

Social enterprise: A model of recovery and social inclusion for occupational therapy practice in the UK

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Social enterprise: A model of recovery and social inclusion for occupational therapy practice in the UK

Abstract

Introduction: Occupational therapists are increasingly working in organisations outside of the public sector. Government policy over the past decade has promoted health and social care provision by social enterprises. This study researched the compatibility of occupational therapy practice and a social enterprise environment, within the UK.

Method: Case study methodology was used with eight social enterprises. Data were collected through: semi-structured interviews; formal organisational documents; field visits and observations. Interviews were conducted with 26 participants who were occupational therapists, service users and social entrepreneurs/managers. The interviews were recorded, transcribed and analysed using thematic analysis.

Findings: Occupational therapists experienced job satisfaction, professional autonomy and were able to practise according to their professional philosophy. Service users valued support with: employment, routine, social relationships and developing a sense of identity, particularly outside of a medical model definition. Challenges with funding social enterprises impacted occupational therapy delivery in some cases.

Conclusion: Social enterprises can provide therapeutic environments to promote recovery and social inclusion which is compatible with occupational therapy. Occupational therapists need to be proactive in creating roles within social enterprises and further research is required into the effectiveness of these interventions.

Key Words: Occupational therapy; social enterprise; social inclusion; recovery; research; case study.

Introduction

Occupational therapy in the UK has been largely shaped by the medical model, however developments within the profession over recent decades has led to a re-focusing on the centrality of occupation for health. As a result, the profession is exploring new environments for practice outside of traditional, medicalised settings. The recent changing landscape of health and social care provision in the UK provides occupational therapists with new and different opportunities for practice. Social enterprise is an emerging arena for occupational therapy practice and is the focus of this paper. Research into health and social care delivery through social enterprise is a recent phenomenon and research remains sparse, especially within the field of occupational therapy. This research reported in this article is believed to be the first to explore the provision of occupational therapy within social enterprises in the UK, and the first to consider the compatibility of the occupational therapy philosophy within a social enterprise model. The data were collected within the context of a changing health and social care landscape in the UK between January 2012 and October 2013.

Occupational therapists and social enterprises generally seek to address social justice with individuals and groups within society and this study explored the combination of these as a new form of a public health intervention (Donaldson et al., 2013). This research study was conducted at a time when health inequalities in the UK were widening (OECD, 2013), impacting on social justice for vulnerable and marginalised groups in society. Occupational therapists contribute to enhancing social justice by developing individual's skills and abilities to engage in society by overcoming personal barriers and challenges (Braverman and Suarez-

Balcazar, 2009; Kielhofner et al., 2011). However, alongside supporting individuals, occupational therapists also have a role in the promotion of environments that are socially inclusive within groups, communities and through political structures such as healthcare services (Stadnyk et al., 2010). With the changes in public policy, there are now opportunities for healthcare professionals to be involved in design and delivery of healthcare services such as social enterprises. Social enterprises can be service providers for the NHS but they can also be distinctively different organisations. Furthermore, they can exist within local communities that create the opportunity for social inclusion and employment, without necessarily having a medical focus. Social enterprise models can be compatible with occupational therapy philosophy as they both seek collaborative coproduction with 'service users' (Boyle and Harris, 2009). Service user involvement within an organisation can promote the principles of recovery such as connectedness; hope and optimism about the future; identity; meaning in life and empowerment (Leamy et al., 2011). Occupational therapists are well placed within such organisations to enable this to happen.

The potential for a social enterprise as an organisational environment for occupational therapists to practise, led to the development of this research. Occupational therapy practice within social enterprises internationally or within the UK is an under researched area despite the political drive for health and social care provision through social enterprise. The aim of this study is to explore the provision of occupational therapy within social enterprises in the UK and the impact on occupational therapists, service users and the occupational therapy profession. Case-study methodology was used to develop key themes within this emerging phenomenon.

Background

The advancement in the profession of occupational therapy to explore practice in 'non-traditional roles' has occurred at a time of political and economic change in public sector provision of health and social care in the UK. Social enterprises, as part of the third sector have been asserted as one model for addressing issues of social injustice and exclusion (Leadbeater, 2007) and have been heavily promoted within recent government policy. This has included an intention to transform the NHS into "the largest social enterprise in the world" (DH, 2010, p5). Over the past decade, there have also been significant health and social care reforms that have had a major impact on how services are provided. This has included a shifting of responsibility to healthcare professionals to create and shape public sector services, through a process of *market-isation* within the public sector involving the outsourcing of public services to other providers such as the third sector and private companies (OTS, 2006; DH, 2010). Service users have also been given a responsibility to organise and purchase their own care through the personalisation agenda. Personal budgets and self-directed support could theoretically be used to purchase such services however there have been limitations and challenges with this model, such as the limited, pre-determined amount of funding for each individual and the commissioning of the cheapest services available (Mandelstam, 2010).

As social enterprises aim to serve vulnerable and marginalised groups, there is the potential for them to be used in occupational therapy delivery. Both social enterprises and occupational therapists work with vulnerable and marginalised groups, with similar aims to enable and equip people to develop: skills; social connectedness; and employment among others (Singh, 2010; Roberts, 2011; Social Enterprise Coalition, 2011). Therefore, by combining the organisational model of a social enterprise with the professional expertise of occupational therapists, there is the potential for social exclusion, injustice and inequalities to be tackled in a more robust

way. Additionally, social enterprise as a new environment for occupational therapy practice could provide an opportunity for addressing some longstanding problems within the profession. Research evidence in the occupational therapy academic literature has indicated a growing dissatisfaction within the profession for a number of decades. This includes concerns among occupational therapists that they were not able to make the difference to service users' lives that they expected when they entered the profession (Bailey, 1990). Furthermore, research into occupational therapists' job satisfaction in Local Authorities revealed high levels of stress, high workloads, compromising standards, low morale and feelings of being undervalued and poorly treated by managers (British Association of Occupational Therapists and Unison, 2003). Furthermore, Arnold et al., (2006) found that occupational therapists felt undervalued and unsupported. In one study, occupational therapists who left the NHS for alternative employment were: more satisfied in their work, able to enjoy professional autonomy; felt valued in their role; perceived that they gave better patient care; and experienced better professional development in their new roles. However, despite the frustrations about the lack of ability to practise according to professional beliefs within the public sector, occupational therapists have reservations about the financial risk of setting up new organisations or working outside statutory services (Turner, 2011).

There are a growing number of social enterprises delivering occupational therapy services in the UK, however very little has been written to date on the topic. A literature search identified four pieces of research on occupational therapy provision within social enterprises worldwide, one of which was in the UK. The three international studies researched the work rehabilitation of people with mental health problems: one in Singapore within a café setting (Tan, 2009); one in Canada within a catering company (Jackson et al., 2009) and one in Australia which provided employment within a cleaning company (Williams et al., 2010). The UK study researched

a social enterprise providing organic produce which also employed people with mental health problems (Fieldhouse et al., 2012 and 2014).

Therefore, this study aims to provide much needed evidence on the use of a social enterprise model in occupational therapy provision, and focuses on the compatibility of occupational therapy with social enterprise and the impact of this on the occupational therapy profession, occupational therapists and service users.

Method

The lack of an evidence base on this subject led to an exploratory research design using mixed methods of data collection. A pluralistic pragmatic position (Morgan, 2007) was taken to collect qualitative and quantitative data regarding occupational therapy provision within social enterprises. This approach to the research enabled the collection of factual information about the social enterprises and subjective responses from the participants however the majority of the data was qualitative, collected by participant interviews.

A mapping exercise was initially conducted to identify social enterprises within the UK through: web based searches; regional social enterprise databases; grey literature; and the occupational therapy specialist sections. Twenty social enterprises were identified as providing occupational therapy within the UK at the time of data collection and of these, eight were willing to participate in the research. The social enterprises that participated were: a fostering and adoption agency; a dementia day service; woodland and forestry for people with mental health problems; health promotion with youth; community sports in mental health, drug and alcohol or probation issues; a housing association; gardening and farming with youth; growing organic produce with people who had wide ranging disabilities.

Due to the sample size and the nature of the study, an in-depth case study methodology was used to explore the experiences and perceptions of occupational therapists, service users and social entrepreneurs on the occupational therapy provision within the eight social enterprises. The specific data collection methods used were: semi-structured interviews; observational field visits; and written organisational documentation. The semi-structured interviews were undertaken with different stakeholders (occupational therapists; social entrepreneurs; and service users), which provided an opportunity for them to talk about their views and experiences. A semi-structured interview schedule provided a guide which allowed for the research aims to be addressed but also for participants to elaborate on their answers. Twenty-six interviews were conducted in total across the participant groups which explored how the social enterprise was run; influences on the occupational therapy provision and the experiences of delivering or receiving occupational therapy. Observations were made whilst conducting field visits, based on the topics in the interview schedule to enable triangulation. Organisational documents such as the business plan, last audited accounts and governance structures were requested and used where available.

The interviews were analysed using thematic analysis as a “method for identifying, analysing, and reporting patterns (themes) within data” (Braun and Clarke, 2006, p6). To ensure that the analytical process was rigorous, Braun and Clarke’s 15 point checklist for methodologically sound analysis was used (Braun and Clarke 2006, p36). Triangulation was used as a strategy to improve quality in this research from multiple sources, strengthening the authenticity and dependability of the study (Silverman, 2010; Yin, 2012). For example, the interview data from the case studies regarding governance was triangulated with the formal organisational documents gathered on the case studies and their websites.

This research was approved by the University of Northampton Research Ethics Committee. As an occupational therapist, the researcher was required to adhere to ethical guidelines and principles outlined in the Health and Care Professions Council (HCPC) Standards of Conduct, Performance and Ethics (HCPC, 2012) and the College of Occupational Therapists Code of Ethics (COT, 2010). All participants were given a participant information sheet and asked to sign a consent form. Confidentiality and anonymity of participants was upheld through coding of participant and case study names. Pseudonyms are used for the purpose of this paper.

Findings

The majority of the findings are drawn from analysis of the qualitative data from the interviews however these findings were then triangulated with the other data sources. The findings were organised into three themes: the impact on occupational therapists; the impact on the profession; and the impact on service users. Within each of these three themes, sub themes of benefits and challenges within each participant group were also generated. The following table summarises the themes and sub-themes:

Table 1: Summary of Findings

Theme	Benefits	Challenges
Occupational therapists	Job satisfaction; professional autonomy; involvement in governance.	Personal financial risk; peer support.
Service users	Work role and employment; support in a non-medical environment; social relationships; a positive	Role confusion; ability to access services.

	routine; impact on identity.	
The occupational therapy profession	Environment to practice which supports the philosophy of occupational therapy.	Funding; self-promotion; outcome measures.

Impact on occupational therapists

Benefits

The occupational therapists expressed a high level of job satisfaction in their work within social enterprises as valued, trusted and respected members of their teams. Through their work within the social enterprises, the occupational therapists were also able to rediscover their passion for occupational therapy which they had lost sight of during many years of working in the public sector. For example:

"...now I've got a real OT job, this is what we were trained to do" (Jill)

"... as an OT I do what I do and that's great. The Chief Executive and the whole of the organisation including the board are very supportive of that they very much take my view as being the expert view in terms of that and trust what I'm doing is appropriate and is right and I think you know in turn what I give to them are very clearly improved outcomes for people" (Pam)

In addition, the occupational therapists described being able to practise according to the philosophy of the profession due to having time for therapeutic interventions and professional autonomy. This was referred to in contrast to the occupational therapists' previous experiences of working within the limitations of statutory services and motivated one occupational therapist to set up a social enterprise:

"I just felt professionally crushed (in the NHS) and I just am so restricted in what I can do, I can provide more and I just thought this is not what I trained to be... I just thought if I do something myself and I can do it the way I want to, do it how I believe it should be done" (Sue)

The occupational therapists in seven out of eight social enterprises expressed that they could be client-centred and work flexibly with the social enterprise to adapt to service users' occupational needs. For example, in five of the case studies, there was the flexibility to create work experience or employment for service users within the social enterprise depending on their interests and skills.

The opportunity for occupational therapists to be involved in social enterprise governance and decision-making, brought a therapeutic and occupational perspective to service delivery within the organisations. The smaller organisations were able to change practice quickly without going through long bureaucratic processes and able to incorporate service user feedback when improving their services:

"You get true feedback (from the service users) ... "oh I think you should change it" that's great, whatever they want, we were not there to go "we know what is best" it's up to the individuals, it's changing all the time" (Liz)

Challenges

Two of the eight social entrepreneurs were occupational therapists, both of which talked about sacrificing their own time and money to invest in the social enterprise such taking personal loans and receiving a small salary.

"I'm going to be living on part-time money not full-time money because there isn't any, so it's the chance we have got to take" (Carol)

One of the occupational therapists who worked for a social enterprise questioned whether the reduced salary (in comparison to statutory services) would have an impact on occupational therapist's sense of self-worth. However, some of the occupational therapists interviewed gained such satisfaction from their work that the personal sacrifice was of less significance.

A challenge some of the occupational therapists expressed was that of professional isolation and the need for peer support:

"Talking to other OTs is quite nice, it is possible to feel a bit isolated, and what am I doing?" (Mike)

One occupational therapist was reluctant to leave the NHS because of her professional connections and support and worked part time in the NHS and part time for the social enterprise.

Impact on service users

Benefits

A work role was a major theme for many of the service users within the social enterprises, whether as a volunteer; doing work experience or gaining paid work within the social enterprise. The social enterprises in six out of eight case studies provided opportunities to get back into employment in a graded, supported way. One case study generated income through providing woodland and forestry services by delivering private contracts. The occupational therapist adapted the woodland and forestry activities to meet individual's therapeutic goals. One volunteer talked about his opportunity within the social enterprise:

" I came two days a week ...until (the occupational therapist) found out I used to be a business process analyst so she said I could come and help to do some stuff here (in the office) and I've been in this role two weeks" (Pete)

The social enterprise environment was also seen as helpful because the focus was on activity rather than their illness:

"It's a different environment, it's much easier you have different conversations that helps no end, it's not all about me here, it's about what we are doing" (Pete)

All six of the case studies where service users were interviewed, mentioned the social benefits of attending. This included: the opportunity to meet other people (whereas they would otherwise be at home alone); acceptance as they had a sense of belonging; ability to develop friendships; develop trust with other people in the social enterprise and support one another.

"It's gone past my expectations because I've made two good friends... proper friends because we know each other's health issues so that makes it a lot easier in life as well because you help each other out really" (Dave)

One service user also expressed the benefit of a structure and routine:

"The experience of coming here, it's better doing something than sitting at home doing nothing and so you know I'm doing something and that's good for my CV...its helping my life get back on track" (Jack)

A 'normal' and socially inclusive culture was also created for the service users' to have a role in the social enterprise as 'volunteers' in five of the case studies:

"...if our volunteers are stopped (in the street) ... they can say I'm a volunteer down at (the social enterprise) they don't have to give an explanation of why that is or why they should be there to volunteer and that's really important" (Pam)

The service users had a role as volunteers in the organisation and were treated as such by visitors. They were not labelled as patients, clients or mental health service users which can bring with it stigma and barriers to social inclusion.

Challenges

One service user expressed some confusion over his role within the social enterprise. He was labelled volunteer in a social enterprise but felt more like he was in a patient role because he was receiving occupational therapy.

"(as a patient) more interactive with (the occupational therapist) you can talk about things to do with mental health, as a volunteer I don't think you can have that... this

is a patient thing and you are around other people with the same illness" (Dave)

The occupational therapists and social entrepreneurs also talked about the challenge for some service users to access the social enterprise because of either funding or their skills and abilities to organise attending a social enterprise. For example, some of the social enterprises were partly funded by direct payments, which service users need to organise and access to pay for the support they receive at a social enterprise. To receive a direct payment, a person needs to have a bank account which some people struggle to organise. In some cases, service users were referred to social enterprises but the Local Authority was not willing to pay for their services. One social entrepreneur expressed her frustration:

"... we have young people with psychosis who I can't get any money for them and it's completely crazy but the mental health services which these people have been referred by don't have a budget to refer to someone else" (Mary)

Impact on the occupational therapy profession

Benefits

The social enterprises were all in natural community settings which is the ideal environment for occupational therapists to practice. The 'normal' social environment provided an optimum setting promoting social inclusion and away from institutional settings. For example, in one case study the occupational therapist/social entrepreneur expressed the following:

"...to look on the positive side, look at this (indicating to the leisure centre they operate in) ... it's a great place to have,

we won this and we are in here, mental health away from the NHS - we've done well" (Carol)

In seven out of eight social enterprises, occupational therapists were able to offer client centred, holistic, flexible, occupational focused sessions. The impact of this on the profession is that occupational therapists can maintain their professional autonomy to practice according to their professional beliefs without having to work under the medical model or within a target driven system such as the NHS. One occupational therapist expressed that she was able to focus on occupation irrespective of medical diagnosis:

"...working in organisations like social enterprises, I think you've then got the ability and the options to be able to offer something where purposeful activity to recovery is the key but we actually don't discriminate about recovery from what" (Pam)

Challenges

Smaller, grass-roots community initiatives such as five of the case studies in this research, struggled to secure any public sector funding, partly due to challenges winning bids or their service users being unable to apply for and using personal budgets. Cuts to public sector funding have also affected the contracts available to other providers such as social enterprises and conditions have been placed on how funding can be spent, interfering with clinical autonomy and practice.

"There's generally more stress around in the system, people (the local authorities) have been wanting discounts, "Can they have two for the price of one"? ... "We want the therapy program but could you just do it this way and could you do it quicker?" (Marion)

The cuts in services have resulted in fewer jobs for occupational therapists within statutory services therefore opportunities need to be created for occupational therapy practice elsewhere. Some social entrepreneurs recognised the need for specialist interventions as a result of the unmet occupational needs of those who attended their service:

“We wouldn't have the expertise and professionalism to deal with people with real challenging mental health, we are putting ourselves our staff and our (location) potentially at risk so I had to get around that, so partnership yes with who? NHS, yes, right who do we need? Occupational therapist? Yes.” (Janet)

However not all social entrepreneurs may know about the benefits of employing an occupational therapist therefore responsibility lies within the occupational therapy profession to promote itself to existing social enterprises.

Discussion

It is believed that this study is the first national research conducted into occupational therapy provision within social enterprises in the UK and therefore has provided a baseline of data and new knowledge on this topic. There are some findings that are consistent with the research conducted by Fieldhouse et al., (2012) such as the service user's experiences of a supportive, relaxed environment; development of social capital; engagement in a work role in a natural environment; and improved mental health. Therefore, this study expands upon the existing (although under-researched) knowledge in this area.

Changes within health and social care provision in the UK have led to new and innovative ways of delivering occupational therapy, which provide an

opportunity for creativity in how the profession is practised (Healey, 2011). This study has evidenced that social enterprises provide a non-medical, non-labelling and non-stigmatising environment for the occupational therapists to practise. Six out of eight of the case studies in this research provide services for people with mental health problems, suggesting a compatibility between social enterprise delivery environments and mental health recovery models (Leamy et al., 2011; Perkins and Repper, 2013). Physical occupational needs were addressed by social enterprises which provide assistive aids. Such provision is similar to current occupational therapy services within Local Authorities, therefore social enterprises could be used as an outsourced service provider to deliver these services.

Occupational therapy practice within social enterprise in this study has enabled the practice of Wilcock's "Occupation for health" (2006) maintaining the centrality of occupation to promote health and wellbeing, rather than medical treatment. This has included public health promotion which is an underdeveloped aspect of occupational therapy within the UK (Reitz, 2013). Such preventative health strategies and asset-based approaches has shown a congruence with Antonovsky's (1996) Salutogenic theory of health and the philosophy of occupational therapy. This has been evident by the social enterprises developing local capacities and strengths through collaboration and partnership between the occupational therapist, the social enterprise and the person attending the service. The connection between the collaborative, bottom-up, grassroots principles within social enterprise and the strengths-based, client-centred, partnership approach used within occupational therapy was evident in the literature review. However, this was primarily theoretical and conceptual due to the scarcity of literature and required a synthesis of the two different schools of occupational therapy and social enterprise. This study has demonstrated that occupational therapy philosophy and principles can work effectively within a social enterprise environment. As asserted by Braveman and Suarez-Balcazar (2009 p17):

“Occupational therapy practitioners are well suited to assist organisations in the effective distribution of resources by virtue of their skills in assessing the match among the individual, his or her needs and the demand of the organisation”

As social enterprise is a viable model for occupational therapy delivery, this needs to be explored further within the profession. The creation of social enterprise environments for people to receive occupational therapy can enable occupational and social justice by providing opportunities for people to engage in society who otherwise may be excluded or marginalised (Nilsson and Townsend, 2010). Some of the social enterprises in this study included a range of occupational therapy interventions with people who do not currently receive such services through the public sector such as the homeless, youth and ex-offenders. Therefore, social enterprise can provide a model for service delivery that enables occupational therapists to reach under-served groups and populations in society. To do so would promote fairness, equality, opportunity and social inclusion that enables those who benefit from these services to address the occupational injustices they experience. It is argued that healthcare professionals have an:

“Ethical, moral and professional obligation to reduce injustice with and for destitute as well as privileged members of society.” (Townsend and Marval, 2013 p215).

This can be addressed through occupational therapists involvement in service design and creation, as was the practice within some of the social enterprises.

This study shows that occupational therapists can combine the social enterprises business and social aims in their interventions if given the flexibility, autonomy and opportunity to do so. As an outcome of this,

people who use the social enterprises have been able to engage in meaningful participation of the social enterprise activities which has begun to address occupational injustices such as difficulties gaining employment or social isolation. Occupational therapists will be required to promote themselves to social enterprises and educate them on the benefit of occupational therapy within the organisation to enable social aims to be achieved successfully.

Small social enterprises need people with the enthusiasm, dedication and skills to be able to compete with other service providers which requires expertise and knowledge that healthcare professionals (such as occupational therapists) might not have (Hall et al., 2012). To overcome this, collaboration between healthcare staff and business managers and entrepreneurs may be required to develop successful services for the future. Occupational therapists can however be trained in business and management skills at an undergraduate and post-graduate level to equip them for the new 'market-ised' healthcare provision. Occupational therapists will need to become efficient at marketing and proving the effectiveness of their interventions in this business environment and should be at the forefront of developments in regard to social impact measurement and funding requirements to be able to equip clinicians in the future (COT, 2013). The occupational therapists' experiences of improved job satisfaction whilst working in a social enterprise compared to working in the public sector, indicates that there could be improvements for retention to the profession.

This study was limited by the small population size of occupational therapists who work with social enterprises, however the small number identified allowed in-depth research to be conducted. The lack of a centralised database of information on occupational therapists who work for social enterprises resulted in challenges identifying potential participants. Thematic analysis has been criticised for a lack of subjectivity and another

researcher may identify slightly different themes with the same data available. However, attempts to maintain the quality of the findings were made by using subjectivity as a tool, ensuring the process was transparent and by reflecting upon it (Braun and Clarke, 2013). It was not possible to gain the same written documents from each case study, therefore this data source was not consistent across the case studies. The data gathered within the written documents were sufficient for triangulation with the other forms of data collected for the purpose of this study.

A comparison study between occupational therapists practice in statutory services and social enterprises could provide data to evidence any differences in practice and perceptions. In addition, the effectiveness of return to work programmes within social enterprises which employ occupational therapists could be examined in comparison to other settings. Research into the effectiveness of occupational therapy interventions in enabling return to mainstream employment from a social enterprise could provide a justification for increasing occupational therapy positions within social enterprises and strengthen bids for contracts.

Conclusion

Occupational therapy professional practice within social enterprises in the UK has been evidenced to be an under-researched area. This study has begun to address the existing gap in knowledge by presenting the findings from eight case-studies on this topic. Social enterprise can be used as an effective model for implementing occupational therapy services that promote health, wellbeing and occupational justice. Occupational therapists can also benefit social enterprises in achieving their social and business aims. Social enterprises can provide an environment where occupational therapists have freedom to practise according to the principles of their profession without the limitations of the medical model and in a socially inclusive environment.

The current health and social care climate provides opportunities for occupational therapists to create and shape their own environments for practice. However, the financial support required for successful and sustainable social enterprises that provide occupational therapy continues to be a challenge. Government policy could incorporate ring-fenced funding for small grassroots social enterprises (which are not public sector 'spin-offs') which deliver health and social care and address issues of inequality and injustice through interventions such as occupational therapy.

Individual occupational therapists will be required to be proactive in bringing about occupational and social justice through developing organisations or taking on roles in established social enterprises that permit practice according to the philosophy of the profession. Occupational therapists need to take a positive, confident approach to the health and social care reform to take the opportunities available to create environments for occupational therapy practice that promotes occupational and social justice in the future.

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