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The Recovery Approach in Mental Health

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Introduction

We investigated the recovery approach in mental health across four European countries. Mental health care is an area that is increasingly prioritised by governments, and in some countries—like the UK and US—it has been given equal status to physical health care ('parity of esteem for mental health'). Those attempts respond to the substantial burden caused by mental ill health: When including substance misuse disorder mental ill health is the leading cause of years lived with disability worldwide (Whiteford et al., 2015). Different from most physical diseases it is an area which is substantially influenced by stigma and discrimination, which explains the need for wider societal responses. Despite an increasing realisation by governments of the importance of investing in mental health care, it is still an area of substantial unmet needs (WHO, 2013). We thus argue that it is an area in which innovations are important and likely to have a high social impact. Our decision to look at innovations in the mental health field was also supported by a number of factors and considerations:

- Mental health care has been found to undergo many innovations in the past decades and it has been argued that other parts of the health system could learn from those (Wise, 2014);
- Innovations in mental health care often incorporate or overlap with innovations in other parts of health care systems such as those in areas of: integration, patient or citizen involvement and public health (health promotion);
- In line with the notions of the social model of disability (e.g., Beresford, 2002), some innovations in mental health care have 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.

The recovery approach is a popular and widely recognised social movement that influenced and transformed mental health policy and practice

in many high-income countries (Jacobson, 2003, p. 4; Jacobson & Curtis, 2000; Slade, 2012). In many high-income countries (such as the UK, New Zealand and the US) the recovery approach presents possibly one of the largest social innovation streams in the mental health field, which evolved over many decades.

In our research we sought to examine the events, actors, conditions and factors that facilitated or hindered the development of the recovery approach in different European countries, with a particular focus on the role of third and public sector organisations (which were known to dominate movements in this area). We included the perspective of four different countries: the Czech Republic, Denmark, France and the UK.

Central Concepts and Key Questions

Social Model of Disability

In order to conceptualise the recovery approach we first introduce the social model of disability as an important underlying political driver of the recovery approach. The social model of disability is based on a realisation by most governments and non-government organisations over the past decade(s) that good health is not simply an outcome of good health care and that wider physical, mental and wellbeing aspects and social and environmental factors play an important role (Wilkinson & Marmot, 2003; WHO, 2006). It is supported by evidence, which suggests that only a small proportion of poor health stems from shortfalls in medical care and that other domains are far more important in impacting on individuals' health and wellbeing such as: Individual behaviour; genetic predispositions; and social and economic circumstances. This wider understanding of health and its determinants has substantial implications for roles and responsibilities of government, including a greater focus on areas such as health promotion, prevention, personalisation and self-management. More fundamentally, it directs government responsibilities towards addressing the 'causes of the causes' of poor health (Dahlgren & Whitehead, 1991). A changing role and responsibility of individuals towards their own health is also implied by the social model as they are conceptualised as potential co-producers of health rather than passive recipients of health care (subject of course to a recognition that opportunities and capacities for such co-production are also socially structured). Within the last decades, participation approaches have become prominent paradigms in public health and, like the social model of care, they often aim to reduce social inequalities in health outcomes. They potentially share a focus on principles of personalisation and empowerment (Wallerstein, 2006). It can be argued that a point of potential difference is that most public health approaches retain some kind of emphasis on the individual as a patient whereas the social model of disability might demand a stronger emphasis on the empowerment of individuals as active citizens.

In the UK the social model of disability stemmed from disability movements which took place decades ago, and which aimed for an understanding of disability that—by deviating from a focus on personal limitations—helped to reduce the barriers that prevent disabled people from fully participating in society or experiencing disadvantage compared to non-disabled people (Oliver & Sapey, 2006; Goodley, 2001). Barriers included environmental ones (e.g., inaccessible buildings and services), people's attitudes (e.g., stereotyping, discrimination and prejudice) and organisational barriers (e.g., inflexible policies, practices and procedures). The social model is the one supported by the vast majority of disabled people and their organisations, and encourages society to become more inclusive. In addition and possibly related to this, there has been a political drive for a cultural change of the relationship between patients and professionals and how 'services' have been defined.

The Recovery Approach

The recovery approach is based on an ideology as well as on evidence that people with mental ill health are not automatically ill or disabled for their whole life but that there is a recovery pathway. Recovery is defined as a "deeply personal, unique process" (Anthony, 1993) rather than something that can be imposed. The concept does not assume immediate or full recovery for everyone but that there is a path which enables the individual to lead as full a life as possible. The recovery approach is thought to be based on principles of individuals' capability and strengths rather than their deficits. It is focused on restoring a person's identity and self-esteem rather than on the remission of symptoms (Davidson et al., 2006). Whilst there is no single definition, the recovery approach is anchored in principles of life satisfaction, hope and optimism, empowerment, knowledge about mental ill health, co-production and community capacity (Deegan, 1997; Resnick et al., 2004; Farone, 2006). The recovery approach is supported by evidence that people can get better and that the principles it promotes (e.g., life satisfaction) are strong predictors of self-reported poor health and depression (e.g., Al-Windi, 2005; Chovil, 2005). The recovery approach focuses on helping people with mental ill health to live as part of and participate in their local community and is thus closely linked to concepts of social inclusion and citizenship (Repper & Perkins, 2003) and therefore located within the realm of the social model of disability.

Methods

We examined the role of individuals and organisations (actors) over time and identified important milestones (legislation, policies, events, publications); this also covered an analysis of the interactions between actors from

different sectors. We gathered information by asking experts in the field and by carrying out our own web-based searches.

Case Selection

We spent some time and effort in selecting the recovery approach as the case study we wanted to focus our investigation on (for details see Bauer & Wistow, 2015). In addition to the importance of the topic as described previously, the rationale for our choice was as follows: Focusing on the recovery approach allowed us to investigate characteristics and determinants that were likely to be applicable to other social innovations in the field of health; the recovery approach reflects the social model of disability applied to the mental health field, which has been a driving force for change in the traditionally highly medicalised world of health care (Degener, 2016). The social model of disability places the responsibility for how illness and disability is defined as well as its causes within the context of society rather than the individual and has been included in the UN Convention on the Rights of Persons with Disabilities (United Nations, 2008). In addition, the recovery approach is likely to address a number of important aspects of other areas of innovation in health care, which were candidates for our case studies such as: integrated care (because the recovery approach takes place at the interface with different government departments, professional disciplines and service user groups); personalisation (because the recovery approach is based on principles of empowerment, choice and control); patient and public involvement (because the recovery approach is driven by user movements).

Data Collection

Innovative practices and activities embodying the recovery approach and driving it have been collected in a snowball sampling effort and resulted from consulting experts in the field knowledgeable about such activities. This process shall be outlined here in an exemplary fashion in relation to our case work in the UK. We applied an equivalent strategy in all other countries. With the help of the "external experts" we identified the organisations described in Table 6.1, most of which were examples of so called recovery colleges or similar co-produced activities. Recovery colleges (also called Recovery Education Centres) were seen as an important activity under the recovery approach, which might be traced back to a South London-based one which started in 2009. Since then projects emerged across England and the UK. A recovery college is run by both peer trainers and mental health practitioners. Courses are typically co-produced, co-delivered and co-received by staff, people with mental health problems and those close to them. They can be public or third sector provided and dynamics between public and third sector vary strongly depending on the organisation that is chosen.

Table 6.1 Exemplified overview of organisations participating in the research, UK

Organisation	*Purpose*
Creative Minds is a Charitable Trust hosted by South West Yorkshire Partnerships NHS Foundation Trust (SWYPFT).	Development of community partnerships. Co-funding of creative projects across Creative Minds' localities and the Trust's forensic services. Support of voluntary organisations that work with Trust. Partnerships and co-production are core to the conception and development of Creative Minds.
Dorset Mental Health Forum (DMHF) is a peer-led charity founded in 1992. The establishment of WaRP allows DMHF to maintain independence from statutory provision.	Promotion of peer-led services. 1-to-1 advocacy service for the whole region and advocacy as organisational identity. Employment service, collaboration with schools, production of evidence.
WaRP (partnership with local NHS Trust) was established as partnership in 2009 of DMHF and NHS Community Health Services.	Purpose and objectives lie within the structure of publicly funded health care, seeking to bring together in partnership people's lived experience expertise and professional expertise to promote personal recovery and unlock people's potential. The overall aim is to change the culture of mental health services and people's attitudes to mental health and wellbeing in Dorset.
Recovery College, South London and Maudsley (SLaM), NHS Foundation Trust.	Workshops and courses aiming 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. Offer of a learning approach that complements the existing services provided by the Trust. Every course and workshop is co-designed and co-run by trainers with lived experience working alongside trainers from the mental health professions.
Nottingham '**Real Lives**' is a third sector non-profit (community interest) company.	Support of people 18 and older in their home or community with mental health challenges and/or learning disabilities. Employment of people with lived experience and help for them to gain and retain employment. Provision of self-directed social support packages to people in the Nottingham community via personal budgets. Support of local community via a café, and volunteers and people on placement in the company seeking experience.
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.**	Emerging of new strands of work including ReCreate. Provision of creative training and facilitation for health and social care professionals. The Dragon Café is the first mental health café in the UK. Non-medical model of provision. A space both safe and inspiring which helps service users take the journey through mental ill health, onwards into recovery and new-found sustainable modes of mental wellbeing.

Organisation	*Purpose*
Scottish Recovery Network collaborates with other local organisations and individuals with experiences of mental health. They cover the whole of Scotland.	Promotion of paid supportive role in recovery. Support of other recovery organisations and individuals with experiences of mental ill health. Work with local organisations to develop knowledge and services such as peer support projects and community-based projects on recovery. Advice to other organisations, guiding and sharing best practice on recovery.

All identified activities were strongly reflective of user-led recovery streams and enabled us to study the interplay of actors in driving the approach. After the identification of the relevant actors we performed interviews, mostly with one interviewee from each of the listed organisations. These were considered "internal experts". Both viewpoints were brought together in the analysis.

Tracing the Social Innovation Stream

The recovery approach has been rooted and contextualised in a number of developments that occurred (although in different chronological order and in different strengths) in many high income countries (Starnino, 2009): The evolution of the psychiatric social work discipline (Schaefer Vourlekis, Edinburg, & Knee, 1998); a focus on deinstitutionalisation and independent living programmes in the community (Schnapp, 2006); psychiatric rehabilitation and the introduction of new forms of therapy such as cognitive rehabilitation strategies and art therapy (Corrigan, 2003); the survivor or ex-patient movement, which challenged the concept of mental ill health as a disease and instead defines it as a societal problem (Jacobson, 2004; Thornicroft et al., 2008); the user-centred (consumer) movement, which puts the consumers' interests at the centre of improvements to quality and outcomes (Mead & Copeland, 2000).

Across the four countries that we investigated, experts agreed that the development of the recovery approach was importantly contextualised in the deinstitutionalisation of mental health services; our experts thought that the deinstitutionalisation had led to the conditions, in which the recovery approach could happen. This included: The provision of services through community mental health teams; the softening of professional boundaries (in particular through the influences of the social work, community development and occupational therapy disciplines on the psychiatric discipline); and a strengthened voice of people with lived experience of mental ill health and of treatment. Because of these overarching trends we outline milestones across countries, with a particular emphasis on the UK as the exemplary

case, and go into national specific in terms of actors and their interplay further in the following.

Milestones Across Countries

Perhaps most evidently in the UK (following international examples from the US and New Zealand) the recovery approach started off (during the 70s) as a 'movement' that was initiated by pioneers. Individuals with lived experiences of mental ill health and of treatment (including psychologists or psychiatrists) shared their stories about what helped them in moving beyond the role as a patient. In addition, there were professionally led movements in each of the countries starting also during the 70s. The influence of professional-led movements on driving some of the principles of the recovery approach that led to new branches of traditional psychiatry was particularly evident in Denmark ('social psychiatry'), France ('citizen psychiatry') and the UK ('critical psychiatry').

In each of the four countries, experts reported how professional or user advocates of the recovery approach faced major challenges in scaling up the approach and in achieving changes in the system of mental health services. Some of the challenges were similar between countries: government departments working in silos; a command and control culture within the mainstream public sector; and a strong resistance from large parts of the mental health profession, which were often protective of traditional structures and practices.

Despite those challenges, there were noticeable policy, practice and research changes over time. In the UK and Denmark, the recovery approach was finally incorporated into national mental health policies and strategies (2006 to now), suggesting a more systematic change (although to a lesser extent in Denmark). A key milestone in England that signalled an important shift in policy attention and thinking was the creation of a national flagship programme called ImROC (Implementing Recovery through Organisational Change) in 2006. ImROC consisted of and was led by individuals who had been campaigning for the recovery approach at a national level and involved organisations (and representatives of those) which had implemented the recovery approach locally (some of them had driven the recovery approaches locally for decades). They successfully influenced the policy and practice landscape. Over the past decade, national mental health policies and strategies have incorporated a focus on recovery and governments have made recovery-oriented practice a key priority and requirement for mental health services; this included the introduction of performance indicators to measure how well services were doing on the recovery dimension.

In Denmark, a key milestone was the introduction of a government-initiated Knowledge (and Research) Centre for Social Psychiatry in the late 90s, which consisted of people who acted as pioneers in the field of social psychiatry and included the concept of recovery. In 2012, the Danish

government set out a national framework which included a section for how mental health services should become more recovery oriented. There were a number of developments that promoted and disseminated evidence on recovery, and advocated for the rights of people with lived experience of mental ill health and treatment.

In France, the recovery approach was much more difficult to 'trace', which was by some experts explained by a resistance of many to what was perceived to be an 'Anglo-Saxon' concept that did not fit to the national context.

> 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.
>
> (Interview 1)

However, a strong role of central government had allowed a wide dissemination of models that incorporated some of the principles of the recovery approach such as Housing First and peer support. Experts had strong and diverse opinions about whether or not the recovery approach had been implemented through those programmes. In addition, an innovative bottom-up project, which incorporated many of the principles of the recovery approach (led by a mental health professional and her husband) had been rolled out to thirteen sites.

In the Czech Republic, movements and practice developments around peer support and user involvement also evidenced an increasing role of the recovery approach (although this had not yet made their way into national policies). Different from France, international influences in particular from countries like the UK were viewed as important drivers of the recovery approach, and international evidence was utilised to support the development of the recovery approach. A range of organisations nationally as well as locally promoted and taught principles of recovery. There was also evidence that those organisations were working together in networks, and that this had facilitated some important developments such as the organisation of a conference on this topic.

Overall, we identified some factors that appeared to act as drivers of the recovery approach (and their absence appeared to hinder its development): a policy focus on prevention and on evidence-based practice; a clear stand on human rights legislation for people with mental ill health (including stigma reduction work); an openness towards international influences; an openness towards collaborative working across disciplines and sectors; and economic pressures on the system that demanded new solutions. However, experts in countries where there had been a wider dissemination (namely in the UK and Denmark) also noted that this had happened by fitting it with existing political agendas and practice developments and had ultimately led to some deviation from its original concept.

The important role of bottom-up movements by third sector organisations (starting from the early 90s) was evident in all four countries: They had often—although perhaps more indirectly—influenced governmental decision-making by demonstrating that the recovery approach was feasible and could be implemented successfully. Sometimes, individuals who founded such organisations and advocated for the recovery approach locally had also strongly influenced national developments. Third sector organisations in form of national user-led organisations, research centres and think tanks had an important role in driving the recovery approach (or some of its principles) in each of the four countries at the national level. Most of them were supported and—at least partially—funded by the government. Whilst some of them had a specific remit to drive recovery-oriented practice, others had a broader remit to inform mental health reforms. It is important to note that experts in all four countries referred to individuals (rather than organisations) who had been driving the recovery approach, and who had acted as recovery pioneers. The engaged actors and their influence on the social innovation stream will be discussed in the following within their national contexts.

Actors and Interplay in the UK

In England, experts agreed that ImROC (Implementing Recovery through Organisational Change) was the most important actor driving the recovery approach. It was led by individuals, who had advocated for the recovery approach for decades and created as a partnership between the third and public sector. It was also closely linked to the academic sector as well as to professional associations, which was likely to reinforce its large influence. At a national level, it promoted key messages of recovery through its guidance materials and at a local level, it supported local recovery initiatives by promoting and informing their good practice. In Scotland, the Scottish Recovery Network had taken on a similar role.

Before the time of ImROC and the Scottish Recovery Network, it was mainly user- and professional-led networks, which promoted the recovery approach (although sometimes with different perspectives); some of those had their origins in international networks and movements. This included the Hearing Voices Network which started as a political psychology and anti-psychiatry movement in 1987 and the Critical Psychiatry Network, which was created by group of British psychiatrists in 1999. Their role is still influential. In addition, there have been more recent movements such as Open Dialogue, which started originally in Finland in the 1980s and made (and continues to make) its way to the UK and other parts of Europe over the last decade.

Some experts emphasised broader changes in societal thinking through complementary policies and societal reflectivity in which the UK's recovery approach gained popularity. For example, one expert thought that whilst

historically health and social care service provision had focused on treating illnesses, "Nowadays services are all about wellbeing". One expert described the increasing dissemination and diffusion of the recovery concept's terminology. Commissioners and people from other professional disciplines started to use it for example in publications in nursing journals:

> Every profession now has recovery paper . . . even OTs (occupational therapists) . . . bizarrely, even security settings had recovery plans and recovery leads.
>
> (Interview 2)

Professional associations and membership bodies for psychiatrists and psychologists were important drivers for the recovery approach. Some of the recovery pioneers had also established positions in the Royal Colleges and advocated the recovery approach to their profession 'from within'. However, some experts were critical of some of the involvement by the psychiatric profession, which they thought had sometimes redefined the term recovery to serve their purpose and reconstructed its meaning.

The key role of the third sector in initiating and driving the recovery approach was highlighted by experts and evident from the literature: Organisations such as the Centre for Mental Health were leading campaigns for the recovery approach in collaboration with and on behalf of people with lived experience. More recent initiatives that support recovery principles included the Time to Change anti-stigma campaign (led by two large third sector organisations in the mental health field: MIND and Rethink). Many other third sector organisations had an influence in driving the recovery approach at a national and local level (although sometimes from different angles) including Making Space, Turning Point and St Mungo's (to name but a few). In addition, there were numerous local third sector organisations, which partnered up with commissioners and providers of publicly funded mental health services to implement the recovery approach locally. They had an important role in informing the evidence base for such approaches by sharing their knowledge nationally and internationally. Those included Dorset Mental Health Forum, Recovery Devon, and the South London and Maudsley (SLaM) NHS Trust Foundation Recovery College (to name but a few).

Actors and Interplay in Denmark

In Denmark, the Knowledge Centre 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. The Centre collected 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 Centre initiated an association that became the

Danish Society for Psycho-social Rehabilitation (Dansk selskab for psyko-social rehabilitering). Whilst the Centre was closed in 2011, the Danish Association for Psycho-social Rehabilitation still exists. It is an association of professionals who promote the recovery approach; its members are regularly invited by the Danish Government to participate in policy making.

Experts thought that municipalities (councils) had an important influence on driving and implementing the recovery approach locally: Most Danish councils ran recovery projects or had a recovery strategy for the field of social psychiatry. Aarhus was the first council to implement the recovery approach and was identified by experts as the most progressive council in regard to the recovery approach. Even though municipalities showed a great ambition in implementing the recovery approach, an expert noticed that this did not necessarily led to the best services in practice. The expert thought they could not pave the way for a structural setting that supports large-scale recovery initiatives before they fully grasp the meaning of recovery. (S)he concluded that today: "Large-scale recovery initiatives are often started by individual enthusiasts".

However, some experts thought that most councils had not yet grasped the meaning of recovery and instead used it only 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. This is outlined in the following quote from a study scrutinising the approach in Denmark:

> 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 healthcare system are not dismantled.
>
> (Neidel, 2011)

In addition, there was national support and funding from the National Board of Social Services Fund to develop and pilot local prevention programs for people with lived experience of mental ill health. Those projects were organised as partnerships between government, private sector and civil society and their goals included the social inclusion of this population.

Similar to the UK, there have been national and international service user movements, including the Hearing Voices Network, which exists in Denmark since 2005 and had influences on the professional discipline of psychiatry. The national service user organisation (LAP) was established in 1999 and was identified as a key actor with national and international influence in the mental health field. Other important third sector organisations, which were driving the recovery approach in Denmark at a national level included Outsider, a Copenhagen-based journal and association of people with lived and treatment experience, which received government funding (from the Ministry of Social Affairs and the local councils); and The Social Network, a prevention oriented organisation founded by the Prime Minister, and which

promoted and influenced recovery-oriented practice as well as the integration between mental health and social care. In addition, experts referred to a private company (PsykoVision) as an important actor, which promoted evidence-based recovery practice—it was seen as an exception, however, and the only private sector provider of recovery-oriented treatment and support.

At a regional level, some professional associations (such as the Joint Council of the Psychiatric Associations—Psykiatriforeningernes Fællesråd) had become active in the recovery field and provided guidance on hospital discharge that followed principles of recovery.

Actors and Interplay in France

In France, whilst there was less of an identifiable movement towards the recovery approach, there had been some important bottom-up and top-down developments led by third sector organisations and partnerships that supported similar principles. Most of them were still recent developments.

Les Invités au Festin (The Guests at the Feast) started off as a bottom-up movement in one region led by two recovery pioneers and was subsequently rolled out across France promoting and offering social inclusion for people with lived experience by creating environments, in which they work and spend time together with volunteers (without lived experience).

'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 third sector organisations in four cities in France. The implementation was led and supported by the WHO Collaborating Centre for Research and Training in Mental Health (CCOMS), which was named by experts as the most important public (health) sector actor; the priorities of the Centre are the empowerment of people with lived experience of treatment and the promotion of citizenship psychiatry.

Groupe d'Entraide Mutuelle (GEM) is an association of 80 self-help groups; it was originally established in the context of the national Disability Law in 2005. Three third sector organisations had actively promoted and supported its establishment: Fédération Croix-Marine pour la Santé Mentale (a movement of psychiatrists, which grew out of Institutional Psychotherapy movement), UNAFAM (an organisation representing the families of people with mental ill health) and FNA-PSY (a movement of service users).

Whilst some experts thought that those self-help groups were primarily about self-management and did not engage in wider policy and practice issues, others felt that they had created an environment and infrastructure for the recovery approach.

> 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.
>
> (Interview 3)

An expert emphasised the intra-organisational challenges of programmes introducing and evaluating the integration of peer mentors into health care teams. Professionals' resistance was at least partly explained by their concerns that peer mentors could take over their role with less training and for lower pay.

Another expert described the consequences when professionals did not incorporate the wider social determinants of mental ill health in their practice (e.g., through peer mentoring) as follows:

> 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.
>
> (Interview 4)

In addition, there were some public sector organisations identified as key actors. This included a mental health service provider (Hôpital Maison Blanche), which had a research unit attached to it that was headed by an Australian psychologist, which most experts viewed as the most prominent advocate of the recovery approach in France.

Actors and Interplay in the Czech Republic

In the Czech Republic, experts thought it was not only important to name key players in the recovery field but also in the mental health field more broadly: The health system was still very medically and physical health focused, and recent mental health reforms had been important in also driving the recovery approach (by providing an infrastructure for change). Experts thought that international bodies such as the European Union and the World Health Organisation had been driving national reforms and policies in mental health, and that without their involvement the recovery approach would not have had any foundation. In addition, they mentioned the following key actors in recent mental health reforms: 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); mental health providers such as Česká psychiatrická společnost; and the Bohnice psychiatric hospital.

At a national level, the National Institute of Mental Health (NIMH) and the Centre for Mental Health Care Development (CMHCD) were third sector organisations that had importantly contributed to the mental health reform by providing knowledge about evidence-based practice and about ensuring that user's voices were incorporated. Another third sector organisation that had played an important role in driving the recovery approach and makes the voices of people with experience of treatment heard was Kolumbus, the largest user-led organisation in the country. At a local level,

a number of third sector initiatives had been driving the recovery approach: FOKUS, Práh (Treshold), Ledovec (Iceberg) and Kolumbus (which also worked at the local level). They were described by experts as 'role models' in the field of community mental health services and had an important role in demonstrating good practice and that the recovery approach was feasible. They also had started offering accredited courses on recovery-oriented practice.

In terms of public sector organisations (and individuals representing those), the Director of the Bohnice Psychiatric Hospital was viewed as the most important person behind the mental health care reform and driver of movements in support of the recovery approach; this included the implementation of peer-led models at his hospital. At the same time, experts described a more or less open opposition to the recovery approach by the managements of some psychiatric hospitals. This included elite psychiatrists, who continued speaking 'very medically' about the remission of symptoms. 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 experts saw as an important step towards the implementation of the recovery approach.

Nonetheless, experts saw variations in the implementation of the recovery approach. The type of institution (e.g., providers of community services, mental hospitals, researchers, patients' and family organisations) seemed decisive with regard to differences in comprehensions of the term 'recovery'. According to one expert non-profit actors showed a particular openness towards the approach:

> There has been no problem with the involvement of peer consultants across the country. However, generally it is much easier to introduce recovery orientation in non-profit organizations, which is true for innovations more broadly.
>
> (Interview 5)

Synthesis

Comparative Analysis

Most evidently in UK the recovery approach started off as a 'movement' that was initiated by pioneers including individuals from the US and New Zealand. However, the movement existed for a long time under the radar of policy makers. So whereas pioneers (through third sector organisations) had advocated for the recovery approach for several decades, it required it at an opportune time when the government was faced with real demand and finance pressures. In England and the UK, the recovery approach has in some regards affected large parts of the mental health system; this relates

to the awareness among professionals and support from governments; however, the resistance from large parts of the medical discipline meant that the medical model still predominates mainstream clinical practice. Experts also thought that the wide dissemination of the recovery approach had partly led to a deviation from some of the original principles by focusing on a narrow understanding of recovery that could be included in performance monitoring.

In Denmark, the beginnings of the recovery approach were marked by the introduction of a government initiated Centre and of a new professional discipline that supported the principles of the recovery approach by combining social, rehabilitative and psychiatric approaches. Since then the implementation of the recovery approach had been driven and implemented by some municipalities (although geographical variation remains strong). Third sector (user-led) organisations had an important influence on those changes. Similar to the UK, some experts thought that the dissemination had happened at the expense of the original, user-focused principles of the recovery approach. 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. Experts thought that the impact of the recovery approach on the system of social psychiatry had been at least moderate to strong (dependent on geographical location) but its impact on mental health and the broader health system had been limited.

In France, the recovery approach as a movement was more difficult to identify and trace compared to the other three countries because the terminology had not been used and was sometimes actively rejected as an Anglo-Saxon concept. However, there had been some important national developments that supported initiatives that followed principles of the recovery approach and which were led by and given to the hands of third sector organisations. Those changes were initiated and organised centrally, which meant they have the potential to be implemented more systematically than in the other three countries. However, so far some initiatives have only been piloted and it thus remains to be seen whether this will lead to a more systemic change at a national level. Overall, there was evidence suggesting that—similar to the other countries—the recovery approach experienced a powerful resistance from the traditional mental health profession that prevented its scaling up.

In the Czech Republic, the recovery approach started much later than in the other three countries. Until now it has not become part of the political agenda as such but there are a range of actors—mainly from the third sector—who continue advocating for the recovery approach and there was also evidence of some government funding and support. A range of practice developments have happened over time; however, they had not scaled up and were often limited to the third sector. Not all developments were directly supporting the recovery approach but they supported some of its principles and were seen as providing an infrastructure. 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. The resistance from the medical discipline and from (large) parts of society was particularly strong thus putting a question mark on whether there can be a wider diffusion any time soon.

Learnings

The recovery approach, as probably many other social movements and innovations, is a complex process that consists of multiple perspectives. Our research involved some particular challenges. For example, ensuring consistency in data collection between countries was difficult. Perhaps unsurprisingly, it was easier to gain information in countries in which the recovery approach had developed stronger and under this name. 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 particularly 'controversial' topic as it is critical of mainstream mental health provision. Experts felt often quite strongly about developments in this field, which made it more difficult to establish robust information. In order to address some of these limitations we carried out additional data searches to validate the information provided by experts. We also sought to make the uncertainty of the information transparent. Whilst some caution needs to be applied to the findings, we believe that we summarised some important trends and highlighted common drivers and barriers of this particular social movement, that might also apply to other areas of social innovations and movements.

Conclusions

In this study, we investigated the recovery approach by using process-tracing methods. Specifically we examined the milestones that signalled important changes in the landscape of the recovery approach and investigated the role of actors (individuals and organisations) in driving it. By doing so we identified some common trends, drivers and barriers as well as some important differences in those between countries.

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 as well as at a local level. 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, which were

often third sector led. Overall, psychiatric institutions did not play a major role in driving the recovery approach although there were exceptions: some leading psychiatrists had shown interest in the recovery approach and had started promoting it. Overall, the culture within psychiatric institutions (and other mental health services) did not support recovery and the professional discipline of psychiatry was seen by most experts as one of the biggest challenges for a wider dissemination of the recovery approach.

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

Note

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Interviews

Interview 1	France	09/2015
Interview 2	England (United Kingdom)	02/2016
Interview 3	France	09/2015
Interview 4	France	09/2015
Interview 5	Czech Republic	10/2016

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