Case selection in Health Care - Social model of health: The mental health recovery approach

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Content

1. Background

A field description was previously conducted to secure general insights into the structure of the field (i.e. the social model of health) in terms of its key characteristics, important changes within the last 10 years and the more important actors from the state, market and third sectors. The analysis was conceptually embedded in the theory of the 'strategic action field' (Fligstein & McAdam, 2012). Its aim was to identify central social innovation trends in relation to the social model of health. The focus on the social model of health (disability) led us to exclude technological innovations and concentrate on social determinants as defined by, for example, the World Health Organisation (WHO 2008).

The field description led us to identify a number of social innovation trends such as: *mental health*, *public health* (including health promotion), i*ntegration of service delivery* (including between health, social care and other services), *community capacity-building* and *patient involvement*. A distinction was made between social innovations that specifically addressed the needs of people with long-term conditions or socially excluded groups and those which took place at general population level. While some social innovations trends primarily promoted the involvement of the individual (e.g. personal budgets), others primarily focused on solidarity and collective aims (e.g. peer support). Innovations in the mental health field were mentioned in all four countries. Countries identified a wide range of activities in the mental health field including prevention packages in Denmark (Bauer A, 2015, p.4), reintegration of mental health patients (including people with dementia) in the community in the Czech Republic (Ibid. p18) and in France (ibid. 13).

Mental ill health is often interdependent with physical conditions and recognized as one of the largest health problems as the leading cause of years lived with disability worldwide (Whiteford et al., 2010). It also captures dimensions of wider health and wellbeing reflected in the social model of health. As also described in the field description report, responses to mental health issues require the integration of services, responsibilities and funding across clinical, social care, public health and other disciplines. As shown by the types of social innovation activities named in the four countries, mental health innovations are often centred around principles of community capacity-building (such as community reintegration) and patient/user involvement (such as peer support). Thus, innovations in the mental health field were thought to incorporate some of the other social innovation trends identified through the field description: integration of services, public health, community capacity-building and patient involvement.

A focus on the social model of health in the mental health field allows us to capture important social innovations, addressed at particularly vulnerable members of society.. People affected by (severe) mental illness experience high levels of suffering and social stigma which may frequently be exacerbated by co-existing physical health problems. The mental health field is closely interlinked with, and an important part of the public health field so that findings from our case study on the role of the third sector in regards to mental health innovations are applicable to health and public health domains more broadly.

The application of the social model of health to the mental health field leads to an understanding of mental ill health as not exclusively oriented around deficits identified through a process of clinical diagnosis but also built on the strengths, capabilities and wishes of the individual. It is thus built on a commitment to recovery as well as treatment so that individuals can be enabled to live their life to the fullest as members of their community. The

concept of recovery has been for example described as peoples' ability to "stay in control of their life despite experiencing a mental health problem"[1]. It is based on a belief that people with mental illness are not automatically ill or disabled for their whole life but that there is a recovery pathway is possible. The focus on social model of mental health and recovery embraces the integration theme because it takes place at the interface with different government departments, professional disciplines and user groups. Social innovation trends are likely to be characterized by strong survivor movements as well as reforms in the clinical field led by health professional bodies. Focusing on the recovery model enables an investigation of characteristics and determinants that are likely to be applicable to social innovation trends under the social model of health more broadly. The recovery model is a trend as part of the social model of health at a highly aggregate level. It embodies several, more specific social innovation streams that have certain characteristics and are reflection of certain movements over time. Focusing on the recovery model enables an investigation of characteristics and determinants that are likely to be applicable to social innovation trends under the social model of health more broadly.

In regards to other possible social innovation trends that could have been chosen (instead of mental health) patient participation was a political priority for health services in all the national systems we reviewed. However, it did not have the characteristics of a social innovation i.e. it did not necessarily suggest or lead to new ways of working and changes in practice, and it was not always clear which social welfare needs it met. Activities under this heading (e.g. patient information, patient experience surveys, consultations about plans for service change) did not incorporate the principles of co-production, community engagement and citizenship that were set out as priorities in WP 5 of the ITSSOIN proposal. Instead, patient participation appeared to be characterized primarily by top-down government programmes, designed to support the implementation of government priorities and predominantly informed by the concept of patients as largely passive recipients of services rather than that of active citizenship. However, the involvement of individuals as the users of services and citizens is a dimension of innovation that can be pursued through our investigation of the social model of (mental) health.

Similarly, whilst integration was a trend which was subject to major health reforms in three of the four countries (Bauer et al 2015, p.38) it did not appear to be a social innovation trend in its own right. Thus it had more features of a policy programme for solving problems associated with bureaucratic and professional boundaries in fragmented service structures (although policy makers might sell it as a mechanism for addressing social needs more effectively). Again, no final conclusions can be drawn at this stage and the role of integration in social innovation can be explored through case studies focused on the social model of (mental) health.

The selection of the social model of health within the field of mental health was derived from the field description, and discussed and shared with partners and experts at the 3rd consortium meeting and mid-term conference in Paris. The next step was to identify a case study that met the features of what has been defined in the process of the ITSSOIN work as social innovation streams. Social innovation streams could refer to a particular sub-theme or target group.

[1] http://www.mentalhealth.org.uk/help-information/mental-health-a-z/r/recovery/

2. Method for case study selection

In order to identify social innovation streams in the four participating countries we first carried out reviews of the literature. We sought to identify information about the application of social model of mental health (recovery) trend in the four countries and case studies of social innovations that had been previously recognised at a European level. The objectives were to gain knowledge about 1) the application of the social model of health to the mental health field i.e. recovery movements; 2) the context of the mental health recovery trend in the different countries.

Based on this knowledge we then derived a questionnaire for country partners in which they were presented with a classification of different types of possible social innovation *streams* in the mental health field. They were then asked to consult with experts to 1) assess whether categories applied to their country; 2) to provide examples of social innovation activities and indicate the category they reflected. The list of categories was provided to make it easier for countries to provide examples of social innovation activities that were reflective of the mental health recovery trend. Its aim was to ensure that countries' experts reflected possible social innovation activities comprehensively based on a framework. By providing a broad framework we sought to create some consistency between countries' responses without placing too many restrictions on experts and limiting their choices. Following such an approach will allow in future case study work to anchor examples of social innovations in their wider policy and political contexts; i.e. understanding their relationship with other factors and variables. This knowledge will be used to ensure that in cross-national comparisons we are able to distinguish between differences in the role of the third sector that are due to the choice of case studies versus those that are due to the social innovation we are interested in. In addition to the framework we also developed a set of criteria that experts were asked to apply to potential social innovation activities in order to ensure the feasibility of a case study approach. Criteria included:

'Observability': experts were asked to consider in their choice of social innovation activities how readily information would be available on an organizational level; an indication could be for example the amount of media and policy attention that the activity had received;

'Relevance': experts were asked to consider whether the social activity was interesting to observe; in particular they were asked to consider whether there were many strong dynamics between different actors and sectors, their respective contributions and influence in social innovation activities;

'Capacity': experts were asked to consider the expected capacity of actors to be involved in the case study;

Countries were given flexibility in the way they could apply the questionnaire either by sending it electronically to experts or by interviewing experts on the phone or face-to-face. They were also given choice in the selection of experts as long as they could be considered experts in the field. Countries were asked to consult with one to three experts in the area but this also depended on their own knowledge of the subject at an institutional level. In the choice of social innovation activities provided by countries we then identified a common social innovation *stream* that best represented the selected social innovation activities in all four countries.

3. Towards a framework of the social model of mental health: Findings from the literature

A number of data sources were found in identified in particular reports from the European Commission on changes in the mental health system in the four countries and the application of the concept of recovery. A US research paper was identified which comprehensively the evolution of the recovery movements in the mental health field. We identified a wide range of literature on what has been named the recovery approach in the UK. Although we used this information we applied a level of caution in order to not create a bias towards UK literature. In addition, several clinical research papers were identified from Denmark that described and evaluated changes in clinical practice carried out to incorporate principles of recovery.

While there was no single definition of recovery in the literature, social innovation streams under this trend are expected to incorporate principles of hope, empowerment, coproduction, community capacity. Under the heading of recovery, 'social model of mental health' movements have taken place which evolved over many decades (Beresford et al 2010). Mental health, similar other areas in the physical and intellectual disability field, is an area which has strong service user and survivor movements leading to changes in policy towards what is called a recovery approach. Such movements and policies, whilst distinguishable in nature, showed also great overlaps and similarities with those in the physical disability field (Beresford et al., 2010). They are, therefore, more consistent notions of active citizenship than patient participation.

Clinical professions in mental health (in particular psychiatrists) have often been strong promoters of the traditional medical model of disability and might have shifted the focus back from recovery to treatment (Mountain & Shah, 2008). The medical profession might be seen as having power incentives to drive a medicalized thinking in order to maintain their role as sole experts. Arguably, some members of the professional discipline used this as a way to sustain their ideological beliefs whilst gaining and securing powerful positions. Whilst medicalised responses to mental illness have been challenged by service users and professionals, the field is still dominated by clinical and psychiatric diagnosis of categories of mental illnesses and policy and practice are often focused on drug therapy (Beresford et al. 2010). People with mental ill health are particularly affected by stigma arising from a medical model that presents the 'mentally ill' person as a one with an enduring long-term condition characterized by pessimistic outlook on recovery.

The recovery approach is supported by evidence that shows that there are factors (such as life satisfaction) that are not necessarily determined by psychiatric or physical symptoms which influence individuals' health substantially (Al-Windi 2005). Overcoming losses of functioning and re-establishing social relationships are important contributors to recovery and rehabilitation; thus treating mental illness only medically is not sufficient (Chovil et al. 2005). Resnick *et al. (*2004) investigated principles correlated with recovery empirically and found that life satisfaction, hope and optimism, empowerment, and knowledge about mental illness and services were all linked to an individual's recovery. Since then additional, related domains have been added such equality and respect, purpose and direction, life experience, social inclusion and connectedness. Activities under the social model of mental health and the concept of recovery might include peer support, training and skills development, recreational and art therapy, employment schemes, outcome and recovery oriented clinical programmes, integration models with recovery focus, housing support options, etc.

Davidson *et al*. (2006) distinguished two recovery approaches: one refers to recovery in the conventional sense i.e. the cure or restoration to former health and stability; the second one refers to restoring health in the broader sense reflected in a sense of well-being regardless of symptoms. The latter is brought about by the person's efforts to live in 'meaningful and gratifying ways despite limitations imposed by enduring disability' (Davidson et al. 2006). Possibly mirroring this divide in practice, innovations in the recovery area appear to pulled into the two different directions: one in which service users remain the owners of what might be regarded by them the original definition of the recovery concept (e.g. advocacy) and, second, the incorporation of the recovery model into professional discipline and practice (e.g. recovery oriented psychosocial interventions). Although the latter is an expression of impact of the social innovation, it might also be seen as dilution from the original model. In our case studies, we plan to explore the implications of this possible divide for the role of the third sector.

Different social innovation streams were identified during the literature review which led to development of two frameworks. The first framework represents a *chronological* classification which takes account of the development of the social model of mental health and recovery as an evolutionary process.

Classification of social innovation streams by movements

This framework was based on an identified complexity associated with the concept of 'recovery' which has been driven by different ideological positions and viewpoints over time. For example, it has been influenced by consumerism movements as well as a political drive to combat costs of institutional and intensive community care (Jacobson, 2004). We derived a classification of social innovation streams as an expression of ideological movements over time which is closely follows the analysis by Starnino (2009) which is a comprehensive analysis of the mental health recovery trend. While Starnino's observations mainly related to the US they are sufficiently applicable to movements in Europe, which were influenced by the US. Some adaptation might need to be made, however, during the case study work. For example, movements might have taken place at different times and in different speeds in the four countries. **Although approaches under those ideological positions are presented in a chronology, they are strongly overlapping and found to co-exist in the current context.**

The recovery trend was characterised by the influence of the social work discipline in the mental health field starting from during the first 50 years of the 20thcentury. An interdisciplinary approach, in the form of the psychiatric social work discipline, was introduced through social workers providing aftercare for people discharged from mental institutions (Schaefer Vourlekis *et al.,* 1998). There was new profession with focus on prevention and community integration strategies. Those changes were linked to deinstitutionalisation processes and the introduction of community mental health centres.

Following on from this, during the 1950s, professional led community integration stream led to piloting of programs focused on supporting independent living. They provided occasions for recreation and socialisation with peers. The aim was to help people learning how to live with limitations imposed by the condition (Corrigan, 2003). Recovery was then defined as the ability to accomplish social gains such as engaging in healthy relationships, employment and independent living (Jacobson, 2004). Types of activities include community and early intervention approaches, work integration and peer support. It might also include social prescribing. Employment or work integration schemes might also be activities falling under

this stream as persons with mental illness gain awareness about their disorder, use their talents, and begin to construct meaningful social roles and identities (Krupa et al., 2004).

The psychiatric rehabilitation stream started around the same time and had a focus on acceptance and symptom management as prerequisite for recovery. This could include co-production activities. Expressions of this stream were the introduction of cognitive rehabilitation strategies (e.g. CBT) and art therapy (De Vecchi et al., 2015).

The survivor or ex-patient stream, which started during the beginning decades of the 20thcentury has been described as a radical reaction to a deeply rooted unhappiness with the mental health sector and the stigma people with mental illness face in society (Jacobsen, 2004). It presents a strong opposing force to the medical model and challenges the concept of mental illness as a disease and instead sees it as a societal problem. It interprets treatment as an attempt to control unwanted behaviours (Gilmartin, 1997). Self-help and advocacy initiatives, social marketing and media campaigns are all activities to promote the cause. They are seen as vehicles of empowerment, to express grievance with the mental health system and to fight discrimination. This can include advocacy for equalities and disability legislation which can act as levers in challenging discriminatory practices and arguing reasonable adjustments at an organisational level such as in workplaces (Thornicroft et al 2008).

The user-centred (consumer) stream came to prominence in public sector reform movements around the end of the 20th century. It emphasises the need to place user rather than producer interests at the centre of improvements to quality and outcomes. Recovery is interpreted as a subjective experience. It has a particular focus is on self-responsibility for one's own wellness plan (Mead and Copeland 2002). Social innovation activities are those that promote individuals' aspirations; personal growth; engagement with creative activities; self-management; co-production; and spirituality focused interventions.

Classification of social innovation streams by characteristics

In addition, we identified literature which showed a range of characteristics of social innovation streams, which are not necessarily mutually exclusive and which were used to inform another classification.

First, the recovery approach could be primarily individualised, based on principles of self-help and self-directed support (Tew et al., 2011). An example might be certain types f personalised approaches. In addition, however, it can include collective elements based on principles of solidarity, mutuality and inter-personal relationships (Rogers et al., 2007; Brown et al., 2008; Resnick & Rosenheck, 2008); an example of a collective approach is peer support or friendship programmes in which people are matched with volunteers from community (Mead & MacNeil 2006; McCorke et al., 2009). The recovery approach can also have social inclusion and citizenship elements; examples are work integration programmes and community development initiatives (Whitley & Prince, 2005; Farone 2006; Seebohm & Gilchrist, 2008). Finally, the approach might be strengths or empowerment based; an example of an empowerment focused approach could be advocacy (Barry et al., 2003; Jones et al., 2007).We would expect case studies to be conducted in examples of the recovery approach which demonstrate aspects of some or all of these characteristics.

4. The social model of mental health (recovery) trend in the four countries: Findings from the literature

From the literature we identified two types of information that provided knowledge about the application of the social model of mental health (recovery) trend in the four countries: (1) Information about the mental health policies and systems in regards to community reintegration and (2) Information about the recovery trend in mental health directly.

Czech Republic

Deinstitutionalisation happened more slowly and more recently in the Czech Republic and might mean the implementation of recovery movements began also only recently as the two are closely interlinked. Deinstitutionalisation is still an especially important process in the Czech context. Czech Republic is traditionally characterized by high level of institutionalization in health and social care; this phenomenon has considerable inertia and is supported by a powerful lobby. Individual care, attention paid to the needs of clients, developing self-sufficiency of people with mental disabilities and high quality of their life are among the objectives of the process of deinstitutionalization. Social services providers in particular have undergone radical transformation. There are now increasing numbers of Community Mental health Centres which employ recovery oriented approaches as part of multi-disciplinary, case management teams including those with outreach functions. Services mostly comprise a variety of programmes provided by the third sector including supported housing options, leisure activities and employment support. Some of the increasing number of third sector projects are run and managed by service users and their families, whose role in the provision of services is increasing; they also take on advocacy for functions (Paldam & Svendsen, 2001). Services have been often initiated and set by individual activists. They are not part of mainstream service provision and thus there is a lot of local variation often leading to a fragmented care system (Roberts, 2002).

France

Reform and innovations in mental health have been centred around and characterised by deinstitutionalization and the development of community based care in cooperation with the third sector. Reforms took place in regards to deinstitutionalisation (such as housing support options and psychiatric rehabilitation programmes) and survivor movements (advocacy and fighting against stigma; European Union, 2011). More recent reform focus lies on integration between mental health, social care and culture and the arts; and involvement of service users, their families and wider communities (European Union, 2011). Local mental health councils are responsible for organising and coordinating such decisions concerning the local care system. Services and programmes to promote social inclusion exist at a community level.

Denmark

In Denmark, public services for people with mental health problems are organised through health and social services. Hospital and district psychiatry falls under the Ministry of Interior and Health; psychiatric services and medical treatment are planned, regulated and provided by the regions. Social psychiatry is a responsibility of the Ministry of Social Affairs and is implemented by local authorities, either in their Disability or Health Units. Cooperation in service planning and delivery is based on formal and broad 'health agreements' between a region and the municipalities (ESN, 2011). In Denmark, there are no preferential employment policies for people with mental health problems, and they are covered under mainstream

legislation. However, special services such as vocational rehabilitation and training are provided to enhance the employment opportunities for persons with mental health problems. Since the 1960s, the user movement has advocated for services to respect their dignity and promote their independence. They have worked alongside professionals towards introducing the recovery approach as a means to improve their quality of life.

United Kingdom

In England (UK), mental health services are mainly delivered through health and social care and organised by the local infrastructure of the National Health Service (NHS). A number of municipalities (counties and unitary authorities) have entered into legal agreements with local NHS trusts to take back direct management of social care staff and resources from the NHS. Whilst policy and legislation has been progressively revised to move towards an integrated model with an emphasis on the social determinants of mental health, in practice local service provision still varies. The increasing interest in social approaches to mental health in recent years is for example reflected in the establishment of the *Social Perspectives Network* (Tew, 2005; Tew et al., 2006; Beresford, 2002, 2004). In the UK, the recovery research is often led by individuals living with mental illness and user-led research in itself is a driver of the recovery model and of the social model of health.

5. Selection of case study: Expert views and identification of common social innovation stream

In particular in Denmark, country representatives had difficulties carrying out the expert consultation. The feedback was that some experts were not sure about the approach that was taken and also struggled to relate to the suggested framework, in particular the one about chronological movements. In discussion with the country partner it was though that a possible explanation could be seen in the fact that experts were health care experts that were knowledge of mainstream health service delivery and traditionally been working as part of the clinical health field. They might have been to a much lesser extent aware of social innovation trends that were possibly provided under the radar of central authorities. This possible explanation was confirmed by the interviews carried out in Denmark and France which showed that one of the three experts from the health ministry was more likely to refer to the clinical field and innovations that did not fall under the trend of social model of mental health and recovery.

Czech Republic

In the Czech Republic, according to the opinion of one expert, the so called 'Home without a lock' was an interesting social innovation example in the field of the social model of (mental) health under the recovery trend. It is project provided social service, which was founded by the regional authority and offers a wide range of services to people with mental health problems. It is interesting in terms of dynamics between public and third sector because it is one of the selected partner organizations of the Ministry of Labour and Social Affairs to verify the transformation process. This also makes it more likely to be 'observable'. The transformation vision of the project is to provide social services that will enable mental health service users to live in a natural environment in mainstream society, without elements of institutionalization. Main goals of the project were to improve quality of life quality of life for users, individualisation and efficient use of (public) resources. This type of social innovation activity met the following streams under the chronological framework: The influence of the social care profession on the mental health discipline is evident and so were aspects of community

integration. In further dialogue with the country representatives it was noted, however, that there were other important examples of innovative activities under the recover approach that had not been mentioned by experts. They were likely to reflective of possible user-led or centred movements and included recovery colleges.

Denmark

One expert suggested focussing on so called "Patients teams" which is currently developed and implemented in psychiatric practice in Northern Jutland (northern part of Denmark). The aim of this project is to organize a transparent and effective patient journey and have a more coherent and coordinated journey for patient through the different treatment facilities. Data collection was considered to be feasible. This case study might not be suitable as it does not incorporate the social model of mental health. It is possible that interesting projects fall under Social services in Denmark. The examples we identified from literature search and other possible case studies were discussed with the Danish partner. Examples from the literature search led us to organisations such as Recovery Denmark and the Danish National Users' Movement and included the well implemented Clubhouse model (EPR, 2010). In collaboration with Recovery Denmark, the Social Services Department at the City of Aarhus (under the Department Social Psychiatry and Vulnerable Adults) has developed recovery oriented approaches.

France

It was reported by one expert that recovery approaches were particularly recognising the role of spirituality, nature and intimate relationships. An example that was provided was therapy with horses which helped people to build a relationship with nature, share a sense of responsibility, and learn to interact with plants or animals. Another expert thought that ENDAT (Nutritional Education for diabetics and Help in case of Eating Behavioural Disorder) was an interesting project. It is a non-profit organisation which involves patient in their treatment to ensure a lasting recovery. The expert thought that the case was interesting in terms of dynamics in regards to public and third sector actors, and that data could be collected. Two experts named 'Les Invités aux Festins' in Besançon as an innovative example, which gets a lot of political and media interest. It is a project that is organised by patients, professionals and volunteers in partnership and who also partly live together.

In the literature it was reported that vocational rehabilitation and employment for people with mental health was promoted through a large range of activities, including therapeutic workshops, vocational training programmes, supported employment schemes and vocational rehabilitation integrated in the city. Most of these programmes are developed in collaboration with mental health services, employment agencies and a range of partners. Supporting the experts' suggestion, in some areas (e.g. Lille) the role of art, culture, nature and leisure activities has been recognised as an important part of the recovery approach.

The activities named by experts and in the literature represented a rich spectrum of social innovation streams and activities. They had characteristics of psychiatric rehabilitation and user-led recovery. In particular the latter appeared dominant

United Kingdom

With the help of two experts we identified the following case studies, most of which were examples of so called recovery colleges or similar co-produced activities. Recovery Colleges

(also called Recovery Education Centre) were seen as an important social innovation under the recovery approach, which might be traced back to a South London-based one which started in 2009. Since then projects emerged across England and UK. A recovery college is run by both peer trainers and mental health practitioners and course are typically co-produced, co-delivered and co-received by staff, people with mental health problems and those close to them. They are thus collective; empowerment based; and they aim to reduce social isolation and increase citizenship. They can be public or third sector provided and dynamics between public and third sector vary strongly depending on the organisation that is chosen. For example, a college run by a charity (St Mungo's Broadway, based in South London) provides course for homeless people with mental health problems; a wide range of courses are provided to improve practical skills and help to rebuild confidence. Another recovery college is provided by one of the largest statutory providers of mental health services (South London Maudsley NHS Foundation trust, based in South London) in collaboration with its own charity.

Experts had existing, well established contacts to projects so that they considered data collection capacity feasible. In addition to recovery colleges, a number of projects were based in the same locality and had some connections, all supporting the recovery process. They include: the Mental Fight Club which runs the so called Dragon café, which provides recovery support and was founded and is run by people with mental health problems but is open to the public; Status Employment which is a charity that helps people with disabilities and mental health problems back to work; Blackfriars Settlement which is a charity that provides a wide range of community services and support; and CoolTanArts. All activities were strongly reflective of user-led recovery streams.

Cross country conclusions

Information from the literature and expert views combined allowed identifying streams under the chronological classification and framework. Across the four countries, a range of activities suggested that user-centred recovery was an important innovation stream. Based on the experts' responses and literature it was not always possible to derive conclusions about characteristics of activities that would have allowed categorising them into streams. Thus the application of the classification framework by characteristics could not support the selection of one social innovation stream across countries. However, during the case study it will be important to explore those characteristics further. An interesting comparative perspective when studying user-centred recovery might be the degree to which this social innovation stream of user-centred recovery is subject to variations in the degree of informality moderated by socio-political constellations, involvement of different actors and their characteristics outlined in ITSSOIN hypotheses. It will be also interesting, for example, to investigate the relationships between user-centred recovery and principles of co-production and community integration in the four countries.

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