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Why do people with mental distress have poor social outcomes? Four lessons from the capabilities approach



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ABSTRACT

Macro level data indicate that people experiencing mental distress experience poor health, social and economic outcomes. The sociology of mental health has a series of dominant competing explanations of the mechanisms at personal, social and structural levels that generate these poor outcomes. This article explains the limitations of these approaches and takes up the challenge of Hopper (2007) who in this journal proposed the capabilities approach as a means of normatively reconceptualising the experiences of people with mental distress, with a renewed focus on agency, equality and genuine opportunity. Using an innovative methodology to operationalise the capabilities approach, findings from an in-depth qualitative study exploring the lived experiences of twenty-two people with recent inpatient experience of psychiatric units in Scotland are presented. The paper demonstrates that the capabilities approach can be applied to reconceptualise how unjust social outcomes happen for this social group. It distinguishes how the results of using a capabilities approach to analysis are distinct from established dominant analytical frameworks through four added features: a focus on actual lived outcomes; the role of capabilities as well as functionings; being normative; and incorporating agency. The capabilities approach is found to be an operationalisable framework; the findings have implications for professionals and systems in the specific context of mental health; and the capabilities approach offers a fertile basis for normative studies in wider aspects of health and wellbeing.

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1. Introduction

Evidence indicates that social outcomes for people with mental distress are persistently poor. They experience lower life expectancy (Thornicroft, 2011, p.441), are more likely than most people to live in relative poverty (Rethink, 2003), be victims of violence (ODPM, 2004, p.25), live in disadvantaged areas (Tew, 2011, p.37), live alone (ODPM, 2004, p.86), have financial problems (ODPM, 2004, p.85), and have less access to employment (ODPM, 2004, p.1). They tend to experience stigma and discrimination (ODPM, 2004, p.24) including at work (e.g. Coppock and Dunn, 2010, pp.111–112). Life for many can become ongoing “predicament” (Barham and Hayward, 1991) or “trap” (Estroff, 1981) caught between living freely and being at risk of having freedom constrained by state actors, including, for example, having their ability to parent questioned (Read and Baker, 1996).

Macro-level research has also contributed to understanding

social determinants of mental distress. Income and relative poverty, unemployment and poor quality employment are associated with risk of mental disorders (WHO and Calouste Gulbenkian Foundation, 2014, p.24). Evidence suggests that “social injustice is killing people on a grand scale” (WHO Commission on Social Determinants of Health 2008, p.26), especially so for people with mental distress (2008, p.98, Table 9.1), determined by socioeconomic context and position, exposure, vulnerability and health care access.

The capabilities approach (CA), developed by Sen (e.g. 1980, 1999) and Nussbaum (e.g. 2006), has been operationalised for other social groups experiencing poor outcomes (e.g. Dean et al., 2005; Wolff and De-Shalit, 2007; Burchardt and Vizard, 2011). Hopper (2007) has argued that in principle the CA offers a framework for analysis of agency/structure relations, diversity, personal experience, normativity and the role of resources which interact to shape social outcomes for people with mental distress. Arguing that capabilities speaks “to citizenship as well as health” (2007, p.875), and enables accounting of “vital contextual features – the enabling resources, rules and connections that make prized

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prospects like a decent job feasible” (2007, p.871), he suggests that this merits empirical work (2007, p.876).

The aim of this paper is to explore the analytical advantages of using a capabilities approach to conceptualise social outcomes experienced by people with mental distress. It applies data from an in-depth qualitative study exploring the lives of people with recent experience of being in psychiatric hospital in Scotland, UK. The paper first outlines the dominant analytical frameworks used to interpret the experiences of people with mental distress. Concepts from the CA are then discussed and the study design described. The paper then highlights empirical findings which demonstrate contributions to analysis activated by applying the CA, namely: maintaining a focus on actual lived outcomes; taking into account what people could alternatively do (capabilities) as well as what people are doing (functionings); highlighting the role of agency; and using a normative framework. These demonstrate the promise of capabilities, as suggested by Hopper (2007), in providing an original explanation of how differential social outcomes happen for people with mental distress.

2. Social perspectives of mental distress and explanation of poor social outcomes

The dominant western interpretation of certain emotional experiences as ‘mental illness’, and the contingent model of treatment as being through a part-coercive psychiatric system of asylums, hospitals, diagnoses and physical, chemical and psychological interventions, was based on a number of dominant post-Enlightenment influences, including notions of rationality and irrationality (Foucault, 1967) and the power of the medical profession (Scull, 1975; Foucault, 1967). There is an underpinning assumption “that there is some underlying pathological process” (Busfield, 2011, pp.17–18) explaining these emotional expressions, subsequently contextualised by evidence on social determinants. The power of the state and psychiatric professionals in classifying people as mentally disordered is maintained through national mental health laws that include elements of compulsion, and also in more subtle forms incorporating community care and notions of “recovery” (Anthony, 1993; Harper and Speed, 2012).

The medically-dominated approach has provided some benefits for people with mental distress, evidence suggesting that medication may for some reduce ‘psychotic’ experiences at least in the short-term (Bentall, 2009, pp.219–221) and reduce repeated experiences in the longer term (Bentall, 2003, p.499); and that diagnosis can provide subjectively helpful explanations for confusing emotional experiences (e.g. Stalker et al., 2005). People with mental distress now spend less time living in physically segregated institutions (Bentall, 2009, pp.42–44; Busfield, 2011, p.178). However, the transformative promise of recovery is institutionally weak in practice (Hopper, 2007; Davidson et al., 2009) whilst arguably more insidious in terms of social control (Davidson, 2003, p.36).

It is against this medical conceptualisation and the persistent evidence of people with mental distress experiencing poor social outcomes, that the sociology of mental distress has been positioned. Whilst these perspectives cross-cut, producing “sedimented layers of knowledge” (Rogers and Pilgrim, 2010, p.11), epistemological ‘waves’ can be distinguished.

Conflict theory-based structuralism uncovered the dominant social norms and professional powers that maintained social injustice for people with mental distress (e.g. Foucault, 1967; Scull, 1975). Symbolic interactionist and social constructivist studies demonstrated the impacts of these power-inflected social relations at a micro-level, including stigmatisation and labelling (e.g. Szasz, 1960; Goffman, 1961; Scheff, 1966). Whilst the former approach

minimised the agency and diversity of people with mental distress, the latter underplayed analysis of wider structural influences on micro-level interactions. Both types of study influenced a third wave of literature foregrounding ‘survivor’ experience of the psychiatric system, with an increasing role for user-led research into experiences of mental health services (e.g. Tew et al., 2006; Reynolds et al., 2009). Survivor-influenced approaches have reinforced the centrality of oppression of people with mental distress, arguing that the psychiatric system both denies meaningful choice and has not improved social outcomes (e.g. Plumb, 1993; Beresford, 2012). However, survivor-influenced research is opaque about diversity of user experiences beyond those which are oppressive (e.g. Reynolds et al., 2009) which holds the risk of leaving the analysis of material experiences of mental distress to medicalised epistemologies, and, as Tew et al. argue (2006, pp.11–13), is in conflict with taking user accounts seriously. These collective limitations have led to a fourth critical realist ‘turn’ (e.g. Rogers and Pilgrim, 2003) which seeks to incorporate all perspectives, including medicalised epistemologies and influences on social outcomes beyond the mental health system itself, whilst maintaining a normative stance (Watson, 2012, p.102). However, in the context of mental distress, this has been applied for the purposes of critique of the medical model (e.g. Rogers and Pilgrim, 2003; Pilgrim and Bentall, 1999) rather than to conduct primary research.

So, whilst successfully highlighting the power of dominant social norms and the oppressive role of professional powers within the psychiatric system (c.f. Bracken et al., 2012), these social perspectives leave analytical gaps. They can diminish normativity, for example in terms of the potential significance of the mental health system in preserving life. The focus on critique of the medical model means that sociological analyses tend to essentialise the agent and neglect diversity in distress trajectories (Bolton, 2008, pp.83–91). The focus on the dominant psychiatric model and system can diminish the role of multiple wider influences on social outcomes (Rogers and Pilgrim, 2003) whilst fuller analyses operate only at the level of critique.

Although the principle in survivor-influenced studies of acting as a “countervailing force to experts’ control and production of knowledge” (Rogers and Pilgrim, 2003, p.186) remains powerful, a gap remains for a theoretically-informed model to conceptualise the experiences of people with mental distress which can normatively draw these sedimented layers of research together, respecting concepts of diversity, agency, social relations and structure. Beresford (2012, p.159) notes that social understandings still lack a model with the power to explain disadvantage and with the potential to transform the way in which people with mental distress are socially perceived. Hopper (2007) suggests that the CA offers such a model.

3. The capabilities approach and mental distress

The CA has the potential to shed light on the social outcomes of people with mental distress in a way which is not restricted to use of services or compliance with treatment regimens because it focuses on whether all people have the freedom to live a valued life. Capabilities is analytically significant in the context of social understandings of mental distress as it does not assume oppression or social injustice, but offers a framework to explain how oppression may or may not occur in the context of the psychiatric system and wider social structures whilst maintaining a normative stance. So, it offers the possibility of bringing together both the biomedical and the social in the study of mental health, expanding the analysis.

The CA utilises a range of interlinking concepts to understand how people achieve social outcomes (see, for example, Robeyns, 2005; Nussbaum, 2011; Venkatapuram, 2011). From this range,

the contributions of functionings, capabilities, a focus on outcomes, agency, and normativity are strongly established (e.g. Deneulin and McGregor, 2010) and are the focus of this paper.

In the capabilities lexicon, functionings refer to what a person is doing; capabilities are the person's practical opportunity to make alternative, valued choices. Capabilities are "the substantive freedoms [that a person] enjoys to lead the kind of life he or she has reason to value" (Sen, 1999, p.87). The CA is concerned not only with what people *do* do, but what people *could* do: the range of alternatives from which people can substantively choose. To what extent, for example, are people with mental distress able to secure meaningful relationships, have children, and pursue satisfying work?

In the CA good social outcomes are understood not simply in terms of resources held or subjective contentment (Deneulin and McGregor, 2010, p.505). Capabilities treats human beings as ends not means (Deneulin and McGregor, 2010, pp. 504–506) and is interested in outcomes in terms of the "actual living that people manage to achieve" (Sen, 1999, p.73).

Agency is fundamental to capabilities, Sen arguing that "the good life is partly a life of genuine choice, and not one in which the person is forced into a particular life - however rich it might be in other respects" (Sen, 1993, p.39 n.26). A capabilities analysis would evaluate the degree to which, for example, service providers "support people in their own choices and pursuits" rather than "act as prerequisites or substitutes for the lives they desire to lead" (Davidson et al., 2009, p.41). For Hopper, in the context of mental distress the significance of agency is in the freedom to pursue "demanding, potentially destabilizing endeavours" so allowing the "dignity of risk" (2007, p.877).

Finally, the CA takes a normative stance. Nussbaum, for example, argues that her version of the CA, incorporating a series of threshold capabilities domains which all societies should be upholding for all citizens (2003, p.40), constitutes a "minimal account of social justice" (2006, p.71; see also 2011, ch.2). Venkatapuram's analysis of justice in health takes a distinctive starting assumption from disease or other health models, his capabilities definition of health being "her abilities to be and do things that make up a minimally good, flourishing and non-humiliating life for a human being in the contemporary world" (2011, p.20). This normative, ethical definition requires good health to be evaluated to a minimum social standard, regardless of disease status. This has particular significance in the context of mental distress, given the contested history of psychiatric diagnosis.

Together these demonstrate the ethical foundation of the CA: normatively exploring substantive freedoms and how these shape social outcomes; and quizzing whether institutional arrangements aid or hinder human flourishing (Holmwood, 2013, p.6). Evaluating social outcomes in terms of "what people are actually able to do and be" suggests a fuller analysis than exploring relations within the mental health system; Davidson et al. (2009) contend that the interest in human freedoms, diversity and self-determination inherent in capabilities can take analysis beyond institutional provision into the issues of social justice at the heart of interest for analysis of health and wellbeing. These suggest the potential for capabilities as a conceptual framework to build on existing sociological 'waves'.

Hopper (2007), Davidson et al. (2009) and Walcraft and Hopper (2015) have argued that applying the CA to understand mental distress from a social perspective using qualitative methods is overdue and may hold conceptual, analytical and theoretical advantages. Although several UK studies have aimed to apply capabilities as a method for evaluating mental health services (e.g. Lorgelly et al., 2008; Simon et al., 2013), only Tang (2016) has used in-depth qualitative methods to apply the CA to psychiatric

service users in the UK, with a focus on recovery in the Chinese community.

The next section explains the methodological approach.

4. Study design

The paper is based on data collected as part of an ESRC funded study exploring whether and how the CA can be applied to provide a normative means of explaining the social justice experiences of people with mental distress (Brunner, 2015). Individual interviews were conducted (December 2012 to October 2013) with twenty-two adults living in Glasgow with recent in-patient experience of psychiatric hospital, sixteen participants being interviewed twice. Ethical approval for the study was granted by the College of Social Sciences Ethics Committee, University of Glasgow.

Participants were purposively recruited as: having experience of being a statutory or voluntary inpatient in a psychiatric unit since the January 2006 implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003; not currently being subject to inpatient treatment; and currently using or not using psychiatric services. This limited the sample to those recently in hospital, reducing retrospective bias. The criteria of hospitalisation acted as a cipher for a likely significance of mental distress experience in each participant's life. In order to draw on a range of experiences, recruitment was through third sector mental health networks, advocacy groups, at a university, and through wider social networks.

Interviews were framed by combining concepts from the CA with sociological literature, seeking to: understand the relationship between personal, social and structural factors affecting lived experiences; consider the character of social justice experienced; and conceptualise this using concepts from the CA. They offered participants an opportunity to talk about their life as a whole, rather than focusing on service provision, averting a common constraint of research with this population (Rogers and Pilgrim, 2010, pp.242–251). As little was known about how the CA would relate to experiences, an innovative approach was used, adapting the research design of Wolff and De-Shailt (2007). The questions in the first interview were framed with implicit regard to the CA, enabling capabilities concepts to be induced. The second interviews were explicitly structured using the CA by devising an original diagram of threshold capabilities domains, adapted from the work of Nussbaum (2000, 2006) and Burchardt and Vizard (2011), to guide the conversation. Participants were encouraged to discuss the 'ingredients', or domains, in the diagram (Fig. 1) in relation to their own experience. An 'anything else' domain enabled participants to highlight additional domains of unanticipated significance.

Both sets of interviews were audio recorded with consent, transcribed, and thematised using Nvivo10 software. Following Braun and Clarke's conceptualisation of thematic analysis using a constructivist epistemology (2006, p.85) and an interpretative approach to analysis (2006, p.84) the study sought to draw out "underlying ideas, assumptions and conceptualizations – and ideologies" (2006, p.84, their emphasis). Therefore, a weak social constructivist position was used (Rogers and Pilgrim, 2010, pp. 15–16) seeking to access discourses, perceptions and meanings, whilst striving for objectivity within this. This approach was compatible with social perspectives on mental distress, which also advocate the engagement of personal experience with structural barriers (e.g. Beresford, 2004, p.218).

In Nvivo10, nodes and levels of sub-node were prioritised by evaluating: saliency of theme across the sample; in-case or small group significance, indicating an exceptional narrative on the research questions; and with reference to theoretical and empirical literature in the sociology of mental distress and in capabilities. This

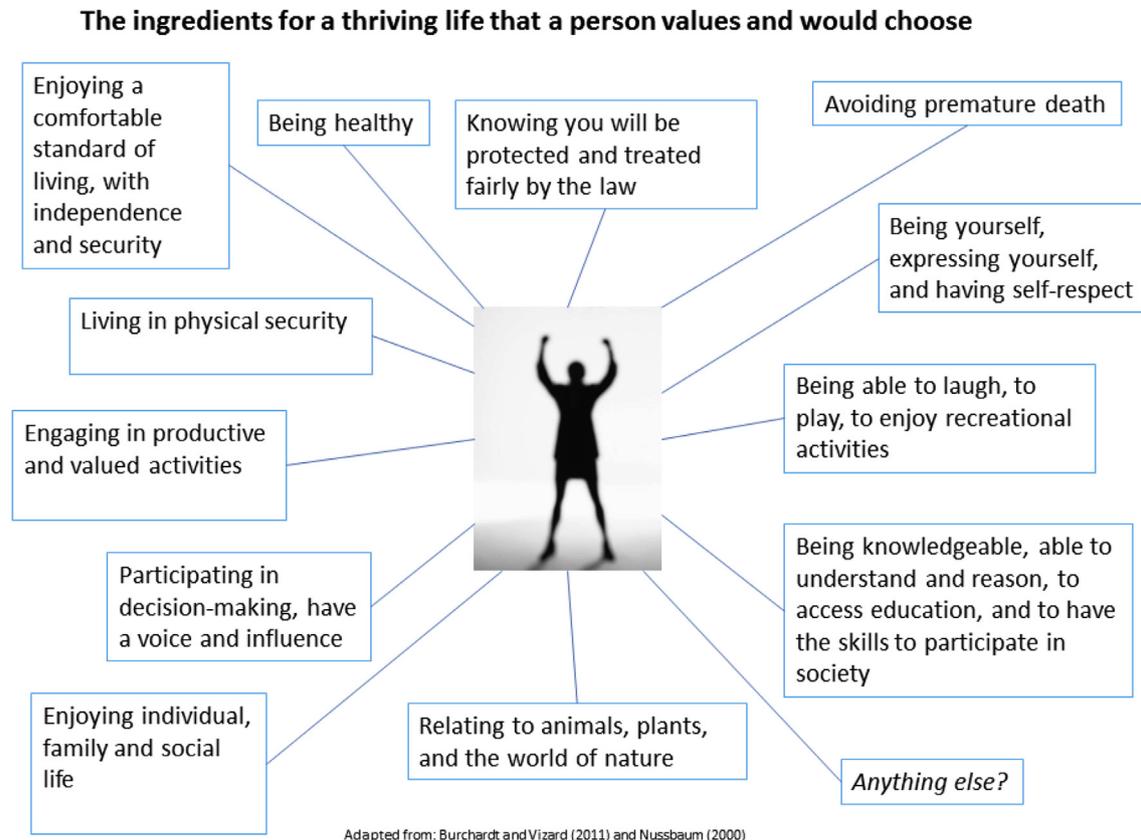


Fig. 1. Threshold capabilities domains diagram.

interpretive process continued until a secure understanding was gained, resulting in conclusive themes, including the four discussed below.

There were limitations to this approach. Data was subjective and no attempt was made to confirm peoples' accounts, although the second interviews provided an opportunity to check interpretations; there was no reliable means of comparing the depth or character of peoples' subjective experiences of mental distress, so the influence of this on outcomes was not explored; and the active choice of participants to join the study, and their connectedness with networks used for recruitment, potentially distinguishes them from others. The small sample reflects the persistent tension in social research between depth of understanding and breadth of generalisation (e.g. Silverman, 2005); Glasgow is not assumed to be representative of any other geographical area; and ethnic minority groups were missing from the sample, despite attempts to recruit, further limiting generalisability. Whilst the researcher's role as framer, interviewer and interpreter of the data shaped the study, research findings were sent to participants and gatekeepers in order to seek face validity. A future study could replicate the methods used.

Eleven men and eleven women participated in the first round of interviews, of whom eight of each participated in the second round. The age range was twenty-four to fifty-eight years, with age of first psychiatric hospitalisation ranging from fifteen to fifty-one. Sixteen participants received welfare benefits, several of these also undertaking minor employment or volunteering; four were students; two were in full-time work. Participants collectively recalled forty-nine periods in psychiatric units through their lives. Sixteen participants described self-harm or suicide attempts. Specification of these features was subject to recall, subjective definitions, and the

distinctive character of each interview.

In the interviews people talked about experiencing mental distress in voices and visions, about feeling low, about suicide attempts, and about feeling high - highs sometimes being insightful, but never entirely non-problematic. They talked about the mental health system and its sometimes positive short-term role in preserving life, but also about some very distressing inpatient experiences. They described the complications of medications and diagnoses, reinforcing the known reliability and validity problems of these (Bentall, 2003). Participants described how they used their agency, about how opportunities to achieve socially valued outcomes like education and employment were shaped, and about how structural features, especially the welfare benefits system, constrained agency and so their functionings, capabilities and outcomes.

5. Findings

Four interlinking themes emerged from the analysis which demonstrate the contribution that taking a capabilities approach offers: focusing on actual lived outcomes; considering what people could do (capabilities) as well as what people are doing (functionings); offering a normative framework for conceptualising these experiences; and maintaining a focus on agency.

5.1. Focusing on actual lived outcomes

The capabilities focus on outcomes, or what people are actually able to be and do in life, constitutes a move away from evaluation on the basis of resources held, subjective wellbeing or other ciphers (Sen, 1980, 2010). This is exemplified here by comparing the

experiences of two participants, Arthur and Martin, in relation to the valued social outcome of gaining employment.

For the five years since he was last discharged from hospital, Martin had support workers from a voluntary organisation visiting him at home seven mornings a week. They “Have a tidy up, sit and talk, do social things, see I’m alright, make sure I take my pills and that sort of thing”. However, Martin’s preference was to find employment: “If it’s a decent job that pays well I’ll be very happy, very happy”. Whilst Martin had avoided further psychiatric hospital admission, by focusing on outcomes, a capabilities analysis exposes an ambiguity in the role of the support workers: are they helping Martin to achieve a valued social outcome, or are they placing him in a “trap” (Estroff, 1981), deprived of the “dignity of risk” (Hopper, 2007). Martin remained out of work, but rather than focus on helping him to achieve this outcome, professionals instead focused on his domestic care.

Psychiatry, with its focus on managing mental distress, could also constrain the possibility of gaining employment. At his first interview, Arthur described how his desire to change from supported employment to mainstream employment was constrained by medical advice:

I would like a full-time job. The doctor says I can’t do it ... every year I think I’m getting better because of medication and every year she says ‘you cannae go to work the now’ ... I used to pick up voices so the doctors don’t want me to go to work and pick all those voices up ... I don’t think I’m going to get a full-time job but that would be a dream come true.

By the second interview, an incident at his supported employment project in which he needed help with shovelling and was “knackered” had led to Arthur changing his position:

...the psychiatrist is right ... I couldn’t ... handle the pressure of a full time job ... I’m not going to be able to work ... [but] I can still go and do volunteer things ... three times a week, a couple of hours a day ... so that’s fine with me at present.

In interview one Arthur wanted to achieve the social outcome of full-time paid work; in interview two voluntary work was sufficient. But Arthur and his medical team had self-limited his preferred outcome, having a mutual limited conception of possible jobs - not all require physical fitness, for example. Whilst, on the face of it, this position sought to reduce the possibility of reoccurrence of Arthur’s mental distress, the experience of Martin demonstrates how this can frustrate the possibility of achieving better social outcomes.

Using a capabilities analysis to focus on actual experienced outcomes, these stories reveal how professionals can constrain the potential for people with mental distress to achieve socially valued outcomes such as employment, so adding to explanation of how poor macro-level outcomes happen for this group.

5.2. Using capabilities and functionings to expand the analysis

Exploring experiences using the concepts of functionings and capabilities demonstrates how public services can open up or close down opportunities for people to expand their potential from what they *can* do to what they *could* do.

Prior to his admission, Gary’s past employment functionings were in factory work. He had dramatically tried to kill himself after a long period with poor mental health and an unsatisfying job, on unchanging anti-depressants. On leaving hospital, Gary had time to pursue creative and therapeutic activities as part of his

rehabilitation. These had offered him a glimpse of new capabilities, with the worst scenario being going back to the same type of unsatisfying work:

...you get quite a lot of freedom when you’re mentally ill because your sick ticket’s out in years ... I’ve got the freedom to come in here and play a drum and ... make a bike and then suddenly you get that [job] interview and it can be all just snatched away, you’re back in the rut, thirty quid a week and your vision is a cleaning job down at the shopping centre ... that is not what I want tae be looking at ... but they think that’s good ... I think that looks bloody as if I’m going to be back in [psychiatric unit] in six months [laughs]...

Gary had a probation officer who aimed to get him into work as a forklift driver similar to the factory jobs he held before his suicide attempt:

I got my probation officer telling me a couple of weeks ago ... that you could go for like a forklift licence ... her drive is to get me back [into work] and I’ve just found the ... bike and the music course ... it’s took me this long tae get back intae wanting tae live again and wanting tae get out - never mind spending all day in a dingy, dark warehouse collecting cardboard boxes for somebody.

The probation officer was revisiting Gary’s functionings, attempting to get him into comparable work to his previous experience. But Gary now saw a new set of capabilities as possible, revealed by experiencing music therapy and bicycle repair, alongside his insight that his previous work environment stimulated his mental distress. His desire to widen his capabilities conflicted with his probation officer’s desire to return him to the same employment field, maintaining the functionings that had led to poor social outcomes and simultaneously limiting his capabilities to change direction.

However, professionals could sometimes provide the basis for expanding capabilities. Prior to psychiatric hospital, Francine had a responsible role in the armed services, which she left as she felt that her expression of mental distress was in conflict with the values of her employer:

...it’s just not appropriate for somebody – an officer – to be walking round a base with tears streaming down her face. Or there were days where I felt I couldn’t put my uniform on because I felt that I was betraying what that uniform stood for.

Francine’s psychiatrist helped her to reconsider her employment functionings:

...my psychiatrist ... had this sympathy towards ... more spiritual, holistic type ideas, instead of just plugging you full of drugs and sending you home, he would do a bit of work. And we ended up one day with ... the thought for me that I wanted to explore ministry again.

Francine was now in training to become a Minister, demonstrating that mental health professionals can open up new capabilities, leading to the potential for new functionings and valued social outcomes.

Using capabilities and functionings enables us to see how institutions and professionals can restrict people with mental distress from changing direction in life. This is important because established evidence on social determinants suggests that placing

people back into the same situation – in capabilities terms, maintaining the same functionings - tends to result in the same outcomes. However, the data show that professionals can also support people with mental distress to widen their capabilities, opening up potential for being and doing different things, and so the opportunity for changing their social position.

5.3. Applying a normative analytical framework

Whether people are able to do and be activities above a minimum threshold in the domains framework (Fig. 1) offers a normative capabilities contribution to understanding social outcomes. Using the domains diagram in the second interviews highlighted a variety of elements that enabled people to live well in each of the domains. The domain 'Relating to animals, plants, and the world of nature' (Fig. 1) drew out the high value that pets can have, even in terms of life and death: "one of the things that keeps me going is my gerbils because then I think well if I die and no one finds me ... what's going to happen to the gerbils?". However, achievements in this domain could be constrained. Jon talked about how lack of money could stop him doing hillwalking to support his mental health:

...when it's not too far it's ok to drive because of the petrol, but you don't want to be going too far on your own if you can get a lift or get some people to go in your car, try and cut the cost. So because of that it's not always easy...

Lack of money strongly constrained participants achieving good social outcomes across the domains that capabilities argues that all should be able to achieve (Nussbaum, 2011), an example of what Wolff and De-Shalit (2007) term "corrosive disadvantages". The impact on the 'Enjoying individual, family and social life' domain was especially salient. Tim highlighted the impact on being with his young son who stayed at weekends if his income was reduced at his forthcoming disability benefit review:

...because I get middle rate [disability benefit] I have my travel card ... if I go to three [mental health organisation] classes, [drama group], that's going to cost ... twelve pound maybe. And then ... getting ... to [town] on the train and bus for myself, and then paying for myself ... and [son] to get back. And then [return journeys]. So you're talking ... thirty-five pound a week ... so if I didn't have this travel card I'd be 'snookered'. And the only reason I get this travel card is because of [disability benefit] ...

Fiona and Gary were each affected by the UK Spare Room Subsidy, or 'Bedroom Tax', policy. Their spare bedrooms were regularly used for family members to stay and provide support. However, Fiona and Gary's incomes would now be reduced if they wanted to continue this, the policy either reducing their ability to 'Enjoy individual, family and social life' or reducing their already low incomes ('Enjoying a comfortable standard of living, with independence and security').

Fiona and Gary, amongst others, lived with persistent threat to their 'Being healthy' domain (Fig. 1) due to inadequate incomes or disruptions to their welfare benefits having a potential impact on their mental health. Taking a normative approach shows how stabilising social security at a decent level for people with experience of psychiatric hospital would make a strong basis for people to achieve personally meaningful outcomes across other domains.

In the 'Enjoying individual, family and social life' domain (Fig. 1) participants discussed tensions between having children and experiencing mental distress (Read and Baker, 1996). Harry and his

partner had not had children as his wife experienced mental distress and took Lithium during the period in which they considered this:

R: ... we don't have any children so and that was a choice because of mental health with [wife] because she ... wouldn't have been able to cope with that and certainly the medications that she was on ... she'd have had to come off of them to have children, and that just wasn't open for discussion.

I: Oh right, that's interesting. So the hospital or hospital specialists were of the view that she would have to come off.

R: Yes.

I: Or you yourselves were convinced of that?

R: We were convinced of that, they said the same because the medications they said were toxic to children. And ... she would have to come off them, and if you'd known her at the time ... she was catatonic half the time and that wasn't down to medication that was just down to depression in the true sense of the word where everything's just shut down.

Their ability to achieve this element of the 'Enjoying individual, family and social life' domain was disadvantaged by a combination of subjective mental distress; their understanding that medication did benefit Harry's wife's distress; and their understanding of the contraindication of lithium with pregnancy affecting the health of their child, a capabilities analysis showing how freedoms and social outcomes are shaped.

Arthur feared that the stress of children might stimulate his and his wife's subjective distress, was apprehensive about potential removal of children by authorities, and was afraid that children may be affected by his own distress:

...well I'm schizophrenic and she's manic depression Richard, I don't think we should have the responsibility of having a child ... maybe when I wasn't schizophrenic but the now I don't think I could cope ... or she could cope, I think it would put us into screaming and shouting and that'd put us into a bad depression. So ... we know we couldn't have any kids ... [W]e've discussed it ... people [wife] knew was ... schizophrenic and got the children taken off them because they couldn't watch them ... that is what would happen to us...

Arthur's ability to achieve this element of the 'Enjoying individual, family and social life' domain (Fig. 1) was constrained by his fatalistic assessment of negative consequences. This was contraindicated by another participant, Bridget, with multiple diagnoses, psychotic experiences, experiences of self-harm, and hospitalisations. She had brought up her daughter ("I've seen some of my notes and I've read through them ... every single one ... said that I was always a very warm and loving mother...") who was now an adult with her own child. They now brought support and meaning to Bridget's life. This not only demonstrates that people with mental distress do not have to follow the scenario feared by Arthur, but also that people can be denied future supportive familial relationships if the dominant normative experience of having children is positioned beyond their capabilities.

Dominant norms, for example that people with mental distress cannot cope with children, are made a living reality by, for example, weak social supports for parents with mental distress (Stalker et al., 2011); a continuing medicine-first approach to managing mental distress; few options for alternative management programmes to medication; lack of informed advice about how other families (such as Bridget) have parented with mental distress; and lack of information about adoption or fostering choices. These reflect, adapting

Sennett and Cobb (1972), one of the “hidden injuries” of mental distress.

5.4. Incorporating agency

The data demonstrate participants using agency, another core capabilities principle, both within and outside the mental health system, and show how this was shaped by professionals and systems.

In the community, people used their agency in order to manage their feelings of mental distress, demonstrating that they are not passive recipients of professional support. Walking, exercise, cooking, and changing lifestyles were used by people to help them through difficult times. Jon demonstrated the diligence and focus required: “You need to put in a lot of hard work yourself ... [Since] I gave up caffeine, coffee ... I've had less problems mentally ...” and Sophie described her active rebalancing of her lifestyle: “...[I've] cut back on social things ... it was like ‘no wonder I was unwell’ because I was working, I was volunteering at three different places, I was in a band ... I was just trying to fill up my life.”

Since her psychotic ‘high’ Becky had given up drinking alcohol and her occasional use of recreational drugs, as she was now “scared of being put in a psychiatric unit. And losing all control ... I'm probably also scared of, like, suicide ... And I'm scared of psychosis”. Her experience highlights the situatedness of agency, her specific choices made to manage a threat to life itself but also by fear of the psychiatric system.

Harry's mental distress made it hard for him to leave the house, so his pre-mental distress pleasures of watching rugby, mountain climbing and holidays “don't happen”. However, he argued that he could still live well as he had created enough “distractions” and “variety” within the home: computer-based activities, watching DVDs, and gardening. Although he was using his agency in his own way, dominant normative expectations about how life should be lived impinged as mental health professionals sought to influence Harry's agency: “I usually see somebody once a week who comes and spends an hour or so with me and will try and force me to go out [laughs]”. Harry accepted that his mental distress largely confined him to home, but he viewed himself as having a rich lifestyle, engaging with the world through the internet – albeit a very different one from his pre-distress lifestyle. However, professionals sought to re-shape Harry's agency towards a standard lifestyle, rather than working to improve the social outcomes to be achieved through Harry's rich and varied indoors lifestyle.

In the community, Jon felt that mental health professionals were forcing him into a path of taking medication with no alternative treatment model considered:

I've not got a problem with the Crisis Team, their qualifications or how they go about their job. The only problem I've got is that you'll not get treated if you're trying to bring any other beliefs, or how you want to see your treatment go ... So I took up my own plan. I've stopped taking two medications.

As well as reinforcing Harry's experience of the domination of agency by medical professionals, this underpins Plumb's (2012, p.22) argument that the medical-ethical principle of informed choice only exists if people have alternative choices that they are able to pursue. Jon pursuing his own covert plan shows that agency remains, despite the perceived control taken by professionals.

This analysis underscores the theoretical concerns of Plumb (1994) and Beresford (2004) over both respect for atypical lifestyles and behaviours, and the role of mental health professionals in promulgating dominant normative lifestyles. It shows that people with mental distress use agency and that this is a necessary

feature to include in explaining social outcomes. Further, a capabilities analysis highlights that the mental health system seeks to restrict agency as its model for seeking to establish the potential for longer-term improvement in social outcomes. The problem is that the macro-level data show that these improvements in social outcome tend not to result.

6. Discussion and conclusion

Exploring peoples' experiences using capabilities demonstrates that poor social outcomes are shaped by more than mental distress experiences alone or the mental health system alone, so complementing biomedical and ‘survivor’ narratives. The data also show how systems and professionals tend to shape social outcomes for people with mental distress through regulation and containment. However, the application of capabilities draws out the complexity surrounding this, the agentic, social and structural working in tension, and the power of the mental health system not removing peoples' agency. Thus capabilities also bridges structuralist and symbolic interactionist framings.

The CA offers a novel and practical approach to understanding how poor social outcomes happen for people with mental distress. The foregrounding not only of functionings – what people *do* do – but also capabilities – what people *could* do – offers a practical framework for exploring how to change those dismal outcomes. The analysis demonstrates how the practices of professionals and systems tend to narrow possibilities for people to change their social circumstances, rather than seeking to widen peoples' capabilities and work with their agency. Instead, the analysis suggests that to improve social outcomes, the role of professionals and systems should be to support peoples' personal interests and potentials, and also to secure peoples' threshold domains.

However, the study also highlights the complexity behind this, adding to the “recovery” agenda: agency is inherent, but irregular; and capabilities are personal. So, account needs to be taken of individual volitions and interests. But by also focusing on the normative: how to support people to secure threshold capabilities or minimum social standards – such as having children or gaining meaningful work – whilst being attentive to the potential impact of corrosive disadvantages acting against the achievement of particular domains, such as very low or insecure incomes, the opportunity for a capabilities-founded recovery agenda emerges. The evidence suggests that this agenda actually necessitates a threefold shift in the role of professionals: working with agency and supporting heterogeneity; supporting people to attain valued social outcomes above minimum standards; and securing threshold capabilities. This also implies that professionals and systems work increasingly with the challenge posed above by Rogers and Pilgrim (2003) in relation to the question of who is the ‘expert’ and whose knowledge counts.

The CA adds methodological, theoretical and normative value to understanding how poor social outcomes tend to be reproduced for people with mental distress. It can be operationalised in a way that complements core sociological concerns of relations between agency and structure, and holds potential for bridging biomedical and social approaches. The study design can be replicated to explore the reproduction of poor social outcomes in wider health and wellbeing contexts. The promise of capabilities offered by Hopper in this journal (2007) is justified; its concepts offer a fuller and original explanation, and with the potential to transform (Beresford, 2012, p.159).

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