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# **An exploration of occupational therapy practice in social enterprises in the UK**

Submitted for the Degree of Doctor of Philosophy  
At the University of Northampton

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Anna Stickley

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# Abstract

**Introduction** Occupational therapy in the UK has been heavily shaped by the medical model, however developments within the occupational therapy profession that have led to a re-focussing on the centrality of occupation for health have resulted in the need for new areas 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 environments for practice. This research explored the provision of occupational therapy within social enterprises in the UK, and the compatibility of the occupational therapy philosophy with a social enterprise model.

**Methods** This mixed methods exploratory study that was conducted within the pragmatic paradigm and had two phases. In Phase 1, twenty-one online questionnaires were completed by occupational therapists working in social enterprises in the UK and focused on their practice and the social enterprise they work for. Social enterprises that employed occupational therapists were also identified through desk based research. In Phase 2, eight of these social enterprises (which were identified in Phase 1) participated as case studies, using case study methodology to explore occupational therapists perceptions of their practice; service users' experiences; and the social entrepreneur's involvement in the provision of occupational therapy. The data collection in the case studies consisted of twenty-six semi-structured interviews with occupational therapists, social entrepreneurs and service users; unstructured observation and formal documentation was used for triangulation. The interviews were analysed using qualitative thematic analysis and the findings of the case studies were combined with findings from Phase 1.

**Findings** Social enterprise has been used as an effective model for implementing holistic occupational therapy services that promote health, wellbeing and occupational justice. Occupational therapists benefit social enterprises to achieve their social and business aims. Funding social enterprise start-ups and ensuring their sustainability continues to be a challenge and government policy needs to be supported with finance to implement it, without which there is a risk of private companies taking over public sector services.

**Conclusions** 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. Social enterprise can provide a rewarding and satisfying environment for occupational therapists

to practise in client centred, holistic ways. The current health and social care climate provides many opportunities for occupational therapists to create and shape their own environments for practise. Alternatively, occupational therapists may need to promote the profession to existing social enterprises to gain employment in the new organisations that deliver public services.

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# Chapter 1: Introduction to the study - Occupational therapy and social enterprise in the UK

## 1.1 Introduction

The occupational therapy profession has functioned within a healthcare system dominated by the medical model within statutory services for most of its existence within the UK. However, to remain true to its professional roots and philosophy, occupational therapists need to be able to practice in a holistic manner and in a non-medical environment to promote everyday occupations in natural settings (Scaffa and Reitz, 2014). Due to recent austerity measures and cuts to the public sector, there has been a decrease in number of jobs for occupational therapists. Although this has been a challenge for the profession of occupational therapy, it is also a time of opportunity to create new and different working environments that facilitate practice according to the philosophy of the profession (Healey, 2011).

Increasing health inequalities (Marmot, 2010) and the reduction in public funding for health and social care services poses a significant challenge for health and social care professionals who have a duty of care to provide services to address the health and social needs of those with whom they work. The financial limitations around public sector provision have resulted in the need for services to be provided that can generate their own income, such as social enterprises. Government policy since 1997 has promoted the outsourcing of public sector services to social enterprises to encourage patient and clinician led services with the intention to increase quality and efficiency (DH, 2010a). The opportunity for health and social care professionals to set up and develop social enterprises could present great benefits for occupational therapists but also many challenges, which this study aims to explore. There is an emerging literature into health and social care provision through social enterprises in the UK (Addicott, 2011; Alcock, 2012; Aldridge, 2012; Hall et al., 2012; Millar et al., 2013) however very little is known about occupational therapy provision within social enterprises. This study begins to address that gap in existing knowledge and equip occupational therapists within this currently unknown area for professional practice.

## 1.2 My position as the researcher in this study

I worked as an occupational therapist in adult mental health in the NHS for a number of years, until I had the opportunity to manage a psychosocial project in Uganda. It had been one of my childhood dreams to live in a mud hut and do humanitarian work in Africa! My experience in Uganda changed my perception of occupational therapy and what occupational therapists can offer. I had the opportunity to design and create a psychosocial program focusing on the needs of displaced children, families and communities as a result of civil war. Even though this sounds like a huge challenge, I had a conviction that my occupational therapy training had prepared me well for it. I knew from my training and my own beliefs that it is important to consider human beings holistically rather than through a medical lens. Back home in the UK and in the humanitarian sector in Uganda, so often people are put into “categories” or seen as “problems” and a service only addresses part of the problem according to their labelled diagnosis. I wanted to try to offer a holistic project, as much as possible to address social, emotional, psychological, physical and spiritual needs in accordance with my occupational therapy training and philosophy.

Next, I had the challenge of narrowing down how to address the multiple and complex needs in the internally displaced community. Again from my occupational therapy training I knew that listening to the person I am working with, understanding them and joining them in the direction they want to go, would be an effective approach. This meant putting aside my Western pre-conceptions of what I thought should be done. I and my team listened to the voices of the children, families and communities affected. We heard what they perceived their problems to be and how they wanted to solve them. Together, with the children, their families, and various members and leaders of the community we designed a project that addressed immediate physical, emotional, psychological and social needs through occupations and activities that were normal in their culture. This included sports events which developed confidence and skills in the players, alongside the physical benefits and community peacebuilding between different clans living in cramped conditions. A community-based approach was taken to address education on topics such as HIV; child labour; stigma towards formally abducted child soldiers; domestic violence and alcohol abuse through dance and drama which the community volunteers carried out themselves. As a team and with the community, we all came up with a long-term sustainable strategy for dealing with the poverty that was the root of many of the psychosocial problems they faced. This was through an income generation project for the

lowest income households to own and breed goats, which would assist in paying for school fees and uniforms. It was through culturally relevant, occupations which enabled the community affected by war to begin healing and recovering from the devastation they had experienced. The project was implemented through employing local staff and training community volunteers to build capacity and knowledge locally which would last after the project ended.

It was only after my return to the UK that I discovered that the work we had done and the approach we had used was called 'community-based rehabilitation' (CBR, Thompson et al., 2010) and was similar to community development which promoted the principles of participation and collaboration as evidenced in the literature (Galvaan et al., 2010; Laclair, 2010; Pollard et al., 2010). Reading about CBR and community development confirmed what I had learnt through my experience in Uganda, that occupational therapists can have a crucial impact on creating and delivering holistic, collaborative, participatory approaches to transform the lives of individuals and communities. I read that similar approaches can be developed in Western countries (Kendall et al., 2009; Reigel and Eglseder, 2009) and I could see that value of these approaches, especially considering the economic decline and cuts to the public sector. Through my experience I realised that occupational therapists can address immediate occupational needs as well as long-term preventative and occupation promoting behaviours in Uganda. I had been liberated from the bureaucracy of the NHS and limitations of the medical model that I had experienced in NHS settings as I was unable to offer a truly holistic client centred way of working. I was able to practise according to my training and do what I knew was 'real' occupational therapy. This led me to discover that a similar approach was being developed in the UK through organisations called social enterprises and I wanted to investigate this further. To do this I needed to find out what work was being carried out in the UK by occupational therapists within social enterprises and to what extent social enterprise enabled occupational therapy provision or not.

### **1.3 Combining occupational therapy and social enterprise**

This study explores the relationship between occupational therapy practice in the UK and social enterprise as an environment for delivering occupational therapy services. This has emerged as a topic requiring research following the development of new environments for occupational therapists to practise their profession, outside of statutory services with a

broader range of occupational needs such as the homeless or long-term unemployed (Herzberg et al., 2006; Bazyk and Bazyk, 2009; Holmes and Scaffa, 2010).

Occupational therapy practice within statutory services alone can limit the ability of occupational therapists to apply their broad range of skills to maximise the functional abilities of service users (Bailey, 1990; British Association of Occupational Therapists and Unison, 2003; Arnold et al., 2006; Culverhouse and Bibby, 2008; Wilding and Whiteford, 2007; Lawson-Porter, 2009). This has largely been due to the influence of the dominant scientific paradigm through which the deficit-based medical model has heavily influenced practice and resource limitations (Turner, 2011). The medical model being the diagnosis and treatment of illness and disease. In contrast to this, Antonovsky (1996) suggested an alternative approach to health and health promotion called *Salutogenesis* that focused on people's capacity and own resources to create health rather than focus on risk and disease (Lindstrom and Erickson, 2005). Antonovsky's (1996) approach has closer alliance with the occupational therapy philosophy than the medical, deficit-based model instead having a focus on empowering people to improve their own health and wellbeing or self-health (Wilcock, 2002).

The development of various approaches to health such as: the recovery model (Frese, 2001; Mountain and Shah, 2008); the advances in the service user movement (Barnes and Cotterell, 2011; Repper and Carter, 2011); and promotion of principles of co-production in service delivery (Gannon and Lawson, 2009; Boyle and Harries, 2009) provide a conducive platform for occupational therapists to practise in more client-centred, holistic and collaborative ways. This is in contrast to traditional medicalised services and may enable occupational therapy practice that is closer to the philosophy underpinning the profession. However, the organisations to host such practice are being developed and explored. One of which is social enterprise which can promote similar principles of co-production, empowerment, social capital, social inclusion health promotion and social justice (HM Treasury, 1999; Donaldson et al. 2011; Roy et al., 2013). This study has therefore been guided by the perception that occupational therapists may be able to use their skills to a better advantage to promote health, wellbeing, independent living skills and engagement in work through social enterprise.

This research study was conducted at a time when health inequalities in the UK were widening (Wilkinson and Pickett, 2009; Marmot, 2010; Joyce, et al., 2010; 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). Alongside supporting individuals, occupational therapists have a role in the promotion of environments that are socially inclusive within groups, communities and through political structures such as healthcare services. This approach within occupational therapy has been termed *occupational justice* (Townsend and Wilcock, 2004; Richardson and MacRae, 2011) which acknowledges the existence of barriers to engagement in occupations within society at an individual, community and national level. The occupational justice framework (Stadnyk et al., 2010) captures the importance of addressing occupational barriers at each of these levels in society to meaningfully attempt occupational justice.

Social enterprises, as part of the third sector are asserted as one model for addressing issues of social injustice and exclusion (Organisation for Economic Co-operation and Development, 2006; Nicholls, 2006; Leadbeater, 2007) and have been heavily promoted within recent government policy. In particular, over the past decade, there have been significant changes in government policy and health and social care reform that have had a major impact on how services are provided (DTI, 2002; OTS, 2006; DH 2008; DH, 2009; DH, 2010a; DH, 2011; Health and Social Care Act, 2012; Public Services (Social Value Act), 2012). This has included an intention to transform the NHS into “the largest social enterprise in the world” (DH, 2010a, p5) and a shifting of responsibility to healthcare professionals to create and shape public sector services, alongside service users responsibility to organise their own care. A major emphasis has been the market-isation of the public sector and outsourcing of public services to other providers such as the third sector and private companies (DH, 2010a). As social enterprises aim to serve vulnerable and marginalised groups in society and have become a popular policy tool for the delivery of the public sector, there is the potential for social enterprise as a model for health interventions, such as occupational therapy to be delivered. Both social enterprise and occupational therapists work with vulnerable and marginalised groups in society, with similar aims to enable and equip people to improve their skills and abilities within society. Therefore, by combining the organisational model of a social enterprise with the professional expertise of occupational therapists, social exclusion, injustice and inequalities can be tackled in a robust way.

Research into health and social care delivery through social enterprise is a fairly new phenomenon and remains sparse, especially within the field of occupational therapy. This research study synthesises the occupational therapy literature with the existing literature on social enterprise and is believed to be the first study that has attempted to bring

together these two different models and approaches. This research was conducted within the context of the changing health and social care landscape in the UK between January 2010 and October 2013, including a change in government in May 2010, which resulted in influential policy changes as part of healthcare reform, (primarily, the outsourcing of the public sector to private providers as well as social enterprises). These policy changes have had an impact on the findings of the study, as the previous labour government provided finance and support for the social enterprise agenda and changes to healthcare reform. This was then replaced by cuts and austerity measures by the coalition government and support for large public sector '*spin-offs*' which negatively affected the ability of smaller third sector and social enterprises to develop alongside the introduction of competition from the private sector (Floyd, 2013).

Chapters two and three in this study discuss the literature base of occupational therapy, social enterprise and the policy context for the study. The first of these chapters (Chapter 2) addresses the developments within the occupational therapy profession, particularly around the need for the development of new practice environments that maximise opportunities for service users to benefit from a wider range of services. The concept of occupational justice is introduced in this chapter and is used as a theoretical framework for this study. This is then followed by Chapter 3 which presents a discussion of the context for occupational therapy delivery within the UK, particularly around the policy landscape affecting health and social care provision and the introduction of social enterprise as a model for public sector provision. This includes the political and economic influences on health and social care delivery as structural factors that may limit or enable occupational therapy practice. The literature review led to the development of the aims, objectives and research questions which were.

#### **1.4 The aims and objectives for the study:**

**Aim 1:** Identify what form of occupational therapy is practiced within social enterprises.

##### **Objectives:**

- a) To identify social enterprises that provide occupational therapy in the UK
- b) Determine which service user groups receive occupational therapy from the occupational therapist employed by social enterprises

**Aim 2:** Explore social entrepreneur and occupational therapists' reasoning for the choice of occupational therapy practised in social enterprises and the relationship to the philosophy of the profession.

**Objectives:**

- a) Establish what influences the decisions about which models and approaches are used by occupational therapists in social enterprises.
- b) To explore the supportive and limiting factors in occupational therapy practice in social enterprise

**Aim 3:** Explore service users' views, opinions and experiences of the occupational therapy they receive within social enterprises.

**Objectives:**

- a) To explore service users' experience of social enterprise delivering occupational therapy, including the benefits and challenges encountered.

**Aim 4:** Examine the factors that determine the different ways occupational therapy is provided in social enterprises.

**Objectives:**

- a) Identify the funding sources or contractual obligations that affect the occupational therapy provision in social enterprises in the UK;
- b) Determine the extent to which the occupational therapists are involved in the management or governance of social enterprises.
- c) Explore to what extent occupational therapy in social enterprises is determined by service users' needs.

**Research questions:**

1. What forms of occupational therapy are practiced within social enterprises in the UK?

2. What is the relationship between occupational therapy practice in social enterprises and the philosophical foundation of the profession?
3. What are service user's views, opinions and experiences about the occupational therapy they receive within a social enterprise?
4. What are the factors that determine the diversity of occupational therapy provision within social enterprises?

To address the research questions, aims and objectives of the study, a research design was developed that was informed by the pragmatic paradigm (Morgan, 2007) which is discussed in Chapter 4 as the philosophical underpinning of the study alongside the methodology of the study which includes two phases for data collection, analysis and ethics. The first phase of the study was a scoping study which generated a baseline of data about occupational therapy provision within social enterprises in the UK using web and desk-based research, field visits and an online questionnaire as methods for data collection. The second phase used an in-depth case study methodology that explored the occupational therapists, service users and social entrepreneur's experiences and perspectives on the occupational therapy provision within these social enterprises. The methods used in the second phase were semi-structured interviews; observation on field visits; written organisational documentation and reflexivity.

The findings of the study were then presented in four chapters: Chapter 5 presents the findings from the scoping study and an overview of the case studies. The subsequent findings chapters present the case study findings and discusses them in relation to the literature. Chapter 6 presents the findings from a macro perspective in relation to the political, economic and structural influences on occupational therapy delivery in social enterprises in the UK. Chapter 7 presents the findings from a meso perspective of occupational therapy provision through social enterprise in relation to the organisational and environmental influences on practice. Chapter 8 presents the individual, micro level experiences of occupational therapy within social enterprise from the perspective of the occupational therapists, service users and social entrepreneurs that were interviewed. Chapter 9 then discusses the findings in relation to the research questions and a critique of the methodology used. Limitations of the study and recommendations for future studies are then discussed alongside implications of the study for policy and occupational therapy practice.



# Chapter 2: The profession of occupational therapy - Past present and future

## 2.1 Introduction

The profession of occupational therapy is in a process of re-conceptualisation and discovery of new settings for practice (Pollard, et al., 2005) therefore it is at a time of transformation internally as a profession and externally as a result of public sector reforms in the UK. Occupational therapy as a profession has changed and evolved over time with varying emphasis on the importance of occupation as it has strived for status and recognition under the domination of the medical model (Turner, 2011). The philosophy and principles of occupational therapy have remained relatively unchanged over the course of the history of the profession; however its practice has varied widely and changed over time as a result of socio-political changes in health and social care provision in the UK.

Through the development of an academic knowledge-base, for example with occupational science (Yerxa, 1993, Hocking, 2009), the profession of occupational therapy has gained clarity regarding its identity and confidence in the unique contribution the profession can offer health and social care through occupation. This development converges with the UK's health and social care reforms (DH, 2010a) which are discussed in detail in the next chapter. These significant changes may provide the opportunity for the profession to further create new settings in which to practise.

This chapter presents the concepts currently understood within occupational therapy and how the profession has developed and adapted with socio-political changes in the UK over the past century. The development of the knowledge-base of occupational science was introduced with the implications for practice around occupational justice and health promotion. These theoretical developments have begun to have implications for practice and emerging settings for occupational therapy. This study was conducted as a response to the new and emerging opportunities for occupational therapists to practise within social enterprises in the UK. This is a new and innovative research study that brings together occupational therapy philosophy and practice within a social enterprise in order to explore the potential of practicing occupational therapy within a social enterprise. Occupational

therapy and social enterprise seek to address occupational and social justice respectively, with individuals and groups within society and this study explores the combination of these as a new form of a public health intervention (Donaldson et al., 2013; Roy et al., 2013). Before presenting an overview of the development of the profession of occupational therapy, the key concepts and definitions within the profession are presented and discussed. Social enterprise is then discussed in the following chapter which incorporates a discussion of the literature on occupational therapy within social enterprise in the UK and an amalgamation of the two different fields.

## **2.2 The meaning and value of occupation**

The term *occupation* is a complex, confusing and misunderstood concept (Whiteford, Klomp and Wright-StClair 2005). It is asserted that occupation encompasses all the things that people do and it is purposeful activity that is central to human experience (Wilcock, 1993; Wilcock and Townsend, 2000; Wilcock, 2001). Alternatively, occupation has been explained as groups of activities and tasks of everyday life, given value and meaning by individuals and culture, as it is everything people do to occupy themselves including self-care, leisure and productivity (Wilcock and Townsend, 2000). The term 'occupation' within this context represents more than 'activity' or 'behaviour' as 'occupation' refers to the complex synthesis of the individual's psychological, social and physical interactions within their environment to achieve a specific purpose. The word occupation therefore, has greater depth and meaning within the profession of occupational therapy than may normally be understood in the common use of the English language.

It has been asserted that occupation is a complex and multifaceted phenomenon that is specific to the individual in an environment at a particular time (Yerxa et al., 1990; Molineux, 2010). Molineux, (2010) suggested that it is because of this complexity, a single definition of occupation has not been agreed upon. Through his study of the literature, the nature of occupation can be summarised as having the characteristics of; active engagement, purpose and meaning which is relevant in each context of human experience. These characteristics however require further explanation as they are open to interpretation as they can be subjectively defined. There are various dimensions of occupation that are not acknowledged in Molineux's conceptualisation. This includes the concept of 'flow', having total involvement in the experience of the activity (Wright, 2003; Reynolds and Prior, 2006; Reid, 2011); occupation as over-activity, for example a single mother who has multiple jobs to pay the bills (Van-Houdenove et al., 2001; Birkholtz et

al. 2006; Whiteford, 2011) or 'negative' occupations such as smoking, crime, substance misuse or prostitution (Eggers et al., 2006; Du Preez, 2013; O'Doherty, 2013; Luck, 2013). Occupation is used within occupational therapy as the medium to promote health and wellbeing and the current policy changes affecting health and social care provision will affect and are already affecting occupational therapists practice within the UK. The following section further explores the definitions and meaning of occupational therapy and later in this chapter, the different environments for occupational therapy practice are discussed.

### **“Occupational therapy”**

The World Federation of Occupational Therapy (WFOT) states that occupational therapy is concerned with promoting health and wellbeing through occupation with the goal of enabling people to participate in activities of everyday life (WFOT, 2010). People in need of occupational therapy are generally those diagnosed with disabling conditions or situations whose capacity to engage in everyday activities is impaired. The WFOT (2006) depicts occupation as everyday activities that people do as individuals, in families and with communities to occupy their time and bring meaning and purpose to everyday life. This includes things people need to, want to and are expected to do. The profession of occupational therapy provides a humanistic, critical and social view of occupation which is in contrast to the economic view of occupation, usually defined as work (Townsend et al., 2003). It is suggested that through the practice of occupational therapy, people are enabled to be active participants in shaping their lives individually and collectively, with the inclusion of unpaid as well as paid occupation (Wilcock and Townsend, 2000).

Creek's (2003) extensive research commissioned by the College of Occupational Therapists (COT) in the UK attempts to define occupational therapy. It was concluded from this study that occupational therapy is a complex synthesis of “doing, being and becoming” (Wilcock, 1998 p249) central to everyday life, incorporating physical, social, psychological and spiritual dimensions of human existence (Creek, 2003). This holistic definition is consistent with the historical research into occupation and occupational therapy conducted by Wilcock (1998; 2001).

There are variations in the literature regarding the definition of occupational therapy. For example, Creek (2006) found thirty-seven definitions of occupational therapy in international documentation. Based on her view of the literature, Creek (2006) then developed a standard terminology for occupational therapy by using a Delphi approach

which consulted expert practitioners. Through this study she identified six definitions of key terms of occupational therapy, but was unable to produce a single definition of occupational therapy due to its complexity. Hocking (2010) summarised the core values of occupational therapy to be “enabling people to engage in a range of occupations and building people’s capacity and ability to perform occupations” (p10).

Wilding (2010) suggested that the focus of occupational therapy is about enabling people to engage in their chosen occupations and meeting peoples’ occupational needs. This is also similar to Creek’s (2003) work, which identified the main goal of occupational therapy as to support recovery, health, wellbeing and social interaction through assisting the client to achieve a satisfying balance of occupations. Wilcock and Townsend (2000) also include a focus not only on the occupations of individuals but also communities and governments, offering a broader understanding and application of occupational therapy, which has implications for wider opportunities for practice in more diverse settings. Watson and Fourie (2004) offered an explanation of occupational therapy that combines both Creek and Wilcock and Townsend’s definitions. They assert that occupational therapy is a service that is offered by professionals who aim to collaborate with individuals, groups, organisations and communities to achieve particular health and wellbeing related purposes associated with everyday occupational behaviours or circumstances that facilitate occupational development or achievement (Watson and Fourie, 2004). This definition of occupational therapy is particularly relevant when considering its practice within the context of a social enterprise as the wider sociological aspects of occupation are taken into account. Therefore this definition has been used for the purpose of this study.

The client and the therapist bring unique contributions to the occupational therapy intervention, within a specific health and social care policy context and environment. Therefore, each occupational therapy intervention is unique which highlights the challenges in defining occupational therapy simplistically. The philosophy which underpins occupational therapy in all different contexts remains the same but different aspects of it have been emphasised over time. An overview of the historical development of occupational therapy is explored next to provide a background to current occupational therapy practice. This is important in this study as a justification for social enterprise as a new area of professional practice for occupational therapists. Following this is a discussion of the philosophy of occupational therapy that underpins current practice.

## 2.3 A historical overview of the development of the occupational therapy profession

The importance of therapeutic occupation has been documented from ancient times although little was recorded about the benefit of occupation in the Dark Ages (Turner, 1992). Writings attributed to Hippocrates, Galen and Aesculapius promoted exercise, activity treatment and employment as important therapeutic components (Radomski and Trombly-Latham, 2008). Some of the earliest documentation of the value of activity in healthcare was in the nineteenth century. The benefits of occupational activity and health were recognised in North American hospitals which included the use of spinning wheels, wool and flax with patients (Radomski and Trombly-Latham, 2008).

One of the significant influences on the development of the occupational therapy profession was the arts and craft movement which developed between 1875 and 1920. The link that the Romantics recognised between work, sensitivity, and creativity became central to the arts and crafts movement and influenced the early development of the occupational therapy profession (Hocking, 2008a). While the romantic ideals of the power of creativity developed in the UK, the therapeutic value of activity was recognised by Adolf Meyer, a Swiss physician who emigrated to the United States in 1892. Meyer was a professor of psychiatry at John Hopkins University and he became concerned with meaningful activity as a core treatment (Radomski and Trombly-Latham, 2008). Due to Meyer's interest, psychiatry was the first discipline to recognise the need for adaptation of daily activities and the value of work. In 1893, Meyer observed the value of 'ward' work and gardening for patients while admitted to hospital. It was Meyer's perspective of valuing the patient's personal, social and psychological experiences that brought a holistic approach to occupational therapy (Yerxa, 1992). Meyer's beliefs that people should be studied in their environments revealed how he was influenced by Deweyan philosophy, a philosophy that suggests that individuals are not separate to, but part of, their environment (Cutchin, 2004). This then became an influencing factor in the development of occupational therapy philosophy and practice. Adolph Meyer and Eleanor Clark Slagle articulated occupational therapy in 1922 (Yerxa et al., 1990) and Meyer wrote the paper *The Philosophy of Occupational Therapy*, the first written piece of occupational therapy literature. In this Meyer emphasised:

*"Work and play, ambition and satisfaction, are apt to lose their natural contact with the natural rhythms of appetite and gratification, vision and*

*performance, and finish cycles of completion - of work and play and rest and sleep" (Meyer, 1922 p.8).*

This early philosophy of occupational therapy recognised the value of occupation, leisure, routine and balance in daily activities. His philosophy was that:

*"Man learns to organise his time and he does it in terms of doing things, and one of the many good things he does between eating and drinking and wholesome nutrition generally and with flights of fancy and aspiration, we call work and occupation" (Meyer, 1922 p.9).*

Meyer recognised the diversity of occupation as all that fills the time between basic human needs such as eating and drinking. The founders had a view of occupation as fundamentally important to human health and wellbeing, having the potential to be curative if correctly selected and used (Hagadorn, 2001).

Occupational therapy combined two very different paradigms of positivist, rational medical science and the romantic, idealist arts and crafts movement by valuing a holistic approach of psychological, social and physical aspects of human occupation. Hagadorn (2001) and Turner (2011) suggest that these differing perspectives created an inbuilt philosophical inconsistency for the profession of occupational therapy that has continued throughout its history. This clash of paradigms was apparent in the 1930's when the medical profession demanded occupational therapy to deliver outcomes. However, the occupational therapy profession did not have tools to measure progress and the impact of therapeutic activity other than observation (Hocking, 2007).

## **Occupational Therapy within the UK**

The commitment to the value of occupation and crafts as therapy declined in favour of bio-mechanical goals, adaptive equipment was used to address the needs of disabled veterans (Radomski and Trombly-Latham, 2008). The dominance of the medical model influenced the direction of the profession of occupational therapy towards ill health rather than 'self-health' - the empowerment of the individual to be actively involved in their own recovery (Turner, 2011).

In 1948, the establishment of the NHS was founded on managing and where possible, preventing and curing ill-health. This was significant in the influence on occupational

therapy profession which originated from principles of self-health and wellbeing as the NHS developed a passive attitude within the British population towards health and recovery (Lawson-Porter, 2009). This brought in conflict with occupational therapy approaches and philosophy which was founded on self-health and wellness through occupation. Instead, the medical approach that was embedded in the NHS culture promoted a remedial, deficit-based approach.

The social model of disability, conceptualised in the 1980s, emphasised that the environment, culture, attitudes and resources are disabling and limit occupational function rather than the emphasis on the individual's disabilities (Oliver, 1996). This new approach to disability then brought a conflict with the earlier biomechanical model and led to the development of the bio-psychosocial model, which combined all medical and social factors in an individual's experience, supporting a holistic approach to occupational therapy (Hagadorn, 2001), found in the early conceptualisations of the profession.

Dissatisfaction among people with disabilities in relation to the care they received, led to the development of the independent living movement (Evans, 2003) in the 1970s and 80s. Together with the antipsychiatry movement and the emergence of organised mental health service user/survivor networks such as the National Advocacy Network and the National Advocacy Group, there became a growing momentum for significant change in not only how society regarded those with disabilities and mental health problems, but also how they were treated. The National Health Service and Community Care Act, 1990 indicated a significant shift from institutional care to care in the community. This resulted in an increase in the number of occupational therapists, to support individuals with disability to live independently in the community and consolidated Local Authorities as employers for occupational therapists. As a result, the occupational therapy profession moved away from focusing on disabling conditions and was able to rediscover valued occupations and purposeful activity with service users within the community (Radomski and Trombly-Latham, 2008).

Alongside these changes, in the late 1980s, graduate education for occupational therapists became available, developing a more critical approach to the profession (Alsop, 2006). Occupational therapy models began to be published such as Keilhofner's model for human occupation (Keilhofner, 1985) steering the focus in the profession from medical illness back to the importance of occupation. Qualitative research methods also became more acceptable (Lincoln and Guba, 1985) which were more appropriate for occupational therapy practice and research as they incorporated the subjective, human experience.

Occupational therapists were able to produce more evidence of their effectiveness and an academic knowledge-base began to develop (Turner, 2011). Some of this new knowledge was termed 'occupational science'.

Occupational science is the academic discipline that studies humans as occupational beings (Yerxa, 1993, Hocking, 2009). Occupational science promised to provide a substantial knowledge-base for the profession which could reflect the values in occupational therapy practice (Yerxa, 1993; WFOT, 2012). It has been asserted that occupational science is a basic science that supports the practice of occupational therapy (Yerxa et al 1990; Wilcock, 2001; 2002; 2006). However, it has been asserted that occupational science is yet to be critically appraised by the occupational therapy profession (Turner, 2011). Occupational science also has relevance and application in wider society in relation to "the impact of economics, environmental issues and government policies on people's occupational opportunities and choices" (WFOT, 2012 p1). This development in the academic knowledge-base has broader implications for the application of the meaning and value of occupation in wider society than occupational therapy practice that is embryonic in its application in the UK.

Underlying occupational science is an assumption of holism (which has been fundamental in occupational therapy philosophy) which acknowledges a human being as not only physical but also social, relational and embedded in culture and environment which impacts on their daily activities (Yerxa, 1993). This was not reflected in the medical approach. The holistic aspects of occupational science and the practice of occupational therapy, suggest that occupational therapy needs to be practised outside of institutional settings, such as a hospital. Therefore occupational therapists might seek opportunities to practise in environments that support and promote the philosophy of the profession that reflects holism. Such environments are presented later in this chapter. However the philosophy of the profession of occupational therapy is first discussed.

## **2.4 The philosophy of the occupational therapy profession**

A profession's philosophy is the beliefs and values that describe what it believes to be important and can be dynamic, changing and evolving over time (Hinojosa et al., 2003). The philosophy of occupational therapy is the profession's beliefs about occupation and its centrality to human existence (Yerxa, 1998; Polatajko, 2007) and the role of occupation in health (Wilcock, 1999). The first published philosophy of occupational therapy by Meyer



(1922) was founded on the belief in the value of what human beings do to fill their time and this was termed 'occupation'. The early principles of occupational therapy and published by Meyer were:

- Use of time;
- Pleasure in achievement;
- Engagement of interest;
- Daily rhythm of rest and activity to maintain balance and;
- Habit training.

(Posatery Burke, 2003).

Occupation has remained central to the philosophy of occupational therapy although the term has become synonymous with 'purposeful and meaningful activity' (Hinojosa et al., 2003). It has been suggested that the philosophy of occupational therapy is the importance of purposeful activity in human beings daily interaction in the social and physical environment (Blanche and Henny-Kohler, 2000). However, Wilcock (1993) makes a much bolder statement that the need to engage in purposeful occupation is a human need for health and survival. Wilcock's (2001) theories of occupation and the relationship to health are based on an in-depth study, using a history of ideas methodology to study occupation throughout human history. As a result of her study, Wilcock makes the claim that occupation is essential for human survival which introduces a rights based approach to concepts of occupation.

The early beliefs about occupation have evolved over time into contemporary principles underlying occupational therapy such as:

- **A holistic view of the person:** the perspective of human experience incorporating the physical, social, cognitive, psychological and spiritual.
- **Occupational behaviour:** humans have an innate need to engage in occupation and the set of skills required to perform tasks. Occupational behaviour organises time and creates structure in living.

- **The influence of culture on occupation:** for example in shaping roles and identities.
- **The dynamic relationship between the person and the environment:** the interaction of the individual with their physical and social surroundings and the impact on their ability to perform chosen occupational tasks.
- **An emphasis on the uniqueness of the individual:** client-centeredness in therapeutic interventions in relation to the individual person's motivation, interests, abilities, values and goals.
- **The significance of occupation to health and wellbeing:** occupational engagement can produce a sense of meaning, competence, achievement and engagement in activities that promote health and wellbeing. A lack of occupation can have a negative impact on health and wellbeing.

(Baptiste, 2003; Posatery Burke, 2003; Wilcock, 2006; Polatajko et al., 2007; WFOT, 2010; 2011).

A significant development of the philosophy and principles of occupational therapy is the client centeredness of interventions (Baptiste, 2003; WFOT, 2010; 2011). Indications of this can be found in the early philosophy of occupational therapy that highlighted the importance of the individual's interest and pleasure in chosen activities. This has now developed into being a client centred profession, where clients are "actively involved in the occupational therapy process" (WFOT, 2011 p1) and that occupational therapy is a collaborative intervention between the therapist, the client and carers (Hanna and Rodger, 2002). This client-centeredness includes aspects of self-measurement when using outcome measures based on satisfaction. The belief in individuals as unique occupational beings, with individual capacity, potential and creativity (COT, 2011) has become a core aspect of occupational therapy philosophy in the UK and internationally (WFOT, 2010).

The search for a definitive philosophical basis for the profession of occupational therapy has been challenged by Hammell (2011) who states that intellectual consensus is premature and has driven out theoretical imperialism. Hammell recognises that academic theorising within the profession of occupational therapy is dominated by white, western, privileged and powerful individuals who have assumed a universalism to the theories they create. She suggests this can be overcome by incorporating multiple perspectives from

different cultures around the world. However, the number of different cultures that need to be incorporated to develop universal principles and a philosophy for the profession is unknown and not explored by Hammell. In addition, incorporating multiple perspectives (from different countries) does not necessarily avoid theoretical imperialism as taking one perspective from one country does not necessarily represent that country's experience. Rather than seeking a universal understanding of the philosophy of occupational therapy and its application, a British or 'western' perspective is used for the purpose of this study. This focuses on UK practice where the limitations and bias of the philosophy are explicit without proposing universal application, in an attempt to avoid theoretical imperialism.

## **2.5 The development of new environments for practice**

Over the past couple of decades, the profession of occupational therapy has been reasserting its claim on occupation and its meaning to individuals and in society by engaging in a process of re-conceptualisation (Pollard, Alsop, and Kronenberg, 2005). As a result of the development of occupational science, the profession is reappraising the holistic understanding of occupation in relation to the broader political, economic, social and cultural context of human existence (Pollard and Sakellariou, 2007). This has involved the development of a socio-political definition of the practice of occupational therapy which is an enabling type of therapy that focuses on the occupations of individuals, communities and governments (Wilcock and Townsend, 2000). Previously, occupational therapy interventions have had an individualised focus which has now been broadened by the application of an occupational philosophy in wider settings. These recent developments in the conceptualisation of occupational therapy are concerned with restoring functioning to occupation has developed as necessary for survival, wellbeing, community participation and the exercise of citizenship (Pollard and Sakellariou, 2007). Therefore there are implications for occupational therapy practice outside of previous medical and social care settings to a wider remit in communities and in society.

The World Federation of Occupational Therapists supported the development of an occupational perspective on human rights asserting that as a core principle of occupational therapy, it is the right of all people to develop their capacity and power to construct their own destiny through occupation (WFOT, 2004). However, these concepts remain largely theoretical and the profession has only just begun to appreciate the political potential of occupation and that interventions can go beyond health and social care to address the socio-political dimensions of disability in society in general (Pollard, et al.,

2008; Hocking and Nicholson, 2007). Interventions to address occupational injustice are currently being carried out with individuals and groups however occupational interventions with communities and society are a new concept for the occupational therapy profession to address in the UK. This could include occupational health promotion as part of a public health strategy to address obesity, alcohol abuse, smoking or substance misuse among others. Alternatively, occupational justice at a community and societal level could involve occupational therapists preventing recurring patterns of re-offending once leaving prison; homelessness or intergenerational unemployment for example. This will require adaptation within the profession to practise in environments that support this wider remit of occupational therapy.

Occupational therapists have been providing care in the community for a number of decades. However, therapists are now being challenged to work *with* not *in* the community (Sakellariou and Pollard, 2006). There has been a shift in emphasis from the therapist as the expert providing care to service users, to therapists working with individuals, groups and communities to jointly find solutions to occupational issues. This has been promoted by the development of a strategic approach termed community-based rehabilitation (Thompson et al., 2010) which has been widely used in other international contexts but with limited application of working with groups and communities in the UK.

The concept of occupational justice provides a theoretical framework for the profession of occupational therapy to aim for occupational engagement at an individual, community and society level (Stadnyk et al., 2010). They conceptualised occupational justice into three parts: structural factors; contextual factors and occupational outcomes. The structural factors were differentiated into: 1. underlying occupational determinants (such as the economy, politics, policy and culture); and 2. Occupational instruments or programs (such as healthcare services; employment; education; and community support). Contextual factors were considered as personal, historical and spatial contexts (such as age; gender; disability; and social support). Finally, under occupational outcomes, issues of occupational rights, dis-ease and injustice are included (such as occupational deprivation; marginalisation; imbalance and alienation).

An occupational justice approach to research takes into consideration social and political structures that influence the ability of individuals and communities to engage in meaningful health-giving occupations (Townsend and Wilcock, 2004; Richardson and MacRae, 2011). It has been asserted that framing issues within an occupational justice

framework means that the barriers in the environment that prevent engagement in health promoting occupations are identified (Wolf et al., 2010).

The occupational justice framework published by Stadnyk et al., (2010) has been used as a theoretical framework for this study because of the inclusion of the broad socio-political influences on individual, group and community engagement in occupation in society. This is relevant when considering research into the individual experience of occupational therapy whilst attending a social enterprise which is a social and politically created structure. As individuals do not exist within society alone, but are affected by cultural, social and contextual factors which limit or enhance their ability to engage in society (Stadnyk et al., 2010) it is deemed important within this research to take these into consideration. In addition, both occupational therapists and social enterprises aim to promote social inclusion and social justice, therefore these two previously unrelated models are brought together and can be conceptualised within one overall framework.

The use of the occupational justice framework has been used to frame the research questions, aims and objectives, which include a focus on structural, contextual and occupational outcomes. The structural aspects of occupational justice applied to this study include: the policy drivers within health and social care and the organisations that provide such services; educational and employment opportunities and community support structures. The contextual aspects of the framework relate to the individual characteristics of the service users, occupational therapists and social entrepreneurs and how they enhance or limit occupational justice, and the individual experience of occupational justice, which are taken into account within this study. Finally, the relevance of the occupational outcomes aspect of the framework within this study relate to the extent occupational therapists and social enterprises are able to enhance occupational justice whilst working with vulnerable groups within society.

## **2.6 Current occupational therapy practice in the UK**

Following the development of the concept of occupational justice, new environments could therefore offer occupational therapists opportunities to practise in ways that enable this wider remit for occupational engagement. Occupational therapists are being challenged to consider their role in addressing the occupational needs of people in their own communities and to enable their communities to promote social cohesion, identify common goals and work together to achieve these aims (Pollard et al., 2010). The

environments that occupational therapists practice within can be considered the structural factors that influence occupational justice referred to within the Stadnyk et al (2010) framework.

There were 32,083 registered occupational therapists in the UK in 2012 (COT, 2012). The majority of these worked for the NHS with Local Authorities being the second most common employer. In 2012, the total number of occupational therapist employed by the NHS was 17,472 and 2,850 were employed in social services (HSCIC, 2013). Approximately 4,000 occupational therapy students are included in this total statistic and 560 are self-employed occupational therapists (COT, 2012). The remainder of occupational therapists registered with COT are unaccounted for and may be registered but not practicing or not in employment.

Occupational therapists work in a variety of settings outside public health and care services such as: education; private companies; prisons and charities among other areas which have increased over the past decade. It has been observed internationally and in the UK that many occupational therapists work in systems and environments which make it difficult to address the occupational needs of their clients (Molineux, 2004; Lawson-Porter, 2009). Within existing occupational therapy provision, such as social services, research revealed that 76% of occupational therapists said that they were not able to address all their clients' occupational needs and that the majority of their interventions were limited to equipment provision and adaptations (Forsyth and Hamilton, 2008).

Occupational therapists inability to practice according to the philosophy of the profession and meet service user's needs has led to dissatisfaction within the profession which has been evidenced in the occupational therapy literature for a number of decades. In 1990, research found dissatisfaction among occupational therapists with their role, that it was not what they expected and they were not able to make a difference in service users' lives (Bailey, 1990). Research into occupational therapists' job satisfaction in Local Authorities revealed stress, high workload, compromising standards, low morale and feelings of being undervalued and poorly treated by their managers (British Association of Occupational Therapists and Unison, 2003).

An in-depth study by Arnold et al (2006) of Allied Health Professional's job satisfaction in the NHS revealed that occupational therapists considered leaving due to high workload and stress; not being able to address clients' needs; and feeling personally undervalued and unsupported. Arnold et al (2006) also found that occupational therapist who left the

NHS for alternative employment were able to enjoy professional autonomy; felt valued in their work; felt they gave better patient care; and had better professional development experience in their new roles.

Occupational therapy students have also compared their practice experiences in statutory care with those in 'role emerging placements' (in new non-medical settings) such as with the homeless or with refugees. They comment on the limited ability to use the range of skills in statutory services in contrast to the wide range of opportunities in these new settings (Lawson-Porter, 2009). An example in mental healthcare showed increasing challenges for occupational therapists to be able to practise occupational therapy, as demands on them to take on generic roles such as care coordinator increase (Culverhouse and Bibby, 2008). In Australia, Wilding and Whiteford (2007) evidenced challenges occupational therapists experience when working in acute medical settings, such as occupational needs being a low priority in comparison to medical needs. Maintaining the importance of occupation in the practice of occupational therapy may ensure the unique aspect of the profession is upheld and distinct from other professionals. However despite the frustrations about the lack of ability to practise according to professional beliefs, occupational therapists have reservations about the financial risk of setting up new services or working outside the public sector (Turner, 2011).

The frustrations and limitations experienced by occupational therapists discussed above can be conceptualised using the occupational justice framework as a result of structural factors within the healthcare service provision. However, the contextual aspects of the framework could offer insights into these issues and challenges from a gender perspective. Occupational therapy is a female dominated profession which has 'grown-up' within the medical, historically male dominated profession. Turner, (2011) presented an analysis of the development of the profession of occupational therapy which proposed that it has been the handmaiden to the medical profession. Occupational therapists may have developed a sense of inferiority in the perceived hierarchy within the NHS and as such not developed the confidence to assert the meaning and value of occupation for health (Wilcock, 2001). Therefore, if occupational therapists are to proactively promote occupational justice, they need to not only contribute to changing the structure of services they work within but also consider developing the personal characteristics and skills that are required to promote occupational justice at an individual level.

## 2.7 Occupation-based practice

The dissatisfaction among some occupational therapists in statutory services alongside the policy initiatives to promote innovation among healthcare professionals to branch out into social enterprises, provide an incentive for occupational therapists to create new environments for service delivery. As this is a new development for the profession of occupational therapy in the UK which is currently lacking in research and evidence base, research and literature has been drawn upon from international contexts which can inform the development of the profession of occupational therapy within the UK.

People with occupational needs may be found in a wide variety of operational sectors in the UK such as housing, education or community development. As stated earlier, occupational therapy not only addresses function but can also address deprivation; the opportunity for activity participation and overcoming environmental restriction wherever there is limitation on human potential for growth and change (Watson and Fourie, 2004). These developments within occupational therapy suggest that practice does not need to be within a medical remit or with the presence of illness (Turner, 2011). Given this perspective, it is argued that occupational injustice exists in the UK (Lawson-Porter, 2009) for example a lack of opportunity to work with vulnerable groups such as refugees; the homeless; youth; prisoners and teenage mothers. Within the occupational justice framework, the lack of occupational therapy services with these groups in society could lead to occupational deprivation.

Occupational therapy literature internationally, records practice with diverse populations, such as the homeless (Herzberg et al., 2006), low income urban youths (Bazyk and Bazyk 2009) or transitional housing and employment programmes (Holmes and Scaffa, 2010). The development of role emerging student placements and emerging practice for practitioners also demonstrates the shift in service delivery from health to more social and community interventions. More graduates are now finding employment outside statutory services, highlighting a change in emphasis of healthcare provision from a medical model to a community-based rehabilitation approach (Cooper and Raine, 2009). It has been suggested that community development should be addressed in occupational therapy curricula (Watson, 2004) as an occupational philosophy can also be applied to addressing occupational issues at a community level. Therefore the profession of occupational therapy is developing new environments for practice to improve on the limitations within the current health and social care services within the UK and broaden opportunities for



addressing service users' needs and aspirations. Within the occupational justice framework, these are changes within the structural factors that can affect occupational justice.

Health promotion within occupational therapy has also developed out of Wilcock's Utopian vision for an occupationally just society. Wilcock asserted that working at an individual, community or population level, a preventative approach may be appropriate not only in the health sector but also in public health, looking at the underlying occupational causes which can lead to disease or disability (Wilcock, 2001a). Adoption of a public health focus will require occupational therapists to broaden their perspective about their roles to address public health issues that are occupational (Mallinson et al., 2009).

The importance of health promotion and the development of up-stream services to address health promotion strategies, was emphasised by Lawson-Porter (2009) in her Casson Memorial lecture, however practice still remains limited. Occupational therapists within Local Authority services reported that they believed their work should be expanded to include health promotion and prevention, return to work, rehabilitation and re-ablement (Riley et al., 2008). However, public health promotion is an area of occupational therapy provision that requires further development in practice in the UK, despite recognition in the literature spanning a number of decades, for its potential within occupational therapy practice (Jaffe, 1986; Finlayson and Edwards, 1995) and endorsement by the College of Occupational Therapists (2008). The application of a public health promotion approach within the occupational therapy profession would include health and social care service provision, therefore changing the structural components of occupational justice.

Antonovsky (1996) presented an approach to health and health promotion that focused on people's capacity and resources to create health rather than focus on risk and disease (Lindstrom and Erickson, 2005). Antonovsky termed this approach 'Salutogenesis' and is opposite to the traditional deficit-based approach of the medical model because it focuses on strengths and abilities rather than illness and disabilities. This problem-solving and empowering approach shares many similarities with principles underlying occupational therapy and the occupational therapy profession may find greater affinity to a Salutogenic framework for practice than within the medical model.

Research into diverse methods of service delivery are required for the profession of occupational therapy to develop practice and services that occupational therapists are satisfied with and that is in accordance with the philosophical foundations of the

profession. These changes within the development of occupational therapy align with the call for occupational therapy practitioners to evaluate their services in light of the philosophical foundations of the profession (Holmes and Scaffa, 2010).

## **2.8 Chapter summary: The profession of occupational therapy - Past present and future**

This literature review has investigated the development of the profession of occupational therapy over the twentieth and twenty-first centuries. The profession has been heavily influenced by the dominant positivistic paradigm of medical science and has frequently lost sight of its roots in occupation for health. The emergence of occupational science provided the profession of occupational therapy the confidence of a scientific knowledge-base and clarity in its identity that it had long been searching for (Turner, 2011). With this new confidence, occupational therapists began developing 'non-traditional roles' in new practice settings that provide the freedom for occupational therapists to practise away from the dominant medical model and more in keeping with their philosophical beliefs. The advancement in the profession has converged with political and economic changes in public sector provision of health and social care, which are discussed in greater detail in the next chapter. The political agenda towards personalisation and the outsourcing of health and social care for professionals to deliver services through social enterprises, provides occupational therapists with new opportunities to develop new ways to provide their service. This could enable occupational therapists to work within an occupational justice framework in some settings, promoting social justice and contributing to health and social equality.

It has been asserted that now is the time for occupational therapists to set their own agenda (Drummond, 2010) but this will require occupational therapists within the profession to develop the capacity and power to create its own destiny (Pattison, 2008). This brings new challenges for members of the profession of occupational therapy, as it involves moving away from medicine towards practice in new and different environments. One of these is the practice of occupational therapy within social enterprise. There is a very small body of knowledge supporting this new development which is discussed in the next chapter and further research is required, which this study begins to address.

# Chapter 3: Social enterprise and occupational therapy practice within the UK

## 3.1 Introduction

This chapter presents the socio-political and policy context for health and social care at the time the study was conducted and the relevance of this in occupational therapy provision through social enterprises in the UK. The purpose of this chapter is to make explicit the structural factors around occupational therapy provision in the UK, concerning politics, policy and economy. These structural factors are one level of analysis within the occupational justice theoretical framework that is used in this study which influence the occupational outcomes within the framework (Stadnyk et al., 2010). The main structural factors that are focused on within this chapter are the context of health inequalities that health and social care provision operates within in the UK and the policy drivers that have begun to reshape the health and social care landscape within the UK over the past decade, particularly around service provision through social enterprise.

Social enterprise has been promoted within public policy as a model to address social and health inequalities, therefore the beginning aspect of this chapter includes an overview of this as the context that the study was conducted within. Following this are definitional issues around the term 'social enterprise' and the emergence of the concept of social enterprise in UK public policy. This covers the reforms of the public sector, specifically in health and social care such as the outsourcing of public sector services to social enterprises and the personalisation agenda. Two themes emerged from the literature, the first being government policy driver for outsourcing public sector services; the other is the promotion of social enterprise as a public health intervention to address health inequalities. The former is an assertion of social enterprise as a provider of healthcare services but the latter promotes the social enterprise itself as being the intervention that is used as a vehicle to improve health, wellbeing and reduce health inequalities through the support and opportunities they offer (Donaldson et al., 2011). It was found in this study that there is a wealth of literature and documents about the policies around public sector 'spin-offs' but very limited literature about social enterprise as public health promotion, enhancing individual wellbeing and improving inequality and social justice. This chapter introduces the broad and overarching issues relating to social enterprise and health and

social care provision in the UK and then specifically in relation to occupational therapy. It is suggested throughout this literature review that occupational therapy provision through social enterprise can address health and social inequalities in the UK, however there is limited evidence supporting this to date. This highlights the need for research into such an intervention which this study begins to address.

### **3.2 The socio-political and economic context for health and social care in the UK**

The economic crisis in the UK, which began in 2008, has had a significant impact on welfare reform in the UK. Similar to other industrialised countries, the UK has experienced rising healthcare costs alongside increased public expenditure, medical and technical advances and an ageing population (Randall and Williams, 2005). Alongside this, the UK is experiencing widening inequalities affecting population health (Wilkinson and Pickett, 2009; Marmot, 2010). This has resulted in increasing health and social care costs. In 2010 a poverty and inequality report was conducted by the Institute for Fiscal Studies which concluded that inequality and poverty in the UK remained near its highest point since their research began in 1961 (Joyce, et al 2010). In addition, a recent report by OECD (2013) has demonstrated rising levels of inequality in the UK, with the youngest being affected the most severely by poverty, social injustice and health inequalities.

In the same year as the economic crisis began, the World Health Organisation published a report about the Commission on Social Determinants of Health to advise on how to reduce widening health inequalities (WHO, 2008). They asserted three key principles which were: Improve daily living conditions; Tackle the inequitable distribution of power, money and resources and; measure and understand the problem and assess the impact of action (WHO, 2008, p6). As a result of this report, an independent review was conducted in England to propose a strategy for reducing health inequalities (Marmot, 2010). The report recommended two policy goals to address the widening inequalities which were:

- 1. To create an enabling society that maximises individual and community potential;*
- 2. To ensure that social justice, health and sustainability are at the heart of all policy making (p3).*

These two goals can be conceptualised within the occupational framework as creation of an enabling society requires the development of health and social care systems and structures that promote this. When such systems and structures are in place, occupational outcomes such as social justice and health can be achieved. Inclusion of these goals in policy was advised in the implementation of health and social care reform in the UK to address widening inequalities. The report identified that increased unemployment in the UK was likely to worsen health inequalities and therefore it promoted employment as a strategy for improving health. Employment and vocational rehabilitation are significant interventions for occupational therapists to have a role to work within (Kirsh et al., 2005; Schene et al., 2007; Ross, 2008; Arbesman and Logsdon, 2011) and therefore such policy recommendations can be used to justify greater occupational therapy involvement in this policy context.

The Marmot review (2010) also recommended that government policy should address the complex causes of health problems by increasing investment in health prevention. Without which he states, "Health inequalities will persist if the more fundamental causes of inequality remain" (p7). These fundamental causes lie in the social determinants of health such as where someone lives, works, their social status and lifestyle choices (WHO, 2008). These complex causes of poverty and inequality require interventions that address the deeper rooted societal issues that impact on population health. It has been proposed that holistic interventions are needed which come from the communities themselves to address these social problems that affect health inequalities (Donaldson et al., 2013), a concept which is consistent in occupational therapy literature on community-based rehabilitation and community development. It has also been asserted that occupational therapists can have a role in health promotion (Wilcock, 2001; Riley et al., 2008; Mallinson et al., 2009) as discussed in the previous chapter, and therefore also address health inequalities. However, occupational therapists require environments and organisations to practice within that promote roles such as in health promotion and vocational rehabilitation. It has been asserted that social enterprise can be used as an "innovative and sustainable public health intervention" which could be used as a strategy to address health inequalities through an asset based approach (Roy et al., 2013 p55). A definition of social enterprise is explored next and the topic of social enterprise as a health promotion strategy to promote social justice is revisited later in the chapter.

### 3.3 Defining the concept of social enterprise

The term 'social enterprise' was initially used in England in the early 1990s as models for co-operatives and mutuals that were used in the public and private sector to combat market failure and address issues in deprived areas (Teasdale, 2012). The 1990's saw the beginning of a new era for UK policy that incorporated 'new public management'- the outsourcing of public services to other providers (Ridley-Duff and Bull, 2011). Social enterprise has been heavily promoted in UK policy as an alternative strategy for delivering public services, therefore the concept is intricately entwined with UK politics and has been defined as a 'policy vehicle' (Spear et al., 2009) that has been used across political parties since 1997. This drive initially came from the private sector and became popular among policy makers in the UK (Spear et al., 2009). The term 'social enterprise' is a contested concept with varying definitions found in the academic literature as well as in policy documents (Teasdale, 2012). It has been argued that the wide variety of different definitions of social enterprise is because it is a fluid concept and it can serve different political or organisational agendas (Teasdale, 2012). Therefore, the maintenance of a loose concept of social enterprise enabled policy-makers to claim success for the variety of social enterprises that tackle social problems (Teasdale, 2012).

The Department of Trade and Industry's publication of: *Social Enterprise, a strategy for success* (DTI, 2002) published the first definition of social enterprise in public policy which is still the most commonly cited in the social enterprise academic literature:

*"A social enterprise is a business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners." (DTI, 2002 p13)*

This definition is broad and can include a wide variation of organisational types, which benefited the political agenda of New Labour to develop a wide range of organisations that could address social problems as part of their public policy (Teasdale, 2012). It was the aim of the Government at the time to use the model of social enterprise to provide an alternative to public sector bureaucracy (Teasdale, 2012), promote innovation, choice and quality of public sector services (DTI, 2002). For the purpose of this study, the DTI (2002) definition of social enterprise has been used. This is because it contains the elements of a social enterprise that are consistent in all definitions, which are: social aims within a business structure and is the most widely used and accepted definition. Even though

trading activities within a business structure is a consistent component of the definition of a social enterprise, some social enterprises may not seek to maximise profit but cover costs and 'break-even' to achieve their social aims (Connelly and Kelly, 2011). However, a minimum amount is required in a social enterprise to make sufficient surplus to ensure its survival (Chell, 2007).

The social enterprise academic literature presents a variety of definitions of social enterprise as the term is used to refer to a range of different types of organisations (Teasdale, 2012). The term 'social enterprise' is relatively new (since the 1990s) however it is not a new organisational form as it covers a range of types of organisations such as: co-operatives; not-for profit companies; community organisations; industrial provident societies; charities and social businesses among others. Some of these organisational forms have existed for many years before the term 'social enterprise' was used and some of which have been in existence since the industrial revolution (Connelly and Kelly, 2011; Teasdale, 2012). Research by Spear et al., (2009) evidenced a typology of social enterprises, which were: mutuals; trading charities; public sector *spin-offs*; and new start social enterprises. The commonalities between these different organisational structures is the existence of social aims and trading activities. Therefore, social enterprise has been defined as businesses that trade for social or environmental purposes (Spear et al., 2009; DTI 2002). The social mission that is at the centre of a social enterprise is intended to be focused around improving the daily lives of individuals and communities, through enhancing physical, mental and social wellbeing (Roy et al., 2013). This definition is similar to the definition of occupational therapy, (Creek, 2003) although occupational therapy is the specific, individualised therapeutic intervention of how the enhanced wellbeing is achieved in individuals and communities, whereas a social enterprise is an organisational environment that promotes enhanced wellbeing. Therefore social enterprise is not only an organisational model, it is also a vehicle for delivering health and social care to promote health, wellbeing and social capital (Bertotti et al., 2011) and could be complimentary to an occupational therapy philosophy and interventions.

Early policy documents on social enterprise included notion of stakeholder participation and democratic participatory management (DTI, 2002) which links with occupational therapy principles of participation and collaboration. However, Reid and Griffith (2006) assert that it is an assumption that all social enterprises are democratic and participatory in their governance. Whilst social enterprises that have developed out of the co-operative movement will be democratic and participatory, it is not necessarily the case for all. The first legal form of social enterprise in 2005, a Community Interest Company (CIC), did not

require democratic control or ownership (Teasdale, 2012). A CIC is a social enterprise that has been legally registered as a limited company with an 'asset lock' that protects all assets owned by it to remain within the community (UK Government, 2013). CIC's were created to prevent private investors and shareholders from benefitting from social enterprise activities that were meant to benefit their communities. The only legal structure that a social enterprise can register as that ensures democratic governance is an Industrial Provident Society (HMRC, 2013). Social enterprises that do incorporate democratic governance could promote an asset-based, salutogenic approach to health as they could incorporate service users into the design and delivery of services.

Social enterprises are organisations that can have a variety of legal forms, a situation which can create challenges when defining the sector (Smith and Teasdale, 2012). However, Connelly and Kelly (2011) suggest that it is not the legal structure that defines social enterprise but their ethos and purpose. This ethos found within social enterprises is based on principles of volunteerism, ethical behaviour and mission around social aims (Chell, 2007) which are all principles that can promote health inequalities (Marmot, 2010). The definitional challenges with social enterprise have resulted in a critique of the statistics reported on the number of social enterprises that have emerged in the UK over the past 10 years (Spear et al., 2009; Teasdale et al., 2013). For example, in 2003, the UK Government estimated that there were 5,300 social enterprises (ECOTEC 2003). This then grew dramatically to 55,000 in 2005 in an Annual Survey of Small Business (IFF Research, 2005) and the cause of this dramatic increase has been asserted by Teasdale et al., (2013) as a result of the inclusion of private, for-profit businesses in this. In 2009/10, The National Survey for Third Sector Organisations, identified 8,507 social enterprises based on a narrow definition of organisations that primarily had social aims and reinvested surplus back into the organisation. More recently, Social Enterprise UK (2013) stated that there are approximately 70,000 social enterprises based on a rolling average of previously collected Government statistics. Therefore the current number of social enterprises is unknown because of the different definitions used to identify these social enterprises.

Over the past two decades, public sector reform has involved a "disaggregation and decentralisation of services" (Millar et al., 2013 p4). This has meant a shift in emphasis from central government public sector provision to local ownership and control over services. This could provide an opportunity for local, community owned, asset-based health service. Since 1991, respective UK governments have implemented new strategies for delivering public services in contrast to the state controlled, tax financed public sector that had existed since the establishment of the NHS (Price et al., 2011). This



decentralisation and independence from the State as a result of the Localism agenda has had a strong emphasis on community engagement and representation (Lewis et al., 2006) which if implemented well, could lead to community driven, asset-based healthcare services, based on local strengths and resources (GCPH, 2011; Lockwood, 2013). These new strategies involved the introduction of a purchaser provider split and in the NHS hospitals became NHS Trusts with their own institutional identity which introduced a degree of separation from Government (Price et al., 2011).

The term social enterprise became popular as a result of New Labour promoting the concept within public policy. The first use of the term 'social enterprise' was in 1999 in The Treasury's Neighbourhood Renewal Unit report: *Enterprise and Social Exclusion* (HM Treasury, 1999) which included a wide range of types of organisations (Teasdale, 2012). The introduction of social enterprise into policy was hoped to improve social inclusion in deprived communities through employment, economic development and improving social capital (Teasdale, 2009). Following this, in 2002, New Labour launched its social enterprise strategy and a Social Enterprise Unit was established within the Department of Trade and Industry. This began the first in a series of strategy and policy documents around the concept of delivering public sector services through social enterprises. The first of these was: *Social enterprise, a strategy for success* (DTI, 2002) which promoted social enterprises as businesses that could transform societies by delivering public services with improvements to productivity and effectiveness. The government supported the development of the Social Enterprise Coalition to strengthen a unified voice in the sector (DTI, 2002).

### **3.4 Emergence of the concept of social enterprise in UK health and social policy**

In 2003, NHS Foundation Trusts were created which enabled hospitals and community services to become independent, non-profit organisations, however for the first time both NHS and private organisations were able to apply for Foundation Trust status (Price et al., 2011). These Foundation Trusts were 'mutuals' which were owned by their membership which comprised patients, public and staff and were governed democratically (Lewis et al., 2006). These were some of the first government created 'social enterprises' that were set up in the UK out of the public sector. The introduction of these Foundation Trusts represented a shift in emphasis within health and social care policy towards a consumer-orientated, market-based approach to service provision. The aim of this has been to

enhance patient choice, promoting staff involvement and improving quality and efficiency (Lewis et al., 2006). This was based on the theory and belief that effective stakeholder engagement would deliver more responsive better value services and improve health outcomes (Lewis et al., 2006) which is consistent with the principles and practice of occupational therapy to collaborate with service users alongside theories of community-based rehabilitation and community development.

Following this, the UK Government published a series of policy documents promoting social enterprise as a solution to social problems by incorporating third sector and private providers into public sector provision (Hall et al., 2012). As a result, third sector providers were encouraged to deliver public services (Alcock, 2012). Social enterprise was seen as utilising self-help to address community needs involving active engagement with local people through democratic structures and the development of sustainable organisations to address social, environmental and economic issues (Mawson, 2010). Social enterprise was viewed as a new method for delivering health and social care services and the Department of Health set up a Social Enterprise Unit to support this agenda (Spear et al., 2009). The Office of the Third Sector (OTS) was created in 2006 and social enterprise was included as part of the third sector as the Social Enterprise Unit moved to the OTS. Following this, the *Social Enterprise Action Plan* was launched (OTS, 2006). This proposed a range of support that would be offered to social enterprises to develop the sector and work with the government in providing public sector services. This document was in response to some of the challenges faced in implementing the initial social enterprise strategy, particularly around availability of funding for social enterprises (Mason, 2012).

Social enterprise as a public health intervention is a new and underdeveloped concept (Donaldson et al., 2011; 2013). Charities, community organisations and the third sector have been asserted to be more appropriately situated than the public sector to address issues of inequality affecting the most marginalised populations (Marmot, 2010). This is because they have a greater connectedness to communities and are grassroots in their functioning (Meek, 2012). Furthermore, the Marmot review emphasised the role of the third sector to develop engagement and partnerships with people and families on a local level in their communities to address inequality. However, the review also raised concerns about the support and funding available to the third sector to enable it to fulfil this function. In particular, the commissioning environment at the time of the report, was threatening the survival of smaller voluntary organisations. This was a concern that has become a reality as Local Authorities favour contracting with larger organisations (Ferguson, 2011) and the

voluntary sector has become further financially squeezed by cuts in public sector spending (Plummer, 2011).

It has been suggested that the shortcomings of the deficit or treatment approach in public services alongside the cuts in the budget, require new approaches to addressing health and social care (GCPH, 2011), particularly in light of the growing inequalities. One strategy that has been suggested is an asset-based approach (GCPH, 2011) which would promote the policy goals recommended in the Marmot report (2010). Asset-based community development is an approach that develops strengths as assets in a community which are used to address local needs (Ottman et al., 2006). This asset-based approach reveals the skills, knowledge and potential within a community available to be used in promoting their own health and wellbeing (GCPH, 2011). This is achieved by identifying the protective factors that support health and wellbeing and promoting the self-esteem and coping strategies of individuals and communities (Morgan et al. 2010). The asset-based approach draws on the same principles inherent in Antonovsky's Salutogenic theory of health as an alternative approach to the deficit-based medical model (Antonovsky, 1996). This empowering, capacity-building approach encourages communities to become co-producers of health, based on their strengths rather than passive recipients and consumers of services (GCPH, 2011; Tedmanson and Guerin, 2011). It has been asserted that an asset based approach emphasises and develops the social capital of communities which has been linked to improved health and wellbeing (Tedmanson and Guerin, 2011). This asset-based approach is consistent with occupational therapy's move away from "impairment-based interventions...toward an enabling approach to promote participation in society" which promotes occupational justice (Reigel and Eglseder, 2009, p.289).

As inequalities are intricately connected to social problems (Marmot, 2010; WHO, 2008), an asset-based approach which addresses the social context of people's lives has the potential to address the deeper causes of inequalities (GCPH, 2011). This in turn could reduce the dependency on the public sector in the long-term (GCPH, 2011) which reflects Marmot's (2010) recommendations for a long-term committed strategy to reducing health inequalities through community engagement. It has been found that health and wellbeing can be improved through the empowerment of individuals and communities (Woodall et al., 2010). However, there is currently little evidence for the practical application for a salutogenic and asset-based approach to health and wellbeing (GCPH, 2011; Roy et al., 2013).

The salutogenic, asset based principles are well suited to the empowering, capacity-building, community-focused models found within social enterprises. It has been suggested that social enterprise can be used in a much wider context than this to address inequalities as a public health intervention to address the broader social determinants of health (Donaldson et al., 2013; Roy et al., 2013). The developments within the occupational therapy profession include: community and group-based strategies; a focus on targeting the wider population experiencing deprivation and injustice; alongside health promotion (in parallel to the deficit-based medical model that is still required in acute services) suggest that there is a congruence in approaches with the asset based, Salutogenic model of health. There is also a compatibility between the empowering principles of co-production (Gannon and Lawson, 2009) and partnership with service users that is inherent within the occupational therapy philosophy, the asset based Salutogenic approach and social enterprise models. Empowerment of individuals to participate within society is a central aspect of occupational justice by facilitating fair and equal rights for all (Braverman and Suarez-Balcazar, 2009; Reigel and Eglseider, 2009; Nilsson and Townsend, 2010; Stadnyk et al., 2010).

The Department of Health released: *'Our health, our care, our say'* in 2006 which promoted the empowerment of staff who were encouraged to innovate and create their own services either from scratch or to 'spin-out' from public services. Following this, New Labour created the Social Enterprise Investment Fund (SEIF) in 2007 to support and finance the development of new or existing social enterprises within the health sector. A pathfinder program was developed in 2006 to support social enterprises in providing health and social care services (DH, 2010b). NHS staff were encouraged to become health entrepreneurs, leading and managing their own services (DH, 2008). The Department of Health introduced the Transforming Community Services program (DH, 2009) which gave NHS employees the 'Right to Request' and then the 'Right to Provide' setting up a social enterprise that would deliver community services (Miller and Millar, 2011). The Right to Request and the Right to Provide were opportunities for individuals and services to 'spin-out' of the public sector. It was promoted as enabling staff to innovate their own services by taking them out of the public sector and setting them up as independent organisations, contracted by the public sector to deliver services. These policies also promoted the benefits for patients in stating that these new social enterprises would improve the quality of services offered and greater inclusion of service users and staff. However, this was not evidenced based but a belief held by policy writers at the time. There was a congruence between these policies and the principles of collaboration and participation that are inherent with an occupational therapy approach and also

promoted by the asset based, salutogenic approaches to health as discussed previously. As a result of this policy initiative, successful Right to Request applications were supported by the Social Enterprise Unit and provided with some SEIF funding, some applicants were awarded up to five years of a contract with a PCT (Miller, et al., 2013).

### **3.5 The impact of a changing government**

During the general election campaign in 2010, all political parties recognised the need for public sector cuts to attempt to reduce the budget deficit (Smith, 2010). Labour positioned itself as growing the state and using state resources to stimulate the economy as a response to the deficit. However, the Conservatives and Liberal Democrats introduced a re-conceptualisation of the role of the state in relationship to welfare and the market (Smith, 2010). The social enterprise agenda continued when the coalition government came to power in 2010 and was a central aspect to the Prime Minister, David Cameron's 'Big Society', particularly in delivering public sector services. The coalition government proposed welfare reforms as the reduction of the role of the state and the growth of the 'Big Society' by the provision of services by non-governmental providers and decentralisation of responsibility to civil society (Smith, 2010; Addicott, 2011). The Big Society was based on the assumption that civil society will respond to social problems through volunteerism, and that civil society will be strengthened through community empowerment (Smith, 2010; Addicott, 2011). However, the Big Society vision has been criticised for being a smokescreen for privatisation of the public sector (Rainford and Tinkler, 2010; Roy et al., 2013) and it has been questioned whether it is possible for the Big Society to develop in a time of austerity without significant investment and support by the State (Smith, 2010). This is because significant financial investment is required to train, equip and establish community structures to provide public services as transition funding (Macmillan and Rees, 2012). New Labour's social enterprise agenda was accompanied by support and finance to the third sector and development of social enterprises (Mawson, 2010). In contrast, the coalition government continued this agenda whilst implementing the most severe cuts the UK has experienced in decades. As a result of this, public sector bodies and third sector organisations were expected to innovate, develop and provide services with less funding than they had previously (Bertotti et al., 2011). The lack of financial support is predicted to worsen as Government funding for third sector organisations is due to decrease until 2016 (Aldridge, 2012).

The Coalition Government came to power in 2010 and continued with the social enterprise policy agenda in health and social care and introduced the Right to Provide (DH, 2011) as an expansion of the Right to Request. This was available for the whole of the public sector (except Foundation Trusts), and not only for community health services, however it did not guarantee contracts which the Right to Request did (Hall et al., 2012). Following this, the white paper: *Liberating the NHS* was published which stated the government's desire to convert the NHS into the "largest social enterprise in the world" (DH, 2010a p5). This policy agenda was driven by the desire for greater efficiency and effectiveness in public sector services and social enterprises were viewed as the vehicle to deliver this. However this was based on their *belief* that social enterprise would be an effective method for delivering public services, rather than based on research or evidence for this strategy. As a result of the policy initiatives promoting social enterprise within the public sector, there was a mixed response from within the health and social care sector, including some staff feeling 'pushed' whilst others 'jumped' at the opportunity (Hall et al., 2012).

Following this, the Health and Social Care Act 2012 brought in a major change to health and social care commissioning and provision (Addicott, 2011). This involved the abolition of Primary Care Trusts and Strategic Health Authorities, the creation of a national NHS Commissioning Board and Clinical Commissioning Groups which would commission services at a local level (Addicott, 2011). The Public Services (Social Enterprise and Social Value) Act (Great Britain Parliament, 2012) was also released to promote the role of social enterprises to deliver public sector contracts. This was through a requirement for contracting authorities to consider the economic, social and environmental concerns as part of their contracting and commissioning (section 1:3 of the Act). The challenge in implementing The Public Services (Social Enterprise and Social Value) Act (2012) was the limited finances available for social enterprises after the announcement of the budget cuts in 2010, therefore limiting its success (Floyd, 2013). The Government avoided defining social enterprise in the Act (Teasdale, 2012) as a definition was removed from an earlier draft of the Bill. The lack of a definition meant that any providers could tender for contracts that could demonstrate their economic, social and environmental impact, including private sector providers. The Act also lacked enforcement because if a commissioner did not take the Act into account, there were not procedures or an asset lock to ensure the social purpose was being achieved (Floyd, 2013) which could render the Act meaningless. There are also inherent problems with the Act as there are not agreed social impact measures that commissioners and providers can use. These political decisions support the claims that social enterprise and The Public Services (Social Enterprise and Social Value) Act (2012) were a cloak for privatisation (Rainford and

Tinkler, 2010; Roy et al., 2013) of the public sector due to the lack of protection for social enterprises.

Alongside the social enterprise policy agenda, the personalisation agenda was also developed and implemented which overlapped with the developments in third sector provision of public services. The personalisation agenda is considered next regarding the changing landscape for health and social care provision and then in relation to occupational therapy delivery in the UK through social enterprises.

### **3.6 The personalisation agenda**

As part of the health and social care reforms, the personalisation agenda was introduced to develop a more personalised, tailored and flexible service provision for patients as part of the consumerist agenda (Powell, 2012). The aim of personalisation was for people to decide how they wanted to be supported with maximum independence (Sowerby, 2010). This has resulted in a more individual and community orientated focus of services (rather than emphasising state responsibility) where the individuals who use the services choose what they want and need (Leadbeater, 2004; Powell, 2012).

Personalisation has included: self-directed support; personal or individual budgets; and direct payments. Self-directed support involved ensuring that recipients of services are included in the planning and decision-making over their care (Putting People First, 2009). Personal or individual budgets can include the costs for health or social care needs as well as for independent living (NHS, 2012). These budgets are managed through direct payments which are a financial payment made to a patient or their carer to access and pay for services themselves, which may require a contribution from the individual (NHS, 2013). Individual budgets were announced in the White Paper; *Our Health Our Care, Our Say* (DH, 2006) although direct payments had been introduced in 1997 by New Labour. The language within the personalisation agenda demonstrated a shift towards individualisation and consumerism in health and social care provision (Crib and Owens, 2010). Within the personalisation agenda, service users or patients are responsible to 'self-assess' their needs at times and seek the services they require. As part of this agenda, principles of co-production and partnership between service providers and consumers were promoted to enable choice and control over services that were offered (DH 2006). Social enterprises and microenterprises were models promoted through this agenda (Glendinning et al., 2008; DH and NAAPS, 2009; Dickinson and Glasby, 2010;

and Lockwood, 2013). It was proposed that people who use public sector services were able to choose their care and support from organisations such as social enterprises and staff could choose to set up and work for a social enterprise. Individuals who held direct payments would be able to access services by directly paying for them, therefore providing a source of income and funding for that service.

However, despite the wealth of policy documents in favour of personalisation from New Labour and the Coalition Government, there has been a lack of evidence and research supporting its effectiveness (Powell, 2012). It has been found that younger adults with physical disabilities are more likely to use direct payments but that people with mental health problems are less likely to do so (Fernandez et al., 2007). Personal budgets have also been found to have a negative impact on the wellbeing of older people and more support has been needed for carers of the elderly regarding personal budgets (Netten et al., 2012).

There are also concerns about the increased support required to set up personalised budgets considering the cuts to the public sector and questions have been raised about whether there will be sufficient professional support available to sustain the personalisation agenda (Netten et al., 2012). The Equality and Human Rights Commission (EHRC) reported in 2009 that there was an absence of advocacy for the use of personal budgets with service user groups such as people with mental health problems or learning disabilities. The report stated a post-code lottery had developed, leading to inequality of access to services. This raises concerns if government policy is at risk of worsening the levels of inequality in the UK. Under New Labour, the personalisation agenda developed out of the Disability Movement to promote independence, control and choice for those who used public services. However, the continuation of the personalisation agenda at a time of austerity and the worst cuts the UK has experienced in nearly a century has resulted in some people being unable to access the support and services that the Government has a legal obligation to provide (Mandelstam, 2010; Ferguson, 2011). It has been asserted that the effectiveness of the personalisation agenda has been undermined



by the Coalition Government's drive for the market consumerism of the neo-liberal<sup>1</sup> agenda that has dominated health and social care reform (Ferguson, 2011). The personalisation agenda is also being implemented at a time when the Coalition Government are transferring 1.5 million disabled people from incapacity Benefit to the much lower paid Employment Support Allowance (Ferguson, 2011). Therefore this raises questions about political rhetoric of personalisation being used as a cover for cuts to the public sector.

The implementation of the personalisation agenda alongside the outsourcing of public services created opportunities for healthcare professionals to innovate and create new types of services (such as social enterprises) based on their clinical judgement. Furthermore it would be down to service users' to choose to use their services.

### **Personalisation and occupational therapy**

The personalisation agenda promotes and supports the values and principles that are also inherent within occupational therapy. This includes: promotion of service users' control and choice; self-reliance and personal resources; a person centred approach; addressing environmental barriers in people lives; promoting independence through enablement; support with employment; and access to information and advice (SCIE/COT, 2010). As these principles are inherent within occupational therapy practice, it can be argued occupational therapy is best placed to support the personalisation agenda. However, there are challenges and pitfalls within the personalisation agenda. One of these is that there is a maximum financial amount available for each person. As a result, there are cases where higher needs are not met because of a lack of funding for a professional assessment (Mandelstam, 2010). This is despite a legal requirement of Local Authorities to assess and provide services according to need.

Personal budgets are regarded as an opportunity for independence and choice for the service user. However, this model introduced the requirement of service users' ability to self-assess and to know what services to access; to have the initiative, motivation and

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<sup>1</sup> Neoliberalism as "market deregulation, state decentralization, and reduced political intervention in national economies" (Campbell and Pederson, 2001 p290), in particular to 'marketise' the health and social care sector.

support to be able to access the services they need. Some service users who require occupational therapy, need the support offered by an occupational therapist to be able to access other services and support available. This can result in a situation where the service user is unable to access services and the occupational therapist is unable to offer them because they have not been contracted by the service user to do so. This raises issues and challenges regarding the risk of marginalisation of the most vulnerable groups of people in society, who are already experiencing the greatest levels of social exclusion and occupational injustice. The shift of responsibility to the service users to proactively organise their own support has been termed “self-association” (Smith and Teasdale, 2012) however, the issues that affect a service user’s ability to take up support opportunities such as those proposed in the personalisation agenda, have not been addressed in Government policy. Assumptions have been made in policy about the ability of people to seek and organise the support they require and the reduction in public sector spending is likely to have implications for the availability for supporting these vulnerable groups. The personalisation agenda proposes that support brokerage will involve providing advice and support for how to use personalised budgets however this will not necessarily need to be carried out by professionals or public sector staff (Mandelstam, 2010). This can have implications for the quality of advice that people receive and potentially fewer jobs for professionals such as occupational therapists within the public sector.

### **3.7 A critique of outsourcing the public sector**

Throughout the policy agenda supporting social enterprise in health and social care reform, an assumption was made that the third sector was the appropriate sector to address social problems with support from the state (OTS, 2009). The health and social care reform has been founded on the belief that the introduction of market forces will promote quality and efficiency, therefore cutting costs to services (Lewis et al., 2006). This has been based on the concept of social enterprise as a neo-liberal assertion which promotes business to achieve social change (Dey and Steyaert, 2010). However, there is a lack of evidence demonstrating the effectiveness of neo-liberalism in health and social care and some research suggests that this is detrimental to the quality of services when there is a lack of an effective market (Randall and Williams, 2005). Despite this wealth of policy documents promoting the belief in the success of social enterprises, research and evidence into this as a model for public sector provision remained sparse (Pollock et al., 2007). It is an under researched organisational form generally (Addicott, 2011; Connolly

and Kelly, 2011) and specifically around governance and support needs (Spear et al., 2009).

Early research into social enterprises that have developed out of the public sector has found that the benefits have included saving time by reducing bureaucracy; greater accountability across the organisation and the reinvestment of profits into services and staff (Addicott, 2011). However, even though social enterprise has become the preferred model of delivery for health and social care in the UK, there is uncertainty about how social enterprises will actually develop and function to achieve the policy aims (Addicott, 2011). It has been argued that it is a simplistic idea that social enterprise could fill the gaps left by the state (Roy et al., 2013) and questions remain about whether social enterprises *should* fill gaps left by the state.

The healthcare reform has led to increasing fragmentation of services with growing numbers of private and third sector providers involved (Millar, 2012) which could lead to a patchwork of services resulting in an inequality of access to the support service users require. Inconsistency in service provision has been asserted by Stadnyk et al., (2010) as a contextual factor that can limit occupational justice as this is a barrier for some people. New NHS community-based social enterprise providers are now competing with other providers for contracts who have more success of winning such contracts (Addicott, 2011). This competition was hoped to bring about quality in the health and social care marketplace, however it is questioned whether commissioners will offer contracts based on the best outcomes or the cheapest provider to deliver the services (Addicott, 2011). In addition, it has been asserted that private sector opportunists have been masquerading as social entrepreneurs to win public sector contracts (Jones, 2012). Third sector providers have experienced disadvantage in competing with private sector providers due to piecemeal funding which limits their ability to plan ahead and a lack of support in delivering public sector contracts (Harlock, 2012), limiting their effectiveness.

Hall et al., (2012) researched the motivations of NHS staff who applied to the Right to Request as social entrepreneurs. Their research showed that preserving the service by taking control and “making it better” was a main driving force in the social entrepreneur’s motivations with the hope of being able to work as they should be outside of NHS constraints. However, it has been found that there was limited interest in taking up Right to Request due to a lack of support from staff, the organisations and commissioners alongside a lack of leadership (Miller and Millar, 2011). Staff concerns about the loss of job security, pay and benefits was also an issue affecting its success. In some instances,

it was also found that instead of the Right to Request being clinician-led, some provider organisations were directed to take up the opportunity (Millar et al., 2013) and some social entrepreneurs felt pushed out of the NHS from the top down (Addicott, 2011; Hall et al., 2012), conflicting with Department of Health policy for clinician led innovation of services. As a result, it has been asserted that social enterprises may be more successful if they are established from the bottom-up rather than from the top-down (Addicott, 2011) which was the intention in public policy initially.

An evaluation of the NHS pathfinder program also identified that staff felt unclear about the benefits of social enterprise; that social enterprise were not at an equal advantage to other providers; they felt a loss at being part of the NHS; concerns around terms and conditions, especially pensions; and that unrealistic timescales for the development of a social enterprise were proposed (DH, 2010a). Miller and Millar, (2011) and Lewis et al., (2006) also identified barriers experienced by social entrepreneurs and social enterprises which wanted to develop out of the NHS. These barriers were around skills and confidence to become an entrepreneur; funding and capacity to develop a business case; a lack of internal and external support; and staff fear of loss of pensions and benefits. Such barriers need addressing to prevent private sector providers from taking over. Social enterprises funded by the NHS may be vulnerable to the competitive market that is developing, particularly small social enterprises or those that do not have a strong business orientation (Addicott, 2011). Long-term commissioning and political and financial support will be required to enable the success of social enterprises as a provider of health and social care services (Addicott, 2011). Research by Millar et al., (2013) showed that commissioners were less willing to contract with social enterprises than other NHS services. Commissioner support was found to be crucial in the successful Right to Request applications. The acceptance of social enterprise as a legitimate form by public sector organisations is essential for social enterprises to be successful in health and social care delivery (Millar et al., 2013).

Staff within the newly created social enterprises have also faced challenges with adapting to their new roles. The staff within such organisations are individuals who contribute to the context of health and social care delivery when conceptualised within the occupational justice framework, therefore they have opportunities to enhance or limit occupational justice. The challenge for staff who took part in the Right to Request which was found to be a lack of confidence and business skills alongside the balance between being a clinician and being a social enterprise manager or social entrepreneur (Miller and Millar, 2011; Millar et al., 2013). Spear et al., (2009) research identified that within public sector

*spin-offs*, the culture of the public sector brought with staff a lack of business skills and expertise. This was supported by Miller and Millar's (2011) research which also identified a lack of business skills and asserted that it is a challenge for clinicians to see themselves as entrepreneurs and being willing to adapt to a business culture. This change from the role of a clinician to an entrepreneur is not necessarily something that can happen as quickly as policy reform required. The skills and expertise required to achieve social enterprise aims and goals are contextual aspects that require training and support for health and social care staff such as occupational therapists.

Research into governance issues in social enterprises has also identified a number of challenges. This included: recruiting the right board members with the right skills and experience; choosing the right legal structure; managing external stakeholder interests; managing membership; the power of boards to control management; and balancing social and financial goals (Spear et al., 2009). This research found that the governance challenges within social enterprises were similar to those in the voluntary and non-profit organisations although there were unique aspects also. Lewis et al (2006) also raised challenges about governance and membership in mutuals. For example, if multiple providers emerge, which organisations should stakeholders become a member of as being a member of multiple organisations would defeat the purpose.

Funding and sustainability is also a significant challenge for social enterprises within health and social care. For example, work integration social enterprises which employ disadvantaged people cannot compete with the market as they will not necessarily be as productive (Aiken, 2007). This is likely because of lower skills, support required to complete tasks, flexibility in work hours and physical or cognitive disability. Therefore, the higher the level of disadvantage, the higher likelihood that there will be a requirement for public sector funding to subsidise the business to enable it to be sustainable (Aiken, 2007).

The measurement of social value and impact generated by these social enterprises is important for commissioners procuring these services (Bertotti et al., 2011). However, despite the popular policy promoting social enterprise in the delivery of public services, there is limited evidence proving its effectiveness or a systematic method for measuring and comparing the social value created by such organisations (Bertotti et al., 2011). The State of Social Enterprise Survey (Leahy and Villeneuve-Smith, 2009) identified that three out of five social enterprises did not measure their performance. This may be because of challenges in measuring social impact such as calculating a figure that is attributable to

the social impact (which may be a soft outcome) and the variation in types of social enterprises (Bertotti et al., 2011). It is a challenge for social enterprises to measure social impact which can be intangible and difficult to quantify (Connelly and Kelly, 2011; Roy et al., 2013). Most social enterprise impact measures only use quantitative measures, however it is asserted that a measurement tool is required that uses both qualitative and quantitative methods (Donaldson et al., 2011).

The development of the Social Return On Investment (SROI) measurement tool has been a beneficial step towards measuring social impact by identifying a monetary figure that equates to the social value of the organisation's activities (Millar and Hall, 2012). However despite its adoption by the Department of Health Social Investment Fund, there are practical limitations to its use. The methodology used to calculate an organisation's SROI is beneficial for the organisation to benchmark and measure against its own progress over time. SROI is not however a measurement tool that can be used to compare different organisations with one another, because of the variety of organisations and the different types of social value generated by their activities (Arvidson et al., 2010). The stipulation of the use of SROI by the Department of Health's Social Investment Fund may encourage commissioners to compare organisation's SROI when choosing which services to procure. This would be an inappropriate use of SROI and Bertotti et al., (2011) suggest that SROI may benefit from the involvement of Health Economists in the development of a more appropriate measure.

The need for research into social impact measurement has been frequently cited in the literature (Miller and Millar, 2011; Donaldson, 2013). Furthermore The Young Foundation, as an influential body for the development of social enterprise in the UK has called for standardised impact measurements to be researched in depth to fill the current gap. The development of such measures will require interdisciplinary work (Donaldson, 2013), which healthcare professionals would be well placed to contribute to.

### **3.8 Social enterprise and occupational therapy: Evidence in the literature**

There are examples in the international literature that demonstrate the effectiveness of social enterprises in rehabilitation and return to work programmes without the involvement of occupational therapists (Ferguson, 2007; Hsu, Huang and Ososkie, 2009; Morrow et al 2009). This is despite a clear occupational therapy remit that is apparent in these case

studies. An example of this is a case study in Canada which showed the effectiveness of cross sector employment of people with mental health problems in a social enterprise (Lal and Mercier, 2009). A phenomenological study conducted by Lanctot et al., (2011) also in Canada, measured the quality of work life of people with mental health problems who work for social enterprises. Their findings included some participants having a sense of belonging as if part of a family and developing friendships; and achievement, satisfaction and enjoyment in a structured and organised environment. It was also found that certain environmental aspects such as noise or poor physical conditions effected the quality of work life within the social enterprises studied.

Donaldson et al., (2013) have presented a conceptual framework for how social enterprises may lead to improved health and wellbeing. They propose to conduct empirical qualitative research to apply the framework in various different settings as part of a program of research over the coming years which would contribute to the current research-gap that exists in the literature. The conceptual model that they propose incorporates the social enterprise structure and organisation that offers an intervention, which contributes to interactions between the individual and their community. In the context of this study, the intervention offered could be occupational therapy, to enable employment and integration into the local community by the development of skills and abilities necessary to do this. Interactions such as these are believed to develop assets, social capital and a sense of coherence (Antonovsky, 1996) leading to improved health and wellbeing. Despite the lack of empirical evidence at this stage, Donaldson et al., (2013) conceptual model is the only known attempt in the social enterprise literature to combine a social enterprise model with an asset based public health intervention, to promote health and wellbeing. A model such as this is important for occupational therapists working within social enterprises, who also aim to promote health and wellbeing using meaningful occupation as the means to do so. Occupational therapists working within social enterprises are in a position to put this theoretical framework into practice and enable health and wellbeing to become a reality for those who attend the social enterprise.

There are limited examples in the academic literature which evidence occupational therapy practice within social enterprises. This is likely because the term 'social enterprise' is relatively new or is an underused term in practice and is an under researched phenomenon within occupational therapy. A literature search was conducted across ten databases using variation of the terms relating to occupational therapy and social enterprise and Boolean phases (list in Appendix 1). The literature search revealed

three pieces of research about occupational therapy in social enterprise, one of which was from Singapore (Tan, 2009); another from Canada (Jackson et al., 2009) and the third from the UK (Fieldhouse, 2012). A conceptual article, which included a review of literature and policy relating to occupational therapy and social enterprise was also identified (Pollard, 2012).

The research study carried out in Singapore reported the effectiveness of occupational therapy in a social enterprise (Tan, 2009). This evidenced a work integration program for people with mental health problems within a city centre café which was a program involving training, counselling, therapy, as well as stress management and support with managing a healthy lifestyle. From an occupational justice perspective, the social enterprise in this study was a structure within society that was in a position to promote occupational justice through supported employment of individuals who were otherwise occupationally deprived. The outcomes were measured using the 'Work Behaviour Inventory' and the length of time each participant spent in subsequent employment was also measured. The findings of the study concluded that engagement in the social enterprise enabled positive employment outcomes. However, this study was published as a "brief report" (P53) with limited detail about the research process. The study was quantitative in approach and used statistical analysis on standardised assessment and intervention tools which could be repeated or conducted in other settings for further research. However, the study has a small sample size ( $n=25$ ) which could have led to errors in the regression analysis and statistical comparisons (Tan, 2009). Service users did not participate in the research such as their subjective experiences of their engagement in the social enterprise. The hypothetical-deductive approach and medical language used in this research did not address the deeper and more complex issues surrounding mental health, such as the broader social, psychological or other reasons for employment success or failure. Tan's study focused on the social enterprise and the effect on services users but did not research the actual occupational therapy intervention. Therefore, further research is required into the service user experience and the occupational therapy practice within the social enterprise which this study begins to address.

A similar work rehabilitation project was researched in Canada (Jackson et al., 2009) which included interventions by occupational therapists as part of a wider project. This study found that the individuals with mental health problems had:

- Reduced number of emergency hospital visits;



- Required fewer ambulatory care visits and
- Less hospital admissions.

Although these are beneficial outcomes, the research was quantitative and lacked the service user or occupational therapists perspective and experience of involvement in the service. Jackson et al., (2009) did comment on the occupational therapists being able to provide individualised interventions based on users' level of functioning which indicated the ability of the occupational therapist to practise in a client-centred way.

Neither of these studies commented on the new development of social enterprise as a context for occupational therapy delivery or the opportunities and challenges around this. However Jackson et al., (2009) reported that the social enterprise enabled service users to work at their individual skill level without requirements to meet set standards (set by the business or the health sector). This indicates that the social enterprise prioritised social goals over business needs to generate profit. The study did not mention the funding of the social enterprise but it was developed out of the health services so it is likely that it was subsidised by public funding which enabled staff to prioritise 'social' aspects over 'business' aspects. Flexibility was provided within the social enterprise to adapt to the individual's needs around work schedules and appointments which also indicates that the social needs were prioritised over the business needs. The social enterprise employed professionals to address the mental health needs of those who used the service which may be as a result of the social enterprise being set up as a development from the public sector.

The development of social networks was also encouraged at this social enterprise, therefore the focus of this intervention was not solely about return to work, but also mental health and wellbeing which also reflects the health professionals input in the design of the social enterprise. The social enterprise involved the people who used the service into the business model to take part in decision-making about the running of the business. This is consistent with ideas of service user empowerment in mental health services (Barnes and Cotterell, 2011), co-production in public services (Gannon and Lawson, 2009; Boyle and Harries, 2009; Aldridge, 2012) and Antonovsky's salutogenic approach to health. The language used in this study to refer to those who used the social enterprise as consumers or survivors indicates a shift away from a medical model orientation of 'patients'. The support offered by the social enterprise provided a "safe and welcoming environment" (p383) where those attending could gain a sense of acceptance and identity which are significant in mental health recovery (Bonney and Stickley, 2008).

Both the studies from Singapore and Canada combined mental health support and occupational therapy with opportunity for employment and integrated the two aims into one service which could enable a more comprehensive intervention than these being offered separately. However both of these studies were conducted outside of the UK and the cultural implications of both contexts need to be taken into account when applying knowledge into a UK context. However both of these studies raise interesting issues such as:

- The balance between social and business aims;
- Whether the focus is solely on employment or on supporting the individual holistically to promote wellbeing;
- The role of the occupational therapist in adapting tasks to enable inclusion of people with mental health problems to contribute to the social enterprise outputs;
- Involvement of service users in governance and decision-making;
- The term used for service users ('patients', 'survivors') and,
- The use of the recovery model in social enterprises which offer services to people with mental health problems.

All of these points could be relevant to include in a study in the UK and are not necessarily culturally bound within the countries the above research was conducted within, therefore these topics have been included in this research study.

The only known research conducted in the UK which included occupational therapy intervention in a social enterprise was by Fieldhouse et al., (2012) and Fieldhouse et al., (2014). This study took a qualitative, participatory action research approach and included staff and people who used the social enterprise. The project was focused on growing organic produce and therapeutic activities were incorporated within this. The benefits of involvement in the social enterprise were:

For service users:

- Perceived improvement in vocational and life skills;
- Perceived experience of increased social inclusion;
- Activities in the outdoor environment and;
- Daily structure which enabled them to grade and pace their work.

For staff:

- The staff in this social enterprise reported a “therapeutic milieu” (Fieldhouse et al., 2014, p9) within the organisation based on empathetic relationships and the natural environment;
- The combination of the physical environment and social support was found to have positive psychosocial benefits and promote recovery;
- The staff also perceived high degree of control over the project and were able to quickly learn from their experiences to improve the work;
- Valued the flexible, creative and non-bureaucratic approach within the social enterprise but also appreciated the support and expertise from the mental health professionals from the public sector.

This social enterprise was run as a commercial activity rather than with the primary aim to deliver therapy. This was perceived to be a “de-stigmatising, real world context for skills acquisition” (Fieldhouse et al., 2014 p10). This study included the ‘soft’ outcomes of the benefit of the social enterprise which the previous two studies lacked and therefore adds greater depth and understanding of the experience of staff and those involved in the social enterprise. This study also acknowledged the ‘fusion’ between therapy and business models and found that they could work together, with the therapeutic and business goals being used to enable the other to be achieved.

From these three studies, there are common themes that have been found to be effective in all of these social enterprises. One of these is that the incorporation of support around health and wellbeing which was offered within and as part of the social enterprise alongside the therapeutic interventions in the work role to enable the success of the project. These studies support the suggestion that occupational therapy practice within social enterprise models can promote health equalities through recovery and inclusion in society. The importance of a holistic and comprehensive service that can address the wide range of needs of people who have mental health problems has also been indicated. There were similarities between the study in Canada and the UK which both identified the importance of flexibility in the social enterprise according to individual needs, prioritisation of social aims over the business aims and the importance of a relaxed and supportive environment that promotes recovery. All three of these studies were of social enterprises that worked with adults with mental health problems which suggests a congruence between mental health and social enterprise but also the need for research with other groups of people as there is currently limited application of these studies to other user groups.

In contrast to these three empirical research studies, Pollard (2012) published a conceptual paper about occupational therapy and social enterprise by drawing together examples from international contexts and their potential application in the UK. He recognised the potential for occupational therapy in social enterprise in the UK considering the emerging health and social care landscape. However, despite Pollard's ability to conceptualise occupational therapy provision through social enterprise in the UK and the opportunities in the current context, his article lacked evidence and of this from the UK. Pollard recognised the opportunity that the recent changes in the health and social care environment in the UK can have for the profession of occupational therapy and recommends that learning is taken from international contexts where occupational therapists are already working with local communities in creative ways to enable occupational performance. The principles within community-based rehabilitation and community development that Pollard referred to have been incorporated within the literature review in Chapter 2 and the theme of collaboration between occupational therapists, social enterprises and service users has also been discussed earlier in this chapter.

The College of Occupational Therapists recognised the lack of evidence in the occupational therapy literature concerning social enterprise and requested the submission of articles for publication on occupational therapy in social enterprise in the UK as this current PhD study progressed. This resulted in a series of publications in OT News (Stickley, 2011; Tuppeny and Stickley 2011; Gash, 2013). Prior to this, social enterprise has been referred to within occupational therapy grey literature in the context of health and social care reforms, the Right to Request and Unison's<sup>2</sup> concerns over reduced pay and benefits.

As there is a lack of evidence in the literature about how occupational therapy provision can be transformed through delivery via social enterprises, there are many unanswered questions about how occupational therapists may work in social enterprises in the UK. There is the potential that social enterprises could facilitate occupational therapists to practice with greater freedom and autonomy; to prioritise occupational needs; support

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<sup>2</sup> UNISON is the union which represents occupational therapists in conjunction with The College of Occupational Therapists

occupational needs in natural settings away from clinical and institutional environments reducing stigma and the 'sick role'; and to practice in holistic and client centred ways.

Social enterprises that are "*spin-offs*" from the public sector, occupational therapists may be included as part of a whole service that is transferred into a social enterprise. However, the rebranding of a service from being NHS to a social enterprise does not necessarily mean that the culture or roles of the professionals within it will change. Therefore public sector *spin-off's* may continue to experience the dissatisfaction with their role that was experienced in the public sector. As public sector *spin-offs* are a new phenomenon with limited research evidencing the changes in practice, the implications of this on occupational therapists are currently unknown.

Another challenge for the occupational therapy profession branching out into social enterprises could be the need for occupational therapists to be able to promote and market themselves with clarity about what the product is that they can offer. Occupational therapy is a complex intervention (Creek, 2003). However this complexity requires simplification to be able to be sold as a marketable product. This presents a challenge to the profession of occupational therapy as it engages with the business and third sector.

From an occupational therapy perspective, there are multiple opportunities for occupational therapists to work in social enterprises. This could be around return to work and the provision of graded therapeutic activities as part of the commercial business. Work integration social enterprises (WISE) help disadvantaged unemployed people who are at risk of permanent exclusion from the labour market, by integrating them back into work and society through productive activity (Defourny and Nyssens, 2006). This is an example of a social enterprise promoting social justice through social inclusion in employment, which is a key factor in reducing inequalities (Marmot, 2010). Social enterprises that are focused on work integration can be either finding work in the mainstream and providing some training or, actually creating employment with training inbuilt (Aiken, 2007). Both have potential roles for occupational therapists. The former model would be more applicable for service users at a higher level of functioning and the latter would benefit people who require a greater degree of support and intervention to ensure the success of their involvement. These models could replace traditional vocational rehabilitation programs and day centres without the associated stigma and which promote social inclusion.

Social enterprises may provide opportunities for occupational therapists to engage in a wide range of occupation-based interventions with people that are currently underserved by occupational therapists in the UK, such as the homeless or offenders to address occupational injustice. This is alongside mainstream health and social care provision through social enterprises where occupational therapists may be employed. Similarities between the philosophy of occupational therapy and the model of social enterprise have been identified as the intention to improve the physical, mental and social wellbeing of individuals and groups in society. Both the occupational therapy philosophy and models of social enterprise hold shared values of empowerment and collaboration with service users which could work compatibly with one another. The social enterprise could provide the supportive organisational structure that can facilitate the occupational therapist to provide individual interventions to the service user as well as a therapeutic environment to promote recovery.

### **3.9 Chapter summary: The emergence of social enterprise in health and social care in the UK**

This review of the literature and policy around social enterprise in the UK has revealed two separate agendas. One relates to social enterprise as a public health intervention to address the widening inequalities in the UK; the other concerns the political drive for the outsourcing of public services into social enterprises. Both of these can be supported by the personalisation agenda. The political drive to outsource public sector services to social enterprises has become the dominant discourse which has shaped the development and understanding of social enterprise in the UK. This dominance has also been represented in this chapter. However, the emphasis on transforming the public sector to become the “largest social enterprise in the world” (DH, 2010a, p5) has overshadowed the focus on social enterprise as a public health intervention as proposed by Roy et al., (2013) and Donaldson et al., (2013). They assert that social enterprise as a public health intervention could reduce the long-term demands on the public sector by addressing some of the underlying causes for health problems with an asset based Salutogenic approach. However this would require a long-term commitment from the Government to invest in community, asset-based strategies and shift the emphasis from a deficit-based approach to a strengths-based approach to health and social care. Social enterprise as a public health intervention has received little attention in the literature or in research despite the opportunities currently presented for social enterprises to address health inequalities in the current political and economic environment. The adoption of policies that promote

social enterprise as a public health intervention incorporating expertise of healthcare professionals such as occupational therapists, could develop into a structural factor that facilitates occupational justice (Stadnyk et al., 2010).

The dominant discourse promoting the outsourcing of public services to social enterprises involves these social enterprises conforming to public sector approaches to health and social care, which still primarily use the deficit-based medical model. However, occupational therapists need to practice within diverse environments to explore the potential for professional practice and promote occupational justice without the restrictions and limitations within the public sector (Healey, 2011). Therefore, in the changing health and social care environment, occupational therapists require opportunities to develop practice within environments such as social enterprises but outside of the control of the public sector to have freedom to be creative, innovative and autonomous. Evidence in the occupational therapy literature supports the development of 'non-traditional settings' for practice 'role emerging placements' for students where an occupational therapy role has been developed and created where one was not previously. This can support the possibility of occupational therapy roles being developed in social enterprises and in the third sector. However, there are many unresolved issues and challenges surrounding occupational therapy practice within social enterprises which require further exploration.

The public-sector '*spin-offs*' incorporate aspects of community and staff ownership in their governance structures however, these are not necessarily grassroots, organisations that have been created from the bottom up, but top down from public policy. Such social enterprises may struggle to develop genuine collaboration with staff and service users. Therefore the quality of involvement of stakeholders from the community may be questionable. The public sector providers also have duties and contracts to fulfil to their funders, bringing into question to whom are they really accountable and who really holds the power and influence over the services offered.

Despite the initial intention of social enterprise within public policy to impact social exclusion, there is a mismatch between policy expectations and the reality within existing social enterprises (Teasdale, 2009). It is proposed in this study that this gap could begin to be addressed through the provision of occupational therapy within social enterprises as the core principles of social inclusion are central to occupational therapy practice (Perkins and Repper, 2013). Social enterprises have been successful at promoting social capital as they open up new opportunities and bridges within communities (Teasdale, 2009). However, occupational therapists bring professional expertise and knowledge of how to

enable service users to gain skills and abilities to re-engage in society in a holistic way, that that is unique to the profession. The practical contribution that occupational therapists could make within social enterprises could impact the effectiveness of social enterprises to achieve their social aims.

The review of the social enterprise literature within the health and social care sector also revealed a lack of evidence of service users' perspectives. The lack of service users' voices in this discourse alongside the strong influence of public policy demonstrates an imbalance of power in the development of the social enterprise evidence base. Therefore, there is a need for the voices of service users within social enterprises to be heard and included in research, which this study also begins to address.

The findings from the literature reviews informed the choice of methodology taken in this study. This included the potential small number of social enterprises which employ occupational therapists, the lack of service user involvement in research and the influence of broader political factors on occupational therapy practice within social enterprise. The following chapter discusses the overall methodological approach taken to this study to address the research questions, aims and objectives.



# Chapter 4: The research methodology for the study

## 4.1 Introduction

In Chapter two, the need for a new environment for occupational therapists to practice was presented. It was also asserted in Chapter three that there are gaps in the academic research literature to evidence the occupational therapy professional practice within social enterprises. This led to the formulation of the research questions, aims and objectives that were presented at the end of Chapter 1 and are restated in this chapter. The overall methodological approach to this study has been guided by the use of the pragmatic paradigm that is presented first in this chapter followed by the research methodology for this study. This chapter justifies the methodological approach used, the research process, and the methods used to gather and analyse data to respond to the research questions. The ethical considerations for this study are also addressed and a critique of the methodology of this study is presented in the discussion chapter (Chapter 9).

## 4.2 The philosophical underpinning of the study

The purpose of this section is to make explicit the worldview that has influenced the study (Creswell, 2009). Worldviews are beliefs and values that researchers bring to a study and can be drawn from one or more perspectives (Creswell and Plano Clarke, 2011). It is asserted that worldviews are formed within research communities and that they can differ among communities (Morgan, 2007; Creswell and Plano Clarke, 2011). Within the academic research literature, terms such as *worldview* and *paradigm* are used interchangeably, and a paradigm is a worldview with inherent philosophical assumptions. The concept of paradigms became significant following Kuhn's work *The Structure of Scientific Revolutions* published in 1970. Kuhn defined paradigms as a set of generalisations, beliefs and values by a community of specialists (Kuhn, 1970) and this definition is used in this study. Kuhn also refers to *values*, introducing the role of axiology in research, which is defined as a branch of philosophy that addresses ethics and values (Heron and Reason, 1997) which is considered in this chapter in relation to this study.

A researcher's worldview influences their epistemology, which is defined as assumptions concerning how knowledge is gained (Creswell and Plano Clarke, 2011). Epistemology is

a branch of philosophy which is defined as the theory of knowledge (Green and Thorogood, 2009) and involves exploring how we know what we know. In addition, the researcher's philosophical assumptions shape their ontological position, which is their view on the nature of reality. Ontology refers to the researcher's beliefs about the relationship of human beings to the world (Denzin and Lincoln, 2008) such as whether there are one or multiple realities. The different ontological positions are concerned with whether social entities can be considered objective or as social constructions created by the perceptions of social actors (Bryman, 2012).

Two of the most frequently cited major worldviews in the academic research literature are: positivist and interpretivist. However, other authors suggest that there are two additional worldviews: participatory and pragmatic (Creswell, 2009; Green and Thorogood, 2009; Creswell and Plano Clarke, 2011). In contrast to the dialectic *either/or* positioning of positivism and interpretivism, pragmatists reject the dualism which occurs in other paradigms and instead explore how paradigms and different methods can work together. Therefore pragmatism is a practical, 'pragmatic' method that provided an alternative perspective. A pragmatic position has been chosen for this study and a discussion of pragmatism follows next.

### **Pragmatism and this study**

A useful historical analysis of the development of pragmatism and mixed methodology has been provided by Morgan (2007), Teddlie and Tashakkori, (2009) and Creswell and Plano Clarke (2011). They present the developmental process that the academic research community have engaged with that has led to a recent development of a community of pragmatists. Pragmatism was influenced by John Dewey, William James and Charles Sanders Pierce and as a worldview it draws upon the notion of 'what works' using diverse approaches, valuing objective and subjective knowledge (Creswell and Plano Clarke, 2011).

Pragmatism developed out of the paradigm debate which developed after the emergence of constructionism and was most prominent in the 1990's. The paradigm debate highlighted the conflict between the scientific worldviews of positivism and constructionism on philosophical methodological issues (Teddlie and Tashakkori, 2009). Researchers who believed that it was not possible to mix paradigms were at one extreme side of the debate and the incompatibility thesis was developed. Positivist (and post-positivist) paradigms were viewed as incompatible with constructionist paradigms because of the

belief that it was not possible to shift between paradigms. However, Morgan (2007) critiqued what he called the metaphysical paradigms (positivism and constructionism) which focused on philosophical, epistemological issues. As a product of the debate, pragmatism emerged as a new paradigm among the community of mixed methodologists. It was argued that different paradigms were compatible with each other by rejecting the metaphysical philosophical notions of truth and reality and focusing on what works to answer the research question (Morgan, 2007; Teddlie and Tashakkori, 2009). The pragmatic perspective meant that researchers could change between different worldviews within their study which has been termed the inductive-deductive cycle (Teddlie and Tashakkori, 2009) which was also defined by Kuhn as a paradigm shift (Kuhn, 1970).

Within the pragmatic paradigm, it is possible to move between paradigms in a research study and use different worldviews to answer the research question. Creswell and Plano Clarke (2011) take the position that within a pragmatic paradigm, the research design determines the worldview that is used at each stage in the research. They assert two types of pragmatic research designs. One is a convergent research design which uses pragmatism as an overall paradigm for the research; and second, - a sequential research design which enables multiple worldviews that can be taken which relate to different stages in the research (Creswell and Plano Clarke, 2011, p.279). The latter research design is called a pluralistic pragmatic approach and has the advantages of being an all-encompassing approach to a research project.

The pragmatic perspective has been used in this study in guiding the choice of research design and data collection methods. This has meant that choices have been made in the research design that are the most appropriate to answer the research question as the study unfolded. This happened inductively as the lack of an evidence base in the literature led to an exploratory research design using mixed methods. By using a pragmatic approach (which allows for mixed methods of data collection), all forms of qualitative and quantitative data can be useful in gaining understanding of the research topic. A pluralistic pragmatic position was taken to enable collection of factual information about which social enterprises employ occupational therapists and subjective responses about what their role involved. This pluralistic pragmatic position integrates a post-positivist position (assuming that there is one reality that can be known, such as the existence of occupational therapy or a social enterprise that can be researched) with the constructionist position of subjective meanings the participants give to their experiences. This enables a more holistic picture of occupational therapy professional practice within social enterprises in the UK. This approach benefits from the strengths of multiple epistemological and

ontological perspectives and the strengths of both quantitative and qualitative methodologies. In addition, a pragmatic approach to this study is also reflective of the philosophy of occupational therapy which is holistic and pluralistic in nature in relation to how humans interact with the world.

The pragmatic paradigm has been criticised for rejecting or neglecting the metaphysical aspects of truth and reality. However, using a pragmatic approach means that the researcher can move within different paradigms and view the research and data from multiple perspectives, applying different epistemological and ontological views on truth and reality if this will be beneficial to the research. The pragmatic paradigm has been criticised by some in the academic research community who do not believe that it is possible to move between paradigms as they are incompatible. However, the paradigm debate has largely been settled with an acceptance of the pragmatic paradigm as a third worldview, using Kuhn's definition of a paradigm being a set of beliefs and values among a community. This community of pragmatists face challenges of developing a common language and on-going acceptance among the research community who hold onto the inflexible, dualistic limitations of other worldviews (Teddle and Tashakkori, 2009).

### **4.3 Research design**

A pragmatic approach was used when devising the research questions and constructing the research design. As limited evidence of occupational therapy practice within social enterprises in the UK was evident in the literature review, it was a pragmatic decision to start the research by identifying a baseline of what practice existed at the time of the study, then to incorporate various methods of data collection to address the research questions. The research questions presented in Chapter 1 are repeated here and the research design is presented in the following diagram. The methods of data collection and analysis are presented in the next two sections as Phase 1 and Phase 2 of the study.

#### **Research questions:**

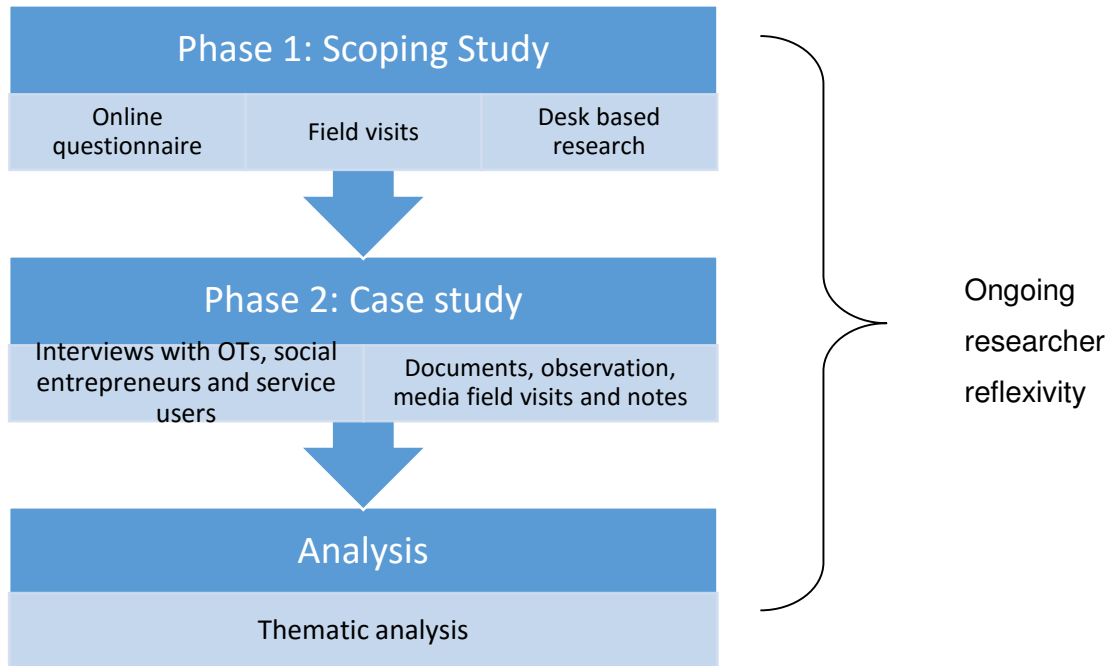
1. What forms of occupational therapy are practiced within social enterprises in the UK?
2. What is the relationship between occupational therapy practice in social enterprises and the philosophical foundation of the profession?

3. What are service users' views, opinions and experiences about the occupational therapy they receive within a social enterprise?
4. What are the factors that determine the diversity of occupational therapy provision within social enterprises?

The research questions focus on all three aspects of the occupational justice framework. The first research question led to identification of what organisational structures existed at the time of the study (an occupational instrument or programme, Stadnyk, 2010). The second research question focused on the combination of occupational therapy practice and social enterprise as an environment for service delivery, as they share similar goals of enabling social justice. This question addressed structural and contextual factors within the framework as it combines the organisation with individual interventions but also provided indications of occupational outcomes. The third research question was specifically included as a result of the lack of service users' voices in the literature review and the individual's included in this research contributed to the contextual aspects within the occupational justice framework. Their experiences also gave indications of the occupational outcomes, such as the extent they were socially included or marginalised. Finally, the last research question provided opportunity for exploration of the influential factors on occupational therapy practice within social enterprises in the UK, which could be conceptualised from any of three aspects of the occupational justice framework.

The literature review revealed limited existing knowledge concerning the different forms of occupational therapy practice within social enterprises in the UK. Therefore, this research was an exploratory study conducted within the pragmatic paradigm. The research design consisted of two phases of the project. Phase 1 was the scoping study which was essential to generate a sample and gather baseline data about occupational therapy provision through social enterprises. This addressed research question 1. Phase 1 then informed the creation and design of Phase 2, which was a case study approach to address research questions 2-4. The following sections of this chapter justify why these decisions were made about each method used in the research design. The following figure (4.2) demonstrates the research design for this study:

**Figure 4.3(a) The research design for this study**



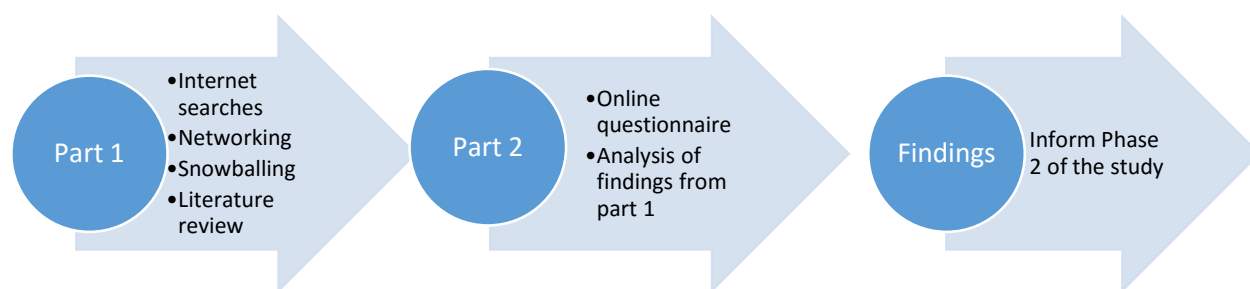
### **Phase 1: Scoping study**

The scoping exercise explored existing forms of occupational therapy professional practice within social enterprises in the UK. This was necessary because there was no previously known information, data or research on the topic of occupational therapy provision in social enterprises within the UK. The scoping exercise was limited to the UK to maintain a consistent health and social care context for the research about occupational therapy delivery under national policies and guidelines.

Scoping is a widely used approach within health services in order to gain greater understanding of a topic, usually leading to further research (Davis, Drey and Gould 2009). There is evidence of scoping carried out on the existing literature on a research topic (Arksey, 2003; Ravenek et al., 2010; Hand, Law and McColl, 2011) and as a means for understanding the topic (Rumrill, Fitzgerald and Merchant, 2010). Scoping can also be used as a method to research healthcare services (Cook, Owen and Wilson, 2002) and professional practice (White and Roche 2006). An extensive piece of research exploring scoping studies in the nursing literature concluded that scoping studies include a fact finding exercise and provide conceptual clarification on a topic where there is little evidence (Davis et al., 2009) therefore it is relevant for this study. As occupational therapy practice within social enterprise is a new area of research, it was the purpose of

this scoping exercise to not only gain relevant information but to move beyond fact-finding and to develop new conceptual insights into this new area of service delivery. This scoping exercise not only consisted of peer reviewed and published literature but also the grey literature of reports, working documents and web based information as desk based research. This was also accompanied with field visits, networking events and snowballing as a result of networking. The information generated informed the development of an online questionnaire which was also part of the scoping exercise. The following figure (4.3) depicts the process of the scoping exercise and this is followed by a full explanation of each part of the process:

**Figure 4.3(b) Process of the scoping study**



#### **4.4 Methods for the scoping study**

To gather information about which social enterprises provided occupational therapy, a scoping study was conducted to generate a baseline of data. This was carried out using the following methods:

- Literature search
- Internet based searches
- Database searches
- Networking and snowballing
- Online questionnaire

## **Literature search**

Occupational therapy, social enterprise and health related academic literature were searched using the following research key words: “occupational therapy”; “social enterprise”; “health”; “nursing”; “physiotherapy”; “community interest company”; and “community organisation” using six journal databases (CINAHL, Medline, Amed, Sports Discuss, Emerald and Web of Science) to investigate if any organisations had been documented in the literature. Two years of the occupational therapy professional monthly publication, *OT News* were scrutinised to identify any documentation of occupational therapy provision within social enterprise<sup>3</sup>. Further publications of *OT News* were to be investigated if this proved to be a useful method for finding a sample, however none were identified at that point in the research. Following this, three articles were written by the researcher for *OT News* on the topic of occupational therapy in social enterprise (in Appendix 2) and a request was placed for any occupational therapists working in or interested in social enterprise to contact the researcher and an email address was provided (Stickley, 2011). The success of this strategy was minimal. However, two occupational therapists responded to the article and both subsequently took part in the study. As a result of the advert and articles in *OT News*, the researcher was contacted by three occupational therapists that had recently begun working for public sector NHS funded organisations that call themselves social enterprises.

## **Internet based searches**

Internet based searches using ‘Google’ were used to explore information in the public domain. Searches consisted of combinations of the same research keywords stated in the previous section. This strategy was successful as five social enterprises employing occupational therapists were identified.

## **Database searches**

The databases held online by social enterprise support organisations provided information about social enterprises. These were reviewed and those that were identified as potential providers of occupational therapy (based on their mission, social aims or mandate) were

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<sup>3</sup> Two years was chosen as this was the amount of time since social enterprise had been promoted within public policy as a method of health and social care provision.



identified. Phone calls were made and emails sent to these social enterprises to enquire if an occupational therapist was employed by the social enterprise. In addition to the information available online, two regional and one national social enterprise support organisation were contacted by email or telephone.

There were no records of social enterprises that deliver occupational therapy listed on national databases such as those held by the Social Enterprise Coalition or The Social Investment Business (Social Enterprise Investment Fund, SEIF). There were also no records of social enterprises providing occupational therapy held by one social enterprise support organisation, Social Enterprise East Midlands (SEEM). If this was a successful strategy, further support organisations were to be explored. Of the organisations listed by SEEM, twenty-eight were identified as potential social enterprises that could employ occupational therapists, based on the organisation's mission statement and content on their websites.

The social enterprises targeted in this research did not need to provide occupational therapy solely, but could have a wide ranging social mission and mandate and employ an occupational therapist as part of their team. The organisations identified were contacted by telephone or email to identify if they employ occupational therapists. Of these twenty eight organisations, none employed occupational therapists. Two organisations previously employed occupational therapists in the past but could not afford to employ them at present, although they wanted to do so. As these two organisations did not provide occupational therapy or employ an occupational therapist, they were not included in the study. As database searches and support organisations proved to be unsuccessful for identifying occupational therapists in social enterprises, further attempts to explore national and regional databases were not pursued.

### **Networking and snowballing**

Networking and snowballing was used to gather information about occupational therapy practice within social enterprises in the UK through discussions with occupational therapy academics and colleagues informally and formally at conferences and events.

Snowballing is a particular technique where participants suggest others to participate (Roberts and Priest, 2010). It is an appropriate technique with an unknown or hidden population (Atkinson and Flint, 2001; Lopes, Rodrigues and Sichieri, 1996) such as the unknown number of occupational therapists working for social enterprises in the UK. However, there are criticisms of this sampling method as positivists would argue that it

lacks validity to produce consistent samples (Heckathorn, 1997; Van Meter, 1990). Snowball sampling is a type of sampling process known as purposeful or theoretical sampling and is used to select participants according to the research aims and purpose (Tuckett, 2004) and is common in qualitative research (Miles and Huberman, 1994). As this study is conducted within the pragmatic paradigm, the sampling strategies used were determined by what worked to generate a sample.

The strategies which were used are detailed below with the success of each strategy:

- 1) Links were made with the College of Occupational Therapists (COT) and the COT Specialist Section in Independent Practice (COTSS-IP). All 181 of the occupational therapists on the COTSS-IP database were emailed and asked if they work for a social enterprise and to forward the email onto anyone they might know that may work for a social enterprise. This strategy was not successful as none of the occupational therapists in the specialist interest group were employed by a social enterprise. One private company was considering becoming a social enterprise and the director contacted the researcher for support and to network with other social enterprises.
- 2) Contacts were made through attendance at conferences and events. This was a successful strategy for finding occupational therapists in social enterprises. One occupational therapist that was in the process of setting up a social enterprise became known to the researcher through a conference. One participant was recruited at a regional occupational therapy event and met another occupational therapist who subsequently participated in the study. Through networking at this event, another occupational therapist in a social enterprise was contacted and agreed to participate.
- 3) An event was hosted at the University of Northampton for occupational therapists interested in social enterprise (Appendix 3). This event generated a significant amount of interest (there were 85 delegates) and two social enterprises participated in the study as a result of this.
- 4) A letter was written to the COT national practice placement tutor forum and information about this research was disseminated requesting any fieldwork co-ordinators who knew of any social enterprises employing occupational therapists, to contact the researcher. This did not lead to further participants for the study.
- 5) One social enterprise was suggested by the social enterprise academic supervisor which subsequently led to their participation in the study.

The following table (Table 4.4) summarises how many participating social enterprises were identified:

**Table 4.4: Findings from generating a sample**

<b>Sample generating strategy</b>	<b>Number of social enterprises identified</b>
Internet based searching	5
OT News	3
Academic literature	1
Attending conferences	3
Hosting a networking day	2
Snowballing	3
Academic supervisor	1
<b>Total</b>	<b>18</b>

### **Online questionnaire**

Once a number of social enterprises had been identified, visits to two social enterprises were carried out to explore issues relating to occupational therapy practice within social enterprise. Initial questions during visits to the occupational therapists were focused on their role, the types of interventions they provide and about the social enterprise that they work for. An online questionnaire was then developed to address: Aim 1, objectives (a) and (b) to identify any additional occupational therapists working in social enterprises and which service user groups receive occupational therapy; Aim 2 (b) and (e); and Aim 4 (a), (d) and (e) to identify who funds the social enterprises, the types of interventions offered and occupational therapists involvement in the management and governance of the social enterprise. A copy of the questionnaire is in Appendix 4. Participants were recruited through the use of an advert that was disseminated to all the social enterprises found through the strategies mentioned above. A copy of the advert is in Appendix 5.

An online questionnaire was chosen because it can be used to explore knowledge, opinions and attitudes of groups of people (Marshall and Rosman, 1995; Graziano and Raulin, 2004). There is now a growing body of literature evidencing the use of web-based surveys (Witte et al., 2000; Yun and Trumbo, 2000; Andrews et al., 2003; Granello and Wheaton, 2004; Wright, 2005; Perkins, 2011) which demonstrates their use.

### **Advantages/disadvantages of online questionnaires**

Online questionnaires are cheap to administer (Evans and Mathur, 2005) which is important when choosing the type of methodology to use, particularly due to the limitations of an expense budget for this project. A drawback of this data collection method is that online questionnaires can exclude people who do not have access to computers and the internet or those without computer skills. However, as the target population are occupational therapists (qualified to degree or diploma level), it was assumed that all were likely to have access to computers and adequate computer skills as this could be a necessary requirement for their work. It was identified that a web based survey may provide the best opportunity to reach the maximum number of participants as possible because through advertising, the number of participants was not limited. A disadvantage of online questionnaires is that the researcher cannot assume the participant will contact them if there is something they do not understand. Explanatory text can be added, however this is not always beneficial because they are not consistently read (Fowler, 2002). In addition, as the questionnaire is anonymous, it was not possible to verify that all the respondents were occupational therapists or to track their responses in the analysis of the findings. The use of an online questionnaire tool meant that quick, simple factual data could be gathered as well as short qualitative information. Therefore, this was the most appropriate method to gather initial data at this early stage in the study.

### **Questionnaire design**

The benefits of using developed, well established questionnaires are asserted by Fowler, (2002) and De Vaus, (2002). However, since this is a new area of research, such established data collection tools are not available. For this study it was decided that the design of questions should develop out of the concepts within the research question (De Vaus, 2002). The key topic areas in this study were the type of occupational therapy provided, to who and how alongside the influential factors on this by the social enterprise, therefore exploration of these concepts was required in the online questionnaire. This was done through a process of examining the literature, visiting social enterprises and

discussions with social enterprise staff, occupational therapists and academics in both fields.

The questionnaire consisted of two parts, the first was to gather data about the organisation. This included the following:

- The legal structure of the organisation
- Who set up the organisation
- The occupational therapist and service users' involvement in management or governance
- Who the service users or consumers of the organisation were
- How the organisation was funded and if it was profit-making

Following this, questions were then asked about the provision of occupational therapy in part two, requiring more personal reflections and opinions on their own practice. This included:

- If an occupational therapy specific role was held
- Which client group they worked with, the problems they experienced and occupational interventions offered
- The use of standardised assessments
- Any limitations experienced in their practice
- An estimation of the amount of time spent with service users and on admin tasks
- Peer support
- A comparison in their practice between their current work and previous employment

An open, non-directive question at the end of the questionnaire provided an opportunity for participants to express any thoughts or opinions about occupational therapy practice in social enterprises. The full list of questions is available in Appendix 4.

Advice on designing a questionnaire was taken from the research literature. The process required to conduct an online questionnaire is consistent in the literature which is: to define the sample; construct the questionnaire; administer the questionnaire; analyse and interpret the data (Salant and Dillman, 1994; Fowler, 2002; Graziano and Raulin, 2004). The wording of questions needed to be considered carefully, with clear unambiguous questions that are not leading (De Vaus, 2002). These principles were followed when designing the questionnaire as good questionnaire design is important to ensure a high response rate (Fowler, 2002) and to meet the aims and objectives of this study.

Occupational therapists who had been identified through the scoping exercise were recruited to complete the questionnaire. In addition, the questionnaire was advertised widely so that other occupational therapists working for social enterprises who were not already known to the researcher could participate. The criteria for the sample were occupational therapists currently (or previously) working in social enterprises. A definition of social enterprise was not given in the advert for the questionnaire (which can be found in Appendix 5), therefore any occupational therapist who perceived that they are working in or have worked in a social enterprise were able to participate. A definition of social enterprise was not given, as it is not the aim of this study to explore the definitional issues relating to social enterprise, therefore it was the decision of the participant to respond if they perceived themselves to work in a social enterprise.

Prior to conducting the online questionnaire, consideration had not been given to whether to include student occupational therapists on placement in social enterprises. However during the process of data collection, it became apparent that student occupational therapists on placement within social enterprises would be able to contribute valuable information to this research. As a result, the advert was given to them to participate in the survey. Due to anonymity of research participants who completed the online questionnaire, it was not possible to identify if any student occupational therapists did complete it. During the process of finding potential research participants, occupational therapists setting up social enterprises were also identified. Consideration was given to whether they should complete the survey with their intention of what they aim to achieve. However, it was decided that these occupational therapists would not be included in the sample as actual occupational therapy provision was not yet taking place in these

organisations and they would not be able to provide the relevant information needed about their role within the social enterprise.

Service users' experiences of the occupational therapy they received through the social enterprises had not been included in Phase 1 of this study as this was preliminary research addressing question 1, to identify what form of occupational therapy practice existed within social enterprises in the UK. As occupational therapy is a person-centred, humanistic profession that promotes collaboration with service users throughout the occupational therapy intervention, involvement of service users within this research was also deemed important. In addition, involvement of service users may corroborate or contradict the occupational therapists' views and so is a valuable method for triangulation. Inclusion of service users' participation was therefore incorporated in Phase 2 of the study.

A full exploration of ethical issues relating to the study is presented at the end of this chapter.

## **4.5 Phase 2: Case study**

As a result of the findings in Phase 1, a case study methodology was chosen for Phase 2. Case study as a research design is explained in this section and then applied with a justification for the relevance in this study. The advantages and disadvantages for using case study research are explored and other research methodologies that have been considered are discussed in this section.

### **Case study definitions**

A case study according to Hamel et al., (1993) is an in-depth study of cases under consideration. Put another way, case study research is the detailed study of a particular case, with the case usually being defined as a location, community or an organisation (Bryman, 2008). Yin (2003) asserted that defining case study as a research strategy cannot be done through identifying the topic to be researched (such as an organisation) but that case study is the approach taken when investigating a research subject. Gillham (2000) acknowledges the difficulties with defining a 'case' and suggests that it:

- Is a unit of human activity that is embedded in the real world;
- Can only be studied or understood in context;

- Exists in the here and now
- Merges in with its context so that precise boundaries are difficult to draw

(Gillham, 2000, p.1)

Gillham's (2000) definition brings more clarity and detail in understanding the concept of a 'case'. Gillham (2000) develops his definition further to explain that a case study constitutes the investigation of a case to respond to specific research questions through the collection of different types of evidence. Even though Gillham's definition is more detailed, Stake (1995) and Yin (2003) are two of the predominant authors on case study methodology. They propose slightly different definitions. According to Stake (1995), case study methodology seeks out the unique complexity of a single case, coming to understand its activity within important circumstances. However, Yin suggests that:

*“A case study is an empirical inquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between phenomenon are not clearly evident” (Yin, 2003 p13).*

Both Yin and Stake are consistent about the importance of the context and circumstances of a particular phenomenon when conducting case study research. However, Yin introduces the concept of blurred boundaries between phenomena which Gillham (2000) also supports. For the purpose of this research, Yin's definition of case study has been used. This is because Yin's writings on case study methodology are beneficial for a novice researcher as guidance in conducting case studies. The various types of data collection methods that will be used in this study will be covered in the section covering data collection methods later in this chapter.

## **Case study research**

Case study as a research design is common in the academic research literature, (Yin, 2009; Eisenhardt, 2002; Bryman, 2008; Silverman, 2010) and is used across many disciplines (Johansen, 2003) in a variety of contexts, such as: exploring user perceptions of services (Maceli, et al., 2011); academics publishing behaviours (Bennett, Genoni and Haddow, 2011); inclusive education (Lindsay, 2007); performance measurement in organisations (Amaratunga and Baldry, 2001); and influences on healthcare professionals (Fitzgerald, 2003).



A literature review conducted on case study research revealed that it is the most common type of research evidenced in the social enterprise literature at present. The literature review identified 219 articles using the key words “social enterprise” and “research” in 10 databases (ASSIA; Directory of Open access journals; Emerald; Ingenta; Sage; Science Direct; Springer Link; Swetwise; Web of Science; and Zetoc). Of the 219 articles found, the majority, (59%) used case study methodology. This could be reflective of the early development of the social enterprise research literature and the need for case study research to develop theory and concepts that can be transferred into other contexts.

Case study research has been used to investigate a small sample of organisations in detail to gain in-depth information on specific social enterprises or multiple organisations (Jones and Keogh, 2006; Seanor and Meaton, 2007; Gibbon and Affleck, 2008; McCarthy, 2008; Overall, et al., 2010). The lack of diversity in research methodologies within the social enterprise literature is apparent. The choice of the most appropriate research design and methodology in this study has been determined by consideration of the most appropriate method to respond to the research question (Silverman, 2010).

Within the occupational therapy academic literature, there are numerous publications of ‘case studies’ of individuals with a specific problem (for example, a stroke or having a mental health diagnosis). However, these are not examples of actual case study research (Salminen et al., 2006). This is because case study research explores more than a cause and effect relationship that is typically detailed in the clinical examples in the occupational therapy literature. It is argued that case study research (as detailed and defined above) should be used more extensively by occupational therapists as the method respects the basic principles of occupational therapy, particularly a holistic approach (Salminen et al., 2006). Currently there is limited evidence of actual case study research within the occupational therapy literature and confusion exists within the occupational therapy profession about the distinction between patient case studies and case study research (Salminen et al., 2006). Case study research that has been published within the occupational therapy literature includes: a single case study of an occupational therapist in an assistive outreach team (Egan et al., 2010); a single case study on service learning in occupational therapy (Vroman et al., 2010); a collective case study of occupational therapy managers job satisfaction (Gamble et al., 2007); and a model for using explanatory case study research in clinical settings that has been developed by occupational therapists (Fisher and Zivani, 2004). There is a lack in the occupational therapy research literature about the environments that occupational therapists work in and the implications on of the organisations they work in on their practice.

## Types of case studies

Various types of case studies were considered for this research. Yin (2003; 2012) identified three types of case studies which are: exploratory; explanatory; and descriptive. These are explained and defined in the following table (Table 4.5(a)):

**Table 4.5(a): Types of case studies**

Type of case study	Definition/Explanation
Exploratory	Explore a new phenomenon that can then lead to further inquiry. This is usually used with 'what' and 'who' research questions.
Explanatory	Understand a phenomenon over a period of time. Usually used with 'how' and 'why' research questions.
Descriptive	Description of phenomena, which may also occur during the initial exploratory phase of a study.

(Yin, 2003; 2012)

The choice of which type of case study was most relevant for this research was determined by the research questions. As the research questions sought to explore the ways in which occupational therapy is practiced within social enterprises in the UK and various participants' responses to this provision, an exploratory approach was most appropriate. Stake (1995) categorises case studies as: intrinsic, instrumental or collective case studies. He explains that the intrinsic type investigates one specific organisation and does not attempt to generalise; the instrumental aspect researches one case or more to understand phenomena and collective case studies investigate a phenomenon across them. Yin's (2003) description of single or multiple case study designs are similar to Stake's explanation of intrinsic and collective case studies respectively. Yin's 'explanatory' category could also be understood to mean the same as Stake's 'instrumental' type because both aim to explain a phenomenon using one or more cases. Both Yin and Stake's distinctions of case studies can be helpful in defining the type that is relevant for this research as they are not mutually exclusive concepts.

In this study, the most appropriate type of case study is an exploratory, multiple one because of the number of social enterprises that were researched. This study was

considered to be exploratory because even though there are well established knowledge-bases on occupational therapy theory and social enterprise, there is no previous research into this combination and synthesis (as shown in the literature review). Multiple cases are relevant for this study because each of the social enterprises were likely to be different from one another and have a unique contribution to make in understanding the determining factors in occupational therapy provision.

When conducting exploratory case study research a selection of different types of cases can be used, (Yin, 2003; Bryman, 2008). Due to time restrictions with this study, a longitudinal case study was not considered appropriate, however this could be relevant for future research. This research used an exploratory multiple study approach with a variety of different case studies which provided the opportunity for comparison. Exploratory case study was chosen because of the lack of prior knowledge into occupational therapy practice within social enterprises and multiple cases were available to be included in this research from the scoping study. Researching multiple cases provided greater knowledge and insights into this new phenomenon and the opportunity for comparison between different cases.

### **Advantages and limitations of case study design**

This section reviews the strengths and limitations of case study research and then discusses these in relation to this study. Case study methodology can be advantageous when the aim of the study is to develop in-depth knowledge and understanding about a specific phenomenon or unique circumstance. Case study methodology uses a variety of sources of evidence for data collection which is one of its major strengths as a research approach (Yin, 2003). These data collection methods can include observation, interview, document analysis and questionnaires among other methods. Multiple methods can strengthen authenticity of the findings through data triangulation (Cohen and Crabtree, 2008). For example, the data gained through the interviews in this study can then be compared to data in formal documents or observations on filed visits and the findings may corroborate or contradict each other, adding to the quality of the study.

Case study methodology is criticised within the research literature, particularly by those from the positivist tradition. The two main criticisms of case study methodology are that findings are not generalisable and lack rigour (Bryman, 2008). Yin (2003) challenges the criticisms concerning generalisability by stating that case studies “are generalisable to theoretical propositions and not to populations or universes” (p10). Therefore, case

studies can be generalised in terms of theory but it is a misunderstanding of the purpose of case study research to expect that it will provide results that can be applicable to populations. The aim of the current study is not to create results that can be generalised to populations but to develop transferable knowledge.

The case study is arguably an appropriate methodology when researching a specific organisation, such as a social enterprise or a professional role within the context of a healthcare service because of the focus of the context of the research subject. Through studying specific social enterprises that employ occupational therapists and through the examination of the factors that determine the type of occupational therapy provided, new knowledge can be developed. The purpose of this research was to study the phenomenon of the provision of occupational therapy in various settings. This required a number of case studies to reveal patterns, themes or differences among the individual cases.

Within this study, not only was the occupational therapy the subject of interest, but also the users of the organisation, those in management and leadership, the social and relational processes within the social enterprise as well as the social, political and economic structure and context of the organisation that influences the occupational therapy provision. Case study methodology allowed for exploration of all of these wider issues and therefore the research questions, aims and objectives could be addressed. The use of this methodology was guided by the occupational justice framework which incorporated the wider socio-political influences on occupational therapy and within the broader health and social care landscape. Case study was also judged to be the most appropriate methodology to use in this study within a pragmatic paradigm because a small number of social enterprises which were identified in the scoping study. The small number allowed for in-depth research on each of these. As a mixed methods study, within the pragmatic paradigm, the inclusion of various types of data collection methods corresponded with a case study approach.

### **Quality in case study research**

Within the case study literature, Yin (2003) uses quantitative, positivist language of validity and reliability that can be attained and are of importance in producing quality case study research. Yin (2003) asserts that validity can be achieved through ensuring that the study does what it sets out to do and by establishing how the findings can be generalised to theory and that reliability can also be attained by ensuring that the data collection procedures can be repeated (Yin, 2003). This is in contrast to Stake (1995) who does not

place emphasis on validity and reliability or authenticity and trustworthiness in case study research. Therefore, the lack of consistency in the case study research literature about measuring quality indicates that the research design itself does not influence the perspective the researcher should take on issues of quality in research. Instead, this was guided by the pragmatic position taken in this study. As qualitative methods were predominantly used in the case study, the qualitative quality measures identified by and Cohen and Crabtree (2008) were used as a guide<sup>4</sup>.

A strength of case study research is that it can use multiple types of data collected from different sources. Through triangulating the data from multiple sources, the findings and conclusions drawn can be strengthened. Through this method, triangulation can be used as a strategy to improve quality in qualitative research (Hansen, 2006). Multiple data sources were used in this study to strive for quality in this research.

### **Selection of the cases**

Within case study research, Creswell (2007) prefers to use unusual cases and uses maximum variation as a sampling strategy to describe multiple perspectives. This is not appropriate in this study because this is the first research of its kind so it was important to generate a baseline of knowledge about all occupational therapy provision through social enterprises. As the sample size was small, it was possible to include all cases that consented to participate in the study. It is also not appropriate to select unusual cases in this study as “usual” cases have not yet been identified. In contrast, Silverman (2007) presents purposive and theoretical sampling as appropriate sampling strategies when conducting case studies. In this study, the selection of the cases was purposeful to maximise learning (Stake, 1995). Purposive, criterion sampling was used for this research, where the researcher established pre-determined criteria about which social enterprises were included in the study (Hansen, 2006). The inclusion criteria for this study are detailed in the following table (Table 4.5(b)) with the justification for the decisions made:

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<sup>4</sup> “Seven criteria for good qualitative research: (1) carrying out ethical research; (2) importance of the research; (3) clarity and coherence of the research report; (4) use of appropriate and rigorous methods; (5) importance of reflexivity or attending to researcher bias; (6) importance of establishing validity or credibility; and (7) importance of verification or reliability.”(p331)

**Table 4.5(b): Inclusion and exclusion criteria**

<b>Inclusion Criteria</b>	<b>Justification</b>	<b>Exclusion Criteria</b>	<b>Justification</b>
Social enterprise defined by The Cabinet Office (DTI, 2002).	Inclusion of social aims and reinvestment of profit into the business which are the pertinent aspects defining a social enterprise.	Private companies or any organisation that distribute profit to shareholders.	Companies and organisations that make private profit are not social enterprises as profit does not further a social aim.
An occupational therapist delivering OT within a social enterprise.	Some of the social enterprises found that employed an OT, did not actually provide OT (e.g. one provided training, another sold adaptive equipment).	Organisations set up out of the public sector and created as social enterprises as a direct result of public policy (Such as the Right to Request and Right to Provide within the NHS).	Many public sector providers are called social enterprises but as these have contractor-provider relationships, these are a form of “new public management” (Ridley-Duff and Bull, 2011). Evidence gathered in the scoping study demonstrated that the occupational therapy role remained the same in these newly emerged public sector social enterprises as previous roles in the NHS.
Within the UK	Different countries vary in their health and social care policy, guidelines and occupational therapy standards.  This study was limited by the time and funding allocated to complete it.		

All the social enterprises that were identified in the scoping study which fitted the above criteria and consented to taking part in the research totalled eight and were included in Phase 2.

Social enterprises which were public sector “spin-offs” were excluded from the study because during the scoping study, the occupational therapists within these organisations stated that their role and the organisation had not changed from when it was a public sector body. This was explained by these occupational therapists as being because of the short amount of time since the change to become a social enterprise and also because they were delivering public sector contracts with similar targets and ways of working (despite the aim of ‘spin-outs’ to create new ways of working). Case study 6 originated from the public sector but was not a ‘spin-out’ as a result of policy as it was in Wales and public sector ‘spin-outs’ were promoted policy that was England specific.

### **Case study data collection methods**

The main method used in this phase of the study was interviews with different stakeholders. This was complimented with other forms of data gathering such as information from organisational documents, informal observations, field notes and reflexivity. This mixed method approach was employed because varieties of data from diverse sources were required to enable the research questions to be addressed. This triangulated approach strengthens the authenticity and dependability of the study (Cohen and Crabtree, 2008; Silverman, 2010) as data that verifies other data gathered by a different source strengthens the findings (Yin, 2012). Any contradictions in the data gathered provide an opportunity for the researcher to further investigate the issue.

### **Interviews**

To address the research questions, aims and objectives of this study, a data collection method was required that enabled exploration of the factors that determine the occupational therapy professional practice within social enterprises (Aim 2 and 4); and explore the service users’ views, opinions and experiences of the occupational therapy they receive. Both of these aims require a data collection tool that allowed the participants to freely express their views, opinions and experiences. It has been asserted that interviewing provides a crucial opportunity to gain insights into the participants’ thoughts, feelings and experiences (Miller and Brewer, 2003). To be able to collect such data, it was judged that interviews were the most appropriate method for data collection. The various

types of interviews are considered in this section and a justification for the type of interview used in this study is presented.

Interviews can be considered as 'conversations with a purpose', to collect information about a research topic (Miller and Brewer, 2003) and can be carried out in person, over the phone, through email or over the internet (Hansen, 2006). In this study, interviews were conducted in person during field visits to the case studies. Interviews provide the opportunity for the participants to express their views, behaviours and experiences and the interpretations they put on them to be explored. However, it is asserted that interviews are more than a neutral question and answer exchange but a collaborative effort of the participant and interviewer (Fontana and Frey, 2005). Interviews are contextual in time, history, society and culture and are constructions created within the research (Denzin, 2001; Fontana and Frey, 2005). The findings that resulted from the interviews in this study are to be understood within the social, political and historical context within which the interviews and this research study was carried out.

The three main types of interviews found within the academic research literature are:

- Structured;
- Semi-structured;
- Unstructured informal or unstructured in-depth interviews

(Miller and Brewer, 2003; Hansen, 2006)

Structured interviews involve the use of an interview schedule and clearly direct participants' responses by collecting data using lists of closed questions or questions limited by choice (Fontana and Frey, 2005; Bryman, 2008). The structured interview schedule aims to limit bias and subjectivity and maximise reliability and validity (Hansen, 2006; Bryman, 2008) therefore is more likely to be used within the positivist paradigm and quantitative approach. As participants' views and opinions become limited by a structured format, this data collection method for the current study was rejected because this would not generate data to answer the aims and objectives of the research.

Semi-structured interviews provide the opportunity for in-depth understanding of the participant's point of view which enabled deeper exploration (Gillham, 2000). It has been



asserted that semi-structured interviews are a valuable source of data collection in case study research as this method could provide rich data (Gillham, 2000). A semi-structured interview format could meet the aims and objectives of this study through the use of an interview schedule that was used as a guide (Bryman, 2008). It has been asserted that a more informal manner engaged participants, generated personal narratives and encouraged opinions to be expressed (Foley and Valenzuela, 2005).

Unstructured interviews can be informal conversations that may be on-going over a period of time or in-depth unstructured interviews which seek to gain detailed insight into the person's experiences (Hansen, 2006). The interviewer is not bound by questions and the interview can become a discussion during either of these types of interview. However, both semi-structured and unstructured interviews take time to conduct and to transcribe (Thomas, 2011) which can be costly.

For the purpose of this study, a semi-structured interview has been selected as the most appropriate method for data collection. This is because as an exploratory study, participants needed the opportunity to talk about their views and experiences. As this study was thought to be the first of its kind, pre-set questions could limit the knowledge that can be learned about the research topic. There is also a lack of research evidence and understanding about the research subject to inform a structured interview schedule. However, to be able to address the research aims and objectives, a guide was needed for the researcher to conduct the interview. For this reason, unstructured interviews were rejected as a method for data collection in this study.

## **Interview process**

Before each interview, the participant was asked to complete a consent form which is available in Appendix 8. The ethical issues pertaining to informed consent and other aspects of the interviews are discussed in the ethics section at the end of this chapter. It is asserted within the academic research literature that when conducting semi-structured interviews, the questions should be open-ended (Gillham, 2000; Travers, 2001) and only used by the researcher as a guide to cover the most relevant topics (Thomas, 2011) to fulfil the aims and objectives of the study. These principles were applied in this study and interview schedules were designed based on the aims and objectives of the study (Appendix 9). The following table (Table 4.5(c)) presents the topics covered in the interview schedule for each participant group and a justification for this. The participant

groups to be interviewed were, occupational therapists, social entrepreneurs and service users.

**Table 4.5(c): Interview schedule topics**

<b>Participant group</b> (in every case study where possible)	<b>Topics in interview schedule</b>	<b>Justification</b>
Social entrepreneur	Structure, governance and legal form of the social enterprise; funding; contractual requirements; occupational therapy provision (their involvement in the set up and delivery; determining factors on the occupational therapy service; effectiveness).	Addresses Aims 2 and 4 by exploring their perspective on the reasons for occupational therapy practice through social enterprise and their views on what may determine the service provided.
Occupational therapist	The occupational therapy service; limitations or restrictions on their interventions; approach with service users; determination of interventions provided; ability for client centeredness; comparisons with previous roles in other employment; involvement in the organisation; their motivation to work in a social enterprise.	Addresses Aims 1, 2 and 4 by exploring the occupational therapists perspective of the service they provide and what they think are the determining factors in their practice.
Service user	Why they attend; challenges and benefits for them; what they hope to achieve by attending; how it differs to other services; involvement in the organisation.	Addresses Aim 3 by exploring the service users' experiences of the occupational therapy provision through the social enterprise.

It was deemed important that the participant had the opportunity to comment on the interpretation of the responses given in the interview (Travers, 2001) in order to gain a depth of understanding about the phenomenon being studied. This was done through an active reflective process in the interview, where the researcher commented on her interpretation of the participant's comments back to the participant and sought clarification.

Interviews were carried out with occupational therapists, the social entrepreneur and service users in each case study wherever that was possible. Interview schedules were developed as a result of information gathered through the scoping study for each of these three categories and are found in Appendix 9. The service users were given the opportunity to volunteer to participate in the research by the occupational therapist in the social enterprise prior to the researcher's visit. The service users were also asked if they wanted to participate by the researcher on the day of the data collection visit. The number of service users interviewed in each case study varied depending on the number of participants who were willing to participate at each social enterprise.

Whilst collecting data at one of the case studies (Case study two), the occupational therapist (also the director of the social enterprise) decided it was not appropriate to conduct semi-structured interviews with the service users as they had dementia and would not be able to maintain concentration for a formal interview. The occupational therapist and researcher decided that informal conversational interviews were more appropriate with this participant group and notes were taken of their responses. The importance of involvement of people with dementia in research has been argued by Hellstrom et al., (2007) if it is done in a dignified, ethical manner, always finishing the interaction positively. The ethical issues relevant to this participant group are discussed further in the ethics section, later in this chapter.

The majority of interviews were conducted with one participant at a time, however when visiting two of the case studies, it was deemed appropriate to conduct the interviews in pairs. In both cases, the participants were in the same stakeholder group and the participants were observed to be comfortable and open in the interview, without power dynamics such as one dominating the conversation. In both cases, it is possible that the presence of another person in the interview may have influenced the responses they gave. Taylor and De Vocht (2011) state quite deterministically that the presence of a spouse or partner will influence the participant's contributions to the interview. However, it is not possible to know this unless interviews were carried out individually as well as in

couples and compared, which is not the aim of this study. Joint interviews can have beneficial and detrimental effects. It can be argued that participants may feel more comfortable to talk when interviewed individually but considering that in this particular circumstance, taking the participants mental health needs into consideration, conducting the interview jointly was considered best for the participants and provided the opportunity for the participants to contribute to the study. Conducting joint interviews may change the dynamics of the interview and topics can become discussion points and provide opportunity for new knowledge to be generated between the participants during the interview. Eisikovites and Koren's (2010) research into couplehood in old age found that even though individual interviews provided the best quality data, joint interviews can be effective with couples where both are affected by the topic being researched. This was the situation in Case study 6 where couples were beneficiaries of the social enterprise (as tenants) but only one was receiving occupational therapy intervention. However, the occupational therapist in this case was working with the spouse as a carer therefore it was appropriate to include them in the interview.

After conducting one interview, the researcher discovered that the interview had not recorded onto the voice recorder. As a result, the researcher contacted the occupational therapist at the social enterprise and sought permission from the relevant participant to repeat the interview over the phone. The participant did consent to a telephone interview and this was conducted with the phone on loudspeaker and the voice recorder recording the interview. After that, the original interview was found and all the data gathered from this participant was included in the analysis.

### **Recording interviews**

A digital recorder was used to record the interviews wherever participants consented to this. The digital recorder was placed near the participant but to the side so that it did not distract them. After the data was collected, the interviews were transcribed (using computer software that recognised speech) as taking notes during an interview does not provide sufficient amounts of detail or qualitative data collection and analysis (Bailey, 2008). The researcher repeated the exact wording captured in the interview using the transcription software. The approach taken in the transcription process was to capture the precise words during the interview but not to document the detail required for conversation analysis (Bailey, 2008; Green and Thorogood, 2009). This is because in this study, the researcher listened to the original audio recording of the interview whilst conducting the analysis to ensure that the meaning of the quotes captured during the interview were

consistent with the original data. Once the interview had been transcribed, the transcribed interview document was then checked twice for errors, whilst listening to the original audio version of the interview. The participant was offered the opportunity to have a copy of their transcript to read through and make comments. Four asked for a copy of their transcript and five asked for a copy of the audio file of the interview. All were provided but none replied with any comments. One participant asked for a copy of any quotes that will be published in the final thesis which were provided to her. No further comments were made on this.

The researcher and participant were identified by a new line beginning when each spoke. The timing of the interview was recorded on the transcript at one minute intervals to enable the researcher to easily locate the original audio recording during analysis. During transcription of the joint interviews, a method was undertaken to distinguish between the service user and carer (in the case where there were married couples in the interview) and between service users (in the case with two friends). The transcripts were labelled with “service user”; “service user A”; “service user B”; or “carer” for every section of the transcript that they contributed to.

### **Pilot of the interview**

A pilot interview was carried out with an occupational therapist who previously worked in a social enterprise. This social enterprise was chosen to be a pilot as the occupational therapist did not work for the social enterprise any longer and had not been replaced by another occupational therapist. Therefore, this case could not be included in the final study as further data collection such as with other participants or documentation could not be collected. However, the occupational therapists previous experiences was relevant for piloting the interview schedule (Appendix 6). A review of the organisational documents and interviews with others (service users and social entrepreneur) was not carried out as it was not appropriate in this situation. It was not possible to conduct a more in-depth pilot case study because all the cases identified needed to be included in the actual study due to the small number of social enterprises in total.

During the pilot interview, the occupational therapist spoke freely covering many of the topics that had been prepared on the interview schedule without the researcher needing to make reference to it. This confirmed the relevance of the topics that the researcher had prepared to discuss. The pilot interview also confirmed that a semi-structured interview was the most appropriate tool for data collection as rich information was gained by

enabling the participant to have the freedom to talk openly about their experiences. The pilot interview also led to the conclusion that it was not necessary to ask the occupational therapist to complete a questionnaire in advance as pertinent information was covered through the interview and did not need to be repeated. Conducting the pilot was also beneficial for the researcher to develop her interview technique. This involved practicing active listening to the participant's views whilst also ensuring that all the relevant topics relating to the research question were covered. This was in addition to the use of silence, prompts and probes to encourage the participant to express themselves (Ryan et al., 2009).

### **Interviews conducted**

A total of 26 interviews were conducted, eight of which were with occupational therapists, seven with social entrepreneurs/social enterprise managers and eleven with service users. The average length of interview was 38 minutes and 15 seconds. The specific length of each interview is detailed in each of the case study descriptions in Chapter 5. A breakdown of interviews conducted with each participant group at each case study is listed below:

**Table 4.5(d): Participants interviewed**

<b>Case study number</b>	<b>Participant group</b>	<b>Number of participants</b>	<b>Total</b>
1	Occupational therapist Social entrepreneur Service users	1 1 0	2
2	Occupational therapist/social entrepreneur	1	1
3	Occupational therapist Social enterprise manager Service users	1 1 6 (one joint interview)	8
4	Occupational therapist Social entrepreneur Service user	1 1 1	3
5	Occupational therapist Social entrepreneur Service users	1 1 2	4
6	Occupational therapist Social enterprise manager Service users	1 1 4 (2 joint interviews)	4
7	Occupational therapist Social entrepreneur Service users	1 1 3	5
8	Occupational therapist Social entrepreneur Service users	1 0 0	1
Total			26

## **Other data collection methods**

**Data from written or formal documentation and media:** Data was used from written and formal documents from the social enterprises such as annual reports, business plans, articles of association and the organisational website. A full list of documents requested from the social enterprises is listed in Appendix 11. Document review involves reading and analysing the text (Thomas, 2011) and in this study, documents were reviewed and analysed using the framework of findings from the interviews to triangulate data from other sources. Within this study, data from formal or written documents can be beneficial in understanding whether the structure, governance, funding and mission of the organisation influences the occupational therapy provided. The advantage of examining documents is that documents provide a context for other data collected (Hansen, 2006) and it is an unobtrusive form of data collection. Other media was also used to gather data about the social enterprise, such as documentaries by independent television companies and videos made by the social enterprise. Case study 1 and 5 had documentaries that had been made and broadcast on national television during the course of the research. Case studies 3, 4, 5, 6, 7 and 8 all made promotional videos about their work which were available in the public domain. The data from the documents and media was triangulated with the data gathered through conducting interviews with various participants from the social enterprise. Additional secondary data was used where it was available such as outcome measures collected by the social enterprise. In addition, in case study 2, the social entrepreneur/occupational therapist had conducted a carer satisfaction survey which was also included as secondary data.

Yin (2003) states that the most important use of documents is to corroborate and augment evidence from other sources. However, data contained within documents may be out of date as documents are bound within the time they were written. There may be a delay between the time the document was written and the time the interviews took place. Documents may also be written for a particular audience and may omit or emphasise what is relevant for that audience. Therefore, it is possible that data obtained from documents may not support data obtained from other sources.

Data was selected for use in this study by requesting formal documents about the social enterprise organisation from the CEO such as; the business plan, governance procedures and contractual obligations in relation to occupational therapy provision. Other written documentation about the social enterprise such as information in their websites and promotional material was also included in analysis. Not all of the 8 case studies were able



to provide the formal documentation requested. In these cases, information available in the public domain was used instead.

**Unstructured observation, field notes and reflexivity:** Field notes (Bryman, 2001) were kept of all contact with social enterprises before, during and after field visits. These field notes were recorded in an academic journal and consisted of unstructured observation and reflexivity. Unstructured observations are a method of data gathering which allows for observations to be taken on an ad hoc basis, without previously defined categories (Turnock and Gibson, 2000) to generate qualitative data (Kingsley, 2000). Unstructured observations are conducted when “observers using unstructured methods usually enter ‘the field’ with no predetermined notions as to the discrete behaviours that they might observe” (Mulhall, 2002 p307). During field visits, unstructured observations were taken and recorded in the field notes. This form of data collection was chosen as a more appropriate method than structured observation because of the exploratory nature of this study and the variation of each of the social enterprises. Therefore, the pragmatic paradigm within which this study was conducted, influenced the choice of the unstructured observation method (Mulhall, 2002). It would not have been possible to create a structured observation data collection tool that would be applicable in each of the case study settings. In addition, there are limitations of structured observation and time constraints which were not practical for this study (Kingsley, 2000). The unstructured observations were included in the reflexive account of each of the case study visits and excerpts are presented in the findings.

Within the pragmatic paradigm of this study, reflexivity of the data collection methods, observations and insights gained from the field visits were recorded according to what would be beneficial to the study and enable transparency and trustworthiness of the research process (Finlay, 2002). Various reflexive approaches can be adopted in research based on different theoretical foundations (Harris, 2001; Finlay, 2002; Doyle, 2012) however a specific theoretical position on reflexivity was not adopted within this study. This is because, from a pragmatic position, there are valuable insights that can be gained from moving between different theoretical positions to view the data. For example, from a phenomenological position the focus would include what the researcher brings to the research; a social constructionist position would reflect on the dynamics between the researcher and the participant and a psychodynamic approach would incorporate introspection and the emotional world of the participant (Finlay, 2002). All of these perspectives offer valuable insights into this research and were drawn upon within the findings chapters and to form a reflective chapter (Chapter 9).

## **4.6 Analysis**

There are various different approaches to analysis depending on the epistemological or theoretical positioning of the researcher (Braun and Clarke, 2006). The methods of data analysis in this study needed to be practical, useful and enable the researcher to address the research questions within the time and cost limitations of the study. Different approaches to data analysis were required in this study as both quantitative and qualitative data collection methods were used. This section addresses the analytical methods used and the analytical process that was conducted. The quantitative analysis was largely descriptive and so was not presented in as much depth as the section on qualitative analysis.

### **Quantitative data analysis**

The quantitative data from the online survey were analysed initially within the Bristol online survey report which indicated percentages of responses for each closed question. Following this, the data was entered into a statistical package for social sciences (SPSS) spread sheet. SPSS is a statistical programme that can be used to analyse quantitative data (Field, 2005) and has been used effectively in mixed methods studies (Sims, 2011). SPSS has been used as a tool for analysis in social science research (Portillo, 2009; Norton, 2011; Yong 2012) and is used alongside other methods of analysis (Mullen, 2010; Rani, 2012). The quantitative data in this study was not of a sufficient sample size to carry out more complex statistical data analysis, therefore the findings were analysed descriptively. Descriptive statistics were used to present, describe and summarise the data that was generated through the questionnaire. The quantitative closed questions generated nominal data within set categories (Rogerson, 2005). Univariate, bivariate and multivariate analysis was also conducted with the data to present the findings with one, two or multiple variables respectively (Field, 2005). The descriptive statistics were represented using frequency bar charts or pie charts (Appendix 8).

### **Qualitative data analysis**

In order to address the aims and objectives of this study, the analytical process needed to explore the participant's experiences, thoughts and opinions about occupational therapy provision within social enterprises alongside formal and informal written documentation about the social enterprise. The data collection methods used in this study were chosen to generate information that could then be analysed to address the research questions. As

the research questions predominately required qualitative data, qualitative data analysis was selected as the most appropriate overall approach.

It is asserted that qualitative data analysis should provide a rich, 'thick' description of the subject studied, linking to theory and providing a credible account (Green and Thorogood, 2009). Qualitative data analysis involves the researcher becoming immersed in the data to understand and interpret the thoughts, feelings, opinions and experiences (Hutter and Hennink, 2011) of the research participants. To inform this process, an analytic cycle is proposed by Hutter and Hennink, (2011) involving: developing codes; description and comparison; categorisation and conceptualisation; and developing theory. This analytical cycle is beneficial for summarising the process of qualitative analysis. However, Braun and Clarke (2006) provide a useful, more detailed account of the analytic process using thematic analysis. The open-ended questionnaire questions, semi-structured interview, informal conversational interview and documents have been analysed using thematic analysis.

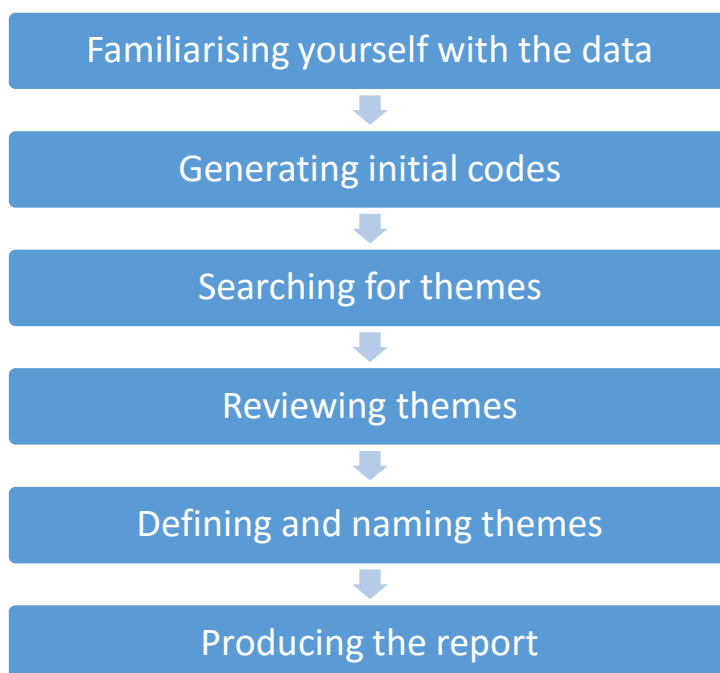
### **Thematic analysis**

Thematic analysis is a "method for identifying, analysing, and reporting patterns (themes) within data" (Braun and Clarke, 2006 p6). Thematic analysis is not theoretically bound such as narrative analysis or interpretive phenomenological analysis (Braun and Clarke, 2006). Therefore, thematic analysis can be used within a pragmatic paradigm as such it is appropriate for this study (as this study is inductive and not theoretically driven). Thematic analysis allowed the researcher to be guided by the data (Hansen, 2006) rather than having pre-set themes or expectations of what will be contained within the data. Therefore this is appropriate for this exploratory, inductive study in addressing the aims, objectives and research questions.

### **Process of analysis**

There are six stages of thematic analysis that have been developed by Braun and Clarke (2006) which were used in this study. These are shown in the following diagram (Figure 4.6):

**Figure 4.6: Six Phases of Thematic Analysis**



Adapted from Braun and Clarke (2006)

### **The analytical process of the case study data**

The majority of the data was generated from interviews and thematic analysis as described above was conducted. The findings from the analysis of the interviews formed a framework from which the other data such as documents and media were analysed.

Each interview transcript was read one at a time to become familiar with the data. Then read again and as an initial code became apparent, it was recorded in the margin of the transcript. The transcripts were checked against the initial interview recording for accuracy. The researcher read the transcripts seeking latent patterns and meaning in the data (Braun and Clarke, 2006). After the identification of the initial patterns in the transcripts, the researcher read through the transcripts again, taking notes from each transcript which were reported in a table for each case study with separate columns for each of the three categories of participants (occupational therapist; social entrepreneur and service user). The content of the table that was generated were cross referenced so that each of the initial notes could be traced to the original piece of data in each transcript. These notes or codes were either brief extracts from the interviews or in some instances first level interpretation. Where interpretation occurred the interpreted notes are highlighted in italics to ensure transparency. The interpretations were directly cross

referenced with the original data in the interview transcripts according to line number. These columns were then colour coded (according to case study) and printed. The printed out initial codes were then organised into themes by hand.

A second table was generated to capture the descriptive, semantic and factual data (whilst shifting paradigm to conceptualise the data from the perspective of a single reality). This included the business and financial structure of the organisation, income streams, governance and background from field notes. Data was not duplicated in these two tables therefore both tables were analysed concurrently.

Following this, a third table was then generated to analyse the data gathered according to participant group (Appendix 12). For example one table for all the occupational therapists data, with columns representing each of the different social enterprises, using the same colour coding. These columns were then printed and were then manually organised into themes.

The researcher took an active role in conducting the analysis by making decisions about what is considered of interest, relevant to the research questions and in synthesising and interpreting data (Braun and Clarke, 2006). To ensure that the codes were interpreted accurately according to the meaning in the interview, the researcher regularly checked the original transcripts. Themes were created by the researcher reading through each code and laying them out on a table. When a code was similar to another code on a topic, these were then piled together which created a theme. The themes were then reviewed and refined (Braun and Clarke, 2006). Notes were taken through these processes which were used in writing the findings and discussion chapter. These notes included themes that overlapped or related to one another. To ensure that the analytical process had been completed thoroughly and rigorously, Braun and Clarke's (2006, p36) 15 point checklist was also used (reproduced with permission, Appendix 13).

When the thematic analysis of the interview data had been completed a structure was then created to then compare the findings from the other data sources such as observations and formal documents.

### **Critique of thematic analysis**

Thematic analysis has been used in a range of research studies and is also an effective analytical approach when analysing documents (Humpage, 2011). A useful benefit of a

thematic approach to data analysis is that it is flexible according to each research project and can be used within various epistemological and theoretical frameworks. It was also a pragmatic decision to use thematic analysis as it is argued that it is the first method for qualitative analysis that novice researchers should learn (Braun and Clarke, 2006 p4) and therefore appropriate as the researcher is inexperienced in data analysis.

Thematic analysis has been criticised for lacking any clear guidelines, researcher subjectivity and lacking rigour (Antaki et al., 2002) but this has been challenged by Braun and Clarke's six phase guide for conducting thematic analysis and fifteen point checklist for methodologically sound analysis (Braun and Clarke, 2006). Therefore this evidence based guide and checklist was used to conduct this study. In addition, these criticisms can be overcome by researcher transparency in the analytical process via a reflexive stance to demonstrate that analysis was conducted rigorously (an example of the analytic process is shown in Appendix 11, 12, 14 and 15). Reflexive analysis was used (Gough and Finlay, 2003) to document reflections on the thematic analysis process of this research study and included in the final chapter.

### **Challenges with thematic analysis**

Whilst conducting thematic analysis, challenges were experienced such as the initial generation of large numbers of codes. These codes needed to be sorted into themes and were done so by hand which took a significant amount of time and it is acknowledged that this was a subjective process. However, attempts to maintain the quality of the findings to use subjectivity as a tool were made by ensuring the process was transparent and by reflecting upon it (Braun and Clarke, 2013; Newton et al., 2012). A large number of themes were identified and so the refining of the themes was repeated and then collapsed into categories. Some of the initial codes identified on a case by case basis did not form themes (due to lack of frequency, only appearing once) yet they were potentially important topics that were raised in the interviews. When the thematic analysis was repeated according to participant groups, the codes that were previously not included did form themes according to each participant grouping. This allowed a stronger participant voice to be heard through the thematic analysis. The large number of themes that were developed resulted in complexity in simplifying the findings to draw conclusions and further refining was required of the themes identified.

The themes presented in the findings chapters are not of equal length as the depth of each theme depended on the data provided by the participants. The content of some of

these themes are not directly reflective of the interview schedules (Appendix 9). This is because of the semi-structured data collection method that was used which provided opportunity for the participants to respond to questions to a greater or lesser extent and elaborate if they wanted to do so.

### **Presentation of the themes**

Within the description of the themes, a code was inserted which references which participant commented on issues relating to that theme and the line number of the transcript. For example (P14L248) refers to a comment by participant number 14 and can be identified in line number 248 of the transcript. Within some of the quotes used to evidence the themes, explanatory comments have been inserted in brackets to enable the meaning of the quote to be understood to the reader. Names and locations have also been removed from the quotes to uphold anonymity and confidentiality as discussed in regard to conducting ethical research in this chapter. Within the body of text in the findings chapters, the participant was referred to in regards to the stakeholder group they belonged to.

## **4.7 Ethics**

This section introduces the ethical issues relating to this study and discusses the ethical guidelines and procedures that were relevant in this study. The key ethical considerations of informed consent, confidentiality, privacy, anonymity and protection from harm are presented in relation to this study.

### **Ethical guidelines and approvals**

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). Within both HCPC and COT standards, it is essential that the researcher upheld professional conduct, confidentiality, integrity and honesty. Overall these standards can be summarised as relating to beneficence and non-maleficance; to do good and to do no harm (HCPC, 2012; COT, 2010). These principles are central to this research as it is the motivation of the researcher to conduct this research for the development of the occupational therapy profession, to improve service provision for the benefit those who require occupational therapy. In addition, it is a

requirement of the COT Code of Ethics that research is disseminated to be able to benefit the profession, and to be put into practice to benefit service users. This was carried out through submission of articles to the British Journal of Occupational Therapy and the Social Enterprise Journal following completion of the thesis. Each of the participating social enterprises were also given copies of any published articles disseminating this research.

This research was approved by the University of Northampton Research Ethics Committee (REC) and the researcher also operated within the University of Northampton's Code of Practice for Research Ethics. The researcher explored whether NHS ethical approval was required for this study. As health and social care provision through the vehicle of social enterprises is a new phenomenon, the NHS ethical procedures governing this were updated during the timescale of this research. The new Department of Health ethical guidelines (DH, 2011) did not require NHS ethical approval for research in social enterprises unless the service users were funded by the NHS. In two of the social enterprises identified, some of the service users were funded by the NHS but they were not involved in the research. The online questionnaire structure, design and questions were reviewed by the University of Northampton Research Ethics Committee (REC) and accepted (a copy of the questionnaire can be seen in Appendix 4).

The researcher acknowledges that she is involved in the research process as a researcher and as an occupational therapist and does not make claims of objectivity or the exclusion of researcher bias. Instead the values and motivations of the researcher are made explicit through transparency and reflexivity throughout the research process. The researcher recorded her involvement in a reflective journal and excerpts of this are included in the findings and in Chapter 10.

### **Informed consent in this study**

Informed consent based on volunteerism is essential in conducting ethical research (Green and Thorogood, 2009) and it is necessary that participants fully understood what was involved (Hansen, 2006), which was included in the participant information sheet. In the first phase of the study, verbal consent was given when gathering initial information about social enterprises. Three occupational therapists spoken to willingly gave information at that stage but declined further involvement in the case study. Participant consent to complete the questionnaire was given once the participant had read the information page at the beginning of the questionnaire. If the participant consented, they



then clicked on the link to begin the online questionnaire. This method for obtaining consent upholds confidentiality and anonymity as the participant did not need to identify themselves and avoids the use of consent forms. A copy of the consent page that was at the beginning of the survey is in Appendix 7. The method used in this study of not asking for participant information overcame the ethical issues identified by Brownlow and O'Dell (2002) of the risk of confidentiality and privacy being compromised.

The participants who were willing to participate in the study, were given a participant information sheet (PIS) in advance of the interview (Appendix 10). It is asserted that the PIS should be a detailed but not technical account of the aims of the research (Silverman, 2006). The PIS detailed the following:

- Description of the study;
- What happened to the participants' private information;
- Confidentiality and anonymity;
- Voluntary participation without any coercion;
- They could withdraw at any time;
- The researcher's contact details and what to do if they want to make a complaint.

(Thomas, 2011 p69-70)

Guidance was taken from the academic research literature that the PIS should be a detailed but not technical account of the aims of the research (Silverman, 2006). The PIS was given to the participant in advance of signing the consent form to ensure they had adequate time to read it and ask any questions. The occupational therapist in each of the case studies ensured that all participating service users had adequate support to understand the PIS and ask questions. Contacts details of the director of studies were also provided on the PIS, if the participant had any questions or concerns that needed to be communicated to a different person than the researcher. The participants were given a consent form for them to sign if they wanted to take part in the study on the day of the field visit for data collection. The consent form was signed by both the participant and the researcher and both kept a copy. It was also made clear that it was the right of any

individual to refuse to consent to participating in the research without any repercussions (COT, 2010) and the researcher abided by this.

### **Confidentiality and anonymity**

Confidentiality refers to protecting the privacy of the participants' information and identity throughout the study (Hennink, et al., 2011). This involved the researcher not disclosing any confidential information verbally or in published documents (Green and Thorogood, 2009; Hennink, et al., 2011). Anonymity refers to any identifiable information being removed from the data (Hennink, et al., 2011). Only the researcher had access to the online questionnaire responses and all responses were entirely anonymous therefore coding was not necessary to protect participants' details in the online questionnaire. Only the researcher had access to participants' details that were held in a separate online questionnaire if the participant wanted to leave contact details at the end of the questionnaire as an invitation to participate in future research. This included the name of the organisation they work for and contact details. Both web pages were held on Bristol Online Surveys and were password protected. Only the researcher held the password and had access to the data. Prompts and reminders were sent twice to participants to encourage participation, however this was not coercive or intrusive (Salant and Dillman, 1994).

In the case study, due to the research design, the participant's anonymity cannot be held from the researcher. However, participant and organisations anonymity was protected by both of these being anonymised at the point of data collection. Each participant was given a reference number on the consent form and they were anonymised from that stage in the research onwards, including data analysis and in all written accounts of the study. In the written piece, participants were only referred to for example, an occupational therapist working in a particular field of occupational therapy (e.g. "in community mental health" but not revealing the location, employer etc.) or as a social enterprise manager or service user. The names of the organisations used as case studies were not revealed to protect the anonymity of the participants and all identifiable information was removed from the transcript of all interviews. Participants' names were replaced with pseudonyms in the findings.

All data gathered through the process of this research project was subject to the Data Protection Act (Great Britain Parliament, 1998) and was treated confidentially. The data was kept by the researcher for analysis and retained on file in a locked filing cabinet at the

University of Northampton for five years after the study. All data stored on the computer was kept secure by the use of password protected files and was stored for five years after the end of the study. The purpose of keeping all data is to cater for any issues arising from the final thesis or subsequent publications.

There are exceptions to maintaining confidentiality as outlined in the College of Occupational Therapists Code of Ethics (COT, 2010), and the Health and Care Professions Council (HCPC) Standards of Conduct, Performance and Ethics (HCPC, 2012). These exceptions were if the researcher witnessed any criminal, illegal or abusive behaviour which the researcher had a duty to report. This did not occur in this study.

### **Protection from harm**

Ethical concerns were central to the questionnaire design in ensuring that it was quick and easy to complete, as well as being purposeful and meaningful to the participant. Service user involvement in the research was dependent on the context of each of the social enterprises. In one case the occupational therapist in a social enterprise decided that some vulnerable participants with dementia would not be included in the study. In another case, the social entrepreneur decided not to include children who have been assessed as not being able to participate in the study (due to ill health) at the time of data collection. Such decisions were based on a clinical assessment about the service users' ability to engage in an interview depending on their health at the time of data collection. The occupational therapist in one social enterprise identified that a formal interview with service users with dementia would not be appropriate due to the severity of their condition. However, the occupational therapist gave permission for informal conversational interviews without recording them. The inclusion of older people with dementia has been identified as an important contribution in research, when conducted in sensitive, ethical manner (Hellstrom et al., 2007) and to ensure their voice is heard.

The two cases discussed above raise issues of gatekeeping in relation to access to potential research participants. It can be argued that, in the situation where the social entrepreneur withheld access to children to engage in the research, she denied their right to have their voices heard. However, considering that in this specific case these children were particularly vulnerable (traumatised and abused in most cases), it can also be argued that it was inappropriate to engage them in this research.

In a number of the social enterprises, the service users chose to be interviewed within the normal context of the activity that they engaged in at the social enterprise (such as talking while gardening or while on the side of the sports pitch) rather than in the traditional interview setting of a quiet room with two chairs). Accommodating to the service users' preference for the interview location was essential for each individual to feel comfortable and relaxed. Enforcing a clinical or formal setting (such as a traditional interview room) may not have been comfortable for some participants and could inhibit them from feeling able to talk freely in their natural environment. This would also contravene the Code of Ethics (2010) on the basis of respect for the individual. Adapting the context for data collection also readdressed the power imbalance between the researcher and the participants (Green and Thorogood, 2009). This had implications for the interviews as they were not all carried out in a quiet, private location.

Two interviews were conducted with couples and one interview was with two friends. The presence of another person in the interview can readdress the power imbalance between the researcher and the participant (Green and Thorogood, 2009), particularly with vulnerable participants with mental health problems. However, the presence of another person in the interview can also affect the content of what they share in the interview if they do not feel comfortable to express their views. In all the interviews conducted in this study, the researcher did not observe any dynamics that indicated that the presence of another influenced their participation. Service users involved in the research project were informed that any information they gave would not be passed onto anyone else within the social enterprise or outside the research team. There was a risk that service users may be inhibited to share any views that may be seen to be critical of the social enterprise they are involved in. The researcher reassured the service users of confidentiality however this remained a reality that was taken into consideration during analysis.

### **Practical ethical considerations**

The safety of the researcher was taken into account when arranging to conduct the data gathering (Barr and Welch, 2012). Visits to participants for data collection were held in public places and during work hours. The researcher travelled to the social enterprise to carry out interviews with all participants at that social enterprise on the same visit. The date of the visit was arranged in advance and agreed upon by all participants and the researcher as mutually convenient.

The researcher requested a copy of the organisations formal documents one week prior to the data collection visit (a full list is in Appendix 15). This provided time for copies of the relevant documents to be made in advance and given to the researcher on the day of the visit. The researcher requested for consent to have access to these documents and reaffirmed the principles of confidentiality and data protection.

## **4.8 Conclusion**

This chapter has presented and justified the philosophical foundations of the study, the research design and methodology used. The study was conducted through two phases of data collection, using an inductive pragmatic approach. A scoping exercise was completed to gain a baseline of information on the topic of occupational therapy provision in social enterprises. The findings from the scoping exercise then informed the decision to conduct case study methodology in Phase 2. Data was collected about the eight case studies using a range of data collections methods. The data was then analysed and the findings of this are presented in the next four findings chapters. Chapter 5 presents the findings from the scoping study and the eight case studies that were identified as a result of Phase 1. Chapters 6, 7, and 8 present and discuss the findings from Phase 2 and they are organised into three levels of analysis of the influences on occupational therapy provision within social enterprises in the UK:

- Socio-political and economic (Macro), such as government policy and funding;
- Organisational influences of the social enterprise (Meso), such as the working environment and restrictions and freedom for occupational therapy practice.
- Individual influences and experiences (Micro) of the occupational therapists, service users and the social entrepreneurs.

# **Chapter 5: The practice of occupational therapy within social enterprises in the UK**

## **Phase 1 findings and the case studies**

### **5.1 Introduction**

The previous chapter presented the research design for this study, which included two phases: the scoping study and the Case Studies. The methods used for data collection were presented and discussed in detail in the previous methodology chapter. This chapter presents the findings from scoping study, as well as presenting an overview of the case studies that were identified through the scoping study. These case studies are presented in this chapter descriptively as an overview, with the qualitative in-depth thematic analysis of the findings from the case studies forming the three findings chapters. This chapter addresses the first research question which is: What occupational therapy is practiced in social enterprises in the UK?

### **5.2 The scoping study - Findings**

The scoping study involved various methods to generate a sample of social enterprises that provided occupational therapy and to explore the issues relating to the occupational therapy practice within the social enterprises identified. This involved: desk-based research; online searches; field visits; and an online survey. As a result of the scoping study, twenty social enterprises were identified as providing occupational therapy in the UK and three additional social enterprises were being set-up but were not functioning at the time of the research. The findings from the various different data collection methods led to the development of five themes that represented the different issues surrounding occupational therapy provision through these organisations. These were:

1. The types of services offered by occupational therapists in social enterprises;
2. The implications for occupational therapy practice;

3. Funding for the social enterprises;
4. The structure and governance of social enterprises;
5. Social entrepreneurship and social enterprise management.

The findings from the scoping study for each of these themes are presented here and a further discussion of these findings, combined with Phase 2 is presented in the final discussion chapter (Chapter 9).

### **Types of services offered by occupational therapists in social enterprises**

The following table presents the types of social enterprises identified through the scoping study:

**Table 5.2(a): Types of social enterprises identified in the scoping study**

<b>Activity of the social enterprise</b>	<b>Category of beneficiaries of the social enterprise/OT</b>	<b>Number of social enterprises</b>
Primary healthcare (NHS spin-off)	Adults with physical disabilities	2
Primary mental healthcare (NHS spin-off)	Adults with mental health problems	1
Community mental healthcare (forestry/woodland conservation; sports; gardening; farming; daycentre)	Adults with mental health and complex social problems	6
Community assessment and provision of mobility aids and home adaptations	Children and adults with physical disabilities	3
Social housing	Tenants with physical disabilities	1
Independent living skills with the homeless	Combined physical, mental health and social problems	1
Community social support (vocational rehabilitation/employment; life skills)	Adults with physical and mental health problems	1
Health promotion	Children and youth	1
Therapeutic rehabilitation	Children	2
Legal assessments for accident compensation	Any individual affected by an accident	1
Training	Occupational therapists	1
<b>Total</b>		<b>20</b>

Six of the twenty social enterprises found through the desk based research methods addressed physical health and occupational issues. The occupational therapy role was very similar to that found in the NHS and Social Services, which focused on functional daily activities, the need for equipment and methods of adaptation to limitations in function. This demonstrates that social enterprise can be used as a model of service delivery that is consistent with the bio-medical and remedial approaches that have



become dominant in occupational therapy practice in the UK's statutory services. Six other social enterprises supported adults with mental health problems through the activity of the organisation, for example farming or gardening which suggests the compatibility between a social enterprise as a model of service delivery and occupational therapy interventions with people with mental health problems in a variety of business settings. One of the twenty social enterprises was different from the remainder as the organisation trained occupational therapists in the use of creative activity as the main purpose and did not directly provide occupational therapy to end users. This indicates the variety of different business models that can be developed through social enterprise to facilitate the development of the occupational therapy profession.

It was difficult to categorise some of the social enterprises as they were often unique and served different user groups. There were some overlaps between the organisations, for example those who worked with people with mental health problems but it was not possible to draw clear distinctions between the types of social enterprises. The challenge in distinguishing between the social enterprises may be because of the holistic approach of some of them used, for example, one which addressed homelessness in its entirety, rather than just one aspect of it such as housing, physical health needs or mental health. An interpretation of this could be that it is a positive development of health and social care provision that is not based upon medical distinctions. This is in contrast to traditional NHS service provision which are categorised by specific client or diagnostic groups such as paediatrics, elderly, neurology and psychiatry.

### **The implications for occupational therapy practice**

The scoping study has revealed that occupational therapists work for social enterprises in a variety of different settings. This ranges from health and social care service provision in a similar form as social services or the NHS to new, creative and diverse settings for practice such as in farming or in a sports club. The new and innovative ways of delivering occupational therapy provide an opportunity for creativity in how the profession is practised (Healey, 2011). It was interesting to discover that the social enterprises with an activity as its main purpose (gardening, farming etc) did not focus on health limitations but on what the organisation, and the individuals within it could achieve. This challenges the historical and traditional public sector services within which occupational therapy has been provided and the associated stigma for 'patients' and the power dynamics with health professionals under the medical model. The occupational therapists within these new

settings were interacting with the services users from a variety of different roles, such as 'coach', 'mentor' or 'employer'.

The social enterprises that employed occupational therapists working in a holistic way could be examples of practice that is congruent with the philosophy of the profession without medicalised boundaries or limitations. Such roles may be more rewarding and provide greater job satisfaction for occupational therapists as they have received training to work holistically. The occupational therapists described having more choice, autonomy and control over their practise alongside being trusted and believed in which suggests that social enterprise may be a conducive environment for occupational therapists to practice within.

Some of the occupational therapists that completed the online questionnaire described their practice as being occupation-focused, client-centred, holistic, creative and innovative. This indicates that social enterprise may provide conducive environments for occupational therapy and client centred practice. The reasons for the majority of occupational therapists being able to practise with greater freedom, creativity and in a client centred way could not be explored within a survey format and this raised further questions that were developed and used in the second phase of the study.

### **Funding the social enterprises**

The majority of the social enterprises were funded through the public sector, followed by private funding through trading and donations. The various funding sources are captured in the following table:

**Table 5.2(b): Funding sources of the social enterprises**

<b>Type of funding</b>	<b>Number of social enterprises</b>
Public funds	6
Private (through trading or donations)	8
Community owned	0
Mixed funding sources	6
<b>Total</b>	<b>20</b>

The high proportion of social enterprises that were funded by public bodies raises questions about the financial independence and sustainability of these organisations if government policy changes and the funding is removed. This also raises questions about the definition of social enterprise in relation to political use of the term 'social enterprise' to outsource public sector services. It has been argued that such organisations are not social enterprises but a new form of management of public services (Ridley-Duff and Bull, 2011). The findings from this scoping study also raises questions about whether social enterprises what operate within health and social care, such as providing occupational therapy, struggle to generate income through trading and therefore require subsidised funding from elsewhere.

Whilst the scoping study was being conducted, one of the social enterprises which was funded by public sources had its funding stopped due to cut and austerity measures as a result of the coalition government coming to power in 2010. This was despite the policy at the time to fund such social enterprises which raises questions about the inconsistency between policy and actual funding available.

### **The structure and governance of social enterprises**

Of the social enterprises identified through desk based research, each of them varied in their financial, organisational and business structure. These were categorised as the following:

**Table 5.2(c): Social Enterprise legal structures**

<b>Type of organisation/business structure</b>	<b>Number of social enterprises</b>
public sector <i>spin-offs</i>	4
companies limited by guarantee	10
industrial provident society	1
charity	3
co-operative	1
unknown	1

These were consistent with categorisation of social enterprises that are evidenced in the literature (Spear et al., 2009). In relation to governance structure, four of the social enterprises identified through desk based research included feedback from those who used the service and involved them in decision-making about the organisation. Eight of the occupational therapists who completed the online survey stated they were involved in the set-up of the organisation to some extent. However, two of the participants were actively involved in setting up the organisation and the remainder were either consulted or involved in less direct ways. Eleven of the participants of the online survey said they were involved in the management or governance of the social enterprise to a certain extent and ten said they were not. These findings suggest a mixed uptake of occupational therapists' involvement in social entrepreneurship, despite the policy reforms, promotion of healthcare, professional leadership and innovation in such organisations. The reasons for this were not explored further in this initial scoping study and so were developed in the subsequent case studies.

### **Social entrepreneurship and social enterprise management**

Three of the social enterprises identified through desk based research were led by the occupational therapist as the social entrepreneur and director of the organisation. One social enterprise was led by two clinical allied health professionals who were not occupational therapists and one was jointly run by an occupational therapist and a social worker. This indicates the various potential roles for occupational therapists as social

entrepreneurs or remaining as practitioners within social enterprises. Three of the social enterprises were set-up by an occupational therapist as the social entrepreneur which may provide opportunity for these organisations to be designed around an occupational therapy philosophy. However there may be challenges for them around having the skills and experience necessary to run a business as this was not part of their professional training or expertise. Alternatively, if a social enterprise has not been set up by an occupational therapist, there are issues about how occupational therapists market themselves to social enterprise managers to create employment within social enterprises.

### **Scoping study summary**

The scoping study provided a baseline of data about the provision of occupational therapy in social enterprises in the UK for the first time. A wide variety of types of service provision have been identified including innovative, occupation-based practice, alongside occupational therapy roles that were replications of statutory service roles in a new environment. Through contact with occupational therapists within public sector spin-offs, it was evident that their role had not changed from their previous experience within the NHS. However, the occupational therapists in the independent social enterprises who had developed new and innovative roles suggested a greater freedom and professional autonomy within the social enterprise to be able to practise in accordance with their philosophical beliefs. Therefore, to develop new knowledge into occupational therapy practice within social enterprise, public sector spin-offs were excluded from the second phase of the study.

The small sample size identified in the scoping study indicated the benefit of conducting a case study methodology in Phase 2 to gather more in-depth data about the occupational therapy provision and the organisational factors that affect the occupational therapy provision. The eight case studies that participated in Phase 2 were identified as a result of the scoping study and were selected using the criteria presented in the methodology chapter. An overview of these case studies are presented next as an outcome of phase 1.

### **5.3 The case study social enterprises**

This section of the findings presents the eight case studies descriptively, drawing upon a range of data sources. The data sources that were available vary between the case studies however this includes the following which were presented in the methodology chapter:

- Formal organisational documents
- Organisational websites
- Interviews
- Field notes
- Observations and reflections from the field visits

In each of the case studies, the source of the data is stated. This chapter presents the 'factual' data about each of the case studies. This is complemented the interpretation of the findings from the thematic analysis from the interviews in the different case studies which is presented in depth in the subsequent findings chapters alongside field notes of observations and reflections.

The total data collected from the case studies is represented in the following table (5.3):

**Table 5.3: Data collected from the case studies**

<b>Data collection method</b>		<b>CS 1</b>	<b>CS 2</b>	<b>CS 3</b>	<b>CS 4</b>	<b>CS 5</b>	<b>CS 6</b>	<b>CS 7</b>	<b>CS 8</b>
Interviews	Social entrepreneur	√	√	√	√	√	√	√	x
	Occupational therapist	√	√	√	√	√	√	√	√
	Service users	x	√	√	√	√	√	√	x
Documents / Media		√	√	√	√	√	√	√	√
Informal observation		√	√	√	√	√	√	√	x

## **Overview of the case studies**

The case studies range from: being in operation between 2 and 15 years at the time of data collection; had a range of annual turnover between £32,000 and £34 million and range from having two staff to 550. The different types of legal structures included in this study were: an Industrial Provident Society; a registered Charity; a Co-operative and Company's Limited by Guarantee. The number of occupational therapists employed by the social enterprises ranged from one to four with the exception of one who volunteered for the social enterprise. Six out of eight of the case studies provided a service for people who experienced mental health problems, one provided a health promotion service for youth and the remainder offered an occupational therapy service for people with physical disabilities. Each case study is presented individually in the remainder of this chapter.

**Table 5.4: Case Study 1 - A fostering and adoption agency**

<b>Mission/Mandate</b> (Data Source: organisational website; organisational documents)	This organisation offers a specialist assessment and treatment programme and an adoption service. The staff provide an Adoption and Post Placement/Post Adoption services to traumatised children and their families around the country as well as to professionals seeking advice, consultation and training. Treatment services are also available to Looked After Children in foster care as well as children living with their birth families.
<b>Social Aims</b> (Data Source: organisational website and	1) To provide post-placement, post-adoption and integrated, comprehensive, multi-disciplinary, assessment and treatment services, utilising research based, pioneering therapeutic approaches. 2) To recruit, prepare and approve prospective adoptive parents for the in-care population of older, traumatised children.
<b>Years in operation</b> (Data Source: Companies house website)	16 years (since 1998)
<b>Legal structure</b> (Data Source: Companies house website; interview with social entrepreneur)	Private Limited Company (not-for-private-profit)
<b>Governance structure</b> (Source: organisation's formal documents)	Three directors
<b>Product or services offered</b> (Data Source: Organisational website; formal documents; TV documentary and interviews)	Adoption and fostering support and therapy
<b>Annual turnover</b> (Data Source: Companies house website)	£1.5m in 2009
<b>Sources of income</b> (Data source: Interviews)	Contracts with Local Authorities nationally on a case by case basis Individual families who privately fund their therapy
<b>Size of staff</b> (Data source: organisational document)	23 staff, 8 consultants
<b>Occupational therapy role</b> (Data source: Interviews)	Work with children and families who are going through adoption or fostering using a sensory integration approach and functional life skill interventions. This enabled children to engage in their normal daily life.
<b>Number of occupational therapists</b> (Data source: organisational documents; Interviews)	1
<b>Term used for service users</b> (Data source: Interviews; TV documentary; organisational documentation)	Children and families
<b>Referral Pathway</b> (Data source: Interviews; organisational documentation)	Health authorities from across the country Private, self-referrals

The social entrepreneurs who set up and established this social enterprise were practitioners who had previously worked for a Local Authority looked after children's



department which had closed. These practitioners were motivated to fill the gap that had been created by developing their own service to replace it. As a result of their personal investment of re-mortgaging their own house, they established this organisation to address the unmet needs they were aware of.

The occupational therapy intervention in the social enterprise had been as a result of the social entrepreneur's adoption of a specific evidence-based model of practice developed by Hughes (2006) called dyadic developmental psychotherapy. This specific approach advocates a multidisciplinary approach including occupational therapy, which was adopted in this social enterprise.

### **Case Study 1: Data sources**

- The first case study was visited twice, the first time was during the initial scoping exercise of the first phase of the research. On the second visit, two interviews were conducted in this case study, with one of the social entrepreneurs (42 minutes 30 seconds) and the occupational therapist (79 minutes 26 seconds). Service users were not interviewed in the case study because the service users consisted of vulnerable children and families and it was decided by the social enterprise manager that it was not appropriate to include them in the study. This meant that the data gathered at this case study was limited to the perspective of the professionals interviewed and did not include the voice of the service user. Such gatekeeping issues are discussed in Chapter 9 under limitations of the study. The documentary evidence provided valuable insights from the perspective of the child and family involved.
- Formal organisational documents were used which included the financial accounts of the organisation; an annual report; the organisation's information brochure; statement of purpose; complaint guide; and the organisation's website.
- Observation of therapeutic sessions at this social enterprise was not possible because of the sensitive nature of client group. Informal observations of the social enterprise environment were made during both visits to the social enterprise and field notes were taken. A documentary film was made by an independent television company of one case study example of a child and family undergoing therapy at the social enterprise. Analysis were made of the documentary film in relation to the framework identified by the findings from the thematic analysis.

**Table 5.5: Case Study 2 - Dementia day service**

<b>Social Aims /Mission</b> (Data source: organisation's website)	This social enterprise aspires to provide a high quality, client-centred day service for its members; adults aged over 65 year old living with dementia. The aim is to encourage social inclusion and engagement in purposeful activities, promoting a sense of self-worth improving quality of life. Individuals are treated with dignity and respect in a safe, caring environment. They put their members at the centre of the service they provide, to ensure their voices are heard.
<b>Years in operation</b> (Data source: field notes, November 2011)	3 years, (since May 2011)
<b>Legal structure</b> (Data source: Companies House website)	Private Limited Company
<b>Governance structure</b> (Data source: Organisational business plan)	Two directors
<b>Product or services offered</b> (Data source: organisational website; interviews; observation)	Therapeutic day service for people with dementia
<b>Annual turnover</b> (Data source: Organisational document of Financial accounts)	£32,869 (2011-2012 financial year)
<b>Sources of income/funding</b> (Data source: Interviews; organisation's financial accounts; organisation business plan)	Privately funded individuals who pay £65 per day including transport Contract with Local Authority (for 2 placements) Donations Private start-up investment by the social entrepreneur
<b>Size of staff</b> (Data source: Field visit, February 2012)	5 (1 Occupational therapist, 4 support staff), 2 volunteers
<b>Occupational therapy role</b> (Data source: Interview)	To provide a therapeutic day service for people with dementia including reminiscence therapy; structured social interaction; orientation to time and place; promotion of physical health through exercise; maintenance and promotion of cognitive abilities through structured tasks.
<b>Number of occupational therapists</b> (Data source: field visit; observation; email communication)	2
<b>Term used for service users</b> (Data source: Observation; organisation website)	Members
<b>Referral pathway</b> (Data source: Interview and promotional leaflet)	Self-referral, local health authority and social services

The dementia day service was set up by an occupational therapist who also worked part time for the NHS as a dementia specialist. She had felt limited in her role in the NHS, being unable to fully practice as an occupational therapist which motivated her to establish her own service. This occupational therapist did not have any previous business experience but jointly set up the social enterprise with a business partner. She invested personal finance into the start-up of the organisation and demonstrated passion and commitment for the vision she had to provide an occupational therapy day service for people with dementia.

The occupational therapy training that the occupational therapist and social entrepreneur received, equipped her to address occupational issues in mental health and physical rehabilitation. Such training enabled her to meet a range of needs the members presented with which without the presence of an occupational therapist, would remain unaddressed. She was able to accept referrals for people who could not be taken into other day services because she was able to provide a combined holistic service which addressed people's deteriorating physical abilities as well as their social and cognitive occupational needs.

## **Case Study 2: Data sources**

Data were collected about this social enterprise through the following methods:

- An interview with the social entrepreneur who was also the occupational therapist (60 minutes, 50 seconds). A second occupational therapist was employed by the social enterprise but after data collection had finished.
- Four informal conversational interviews were conducted with service users during the field visit. This was because structured formal interviews were not appropriate with this participant group as they were elderly people with dementia. These conversational interviews were not timed but lasted a couple of minutes each due to short attention and concentration of participants.
- Formal organisational documents: the business plan; articles of association; and financial accounts.
- Organisational website and promotional leaflet.

- A carer satisfaction survey conducted by the social entrepreneur/occupational therapist.
- A one day field visit which involved informal observations which took place over five hours. Field notes were taken of the visit.

**Table 5.6: Case Study 3 - Occupational therapy in Woodland and forestry**

<b>Mission/Mandate</b> (Data Source: Organisational website)	The social enterprise operates in the community to provide a wide range of different services, from education and training to 14-19 year olds, adult education courses in the woodland, countryside and forestry management to the provision of “green space” at our other sites for those suffering from mental health issues.
<b>Social Aims</b> (Data Source: Organisational website)	Providing amenity, facilities and access to local people and organisations within a safe, accessible, supportive and informative site. Providing education, training and employment preparation advice to excluded school-children, young offenders and unemployed or otherwise disadvantaged young people. Developing and implementing structures which facilitate community control. Using local wood, materials and services.
<b>Years in operation</b> (Data Source: Companies House website)	12 (since 2002)
<b>Legal structure</b> (Data Source: Companies House website; Interview)	Company Limited by Guarantee
<b>Governance structure</b> (Data Source: Interview)	Board of Directors
<b>Product or services offered</b> (Data Source: Organisational website; interviews)	Woodland and forestry management Alternative education for youth Mental health support for adults
<b>Annual turnover</b> (Data Source: Companies House website)	£1 million
<b>Sources of income</b> (Data Source: Interviews; organisations website)	Contracts with Local Authority and local education department Private contract (woodland management) Sale of produce (cafe, wood items) Venue hire
<b>Size of staff</b> (Data Source: Interview)	29
<b>Occupational therapy role</b> (Data Source: Interview)	To enable adults with mental health problems to engage in therapeutic, graded, meaningful activities such as cooking, carpentry, art, woodland management, conservation to facilitate moving into a paid work role
<b>Number of occupational therapists</b> (Data Source: Interviews)	1
<b>Term used for service users</b> (Data Source: Interviews)	Volunteers
<b>Referral pathway</b> (Data source: Interviews; promotional leaflet)	Self-referral

The social enterprise manager in this case study was not a practitioner or from a health and social care background but had a depth of business knowledge and experience. She

came from a corporate business background which is likely to have influenced the organisations sustainability, as well as the financial and business models used.

The directors of the organisation recognised their need for mental health expertise to be able to deliver their social aims which led to the secondment of an occupational therapist from the local NHS Trust. Their decision to employ an occupational therapist was because they wanted a healthcare professional who had expertise in providing practical rehabilitation to enable people to return to work. This occupational therapist had worked in the NHS for over 20 years and was confident in her identity as an occupational therapist and in her ability to have an influence in the social enterprise. The social enterprise manager also recognised the need for an occupational therapist specifically for the social enterprise because of her desire for the people who use the service to transition through the social enterprise into employment and not to just to do activities without a longer term purpose.

### **Case Study 3: Data sources**

- Two field visits were conducted, both lasting for five hours each. The first was an initial informal visit during the first phase of the research and the second field visit was to conduct the semi-structured interviews with all the participants.
- Interviews were carried out with the social enterprise manager (46 minutes), the occupational therapist (73 minutes 58 seconds) and six service users ('volunteers') were interviewed (19m03s; 18m38s; 35m42s; 12m32s; and 9m39s). The social enterprise manager was interviewed instead of the social entrepreneur as the social entrepreneur had initially set up the organisation and then withdrew a number of years prior to this research.
- Formal documents were requested but none were provided.
- Organisational website and promotional leaflet.
- Informal observations and field notes were taken on both visits.

**Table 5.7: Case Study 4 - Health promotion with youth**

<b>Mission/Mandate</b> (Data source: organisational business plan; organisational website)	To inform, educate and motivate individuals and especially young people to take action regarding their own personal safety issues. To create aware communities that take responsibility for personal safety and wellbeing and that challenge homophobic, racist and exclusionary behaviour.
<b>Social Aims</b> (Data source: organisational business plan; organisational website)	<ul style="list-style-type: none"> <li>• Increase awareness and action among young people of health and related social issues so that they can achieve positive actions to improve their own personal safety</li> <li>• Enhance awareness of basic methods of reducing the likelihood of violent crime against the person</li> <li>• Help bring about more community ownership, responsibility and action in advancing personal safety, wellbeing and inclusiveness.</li> </ul>
<b>Years in operation</b> (Data source: Company's House website)	6 years (since 2008)
<b>Legal structure</b> (Data source: Company's House website)	Private Company Limited by Guarantee
<b>Governance structure</b> (Data source: Interview; organisational business plan)	Board of Directors
<b>Product or services offered</b> (Data source: interviews organisational website)	Health promotion workshops
<b>Annual turnover</b>	Unknown
<b>Sources of income/funding</b> (Data source: interviews)	Contracts with individual schools Grants Hosting fundraising events National funding bodies (Skills for Life/Skills for Health) European Funding
<b>Size of staff</b> (Data source: Interviews; observation)	2 paid staff and 1 volunteer. Sessional staff were also employed on contract basis
<b>Occupational therapy role</b>	Providing workshops to teenagers to schools and community centres to teenagers to promote healthy occupational behaviours on issues such as sex, drugs, cyber bullying, knife crime and gangs.
<b>Number of occupational therapists</b> (Data source: interviews; observation)	1
<b>Term used for service users</b> (Data source: interviews; organisational website)	Children / youth
<b>Referral pathway</b> (Data source: Interviews)	Schools, youth clubs

This was a small social enterprise that has been reliant on grants alongside winning contracts with local schools to deliver health promotion to children and teenagers. However, financial independence and sustainability was a challenge for this social enterprise. The social entrepreneur was a practitioner whose passion was to work with the children and youth that the social enterprise provided services to. The occupational therapist worked closely with the social entrepreneur developing the workshops however the social entrepreneur who managed the organisation and fundraising. The occupational therapist worked closely with the social entrepreneur from the outset of the organisation and both emphasised the importance and relevance of addressing complex social problems holistically.

The social entrepreneur and occupational therapist were motivated to provide a service to address issues that were not being addressed elsewhere. The gaps in services influenced the content of the sexual health promotion interventions they carried out.

The occupational therapist chose to approach her work in the social enterprise from a social model, promoting healthy occupations from an educational perspective and viewed this as an opportunity for occupational therapy.

#### **Case Study 4: Data sources**

- One field visit was conducted
- A semi-structured interview was carried out jointly with the social entrepreneur and the occupational therapist (103 minutes, 30 seconds) and one individual who had previously used the service but was currently a volunteer member of staff (6 minutes 5 seconds).
- Organisational documents: Articles of Association; Business plan.
- Organisational website, leaflet and brochure.
- Informal observations and field notes were taken during the two and a half hour field visit.



**Table 5.8: Case Study 5 - Therapy through sport**

<b>Social Aims Mission/Mandate</b> (Data source: Organisation's website)	A unique award winning sports charity that uses sport as a tool to aid the recovery of people living with challenges surrounding mental health, such as social integration; communication skills; confidence; social relationships; personal care; daily living skills and employment. It provides tailored support through a specific effective program that enables the member to achieve their full potential in every part of their lives. The program is specifically designed to enable individuals to make informed and appropriate choices about their future goals and enable them to enter and sustain employment, education and training, through a positive team environment.
<b>Years in operation</b> (Data source: Company's House website)	12 years (Since 2002)
<b>Legal structure</b> (Data source: Interview)	Previously a registered company but then changed to be a registered charity during the course of this research
<b>Governance structure</b> (Data source: Interview)	Board of directors whilst a registered company, replaced by a board of trustees
<b>Product or services offered</b> (Data source: Organisation's website; interviews)	Sports groups and occupational therapy service for adults who experience mental health, drug and alcohol issues or who are on probation.
<b>Annual turnover</b>	Not available
<b>Sources of income/funding</b> (Data source: Interviews)	Grants Hosting fundraising events Direct payments Membership from people who use the service Local Authority provision of sports field/office space Membership fees
<b>Size of staff</b> (Data source: Interviews)	3
<b>Occupational therapy role</b> (Data source: Interviews)	Client centred therapeutic group and 1:1 interventions to address occupational issues such as daily living skills (shopping, cooking, budgeting); social and communication skills in a variety of settings; return to work and employment skills.
<b>Number of occupational therapists</b> (Data source: Field notes; Interviews)	2
<b>Term used for service users</b> (Data source: Interviews; observation; organisational website; online videos and promotional DVD)	Players
<b>Referral pathway</b> (Data source: Interviews)	Self-referral; GP; Community mental health teams; Drug and alcohol services; probation services

The social entrepreneur was an occupational therapist and her background in professional football led to her developing the service combining both of her expertise. She sought funding from grants, donations and contracts with the local authority. The members of the sports teams paid a fee to join and cover basic costs such as a membership badge and sports equipment. The organisation was initially set up out of the NHS and funded by the NHS for 10 years alongside a private sponsor. The local council provided support by giving premises and sports field for the social enterprise to use without cost. At the time this research was conducted, the NHS and the private sponsor stopped funding this social enterprise and the social entrepreneur had to change the legal status of the organisation into a charity as a result. The reason for the funding being withdrawn was not clear to the social entrepreneur who thought this contradicted the government policy at the time to fund such social enterprises which deliver health and social care. She speculated that the reason was because the funding was directed to large providers as the local NHS mental health trust was given the contract for all mental health provision within the area.

### **Case Study 5: Data sources**

- Two field visits were conducted. The first was an informal information-gathering visit during the first phase of the study. The second was to conduct semi-structured interviews with the participants.
- Interviews were conducted with the social entrepreneur who was also an occupational therapist (59 minutes and 51 seconds); an occupational therapist (38 minutes 04 seconds) and two service users ('members' or 'players': 9minutes 13 seconds and; 14 minutes 33 seconds).
- Formal documents were requested but none were provided.
- Organisational website and online video clips.
- Informal observations and field notes were taken on both visits which lasted approximately four hours each.

**Table 5.9: Case Study 6 - Social Housing**

<b>Mission/Mandate</b> (Data sources: Organisational website)	A community housing company which is a social landlord set up specifically to let, manage and improve the homes previously owned by the local County Borough Council.
<b>Social aims</b> (Data sources: Organisational website)	To provide high quality, energy efficient, affordable homes, high quality communal areas and excellent services to tenants and leaseholders. To promote and support vibrant, safe, clean and healthy communities working in close partnership with residents and the council. To run an open and democratic organisation with high levels of community involvement. To use resources to maximize other benefits to the community, including creating and sustaining local jobs. To provide support for people who need it.
<b>Years in operation</b> (Data sources: Interview)	7 years (since 2007)
<b>Legal structure</b> (Data sources: Interview)	Industrial Provident Society
<b>Governance structure</b> (Data sources: Interview; organisational documents)	Board, membership, policy development forums
<b>Product or services offered</b> (Data sources: Organisational website; organisational documents)	Social housing
<b>Annual turnover</b> (Data sources: company's House website)	£34m
<b>Sources of income</b> (Data sources: Interview)	Rent from properties through housing benefit (£30m approximately) Public funds (£5m approximately) Cafe/restaurant for staff and tenants
<b>Size of staff</b> (Data sources: PA to CEO)	550
<b>Occupational therapy role</b> (Data sources: Interview)	The assessment of appropriate housing for people with a range of physical disabilities and the provision of assistive equipment, to enable essential daily activities to be carried out. Such as cooking, shopping, accessing local facilities, home maintenance, personal care and mobility.
<b>Number of occupational therapists</b> (Data sources: Interview)	4
<b>Term used for service users</b> (Data sources: Organisations promotional literature; online videos; interviews)	Tenants
<b>Referral pathway</b> (Data source: Interviews; organisational documents)	Self-referral to the organisation for social housing. Internal referral to an occupational therapist.

Case study six was distinctly different from all the other case studies for a number of reasons. The organisation was developed out of the Local Authority when the housing

department was converted into being a social enterprise. This resulted in a very large organisation from the outset of over 8,000 properties. As a result, the social enterprise had significant financial stability and did not have funding or financial challenges. Ridley-Duff and Bull (2011) question and challenge whether organisations such as case study six should actually be called social enterprises as an organisation such as this is reliant on the state for its income in the form of housing benefit. However this critique is usually on the basis that public funding is unreliable, whereas in this case study example, housing benefit was a reliable income stream.

Case study six was also the only social enterprise which had democratic governance incorporated into its legal structure as it was an Industrial Provident Society. As a result, it had the most developed governance structure which was inclusive of the tenant's voice. The social entrepreneur's perspective was that as the organisation was in such a strong financial position, it was able to make the most out of being as inclusive as possible. Tenants involvement in the organisation affected the overall running of the organisation and had a direct impact on the occupational therapy service offered. The tenants had significant involvement in increasing the provision of the occupational therapy service since the organisation was established. As a response to tenants needs for occupational therapy, the social enterprise increased the employment of occupational therapists from one to four.

The history of this social enterprise also meant that the occupational therapy role had been inherited from the previous traditional social service in the local authority. The role had not changed from the previous social services occupational therapy role but there was an opportunity for this to develop in the future. The occupational therapy service with the social enterprise was largely determined by the demand upon them which resulted in interventions focusing on a compensatory approach, giving disability aids and adaptations to enable independent living at home. The occupational therapist saw there was opportunity to develop the occupational therapy service in the future once the immediate demands for basic activities of daily living were met.

### **Case Study 6: Data sources**

- Two field visits were conducted totalling eight hours. The first visit was to interview the occupational therapist and tenants who used the social enterprise. The second visit was to interview the social enterprise manager.

- Semi-structured interviews with the social enterprise manager (27 minutes, 31 seconds), the lead occupational therapist (44 minutes and 36 seconds) and four service users ('tenants': two couples in joint interviews: 26 minutes and 23 seconds and; 18 minutes eleven seconds) were conducted. The service user interviews were conducted with participants who had received occupational therapy. Their spouses participated in the interviews as carers and service users of the social enterprise.
- Formal written organisational documents – statutory financial statements, governance and decision-making diagram
- Organisational website, brochure and leaflets, membership application information pack, community magazine
- Informal observation and field notes were taken on both visits.

**Table 5.10: Case Study 7 - Occupational therapy through gardening and farming**

<b>Mission/Mandate</b> (Data source: Promotional leaflet)	To grow organic fruit and vegetables, alongside caring for farm animals and livestock. Young people with social, behavioural or mental health problems aged 14-24 attend the project to learn new skills. Specialise in supporting the most vulnerable and disadvantaged young people including those with complex mental health problems and young people in, and leaving care.
<b>Social aims</b> (Data source: Promotional leaflet)	To offer supported placements for up to two days per week, over a maximum period of two years. To work at the client's pace, with the wider family and others to facilitate sustainable social, behavioural and psychological change. To provide a non-stigmatising environment, where young people are integrated into daily farm life. To encourage young people contribute to the community and society, increasing feelings of self-worth and belonging.
<b>Years in operation</b> (Data source: Interview)	4 years (Since March 2010)
<b>Legal structure</b> (Data source: Interview)	Charity
<b>Governance structure</b> (Data source: Interview)	Board of Directors
<b>Product or services offered</b> (Data source: Promotional leaflet Interview)	Therapeutic interventions for young adults with mental health problems. Generates produce from a market garden that is sold to the local restaurant.
<b>Annual turnover</b>	Unknown
<b>Sources of income</b> (Data source: Interview)	Grant funding (Ecominds) Direct payments (1 placement)
<b>Size of staff</b> (Data source: Interview; observation)	3
<b>Occupational therapy role</b> (Data source: Interview)	Adaptation of the activities of the social enterprise to enable young adults to carry out meaningful work (gardening, cooking, animal care) whilst developing their psychological and social skills (such as motivation, mood, social relationships, confidence, living with psychosis).
<b>Number of occupational therapists</b> (Data source: Interview)	1
<b>Term used for service users</b> (Data source: Interview; observation; leaflet)	Young people / clients
<b>Referral pathway</b> (Data source: interviews; documents and promotional leaflet)	Community mental health teams; Looked after children's teams; Self-referral

The social entrepreneur's vision when setting up the social enterprise was to address unmet need in young adults with mental health problems. Her desire to respond to unmet need shaped the design of the social enterprise and therefore, the remit for the occupational therapist to work within. The social entrepreneur was also a clinical psychologist and implemented a psychodynamic approach to the work with the young people who attended. As all staff took part in individual key-working sessions, the occupational therapist was also required to work within a psychodynamic approach in these sessions.

This social enterprise had underpinning funding in the form of a grant to fund its work. This enabled the social enterprise to continue offering services despite the unpredictability of the paid placements. The grant funding also acted as a buffer to provide some financial stability as the paid placements (through direct payments and personal budgets) were not sufficient to cover all costs or commit to longer term funding.

### **Case Study 7: Data sources**

- A field visit was conducted for five and a half hours which consisted of semi-structured interviews with the occupational therapist (55 minutes, 17 seconds), the social entrepreneur (42 minutes 12 seconds) and three service users (5 minutes, 36 seconds; 5 minutes 42 seconds and 14 minutes 48 seconds). Two service user interviews were short due to the low confidence and self-esteem of the participants to be able to verbalise and articulate their thoughts and experiences.
- Formal organisational documents were requested but not provided.
- Organisation's website, brochure and video.
- Informal observations and field notes were taken during the visit.

**Table 5.11: Case Study 8 – Organic growing**

<b>Social aims / vision</b> (Data source: Organisational website)	To provide a socially and environmentally just food system including production and distribution, which is controlled by the people themselves. To provide a fair income to food producers and guarantee the rights of communities to access healthy and nutritious food produced using ecologically sound and sustainable methods. It is a food system that exists within a wider context of social justice.
<b>Mission/Mandate</b> (Data source: Organisational website)	To produce and distribute food and plants locally, and inspire and support others to do the same. With a workers' cooperative at the core, they bring people together to take action towards a more just and sustainable society.
<b>Years in operation</b> (Data source: Company's House website)	10 years (opened in 2001 but incorporated as a business in 2004)
<b>Legal structure</b> (Data source: Company's House website)	Company limited by guarantee
<b>Governance structure</b> (Data source: Organisational document)	Board of Directors. Co-operative
<b>Product or services offered</b> (Data source: Organisational website)	Organic food produce
<b>Annual turnover</b>	Unknown/not available
<b>Sources of income</b> (Data source: Organisational website; interview)	Contract with NHS and Local Authority (specific placements for individuals requiring support) High street shop and café Selling produce to local restaurants Charitable grants
<b>Size of staff</b> (Data source: email contact with a staff member)	10
<b>Occupational therapy role</b> (Data source: Interview)	Adaption and grading of gardening activities to enable inclusion of people with various physical, mental health and learning difficulties into the activities of the project. Training and empowering staff in strategies for inclusion of these people groups. Influence in the project to become more inclusive of people with disabilities.
<b>Number of occupational therapists</b> (Data source: Interview)	1
<b>Term used for service users</b> (Data source: Interview)	Volunteers
<b>Referral pathway</b> (Data sources: Interview)	Self-referral; Community mental health team; Learning disability service; Social services.



It was the hope and aim of this social enterprise to become a self-sustaining business but this was not imminent at the time of the research. The organisation was primarily funded on grants and some contracts with the local health authority and social services with some additional income through trading. The occupational therapist viewed the grant funding of the social enterprise as necessary until it could be self-sustaining. This social enterprise was the only co-operative to participate in the study and this was the only case study where the occupational therapist was not employed but a volunteer at the organisation. The occupational therapist decided to maintain an informal role within the social enterprise and only use her title when it was needed in certain situations. She perceived herself as an equal as the other volunteers and provided informal support to the volunteers and staff using her occupational therapy training, knowledge and experience.

The occupational therapist was the only participant who consented to participate in the research. This was due to another research project that was already being undertaken at the social enterprise. As a result, a field visit was not carried out and interviews were not conducted with service users or the social entrepreneur. This resulted in limited data available about this case study. The occupational therapist was keen to participate in the study and it was decided that it was still valuable to hear her perspective even though other interviews and a field visit were not possible. She provided organisational documents and videos were available online about the organisation which gave a fuller picture.

### **Case Study 8: Data sources**

- Semi-structured interview with the occupational therapist (75 minutes, 38 seconds)
- Organisational written documents: secondary rules; internal report on organisational support impact
- Organisation's website and online videos

### **5.12: Summary of Phase 1**

The social enterprises that provided occupational therapy in the UK were identified in the first phase of this research. Of these, there was a wide variety of types of social enterprises and variation in the occupational therapy provision within them. Whilst some of the social enterprises identified demonstrated a continuation of the occupational therapy

provision within statutory services in the UK, other social enterprises evidenced occupational therapy provision that was innovative, client-centred and occupation-focused. This could indicate the opportunity for social enterprise to be used as a model for occupational therapy delivery that is consistent with the philosophy of the profession. The data generated in the first phase of this research was used inductively to determine that case study methodology was the most appropriate approach for the next phase of the research. This led to the selection of the eight case studies that have been presented in this chapter. The following three chapters present the qualitative findings of the themes that were generated from the interviews conducted with these case studies and complimented with remaining data from other sources. An overview of the next three findings chapters is presented next.

### **5.13 Overview of the findings chapters**

The next three chapters are a presentation of the findings from the case studies. These findings chapters address the research questions:

1. What forms of occupational therapy are practiced within social enterprises in the UK?
2. What is the relationship between occupational therapy practice in social enterprises and the philosophical foundation of the profession?
3. What are service users' views, opinions and experiences about the occupational therapy they receive within a social enterprise?
4. What are the factors that determine the diversity of occupational therapy provision within social enterprises?

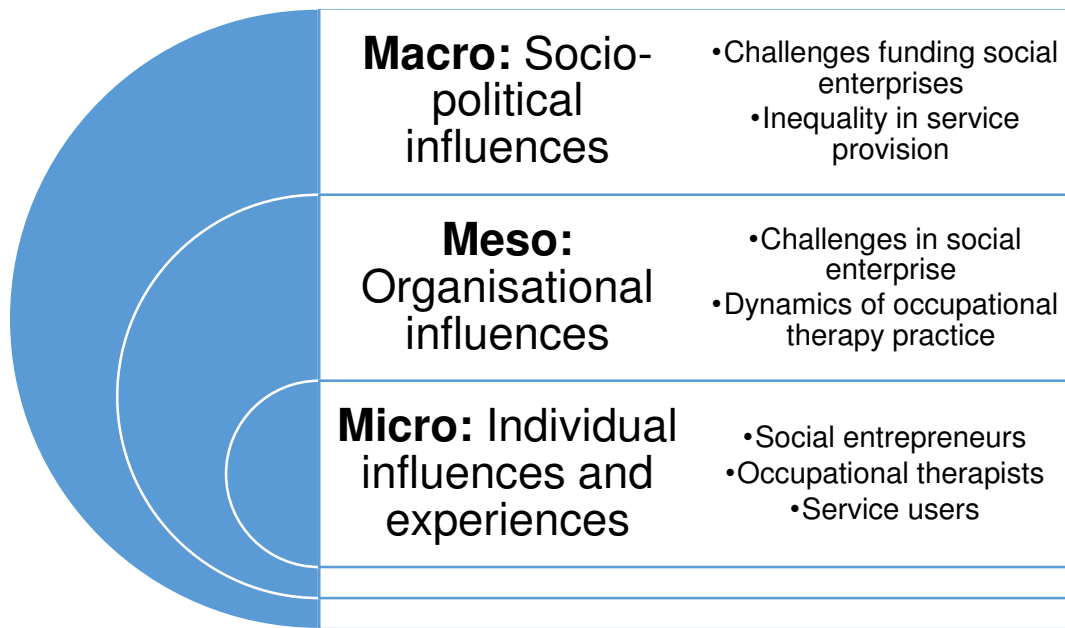
The data gathered in phase 1 addressed the first research question, however more detailed findings are also evident in phase 2 in relation to the first research question. These remaining chapters present the findings that address the research questions. The findings in these chapters are an outcome of the combination of thematic analysis using the process promoted by Braun and Clarke (2006) and integration of other data sources such as formal documents, organisational websites and unstructured observations as discussed in the methodology chapter. The themes that emerged from the data were

conceptualised into three overall levels of analysis which were macro, meso and micro (Merton, 1968; Giddens, 1984; Turner, 2003) in relation to influential factors on occupational therapy provision within social enterprises in the UK.

Macro, meso, micro are concepts widely used across different disciplines such as sociology and political science when conceptualising phenomenon within society. These levels are “interrelated and embedded within each other” (Turner, 2003, p3) as macro level structures within society such as the government are constructed of multiple organisations (meso) which are also constituted of individual interactions (micro). The existence of macro, meso and micro levels in society has been disputed as abstract and theoretical (Giddens, 1984; Berger et al., 1998). However, according to Turner (2003), macro, meso and micro are realist structures that actually exist in society and can be seen. For example, within this study, the policy issues by the government the Department of Health regarding health and social care provision through social enterprises are a macro influence on occupational therapy practice. The meso level is the influence of the social enterprise as an organisation including the culture and environment of the social enterprise on the occupational therapy practice at a community level. At a micro level of analysis, the focus is on the individuals within the social enterprise such as the staff and service users. The macro, meso, micro framework was used to structure the findings because it enabled clear distinctions between the socio-political, organisational and individual influences on occupational therapy professional practice within social enterprises.

The use of macro, meso and micro levels of analysis was guided by the overall theoretical framework used in this study, as it reflected the structural (macro, socio-political), contextual (meso, organisation and culture) and occupational outcomes (micro, individual) within occupational justice. The structure of the findings from the case study data is demonstrated in the following figure (Figure 5.13):

**Figure 5.13: Overview of findings chapters and themes**



The above analytical structure has been used to formulate the remaining three findings chapters. The themes in relation to these three levels of analysis are presented in tables at the beginning of each chapter.

Themes were originally identified according to each case study (Appendix 10) and then separately, themes were developed according to each stakeholder group (Appendix 11) which enabled different analysis to be conducted. For example, within one case study, there were particular themes generated across the different stakeholders such as issues with funding for the social enterprise or an individual to attend. Whereas it was not possible to develop themes of occupational therapists experiences within one case study as there was one occupational therapist within most the case studies. By combining the findings according to stakeholder groups across the case studies, the voices and issues of each group could be heard through the development of themes within these. The three findings chapters are a combination of the thematic analysis of each of the case studies and the stakeholder analysis. The similarities and contrasts as well as unique aspects of each case study are referred to where this has been evident under each theme.

Reference to the case studies in these chapters is abbreviated to 'CS' followed by the number case study eg. 'CS3' refers to case study three where appropriate. Within the text, where it was relevant the case studies have been referred to by the type of case study it was with shortened names for each case study presented in the following table:

**Table 5.13: Summary names for case studies**

<b>Case study</b>	<b>Summarised name</b>
1	Fostering and adoption
2	Dementia day service
3	Woodland and forestry
4	Youth health promotion
5	Therapy through sport
6	Social housing
7	Gardening and farming
8	Organic growing

The following chapter presents the macro, socio-political level of analysis of the findings from the case studies which is followed by the subsequent findings chapters.

# Chapter 6: Findings at the Macro Level: Socio-political influences on occupational therapy practice in social enterprises

## 6.1 Introduction

Chapter 6 presents findings concerning the wider socio-political influence on the occupational therapy practiced within the social enterprises at the time the research was conducted, particularly in relation to government policy and the political agenda to outsource to social enterprises. This research was conducted during a time of austerity in the UK and the “liberation” of the NHS (Department of Health, 2010: title page) through outsourcing the public sector to other providers. It has been argued that the introduction of radical transformation to health and social care provision in the UK (during the time of this research) has been the most dramatic change the NHS has experienced since its inception (Girach et al., 2014). Therefore, the findings are located within a time of significant change in healthcare provision affecting occupational therapy delivery in the UK. The findings within this chapter relate to the macro level issues as they concern institutions such as public sector provision of health and social care (Turner, 2003). The macro level institutions are conceptualised as structures within the occupational justice framework that can limit or enhance occupational justice (Stadnyk et al., 2010). The findings in this chapter formed the first theme which was: ‘The impact of cuts in services on occupational therapy practice within social enterprises in the UK’. The macro perspective in this chapter then leads onto Chapter 8 that presents the findings from an organisational (meso) perspective on the influences on occupational therapy provision within social enterprises in the UK.

**Table 6.1: Findings at the Macro, socio-political level**

<b>Macro Level Analysis</b>	<b>Theme</b>	<b>Sub-themes</b>
	The impact of cuts in services on vulnerable groups	<ul style="list-style-type: none"> <li>• Challenges accessing funding</li> <li>• Inequality in service provision</li> </ul>

## **6.2 Theme 1: The impact of cuts in services on vulnerable groups**

This theme was created following the process of thematic analysis with the interview data and refinement of themes that demonstrated that there were broad political, policy and funding issues that were beyond the scope or control of the social enterprises. This theme captured the influences of policy, funding and inequality that affected either the provision of occupational therapy within social enterprises or the ability of individuals to access occupational therapy that was being provided through social enterprises. The health and social care organisations that exist within the UK to provide occupational therapy are considered occupational instruments and policy is a governmental structure that can enable or limit occupational justice (Stadnyk et al., 2010). The implementation of personalisation during a time of austerity posed significant challenges for those who use services, occupational therapists and social entrepreneurs which are evident in these findings. These findings were organised in to the following sub-themes:

1. Challenges accessing funding;
2. Inequality in service provision.

### **Challenges accessing funding**

Accessing personal budgets or direct payments were a major issue for five of the case studies (Dementia day service; Woodland and forestry; Therapy through sports; Gardening and farming; Organic growing). It had been hoped by the social enterprise managers or social entrepreneurs that personal budgets would be a reliable income stream to fund some of their activities, including occupational therapy provision. Concerns were raised about the challenges and difficulties around accessing direct payments which resulted in some service users being unable to access services, for example some people with mental health problems or learning disabilities may not have the skills to organise application for direct payment and the management of this. One social entrepreneur who was also a clinical psychologist explained that only those well enough or capable of taking up opportunities (such as applying for personal budgets or attending a social enterprise) were benefitting and the most vulnerable were missing out on services. The social enterprises that received some funding through direct payments found that funding was difficult to access and slow to process affecting the cash flow and viability of the organisation. Despite the personalisation agenda proposing clinician-led services, one social entrepreneur and occupational therapist from 'Dementia day service' expressed her

concern that she could not be involved in accessing direct payments for people, as she had no control over accessing funding for service users to attend.

*“(direct payments) they should be (available) but nobody is getting any... how do I plug into that? It (direct payments) needs to come from their (the service users) point of view” (P3L188-193)*

The main challenge for this social entrepreneur was that because of the new system of personalised budgets, she does not have any power or control over organising direct payments for service users, as they have to organise this for themselves. This highlights the question of whether there is an illusion of power around implementation of the personalisation agenda as public policy asserted that both clinicians and those who use the services should have more power and control (DH, 2006; Powell, 2012), whereas in practice clinicians are experiencing less ability to do this. The opportunity does remain with the people who want to access the service to apply for a personalised budget, if they are able to. However, the decision about whether they are allocated it or not still remained within the public sector. Government policy encouraged clinicians to establish and run services however there is a lack of guaranteed or reliable finance from the public sector to do this.

In two case studies (Dementia day service and Therapy through sport), the service users wanted to be able to access a social enterprise and were willing to contribute financially towards the cost of attending however there was a lack of support from GP's and from the Local Authority to meet these needs and provide the remaining funding. In one of these cases, the social entrepreneur and occupational therapist from 'Therapy through sport' encouraged and empowered the service users to persevere with advocating for themselves however this was an ongoing battle:

*“they (service users) even go to the GPs themselves with flyers and say look we need this we want this and they are still being overlooked so they're fighting that there's nothing else we can do” (P18L350-2)*

This highlights an inconsistency between the government's agenda to our-source services to social enterprises and the reality in practice where this is not happening. It also raises concerns about vulnerable and marginalised groups accessing services. In some circumstances, once the service users did have the agreement for a funded place through direct payments, the challenges were not over. The occupational therapist from 'Therapy



through sport' had concerns about the direct payment process and that this could exclude some service users from getting the support they need:

*"They have to have their bank account, they are making it really hard ... for them with mental health problems. They can do it, they're trying ... but then there are some that say: "I'll leave it then" and then they're not getting the service and all they're doing is sitting at home" (P18L426-431)*

As some of the people who used the service in this case study experienced mental health problems, some needed occupational therapy intervention to be able to open a bank account to be able to have a direct payment. This then raises the issue of whether public sector service will provide such support to enable those people without the skills or abilities to access to direct payments. Without such support, the individuals who cannot open a bank account may be discriminated against by being unable to access further services through direct payments. Therefore, the theories of self-association to social enterprises suggested by Smith and Teasdale (2012) have limited practical use when applied for people with varying vulnerabilities and disabilities.

The occupational therapist from the Woodland and forestry case had concerns that there were insufficient funds available from a personal budget to provide services and that not all who need them would be able to access them.

*"People who don't qualify for a personal budget and who perhaps can't afford to pay personally for services will end up with nothing so I do have concerns that there might still be that grey area where people choose to need support and may need some professional input but actually aren't ill enough or affected enough to warrant mainstream or personal budget support and what that will mean for them really?" (P5L333-338)*

In addition, this occupational therapist said that service users did not understand why they should have to pay for services which have been free at the point of delivery in the past. The personalisation agenda and outsourcing of the public sector is likely to challenge the expectations of those who use the services from the previous traditional expectations of the passive role as a patient who can receive services for free.

There were also issues raised about social enterprises depending on direct payment for funding and sustainability. The social entrepreneur and occupational therapist in the Therapy through sport case had been waiting for direct payments (at the time of the interview) which were over five months late and without the payment the social enterprise almost collapsed. This posed ethical dilemmas for them as they provided services to people without funding attached. The social entrepreneur felt unable to turn people away because they were in need of their service and had been referred to them by public sector bodies but the social entrepreneur was also unable to cover costs. This caused a significant amount of stress for the social entrepreneur who decided to convert the social enterprise into a grant dependent charity because of the lack of reliable income from contracts with public sector bodies. In this case, direct payments could not be relied upon as a sustainable income stream to fund their work to provide the occupational therapy interventions.

A challenge that some of the occupational therapists experienced with accessing direct payments was with health and social care staff who were either unwilling to access direct payments for their service users or uninformed about what services were available. One occupational therapist from Therapy through sport expressed this:

*“(we are) really struggling with this direct payments, it really is a minefield. When I was at (location) yesterday, me and Fred done some promotional work and said about direct payments and ... they (the public sector staff) are unaware of it ... how to go about it so you know that's what we are up against ... almost uninformed people because the NHS generally referred them on discharge to the community mental health teams, the regular services that they have used for ages that are free ... part of the NHS, so for us direct payments, ‘Oh we can't get them, haven't tried. I wouldn't even know how to try,’ but this person really wants this” (P17L171-178)*

Two of the social enterprises (Woodland and forestry and Therapy through sport) were experiencing challenges with key workers only being interested in referring to services which are free as they are not used to considering payment for services that service users need. The mind-set of such public sector staff (Mackey, 2011) may not have changed from the previous centralised provision of health and social care by the public sector to the new outsourcing of services. For example one social entrepreneur said:

*“We have loads of referrals wanting to come and I said ‘you have got to pay for it’ and they say “No! We won’t send them” (P18L377-8)*

The requirement of payment for services from a social enterprise constitutes a change in culture from statutory services providing all services based on ‘free at the point of delivery’, particularly about payment of services. Despite the political agenda promoting personal budgets, the reality for service users was that it was difficult to access and that there was a lack of knowledge amongst public sector staff of how to apply for them. These challenges may be reflective of this new system of healthcare delivery and the time lapse in the implementation of this new agenda following policy changes. Occupational therapists ability to provide services within social enterprises may be affected if funding the service is to be accessed through direct payments. In some instances, the staff were motivated to refer individuals to the social enterprises but they were powerless to do so because of a lack of funding to attach to the referrals:

*“... 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” (P27L210-12)*

In this example from a social entrepreneur in CS7, (Gardening and farming), the clinicians in the public sector services and in the social enterprise both recognised the need for the referral to be made but neither had any power or control over access to funding for this placement. This raises questions and concerns about who is making the decisions about funding services as the clinicians at grassroots level are making a clinical assessment of what service is needed but it is being blocked by a lack of funding, denying the individual who needs the intervention the service they should be provided. This could be termed occupational deprivation (an outcome within the occupational justice framework) as service users may be denied access to the services they need to address their occupational needs. One occupational therapist thought part of the challenge with accessing direct payments is because they were not being explained clearly by public sector staff to service users:

*“I don't think personal budgets are being sold properly if that's the right term ... it's about actually the key deliverables ... an improvement in your self-esteem and confidence and attention and work tolerance and all of those sorts of things which then perhaps by the end of year may*

*leave you with the right skills to be able to apply for some work experience or to be able to access a job” (P5L298-308)*

To this occupational therapist (from Woodland and forestry), the challenge rested in others recognising and understanding the therapeutic element of the activities carried out at the social enterprise and the long-term benefits this would have for the service user. Another occupational therapist (Therapy through sport) also had concerns that public sector staff were cautious about referring to the social enterprise because they were not part of the public sector:

*“... what I find challenging is making links with the key workers and everything because we're not an NHS subsidiary service as such people always have doubts almost about what we are providing so I find that very challenging” (P17L31-32)*

This occupational therapist's concern raises the issue around identity and recognition for occupational therapists and social enterprises outside of statutory services. There are new challenges for public sector staff as they will be required to adapt and refer to new and unfamiliar organisations. In the context of this social enterprise however, public sector staff have been cautious and reluctant to refer, even despite the social enterprise previously being set up with support from the NHS and with a history of NHS referrals.

Six of the interviewees expressed challenges with working with local authorities. This may be because of the time delay between the release of the Government policy to outsource the public sector (in 2010) and the local authorities being able to respond to this in practice (data collection occurred in 2012). Such time delays are not unusual but funding for certain services had been cut entirely before new services were available, resulting in unmet need of vulnerable groups such as people with mental health problems. The lack of service provision for people who have been assessed as requiring clinical treatment or interventions has been argued by Mandelstam (2010) as illegal.

The participants from Dementia day service; Woodland and forestry; Health promotion with youth; Gardening and farming and; Organic growing expressed frustrations with their Local Authorities for their lack of willingness to offer contracts to deliver services. The social entrepreneurs from Dementia day service; Health promotion with youth and; Therapy through sport described a battle with the Local Authority over funding issues and two of these talked about corruption within the Local Authority transferring money within

their own services and not contracting it out to others unless they were large organisations. For example, the social entrepreneur from 'Youth health promotion' challenged one individual who sat on a Local Authority board which funded the organisation the same person worked for:

*"if you sit on that board and you sit on that board and your funding goes to that board for your funding to come to here to me that absolutely stinks" (P13L489-90)*

The unfairness that was experienced in this situation may be due to Local Authority commissioner's unwillingness to offer small contracts to numerous providers, preference for fewer contracts with large providers and a general unwillingness to contract with social enterprises as these were new and unfamiliar (Ferguson, 2011; Miller and Millar, 2011). It has been previously asserted that Local Authority commissioners prefer to only contract with other statutory bodies rather than social enterprises (Millar et al., 2013). However, such unwillingness need to be overcome if government policy to outsource to social enterprises is to be implemented.

The financial climate of public sector funding cuts in the UK at the time this research was conducted has had an impact on what the local authorities were willing to pay social enterprises. This in turn has resulted in interference with clinical service provision and the professional autonomy of health and social care staff. The social entrepreneur from Fostering and adoption experienced local authorities trying to limit the service they would pay for, therefore interfering with the provision of services that was based on clinical assessments. The social entrepreneur from this case study explained this as follows:

*"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 (provide the service) this way and could you do it quicker?", "Can we not have this bit because we don't pay for those." For example we get very high-risk cases, very high risk children with suicidal behaviour and self-harming, really worrying stuff and then they don't want us to do a psychiatric assessment so then we really have to stand our ground" (P1L180-185)*

The Local Authority in this case made decisions on a financial basis and not according to service users' needs despite serious vulnerable groups being affected. Both the occupational therapist and the social entrepreneur in this case expressed their concerns with the effects of funding cuts on the children and families affected and prioritised the child's needs as well as their own safety over the financial demands of the funding bodies. The social entrepreneur demonstrated that the social enterprise needed to protect themselves and the children attending their service from being manipulated by funding cuts that could have serious implications.

The challenges with local authorities being willing to contract to social enterprises was not necessarily based on cost as the social entrepreneur and occupational therapist from Dementia day service, experienced challenges with securing funding from the Local Authority despite their service being cheaper than the equivalent service that the Local Authority was paying for and despite it being the preference of someone who wanted to use the social enterprise services.

*“One lady that comes here... would love to come other days but she already goes to another day centre (Social Services)... and asked the Council to swap those two days to here and they said “no we wouldn't do it” although there is no difference in the cost, in fact the other one is slightly more expensive, they won't switch over” (P3L197-202)*

This contradicts public policy around promoting patient choice and control over the services they receive (DH 2006) and may be for the reasons given previously about reluctance to contract to small, unfamiliar organisations.

The occupational therapists in CS2 and 5 (Dementia day service and Therapy through sport) both experienced difficulty with gaining recognition by local health and social care staff who were (from their perspective) unwilling to refer to the social enterprise as they were not part of the NHS or local authority. The social entrepreneur in CS4 (Youth health promotion) said her organisation was in competition with the Local Authority despite trying to work with them. She struggled to gain recognition for her organisation and in her experience, this was in conflict with government policy to outsource to such organisations. In addition, she had particular concerns that decisions were being made in the Local Authority about where to allocate funds without consultation with the service users (who she said preferred the social enterprise and had voted for them):

*“... Certain people in positions of authority that are making decisions on whole communities hundreds and thousands of people when they're not actually consulting with them.” (P13L305-307)*

This case study is an example of a social enterprise providing a service which is in demand by the end-users who prefer them over other services offered and despite government policy in outsourcing public services they were not getting Local Authority funding and support. It was not the aim of this study to identify the reasons for this but further research is required to further knowledge in this area influence policy if social enterprises are going to receive funding from Local Authorities in the future.

### **Inequality in service provision**

Research participants suggested that vulnerable groups in society experience difficulties accessing services as a result of the policy reform to outsource health and social care. In seven out of eight case studies, the staff talked about their concerns that some people are not accessing the services they need as a result of cuts to services and the health and social care reforms. Four occupational therapists referred to their service meeting unmet needs as a result of a shortfall from the public sector. The occupational therapist in CS1 (Adoption and fostering) explained that only the most severe cases were able to access services in the public sector:

*“I can understand it coming from public services there isn't the time that unless you are high-priority there isn't a service for you.” (P2L143-144)*

In this case study (which worked with children who had experienced abuse), the children needed early intervention (Allen, 2011) in prevention of further health and social problems rather than denial of services. The occupational therapist in CS7 (Gardening and farming) expressed unmet needs for adults with mental health problems who were on the borderline between accessing mental health and learning difficulties services in the public sector:

*“... they fall through the net of services so there's a lot of very borderline learning disabilities but not enough learning disabilities to qualify for learning disability services but ... not serious enough mental health issues to be picked up by a mental health” (P23L245-248)*

As a result, the social entrepreneur designed a service to meet some of these otherwise unmet needs. This was similar to the experience of the occupational therapist in CS1 (Adoption and fostering) that had discovered that they were addressing needs of people who had not fitted into a specific medical diagnosis and had fallen through the net. The occupational therapist and social entrepreneur in CS2 (Dementia day service), viewed the unmet needs of elderly people with dementia as an opportunity for her service as she had the skills needed to offer a service which other statutory services did not offer.

The social entrepreneur in CS7 (Gardening and farming) expressed that the new health and social care environment for service provision was a postcode lottery resulting in inequality in service provision. A patchwork of services, with gaps in provision is an example of the structural factors that limit occupational justice within the occupational justice framework (Stanyk et al., 2010). Such inequality could be compounded by findings that those members of society who live in deprived areas who will suffer the most from public sector cuts (Assenova et al., 2013). Occupational therapists particularly need to be able to work with people within such areas as they are most likely to be experiencing multiple occupational problems, physically, socially and in relation to their mental health.

As a result of the lack of provision in certain areas, the social entrepreneurs from Fostering and adoption; Woodland and Forestry; Health promotion with youth and; Gardening and farming were motivated by the unmet needs they could see around them knowing that it was possible to provide a service to address this. The social entrepreneur from 'Gardening and farming' explained:

*"We really were not reaching these very very troubled adolescents and that the limits of the NHS-based service were just not reaching the kind of multiple levels of disadvantage and deprivation and mental health issues that these kids had." (P27L11-13)*

She expressed a desire to address the deprivation and injustice of unmet needs of the people the social entrepreneurs wanted to impact which was out of recognition that the mainstream voluntary sector was unable to meet the needs of some vulnerable groups:

*"...if you don't understand ... what the mental health issues are that prevent someone from making the most of the opportunity then you are only going to reach people who are well enough to make use of an opportunity. So I felt very strongly that, and I've built it back into my*



*proposals that this is what would make this different: that it would start addressing really the most vulnerable people in a way that other services including mainstream services and voluntary sector services are just not touching... we know for example that 90% of people that are diagnosed with schizophrenia never go back to work once they've had a diagnosis and it shouldn't be that way, it doesn't have to be that way but you need a way of engaging and sustaining engagement" (P27L116-125).*

These social entrepreneurs were providing services because of their professional assessment of needs, but also out of a sense of injustice that necessary services were not being provided elsewhere. The services provided by these social enterprises could begin to address health inequalities evidenced in the literature (Bambra et al., 2010; Marmot, 2010; RCN, 2012; Lockwood, 2013). Through engagement of vulnerable people in activities of social enterprises, issues of occupational deprivation and injustice can also begin to be addressed (Stadnyk et al., 2010).

In contrast to all the other case studies, service users' unmet occupational needs were observed in the occupational therapy interventions in CS6 (Social housing) during a field visit. The following was recorded as field notes:

*The social enterprise seemed to have a social services occupational therapy role that had been inherited from the Local Authority and hadn't changed. The occupational therapists were inundated with referrals and so the occupational therapy role remained limited to aids and adaptations as a compensatory approach. The service users had evident mental health and social needs that weren't being addressed. I could see there was scope for so much more of an occupational therapy role to be more holistic, addressing people's motivational issues, supporting them with hobbies and leisure and not accepting that because of the waiting list they should only address essential mobility and activities of daily living. (Extract from academic journal, March 2012).*

The occupational therapist and also the social entrepreneur from this social enterprise confirmed that the occupational therapy role was limited to reducing the waiting list (at the time the wait to see an occupational therapist was one year). Whilst the occupational

therapists were able to address the basic physical occupational needs of the service users, other occupational needs were unaddressed therefore resulting in occupational marginalisation and deprivation as occupational outcomes (Stadnyk et al., 2010). The presence of occupational therapists within an organisation did not necessarily mean that all occupational needs of service users were met as the occupational therapy role was limited by the organisational requirements on them and limited funding to employ more occupational therapists.

There are implications for the remainder of people who could benefit from services but who are not receiving them because of a shortfall in the public sector. If people are not able to gain the support they need from the public sector, they may then turn to the third sector such as social enterprises for support but then questions are raised about whether such organisations equipped to address clinical physical and mental health needs. Occupational therapists and social entrepreneurs from Adoption and fostering; Dementia day service; Woodland and forestry; Therapy through sport and Social housing all referred to the need for professional expertise such as the occupational therapist within their organisation. For example the social entrepreneur from 'Woodland and forestry' stated that:

*"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." (P4L272-5)*

*She continued:*

*"...we needed someone with a mental health background who can get people back to work because we are a business, that mutualisation that thing I spoke of, activating, we didn't want to be just incubating people with mental health problems just by putting a plant in a box, that is not what we wanted to do we needed to activate them so who do we need, who do you call? You call (x) an occupational therapist so it was that specialism of OT that we felt had all the characteristics, get up get out let's go but I'm looking after your wellbeing as well and your mental health" (P4L283-289)*

This social entrepreneur recognised the need for occupational therapy professional expertise to address the mental health problems that the service users presented with, alongside provision of therapeutic rehabilitation to equip the service users to gain skills to engage in the activities of the organisation and move on into paid work. The specialist skills of an occupational therapist, trained in activity analysis, grading and adaptation of tasks alongside clinical expertise in mental health were identified as what the social enterprise needed to enable service users to progress within the organisation. An activity organiser for example could conduct activities of the organisation with service users but may not have the professional, evidenced-based knowledge or skills to use the activity therapeutically to enable rehabilitation and employment.

However, many social enterprises were identified in Phase 1 did not have health and social care professionals in their organisation despite working with vulnerable groups that require this. This was a concern that was also expressed by the social entrepreneur from Gardening and farming, who was a clinical psychologist and psychotherapist.

*“I went and visited a lot of care farms ... I looked at what care farms were there and I was really struck by how little mental health expertise that was on care farms. So mostly its farmers with good intentions who need to diversify to survive, who open their farms for vulnerable populations but actually they've got absolutely no training or understanding of mental health issues and when you sort of ask people what happens when people (those who use the service) don't come for example they will say “they're adults it's up to them” whereas I felt very strongly that what was needed was to really engage the more vulnerable people you need mental health model of understanding disturbance and how disturbance presents itself and how to apply a way of an engaging and sustaining and engaging people” (P27L96-105)*

This social entrepreneur was passionate about addressing the barriers that prevented people from getting the support they needed and she knew from her professional and clinical expertise what was required therapeutically to enable that to happen. The evidence-based models used in Fostering and adoption and Gardening and farming resulted in the provision of interventions that other organisations without healthcare professionals would not be able to provide. The occupational therapists in Woodland and forestry and Therapy through sport also recognised the difference between what they

were able to achieve through their interventions with people in comparison to mainstream organisations that offer the same activities without the therapeutic expertise:

*“Other third sector providers in this area who don't have professionals in them, there are very clear differences between them in what they are able to achieve ... a lot of the focus is about creating products that you can sell or a very sort of informal support group and network and there's nothing wrong with those at all I don't mean that there is but it's very different having an OT in an organisation like this which is now providing social care to people with mental health issues and actually some physical health issues as well” (P5L204-9)*

As raised by the occupational therapist in this quote, there is a need for a professionalisation of social enterprises to address the needs that have previously been provided by the public sector. Specific expertise of healthcare professionals such as occupational therapists is required in some social enterprises to enable engagement and therapeutic rehabilitation, particularly in returning to work. However, finance will be needed to employ professionals in social enterprises and the question remains unanswered as to where the funding will come from. If professionals such as occupational therapists are not employed by social enterprises, only those who use the services who are well enough will make the most of the opportunities and benefit. There is a risk, as that the most vulnerable will be more excluded from services and therefore isolated from society, increasing health inequalities and worsening occupational injustice. This may then have long-term implications on creating a greater demand on the public sector if health and social needs are unaddressed, worsen and become more severe, particularly at a time of high levels of health inequality (Joyce, et al., 2010; Marmot, 2010; OECD, 2013).

### **6.3 Chapter Summary: The macro level analysis - political influences on social enterprise**

This research was conducted during a time of radical change as a result of public sector reform and economic recession. This has had major implications on the implementation of the personalisation agenda, which despite having moral and ethical principles underlying it, its application appears as political rhetoric during a time of austerity. The government policy to outsource health and social care to social enterprises had been delivered effectively with statutory bodies that have been converted into social enterprises. However

smaller, grass-roots community initiatives such as five of the case studies in this research, have struggled to secure any public sector funding. This has been partly due to these social enterprises having difficulties winning bids or their service users being able to successfully apply for and use personal budgets. Small social enterprises need the enthusiasm, dedication and skills to be able to compete with other providers which requires expertise and knowledge that healthcare professionals might not have (Adicott, 2011; Miller and Millar, 2011; Hall et al., 2012). It has been questioned whether the social enterprise and personalisation agenda is being used as a cloak for the neo-liberal marketisation of the public sector (Rainford and Tinkler, 2010; Roy et al., 2013), particularly when large healthcare trusts and private providers frequently win contracts. Small, grassroots organisations (which the majority in this study are) seem to be at an unfair disadvantage. The challenges identified in this study to fund social enterprises which employ occupational therapists raises questions of how realistic and sustainable it is to provide such interventions through social enterprises.

The health and social care reform and the widespread cuts to the public sector seem to be creating inequality in service provision, marginalisation and exclusion. As a result, in some instances occupational therapists are unable to offer services to those who need it leading to occupational deprivation (Stadnyk et al., 2010). There is a need for the professionalisation of social enterprises (for example to employ occupational therapists among others) to be able to address the unmet occupational needs that are emerging as a result of public sector cuts but the funding of such professionals remains challenging. These issues will be addressed in greater detail in the discussion chapter of this study. The next chapter presents the findings of the meso level analysis: the organisational influences of social enterprise on occupational therapy practice.

# **Chapter 7: Findings at the Meso Level: Organisational influences on occupational therapy provision in social enterprises in the UK**

## **7.1 Introduction**

The last chapter presented the findings in relation to the macro level of political, structural influential factors affecting occupational therapy provision within social enterprises. The macro level is constructed of numerous meso level, organisational structures, groups and communities (Turner, 2003). The macro level can influence these organisations and groups in that they form the context within which they function. Within this study, the meso level includes social enterprises as organisations and groups of people within them. This chapter considers the opportunities or limitations for occupational therapists to practice within social enterprises and the reasons for this. The meso level of analysis in this chapter corresponds with the structural, “occupational instruments” (Stadnyk et al., 2003 p336) within the occupational justice framework, referring to organisations which provide health and social care which enable occupation. Findings referring to the culture and environment of the social enterprise and the influence this had on occupational therapy practice are also included in this chapter as meso level, “contextual” factors within the occupational justice framework (Stadnyk et al., 2003 p336). Two themes and their respective sub-themes are described in the following table (Table 7.1) which represent the meso level analysis:

**Table 7.1: Findings at the Meso, Organisational Level**

Meso Level Analysis	Themes	Sub-theme
	1. Challenges in social enterprise	Combining social and business aims
		Governance and decision-making
		Outcome measurement
	2. Dynamics of occupational therapy practice	Creative and innovative practice
		Occupational therapy philosophy and practice
		Social enterprise as a therapeutic environment

## 7.2 Theme 1 - Challenges in social enterprise

This theme comprised of some of the functional and practical organisational aspects of the social enterprises and the influence this had on occupational therapy practice. The findings within this theme addressed Research Question 4 which was: What are the factors that determine the different ways occupational therapy is provided within social enterprises? Questions within the interview schedules explored research participant's views of how working for a social enterprise might influence occupational therapy practice. Typically, the social aims of the organisation directed the occupational therapy intervention and the integration or challenges of this within a business structure were explored. This theme was conceptualised into three sub-themes in relation to the implications on occupational therapy practice:

1. The challenge of combining social and business aims
2. Involvement of stakeholders in governance and decision-making
3. Outcome measurement

## Challenges of combining social aims with business

As social enterprises are run as business with social aims, there were a number of issues and challenges of combining the case study's social aims with their business processes. In Fostering and adoption, Woodland and Forestry, Youth health promotion, Social housing and Gardening and farming, all explicitly prioritised their social aims over business and financial needs. All of the eight social enterprise case studies aimed to become financially self-sustainable however Youth health promotion and Therapy through sport particularly struggled with securing a sustainable income, being largely dependent on grants alongside public sector contracts. It can be suggested that organisations which are dependent on grant funding rather than generating income through trading may be better suited to a charitable financial model rather than a social enterprise business model. Ridley-Duff and Bull (2011) argue that such organisations are not social enterprises, on the basis that they are not self-sustainable. However, this is in contrast to the Department of Health's (2010) definition of social enterprise which does include the delivery of contracts and services on behalf of the public sector. Adoption and fostering and Social housing are examples of social enterprises that deliver services on behalf of the public sector.

*"...all of our funding comes from local authorities and health authorities on a case-by-case basis so we had no underpinning money, so we live and die by the money that comes in and the quality of our work, which I suppose keeps one's focus" (P1L52-54)*

In these cases the social enterprise's mission statement has been entirely focused on their social aims did not mention trading activities or the generation of profit (CS1 and 6 mission statement). The sustainability of such organisations has been questioned by some social enterprise academics because of their dependence on the public sector (Ridley-Duff and Bull, 2011; Millar et al., 2013). However, both of these case studies were financially secure, sustainable and the largest (in terms of annual turnover) in this research.

Therapy through sport became a charity during the time-frame of this research because they were not able to generate enough income to be a sustainable social enterprise. This could be because they were a socially-minded organisation, with intentions to have an impact on people's lives but lacked a clear business and financial model to generate income to fund their activities. For sustainability and to be financially viable, a business



model is required with secure income streams in order to succeed as a social enterprise. If the social aims are of primary importance without a business model for trading goods or services, the organisation would be better suited to a charitable financial model. Some of the social aims of the case studies did not allow opportunity for income generation, for example Youth health promotion's aims were to promote healthy behaviours among youth:

- Increase awareness and action among young people of health and related social issues so that they can achieve positive actions to improve their own personal safety
- Enhance awareness of basic methods of reducing the likelihood of violent crime against the person
- Help bring about more community ownership, responsibility and action in advancing personal safety, wellbeing and inclusiveness.

(Source: CS4 business plan)

These aims do not indicate areas for income generation, and the content of the interviews revealed that their main source of incomes were contracts with the Local Authority in the Department of Education, with individual schools and charitable donations. It is a challenge for social enterprises which operate on a health or social aims to generate income through which health promotion could be carried out. For example, Organic Growing's mission was focused around an income generating activity:

*"To produce and distribute food and plants locally, and inspire and support others to do the same."* (Source: CS4 website)

This example demonstrates the link between the business and social aims but also has an income generation component to it. As social enterprises aim to run as businesses, they need to generate a profit to be able to achieve their social aims. It seems that the majority of the social enterprises in this study are heavily focused on addressing the social aims of the organisation rather than trading to ensure sustainability and profit. This may be reflective of social enterprises that are set up and run by clinicians without business expertise as generating profit within health and social care is at odds with the traditional and historical model of health and social care delivery in the UK. The NHS was first envisioned by Aneurin Bevan that ensured: that it meet the needs of everyone; that it be

free at the point of delivery; that it be based on clinical need, not ability to pay (National Health Service Act, 1946). There are implications for education and training for health and social care professionals (such as occupational therapists) who move to work in social enterprise leadership or management to train in business skills or collaborate with business-minded partners.

In three of the case studies, the occupational therapists talked about the conflict and challenges of combining individual service user's needs with the needs of the business. The occupational therapist from Organic growing felt a tension between her occupational therapy interventions and the business's need to generate produce to make a profit. This was about her need to be client-centred in her practice versus meeting targets for business productivity with the volunteers:

*"They have got a big site and they need to produce a lot of vegetables or food to keep the site running and keep it going and make it profitable and pay themselves and put it back into the organisation. And, if the balance went too far and we are only working on inclusion and we are going to spend a lot of time working on the disability program and the focus was taking taken off plant growing, then they (the social enterprise) wouldn't survive." (P28L80-4)*

The occupational therapist within this example has had to shift her thinking from the service user's needs to also include the productive output of the organisation which in this case was dependent on the involvement of the service users. Occupational therapists in such situations could feel under pressure to meet targets however activities within occupational therapy need to be carried at the service user's pace, dependent on their skills and abilities. This occupational therapist described managing the needs of the service user with the demands of the organisation as needing to be kept in 'balance' being equally focused on both. Managing this tension could be stressful for the occupational therapist if excessive demands are made on the productivity of the service users. However, the occupational therapist in this case managed the 'balance' without expressing stress or concerns in the interview.

In contrast, the Gardening and farming social enterprise had aims which were primarily social and they were funded through charitable grants and public funds therefore they did not need to meet profit requirements to the same extent. The social entrepreneur prioritised the social aims of the organisation over the financial and business aims, in

relation to the level of productivity of the gardening that was achieved. She knew productivity within the social enterprise would be less than commercial equivalents and did not attempt to compete with the market, instead subsidising funding from grants and contracts with the public sector. Social enterprises faces challenges when they attempt to compete with commercial competitors in the open market (Defourny and Nyssens, 2010) and this may particularly be an issue for social enterprises which aim to address health and social care.

The social enterprise manager from Woodland and forestry had come from a corporate business background yet she had been able to achieve a successful balance between the business needs and the social aims. When she was asked how she managed to always make profit, she explained:

*“It's the benefits stacking, it's the multi-streaming of work, it's about approaching it purely as a business...It's about contracting for work rather than drawing down grants it's about going out and contracting with the local District Council” (P4L207-212)*

This social enterprise did have contracts with the public sector but this was a small part of their income stream and they were not solely a public sector provider. They maintained their independence by having the majority of their income from a diversity of non-public sector sources such as private contracts to manage large woodland areas and selling wood felled in their forests (Source: CS3 website 'Objectives'). It seems that inherent in being able to run a social enterprise purely as a business is to remain in control of the income streams rather than taking on grants or contracts with conditions attached.

When using the term 'benefit stacking', the manager was referring to both the social enterprise and those who use the service benefitting from the social enterprise. For example, those who attended the service benefitted from receiving occupational therapy, work experience and learning new skills. In return, the social enterprise benefitted from their time given voluntarily and their skills. The occupational therapists in some of the social enterprises were able to adapt the business activities to suit the service users' skills and interests. In Gardening and farming, the business needs shaped the occupational therapists' focus on which activities to use therapeutically. In contrast, in Social housing the needs of the social enterprise at times overrode the individual's needs (according to the occupational therapist) on the basis of fairness and equality. The occupational therapist from Woodland and forestry was able to use her skills in assessing individual's

occupational skills and tailoring activities to enable service users to become involved in running certain activities, gaining work experience and towards getting employment in the organisation. The following two service users gave examples of their involvement in the social enterprise which demonstrates how they have been empowered by the occupational therapist to take on roles in the social enterprise, which both they and the business benefits from:

*“I’m doing my mechanics today, I was a mechanic before, when I was a lot younger and I’ve just come back to do it now and actually use my brain a bit more on that side of things. This is work experience, I’m doing the mechanics” (P7L31-4)*

*and*

*“So 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” (P6L5-7)*

These two examples demonstrate an integration of an occupational therapy approach with a business model which enabled the organisation to be able to meet their business and social aims at the same time. This is a role that occupational therapists are equipped to undertake as a result of their core skills in assessment, activity analysis and grading according to the individual. The adaptation of individual’s skills with the functioning of the social enterprise is a demonstration of the practical reciprocal relationship between occupational therapy and social enterprise models and an example of how occupational therapy can benefit social enterprises. Occupational therapists have a vital role in such organisations to facilitate more inclusive work environments for people with disabilities or mental health problems. Through such work, occupational therapists are enabling the social inclusion agenda, addressing aspects of health inequalities and occupational justice.

The combination of health and social care provision within a business model raised moral and ethical issues for some of the social entrepreneurs. In Fostering and adoption and Dementia day service, the social entrepreneurs raised concerns particularly about the ethics of making profits in health and social care. The social entrepreneur in Fostering and adoption, the fostering and adoption agency, said that they had to be a not-for-profit

organisation “because of the concept that we can't sell babies” (P1SE1L10) and that they had a responsibility with how they used public money. Despite calling themselves a not-for profit organisation, they acknowledged that they did make profit but that this went back into the organisation. Therefore they were a ‘not-for-private-profit’ business which defined them as a social enterprise. The example from this case study indicates a shift from state provision of some child protection services to the private and third sector which raises issues and concerns about monitoring how such organisations manage child protection. Questions are also raised from a standpoint of social morality about whose responsibility it is to provide services to protect vulnerable children, especially when a profit is being made through the delivery of such services.

The occupational therapist/social entrepreneur from Dementia day service intentionally did not want to generate any profit (even to reinvest into the organisation) through the social enterprise, she only wanted to cover costs:

*“I don't believe in profiting out of other people's downfall and I wanted do the best I can with it with the equipment I need” (P3L146-8)*

This social entrepreneur was an occupational therapist and her desire to provide a service without making profit demonstrates a moral position that she held, not “believing” in profit in such situations, implying that she thought it was wrong to do so. The moral standpoint she brought with her could be as a result of her professional training and experience working within the public sector. Occupational therapists have historically provided their services for free within the public sector and the provision of services through social enterprises which require payment is a new and unfamiliar context for occupational therapists to practice within. Despite not wanting to generate a profit she also did not want to be a charity as she thought that her social enterprise needed to be sustainable and financially independent:

*“At the end of the day I believe it has to pay for itself through longevity, it has to survive” (P3L168-9) ...*

*“If I'm surviving off charity money, on hand-outs what future have I got long-term? I can't see the point in that ... you've got be realistic about it” (P3L171-173)*

These two quotes demonstrate an internal conflict that this social entrepreneur experienced but a social enterprise model enabled her to resolve this by covering costs without making further profits. Social enterprises that 'break-even' to achieve their social aims have been evidenced by Connelly and Kelly (2011), however, the social entrepreneur in this example may not have understood the concept of generating profit for a social purpose, for example to further develop the organisation.

The social entrepreneurs in Therapy through sport and Gardening and farming both generated income to pay for their salaries through providing training on private basis which was well paid. Both of these social entrepreneurs were healthcare professionals (one occupational therapist and one clinical psychologist) which suggests that they struggled to fund their salaries through the activities of the organisation and needed to utilise their skills and expertise to generate an income through training. Occupational therapists have a wealth of professional expertise that can be offered as training and this could be a valuable income source for social enterprises seeking to employ an occupational therapist. This could require selling their knowledge and expertise in the private markets to generate income for the social enterprise.

### **Governance and decision-making**

Historically, occupational therapists and service users have not been involved in governance and decision-making in services within statutory provision. Social enterprises can offer new opportunities for both occupational therapists and service user's voices to be heard about the services offered and their opinions incorporated into how they are delivered. Therefore occupational therapists could have the opportunity to influence the running of social enterprises from a perspective of occupational justice informed by an occupational therapy philosophy. Inclusion of service users in governance and decision-making promotes the principles of co-production (Gannon and Lawson, 2009; Boyle and Harries, 2009; Aldridge, 2012) which supports the recovery agenda and a collaborative approach within occupational therapy.

Both Woodland and forestry and Social housing had a formalised governance structure that included those who were part of the membership of the organisation in their annual general meeting (AGM). Social housing had a very inclusive approach to involving members in their governance structure (Source: CS6 website and leaflet) and incorporated democratic principles and high levels of community involvement in their aims and values (Source: CS6 official publication). This included active involvement in policy

development and evaluating performance with all relevant stakeholders (such as service users and staff) and holding their board to account (Source: CS6 membership application). Active involvement in policy creation involved gathering all stakeholders (tenants, staff such as occupational therapists, managers and board members) to discuss and decide what would constitute the policy. They viewed this as integral to their processes and not only as consulting with them when the decision had already been made by the managers within the organisation. The involvement of stakeholders in policy creation impacted the occupational therapy service as policies were developed that shaped what service the occupational therapists offered. The occupational therapist was included in this policy creation and the collaboration with service users in this dynamic was a new experience for the occupational therapist as both had equal participation. This is a new level of collaboration for occupational therapists with different power relations to that experienced within occupational therapy interventions with service users.

The extent of stakeholder involvement in the organisation was a result of Social housing's legal structure as an Industrial Provident Society (Source: CS6 website: Housing Association Regulatory Assessment, 2013) which is the only legal entity that formally incorporates democratic governance (HMRC, 2013). All other social enterprises included in the study did not necessarily have to include or involve a democratic structure in their decision-making and governance processes. The level of involvement of all stakeholders in the governance of Social housing required significant input from the social entrepreneur to manage the relationships and different agendas. Woodland and forestry invited its members to participate in the AGM but was less inclusive than Social housing. Fostering and Adoption, Woodland and Forestry and Therapy through sport involved staff, volunteers and those who use the service in formal and informal feedback structures. Organic growing was the only co-operative that participated in the study and as a workers co-operative they highly valued community involvement and empowerment (CS8 website, 2012). Whilst the concept of co-production (Gannon and Lawson, 2009; Boyle and Harries, 2009; Aldridge, 2012) is embraced and eluded to, further research would need to be conducted to establish the extent to which it is a reality.

In Social housing, involvement of tenants (service users) was a central part of their governance structure and affected the overall running of the organisation. This had a direct impact on the occupational therapy service offered as the tenants had significant involvement in increasing the provision of the occupational therapy service as there was a demand for occupational therapy:

*“The back-log was about a year in OT assessment and we just thought that was crazy because people just can't wash (themselves) and it takes you a year to sort that out, it's just essentials, so we were determined to drive the timescale right down and we needed to clear the backlog so we brought in a lot more OTs (L166-8) ... tenants were involved in identifying that we needed to increase the resources very much so because we've measured how long it was taking, there was a very strong pressure to improve the timescale.” (P22L191-3)*

In all eight case studies, the occupational therapists were involved in management, governance or feedback structures to varying extents within the social enterprise. This raises questions about the extent to which occupational therapists may have the skills, knowledge or experience to take on some of these roles. In three of the case studies the occupational therapists were on the social enterprise board of directors (in two of these cases the occupational therapist was the social entrepreneur). In four case studies, the occupational therapists were consulted or had an input in the management decision-making process within which they felt appreciated and valued. Their input enables these social enterprises to become more therapeutic in their activities. In the remaining case study, the occupational therapist was involved in informal communication channels of giving feedback. The three social enterprises with occupational therapists on the board (Youth health promotion) or as the social entrepreneur (Dementia day service and Therapy through sport) had a small financial turnover and all of whom had limited business experience and two of these were financially insecure. Despite the financial insecurity for these participants, they were passionate and committed to their work. It is possible that the small size of the social enterprises with occupational therapist social entrepreneurs is a result of a lack of business skills and expertise. Both of these participants expressed their lack of business knowledge and experience as a challenge for them. It is likely that it is a result of the social entrepreneur's lack of business skills that led to Therapy through sport to turn into a charity.

In comparison to these three small social enterprises, the larger case studies (financially and in terms of staffing) were social enterprises without occupational therapists as the social entrepreneur or on the board. The social enterprise managers of Woodland and forestry and Social housing were both experienced in business and management of large organisations prior to managing the social enterprise. This suggests that the most effective social enterprises from a (financial and business perspective) were those which were managed by a person with a business background. However they did incorporate



the occupational therapists at a senior management level to utilise their expertise to have an influence within the organisation in relation to therapeutic rehabilitation.

The occupational therapists appreciated having involvement at a management and policy level, gaining a sense of satisfaction, value and self-worth by being included in decision-making. This is in contrast to the paternalistic structures within the public sector which did not offer such opportunities to occupational therapists. The occupational therapists were able to bring about change and improve practice quickly within their organisations, incorporating service user's feedback and without being delayed by bureaucratic processes they experienced in previous roles in the public sector.

### **Outcome measurement**

In the increasingly competitive market for health and social care delivery, outcome or social impact measurement has become pertinent in relation to funding and finance of social enterprises and third sector bodies (Bertotti et al., 2011). Social enterprises are increasingly being required to prove their effectiveness to win contracts and funding. Occupational therapists in all sectors are increasingly required to prove the outcomes and effectiveness of their practice (Bennett et al., 2003). Within social enterprises, there are implications for occupational therapists use outcome measures that are easily understandable to colleagues and funders who are outside the profession.

Seven of the case studies were exploring how to measure the impact of their work or were already undertaking a type of outcome measure at the time of data collection. Outcome measures are familiar tools for occupational therapists in relation to their interventions with service users, however proving their effectiveness in relation to the funding they receive is a new and challenging prospect for some occupational therapists within social enterprises.

A range of different outcome measures were used by the occupational therapists in the social enterprises in this study. Secondary data was collected from the case studies about their outcome measures. The occupational therapist from Dementia day service wanted to use a standardised outcome measure but had not been able to identify one that was appropriate for use with people with dementia. She was able to observe improved wellbeing of her service users and she designed and implemented a carer satisfaction questionnaire (Data source: CS2 satisfaction survey document). The occupational therapist from Woodland and forestry used the Recovery Star (MacKeith and Burns, 2011) which was chosen by the service users who rejected an occupational therapy specific

outcome measure because it was difficult to use (Data source: CS3 Recovery Star outcome document). The data from this case reported improvement in service user's self-rated abilities and skills in various aspects of their lives whilst attending the social enterprise.

Youth health promotion used DVD footage from their service users to speak for themselves which they presented to donors (Data source: CS4 DVD). In addition, Youth health promotion used questionnaires to record attitude change before and after their interventions (Source: CS4 official publication). In therapy through sport, the occupational therapist found it challenging to evidence the value of occupational therapy and used the goals set by the service users against their achievements as a method for evidencing the value of their interventions. The social entrepreneur in Gardening and farming used the Clinical Global Assessment Scale (CGAS; Data source: CS7 Outcome measure documentation) which demonstrated that with the youth that attended for more than 3 months, there was an improvement in their mental health with one exception.

However, outcome measurement in Youth health promotion and Therapy through sport were perceived as difficult to do with little guidance on how to do it. The social entrepreneur from CS4, (Youth health promotion) expressed her challenges with outcome measurement:

*“Measuring outcomes it's got to be the worst things ever. How do we measure what would stop someone from getting HIV? How do we measure that would stop someone getting pregnant? How can we measure we have stopped someone stabbing someone?” (P13L360-3)*

Health promotion is a particularly difficult intervention to measure and is an example of an area of work where it may not be appropriate to measure. This quote is an example of what has been asserted in the literature as an intangible or un-measurable social outcome (Connelly and Kelly, 2011; Roy et al., 2013) which could be a challenge for many social enterprises. A range of social impact measurements have been designed and evaluated for social enterprises generally (Stevenson et al., 2010) but with criticisms of their validity (Austin et al 2006; Lane and Casile, 2011). Despite the pressure on social enterprises to prove their effectiveness through impact measurement, they may need to resist this and challenge the relevance of attempting to measure non-quantifiable social outcomes. Social enterprises may however be in difficult positions to resist using outcome measure (even if they are inappropriate) if this is a requirement attached to funding.

The development of social impact measures has been led by the business sector and is driven by a need to generate a financial amount as an output that can be used to evaluate the effectiveness of the social enterprise in comparison to the financial investment made. Inherent within this is an assumption that all work carried out by social enterprises is measurable. Social impact measures can ignore or invalidate the actual social impact to the individual or service user group in an attempt to monetarise non-quantifiable impacts (Austin et al., 2006). Social impact and outcome measures designed by health and social care professionals could be more appropriate to demonstrate actual social impact in relation to the interventions of the social enterprise. However, the conversion of these outcomes (for example, return to work) may not satisfy the increasing demands of the government or private sector investors who seek a monetary value for the interventions provided. This highlights a conflict in bringing together business and social models. However, the occupational therapy profession has a wealth of outcome measures that could be adapted and utilised in such settings (COT, 2013).

### **7.3 Theme 2: Dynamics of occupational therapy practice**

At the meso, organisational level, this theme was developed which encapsulated occupational therapy professional practice within the social enterprise. The findings within this theme relate to research questions 1, 2, and 4 which are repeated here:

1. What form of occupational therapy is practiced within social enterprises in the UK?
2. What is the relationship between occupational therapy practice in social enterprises and the philosophical foundation of the profession?
4. What are the factors that determine the different ways occupational therapy is provided within social enterprises?

The findings from the case studies in relation to the dynamics of occupational therapy practice were developed into three sub-themes:

1. Creative and innovative practice
2. Occupational therapy practice according to the philosophy of the profession
3. Social enterprise as a therapeutic environment

## **Creative and innovative practice**

Some of the social enterprises have enabled occupational therapists to develop their practice and apply new ways of working in accordance with theories of occupational therapy and occupational science. One example of this is from Youth health promotion where the occupational therapist provided interventions around preventing social and health problems such as teenage pregnancy, bullying and involvement in gang culture:

*“Our approach is fundamental to our targets and by working in innovative and interactive ways, on concerns such as knife crime; sexual health and relationships; bullying; cyber-crime; alcohol and drug issues, we achieve our goals by fostering an atmosphere in which young people feel able to raise and discuss issues of concern to them”*

*(Source: CS4 official publication)*

This preventative, health promotion aspect of occupational therapy is an example of the theoretical and conceptual assertions of occupational therapy practice written by Wilcock (2006) and supported by the College of Occupational Therapists (COT, 2008) and the World Federation of Occupational Therapists (2004). There is a professional belief inherent within occupational therapy that positive occupations can lead to improved health and wellbeing, therefore occupational therapy can be a health promotion intervention. However, there has been limited guidance in the UK about how to create environments for occupational therapists to practice health promotion. The occupational therapist from Youth health promotion used a health promotion and educational approach to encourage healthy occupations:

*“...my role really is more the social model that OT's work from rather than the medical model and trying to promote people's independence and give them empowerment, run their own lives through education, through teaching them how to be safe before you have to deal with them after something's happened” (P12L15-18)*

This proactive, preventative approach in occupational therapy formed the context for the types of interventions that the occupational therapist provided in this social enterprise.

*“Our main role is to give people independence in life and if you stop them from becoming drug addicts and alcoholics becoming pregnant as teenagers I think that’s a massive role for OT.” (P12L649-51)*

The wording this occupational therapist used to “give” independence is usually phrased as enabling independence within the occupational therapy profession (COT, 2013) as independence cannot be given but enabled, encouraged or developed. The occupational therapist in the quote above saw preventative approaches as an important role to educate others on the impact of negative occupations and their consequences. Interventions to prevent teenage pregnancy, drug or alcohol abuse can be instrumental in addressing health inequalities in low socioeconomic areas (Friedli, 2009). The occupational therapist in CS8 (Organic growing) found it satisfying that she was able to provide preventative interventions as well as treatment:

*“...there is potential for progress in that it is not just fixing things that are broken all the time” (P28L436-7)*

This occupational therapist referred to “progress” as enabling those she worked with to develop their skills and abilities and said this in comparison to “fixing” what was broken, referring to her work within statutory services providing treatment interventions after an accident or illness. In this example, the occupational therapist used a strengths-based approach (Rapp and Goscha, 2012) to develop the skills and abilities of those she worked with from an occupational perspective within the social enterprise. Occupational therapists have historically provided treatment interventions probably because of the influence of working within the medical model. However, theories of occupation and occupational health promotion promote working preventatively and to promote occupational engagement even with the absence of illness (Wilcock, 2006; COT, 2008). The examples above of occupational therapists creative practice within social enterprises demonstrated the ability to promote health through occupation as a preventative measure, rather than as treatment. The approaches adopted by these occupational therapists is resonant of Antonovsky’s (1987) strengths-based health promotion model. Social enterprises could provide the opportunity for occupational therapists to practice in this way and could indicate a move away from the deficit-based approach of the medical model which has dominated occupational therapy practice.

Preventative interventions may have a significant financial impact on the public sector and may be a more effective strategy than cuts in services. For example the cost of running a

workshop with teenagers about the risks of gang culture, versus the costs of medical intervention and rehabilitation after a gunshot wound alongside the cost to probation for the related crime. Occupational therapy interventions in a wide range of health and social care settings could be calculated to as evidence of how to reduce costs on the public sector.

A second development for occupational therapy professional practice was developing an “other” focus in the organisations and the use of peer-support. In relation to being other-focused in Woodland and forestry and Therapy through sport both the occupational therapists described using interventions that encouraged the service users to be focused on helping and supporting others in the group or organisation. For example, in Therapy through sport the occupational therapist (who was also the social entrepreneur) intentionally encouraged the service users to become ‘other’ focused, taking attention away from them, becoming less self-centred and more concerned with other people’s wellbeing as part of their recovery. She explained:

*“It’s about “What can I give?” and that’s everything from the footballers to everyone else to feel self-worth, then “I am good, I can give something out,” their problems don’t become anything anymore” (P18L107-9)*

Peer support and mentoring was one of the aims of the organisation which was evident in their website to “Provide mentoring and peer support” (Source: CS5 Website). The benefit of this approach was spontaneously talked about by two of the service users’ interviews from this case study:

*“I remember coming training one day and they were all down and looking sad and when I come into the team and I started being positive, all of them they just end up being positive and they all back together and trying their best” (P15L123-8)*

*“I’ve got to encourage them to become a better person... To get a better life... Talk to each other” (P16L21-2)*

This phenomenon was also evident in CS3 (Woodland and forestry) by one of their service user’s:

*“I do an art group as well on a Thursday afternoon ...and I enjoy that because with being an artist myself it's nice to be able to, it gives me some confidence to teach other people because that was my main problem losing my confidence” (P8L16-21)*

This approach communicated to the service users that they had something valuable to offer others which could build their confidence and self-esteem and was acted out through the activities of the organisation, whether football or art. Both of these case studies worked with adults who were recovering from mental health problems and the occupational therapists recognised the value of peer-support in mental health recovery. In Therapy through sport, the occupational therapist encouraged some of the members that had been attending for longer periods of time to become mentors to others through peer-support. This involved training and enabling the service users to support others with supervision from the staff. The occupational therapist from Woodland and forestry also paired up service users for peer support and both Woodland and forestry and Therapy through sport provided opportunities for service users to move from one role to another within the organisation, such as taking on voluntary positions and paid work:

*“... he's been shadowing us for every year before he can do on his own, until we feel comfortable and he is now... (the occupational therapist) went in to do some cooking and then gradually we pull out and the buddying mates goes round and does some cooking with them or shopping or whatever needs be ... and then the buddy reports to us straight away” (P18L229-233)*

The social enterprise environment in Woodland and Forestry, Youth health promotion, Gardening and farming and Organic growing enabled those who use the services to progress into taking on roles and responsibilities to support others within the organisation under the support and guidance of the occupational therapists.

Training and equipping those who use services as volunteers in peer-support is a new and innovative approach in occupational therapy in the UK however is common in community-based rehabilitation theory and practice (Thompson et al., 2010) and in the development of the service user movement in mental health fields (Repper and Carter, 2011). The involvement of service users in delivering aspects of the social enterprise as an occupational therapy intervention challenges many traditional roles and dynamics between occupational therapists and service users. In traditional, medicalised healthcare

settings, the occupational therapist is the expert and the service user a patient, with associated power dynamics in the therapeutic relationship (Twibble and Henley, 2000). However in this case study, the occupational therapist is not bound by these traditional roles and is able to perceive the person using the service as a potential colleague and incorporate this into the occupational therapy interventions. Inherent in this is the ability of the occupational therapist and the social enterprise staff to have a mutual respect and trust for each other. This attempt at equality is evident in occupational therapy philosophy which values collaboration and joint effort between the occupational therapist and service user towards achieved goals.

The Woodland and Forestry, Youth health promotion, Therapy through sport and Gardening and farming cases all provided examples of the service user gaining employment within the social enterprise. This provides new opportunities for service users to gain support throughout the process of employment, who may otherwise have attended day centres to engage in therapeutic activities but then need to gain work experience in unsupported environments. This suggests the importance of providing flexibility within social enterprises for people who use the service to progress through the organisation as they develop skills and take on more responsibilities. This also highlights a potential role for occupational therapists to be employed in multiple settings (whether private companies, charities or others) to enable the organisation to become more inclusive of people with disabilities or mental; health problems. Occupational therapists can be valuable assets to social enterprises which aim to promote employment.

The activities that the social enterprises offered could be used and adapted by the occupational therapist for people with wide ranging occupational problems to engage with. This would be in contrast to occupational therapy service in the public sector which is based on medical illnesses (for example a stroke service). The benefit of this is that occupational therapist can work in an occupation focused way, rather than having interventions determined by recovering from a medical illness. Occupation focused interventions widen the scope for occupational therapists to include people who are occupationally deprived such as the unemployed, without having a medical focus. The occupational therapist in CS3 (Woodland and forestry) expressed that she was able to focus on purposeful activity rather than the person's problems or illnesses:

*"...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" (P5L236-238)*

The occupational therapist in this case saw the value in occupational therapy training in preparing her to work holistically and with a broad range of occupational needs. Her experience was that people with a range of medical illnesses (such as a heart condition, learning disability or mental health) could all benefit from the same activities she was offering in the social enterprise. Occupation-based practice outside of the context of medical illness can provide opportunities for occupational therapists to work in environments that supports a holistic approach to address physical, psychological and social needs in one service. This is in comparison to medicalised services within which a patient may be seen by multiple occupational therapists under different departments causing duplication, waste of resources and some occupational needs may be unaddressed. There are implications for the existence of one service rather than multiple services that utilises all the occupational therapists training and skills in physical, mental health and learning disabilities. However, many existing occupational therapists have become specialists within one particular field and may not adapt well or agree with working with people with a range of occupational needs. However, the specialisation of occupational therapists into medicalised settings can be questioned and challenged, particularly when occupational therapists focus for intervention should be based on occupational goals and not on treatment from a medical condition.

In the above cases the occupational therapy centered on the activity of the business (such as woodwork or gardening), the focus was on the activity and not on the individual's illnesses. This provided the opportunity for the individuals who attended the social enterprise to have the main focus of attention on something other than their 'problems' in contrast to statutory services which focused on illness and deficits.

The non-medical environment and removal of clinical boundaries provided the opportunity for the service user to be perceived and accepted as a fellow human being by staff and by other service users (rather than being regarded as a 'patient'). Foucault (1973) referred to the phenomenon of the 'medical gaze' that inevitably accompanies the sick role (Parsons, 1951) whereby an individual's identity becomes tainted through labelling and subsequent treatment as a 'patient'. A positive sense of identity is imperative for good mental health (Erikson, 1995) and the subsequent 'medicalisation' of mental distress according to Goffman (1963) creates 'spoiled identities'. This concept has become an important aspect of mental health recovery in relation to the need for individuals to develop positive

identities (Shepard, Boardman and Slade, 2008; Slade, 2009). This may be achieved because it is not a medically-orientated environment and instead focused on occupation which is central to the recovery agenda and theories of social inclusion (Repper and Perkins, 2008). Without labels and stigma, in a normal social environment, service users may be able to discover and develop their sense of self, confidence and self-esteem. One person who used the service offered by CS3, (Woodland and forestry) recognised the value of the activity he engaged in and the benefit this had on him in comparison to his experience of statutory services:

*“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 (L47-9) ... It’s specific to that role as opposed to it being, doing all the stuff you are meant to do to prevent you having another episode, it’s nice because I’m fed up with it I’m bored of mental health” (P6L54-8)*

This service user expressed relief that the focus in the social enterprise is not on him and his mental health but on the role he had to complete a task and achieve a common goal. His experience is the intention of occupational therapy as occupation is the vehicle for enabling and developing wellbeing. In this example, this man appreciated the role he had within the social enterprise, providing an identity, meaning and purpose which benefitted his mental health as a result. This participant’s experience of activity benefitted his health and is a practical example of the application of the theories of occupation for health (Wilcock, 1998, 2002, 2006). The combination of this with a social enterprise structure benefitted him by offering a non-stigmatising role outside of the medical setting (Repper and Perkins, 2003) which he valued. Whilst the focus was on ‘the doing’ it was not on symptoms and deficits and thus assists a more positive self-worth through accomplishment (Rapp and Goscha, 2012).

The engagement of people in the activities of the business raise issues regarding the protection of vulnerable populations from exploitation. Social enterprises may be required to demonstrate that they are not exploiting the people engaged with their activities for free or illegal labour. Occupational therapists could play an important role in ensuring that the activities are appropriate for the people benefitting from the service, according to their individual therapeutic needs and goals. Social enterprises that do not employ health and social care professionals may be at a greater risk of such exploitation without a professional assessment of individual capabilities. In these circumstances, according to

theories of occupational justice and in line with the Equality Act (2010), occupational therapist should encourage and protect the rights of the people receiving their services to be treated fairly (Townsend and Marval, 2013).

Through activity-based interventions rather than services defined around medical illness, occupational therapists can also gain opportunities to work with service user groups that are previously unreached groups in society by occupational therapists despite significant occupational challenges. One example was in Woodland and forestry, where the occupational therapist was considering expanding her role to work with youth who are not in employment, education or training (NEETS). Such an opportunity would not be available within a medical setting as this group of people do not have a medical problem despite having occupational needs. Engagement with people in society that do not have medical problems but have occupational needs could enable occupational justice and social inclusion.

Six of the case studies in this research, provided an opportunity for the occupational therapist to work with people using the services in a non-medicalised environment, outside of a monolithic institution under the welfare state with the associated roles such as 'patient' and 'therapist'. Woodland and Forestry and Youth health promotion were intentionally not medical or hierarchical in their approach which was intentionally driven by the social enterprise manager. In CS3, (Woodland and forestry) prior to recruitment of the occupational therapist. She explained:

*“What I didn't want was for the patient relationship to become just that, ... just another consultation just in a wood (the social enterprise location), I wanted that to be nothing like a consultation room, 'I've been assessed to death I want freedom' and I've got people who might be getting into work and that's where the occupational therapist came in”*  
(P4L295-8)

The social entrepreneur in this example wanted to provide therapeutic intervention in a normal social environment to be distinctly different from the clinical and unnatural environment of a hospital consultation room. Not only did she want to provide a different environment but she wanted the relationship between the health-care professional to be different from the clinical relationship traditionally found in the public sector. This approach led to the treatment of people as human beings, not their medical condition, or as a

passive recipient of the welfare state. However, in contrast, one man in this social enterprise preferred to be labelled as a patient:

*Participant: "I would have thought myself as being a patient here rather than a volunteer because volunteers are from all walks of life, I would prefer to be (referred to as) patients or people who are recovering from mental health. You could go on to being a volunteer but I see this for myself as being a patient"*

*Researcher: "How would you feel it would be different being a patient versus being a volunteer?"*

*Participant: "(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. I do volunteer somewhere else and I haven't been for a while and I would say that that is volunteering because you just do it in your spare time, this is a patient thing and you are around other people with the same illness" (P7L64-72)*

This participant viewed his recovery as needing medical intervention and wanted to be treated within the traditional medical model. His views represent a historical perception of the sick role (Parsons, 1951). Or it could be because of his interpretation of recovery and the relationship he has had with services whilst recovering from mental health problems. Within the social enterprise, he was around others with mental illness and getting support from the occupational therapist, therefore he felt he should be in the role of a patient, and described the differences between this and the role of a volunteer in a binary way. Therefore not all service users want to accept new ways of relating to healthcare professionals such as occupational therapists. There could be implications for how occupational therapists are perceived if some service users have difficulty accepting they are receiving occupational therapy within social enterprises if it doesn't 'look' like their expectations of receiving therapy. Questions are also raised about the extent to which service users are being included and prepared for the changing approaches to delivering health and social care in different contexts.

As identified in the previous sub-theme, the non-medicalised environment can promote the recovery process. This was important in the case of Therapy through sport, which gained a building and premises away from any association with public services to support

adults who were on probation, or with mental health or drug and alcohol problems. This inclusive environment enabled the occupational therapists to address issues of stigma and social integration by enabling their service users to become involved in what is perceived as normal activities in their local community (Pinfold et al., 2005; Morgan et al., 2007). Therapy through sport, prioritised overcoming stigma as an aim for their work:

*“(name of organisation) uses sport to overcome the stigma and exclusion that exists for those suffering mental ill health” (Source: CS5 website and leaflet)*

The ‘normal’ social environment provided an optimum setting for the social enterprise’s activities and occupational therapy, promoting social inclusion and away from institutional settings:

*“...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 (L196-199) ... everyone's been trying to get into this building but we are in” (P18L201)*

Youth Health promotion also conducted their work in settings in the community which meant meeting the service users in their own environments, such as youth clubs and schools to promote inclusion (Source: CS4 mission and aims; business plan). The ability for occupational therapists to meet people in their normal, natural settings has implications for perceiving them as a person holistically and incorporating the therapy into ordinary everyday activities which is important for mental health recovery and social inclusion (Perkins and Repper, 2013; Leamy et al., 2011). Such community-based locations are therefore preferred to NHS settings as they have become a stark contrast to what Foucault referred to as being under the ‘medical gaze’ (Foucault, 1973).

The social entrepreneur from Therapy through sport intentionally recruited students and newly qualified occupational therapists that did not have an ‘NHS mind-set’. By this she meant the limited role in the NHS for occupational therapists to conduct assessments in basic occupational needs, limited actual therapeutic interventions and operating in the traditional patient – therapist dynamic. The social entrepreneur in this case was an occupational therapist and she wanted to promote occupational therapy skills that are taught in undergraduate training (such as holism and client-centeredness in all occupational interventions) which can be side-lined within the NHS.

As occupational therapy emerged out of the medical profession and has a long history of operating within the welfare state, the impact of working outside of the public sector may be challenging for some occupational therapists (Turner, 2011). Operating outside of the medical model may challenge some occupational therapists who gain status and significance of association with the dominant paradigm in healthcare in the UK. A shift in emphasis from the majority of occupational therapists employed through the NHS to employment in a variety of community organisations may be a threatening and insecure prospect for the occupational therapists involved. However, this may be a necessary change considering the reduction in the number of occupational therapy positions in the NHS and the increasingly limited role for occupational therapists in statutory services. There are particular implications for occupational therapists who may have been qualified for a significant amount of time who have become socialised (Clouder, 2003) or institutionalised into traditional therapeutic relationships, who have taken on the role of the 'professional' or 'expert' (Twibble and Henley, 2000) with associated power dynamics. However as the profession of occupational therapy is rooted in humanism, client centeredness and collaboration, these principles have remained in practice despite a medicalised "culture" that occupational therapists have worked within over the past century. The opportunity for occupational therapists to work in non-medicalised settings that enable occupation-based practice, such as social enterprises, may bridge the 'theory-practice gap' (particularly between occupational justice and occupational therapy) that is evident in the UK (Pollard et al., 2008). The findings from this study demonstrate how this gap can be bridged through engaging with people in society who have occupational needs without medical problems such as children excluded from formal education; the unemployed; or people on probation all of whom could experience occupational deprivation.

The non-medicalised approach in occupational therapy practice observed in six of the case studies in this research and is highly consistent with theories of social inclusion (Fieldhouse and Onyett, 2012) and sociological perspectives in occupational therapy (Eklund et al., 2004; Barros et al., 2005). To date, there is little empirical research however directly related to these phenomena. Furthermore, prior to this research, there has been limited evidence of these models and theories being fully applied to occupational therapy practice. Theory and practice of community-based rehabilitation in other countries around the world provide further examples of a non-medicalised, non-hierarchical therapeutic relationship that occupational therapists can operate within (Twibble and Henley, 2000). For example, the occupational therapist can act as a 'trainer' teaching therapeutic skills to family or other carers involved in a person's life, instead of

the occupational therapist being the only person able to provide the therapy. A community-based rehabilitation approach also facilitates groups of people with a community to problem-solve together and creatively devise their own solutions, with facilitation by the occupational therapist if needed (Sakellariou and Pollard, 2006).

The majority of case studies researched in this project demonstrated practice that is not normally evident in the public sector. This was with the exception of one case study, CS6 (Social housing) which offered an equipment and adaptations service, similar to a traditional occupational therapy role provided by the Local Authority. Services offered by this social enterprise were previously provided by the Local Authority, which included the occupational therapy equipment and adaptations service. The occupational therapist from Social housing explained that in her role she was unable to practise “true OT” (P21L222) because of the overwhelming demand for basic needs assessment (such as washing, dressing, eating and mobilising around the home). By “true OT” the occupational therapist was referring to the aspects of occupational therapy she was unable to do such as therapeutic grading and adaptation of occupational activities in relation to the service user’s social, psychological and physical needs. Instead, the occupational therapists within Social housing were constrained by an overwhelming demand for basic assessments of mobility and functioning. This case study did have the opportunity to creatively develop the occupational therapy role in the future as they were reducing their waiting list and exploring other roles for occupational therapy within the organisation such as gardening with the elderly. Development of such roles would enable the occupational therapists to be more therapeutic in their work (rather than assessment and provision of equipment) and utilise more of the occupational therapists skills and expertise.

### **Occupational therapy philosophy and practice**

The majority of occupational therapists interviewed in this research experienced job satisfaction in their role in the social enterprise because of their autonomy over decision-making and ability to practise according to their training and the philosophy of the profession. This was frequently talked about in comparison with the limitations they had experienced in their previous employment in statutory services. The occupational therapist in CS1 (Fostering and adoption) expressed that she was able to return to the roots of the profession after a long career in statutory services where she was unable to properly practise occupational therapy:

*“...now I've got a real OT job, this is what we were trained to do”  
(P2L399).*

By a “real OT job” this occupational therapist referred to being able to conduct thorough holistic, occupation focused assessments, plan and carry out therapeutic interventions with the children and their families. In her previous work in the statutory sector she was unable to actually conduct the therapeutic aspect of occupational therapy due to a high workload demanding quick assessments and discharge. In Five of the case studies (Woodland and forestry; Youth health promotion; Therapy through sport; Gardening and farming and Organic growing) the occupational therapist was able to work in a client-centred way offering flexibility in the length of attendance, setting individual goals, adapting activities according to occupational abilities and designing apprenticeships specifically for individuals. For example the occupational therapist from CS3, (Woodland and forestry stated):

*“...we will develop some goals ... and that's always done on an individual basis” (P5L113)*

The occupational therapist in CS7 (Gardening and farming) was also able to work with people on an individual basis:

*“...working with each client individually to make sure they can make the most of the experience really get the most out of the experience adjusting the activities is necessary thinking of what activities will challenge them but not challenge them too much” (P23L50-3)*

This client-centeredness was supported by flexibility within these social enterprises to be adaptable with each individual's strengths, abilities and preferences. Such client-centeredness was incorporated into the business plan for Dementia day service as central to the interventions:

*“Interventions will have therapeutic basis and be relevant to the needs and choices of the clients”. (Source: CS6 Business plan, p8)*

In CS6 (Social housing) the occupational therapist was able to practise according to service users' needs within the limitations of the social enterprise. This was an improvement to her previous role within the Local Authority where her clinical decision-



making was over-ruled by Local Councillors who were under pressure by their constituents. However, the occupational therapists in this case study had a long waiting list and so were only able to address people's immediate self-care needs therefore they were unable to offer a holistic occupational therapy service and meet the wider range of occupational issues they faced.

There was a mixture of responses among the occupational therapists interviewed about their perceived ability to take control of their practice and determine the service they offered. Occupational therapists in four of the social enterprises felt that they were able to practise the profession in an unrestricted, flexible way with freedom to make their own clinical decisions which is demonstrated in the following two quotes:

*"I've very much got a free hand in terms of the health perspective of which is fantastic" (P5L136-7)*

*"I'm not tied down by specific models or whether there is a manager with particular ideas about how some things should be done" (P2L193).*

In Youth health promotion; Social housing; Gardening and farming and Organic growing, the occupational therapists provided their interventions in agreement with the social entrepreneur. Case studies 1 (Adoption and fostering) and 7 (Gardening and farming) both used an evidence-based model which informed their practice and was the reason for the need to collaborate with the social entrepreneur on the approach used and service offered. The occupational therapist in CS6 (Social housing) had the authority to determine her own criteria for the occupational therapy service however this was still within the limitations and restrictions placed on her by the social enterprise.

The occupational therapists in seven out of eight of the case studies described being able to practise according to their professional beliefs without the limitations and restrictions they experienced in previous jobs in statutory services. Four of the occupational therapists felt limited in their ability to practise as occupational therapists in statutory services. They commented upon a lack of freedom to make clinical decisions and felt marginalised as professionals within their working environment and these attitudes of other professions narrowed their scope of practice. For example the occupational therapist and social entrepreneur from Dementia day service expressed the following:

*“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 ... I just really feel lovely, I come here and I can do it this way... and I've got so many ideas of things I want to do” (L246-252)*

This occupational therapist sought independence and autonomy to be able to practice according to her professional beliefs and the social enterprise enabled her to do this. The professional autonomy and job satisfaction she experienced in her new role is also consistent with literature which has evidenced occupational therapists experiences who had left the NHS: were able to enjoy professional autonomy; felt valued in their work; felt they gave better patient care; and had better professional development experience (Arnold et al., 2006). She also experienced opportunity to be creative and develop a service according to the needs of those she worked with and her professional expertise, alongside the freedom to act upon this.

Occupational therapists in five of the social enterprises had more time to practice occupational therapy and provide a quicker, more responsive service rather than being caught up in bureaucracy in statutory services:

*“...it was terrible bureaucracy and it was wasteful of my time” (P28L423)*

The experience of these occupational therapists is consistent with the literature evidencing disappointment, disillusionment and inability to meet needs or practice according to professional beliefs (Arnold et al., 2006; Wilding and Whiteford, 2007; Turner, 2011). However, there is very limited research evidence of the dissatisfaction felt by occupational therapists within statutory services, despite this being a common experience for practitioners. The occupational therapists' experiences in this research reveal the level of restriction they experience within statutory services and this warrants further research. This also has implications for occupational therapists' job satisfaction and raises questions about retention in the profession.

The occupational therapists in Fostering and adoption and Gardening and farming explained that they were able to provide therapeutic interventions for people in social enterprises which they were unable to offer in statutory services. This was due to their roles becoming focused on assessment and recommendations without providing therapy

as treatment, due to statutory targets that had to be achieved. This suggests that due to funding cuts and imposed limitations interfering in practice in public services, occupational therapists need to be involved in creating and establishing organisations that are able to provide the interventions deemed appropriate by professional judgment. Clinician led services have been an aspect of the health and social care reforms (DH, 2010a) however adequate training, funding and support is required to enable clinicians to put this into practice (Miller and Millar, 2011). Without clinicians advocating for their own professions and for the needs of those who use their services, therapeutic interventions may be lost.

### **Social enterprise as a therapeutic environment**

In seven out of eight of the case studies, the social enterprise provided a supportive environment that facilitated recovery. In Fostering and adoption, Woodland and forestry, Youth health promotion, Therapy through sport and Gardening and farming the occupational therapists referred to a collaborative approach with their service users incorporating consultative decision-making in the occupational therapy process. This was also evident in some formal documentation (Source: CS1 Statement of purpose; CS4 official publication). Collaborative working is an essential aspect of occupational therapy philosophy (Reed, and Sanderson, 1999), however the social enterprise environment supported this through the service user and the social enterprise having mutual benefits for one another. The 'mutual benefits' for example included work experience of the service user and the voluntary labour the organisation benefitted from (discussed in the theme about combining business and social aims). In five of the social enterprise case studies, there was the opportunity for both the social enterprise and the individuals benefitting from the service to gain something from the interaction. The social enterprise manager in CS3 (Woodland and forestry) verbalised this mutual gain as 'benefit stacking' or 'mutualisation':

*"We are about mutualising, mutualism is about saying to young people and any user group: "This is what we're going to do for you, what are you going to do for us?" We're going to benefit stack this, this is not a hand-out mate, it's activating you, we are activators, now are you in or are you not in? If you are in, fantastic and we will get a brilliant result, if you are not, well go down to the charity" (L106-112)*

The social enterprise manager here is making a clear statement about the significant differences between how they relate to their service users in comparison to charities, the Local Authority or NHS in that they are not paternalistic. The emphasis in this social

enterprise is that everyone has a part to play, something to give and that getting involved in the social enterprise is a two way process. Inherent in this ethos is a collaborative approach and a culture of reciprocity in the social enterprise. A word this social entrepreneur used was “activating” implying that as an organisation they focus on getting the service users involved in activities which proactively benefits their health. This approach, to jointly work towards a common goal through activity is close to the occupational therapy philosophy of mutual collaboration towards the service users’ goals using occupation (Sumsion, 2006). The overt aim of this social enterprise to “activate” people is in contrast to the passive role of patients within the NHS who receive treatment.

One example of how service users were “activated” was through developing a sense of ownership within the project. The shared ownership of the activities of the organisation was described by the occupational therapist in CS3 (Woodland and forestry):

*“...it's not my project it's not (the social enterprise) project, it is all of our project really and certainly if anybody wants to do something different or want to learn something different, we try and do that, accommodate that as much as possible” (P5L162-5)*

The flexible and collaborative approach demonstrated here is not prescriptive or hierarchical and can change and adapt according to the individuals attending the social enterprise at the time. The culture and environment within the social enterprise enabled client-centred occupational therapy interventions and reinforced principles of equality, collaboration and respect among all of those involved. 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” (P5L430-3)*

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 (Sayce, 2000). This social enterprise provided those who used the service an opportunity to take on new roles and responsibilities and learn new skills to go on their CV, whilst getting the support and

therapeutic interventions they needed. An example of this was observed in the case of Gardening and farming:

*“I observed how proudly they (the service users) showed me around with a sense of ownership that this was their project or their job to feed the chickens for example” (Source: academic journal from field notes, May 2012).*

In addition, the experience that the service user gained from their involvement in the social enterprise was beneficial in gaining other voluntary work or employment without any related stigma or association with mental health services. In Woodland and Forestry and Therapy through sport the service users were actively encouraged to take responsibility within the social enterprises through peer support and in promotional work. The change in emphasis for those who use the services from the role of ‘patient’ to someone with a role and responsibilities within the organisation is an important shift and may be challenging for some people who have been using statutory services in the long-term. This may be an implication of the changing health and social care environment that promotes choice and control (DH, 2010a). The extent to which those who use the services have been or are being prepared for new ways of relating to health and social care providers in currently unknown and requires further research.

Observations were made in Fostering and Adoption; Dementia day service; Woodland and forestry; Youth health promotion; Therapy through sport; Gardening and farming; and Organic growing that the social enterprises had intentionally tried to create a relaxed and friendly environment. This included intentionally creating welcoming physical surroundings as well as fostering caring relationships. The following observations were made during the field visit to Fostering and adoption:

*I observed the social enterprise to have a friendly and informal relaxed atmosphere. They employed professionals with expertise and provided interventions to a high standard of quality. However the building and physical environment were not clinical and felt like a large home. The staff did not wear uniforms or name badges which added to the informality and friendly atmosphere. (Source: academic journal from field notes, November 2010).*

The informality of the social enterprise was noticeably different to a hospital or a social services department as the colour of the walls, the lighting and even aromatherapy oils had been chosen to create a 'quasi' home environment. The efforts made by the staff in this social enterprise to create a warm, friendly and relaxed atmosphere was intentional to enable the children and families who attended for therapy to feel at home and comfortable, as opposed to an unfriendly clinical setting. Within this was an implicit message about the social enterprise creating a sense of belonging, an invitation for those who use the service to be a part of it, take on a role and responsibility and engage in a two way relationship with the staff at the organisation. The creation of such an environment for the occupational therapist to work within could benefit the development therapeutic relationship between the occupational therapist and those using the service (Tickle-Degnen, 2008). The informal atmosphere of the social enterprise could convey acceptance of those who use the service as people rather than 'patients' in a non-threatening way.

In CS7, (Gardening and farming) the activities of the social enterprise accommodated the needs of the service users through adaptation of the physical environment. During a field visit the following observations were made:

*"Each of the individuals (service users) chose to talk to me while walking around the farm, rather than being inside. This was an environment where they could move about and weren't restricted between four walls. This made an impression on me that they needed this freedom and the benefit of being outdoors. On another level, they were young adults who had been excluded from mainstream education who didn't fit into a box or category and so needed a different approach to engage with them, something out of the ordinary and this seemed to work." (Source: academic journal from field notes, May 2012).*

In CS2 (Dementia day service) the physical environment as well as the relationships were cultivated intentionally to be friendly, relaxed and informal. The type of furniture, the selection of meals and the décor in the room the day service was held in was all thoughtfully chosen to be appropriate for the elderly people who attended. The service users were greeted personally when they arrived by one of the staff who helped them to find somewhere to sit and get a drink and the staff continually cared for each person for the entire time they remained with them, as a carer or relative would. The Dementia day service incorporated into their philosophy of care that individuals would be treated with

dignity and respect in a safe, caring environment (Source: CS2 Website and promotional leaflet) which was also observed on the field visit:

*During the visit to the social enterprise, the environment and approach was observed to be social, informal and relaxed with structured activities as well as unstructured time for the members to have leisure activities or social time together. It was observed that there was a love and care for the members that was expressed by the staff and volunteers who spent the day talking with them, taking care of them and doing activities with them. The occupational therapists expertise in dementia care meant that the activities were carefully chosen and tailored to the group and to individuals and were adapted to the members cognitive abilities. (Extract from academic journal, February 2012).*

The occupational therapists in Fostering and adoption; Woodland and forestry; Social Housing and Gardening and farming referred to the relationships within the social enterprise (staff and those who use the service) as being like a family. In Youth health promotion, the occupational therapist perceived their service users were more open with them because they were not seen as a authority figure:

*"...it's more like a family type social environment for me ... it feels closer to a family social environment and to being a work environment I suppose and I bring more of myself into the role here than in the NHS"  
(P23L331-3)*

The ideal family environment provides an opportunity for love, support, affirmation, sharing experience, personal growth, making mistakes together and forgiveness. Although historically, such qualities may have been associated with religious constructions, such conceptualisations have more recently found their way into contemporary thinking through positive psychology (MacConville and Rae, 2012). Furthermore, there are the therapeutic and health benefits of environments such as these to facilitate recovery (Jacobson and Greenley, 2001). In these case studies, the participants referred to this family environment as a reflection of a different way of relating to one another as colleagues as well as those who use the service in comparison to their previous experiences in statutory services:

*“...it's a sort of loving culture really I can't tell you the difference with working in public service where you are just a minion and I can't believe I put up with that for so long” (P2L113-4)*

The occupational therapists in six of the case studies referred to a humanistic, non-authoritarian, non-labelling approach in the social enterprise. In contrast to their experience of a hierarchical, medical model with the associated power dynamics in statutory services:

*“I think we're just on a level really and it's not there is no hierarchy I find here I find my experience of going to the ward and meeting some of the guys on the ward I find there is a hierarchy” (P17L118).*

Similarly, the staff in CS4 (Youth health promotion) sought feedback from their service users so they could modify their approach to be most appropriate for them. The staff in the social enterprise valued collaboration from the youth they worked with to consistently evaluate and improve their service. Questionnaires were used to gain this feedback alongside DVDs which were made which asked the youth for their opinions. The social enterprise staff were filmed asking the youth their opinions about the organisation and what they had learned. However, the children were all positive without making any critical comments which raises questions about how effective this method is of gaining their views as they could feel they had to 'say the right thing.' A film made independently of the organisation may be a more effective method.

Some of the occupational therapists in the social enterprises chose to relate in a different way to service users by removing barriers such as their titles. The occupational therapist in CS8, (Organic growing) chose not to use her role or title as an occupational therapist as she believed it would interfere in the relationships she had in the social enterprise. She only used the title when she needed to and otherwise wanted to relate to others at the social enterprise as a peer, whether they were staff, members or service users. The occupational therapist in CS4, (Youth health promotion) also had a similar attitude about not needing to use her title as an occupational therapist as she thought this was not important to the youth who used their services. In CS7, (Gardening and farming) the occupational therapist thought it was important to their service users that staff were therapists because they were attending the social enterprise for a specific purpose, but irrelevant to them what type of therapist they were. The occupational therapists in Fostering and adoption; Woodland and forestry; Youth health promotion and Organic



growing described a professional relationship with service users that had less professional distance, being more personal and informal. It was the choice of these occupational therapists to relate to their service users in a different way to their experiences in statutory services to create a greater sense of equality and shared responsibility in facilitating the recovery process.

Not only did the occupational therapists want to create a different type of relationship with service user's, some perceived them as human beings, capable of achieving anything they want to in life and more than patients receiving a service. The occupational therapist explained this as the following:

*“When we first started working with people with mental health problems in statutory organisations our work with them was about maintaining health and wellbeing as much as is possible, but its about supporting them through their recovery and their outcomes at the end of that really have no reason to be any different from what anybody wants out of life and I think all too much in the past people with mental health problems have been second-class citizens in those terms that you know, they (statutory services) don't view the fact that they know could get a job or get married and have children or whatever it might be as being achievable outcomes for them and there's no reason why they shouldn't be” (P5L318-25)*

Through working for this social enterprise (Woodland and forestry), this occupational therapist was able to engage with the people who use their services without the limitations she experienced in statutory services. Her experience was that people who used statutory mental health services were 'maintained' rather than enabled to live out a fulfilled life as a member of society. For example, a person using the mental health services would have their mental health assessed and maintained through medical and clinical therapeutic interventions according to specific criteria and national targets. Within a social enterprise, the occupational therapist may have the freedom from such bureaucracy to be client-centred and holistic whilst still practicing according to professional standards and codes of conduct (COT, 2010; HCPC, 2012). The view the occupational therapist from Woodland and forestry expressed is consistent with the findings of staff's low expectations of people who use mental health services (ODPM, 2004). This occupational therapist was motivated by occupational justice, to enable those she worked with to engage in normal social and

family roles in society. This raises the issue of emancipation of people who use statutory mental health services to be enabled to fulfil their human rights.

#### **7.4 Chapter Summary: Meso Level Organisational influences on occupational therapy provision in social enterprises**

Occupational therapists can be central to enabling social enterprises to combine their business and social aims through the use of core occupational therapy skills. A social enterprise that has an opportunity to generate income through activity is also able to provide occupation-based therapeutic interventions within its remit if there is the flexibility of the organisation to adapt to individual's needs and abilities. Social enterprises can become therapeutic environments that facilitate recovery and social inclusion.

Clinicians have begun to set up social enterprises as a response to the unmet needs that have begun to emerge, however funding for social enterprises continues to be a challenge. Clinician involvement in social enterprise governance and decision-making can provide opportunities for improving service delivery. This can have implications for occupational therapists to apply an occupational philosophy to groups, communities, organisations and at a policy level. This research provides practical examples of this and bridges the theory-practice gap in regard to this.

Social enterprises can facilitate occupational therapy practice according to the philosophy of the profession as a result of similar underlying principles and ethos about mutual responsibility, collaboration, dignity and respect for the individual. Social enterprises provided occupational therapists opportunities to practice holistically and without the limitations of the dominant medical model which is evident in the public sector. Occupational therapists need to take a proactive confident approach to the health and social care reform to take the opportunities available to create environments for occupational therapy practice that is in accordance with the philosophy of the profession.

The next chapter presents the findings from the micro perspective of the different individuals involved occupational therapy in social enterprises in this study. These micro perspectives are presented within the context of the macro and meso levels of analysis already presented and gives further detail about the professional and service user's experiences.

# Chapter 8: Findings at the Micro Level: Individual's experiences of occupational therapy within social enterprises

## 8.1 Introduction

This chapter presents the micro level findings from the case studies which refers to individuals as single units in society which inter-relate (Turner, 2003). Within the context of this study, the individuals referred to are the occupational therapists, the social entrepreneurs (or managers) and the service users. The chapter is divided into three sections according to these three participant groups to represent their experiences of setting up a social enterprise that delivers occupational therapy, providing or receiving occupational therapy within a social enterprise. In two case studies (Dementia day service and therapy through sport), the social entrepreneur was an occupational therapist and therefore their experiences were divided according to their respective roles. The themes within each of these sections are presented in the table (Table 8.1) below:

**Table 8.1: Findings at the Micro level – Individual experiences of occupational therapy within social enterprises**

Micro level analysis	Participant group	Theme
	Social entrepreneurs	<ol style="list-style-type: none"> <li>1. The challenges in social entrepreneurship</li> <li>2. Personal sacrifice, passion and commitment</li> </ol>
	Occupational therapists	<ol style="list-style-type: none"> <li>1. The experience of job satisfaction</li> <li>2. A need for professional support</li> </ol>
	Service users	<ol style="list-style-type: none"> <li>1. The experience of the social enterprise environment</li> <li>2. The benefit of a routine and structure</li> <li>3. Developing skills and a hope for the future</li> </ol>

## 8.2 Social entrepreneur's experiences

The themes in this section were developed from the social entrepreneur and social enterprise manager's responses in the interviews which were analysed into two themes:

1. The challenges in social entrepreneurship
2. Personal sacrifice, passion and commitment

### Challenges in social entrepreneurship

In four case studies (Adoption and fostering; Dementia day service; Youth health promotion and Therapy through sport), the social entrepreneurs were clinicians (two were occupational therapists) who had not had experience of business management prior to setting up and managing the social enterprise. The social entrepreneurs expressed a lack of knowledge of business skills and legal structures for the social enterprise and experienced unhelpful, expensive business advice from the corporate sector. In CS4 (Youth health promotion) and CS5, (Therapy through sport) the social entrepreneur was observed to be struggling with managing the business, which was not her area of expertise as observed during an interview with her:

*She seemed overwhelmed by the amount of work that she had to do and verbalised the need for support in business and management. She was a passionate visionary but struggled with the business aspect of generating an income. She was passionate about occupational therapy and deeply convicted of the power of occupational therapy to change people's lives. However she found it very difficult to provide the support and service that she wanted to because of challenges gaining funding. She asked me for help with the business aspect of running a social enterprise and asked if I knew anyone who could help with business skills, coaching, mentoring, marketing or fundraising. The social entrepreneur seemed stressed, overworked and unsupported in her role which she confirmed in her interview. (Data source: academic journal, field notes, February 2012)*

The social entrepreneurs from Adoption and fostering; Dementia day service; Woodland and forestry and Gardening and farming, set up their social enterprises with a partner who had some business or management experience. This suggests the value of health and

social care professionals (such as occupational therapists) in collaborating with another person who has business skills to set up and run a social enterprise. Such practice has been evidenced as cross sector partnerships and social alliances in the literature (Sakarya et al., 2012). The occupational therapist in CS4, (Youth health promotion) viewed this as essential for occupational therapists to have the freedom to practice in innovative and creative ways:

*“...when you go to uni as well you are taught to think outside the box and social enterprise is a fantastic way of starting that as long as you get a business person that works with you ... You can't have a group of OTs starting up a social enterprise unless they have someone who has business side of things which is not me” (P12L656-60)*

In response to some of the challenges faced by the social entrepreneurs, some developed strategies to try to have some of their needs met. This included contracting for a business mentor or drawing on the support from friends and colleagues with business and management expertise. The social entrepreneur from Gardening and farming experienced challenges starting the organisation as she needed an established organisation to partner with to start the social enterprise to receive the start-up funding. This highlights issues for other social enterprise start-ups who are not able to collaborate with larger charities to gain funding. The social entrepreneur in CS5 (Therapy through sport) felt overwhelmed and isolated in her role, particularly as she was an occupational therapist and did not have the business and management skills required to run the organisation. There could be a place for occupational therapists to be trained in business skills at an undergraduate or take postgraduate level courses as well as the opportunity for collaboration with people who have experience in running businesses (Lewis et al., 2006; Miller and Millar, 2011; Hall et al., 2012).

Two social entrepreneurs experienced other organisations “stealing” their work (P12L725). The social entrepreneur and occupational therapist from Youth health promotion described how the content of their innovative health promotion workshops with youth has been copied and rebranded by another organisation, because they had not patented it:

*“...when I first started I didn't realise the protocol I honestly didn't realise that in this line of work how people steal your work you know it's still really cutthroat business but it's voluntary sector” (P13L129)*

The participants from Youth health promotion admitted that they had been too naive and trusting of others by not patenting their new, creative and innovative practice and openly shared them with others. Their experience of having their work stolen (copied and replicated elsewhere without permission) had been a shock to them as they had expected the third sector to be a similar culture to work in as health and social care. Instead their experience was that the third sector was as competitive as the corporate sector. The occupational therapist/social entrepreneur from Therapy through sport had also experienced other organisations copying their model of therapeutic activity through sports and therefore patented her model to 'sell' to others. These social entrepreneurs were all health and social care professionals who previously would have had the legal protection of the public sector in previous employment. However, establishing a small social enterprise without established operational and legal structures can leave them open to abuse by others and they may not be able to afford legal representation if necessary. There is a need for adequately preparing occupational therapists for the new contexts for delivering services and the culture of working in services that are part of a competitive market.

### **Personal sacrifice, passion and commitment**

The social entrepreneurs in Adoption and fostering; Dementia day service; Woodland and forestry; Youth health promotion; Therapy through sport and Gardening and farming made personal sacrifices to set up the social enterprise, of their own time and their personal money. For example one social entrepreneur from CS1, (Adoption and fostering) re-mortgaged her house to start the social enterprise (Data source: field notes) and another (CS2, Dementia day service) took out bank loans and used personal savings to start the social enterprise (Data source: financial accounts). Such extraordinary measures demonstrate a great passion, vision and commitment these social entrepreneurs held for the social cause their social enterprise was serving. Six of the social entrepreneurs were passionate about the social cause their organisation was attempting to address and willing to make personal sacrifices to achieve this. This suggests an altruism underlying their motivations (Tan et al., 2005; Hall et al., 2012) for their work which could also explain the supportive culture that was also evident in these social enterprises. Two other social entrepreneurs, from CS4, (Youth health promotion) and CS5, (Therapy through sport) took a small salary to have more money for the organisation:

*"I pay myself absolute peanuts which is silly really but I wanna get this up and running" (P13L233-4) ... "I give up a lot of time for free" (P13L626-7)*

*“I’m going to be living in part-time money not full-time money because there isn’t any so it’s the chance we have got to take” (P18L125)*

For some of the occupational therapist social entrepreneurs, there was also a personal sacrifice to work for the social enterprise. This was either a cut in salary and associated financial benefits such as sick pay and pensions. For others, the personal sacrifice was the amount of time they committed to the social enterprise and the occupational therapy service to ensure its success. This level of personal sacrifice was compensated by the occupational therapists job satisfaction:

*“...there is a very clear role for someone like me, I’ve got the passion back for occupational therapy and that really motivates me.” (P2L374-5)*

The level of personal sacrifice expressed by the social entrepreneurs indicates that it was more than just a job to them, it was an important part of their life and personal mission, purpose or cause.

### **8.3 The occupational therapists experiences**

Across the case studies, the occupational therapists described their experiences of delivering occupational therapy within social enterprises and the impact this had upon them and their professional practice. The findings that were developed through the thematic analysis of the occupational therapists responses revealed the following themes:

1. The experience of job satisfaction
2. A need for professional support

#### **The experience of job satisfaction**

Occupational therapists have experienced varying degrees of dissatisfaction in their work within statutory services within the UK (Arnold et al., 2006; British Association of Occupational Therapists and Unison, 2003). However, within this research study, occupational therapists experienced job satisfaction within the social enterprise case studies. Their experiences of job satisfaction included feeling valued as part of a team, trusted in their professional expertise and respected. Some facets identified by Spector (1997) that comprise of job satisfaction have been: appreciation, job conditions, nature of the work itself, the nature of the organisation itself, pay, personal growth, promotion

opportunities, recognition, security and supervision. In Fostering and adoption; Woodland and forestry; Youth health promotion; Social housing; Gardening and farming; and Organic growing they were viewed as a valued member of the multi-disciplinary team (in the other case studies, the whole social enterprise service was occupational therapy service). In CS1, (Fostering and adoption) the decision to employ an occupational therapist was based on research and evidence, validating the importance of occupational therapy intervention with their specific service user group (Source: CS1 statement of purpose). The occupational therapists felt that they were respected and valued in Fostering and adoption; Woodland and forestry; Youth health promotion; Gardening and farming; and Organic growing (Dementia day service and therapy through sport were occupational therapy social entrepreneurs so this was implicit). The occupational therapist in CS3, (Woodland and forestry) felt valued, trusted and respected but equally delivered the outcomes that she was responsible for. All of which gave her a sense of job satisfaction:

*“... 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” (P5L129-132)*

This occupational therapist suggests that she was able to justify her practice because she was able to provide desired outcomes. She was seen as an expert and given autonomy in her practice but with the expectation that she was able to deliver the social outcomes that were required of the service users she worked with. The experiences of the occupational therapists in social enterprises contrasts with the occupational therapists expressing the lack of value they felt in previous positions in statutory services. This raises questions about why occupational therapists may feel more valued and appreciated in the social enterprise than in statutory services and feel free from the limitations of the dominant medical model in the public sector. The findings in this study suggest that this may be because of the compatibility of occupational therapy philosophy with a social enterprise model and the opportunity to practice with the therapeutic culture of recovery in a social enterprise. In such settings the occupational therapists have had freedom to focus on specific occupational needs and achieve desired outcomes with and for services users resulting in job satisfaction. This could have implications for job retention as well as retention to the profession of occupational therapy.



Some of the occupational therapists also experienced and valued being part of something worthwhile (such as the social mission of the social enterprise) and their wellbeing was improved as a result. This was through having a sense of achievement, satisfaction, and being able to put their training into practice within their work in the social enterprise. The following field notes were taken after the interview with the occupational therapist from Organic growing:

*The occupational therapist was eager, enthusiastic and very positive about occupational therapy in a social enterprise. This was clearly because of her frustrations of working within statutory services, which she still did on a part time basis. Her work in the social enterprise was voluntary and she seemed to gain a lot from it personally, as it met some of her own needs. As she talked in the interview, I felt her sense of freedom, relief and liberty in her role in the social enterprise which had helped her rediscover what meaningful occupation was for herself, as well as in her ability to support others. (Extract from academic journal, May 2012).*

Although for two occupational therapists there was an ongoing internal conflict for them about whether to continue working for the social enterprise or not. This conflict was between the lower pay versus job satisfaction. One occupational therapist (from Woodland and forestry) questioned whether the lower pay within a social enterprise would communicate a sense of reduced self-worth to occupational therapists and could also be a challenge to recruit to the position.

*“... one of the ways in which a social enterprise keeps costs down for people is that the salaries are lower you know, so that you have got that impact you know and if that means that as an OT you are not going to earn more than £25,000 a year working in a social enterprise then is that work viable? And it brings in all those issues about am I worth more than that as an OT?” (P5L344-8)*

The lower pay the occupational therapist received was compensated with the value and self-worth that she experienced when working for the social enterprise. This indicates a challenge for occupational therapists in the UK as social enterprise presents the opportunity to practise according to the philosophical basis of profession, enjoy job satisfaction and address personal occupational needs. However, the cost of this may

require some personal sacrifice on the part of clinicians to accept a lower salary, fewer employment benefits and potential job insecurity. The decision to take a lower paid job that contributed to improving social problems alongside giving greater job satisfaction and subsequent health and wellbeing is a proactive decision that could reduce inequality and subsequent health and social outcomes in the UK (Wilkinson and Pickett, 2009). Whether occupational therapists will make such a decision will depend on their willingness to do it for 'the greater good' of society, and for the benefit of the profession of occupational therapy to enable occupational justice.

### **Occupational therapists need for professional support**

The occupational therapists expressed various professional support needs that were either unmet or partially met whilst working at the social enterprises. Included in this was a lack of understanding of occupational therapy by colleagues in the social enterprise; the need for networking and peer support; and the need for professional, clinical supervision. Each of these are considered in this section.

The occupational therapist in Social housing had experienced challenges due to a lack of understanding of the role of an occupational therapist by the wider team who were not from a health and social care background:

*"...they didn't understand why couldn't I go out and do four assessments a day because there was no understanding of the OT role" (P21L152).*

The wider team and some managers in this case did not understand the role of the occupational therapist and had unrealistic expectations of what she was meant to achieve. As the only occupational therapist (and the only health or social care professional) within the organisation, this participant felt it was challenging to enable others to understand what she did. This is however normal in a lot of settings where occupational therapists practice. The occupational therapist in Woodland and forestry however had the opposite experience. She was also the only healthcare professional in the organisation however she was included in the senior management team and in a position of 'expert' to influence all decisions made in the organisation around health and social care. However, the challenge for this occupational therapist was that in the majority of cases, the people who attended the social enterprise did not have any other professional intervention or services involved with them. Therefore there are implications for occupational therapists operating in professional isolation in some social enterprises. It is the occupational therapists

professional responsibility to ensure that she can access professional support and supervision and occupational therapists within social enterprises may need to be proactive in organising this. The occupational therapists in Dementia day service; Gardening and farming and Organic growing raised the need for networking with other occupational therapists working for similar organisations because of feeling isolated:

*“...if there was something else in place that OTs can network I think that would feel more comfortable” (P3L307-8)*

*“Talking to other OTs is quite nice it is possible to feel a bit isolated and what am I doing?” (P23L316)*

One occupational therapist was reluctant to leave the NHS because of her professional connections and support. Therefore there are implications for the need for new professional support networks that need to be established for or by occupational therapist working in social enterprises. Such support groups could be alongside occupational therapists who work in any emerging and “non-traditional” role for example in charities or the corporate sector. It is likely that there will be challenges for occupational therapists about how to organise and co-ordinate such support. The current special interest groups affiliated to the College of Occupational Therapists may not benefit occupational therapists in social enterprises considering the new and diverse environments that they are working in. To date, these have been differentiated by medicalised distinctions (paediatrics, neurology or mental health) which are already becoming irrelevant for some of these new emerging roles such as the occupational therapist in Youth health promotion. For the occupational therapists who worked with people with a range of different problems such as drugs and alcohol, mental health and probation, it would be unrealistic and impractical for an occupational therapist to join multiple special interest groups. This is an issue that is addressed further in the discussion chapter.

Professional supervision is a requirement of all occupational therapists by the Health and Care Professions Council (HCPC) and is the responsibility of the occupational therapist to ensure they receive this. There was a range of experiences of supervision that the occupational therapists in the social enterprises received. In CS1, (Adoption and fostering) the occupational therapist received supervision from the therapy lead manager within the social enterprise (who was not an occupational therapist) as well as specialist occupational therapy supervision which was external and paid for by the social enterprise. This was a contrast to her previous experience in the public sector where there was no

time for supervision. The social enterprise manager in Adoption and fostering placed high value and importance on supervision, incorporating it in to their statement of purpose:

*“There are a variety of forms of professional staff supervision and consultation.*

*The therapy teams attend the following:*

- Weekly referral meeting for senior practitioners to discuss case allocation*
- Monthly individual supervision with the Therapy Services Manager*
- Fortnightly team supervision with the Therapy Services Manager*
- Fortnightly senior practitioner meetings with the Therapy Services*

*Manager*

- Monthly staff meetings*
- Monthly team consultation with Family Futures’ external consultant on case specific issues”*

*(Data source: Organisational document, 2011)*

The occupational therapist in Gardening and farming was supervised by a clinical psychotherapist who was also the social entrepreneur (Source: CS7 website). This had implications for the lack of profession specific supervision and support available for this occupational therapist which he needed to initiate for himself. The occupational therapist in CS2, (Dementia day service), had external supervision with a physiotherapist which was a continuation of the supervision relationship from her role in the NHS. She felt this arrangement met her needs in relation to her clinical practice but she continued to have unmet support needs about running a social enterprise. The occupational therapist in Social housing had external supervision with the local social service occupational therapy

manager (who was her previous manager) which she was satisfied with as this provided the profession specific support she needed.

Occupational therapists in other settings such as independent practice or in specialist services can often be the only occupational therapist and therefore require supervision either from another professional within the organisation or externally. Occupational therapy provision within social enterprises presents opportunities for experienced occupational therapists to provide a service which offers supervision on a contractual basis. This “long arm” supervision is already being practiced with occupational therapy students on practice placements (Boniface et al., 2012). There may be challenges within non-health and social care organisations willingness to pay for external specialist supervision for occupational therapists but this was not found to be an issue in this research. However, the new and innovative practice demonstrated by occupational therapists within social enterprises would need appropriate support from supervisors (whether occupational therapists or not) that encourages such practice, rather than bringing restrictive thinking that has been experienced by some of the occupational therapists in statutory services. Supervision of occupational therapists in social enterprises could be offered by occupational therapists working within universities who are familiar with supervising students in new, non-traditional settings.

#### **8.4 The service user’s experiences**

This section presents the experiences of those who use the social enterprise. In the interviews, the service users talked broadly about their experiences at the social enterprise and at times specifically about the occupational therapists intervention. It was not possible to separate out the impact of occupational therapy from that of the social enterprise as a whole as these were intertwined.

Service users in CS3, (Woodland and forestry) and CS7, (Gardening and farming) talked about the benefit of the social enterprise environment, both of which were outdoors:

*“I feel outdoors gives you a lot more interaction with nature, rather than being stuck in a block in four walls with people that you might not talk to or get to know or they may not talk to you, whereas here everyone shares their bit really and you're doing things as well.” (P7L45-48)*

The health benefits of outdoor environments have been evidenced in the mental health and occupational therapy literature (Bratman et al., 2012) and the flexibility of a social enterprise can facilitate this. In statutory services, occupational therapists may use gardening, horticulture or walking groups as therapeutic activities (Wensley, 2012; York, 2012; Diamant, 2010). However, these social enterprises offered the people who use the services more than a positive outdoor environment as they provided a comprehensive, holistic support package alongside this and opportunity to grow and develop as individuals, establishing a sense of identity and taking on new roles and responsibilities particularly around return to work. The social enterprise also offered these therapeutic activities within a real social environment without service users needing to attend a hospital or clinic appointment to carry out similar activities in an unfamiliar clinical environment. It is important for occupational therapy to be practiced within real environments to enable people to engage and interact with their environment and interact other people in an ordinary social setting without clinical labels or stigma.

Some of the people who used the services explained that they felt the social enterprise was a caring, relaxed environment that was comfortable without any pressure or stigma. One aspect of this was that they did not feel rushed or pressured to complete tasks. One service user from Woodland and forestry explained:

*“It’s so laid back here...you can get on with it at your own speed which I like” (P10L31-32)*

From an occupational therapy perspective, the activities the service user’s were involved with were graded according to the service user’s skills and abilities. This was done subtly without formalising the graded therapeutic steps of the activity but informally coaching the service user to engage at their own pace. In the same case study, another service user had a similar experience and particularly appreciated not being put under any pressure:

*“He lets you smoothly go into the work like no pressure really so but now I’m doing cooking and I do (run) an art group as well” (P8L14-16)*

This service user was formerly an artist and the staff at the social enterprise had utilised his skills and experience to benefit others within the social enterprise by enabling him to run an art group with helped others while facilitating his own recovery. The service users met with the occupational therapist individually as well as carrying out activities as part of

a group. Within this case study, the service users felt the occupational therapist was someone they could talk to about work and future opportunities:

*“Having this place and having (the occupational therapist) you can talk about the work side of things and that can lead onto other things, it’s easier you don’t feel like you’re under any pressure that you not performing, that’s nicer” (P6L44-6)*

The service user’s experience of not being under pressure may have been a result of the occupational therapist grading, adapting and pacing the tasks but it is also reflective of the culture of the social enterprise, which did not put pressure and expectations on the people who used the services to meet targets.

Those who used the social enterprise also talked about the subtle differences between statutory services and the social enterprise such as a more relaxed atmosphere, people talking to them or thoughtfulness about which other service users they were put with to do activities:

*“Here it’s a more relaxed atmosphere but it’s closely knit, you get to know each other and help each other out” (P7L53-4)*

A relaxed environment is important in mental health recovery (Mezzina et al., 2006) alongside the opportunity to develop friendships which this social enterprise enabled. 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, were able to develop friendships, develop trust with other people in the social enterprise and support one another. Two service users from Woodland and forestry both described how they felt a sense of acceptance and were able to develop friendships:

*“I always thought I had to be a different person for people to get on with me but I found by coming here I can just be myself and nobody’s critical of that” (P8L62-63)*

*“It’s gone past my expectations because I’ve made two good friends, they are I would say friends as well more than people you know and don’t see ever again or people you go to football with but that’s it, I see*

*these more as 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" (P7L14-17)*

Developing social networks and support is an integral aspect to occupational therapy philosophy and mental health recovery for an individual to be able to engage in and interact with the world around them (Farrell and Bryant, 2009). It became apparent to the researcher during the interviews that three of the participating service users had developed friendships with one another and met up socially outside of the social enterprise activities. By meeting one another at the social enterprise, they were not only able to form friendships but also develop social capital as they began to trust and support one another in reciprocal relationships (Fieldhouse, 2008) and engage in social activities that they had not have been able to do previously. Some of these participants had received NHS mental health services but had not developed the social relationships with other people that had been developed at the social enterprise. Having a friend or friends to spend time with socially enabled social inclusion. This social enterprise has facilitated this to happen by bringing together like minded people with common interests and experiences and the occupational therapist thoughtfully managing the dynamics between the group.

There were two exceptions from this however. One service user from CS7, (Gardening and farming) felt he could talk to the staff about any problems he had but still felt socially isolated from the other service users. This is likely due to his lack of confidence and mental health problems as he was observed to be withdrawn and uncomfortable with his peers. The service users interviewed in CS6 (Social housing) also had unmet social needs that were not addressed through the occupational therapy intervention or the social enterprise. The reasons for this were due to the demand on the occupational therapy service to only provide basic physical needs assessments because of a lack of resources.

The provision of a social enterprise environment that may be too comfortable for service users may present challenges in encouraging them to move onto other employment. There could be implications for limiting the throughput of service users benefiting from the social enterprise. In the case of Gardening and farming, they addressed this by having a time limited attendance for service users of a maximum of two years (Data source: CS7 website).



These experiences of the support offered by the occupational therapists and the social enterprise as a whole corroborates (Silverman, 2010) the similar experiences of the professionals interviewed that described a caring, family environment.

In addition to the social benefit of attending the social enterprise, the service users from Dementia day service; Woodland and forestry and Gardening and farming identified that the activities run by the social enterprise provided some structure and routine to their week and was an alternative to being at home on their own. A service user from Woodland and forestry explained his motivations for going to the social enterprise:

*“I thought it would be good to get outdoors and meet new people and gain some confidence and to motivate myself to get up in the mornings and do things rather than possibly staying in bed and watching TV and not getting motivated.” (P7L9-11)*

A service user from CS7, (Gardening and farming) 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” (P26L51-53)*

These two quotes are examples of occupational therapy theories in practice about the value of structure and routine which are formed by meaningful activities (Lloyd and Williams, 2010). The occupational therapists created the interventions and interactions at the social enterprise to engage with the service users and give them a sense of meaning and purpose. The above quotes evidences the psychological benefit of meaningful activities that enable recovery which have been offered through the social enterprises.

*“We provide a totally non-stigmatising environment, based on a busy working farm, where young people are integrated into daily farm life. In addition ... clients are engaged with the visiting public through providing produce to the chef and visitors. In this way young people are contributing to the community and society, increasing feelings of self-worth and belonging.” (Data source: CS7 website)*

The social enterprises evidenced here have provided the environment for activities to take place with ongoing interventions (sometimes two or three times a week) from the occupational therapist or support staff. This is in comparison to equivalent occupational therapy interventions with the same service user group (community mental health) where an occupational therapist would meet the person one a week or once a fortnight and plan how that person would structure the rest of their week but complete the activities without support from the occupational therapist in-between sessions. More regular contact could have a greater impact on the speed and rate of recovery therefore a higher turnover of service users and warrants further research incorporating an appropriate outcome measure.

In some of the social enterprises, the service users appreciated the opportunity for volunteering and employment. In woodland and forestry; Youth health promotion and Therapy through sport, those who used the services talked about the role they had taken on within the social enterprise which was facilitated by the occupational therapist. Across four of the case studies (Woodland and forestry; Youth health promotion; Therapy through sport and Gardening and farming), the service users referred to employment as a beneficial outcome of attending the social enterprise. This included learning new skills, gaining work experience and paid placements at the social enterprise alongside hope for future employment. In Gardening and farming, the transition to work was a key aspect of where service users would move on to after the social enterprise:

*"I'm trying to get a weekend job here in the summer. I will be doing a few hours here with the cows getting a few hours paid... the cows can go on my CV ... I've also been working with animals like chickens" (P25L23-25)*

*"I want to be a gardener since I've been coming here I found out what I really want to do now ... since I've been at this project" (P26L30-32)*

Gaining employment was an important motivator for one service user attending CS3, (Woodland and forestry) who had been out of work for four years and had lost his confidence in returning to work. The occupational therapist had enabled him to take on a work role within the social enterprise by combining her knowledge of his skills and abilities with how he could be beneficial to the organisation. This service user described how positive this was for him:

*“And doing this stuff again (working) has been quite mind-blowing because it all came back to me. I've got a computer but when you're out of using one for so long in that sense, can I remember how to use Excel? Which I did so it's good, it's brilliant just to know I can do it because I want to work this year ... as I've been here, my mental health has improved no end” (P6L30-4)*

In CS3, (Woodland and forestry) one service user had taken on the responsibility of running an art group, another two were doing work experience for the social enterprise (one in mechanics and the other in process mapping). All three of these service users were able to use their skills and expertise which had been gained prior to their mental health episode to work for the social enterprise. The occupational therapist enabled them to adapt to a working environment again after a period of time of not working and provided support to ensure that it was a successful placement. Another service user within the same case study initiated an informal role to organise social activities with others in their free time.

In CS4, (Youth health promotion), one individual who had benefitted from the service had taken on the administrative role within the office for the social enterprise voluntarily. This role enabled him to develop his confidence and skills to enter the job market. In CS5, (Therapy through sport) one person was a “buddy” for others in the group which meant visiting them at home, cooking and shopping with them as part of their support programme alongside social activities. Engaging in a role in the social enterprise validated their attendance without any associated stigma and enabled them to be a volunteer rather than a ‘patient’ or ‘service user’. The social enterprise was flexible to be able to accommodate to individuals needs and skills to incorporate them into the organisation in various ways. This is a great advantage of a social enterprise as a structure for service provision in comparison to large public sector bodies that are constrained by bureaucracy.

The value of the work roles expressed by those who use the services has been corroborated by the perceived value of this by the professionals involved. This is directly related to the previous themes at a meso level, which discussed other focused interventions and peer support and the impact of a non-medical and institutional environment.

These social enterprises have provided the environment for people to gain experience, skills, confidence and the ability to take on roles and responsibilities within their

organisations with support from the occupational therapist (Source: CS5, 7 and 8 websites). Such opportunities are in contrast to the limitations of the 'patient' role within the medical model of statutory services. Occupational therapists can offer valuable contributions to social enterprises in integrating service users into roles within the organisation which benefit both the individual and the social enterprise. This is a practical example of outworking co-production evidenced in the literature (Gannon and Lawson, 2009; Boyle and Harries, 2009; Aldridge, 2012).

All the responses about employment were positive except one participant who expressed ongoing difficulty gaining work:

*"It's just getting to the stage where there is just nothing, no jobs really no jobs in the field that I'd like them to be, like in gardening, in animal care so it's just go to the stage where what do I do now?" (P26L42-44)*

This illustrates the need for social enterprises to have links with local businesses and other employers to develop pathways for employment outside of their own organisations. Occupational therapists are also well equipped to adapt roles in mainstream businesses and organisations to facilitate such organisations to be accessible for people who have been in supported work environments such as social enterprises.

In three of the case studies (Woodland and forestry; Therapy through sport; and Gardening and farming), the people who used the services talked about how attending the social enterprise benefitted their mental health. Two of these people acknowledged that this benefit was also as a result of support from others outside of the social enterprise. Some of the ways they felt their mental health improved was by developing a change in perspective, developing hope, improving concentration, developing self-esteem as a result of being believed in, gaining a sense of achievement through tasks and improved motivation. One service user gave an example of how meaningful activity has benefitted him at the social enterprise (CS3, Woodland and forestry):

*"A day's work instead of sitting at home ... you go home and feel that you have achieved something, like all I've done today is cook for everyone, but I will go home and think oh yeah I've achieved something at the end of the day, I haven't just sat at home watching daytime TV"*  
(P8L116-118)

In this case the occupational therapist had carefully planned with the service user what and how he could be involved in the social enterprise. He preferred to get involved in cooking lunch for all the team every day rather than the woodland and forestry activities that most of the other service users engaged with. This occupational therapist explored with him how to ensure his participation at the social enterprise was meaningful to him.

Two service users described how they were able to develop a sense of their identity by meeting other people with mental health problems which challenged the stereotypes of mental illness that they thought they should conform to. This was coupled with a sense of acceptance by others within the social enterprise for who they are as individuals. In a social group, where people feel accepted, they also feel a sense of belonging (Tajfel, 1982; Tajfel and Turner, 1986; Jenkins, 2008).

Aspects of confidence were talked about as an improvement of mental health which were in relation to completing tasks and going out:

*“I’ve got more confidence than I did before, forcing myself to get out my flat because I get really agoraphobic ... there are some good people here I’ve made some good friends. It’s completely a confidence thing I didn’t leave (location) for a year and half because I was too scared to go anywhere but here it’s all right because I know I can go home if I need to” (P6L37-40)*

The development of confidence to complete tasks and to go out is significant in enabling people to engage in meaningful everyday activities (Christiansen, 1999). In four out of the six social enterprises where people who benefitted from the services engaged in the research, confidence was referred to as a beneficial aspect of attendance. This had been a subtle perceived benefit of attendance rather than each of these social enterprises running a ‘confidence building course’ that is often offered in statutory services. The subtlety of this benefit of attending the social enterprise supports the service users’ comments that they appreciate the focus of their attendance being on something other than themselves and their illness or problems. This also supports the finding that a non-stigmatising, non-medicalised environment can promote recovery (Sayce, 2000; Fieldhouse and Onyett, 2012).

## **8.5 Chapter Summary: The micro level - Individual experiences of occupational therapy in the social enterprises**

Social enterprise can provide the opportunity for occupational therapy practice according to the philosophy of the profession and bridge the theory-practice gap in occupation-based practice, occupational health promotion and occupational injustice. Occupational therapists need to take the initiative to create occupation-based environments for practice. To do this, occupational therapists require business skills and support in setting up and running social enterprises or to collaborate with a business person. It is up to individual occupational therapists to be proactive in bringing about occupational and social justice through developing organisations or taking on roles in established organisations that permit practice according to the philosophy of the profession. This could involve personal sacrifice however some of the professionals interviewed gained such satisfaction from their work that the personal sacrifice was of less significance.

The individuals who use the services offered by the social enterprise found it beneficial for gaining confidence, skills, social relationships and progression towards employment. Social enterprises which employ occupational therapists provide the opportunity to reach disadvantaged groups in society in a non-medicalised and non-institutional way to facilitate their recovery without additional stigma and labelling.

The next chapter draws together the findings from this study and discusses the global issues in relation to the literature. These findings are then discussed in relation to policy and practice of occupational therapy in social enterprise in the UK and recommendations are made.

# Chapter 9: Discussion

## Social enterprise – opportunities and challenges for the profession of occupational therapy

### 9.1 Introduction

The previous four chapters have presented the findings of this study, based on a macro, meso and micro level analysis of occupational therapy provision within social enterprises in the UK. The findings of the study are discussed in this chapter, which has been organised into three parts. The first part discusses the findings in relation to the research questions, the literature and the occupational justice theoretical framework. Following this is a discussion of the implications of this study to policy, social enterprise practice development, the occupational therapy profession and for people who use the services. The final part of this chapter presents a methodological critique of the study and reflections on the research process and subsequent recommendations have been proposed including areas for future research.

The findings of this study have evidenced the known occupational therapy provision in the UK that is delivered within a social enterprise model. 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. A review of the academic literature into occupational therapy in social enterprise in the UK revealed one research study which involved an occupational therapist in the service provision of a social enterprise (Fieldhouse et al., 2012). There are some consistent findings between the research conducted by Fieldhouse et al., (2012) and this study, such as the service user's experience 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 support and expands upon the existing (although under-researched) knowledge in this area.

The research questions presented at the beginning of this study were:

1. What forms of occupational therapy are practiced within social enterprises in the UK?

2. What is the relationship between occupational therapy practice in social enterprises and the philosophical foundation of the profession?
3. What are service user's views, opinions and experiences about the occupational therapy they receive within a social enterprise?
4. What are the factors that determine the diversity of occupational therapy provision within social enterprises?

A discussion of the findings from this study according to these research questions follows.

## **9.2 Research Question 1: What form of occupational therapy is practised within social enterprises in the UK?**

The scoping study in Phase 1, revealed an equal number of social enterprises that provided occupational therapy services to people with mental health problems and people with physical occupational needs. Six out of eight of the case studies in this research provided services for people with mental health problems, suggesting a compatibility between social enterprise delivery environments and mental health recovery models (Perkins and Repper, 2013; Leamy et al., 2011). The physical occupational needs were addressed by social enterprises which provided 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 according to government policy (DH, 2010a). Some of the social enterprises identified in this study included a range of occupational therapy interventions with people who do not currently receive such services though the public sector such as the homeless, youth (health promotion) 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, such as in this study. With proper distribution of resources such as health and social care services, attempts can be made to address distributive and social justice (Stadnyk et al., 2010).



The wide variety of occupational therapy interventions evidenced in this study that were provided by social enterprises demonstrated the flexibility that social enterprise models offer for occupational therapy practice. This variety suggests greater opportunity for future occupational therapy provision within social enterprises in the different contexts occupational therapists work within, such as those evidenced in the case studies. This flexibility and variety in social enterprise models is well suited to the variety of different types of occupational therapy services that could be offered through them to reach different groups in society (STSRF, 2011). To create social enterprise environments that are accessible for people to receive occupational therapy can enable occupational justice by providing opportunity for people to engage in society who otherwise may be excluded or marginalised (Nilsson and Townsend, 2010). Theories of occupational injustice (Standnyk et al., 2010; Whiteford and Hocking, 2012) recognise the need for occupational therapy with people excluded from services or from society. This study has demonstrated that social enterprise could enable health equality and inclusion of vulnerable groups (Bambra et al., 2010; RCN, 2012; Lockwood, 2013).

The occupational therapists who developed 'other focused interventions' and peer support structures within the social enterprises provided opportunities for those who used their services that were quite different to the traditional statutory services which are 'expert' and 'patient' therapeutic interventions. These occupational therapists have introduced new dynamics into the therapeutic relationship and therefore challenge the traditional power dynamics between 'therapist' and 'patient' (Twible and Henley, 2000) which promotes equality, opportunity, participation, empowerment and fairness as key aspects of occupational justice (Townsend and Marval, 2013; Stadnyk et al., 2010).

Grey literature has evidenced occupational therapy provision through the newly created public sector spin-offs (Mickel, 2010). However, these were excluded from Phase 2 as the scoping study revealed that occupational therapists experiences within these had not changed since the transfer from the NHS to the social enterprise. This is possibly because these were newly created organisations and had inherited the culture of the statutory services and this may be because it takes time for cultures within such organisations to change (Scott et al., 2003). In addition, the overall deficit-based medical model was maintained throughout these public sector spin-offs potentially determining and constraining the occupational therapy practice. As a result of this finding, the practice of occupational therapy through public sector spin-offs was not researched further which enabled the study to be focused on new and innovative practice of occupational therapy in social enterprises in the UK. This study evidenced occupational therapy being integrated

into social enterprise activities, the promotion of 'other-centred' interventions and peer support around occupational therapy goals to promote recovery.

### **9.3 Research Question 2: What is the relationship between occupational therapy practice in social enterprises and the philosophical foundation of the profession?**

Occupational therapy 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. The social entrepreneurs and occupational therapists researched in this study have designed services specifically to enable the theories of occupational justice to be transformed into reality. This has included public health promotion (Wilcock, 1998; 1999; 2005; 2006; Kosma et al., 2013) which is an undeveloped aspect of occupational therapy within the UK (Reitz, 2013). The occupational therapy practice within the majority of social enterprises in this study have evidenced the practice of preventative health strategies through asset-based approaches and has shown a congruence with Antonovsky's (1996) Salutogenic theory of health and the philosophy of occupational therapy. This has been through developing local capacities and strengths through collaboration and partnership between the occupational therapist, the social enterprise and the person attending the service.

A review of the academic literature suggested congruence between the collaborative, bottom-up, grassroots principles within social enterprise and the collaborative, strengths-based, client-centred approaches used within occupational therapy. This was primarily theoretical and conceptual due to the scarcity of literature, however this study has demonstrated the synthesis of occupational therapy philosophy and principles which work effectively within a social enterprise environment. One example of this which utilised the occupational therapists specific expertise was through assessing and matching the skills of the individual with the needs of the organisation for a mutual benefit. 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"*

Through doing so, the occupational therapist enabled both the business and social aims of the organisation to be met as well as the individual's therapeutic goals to be achieved. This study has shown 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 used 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 (in Woodland and forestry; Youth health promotion; Therapy through sport; and Gardening and farming).

Service user involvement in the social enterprise also facilitated participation and choice as occupational rights (Stadnyk et al., 2010). The social enterprise structure has been shown in this study to enable this collaborative process and it is believed that this is because of the culture and environment of 'co-production' (Gannon and Lawson, 2009; Boyle and Harries, 2009; Aldridge, 2012) and 'mutualisation' within these organisations. This collaborative partnership in the therapeutic relationship between the occupational therapist and the service users has also been evident in community-based rehabilitation in international contexts (Twibble and Henley, 2000) and evidence from this literature may provide useful insights for occupational therapists developing new and innovative practice within social enterprises in the UK, outside of medicalised settings.

The social enterprise environment in the majority of cases in this study has been found to promote principles of humanism, equality, mutualism, collaboration, responsibility and social capital. This was particularly evident within the mental health case studies (Woodland and forestry; Therapy through sport; Gardening and farming; and Organic growing) where service users were empowered to take on a role within the organisation; treated with dignity and respect without labelling; involved in decision-making about activities within the organisation; and provided with opportunities to develop trusting, reciprocal relationships. These principles are similar and congruent with the fundamental principles within occupational therapy philosophy such as client centeredness, collaborative and humanistic approaches, engagement in everyday social roles and activities, and the promotion of responsibility and independence in everyday occupations (Baptise, 2003; Posatery Burke, 2003; Wilcock, 2006; Polatajko et al., 2007; WFOT, 2010; 2011). Leamy et al., (2011) through their narrative synthesis of the recovery literature, have identified the core components of what constitutes recovery and their findings support the findings of my study. The theoretical framework Leamy et al., (2011) developed identified five aspects of the recovery process as: connectedness; hope and

optimism about the future; identity; meaning in life; and empowerment (creating the acronym 'CHIME'). The following table demonstrates how occupational therapy enabled these five aspects of recovery within social enterprises:

**Table 9.3: Occupational therapy within social enterprise enabled recovery**

‘CHIME’ process of recovery (Leamy et al., 2011)	Examples from this study
Connectedness	The social enterprise environment provided the opportunity for development of friendships; a sense of belonging; and opportunity for social interaction. The occupational therapist worked with each individual and group dynamics to facilitate this to happen (evidence from Dementia day service; Woodland and forestry; Therapy through sport; Gardening and farming).
Hope and optimism about the future	Engagement in work roles in the social enterprises provided a sense of hope that future employment was possible. The occupational therapist carefully tailored these roles within the social enterprise to ensure they were person centered and appropriate for their skills level (evidence from Woodland and forestry; Therapy through sport; Gardening and farming).
Identity	Service users were able to develop a sense of identity through: engagement in roles in the social enterprise; by being treated as an equal or peer (by not being labelled as a patient and being involved in governance); and by the focus not being on them and their illness but on the activity of the social enterprise (evidence from Adoption and fostering; Dementia day service; Woodland and forestry; Youth health promotion; Therapy through sport; Gardening and farming; and Organic growing).
Meaning in life	The occupational therapist ensured that each service user engaged in meaningful activity within the social enterprise and that it was linked to their future hopes. Engagement in the social enterprise gave some people ‘something to get up for’ (evidence from Dementia day service; Woodland and forestry; Therapy through sport; Gardening and farming).
Empowerment	The approach of the occupational therapist and the social enterprise staff was to enable, equip and empower service users to engage in the activities of the social enterprise and move on. Service users were empowered to have a voice, take on roles, coached and taught new skills (evidence from Adoption and fostering; Woodland and forestry; Youth health promotion; Therapy through sport; Gardening and farming; and Organic growing).

Social enterprise culture and occupational therapy philosophy therefore can be mutually compatible and indeed promote recovery for those who use the services, therefore in turn, promoting occupational justice.

#### **9.4 Research Question 3: What are service users' views, opinions and experiences about the occupational therapy they receive within a social enterprise?**

In most instances, the service users did not differentiate between the occupational therapy interventions and their experience of their involvement in the social enterprise as a whole. They talked about their experiences in the social enterprise generally in relation to what they benefitted from, enjoyed and what they found difficult. Some service users had occupational therapy input in every aspect of their involvement in the social enterprise which was integrated to the extent that it could not be distinguished as a separate intervention. The integration of occupational therapy into the running of the social enterprise can have advantages and disadvantages. It could be a benefit that service users can attend the social enterprise and perceive that they are working (such as a volunteer or in a job), rather than thinking that they are going to receive treatment or therapy, because of the associated stigma, negative labelling and impact on their identity (Sayce, 2000). However, if occupational therapy is concealed within a social enterprise, it could disappear to the extent that the profession is not recognised or acknowledged by staff or service users, which could have a negative impact on the profession and the perceived need for occupational therapy (which justifies funding to provide it).

Overall, the service users in this study enjoyed the non-medicalised environment of a social enterprise as a refreshing change to public sector statutory services. This was evidenced in this study as feelings of acceptance and ability to develop a sense of identity outside a 'patient' or 'sick' role. The focus on activity rather than on their illness was also important for some of the service users which enabled them to develop confidence and skills whilst also benefitting their mental health. This supports Wilcock's (2006) theories of 'Occupation for Health' from the perspective of service users as they were able to focus on an occupation (activity) which promoted their health and wellbeing, without the focus being on their illness. A social enterprise can provide such an environment that the National Health Service cannot, due to the nature and function of a monolithic health service. However, there is the risk that service users may become too comfortable within the supportive social enterprise environment that they may not want to move on into

mainstream workplaces. However, there is a lack of any research into this as yet. Three key topics arose from the findings of the service users experiences of occupational therapy within the social enterprises. This was: employment; social enterprise and occupational therapy offering a psychosocial intervention; and therapeutic focus on activity. This are discussed in the following section.

## **Employment**

Employment was an important focus for the youth and adult age participants who used the social enterprises in the study. From an occupational justice perspective, employment is a contextual factor that can enable occupational justice (Stadnyk et al., 2010). The health and wellbeing effects of employment have been well documented in the literature alongside the opportunities for social inclusion; the development of social networks and the benefits for reduction in social inequality (Becker et al., 2007; Hayes et al., 2008; Bambra et al., 2010; Marmot, 2010).

Some of the social enterprises in this study provided opportunities for those who use their services to gain work experience, employment within the social enterprise and support in seeking employment outside the organisation (Woodland and forestry; Youth health promotion; Therapy through sport; and Gardening and farming). The focus on employment resulted in a sense of hope, 'moving-on' and that attendance at the social enterprise was short-term. The return to work interventions within the social enterprises are yet to be measured and evaluated for their effectiveness and limited evidence is available in the literature due to this being a recent phenomenon. However, there is a wealth of evidence of the effectiveness of occupational therapy interventions in vocational rehabilitation and return to work (Kirsh et al., 2005; Hammond, 2008; Reagon, 2011). Therefore occupational therapists can have an important role within social enterprises to enable employment. As social enterprise has been shown to support occupational therapy practice within this study, it is proposed that these vocational rehabilitation strategies are likely to be effective within social enterprises.

Social enterprises may support individuals to become 'work ready' but with currently high levels of unemployment there may be challenges of moving people onto employment outside of the social enterprise. Therefore there are contextual factors outside of the remit and control of the social enterprise to find employment for the people who are ready to move on from their service. Some social enterprises may be able to create long-term employment opportunities for people who are at a disadvantage of gaining employment,

therefore promoting occupational justice through addressing fairness and equality (Reigel and Eglseder, 2009). However, there are challenges of funding and sustaining social enterprises that employs disadvantaged groups and such social enterprises are likely to require public sector or grant funding to subsidise their income (Spear et al., 2009). Therefore funding for social enterprises are structural occupational determinants that can influence occupational justice. The lack of funding available for social enterprises or the third sector as a result of austerity measures is likely to limit the development of such organisations. However if government initiatives are committed to long-term reduction in unemployment and inequality, investment into social enterprises that provide employment and provide occupational therapy to enable this successfully.

The distinct difference that a social enterprise can offer in comparison to other business or third sector providers has been evidenced in this research as 'mutualisation' which has been discussed in the literature as 'co-production' (Gannon and Lawson, 2009; Boyle and Harries, 2009; Aldridge, 2012). The findings within this study have shown a practical application of co-production by including service users in the activity of the organisation as well as in some of the governance structures. It has been found in this study that social enterprises that employ occupational therapists facilitate co-production as they have the unique ability to offer personally tailored, graded and adapted therapeutic interventions that enable service users to become involved in the social enterprise who may struggle to engage without such therapeutic intervention. A social enterprise also has the flexibility to offer voluntary and paid work to facilitate the return to work process of developing confidence and skills in a supportive and socially inclusive environment.

### **A psychosocial intervention**

The findings in this study have evidenced that people who use the social enterprises benefitted from the opportunity to engage in activities in an outdoor environment (Woodland and forestry; Therapy through sport; Gardening and farming). The benefit of outdoor activities, particularly within mental health is well evidenced (Söderback 2004; Frances, 2006; Priest, 2006; Bratman et al., 2012). However, some of the social enterprises not only offered outdoor activities alone, but this was as a part of a comprehensive service comprising of expert therapeutic interventions based on individuals needs and goals alongside the opportunities for developing social networks and social capital. These social enterprises therefore offered a holistic, psychosocial package of support as part of the process of recovery.



The development of friendships, acceptance among others and a sense of belonging has been evident in the experiences of some of the people who attended the social enterprises (Dementia day service; Woodland and forestry; Therapy through sport; and Gardening and farming). The beneficial aspect of social gains to health, wellbeing and recovery has been evidenced in the literature (Spencer and Pahl, 2006; Evans-Lacko et al., 2012) and these findings contribute to this body of knowledge. However this study adds new knowledge as there is a lack of literature that evidences the voices and experiences of the people who use social enterprises. There is currently limited research that includes service users' voice and opinions on social enterprise and as this is an extremely underrepresented area of research generally as well as within the field of occupational therapy. This study begins to address the gap in research and contributes to new knowledge. The development of friendships and social networks has been shown to improve health outcomes (Gardino and Lindstrom, 2010) and therefore engagement of marginalised and disadvantaged groups in social enterprises where they have an opportunity to do this, can be asserted as a health prevention strategy. This may be a more beneficial financial saving for the public sector as a long-term strategy than the public sector cuts. There are widespread concerns that the cuts to public sector spending which has become a feature of the Coalition Government may have a seriously negative impact on the most vulnerable in society (Ramesh, 2012; Ham et al., 2013).

### **Therapeutic focus on activity**

Some of the social enterprises in this study addressed health and social problems within the context of the activity of the organisation, such as Woodland and forestry, Youth health promotion, Gardening and farming and Organic growing. This was commented on by some of the participants who used the social enterprises as something they appreciated and was directly linked to the ability to gain a sense of identity and role that was not attached to their illness (Shepard et al., 2008; Slade, 2009; Leamy et al., 2011). Through the activities that were engaged in at the social enterprises, a sense of confidence, self-worth and achievement was gained (Woodland and forestry, Youth health promotion, Gardening and farming). This activity-based approach is distinctly different from the medicalised approach within statutory services and supports a more socially inclusive approach to health and social care. However, there is a distinct difference between activities that merely occupy people's time and activities that require therapeutic intervention to enable vulnerable people to engage (Radomsky et al., 2008). Most of the social enterprises in this study offered individually tailored, graded and adapted activities that were provided according to goals set by individuals.

In circumstances where a health or social care professional is present, the social enterprise may be more likely to be able to address complex health and social problems with the people who attend the service. However, without such professional expertise, those who require this level of intervention may not gain the support they require and stop attending (as in case study 7). This has been demonstrated through the efforts of the occupational therapists in this study who graded and adapted tasks to enable some people to engage in the service. In some cases, therapeutic engagement was required to intentionally enable the person to attend by supporting them in developing the skills to use public transport; manage anxiety in public; and address the deeper underlying psychological reasons for disengagement in services (SEU, 2003).

Social enterprises that do not employ healthcare professionals are more likely to be attended by people with less severe support needs as they are able to attend and use the opportunity at the social enterprise without therapeutic intervention. This can then unintentionally exclude some people in society (such as people with mental health problems) and could lead to occupational injustice as increased social exclusion and inequality. In addition, the current health and social care provision that requires service users to apply for personal budgets or direct payments also presents particular challenges for people who are unable to do so without the support required. This therefore presents the risk that the most vulnerable may not be able to access the services they are legally obliged to receive (Mandelstam, 2010; Ferguson, 2011). In addition, some people may not be able or willing to 'top-up' their personal budget (as required in some cases) and therefore not access the support that they should be receiving. This may lead to further expense to the public sector if population health deteriorates as a result of a lack of support.

#### **9.5 Research Question 4: What are the factors that determine the different ways occupational therapy is provided?**

It was found in this study that the health and social care reform to outsource to social enterprises alongside the cuts to the public sector has influenced the provision of occupational therapy within social enterprises. In some instances, specific requirements were placed on the social enterprise that limited the occupational therapist to use certain interventions and approaches and not others (such as in Fostering and adoption; Therapy through sport and Social housing). These decisions were not driven by a clinical assessment of best practice for the service user but were made by commissioners

operating within severe budget cuts (Barker, 2014). However, some of the social enterprises overcame this restriction by generating funding from other income streams (Richardson, 2013) which allowed flexibility and independence for them to provide the services that were most appropriate for the service users.

The history of the development of social enterprises was also found to have an influential factor for the provision of occupational therapy. The social enterprise that developed out of the Local Authority (Social housing) retained a 'traditional' occupational therapy role that had been practiced previously (the provision of aids and adaptations). In this case the occupational therapy role was also determined by the long waiting lists for the services, limiting their interventions to basic personal care and mobility. However the social enterprises that were developed independently of the public sector enabled a more holistic and client-centred occupational therapy role.

The social enterprise managers who were not occupational therapists influenced the type of occupational therapy provision based on the therapeutic interventions they wanted to promote within the social enterprise. These were research and evidenced-based approaches (such as psychodynamic; sensory integration and attachment theories) within which the occupational therapists were required to work. As occupational therapists can draw upon a variety of therapeutic approaches, the requirement from the social enterprise managers to work within these remits was acceptable to the occupational therapists if they were able to continue to be holistic and occupation-centred in their overall interventions and not work purely within one model.

The occupational therapists in this study considered themselves to be providing occupational therapy interventions rather than engaging in generic roles, even when their job title was not specific to occupational therapy. Half of the occupational therapists were explicitly practising as occupational therapists. However the other half did not explicitly state they were providing occupational therapy as their interventions were part of a package of care or support. These occupational therapists stated that they did not think it was important to use their title or formally take on the role of a therapist, preferring the more equal role of a facilitator (Twibble and Henley, 2000). The most extreme example of this was in Gardening and farming, where the occupational therapist chose to be a volunteer alongside the staff and service users and informally guide and advise others subtly through the relationship she developed with them. This removed any power dynamic associated with the role and title of an occupational therapist employed as a member of staff which enabled equality in the relationships she developed (Twibble and

Henley, 2000). However there was also the risk that such an approach could result in occupational therapy profession being undervalued and un-recognised.

The level of freedom and professional autonomy the occupational therapists experienced in their role in the social enterprises was also a factor that affected the occupational therapy they provided (Mackay, 2014). This was directly related to the model or approach the occupational therapists worked within in the social enterprise and any specific funding requirements referred to above. A direct relationship was observed between increased perceived levels of professional autonomy and the ability to practise occupational therapy according to the philosophy of the profession.

A barrier preventing occupational therapists from developing practice within social enterprises may be that some occupational therapists have become 'socialised' (Clouder, 2003) or shaped by the culture of statutory services, particularly conforming to the deficit-based medical model. Some occupational therapists may have become accustomed to practice within this approach that strengths based, community-orientated and health promotion approached may seem foreign and outside their perception of the profession of occupational therapy.

The ethos and principles of social enterprise worked well with the philosophy of occupational therapy as both encapsulated collaboration and co-production between staff and service users to achieve goals together. Both social enterprise and occupational therapy focus on activity and 'doing' tasks and the occupational therapy intervention in such activities made them therapeutic to facilitate recovery. The social enterprise provided a 'normal' social environment away from any stigma or labelling within which occupational therapy practice thrived to promote recovery with service users.

## **9.6 Implications of the study**

The next part of this chapter presents and discusses the implication of the study. This has been categorised onto implications for policy; implications for social enterprise practice development; implications for occupational therapy and implications for the people who use social enterprises.

## **Implications for Policy**

The health and social care reform, public sector cuts and the implementation of the personalisation agenda has formed the context of this study and directly affected the findings of this research. The health and social care reform has provided opportunities for occupational therapists to work in new environments and the proposed ideas behind personalisation and the provision of services through social enterprises provided opportunities for new and innovative working. Third sector organisations are well positioned to provide services to marginalised groups in society (Marmot, 2010; Scottish Government and STSRF, 2011) and social enterprises have been evidenced in this study as a model for promoting health and wellbeing and therefore could reduce health inequalities (Donaldson et al., 2011; Roy et al., 2013). However, social enterprises that provide occupational therapy need to be supported financially by the public sector for it to be an effective policy strategy for addressing health and social care.

There has been a lack of financial support by the public sector has also been evident in literature and in this study (Lewis et al., 2006; Addicott, 2011; Miller and Millar, 2011). The lack of financial backing for social enterprise provision of health and social has resulted in gaps in service provision affecting groups in society who need support services. Cuts in public funding, have affected some of the most marginalised groups in society, some of which are not able to access services. As a result of health and social care reform and cuts in the public sector may create greater inequality in the UK and concern has been expressed by healthcare think-tanks and professional bodies (Humphreys, 2012; RCN, 2012).

A lack of support for the development of social enterprises outside of the public sector has been demonstrated by the scarcity of an evidence base for this in health and social enterprise literature (STSRF, 2011). Public policy and academic literature reports on public sector spin-offs in health and social care but the evidence base is limited outside of this within the third sector. The lack of professional support for staff within the public sector to develop social enterprises has also been documented (Addicott, 2011; Miller and Millar, 2011; and Lewis et al., 2006). Therefore there is a contradiction with government policy promoting social enterprise as a provider of public services alongside a reduction in the support offered to the development of social enterprises. Despite public policy that should support occupational justice (such as the promotion of locally owned and run social enterprises), the lack of support in implementation of these policies could have resulted in increased occupational injustice as an outcome. For example, some service users have

been unable to access services as a result of public sector cuts and health and social care reform, such as not being able to access personal budgets (Mandelstam, 2010; Ferguson, 2011). The inability to access services that provide occupational therapy is a barrier to occupational justice in the form of occupational deprivation (Hocking, 2012) as such individuals will not be able to receive therapeutic interventions to enable them to fulfil their occupational needs. It is also a matter of occupational justice for occupational therapists to be able to provide services (Townsend and Marval, 2013), however within the climate of public sector cuts and health and social care reform, occupational therapy social entrepreneurs in this study have felt unsupported to develop their services.

It was surprising that a small number of social enterprises providing occupational therapy were identified through this study. This is possibly because the term 'social enterprise' is still relatively new but this could also reflect the politicised use of the term 'social enterprise' within the UK since 1997 (Spear et al., 2009; Teasdale, 2012). For example, within the UK, 'social enterprise' within the health sector had become associated with outsourcing public sector services, loss of pay and fewer associated benefits (Miller and Millar, 2011). This negative perception of 'social enterprise' has not been countered with the opportunities that social enterprise could offer healthcare professionals, apart from the belief held by government policy writers that social enterprise would improve healthcare services (DH, 2010a). It is possible that the political use of the term 'social enterprise' has created a negative perception of social enterprise (Mickle, 2010) among occupational therapists who do not work for social enterprises although this has not been researched and is currently unknown. This study has evidenced that occupational therapists who work for social enterprises perceive that social enterprise offers a beneficial environment for professional practice although funding challenges remain.

The implementation of the personalisation agenda during a time of austerity has resulted in cuts to services for individuals who have been clinically assessed to require such support for some individuals (Adoption and fostering; Therapy through sport; and Gardening and farming). Similar cases have been referred to in the literature which were taken to court and won on the basis of the government's legal responsibility to provide services under the Chronically Sick and Disabled Person's Act 1970, once a clinical assessment of need had been conducted (Mandelstam, 2010). The social enterprise staff in this study have experienced a lack of funding for services for individuals who have had a clinical assessment of their need for services. Questions and concerns are raised about the decision to provide services on a financial basis, rather than on clinical need which could undermine the occupational therapy profession. This also raises issues regarding

monitoring such inequalities and illegalities in service provision in the new health and social care landscape which has become disparate.

The inability of small social enterprises to respond adequately to win contracts for providing services (because of a lack in public sector support) has opened up the opportunity for private providers to win these contracts. The lack of a definition of social enterprise in the Public Services (Social Value) Act (2012) and the absence of any enforcement process within the Act has enabled private providers to win large contracts with the public sector. Examples of this are evident in the NHS services now provided by Circle Health and Virgin Health. These examples and the findings in this study support the claims that 'social enterprise' has been used as a smokescreen for privatisation of the public sector (Rainford and Tinkler, 2010; Roy et al., 2013).

There are three principles that would need to be enforced to ensure the prevention of privatisation of the public sector and effectiveness of social enterprises as service providers to deliver occupational therapy. Firstly, public policy to support the outsourcing of the public sector to community owned and governed grassroots social enterprises requires financial support alongside training and development programs to enable such providers to develop the capacity to bid for contracts and develop sustainable business models. Occupational therapists would particularly require training in business skills and management if they wanted to set up social enterprises. Secondly, this would require legal enforcement of public sector outsourcing contracts only to organisations that add social value, alongside a definition of this and measurement tools. Thirdly, the provision of such contracts would also need to be implemented in a way that local public sector service providers are involved in the process to enable the acceptance of new social enterprise providers. The evidence in this study demonstrates that this has not occurred in the settings investigated.

This study has identified a discomfort for health and social care professionals and occupational therapists to generate profit out of their work as this is an unfamiliar way of working for them and fear exploiting the vulnerable. However, generating profit within social enterprise is not necessarily a bad outcome, but it is dependent on how the profit is used. If the profit is reinvested back into the social enterprise to employ more staff and increase service provision then it can be positive. Such reinvestment for a social purpose is a defining aim of a social enterprise (DTI, 2002 p13). The inability to generate a profit could result in some people missing out on services as found in this study. The ethical concerns of generation of profit in health and social care is a matter of who monitors

social enterprises profit and where this is used. Such monitoring of government bodies is conducted by the regulatory body, 'Monitor', but there is a lack of monitoring of independent social enterprises. Without monitoring of this issue, there is a risk of a privatisation of health and social care sector and the development of services available for those who can afford them and others for those who cannot. This could lead to a widening drift towards inequalities in access to health and social care (Porter, 2012).

### **Implications for social enterprise**

Social enterprises need to have a profit-making element to their mission, mandate or business aims to be a sustainable business (Ridley-Duff and Bull, 2011). If this is lacking, the organisation is at risk of being financially insecure, dependent of grant funding and may be better suited a charitable model. Social enterprises that deliver health and social care may be too heavily focused on meeting the social aims that the business aims for financial security and stability are overlooked. The social enterprises in this research which had a sustainable business and financial models achieved their social aims through the running of the business. Two examples of this was in Woodland and forestry and Organic growing, where the output of the business was a product but the process of creating the product facilitated the social aims (health or social care) to be achieved. This case study successfully combined the social aims of the organisation with the business model for it to operate successfully.

Guidance is required for social enterprises about how to achieve a viable financial model that enables the social aims to be achieved. The successful social enterprises within this study: ensured a stable business model; had a variety of income streams; was run and managed by a business person but utilised expertise of occupational therapists to address social aims within the budget.

As occupational therapists played a crucial role in ensuring social aims are met through their individual and group work with service users, social enterprises would benefit from actively seeking occupational therapists to work for them. If social enterprises are to develop and compete with other providers for public sector contracts (Addicott, 2011) they will need to employ health and social care professionals to deliver a professional services. This requires substantial funding and an effective business strategy to ensure a sustainable organisation. Occupational therapists will also need to become efficient at proving the effectiveness of their interventions in this market-ised business environment (COT, 2013). Third sector providers who are becoming social enterprises or transforming



their services to win public sector contracts may not know which healthcare professionals they need to employ. Marketing of healthcare professions such as occupational therapy will be essential for ensuring inclusion in these new provider organisations.

In addition, the scoping study evidenced social enterprise models being used to further the occupational therapy profession through training occupational therapists in specialist skills. Therefore, social enterprise can be used to offer various services, such as training and supervision as well as providing direct interventions to the end users.

### **Implications for the profession of occupational therapy**

The occupational therapists within the social enterprises in this study (with the exception of case study 6 – Social housing) experienced the ability to practise according to the philosophy of the profession, therefore promoting occupational justice with those who benefitted from their services. These social enterprises had a non-medical, non-labelling and non-stigmatising environment for the occupational therapists to practise in comparison to occupational therapy provision through statutory services. Working within a social enterprise environments can strengthen the occupational therapist's ability to work collaboratively and in client-centred, holistic manner according to their training and philosophy. The occupational therapy services were therefore able to promote occupational justice through service user engagement in a meaningful role within the social enterprise, development of friendships and participation in governance of the organisation.

### **The political practice of occupational therapy**

This study has evidenced the ability of occupational therapists to engage in application of an occupational therapy philosophy not only with the individuals directly engaged in therapeutic interventions, but also with groups, communities or on a wider political level (Duncan and Watson, 2004; WFOT, 2006; Thompson et al., 2010). The wider, political application of occupational therapy philosophy has been asserted by Wilcock (2006); Pollard et al., (2009); Reigel and Eglseder, (2009) and demonstrated through theories of community-based rehabilitation in other countries (Thompson et al., 2010).

Nilsson and Townsend, (2010) have asserted that occupational injustice occurs as a result social policies that limit civic participation in society. Steps can be taken to address this barrier by involvement of occupational therapists in social enterprises to shape and

create services. Through the application of an occupational philosophy to groups, communities, organisations and at a policy level, health equality may improve by increased participation in society of marginalised groups (Reigel and Eglseder, 2009).

Examples in this study contribute to the body of knowledge about the political practice of occupational therapy which asserts the importance of occupational therapists at all levels of society (Pollard et al., 2009). This includes:

- Involvement in the social enterprise organisational structures for example, occupational therapists inclusion in governance and decision-making about service provision (Woodland and forestry; Youth health promotion; Social housing; gardening and farming; Organic growing);
- Empowerment of service user involvement in decision-making within therapeutic interventions and within the organisation (Woodland and forestry; Youth health promotion; Therapy through sport; Social housing; Gardening and farming; and organic growing).
- Advocacy for service provision and funding at the Local Authority level and at times with members of Parliament (Adoption and fostering; Dementia day service; Woodland and forestry; Youth health promotion; Therapy through sport; Gardening and farming);
- Advocacy for personal budgets for adults with mental health problems to access services (Therapy through sport);
- Advocacy for funding to provide sexual health workshops to teenagers where none is provided (Youth health promotion);
- Advocacy for funding to provide therapeutic rehabilitation to ex-offenders who would otherwise not receive such intervention (Therapy through sport).

This study has demonstrated that social enterprise is a model that can be used to facilitate occupational therapists to gain positions of influence to enable participation of inclusion of vulnerable and marginalised groups in society. Through tackling such barriers to service provision occupational therapists can utilise their roles within social enterprises to enable service users to experience greater participation in society and contribute to occupational justice (Reigel and Eglseder, 2009; Gannon and Lawson, 2009; Boyle and Harries, 2009; Aldridge, 2012). Therefore, the findings from this study suggest that social enterprise can be used as a model for occupational therapists to be a part of creating social change and access to services for and with marginalised and disadvantaged groups within society. As

a result, through occupational therapists engagement with social enterprises, they can positively influence occupational justice through promoting fairness, equality, empowerment and redistribution of services (Stadnyk et al., 2010; Braverman and Suarez-Balcazar, 2009; Reigel and Eglseder, 2009).

Occupational therapists ability to influence occupational justice by involvement in social enterprise governance and decision-making, can provide opportunities for improving service delivery if supported by the social enterprise (Nilsson and Townsend, 2010; Reigel and Eglseder, 2009). For example, occupational therapy research and academic knowledge-base asserts the importance of holistic interventions to promote recovery (Wilcock, 1998; 2001; Hagadorn, 2001; Creek, 2003). Through the integration of physical, social, psychological rehabilitation by the occupational therapist within the structure of the social enterprise, service users will receive a comprehensive package of support and the social enterprise is likely to have improved social outcomes.

### **Opportunities to develop the profession**

Occupational therapists in statutory services have had the amount of time reduced to properly grade and adapt activities with those they provide services to, as a result of reduced hospital stays and therefore less time for rehabilitation in hospital (Arnold et al., 2006). As a result occupational therapists have experienced increased difficulties addressing the goals identified with the people who receive their services within statutory care (Bailey, 1990; British Association of Occupational Therapists and Unison, 2003; Arnold et al., 2006). However, the occupational therapists within most of the social enterprises in this study experienced sufficient time to implement their work according to their professional judgment, with less bureaucracy than previous employment in statutory services and with greater professional autonomy.

Social enterprises are new environments for occupational therapy professional practice contribute to the development of the profession outside of statutory services such as in charities (Hopkins, 2003; Cunningham et al., 2012) and businesses (Merritt et al., 2013) which is in contrast to service provision historically grounded in public sector statutory services. This study has added to the body of evidence of occupational therapy delivery in new and emerging environments in the UK which contributes to the existing international literature (Herzberg et al., 2006; Bazyk and Bazyk 2009; Holmes and Scaffa, 2010).

Occupational therapy students and new graduates demonstrate greater willingness to work outside of statutory services (Lawson-Porter, 2009) which is likely as a result of the changing landscape of health and social care delivery in the UK which now includes a wider variety of service providers. It may also be as a result of the development of occupational therapy education which prepares new graduates by including modules such as business, management and entrepreneurship alongside the opportunity for role emerging placements.

The non-hierarchical approach adopted by most of the occupational therapists within the social enterprises has also been evident in theory and practice of occupational therapy within community-based rehabilitation in less economically developed countries around the world (Twible and Henley, 2000; Thompson et al., 2010). As the UK is now faced with the challenge of providing health and social care with fewer resources than previously available, there may be opportunities to learn from such contexts around the world which may have already developed effective strategies for cheaper services (Kendall et al., 2009). Learning from such situations would require a reversal in the knowledge transfer process that has historically been from the western 'developed' countries to less developed countries. Pollard et al., (2010) have provided examples of multiple situations around the world where occupational therapists in poorer economic nations have been able to provide creative and innovative services with limited finance. Frequently this has involved the development of projects and businesses which people engage in as part of the therapeutic process. Application of such examples to 'developed' nations such as the UK remain sparse despite similarities in the underlying needs to provide occupational therapy with limited resources, that need to generate income and rely on the initiative of the occupational therapist.

Some social enterprises identified in the scoping study attempted to provide support to vulnerable groups in society such as children with autism or adults with learning disabilities without any professional expertise. Whilst such organisations are able to provide some activities, the therapeutic and rehabilitation element may be missing. The employment of occupational therapists in the growing third sector could be essential to address occupational and social justice through promotion of equality and participation in society (Braverman, 2009; Reigal and Eglsedar, 2009; Nilsson and Townsend, 2010). However, occupational therapists need to be proactive in creating jobs for themselves in such organisations. To do this they need to have the evidence of effective interventions through outcome measures to be able to confidently promote themselves and the profession (Bennett et al., 2003; COT, 2013).

There is a need for occupational therapists to market and promote the outcomes of their interventions to third sector providers such as charities and social enterprises but also to private businesses in the corporate sector. Occupational therapy marketing needs to promote the outcomes and the end product of what can be achieved through occupational therapy intervention (COT, 2013) such as enabling someone to get back into work or the ability to manage a tenancy. These outcomes need to be easily understandable to people who are not occupational therapists and beneficial to those who use the services. Occupational therapists need to be at the forefront of developments in regard to social impact measurement and funding requirements to be able to equip clinicians in the future.

The occupational therapists that were identified in this study saw the opportunity that social enterprise could offer the delivery of occupational therapy and their own professional and personal development. They either developed a service or chose to work for a social enterprise. This study evidenced that occupational therapists experiences of job satisfaction and their own personal needs that were met within the social enterprise outweighed the personal sacrifices of financial instability or loss of pay and benefits. This suggests that these occupational therapists were driven by both altruistic values and motives to 'make a difference' through their work but also by the personal need for value, recognition, appreciation and to have a fulfilling work role. The occupational therapists also experienced a development in their own social capital through their involvement in the social enterprise. This was evident in their experience of connectedness, trust, belonging and involvement in a community with shared values (Morgan and Swann, 2004). Social capital has been linked to health and wellbeing therefore it can be suggested that working for a social enterprise can promote health and wellbeing for staff as well as those it aims to benefit (Morgan and Swann, 2004; Kawachi, et al., 2008; Song, 2013).

It was found in this study that the occupational therapists experienced professional autonomy in their work, particularly when reflecting on a comparison to their experiences in statutory services. Their experience of professional autonomy (Mackey, 2014) within the social enterprise structure was purported to be important in their ability to practice according to professional beliefs and the philosophy of the profession. This may also be a part of the job satisfaction and sense of fulfilment that they expressed in their work.

Occupational therapist's autonomous practice within social enterprise addresses some of the challenges within the profession that have been evidenced in statutory services (Arnold et al., 2006; British Association of Occupational Therapists and Unison, 2003).

The reasons for this level of autonomy may be due to the emphasis on a flatter hierarchical structure within social enterprises; the positive, strengths-based approach taken by social enterprise staff that reinforces the abilities of each individual within the organisation and their unique contribution; the appreciation and valued worth of a 'healthcare professional' or 'expert' in an organisation which does not already have such expertise. Occupational therapy practice within organisations that enable professional autonomy may be essential to protect the future of the profession and its ability to assist service users in addressing occupational needs.

When considering working for other service providers outside of statutory services, occupational therapists may need to adjust their expectations of salary and associated benefits which are likely to be less than what has previously been offered. Occupational therapists will also need to ensure they maintain professional links and support whilst working alone in small organisations and be prepared to work within less of a hierarchical and medical model. Recent and newly qualified occupational therapists may adapt to working within social enterprises quicker than those who have worked within statutory services as recent undergraduate training has incorporated non-traditional roles on placement and in the curriculum (Wood, 2005; Thew et al., 2008). Working for a social enterprise in the third and corporate sector can be a new and unfamiliar environment for occupational therapists with challenges and implications for occupational therapists to adapt to working in competitive markets, developing business skills and collaboration with business-minded people (Addicott, 2011).

There are also implications for the cost of employing an occupational therapist, as the rates of pay for a qualified healthcare professional are higher than a non-qualified staff member. With the cuts to the third sector and lack of provision for the support of the third sector to employ professionals, there is a risk that occupational therapy positions could be replaced with cheaper, unqualified staff. This can have implications for the type of services provided by such organisations as people with mental health problems, physical disabilities or complex social problems require professional intervention such as occupational therapy. Without professionals within these third sector providers, there is a risk that these groups in society may be marginalised, contributing to occupational injustice and the growing levels of inequality in the UK (Wilkinson and Pickett, 2009; Marmot, 2010; Joyce, et al., 2010; OECD, 2013). The lack of financial support for social enterprises to employ professionals could also have implications for the reduction in employment of occupational therapists. This is in light of reducing number of occupational

therapy positions in the NHS as a result of public sector cuts and outsourcing of services to other providers.

Similarly, this study has evidenced fears held by occupational therapists of job insecurity and the consequences of a pay cut while working for a social enterprise in comparison to statutory services. This has also been a phenomenon evident in public sector staff that was proposed with the opportunity to 'spin-out of the public sector' (Miller and Millar, 2011). Occupational therapists that may have been qualified for a number of years may be reluctant to leave statutory services with the pay and benefits associated with it, to then work for a social enterprise that is unlikely to match these. This is despite the evidence of dissatisfaction, disillusionment and the inability to practice according to professional beliefs of some occupational therapists within statutory services (Bailey, 1990; British Association of Occupational Therapists and Unison, 2003; Arnold et al., 2006). The question is then raised of whether occupational therapists motivations for practice change from being altruistic upon entry into the profession to more personal and financial motives after working within statutory services.

### **Occupational therapists skills and motivations**

Social enterprises have been evidenced in this study as an effective environment for occupation-based practice and occupational therapists need to take the initiative to create these settings for practice. To do this, occupational therapists require business skills and support in setting up and running social enterprises or to collaborate with a business person (Scaffa and Reitz, 2014). Therefore the incorporation of business and management skills within undergraduate and postgraduate training would be valuable. It is up to individual occupational therapists to be proactive in bringing about occupational and social justice through developing organisations or taking on roles in established organisations that permit practice according to the philosophy of the profession. This could involve personal sacrifice however some of the occupational therapists interviewed gained such satisfaction from their work that the personal sacrifice was of less significance.

Within this study, social entrepreneurs who were also occupational therapists felt that they did not have the skills needed to run the social enterprise and a desire for mentoring or coaching in business skills was expressed. With the changing health and social care landscape, occupational therapists are going to require training and equipping in how to set up and run organisations such as social enterprises. Funding such training will be a

personal decision of such individuals, despite the government policy objective for health and social care provision by social enterprises.

The development of social enterprises that deliver occupational therapy may be limited due to the need for business-minded healthcare professionals with an entrepreneurial vision. Alternatively, a business-minded person could jointly set-up a social enterprise alongside a healthcare professional. The lack of business skills has been evidenced within the literature of health social entrepreneurs (Lewis et al., 2006; Miller and Millar, 2011; Millar et al., 2013) which has been confirmed in this study.

If occupational therapists are equipped with start-up funding, training in business and management skills and supported by a business person to create a sustainable and financially viable organisation, they may be able to take advantage of the policy supporting social enterprise to deliver health and social care. Health and social care professional's involvement in design and implementation of services may create more effective services, however the issue of funding and support for this to happen remains an issue and challenge.

Social enterprise providers may not be familiar with the role of occupational therapists or be aware of the value of them to their services. There are implications for the need for occupational therapists to market themselves, using evidence based outcomes to prove their effectiveness (COT, 2013) and create jobs for themselves in social enterprises. Occupational therapist may also need to consider applying for jobs that are not specifically advertised as requiring an occupational therapist, and convince the prospective employer of the value of an occupational therapist to the organisation. However, voluntary and private sector organisations have been found to have a lower priority for issues of wellbeing, occupational engagement and health promotion (Healey, 2011). Newly qualified occupational therapists may also have to bid for contracts for work or design and set up services to offer. This requires a range of skills that need to be incorporated in occupational therapy education to prepare occupational therapists for the new health and social care environment they will enter into (Healey, 2011).

Further questions also remain unanswered such as whether occupational therapists are interested in or motivated to set up social enterprises, particularly as they trained as healthcare professionals and not entrepreneurs or business people (Addicott, 2011; Miller and Millar, 2011). For those that may be motivated to do this, there are then issues around whether they feel equipped to take the opportunities available to them to start up



social enterprises (Addicott, 2011). There are also issues from this study regarding whether occupational therapists are willing to take jobs with lower salaries and fewer benefits associated with the job such as pension and sick pay. The success of occupational therapy provision through social enterprise may depend on the moral and ethical choice that occupational therapists make when considering a lower salary to be able to further occupational and social justice through social enterprises.

### **Implications for service users**

The changes to health and social care policy and approach taken within social enterprises to equip, collaborate and empower individuals represents a paradigm shift from the medically-orientated, deficit-based approach of statutory services where people are perceived as 'patients' and passive recipients of services. This paradigm shift requires those who use the services to change and adapt to different roles and expectations of them within the social enterprises. This may be challenging for some people, particularly people with long-term mental health problems, who are used to the role of a 'patient'.

Health and social care provision through social enterprise can provide opportunities for some vulnerable and marginalised groups in society to receive support that they may otherwise not benefit from. However, this provision is not necessarily equitable across the country and has been referred to as a "postcode lottery" within this study, the media and the literature (Hilary, 2005; Peck, 2011). Despite the intention of social enterprise to have a social impact with marginalised groups, the inconsistent provision of services as a result of the changing policy landscape, and cuts to services may actually increase inequality and worsen access to services.

### **Limitations of the study**

The findings, implications and recommendations drawn from this study are to be taken within the context of the limitations of the study. This study has been limited by the small population size of occupational therapists who work with social enterprises, however the small numbers identified allowed in-depth research to be conducted. It was also a limitation of the study that this research was conducted whilst confusion over the term 'social enterprise' was evident, particularly considering the politicised use of the phrase in the UK within the health and social care sector (Spear et al., 2009; Teasdale, 2012).

## **Limitations of the scoping exercise**

The total number of occupational therapists working in social enterprises, or the number of social enterprises employing occupational therapists was unknown at the beginning of the study and continues to be unknown. Therefore these findings may not be representative of social enterprises delivering occupational therapy services. However, these findings are representative of the total known population at the time the study was conducted, considering the extent to which participants were sought to participate. The lack of a centralised database of such information and the inability to access databases held by The College of Occupational Therapists or The Health and Care Professions Council (due to data protection), limited access to the full sample of potential participants required. National and regional social enterprise databases did not hold detailed information such as whether occupational therapists were employed by the social enterprise therefore identification of a sample for this study was particularly difficult. If this study were to be repeated by another researcher, other social enterprises employing occupational therapists may be identified. This study is limited by the network of contacts of the researcher, the opportunities available to advertise through the College of Occupational Therapists, the information available on the internet and the social enterprises that had a website.

The design of the online questionnaire was based on very limited knowledge of occupational therapy provision through social enterprise due to the lack of any existing literature in this area. The online questionnaire provided some useful data but had limited opportunity for participants to respond, therefore restricting their choice of answers to some questions. In hindsight, it would have been beneficial to ask open-ended questions in the online questionnaire about the occupational therapists practice within a social enterprise. It is likely that the online questionnaire was completed by more than one participant from an organisation therefore the results were duplicated. The lack of control over who completes the questionnaire is one of the known drawbacks of online questionnaires (Gray, 2004). The identity of the respondents was kept anonymous however as a consequence of this and the computer package used to conduct the online survey, it was not possible to identify the same respondent's answers to the different questions. As a result, this limited the degree of analysis of the results of the online questionnaire. However, this was valuable when conducted alongside various other data collection methods. The limitations identified in the first phase of the research were overcome in the second phase, which enabled more in-depth data gathering.

## **Limitations of the case-study methodology**

The inclusion of case study six into the research resulted in different findings from the other case studies as it was previously a housing department in a Local Authority rather than an organisation which had started 'from scratch' as the other case studies had. This case study was a similar organisation to the NHS public-sector spin-offs which had been excluded from the study. It was included on the basis that it was not created as a direct policy initiative such as the Right to Request in the NHS and that it may offer insights and comparisons with the other case studies. It is possible that the findings from this case study are comparable with the previous research evidenced in the literature which has been conducted with public-sector spin-offs.

The findings from case study eight, (Organic growing) were limited as the occupational therapist was the only participant from this case study. This was as a result of another research study being conducted at the same time at that organisation. In addition it was a limitation of the study that the people who used the service could not all participate in the research. Therefore, it was a limitation of the study that there were not equal participants from each case study.

In some cases, the service user's medical condition was a limitation (such as dementia in case study two), which limited the service user's ability to engage in the semi-structured interviews. This was overcome by using informal conversational interviews which were more appropriate for this group of people but upheld their ability to engage in the research (McKeown et al., 2010). In hindsight, inclusion of carer's in the interviews could have been a valuable contribution to the study. A carer satisfaction survey conducted by the social entrepreneur was considered as secondary evidence.

Within this study, the occupational therapists and social entrepreneurs were the gatekeepers to access the service users which provided a variety of responses. Some occupational therapists wanted to provide the opportunity for the service user's to choose for themselves if they wanted to participate or not. In other cases, the occupational therapist or social entrepreneurs decided who could and could not be approached to participate in the study, potentially introducing bias to the research (Preston et al., 2012). It is widely accepted that gatekeeping is a problem within healthcare research inhibiting the development of a knowledge-base (Patterson, et al., 2011). Access to some participants such as vulnerable children in case study one was a limitation to the study as these participants were prevented from involvement by the social enterprise manager

acting as a gatekeeper (Bryman, 2008; Preston et al., 2012). However, despite the importance of giving all service users an opportunity to participate in the study, the lack of inclusion of the children's experiences did not necessarily affect the findings considering the research topic. In retrospect, the parents, carers or guardians of the vulnerable children could have been approached to participate in the research.

The participating service users who received occupational therapy, talked about their experience of attending the organisation as a whole and rarely distinguished between the occupational therapy intervention and their overall experience. Therefore it was not possible to separate the impact of the occupational therapy intervention from the social enterprise as a whole. There are benefits to the integration of occupational therapy to reducing stigma and associated role of someone receiving 'therapy' however there could also be negative implications for individual occupational therapists and for the occupational therapy profession if they are not acknowledged for their specific contribution and professional expertise. Occupational therapists will be required to continually demonstrate their effectiveness to justify their position and ongoing employment (Bennett et al., 2003; COT, 2013).

The process of thematic analysis was complex, in-depth and difficult to conduct. This is likely because of the amount of data generated and inexperience of the researcher. The use of a computer programme such as NVivo could have been used to help to organise the findings from the interview data. It is acknowledged that thematic analysis was also subjective and another researcher may identify slightly different themes with the same data available.

It was not possible to gain the same written documents from each case study, therefore this data was not consistent across the case studies to enable a thorough analysis or comparison. However the written documents obtained were useful in triangulation with other data sources from the same case study (Silverman, 2010). The use of unstructured observation during the field visits had implications for a lack of standardisation and may be criticised for subjectivity which could result in difficulties replicating the study. However, due to the lack of prior knowledge about occupational therapy provision in social enterprises before this study, this was an appropriate type of data collection, the findings from which can be used to develop future research.

The findings from the interviews were largely positive about occupational therapy with few criticisms or negative comments made by the participants. Such "social desirability"

(Randall and Fernandez, 2013 p174) raises questions about whether this research captured the full picture of all the issues relating to occupational therapy practice delivered within social enterprises. A research design which maintains the participant's anonymity and does not involve meeting the researcher may provoke more critical or negative responses as the desire to please the researcher would be removed.

Despite the positive accounts of occupational therapy service provision within social enterprises, the participants were open and honest about the difficulties with funding, managing and sustaining social enterprises and their perceived lack of skills. This suggests that the participants were able to offer critical or negative comments within the context of the interview.

## **9.6 Reflexive analysis of the research process**

This section contains personal reflections of the research process and is written in the first person for this purpose.

### **Reflections on the topic of research**

This study was funded through a scholarship, and as such the research topic for this study had been pre-set to a certain degree. Initially the focus was to find out if occupational therapy could be practised within social enterprises according to the philosophy of the profession. However, when I started the literature reviews and explored what was already known about occupational therapy practice in social enterprise, I discovered very little pre-existing knowledge on the subject. This then changed my focus for the initial part of the study as I needed to gain a baseline of knowledge of the practice of occupational therapy within social enterprises in the UK, to be able then to explore the topic further in a second phase of the research. Initially I was also going to focus on a comparison study between occupational therapists within statutory services and those in social enterprises to compare practice. However in the initial phase of the study I visited some occupational therapists within social enterprises and discovered creative, innovative practice that enabled them to practise according to the philosophy of the profession. This insight shaped the course and direction of the study because I could see the value of researching this new, un-researched phenomenon in greater depth. As there was already a wealth of knowledge of occupational therapy practice within statutory services within the literature, I did not see the value in committing half of the study to this. Instead, to focus only on

occupational therapy practice within social enterprises would give greater insights and new knowledge into a previously under-researched area.

The choice of the topic for the study was guided by two main influences. These were the government policy drivers for the outsourcing of public services to social enterprises (DH, 2010a) and the second was the need within the occupational therapy profession for new environments to practice according to the philosophy of the profession (Healey, 2011; Holmes and Scaffa, 2010). However, as the researcher, I also brought my individual experiences with me that shaped the direction of the study. As I referred to in the preface to this study, after practicing in the UK for over six years, I had experienced the freedom to practise occupational therapy in an unrestricted way in Uganda and was able to incorporate community-based rehabilitation; an asset-based approach; and health promotion as part of my work. This was with the communities in Uganda, to achieve occupationally focused goals within a damaged, vulnerable, war torn community on a very small budget (Stickley and Stickley, 2010). I had learnt there that there was value in including service users and their communities in planning and implementing the services offered, using strengths-based, empowering approaches.

Upon return to the UK, considering the political drive for social enterprise as a form of service delivery and the reducing budget for delivering public services, I could see the potential opportunity for the application of an occupational therapy philosophy within a social enterprise in the UK context. My simplistic vision was challenged when I learnt more about the politics and policy within the UK driving the social enterprise agenda. I became disillusioned with the focus within the public sector being on improving quality and efficiency (amidst drastic cuts to services), rather than genuine community empowerment and a shift to asset-based strategies. This was coupled with examples from occupational therapists within newly formed public sector 'spin-offs' who said that their work either had not changed or was become more target driven by the public sector. When I found examples of occupational therapists within social enterprises that were able to create and shape their practice with autonomy and freedom, supported by the social enterprise. I was encouraged to witness the empowering, non-medicalised, occupation-focused interventions which were happening, similar to other on-traditional settings (Healey, 2011). These social enterprises were all independent of the public sector or only in partial receipt of public sector funding. This influenced the decision to exclude these spin-offs from the main phase of the study. I was motivated to explore more about the social enterprises that enabled occupational therapists to practise in a way that would enable occupational justice and subsequently social justice and health equality (Kielhofner et al., 2011).

## **Reflections on the research questions, aims and objectives**

Originally there was one aim for the study which was to explore the opportunities social enterprise offered occupational therapy practice according to the philosophy of the profession. This changed and was expanded into four aims that were more specific and directly related to the research questions. This included the aim to understand current practice of occupational therapy within social enterprises in the UK; service users' experiences of this and examination of the influencing factors in occupational therapy provision within social enterprises. The reason for including the aim to gain baseline data into the topic has been discussed above but the inclusion of service users' experiences was for two main reasons. This was because it became evident in the literature review that there was a distinct lack of service users' voice in research into social enterprise generally, as well as in health and social care social enterprises. Also, it is inherent within the occupational therapy philosophy to collaborate and partner with service users in all interventions, it was deemed essential to include their views and perspectives in this research. The final aim to explore the influencing factors in occupational therapy provision became evident in the early stages of the research when it became apparent that occupational therapy was practised in different ways in social enterprises, not only for clinical reasons but also due to financial constraints, the mission of the social enterprise or local management.

I was able to achieve the majority of the aims and objectives of this study but some were not achieved fully. The first aim and research question was to identify the social enterprises in the UK that provide occupational therapy. Various methods were used to identify these however, they were very difficult to identify and new social enterprises which provided occupational therapy became apparent after data collection had ended. Therefore, this aim was achieved within the limitations of this study and as a snapshot in time that the study was conducted.

The second aim and research question to explore occupational therapy practice according to the philosophy of the profession was also challenging as there is not one agreed philosophy of occupational therapy that could be used to evidence the practice within the social enterprises. To overcome this an amalgamation of philosophical principles was established from the literature and this was used.

The third aim and research question was to explore service users' views, experiences and opinions of the occupational therapy they received within the social enterprises and was

also challenging to achieve. This was because they talked about their experiences of the social enterprise generally, with the occupational therapy service as part of this. Only on a few occasions, the service users referred to the occupational therapist or the occupational therapy support worker directly. This can be perceived as a positive indication that the occupational therapist and the service offered were well integrated into the social enterprise without the need for medicalised distinctions (such as a structured “therapy session”), roles or titles used. This may demonstrate the more equal, collaborative relationships the occupational therapists had with the service users without needing the roles of ‘patient’ and ‘therapist’.

The fourth aim and research question was to explore the factors that affected occupational therapy provision within social enterprises which was also partially achieved as some of the data generated indicated financial, structural organisational reasons or contractual obligations. However, some of these influencing factors were directly relating to occupational therapy provision (for example a contract that specified which aspects of occupational therapy would be funded and which would not). However, there were political or financial implications that indirectly affected occupational therapy provision, such as funding for the organisation to employ an occupational therapist.

### **Reflections on methodology design**

Initially the design of the research was to compare three different social enterprises that employed occupational therapists: one that was a public sector spin-off; one that employed an occupational therapist as part of a multidisciplinary team and; one that was solely a social enterprise occupational therapy service. However, for the reasons given above, it was decided to focus only on independent social enterprises that were not public sector spin-offs. A comparative study could have generated new knowledge however due to the lack of pre-existing knowledge on the topic, it was deemed more important to generate an in-depth baseline knowledge of the practice of occupational therapy within social enterprises and recommend a comparative study for future research.

It was also initially planned to conduct Q-methodology (Brown, 1993) with the occupational therapists in three social enterprises. However, once I had completed training into Q-methodology, designed the Q-sort statement pack and piloted it, I discovered that this methodology would not work with these participants. This was because each of the occupational therapists in the social enterprises worked in completely different settings and therefore it was not possible to generate a Q-statement pack that



would be applicable and appropriate to all of them. In addition, Q-methodology limited participant responses and so would not enable the exploratory aspects of the research questions, aims and objectives to be answered. Following this, a re-evaluation of the research design and methodology resulted in the decision to use a multiple case study methodology which would enable the research questions to be addressed using multiple data collection methods.

In hindsight, a narrative approach in the second phase of the study could have elicited the stories of the occupational therapists, social entrepreneurs and service users experiences and provided valuable insights into the practice of occupational therapy within the social enterprises.

### **Reflection on recruitment of participants and data collection**

It was particularly difficult and much harder than expected to recruit participants as this was a new area of research as data on occupational therapists within social enterprises had not been gathered previously. I decided that any method that would enable identification of participants should be considered due to the difficulty encountered. The multiple methods used and the nature of some of the methods such as networking and snowballing could result in challenges to replicate the study for future research. Despite the uncertainty of knowing if I had identified all the potential research participants, I knew I had used extensive attempts to identify them.

When designing the data collection tool for the survey, it was challenging to know what to include as there was no previous research or literature on occupational therapy in social enterprise to guide the design of the tool. In hindsight, I would design the questionnaire with open-ended questions to generate more exploratory data initially. I would also design the questionnaire in a way that was clear to distinguish between participants to identify if any were from the same organisation to aid analysis.

Once I had identified the occupational therapists within the social enterprises it was easier to recruit the social entrepreneurs and services users. However challenges were also experienced with these participant groups. It became evident throughout data collection that not all the social entrepreneurs were the actual individuals who established the organisation but some were managers that were recruited into position to take over from the social entrepreneurs once it had been set up and established. However, this did not present any challenges in generating data to answer the research questions.

In case study eight it was not possible to recruit the social entrepreneur or service users due to another research study being conducted with the social enterprise at the same time. Despite the lack of different perspectives in this case study, it was still deemed valuable to proceed with the interview with the occupational therapist and acknowledge the limitations of this case study.

There were challenges recruiting service users in some of the social enterprises due to them being assessed on a clinical basis by the social enterprise staff as unable to participate in the study. This highlighted the role of social enterprise staff as 'gatekeepers' to accessing service users (Bryman, 2008). In one case study, the staff had either forgotten or not read the request for me to interview service users which was a barrier to their inclusion in the research. Due to the unpredictability of availability of service users in each case study, any service users that wanted to participate in the research on the day of my visit were included. This led to an imbalance of the number of participating service users across the case studies with the majority of service users who did participate being from social enterprises that support people with mental health problems. This could have affected the findings and inclusion of a wider service user group would be beneficial in future research if more social enterprises which provide occupational therapy can be identified.

During phase 2, the only consistent data collection tool across all the case studies was interviews and information from websites. Other than this, all other data were generated from a variety of different sources which were not consistent across all the case studies. For example, not all case studies had business plans or formal documentation available and there was one case study that I was not able to visit and make observations. Therefore the findings were drawn from all available information.

During the interviews, I was aware of being an inexperienced researcher, feeling nervous conducting the interviews and worried that I covered all the topics on the interview schedule. The interviews varied in the level of formality and informality they took, mainly because of the different social enterprise environments and what setting the participants had chosen to hold the interviews. I discovered I was more comfortable with the more informal environment and a less structured interview than the more formal ones but the choice of formality was out of my control. Despite my lack of experience as a researcher, in-depth quality data were gathered through the interviews conducted and the quality of the research was not compromised. This is likely because the skills of interviewing are similar to that of an experienced healthcare professional, such as: active listening;

reflective listening; therapeutic use of self; self-awareness; and use of body language (Colbourne and Sque, 2004). All of which I was familiar with using and contributed to my technique as an interviewer.

I was uncomfortable with the voyeuristic aspect of research, and the power and control that can be associated with the role of researcher (Riley et al., 2003; Huckaby, 2011). At times I observed anxiety and nervousness in some of the participants which made me acutely aware of the power and control I could hold as a researcher. I was aware of using body language and non-verbal communication (Lewis, 2012) to try to put the participants at ease but also conscious that this would not be misinterpreted. When interviewing male participants I was aware that I was a younger female and that body language and facial expressions to encourage them to 'open up' and share their experiences with me could also be misread. I overcame this by using appropriate non-verbal communication within a professional manner, which was similar to my previous role as an occupational therapist.

My role as a researcher blurred with the role of an occupational therapist during the interviews at one case study. Blurring of boundaries between the therapist/researcher role can be expected and managed if protective strategies are put in place, such as supervision to deal with issues that arouse (Colbourne and Sque, 2004; Dickson-Swift et al., 2006). It has been argued that as a healthcare professional conducting research, it is impossible to become divorced from the welfare of patients or service users (Holloway and Wheeler, 2002). The blurring of boundaries within this study occurred during an interview with a service user and an area of unmet need arose. Whilst exploring the issues around the unmet need, I was aware that this was the role of the occupational therapist in an assessment, who then had the ability to plan interventions around the identified need. I was aware that I was not in a position to do anything about the need that had been identified and I was conscious that I could not leave it un-addressed. To resolve this, I sought permission from the service user to share this information with their occupational therapist for them to follow up, which I did. This was then an uncomfortable conversation with the occupational therapist as it highlighted a gap in their service and could be interpreted as criticism. However this gap was an important finding in relation to the occupational therapy service offered.

During some of the interviews, I was surprised at the level of personal disclosure that some of the participants chose to share with me without being asked. Interviews have been criticised as an interview technique for inhibiting personal disclosure (Opdenakker, 2006). However, within this study this was not the case in some interviews where

participants not only answered questions asked but offered additional personal information about themselves that had not been sought. This evidenced that the participants felt safe to disclose personal information in the interview context (Knox and Berkard, 2009) which could enhance the quality of the interview findings. I wondered if the participants benefitted from having someone to talk to and to confide in (Dickson-Swift et al., 2006) which challenged by pre-conception that the interviews were 'one-way' for the purpose of my research.

It was possible that the participants also gained something out of the interaction with the research. Some of the occupational therapists were also keen to know about other occupational therapists working in social enterprises as they had felt alone and did not have any other contacts. This presented as a challenge because of the need for confidentiality among my participants. To overcome this, I asked each participant if they wanted to share their contact details with other participants, all of which did. I then emailed all participants with the contact details of those who requested that I share them. The participants were then able to contact one another separately, aside from the research.

When talking with the elderly service users with dementia, I was aware that they regularly forgot who I was and referred to me as one of the support staff in the social enterprise. I frequently reminded them that I was a researcher and in my mind, I questioned the ethics of talking to someone who frequently forgot who I was whilst conducting research. I was acutely aware of their vulnerability in this situation and the importance of conducting research in a respectful manner. In such situations, inclusion of people with dementia is possible when informed consent is seen as a process, where consent is regularly sought (Higgins, 2013). Despite the vulnerability of the participants in this case and the complex ethical issues of interviewing this participant group (Berghmans and Ter Meulen, 2004) I was also aware that it is valuable to give people with dementia a voice within research (Higgins, 2013).

With the service users who were teenagers, I was able to observe the benefit they gained from attending the social enterprise but it was difficult to capture this within an interview because of their difficulty expressing themselves verbally, which is likely because of observed low confidence and undeveloped self-awareness. In hindsight, it would have been beneficial to use another data collection tool such as a questionnaire that they could complete during the field visit or a more structured observational tool to gather data about their engagement in the social enterprise activities.

During a number of the interviews, I was aware that issues of inequality and injustice arose. One example of this was the refusal of a personal budget for a 21 year old man with psychosis to access mental health services; this left me wondering what hope there was for this man unable to get the help and support he clearly needed. This example also raised ethical issues as the public sector has a legal duty to provide services to meet assessed need which was being denied (Mandelstam, 2010). A further example involved the local NHS inexplicably withholding £56,000 of pre-agreed direct payments which caused the social enterprise to collapse because it was reliant upon each payment to survive. Stories such as these left me feeling angry and I felt an urge to become involved in the situations and do something about it, however I was left powerless in my role as a researcher to act on this. Involvement in such issues could introduce bias to the research and would be inappropriate within my role as a researcher (Fouka and Mantzourou, 2011).

### **Reflection on the process of analysis and interpretation of the data**

After conducting the survey I had hoped that I could use statistical analysis on some of the data gathered. However, this was not possible to do due to the small sample size. This limited the findings of the survey but the process was beneficial in refining the data collection tools for phase 2 as I realised that I needed to use open-ended questions in an interview format to elicit responses that were relevant to address the research questions.

After conducting the interviews, I used Braun and Clarke's (2006) guide to thematic analysis which I found was a useful structure. However, my thematic analysis was very complex due to large amounts of data and Braun and Clarke's guidance did not address how to handle large quantities of data other than repeating the process of refining the data. I was concerned that I did not want any data to be discarded but there were some codes that did not 'fit' into any categories or themes. To me, every code was important and relevant and I found it very difficult to accept that if codes did not fit into themes, then I could not include them in the thematic analysis.

I was conscious throughout the process of thematic analysis that I needed to be able to trace every code to the original transcript to be able to refer to it which led to the development of a complex numbering and labelling system. In hindsight, the use of a computer programme such as N-Vivo may have helped me in this process.

While interpreting the data, I felt limited and constrained by the research questions, aims and objectives, instead I wanted the data to 'speak for itself'. I was frustrated that I had not

used a narrative approach to present the stories and the voices of the participants I had interviewed.

## **9.7 Conclusions and recommendations**

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 a national scoping exercise and in-depth knowledge through eight case-studies on this topic. The current health and social care climate provides opportunities for occupational therapists to create and shape their own environments for practise. However, funding social enterprise start-ups and ensuring their sustainability continues to be a challenge and government policy needs to be supported with finance to implement it.

Social enterprise can be used as an effective model for implementing holistic 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.

There are challenges for occupational therapists within the UK to be proactive and take risks to either set up social enterprises or seek out employment within them. This may require some personal sacrifice but could also offer greater benefits of job and personal satisfaction in the role.

### **Recommendations as a result of the implications**

The following are recommendations as a result of this study for the pursuit of occupational therapy professional practice within social enterprises in the UK:

1. Substantial long-term Department of Health funding for social enterprises, especially small, grassroots third sector organisations and priority with public sector commissioners through ring-fenced contracts.
2. Training for healthcare professionals by educational establishments and by the College of Occupational Therapists at undergraduate and postgraduate levels in

social enterprise, business and management to develop services based on their professional judgement.

3. Collaboration and partnership of occupational therapists with business-minded people who can develop and manage sustainable social enterprises. This could be facilitated at educational establishments or through social enterprise support organisations, conferences and networking events.
4. Marketing of occupational therapy to existing social enterprises, including outcomes evidencing the effectiveness of occupational therapy interventions. This needs to be incorporated at an undergraduate level in educational institutions (through cross-discipline working with business schools) and post-qualification training could be offered by occupational therapists in the private sector to share their knowledge.
5. Promotion of the opportunities for occupation-based practice within social enterprise with occupational therapy students and practitioners at all levels to educate on the improved job satisfaction and professional autonomy enjoyed by occupational therapists within social enterprises. Identification of occupational therapists with entrepreneurial abilities among undergraduate students and occupational therapists within statutory services and pathway programs that promote them into strategic positions.
6. The development of a support network for occupational therapists within social enterprises through websites and social media forums.
7. Re-conceptualisation of occupational therapy within a Salutogenic model for health to complement the deficit-based approach of the medical model and integration of this into occupational therapy academic programmes.

### **Recommendations for future studies**

In the course of this research, it has become apparent that there are a number of further opportunities for future research but most especially in the light of the findings and conclusions of this research. Firstly, a comparison study between occupational therapists practice in statutory services and social enterprises would potentially provide data to contrast with the occupational therapy provision in social enterprises. Secondly, the effectiveness of return to work programs within social enterprises which employ occupational therapists could be examined in comparison to other settings. Evidence for 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.

Thirdly, outcome measures could be identified and applied to social impact studies to equip occupational therapists in promotion and marketing of their services which could build capacity and help develop opportunities for occupational therapy within the social enterprise sector. Fourthly, a scoping study amongst vulnerable and marginalised groups could be employed to assess levels of unmet needs and to explore if assessed clinical need is being met by the public sector and social enterprises since the healthcare reform. Fifth, Freedom of Information could be used to determine the evidence of whether small, grassroots social enterprises are able to win contracts with public sector commissioners and to what extent the contracts are going to private providers. The value of small, grassroots community-based organisations is widely recognised as having a closer, more direct relationship with service users (Marmot, 2010; Scottish Government and STSRF, 2011; Meek, 2012) however research evidencing the challenges they confront with a lack of funding and support may enable this sector to be better resourced and address some of the underlying issues affecting health inequality.



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# Appendix

## Appendix1: List of Boolean phrases used in the literature search

Search term	Additional search terms
work integration social enterprise	-
employment integration	-
work integration and OT	-
employment integration and OT	-
occupation definitions and SE	-
occupation definitions and employment integration	-
empirical research in work integration in WISE	-
empirical research in employment integration	-
empirical research in OT and employment	-
Occupational therapy	Private practice
	Independent practice
	Charity
	Third sector
	Non-traditional settings
	Professional autonomy
	Retention
	Job retention
	Job satisfaction
	Dissatisfaction
Health promotion	

Social enterprise	Definition
Social entrepreneurship	Health
Social entrepreneur	Healthcare
Community Interest Company	Health and social care
	Public sector
	Public sector UK
	Nursing
	Allied health professions
	Occupational therapy
Neo-liberal	Public sector
outsourcing	Third sector
New public management	Health
Personalisation	Healthcare
Self-directed support	Health and social care
Direct payments	Nursing
Right to Request	Occupational therapy
Right to Provide	
Social Value Act	-

## Appendix 2: Advert for a training day at the College of Occupational Therapists

# Business planning skills for Occupational Therapists – Social Enterprise and beyond...

COT in partnership with The University of Northampton

College of Occupational Therapists, London, Tuesday 1st May 2012, 9.45am – 4.45pm

Are you considering setting up your own business? Are you interested in the opportunities Social Enterprise may offer? Starting a new enterprise or continuing to build an existing one, requires a mix of vision and self belief alongside good business sense. How do we tap into creative thinking, the core of innovation? What are the elements of business planning which will form the basis of a successful enterprise?

Jen Gash, occupational therapist, coach and entrepreneur and Wray Irwin, Social Entrepreneur in residence, will help answer those questions providing you with plenty of ideas and food for thought.

### Benefits from attending the day:

- Consider how we use our diverse skills to create innovative business ideas
- Participate in business planning activities and consider how to market your ideas
- Hear from others who have set up their own Social Enterprise

### After attending delegates will be able to:

- Understand the elements of business planning and develop their own business plan
- Consider if Social Enterprise is the appropriate model for their business

### Provisional Programme

9.45	Welcome – Julia Scott CEO	1.15	Business planning and design – Wray Irwin, University Northampton.
10.00	Becoming an innovative thinker – Jen Gash	2.45	Social Enterprise or private practice? – Occupational Therapists tell their story
11.30	Social Enterprise example – Taking the opportunities	3.15	Forms of Social Enterprise – Wray Irwin
12.00	The story so far – Occupational Therapists in Social Enterprise – Anna Stickley, University of Northampton	3.45	Demonstrating added value – Sharon Tuppeny and Professor Susan Corr
12.30	Lunch – provided	4.15	Q and A panel
		4.45	Close



All College of Occupational Therapists events are intended to support members continuing professional development. Authorised certificates of attendance are issued to all delegates attending College of Occupational Therapists approved events.

Places on this event are limited and BAOT members will be given priority.



College of  
Occupational  
Therapists



College of Occupational Therapists, 106–114 Borough High Street, London SE1 1LB. w: [www.cot.org.uk](http://www.cot.org.uk) e: [marketing@cot.org.uk](mailto:marketing@cot.org.uk)  
The College of Occupational Therapists Ltd is a registered charity in England and Wales (No: 275119) and in Scotland (No. SC039573)  
and a company registered in England (No. 1347374) VAT Reg. No. 742 7829 47

## **Appendix 3: Advert of the event held by The University of Northampton on Occupational Therapy in Social Enterprise**

### **The Future for Occupational Therapists working in Social Enterprise** Networking day

COT in partnership with The University of Northampton

Sunley Management Centre, University of Northampton

This networking day will provide a review of Social Enterprise and the potential for facilitating new and innovative ways for Occupational Therapists to offer services through the Social Enterprise Model. It will enable Occupational Therapists to consider the relevance for their area of practice and considerations to make before establishing a Social Enterprise.

#### **Included within the day:**

- What is Social Enterprise?
- The pros and cons of Social Enterprise
- Social Enterprise and Occupational Therapy
- What does this mean for you and your area of practice?

There will also be presentations from OTs and business leaders working in and developing Social Enterprises

#### **Contributors:**

Susan Corr - Professor of Occupational Science, University of Northampton

Professor Simon Denney – Northampton Business School

OTs and business leaders working in Social Enterprise

The day is free

Lunch will be provided

All College of Occupational Therapists events are intended to support members continuing professional development. Authorised certificates of attendance are issued to all delegates attending College of Occupational Therapists approved events. **Places on this event are limited to 40 delegates.**

For a booking form please contact Christina Burgess, College of Occupational Therapists

Tel: 020 7450 2370 Fax: 020 7450 2367

email:

## Appendix 4: The online questionnaire

### Section 1: About your organisation

- What type of organisation do you work for? (*list options: CIC, Social enterprise, private company, charity, other - please state*)
- Were you involved in the set up/establishment of the organisation? (*yes/no, if yes what was your role?*)
- Are you involved in the management/governance of the organisation? (*if yes, in what way? Examples*)
- Are the service users involved in the management/governance of the organisation? (*if yes, in what way? List examples: on management board, consultation in decision making, voting, membership*)
- Who are the service users or consumers of the organisation?
- How is the organisation funded? (*list – you can select more than one: private, Government/ NHS, other: please specify*)
- Is the organisation profit making? (*yes/no if yes, how?*)

### Section 2: Occupational Therapy Practice

- Are you employed as an Occupational therapist? (*yes/no if not what is your job title?*)
- What client group do you work with?
- Do you use any standardised assessments? (*yes/no, if yes, which? Please list*)
- What are the 3 main types of problems your clients experience? (*list examples*)
- What range of occupations you address in your interventions? (*Please give examples*)
- Are there any limitations on your ability to provide some interventions? (*Please give examples ie. limited time, restricted budget, demands of the organisation, targets to achieve*)
- Creek (2003) states that the outcome of Occupational therapy is for a client to achieve a satisfying performance and balance of occupations, in the areas of self-care, productivity and leisure, that will support recovery, health, wellbeing and social participation. Please rate the extent that you carry this out in your interventions (*1=never to 5=always*)

Self-care	1	2	3	4	5
Productivity	1	2	3	4	5

Leisure            1            2            3            4            5

- How much of your time do you spend providing Occupational therapy with your clients? (approx percentage)
- How much of your time do you spend doing admin/managerial tasks? (approx percentage)
- Are you a member of The College of Occupational Therapists or any other professional groups? *(yes/no if yes which? Please list)*
- Do you meet up with other Occupational therapists for peer support? *(yes/no, if yes, informally or formally?)*
- Have you worked for statutory services before? *(yes/no, if yes are there any differences between the way you provide Occupational therapy? Please provide examples)*
- Are there any further limitations on your ability to provide Occupational Therapy as you would want to in the organisation? *(yes/no, if yes please state why?)*

### **End of Questions**

#### **Additional information**

Are you willing to provide your contact details to the researcher? This will be used to generate a database of Occupational Therapists working in social enterprises and you may be contacted again for research purposes. All contact details will be kept confidential. Your answers to this questionnaire will remain anonymous. Please click the following link which will take you to a different page to give your contact details.

## Appendix 5: The advert for participants to complete the online questionnaire



### Occupational Therapy Research

Are you an Occupational therapist working in a social enterprise? If so, are you willing to take part in a research study?

Currently there is no known research in the UK about occupational therapy provision through social enterprise. This study aims to research what opportunities social enterprise offer for the provision of occupational therapy.

If you are interested in participating, all you need to do is complete a short online questionnaire found at

<https://survey.northampton.ac.uk/ot-socialenterprise>.

The information you give will be anonymous.

If you have any questions, please contact:

Anna Stickley, PhD Researcher,

University of Northampton

anna.stickley@northampton.ac.uk



## Appendix 6: Pilot interview questions

### Interview schedule for semi-structured interview with occupational therapists in social enterprises

1. What occupational therapy service do you provide? (What type of interventions, who decide this?)
2. Are there any limitations or restrictions about who can access this occupational therapy service? (if so what are they, who decides this?)
3. What term do you use for those who use the service? (*Prompts if necessary – service user, member, patient, client, and customer*). Why? Who decided this or how was this decided? Do you think this is important?
4. What determines how long you work with a service user for? (Who decides this?)
5. What is the flexibility of service provision according to individual's goals?
6. How does funding of this organisation affect the service you offer? (positively and negatively)
7. Is there any aspect of occupational therapy that you are not offering? (If so what is this and why do you think that is the case?)
8. Is there anything unique or different about your service to others?
9. Are you able to develop the service according to what you see is needed?
10. What are the supporting factors that enable you to provide the occupational therapy service according to how you want to deliver it? (What are the limiting factors?)
11. What models and approaches do you use?
12. Have you worked in statutory services? (Is your work here different in any way from there? If so why do you think this is?)
13. Are you involved in decision making at any level in this organisation?
14. Who do you think holds the power and control in how this occupational therapy service is run?
15. Why do you work for a social enterprise? What led you to this?
16. What motivates you in your work? (What do you hope to achieve through your work?)
17. Does your professional background and experience affect the type of service you offer here?

## **Appendix 7: Consent page for the online questionnaire**

### Participant Information and Consent

Thank you for your willingness to complete the online questionnaire about Occupational therapy in social enterprise. The information you give will be anonymous and confidential. It will take you about 20 minutes to complete the questions. When you have finished, you will be asked if you are willing to provide your contact details and if so, you will be directed to a different page.

If you have any questions or concerns, please contact the researcher on [anna.stickley@northampton.ac.uk](mailto:anna.stickley@northampton.ac.uk).

If you are willing to complete the survey, please select the option below and the questionnaire will begin.

Thank you for your time.

Anna Stickley

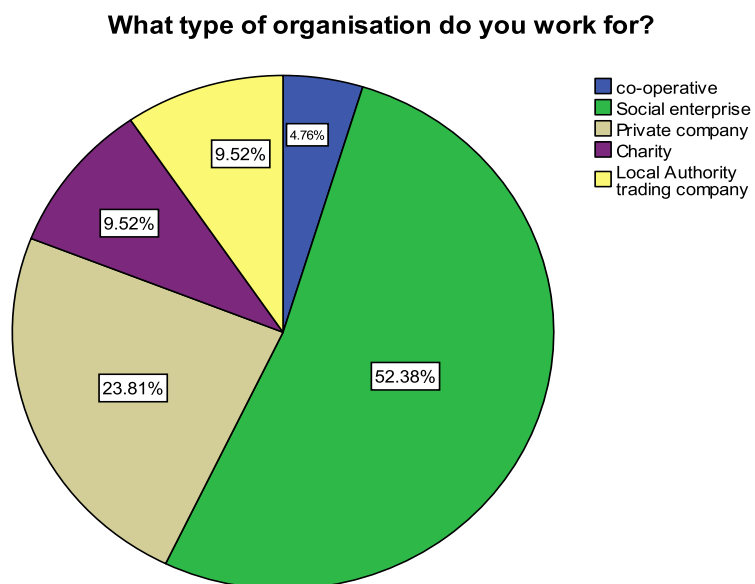
PhD Researcher, School of Health

University of Northampton

## Appendix 8: Descriptive data from the questionnaire

When asked what type of organisation the occupational therapist worked for, the following results were found:

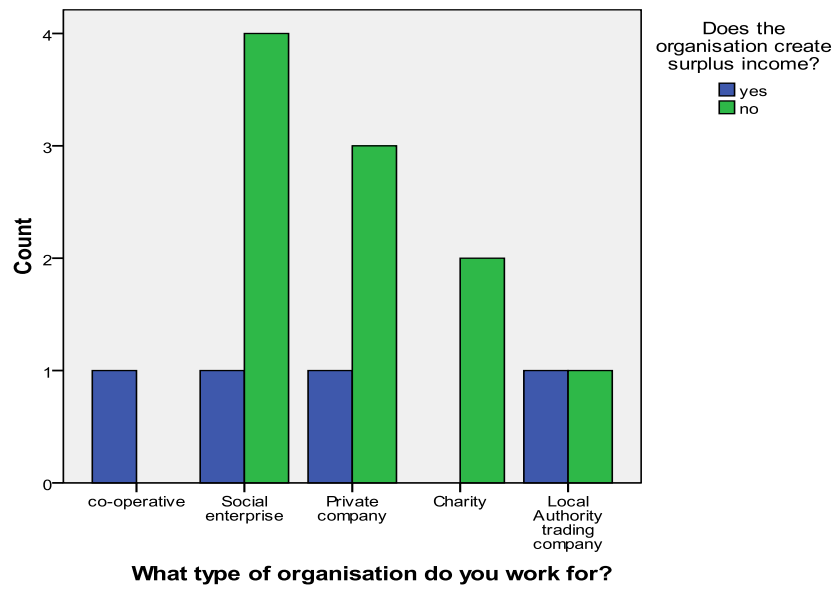
**Chart 1: Types of organisations**



## Appendix 8: Continued

The types of organisations were compared against whether they generated an income or not:

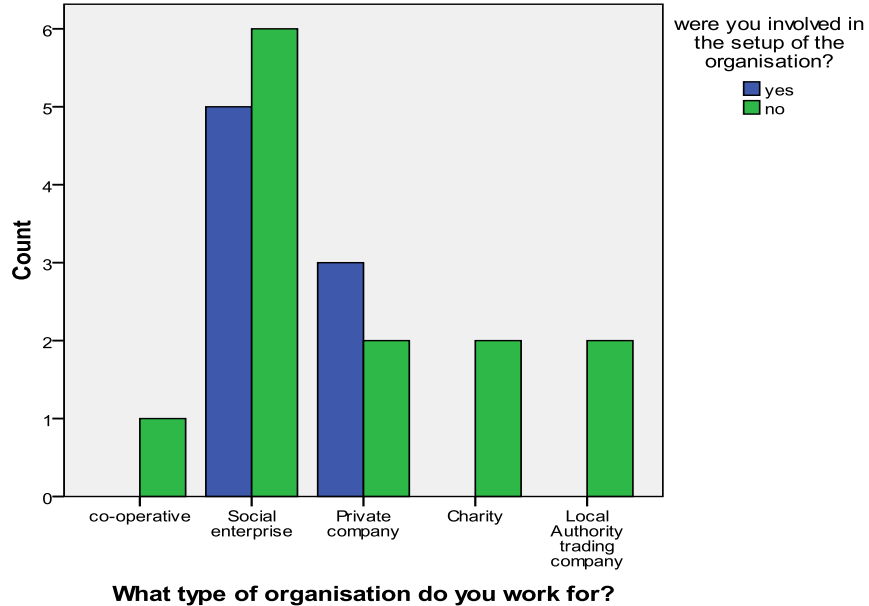
**Chart 2: Types of organisations and income**



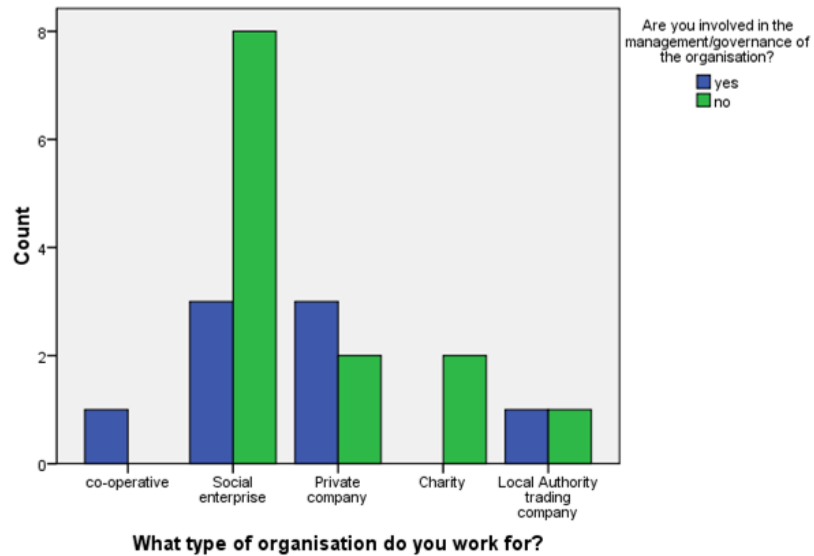
## Appendix 8: Continued

The types of organisations were then analysed against the involvement of the occupational therapists in the establishment of the organisations and the management or governance of it:

**Chart 3: Involvement of occupational therapists in establishing the social enterprises**



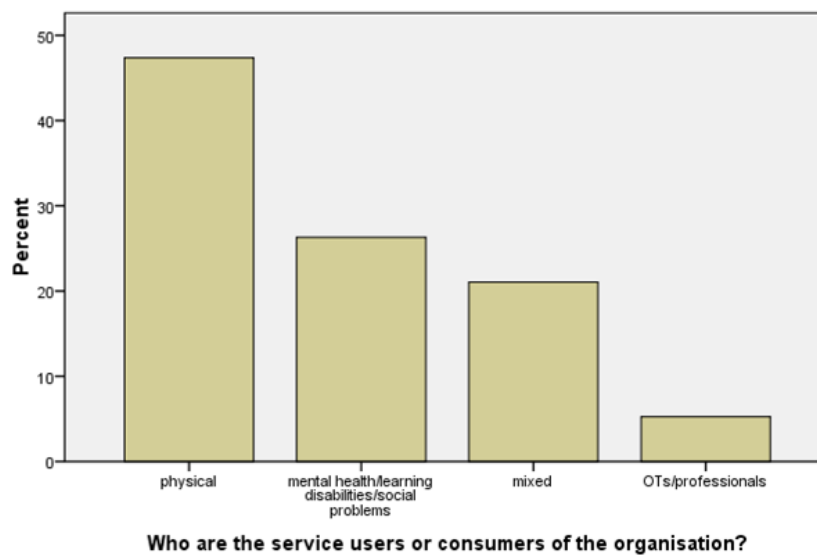
**Chart 4: Occupational Therapist involvement in governance**



## Appendix 8: Continued

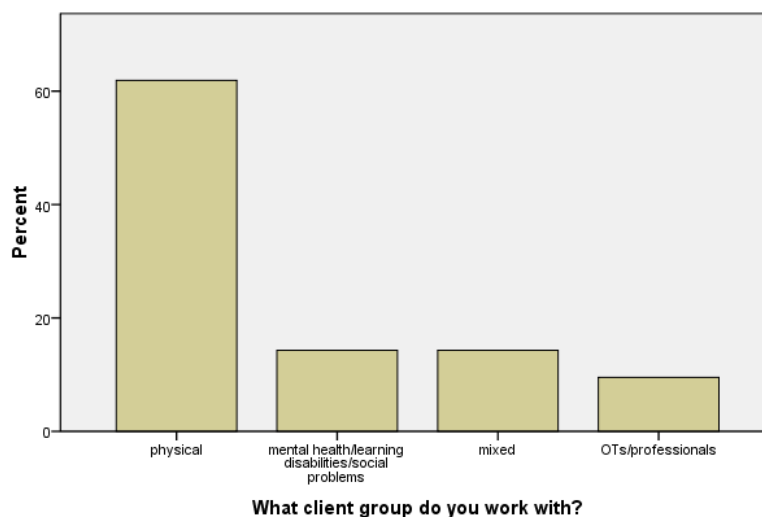
The occupational therapists were asked the consumers of the services offered by the social enterprise:

**Chart 5: Categorisation of service users**



The occupational therapists were also asked who their service user group were:

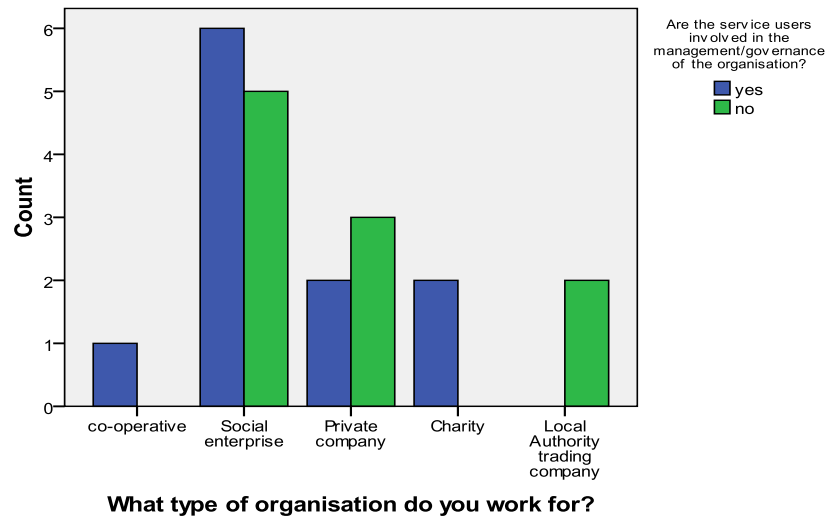
**Chart 6: Occupational Therapy client group**



## Appendix 8: Continued

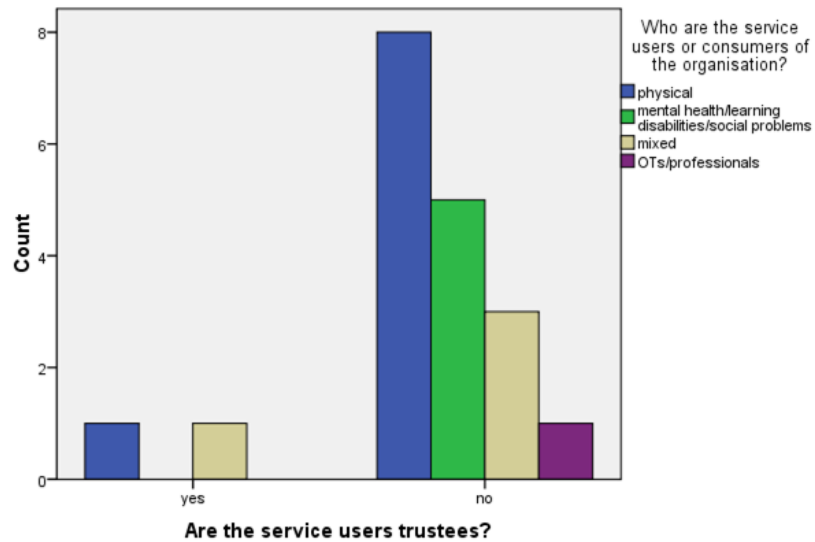
The organisation types was compared against the involvement of service users in governance and decision making in the social enterprise:

**Chart 7: Types of organisations and involvement in set up of the organisation**



The service user groups were compared against those who were trustees:

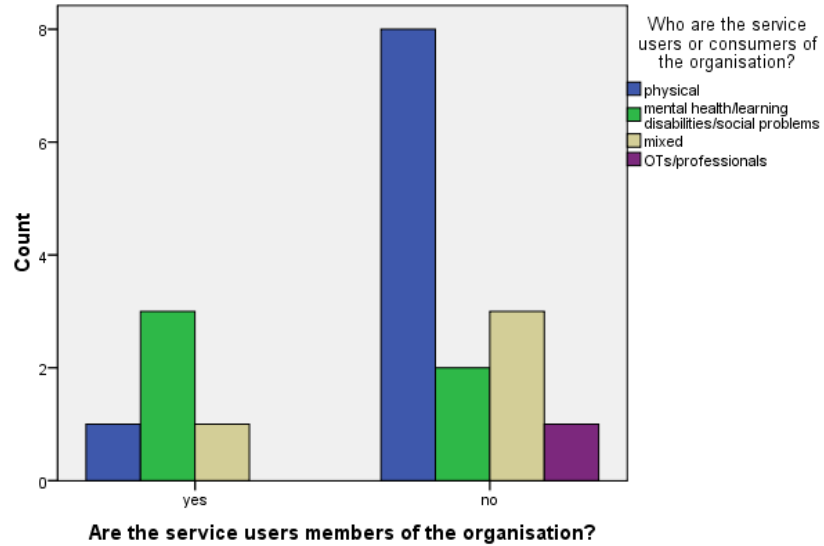
**Chart 8: Trustees in the social enterprise**



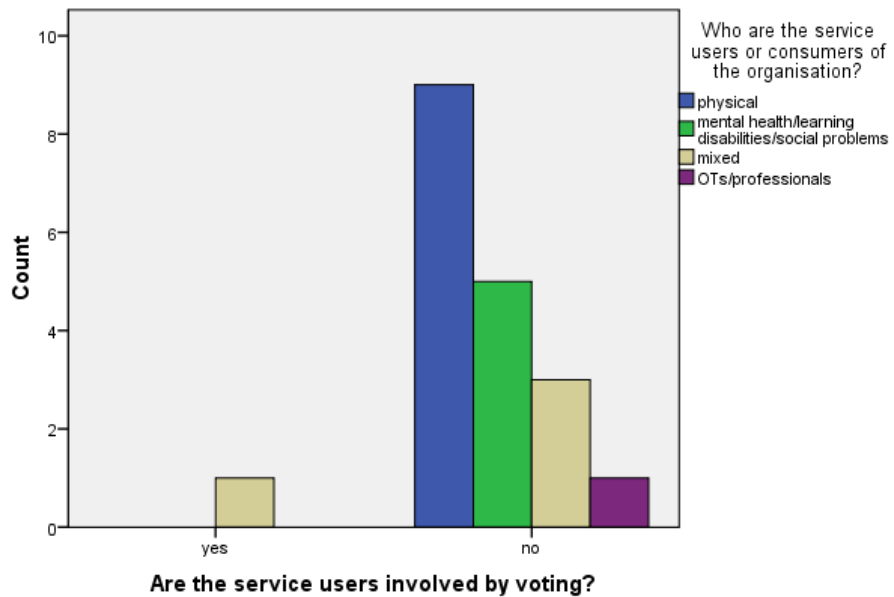
## Appendix 8: Continued

The occupational therapists were asked if service users were members of the social enterprise or involved in governance through voting:

### Chart 9: Service user membership



### Chart 10: Involvement of service users through voting

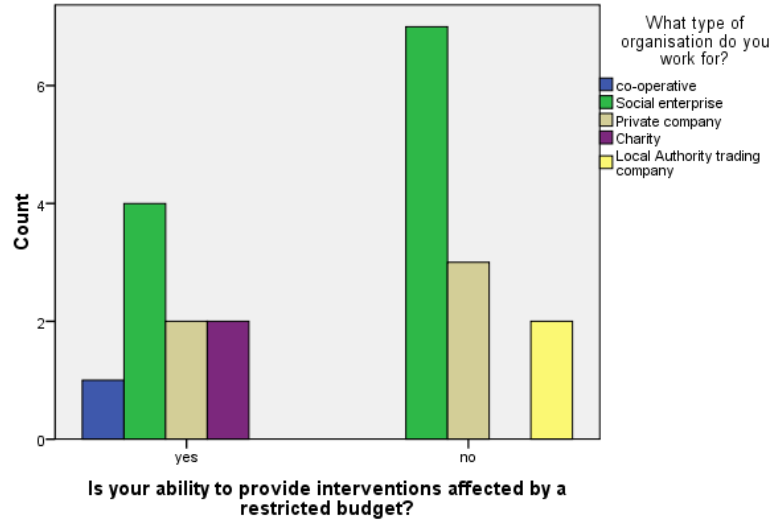




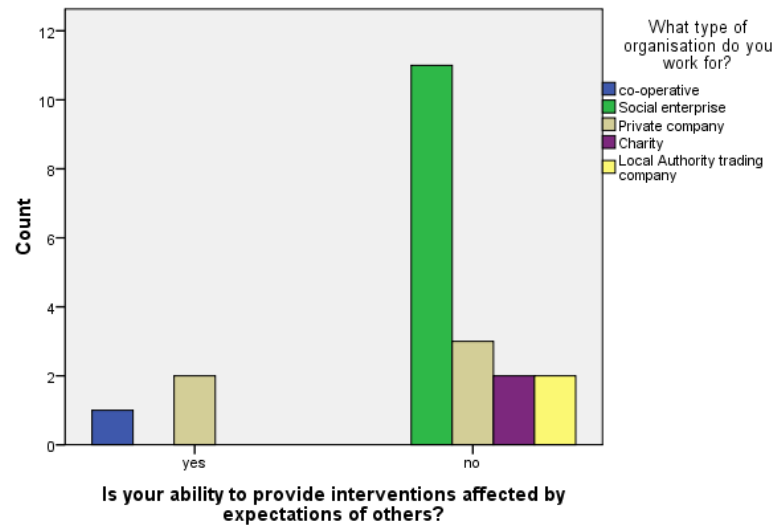
## Appendix 8: Continued

The occupational therapists were asked if their interventions were restricted or limited:

### Chart 11: Implications of budgets on occupational therapy



### Chart 12: Expectations of others within the social enterprise



## **Appendix 9: Interview schedules**

### **Structured interview to be completed by the CEO, social enterprise manager or social entrepreneur**

1. What is the structure and legal form of the organisation?
2. Who funds the organisation? (if there are multiple funding streams, what is the breakdown between them?)
3. What degree of independence and autonomy does the social enterprise have in decision making?
4. How was the governance and decision making structure decided? How effective do you think it is?
5. Are staff and the users of the service involved in the governance and decision making of the organisation? (In what way? Is there a feedback mechanism?)
6. What are the reporting requirements and targets of the funders of the organisation? (to what extent does this determine what service is provided?)

### **Interview schedule for semi-structured interview with occupational therapists in social enterprises**

1. What occupational therapy service do you provide? (What type of interventions, who decide this?)
2. Are there any limitations or restrictions about who can access this occupational therapy service? (if so what are they, who decides this?)
3. What term do you use for those who use the service? (*Prompts if necessary – service user, member, patient, client, and customer*). Why? Who decided this or how was this decided? Do you think this is important?
4. What determines how long you work with a service user for? (Who decides this?)
5. What is the flexibility of service provision according to individual's goals?
6. How does funding of this organisation affect the service you offer? (positively and negatively)
7. Is there any aspect of occupational therapy that you are not offering? (If so what is this and why do you think that is the case?)
8. Is there anything unique or different about your service to others?
9. Are you able to develop the service according to what you see is needed?
10. What are the supporting factors that enable you to provide the occupational therapy service according to how you want to deliver it? (What are the limiting factors?)
11. What models and approaches do you use?
12. Have you worked in statutory services? (Is your work here different in any way from there? If so why do you think this is?)
13. Are you involved in decision making at any level in this organisation?
14. Who do you think holds the power and control in how this occupational therapy service is run?
15. Why do you work for a social enterprise? What led you to this?
16. What motivates you in your work? (What do you hope to achieve through your work?)
17. Does your professional background and experience affect the type of service you offer here?

### **Semi-structured interview to be conducted with service user's (where appropriate)**

1. How did you find out about this organisation?

2. If attending here helps you, how does it help you?
3. What is different about the support you receive here compared to other organisations?
4. What do you think are the advantages and disadvantages of getting support from a social enterprise? (Compared to statutory health/social care)
5. Has this organisation given you new opportunities? If so, what does it offer you?
6. What are some of the roles or responsibilities you have here?
7. What do you think are some of the challenges or problems with receiving support from a social enterprise?
8. Would you use this service if you had to pay for it?
9. How much would you be willing to pay each time you come here? (e.g. £2, £5, £10)
10. What else could help you that is not currently offered by this organisation?
11. Are you asked your opinions by staff about how this social enterprise is run?
12. In what ways are you able to give feedback about the organisation?
13. In what way are you involved in improving how this organisation is run?
14. What do you think is important in making sure a social enterprise supports people well?

## **Appendix 10: Participant information sheet and Interview consent form**

### **PARTICIPANT INFORMATION SHEET**

#### **Research title: Occupational therapy practice in social enterprise**

This research project is investigating occupational therapy practice within social enterprises and what determines the type of occupational therapy provided within social enterprises. The data is collected by questionnaires and interviewing occupational therapists who are working in or have worked for a social enterprise. The CEO and the service users are also interviewed to give their views. Data is also collected about the social enterprise from organisational documents. This research is being carried out because there is currently no research on occupational therapy provision in social enterprises.

This research is funded by the University of Northampton and is being carried out as part of a PhD research project.

Participation in this research is entirely voluntary and you can withdraw from the study at any time. You have been chosen to take part in this research because you either work for a social enterprise or attend one. If you have any questions at any point, please ask.

Participating in this research will take approximately an hour. You will be asked questions about your views, opinions and experience of occupational therapy provision in the social enterprise you work for or attend. There are no right or wrong answers. With your permission, an audio recording will be made of the session.

You will be assigned a participant reference number. All of your personal details and the data you provide will only be available to the researcher and the supervisors of this project and will be treated confidentially. You will not be named in any written pieces relating to this research. The name of the organisation will only be used if you want to provide that information.

If you have any questions or comments about any part of this research study, please contact the researcher on the following:

Anna Stickley, PhD Researcher

[Anna.stickley@northampton.ac.uk](mailto:Anna.stickley@northampton.ac.uk)

If you would like to speak to someone else at the University of Northampton about this research, or if you have any concerns, please contact the Director of Studies for this project:

Judith Sixsmith

[Judith.sixsmith@northampton.ac.uk](mailto:Judith.sixsmith@northampton.ac.uk)

## PARTICIPANT CONSENT FORM

Title of Project: Occupational therapy provision in social enterprise

Name of Researcher: Anna Stickley

Participant reference number:

*(please initial)*

1. I confirm that I have read and understand the information sheet dated November 2011 for the above study. I have had the opportunity to consider the information,

ask questions and have had these answered satisfactorily.

Yes	No

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

--	--

3. I agree to take part in the above study.

--	--

\_\_\_\_\_  
\_\_\_\_\_

Name of Participant

\_\_\_\_\_

Date

Signature

\_\_\_\_\_  
\_\_\_\_\_

Name of Person

\_\_\_\_\_

Date

Signature

taking consent

**Appendix 11: List of written documentation requested from the case studies prior to field visits**

- Mission statement
- Social aims and goals
- Business plan
- Articles of association
- Governance structure, policy and implementation documentation
- Contracts with donors including terms and conditions

## Appendix 12: Findings according to participant groups

**Table 2: Thematic Analysis of each of the Stakeholder Perspectives (overview)**

<b>Categories</b>	<b>Social entrepreneur: Themes</b>	<b>Occupational therapist: Themes</b>	<b>Service user: Themes</b>
<b>Organisational</b>	Identity, Governance, Funding, Marketing, mutualisation and equality	Business and management	-
<b>Motivational</b>	Motivations of a social entrepreneur	Motivations and priorities of an OT	-
<b>Professional</b>	Perspective on OT	Professional practice, Therapeutic value, The OT role	-
<b>Personal</b>	Support the social entrepreneur needed	support needed for an OT in a social enterprise	-
<b>In context with other services</b>	-	Comparisons with other services	support from other services
<b>Service user experiences</b>	-	-	The impact of the social enterprise, the benefit of routine and structure and the social enterprise environment

**Appendix 12 continued:**

**Table 3: Themes and sub themes of the three participant groups (in full)**

<b>Theme</b>	<b>Social entrepreneur</b>	<b>Occupational therapist</b>	<b>Service user</b>
1	<p>The identity of the organisation</p> <ul style="list-style-type: none"> <li>a) Social aims before business</li> <li>b) Use of profit</li> </ul>	<p>Business and management issues</p> <ul style="list-style-type: none"> <li>a) Business vs social aims</li> <li>b) Marketing</li> <li>c) Management and governance</li> <li>d) funding</li> </ul>	<p>The impact of the social enterprise</p> <ul style="list-style-type: none"> <li>a) Employment</li> <li>b) Improved mental health</li> <li>c) Confidence</li> <li>d) Social interactions</li> <li>e) Support from OT</li> <li>f) Role</li> </ul>
2	<p>Types of governance in a social enterprise</p>	<p>Motivations and priorities for working in a social enterprise</p> <ul style="list-style-type: none"> <li>a) Motivation and drive</li> <li>b) Job satisfaction vs higher salary</li> </ul>	<p>Support from other services</p>



3	A managerial perspective on OT within the organisation	Support needed in a social enterprise  a) Networking b) Supervision c) Setting up a SE	The benefit of a routine and structure
4	Funding issues  a) The influence of politics b) Limitations and restrictions caused by funding c) Opportunities that are provided through funding d) The battle for funding e) Issues with the Local Authority over funding f) Establishing sustainability in the organisation	Professional practice of OT  a) Models b) Outcome measures	The impact of the social enterprise environment

**Appendix 12 continued:**

**Table 3: Themes and sub themes of the three participant groups (continued)**

<b>Theme</b>	<b>Social entrepreneur</b>	<b>Occupational therapist</b>	<b>Service user</b>
5	Motivations of the social entrepreneurs Desire for change Passion and commitment Personal interest	Therapeutic value of OT in the social enterprise Unmet needs identified 'other' focused interventions Unique therapeutic value of OT The value of person centeredness of OT	
6	Support needed in social entrepreneurship Supporting factors Outcome measures Unmet needs	Comparisons with statutory services Opportunities and limitations Humanism and equality	
7	Mutualisation and equality	The OT role in the social enterprise In practice	
8	Marketing opportunities and challenges	Specialist vs generic roles Challenges for OTs	

## **Appendix 14: Braun and Clarke's (2006) 15 point checklist**

### **A 15-Point Checklist of Criteria for Good Thematic Analysis**

#### Transcription

1. The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for accuracy.

#### Coding

2. Each data item has been given equal attention in the coding process.

3. Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.

4. All relevant extracts for all each theme have been collated.

5. Themes have been checked against each other and back to the original data set.

6. Themes are internally coherent, consistent, and distinctive.

#### Analysis

7. Data have been analysed – interpreted, made sense of - rather than just paraphrased or described.

8. Analysis and data match each other – the extracts illustrate the analytic claims.

9. Analysis tells a convincing and well-organised story about the data and topic.

10. A good balance between analytic narrative and illustrative extracts is provided.

#### Overall

11. Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.

#### Written report

12. The assumptions about, and specific approach to, thematic analysis are clearly explicated.

13. There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent.

14. The language and concepts used in the report are consistent with the epistemological position of the analysis.

15. The researcher is positioned as *active* in the research process; themes do not just emerge.

## Appendix 14: Thematic analysis of case study data

**Table 1: Thematic analysis of each case study**

Case study	Theme 1:	Theme 2:	Theme 3:	Theme 4:	Theme 5:	Theme 6:	Theme 7:
	Funding	Supporting factors in social entrepreneurship	Issues with local authorities and unmet needs	Marketing	OT professional issues	Respect, Morality and Equality	Impact on service users
<b>1</b>	Funding issues and unmet needs	Making it as a social entrepreneur	Funding and unmet needs	-	OT practice – opportunities and limitations	A moral and ethical organisation, The work environment	-
<b>2</b>	Challenges with funding	What it takes to create a social enterprise	Challenges with funding	Discomfort with marketing	Added value of OT	-	Impact on service users

<b>3</b>	Importance of sustainability and control over funding	The value of good governance	Issues with statutory services, Challenges with personal budgets	-	Value of OT, Opportunity for OT	Mutualisation and benefit stacking	Having an impact in people's lives
<b>4</b>	Challenges gaining funding	Lessons learned in social entrepreneurship	Unmet needs, Issues with Local Authorities	Effective marketing	Opportunities in OT practice	Respect and equality impacting service users	
<b>5</b>	Funding, Competition	Opportunities & challenges in setting up the SE	Challenges with direct payments	-	Opportunity for OT practice	Politics and inequality, Involvement and equality in the SE	Effects on service users
<b>6</b>	Governance and involvement, Demand for OT	-	-	-	Opportunities and limitations on OT, Demand for OT, Understanding of OT in the SE	Governance and involvement	Meeting service user needs, Governance and involvement

7	Funding opportunities and challenges	What it takes to create a social enterprise, Shaping and defining the project	Funding opportunities and challenges	-	Opportunities for OT, Adjusting to change, OT collaboration with social entrepreneur	-	Impact on service users, Making a difference
8	Sustainability & mutual benefits	-	-	Marketing – the product sells itself	Rediscovering meaningful occupation, Added value of OT	-	Mutual benefits

## Annex 15: Thematic analysis, aims and objectives

**Table 4: Findings in relation to the aims and objectives**

Aims	Objectives	Findings that address the aims and objectives
<p><b>Aim 2:</b> To explore the reasons for occupational therapy practice through social enterprise in the UK, what facilitates practice according to the philosophical basis of the profession and what is distinctive about social enterprise that enables this to happen.</p>	<p>To explore and analyse social entrepreneur and occupational therapists reasons and motivations for occupational therapy practice in social enterprises</p>	<p>Case study 1 Theme 5: 'OT practice – opportunities and limitations'</p> <p>Case study 2 Theme 5: 'Added value of OT'</p> <p>Case study 3 Theme 5: 'Value of OT, Opportunity for OT'</p> <p>Case study 3 Theme 6: 'Mutualisation and benefit stacking'</p> <p>Case study 4 Theme 5: 'Opportunities in OT practice'</p> <p>Case study 5 Theme 5: 'Opportunity for OT practice'</p> <p>Case study 6 Theme 1: 'Governance and involvement'; 'Demand for OT'</p> <p>Case study 6 Theme 5: 'Demand for OT'; 'Understanding of OT in the SE'</p> <p>Case study 7 Theme 5: 'Opportunities for OT'</p> <p>Case study 8 Theme 5: 'Rediscovering meaningful occupation'; 'Added value of OT'</p> <p>Stakeholder theme: Motivational</p> <p>'Motivations of a social entrepreneur'</p> <p>'Motivations and priorities of an occupational therapist'</p> <p>Stakeholder theme: Professional</p> <p>Perspective on occupational therapy</p> <p>Therapeutic value, The occupational therapy role</p>



Aims	Objectives	Findings that address the aims and objectives
	Identify which social enterprises are led by an occupational therapist as the social entrepreneur and compare the occupational therapy provision with those not led by an occupational therapist	Case studies 2 and 5: The social entrepreneur was an occupational therapist <i>(case study comparisons to be carried out)</i>
	Establish what influences the decision about which models and approaches are used by occupational therapists in social enterprises	<p>Case study 1 Theme 5: 'OT practice – opportunities and limitations'</p> <p>Case study 2 Theme 5: 'Added value of OT'</p> <p>Case study 3 Theme 5: 'Value of OT, Opportunity for OT'</p> <p>Case study 3 Theme 6: 'Mutualisation and benefit stacking'</p> <p>Case study 4 Theme 3: 'Unmet needs; Issues with Local Authorities'</p> <p>Case study 4 Theme 5: 'Opportunities in OT practice'</p> <p>Case study 5 Theme 5: 'Opportunity for OT practice'</p> <p>Case study 5 Theme 6: 'Politics and inequality'; 'Involvement and equality in the SE'</p> <p>Case study 6 Theme 1: 'Governance and involvement'; 'Demand for OT'</p> <p>Case study 6 Theme 5: 'Demand for OT'; 'Opportunities and limitations on OT'</p> <p>Case study 7 Theme 5: 'Opportunities for OT'</p> <p>Case study 8 Theme 5: 'Rediscovering meaningful occupation'; 'Added value of OT'</p>

Aims	Objectives	Findings that address the aims and objectives
	Explore to what extent the occupational therapy is determined by individual service user's needs	<p>Case study 1 Theme 5: 'OT practice – opportunities and limitations'</p> <p>Case study 2 Theme 5: 'Added value of OT'</p> <p>Case study 3 Theme 5: 'Value of OT, Opportunity for OT'</p> <p>Case study 3 Theme 7: 'Having an impact in people's lives'</p> <p>Case study 4 Theme 3: 'Unmet needs; Issues with Local Authorities'</p> <p>Case study 4 Theme 6/7: 'Respect and equality impacting service users'</p> <p>Case study 5 Theme 5: 'Opportunity for OT practice'</p> <p>Case study 5 Theme 7: 'Effects on service users'</p> <p>Case study 6 Theme 1: 'Governance and involvement'; 'Demand for OT'</p> <p>Case study 6 Theme 5: 'Demand for OT'; 'Understanding of OT in the SE'</p> <p>Case study 6 Theme 7: 'Meeting service user needs'; 'Governance and involvement'</p> <p>Case study 7 Theme 2: 'Shaping and defining the project'</p> <p>Case study 7 Theme 5: 'Opportunities for OT'</p> <p>Case study 7 Theme 7: 'Impact on service users'; 'Making a difference'</p>
	To analyse occupational therapists views and experiences of occupational therapy practice within a social enterprise (for example exploring the supportive and limiting factors to their practice in social enterprise) and how this facilitates	<p>Case study 1 Theme 3: 'Funding and unmet needs'</p> <p>Case study 1 Theme 5: 'OT practice – opportunities and limitations'</p> <p>Case study 1 Theme 6: 'A moral and ethical organisation'; 'The work environment'</p> <p>Case study 2 Theme 3: 'Challenges with funding'</p>

Aims	Objectives	Findings that address the aims and objectives
	the practice of the profession according to its philosophy	<p>Case study 2 Theme 5: 'Added value of OT'</p> <p>Case study 3 Theme 5: 'Value of OT, Opportunity for OT'</p> <p>Case study 3 Theme 6: 'Mutualisation and benefit stacking'</p> <p>Case study 4 Theme 5: 'Opportunities in OT practice'</p> <p>Case study 4 Theme 6/7: 'Respect and equality impacting service users'</p> <p>Case study 5 Theme 1: 'Challenges gaining funding'; 'Competition'</p> <p>Case study 5 Theme 5: 'Opportunity for OT practice'</p> <p>Case study 5 Theme 6: 'Politics and inequality, Involvement and equality in the SE'</p> <p>Case study 6 Theme 1: 'Governance and involvement'; 'Demand for OT'</p> <p>Case study 6 Theme 5: 'Demand for OT'; 'Understanding of OT in the SE'</p> <p>Case study 6 Theme 7: 'Meeting service user needs'; 'Governance and involvement'</p> <p>Case study 7 Theme 5: 'Opportunities for OT'</p> <p>Case study 8 Theme 1: 'Sustainability &amp; mutual benefits'</p> <p>Case study 8 Theme 5: 'Rediscovering meaningful occupation'; 'Added value of OT'</p>
<p><b>Aim 3:</b> Explore the service user's views, opinions and experiences of the occupational therapy</p>	<p>Explore the service user's views, opinions and experiences of their involvement in the social enterprise and in occupational therapy</p>	<p>Case study 2 Theme 7: 'Impact on service users'</p> <p>Case study 3 Theme 7: 'Having an impact in people's lives'</p> <p>Case study 4 Theme 7: 'Respect and equality impacting service users'</p> <p>Case study 5 Theme 7: 'Effects on service users'</p>

Aims	Objectives	Findings that address the aims and objectives
they receive within the social enterprise		Case study 6 Theme 7: 'Meeting service user needs'; 'Governance and involvement' Case study 7 Theme 7: 'Impact on service users'; 'Making a difference'
	Determine if the service users are involved in the management or governance of the social enterprise	Case study 1 Theme 6: 'A moral and ethical organisation'; 'The work environment' Case study 3 Theme 2: 'The value of good governance' Case study 4 Theme 6/7: 'Respect and equality impacting service users' Case study 5 Theme 6: 'Involvement and equality in the SE' Case study 6 Theme 1: 'Governance and involvement'; 'Demand for OT' Case study 6 Theme 5: 'Demand for OT' Case study 8 Theme 1: 'Sustainability & mutual benefits'
<b>Aim 4:</b> Examine the factors that determine the different ways occupational therapy is provided	Identify who funds the social enterprises that provide occupational therapy in the UK	Case study 1 Theme 1: 'Funding issues' Case study 1 Theme 3: 'Funding and unmet needs' Case study 2 Theme 1&3: 'Challenges with funding' Case study 3 Theme 1: 'Importance of sustainability and control over funding' Case study 3 Theme 3: 'Issues with statutory services'; 'Challenges with personal budgets' Case study 4 Theme 1: 'Challenges gaining funding' Case study 4 Theme 3: 'Unmet needs; Issues with Local Authorities' Case study 5 Theme 1: 'Challenges gaining funding'

Aims	Objectives	Findings that address the aims and objectives
		<p>Case study 5 Theme 3: 'Challenges with direct payments'</p> <p>Case study 5 Theme 6: 'Politics and inequality'</p> <p>Case study 7 Theme 1&amp;3: 'Funding opportunities and challenges'</p> <p>Case study 8 Theme 1: 'Sustainability &amp; mutual benefits'</p>
	<p>Determine if contractual obligations influence the provision of occupational therapy in social enterprises; including different types of employment relationships between the occupational therapist and the organisation</p>	<p>Case study 1 Theme 1&amp;3: 'Funding and unmet needs'</p> <p>Case study 1 Theme 5: 'OT practice – opportunities and limitations'</p> <p>Case study 2 Theme 3: 'Challenges with funding'</p> <p>Case study 3 Theme 1: 'Importance of sustainability and control over funding'</p>
	<p>Investigate, examine and analyse organisational documentation to identify factors that determine the provision of occupational therapy (including business plans, contracts, job descriptions and finance)</p>	<p><i>(analysis yet to be conducted)</i></p>
	<p>Explore the types of interventions the occupational therapists provide in the social enterprises and the reasons for this (such as who makes the decisions about the type of interventions used)</p>	<p>Case study 1 Theme 5: 'OT practice – opportunities and limitations'</p> <p>Case study 2 Theme 5: 'Added value of OT'</p> <p>Case study 3 Theme 5: 'Value of OT, Opportunity for OT'</p> <p>Case study 3 Theme 6: 'Mutualisation and benefit stacking'</p> <p>Case study 3 Theme 7: 'Having an impact in people's lives'</p> <p>Case study 4 Theme 3: 'Unmet needs; Issues with Local Authorities'</p>

Aims	Objectives	Findings that address the aims and objectives
		<p>Case study 4 Theme 5: 'Opportunities in OT practice'</p> <p>Case study 4 Theme 6/7: 'Respect and equality impacting service users'</p> <p>Case study 5 Theme 5: 'Opportunity for OT practice'</p> <p>Case study 5 Theme 6: 'Politics and inequality'</p> <p>Case study 5 Theme 7: 'Effects on service users'</p> <p>Case study 6 Theme 1: 'Governance and involvement'; 'Demand for OT'</p> <p>Case study 6 Theme 5: 'Demand for OT'; 'Understanding of OT in the SE'</p> <p>Case study 6 Theme 6: 'Governance and involvement'</p> <p>Case study 7 Theme 2: 'Shaping and defining the project'</p> <p>Case study 7 Theme 5: 'Opportunities for OT'</p> <p>Case study 7 Theme 7: 'Impact on service users'; 'Making a difference'</p> <p>Case study 8 Theme 5: 'Rediscovering meaningful occupation'; 'Added value of OT'</p> <p>Case study 8 Theme 7: 'Mutual benefits'</p>
	<p>Determine if the occupational therapists are involved in the management or governance of the social enterprise and if so, to what extent</p>	<p>Case study 2 Theme 2: 'What it takes to create a social enterprise'</p> <p>Case study 3 Theme 2: 'The value of good governance'</p> <p>Case study 4 Theme 6/7: 'Respect and equality impacting service users'</p> <p>Case study 6 Theme 1: 'Governance and involvement'</p> <p>Case study 6 Theme 5: 'Opportunities and limitations on OT'</p>

<b>Aims</b>	<b>Objectives</b>	<b>Findings that address the aims and objectives</b>
		Case study 7 Theme 5: 'Opportunities for OT'; 'OT collaboration with social entrepreneur' Case study 8 Theme 1: 'Sustainability & mutual benefits'