A Capabilities Approach to Mental Health Transformation: A Conceptual Framework for the Recovery Era

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ABSTRACT

Recent commissions in Canada and the United States have stipulated recovery to be the overarching aim of mental health care and have called for systems of care to be transformed to be made consistent with this aim. If these efforts are not simply to repeat the mistakes of the past, a new conceptual framework will be needed to provide an alternative foundation for rethinking the nature of care for people with serious mental illnesses. In this paper, the authors identify the limitations of the conceptual framework of the de-institutionalization movement and then offer the capabilities approach developed by Sen (1992, 1999) and others as a more adequate framework for the post-institutional era.

Recent years have seen the publication of two landmark reports in the history of mental health policy. In 2003, the U.S. government released the final report of the President's New Freedom Commission on Mental Health entitled *Achieving the Promise: Transforming Mental Health Care in America.* In 2006, the Canadian government released a report by the Standing Senate Committee on Social Affairs, Science and Technology entitled *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (Kirby & Keon, 2006). One of the many things that are interesting about these two reports is the similarity in their titles. The "promise" that we are being called on to achieve in the United States is that of the deinstitutionalization movement of the last half-century, aimed at enabling individuals with serious

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mental illnesses to lead normal lives in the community (Joint Commission on Mental Illness and Health, 1961). It is these same individuals whom we are now, "at last," being asked to bring "out of the shadows" by the Canadian report. As both reports amply document, previous efforts to reform mental health failed to achieve their aims, and it is now time to try once again to transform the system. But how? And how can we ensure that we will get it right this time, rather than merely repeat the mistakes of the past?

On this score, neither report unfortunately is as helpful as we might like. It is true that both reports unequivocally endorse the "recovery" vision that has been emerging over the last three decades from a variety of sources, including the mental health consumer/survivor/user movement, longitudinal clinical research, and the field of psychiatric rehabilitation, moving this promising notion from the margins of the field squarely onto centre stage (Anthony, 1993, 2000). What is not at all clear is how the field needs to transform itself in order to be consistent with this emerging vision of recovery (Davidson, O'Connell, Tondora, Staeheli, & Evans, 2005; Davidson, O'Connell, Tondora, Styron, & Kangas, 2006; Jacobson & Curtis, 2000).

In prior publications, we have argued that one dimension missing from previous efforts to transform mental health services, and to which we must give priority in current efforts if we are not simply to repeat past mistakes, is that of restoring the rights of persons with serious mental illnesses (e.g., Davidson, 2006; Davidson et al., 2006). In the following article, we develop this line of argument further to propose the adoption of a capabilities approach, based on the work of Amartya Sen (e.g., 1992, 1999), as a guiding conceptual framework for incorporating a rights perspective into the work of transformation. Our proposal is based on our assessment that the conceptual framework offered a half-century ago by deinstitutionalization is no longer adequate to the tasks at hand and that a new conceptual framework is needed for the "post-institutional" era (Minkoff, 1987), an era which is to be guided by the emerging recovery vision. We begin by highlighting some of the limitations of the current approach, and then move on to describe the capabilities approach as offering a promising foundation for the proposed transformation of mental health care.

BEYOND DEINSTITUTIONALIZATION AND COMMUNITY TENURE

In reading through materials from the early days of deinstitutionalization, and reflecting on the mechanisms developed to effect the depopulation of mental hospitals (e.g., community mental health centres, entitlement programs), one gets the impression that the sole function of mental health services was to treat and eradicate the illness. The fact that this statement appears obvious confirms the central role of medical treatment as an underlying core assumption of the overall approach. But what other functions might mental health services serve? Several other functions were proposed for the developing community mental health centres, including prevention, community education, and community consultation (Snow & Swift, 1985). As primarily treatment facilities, though, the model of service delivery devolved to one of acute care involving office-based therapy and administration of psychiatric medications (Snow & Newton, 1976). This approach assumed that people with psychiatric disorders would be able to benefit from these treatments to resolve their episodes of illness so that they would then be able to live in a "normal manner" in the community (Joint Commission on Mental Illness and Health, 1961, p. xvii). Treatment would reduce the illness to a point at which normal life could be resumed with minimal, if any, residual symptoms. People would be cured of the illness first and then return to a normal life afterwards.

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Paradoxically, perhaps, this policy direction evolved during a time when the illnesses for which people were being treated were considered largely to be incurable. Even if not incurable, the field quickly learned that a combination of Thorazine and therapy was inadequate to engage people in care, not to mention to eliminate the barriers to their returning to a normal life. By the 1970s, when it had become clear that this model was not meeting the many complex needs of persons with serious mental illnesses, the community support movement was launched (Turner & TenHoor, 1978). An idealistic effort from which the recovery movement derives many of its values, this movement has played a key transitional role in bringing the field to where it is today through the introduction of such advances as assertive community treatment, supported housing and employment, self-help, peer support, and family support. With recognition that many persons with serious mental illnesses were not being served adequately by office-based care, practitioners developed an array of intensive community-based services and supports to close the gap in care people faced upon discharge from the hospital.

We view the community support movement as transitional for two reasons. First, it did not bring about a fundamental rethinking of the original conceptual model of recover first and get your life back later. The movement made initial forays away from acute care toward a disability model, but was not able to complete this process (e.g., Hoge, Davidson, Griffith, & Jacobs, 1998). This is one of the reasons why current systems are faced with the contradictory mandates of providing community supports to people with enduring disabilities but then having to terminate those same supports (e.g., job coaches) after an initial period when the person fails to show adequate improvement. When viewed from the perspective of a disability model, this would be equivalent to retracting a person's wheelchair after a year or so because he or she had not relearned how to walk.

The second reason for viewing the community support movement as transitional is that it continued to focus almost exclusively on what mental health practitioners needed to do, or to provide, in order to treat the illness. The idea that recovery is actually the responsibility of the person with the illness, and that it is primarily up to the person to pursue, establish, and enhance his or her own recovery—as opposed to recovery-oriented care, which is the responsibility of practitioners to offer—is a fairly recent development (e.g., Davidson et al., 2006; Davidson & White, 2007). We view this fact as a further by-product of the acute care model we described above, in which the person's only role while ill was to receive care. We suggest that this is not merely a semantic difference, but leads to a substantive difference in practice to shift from viewing people with mental illnesses as passive recipients of the actions of others to viewing them as active agents in their own recovery.

It is perhaps easiest to see the implications of this framework in how we currently assess the "outcomes" of care. In other words, how do we conceptualize the "life in the community" that we are striving to make available to everyone?

Historically, one way we assessed outcomes was by counting the days a person spent outside hospitals or other institutional settings such as jails—a concept we might term "time *in* the community" or "community tenure." From the prominence of this indicator, one might surmise that the objective of deinstitutionalization was not so much to enable people to have a life in the community as it was to get and keep people out of the hospital. At its inception, for instance, assertive community treatment was conceptualized as a "hospital

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without walls" (Stein & Test, 1978, 1980). This approach made sense earlier in the process of closing mental hospitals, when it still seemed like a formidable challenge to find ways to support people outside of hospital settings. But now we are faced with entire generations of individuals with serious mental illnesses who have never lived in hospitals in the first place, and whose use of hospitals is limited to acute stays of days or perhaps weeks. The goal of getting and keeping people out of hospitals is clearly not equivalent to the goal of affording them a life in the community to be maintained in a normal manner. *Time* in the community is not the same as *life* in the community.

What is the difference between the two? In the first case, there does not appear to be any positive conceptualization of what such a life might entail beyond the desideratum of staying out of a hospital or jail. This may be because our role has been to eradicate the illness; it has been the person's responsibility to pursue his or her life once the illness was contained. Such a division of labour is not only simplistic but also overlooks the active role people have to play in learning how to contain, or how to deal with the enduring presence of, the illness. In a post-institutional era, it is important to recognize that both of these tasks take place within the context of the person's ongoing life *in* the community (Davidson & Strauss, 1995). People can no longer be viewed as resuming their lives at some point later (i.e., when the illness becomes more manageable), because they are always already engaged in the process of having to live their lives now.

Previous models did not have to grapple directly with the fact that people are always already living their lives in the community in the presence of mental illness. This fact has been introduced as the goal posts of care have moved from hospital discharge, to community tenure, to emerging visions of recovery—visions that hold out the expectation that people with serious mental illnesses will be supported in their efforts to live meaningful and gratifying lives in the community. It is in order to embrace this fact of the active role people play in their own recovery, and to explore its various implications for practice, that we suggest a capabilities approach is needed.

THE CAPABILITIES APPROACH

What is the capabilities approach, and how is it relevant to mental illness? The capabilities approach was initially developed by economic theorists and political philosophers keen to emphasize that any legitimate approach to social justice must begin with the recognition that human beings are agents who need to be free to determine their own lives. The concept of agency and the freedom to exercise that agency autonomously is the core aspect of human nature on which this approach to political and economic theory is built. In part due to its role in reorienting the human development program of the United Nations to promote freedom around the world, this approach has been increasingly influential in recent years, earning Sen the Nobel Prize in 1998. Stated in the reverse, the first priority of a capabilities approach is to liberate persons from the "substantive unfreedoms" (Sen, 1999, p. 8) currently constraining their exercise of agency, by encouraging political leaders, policy-makers, and activists to look beyond their usual concerns with material deprivations (e.g., poverty or hunger) to social and political deprivations such as oppression, prejudice, and discrimination as well. Expanding the scope to include freedom is essential, according to the capabilities approach, because the nature of human beings is such that what people can *do* and *be* is more important than what people *have*. As Nussbaum (2000), another proponent of the capabilities approach, described it:

> The central question asked by the capabilities approach is not, "How satisfied is Vasanti?" or even "How much in the way of resources is she able to command?" It is, instead, "What is Vasanti actually able to do and to be?" (p. 71)

An economist by training, Sen has argued that the capabilities approach does not disregard the role of material resources—or the other traditional preoccupations of economists with utility, income, or satisfaction—but rather the capabilities approach adds to these a central focus on freedom. And for Sen, the relative importance of these different indicators and outcomes of development is clear:

> Freedoms are not only the primary ends of development, they are also among its principal means … Freedom is not only the basis of the evaluation of success and failure, but it is also a principal determinant of individual initiative and social effectiveness. Greater freedom enhances the ability of people to help themselves and also to influence the world, and these matters are central to the process of development. The concern here relates to what we may call … the "agency aspect" of the individual. (1999, pp. 10, 18)

According to Sen, the primary ends of human development are first to establish and then to enhance the freedoms people are able to enjoy. The primary means we have for undertaking this work are the same as the ends: first to establish freedoms by reducing substantive unfreedoms, and then to enhance the freedoms people are able to enjoy. But does this equating of the ends of development with the means of development amount to circular reasoning? No, and three illustrations of the implications of this position will suffice both to demonstrate the non-circular nature of the reasoning and to suggest useful parallels between this perspective on development and the recovery-oriented approach to transformation.

Implication #1: There can be no recovery without self-determination

As a first implication of this position, it would be inconsistent with the central value placed on freedom and agency for one group of people—regardless of how well-intentioned or well-resourced they may be—to attempt to "develop" another group of people. While it might seem on the surface reasonable, if not noble, for one group to attempt to remove the substantive unfreedoms that another group is labouring under, there is no way for members of this second group to be made truly free other than for them to seize the reins and take control of their own situation. Otherwise, one oppressor has been replaced with another. The core focus on agency dictates that all parties be viewed as agents from the very first moment of the process, rather than having the conditions for one party's agency be determined by others.

Sen (1999) made this important point in relation to the approach of many development programs that presume to know ahead of time what is in the best interest of a community without the members of the community in question being actively involved in the conversation. To be consistent, he wrote, "people have to be seen, in this perspective, as being actively involved—given the opportunity—in shaping their own destiny, and not just as passive recipients of the fruits of cunning development programs" (p. 53).

Rather than cunning developers from another country, Sen (1999) suggested "it is the people directly involved who must have the opportunity to participate in deciding" (p. 31) their own fate. This is not only because they will have the most intimate knowledge of their values, their challenges, and the resources available to tackle these challenges, but also because "the *process* through which outcomes are generated has significance of its own. Indeed, 'choosing' itself can be seen as a valuable functioning" (p. 76). If the freedom to exercise one's agency (i.e., to make choices) is the desired outcome of the process of development, it can

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be brought about only by offering the people in question the opportunity to exercise their own agency (i.e., make their own choices). No amount of planning, or infusion of resources, by another party will be able to effect this transformation. It is only freedom that engenders and enhances freedoms. It is for this reason that many previous revolutions have resulted in liberators turning into tyrants.

What implications does this approach have for the way we look at, and carry out the work of, transformation? The capabilities approach draws our attention to the fact that people with serious mental illnesses, as people first and foremost, are active agents and citizens of their communities, who—like other citizens—need to be able to exercise their agency freely and autonomously in order to function as fully human. Within the constraints of whatever substantive unfreedoms they may be subjected to based on historical legacies and current circumstances (e.g., stigma, discrimination), they are always already making choices in their day-to-day lives based on which capabilities they value and what choices may be available to them (based also on available resources, social structures, etc.).

Affording people with serious mental illnesses "a life in the community" thus no longer remains limited to community tenure, but shifts with this framework to focusing on the "*actual living* that people manage to achieve" (Sen, 1999, p. 73). This makes sense as a logical next step beyond the deinstitutionalization model if one considers that what is most problematic about long-term hospitalization from the point of view of the person with mental illness is the loss of freedom and autonomy that results (Davidson, Hoge, Godleski, Rakfeldt, & Griffith, 1996). What the capabilities approach adds is that more can be done in a positive way beyond releasing someone from an institution; in addition to no longer denying people their rights, constructive efforts can be made—and in some cases must be made—to promote and enhance their ability to choose freely those activities and lifestyles they have reason to value.

While it is tempting to view the process of eradicating unfreedoms and promoting freedoms as something that a concerned and compassionate person or group of persons may do for others less fortunate or less able (however that may be determined), it is crucially important within this framework to understand that freedom is not a "thing" (i.e., a resource) that one person can give *to* or establish *for* another. Rather, it becomes incumbent on the first party, morally and practically, to afford the second party opportunities to make his or her own choices (of what to do and be) and to determine his or her own fate. This is necessary not only because members of the second party have the most intimate familiarity with the activities they value, the challenges they face in pursuing these activities, and the resources they have available for tackling these challenges, but also because it is only through achievement of this substantive freedom that people will be able to generate additional freedoms for themselves. It is only by acting as agents in determining their own lives that people will be able to achieve the substantive freedom required to be autonomous agents in the world.

How is the nature of mental illness understood within such a framework? According to Sen, disabilities can be viewed as "deprivations" that either limit people's opportunities or compromise their abilities to choose freely and achieve those functionings that they value. Mental illness may pose an obstacle to the person's achievement of the kind of life he or she wishes to have, may make it more difficult to live that life, and, at its most extreme, may even deprive the person of life altogether. In none of these cases, though, does mental illness fundamentally alter the basic nature of human beings, which is that of being self-determined agents, free to choose and pursue the kind of life they as individuals value.

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Mental illness does not rob people of their agency, nor does it deprive them of their fundamental civil rights. Rather, given the obstacles mental illness often brings with it, this makes it all the more important that individuals be enabled and supported in their efforts to exercise those freedoms and attain the kind of life they value to the greatest degree possible. Treatments, rehabilitation strategies, and the provision of community supports may be essential to the person's ability to choose and pursue such a life, but their function is to be understood squarely within this context. The function of mental health care, in other words, is to support people in their own choices and pursuits and to offer them "tools" to use for their own recovery, rather than to act as prerequisites or substitutes for the lives they desire to lead.

Implication #2: There can be no preconditions for recovery

The second implication of the capabilities approach is implicit in the first, but given its parallels to recovery it is worth spelling out explicitly. As Sen (1999) has stated, the capabilities approach

> goes against—and to a great extent undermines—the belief that has been so dominant in many policy circles that "human development" (as the process of expanding education, health care, and other conditions of human life is often called) is really a kind of luxury that only richer countries can afford. (p. 41)

The dominant approach to development has been to focus on economic growth and stability first—that is, to increase a country's Gross National Product (GNP)—with the other concerns of education, health care, quality of life, and political participation delayed to some point "later" when the country has secured an adequate resource (i.e., financial) base. Sen's empirical research has been instrumental in demonstrating that this approach has not worked in the past; economic growth in terms of GNP, income, or utility—no matter on what scale—has not translated into or effected political or social growth. The opposite, however, has worked. As he observed, "The fact that education and health care are also productive in raising economic growth adds to the argument for putting major emphasis on these social arrangements in poor economies, *without* having to wait for 'getting rich' *first*" (emphasis added; 1999, p. 49).

Securing freedoms as a direct means of development, according to Sen, is "a principal determinant of individual initiative and social effectiveness" (1999, p. 18). If afforded their freedoms, citizens of poor countries will be effective in pursuing economic growth. No amount of wealth, however, can buy a population's freedom from slavery or political oppression. The oppressors can always desire to get still richer (one of the dangers of money is that one can never have enough of it); a free citizenry, on the other hand, will undoubtedly elect to act in their own collective best interests, which typically involves generating an adequate resource base to support the population. As one striking example of this, Sen points out that "no famine has ever taken place in the history of the world in a functioning democracy" (1999, p. 16; see also Drèze & Sen, 1989), regardless of a country's GNP or its level of food productivity or availability.

In terms of transformation, this principle suggests that people should not be made to wait until some point farther down the road, some mythical "later" time when all of the necessary preconditions are in place, to achieve and exercise their freedoms. There can be no material, social, or political preconditions required for people to be afforded the freedoms that are rightfully theirs as citizens of communities. In mental health, as we noted earlier, the precondition held out for people with serious mental illnesses has been the need for them to be cured of their illnesses or to become "normal" before they can rejoin community life. A capabilities

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approach asserts to the contrary that it is only through participation in community life as self-determined agents that people with mental illnesses will acquire the capabilities needed to manage their conditions. As it is, we have no cure for mental illness, but we do have decades-worth of experiences demonstrating that people cannot and will not learn how to manage their conditions effectively as long as they are viewed as defective and dependent and are confined to institutional settings.

Implication #3: There can be no recovery without diversity

A final illustration of the capabilities approach relates to the issue of diversity. Dominant approaches either ignore the issue of diversity by identifying one measure as common across all possible domains of choice—the best example here again being that of wealth—or by relegating issues of diversity to a secondary status to be addressed after the "real" work of development has taken hold. This second possibility is evident in theoretical approaches that stipulate that all people are fundamentally the same in their basic quest for X (e.g., safety, income), with all possible markers of difference such as culture being seen as introducing only minor or surface modifications. Sen is sensitive to the tendency on the part of adherents of this approach to make "freedom" simply the latest X in that equation, and therefore he has gone to some length to reject the notion that freedom is just another commodity, to reinforce the centrality of choice, and to highlight the fact that choice necessarily generates diversity, both among individuals and among countries and cultures. He explained this point using an analogy to food:

> The capability perspective is inescapably pluralist … to insist on the mechanical comfort of having just one homogeneous "good thing" would be to deny our humanity.… It is like seeking to make the life of the chef easier by finding something which—and which alone—we all like (such as smoked salmon, or perhaps even french fries). (1999, p. 77)

It is in the very nature of choice to result in variability, otherwise choice would not really be free but would refer only to changes in the quantity of some basic universal. While smoked salmon and french fries are, in fact, both foods, to say that a person who prefers smoked salmon to french fries has no real preference because they are both foods is to miss the point of having preferences to begin with. It is to gloss over the issue of choice, but this is precisely where our primary interest lies. Without choice there is no freedom, and therefore no justice; with choice there inevitably will be differences and diversity. Sen (1992) therefore concluded,

> Investigations of equality—theoretical as well as practical—that proceed with the assumption of antecedent uniformity … thus miss out on a major aspect of the problem. Human diversity is no secondary complication (to be ignored, or to be introduced "later on"); it is a fundamental aspect of our interest in equality. (p. xi)

An implication for transformation is that free choice presumes and necessarily involves and generates diversity. Material, social, and political preconditions for the exercise of agency have typically been stipulated as safeguards to ensure that people will choose only certain things or in only certain ways, but this amounts to the illusion of choice rather than true freedom. In mental health, similarly, there has been a history in which various lifestyles or choices that were initially considered pathological (e.g., running away from slavery, homosexuality) are now considered legitimate. Thus, in order to acknowledge that free choice necessarily results in difference and diversity, we must first accept Winnicott's bold assertion that "with human beings, there is an infinite variety in normality or health" (1986, p. 45). Once this is accepted

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as a foundational principle for our science and practice, and we reject any univocal, static, or predetermined notion of "normality," it no longer makes sense to make people wait to rejoin community life until they first regain it. This is because we have no way to know ahead of time what "normal" will look like for any given individual, and each person will be able to determine this only over time through pursuit of those activities and lifestyles that he or she has reasons to value. There is no other way, other than trial and error, to figure out what "normal" will look like for me. And this is as true of people with serious mental illnesses as it is for anyone, and everyone, else.

In summary, then, the capabilities approach diverts our attention from the usual concerns of policy-makers with the possession of *resources* (e.g., utility, income) to the exercise of *freedoms*. This shift is not meant to deny the crucial role resources play in social and political life, but rather to emphasize the fact that "the usefulness of wealth lies in the things that it allows us to do—the substantive freedoms it helps us to achieve" (Sen, 1999, p. 14). It is not effective to view wealth as an end in itself, but only as a "means for having more freedom to lead the kind of lives we have reason to value" (Sen, 1999, p. 14). The focus of our efforts thereby shifts from what people or populations have, to what they can do, to "the *actual living* that people manage to achieve" (Sen, 1999, p. 73).

Given the centrality of freedom to this view, it is important to understand that this "actual living," also referred to as the person's "capability," is necessarily a function of the person's free exercise of his or her own agency. The primary concern of this approach thus becomes the capabilities of people to function, to do or to be what they value, and "to take part in the life of the community" (Sen, 1999, p. 73) as they choose. Finally, people should not be made to wait until certain material, social, or political preconditions are in place in order to begin to choose, as people are active agents who are always already making choices in their lives on an everyday basis. In the same fashion, it does not work for people to wait until some mythical point, always "later," at which another party will step in to provide whatever is needed or to act in whatever ways are needed to restore to them their freedoms.

While taking freedom seriously in this way obviously complicates the picture and challenges our usual notion of science (which involves causality and prediction), the capabilities approach insists that freedom and self-determination are essential to what makes us human. Any approach that excludes these considerations in the name of science or expediency (as in, we'll get around to those issues "later," when the time is right) omits the very things with which it should be primarily concerned, and thus proves to be inadequate to the tasks at hand. We now will close by considering how the capabilities approach, as a new conceptual framework, can be used to help overcome such limitations in the field of mental health.

ADDITIONAL IMPLICATIONS FOR TRANSFORMATION

The major thrust of a capabilities-oriented system of care will be to increase the access of people with serious mental illnesses to opportunities and supports that will enable them to live a decent and self-determined quality life. A quality life is composed of "achieved functionings" in domains that the person values, incorporating but not limited to personal and social well-being. The core focus of the system will be on facilitating the process of development in which each person with a psychiatric disability actively engages, ensuring that a historically oppressed and presently vulnerable population has the resources, opportunities,

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and ongoing supports necessary to function well in the environments and roles that each person chooses, with the eventual goal of achieving the capability to live a dignified and fulfilling life despite the enduring presence of a disability.

An early component of transformation will involve identifying and removing obstacles and impediments to development that keep people with disabilities in circumstances of relative and real disadvantage. That is, system-level activities will critically assess and act to reduce the myriad "substantive unfreedoms" and layered aspects of disadvantage that are experienced every day by many people with psychiatric disabilities, and which have catastrophic effects on their personal health (e.g., increased morbidity) as well as on their social lives (e.g., isolation). Redress of such inequalities and deprivations must occur so that people have increased chances "to do" and "to be" by engaging in activities and roles of their choice.

In this respect, systemic efforts will focus on dismantling structural barriers, inequitable power arrangements, practices of social discrimination, and unnecessarily constrained choices—including those embedded within a system of care—that serve to perpetuate social, economic, cultural, and health disparities. Building capabilities of the people served, on the other hand, will reduce the vulnerabilities of these same people as well as increase their substantive freedoms to do or to be as they choose. To build capabilities, systems will invest in creating, enriching, and making more flexible and responsive the policies and opportunity sets available, expand the range of accessible and valued options and choices, and improve access to resources and supports so that people have the means necessary to engage in the activities they value (Nelson, Lord, & Ochocka, 2001). These directions of reducing substantive unfreedoms and expanding opportunities and supports are consistent with what people in recovery have been advocating for over 20 years when they identified stigma, discrimination, and coercion as well as lost opportunities, relationships, and roles as binding them to lives of prolonged disability and dependency. These systemic unfreedoms have proved to pose more formidable barriers to recovery than serious mental illness itself (e.g., Chamberlin, 1990; Deegan, 1992, 1996).

This last comment reminds us of a crucially important principle of the capabilities approach which, in our experience, becomes easily lost or overshadowed by the multitude of political, financial, and practical complexities impinging on transformational leaders at the system level. This is the principle we went to some length to reinforce in our earlier discussion, which suggests that one group of people, regardless of how well-intentioned or well-resourced they may be, cannot remove the substantive unfreedoms that another group labours under, nor can they pursue a development process for the benefit of others, without those others being actively and substantively involved in "shaping their own destiny." Bluntly stated, system leaders cannot view themselves as being more experienced and more capable of creating a vision and setting an agenda for transformation than people living with serious mental illnesses themselves. People in recovery are the most intimately familiar with the realities of living with mental illness, the challenges this poses, and the resources available to them to overcome these challenges. Given the opportunity, their actions of creating a vision and setting an agenda for their own recovery will contribute importantly and directly to system change.

Consistent with Sen's concerns about countries waiting to become rich first or wanting to disregard issues of diversity in their development efforts, system leaders are tempted to set preconditions for, or to place parameters around, the involvement of people in recovery in transformation initiatives. In our own work in pursuing transformation (e.g., Davidson et al., 2007) and in consulting with other systems in their transformation initiatives (e.g., Davidson & White, 2007), involving people in recovery in these initiatives

remains the most challenging, but also the most effective, lever for change. As a result, we remain convinced that if restoration of the rights of people in recovery, and their assumption of the responsibilities of this role, are not front and centre in transformation efforts, then this process will inevitably fall short of accomplishing its goals. If people in recovery are not allowed, or do not step up, to lead the process, then we will surely fail once again to establish the means for them to emerge from "out of the shadows," fail once again to "achieve the promise" of a life in the community first promised over half a century ago.

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RÉSUMÉ

Au Canada et aux États-Unis, des commissions d'enquête ont récemment conclu que l'objectif le plus important d'un système de soins de santé mentale doit être le rétablissement, et elles ont par conséquent recommandé la transformation des systèmes en fonction de cet objectif. Si l'on veut que les efforts nécessaires à cette transformation n'aboutissent pas simplement à la répétition des erreurs du passé, il est essentiel d'adopter un nouveau cadre de référence pour repenser la nature des soins offerts aux personnes vivant avec un grave problème de santé mentale. Dans cet article, nous établissons les limites du modèle de la désinstitutionnalisation, et nous montrons que l'approche axée sur les capacités, conçue par Sen (1992, 1999) et d'autres experts, est le cadre de référence le mieux approprié à la période de « post-institutionnalisation ».

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