How to Recover? Recovery in Denmark: A Work in Progress

Korsbek, Lisa

Competence Center for Rehabilitation and Recovery, Mental Health Services in the Capital Region, Mental Health Centre Ballerup, Ballerup, Denmark.

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Introduction
Twenty-five years ago, I was admitted into the Danish Mental Health Care System for the first time. Nobody talked about recovery, and nobody expected me to be where I am today. This was back in 1991, a few years after the emergence of the findings from the first long-term follow-up study of Harding et al., and two years before William Anthony introduced the concept of recovery as the guiding vision of the Mental Health Service System in the 1990s, today a publication of almost iconic status.

But these things were mostly discussed in narrow scientific circles, and generally 'over there'. Nothing of it had reached Danish mental health practice, as the time of my first admission was also 10 years before the concept of recovery hit the shores of Denmark from both sides of the surrounding sea - from Sweden on the one side of the coast and from the U.K. and U.S. on the other.

The next years of my life were difficult. All too easily, I internalized the image of a person with a severe psychiatric diagnosis that the system and the professionals, either directly or indirectly, communicated to me; and I was engulfed in the stigma of the outside world. I have always been good at adapting to ambient influences, and it was not an advantage for me when it came to maintaining my own identity and a non-broken self-image.

Nevertheless, the ability to adapt might be, to a certain extent, an advantage. By reading the system's expectations, I was, in time, able to turn, modify, and redesign the expectations more and more and put myself increasingly into the driver's seat, thereby propelling a recovery process that the system ended up not only supporting, but also encouraging, and, even in times of crisis, to ensure and maintain.

The years to come as a patient therefore became easier. Although I was often hospitalized for a very long time, I also completed my university education during the hospitalizations. I could more or less come and go as I needed, and I had an incredibly stable primary contact among the staff.
She was there all along and was extremely adept in reading me. She knew very precisely when the limit was reached and I needed to be hospitalized. She often arranged my admission directly, bypassing the emergency visit and all administrative procedures. At the same time, she also very clearly saw all my strengths and resources and respectfully recognized my needs and preferences, including my need for self-determination and of exercising influence on my own treatment.

In fact, she followed me from almost the first admission and right up to the day I - after being a distinctive user (i.e. what at that time would be termed a rather 'chronic' patient) of the mental health services for ten years - left the system altogether, ready for proceeding with treatment with a psychiatrist practicing outside the statutory mental health treatment services.

In many ways, the system in fact ended up being fairly recovery-oriented, without ever having heard of the term.

The Paradox of the Mental Health Landscape Today

Today, we in the mental health care of Denmark have all heard of recovery; but the mental health system has, in the same period of 25 years, changed radically. Nowadays, almost no one using the mental health services, except in forensic psychiatry, is hospitalized for a long period. Very few people have the same primary contact among staff members for several years. It is almost impossible to be hospitalized without an emergency visit and triggering the legal procedures when in a crisis situation. For staff, it can be difficult to get to know the individual patients well enough to ensure the patient's autonomy and influence. The staff is generally very occupied with, among many other system-driven things, the documenting of their services, and rarely is there time for much in-depth dialogue with the patients.

There are, however, many ongoing recovery-oriented projects in the Danish mental health and a national campaign addressing stigma and self-stigma has been around for several years. But often the initiatives are time-limited or conducted as research, and Denmark does not yet, as is the case in some other countries, have an overall strategy on recovery in mental health.

At the same time, some of the ongoing recovery-oriented projects in the Danish mental health care systems remind me of some of the methods and approaches that were, to a greater or lesser degree - because sometimes, indeed, they were very much dependent on the culture and management of each unit - inscribed in the system I met in the 1990s. The overall landscape of mental health in Denmark today therefore sometimes looks a bit like a paradox.

If there is a paradox, it is, however, hardly a paradox only to be observed in the mental health system of Denmark. Instead, it is perhaps the paradox par excellence, the master paradox, which we, at this time of modern mental health care history, are caught up in and must face. From an optimistic angle, it might just be one of the bumps along the way of the work in progress to transform the mental health care services into a fully recovery-oriented mental health care practice; and probably there is one central reason for the paradox.
As part of the process of relieving people with mental health issues, their relatives, and the mental health care providers of the chronicity paradigm which has dominated our thinking on mental illness throughout much of the 20th century, we have had very good cause to be quite systematic in the deinstitutionalizing of our service settings. But time and time again we have forgotten, and still forget, or perhaps want to forget, that recovery does not follow a master plan or the organizing structures of any mental health services system, and that services must therefore be available and able to re-engage with people whenever needed in order to support their recovery processes.

The aspect of the inpatient mental health service settings that helped to facilitate my recovery was, especially in the beginning, also an obstacle to it. And this is what the paradox of inpatient treatment looks like at the individual level. On the one hand, there is the risk of engulfment, and thereby of the constructing of an illness identity that can be very hard to deconstruct. However, on the other, there is an essential need for most people with severe mental health issues to have a stable and often long-lasting and caring framework for a process of recovery to take place.

As it really takes time to find a way in the system, when struggling not to be engulfed, and it also takes time to find a way out of the system again, long-term inpatient treatment is not, in itself, a solution. But as it also takes time for each individual person who uses mental health services and for the providers of the services to meet and find ways together to make a road to recovery visible and possible, a very short engagement with a caring system is not always a solution either.

**When Recovery Came to Denmark**

In Denmark, the introduction of the concept of recovery coincided with the start of the new millennium. It was presented by the national Knowledge Centre for Social Psychiatry and mediated through a reception and translation of the work of the Swedish-based psychologist, Alain Topor.

The concept was immediately put on the political agenda and an initiative to set up a pilot on recovery in Denmark was approved by the Danish parliament in 2001, resulting in the publication of a state of the art report and then the initiation of a three-year project on recovery.

The project was undertaken by the national mental health NGO Bedre Psykiatri (Improving Mental Health Care) and The National Association of former and current mental health users (LAP). It resulted in two central Danish publications. The first publication, Recovery på dansk ("Recovery in Danish"), disseminated and discussed the international research of, and experiences with, recovery, and linked this knowledge to the Danish reality and practice. The second was the publication of En helt anden hjælp ("A completely different aid") that was based on qualitative interviews with a total of 55 respondents from across the country and is still a pioneering first empirical study of recovery in Denmark.

The mental health system in Denmark consists of two different and separate service sectors. On the one hand, there is a regional health sector, which is geographically organized into five administrative sections and responsible for the mental health
treatment services, i.e. for all the mental health hospitals and for the outpatient community mental health care. And, on the other hand, there is a social psychiatry service that is driven by the 98 municipalities of Denmark existing within the five regions and responsible for the social support of people with mental health problems, including rehabilitation, education, and employment.

In the beginning of the millennium, the new knowledge of recovery in mental health was primarily discussed within social psychiatry. In 2005, when it was also introduced into the mental health treatment services by a few psychiatrists that had looked abroad and into the international literature on recovery, it caused a subsequent fierce debate in the leading Danish Journal of Medicine between different psychiatrists, with some of the participants in the debate declaring recovery a nearly sectarian pseudo concept with no scientific substance. Several years went by before recovery was more seriously put on the agenda in the mental health treatment services and gradually became part of the visions and policies of these helping systems.

The Adoption of the Recovery Vision: The Case of the Mental Health Services of the Capital Region

In 2011, the first policy paper declaring recovery a central vision of the mental health treatment services in Denmark was conceived. It was conceived in the mental health services of the Capital Region of Denmark, as a starting point for providing a more recovery-oriented mental health care practice.

In 2012, to further support the new vision of recovery-oriented mental health treatment services, an ambitious two-day conference was organized, which featured Patricia Deegan as one of its keynote speakers. Patricia Deegan published her first paper on recovery in 1988 and has since been a leader, instilling hope for many people with lived experience. She has been an advocate for recovery and has succeeded in introducing recovery to the mental health agenda in many countries around the world.

In 2004, Deegan had also been the keynote speaker at a conference arranged by the earlier three-year project on recovery in Denmark. But in 2012, the conference was also attended by many mental health providers of the treatment services and by senior management teams who, in their communication throughout the organization, had stressed the importance of the conference and made it clear that it should be given priority.

Since then, the mental health services of the Capital Region have worked towards implementing the recovery concept and turning it into a driving force for the development of the services. The region has launched a central strategy of involving consumers in the mental health services, focusing on certain areas of action and combining the areas of action with strategic goals and ways to attain them; and it has established a broad range of projects and activities on recovery and recovery-oriented mental health practice.

One of the first systematic initiatives of the mental health services of the Capital Region was to ensure that the vision of recovery was heard and understood throughout the organization. Within a year over 2013-2014, all 4500 employees in
the treatment services of the region were taught recovery and recovery-oriented practice by teaching teams consisting of both professionals and people with lived experiences. This was an initiative that subsequently resulted in the establishment of the first recovery college in the region, the first of its kind in Denmark.

By defining recovery not as a necessary clinical outcome, but by basing recovery on the definition of William Anthony as a personal journey, the Capital Region has asserted its willingness to take the lead among the mental health treatment services of the five regions in Denmark. As a consequence, one of the main goals in the treatment services of the Capital Region has been to ensure that the personal recovery goals of each person using the services are integrated into the treatment plans, and then, by following the nothing about us without us statement, to make sure that the person in treatment is present as a partner in the meetings of the treatment team in the services’ units.

Peer support was also a central initiative from the very outset. A pilot project in 2013-2014 that involved the hiring of people with lived experiences as peer-support staff members in six inpatient mental health treatment units of the Capital Region rapidly evolved into peer support being an integrated part of all the mental health treatment centres of the region, so that today there are peer workers in nearly every inpatient mental health unit. At the same time, the region has worked systematically to ensure consumer participation at an organizational level, and people with lived experience are now members of all central decision boards of the region alongside providers, professionals, and management.

In all this, the Capital Region has looked very much towards the U.K., i.e. the work conducted by the Centre for Mental Health in London, and by ImROC (Implementing Recovery through Organisational Change). This has entailed, for example, basing the recovery college of the region on the concept of co-production and on the principles of recovery colleges in general, as they are formulated in a briefing paper by ImROC. 19

Today, the mental health services of the Capital Region are just about to start a new recovery initiative with the aim of consolidating and further implementing the existing initiatives and activities and to develop the recovery strategy for the coming years. It is expected that recovery, in the years to come, will be brought closer to the operating activities of the region and that the effects of interventions will, to a wider extent, be based on what people using the services consider meaningful and important.

**Danish Research into Recovery: Sporadic and Driven by a Few Enthusiasts**

While recovery has been central to the development and provision of mental health in Denmark, at least in some parts of the social psychiatry services and in some settings of the mental health treatment services, Danish research into recovery as part of these developments has been somewhat neglected. Recovery was, to some degree, put on the central political agenda by a national strategy for research into mental health in 2015; nevertheless, research into recovery is in Denmark scattered and mostly driven by a few researchers with a special interest in interventions and practices to support a recovery-oriented mental health practice.
Some of this can be explained by the great competition for the very limited research funds in mental health, and with existing research groups in other areas of interest, including biological and genetic research, which, on the grounds of many years of research, has a stronger research profile to receive the funds. But partly, it can also be attributed to the fact that recovery is not yet understood as a real field of research, but rather it is viewed as a development initiative.

Although it is increasingly recognizing that individuals’ personal recovery goals and preferences have to be a part of mental health practice, research into interventions in mental health still focuses primarily on traditional clinical outcomes such as symptoms and functioning. In addition, a culture of involving people with lived experiences in identifying, designing, producing, and distributing research has not yet, or not very particularly, reached mental health research in Denmark.

Some of the current intervention research projects in Denmark, which in the international literature on recovery are classified as specific recovery-oriented interventions in mental health, are research projects in illness management and recovery in individual placement and support, and in shared decision making. Some other Danish research initiatives related to recovery in mental health involve, research on patient-controlled hospital admissions, recovery in inpatient mental health care, and peer support.

Perspectives and Challenges: Peer Support, Tokenism and a Work in Progress

Peer support is sometimes seen as the single most important factor contributing to changes towards more recovery-oriented services, and peer support is a rapidly evolving practice in Denmark in both the mental health treatment settings and in mental health in general. In 2014, Denmark also established a national network of peer workers. It is a network that has already attracted many members and is expected to increasingly affect the agenda within the landscape of mental health.

However, as in most other countries with peer workers in mental health, peer support is also a practice meeting several challenges and sometimes also a practice to be questioned. The challenges lie in the extent to which peer workers can optimize their practice in the actual treatment settings and how each peer worker perceives the meaning of peer support and exerts the role, as well as the extent to which peer workers are hired as only a symbolic manifestation of a recovery-oriented practice and expressing a politically correct tokenism.

Tokenism is a word used by Anderson and Deegan in their 1998 publication on how to include people with lived experiences on boards and committees in mental health. Tokenism, a practice of making only a perfunctory or symbolic effort to be inclusive to members of a group, can manifest itself when only one person is recruited to be a representative of all, or if one or several individuals recruited are those with positions and perspectives identical with, or close to, the prevailing understanding of the group.

The final perspective on recovery in Denmark must be on the concept of tokenism as it applies to the broader mental health mandate of a nation, because while some initiatives and practices of the recovery paradigm have in Denmark been highly
prioritized and, to a certain degree, been transferred into a form of new mainstream practice of mental health, other initiatives and practices are rather neglected.

Although this barely differs from what can be seen in many other countries, Denmark does not seem quite ready to integrate all perspectives on recovery in mental health. This, in particular, applies to the more activist parts of recovery in mental health, evolving from the long international history of civil rights movements, to the alternative understandings and approaches in mental health regarding medication, trauma and voice hearing that are often judged to be too different or too radical to be accepted.

At the same time, there are still great differences as to which degree each of the five regions in Denmark responsible for the mental health treatment services are embracing the concept of recovery and have made it a paradigm for the service delivery. The mental services of the Capital Region have certainly been at the forefront, while other regions are, to a greater or lesser extent, lagging somewhat behind or understand recovery in a different way, sometimes still as just another word for clinical remission.

Recovery, in Denmark, is a work in progress, and probably will be for a long time yet, as the question of how to recover is not only a question to be asked to the individual users of the services’ systems, but also to the systems themselves. To the service systems, it is a question of how to recover from a long history of paternalism and of viewing illnesses categorically, with very limited expectations for improvement, and of how to design services to fit individuals, and how to avoid services designed so that individuals must fit into them. And it is a question that also pertains to what is perhaps a paradox of today’s mental health agenda, as pointed out earlier in this paper.

Research has shown that a vast majority of providers in mental health have a fairly positive attitude towards the idea of recovery-oriented care, but that the actual application of recovery-oriented practice is challenged by the demands of an organizational system taking precedence over approaches that support personal recovery. People in recovery are still not in the driver’s seat when it comes to decide when, and how, to be helped. Although it is to a certain extent probably avoidable that a system is also system-driven, we must, in Denmark as in everywhere else, ask ourselves how much and how often we forget that recovery is not linear, does not follow a master plan, and is rarely attained within a short period of time.

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