

## Enhancing active citizenship for persons with psychosocial disabilities

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### ABSTRACT

By the adoption of the United Nation Convention on the Rights of Persons with Disabilities, many countries have committed to providing conditions for persons with disabilities to actively participate in the community. This article explores the meaning of active citizenship for persons with psychosocial disabilities and focuses in particular on the role of the state. Illustrated with examples from Sweden, the analysis underlines the complexity of the relationship between mental health and society by taking into account several models of disability, different conceptions of citizenship and the broader socio-economic context. We suggest that the use of a dynamic approach to psychosocial disabilities is appropriate for dealing with the manifold issue of mental health in welfare states. In conclusion, we point at important challenges facing the realization of full inclusion and citizenship in contemporary societies.

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### Introduction

This article explores the issue of psychosocial disabilities in relation to active citizenship. We start with a general overview of the way mental health and citizenship have been conceptualized in social science scholarship. We then sketch recent societal changes which have had a considerable impact on the perception of psychosocial disabilities in contemporary society. Finally, we discuss the role of the state in supporting active citizenship for persons with psychosocial disabilities.

### The challenging issue of conceptualizing mental health problems

At the outset, we can note with Pilgrim and Tomasini (2012, 631) that both medicine and social sciences have struggled to find a consensus for understanding mental health and ill-health. The most common understanding is probably the traditional medical conception which considers that mental illness is caused by a bodily dysfunction. However, this view was strongly put into question by the anti-psychiatry movement in the 1960s (see e.g. Szasz 1960). The anti-psychiatry critique was echoed in social science studies in general and in Disability Studies in particular. Social scientists explored the social embeddedness of mental health and analysed, to name but a few studies, the genealogy of madness (Foucault 1965), the social construction of mental illness (Scheff 1966) and the impact of stigma in face to face encounters (Goffman 1963). Their research showed that mental ill-health is influenced by society and pointed at the social processes lying behind them. Moreover, they analysed societal responses to mental ill-health, such as mechanisms of social control and processes of stigmatization and discrimination.

Meanwhile, the disability rights movement became influential and denounced the impact of society on disability. Its main ideas were theorized by disability scholars as ‘the social model of disability’ (Barnes, Mercer, and Shakespeare 1999; Oliver 1990). The social model came thus as a reaction to the traditional medical vision, also called ‘the medical or individual model of disability’. Disability researchers argued that the medical model left social factors as a vague, undefined background while concentrating on individual and psychological problems and processes (Estroff 1983, 6–20). The social model of disability shifted the focus from the individual’s health problem towards societal barriers to participation and pointed at the importance of taking the broad environment into account. However influential the social model of disability has been to change the vision on disability, it has also been heavily debated and criticized – especially its radical version which depicts disability as entirely socially caused (Oliver 1996). Critiques have argued among other things that the social model lacks an explanation of the causal link between impairment and disability (Bickenbach et al. 1999; Shakespeare 2006), that the model sheds light on the social origins of disability but fails to consider the social construction of impairments (Hughes and Paterson 1997) and that it is too much focused on structural aspects of disability, forgetting personal experiences, cultural factors and the relationship to non-disabled people (Goodley 2012; Humphrey 2000; Tregaskis 2002). Furthermore, some persons with mental health issues have been reluctant to embrace the social model of disability because they do not consider themselves as being disabled (Beresford 2002, 581–584). Hence, while some researchers have defended the social model of disability as a useful conceptual tool to raise political claims (Oliver 1990; Thomas 2004), others have argued that it should be changed or abandoned in order to take into account the shortcomings brought forward by critiques (Shakespeare 2006). Two alternative models can be mentioned in particular. The ‘relational model’ of disability, also referred to as the Nordic conception of disability, understands disability as a situational mismatch between an environment and a person’s needs (Söder 2013). And the ‘universal model’ of disability, which argues that disability is not the condition of a particular group of people but that the whole population is potentially at risk of being disabled (Zola 1989, 1–19). The individual–environment interactions and the universality of disability are also found in the ‘biopsychosocial model’ of disability which lies at the basis of the International Classification of Functioning Disability and Health (ICF) of the WHO (Bickenbach et al. 1999; Imrie 2004). These models include a dynamic component as they take into account the fact that psychosocial difficulties may happen at any time during a person’s life-course and evolve over time (see also Priestley 2003; Wendell 2001). Building on a relational, universal and dynamic conception of disability, we adopt a flexible understanding of disability in this article instead of an essentialist vision of a bodily or mental condition. We do not claim that this is the only valid approach, but we think that it is the most fruitful approach for our purpose because it enables us to consider difficulties resulting from both severe and mild psychosocial disorders, in relation to the broader environment.

### Psychosocial disabilities and citizenship: not a self-evident compatibility

Quite similar to the controversies around the conceptualisation of mental health, the concept of citizenship has been the object of many debates. Social science literature usually starts from T.H. Marshall’s seminal essay (1992) and considers that citizenship consists in civic, political and social rights. The concept has been heavily discussed because people have different ideas about the content of citizenship rights, duties and obligations. Probably the best-known discussion concerns the opposition between the republican conception of citizenship – which views that citizens should actively participate in public affairs – and the liberal conception – which stresses the citizens’ freedoms and rights. The latter conception can be further classified into a liberal (or socio-liberal) and a libertarian (or neo-liberal) definition of citizenship (Miller 2000), where the liberal conception defines citizenship as a set of rights enjoyed equally by every member of a political community<sup>1</sup> (Miller 2000, 44) and the libertarian conception regards citizens as rational consumers of public goods (Miller 2000, 50). However, full citizenship is not self-evident for all individuals. The obvious

criterion is whether an individual is a member of a given nation state, but there are also factors of in-/exclusion inside a country (Lister 2003). From the twentieth century on, marginalized groups of citizens initiated struggles for citizenship and demanded recognition and the possibility to exercise their right to participate in society (Lister 2003). The question of citizenship and psychosocial disabilities has to be understood against this background.<sup>2</sup>

Until recently, people with severe psychosocial disabilities in the western world were treated by psychiatric experts, often in large psychiatric hospitals or other segregated settings (Porter, Bynum, and Shepherd 1985). The rights of the psychiatric patients were limited and compulsory treatments violated their basic human right of bodily integrity and freedom of movement (Sayce 2000). Other people considered as deviant or 'feble-minded' lived in the community and stayed under the responsibility of their family (Carey 2003). Even they had reduced human and citizenship rights as they were denied, for example, the right to marry and to vote. This situation was not contested by the general population because the dominant narrative of citizenship was underpinned by the idea of the citizen as a rational agent<sup>3</sup> (Carey 2003).

In contrast, today's politically correct perspective is that everyone should be included and receive the possibility to actively participate in society. But despite the efforts made toward inclusion, many recent studies show that persons with a disability do not enjoy the same life conditions as the whole population (OECD 2012; WHO 2011b, 2012). The inclusion of disabled people in society is not self-evident and the *raison d'être* of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) is precisely to reassert the intrinsic value of persons with disabilities and their right to the full set of Human Rights. The CRPD's definition of disability reflects a relational approach to disability and states that persons with disabilities include 'those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others' (CRPD, art1). The Convention also understands disability as an evolving concept by acknowledging that a disability occurs in some situations while not in others and that persons can acquire and recover from an impairment or disability (CRPD, preamble, §e). Several authors have argued that the adoption of the CRPD represents a change of paradigm in the way society looks upon disability (Bickenbach 2009; Lang 2009; Priestley 2007). Concerning persons with psychosocial disabilities, Minkowitz (2007) commented that

With the advent of CRPD, a new era is in the making, in which large numbers of people will no longer have to fear nonconsensual psychiatric interventions and will have a better opportunity to heal individual trauma and to participate actively in social change. (Minkowitz 2007, 428)

By signing the Convention, 159 countries<sup>4</sup> have indeed committed to start treating disability as a human right issue and viewing persons with disabilities as full citizens.

## Psychosocial disabilities in the context of societal changes

Since the second half of last century, a series of societal changes have played a significant role in enabling persons with psychosocial disabilities to become full citizens. These have created new possibilities but also new risks for citizens with psychosocial disabilities.<sup>5</sup>

### Deinstitutionalization

Major changes occurred in the way the state provides for persons with psychosocial disabilities in Western societies. Until the 1950s, people with severe mental health problems usually lived in segregated residential institutions (Scull 1979; Stiker 1999; Wright and Digby 1996), but such services were widely criticized because of their poor conditions, segregation from the wider community and reported human rights abuses such as compulsory treatments and arbitrary deprivation of liberty (Borbasi et al. 2008; Goffman 1961; Rogers and Pilgrim 1989). Moreover, states began to worry about the huge costs of residential institutions. There was a need for change and the discovery

of antipsychotics in the 1950s worked as a catalyst for changing social policies and closing down institutions (Gronfein 1985; Wetterberg 2012, 49). The deinstitutionalization process took various forms. In a European context, some countries opted for closing down the institutions as soon as possible (e.g. Italy, Sweden) while others decided to take more time for this process (e.g. Germany, France). In Sweden, deinstitutionalization started in the 1970s but it was not until the first half of the 1980s that the state started to close down psychiatric hospitals and develop community mental health care (Silfverhielm and Kamis-Gould 2000). The ex-patients moved out and the municipalities' responsibility was widened to encompass an array of services including residential facilities, personal support and occupational activities. Swedish reform measures were characterized by weak steering mechanisms and a commitment to transform practices by means of pilot projects to propel the development of community mental health services in the municipalities (Markström, Sandlund, and Lindqvist 2004). Moreover, disability and patients' organizations worked for strengthening the patient's rights and obtaining facilities for people living in the community. Recent scholarship notes the start of deinstitutionalization in countries where large residential institutions can still be found (e.g. Serbia, the Czech Republic), but underlines also a trend of re-institutionalization in countries which had been moving away from institutionalized care (Priebe and Turner 2003, 175). Moreover, many countries – including Sweden (Sjöström, Zetterberg, and Markström 2011; Svedberg and Trägårdh 2012) – have legislations which permit compulsory treatments in certain cases. Hence, even though the overall international normative framework (e.g. the CRPD and the European Disability Strategy 2010–2020) pushes countries towards deinstitutionalization and encourages them to develop measures for supporting persons with psychosocial disabilities in a community setting, many persons with mental health problems are still living in residential institutions and are submitted to treatments which do not comply with a Human Rights framework (Kozma and Petri 2012, 25; WHO 2005, xxiii).

The spatial shift from the asylum to the community brought forward the issue of interactions between the ex-psychiatry patients and the larger population. Inclusion in the community is far from obvious and Knowles (2000) argued that confinement still exists because persons are often excluded from participation in the community. Indeed, stigma is a major factor influencing social opportunities and care seeking for persons with psychosocial disabilities (Corrigan 2004). Neighbourhood exclusionary campaigns are often initiated by small but vigorous minorities of residents who stereotype persons with psychosocial problems as unpredictable and dangerous (Leff and Warner 2006, 47). In order to avoid such reactions, service planners tend to either keep the development of group homes as quiet as possible or adopt the alternative strategy of educating the neighbourhood (Wolff et al. 1996). Taking into account the social interactions in the neighbourhood is important since research shows that stigmatization leads to psychosocial stress, low socio-economic status, delayed help-seeking and reduced access to mental health services and psychiatric treatment (Corrigan 2004; Svensson et al. 2011). Although campaigns<sup>6</sup> have been initiated for the purpose of increasing public knowledge about mental illness and recovery, stigma remains an important barrier for people with psychosocial disabilities (Beldie et al. 2012; Svensson et al. 2011). Many countries also aim at diminishing stigma by adopting anti-discrimination legislation but this type of legislation is often insufficiently implemented and tends to be unknown by the majority of the population. Hence, it is rather rare that people file complaints of discrimination on the basis of a psychosocial disability, at least in Sweden (Engwall 2014, 59).

### **Decentralization**

Following the wave of 'new public management' in the 1980s, many European countries opted for decentralization. This meant a reorganization of the state where the responsibility for organizing welfare was transferred from central government authorities to local governments (Christensen and Lægread 2007). In most countries, this process was accompanied by a marketization of care, implying that welfare provisions are now being delivered by a variety of public and private suppliers.

Both deinstitutionalization and decentralization were conceived as a way to provide better living conditions for persons with psychosocial impairments at a lesser cost. The context of this change was a growing critique of the welfare state as costly, ineffective, bureaucratic and as causing the individuals to become passive recipients of welfare support. Yet, a few decades after the implementation of these reforms, both scholarship (see e.g. Arvidsson and Arvidsson 2005; Christensen and Lægheid 2007; Kinn et al. 2011) and international reports (Knapp et al. 2007, 235ff; WHO 2011b) point at new challenges for the state and social risks for the individual. Concerning the state, challenges include the coordination of the many actors involved in the provision of care and the ability to reach to those who need support but are dispersed in the community. As for the individuals, getting lost in complicated administrative procedures, lacking adequate housing and financial resources and being isolated are examples of risks that appear when one lives in the community (Rosenberg, Lindqvist, and Markström 2009).

Different countries have designed solutions for supporting the individual in the community. Case management is one type of support for persons with mental health problems. Originally developed in the USA, it was implemented in several countries in Europe and took different forms according to the country (Mechanic 1999, 199; Moxley 1997). Sweden has developed its own model of case management called 'personligtombud' (English translation: private representative). The case worker has a variety of tasks such as helping the person to obtain welfare benefits and services, supporting the person to solve long-standing problems (Jespersen 2007) and giving advice (Klockmo, Marnetoft, and Nordenmark 2012). However, case managers usually have a large leeway to design their work and tend to act as 'welfare entrepreneurs' and are consequently at risk of being poorly integrated in the generic welfare system (Markström, Lindqvist, and Sandlund 2009). Another form of support for persons with psychosocial disabilities developed in Sweden is 'boendestöd' (English translation: home support). Personal come to the person's home to provide practical and social support for chores like cleaning, doing the laundry, shopping, out-door activities, contacts with authorities etc. The difference to home care services is that all the chores are done in collaboration with the user. Both 'personligtombud' and 'boendestöd' are provided free of charge by the municipality but it is the responsibility of the users to claim them.

### *Evolutions in treatments for mental illness*

In the first half of the twentieth century, there was a lack of effective treatments to cope with severe mental disorder and, in Sweden as in other countries, 'several different draconian methods were tested to reassure worried and confused patients, e.g. malaria treatment, shock therapy, insulin-induced coma and psychosurgery' (Wetterberg 2012, 48). Important innovations were then made in the biomedical field with the discovery of antipsychotics in the 1950s. Pharmacotherapy became soon 'the primary form of treatment in schizophrenia and mania in the 1960s, in depression and bipolar disorder in the 1970s, in the anxiety disorders in the 1980s, and in Alzheimer's type of dementia in the 1990s' (Ban 2006, 434). Moreover, different schools of psychotherapy were developed in parallel to the pharmacotherapy during the twentieth century (Guimón 2003).

Reactions came to the intensive use of (pharmaco)therapy and the 1990s saw another important change in the field of mental health with the development of a recovery approach promoted by the international recovery-movement (Roberts 2004). The idea of recovery does not imply the elimination of all symptoms of a mental illness but it focuses on improving a person's well-being in order to regain her role as a citizen (Slade 2010; Turton et al. 2011). In this perspective, practitioners and case-workers support their clients with social skills and social inclusion (Anthony 2003; Craig 2008; Farkas 2007; Slade 2009) and communicate hope (Davidson et al. 2007; Deegan 1996). Recovery treatments start from the person's own experiences and help her develop a new identity beyond the status of patient. Moreover, the recovery approach takes into account the fact that mental well-being is also narrowly connected to the availability of material resources such as housing, occupation, medical treatment and access to responsive services providing counselling and support (Morrow et al.

2009, 659; Topor et al. 2011). In addition, psychoeducation integrating psychotherapeutic and educational interventions has been established in mental health systems. Psychoeducation is a holistic approach which stresses health, empowerment and cooperation between patient, family and professionals. Its main idea is that increasing knowledge about a psychosocial condition will help the person to deal with her difficulties (Lukens and McFarlane 2004, 206). Finally we can mention the development of internet-administered mental health therapies which have the advantage of being available without waiting list and without the stigma associated to consulting a therapist (Cuijpers, Van Straten, and Andersson 2008; Postel et al. 2008). In Scandinavia, such services are provided by the public health sector and by voluntary organizations and might indicate a shift in the delivery of mental health services (Andersen and Svensson 2013).

### *Increasing demands of the labour market*

Compared to the 1960s, the labour market is currently characterized by higher unemployment rates, insecure job contracts, diversified career paths, an internationalized labour market and the expectation for workers to be flexible and proactive (see e.g. Muffels 2008). This situation can lead to higher stress at work and the fear of losing one's job (OECD 2012), that is, the features of the current labour market can work as barriers for persons with psychosocial disabilities and even cause mental ill-health. The creation of adequate work conditions for persons with disabilities represents, therefore, an important challenge for contemporary society and was included in the UN CRPD (article 27).

People with mental health problems have the lowest employment participation across Europe (Eurofound 2003); the employment rate of persons with common mental disorders is estimated at 60–70% (or 10–15% lower than for the population without mental disorder) and to 45–55% for people with a severe mental disorder (OECD 2012, 12). Based on the assumption that work has a positive influence on mental well-being (WHO Regional Office for Europe 2011), supported employment schemes have been developed in order to help persons with impairments (re)entering the labour market. For example, the Individual Placement and Support model (IPS) has shown positive results for supporting persons with psychosocial difficulties in Sweden (Bejerholm et al. 2015). The model presupposes that people want to enter the mainstream labour market and focuses on the person's preferences. Job search is initiated early in the process and job seekers receive individualized support in the workplace through a close cooperation between mental health services and IPS coaches. It is worth noting that IPS does require active agency from the person with psychosocial disabilities as well as from the side of employers and caseworkers. Besides the mainstream labour market, some people also find jobs in sheltered workplaces which are adapted to the needs of the employees and sometimes include a goal of reinsertion and rehabilitation. Outcomes are, however, mitigated and a study about Swedish sheltered workshops concluded that this type of work is stigmatizing and contributes to the construction of disability (Holmqvist 2009).

In sum, apart from measures designed to enhance the employability of the individuals, there is a need to tackle the prejudices about psychosocial disabilities of the employers and create good work environments so that people can gain and maintain employment (WHO 2011a).

### *Active citizens*

The developments of the socio-economic context have brought changes in the construction of citizenship in the past few decades and Johansson and Hvinden (2007a, 6) analyse these changes as a 'turn towards active citizenship'. For the republican understanding of citizenship, this means that the state encourages citizen participation and, in the context of the promotion of a participation-led welfare state, user participation receives particular attention (Johansson and Hvinden 2007b, 46). An active turn in the liberal understanding of citizenship can be noticed in the call for rights to be balanced with duties. That is, states emphasize that rights are conditional (Johansson and Hvinden



2007b, 41). Finally, the libertarian understanding of active citizenship rests upon 'the belief that people should take responsibility for their own well-being and protection against risks by exercising choice in the market and in relation to public provision' (Johansson and Hvinden 2007b, 45). Since citizenship refers to the relationship between a nation state and its members, changes in expectations from citizens go together with changes in the role of the state. With regard to disability, the critique according to which welfare states treated disabled people as dependent patients brought a change in policy from a focus on welfare provision to a discourse on citizenship and human rights, as appeared, for example, in the Swedish government's proposition entitled 'from patient to citizen – a national strategy for disability politics' (prop. 1999/2000, 79). However, while some have welcomed this change of perspective as good news for persons with disabilities, others are concerned that this shift only benefits the citizens who are aware of their rights and know how to claim them (Hilberink and Cardol 2013). Indeed, even if a wide range of support is available, many persons with psychosocial disabilities are unlikely to obtain support from the welfare state at the moments when they face great distress, if welfare provisions require active agency from their part.

### Discussion: active citizenship and the role of the state

We argued that psychosocial disabilities should be understood as a complex and dynamic phenomenon resulting from personal and environmental factors. Citizenship on the other hand, is a normative concept which carries narratives and expectations about the role of the state and its citizens. Halvorsen and Hvinden (2013) have summarized the republican, socio-liberal and libertarian understandings of active citizenship in three concepts: influence, security and autonomy. That is, the republican conception is linked to the capacity of the individual to influence decisions related to society, the socio-liberal conception underlines the importance of rights to be able to enjoy a basic level of security and the libertarian conception is about having autonomy and being able to choose how to live one's own life (Halvorsen and Hvinden 2013, 20). Together, these three concepts form the conditions for enabling disabled persons to enjoy non-discriminated life situations on an equal basis with others (Waldschmidt 2013, 64).

Each country has its own tradition of citizenship combining different elements of the different forms of citizenship distinguished at a theoretical level. Since we referred to examples from Sweden throughout the article, we take this country as an illustration to discuss the role of the state when it comes to enhancing full citizenship for persons with psychosocial disabilities. In the republican perspective of citizenship (related to the concept of 'influence'), civic membership in the community is strongly emphasized. Activities like voting, involvement in political parties and voluntary work are encouraged and civil society provides a basis for criticizing the shortcomings of the state and the market (Abowitz and Harnish 2006). This is observable in Sweden where civil society organizations play a crucial role in democratic governance and formulation of policies and laws (Trägårdh 2007). Indeed, most disability organizations are financially supported by the state and are considered as dialogue partners for decisions regarding disability issues. Moreover, citizens are encouraged to participate in political decisions in general and Sweden does not restrict the right to vote on the basis of mental capacity. The socio-liberal view of citizenship (related to the concept of 'security') draws attention to the social rights of the citizens in the modern welfare state (Marshall 1992). Sweden is usually considered in terms of the Nordic welfare model, which is characterized by universalism, generous welfare provisions and collective social rights. Interestingly, the disability legislation adopted since the 1990s (inspired by the Independent Living Movement in the United States) forms an exception because it introduced individualized social rights in addition to collective social rights in Sweden (Svedberg and Trägårdh 2012). Concerning social rights, it should be noted that the Swedish welfare provision was impacted by the privatization of many services and the cuts in the welfare budget during the last two decades. Finally, the libertarian conception of citizenship (related to the concept of 'autonomy') implies that individuals should be able to decide about

their own lives without interference of the government. The libertarian position is therefore strongly opposed to compulsory treatments and holds that the idea of mental illness is constructed to legitimate control through psychiatry and law (Sayce 2000, 117). The right to an autonomous life for persons with disabilities is emphasized in Sweden through the 'The Act Concerning Support and Service for Persons with Certain Functional Impairments' (Regeringen 1993), but the Swedish legislation also includes the possibility to impose compulsory care to substance abusers, which stands in opposition to the liberal thinking that stresses individual rights (Svedberg and Trägårdh 2012, 14).

## Conclusion

This article has drawn attention to the developments from a welfare discourse to a rights discourse ('from patient to citizen') in relation to mental health in Europe. Our argument is that this shift presents both new opportunities and new risks for individuals with psychosocial disabilities and that a sociological perspective is crucial for counterbalancing a rights-based debate which has a tendency to narrowly focus on the individual and omit the responsibilities of society (Sayce 2000, 127). Building on a social approach to mental health and on a multidimensional understanding of citizenship, we pointed at the role of the state as the main responsible agent for ensuring that human rights are respected for all people living in a given country and for providing the conditions for being able to participate in society. Hence, we referred to the UN Convention on the Rights of Persons with Disabilities which strongly encourages the signatory states to develop clear measures enhancing the rights of persons with disabilities. The goal of full citizenship for all is still far from being a reality but states and international agencies are developing strategies and policies targeting psychosocial disabilities. Scholarship has drawn attention to the fact that states need to recognize that full citizenship covers different types of rights and that psychosocial disabilities are embedded in a larger socio-structural context (see e.g. Halvorsen and Hvinden 2013; Morrow et al. 2009; Rogers and Pilgrim 1989; Sayce 2000; Stein and Stein 2007; Waldschmidt 2013). This means that states need to adopt a holistic and integrated human rights approach which 'combines the type of civil and political rights provided by anti-discrimination legislation (also called negative or first-generation rights) with the full spectrum of social, cultural, and economic measures (also called positive or second-generation rights)' (Stein and Stein 2007, 1205). Moreover, states should tackle problems grounded in the wider structural environment such as housing and job availability, structural classicism, racism and sexism and the stigma attached to psychosocial disabilities (Rogers and Pilgrim 1989, 54). Most importantly, states have to make sure that legislations and policies are implemented and become reality for all citizens. Further research is needed to get a better understanding of the way in which citizenship is promoted by governmental and non-governmental initiatives. For this purpose, we suggest that a multidimensional understanding of citizenship combined with a social, relational and dynamic approach to psychosocial disabilities offers a fruitful point of departure.

## Notes

1. The liberal conception of citizenship builds on the work of T.H. Marshall (1992) and John Rawls (1972) cf. Miller (2000, 43).
2. In this article, we limit our discussion to the question of full citizenship inside a country, but there is also much to say about the relationship between mental health and immigration (see e.g. Menzies et al. 1998; Sayce 2000, 56ff.).
3. Rationality is still an important element of citizenship and several authors have argued (see e.g. Arneil 2009; Dowse 2009) for reconsidering the foundations of citizenship so as to include all individuals in society, and in particular persons with intellectual impairments.
4. <http://www.un.org/disabilities/latest.asp?id=169> (retrieved 9 June 2015).
5. For a discussion about old and new risks in relation to the European welfare state see also (Taylor-Gooby 2004).
6. Examples of such campaigns in Sweden include PSYKE in 1999 and (H)järnkoll from 2009 to 2014, which were conducted in collaboration with the Swedish Agency for Disability Policy and the Swedish umbrella organisation for psychosocial disabilities (National Coordination for Mental Health, NSPH).



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