Social Innovation in the Care of the Differently Abled

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Abstract

Social work had entered into social innovation scenario to address a host of issues like income deprivations, displacement, disability, racism, social conflicts, and social exclusion. In Indian situation care giving to the differently abled particularly those having mental illness is a matter of grave concern. Varied approaches including institutionalized care and family and community based care are tried out in different contexts depending on the nature and severity of illness. This study tries to examine the care and rehabilitation of the differently abled through the individual initiatives inspired by faith dimensions of Catholic Church lasting over a period of twenty years in the State of Kerala and outside. The objective is to explore the process and outcome dimensions of such social innovation to find out the motivating drivers and aspects of sustainability. The personal and familial dedication is also come under the purview of analysis. The study adopted a Grounded Theory approach and methodology to analyse and theorise the processes and outcomes of such initiatives. The sample was chosen using purposive sampling methods and data was collected using in-depth interviews of individual innovators, their family members, volunteers, professionals and community representatives taking 22 centers reaching theoretical saturation. Being a qualitative study, a conceptual framework is given to such home based social innovation rooted in faith based dimensions with social responsibility for social value creation through sustainability leading to a social mission. The committed and sustained involvement of the community and the neighbourhood generated an innovative model for care of the persons with mental illness. The results of the study brings out new relationships and innovative drives and motivations exceptional to the traditional philanthropic methods as well as professional care and rehabilitation approaches thereby characterising social innovation in care giving and rehabilitation of the mentally challenged. Unlike the western model of community care and rehabilitation of persons with mental illness, the new approach evolved through the study is a family based community supported care and rehabilitation. There is a new relationship paradigm emerges at different levels – between the client and innovator, the institution and the community, clients and the family members of the innovator, clients and their

family, clients and the professionals etc.. It is a model for effective family education, care and compassion to complement other models of care and rehabilitation leading to theory of participatory family based care with community support in a spiral progressive paradigm.

Key Words: *Social Innovation, Faith Dimension, Care and Rehabilitation of the Differently Abled, Family Based Community Support Model.*

Introduction

Social innovation was seen as a conceptual frame across the Globe, towards the end of the twentieth century referring to a multitude of approaches in addressing long standing social and developmental issues leading to apparently innovative and sustainable solutions. In the context of technological advancement, high-tech communication alongside increased social needs, the disparity between the haves and the have-nots got widened. The problems like poverty, unemployment, illiteracy, climatic change, racism, ageism and increased criminality required new methods of finding sustainable solutions to such problems. Developing innovative solutions to such social problems and new forms of organising and interactions; both in bridging the gap as well as in addressing the issues at hand; led to social innovation theorisations and practices with greater emphasis on processes and not the outcome alone.

Nuances in Social Innovation

Originated from the ideas of innovation social innovation combines the passion of a social mission with an image of business-like discipline, innovation, and determination. It is an answer and entrepreneurial approache to social problems. Social innovation can be defined as new responses to pressing social demands, which affect the process of social interactions. It is aimed at improving human welfare. Critical analysis of the role of varied stakeholders and a firm belief in participatory processes point to the importance of a non-linear approach to addressing pressing social concerns (Hulgard and Shajahan, 2013). According to Agnes et al (2010), Social innovations are innovations that are social in both their ends and their means. Social innovations are also defined as new ideas (products, services and models) that simultaneously meet social needs (more effectively than alternatives) and create new social relationships or collaborations. In other words they are innovations that are not only good for society but also enhance society's capacity to act. Elaborating the concept Agnes (*ibid*) further refers **'Innovation'** as the capacity to create and implement novel ideas which are proven to deliver value and **'Social'** as the kind of value that innovation is expected to deliver: a value that is less concerned with profit and more with

issues such as quality of life, solidarity and well-being. A social innovation is a new combination and/or new configuration of social practices in certain areas of action or social contexts prompted by certain actors or constellations of actors in an intentional targeted manner with the goal of better satisfying or answering needs and problems than is possible on the basis of established practices (Howaldt and Kopp, 2012, p.47).

According to Frank Moulaert et al (2013), Social innovation refers to finding acceptable progressive solutions for a whole range of problems of exclusion, deprivation, alienation, lack of wellbeing, and also to those actions that contribute positively to significant human progress and development. Social innovation means fostering inclusion and wellbeing through improving social relations and empowerment processes: imagining and pursuing a world, a nation, a region, a locality, a community that would grant universal rights and be more socially inclusive.

A definition focused on practice, intention, and outcomes addressing social challenges, was originally developed by Robin Murray, Julie Caulier-Grice, and Geoff Mulgan in The Handbook of Social Innovation (Murray et.al., 2010, p.3). This definition was slightly refined by Agnes Hubert et.al. within the European context as follows: "specifically, we define social innovations as new ideas (products, services and models) that simultaneously meet social needs (more effectively than alternatives) and create new social relationships or collaborations. They are innovations that are not only good for society but also enhance society's capacity to act" (Agnes Hubert et.al., 2010, p.9).

Therefore social innovation, beyond its object of bringing measurable or perceptible changes in situations of vulnerability processes and practices which are inclusive and interactive, forms bedrock of social innovation. Further, Michael Mumford (2002) defines social innovation as "the generation and implementation of new ideas about how people should organize interpersonal activities, or social interactions, to meet one or more common goals. Mulgan et al. (2007) and Mulgan (2006) described social innovation as: innovative activities and services that are motivated by the goal of meeting a social need and that are predominantly developed and diffused through organisations whose primary purposes are social (2007: 8).

Thus social innovation leads to a commitment to the society to transform the society from the existing situation to a new status that could aim at eliminating the existing structures of risk or create new structures which are more empowering and sustainable.

Process and Outcome Dimensions in Social Innovation

All the existing scholarships in social innovation have invariably stressed the process of social interactions between individuals to reach certain outcomes as one of the important aspects of social innovation (Moulaert and Sekia 2003; Moulaert et al. 2005; MacCallum et al. 2009; Phills 2008; Defourny et al. 2010; Hulgård 2011). Ayob, Teasdale and Fagan (2016) make the distinction between strong and weak tradition in the evolution of social innovation as an academic discipline. Accordingly, the strong tradition argues that participatory and collaborative processes targeting a reconfiguration of 'power relations', whereas the weak tradition focus on 'the utilitarian social value of the innovation' (Ayob, Teasdale and Fagan, 2016:637).

Social innovation emerges from a set of drivers oriented by co-creative processes (for clients and users), based on collaborative networks**,** and originated from global challenges and social needs (Guida and Maiolini, 2013). In other words, social innovation is generated from individual and ethical considerations that serve to create new knowledge through a social capital perspective.

The outcome is the end result which could be social status, satisfaction as ulterior motive and the welfare of the immediate beneficiaries as immediate motive. The outcome could be varied based on the purpose, process and performance. The outcome in social innovation may be service of the society. Further there are several scholars (Borzaga and Defourny 2001; Moulaert and Sekia 2003; Moulaert et al. 2005; MacCallum et al. 2009; Chesbrough 2006; Hulgård 2011) who argue that an integrated approach that observes 'process' and 'outcome' as being equally important in enabling social innovation. This process-outcome integration links to an emphasis throughout the social innovation literature on participatory governance.

The entire study focuses on how the individual initiatives from a faith based experience in the care and rehabilitation of wandering persons with mental illness is cared in a family environment with community support in a process of social innovation creating social values and how the outcome turn into turns a sustainable model. A brief review of literature is done in this synopsis to map the subject in the world of research and studies.

Literature Review

The care and rehabilitation of the differently abled is to be studied in background of research, both quantitative and qualitative done in India and outside to fix the social innovation under study. The review is done starting from rehabilitation in mental health care, role of spirituality in mental health care, social innovation and its theoretical perspectives, focusing on social

value creation as a variable under study, the role of families and communities in rehabilitation and on differently abled chiefly persons with mental illness.

Mental Health Care and Rehabilitation

In Indian context there are approximately 30 million people affected by various types of mental disorders. However the personnel to treat them are not sufficient. Therefore a vast majority of the persons with mental illness is either partially treated or not treated. In the bargain the untreated persons aggravate the symptoms and subsequently get out of the house and being exposed to the hard realities on the street.

Agarwal (2000) in his review of the book, 'Innovation in Psychiatric Rehabilitation,' published by The Richmond Fellowship Society (India) comments, 'Large rehabilitation facilities may be the only viable option'. He opines that there were many rehabilitative initiatives, but unfortunately most of them have not tried to evaluate their efforts scientifically as well as in economic terms.

Kumar et al., (2008) have assessed the prevalence and pattern of mental disability among the rural population in Karnataka. It was a community-based, cross-sectional, house-to-house survey. They used Indian disability evaluation and assessment scale (IDEAS), developed by Rehabilitation Committee of Indian Psychiatric Society (IPS). They studied one thousand subjects randomly. The prevalence of mental disability was found to be 2.3%. The prevalence was higher among females (3.1%) than among males (1.5%). The prevalence was the highest among the elderly and illiterates.

Suresh Kumar (2008) observed that there is a definite limitation to the domains of social functioning, cognitive functioning, and psychopathology in chronic schizophrenia patients who have had no rehabilitation. Vocational rehabilitation significantly improves these limitations, which in turn helps these patients to integrate into the society so as to function efficiently in their roles.

Further studies show the inevitable need of care and rehabilitation of the mentally ill which is termed here as differently abled.

In Erving Goffman's terms, stigma is "a special discrepancy between virtual and actual social identity," where virtual social identity refers to an imputed characterization, while actual social identity is defined as the qualities a person "could in fact be proved to possess" (1963:2-3)

To many contemporary social scientists, the stigma of mental illness has become an object that is measurable with tools such as the Bogardus Social Distance Scale, quantitative surveys, or qualitative interviewing (Angermeyer 2005; Baldwin and Marcus 2006; Borenstein 1992; Cook 2006; Corrigan et

al. 2003; Corrigan 2004b; Corrigan et al. 2005; Falk 2001; Lauber 2004; Wahl 1997; Wahl 1999). Therefore stigma reduction is also a major concern in mental health care and rehabilitation.

Mental Health Care and Spirituality

The care and rehabilitation in mental health sector has close links with spirituality. Religiosity and spirituality can be defined broadly as any feelings, thoughts, experiences, and behaviours that arise from a search for the 'sacred,' with the former implying group or social practices and doctrines and the latter tending to refer to personal experiences and beliefs (Hill et al.2000). Raphael Bonelli et al (2012) studied at least 444 original quantitative studies examined the relationship between Religion/Spirituality and depression or the effect of Religion/Spirituality intervention on depression between 1962 and 2010. Of those, there were 414 observational studies and 30 clinical trials (Table 1). Overall, of the 444 total studies, 272 (61%) found less depression, faster recovery from depression, or a reduction in depressive symptoms in response to a Religion/Spirituality intervention, whereas 28 studies (6%) found the opposite. Diana et al (2013) studied on multi faith based intervention in comparison with supportive therapy in cases of generalised anxiety disorder and found that faith based intervention is far more effective than supportive therapy. Whereas in another study on services among homeless women spirituality has less significance compared to funding from the government (Kevin C et al, 2003).

Social Innovation and Social Value Creation

Social innovation has multiple definitions which are briefly given in the thesis and social value creation is briefly touched upon here.

Individuals create value by developing novel and appropriate tasks, services, jobs, products, processes, or other contributions perceived to be of value by a target user (e.g., employer, client, customer) relative to the target's needs and when the monetary amount realized for this service is greater than what might be derived from an alternative source producing the same task, service, job, and so forth. The value created may be from any new task, service, or job that provides greater utility or lower unit costs for the user over the closest alternative (Lepak et al, 2007).

At a societal level, the process of value creation can be conceived in terms of programs and incentives for entrepreneurship and innovation intended to

encourage existing organizations and new entrepreneurial ventures to innovate and expand their value to society and its members (Lepak et al, 2007).

Value is a concept of worth which is "linked to the use of a product or service and perceived by customers rather than objectively determined (Dumond, 2000, p. 1062). Bowman and Ambrosini introduce two perspectives on value. First, use value which is defined as "subjected by customers, based upon their perception of usefulness of the product on offer", and second exchange value, explained as "the amount paid by the buyer to the producer for the perceived use value" (2000, p. 4). Lepak et al. (2007, p. 182) suggest on the above mentioned definition, that "value creation depends on the subjective value realization of a user - whether individual, organization, or society – and translates into the user's willingness to exchange a monetary amount for the value received".

What exactly is social value about? Certo and Miller clarify that "social value has little to do with wealth creation but instead with the fulfilment of basic and long-standing needs such as providing food, water, shelter, education, and medical services to those members of society who are in need" (2008, p. 267). Further, social value is among others explained as the creation of social wealth like education and economic development (McLean, 2006; Sullivan Mort, Weerawardena and Carnegie, 2003), social justice (e.g. reduction of gender inequalities) (Thake & Zadek, 1997) or the resolution of social problems (e.g. reduction of poverty) (Drayton, 2002). In an economic perspective social value may be similar to what Bowman and Ambrosini call use-value with the constraint that an adequate exchange value may not be paid. Santos comments, "[social] value creation can be defined as the sum of the value added to all members of society minus the value for all resources used" (2009, p. 27).

Differently Abled

Although precise numbers are difficult to determine, research indicates that as much as 7-10 percent of the world's population has a disability. Hereafter the disability is renamed as people with differently abled to avoid the value loaded judgment and labelling. The specialists note that people who are differently abled face many of the challenges that other poor, marginalized, and vulnerable groups face, such as lack of adequate support services in their communities, lack of resources and economic opportunities, and physical and attitudinal barriers to their participation fully in the society. The "disability" as defined by the United Nations Standard Rules on the Equalization of Opportunities for People who are differently abled is "physical, intellectual

or sensory impairment, medical conditions or mental illness," whether long or short-term, which leads to the "loss or limitation of opportunities to take part in the life of the community on an equal level with others."

The work of Albert et al (2006) on disability advocacy among religious organizations, histories and reflections speak on the experiences of different religious sects in North America. The edited works of Renu et al (2009) discussed the cultural and societal forces behind the disability rehabilitation.

This study focuses on the existing model of rehabilitation of the differently abled evolved in a faith based perspective through individual initiatives turning into a social enterprise. Being inspired by Charismatic movement of the Catholic Church in Kerala several individuals initiated rehabilitation of the differently abled, home based depending upon the providence of God. Majority of the differently abled were destitute or their family members were unable to care them. These individual initiatives were supported by men of good will from the neighbourhood and the community who supported the venture with money, material and voluntary services.

This study is an attempt to explore the process and outcome dimensions in social innovations of rehabilitation of the differently abled by individual initiative with community support in special reference to Kerala.

Methodology

Conceptual Mapping on Social Innovation in the Rehabilitation of the Differently Abled

Overview of the community rehabilitation of the differently abled should brief the history of more than twenty years when a few individuals inspired from catholic charismatic retreats in Kerala state took initiative to care the destitute differently abled in their own homes. It was the beginning of social innovation with a faith perspective believing the words of Jesus, 'When you do to the least of my brethren you do unto me' (Mt. 25: 40). The members of the community observed such innovative centre and understood the sincerity and commitment behind the humanitarian task, owned the entire project as community responsibility and provided financial and material support to such centers. The similar episodes continued and today nearly ninety such centers having inmates of 50 to 400 or more are functioning in a miraculous way in the community expression of participation and community ownership.

The nucleus would be individual initiated innovation that established the rehabilitation centre. The framework conditions include family involvement, community participation and tertiary resources including hospitals, Primary Health Centres, medical camps on top layer of and bottom layer of framework includes legal regulations, institutional infrastructure and facilities and political framework.

The inner circles would include the drivers chiefly the religious faith based inspiration, the societal output which is the social value creation, the social outcome which is the social responsibility or ownership leading to a social mission and sustainability which needs to be established through this study.

The drivers are the religious faith based spirituality which is the total trust in the providence of the Almighty God which is followed by faith in good works that contributes eternal life. It gives a social responsibility which makes the individual and the community to proceed towards a social mission. When such a social mission is with conviction and commitment it becomes sustainable. When the entire family is involved in the enterprise the very rehabilitation itself becomes a livelihood upon social enterprise parameters. This process leads to an outcome which is also socially innovative. It leads to social value creation. The community feels that every destitute disabled in the community is a member in their own family and it is the responsibility of everyone in the community to look after them and to meet all possible needs of such disabled.

Besides the social innovation objective looks into the generation of new idea creation which should be focused on social welfare. It should develop a new relationship between different groups of people involved in the given project.

Process

The qualitative research design with grounded theory methodology is followed in the study. The researcher visited the social innovation centers, interacted with the director of the centre, his/her family members, staff, and other caregivers. An in-depth interview with them is audio recorded which is transcribed. The transcribed data is processed using Atlas Ti software for coding and analysis. Initially open coding was done for the entire data. In the second stage axial coding was done and finally theoretical coding is done. In the analysis codified data is done taking the axial coding data. In open coding 300 codes were used and it was categorised to 15 axial codes. Those

15 themes are further clustered into sections for analysis. The discussion of the analysis is included in this paper.

The Discussion

Care and Rehabilitation of the persons with mental illness in a family environment developed as a social innovation is analysed based on the in-depth interviews with individuals, family members, community representatives, volunteers, recovered patients, professionals, volunteers and others.

The discussion session is divided into four sections and each is framed based on the objectives and the research questions of the study. It covers the following components such as drivers and motivating factors, personal and family involvement, social value creation and the role of the community, process and outcome of social innovation leading to sustainability. Further grounded theory formulation is explained.

1. Drivers and Motivating Factors in Social Innovation

Drivers in any social innovation could be a sustainable force behind any action. Those sustainable forces lead to change in any social innovation.

The drivers include factors from causal conditions, strategies, consequences and intervening conditions as per the selective coding in grounded theory method. Causal conditions are family involvement, community support, spiritual values like trust in the providence of God, and social value creation. Strategies include resource mobilization and utilization, professional services, individual and group care, active engagement of inmates through spiritual exercises, activity scheduling and occupational engagement, financial support, professional and voluntary support. Consequences include individual improvement and recovery through regular medication and disciplined life. Intervening conditions also become part of drivers which include family training, mental health awareness programmes to the community and preparing the families of ill members for family care and rehabilitation. Any social innovation itself is a driver to social change (Howaldt, 2012). Comparing and contrast of the construct is done along with the discussion.

Motivations of the individual social innovators include inspiring philosophies, the poor living conditions of wandering persons with mental illness, inspiring scriptural passages, lives of inspiring people, spiritual gain of eternity, financial gain, and sense of self satisfaction, social recognition and acceptance and host of others.

1.1 Triggers

Discussing the triggering factors of the social innovation under study most of them are life events physical, psychological, social or spiritual. The physical trigger may be watching the inhuman condition of wandering persons with mental illness. Continuous struggles in life made Mr. Manuel (an innovator)to involve in caring mission. A motor bike accident and subsequent event made Mr. Sathish (another innovator) to reflect upon the utility of a coconut tree and his own useless life as human being.

1.2 Drivers

The drivers include factors from causal conditions, strategies, consequences and intervening conditions. Causal conditions are family involvement, community support, spiritual values like trust in the providence of God, and social value creation.

Those who walked in realised what is going on inside and started to collaborate by contributing in terms of money, material and man power.

The spiritual values are another causal factor that acts as drivers. It is the deep trust in the providence of God. Almost all the social innovation centers are started in a spiritual background give primary importance to spirituality. The providence of God they felt at times of difficulty as the unknown hands opening the door to a resolution of the problem.

The community mental health experimented in the West had its own limitations of replicating the family values as the society itself in the West is facing degeneration of family values from 1950 onwards. Hence the regeneration of family values in the context of care and rehabilitation of persons with mental illness is a social value created in this model. Again the family involvement for social mission is a major social value regenerated.

Next set of drivers emerge from strategies. Strategies include resource mobilization and utilization, professional services, individual and group care, active engagement of inmates through spiritual exercises, activity scheduling and occupational engagement, financial support, professional and voluntary support.

Financial support is another strategical area in which the innovation center tries to tap all the possible resources although hardly they go for permanent financial sources. People like Tony and Tomy do not want excess money than the daily bread as they fully trust in the providence of God.

Professional and voluntary support is another strategical condition.

Consequences include individual improvement and recovery through regular medication and disciplined life. As there is professional support in most of the centers they focus on regular treatment of the inmates.

Family training takes place in different levels. The families of the innovator through their intervention gradually learn the care giving method.

Another set of family training is to the families in the neighbourhood and the community through various training programmes conducted by the centre from time to time. They also visit the social innovation centre and learn about mental illness and people's behaviour through observation and interaction. The third set of families includes the families of the inmates. Some of them are not ready to come. Those who are ready to respond are given Psycho education by the professionals or trained volunteers from the centre. Such training helps them to take the patient back home and give better care with proper medication and other requirements.

Mental health awareness program in the community is another intervening condition. There are different types of awareness program taking place. The home visits of volunteers and professionals from the centre could be another method of mental health information dissemination. A few centers reach out to the community through programmes like drama, music and other cultural events. A few centers have magazines.

1.3 Motivations

Motivations of the individual social innovators include inspiring philosophies, the poor living conditions of wandering persons with mental illness, inspiring scriptural passages, lives of inspiring people, spiritual gain of eternity, financial gain, and sense of self satisfaction, social recognition and acceptance.

2 Personal and Family Involvement

The personal involvement of the social innovator varied in each centre. In the case of a few it was a strong personal conviction born out of the philosophy they formed from the life events or environment made them to commit for a social cause.

Family involvement also varied from place to place. There were three levels of involvement in general. There was total and full involvement, partial involvement and neutral involvement.

3 Social Value Creation and the Role of community Involvement in Social Mission and Social Responsibility

There are individuals who define the social value or conceptualize as they perceive, family perspective which could be more or less organizational and societal point of view.

In the context of family the social value creation is in the process of helping the families having a mentally ill member by innovator and his family taking up the burden and cares the ill member. On recovery the family of the ill member is engaged with psycho education and training to prepare to accommodate the ill member. The support of the families in the community also adds a social value. It serves the social innovation centre with voluntary services, and mobilization of resources.

4 Process and Outcome Dimensions of Social Innovation to Sustainability

Murray, Caulier-Grice and Mulgan (2010) in The Open Book of Social Innovation define social innovation as new products, services or methods that tackle pressing and emerging social issues which, at the same time, transform social interactions promoting new collaboration and relationships. Hubert et.al. within the European context defines as follows: "Social innovations are defined as new ideas (products, services and models) that simultaneously meet social needs (more effectively than alternatives) and create new social relationships or collaborations.

In the study context the social innovation process and outcome are discussed using grounded theory approach with an objective of deriving a theoretical paradigm from the ground.

As per the grounded theoretical framework paradigm there are six axial codes chosen such as contextual conditions, causal conditions, strategies, intervening conditions, consequences and central phenomenon. The entire process of social innovation is discussed within this theoretical frame work. Further in the outcome dimension of the social innovation the outcome is discussed towards arriving at a new theoretical paradigm which is summed up in the grounded theory.

The process discussion could begin with the contextual conditions.

4.1 Contextual conditions

A family member who is affected by a serious mental illness is coming out of his home either being thrown out or on his own interest leave home and wander in the street. He or she felt to be a burden for the family once upon a time becomes a society burden as his/her disorganized life on the street challenges the people of good will. Any civic society with high ethical or moral concern would consider it as a 'sorrow of the society' and the developing countries like India may not be in a position to look after their welfare and rehabilitation by the State. In this context of social deprivation and alienation, a social problem to be classified, there came inspired men and women of good will to welcome such wandering mentally ill persons from the street, rescue and care in the shelter of the inspired individuals' family.

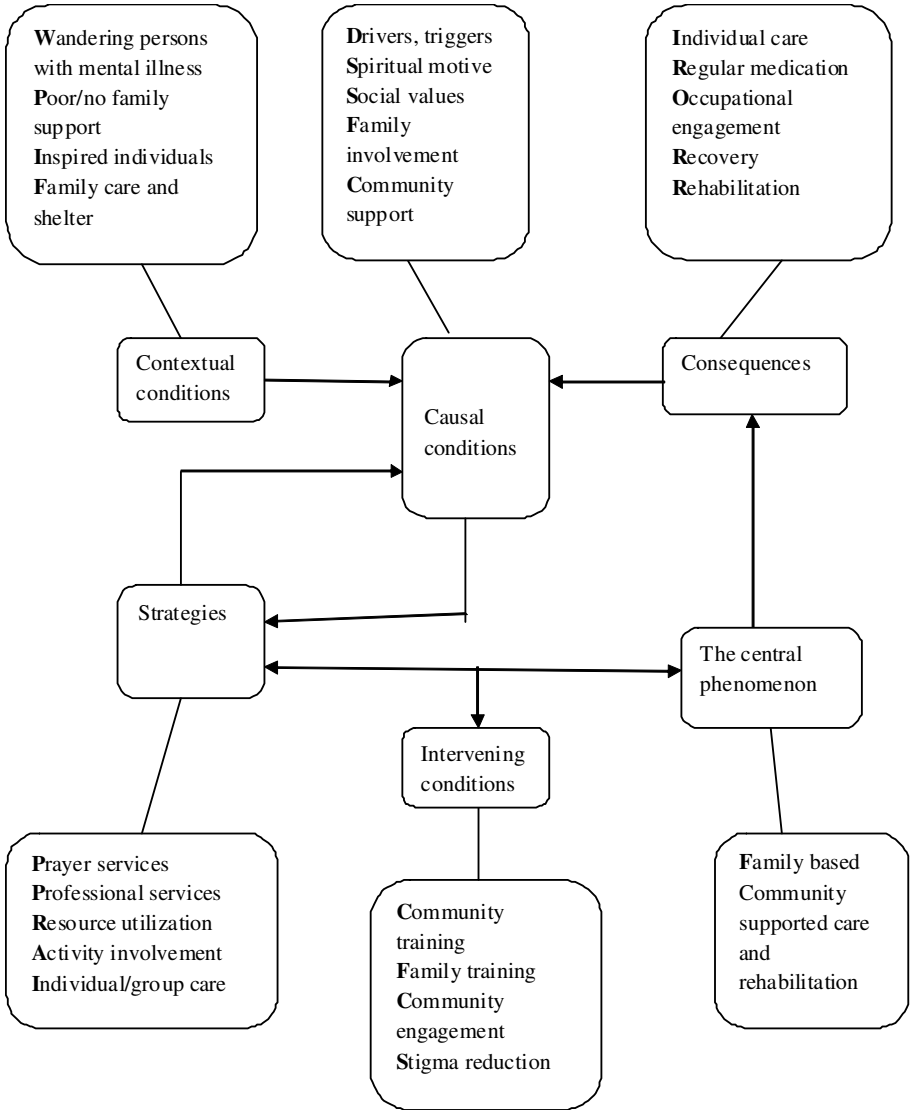
4.2 Causal Conditions

There is variety of causal conditions leading to the formation of the social innovation. There are triggers, drivers and motivations. Drivers are those sustainable factors that lead to the social action.

4.3 Strategies

Strategies are another selective coding done to fix the factors that contributed the day today functioning of the social innovation. The clients are supplied with daily food, clothing, shelter, periodical psychiatric consultation and regular medication. In the daily routine most of the centers engage the clients in prayer services that include singing and verbal prayers. The clients participate and some give a lead. There is occupational engagement either through some group activities or engaging in any service of the agency such as cleaning the premise, serving in the kitchen, gardening or farming.

Figure 1: Selective Coding and Theoretical Framework of Social Innovation in the Care of Differently Abled.



4.4 Intervening Conditions

It includes mental health awareness program through individual and family education, family training, community training and other conscientization activities leading to stigma reduction and promotion of mental health education.

4.5 Consequences

The consequence of the social innovation is the individual care and rehabilitation through a process of meeting the physical and psycho social needs of the clients.

4.6 Central Phenomenon

The core focus of the social innovation is described as central phenomenon. In this social innovation model the central phenomenon is nothing but the family based community supported care and rehabilitation. The entire process leads to this outcome.

Although there are several political theories of participation, none of them are suited to the study context. Hence the participation theory developed by Karol Wojtyla is partially used to explain the grounded theory derived through the study.

It could be roughly framed as 'Spiral, progressive regeneration theory of participation' in social innovation context. It is explained below using the selective coding derived in the study.

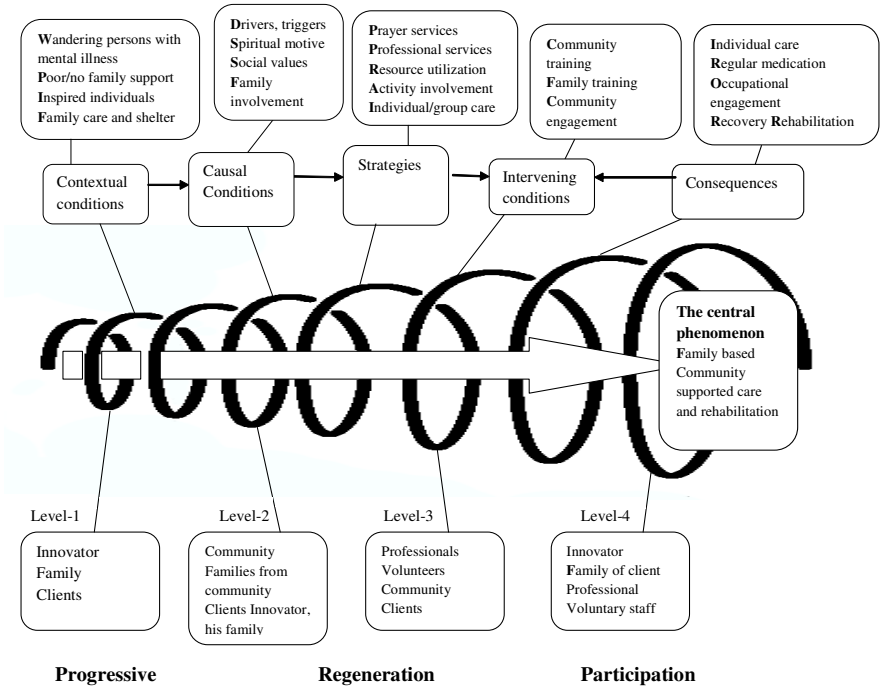
It is spiral in nature which is progressive and upward. It is narrated in an inverted pyramid structure of the selective coding. Thus the central phenomenon is considered as the nucleus of the spiral form. All other selective coding and their subcategories are explained along the cyclical peripherals of the spiral shape which is progressive in nature.

The individual innovator discovered the spirituality within and was able to recognise the reflections of the Divine in the other, particularly the man on the street. In fact this reflection moved him to the act of care and concern which made him bring the person on the street home attending as his own family member. The interpersonal community is a community of persons who are responsible for themselves as well as for others. Such responsibility is a reflection of conscience and of the transcendence that for both 'the I and the thou' constitutes the path to self-fulfillment, and at the same time, characterizes the proper, authentically personal dimension of the community (Wojtyla, 1993).

The person with mental illness who was alienated in his own family was brought into another family of participation and sharing. Moving beyond the literature, the participation found in the study model has a progressive spiral form of regenerative participation. It is spiral as there is a give and take which is cyclical, yet progressive. The social innovation centre in the beginning had several struggles to fight against powers of alienation, which they termed as struggles within, from the family and from the community. Ultimately through relentless action they proved that what they are trying is nothing but giving back the family life they lost in the past. The family environment of the innovator made the clients feel that it is like their own family with a difference. In their own family there were elements of negative expressed emotions like, severe criticism, hostility and over involvement, the current adopted family fills life with genuine care and love gives new meaning to life. The ultimate need of every man is the need for love and when it is met the disorganization within the person gets settled and resulted in speedy recovery.

It is regenerative as it creates social values for the promotion of social innovation. It is also progressive. Progress means not only a change, but also improvement (Matei et al, 2015). Innovation applies to processes and systems. When we try to limit our study to only one part of a system, we cannot see the interconnections that appear between our focus and the rest of the picture. Complexity is about a very large number of parts with emergent properties. An adaptive system is a dynamic of the networks and relationships and not a static entity. The social systems that we mentioned before are the communities, the political parties, the public services. All of this need to progress and therefore innovation applies to them. Their behaviour, the changes that occur in those systems is the translation of adaptation. Thus complex theory speaks about social innovation which is progressive.

Figure 2.: Spiral, Progressive Regeneration Social Innovation Theory of participation.



The current study is both regenerative and progressive towards a sustainable context. In the study context it could be operationally defined as those sustainable features in the social innovation which were rediscovered in the process and given new meaning in the new context to ensure the sustainability and psychosocial development. It has also got a new relationship paradigm. Hence it could be briefed as those elements of participation regenerated or rediscovered in the process of social innovation through the process of social value creation and subsequently progressive in nature leading to a sustainable outcome. They are discussed in different levels of involvement.

1st level is between the social innovator, his family and clients. 2nd level of participation is between community members, their families, clients, innovator

and his family. 3rd level of participation is between professionals, volunteers, clients and community. 4th level is between the innovator, families of the clients and the professionals or voluntary staff.

Suggestions

Suggestions include promotion of social work research in social innovation areas, developing both positive and constructive research paradigms, promotion of individual, family and community training to reduce stigma and to create mental health awareness programmes, need for promoting networking between social innovation centers, new dimensions of family empowerment, tapping social values generated in social innovation centers including spirituality.

Conclusion

Social innovation in the care of the differently abled with sustainable features is an eye opening reality in the growth and development of community mental health. The family care although wanted was less tapped area in the west due to the cultural factors in those countries. The eastern countries like India with high and effective family supportive system is fertile land to promote family care model. The social values created in the process strengthen the families and communities. When the family values wither away in the west and family care seems to be impossible in the care of the persons with mental illness, the family based care with community support becomes an effective method of care and rehabilitation with fast recovery and higher rehabilitation. The study also opens discussion into new avenue of foster care of the persons with mental illness. In the direct practice of social work the family intervention would be a key area of field intervention in the long term care and rehabilitation of persons with mental illness.

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