The Case to Encourage Social Recovery in the Community through Sport and Physical Activity.

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Introduction

It has been suggested that, to date, social recovery, compared to personal recovery, has remained a somewhat overlooked dimension in mental health and addiction research (Ogundipe et al., 2022). In the literature pertaining to personal recovery, the CHIME framework (Leamy et al., 2011) is particularly significant. However, there is a limit to how much CHIME explicitly recognises the social dimension to recovery, with perhaps 'Connectedness' being the most closely linked, however even here there is often the temptation to focus on the benefits to the individual of the connectedness as opposed to the interplay and interaction of what the person contributes to the community/society, and then again in turn what benefits that provides to the person (e.g., feeling positive about making connections and contributing to their society). Evidence suggests that both 'social' and 'clinical' recovery rates correlate much more closely with socio-economic factors (Tew et al., 2012), such as social class inequalities (Wilkinson & Pickett, 2018), employment rates (Burns, Catty, White, Becker, Koletsi, Fioritti et al, 2008) or cultural contexts (Clarke, Lumbard, Sambrook, & Kerr, 2016; Smith et al., 2016), than they do with any advances in medical treatment (Warner, 2004). In a very similar way to the personal recovery focus, social recovery is about "rebuilding a worthwhile life, irrespective of whether or not one may continue to have particular distress experiences – and central to this can be reclaiming valued social roles and a positive self-identity" (Tew et al., 2012., p.444). Ramon (2018) highlighted how important it is for people to lead "meaningful and contributing lives as active citizens while experiencing mental ill health" (p.1), which exemplifies going beyond the personal focus. Ramon's (2018) model for social recovery specifically highlighted the key areas for consideration as being: Shared decision making, Co-production and Active citizenship; Employment; Living in poverty; the Economic case for recovery, and the Scientific evidence for the recovery model. Or, in other words, these areas reflect people's ability to lead meaningful and contributing lives as active citizens while experiencing mental ill health (Ramon 2018).

Norton and Swords (2021) built on Ramon's (2018) conceptual framework (as well as Goffman's (1963) stigma), suggesting that social recovery can explain how a person moves from an identity associated with stigma and social deviance, instead to a socially acceptable identity. This change to the acceptable identity is said to be 'influenced' by: Health, Economics, Social interaction/connection, Housing, Personal relationships and Support. The following sections aim to suggest how sport and/or physical activity within community settings can be a 'site' for these 'influencers' to (re)shape a person's identity to become "an active and participating citizen, with a sense of belonging" (Norton and Swords, 2021: p.10).

Context is Key

Currently, in the UK context, the attempts at deinstitutionalisation of services into the community remains patchy and poorly evaluated/evidenced. Though there is a growing consensus that the social aspect of recovery matters more widely (Ramon, 2018; Swords, 2019; Topor et al., 2011), the initiatives needed to support the transformation of health services towards becoming social recovery-oriented are lacking (Ogundipe et al., 2022). In an effort to explore 'what works?' (Tew et al., 2012: p.455), the argument here is that sport and/or physical activity 'works'. A perhaps limited, but growing, body of literature relating to mental health and physical activity is increasingly acknowledging the significance of the settings, contexts and cultures where activities actually take place (Tweed et al., 2020), as they have varying 'ingredients' and

may have varying outcomes (Smith et al., 2016). There is undoubtedly a long history of physical activity being offered within mental health service institutions, although the quality and quantity of opportunities will depend on many factors (e.g., facilities, equipment, staff capacity, confidence and expertise, motivation, and so on). The research base for physical activity in mental health service settings is less established and wide-ranging (for recent examples see: Benkwitz et al., 2019; Rogers et al., 2019, 2021). The literature for sport or physical activity in community settings is growing, albeit across idiosyncratic contexts, but it is felt that whilst not 'generalisable', the findings in these types of studies can resonate (Smith, 2017) with those working or researching in other somewhat similar settings and help inform practice. Some examples include: using physical activity to improve mental health in community settings for veterans (Harrold et al., 2018) or for individuals with serious mental illness alongside a chronic physical health condition (Lesley & Livingwood, 2015); or using football clubs as a 'hook' in the community to attract participants to be more physically active (Benkwitz & Healy, 2019; Friedrich & Mason, 2017); or using the subcultural capital of rugby league to engage men in community sport settings (Wilcock et al., 2021); or alternatively using multi-sport approaches as part of a national project to improve mental wellbeing through being more active (Get Set to Go, 2017). A common thread across the findings of these studies is the negative impact of social isolation for those with poorer mental health, and how physical activity interventions can be really beneficial in offering a 'space' to interact with other people and to rehabilitate social skills (Tweed et al., 2020), creating a social identity that encourages physical activity engagement (Soundy et al., 2014). Often these community-based initiatives are utilising existing facilities, equipment and expertise, which further adds weight to the argument of moving provision for mental health service users into the community (in the context of physical activity and physical health).

Reflecting on Social Recovery and Physical Activity

For Ramon (2018), shared decision making is a central component of social recovery, which includes sharing experiential knowledge and scientific knowledge. This could be a GP or community mental health practitioner suggesting an 'intervention' of cycling for 1 hour, three times a week, but the person explaining that actually they don't particularly like cycling (or cannot afford a bicycle) and perhaps would like to join a running group or a yoga class, and so on. Perhaps there would be a discussion about the social aspect (feeling nervous joining an existing group versus the benefits of making new connections/friendships), and how they could be supported in the process by practitioners or others in the community (ideally peer mentors). Similarly, co-production quite naturally follows on from the sharing of experiential and scientific knowledge. With further appreciation of the relationship between physical activity and mental health recovery in the community, preferably the setting or session of the physical activity would be co-produced, with the activities and organisation being co-produced to meet the needs of the participants (as opposed to something being offered in the community that is not suitable, or not desired, or both).

With regards to active citizenship, it has been suggested that people who increase their citizenship activities increase their recovery (Pelletier et al., 2015), and it could be argued that sport or physical activity sessions and opportunities in the community could be a really helpful mechanism to help to move people towards being more of an active citizen, especially in the early stages (Benkwitz and Healy, 2019). Qualitative studies have often found that sport or physical activity sessions can be a useful stepping stone in this sense, with frequent comments along the lines of 'if it wasn't for this I wouldn't have left the house' (Benkwitz et al., 2019) or 'I'd probably still be in bed right now' (Benkwitz and Healy, 2019), and then potentially progressing on to making friends from the sessions and meeting up socially outside of the sessions, and so on. This is obviously dependent on where someone is on their own recovery journey, and on the different projects or initiatives available, and many other factors, but it is useful to fully reflect on Ramon's (2018) excerpt about active citizenship in social recovery, keeping in mind the potential of sport or physical activity sessions:

> *"This can take many forms, such as beginning by membership in a mutual support group, moving to represent that group in a larger forum, and/or being active in their local community, on a range from a local family circle to membership in a political party. The value of such activities lies in enlarging one's meaningful network, moving from being a passive to an active citizen, being validated by other people in the community, learning skills necessary for the specific activity, learning more about one's potential and one's strengths, and becoming motivated for further such activities due to the success experienced. The fact that many such activities take place outside the arena of mental health services is a bonus, as it expands and reinforces people's connectedness, living beyond the illness, and their recovery capital." (Ramon, 2018: p.6)*

In terms of employment when considering the relationship between physical activity and mental health, this is an area that requires more attention (in other words, there is not yet an evidence base to help us understand the relationship between mental health, employment and physical activity, either for people currently in work who struggle with their mental health; or those who are not currently in work but are also struggling). As suggested in Benkwitz and Healy (2019), sporting and physical activity settings can often be masculine environments where individuals are somewhat reluctant to discuss topics such as their (un) employment or financial circumstances due to stigma (Goffman, 1963). Therefore, researchers could adopt participant observation as a method to gain a richer insight into the role of sport/physical activity in terms of employment and socio-economic status when considering people's social recovery. When contemplating poverty (and employment), regular physical activity sessions may not be able to directly link (and poverty could potentially be a barrier from being able to attend when considering the potential to need equipment, clothing or transport, as highlighted by Ogundipe et al., 2022), but some aspects to consider might include if there is a role for physical activity to play in helping in a person's personal and social recovery towards having the confidence and networking support to seek, gain and retain employment. Also, when organisations or community groups are considering providing some form of physical activity opportunity or intervention it is important to consider access and any costs that are passed on to the individual that may prohibit their involvement. Instead, societies and governments should consider bearing the economic burden (rather than it being passed onto individuals). For instance, consider the cost of doing some form of physical activity to help in your recovery (and potentially to manage symptoms) versus the cost for continued reliance on services. It is also evident, in a UK context at least, that there is a growing appreciation and utilisation of social prescribing for people struggling with their mental health, and various types of physical activities are being prescribed (Drinkwater et al., 2019).

Concluding Thoughts

As some of the 6 'influencers' outlined by Norton and Swords (2021) suggest, health services, policy makers and practitioners must look beyond the person, and appreciate issues of social justice and social inclusion (Davidson et al., 2006), as well as considering how the recovery processes can be supported in communities and facilitate social relationships (Fenton et al., 2017). Norton and Swords (2021) encouraged recognition in mental health policy provision and service delivery globally that social recovery is considered alongside personal recovery, with individuals' recovery journeys being supported socially within a shift from institutionalisation to community. Sport and physical activity might be a really beneficial initial catalyst to help people (re)gain confidence in order to facilitate them feeling enabled to be more of an 'active' and 'participating' citizen in their community. Furthermore, there remains a scarcity of focus on those with severe mental illness (SMI), which is problematic as those with SMI often experience poorer physical health than the wider population (Rogers et al., 2021; Vancampfort et al., 2018), and are less physically active and more sedentary than the wider population (Schuch et al., 2018). Therefore, whilst continuing to transition from institutions to communities we must appreciate the complexity of experiences and contexts. Finally, all of the

above commentary reflects the need for a wider evidence base in mental health services, and different outcome measures that reflect the complexity of people's lives and idiosyncratic recoveries within, and as a part of, their own communities. A positive result is not how many patients that are treated within services, but instead people being empowered and supported to live meaningful and contributing lives as active citizens alongside their mental illness (Ramon, 2018).

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