. In taking on this valued role, she proved otherwise to both parties.

The valued role component of the intervention was supervised by the project director, who helped facilitate students' exploration of areas of interest and of their passions and values, as well as helping to organize logistics of some projects, as with the police academy. Peer mentors also supported students throughout the project.

Upon completion of the citizenship intervention, a Citizenship Graduation Ceremony was held at City Hall for each cohort. Family members, friends, mental health and other professionals were invited to attend. Maruna and LeBel (2003) describe the criminal justice system as a (negative) rite of passage for a large subset of our society, with no corresponding ritual to mark people's exit from this world and re-entry into society. They propose a strengths-based paradigm focused on the contributions people can make to society and the importance of assuming a helping role (Maruna 2011; Maruna and LeBel 2003). This approach resonates for the authors with the citizens intervention as a whole and with its three main

components: the classes, in which participants who, often, had not performed well in school, took on the mantle of student, with its rite of passage toward graduation; valued role projects, in which participants marginalized in society took on the mantle of citizen within a supportive yet challenging program environment; and graduation, a classic rite of passage in society.

Sample and Procedures

Participants were recruited through postings at a local social rehabilitation center and emergency shelter and social service agency newsletters and through use of an information table at a local mental health center. Forty-one participants (36 %) were randomly assigned to the control, or standard services, condition. Seventy-three participants (64 %) were assigned to the experimental condition, involving the standard services and the citizenship intervention. Randomization reflected a 2:3 control–intervention ratio designed to maintain sufficient numbers in the intervention cohort. Participants completed a baseline interview at the time of enrollment, 6 and 12-month follow-up interviews. The study period was June 2001 to November 2003. We received approval for the study from the institutional review board of our academic institution.

Measures

Instruments used were a sociodemographic questionnaire, the *Addiction Severity Index*, Lehman's *Quality of Life–Brief* measure, the *Brief Psychiatric Rating Scale,* and a Social Capital scale.

Lehman's Quality of Life Scale (QOL; Lehman et al. 1993)

The Quality of Life Interview—Brief, is a structured interview that is used to assess life circumstances of persons with severe mental illness in "objective terms"—what they actually do, and "subjective terms"—how they feel or what they think about their experiences. This interview assesses both the objective and subjective domains of a person's living situation, leisure activities, familial relations, social relations, work/school, legal and safety, and health with possible scores ranging from 1 to 7 on each subscale, with higher scores indicating better quality of life. The QOL is reported to have good reliability and validity with Cronbach's alpha ranging from .56 to .87 on subscales (Burckhardt and Anderson 2003).

The Addiction Severity Index (ASI; McClellan et al. 1985)

The ASI is a structured interview for gauging the degree of potential treatment barriers across domains typically affected by alcohol and drug use disorders, including psychiatric and social considerations. For this investigation, investigators used only the alcohol and drug use ASI subscales with possible scores ranging from 0 to 1 where higher scores indicate higher severity of problems. The ASI has been rigorously assessed within similar client populations and shown to be both a reliable and valid way to assess alcohol and drug use, with Cronbach's alpha levels measuring .81 and .67 respectively (Zanis et al. 1997).

Brief Psychiatric Rating Scale (BPRS; Overall and Gorham 1962)

The BPRS is a 24-item rating scale that is widely used to measure psychiatric symptoms. Five factors of the BPRS, thinking disorder, withdrawal, anxiety/depression, hostility-suspicion, and activity, have been documented by Burger and Calysn (1997). Cronbach's alpha coefficients of four of the five factor range from .73 to .81, with the hostility-suspicion factor having an internal consistency coefficient of .49. Scores on these subscales range from 1 to 7, where higher scores are indicative of higher levels of symptomatology.

Social Capital Scale (Hogan and Owen 2000)

Using Hogan and Owen's adaptation of the *World Values Survey,* participants were given a list of 21 institutions (e.g. the local police, the legal system generally, etc.) and asked to rate how often they trust that each of the named institutions will act in their best interests. Scores range from 1 to 5 with higher scores being indicative of higher levels of trust in the named institution. Reliability information is not available for this instrument.

Analyses

One-way ANOVAs and Chi-square statistics were conducted on baseline variables to determine if there were any between-group differences on sociodemographic or clinical characteristics. Linear Mixed Models analyses were used to assess both main and interaction effects of the intervention and time. All significant baseline differences, as well as baseline values of the dependent variable, were held as covariates in the model.

Results

Sample Characteristics

One hundred fourteen participants were enrolled in the study, with an average age of 40 years ± 8.8. Sixty-eight percent of participants were male ($n = 77$). The racial composition of the sample was largely African American (58 %, $n = 66$) and

Table 1 Participants' primary and secondary diagnoses

	Citizenship Intervention		Control	
	N	%	N	%
Primary diagnosis[a]				
Psychotic disorder	26	36	17	42
Major mood disorder	29	40	17	42
Alcohol use disorder	4	6	1	2
Substance use disorder	5	7	3	7
Other disorder	9	12	3	7
Secondary diagnosis[a]				
Psychotic disorder	2	3	1	2
Major mood disorder	6	8	2	5
Alcohol use disorder	17	23	13	32
Substance use disorder	27	37	13	32
Other disorders	12	16	5	12

[a] Eighty-six percent of participants carried a secondary diagnosis

Caucasian (31 %, $n = 34$). Fifteen percent ($n = 17$) of participants endorsed Hispanic ethnicity. All participants were receiving outpatient treatment at the time of enrollment and during their participation in the study.

Ninety-seven percent of participants ($n = 111$) had either a primary or secondary diagnosis of psychiatric illness. Approximately 42 % had a primary or secondary substance use diagnosis ($n = 48$), 31 % an alcohol use diagnosis ($n = 35$), and 70 % had co-occurring psychiatric and substance/alcohol use diagnoses ($n = 80$). The diagnoses of three individuals were unknown. As detailed in Table 1, proportional diagnostic distributions were equivalent across the two groups, with a Pearson Chi-square test yielding no systematic relationship between condition and diagnosis. All participants had a recent criminal history with offenses ranging from petty crimes to felonies.

Baseline Analysis

Although there were no demographic differences between the two groups at baseline, there were differences between the groups on several variables at baseline. Participants in the citizenship intervention reported significantly higher drug use ($.09 \pm .09$ vs. $.05 \pm .06$; $p < .05$), lower levels of quality of life (3.63 ± 1.79 vs. 4.39 ± 1.75, $p < .05$), lower levels of motor retardation ($2.31 \pm .54$ vs. $2.57 \pm .72$, $p < .05$), and lower levels of social capital ($2.93 \pm .82$ vs. $3.38 \pm .68$, $p < .010$) than participants in the comparison condition at baseline (Tables 2, 3).

Quality of Life

Controlling for significant baseline differences noted above, as well as the baseline value of the dependent variable, linear mixed models analysis showed that citizenship intervention participants had significantly greater increases in quality of life from baseline to 12 months than those who received treatment as usual (B = .68, $p = .05$). Additionally, citizenship intervention participants showed significantly greater increases in amount of and satisfaction with activity level from baseline to 6 months (B = 1.37, $p = .001$; B = .72, $p = .01$, respectively) and baseline to 12 months than usual services participants (B = .80, $p = .05$; B = .68, $p = .02$, respectively).

Of those who were working within the 6-months prior to the baseline interview, part- or full-time ($n = 42$, 37 %), citizenship intervention participants had significantly higher increases in satisfaction with work from baseline to both 6 and 12 months (B = .85, $p = .01$; B = 5.19, $p < .001$, respectively). A higher increase in satisfaction with ones' finances from baseline to 6 months was found for those who received the intervention (B = .75, $p = .01$).

Addiction Severity Index

Citizenship intervention participants had a significantly greater decrease in drug use from baseline to 6 month (B = −.07, $p = .001$) and baseline to 12 months (B = −.04, $p = .04$) than participants in the comparison condition, even after controlling for baseline demographic variables and the baseline value of the dependent variable. In contrast to the findings reported from first-phase analysis (Rowe et al. 2007), results from the present analysis indicate that intervention participants also had a significantly greater decrease in alcohol use from baseline to 12 months (B = −.29, $p = .04$) than the usual services participants when controlling for baseline demographic variables and baseline values of the dependent variable.

Brief Psychiatric Rating Scale

In addition to the positive outcomes observed, participants in the citizenship intervention also reported having significantly higher increases in levels of anxiety/depression as well as higher increases in levels of activity (agitation, tension, etc.) on the BPRS from baseline to 6 months (B = .64, $p = .01$; B = .50; $p = .01$). This finding did not hold at the 12 month follow-up. At 12 month follow-up, intervention participants reported having a significantly higher increase in levels of some negative symptoms (disorientation and emotional withdrawal) than those who did not receive the intervention (B = .28, $p = .04$).

Social Capital

No significant differences were found relating to social capital as measured by Hogan and Owen's (2000) adaptation of the *World Values Survey*.

Table 2 Baseline demographics

	Citizenship Intervention (n = 73)		Control (n = 41)	
	N	%	N	%
Race				
American Indian	3	4	0	0
African American	45	63	21	51
Caucasian	21	29	13	32
Other race	3	4	7	17
Hispanic	9	12	8	20
Gender				
Female	19	26	18	44
Male	54	74	23	56
Marital status				
Married	5	6	2	5
Separated	2	2	4	10
Divorced	22	30	11	27
Single	44	60	24	59
Lives with partner	13	17	6	15
CJ status				
Diversion	4	5	6	15
Probation	40	54	21	51
Other	29	39	14	34
ASI				
Alcohol use	.32	±.61	.14	±.29
Drug use	.09	±.09*	.05	±.06
# days using alcohol/past 30 days	2.50	±5.60	1.98	±4.55
# days intoxicated/past 30 days	2.26	±5.36	2.32	±5.79
# days using multiple drugs/past 30 days	.17	±.77	.83	±3.78
BPRS				
Total score	42.40	±13.13	43.51	±12.05
Anxious/depressed	2.42	±.96	2.23	±1.18
Hostile/suspicious	1.94	±.95	1.76	±.73
Activity	1.52	±.80	1.77	±1.06
Withdrawal	2.31	±.54	2.57	±.72*
Thinking disorder	1.56	±.74	1.51	±.75
QOL overall	3.63	±1.79	4.39	±1.75*
QOL—satisfaction with living situation	3.63	±1.58	3.79	±1.60
QOL—amt of activity	12.47	±1.88	12.78	±1.80
QOL—sat with activity	3.95	±1.31	4.45	±1.41
QOL—amt of contact with family	3.06	±1.33	3.29	±1.18
QOL—sat with family relationships	3.77	±2.03	4.05	±1.65
QOL—frequency of contact with friends	2.99	±1.18	3.12	±1.14
QOL—sat with social relationships	4.59	±1.31	4.72	±1.72
QOL—sat with finances	2.14	±1.27	2.81	±1.59*
QOL—sat with work	4.56	±1.74	4.30	±1.88
QOL—sat with health	4.14	±1.41	4.59	±1.51
Social capital	2.93	±.82	3.38	±.68

* $p < .05$, ** $p < .01$, *** $p < .001$

Table 3 Linear mixed models

Dependent variable[a]	Intervention × 6 months				Intervention × 12 months			
	Est. (B)	t	df	95 % CI	Est. (B)	t	df	95 % CI
Alcohol/drug use (ASI)								
Alcohol index	−.20	−1.41	222	−.47, .07	−.29	−2.09*	222	−.57, −.02
Drug index	−.07	−3.40**	222	−.10, −.03	−.04	−2.04*	222	−.08, −.00
Quality of life (QOL)								
Overall life satisfaction	.36	1.05	222	−.32, 1.05	.68	1.98*	222	.00, 1.36
Satisfaction with living sit	.38	1.01	222	−.36, 1.12	.46	1.22	222	−.28, 1.19
Amount of activity	1.37	3.32**	222	.56, 2.19	.80	1.95*	222	−.01, 1.61
Satisfaction with activity level	.72	2.56**	221	.17, 1.28	.68	2.41*	221	.12, 1.23
Amount of family contact	.30	1.13	219	−.22, .81	.29	.73	219	−.18, .85
Satisfaction with family relationships	.45	1.14	215	−.33, 1.23	.29	.73	215	−.49, 1.06
Frequency of contact with friends	.07	.29	221	−.40, .55	.38	.16	221	−.09, .86
Satisfaction with social relationships	.12	.44	221	−.41, .65	.51	1.93	221	−.01, 1.04
Satisfaction with finances	.75	2.53**	219	.17, 1.34	.50	1.69	219	−.08, 1.08
Satisfaction with work	.85	3.06**	26	.28, 1.42	5.19	12.64***	26	4.35, 6.04
Satisfaction with health	.29	1.02	219	−.27, .84	.38	1.17	219	−.22, .88
Symptoms (BPRS)								
Thinking disorder	−.08	−.49	222	−.40, .24	.07	.43	222	−.25, .38
Anxiety/depression	.64	2.52**	222	.14, 1.15	.36	1.43	222	−.14, .86
Hostility-suspicion	−.24	−1.12	222	−.67, .19	.17	.78	222	−.29, .60
Activity	.50	2.52**	222	.11, .90	.37	1.87	222	−.02, .76
Withdrawal	.25	1.84	223	−.02, .52	.28	2.05*	223	.01, .55
Social capital composite	−.27	−1.44	217	−.64, .10	−.03	−.17	217	−.40, .34

* $p < .05$, ** $p < .01$, *** $p < .001$

[a] Controlling for baseline differences on ASI-D, QOL overall, BPRS-withdrawal, social capital composite and baseline dependent variables

Subgroup Analysis

Three subgroup analyses were run looking at gender, race and criminal justice status, to see if one subgroup benefited more or less than another, therefore, driving the main effect. No subgroup differences were found on main variables (ASI drug and alcohol, Quality of Life, and symptoms).

Discussion

In addition to decreased alcohol use identified in the original analyses of these data from the citizenship project, our second-phase analysis identified several areas of additional benefit for citizenship intervention participants. When controlling for baseline covariates, individuals in the citizenship intervention had reductions in alcohol and drug use as well as enhancements in amount of and satisfaction with social activity, satisfaction with finances, satisfaction with work, and overall quality of life. These findings suggest that the citizenship intervention may have facilitated, to some degree, participants' efforts to build a life in the community. It is possible that increasing participants' knowledge of community resources/programs facilitated their increased community activity. It is also possible (and consistent with project staff and investigators' observations), that valued role projects supported participants' confidence in their abilities to "give back" something of value to their community and thus supported and encouraged them to engage in more community activities.

Despite these positive findings, individuals in the citizenship intervention had significantly higher levels of anxiety/depression and agitation (e.g., tension, excitement, distractibility) at the 6-month assessment period. This finding may not be surprising when considering the oft-observed (by clinicians) but little-studied phenomenon in which major, socially positive life changes are associated, in the achiever, with anxiety and/or agitation (Johnson et al. 2000; Myers et al. 1975). It is also possible, based on "self medication" theory (Bolton et al. 2009), that these "symptoms" were related to decreased substance use among intervention participants, which may exacerbate symptoms initially. Increased anxiety and agitation, however, was not present at the 12-month follow-up period. This may suggest that the 6-month finding reflects a short-term effect associated with a new approach to community life and participation.

At the 12-month follow-up period, participants in the citizenship intervention reported a significant increase in negative psychiatric symptoms over time, which may have been associated with the removal of the intervention. While it is unclear why this occurred at 12-month and not 6-month follow-up, our working hypothesis is that enhancement of the citizenship intervention by post-core intervention peer mentor support, along with periodic group lunches, will help to address these symptoms. Gaining, or regaining, one's citizenship cannot be envisioned as protecting the new citizen from the struggles as well as the satisfactions of community membership and the acquisition of valued roles, but limited post-intervention support may be a reasonable enhancement to the tested intervention. These are questions for further research.

This research has some limitations. First, our research design involved comparison of standard treatment alone to standard treatment plus the experimental intervention. It is possible that the extra assistance and attention intervention participants received facilitated the outcomes we found, independent of the specific elements of the citizenship intervention. Second, our design did not allow us to differentiate the relative importance of peer mentor, class, and valued role components in producing our findings. Third, the development of the three-pronged intervention itself—peer mentor support, classes, and valued roles represented the investigators' "reasonable" approach to translating our theoretical framework of the five Rs of citizenship (rights, responsibilities, roles, resources, and relationships) into program elements. Further research including a programmatic components analysis may help to identify the most potent features of the intervention. In addition, our identification of domains of citizenship, derived from concept-mapping-based research to develop an individual instrument to enhance citizenship, has provided us with additional knowledge of our target group's hopes for, and perceived barriers to, achieving full citizenship and community membership (Rowe et al. 2012). We anticipate that these finding will help us to identify new program elements to address these hopes and barriers, thus enhancing the citizenship intervention on which we have reported here, as well as to strengthen the link between our theoretical framework of citizenship and its applications.

Conclusion

The Citizens Project is a promising intervention that has demonstrated positive outcomes for persons with severe mental illness and criminal justice histories. The intervention may also address aspects of the challenge of helping persons with severe mental illness and criminal justice charges live more productively in their communities. Future research and programmatic efforts must continue to address ways to adequately devise citizenship-based interventions, as well as to test the causal relationships between clinical and community outcomes, that is, the extent to which enhancing one's social integration through citizenship is the result or cause of clinical improvement, or the extent to which the two may be interchangeable in successful citizenship interventions.

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