Social Innovation in Health Care

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ITSSOIN

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Content

1. Executive summary

For this deliverable we investigated the recovery approach in mental health across four European countries. The recovery approach was chosen as it is an important driver of the social model of disability which was the area that this work package on health focused on. Our analysis covers two parts: First, we examined the role of individuals and organisations (so called actors) over time and identified important milestones (legislation, policies, events, publications); this also covered an analysis of 'dynamics' i.e. interactions between actors from different sector, how the recovery approach related to the life cycle of an innovation, and how those dynamics could be analysed in the context of different welfare state regimes (Esping-Anderson's typology of decommodification and stratification). Next, in a second part, we analysed the characteristics of organisations, which had been identified as driving and implementing the recovery approach in each of the four countries. Characteristics had been linked in the literature to organisation's ability to innovative ('hypothesis testing'). We summarized findings based on two parts of the analysis deriving some commonalities and important differences between countries in regards the existence of the recovery approach.

In all but one of the four countries the recovery approach could be traced as a social innovation. The nature of the process varied across countries but was generally gradual. The third sector role in influencing governments at the national level was evident in all four countries. Furthermore, bottom-up developments of innovations were often third sector led or reliant on third sector infrastructure. The private sector did not have a role in driving the recovery approach in any of the countries. Collaborations between the third and public sector were important drivers of this social innovation. The constellation of collaborations took different shapes within country settings. National service-user led organisations were informing policy change at a national level in all four countries and so did to thinks tanks and research centres. In some countries government funded bodies were dedicated to promote the recovery approach or at least its principles. The recovery approach made it into national policy documents in two of the four countries but was occurred in form of in practice developments in all four countries. In the countries where the recovery approach had been included into national policy documents, experts were also more likely to report that the recovery approach had reached the scaling stage.

It was difficult to derive conclusions about levels and impact of (de-)commodification and stratification across countries. It appeared that the recovery approach was in some countries leading to commodification of certain types of skills and support although this could have been seen as in conflict with some of the principles of the recovery approach. In regards to stratification, the recovery approach was leading to the inclusion of groups that had been marginalised before.

In terms of characteristics of organisations that had implemented the recovery approach, they had in common that they were highly value-driven and focused on supporting highly stigmatised and vulnerable groups. Voluntary engagement – often in form of peer support – was an essential part of the work in all of the third sector organisations. Third sector organisations were also more likely to operate highly open internally and externally. This included that the transition between roles and organisations groups – in form of staff, volunteers and service users – was actively supported. Boundaries between groups were kept to the minimum that was necessary for the operational running of the organisation. A strong interconnection and the use of synergies were identified between advocacy and service provision functions of third sector organisations (whereas public sector organisations did not have advocacy functions). Third sector organisations had close links with their local communities in particular if they provided support to individuals. Third sector organisations were more likely to report to be able to act independently of political or media pressures than public sector organisations but they did consider financial pressures as a hindering factor in their ability to be innovate.

Overall, it was interesting to note that in this field of the recovery approach, change often dependent on individuals who believed in the recovery approach based on lived experiences or other personal experiences. The existence of the recovery approach could be sometimes traced to such individuals who would advocate for the recovery approach at national and local levels. Future research would be useful to understand the roles of such pioneers and social entrepreneurs in innovation processes more generally and explore country differences. In particular, it would be interesting to investigate the challenges faced by

individuals who seek to implement social innovation and how they experience and manage the paradoxes of organising social innovations.

2. Introduction: The social innovation stream across the Czech Republic, Denmark, France and the United Kingdom

In our previous field description work we provided a general insight into the structure of the health field in terms of regulative characteristics, important changes within the last 10 years and important actors from state, market and third sector. The analysis was conceptually embedded in the theory of the 'strategic action field' (Fligstein & McAdam, 2012). The aim was the identification of central social innovation streams in relation to the social model of disability (which was the social innovation trend of this work package on health). The focus on the social model of disability (or health) had the advantage that it excluded technological innovations, following a broader understanding of the concept of health and the importance of the social determinants of health.

During the field description work a number of social innovation streams were identified. They included mental health, public health (including health promotion), integration and patient (and citizen) capacity building. Am important result was achieved during the 3rd consortium meeting and mid-term conference: The experts who attended the workshop agreed that among the different possible social innovation streams, the mental health one was particularly interesting to investigate. This was supported by the following rationale:

- Mental health care has been found to undergo many innovations in the past decades; an article in the BMJ for example stated that the physical health oriented NHS could learn from the innovations in the NHS mental health field (NHS should learn lessons from mental health services, says report, BMJ 2014;348:g1386);
- In line with the notions of the social model of disability, mental health has played an important role in shedding light on those dimensions of health that go beyond physical aspects and that are more closely linked to social care and public health;
- Innovations in the mental health field often incorporate or overlap with other innovations that we identified as being part of the social innovation streams on integration, patient or citizen involvement and public health (health promotion);

Other arguments for focusing on this social innovation stream were that it was an area of high social importance with innovations likely to have a high social impact. People affected by (severe) mental illness are a particularly vulnerable group who experience high levels of stigma and suffering; mental illness is recognized as one of the largest health problems with mental health disorders (including substance misuse disorders) being the leading cause of years lived with disability worldwide (Whiteford et al., 2010).

The application of the social model of disability to the mental health field led us to focus on the recovery approach, which in some high income countries (such as the UK, New Zealand and US) presents possibly one of the largest social movements in the mental health field, which evolved over many decades. It is likely to have contributed to many innovations in this field. The recovery approach in mental health field 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. This does not necessarily imply an assumption of immediate and full recovery for everyone but it assumes that there is a path which enables the individual to lead an as full a life as possible. The recovery approach is thought be based on principles of individuals' capability and strengths rather than their deficits. As a movement it evolved in response to the traditional focus in policy and professional practice on the concept of illness which keeps the person in treatment. Furthermore, tt responded to a wider recognition by some parts of society that individuals have a healing process, which highly personal and often does not align easily with a standardized medical approach of treating an illness. Whilst there is no single definition as such the recovery approach is closely anchored with the principles of hope, empowerment, coproduction and community capacity. 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 and 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 may not be sufficient for people to get better (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.

Focusing on the recovery approach allowed us investigating characteristics and determinants that are likely to be applicable to social innovation trends under the social model of disability more broadly that also relate to other areas of health. 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 likely to be applicable to other public health domains. The recovery approach is likely to address a number of integration aspects because it takes place at the interface with different government departments, professional disciplines and service user groups. The recovery approach is built on strong survivor movements as well as reforms of the clinical field which makes it a particularly interesting area of research for this project. We expected that we would find a range of activities that would be part of the recovery model such as 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.

There is a complexity associated with the term 'recovery approach' which has been driven by different ideological positions over time. In order to avoid misunderstanding about the interpretation of the recovery approach we narrowed this down to *user-focused* recovery approach in mental health i.e. an approach towards recovery that is centred on the person rather than on services or societal beliefs about what is good for a person. Thus personal goals, preferences and aspirations are at the heart of recovery from mental illness.

Milestones and general trends across countries

In each of the four countries (and across the world of high income countries more generally) the beginning of the recovery approach is contextualised in the deinstitutionalisation process that happened in each of the four countries although at different time points. Across all countries community mental health teams were established, which were given important role in helping to prevent people going into hospitals. These community teams or centres involved not only psychiatrists and psychologists, but also social workers, occupational therapists, and the centres not only have a role on treatment, but also (at least theoretically) in prevention as well. Professional movements within the discipline of psychiatry occurred in relation to the deinstitutionalisation process in each of the four countries. Often professional movements were characterised by some new interdisciplinary influence (such as social work, community development, occupational therapy). It was not clear to what extent some of these developments positively influenced the (user-focused) recovery approach. Service user movements in the mental health field happened in relation to the deinstitutionalisation process in each of the four countries although with different strengths. Again, it was not always possible to identify the direct influence on the recovery approach. Below are the country specific developments summarized.

In **UK**, polices concerned with the deinstitutionalisation of mental health services and community provision started in the 70s and created pressure for psychiatry to shift care from the hospital to the community. Around the same time civil rights movements took place, which were an expression of the unhappiness of the civilians with public service provision more generally (Geoff Shepherd, personal communication). In the mental health field, service user and anti-psychiatry movements, professional groups and third sector bodies all created pressure on government to move towards community approaches. The challenges of successfully operationalising community mental health provision, and the recognition of failure of a successful reform in this area, were drivers of the recovery approach which was then implemented through the establishment of the publicly funded improvement programme 'Implementing Recovery through Organisational Change' (ImROC). The role of individuals with lived experience has been arguably particularly important in these developments.

In the **Czech Republic** deinstitutionalisation happened more recently and similarly recovery movements and the implementation of the recovery approach began more recently. Deinstitutionalisation is still a very much on-going process in the current Czech context with many challenges still needing to be addressed. The health and social care system was traditionally characterized by high level of institutionalization; this phenomenon has considerable inertia supported by a powerful lobby. The aims of deinstitutionalization included personalisation, user-focus-ness, self-sufficiency and high quality of their life. Social services providers underwent radical transformation. A growing number of community mental health centres nowadays apply recovery principles s 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).

In **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 in regards to deinstitutionalisation included housing support options and psychiatric rehabilitation programmes. Survivor movements in France included those of advocacy and fighting against stigma (European Union, 2011). More recent reform focus on: integration between mental health, social care culture and the arts; 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.

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.

3. Methods

One aim of the work package was to explore the recovery approach over time with a particular focus on identifying the most important actors driving the recovery approach, describing their role in driving the recovery approach and how those led to changes (that might otherwise not have happened). Changes referred to milestones such as the introduction of legislation, policies and practice. This part of the research was done under the framework of process tracing (Collier 2011). The second part of the work was concerned with understanding the characteristics of organisations that were identified during the process tracing as important in driving the recovery approach locally or nationally. The aim was to understand whether those organisations had different abilities to be socially innovative in particular in regards to their attachment or affiliation with the third sector. This step was performed by investigating the range hypotheses derived as part of the earlier ITSSOIN work and will provide a foundation for the next step of the work as part of a cross-country comparison in form of qualitative comparative analysis (QCA).

The analysis was carried out in the context of and responding to the two main propositions of the ITSSOIN project:

- Social innovativeness varies by organisational form and actor involvement, in the sense that the properties of third sector organisations and volunteering make its formation particularly likely.
- Social innovativeness varies by contextual factors and conditions, including - for our work package - those of societal norms and beliefs about mental health, of existing professional bodies and institutions and of developments in mental health policy and practice.

Social innovation was investigated at the level of social innovation stream and activities. Organisations and actors engage in activities to implement and sustain the stream and activities are thus expressions of the social innovation stream. The social innovation stream was the *user-focused recovery approach in mental health*.

For the social innovation stream, *user-focused recovery approaches in mental health*, we decided that it would be helpful to have a common anchor point to address the issue that there could be different interpretations of user-focused recovery approaches and to set a time reference point. It was therefore considered helpful to relate the research to an important legislation that is shared among the four countries: the United Nations Convention on the Rights of Persons with Disabilities. The legislation came into force in 2008. In Article 1 the Convention specifically includes and refers to persons with mental impairments; it is a legislation that can be seen as an important corner stone of user-focused recovery in mental health because it is a written commitment to move away from the historically dominant medical model towards a social model of health (Scotch 2000, Clifford 2011).

Data collection for the process tracing

We considered the best suitable way to collect data for the process tracing: The options that we considered were workshops, semi-structured interviews and electronic questionnaires with experts in the field. Whilst workshops have the disadvantage that they are more difficult and time-consuming to organise they have the advantage that consensus can be reached between experts at the time of the workshop which can ease the analysis. Especially as they recovery approach is still considered by some as 'controversial' and an area with not much 'hard' evidence, a workshop was considered a particularly suitable method. On the other hand, semi-structured interviews or questionnaire had the advantage that experts could complete at a time convenient to them; this was particularly important for those country representatives who expected that it would difficult to get a sufficient number of experts involved. The disadvantage is that requires more time to analyse common themes and sometimes could mean that partners analysing the data had to get back to interviewees to clarify responses. In consultation with our country representatives it became clear that it would not be possible or very difficult to organise expert workshops for them and they thus carried out interviews. In the UK, we decided to organise an expert workshop as people in this particular area are known to be highly passionate and interested in exchanging their ideas and views.

The number of experts that needed to be reached through workshops or interviews was set at four to six per country. Experts could include researchers, policy makers or influencers and mental health professionals (clinicians or practitioners), commissioners and service managers. They had to have a national understanding of the mental health field and be familiar with the recovery approach. Experts were identified through a range of channels including the literature, conference proceedings, blog posts and recommendations from other experts (snowballing).

We developed two guides. One was a topic guide for the expert workshop and the second guide was a semi-structured questionnaire that could be sent to experts electronically or be used in face-to-face interviews. The guides followed the same aims and structure (the complete guides can be found in the Appendix).

The aims included

- Review of the **current state of play** of recovery approaches (including its main characteristics) in the UK;
- Tracing **key decisions and influences** (=milestones), which have helped shape policy and practice in this area;
- Identify the **drivers for and barriers of** the recovery approach (if possible based on thoughts of what might have happened otherwise);
- Explore **dynamics between individuals and organisations** who contribute(d) to the recovery approach;
- Identify **evidence** that can support the views of experts, including any research currently underway;

More specifically, experts were asked describe the current landscape of user-focused recovery in mental health in terms of:

- Actors (individuals, organisations, collaborations) who were/ are involved; first the group/person were asked to name all those they could think of; then they were asked to prioritise them based on who are the most important ones in driving or hindering the development and implementation of the user-focused recovery approach; next, they were asked to explain the reason for their choice;
- For the most important actors, experts were asked more details including a description of their roles and activities (formal and informal ones);
- Geographical variations that they were aware of;
- Other features that they thought were important to the landscape (this could include legislation or policy);

If geographical variations were regarded as very strong, group/persons were given the option to focus their responses to further questions on a particular region or locality.

Furthermore, experts were asked to consider to what extent they thought that the *user focused recovery approach* to date had been developed and implemented in practice; this question was asked in relation to the life cycle of innovation based on Murray, Caulier-Grice and Mulgan (2010) source and experts were provided with a graph and a short description to the different life stages of an innovation.

Experts were asked about key influences and decision points that led to the situation/ landscape they described in regards to a user-focused recovery approach. They were asked to name milestones in this process (evolution) and barriers that had to be overcome along the way. They were asked which actors (individuals, organisations, collaborations) influenced the process the most and whether some actors had more influence than others. Furthermore, experts were asked at what point individuals or organisations that influenced the process the most had become engaged with the process.

Although we did not ask specific questions about contextual factors we expected that experts would explain some of the conditions - including institutional and environmental ones - under which the recovery approach took place. We made sure to elicit information about conditions distinctively so that they could be analysed.

The analysis of the data from the expert workshop or questionnaires was enriched with data from the literature. Searches should identify literature in which user-focused recovery approaches in mental health is discussed as well as website searches of organisations that were named by experts (possibly with focus on those one or two projects that will be subject to in-depth analysis). The analysis of the literature aimed to validate the knowledge gathered from consultation with experts. This additional information also helped to ensure that make potential bias could be made transparent and to consider points in favour of dismissing the original research proposition.

Tables 1.-4. show the experts we interviewed or consulted as part of the process tracing.

Table 1: Experts from UK

Name	Position	Description of expertise
Dr Julie Repper	Director of ImROC Programme (Implementing Recovery through Organisational Change)	Pioneer; part of the recovery movement in UK; expertise in recovery work taking organisational approach, involvement in Mental health trusts, mentorship, Nottingham recover lead; author of author of books on recovery such as 'Recovery and Social Inclusion' Recovery Lead, Nottinghamshire Healthcare Trust; User and Carer Engagement Fellow, East Midlands; Senior Fellow, Institute of Mental Health; Honorary Research Fellow, University of Lincoln
Professor Mike Slade	Professor of Mental Health Recovery and Social Inclusion, Nottingham University	Pioneer of research in recovery; formerly Professor of Health Services Research at the Institute of Psychiatry, Psychology and Neuroscience (IoPPN) at King's College London, and Consultant Clinical Psychologist in South London
Dr David Blazey,	Head of Social Inclusion and Recovery Projects, South London and Maudsley NHS Foundation Trust	Expertise on periphery of wide range of projects that are service user led, on steering groups; international experiences; mentorship; lined to IoPPN
Dr Petr Winkler	Head of department of Social Psychiatry at the National Institute for Mental Health, Prague	Expertise on mental health policy in Czech Republic; PhD research at IoPNN on service user movements
Maria Flanagan	National Operations Manager, Mental Health, Turning Point	Expertise in Richmond Fellowship, supported living, crises forensic services, Turning Point
Professor Geoff Shepherd	Retired, former ImROC Lead, former clinical consultant and senior consultant for Sainsbury Centre and Centre for Mental health	Pioneer, involved in recovery movement from the start, started ImROC
Dr Glenn Roberts	Co-founder of Recovery Devon, clinical consultant retired from NHS and now in private practice	Expertise in implementing recovery capacities in practice and in wider national and international recovery and related movements (e.g. mindfulness)

Table 2: Experts from Czech Republic

Name	Position	Description of expertise
Dr Petr Winkler	Head of Department of Social Psychiatry at the National Institute for Mental Health, Prague	Expertise on mental health policy in Czech Republic; PhD research at IoPNN in UK on service user movements in mental health
Pavel Říčan	Director, Centre for Mental Health Care Development	Expertise on mental health policy

Martin Fojtíček	Ledovec/Iceberg - a nonprofit organization focused on people with mental illness and / or mental handicaps of the Pilsen region; Ledovec provides support in maintaining and improving their life quality in as normal conditions as possible)	Expertise as representative recovery services providers; his organization is very active in pushing the recovery topic forward; Ledovec is also engaged in the knowledge and know-how transfer, especially from MHA Village

Table 3: Experts from France

Name	Position, organisation	Description of expertise
Dr. Brigitte Ouhayoun	Community-based Psychiatrist at Hospital Maison Blanche, Paris (BO)	Expertise in community-based psychiatry
Dr. Bernard Pachoud	Psychiatrist and Professor at Universite de Paris Diderot	Coordination of the Groups d'Entreaide Mutuelle (GEMs) – self-help groups
Dr. Marie-Noelle Besançon	Psychiatrist (non-practicing) and founder of Les Invites au Festins (M-NB) (short conversation that was not a full interview)	Recovery in community contexts
Dr Tim Greacen	Director of Research, Hospital Maison Blanche, Paris	Recovery in France and at a European level
Dr Bernard Durand	Honourary President of the Federation Croix-Marine for Mental Health	The spread of the recovery model in France

Table 4: Experts from Denmark

Name	Position	Description of expertise
Pernille Jensen	Manager, Development initiatives at Orion, a public rehabilitation center, located in Central Region of Denmark	Pernille is a recovery pioneer who used to work for the Knowledge Centre of Social Psychiatry, which was closed five years ago; after the Centre closed Pernille started being engaged in recovery-oriented work in her current position at the rehabilitation center Orion
Agnete Neigel	Director of Research and Analysis, Det Sociale Netværk, (The Social Network) which is an NGO	Research and third sector expertise
Henrik Suhr	Director of the Public Center for Socialpsykiatri (Center for Social	Managerial and policy expertise

	Psychiatry) in the municipality of Roskilde, Denmark	
Jørn Ditlev Eriksen	Co-founder and owner of the private company Psykovision	Clinical and managerial expertise; former Head of Slotsvænget, a municipal recovery focused residence and rehabilitation center for citizens with mental diagnoses
Marianne Cohen	Project manager and former 'Recovery Coordinator' at the Social Services section in the Municipality of Aarhus, Jutland (West Denmark).	Managerial expertise including operational experience of partnership working and managing recovery projects

Data collection for testing organisational hypotheses

In each country, organisations were identified that had implemented the recovery approach locally. Most organisations were identified by the experts who had been involved in the process analysis. In some countries additional criteria were applied for identifying organisations. For example, in Denmark there was one national funding stream for recovery oriented projects and the Danish partners contacted those projects. In UK, we contacted organisations that were linked to and members of the national body responsible for leading the implementation of the recovery approach (ImROC).

Data were collected in form of a semi-structured questionnaire. The full questionnaire can be found in the Appendix. Partners were given the choice to either apply the questionnaire in interviews or to send it out electronically. The structure of the questionnaire was designed specifically to answer the hypotheses. For each hypothesis, a range of questions were asked from different angles to increase the validity of the responses and to gather more information identifying potential discrepancies and more complex relationships.

The questionnaire sought to cover the following themes:

- A brief description of the organisations;
- Population served by the organisations, reasons for supporting this population and potential challenges working for and with this population;
- Organisations' values and mission, and their ability to operationalize those;
- Organisations' culture in particular in regards to degree of decentralisation, shared decision-making with non-managerial staff and staff dedication; this also included questions about opportunities for staff to develop and about their diversity;
- Organisations' collaborations and ways of working with external partners; this included: Resources and assets they shared with or had access to through partners; strengths and weaknesses of partnerships; ways of incorporating stakeholders into the organisation's decision-making processes;
- Organisations' transaction costs in following their organisational purpose including their ability to be innovative and meet social needs; this included questions about funding arrangements and access to knowledge exchange and resources (for example through collaborations with partners);
- Embeddedness in the community or local context; community referred to individuals as well as organisations; questions about the relationship were asked for example in form of participation and role in networks; other information for this theme were extracted from questions about activities that were organised by organisation and how they defined the population they served;
- Organisations' advocacy and campaigning function and potential relationship and tension with their service delivery function; this included the importance organisations gave to advocacy or campaigning, how they practiced this and how they combined this with their service delivery function;

- Volunteer engagement; this referred to the role of volunteers in the organisations including the opportunities they were given to develop and participate in the organisation's decision-making processes; this included opportunities for service users to become volunteers and for volunteers to become staff members;
- External pressures in form of the market, policy, media, financial situation and how this affected the organisation;

In addition, questions were asked to understand which aspects or characteristics organisations felt influenced their ability to be socially innovative and drive or implement the recovery approach.

In terms of the analysis of data, for closed questions, responses were taken directly to inform the analysis; often closed questions included an additional open question that requested an explanation from the interviewee why they had chosen this response; this was done to encourage interviewees to reflect on their responses; this information was analysed to support the response to the closed question. Work package partners handed over the completed questionnaires to the work package leader who analysed the responses. This was done to ensure a consistent approach of interpreting responses. Open-ended questions were coded by the work package leader, which ensured consistency across the countries Data were coded and analysed by the work package leader in an iterative process: first, the researcher went through all responses to identify common themes between countries; then based on those initial broader themes the researcher analysed data in the questionnaires and refined themes.

An exception to this approach of data collection and analysis was done in the Danish case; due to challenges in getting hold of interviewees and applying the questionnaire, the Danish partner developed a shorter set of more open-ended questions. The Danish partner submitted their analysed data to the work package leader in form of a description of the projects they interviewed, the QCA truth table and quotes from the interviews to each of the theme. This data was then analysed by the work package leader together with some contextual data that experts provided as part of the process analysis and which provided information about likely organisational characteristics.

The individuals (as representatives of organisations or projects) that were interviewed together with a description of the organisations are shown for each country in the tables below. All interviewees were founders and/or managers of projects or organisations.

Table 5: Organisations participating in the research, UK

Interviewee (s)	Organisation	Description
Phil Walters (lead)	Creative Minds	Creative Minds is a Charitable Trust hosted by SWYPFT (further below) that develops community partnerships and co-funds creative projects across our localities and in the Trust's forensic services. Creative Minds supports a strong infrastructure of community and voluntary organisations that work with Trust staff to provide excellent creative projects for all who access our services. Partnerships and co-production is core to the conception and development of Creative Minds. South West Yorkshire Partnerships NHS Foundation Trust (SWYPFT) provides community, mental health, and learning disability services to the people of Barnsley, Calderdale, Kirklees, Wakefield and forensic services to Yorkshire and Humber
Becky Aldridge (chief executive Dorset Mental	Dorset Mental Health Forum (DMHF), and	WaRP and DMHF are two different organisations with different purposes; establishment of WaRP allows DMHF to maintain independence from

Health Forum, co-lead WaRP) Phil Morgan (lead for recovery and social inclusion, mental health directorate at local NHS Trust , Co-lead WaRP)	WaRP (partnership with local NHS Trust)	statutory provision; DMHF is peer-led charity founded in 1992; activities of DMHF: Promoting peer led services; advocacy service (1-to-1) for the whole of the region (=advocacy as part of service provision); but also advocacy as organisational identity; employment service; collaboration with schools; producing evidence; WaRP was established as partnership in 2009 of DMHF and NHS Community health services; its purpose and objectives lie within the structure of publicly funded healthcare; WaRP seeks to bring together in partnership people's lived experience expertise and professional expertise to promote personal recovery. The broader aim of WaRP is to change the culture of mental health services and people's attitudes to mental health and wellbeing in Dorset, to transform people's experience and unlock their potential.
Gabrielle Richards (head of occupational therapy and trust social inclusion and recovery lead) Kirsty Giles (project manager)	Recovery College, South London and Maudsley (SLaM) NHS Foundation Trust	The college runs workshops and courses which aim to provide the tools to make recovery happen, to help people become an expert in their own recovery or that of someone they care for or work with. It offers a learning approach that complements the existing services provided by the Trust. Co-production is at the heart of everything they do and every course and workshop is co-designed and co-run by trainers with lived experience working alongside trainers from the mental health professions. Courses are free of charge and open to people who use SLaM services, their upporters (carers, family and friends), and volunteers and peer supporters working with SLaM, SLaM staff
Poppy Repper (head)	Nottingham 'Real lives'	Third sector non-profit (community interest) company, that provides self-directed social support packages to people in the Nottingham community via personal budgets. They support people 18 and over in their home or community with mental health challenges and or learning disabilities. They also provide support to the local community via a café, and volunteers and people on placement in the company seeking experience. They employ people with lived experience and help them gain and retain employment.
Grace Smith (finance), Lamis Mary Bayar (manager)	Dragon Cafe	Mental Fight Club (MFC) is a registered charity and constitutional objective is to promote social inclusion. Currently the main service delivered is The Dragon Café and from this new strands of work have emerged, including ReCreate Psychiatry and the provision of creative training and facilitation for health and social care professionals. The Dragon Café, in the crypt of St George the Martyr Church in Southwark, is the first mental health café in the UK. It is a space both safe and inspiring which helps service users take the journey

		through mental illness, onwards into recovery and new-found sustainable modes of mental wellbeing. We are an innovative and creative provider of social support for current, past, on-going mental ill health. We are user created and an anecdote to the current style of mental health services. We are a non-medical model of provision.
Louise Christie (manager)	Scottish Recovery Network	This organisation collaborates with other local organisations and individuals with experiences of mental health. They cover the whole of Scotland. They promote paid supportive role in recovery; they support other recovery organisations and individuals with experiences of mental illness. They work with local organisations to develop knowledge and services such as: peer support projects, community based projects on recovery. They advise organisations, guide and share best practice on recovery.

Table 6: Organisations participating in the research, Czech Republic

Interviewee (s)	Organisation	Description
Martin Fojtíček (founder and manager)	Ledovec	A non-profit organization providing support for people with mental illness and/or mental handicaps of the Pilsen region with the support in maintaining and improving their quality of their life under normal conditions. “Through the concept of mutual social rehabilitation Ledovec helps to better understanding in the world of diversity.” They offer counselling, social rehabilitation, sheltered living, day centre, supported education and external support of social firms. They also realize Cirkus Paciento in mental hospitals of Czech Republic.
Jela Hrnčiarová (chief physician)	Hospital for Addictive Diseases Nechanice (Léčebna návykových nemocí v Nechanicích)	Hospital for Addictive Diseases Nechanice is a detached unit of University Hospital in Hradec Kralove and its psychiatric clinic. HAD physicians realise an admission of patients to a hospital in outpatient clinics at the psychiatric clinic in Hradec Kralove.The hospital provides voluntary addiction treatment for men and women addicted to psychoactive substances and/or gambling addiction/compulsive gambling. The main treatment method is professionally headed group psychotherapy in the therapeutic community. There are working therapy, art therapy, relaxation and sport activities part of the treatment. The hospital is an organization founded by the Ministry of Health.
Jana Holická (manager)	Libníč Home and Centre of Social Services EMPATIE (Domov Libnic a CSS Empatie)	Domov Libníč is a state-funded institution. The organization provides several social care services: residential services, day care/service, weekly care/service, sheltered housing, work centers/sheltered workshops/social work

		therapy. They support people with health problems particularly mentally handicapped people. They cooperate with a large number of volunteers.
Monika Hyánková (psychiatric nurse with the experience of short-term internship in PRAH and other social work CSOs)	Psychiatric Clinic (University Hospital Brno) Department of psychiatry of the University Hospital Brno	The University Hospital Brno was founded by the Ministry of Health, Czech Republic. The basic source of financing the University Hospital Brno consists in income received for medical care from health insurers. Department of psychiatry of the University Hospital Brno and Faculty of Medicine of Masaryk University is an outpatient and inpatient clinic focused on acute psychiatric and psychological care.
Jiří Šupa community care service supervisor	Sdružení Práh (Prah=Threshold)	A non-profit organization that operates in the sphere of social services provision; they provide six social: social rehabilitation, sheltered housing, supported housing, day centre services, therapeutic workshops, professional social counselling. They support self-help activities of clients and their families and also offer optional extras such as individual psychotherapy, a support group for relatives, etc. They realize various projects funded by the EU, Norwegian funds. Their target group are people with severe mental illness - schizophrenia, affective disorders, partially also people with a diagnosis of personality disorder, etc.

Table 7: Organisations participating in the research, France

Interviewee (s)	Organisation	Description
Marie-Noëlle Besançon and her husband Jean Besançon (founders and presidents)	Les Invités au Festin	Project works with people with mental health problems or brain injury. 13 people live in the residence, which is also home to a day centre. During the day, a wide range of activities, organised by volunteers from the local community, take place. Volunteers from outside also participate in the activities, and residents and participants with mental health problems/brain injury are encouraged to take on responsibilities, like staffing the bar/café, or running the patisserie workshop. In 1995, the organisation decided to define the place and what goes on in there. This is what they formulated: 1A place where you can find a listening ear, someone to travel with you when you're suffering 2 An effort to rediscover and mobilise people's resources 3 A place that is useful to social and psychiatric workers. 4 A place outside institutional walls 5 Not a place of care, but an actor that helps create a better quality of life, and thus well-being and health 6 A place that acts to prevent exclusion, illness and relapse 7 Creates social links 8 Acts to reintegrate and rehabilitate.
Aude Allaire (president), Nadine	CAP GEM	It works with people who have suffered a brain injury or mental illness (predominantly the former)

Bellion (facilitator), Manuella Oswald (coordinator)		and provides a mutual support group, run by the service users themselves (with limited input from the two professional staff) It's the members who run activities such as sewing, baking and film clubs. The organisation thus encourages the autonomy and growth of people who may have grown pessimistic about their capacities. There are 38 members, and about 20 who are really active. Between 10-15 people visit their premises (just to the south of Paris) every day.
Olivier Vilt (head)	Un Chez Soi D'Abord (Housing First) programme, ABEJ Solidarities	The organisation ABEJ solidarities (which was chosen by the French government to implement the "Un Chez Soi D'Abord" programme, the French name for 'Housing First') is a non-profit organisation which works with homeless people in the vicinity of Lille, one of France's largest cities. In addition to the Housing First project, the non-profit also runs daycentres and hostels for homeless people.

Table 8: Organisations participating in the research, Denmark

Interviewee (s)	Organisation	Description
Anni Ehers	INSP!, Roskilde	NSP! is both a *place* where volunteers and citizens meet through creative activities, concerts, events and food and an *association*. The role of INSP! is to educate vulnerable citizens to become staff members at the INSP! activity center. This way recovery takes place in the process from vulnerable citizen to INSP! staff. The project is a joint venture with stakeholders from the Center for Social Psychiatry and health care authorities under the Municipal administration in Roskilde and the association INSP! (Originally an acronym for 'Inspiratorium'). The association INSP makes available the activity center located in a former industrial location. The place has been re-designed and has an open and inviting atmosphere. The center opens daily and offers a number of different activities. All activities are carried out by volunteer staff that take initiatives and visit frequently in order to structure and give life to the activity. In this way INSP houses volunteers, aiming at creating solutions and inputs to particular and general problems. Some of the most active and engaged participants are young people. However, there is no age limit to visit and engage in any of the many activities organized there
Ditte Ågård Kristensen	Project Følgeven, Aarhus	Project Følgeven is a project that was initiated by the Municipality of Aarhus in 2013. In translation to English "Følgeven" comes close to "friend" or "companion". The aim of the project is to make mentally vulnerable citizens over 18 years part of a community located in civil society and thus

		strengthen their feeling of inclusion. This is done by matching a volunteer "friend" from the Municipality's Volunteer Center with a vulnerable citizen on basis of a common social interest or activity. The pairs of volunteer followers and vulnerable engage together in a civil society based community. Such a community might take the form of a volunteer based sports association or the like.

4. Country perspectives on the social innovation stream

4.1. The user-led recovery approach in mental health

4.1.1. Specific focal points and milestones of the SI

United Kingdom

Experts thought that international and national legislation were important milestones as they were concerned with moving away from the medical model and addressing structural discrimination. This referred to the introduction of the social model of disability in the UN Convention in 2008, as well as of a number of national legislations such as the Mental Health Discrimination Act and the Equalities Acts in 2005 and 2010. Those reflected important human rights movements such as the shift away from seeing the person as the problem and way from locating social problems in the person, which presented barriers to their recovery.

The National Service Framework (NSF) in 1999/2000, which was as the overarching policy document for all mental health provision and major milestone in English mental health policy, set out a major service reform that did not refer to recovery. One expert confirmed that recovery at the time was not in the Zeitgeist of policy makers. Instead the focus was on redesigning services in the community (and defining the roles of community mental health teams) to improve quality of care and reduce large variations in practice. Monitoring targets were the key objectives, which were set in the context of the focus on evidence-based practice. Evidence-based practice was promoted based on the traditional hierarchy of evidence, which gave priority to practice that can be evaluated by randomised controlled trials and gave only low priority to the types of evidence most commonly used in the recovery oriented practice (i.e. views, experiences and personal accounts). However, the NSF also had led to more debate of what mental health meant to people, including debates around recovery and social inclusion (Gilbert and Clark 2010). The National Mental Health Institute, established to support the operationalisation of the NSF, introduced recovery guidance.

Under the radar, projects following the principles of the recovery approach were implemented and networks of pioneers led discussions around recovery. A range of knowledge exchange happened, again, largely under the radar formal government structures. This took the form of workshops, meetings, conferences and visits by pioneers (including international ones) to the sites. Individuals also worked to influence policymaking. Some service users collaborated with psychiatrists and third sector organisations and started influencing national policy (for example, a service user went to Parliament together with psychiatrist and representatives of the Hearing Voices Network advocating the recovery approach). Even commissioners started using terminology of recovery (to address for example revolving door issues that created pressures on budgets).

Finally, after the new system (set out in the service reform) started crumbling due to too many demand pressures and lack of capacity (including lack of access to third sector provided community support) government was under pressure to operate differently. At the same time the government had committed itself to give high priority to mental health and set out in its Public Health White Paper for the first time equal priority between mental and physical health.

The establishment of ImROC in 2006, a partnership that was specifically tasked with supporting the organisational change towards recovery was one of the most important milestones in the history of the recovery approach in England, demonstrating political buy in and a (financial) commitment towards a cultural change in the mental health system. ImROC consisted of individuals who had been campaigning for the recovery approach at a national level as well as practitioners who had been implemented the recovery approach in their organisations.

In a third sector published manifesto on recovery 'Making recovery a reality', led by pioneers (including those leading ImROC) set out the importance of recovery and how it had been successfully implemented.

The 'No health without mental health strategy' was informed by recovery pioneers and introduced CQUIN, which provided a commissioning framework that aimed to reward providers' excellence based on a set of quality indicators. The recovery approach had thus become a requirement for commissioners and practitioners and the concept of the recovery approach was operationalised in the performance management of the NHS. However, initially crude measures were used such as 'having a job' reflecting a very narrow focus on recovery, which were addressed by some commissioners only through ticking box strategies rather than focusing on genuine recovery oriented approaches. This evolved into measuring success of treatment based on recovery principles in more sophisticated ways: outcome measures and toolkits were developed that could be used by mental health service providers and commissioners of services (e.g. recovery star; and PROMS). Those developments were initiated or supported by the third sector (for example the recovery start was developed at first for the homelessness charity St Mungos). However, often the driving forces behind these measures were national benchmarks, which were prescriptive of how to individualised care.

The Five Year Forward View for Mental Health 2016, a report from the Independent Mental Health task Force to the NHS in England, was seen by experts as the most recent key milestone for the recovery approach. The report recommends the use of recovery oriented pathways which includes housing and employment provision, which are often key barriers that prevent individuals with mental illness to achieve full recovery.

A number of policies, programmes and movements might have facilitated the recovery approach although these developments and relationships between them were complicated so that their influence on the recovery approach (or vice versa) is far from established. Prevention, early intervention, integration and personalisation policies all promoted some similar principles such as focusing on individuals' assets, strengths and preferences. Experts agreed that that certain policies had been indeed driving the user-led recovery approach but others had adapted the recovery approach in a way that it might have even been counterproductive and possibly even a disruption to the original recovery movement. For example, care coordination and outcomes-based commissioning policies had often been introduced under a political agenda concerned with reducing costs and preventing revolving door effects (i.e. people coming back to services). For similar reasons the government developed pathways into employment and education programmes. Other related health and social care policies and movements included those reaching far back in time. Examples of such earlier policies and programmes were in areas of community reintegration, social inclusion, self-management, social prescribing and housing (such as the Supporting People programme). Important movements in psychiatry were those of community psychiatry, Critical psychiatry and the more recent Open Dialogue approach. It was discussed whether consumerism movements were helpful for recovery or more a distraction.

Experts agreed that the popularity of the recovery approach in the UK was partly explained by the existence of other complementary policies and reflective of changes in societal thinking more broadly. For example one expert thought, whilst historically health and social care service provision had focused on treating illnesses that:

"Nowadays services are all about wellbeing."

The recovery approach started to be widely subscribed to including by commissioners who started using the terminology; recovery concept started being referred to by other professional disciplines (e.g. publications in nursing journals).

Experts described the wider dissemination and diffusion:

> *"Every profession now has recovery paper … even OTs (occupational therapists) … bizarrely, even security settings had recovery plans and recovery leads".*

Table 9: Overview of milestones in relation to the recovery approach in the United Kingdom

60/70s	Summary • De-institutionalisation of mental health services • Scandals in mental health hospitals hit the newspapers headlines • Concept of 'therapeutic communities' dominated the field of inpatient psychiatry throughout 1960s seeking for a more democratic, user-led form of therapeutic environment • Cross overs with disciplines that influenced the psychiatric field such as anthropology, social work, community development, occupational therapy • Psychiatric survivor movement arose out of the civil rights movement and personal stories of abuse experienced by ex-patients of psychiatric institutions (influenced by survivor and civil rights movements in the US) Events by years • 1959: Mental Health Act set out when people are allowed to be treated and detained against their will, replacing the legislation under which service were provided since the 1890 Lunacy Act • 1961: Famous Water Tower Speech by Enoch Powell, Minister of Health, initiated the discussions about de-institutionalisation and shifting mental health care into the community, leading to Community Care policy (see for example http://www.canehill.org/history/enoch-powells-1961-speech) • 1962: Hospital Plan focused on the development of community care • 1967: Book 'Sans Everything' by Barbara Rob as part of her campaign to close long stay facilities • 1968: Report of the Committee on Local Authority and Allied Personal Social Services (The Seebohm Report) led to integrated social work profession • 1971: Scottish Union of Mental Patients as a survivor and peer support group fighting for peoples' rights in disapproval of medical model • 1973: Mental Patients' Union in London founded in Paddington Day Hospital of the founders who had previously been members of the Scottish Union of Mental Patients
80/90s	Summary • Administration of NHS is being reorganized two times • Improving care for people with severe mental illness as main policy focus • Civil rights movements voicing disapproval of public services; service user movements in mental health • By end of 90s most large asylum had closed or were planned to be closed • No focus on recovery in mental health policy (but recovery promoted in mental health policy in US and New Zealand) • Recovery movement only a small movement in UK but international linkages through personal story telling by recovery pioneers from US, NZ, UK (in form of conferences, books etc.) Events by years • 1983: Mental Health Act, strengthening protection for the civil rights of mentally ill patients

	• 1988: Hearing Voices Movement was established in England by Romme Marius from the Netherlands where the Movement started in the year before; positioned outside the mental health field the movement advocates for holistic solutions and disapproves medical model • 1990: National Health Service and Community Care Act in response to the Griffith Report and White Paper 'Caring for People' setting out plans for community provision and ensuring that people were assessed for social care support and received services they were entitled to • 1998: Modernising Mental Health Services White Paper committed investment and set out plan for future mental health policy • 1999: National Service Framework for adult mental health presented the overarching policy document for mental health services in England; set out large service reform for community mental health provision but did not refer to recovery and was focused on severe mental illness and managing risks • 1999: Critical Psychiatry Network established in response to proposed changes to 1983 Mental Health Act, criticising narrow focus on clinical diagnosis
2000-5	<u>Summary</u> • Service users and carers become increasing vocal, membership of campaigning charities increased and broadened perspective from original asylum service user movement • Realisation that service reform as part of National Service Framework and other mental health policy did not meet set targets and expectations with new levels of unmet demand emerging; leading to pressure on system of community mental health provision • National policy starts supporting local innovation • Innovative recovery practice implemented in UK under the radar of government • Recovery books and recovery stories published <u>Events by years</u> • 2002: National Institute for Mental Health in England (NIMHE) founded with the aim to support and lead the operationalization of the NSF with a particular focus on research and evidence-based practice • 2003: Outcome measurement tool developed for homelessness charity St Mungo's building the foundation for the Mental Health Recovery Star • 2004: Scottish Executive included recovery into one of four mental health policy aims and funded the Scottish Recovery Network to support this; the Network is designed as an initiative to raise awareness of recovery from mental disorders • 2004: National Service Framework for children, young people and maternity services incorporated guidance in child and adolescent psychiatric services • 2005: NIMHE produces 'Guiding statement on recovery' endorsing the recovery approach as possible guiding principle of service delivery and public education; and introduction of professional role of Support Time and Recovery Worker • 2005: Equalities Act supporting rights of people with mental illness • 2005: Mental Capacity Act
2006-10	<u>Summary</u> • Further drive to personalisation but some of those movements were also seen as a putting real user-focused recovery at risk and a deviation from the original movement • Employment focused policies and programmes incorporated recovery principle • 'Individual placement and support' programme championed by Centre for Mental Health; seeks to get people with mental health conditions into competitive work first with wrap-around support on the job

	• NHS Confederation used recovery as umbrella for mental health agenda/ reform • Publications of recovery books and documents guiding the implementation of the recovery approach including series produced by Sainsbury Centre for Mental project <u>Events by year</u> • 2006: 'Everybody's business: integrated mental health services for older adults; with focus on integration of mental health services with other public services to support older people • 2006: Improving Access to Psychological Therapies (IAPT) programme introduced with the aim to provide evidence-based interventions for common mental health problems; focus on achieving recovery • 2007: Mental Health Act • 2008: Direct payments and personal budgets introduced • 2008: Centre for Mental issued policy paper predicting that the time for the recovery approach has come • 2009: 'Implementing Recovery through Organisational Change' (ImROC) established by the Department of Health in England; delivered by a partnership between the Centre for Mental Health and the Mental Health Network of the NHS Confederation • 2009: ImROC published 'The ten organisational challenges' demanding cultural change in the NHS following principles of co-production and personalisation; the introduction of recovery colleges and peer support in all areas; roadshow led by ImROC with planned visits of recovery projects across the country • 2009: 'New Horizons, A shared vision for mental health' strategy focused on personalized services and introduced employment support for people with mental health conditions
2011-16	<u>Summary</u> • National mental health outcomes strategy introduced in England; equivalent national mental health strategies in Scotland (Mental health strategy 2012-15) and Wales (Together for mental health) • Related movements such as Open Dialogue and Time to Change anti-stigma campaign run by MIND and Rethink • Evidence of wide dissemination and diffusion: Realising the value; New Care Model Vanguards; Recovery Focus network • Recovery made a priority in Mental Health Commissioner Network • Employment focused programmes and policies → recovery oriented focus and part of recovery pathways <u>Events by year</u> • 2011: Mental health outcomes strategy 'No health without mental health', informed by recovery pioneers (some from Centre for Mental Health) superseding 2009 New Horizons policy; sets out objective that more people with mental health problems will receiver and refers to personal recovery introduced development of CQUIN measures; provides steer how to commission recovery • 2012: The Health and Social Care Act together with No Health without mental health; sets out a much broader concept of mental wellbeing with fouc on equal involvement of service users in their care including in decisions about the management of services • 2014: 'Closing the Gap: Priorities for essential change in mental health' demanding that high quality mental health services with an emphasis on recovery should be commissioned in all areas

	• 2016: Five Years Forward View in Mental Health provided recommendations for recovery-oriented pathways across settings and disciplines

Czech Republic

In terms of legislation the UN Convention on the Rights of Persons with Disabilities (Article 19) was named as an important milestone in the mental health field as it promotes deinstitutionalization and the right of people to live in the community. The CR did not have national legislation that dealt with mental health services explicitly. In terms of policy, the national Mental Health Care Reform was seen as an important milestone as it aimed to shift the focus of mental health care from large mental hospitals to the community. The Mental Health Care Reform made specific reference to quality of life, which was seen as important emphasis that supported at least some of the principles of the recovery approach. The Ministry of Health tasked eight working groups with the implementation of the Mental Health Care Reform strategy. Users were represented and participated in all of these working groups. Experts thought that the Czech Mental Health Care Reform was only possible because of the policy of larger international bodies such as EU and WHO. However, the recovery approach was seen as only indirectly affected by the UN Convention on the Rights of Persons with Disabilities and the Action Plan for Mental Health (2005) and the more recent Psychiatry Reform Strategy from 2013. The UN Convention was useful for users, mental health professionals and other stakeholders to refer to when advocating for changes in the system. Experts thought that the Mental Health Care Reform would not have been possible if there had not been EU support including financial one in form of structural funds. Although the impact of the UN Convention for people with disability was felt as "rather loose", it was thought that at the same time, the Convention undoubtedly generated pressure on deinstitutionalization and the cultivation of a legal environment in mental health care. For example, since then conceptual policy documents focused on changes in the care of mentally ill people and suggesting in particular that the coordination and development of community mental health provision needed to be improved. The Norwegian funds projects (SUPR), from 2014 to 2016 sought to create a system of comprehensive psychiatric rehabilitation and implementation in inpatient care facilities; the main objective of the project is the creation of a newly unified system of rehabilitation in inpatient psychiatric facilities with a particular focus on subsequent psychiatric care for patients with serious mental illness. Other goals of the project included the prevention of psychotic illness through awareness campaign; 13 psychiatric hospitals and clinics actively participated in SUPR.

Despite the lack of legislations or policies that would promote the recovery approach, a range of movements and practice developments evidence an increasing role of the recovery approach. For example:

- The development of *the role of peer support workers* who started to believe in the idea of recovery and practically or personally got involved and participated in service delivery and policy decision that support recovery;
- The development of *user involvement infrastructure* in mainstream mental health services and in policy reform;
- The establishment of *nonprofit organizations that provided user-focused recovery services*, which even operated under an umbrella Association of Community Services;
- Organisations such as the Centre for Mental Health Care Development, Fokus, Praha and Ledovec (Iceberg) started to offer *accredited courses on recovery*;
- In addition, Ledovec (Iceberg) organized in 2016 the *first international conference on recovery* in the Czech Republic;

Although this could not be pinpointed to specific events, international influences in particular from countries like the UK were viewed as important drivers of the recovery approach. This referred to the personal stories that were told by people with lived experience but also to the role of policy and research. Whilst psychologists' training and professional development was informed by academic journals from countries like the UK, which included evidence on more recovery-oriented approaches, psychiatrists' training and development was more influenced by the medical model of disability led by the more traditional psychiatric discipline (originating from the US).

Some milestones evidenced the resistance of some psychiatrists towards the social model of disability and the recovery approach in mental health: for example, at conferences and in publication they continue referring to the clinical remission of symptom and would not refer to publications of people with lived experience (Bankovská Motlová a Spaniard, 2011).

Whilst individuals could be identified which took on pioneer roles, their influence on specific milestones was not easily to track.

Table 10: Overview of milestones in relation to the recovery approach in Czech Republic

90s	• Formation of a community-oriented services in the non-profit sector • Pilots that involved users as peer-workers in community mental health services • Establishment of the patient organization 'Kolumbus' • Mental health care reform • Establishment of National Institute for Mental Health (NIMH)
2009	• Recovery concept first appears in the national journal Psychosis (Pěč & Probstová eds., 2009)
2012	• Centre for Mental Health Care Development introduced the role of peer consultants in community mental health services
2012/13	• Establishment of a working group by the Minister of Health to develop and approve mental health care reform/ strategy • Reform of psychiatry (Strategy published in 2013) with allocated EU funds
2014	• Translation of the publication Paths to Recovery into Czech • Pilot teaching by peer tutors on recovery at universities • Pěč & Probstová mention recovery in national Journal 'Psychiatry for social workers' • Norwegian funds, for projects in psychiatric hospitals (project SUPR)
2015	• Report on the benefits of involving peer consultants or mentors, an evaluation report of a project on education and training of people with mental illness as peer consultants → includes outputs from discussions with peer consultants, interviews with peer consultants' clients, and evidence review
2016	• 1st International conference on recovery in Pilsen (organized by Ledovec – Iceberg)

France

The experts we interviewed had strong views about the degree of resistance from the psychiatric field, which they thought made it difficult for the recovery approach to emerge or develop. They stated somehow different reasons for this phenomenon. Though there has been a firm move away for the use of treatment within hospital walls, there remains a group of patients for whom hospitalization remains a risk. Some activists and professionals think even alternatives to these high risk patients can be avoided.

The 2005 law of disability in France created a new category of disability 'psychological handicap' and this was considered an important development:

> *"The recognition of psychological handicap is part of a process of breaking down self-stigma and reclaiming one's voice: we've gone from a world of unheard voices to a world where, the simple fact of saying "I am a person suffering from a psychological handicap" restores the dignity of that person and gives him a different status'" Durand (2016), citing Baillon (2009).*

The law opened up new possibilities for user mutual support and representation, by legislating to create not-for-profits called "Groupes d'Entreaide Mutuelles' (mutual aid groups) or GEMs.

In terms of legislation, experts did not think that the 2008 UN Convention had any influence on the recovery approach in France. One expert thought that there remained work to be done to avoid institutionalisation of large groups of patients and another felt that there was there was a lack of desire to change the institutionalisation of the sickest patients. Almost all developments referred to the orientation of psychiatric profession and movements were only described in relation to psychiatry rather than in relation to other movements. The large absence of service user led movements was argued by one expert (a psychiatrist) to reflect a system in which service users were perceived to be happy with service provision and that there was thus no need for them to revolt. This was explained by a psychiatry that sought to place patient and therapist on the same level, abolishing (or at least reducing) power dynamics.

The expert, who was a psychiatrist, added that:

> *"This does not free us from a duty to ceaselessly question our practices…from the temptation to put our own vision (for a patient's life) ahead of the patient's own".*

Movements in French psychiatry included in particular, institutional psychotherapy and community psychiatry. The institutional psychotherapy views treatment for schizophrenia as a therapy in which relationships with everyone in the institution (presumably a psychiatric hospital) can be used to understand dynamics and promote healing. The movement had its roots in the second-world war as well as in Marxism. It was a reaction to a trauma in the history of French psychiatry during the 2nd world war in which 40,000 psychiatric patients died of hunger in French asylums; a Spanish psychiatrist demolished an asylum building and rebuilt it into a more humane site with patients participating in the reconstruction. Patients were no longer locked up and instead encouraged to join clubs in the village and to go to the cinema alongside the other residents. One interviewee described these clubs as follows:

> *"The spirit of these clubs where the patient can find his place, independently of his illness, helps him to rediscover his identity, build self-esteem and to find hope in his relationships with others: we find ourselves at the plausible beginning of a recovery process: even though the framework is put in place by psychiatrists"*

It was suggested that many psychiatrists still believed that this was an innovation that had relevance in the current system. An expert noted that it is not very clear where this institutional psychotherapy is still practiced, and he notes that its effectiveness has never be evaluated. Whilst some experts thought institutional psychotherapy may have paved the way for recovery in the French context, others think it may even be an obstacle to the more radical, user-led perspective embodied by recovery. Another expert, himself a psychiatrist, disputed that this movement had really caught on – he takes the view that this revolution, which saw its heyday in the 1950s, has been more talked about than practiced, and more talked up than evaluated. In this person's point of view, institutional psychotherapy – which created a more level playing field between doctor and patient – does not preclude the need for recovery, which is fundamentally patient-focused and patient-led – and, crucially, does not typically require an institution. The intellectual foundations of institutional psychotherapy – which draws on Marxism and Psychoanalysis, are different to those of recovery, which rest upon Anglo-Saxon thinkers, such as Hobbes and Emerson. One interviewee described an opposition to the recovery approach:

> *"The psychiatric community abhor the idea that there is a school of thought with Anglo-Saxon origins, which is based on different philosophic and theoretical underpinnings to their own."*

The introduction of community psychiatry in 1975 in France was perceived as replacing the need for a user-focused recovery approach. One of the experts we interviewed took the view that these services should be considered part of a recovery approach. Another expert referred to the mental health system in France (including community psychiatry) as a "Golden Cage" and noted that there is a need to transform the system from a paternalistic one, in which people do things to a patient to something that users take advantage of when they need it. Generally, despite the introduction of community centres, experts described the largely prevailing dominance of institutions.

One expert stated:

"It [recovery] involves helping them [people with mental illnesses] to help themselves, by building their self-resilience…the role of the institution in responding to problems of a social nature, to a lack of integration in society, is a point of divergence between the Anglo-Saxon approach, and the French tradition in this field. We can now understand better the resistance that the idea of recovery brings up in France, which embodies a radical perspective: the decision to adopt the strategy of empowerment, and thus to take a distance from the traditional strategy of social protection. It is indeed the whole French social system, structured around the institution, and considered as a value worth fighting for, that finds itself in question."

Another expert explained that the strong, prevailing norms and rules in the area of psychiatric care presented a barrier towards integrated and multi-disciplinary working:

"The legal framework and culture of psychiatric care, which is pretty all-encompassing, has held back the possibilities for finding common ground between psychiatric practice and social work."

The introduction of mental illness in Disability legislation in 2005 was seen as an important driver of the recovery approach (although it did not have an immediate effect). It provided more rights for people with mental illness and put more responsibilities on government to provide services for this group. By reducing stigma, experts felt it had an important impact on individuals' empowerment:

"The recognition of psychological handicap is part of a process of breaking down self-stigma and reclaiming one's voice: we've gone from a world of unheard voices to a world where, the simple fact of saying "I am a person suffering from a psychological handicap" restores the dignity of that person and gives him a different status'"

The new law opened up possibilities for user mutual support and representation, by legislating to create not-for-profits called "Groupes d'Entreaide Mutuelles' (mutual aid groups) or GEMs (Baillon 2009).

Some the experts named "la psychiatrie citoyenne" – or citizen's psychiatry – as an important movement which, they thought was closely related to the idea of recovery, but had a greater focus on the role of ordinary people in assisting the recovery process.

Table 11: Overview of milestones in relation to the recovery approach in France

Before 1990	During the Second World War, 40,000 psychiatric patients died of hunger in French asylums. In response to this: • Concept of institutional psychiatry introduced by Catalan republican psychiatrist, taking refuge in France hospital in Saint-Alban-sur-Limagnole after the war; • A group of doctors revolutionised concept of psychiatric institutions drawing their philosophy upon Marxism. • 1975: Introduction of community psychiatry in France → Law put in place a number of structures to replace inpatient care and reinforce community care.
2002-04	• 2002 and 2004 laws on service user involvement in health establishment introduced patient representation at strategic decision making of psychiatric institutions; service users can organise themselves in form of groups that need to be recognised officially by the French State
2005	• 2005 Disability Law included for the first time explicitly mental disability ('psychological handicap'); provided legislation and funding for 300 mutual self-help groups across the country as well as for piloting Clubhouse model at different sites
2011-15	• Four-years forward plan by Ministry of Health does not mention recovery

Denmark

The history of the social psychiatry in Denmark started only in the 70s when the state hospitals (including psychiatric ones) became assigned to regions and the organisation and delivery of treatment for people with mental difficulties was handed over to regions and municipalities (Bengtsson and Kilskou Kristensen 2006: 27). At the national level the management of psychiatry services is nowadays shared between the Ministry of Social Affairs and the Ministry of Health. The responsibilities of the Ministry of Social Affairs include the municipal social services for people with mental health problems such as social and educational support and housing. The responsibilities of The Ministry of Health include the health system and the regions, which are in charge of psychiatric examination and treatment (Social- og Indenrigsministeriet). This split in responsibilities resulted in a fragmented system for the support for people with mental health difficulties.

The interviewed experts agreed that a strong division between the treatment of social and mental difficulties had made it very difficult to implement recovery principles, which required the close collaboration from the two departments. Moreover experts thought that the recovery approach had mostly been integrated at the municipal level, that is, in the field of social psychiatry, whilst the psychiatric field continued to treat citizens with mental diagnoses in a traditional way. Whereas many municipalities worked following recovery principles for many years it was only recently that regional authorities started recognising the importance of the recovery approach.

Social psychiatry was seen as the main driver of the recovery approach because it has a focus on socially oriented efforts aiming at supporting people with mental health problems in 'a life as normal as possible' including shelters, housing, leisure activities (Neidel, 2011: 16). Institutions not affiliating with social psychiatry but with hospital psychiatry or district psychiatry did not show any attempt to implement user-focused recovery approach. With the establishment of Videnscenter for Socialpsykiatri (Knowledge Center for Social Psychiatry) by the Ministry of Social Affairs in 1997 the field of social psychiatry officially became a professional field. In the year 2000 the Center introduced the term 'recovery' in a Danish context. The Center collected the existing international knowledge on recovery and published it in Danish in order to make the literature available to a wider national audience. The Center's magazine 'Socialpsykiatri' (2000) challenged that mental illness was as chronic condition and that individuals could not recover. The work of the Center built on the research by the Swedish/French psychologist Alain Topor. In a literature study Topor (2002) documented how quantitative research revealed that a number between 1/3 and 2/3 of all people diagnosed with schizophrenia recover. On basis of qualitative interviews with people who recovered from their mental illness Topor emphasized that it was not first and foremost treatment by professionals (or at least what the professionals themselves perceived as core treatment) that supported the recovery process. Instead he pointed towards factors such as reciprocal relationships with other people, and professionals acting more like 'real persons' than 'professionals'. The Center was closed five years ago, but today the initiators and personnel hold key positions in the Social Services Administration.

Opportunities for recovering were in the beginning primarily discussed for individuals with severe mental illness (Videnscenter for Socialpsykiatri 2000: 4). However, over the years recovery and psychosocial rehabilitation became central to most of the discussions revolving around the development of social psychiatry (Neidel 2011). The central appearance of recovery in these discussions was explained by the influence of user-led organizations, with The National Association of Current and Former Psychiatry-users (LAP) in the lead, which emphasized recovery approaches. LAP was, among other organisations, represented in decisions about national developments of psychiatry and social psychiatry programs and services. The Government produced a report on how to facilitate cooperation between the areas of psychiatry and social psychiatry: "Rapport fra Udvalget vedrørende bedre samspil mellem tilbuddene I psykiatrien og socialpsykiatrien" (Sundhedsministeriet, Maj 2001). The report was the first national policy text that used the term recovery.

Two main legislations set the context for the recovery approach:

- The Servicelov (The Consolidation Act on Social Services), which regulates social psychiatry services managed by the Ministry of Social Affairs and carried out by municipal and regional authorities, advocated a collaborative perspective between users and professionals.

- The Psykiatrilov (The Mental Health Act), which regulates psychiatric services managed by the Ministry of Health and carried out by psychiatric hospital and outpatient services sets out that the citizens' opinions must be taken into account as much as possible in psychiatric care decisions.

Denmark joined the international "Mental Health Declaration for Europe" by the WHO in Helsinki, 2005. This declaration followed the recovery approach emphasizing that treatment should be focused on individuals' assets and strengths and that the ultimate goals are to increase quality of life and social inclusion. At a national level the Danish Parliament set out that mental health initiatives should focus on recovery (Socialforvaltningen Århus Kommune, 2007).

In regards to the UN Convention, experts' views were divided about the impact it had on the recovery approach nationally. They thought that on the hand it gave individuals and organizational a legal basis to refer to. For example, user organisations and international human rights organisations were able to use the Convention as leverage for pushing their agenda of equal treatment of people with physical and mental handicaps. It was seen by some as a point of reference that provided legitimacy for criticising conventional psychiatric institutions. It also helped organisations concerned with human right aspects in this area to unite their interests. However, some experts doubted that it actually had much impact on recovery-oriented practice. Experts offered different explanations for this: One expert felt that the Convention had limited impact because h(s)he thought it did not specifically include mental illness as a type of disability, thus giving it leeway to interpretation; implications of this were that individuals with mental health difficulties did not have certain rights that people with physical disabilities had (e.g. having an advocate). Another expert felt that a law protecting the rights of people with disability was in fact against the spirit of the recovery approach, which was trying to move away from the concept of permanent conditions that individuals could not recover from.

The national reform of early retirement pension in 2012 was another important milestone giving young people with a mental illness the opportunity to gain an early pension. Another important milestone in the following year was the national Report on Psychiatry, which the Government published setting a framework to the work of the newly established Government Committee on Psychiatry. The report sets out, among other things, how the mental care system can become a more recovery oriented one.

Table 12: Overview of milestones in relation to the recovery approach in Denmark

1997-99	• Establishment of Videnscenter for Socialpsykiatri (Knowledge Center for Social Psychiatry) by the Ministry of Social Affairs in 1997 • 1999 National Assosiation of users and ex-users of mental health care (LAP) was founded
2000-05	• Center's magazine 'Socialpsykiatri' (2000) introduces the concept of and evidence for recovery; referred to severe mental illness • Government Committee on interaction between treatment programs in psychiatry and social psychiatry • Government produced report on cooperation between the areas of psychiatry and social psychiatry: "Rapport fra Udvalget vedrørende bedre samspil mellem tilbuddene I psykiatrien og socialpsykiatrien" (Sundhedsministeriet, Maj 2001). → The report was the first national policy text that used the term recovery. • 2004 First Danish book on recovery in a Danish context 'Recovery på dansk' (Authers from LAP and the Knowledge Center) • 2005 Denmark joined the Mental Health Declaration by the World Health Organisation which was focused on recovery principles
2006-13	• 2009 Former prime minister initiates the association *The Social Network* • Danish Parliament incorporates the principles of the Declaration in national policy • Knowledge Centre for Social Psychiatry closed in 2011

	• 2012 Reform of early retirement gives new rights to young people with a diagnosis of mental illness • 2013 Report on Psychiatry

4.1.2. Central actors and their primary roles in advancing the SI stream

United Kingdom

Pioneers

The recovery approach started as a movement in which individuals with lived experiences of mental illness and mental health treatment voiced their concerns about the system of mental health treatment and shared their stories about what helped them in moving beyond the role as a patient. They provided and shared accounts of their stories in books, talks and social media. They started defining the term 'recovery' as a key concept in this debate. Those individuals took on the role of pioneers; they were from the US, New Zealand and UK followed by other countries.

Table 13: Description of recovery pioneers, UK

Name	Country	Organisation	Sector	Role(s) and profession(s)
Mary Ellen Copeland	US	Copeland Centre for Wellness and Recovery	Third sector	Author, educator and mental health recovery advocate; pioneered the Wellness Recovery Action Plan in 1997; was awarded the United States Psychiatric Rehabilitation Association's John Beard Award for outstanding contributions to the field of psychosocial rehabilitation in 2006 She received Substance Abuse and Mental Health Services Administration's Lifetime Achievement Voice Award in 2009
Patricia Deegan	US	Independent consultant and advisor	Private sector	Individual with lived experience and psychologist; international writer, speaker and consultant; including author of book 'Right to recover'
Mary O'Hagan	NZ	Independent consultant and advisor	Private sector (previously public sector)	Initiator of the service user movement in NZ; first chair of the World Network of Users and Survivors of Psychiatry; advisor to the UN and WHO; previous mental health commissioner in NZ; international writer, speaker and consultant; including author of book 'Madness made me'
Rachel Perkins	UK	Consultant, Implementing Recovery through Organisational Change (ImROC) programme	Third / public sector	Pioneer of national employment programme 'Individual Placement with Support'; led setting up the first English Recovery College; previous role of Director of Quality Assurance and User Experience at the largest NHS Mental Health Trust in the country; currently acts a chair on Equality 2025, is a member and co-chair of important ministerial advisory and working groups in this area and has strong involvements with MIND, the largest national mental health charity

Dr Julie Repper	UK	Director of ImROC programme	Third/ public sector	Director of the national improvement programme for recovery in mental health (ImROC); has/had academic involvements at a number of universities; (former) recovery lead for her local NHS Trust; worked closely together with Rachel Perkins and together they are authors of books on recovery such as 'Recovery and Social Inclusion'
Geoff Shepherd	UK	Previous Director of ImROC programme, Professor	Retired, formerly third and public sectors	Trained as clinical psychologist; worked most of his career in the NHS as a practitioner, manager and researcher, was employed part-time by the Centre for Mental Health and the NHS Confederation's Mental Health Network to lead ImROC; hold visiting chair at the Institute of Psychiatry
Mike Slade	UK	Professor of Mental Health Recovery and Social Inclusion, University of Nottingham and Institute of Mental Health	Third sector/ university	Pioneered research in recovery; used to be employed as Professor of Health Services Research at the Institute of Psychiatry, Psychology and Neuroscience at King's College London, and as a Consultant Clinical Psychologist in South London; among many other academic publications he is author of 'Making Recovery a Reality', '100 Ways to Support Recovery' and 'REFOCUS: Promoting recovery in community mental health services'
Jed Boardman	UK	Consultant ImROC and senior policy advisor at the Centre for Mental Health	Third sector; third/publi c sector	Works also as a Consultant Psychiatrist and Senior Lecturer in Social Psychiatry at South London and Maudsley NHS Foundation Trust and the Institute of Psychiatry; Clinical Advisor to the Healthcare Commission; was Chair of the General and Community Faculty of the Royal College of Psychiatrists and is now lead for Social Inclusion at the Royal Colleges; published widely on social inclusion, psychiatry, recovery
Glenn Roberts	UK	Independent consultant	Private sector, formerly public and third sector	Worked in NHS psychiatry; previously consultant psychiatrist with Devon Partnership NHS Trust; lead for the Royal College of Psychiatrists on Recovery and Academic Secretary to the Faculty of Rehabilitation and Social Psychiatry; co-founder of Recovery Devon and the founder and coordinator of the Devon consultant mentorship scheme

Some important user-led and professional networks have shade the landscape of the recovery approach in the UK (and some are also international ones).

- The *Hearing Voices Network* which started as a political psychology and anti-psychiatry movement in 1987 led by Marius Romme, Sandra Escher and Patsy Hage. It challenges the notion that hearing voices is a mental illness and instead regards it as a meaningful and understandable, although unusual, human experience; it is an anti-stigma movement that advocates human rights,

social justice and support for people who hear voices that is empowering and recovery focused. The movement thus challenges the medical model of mental illness.

- The *Critical Psychiatry Network* was created by a group of British psychiatrists who met in Bradford, England in January 1999 in response to proposals by the British government to amend the 1983 Mental Health Act (MHA). They expressed concern about the implications of the proposed changes for human rights and the civil liberties of people with mental health illness. Most people associated with the group are practicing consultant psychiatrists in the United Kingdom's National Health Service (NHS) among them Dr Joanna Moncrieff. A number of non-consultant grade and trainee psychiatrists are also involved in the network. Participants in the Critical Psychiatry Network (CPN) share concerns about psychiatric practice where and when it is heavily dependent upon diagnostic classification and the use of psychopharmacology. CPN has similarities and contrasts with earlier criticisms of conventional psychiatric practice, for example those associated with David Cooper, Ronald Laing and Thomas Szasz. Features of CPN are pragmatism and full acknowledgment of the suffering commonly associated with mental health difficulties. As a result, it functions primarily as a forum within which practitioners can share experiences of practice, and provide support and encouragement in developing improvements in mainstream NHS practice where most participants are employed. CPN maintains close links with service user or survivor led organisations such as the Hearing Voices Network, Intervoice and the Soteria Network, and with like-minded psychiatrists in other countries. It maintains its own website.
- *Open Dialogue* is another network reflecting innovations within the psychiatric and psychological discipline; the Open Dialogue approach is both a philosophical/theoretical approach to people experiencing a mental health crisis and their families/networks, and a system of care, developed in Western Lapland in Finland over the last 25-30 years. The first full Open Dialogue training programme to be run outside of Finland commenced in London in April 2015. Teams from four NHS Trusts joined the program, along with teams from international public services, peers and independent practitioners. The Open Dialogue movement stemmed from similar concerns than those in the recovery field including the issue if revolving doors and people not getting better. However, the movement is led by mental health professions (rather than people with lived experience) and it is not clear how they relate to the recovery movement.
- *Professional membership bodies for psychiatrists and psychologists* (The Royal Colleges) presented important drivers for the recovery approach. Experts reported that there was not only resistance but also support from the psychiatric discipline leading indeed to close collaborations between people with lived experience and other third sector organisations representing recovery principles. Some of the recovery pioneers gained established positions in the Royal Colleges and advocates the recovery approach to their profession. However, some also felt that the psychiatric professionals redefined the term recovery to serve their purpose and reconstructed the meaning. This included consultants who were part of the 'community psychiatry' movement, which was a related movement led by individuals from different user and professional groups including social anthropologist, social and political activist, community groups.

A number of *mental health politicians* supported the recovery approach. Most recently this included: Phil Moore, Chair of the NHSCC Mental Health Commissioner Network; Geraldine Strathdee, National Clinical Lead Director for Mental Health, NHS England; David Smith, Co-Chair, Mental Health Network and Director of Adult Social Services, Oxford Care Quality Commission (although the Care Quality Commission as an organization was also seen as potential barrier because it described recovery with inwards focus not outwards oriented (in document about dignity and person-centredness). Government funded bodies or networks such as ImROC and the Scottish Recovery Network played an important role in supporting the dissemination of recovery oriented mental health practice.

The role of the *third sector* in initiating was evident in the UK with organisations such as the Sainsbury Centre for Mental Health, the Centre for Mental Health and others leading on campaigning for the recovery approach in collaboration and on behalf of people with lived experience. There were also some radical voices from the third sector in protest of statutory provision sometimes led by few individuals with lived experience. More recent initiatives that support recovery principles included Time to Change anti-stigma

campaign run by MIND and Rethink. There are also other charities that provide support for people with mental health problems such as Making Space, Turning Point and St Mungo's.

Czech Republic

In the Czech Republic, the national Mental Health Care Reform was driven by the EU, the WHO, the Ministry of Health, the National Institute for Mental Health, the Centre for Mental Health Care Development (CMHCD), the largest national health insurance company (VZP), Česká psychiatrická společnost, and the Bohnice psychiatric hospital. A number of individuals were driving the reform including Martin Hollý, Petr Winkler, Ivan Duškov, Mat Muijen and Jan Jaroš. Other important individuals included 'The Psychosis' editors, individuals from the CRPDZ and from 'Iceberg' and peer specialists. Individuals from "generation of the 90s" were seen as important pioneers and included: Jan Pfeiffer, Pavel Novák, Beate Albrich, Martin Jarolímek, Zuzana Foitová. Individuals driving the psychiatry reform were Marek Ženíšek, Ivan Duškov and Martin Holly. A list of individuals, the organisations they represent and the sectors of organisations, and roles of individuals is presented in Table 14 below.

Table 14: Description of recovery pioneers and important actors, Czech Republic

Name	Organisation	Sector	Role(s) and profession(s)
Jan Jaroš	Kolumbus	Third sector	• Chief Executive Officer
Jan Pfeiffer	now employed in UK at Children's High Level Group founded by JK Rowling	Public and Third Sector	• Psychiatrist • Pioneered the recovery approach in CR and was involved in the deinstitutionalization reform; • Advocate of mental health care reform at European level
Jan Stuchlík	Fokus Mladá Boleslav	Third sector	• Consultant for Centre for Mental Health Care Development • Director Fokus • Psychiatrist
Barbora Wenigová	Klinická psychologie – Karlovy Vary	Private and third sector	• Psychologist
Pavel Říčan	Centre for Mental Health Care Development	Third sector	• Managing Director
Petr Hejzlar	Mental Health Care	Third sector	• Director • Psychiatrist
Petr Winkler	National Institute for Mental Health, Prague	Public sector	• Head of Department of Social Psychiatry • Researcher
Filip Španiel	National Institute of Mental Health	Public sector	• Researcher • Psychiatrist
Dana Chrtková	National Institute of Mental Health	Public sector	• Peer researcher
Cyril Höschl	National Institute of Mental Health	Public sector	• Director • Psychiatrist
Martin Fojtíček	Ledovec	Third sector	• Director • Community worker
Blanka Veškrnová	Práh Brno	Third sector	• Director
Jiří Šupa	Práh Brno	Third sector	• Community care manager

Martin Hollý	Psychiatric hospital Bohnice	Public sector	• Director • Psychiatrist
Ivan Duškov	Ministry of Health	Public sector	• Ministry official • Co-author of the reform of psychiatric care
Mat Muijen	WHO Europe	Public sector	• WHO Europe mental health programme manager
Zuzana Foitová	Fokus Praha	Third Sector	• Consultant for CMHCD; • Manager of day care centre in Fokus Praha • Doctor, Psychotherapist
Pavel Novák	Fokus Praha	Third Sector	• Managing Director
Beate Albrich	Atelier DADA Extraart, z.s.	Third sector	• Art therapist, PCA psychotherapist
Martin Jarolímek	Daily psychotherapeutic sanatorium „Ondřejov“ s. r. o.	Private sector	• Executive director • Psychiatrist
Marek Ženíšek	Member of parliament	Public sector	• Former permanent secretary of Minister of health – active in the reform of psychiatry

The following organisations were described as having been driving or influencing the recovery approach:

The *National Institute of Mental Health (NIMH)* is the country's largest think tank and produces and disseminates knowledge and evidence related to the mental health care development. The establishment of the NIMH was led by Dana Chrtková, Cyril Höschl, Petr Winkler. It was importantly involved in the development of mental health care reform strategy and contributes to all of its eight working groups. It is responsible for developing the knowledge base for the reform as well as for its evaluation; it collaborates with patient and family organizations am employed two user-researchers working at the Department of Social Psychiatry whose role is, among others, to shape the research priorities to better reflect priorities of users.

The *Centre for Mental Health Care Development (CMHCD)* is another third sector organisation that provides methodological support and other services to mental health care providers, organization and employs users to better reflect priorities, needs and attitudes of users.

There are other third sector organisations, such as *Kolumbus*, which play an important role in driving the recovery approach. Kolumbus is a user-led civic organization and presents the single largest voice of users in the country.

In regards to government and public sector influence, the *Ministry of Health* was responsible for the development and implementation of the Mental Health Care Reform. It involved people with lived experience including experiences of using services in developing the Reform.

The Director of the *Bohnice Psychiatric Hospital* was described as the most important person behind the mental health care reform in the Czech Republic and had the great power to influence it.

One expert described him as

> *"one of the few senior psychiatrists in the country who is accepted by all stakeholders – psychiatric hospitals, Ministry of Health, providers of community services, public, and others".*

The Bohnice Psychiatric Hospital Prague started to employ users as peer-workers in order to promote recovery.

At the same, there has been more or less open opposition to the recovery approach by the managements of some *psychiatric hospitals*. Whilst some hospitals acted relatively open-minded towards the recovery approach (although they would not implement in their institutions), others were openly resistant toward it. This included elite psychiatrists, who continued speaking 'very medically' about the remission of symptoms (eg. Bankovská Motlová a Spaniard, 2011). They were sceptic towards the recovery approach and would, for example not refer to the publications of people with personal experience with illness and recovery, such as Patricia Deegan, Vilma Boevink or Mary Ellen Copeland.

Public sector providers of community mental health services appeared more open towards the principles of the recovery approach than institutional providers: Nearly all of the big providers employed some experts by experience (users) which was seen as an important step towards the implementation of the recovery approach.

Third sector providers of community mental health services were generally described as being very open to the recovery principles. A few were leading examples of the user-focused recovery approach: FOKUS, Práh (Treshold) and Ledovec (Iceberg) are – together with Kolumbus – the leading non-profit organizations in the recovery field. They support individuals who experience mental disorders in their efforts to manage their lives and find opportunities for self-fulfillment in the community; they consist of a group of psychiatrists, psychologists, psychotherapists, social therapists, vocational therapists, social workers, educational and other professionals as well as volunteers; they offer free-of-charge comprehensive social and healthcare services in a non-institutionalized settings, focusing on individual care for people with a long-term mental disorders; they advocate for the rights and interests of people with mental illnesses; and work with clients' families. They acted as 'role models' in the field and had an important role in demonstrating good practice and that the recovery approach was feasible.

The *Association of Community Services* is the umbrella organization for community providers of social and health services (both publicly and third sector ones); it promotes the interests of people with a psychotic mental disorder as well as the interests of the whole community care for this population.

France

In terms of actors that were important in driving the recovery approach locally, the following organisations were named:

In recent years, new models of recovery have emerged or come to greater prominence in France. The truly home-grown example is Les Invités au Festin (which means the guests at the feast) and the IAF network. This community-based approach to recovery comprises of a residential community and a day centre whereby volunteers from the local community participate in and run activities (dance, baking, DIY, charity shop…) alongside the residents and participants who have been touched by mental health problems, thus breaking down barriers. 'It's a place that heals, rather than a place of treatment' says Marie-Noëlle Besancon, Les Invités au Festin's founder and director. Les Invites au Festin is a non-profit organization that is strongly based on contact between "normal' volunteers and those with mental health problems. Originally based in Bescancon, there are now 13 structures throughout France, mostly day centres, but there is now a second residential house, also near Besancon). It has also been evaluated in form of a Social Return on Investment analysis which was carried out by ESSEC Business School.

A second example is 'Un Chez Soi D'Abord' (Housing First) is a model that is based on the American model of Housing First, and has been implemented by non-profit organization in Lille, Marseille, Toulouse, Paris. The idea of the programme is to give housing to homeless people suffering from mental health problems without condition, and follow them, including by mentors who have themselves recovered. Part of the aim of the program is to put choices – such as where they would like to live – back in the hands of those with mental health problems. This initiative, which aims to reach 800 people a year, is entirely funded using public money and is undergoing rigourous evaluation. It has already shown its effectiveness in Canada and the United States.

The WHO Collaborating Centre for Research and Training in Mental Health (CCOMS) in Lille was named as important public health project. They are implementing Un Chez Soi D'Abord and there are a number of researchers working on recovery. The CCOMS has the legal status of public sector establishment but also receive some grants from philanthropic organisations. Among the centre's priorities are the empowerment of service users and citizenship psychiatry. In particular, they have programmes introducing and evaluating the use of peer mentors. This is a relatively new work strand which is carried out in collaboration with patient organizations: For example, FNA-PSY trains them with the support from Université de Paris VIII, and finds placements for them in psychiatric institutions; the effectiveness of the peer support is also being evaluated. So far 29 peer mentors have been trained, of whom 16 were still exercising three years later. Initial indications about their influence on patient self-stigma and need to use formal healthcare services are promising. However, challenges remain, particularly with regards to the integration of the mentor into the healthcare team. There have been resistances from professionals such as nurses, who were concerned that peer mentors would take over their role, with less training and skills, and for lower pay. One expert was concerned about relationships between peer mentors and service users that might be affected negatively if service users saw peer mentors working alongside healthcare team. CCOMS is also participating in a European mapping of the empowerment of mental health service users. The link with recovery is made clear:

> *"If a patient is denied recognition as a person, if his or her fundamental rights are not respected, if his opinion is not taken into account, on the ground that he is 'mad' then it is impossible to imagine a fulfilled life, a recovery journey or path as a recognized citizen."*

Groupe d'Entraide Mutuelle (GEM; Self-help groups) were established, incubated and funded in the context of the national Disability Law in 2005. There were now over 80 of these groups in the country. Three mental health oriented third sector organisations had been drivers of these groups: Fédération Croix-Marine pour la Santé Mentale (a movement of psychiatrists, which grew out of Institutional Psychotherapy movement), UNAFAM (representing the families of people with mental illness) and FNA-PSY (a movement of service users). Some experts felt that those self-help groups did not engage with issues of psychiatric care and were more involved in self-care activities, whilst others felt that they had created an environment and infrastructure for the recovery approach.

Interviewees described some of the resistances faced by GEM

> *"Some psychotherapeutically-oriented practitioners doubt that patients can help and support one another, away from the gaze of professionals"*

One expert had also reservations about the groups stating that patients did not seem to be interested in becoming involved with consultations about psychiatric services. Another thought, however, that

> *"These mutual-help clubs, governed by users themselves, have emerged very quickly as special places where users can engage in their recovery journey and discover the importance of peer support away from the gaze of professionals"*

Another expert felt that as long as it was still led or facilitated by professional it was still not breaking down the boundaries between professionals and service users.

UNAFAM is a national mental health third sector organization, which seeks to represent the views and interests of affected families. They were influential in investigating and promoting user self-help organisations, which were eventually incorporated into law as the GEMs. The organisation currently supports several GEMs.

FNAPSY is the French national federation of users in mental health; their role has traditionally been in highlighting human right violations for individuals using mental health services and formulating good practice with policy makers. Together with UNAFAM, FNAPSY had an important role in raising awareness of the need for GEMs.

Hôpital Maison Blanche provides psychiatric care in the north-east of Paris, over several sites. As well as inpatient care, community care is provided. The hospital has a research unit, headed by Dr. Tim Greacen, an Australian psychologist, identified by several experts as being the most prominent advocate of the recovery approach in France. In addition to his research activity, he and his colleagues are hoping to start up a mental health empowerment centre, in partnership with patient organisations. The idea is to have a patient-led service, which users can dip in and out of when they feel the need, in contrast to what Dr. Greacen sees as paternalistic, all-encompassing institutions. His team also participated in a European project EMILIA, on the use of life-long learning in recovery. As part of this project, they developed training on recovery. Dr. Greacen notes that there has been an upsurge in demand for this over the last four years.

Psychiatrists was seen another important group of actors. For example, Dr Roelandt was mentioned as one of the principal proponents of citizen psychiatry. The focus of such this movement the breaking down of barriers between the hospital and the community; the influence on the implementation of the recovery approach was, however, less clear. Another group of psychiatrists were those who concentrated on the biological aspects of mental illness; these psychiatrists tended to be inspired by what they called more traditional 'American psychiatry'; as such, if they have heard of recovery, they tended to associate it with an anti-psychiatry movement, and were in general hostile to it. Many community-based psychiatrists and those with a psychoanalytic training had beliefs that they were already 'doing' recovery and hence that there was no need for such concept. For example, whilst some neuro-biologically focused psychiatrists were quite favourable to the concept, they were reluctant to the idea of the recovery approach because of its anglo-saxon orgins.

An expert explained that

> *"the French have difficulty tolerating the idea that anglo-saxons are ahead of them on this subject – in their worldview, it must be the French who are ahead. They absolutely do not want to hear about recovery".*

Federation Croix-Marine is an organisation representing a national movement for persons suffering from mental disorders; it was established in 1952 and is now an association of more than 300 organisations including public and private health care providers; its aims are to mobilise community resources and to advocate, campaign and innovate in the fields of mental health care, rehabilitation, reintegration and prevention.

The Ministry of Health has provided the legal structures and the financing to launch GEMs across France. The Ministry's legislation in 2002 and 2004 led to greater user-involvement in hospitals. The Ministry, together with the Ministry for Housing, decided to import the Housing First model to France, launching a tender for non-profit partners to implement the scheme. They provided 3-year funding to partners to pilot the scheme in Paris, Lille, Marseille and Toulouse to house 800 people. Following evaluation, a renewal of funding is expected towards the end of the year. Yet curiously, recovery is not mentioned in their four-year plan for mental health, covering the period from 2011-2015.

Denmark

In Denmark, municipalities had an important influence on driving and implementing the recovery approach in their areas. Most Danish municipalities ran recovery projects or had a recovery strategy for the field of social psychiatry. The municipality of Aarhus was the first municipality to implement the recovery approach. The municipality of Aarhus has moreover started initiatives for knowledge sharing and other events in relation to recovery in between municipalities. The Municipality of Aarhus (the second largest city in Denmark) was identified by experts as the most progressive in regards to recovery.

Even though Aarhus has been the most ambitious municipality regarding the implementation of the recovery approach on a strategic level, this had according to one expert not necessarily led to the best services in practice. The same interviewee thought that there was still a long way to go before municipalities and regions would fully engage in recovery. The expert thought that authorities could not pave the way for

a structural setting that supports large-scale recovery-initiatives before they fully grasp the meaning of recovery. The expert concluded that today:

> *"Large-scale recovery initiatives are often started by individual enthusiasts"*

Some municipalities used the recovery approach as a tool that could be implemented as part of their political agenda, which was concerned with getting people (back) into the labour market or into education. Experts felt that this was an unhelpful deviation from the recovery approach because it predefined goals for the recovering citizens. Agnete Neidel writes in her PhD:

> *"When Recovery is used as a tool and is thereby integrated in the existing system the system itself is not changed. In this process there has been a development towards more humanity and equality in the system, but the difference between citizen and system is preserved and hence the power relations in the health care system are not dismantled".*

In addition to municipalities a number of following actors and organisations were identified as influencing the recovery approach:

The *Knowledge Center for Social Psychiatry (Videnscenter for socialpsykiatri)* had been established in 1997 by the Ministry of Social Affairs and was an important forerunner in the field of recovery. The Knowledge Center collected the existing international knowledge and evidence on recovery and published it in Danish in order to make the literature available to a wider national audience. Furthermore the Knowledge Center initiated an association that became the Danish Society for Psycho Social Rehabilitation (Dansk selskab for psykosocial rehabilitering).

The *National Board of Social Services* is a government agency under the Ministry of Social Affairs and the Interior. Among other things the Board is responsible for psychosocial initiatives in the social area. The National Board of Social Services works to obtain knowledge available of effective methods and practice within the field of social work, as well as communicating and distributing this knowledge to ensure its use in practice. This is done through comprehensive counseling of municipalities, the Danish Regions and individual citizens on questions related to social work and by supporting the municipalities when implementing social methods and practices. At the national level there are more and more funds available from the national monetary distribution pool to recovery-oriented projects. The National Board of Social Services Fund is funding projects that develop and test prevention programs for citizens with mental difficulties. The funded projects are partnerships between government, private sector and civil society and their goal is to contribute to inclusion and participation in the community of people with mental health difficulties (Socialstyrelsen, 2015).

At a regional level, professional associations have become active in the recovery field. For example in the Capital Region, the *Joint Council of the Psychiatric Associations (Psykiatriforeningernes Fællesråd*) has worked out a guide to personnel on how hospitalized citizens with a mental diagnosis can prepare themselves to leave the hospital by considering their prospects and wishes for a happy life.

The *Danish Association for Psychosocial Rehabilitation* was initiated by the Knowledge Center for Social Psychiatry and is an association of professionals who push the recovery agenda and is regularly invited by the Danish Government as stakeholder to participate in policy making.

LAP was established in 1999 and is an organization in which current and former psychiatry users support each other, take joint initiatives, and formulate policies and requirements concerning their own interests. LAP plays a great formal role because the organization promotes recovery thinking through advocacy. Their importance is reflected in the fact that LAP is often sitting at the table at political task force groups and projects. Hence LAP had a big role in the development of the Government's Report on Psychiatry. It is linked with national and international user-led campaign organisations such as the Hearing Voices Network and the World Network of Psychiatric Users.

The *Hearing Voices Network* exists in Denmark since 2005 and led debates on human rights combined with a critique of the medical model and the biological or genetic foundation upon which it is built. For example they fought for that schizophrenia should no longer be seen as a chronic illness in psychiatry. They influenced the psychiatric profession. For example, as a result of their advocacy the Danish Psychiatric Foundation published a revised book on schizophrenia and other psychosis acknowledging that hearing voices was not necessarily a symptom of schizophrenia and that it was possible to recover.

Outsider is a Copenhagen-based journal and an association where previous users of the psychiatric health system reports on the field of recovery. The Outsider was established in 1995, and publishes journalistic articles and personal accounts and thereby strives to promote understanding of living conditions for people with a mental diagnosis, among those who have not experienced it. They also work to present the many ways to create a meaningful everyday life, in spite of a mental disorder. The journal is dependent on funding from The Ministry of Social Affairs, Municipality of Copenhagen and Municipality of Frederiksberg.

The *Social Network* is an NGO that primarily works on the prevention agenda. The former Danish Prime Minister Poul Nyrup Rasmussen initiated the Social Network in 2009. They arrange annual meetings with a range of diverse national third sector organisations in the psychiatric field such as associations on depression, OCD, anxiety and so on - and it is a forum where the organisations can discuss ideas. In this setting, The Social Network has introduced the recovery approach to these organisations. The Social Network has brought important recovery approaches to the psychiatric field and was also important in influencing interdisciplinary collaboration between the fields of mental health and social care at the Government's Committee on Psychiatry (2013).

The private company *PsykoVision* was founded in 2013 by two psychiatrists and offers customized recovery programs in a non-institutional framework. They teach people suffering from schizophrenia how to live with and master the voices and hence move on in life. PsykoVision is however an exception and the only private sector provider of recovery oriented treatment and support. The idea of PsykoVision and recovery-oriented approach was based on and influenced by international practices of recovery

4.1.3. Dynamics in the field

United Kingdom

Over decades the recovery approach appeared and disappeared as a concept before and it gained growing attraction in 2006/7. During the 80s and 90s recovery was only a small movement outside of mainstream psychiatry. And, whilst the ideological argument for the recovery approach was already made in 2001 (e.g. in 'The Roads to Recovery' book), policy makers did not see its fit with wider government goals at the time and experts concluded that the recovery approach was not in the "Zeitgeist"

The reason why the recovery approach could finally happen was linked to a number of circumstances and conditions:

- The unsustainable situation of community mental health teams, which as a result of the deinstitutionalisation process had become under substantial pressure to manage the vast majority of people living with mental illness – including those with severe conditions; they did not have access to social support infrastructure in the community that was provided typically provided by the third sector; the issue of revolving door (people always returning) made the concept of recovery appealing to commissioners who were under pressure to demonstrate value for money;
- Related to this was the political context in which a major service reform in 2000 had failed addressing the demands and pressures of community mental health provision; the reform had set out a comprehensive strategy for providing crisis services (with the aim to keep people out of hospital), assertive outreach (with the aim to chase people who did not want to be in the system); and early intervention (with the aim to prevent illness from getting worse); the need for change was recognised in 2005 when the reform was reviewed and policy makers needed to come up with a different policy approach;

- At around the same time government declared that mental health would have an equal policy status as physical health; this was informed by evidence on the disease burden of mental health and the influence of important national and international mental health researchers and clinicians (public health white paper "Healthy Lives, Health People"); this was a major push in the mental health field and again demanded from policy makers to come up with a new approach acceptable to the majority of stakeholders.

Around the time when the service reform started to crumble, discussions took place between national recovery pioneers and government officials and there were a number of facilitating factors that convinced government officials of the benefits of promoting the recovery approach as an umbrella mental health policy (i.e. the likelihood that it could work to address the current challenges):

- Locally, examples of projects that followed user-focused recovery approaches were already being implemented successfully;
- Knowledge and expertise was available through network of pioneers who could take on the political leadership; those were well connected with local champions (social entrepreneurs) as well as other professionals supporting the recovery approach; this included
- Support from the professional membership body for psychiatrist, the Royal College of Psychiatrists; some of the pioneers were members of the Royal Colleges and could thus influence the bodies from inside;
- The recovery approach had support from local commissioners, which had already started using the terminology of recovery;
- The recovery approach had been already 'successfully' implemented in other countries such as US and New Zealand; in particular the New Zealand example might have played a role as it is recognized as a country with similar health and social care system and which had been at the time it implemented the recovery approach in similar situation in regards to economic pressure;

Taken together, these circumstances provided some assurance to government officials that the recovery approach was likely to be feasible. The success and relatively wide implementation of the recovery approach was partly explained by the way it fitted well with other policy programmes, societal thinking and care ideology at that time. Some experts felt that the term 'recovery' was power – and successful due to its "polyvalence" i.e. it was an attractive concept that was used differently by different individuals and groups and allowed for multiple perspectives and interpretations.

Experts also identified the following potential barriers of the recovery approach:

- Segregation of government departments: Whilst recovery happens outside of health services, no government department (other than potentially public health) worked across sector boundaries; the recovery approach required cross professional disciplines and the health sector had to learn from other sectors;
- Too many political changes had happened too fast and lead to what was described as a "memory loss"; this referred in particular to the NHS and the changes in commissioning such as the demolition of Primary Care Trusts and the introduction of Clinical Commissioning Groups;
- Supporting people who were supported by adult social care was seen as a particularly challenging area (because people in social care were perceived as needing and being eligible for social care for the rest of their lives);
- Stigma and discrimination as well as the societal and public sector focus on risk and a very cautious perception of risk were seen as hindering factors;
- A narrow focus on quality and performance of public service delivery was seen as potential barrier to a genuine implementation of the recovery approach in which individuals define recovery for themselves and the process of recovery can be a lifetime experience;
- Shortcoming in the statutory sector in regards to community mental health teams (CMHT), which often did not have good relationships with the third sector, meant that the third sector was not well integrated into service delivery pathways; this led to a situation in which CMHT could not cope

with the pressure and caseload whilst capacities of the third sector were thus not sufficiently utilized or created;
- As a result of these tensions at a system level, people on the ground needed to be activists in order to deliver change;

Experts identified the following drivers and successes of the recovery approach:

- A growing evidence base was seen as a driver as well as a success of the recovery approach; scientific research validated individuals' stories; evidence that was being produced in this area was manifold and included systematic reviews, RCTs, intervention manuals, scholarly overviews and practice guides; international best practice evidence;
- Other drivers from the professional discipline included the development of clinical outcomes measures and clinical discourse;
- The recovery approach was seen as providing a common language (although people also often meant different things); in policy it had allowed to establish some ground rules; and offered helpful practical things for mental health practice;
- Consumer and civil rights movements had been the starting point and building ground for the recovery approach (interestingly, whilst there were necessary in the early stages of the recovery approach, these days they were also perceived by some as potential resistance because individuals pursued a radical understanding of recovery that was strongly critical of psychiatric practice and was thus perceived as challenging and disruptive);
- It had fitted competing policy priorities to get people better (and out of institutions) and whilst policy was not seen as a key driver the fact that polices incorporated the recovery approach as a concept more and more was seen as an important success;

Czech Republic

In the Czech Republic variations in the implementation of the recovery approach were more seen in the context of institutional rather than geographical variations. It was felt that there were differences in understandings of the term 'recovery' and what it really meant. Those differences were seen in relation to the type of institution (e.g. providers of community services, mental hospitals, researchers, patients' and family organizations). It was considered possible that Prague was more advanced than other regions but that generally geographical variations were not a decisive factor in explaining the implementation of the recovery approach. According to one expert:

> *"(...) for example, with the involvement of peer consultants basically there has not been a problem across the country. Generally, it is much easier to introduce recovery orientation in non-profit organizations, but it is true in case of innovations in general."*

Another expert described the phenomena of the "*islands of positive deviance*" where the recovery approach was developing.

The following barriers and challenges were identified:

- There was resistance to implement the mental health reform from particular parts of the old system such as hospital psychiatrists and insurance companies (which were reluctant to dedicate more money into the mental health system); on the other hand, some large psychiatric hospitals started being more sympathetic towards community care and are willing to cooperate.
- It was felt that there was an absence of a system where decisions on allocations of resources would be based on evidence, a lack of political leadership, and attempts to use reform money to strengthen instead of reform the current mental health care system – partly those were overcome by discussions, scientific evidence, interventions of European Commission and WHO.
- The establishment of the NIMH was described also as being a struggle financially and the organization found it initially difficult to secure funding which was partly then overcome when they received funding from the National Sustainability Programme.

- Introducing peer consultants to the service and transforming the role of individuals from being a 'patient' into a 'member of the team' was described as a challenging process which the professional management of the project had to overcome; they did this with the help of and close cooperation with partners from the Netherlands, a series of internships, flexibility and enthusiasm of participating third sector organisations. The change required both, the acceptance of new roles by participating NGOs as well as the support of the more traditionally minded actors such as psychiatric hospitals.
- Barriers were seen in the stigma surrounding mental illness and in psychiatry as a discipline; public opinion was negatively shaped by several murders committed by mentally ill released patients (including the way it had been presented in the media).
- Generally the mental health field had been at least historically of low priority and regarded 'unattractive'; this was also reflected in chronic underfinancing and underestimating the voice of service users in the mental health system.

There was no agreement among experts what would have happened if the identified actors had not been involved; one felt that the recovery concept would have make its way through anyway because the process was a paradigm shift that was not dependent on individuals' action. Another expert thought of system evolutions often being directed or influenced by some kind of coincidental meeting of relevant actors. Similarly, having a strong interpretation of recovery (inspired by individuals such as by Mark Ragins from MHA Village in the US) informed a general understanding of the recovery concept. A common language of the concept driven by individuals from the non-profit sector was seen as being an important condition that needed to be in place in order for change to happen.

In terms of other conditions and actors that were important in reaching some of the milestones of the recovery approach, experts considered the overall socio-historical development in the country as well as the situation abroad as important influencing variables. The expansion of the recovery approach was seen as being accelerated by the contact with foreign countries including contacts with and visits by the international recovery 'celebrities' (pioneers). The important role of education and international knowledge exchange was emphasised such as in form of events, courses, conference papers. There were people who were searching and transferring innovations on the professional base and, of course, there was EU funding. The role of so called peer specialists was emphasised in implementing the recovery concept and developing good practice.

France

Experts felt that a recovery approach - either individually or collectively - which did not involve institutions and professions was unthinkable in the current psychiatric system. The social model of disability was still only defined in terms of institutions and professions and experts thought that this presented the main resistance to the recovery approach.

However, there were some key divers of the recovery approach such as the 2005 Disability Law and the influence of three third sector organisations, which led to funding for new service delivery models and establishment of the GEM (together with the implementation of the new legislation). This started with reflections of these three third sector organisations on the role of user groups, with plans and suggestions being laid out in workshops, conferences and publications; those eventually gained the interest of the Minister of State for Disabled People, who attended a joint UNAFAM-FNA-PSY day of reflection on the potential of clubs. The Minister expressed her desire to create such clubs and proposed funding of €20m to fund their establishment and running costs as part of the forthcoming law on disability. The budget offered was sufficient to provide for €75,000 for each organisation. The aim was to support emerging groups of vulnerable people, not only already existing, mature organisations. These newer groups could decide to become independent parts of existing non-profits, such as UNAFAM. The growth of the GEMs was rapid. By the end of 2006, there were already 204 clubs across France, and by 2010, 340. One expert described that this move went some way to recognising the principle of 'nothing for us, without us' but there is still too little patient participation and voice in their care.

Despite these drivers, experts stated that France was at the stage of prompts on the social innovation scale; there were a few prototypes available, but they were little known.

The resistance from psychiatry was very evident; one experts thought that

"less than 10% of French psychiatrists ever heard of the term"

and another felt

"it would take 20 years for the idea of recovery to catch on in France".

All experts consulted spoke of strong resistances to the concept of recovery in France. Examples in which this had become evident included: a proposed workshop on recovery being turned down by the scientific committee and a special edition on recovery that almost did not happen.

Experts gave the following explanations for resistances: Professionals in the current system spend their time focusing on the sickest patients, who were probably less likely to progress than others. Professionals internalised an image of the person as a sick patient who will remain a patient, rather than as individual who can evolve, recover and grow.

An expert explained that professionals can become comfortable in their position. Further, the same expert noted that many professionals were trained in silos, having little contact with developments in mental health on an international level. Even though the health system also involves a significant number of staff, who bridge the field of medical and social work, an expert believed that their faith still relies on an institution healing an individual, rather than the individual taking power and defining their needs, goals and dreams.

Resistance was also noted in regards to some of the prototypes such as the Invites au Festin model. Many people felt the model could not be rolled out widely because it was reliant on a large number of volunteers. The expert thought that some of these resistances were reflections of laziness on the part of ordinary citizens, a desire to avoid the (sometimes heavy) responsibility of getting involved with such a model. Furthermore, the expert thought that this resistance reflected a lack of desire by health professional to change prevailing psychiatric practices, and particularly to imagine alternatives to the institutionalization of the sickest patients. Recently, the charity had undertaken a Social Return on Investment analysis (carried out by ESSEC Business School) which showed its effectiveness. The last few years have demonstrated that the model can be replicated, with a dozen or so franchised Invites au Festin Network house opening in France, Belgium and Rwanda.

Denmark

In Denmark a there were wide variations in the way the recovery approach has been implemented in practice and by different municipalities.

According to one expert, barriers towards the recovery approach exist within the structures of the way that the public institutions are organized and experts agreed that a paradigm shifts was needed in order to implement the recovery approach. A barrier towards this paradigm shift was the way that recovery was difficult to define. This had allowed people to think that recovery was just another way of justifying budget cuts. Resistance from professional disciplines based on fears and concerns that the recovery approach jeopardized professionalism and evidence-based practice, was another barrier.

One expert mentioned:

"There has been a fight among professionals from different sectors for the right to define in the area"

Another barrier for a shift of paradigm was seen in that the transition to a recovery-oriented system required resources and a dismantling of power structures. One expert explained that many actors and institutions

used the word 'recovery' because it has a positive 'sound', but very few actors put forward concrete initiatives:

> *"Many organizations are very inert in the transition to recovery, because transition entails big alterations of organizational structures and professional perspectives on mental illness. The fundamental structures of mental illness have not adopted recovery approaches. Most recovery projects are mostly temporary and recovery does not get permanent funding."*

The reason for this resistance was that the recovery approach challenged expert models and New Public Management models because recovery is focused on individuals and is hence breaking loose of exclusive focus on pre-set factors for mental illness and treatment hereof. The work by Larry Davidson was mentioned as it illustrated how recovery required great changes in fundamental systemic structures. A power related barrier for implementation of recovery was that the field of psychiatry was understood as a purely medical field and profession. This created some challenges in regards to applying a more multidisciplinary approach.

> *"The recovery paradigm is especially challenging for the established expert role of the psychiatric institutions, since recovery promotes a meeting between two experts and not between patient and expert. This new relation between expert and user challenges the culture in the established institutions."*

A barrier to a paradigm shift was the strong power position of the municipalities, which were the frontrunners in recovery approaches which often were not user-focused or user-led. This top-down integration of the recovery approach in the formal systems was criticised by experts who thought that by definition the recovery approach needed to be implemented in bottom up manners

Further, the extent to which regional authorities (as the responsible body for the psychiatric field) were oriented towards recovery varied widely. So, whilst there were a number of smaller recovery projects initiated by the regions, mainstream psychiatry did not usually get substantially involved in recovery.

One expert thought that organisations needed to be able to reformulate their fundamental thinking in order to successfully adapting practice to the recovery approach, which he described as:

> *"Change the thinking, change the practice, change the system"*

4.1.4. Stratification and (de-)commodification in the field

Each of the countries faced major challenges in scaling up the recovery approach. Some of the key challenges were similar between countries such as: government departments working in silos, a command and control culture within the mainstream public sector and the strong influence of professional disciplines, which were often protective of traditional structures. There was some evidence that bottom-up movements influenced by third sector organisations could influence government decision making in each of the countries. However, in Denmark the recovery approach appeared to be heavily reliant on the municipalities, which had some power to decide if and how to lead the implementation of the recovery approach in their areas. In France, the state has not (yet) made a concerted drive to spread the recovery approach, although it has – with Housing First (known in France as Un Chez Soi D'Abord) - piloted and evaluated a programme that follows the recovery approach. Innovations in both, UK and Czech Republic seemed to be able to be done more easily in collaborative efforts between a wide range of actors from the private and third sectors. Both systems also showed a higher openness towards international influences which had initiated and supported the recovery approach.

In regards to *(de-)commodification*, there was no evidence as such that commercial market forces (i.e. the private sector) had a role in driving the recovery approach in any of the four countries suggesting high decommodification in all countries. In all four countries mental health services were largely state funded and seen as an entitlement rather than something that people needed to pay for, again suggesting high decommodifiaction in this (sub-)field. Whilst international and national legislation demanded in each of

the countries to some extent a wider mental wellbeing approach in line with the social model of disability, governments had not always implemented such approaches, which resulted in large unmet needs and gaps in service provision. Thus, there is a question about who would be providing and paying for the support individuals needed to achieve their full recovery including support that would reduce societal stigma and discrimination. In at least three of the four the countries the third sector played an important role in addressing some the gaps; France was an exception as the dominant role of the State did not leave much room for third sector influence.

In regards to *stratification*, in each of the country the recovery approach had a role in including population groups that were otherwise excluded from society and sometimes also excluded from publicly funded mental health services. Whilst projects offering support that followed the principles of the recovery approach was operating highly inclusively in all four countries, it was possible that they did not reach out to all sections of the community. Additionally, the fact that in some countries mental health professionals, who wanted to practice the recovery approach moved into private practice meant that it would only be available to people who could afford to pay for it. In the comparison across countries it became evident that an overemphasis on social protection could be in conflict with a focus on empowerment-based approaches (and thus with the recovery approach).

In addition to these commonalities between countries, there were also some country specific characteristics and differences which are explained in more detail.

In **UK**, increasingly political attempts were made to include the recovery approach into the performance management of the publicly funded (mental) health system and thus lead to some commodification. Experts saw this development as a potential threat to the originality of the recovery approach whilst they also thought that this process had allowed the scaling up and diffusion of the recovery approach. In comparison with the other three countries, UK appeared to country were the commodification of mental health services was the strongest and the recovery approach needed to be commodified in order to become part of the mainstream services; in fact it was used as a vehicle to commodify mental and other public services by deriving outcomes tool. In the UK, there was also movement driven by some of the key stakeholders involved in the process that the time, skills and experiences of people with lived experience should be financially valued and not seen as a free good. Again, this suggested higher degrees of commodification. Additionally, a commodification of recovery approach might have been suggested by the availability of books that could be purchased, the consultancy activities of recovery pioneers, who offered their expertise in redesigning systems; however, most such activities and exchanges were provided or took place as part of quasi-markets within the public sector (rather than the private sector).

In **Czech Republic**, local and national activities were closely interlinked, which might be explained by the smaller size of the country. This close network allowed for substantial achievements in the mental health area. However, traditional values and beliefs in society (stigma) were predominant and hindered the dissemination of innovation in the social welfare state. The traditional focus on social protection of vulnerable individuals appeared to hinder the implementation of empowerment principles that are the basis of the recovery approach. The strong notion that individuals with mental health difficulties were second-class citizens that needed to be covered by (minimum) social protection was an evident barrier towards scaling up the recovery approach. The recovery field was thus characterised by moderate levels of decommodification with people being seen as being entitled to some basic state-funded support. The role of the recovery approach in supporting people who were socially excluded and in addressing stigma faced by those groups was evident. In Czech Republic (as in the UK), human rights legislation had been utilized to some extent to support the rights base for people with mental health difficulties and to advocate for some political attention as a precondition for making the recovery approach happen. Some of the terminology used in Czech Republic to describe people with mental health needs, such as ‘handicapped’, indicated traditional social welfare norms which assumed that people, once handicapped or disabled could not move on. On the other hand,

In **France**, there was evidence that the third sector was able to inform government legislation, but generally the infrastructure of the third sector appeared in a weaker position than in the UK and Czech Republic. For example, they did not seem to have the power to suggest more controversial ideas and to the challenges the

government. Experts also felt the lack of influence from other countries was seen as hampering innovations and the social inertia was particularly strong. There was not much evidence of movements that could have challenged the existing system, which was accepted by many professionals as satisfactory. The lack of using evidence and research (including personal stories) to inform changes appeared to be another barrier towards the recovery approach. There appeared to a lack of infrastructure that could have facilitated the learning from local innovations driven by third sector organisations and the scaling to the national level. Since there was not much evidence of the existence of the recovery approach in France, it was not possible to derive final conclusions about commodification and stratification in this area.

In **Denmark**, the development and implementation of the recovery approach was mainly led by municipalities in the field of social psychiatry whilst the psychiatric field continued to treat citizens with a mental diagnosis in a traditional way; the disintegration between local and regional health and social care authorities was seen as a particularly strong barrier to the implementation of recovery approach that crossed different public sector areas. At the same time there were strong service user led organisations driving recovery movements by influencing government. Funds were made available by government to encourage collaborative working between sectors (including the private sector). Some experts thought that the recovery approach would lose its true nature if it was just made part of the system and thus a concern to deal with the recovery approach as a commodity. On the other hand, there was evidence of some professionals offering their 'recovery' skills on the private market. A high level of social protection and decommodification in the mental health system might have contributed to reduced demand for the recovery approach as there might have been less of an expectation that people would move on. Experts reported that UN Convention for people with disability led to some confusion as to whether this covered mental illness and whether it contradicted the recovery approach (because it socially protected people with 'disability'). There was some evidence that mental health professionals, who did not agree with the traditional medical model of providing services, moved private practice to be able to carry out activities that followed the principles of the recovery approach.

5. Country perspectives on actor characteristics

5.1. Sector affiliation of actors

In **UK**, the majority of the organisations that participated in the research were charities although the way they had been set up varied widely. One organisation was a large public sector run NHS Trust and the project we interviewed was funded by the charity of this Trust. Another charitable trust was hosted by the local NHS partnership Trust. Two organisations were set up as community interest companies (social enterprises).

In **Czech Republic**, interviews were carried out with public sector and third sector providers in the community. In the process tracing analysis, public sector providers in the community had not been identified as a major actor in regards to the recovery approach whereas third sector organisations were reported as having an important role in driving in bottom up movements. In Czech Republic, public sector organisations which provided social services (under national law) were led by regional authorities; a hospital provider for addiction problem was included but did not seem to have major role in driving the recovery approach; two non-profit organisations which were strong actors in regards to driving the recovery approach.

In **France**, one organisation had been founded by an individual psychiatrist (and her husband) because she was frustrated with the culture in mental health hospitals which left people without hope of recovery and there was minimal stimulation for this group; individuals engaging with the project had many years of life without progress and hope behind them and suffered from stigma and discrimination. The other two third sector organisations had strong government ties and originated from changes to the Disability Law that the government decided to support with funding for mutual self-help groups and for homelessness projects; this decision was strongly informed by third sector organisations, which had demonstrated the need for such support.

In **Denmark,** municipalities were seen as the frontrunner in regards to the implementation of the recovery approach. The two projects included in the research, had been initiated by municipalities; whilst one project was strongly involved in the governance of the project, the other one was not and had evolved in a bottom-up manner based on non-governed and volunteer-driven processes. Psychiatric institutions did not have any role in being involved in the recovery approach.

5.2. Social needs orientation (H 1.1)

In **UK**, both public and third sector organisations addressed social needs of people with mental health problems inclusively although public sector organisations had a clear focus on individuals who were using NHS services. They felt that the main challenge working with this population was the stigma given by society and the attitudes of the majority of mental health professionals; organisations had been developed based on identified needs; for some this was based on a personal motivation and desires for change, for others this was based on perceived market gaps and for others again it was based on needs identified in collaboration with individuals and the community . For example one organisation that was linked to the NHS described the way they had been established as follows:

> *"It [the organisation] was launched in (...) in response to service users and carers expressing their desire for more creative approaches to understanding and supporting their health and wellbeing. The strategy was co-produced through a series of workshops which focused on working with and listening to the views of service users, carers, Trust staff and community organisations and groups."*

Often, ways of identifying needs were more informal and took place through *"placing the individual at the centre"*.

In the **Czech Republic**, the public sector led projects that were interviewed employed recovery approaches that were activation and rehabilitation focused but did not necessarily took the person' ambitions into account. The primary focus was still on the person's disability rather than on the individual. Organisations typically used satisfaction surveys and person-centred planning to identify and assess individuals' needs but it was less clear how wider community needs were assessed. Organisations struggled with too much demand and this was viewed as a major challenges working with this population. Whilst organisations were aware that persons with mental illness were a marginalised group that was not being valued by society (and investments in this area were seen as 'waste of money'), it was unclear if they had a role in addressing this. Terms used by public sector organisations reflected less social needs orientations (e.g. 'disability', 'therapeutic', 'normal life' 'reintegration').

Third sector organisation in the CR had less formal processes for identifying social needs in addition to more formal, individualistic ones such as satisfaction survey or interviews and questionnaires. For example, they asked individuals and families what they needed/ wanted and employed more person-centred processes. However, they were also exclusive of some groups such as those with co-occurring gambling or substance addictions. Third sector organisations saw the challenges of working with a highly marginalised group whose human rights were often violated and in which public and societal pressures meant that not much public sector support was given to this population. The population was described as affected by poverty and inequalities, highly stigmatised group with barriers to employment and living a 'normal life'. Generally, there was more evidence of the motivation of third sector organisations to fill an important gap and of awareness of the role of society and environment and that those needed to change rather than the person. They also had more awareness of human rights aspects and government's lack of support for this population. There was clear evidence of the motivation and belief that support should not focus on the person's disability but on the challenges presented in the way society dealt with disability (in line with the social model of disability).

In **France**, some form of assessment or interview process by two organisations in which they check whether a person would fit into the community could indicate they are not taken everyone and operate not fully inclusively; student psychologists were mentioned as a resource to help checking whether they met needs an put their values into action. For the organisation that was running successfully for many years and that had a great reputation, there were fewer challenges of supporting this group; however, the initial starting of

recovery projects was described as 'very challenging'. Challenges of working on the recovery approach included: achieving sufficient state funding to make the financial model sustainable; transmitting the belief that ordinary citizens can play a role in recovery; and believing that long-term mentally ill people can take on responsibilities. These required many personal and financial sacrifices.

One organisation reported challenges in reaching out to individuals.

> *"Individuals find it difficult to get motivated, even if they need and want social contacts"*

This organisation specifically aimed to break down social barriers and to open up norms set by society providing a space for creativity and to focus also on wider community relationships.

In **Denmark**, one of the two projects that were part of the research had a process in place how they assessed and reviewed needs of individuals following placing emphasis on individuals' motivation:

> *"In project (...) it is very important that it is the citizen's own wish to move on and recover that is the core of the service. It cannot be an institution that detects a need and refers a citizen to the project, it needs to be the citizen him- or herself that must define the recovery need that they will seek to meet through the participation in project (...). At an introducing dialogue it is established whether the citizens that have been signed up for a match with a companion is motivated for the process. If the citizen is not motivated and it seems like it is a professional from i.e. home support services who have taken the citizen then he or her should not be in the program. Hence this personal introductory dialogue is very important for detecting needs and in detecting the absence of a need for a companion (...). It is not a requirement that people have a diagnosis. Hence a citizen without can communicate the need for a companion and be entitled to be enrolled in the project on equal terms with people who have a diagnosis. If people see themselves as mentally vulnerable then they are very welcome here."*

5.3. Organisational value sets (H 1.2)

In the UK, all organisations reported to follow strong and wide range of social value sets which included personalisation, human rights, co-production, dignity, empowerment, equality. Whilst all organisations strongly disagreed that profit was an important value for them, performance, excellence and quality were usually seen as core parts of what they were seeking to achieve. One user-led organisation that provided a creative and inclusive space for people with mental illness felt that quality was an essential part of what they were trying to do in order to signal dignity and worthiness to individuals who had in their lives generally been treated without dignity.

The constitutional objective of one third sector organization was

> *"to promote social inclusion among people who are socially excluded from society due to mental ill-health - through the provision social events which foster social connection, and allow for the creative exploration of mental illness, recovery and well-being for all".*

Creativity was seen by many of the organization as an important human need that an important value.

In **Czech Republic**, in the third sector, individuals started their own organization (very small initially) and value sets reflected personal values (e.g. terms like 'feeling proud') and recovery is defined as a deeply personal and unique process. Values of organisations include empowerment, quality, equality, human rights, dignity and service user involvement. There was less focus on values such as solidarity, profit, personalization. However, organisations struggled with strategic decision making and only some of the values could be implemented easily; dignity was a main priority; all values were seen as important including quality, excellence and performance. Public sector organisations in health and social care (CR) had similar value sets as third sector organisations with slightly less focus on human rights, coproduction and citizenship.

In **France**, organisational values of third sector organisations were also very much determined by individuals who founded and led the organisation.

One interviewee and founder said his/her aim was to:

> *"(...) recreate the links and the journey between people touched by mental illness and the rest of society" and "to develop the citizenship of everybody, because everyone is touched in some way by mental illness".*

She/he then also stated:

> *"The values come first and then the organization follows."*

They also agreed that they followed values such equality, human rights, citizenship, compassion, mentor- and friendship. Some values were difficult to implement such as 'brotherhood' and 'empowerment'. Quality was seen as an important organisational value.

In **Denmark**, the municipality that was seen as most innovative in regards to recovery had implemented several values at the strategic level based on "user-driven" recovery. They developed four core values, which they used to navigate their interaction with the citizen.

These values were formulated as follows:

> *"1) you can move on in life, 2) your perspective is the starting point, 3) you make the decisions, 4) nothing about you without you" (Municipality of Aarhus, 2009).*

As these core values suggest, the municipality of Aarhus wanted to make it clear that mentally ill citizens can recover and that the recovery process might be very specific and uniquely tied to the individual; the citizen hence had influence on his or her own recovery-process, within the framework of choices and possibilities provided by the municipality's institutions.

In regards to the recovery project that was organised by the municipality the interviewee stated that values were those of recovery defined as

> *"hope and potential for progress",* and the project aimed *"to support the citizens' process to move on with their lives"* and to achieve social inclusion.

5.4. Internal organisational culture (H 1.3)

In the **UK**, each of the organisations showed high levels of staff dedication; the starting up of each of the organisations (or project in the case of the public sector organisation) was initiated by one or two individuals who were best described as founders and had characteristics of social entrepreneurs. Organisational culture was thus also highly influenced by individuals' values, which reflected the values of the recovery approach i.e. being focused on empowerment. Organisations had in common that their culture was based on the principles of recovery and co-production, and this led their organisational decision-making. However, this was seen as a complex process that required the management of organisational paradoxes. This included managing paradoxes between on the one hand the need and determination to be informal, inclusive, personal, and giving everyone equal status and, on the other hand, the need to also be sustainable (and possibly scale-able if demand required this). Some of these paradoxes were managed less explicitly, but all organisation employed principles of bottom up decision making; one organisation operated highly informally with only one person employed to manage the core business.

The conflict between the recovery movement and pursuing organisational norms was described by one interviewee:

> *"The more I think about it the more nuanced the issue of 'organisation' becomes … conventionally we do think of activities and outcomes arising from organisations but in some ways the heart of the recovery movement is about disorganisation as it arose in protest of the status quo and how a health care response for the population dominated by professions working in organisations seemed to have become depersonalised and unable to respond to individuals. (…) in many ways the recovery ethos has arisen outside of organisations as a critical reform movement – recovery has not so much been an organisational project as the ethically and experientially driven mission of motivate people seeking to influence the organisations who hold most of the resources."*

Non-profit organisations in the **Czech Republic** delegated decisions to staff by following principles of subsidiarity, which was seen as a 'win-win' situation; training was provided including external training and internal courses and provide online agenda. Peer members and consultants with lived experience were employed; there was evidence of a supportive environment for staff and modern management in which case managers support their staff in achieving what they want. Staff was highly dedicated staff and proud to work there

One interviewee reported

> *"No one is forced to work overtime but some people do (it is up to them and both is respected)."*

The job environment was seen as an important driver for a high quality service; values practiced by staff included mutual support, friendliness and openness; however, another non-profit organisation did not involve non-managerial staff in decision-making whilst one public sector organisation included non-managerial (clinical) staff in decision-making on regular basis as part of multi-disciplinary team working. There was less evidence of high staff dedication in the public sector organisation.

In **France**, one third sector organisation did not have a formal hierarchy and decisions were being made in teams; teams were encouraged to make decisions autonomously; they had a strategic committee for major decisions and the committee was composed of volunteers, administrators and staff representatives; the interviewee takes on administrative and financial decisions that need to be dealt with on a daily basis

> (but *"these are the decisions that no-one else wants to take");*

volunteers had monthly meetings and there was a lot of exchange between volunteers and staff on-site. Staff were highly committed in particular those who had been there since its beginning; more recently they have started employing more staff with a professional background in medical and social care.

New staff sometimes needed

> *"to relax a little, to lose some of their professional persona, in order to enter into the spirit of things as they are done (in that organization)".*

Whilst staff was highly diverse in terms of skills and experiences they were diverse in regards to gender, religious and ethnic backgrounds, sexual orientation and disability. This third sector organization did not make a distinction between managerial and non-managerial staff; another third sector organization saw participative decision making seen as innovation (suggesting that traditionally decision making was more hierarchical). Another third sector organization noted that it took

> *"time to put values into action"*

and in particular helping people help themselves took more time than doing things for them (but would be against value of empowerment); this organization only had two employed member of staff; service users were involved in governance, management and running of the organization. The focus of third sector organisations was following social protection aims and their experience of how to implement empowerment-based approaches was limited.

In **Denmark**, the recovery approach almost exclusively happened in municipalities, which were seen as the frontrunner of the recovery approach; one interviewee thought that:

> *"Many organizations are very inert in the transition to recovery, because transition entails big alterations of organizational structures and professional perspectives on mental illness. The fundamental structures of mental illness have not adopted recovery approaches".*

An exception to this was one of the interviewed projects, which had been initiated by a municipality but which was largely self-governed and grew in a bottom-up approach. The other project that was part of the research and which was governed by a partnership including a municipality appeared to have a productive culture in which employees felt highly valued:

> *"…what makes the partnership so good is that all the actors feel that they have value to the project and they feel involved in the process. We gather the actors at a steering committee meeting every third month during the three years. At these meetings both employees and leaders are represented and everybody is very engaged, and all the partners believe in the project. Further, there is mutual recognition of the competences that the different actors bring to the group, and an awareness that these competences complement each other".*

For psychiatric institutions, organizational culture was thought to present a strong barrier towards the effective implementation of the recovery approach:

> *"The recovery paradigm is especially challenging for the established expert role of the psychiatric institutions, since recovery promotes a meeting between two experts and not between patient and expert. This new relation between expert and user challenges the culture in the established structures".*

5.5. External organisational openness (H 1.4)

In **UK**, each of the organisations worked within networks of a wide range of organisation; each of the organisation had been the driver of new relationships and the development of networks connecting often a wide range of organisations from different actors. For example, the public sector organisation and the charity hosted by a public sector organisation were having a strong hub position in a network of generally much smaller third sector organisations. One organisation was specifically funded by government at a national level to support public and third sector organisations in following the recovery approach and building their skills and capacity to do so. The other third sector organisations were more focused on building and developing relationships with a wide range of partners including much larger public sector ones. In one case they had developed a separate organisational entity (in form of a partnership) with the local NHS Trust. Relationship building and knowledge exchange with external stakeholders was seen as a core part of each organisation's business taking up substantial amount of time and effort. Aims and types of knowledge exchange activities varied depending on the organisational purpose i.e. service delivery or capacity building. For example, organisations that sought to influence the culture of organisations, in particular the NHS, provided a range of consultancy, teaching and information sharing events. Organisations that focused on service delivery worked in close collaboration to provide a wide range of creative, social support and educational activities. Organisations often involved external stakeholders including staff and volunteers in their decision making processes, either formally through their role as Trustees on their Board or informally. External influences were seen by most third sector organisations as essential drivers of innovation:

> *"To believe and have the vision that change can happen– that nothing is impossible to achieve. To identify other key influencers who have similar aims and work with them."*

In **Czech Republic**, non-profit organisations were recognised by external stakeholders locally and beyond; the importance of reputation and recognition through awards was evident; there was a limited involvement of external stakeholders in strategic decision-making but stakeholders were listened to and they had

knowledge exchange with external organisations; one organisation had plans to incorporate service user views more.

Whilst one organisation stated that they were

"respecting views of politicians (they) do not work to their order".

Learning from international projects was seen as particularly valuable. Knowledge exchange activities included organising mental health awareness courses for students and teachers; destigmatisation events; reaching out also to inpatient psychiatrist and explaining work to them; this included communication with doctors. One organisation saw their role in influencing state authorities, politicians, officials and they participated in local community planning. Public sector organisations did not share decisions with external stakeholders; it was seen that this could not be aligned with fixed rules of their community-based treatment and also it was not seen as something needed; they seemed thus more inwards oriented.

In **France**, one third sector organisation appeared more inwards focused and strategic decision making was only made internally; it was possible that in order to be able to maintain their own unique organisational cultural they acted protectively against the outside world (which often did not employ their values); however they welcomed anyone who was interested to visit and had regular open days and other knowledge exchange session, events and conferences to which they invited external stakeholders; so they shared their culture with the outside world.

The differences in organisational cultures of partners were acknowledged and it was also appreciated that it was

"vital to stay in touch".

Another third sector organization referred their clients to wide range organization with which they work operationally (but no evidence that they worked strategically together). In another third sector organisation two members of the Board of Trustees were from external stakeholder organisations representing partner and mentor organisations. Again, there was no evidence of shared decision making with stakeholders although the two partner organisations provided them with financial security, knowledge and skills. These organisations worked closely in a network with other third sector organisations of the same kind (i.e. mutual self-help).

In **Denmark**, it was generally reported that multi-disciplinary working between public sector organisations was often limited especially between municipalities and psychiatric institutions. One issue was that different professional groups wanted to take control over what recovery meant and fitting it to their own professional understanding. In regards to the two interviewed projects, they were set up in collaborative efforts between municipalities and third sector organisations (including a social enterprise) and collaborations with external partners was one of their key objectives. Partnership work was described by one of the interviewees as follows:

"The citizens and the volunteers as well as the leisure activity organisations and communities that form essential part of the service are all external partners, which we the project partners work to pair and integrate into companionships."

5.6. Transaction costs in detecting societal challenges and know-how (H 1.5)

In **UK**, the third sector organisation linked to the public sector was a large organisation that was getting most of the funding from the local NHS (Clinical Commissioning Groups); other funding sources included those from national charities and it was felt that government was just one funding body of many. Whilst trust replaced reporting contracts at large, a lot of time was also spent on looking for new funding sources.

Within NHS networks the organisation had easy and low cost access to knowledge exchange with other organisations; competition with other providers, however, made knowledge exchange more complicated. In regards to ease of decision-making the representative of the organisation described the situation as follows:

> *"I think that shared decisions can be made quickly, but not effortlessly. Maintaining relationships and links does require a lot of effort."*

One of the peer-led third sector organisations was funded from contracts with the local NHS and local authority as well as from smaller local and national third sector grants and some fund raising activities. The organisation had to spend a lot of time looking for new funding sources as well as on ensuring the reporting requirements were met. Partnerships with stakeholders were seen as very important in order to access specialist knowledge, build and maintain connections with local professional communities and to utilise national and international connections. Challenges for some third sector organisations working with public sector included their limited time and accessibility and flexibility.

Most organisations felt, that there was an increasing need for the organisation to manage multiple relationships with funding bodies and also that, relationships were primarily based on trust, loyalty and reciprocity. Having local, national and international reputations played an important part in organisations' abilities of securing funds and in developing and implementing innovative ideas.

The organisations linked to the public sector were more likely to lead networks and hold resources and knowledge (the term power was generally not used); third sector organisations were more likely to be part of loosely connected networks that were more diverse but shared values and emphasised service user involvement; networks' capacity for radical change and for shared decision making was seen as relatively low but access to knowledge exchange was rated high

In **Czech Republic**, one non-profit organisation had many different funding sources including private funding; they struggled for finances and spent a lot of time ensuring that reporting requirements were met. Relationships with external stakeholders were primarily based on trust, loyalty and reciprocity, which also meant that the organisation had easy and low cost access to knowledge exchange.

However, they reported that decision making with external parties required efforts and time, in particular with the city and council, which did not

> *"understand their ways of working"*

and placed too much administrative burden on them. A lack of long-term financing was seen as major barrier towards their ability to share decision-making and this was also seen as major barrier for being able to innovate. Public sector organisations had stable statutory funding but a lot of time was spent on meeting procurement requirements although it was also thought that government consortia or initiatives had substantially reduced procurement requirements. Access to knowledge exchange with other organisations was seen as easy and low cost. However, processes appeared more complex if external organisations wanted to support from or work with their local hospitals.

In **France**, decision-making internally was described by one organisation as easy with short decision ways and lots of knowledge exchange within the organisation that also allowed them to understand social needs (at least as they occurred for individuals engaged with the organisation). The same organisation had three main types of income sources and resources:

- Income from the sale of goods and services and income paid by residents for their board and lodging,
- Income from external funders, mainly government,
- Donations (but very small only 3% of total budget),
- The value of goods given and volunteer time

In regards to government funding, the organisation did not think that trust replaced contracts and government planned to provide less funding over time; this also meant more time needed to be spent on ensuring reporting requirements were met and funding secured. Knowledge exchange with health and social care organisations was seen as complicated and it was not always easy to work with hospital psychiatrists who had a different understanding of mental illness and approach to working with service users Shared decision-making with external stakeholders was seen as very time consuming. Stakeholders included: parents and family members; service users themselves; local authorities; regional authorities; social services (the organisation had good relationships with an integrated health and social care team which helped service users to attain autonomy and with social links). Doing things differently – although very successfully as reflected in its reputation among funders, volunteers - was not always well perceived among local public sector organisations (refers to mental health services). Another third organisation reported that they operated in a highly state dominated field and within a network of public sector organisations that were closely connected and dependent on another. Trust was rated as low in this network and organisations did not share many values. Within this network shared decision making, the ability to problem-solve, and capacity for radical changes were all rated low; however there was a higher capacity for more incremental changes, knowledge exchange and access to diverse assets. The funding of another third sector organisation was largely from government and some stability and they felt some security for accessing such funds; funding of one organisations included health funding (from Department of Health in Paris) as well as local authority/ city funding; also some private funding; but over 90% from government; reporting requirements only for public funds; trust based relationships with other third sector organizationIn terms of legislation, experts did not think that the 2008 UN Convention had any influence on the recovery movement in France., the mentor/parent organization; but less the case for the relationships with the regional healthcare authority which are described as 'more formal' and knowledge exchange is more complicated and time consuming.

In **Denmark**, funding for the projects comes from a 'pool' hold by the Ministry of Social Affairs and more specifically the National Board of Social Services Fund, which provides 15 million Danish kroners over the period of three years. The interviewee described the ways of communicating as part of the partnership as easy, which was mainly due to partnerships built over many years:

> *"The different organisational actors that partake in this project knew of each other even before the project (…) was established. They were in the same field or network, though not necessarily connected or in direct contact. The acquaintance has made initiation of the project fast and efficient. Hence, it has had a positive influence on the project that the actors had a good relation in advance of the collaboration. (…) We have had many discussions about how we can continue the project after the financial support from the pool stops in November. All the project partners wish the project to go on. We are thus now working to find new financial supporters for the project. Some of the money will come from the municipality of Aarhus. In this process we have also recruited some volunteers who will be part of the coordinating team instead of being companions, because we will not have as much money for paid coordinator work".*

5.7. Embeddedness in social/local context (H 1.6)

In **UK**, each of the organisations showed strong embeddedness in their local community; most of them provided a wide range of activities at the interface with the local community such as cafes, exhibitions, courses, workshops, open days, cultural events. The local community or environment often referred to individuals with mental health needs and their families and organisations supporting the same population. However, they also could refer to organisation that they shared values or interests with (in particular passion for arts and culture). As part of their capacity building role, third sector organisations had developed strong skills and experiences in reaching out to a wide range of stakeholders including stakeholders that had different value sets. The organisations more closely attached to NHS Trusts utilised and were planning to expand their relationships with smaller third sector organisations to reach out to local communities. Some organisation had broader aims to support the whole community (for example in order to reduce stigma of mental illness or to offer preventative support) whilst others were specifically focused on the population of people with mental illness and their families. Interviewee responses showed that organisations defined their local context and social capital in broader terms i.e. including not only citizens and service users and families but also staff and volunteers, and organisations they were connected with. Whilst smaller

organisations were closely geographically oriented in their definition of stakeholders some also had national and international connections to other organisations. The third sector organisation that was closely linked to the NHS saw an important role in connecting to their local communities through their many collaborations including service user led projects and creative partners.

One of the smaller organisations that had been founded by an entrepreneur described their wide and diverse reach as follows:

> *"Approximately 60% of (..) [members] have used services in the past three years and 40% are from the wider public including providers, commissioners, funders, carers, mental health and medical professionals, artists, performers and researchers, which illustrates this mix."*

In **Czech Republic**, third sector organisation were also known and recognised locally and beyond; reputation and recognition through awards beyond the local context was important to them. They also organised lots of activities with community interface such as festivals and days of corporate voluntarism and a 'Cirkus Patiento', which works with families and wider public. Organisations operated as part of networks that were closely connected and followed similar values and employed similar assets. In addition, they had more loosely formed connections with other partners. Working within the network was described as at times challenging leaving them with a feeling that they were not able to achieve change.

In **France**, one third-sector organisation in particular had a strong focus on community and the local context; it was reaching out to the wider community and invited individuals from the community more widely. Another organisation also arranged and set up a wide range of activities to interact with the wider community. Third sector organisations had some assessment processes in place where they excluded certain individuals that were not deemed suitable (e.g. when they did not come based on their own motivation or when they had violent behaviours).

In **Denmark**, the projects carried out in collaboration between government and the third sector had strong community orientation; in fact the aim of one of the project was to integrate mentally vulnerable individuals back into the community. Communities were defined by the individuals' characteristics and interests and could include a volunteer-run sports association or similar. The other project was also a community-based project that offered a range of activities and had an open and inviting atmosphere that was inclusive but targeted also at vulnerable populations. The project emphasized the importance of the two persons finding common interests in a civil society based organization /association/community rather than a community driven by the municipality.

5.8. The role of voluntary engagement (H 1.8)

In the **UK**, individuals and organisations emphasised the importance of paying people with lived experience of mental illness when they took on role of peer support and similar in organisations. The aim is to prevent an exploitation and devaluation of individuals with lived experience. This was seen as an important part of ensuring that expertise from lived experience is given an equal value to professional experience. Two of the third sector organisations were user- or peer-led; whilst they employed a few paid staff to manage the organisation, volunteers contributed essentially to the running of the organisation. Whilst transitions or progressions from roles of service users to volunteers and from volunteers to staff were encouraged, it was important that roles were clearly distinguishable. Setting some boundaries between roles of staff and volunteers was seen as important in order for the organisation to run smoothly.

> *"There are significant differences between what is required from paid staff and volunteers. Volunteers are given a 4 hour shift for a specific time and tasks. Paid staff cover 12 hour shift (…)*
>
> *The volunteers are not expected to supervise other volunteers but to work as part of the team. The paid staff are expected to take the lead, supervise and ensure the space is a safe environment. The volunteers do support the patrons but are asked to pass it on to paid staff if there are any issues they are uncomfortable with."*

The organisation that was a third sector one linked to the public sector distinguished the role of volunteering for their own organisation from the one that was taken on by the NHS Trust; whilst for the Trust volunteering was still something new that they wanted to develop, for the organisation had established infrastructures for a large number of volunteers through their many partnerships. Activities included befriending activities. Across all organisations, volunteers had many opportunities to get engaged in education and employment.

In **Czech Republic**, one third sector organisation reported that their ways of engaging volunteers was diverse and that they experimented new approaches to break down barriers between the "dichotomy" of being either service user or professional. However, they also reported that legislative barriers prevented them from experimenting more freely. Volunteering opportunities included those of recruiting volunteers from corporate environments (who helped with construction and maintenance work), from the European Voluntary Service, foreign volunteers for summer camps, permanent volunteers who helped running the service (e.g. cooking and cleaning up together with service users, planning and participating in events). Another third sector organisation offered volunteering opportunities to both service users and staff and offered employment to volunteers indicating no strong boundaries between the three groups. Service users were involved in decision-making and the organisation offered training and development opportunities for staff. One public organisation provided more formal volunteering opportunities with defined roles and responsibilities; this included the opportunity for volunteers to become staff members. Volunteers were recruited from national charities (including with religious values such as the Diocese); altogether eighteen volunteers provided more than 800 hours in a year. Volunteers' activities included primarily the planning and engagement in social events and befriending and social support of service users. The other public sector organisation, a psychiatric institution did not engage volunteers.

In **France**, in the third sector organisation that had been founded by an individual entrepreneur employed many volunteers who were highly diverse in terms of their socio-demographic characteristics; the organisation provided volunteers with employment opportunities; service users in this organisation were supported to become involved in organisational decision-making or activities. Volunteers were at the heart of the organisational approach. They participated in the organisation by running and taking part in activities.

Their role was to

> *"help service users see that many of the barriers they have faced in terms of stigma and isolation are not irrevocable, but can be overcome by allowing oneself to be surrounded by people who are open, kind and compassionate".*

Some service users took on volunteer roles such as producing the newsletter or vetting potential new residents (it was less clear if they could also progress into paid employment).

The organisation reported that they sought to avoid divides between service users and volunteers' – because

> *"everyone who was there had the same key skill to put to use – their humanity".*

There were 60 volunteers and many of them were highly committed and have been volunteering for the organisation for a long time. Volunteering the government-associated third sector organisations was less common and one organisation deliberately avoided the term volunteer as this was felt to emphasise a distinction between those helped and those helping although; the other organisation provided peer mentor roles.

In **Denmark**, the two projects were heavily reliant on volunteers; one project provided befriending, which was provided by volunteers; the second project offered opportunities for individuals to become involved in the project as volunteers; volunteers were then called staff members. Boundaries between volunteers and staff were being seen as fluent; for example one of the projects considered recruiting more volunteers into the coordinating team to address future budgets cuts.

"The fact that the companions are volunteers is important because it is one step further on the way to recovering than interaction with professionals in the psychiatric services. The citizens are very grateful that the volunteers want to help them getting on with their lives"

"We have four organizational volunteers, who are not companions. But they have chosen to be organizational volunteers because they wish to make an impact for the project and for the vulnerable citizens."

5.9. 'Unengaged' forms of volunteering (if applicable) (H 1.9)

Not applicable to this field

5.10. Linkage between advocacy work and service provision (H 1.10)

In **UK**, the core function for the majority of organisations was to provide activities and support for people with mental illness; it was interesting to note that none of the organisations had a strong advocacy or campaign function as defined by the literature but that most organisations had developed a sophisticated capacity building role that allowed them to influence other actors and organisations, often (but not only) from the public sector; this role might have been at least partly developed as a way of dealing with limited budgets and possibly reflecting their small size and in some ways limited possibilities to officially criticise or act against public sector organisations. However, interviewees did not mention this and instead emphasised that this approach was more line with the recovery approach, which by definition could not be imposed and it a process that is personal to the needs of individuals or groups of individuals. One organisation had been through a learning process, during which they had changed from initially be prescriptive about recovery approach to then work with the organisation to develop the organisation's own understanding of the recovery approach. So, over time most of the third sector organisations had acquired skills and experiences in convincing stakeholders to adopt the recovery approach by promoting the positive benefits of doing it. One peer/ user-led organisation stated that whilst their main function was a service provider one, they were campaigning from service or projects by giving service users a voice which also meant they were empowered to self-advocacy.

Potential tensions between service delivery and advocacy functions were managed

"through developing relationships with other organisations and interested parties who have similar goals".

Organisations that were part of NHS Trusts had a stronger focus on delivering services rather than on developing the capacity; a certain independence from the NHS Trust seemed necessary for third sector organisation in order to develop their capacity building role although the one organisation that was a charity under the structure of a NHS Trust felt that they had

"the best of the two worlds".

In **Czech Republic**, the interviewed third sector organisations were members of the Association of Community Services which carried out campaign and advocacy work. Whilst organisations received their main funding for providing services they also carried out their own destigmatising campaigns (which was supported by the Norwegian Fund). Service provision and advocacy went hand in hand in form of community engagement activities such as neighbourhood festivals or craft workshops. One interviewee reported that whilst they did not see their primary organisational purpose in campaign activities, they had plans to expand their public relations activities.

In **France**, organisations had mainly service provider roles and received most of their funding from service provision (also in media mainly represented with their activities); not much evidence that organisation seeks to proactively influence publicly funded and run health and social care providers – probably out of their ability to influence as they describe this as a very closely connected network that is not based on shared values and trust; however, founder is a pioneer and writes books and seeks to influence the public and profession. Another third sector organisation provided one-to-one advocacy with the aim to empower

individuals and enable them to become self-advocates; the same organisation also carried out some work with local and national media.

In **Denmark**, one of the two collaborative projects worked with a social enterprise (which was pat of the collaboration) on media presentation thus carrying out some advocacy of their work. The main focus was, however, on providing support for individuals with mental illness by linking them up with volunteer befrienders. The project representative stated that:

> *"We do advocacy activities. I have presented … (the project) to different departments of the municipality of Aarhus, which is a political organization, and hereby advocated for the project. We seek to gain support within the municipality's departments, also in economic terms. The combination of providing our service and of spreading knowledge of the project goes very well hand in hand, and everybody that I have talked to have been very positive"*

5.11. Independence from external pressures (H 1.11)

In **UK**, most organisations felt able to act relatively independent of external pressures although challenges were experienced in regards to the NHS culture. For organisation having some secure core funding was seen as important in order to maintain organisation's ability to innovate. Most interviewees emphasised the importance of local and (inter-) national recognition to access or secure existing funding.

In **Czech Republic**, public sector providers felt less able to have external influence and although they had some funding stability to maintain their business they were under pressure of excess demand; non-profit sector organisations were more likely to be under funding threats and staff was only on low salaries; the medical profession was perceived as the main resistance that was causing pressures. However, third sector organisations reported high abilities to influence change. This was also evidenced by the national and local recognition they received; they were being taken seriously by local health service providers. One organisation felt that they had high ability to act independently from market pressures but low ability act independently from financial and media pressures.

In **France**, one organisation stated that there were not able to act independently from financial pressures but able to operate free from political and media pressures and largely free from competition.

In **Denmark**, challenges were described as follows:

> *"Most recovery projects are mostly temporary and recovery does not get permanent funding".*

The reason for this was seen in the fact that the recovery approach challenged professionalism and theoretical concepts and explanations such as the New Public Management model or concepts about risk factors for mental illness and treatment approaches. The implementation of the recovery approach was seen as requiring fundamental changes to the current system. Pressures were thus seen as barriers that were almost insurmountable and as largely preventing the initiation and growth of the individual organisations. Project representatives also reported financial pressures:

> *"We are very dependent on political discourses and priorities (…); (the funding) of the Ministry of Social Affairs that has funded our first three years has roots in a political orientation that our project can benefit from because there is a match. Now that the money from the pool stops we are very dependent on political willingness, and we have only just managed to secure money for the continued running of the project"*

6. Innovation properties

In regards to innovation properties, a distinction could be made between i) the process and nature of the change in which the recovery approach happened; ii) the impact that the recovery approach had on the field of health care. This also specifically refers to the life cycle of innovations.

6.1. Innovation trajectories and dynamism (disruptiveness of the innovation)

Across countries, it was sometimes difficult to distinguish incremental from radical changes; generally the scaling up phase (where it had taken place) was incremental. However, there were also radical moments (most evidently in the UK and Czech Republic) when change happened more quickly and rapidly.

Most evidently in **UK** the recovery approach started off as a 'movement' by being initiated by pioneers including individuals from the US and New Zealand. The movement was for a long time only very small and only became part of the policy agenda when it was seen as able to address economic and political pressures. One third sector organisation announced that the time for the recovery approach had come. So whereas pioneers (through third sector organisations) had advocated for the recovery approach for several decades, it required at an opportune time when the government was faced with real demand and finance pressures. Especially at its beginnings the recovery approach was considered 'radical' in the sense that that it was 'controversial' and questioned societal norms; experts felt that process overall had been both at times fast and abrupt and at other times very slow. It was also closely linked to the dynamics of other innovations and movements.

In **Czech Republic**, the recovery approach started much later than in the UK and happened more gradually and slowly (but steadily). Interestingly, until now it has not become part of any political agenda as such but there are powerful actors who continue pushing for the recovery approach and there is also evidence of government funding and support. A range of practice developments have happened over time contributing to a steady change. This includes the introduction of peer support workers, service user involvement initiatives and training and awareness courses on recovery. Not all developments are directly supporting the recovery approach but they support the principles of the recovery approach. The resistance in Czech Republic is quite strong which might have contributed to the slower and steady developments.

In **France**, the recovery approach as a movement is small compared to the other three countries. There have been some developments that supported some of the principles of the recovery approach such as the Housing First initiative. Those changes were initiated and organized centrally, which meant they could potentially happen systematically. However, some initiatives were only piloted initially and it thus remains to be seen whether this will lead to a change at a national level.

In **Denmark**, the beginnings of the recovery approach were marked by the introduction of a government initiated knowledge centre in the late 90s and of a new professional discipline that – supporting the principles of the recovery approach - combined social, rehabilitative and psychiatric approaches. Since then the implementation of the recovery approach happened steadily and had reached the 'scaling' stage according to some experts (although other felt that it was still the earlier stages because a lot of the recovery practice was not truly user-focused). The resistance from the traditional mental health profession was described as strong and so was the culture of the medical model within mainstream public services that needed to change.

6.2. 'Strength' of the innovation: country-specific particularities

In **UK**, the recovery approach has in some regards affected large parts of the mental health system; this relates to the awareness among professionals; this is because of the support from government in policies and the polyvalence of the term that fitted wo well with many actors and agendas; however, the resistance from large parts of the medical discipline and possibly even from parts of society meant that the medical model still predominates mainstream clinical practice and the recovery approach remains in large parts of the NHS a rhetoric. Experts thought that in regards to the current stage of the innovation life cycle, there was some evidence that recovery approach had reached the diffusion phase and moved outside of the mental health system; on the other hand it still continued to provide prompts. Because it started off as something more radical it was sometimes hard to feel progress (this could be indication of the diffusion of the original concept of recovery). It was not easy to identify if the recovery approach had led to a real system change if 'system' referred to the NHS. If the 'system' was defined more broadly then there was evidence of systemic changes. For example, changes in the local communities had happened as a result of the wide range of recovery projects (such as recovery colleges); it also had led to many new partnership initiatives working across system (or at least recovery had been the name driving those). It had informed the work in other

sectors such as the long-term conditions field in which a new government programme seeks to move specialist provision out of hospital (vanguards sites of New Care Models Programme work with Mental Health Partnerships and ImROC). The recovery approach had been also picked up by the private sector (e.g. pharma industry) and created demand in form social marketing (used by publicly funded organisations such as CQC and Monitor). However, in some areas there was only limited progress. In particular, the employment area in which mental health stigma was even a bigger barrier and workforce was left out. Experts felt that that in particular the ImRoC programme had allowed to influence the sector. However, tin the overall context of the NHS it was felt that progress was relatively little. This was supported by experiences from other service developments in physical health which had been difficult to implement.

In the **Czech Republic**, experts felt it was difficult to derive final conclusion about the stage or phase of the life cycle that the recovery approach had reached. Generally experts thought that prototypes had been developed and that those were in the scaling up phase. However, not all experts thought that the scaling was an indication of a process towards systematic change. For example, whilst there was evidence of important changes such as having peer consultants and tutors, the growing influence of user movements and growing interest in the use of technologies connected with recovery, most changes did not scale up and were often limited to the third sector. In regards to the whole domain of mental health care, the recovery approach was still seen as only in the "prototypes" phase. This was supported by the fact that the term recovery was not contained in the official public policy or strategic documents. Overall, the recovery approach had not led to systematic changes but it was likely that it contributed importantly by creating capacities for change in the mental health field.

In **France**, the recovery approach was emerging as evidenced by a few programmes that supported the principles of the recovery approach. There were certain prompts and prototypes initiated by central government and provided by the third sector. In addition, a few individuals who were advocating and practicing the recovery approach locally leading to local innovation. Overall, there was evidence suggesting that the recovery approach experienced a powerful resistance that prevented the scaling up.

In **Denmark**, the recovery approach had been driven and implemented by some municipalities but geographical variation was particularly strong. There was evidence of that certain parts of government (namely the Ministry of Social Affairs) were strongly supportive of the recovery approach. For example, they provided municipalities with funding for collaborative working towards the recovery approach. However, resistance from the more traditional mental health system (in form of public psychiatry hospitals and district psychiatry), which was centrally led by the Ministry of Health and Prevention, hindered systematic change. Overall the impact of the recovery approach on the system of social psychiatry had been at least moderate to strong (dependant on geographical location) but its impact on mental health and broader health was more limited. The role of national service user-led third sector organisations, which were promoting the principles of the recovery approach, had been an important one.

7. Conclusions

In this work, we investigated the recovery approach from a dynamic perspective; specifically we examined the milestones and legislation that changed the landscape of the recovery approach and investigated the role of actors (individuals and organisations) in driving the recovery approach. We then analysed the characteristics of organisations which had implemented the recovery approach. With this analysis we were able to shed light on the two main ITSSOIN propositions concerned with the role of the third sector in the formation of social innovation and the influence of contextual factors.

Across countries, there were some commonalities in the way individuals or organisations were driving the recovery approach. In all four countries there was some evidence that the recovery approach (or at least some of the principles of the recovery approach) was initiated and driven by pioneers at a national level and implemented by individuals on the ground, who acted as champions or social entrepreneurs. National user-led organisations had an important role in driving the recovery approach by influencing central government. Other types of national third sector organisations played a role in influencing government including think tanks and research centres. There was evidence of some bottom-up developments in all countries.

In none of the countries played psychiatric institutions an important role in driving the recovery approach; however, there were exceptions in all countries (but Denmark), in which certain chief psychiatrists had shown interest in the recovery approach had started promoted it. However, in general terms, the culture within psychiatric institutions did not support recovery and this was seen as the biggest barrier of the recovery approach in all countries.

The role of collaboration and networks in driving the recovery approach was evident in all four countries and most evident in UK. Government departments working in silos appeared to be a main barrier to social innovation in all countries (although possibly to a lesser extent in Czech Republic). Across countries, and perhaps most evidently in Denmark, there were clear attempts to break down barriers of disintegration (in particular between health and social care). In UK, where the recovery approach had been taken on by government and implemented to the greatest extent (followed by Denmark), the a complexity of policies, relationships between a wide range stakeholders and quickly changing structures and policies presented barriers towards a systematic dissemination of bottom-up movements. The role of networks between individuals with same beliefs and values about recovery across organisations and sector boundaries was also evident in Czech Republic but less so in Denmark and in France.

In terms of local organisations or projects implementing the recovery approach, the organisational form they chose in establishing their activity was often the one of small charities. Most projects gained substantial recognition and reputation for their work, which allowed them to sustain their income and continue with their activities. There were some tensions for organisations in following recovery approach principles as well as ensuring the sustainability of their organisations. This was felt particularly by third sector organisations, which had often a stronger emphasis on social inclusion and empowerment of individuals.

Overall and across countries, third sector organisations appeared to be more likely than public sector organisations to have an advocacy function in addition to a service provider function (when compared with public sector organisations). Organisations had different ways of combining service delivery and advocacy function; for example some focused their advocacy work on their organisation's activities in form of Public Relations and Marketing; others developed capacity building functions by offering their skills to the public sector. Generally, the focus of third sector organisations was on convincing others (in particular the public sector) of the benefits of recovery approach and leading by example.

Across countries, there were some similarities in regards to the relationship between third sector organisations and their local communities. Organisations that offered local support were more strongly focused on the geographical locality whilst organisations with advocacy or capacity building roles were more oriented towards linking with organisations, which were often but not always based in geographical proximity. Third sector organisations offering services including leisure space, housing or accommodation, had possibly the closest connections with their local communities.

Important differences between countries referred to the role of (national) pioneers, who led service user- and political movements and had strong advocacy and campaigning abilities and skills. Although all countries had some pioneers, their ability to influence change at the national level varied strongly between countries and was most evident in the UK.

In regards to organisational values, they were often strongly influenced by individuals who founded and contributed to the organisation. Across countries, such organisations had in common that individuals working for them were highly dedicated to implementing the recovery principles and social value driven. Interestingly, whilst in France (as a country with a conservative social welfare systems according to Esping-Anderson typology used for ITSSOIN), values such as quality, performance, excellence seemed to have negative connotation, in UK and Czech Republic those values were seen as being equally important as – and not in conflict with - 'social' values such as equality or co-production. Values appeared to be more strongly oriented towards principles of solidarity in countries with less stratification (Denmark, France, Czech Republic) whilst human rights, empowerment and coproduction were more common in UK.

8. Limitations and outlook

This part of the ITSSOIN research involved some particular challenges. For example, ensuring consistency in data collection between countries was difficult. There were differences in the ways in which research participants could be approached for the purpose of the research and sometimes it was difficult to involve participants in the research. Another challenge was that the recovery approach was a particular 'controversial' topic as it is critical of mainstream mental health provision. Experts thus felt often quite strongly about developments in this field which made it more difficult to establish the type of information required for this work package. Perhaps unsurprisingly, it was easier to gain information in countries in which the recovery approach had developed stronger. We tried to address those challenges by providing partners with different options for collecting data and tried to analyse data in the context of how data had been collected.

This research shed light on the recovery approach as a social movement and area for innovation and the characteristics of organisations that were driving the recovery approach. We identified an important role of pioneers (as leaders of the social movement) and social entrepreneurs (as founders of organisations) across countries but their influence and ways of leading social innovation differed between countries. Future research would be useful to understand the roles of pioneers and social entrepreneurs in innovation processes more generally and explore country differences. In particular, it would be interesting to investigate the challenges faced by individuals who seek to implement social innovation and how they experience and manage the paradoxes of organising social innovations. This kind of knowledge would be useful in understanding how to support individuals and organisations in driving and implementing social innovations.

9. References

9.1. United Kingdom

Classics and narratives of recovery

Adame, A. L., & Knudson, R. M. (2007). Beyond the counter-narrative: Exploring alternative narratives of recovery from the psychiatric survivor movement. *Narrative Inquiry*, *17*(2), 157-178.

Anthony, W.A. Recovery from mental illness: The guiding vision of the mental health service system in the 1990s." *Psychosocial rehabilitation journal* 16 (1993): 11-11.

Coleman, R. 1999. *Recovery: An alien concept.* Gloucester: Handsell.

Deegan, P. (1996). Recovery as a journey of the heart. *Humanistic Psychologist*, *18*(3), 301313.

Deegan, P. 2002. Recovery as a self-directed process of healing and transformation. *Occupational Therapy in Mental Health.* 17, (5) pp. 5- 21.

Gray, P. (2006). *The madness of our lives: Experiences of mental breakdown and recovery*. Jessica Kingsley Publishers.

Lapsley, H., Nikora, L. W., & Black, R. (2002). *" Kia Mauri Tau!" Narratives of recovery from disabling mental health problems*. New Zealand: Mental health Commission.

Ridgway, P. (2001). Restorying psychiatric disability: Learning from first person recovery narratives. *Psychiatric rehabilitation journal*, *24*(4), 335-343.

Slade, M., Adams, N., & O'Hagan, M. (2012). Recovery: past progress and future challenges. *International Review of Psychiatry*, *24*(1), 1-4.

Critiques

Edgley, A., Stickley, T., Wright, N., & Repper, J. (2012). The politics of recovery in mental health: A left libertarian policy analysis. *Social Theory & Health*, *10*(2), 121-140.

Mind (2000). Life and times of a supermodel. The Recovery paradigm for mental health. London: Mind.

Pilgrim, D. (2008). Recovery and current mental health policy. *Chronic Illness*, *4*(4), 295-304.

Pilgrim, D. (2009). Recovery from mental health problems: Scratching the surface without ethnography. *Journal of Social Work Practice*, *23*(4), 475-487.

Wallcraft (2006). Recovery from mental breakdown or Illness in Gray, P. (ed). *The madness of our lives: Experiences of mental breakdown and recovery*. Jessica Kingsley Publishers.

Warner, R. (2004). *Recovery from schizophrenia: Psychiatry and political economy*. Routledge.

UK perspectives on recovery

Davidson, L. (2005). Recovery, self-management and the expert patient-Changing the culture of mental health from a UK perspective. Journal of Mental Health, 14(1), 25-35.

Turner-Crowson, J. & Wallcraft, J. 2002. The recovery vision for mental health services and research: A British perspective. Psychiatry Rehabilitation Journal. 25, pp. 245-254.

See also Stickley & Wright (2011) below.

Conceptual papers

Allott P. (2004). What is mental health, illness and recovery in Ryab, T. & Pritchard, J. (eds). *Good practice in adult mental health* pp 13-31.

Allott P, Loganathan L, Fulford KWM. Discovering hope for recovery. Canadian Journal of Community Mental Health (Revue canadienne de santq mentale communautaire) 2002;21(2):13-33.

Davidson, L. & Strauss, J.S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology.* 65, (2) pp. 131-145.

Davidson, L., Ridgway, P., Wieland, M., & O'Connell, M. (2009). A capabilities approach to mental health transformation: a conceptual framework for the recovery era. *Canadian Journal of Community Mental Health (Revue canadienne de santé mentale communautaire)*, *28*(2), 35-46.

Hopper, K. 2007. Rethinking social recovery in schizophrenia: what a capabilities approach might offer. *Social Science & Medicine.* 65, (5) pp. 868-879.

Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric services*, *52*(4), 482-485.

Ralph, R. 2007. Verbal definitions and visual models of recovery: Focus on the recovery model. In: *Recovery in mental illness*, (2nd ed.) Ralph, R.O. & Corrigan, P.W., eds., American Psychological Association.

Roberts, G. & Wolfson, P. 2004. The rediscovery of recovery: Open to all. *Advances in Psychiatric Treatment.* 10, pp. 37-49.

Slade, M., Adams, N., & O'Hagan, M. (2012). Recovery: past progress and future challenges. *International Review of Psychiatry*, *24*(1), 1-4.

Thornton, T., & Lucas, P. (2011). On the very idea of a recovery model for mental health. *Journal of Medical Ethics*, *37*(1), 24-28.

Topor, A., Borg, M., Di Girolamo, S. & Davidson, L. (2011). Not just an individual journey: Social aspects of recovery. *International Journal of Social Psychiatry.* 57, (1) pp. 90-99.

Literature reviews/synthesis

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, *199*(6), 445-452.

Onken, S.J., Craig, C.M., Ridgway, P., Ralph, R.O, & Cook, J.A. 2007. An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal.* 31, (1) pp. 9-22.

Stickley, T. & Wright, N. (2011). The British research evidence for recovery. Papers published between 2006 and 2009 (inclusive). Part One: a review of the peer reviewed literature using a systematic approach. *Journal of Psychiatric and Mental Health Nursing.* 18, (3) pp. 247-256.

Stickley, T., & Wright, N. (2011). The British research evidence for recovery, papers published between 2006 and 2009 (inclusive). Part Two: a review of the grey literature including book chapters and policy documents. *Journal of Psychiatric and Mental Health Nursing*, *18*(4), 297-307.

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2012). Social factors and recovery from mental health difficulties: a review of the evidence. *British Journal of Social Work*, *42*(3), 443-460.

Weisser J, Morrow M, Jamer B. (2011). *A Critical Exploration of Social Inequities in the Mental Health Recovery Literature.* Vancouver, BC: Centre for the Study of Gender, Social Inequities and Mental Health.

Empirical studies

Andresen, R., Oades, L. & Caputi, P. 2003. The experience of recovery from schizophrenia: Towards an empirically validated stage model. *Australian & New Zealand Journal of Psychiatry.* 37, (5) 586-594.

Davidson, L. 2003. *Living outside mental illness: Qualitative studies of recovery in schizophrenia.* New York: New York University Press.

Huxley, P., Evans, S., Beresford, P., Davidson, B. & King, S. 2009. The principles and provisions of relationships; Findings from an evaluation of support, time and recovery workers in Mental Health Services in England. *Journal of Social Work.* 9, (1) pp. 99-117.

Mancini, M. A., Hardiman, E. R., & Lawson, H. A. (2005). Making sense of it all: Consumer providers' theories about factors facilitating and impeding recovery from psychiatric disabilities. *Psychiatric Rehabilitation Journal*, *29*(1), 48-55.

Mancini, M. A. (2007). A qualitative analysis of turning points in the recovery process. *American Journal of Psychiatric Rehabilitation*, 10(3), 223-244.

Jenkins, J. H., & Carpenter-Song, E. (2005). The new paradigm of recovery from schizophrenia: cultural conundrums of improvement without cure. *Culture, Medicine and Psychiatry*, *29*(4), 379-413.

Resnick, S. G., Fontana, A., Lehman, A. F., & Rosenheck, R. A. (2005). An empirical conceptualization of the recovery orientation. *Schizophrenia research*, *75*(1), 119-128.

Wisdom, J. P., Bruce, K., Saedi, G. A., Weis, T., & Green, C. A. (2008). 'Stealing me from myself': identity and recovery in personal accounts of mental illness. *Australian and New Zealand Journal of Psychiatry*, *42*(6), 489-495.

Recovery as policy

Jacobson, N. 2004. *In recovery: The making of mental health policy.* Nashville: Vanderbilt University Press.

Jacobson, N. & Curtis, L. 2000. Recovery as policy in mental health services: Strategies emerging from the States. *Psychosocial Rehabilitation Journal.* 23, (4) pp. 333-341.

Jacobson, N. (2003). Defining recovery: An interactionist analysis of mental health policy development, Wisconsin 1996-1999. *Qualitative Health Research*, *13*(3), 378-393.

National Institute for Mental Health England. 2005. *NIMHE Guiding Statement on Recovery*. London: NIMHE.

Recovery focused system development

Boardman, J. & Frieldi, L. (2012). *Implementing Recovery through organisational change: Recovery, Public Mental health and Wellbeing*. London: Centre for Mental Health.

Carling. P.J. & Allott (2004). Roads to Recovery (Papers 1-5). CSIP: East Midlands.

Davidson, L., O'Connell, M., Tandora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health. System transformation. Psychiatric Services. 57 (5), pp. 640-645.

Davidson, L., Rowe, M., Tondora, J., O'Connell, M. J., & Lawless, M. S. (2008). *A practical guide to recovery-oriented practice: Tools for transforming mental health care*. Oxford University Press, USA.

Farkas, Marianne, et al. (2005). Implementing recovery oriented evidence based programs: Identifying the critical dimensions." *Community Mental Health Journal* 41(2): 141-158.

Onken, S. J., Dumont, J. M., Ridgway, P., Dornan, D. H., & Ralph, R. O. (2002). Mental health recovery: What helps and what hinders? A national research project for the development of recovery facilitating system performance indicators. *Prepared for National Technical Assistance Center for State Mental Health Planning, National Association of State Mental Health Program Directors*.

Perkins, Rachel, and Mike Slade. (2012). Recovery in England: Transforming statutory services? *International Review of Psychiatry* 24.1 (2012): 29-39.

Shepherd, G., Boardman, J. & Slade, M. (2008). *Making Recovery a Reality*. London: Centre for Mental Health.

Recovery-focused practice development

Buck, K. D., Roe, D., Yanos, P., Buck, B., Fogley, R. L., Grant, M., & Lysaker, P. H. (2012). Challenges to assisting with the recovery of personal identity and wellness for persons with serious mental illness: Considerations for mental health professionals. *Psychosis*, (ahead-of-print), 1-10.

Deegan, P.E. 1988. Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal.* 11, (4) pp. 11-19.

Ramon S, Healy B, Renouf N. (2007). Recovery from mental illness as an emergent concept and practice in Australia and the UK. *International Journal of Social Psychiatry* 53(2):108-22.

Perkins, R. (2006). First person: 'you need hope to cope'. *Enabling Recovery: The Principles and Practice of Rehabilitation Psychiatry*, 112.

Repper, J. & Perkins, R. 2003. *Social inclusion and recovery: A model for mental health practice.* Oxford: Bailliere Tindall.

Shepherd, G., Boardamn, J. & Slade, M. *Ten Top Tips for recovery oriented practice*, 2008. London: Sainsbury Centre for Mental Health.

Shepherd, G., Boardman, J., & Slade, M. (2008). *Making recovery a reality* (pp. 1-3). London: Sainsbury Centre for Mental Health.

Slade, M. (2009). *Personal recovery and mental illness*. Cambridge: Cambridge University Press.

Miscellaneous

Amering, M., & Schmolke, M. (2009). Recovery in mental health: reshaping scientific and clinical responsibilities (Vol. 7). Chichester: Wiley.

Slade, M., Amering, M., & Oades, L. (2008). Recovery: an international perspective. Epidemiologia e Psichiatria Sociale, 17(2), 128.

Social Perspectives Network (2007). Whose recovery is it Anyway? London: SPN, SCIE and CSIP.

Ralph, R. O., & Corrigan, P. W. (2005). Recovery in mental illness. Washington, DC: American Psychological Association.

Websites

http://bjp.rcpsych.org/content/206/2/115

http://www.crisiscareconcordat.org.uk/wp-content/uploads/2015/09/20153006-Final-crisis-recovery.pdf

http://opendialogueapproach.co.uk/2016-conference/

9.2. Czech Republic

Pěč, O. a Probstová, V.(2009). Psychózy psychoterapie,rehabilitace a komunitní péče. Praha: Triton.

Pěč, O. a Probstová, V. (2014). Psychiatrie pro sociální pracovníky. Praha: Portál.

Ridgway, P., cDiarmid, D., Davidson, L., Bayes, J. a Ratzlaff, S. (2002). Pathways to Recovery: A Strength Recovery Self-Help Workbook. Lawrence KS: University of Kansas School of Social Welfare. Literature

Conference proceedings, “Au dela de la maladie et du handicap se rétablir?” (Beyond illness and disability, recovery ?) 27th and 28th March, 2014.

Besancon, Marie-Noelle (2015) On dit qu’ils sont fou et je vis avec eux, Paris : Les Editions de l’Atelier

Pachoud, B. (2012) Se rétablir de troubles psychiatriques: un changement de regard sur le devenir des personnes, Information psychiatrique 88 :257-266

Pachoud, B. (2012) Se rétablir de la maladie, Sante Mentale, 166: 24-30

Ouhayoun, B. Le « rétablissement » au pays des mangeurs de grenouilles … et de la psychothérapie institutionnelle…. http://www.congresfrancaispsychiatrie.org/nl5_8/

Roelandt, Jean-Luc et al (2015) Programme Mediation Sante/Pairs Rapport Finale de l’Experimentation, 2012-2014. CCOMS.

9.3. France

Conference proceedings, "Au dela de la maladie et du handicap se rétablir?" (Beyond illness and disability, recovery ?) 27th and 28th March, 2014.

Besancon, Marie-Noelle (2015) On dit qu'ils sont fou et je vis avec eux, Paris : Les Editions de l'Atelier

Pachoud, B. (2012) Se rétablir de troubles psychiatriques: un changement de regard sur le devenir des personnes, Information psychiatrique 88 :257-266

Pachoud, B. (2012) Se rétablir de la maladie, Sante Mentale, 166: 24-30

Ouhayoun, B. Le « rétablissement » au pays des mangeurs de grenouilles … et de la psychothérapie institutionnelle…. http://www.congresfrancaispsychiatrie.org/nl5_8/

http://tempsreel.nouvelobs.com/societe/20160201.OBS3786/hopital-psychiatrique-ces-anciens-patients-qui-soignent-les-malades.html#

9.4. Denmark

Bengtsson, Steen and Linda Kilskou Kristensen. (2006) Særforsorgens Udlægning: Et Litteraturstudie. København: Socialforskningsinstituttet.

Municipality of Aarhus (2009). Plan for fortsat implementering af styrket Recovery-orientering i den psykosociale rehabilitering. Aarhus: Aarhus Kommune, Socialforvaltningen. Can be extracted from: http://www.aarhus.dk/~/media/Dokumenter/MSB/SOC/Organisation/SUV/Implementeringsplan-2009-2011.ashx

Neidel Agnete (2011). På vej? Kritiske analyser af recovery-orienteringen af det socialpsykiatriske arbejde. PhD Afhandlinger Roskilde Universitet og © Forskerskolen i Livslang Læring ISBN: 978-87-91387-48-7

Socialministeriet (2010). FNs Komvention Om Rettightheder for Mennekser Med Handicap -på Let Dansk. København: Socialministeriet.

Social- og Indenrigsministeriet (no date). "Psykiske ledelser" at http://sim.dk/arbejdsomraader/udsatte-voksne/psykiske-lidelser.aspx

Socialtyrelsen (2015). " Samarbejder mellem det offentlige og civilsamfundet til forebyggende indsatser for personer med sindslidelser (15M-puljen, 2013-2016)" at http://socialstyrelsen.dk/projekter-og-initiativer/handicap/15m-puljen-2013-2016

Sundhedsministeriet 2001. "Rapport fra Udvalget vedrørende bedre samspil mellem tilbuddene I psykiatrien og socialpsykiatrien" Maj 2001

Topor, Alain, Johan Svensson, Carsten Bjerke, Marit Borg, and Elin Kufås. (2002) Vendepunkter Et Nærstudie Af Vendepunkter for Mennesker Der ErKommet Sig Efter Alvorlig Psykisk Lidelse. København: Videnscenter for Sociaipsykiatri.

Videnscenter for Socialpsykiatri 2000:4 – Socialpsykiatri 3/2000

Online resources

http://socialstyrelsen.dk/projekter-og-initiativer/handicap/15m-puljen-2013-2016

http://www.frivilligcenteraarhus.dk/om-os/frivilligcenter-aarhus

http://cfdp.dk/more-about-centre-for-digital-youth-care/

http://www.antv.dk/om-os/

http://www.sind.dk/english

http://www.socialpsykiatri.roskilde.dk/omnavnpaainstitutionentilbuddet.asp

http://insp.dk/forside/

Web pages for organisations and actors

Knowledge Center for Social Psychiatry (no webpage, no longer exists)

National Board of Social Services: http://socialstyrelsen.dk/om-os/about-the-national-board-of-social-services

Ministry of Social Affairs and the Interior: http://english.sim.dk/

Capital Region: https://www.regionh.dk/english/Pages/default.aspx

The Psychiatric Associations' Joint Council: http://www.psykiatriforening.dk/

Danish association for psycho social rehabilitation: http://psykosocialrehabilitering.dk/

LAP: http://www.lap.dk/what-is-lap/

Outsideren: http://outsideren.dk/

The social network: http://english.psykisksaarbar.dk/

Project Følgeven: https://foelgeven.dk/

INSP!: http://insp.dk/

PsykoVision: https://www.psykovision.dk/recovery-forlob

Lundbeck Pharma: https://lundbeck.com/uk/about-us/lundbeck-uk

Other resources

Davidson, L.; Rakfeldt, J.; & Strauss, J.S.: The roots of the recovery movement: Lessons learned. London: Wiley-Blackwell, 2010.

Davidson, L.; Tondora, J.; O'Connell, M.J.; Lawless, M.S.; & Rowe, M.: A practical guide to recovery-oriented practice: Tools for transforming mental health care. New York: Oxford University Press, 2009.

Davidson, L.; Harding, C.M.; & Spaniol, L.: Recovery from severe mental illnesses:Research evidence and implications for practice. Volumes 1 and 2. Boston, MA: Center for Psychiatric Rehabilitation of Boston University, 2005 and 2006.

10. Appendix

10.1. Appendix A: Topic guide for expert workshop carried out as part of process tracing

London 3rd Feb 2016, 2.30-4.30pm
Topic Guide
"Recovery approaches in mental health"; as part of Itssoin project, FP7, European Commission

Arrival Time: 10 min
(Refreshments)

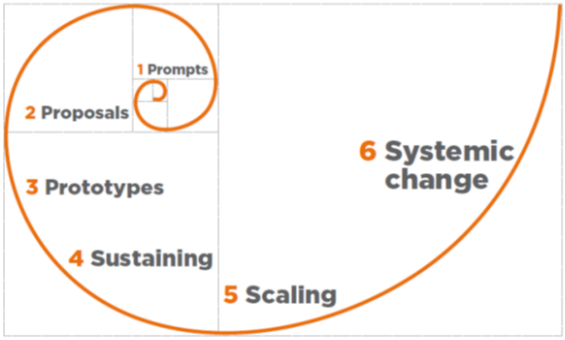
Introduction Time: 15 min
Welcome – thank you, brief introductions, broad aims of Itssoin (social innovation, role of third sector); LSE role in WP leadership for health; focus on social model of (mental) health led to user-focused recovery approaches (i.e. approaches that take the person's ambitions into account as opposed to recovery that is focused on clinical aims only) recovery approaches in mental health;
Aims of todays' session:
Review the current state of play of recovery approaches in UK [I suggest we leave it as UK and offer experts the possibility to narrow it down; this is more line with what we did in Itssoin work so far];
Trace key decisions and influences (=milestones) over the last decade which have helped shape policy and practice in this area;
Identify the drivers, barriers and characteristics of the recovery approach (what might have happened otherwise); and
Explore dynamics between actors and organisations who contributed to the recovery approach;
Identify information sources that can help to validate what has been said today;
Identify possible projects suitable for more in-depth work.
Explain time frame and approach: We will hand out the full set of questions [I suggest best way of ensuring that we get answers to all question is that we explain that is very important that we manage to get through the questions in 1.5hrs; this might mean that sometimes we will have to move on without reaching consent; this is fine; in fact the purpose is to get diverse views and gather many different ideas and pointers for where we will be looking for evidence over the next year rather than achieving consent; there will be other ways later on where we can verify points made in the discussions including another meeting (if people are still happy to further contribute; this will be then informed by further work including a survey and literature searches]
Explain about recording, data protection

Part 1
What is the state of play in user-focused recovery? Time 30 min
[The following sub-questions should lead the answer to that question:]
Which current legislation and policy is most relevant in the current context of user-focused recovery?
Which actors are currently involved in user-focused recovery?
How powerful are those and how do they use power?
Where has user-focused recovery fallen short and why?
What are the activities and roles of the most important actors?
What are important regional differences in the state of play between regions?

Part 2
What led to the current state of play in user-focused recovery? Time 30 min
[The following sub-questions should lead the answer to this question:]

Which of the phases describes the current state of play shown in the life cycle of innovations (Graph 1)?

What were the most important decisions and influences (=milestones) that led to the current state of play? This might include changes in national and international legislation (e.g. UN Convention), policy, practices, society, and economy).
Who (individuals, organisations) influenced those milestones most importantly?
When did they become involved in regards to refer to life cycle (Graph 1)?
What were the most important barriers along the way and how were they overcome?
What are likely alternative scenarios that could have happened?
What might have happened if the actors had not been involved?



Graph 1: The life cycle of innovations (Murray, Caulier-Grice and Mulgan 2010) – Illustrates different life stages of innovations: they start off highlighting the need for social innovation (prompts); develop into formulated ideas (proposals); get tested in practice (prototypes); become everyday practice (sustaining); grow and spread further (scaling); and finally reach the whole sector and even influence other sectors (systemic change).

Part 3 Time 30 min
What do you think are possible ways of validating what has been discussed today considering that traditional literature might not always capture some the dynamics between actors and developments over time?
Are there are any particular information sources –including unconventional ones - that you think are better than others to gather evidence? This might include minutes from parliament debates or other grey literature.
A next step of our work is to seek information on characteristics of organisations that influenced user-focused recovery. The aim is to understand which of those are associated with their abilities to be social innovative. Which organisations would you suggest should be evaluated (in addition to the ones you mentioned already)? Who would be best placed to provide information about those?
Another step will be to carry out an explorative economic impact analysis of one or two particular projects. Do you know of any good practice projects that would be interested?

Closure Time: 5 min
(Travel reimbursement)

10.2. Appendix B: Invite and questionnaire for interviews with experts as part of process tracing

[add location and date]

Subject: Questions to the mental health recovery approach

Dear [add name]

Thank you for agreeing to respond to this questionnaire. Your response will contribute to the European Commission funded research project, "Impact of the Third Sector as Social Innovation" (ITSSOIN). The project examines social innovations in different fields of policy and practice across a number of EU member states. You can find more information about the project at http://itssoin.eu/.

We approach you as an expert in mental health recovery. Mental health recovery has been chosen as a particularly interesting social innovation that we would like to explore. For the purpose of this research we are interested in user-focused recovery. This refers to person-centred recovery that put the person's goals and ambitions at the heart of recovery. This goes beyond clinical recovery and refers to the person's life.

Our aim is to assess the current state of play of recovery approaches in [add your country]) and trace key decisions and influences over the last decade which have helped shape policy and practice relating to the initiation and take up of this social innovation. We seek to identify drivers, barriers and characteristics of the recovery approach and explore dynamics between actors and organisations who contributed to the recovery approach. A particular objective for the study is to understand the role of the third sector alongside that of the state and the market in developing this innovation stream.

We thank you very much for your time and efforts contributing to this research. Please note that is very important to the success of the research that you answer the questions with as much detail as possible. By returning the questionnaire to use we assume that you agree that we share the information with our project partners. If you wish that your responses remain anonymous or if you have any questions, please contact [add the detail of the person they can contact].

With best wishes

Yours,
[add name], on behalf of Itssoin team

Part 1: Questions about the current state of play (i.e. landscape) in user-led recovery

Which legislation and policy in [add country] do you think is most relevant to user-focused recovery?

How do you think has the UN Convention for people with disability impact on the context of recovery in [add country]?

Which actors (individuals, organisations, collaborations) do you know that are currently involved in user-focused recovery in [add country]?

Which of those are particularly influential? (By 'influential' we mean whether they managed to drive or hinder the development and implementation of user-focused recovery.) Please provide details about your choices.

What are the formal and informal roles and activities of those most influential actors? (Formal roles might be those that are stated on their website; informal roles might be visible in behaviours that they display or role that they take in response to pressures and contextual factors.)

How strongly do approaches towards recovery vary between different regions, and which regions have adopted user-focused recovery the most/least?

If regional variations are very strong, could you please select an area in which user-focused recovery has been adopted the most? Please refer to this area only when responding to questions in Part 2.

Part 2: Questions about what led to the current state of play (or landscape) in user-focused recovery

We would like you to consider Figure 1 (and the explanation provided).

Which of the cycles describes the current state of play of user-focused recovery best? Please explain why.

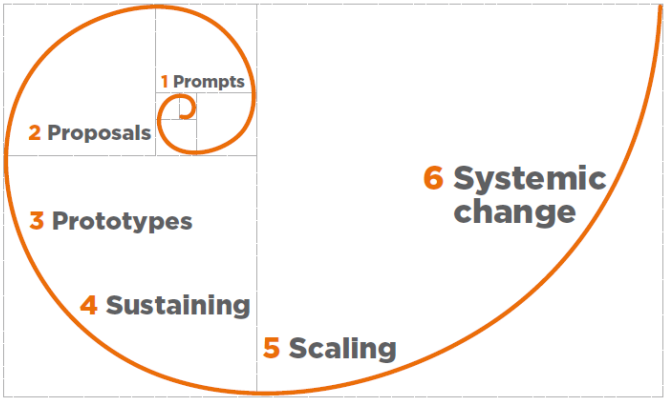


Figure 1: The process of social innovation (Murray, Caulier-Grice and Mulgan 2010) – It illustrates different life stages of innovations in highly simplified form: they start off being prompts highlighting the need for social innovations, develop into proposals , get tested in practice as prototypes, become everyday practice (sustaining), grow and spread further (scaling) and finally lead to systemic change across sectors.

How would you describe the most important milestones that led to the current state of play, and how would you place them in regards to the life cycle (if that is possible)? (Milestones and decision points could be changes in legislation, economy, society, policy , practice etc.)

Which actors (individuals, organisations, collaborations) do you think influenced those milestones?

Can you please refer to each milestone and explain which actors were involved and which ones were most influential? Can you describe some of the power dynamics between actors?

Based on the life cycle of social innovation in Figure 1, can you tell at which point those most influential actors became involved?

What were the most important barriers along the way and how were they overcome?

For each milestone, what do you think would have happened if the actors would not have been involved? (This refers to other possible scenarios based on your experience what happened in the past in this or in other fields.)

Which other conditions (if any) do you think might have influenced those milestones?

10.3. Appendix C: Questionnaire for organisations

Questionnaire

Title: "Recovery in mental health: innovation at an organisational level"

Part of European funded FP7 programme social innovation and civic engagement
Impact of the Third sector as social innovation www.ITSSOIN.eu

Names of Researcher(s):
Annette Bauer, Gerald Wistow, Martin Knapp, Josephine Bardi

Personal Social Services Research Unit, London School of Economics and Political Science, Houghton Street, London WC2A 2AE

About the organisation

1. Could you briefly describe what your organisation does, which services or support it provides and which sector (private/ public/third) it belongs to?

2. Could you please briefly describe the individuals that your organisation is supporting? This includes individuals who benefit directly (e.g. service users or clients) as well as individuals who benefit indirectly (e.g. carers, volunteers, staff).

3. What do you think are the reasons of your organisation to focus on this particular group of service users or clients? For example, reasons might refer to personal experiences, conditions concerning the market and demand, human rights, or political priorities.

4. Is there a shared understanding of recovery in your organisation, and, if yes, how would you describe it?

About service users' needs

5. How does you organisation identify and meet the needs of existing and potential clients or service users? This might include processes or mechanisms to identify or monitor needs.

6. Do you think that there are particular challenges or barriers linked to the specific focus of your organisation? Examples might include small profits, a lot of competition, or that clients or service users present hard-to-reach groups.

7. To what extent do you agree that your organisation is concerned with issues that are a highly important to society as a whole?

	Please mark the relevant field.
I fully agree	
I somewhat agree	
I don't agree or disagree	
I somewhat disagree	
I strongly disagree	

Please explain your answer:

8. To what extent do you agree that your organisation is concerned with groups that are highly marginalised?

	Please mark the relevant field.
I fully agree	
I somewhat agree	
I don't agree or disagree	
I somewhat disagree	
I strongly disagree	

Please explain your answer:

About values

9. To what extent do you agree that the following values present an important part of what your organisation seeks to achieve (as manifested in mission statements and organisational strategies)?

	I fully agree	*I somewhat agree*	*I don't agree or disagree*	*I somewhat disagree*	*I strongly disagree*
Empowerment (incl. strengths based, bottom up)					
Quality					
Equality					
Human rights					
Religious values					
Spiritual values					
Excellence					
Performance					
Solidarity					
Personalisation					
Citizenship					
Dignity					
Coproduction					
Service user involvement					
Profit					
Other					

10. To what extent do you agree that those values are reflected in the strategic and operational decision-making of your organisation?

	I fully agree	*I somewhat agree*	*I don't agree or disagree*	*I somewhat disagree*	*I strongly disagree*

Empowerment (incl. strengths based, bottom up)					
Quality					
Equality					
Human rights					
Religious values					
Spiritual values					
Excellence					
Performance					
Solidarity					
Personalisation					
Citizenship					
Dignity					
Coproduction					
Service user involvement					
Profit					
Other					

11. How would you describe the ability of your organisation in initiating or securing change externally, in a way that it reflects the values of your organisation?

	Please mark the relevant field.
Very high	
High	
Medium	
Low	
Very low	

Please explain your answer:

About knowledge exchange and decision-making

12. To what extent does your organisation involve non-managerial staff in strategic decisions?

	Please mark the relevant field.
Very often	
Often	
Sometimes	
Rarely	
Never	

Please explain your answer (optional):

13. To what extent does your organisation involve other stakeholders in strategic decisions? This includes partner organisations, service users and other groups of beneficiaries (e.g. the public). Examples might include elected representatives of the public, or patient and public involvement initiatives.

	Please mark the relevant field.
Very often	
Often	
Sometimes	
Rarely	
Never	

Please explain your answer

14. How well do you think does your organisation support knowledge exchange among staff? This might include formal as well as informal ways; examples for formal ways include staff meetings, intranet, shared folders and events that facilitate information sharing.

	Please mark the relevant field.
Very well	
Well	
Fair	
Badly	
Very badly	

Please explain your answer

15. How well does your organisation support knowledge exchange with other stakeholders such as partners, service user and the public? If this is different for different groups of stakeholders can you please explain?

	Please mark the relevant field(s).
Very well	
Well	
Fair	
Badly	
Very badly	

Please explain your answer:

16. Would you say that such knowledge exchange with staff or stakeholders led to changes in organisational activities (such as service delivery, advocacy or campaigning)?

	Please mark the relevant field.
Very often	
Often	
Sometimes	
Rarely	
Never	

Please explain your answer. Please provide one or two examples.

17. To what extent do you agree with the following statement? The organisation I work for has flat organisational hierarchies (i.e. authority for decision making is delegated)?

	Please mark the relevant field.
I fully agree	
I somewhat agree	
I don't agree or disagree	

I somewhat disagree	
I strongly disagree	

Please explain your answer (optional):

18. To what extent do you agree that staff is highly dedicated to the values and activities of your organisation? For example, an indication of highly motivated staff might be that they work over and above contracted hours.

	Please mark the relevant field.
I fully agree	
I somewhat agree	
I don't agree or disagree	
I somewhat disagree	
I strongly disagree	

Please explain your answer (optional):

19. Which of the factors covered in questions 12. -18. (if any), do you think play an important role in driving the recovery approach locally or nationally?

About governance

20. How many different sources of funding does your organisation have, from which sectors are they, and how often do they change?

Funding source or body	Sector (private/ public/ third); if public sector specify whether local/regional/national	Duration of funding (in years)
1		
2		

3		
4		
5		
6		
7		

21. How would you describe the contractual arrangements and reporting requirements with your main funding bodies?

	Please mark the relevant field(s)
Trust replaced reporting and contracts at large	
A lot of time is spent on looking for new funding sources	
A lot of time is spent on ensuring that reporting requirements are met	
Government initiated consortia or initiatives have substantially reduced procurement	
Government is one funding body of many	
Other *(please explain)*	

22. How would you describe collaborations with external stakeholders (staff excluded)? If this is different for different groups of stakeholders could you please explain?

	Please mark the relevant field(s) and add a brief explanation.
There is an increasing need for the organisation to manage multiple relationships.	
Relationships with stakeholder are primarily based on trust, loyalty and reciprocity.	
The organisation has easy and low-cost access to knowledge exchange with other organisations.	
Other (*please explain*)	

23. To what extent do you agree with the following statement: "*Shared decisions with external stakeholders can be made quite quickly and effort-less*." If this is different for different groups of stakeholders could you please explain?

	Please mark the relevant field (if relevant refer your response to a stakeholder group by adding this detail into the field)

I fully agree	
I somewhat agree	
I don't agree or disagree	
I somewhat disagree	
I strongly disagree	

Please explain your answer:

24. Which of the factors covered in questions 20. -23. (if any), do you think play an important role in driving the recovery approach locally or nationally?

About collaborations

25. Could you please tell us about the most important external stakeholders of your organisations, and (briefly) explain:
    - Their role in relation to your organisation (for example, they might operate as co-producers, suppliers or clients);
    - Their assets and resources (for example, they might have specialist knowledge about the needs of service users or good relationships with policy makers);
    - The main strengths and weaknesses in the relationship between your organisation and the stakeholder.

Description	Role	Assets and resources	Strengths and weaknesses
1			
2			
3			
4			
5			
6			
7			
8			
9			

26. Do you consider your organisation to be part of a 'network' of different organisations? By network we mean, formal or informal connections between more than two organisations.

If no, please go to question 30.

27. Which of the following statements best describe your position in the network (several responses are possible)?

	Please mark the relevant field(s).

The organisation I work for connects organisations that would otherwise not be connected.	
The organisation I work is part of a closely connected network of organisations, and contributes similar kind of assets than other partners.	
The organisation I work for is part of a loosely connected network of organisations, and contributes a particular set of assets that most other organisations do not have.	
Other (*please explain*)	

28. Could you please tell which of the following statements best describe the formation of the network?

	Please mark the relevant field(s).
The network is led by an organisation that holds a lot of power and resources.	
Other organisations are dependent on one or two organisations, which have a key role in the network.	
Organisations in the network have close ties and connections.	
Organisations in the network are only loosely connected.	
Other (*please explain*)	

29. To what extent do you agree that the network has the following characteristics?

	I fully agree	*I somewhat agree*	*I don't agree or disagree*	*I somewhat disagree*	*I strongly disagree*
High levels of trust					
High levels of shared decision making					
High quality knowledge					
High diversity in terms of organisational purpose, activities, sectors					
High levels of joint problem solving skills					
High capacity for radical changes					
High capacity for incremental and continuous change					
High access to a range of diverse assets					

High overlap in shared values					
High emphasis on service user involvement					

30. Which of the factors covered in question(s) 25. (-29.), if any, do you think play an important role in driving the recovery approach locally or nationally?

About staff, volunteers and service users

31. To which extent do you agree with the following statements concerning staff, volunteers and service users? If you do not employ volunteers, please only fill the boxes concerning staff and service users.

	I fully agree	*I somewhat agree*	*I don't agree or disagree*	*I somewhat disagree*	*I strongly disagree*
Skills, experiences and knowledge of managerial staff are highly diverse					
Skills, experiences and knowledge of non-managerial staff are highly diverse					
Staff is highly diverse in terms of gender, religious and ethnic background, sexual orientation, and disability.					
Skills, experiences and knowledge of volunteers are highly diverse.					
Volunteers are highly diverse in terms of gender, religious and ethnic background, sexual orientation, and disability.					
The organisation offers a wide range of training and development opportunities for staff.					
The organisation offers a wide range of training and development opportunities for volunteers.					
The organisation offers good employment opportunities for volunteers.					
Service users are highly diverse in terms of gender, religious and ethnic backgrounds, sexual orientation, and disability.					
Service users are supported to become involved in organisational decision making or activities					

If you do not employ volunteers please go to question 35.

32. If your organisation employs volunteers, could you please specify their relationship with staff and service users; and whether boundaries are clearly defined? For example, can service users become volunteers; can volunteers become staff; do volunteers support service users in a similar way than staff?

33. How many volunteers participate in your organisation; and how many hours do individuals volunteer per year?
34. What types of volunteering does your organisation offer and what kind of activities do volunteers engage in? By types of volunteering we mean for example formal versus informal volunteering. By activities we mean the kind of things that volunteers do.

35. Which of the factors covered by question(s) 31.(-34.), if any, do you think play an important role in your organisation's ability to drive the recovery approach locally or nationally?

About campaigning and advocacy

36. Does your organisation have an advocacy or campaign function? This might include active memberships in bodies or networks that have campaigning roles.

If the answer is no, please go to question 42.

37. How would you describe the main purpose of your organisation's advocacy or campaign strategy at a local or national level?

38. Which of the following statements best describe your organisation's situation?

	Please mark the relevant field(s) .
Most of our funding comes from our function as service provider.	
Most of our funding comes from our function as campaigner.	
Funding comes about equally from both functions: campaigning and service provision.	

Please explain your answer (optional):

39. Is your organisation represented in the media primarily as a campaigner (advocate) or as a service provider?

40. If your organisations provides both functions, (i.e. service delivery and campaigning/ advocacy), how does your organisation manage potential tensions between the two (if any)?

41. Which of the factors covered by questions 36.-40. (if any), do you think play an important role in your organisation's ability to drive the recovery approach locally or nationally?

About drivers and barriers of innovation, challenges and pressures

42. Considering all previous questions, what would you say are the most important factors driving your organisation's ability to innovate? Have those changed over time?

43. Considering all previous questions, what would you say are the most important factors limiting your organisation's ability to innovate? Have those changed over time?

44. To what extent do you agree with the following statements?

	I fully agree	*I somewhat agree*	*I don't agree or disagree*	*I somewhat disagree*	*I strongly disagree*
The organisation is able to act independently from market pressures (i.e. competition).					
The organisation is able to act independently from political pressures.					
The organisation I work is able to act independently from financial pressures					
The organisation I work for is able to act independently from media pressures.					

Thank you for completing the questionnaire and contributing so importantly to the research!