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“We are a rehabilitation unit, at least on paper” – *Competing representations of recovery-oriented rehabilitation in dual diagnosis treatment policy and practice*

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ABSTRACT

Within dual diagnosis treatment, principles of recovery are increasingly acknowledged. Nevertheless, recovery-oriented rehabilitation often becomes an abstract concept, leaving professionals in various dilemmas. This article examines competing representations of recovery-oriented rehabilitation across Danish dual diagnosis treatment policy and practice from a post-structural, analytical perspective inspired by governmentality and problematization studies. The empirical foundation consists of a qualitative ethnographic study including conducting and examining 12 national policies relevant to contemporary Danish dual diagnosis treatment practice and 23 interviews with health/welfare professionals employed at a Danish in-patient, dual diagnosis rehabilitation unit. The analysis points to a complexity between three sets of competing representations reflected in 1) the conceptual relationship between *rehabilitation* and *recovery*, 2) perceptions of knowledge based on *experience* or *evidence*, and 3) ideals of *optimization* and *emancipation*. Finally, the article discusses convergences between the competing and, at times, conflictual ideals, attempting to explain the conceptual *fluffiness*, discrepancies, and dilemmas experienced by professionals in dual diagnosis treatment within broader epistemological and ideological debates in social sciences and humanities.

1. Introduction

“However, it is a bit fluffy that recovery. What is it actually like for the individual patient, and when do you reach rehabilitation? [...] When is it possible to say that someone is rehabilitated? And when is it a success? That is a bit un-measurable.”

This quote is drawn from an interview with a health/welfare professional conducted as a part of a qualitative ethnographic study in a Danish in-patient treatment unit for dually diagnosed persons (DDPs). Dual diagnosis treatment (DD-treatment) is well-known for being challenging in terms of providing integrated mental healthcare and substance use treatment services due to conflictual professional knowledge traditions, political/institutional requirements, and models of care (Bjerger et al., 2020; Johansen, 2018). Recovery, in a Danish context conceptualized “recovery-oriented rehabilitation” (Juliussen, 2021), has been acknowledged in both research and policy, as providing a

promising conceptual common ground and new organizing principle for bringing psychiatry/mental healthcare and substance use treatment together (Davidson and White, 2007; McPherson and Oute, 2021). However, professionals still struggle explaining what it is and how it is applied in everyday treatment practice (Le Boutillier et al., 2011; Waldemar et al., 2016). As the above excerpt suggests, it often becomes a *fluffy*, rather abstract concept, leaving professionals in various dilemmas of what recovery and/or rehabilitation means for them, their practice, and the patients they try to represent. In fact, recovery has become a political, mainstream concept (Rose, 2014), ideologically appropriated to support competing political and professional purposes (De Ruysscher et al., 2019; McWade, 2016; O'Donnell and Shaw, 2016). This article examines how recovery-oriented rehabilitation is represented across policy and practice with the attempt to grasp and discuss the conceptual unclarity embedded in the emic notion of *fluffiness* expressed by professionals within DD-treatment.

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2. Background

Historically, inspired by critical psychiatric research as well as influential social justice studies (e.g. Cooper, 1967; Foucault, 1965; Goffman, 1961), the notion of recovery developed on the normative basis of broader civil rights, de-institutionalization, and *anti-psychiatric* movements (Davidson et al., 2010). In this sense, the recovery concept is to be understood in opposition to the established Western (bio)medically-based, arguably objectifying, authoritarian, and stigmatizing psychiatry and its “total institutions” (Goffman, 1961). Later, in attempts to define and analyze multiple aspects of recovery, researchers have used different prefixes such as *clinical*, *personal*, and *social/relational* recovery. To understand the representations of recovery-oriented rehabilitation across policy and practice today, in the following, we will describe the development of recovery as both an analytical and a political concept.

2.1. Recovery as an analytical concept

Rooted in the activist Psychiatric Consumer-/Survivor/Ex-patient (C/S/X) movement, in the late 1980s recovery was introduced as an analytical concept to describe the “*lived experience of rehabilitation*” (Deegan, 1988), insisting on the emancipation and autonomous voice of people who had earlier been labeled as mad or mentally diseased “patients.” In her definition, Deegan explicitly refers to the concept of rehabilitation, which she - in contrast to recovery - defines as the “*services and technologies that are made available to disabled persons so that they might learn to adapt to their world*” (1988, p. 11). As Deegan points out, persons with mental struggles do not “*get rehabilitated*” as recovery does not refer to an end-product or result but rather an ongoing experience of “*recovering a new sense of self and of purpose within and beyond the limits of the disability*” (1988, p. 11). Thus, the recovery concept calls for a humanistic, experience-based approach focused on subjective purpose, human capability and flourishing, and the participation and inclusion of the individual in society (Ness et al., 2020), rather than evidence-based biomedical knowledge and standardized, professional rehabilitation services.

Another still widely influential definition identifies recovery as a “*deeply personal, unique process*” and “*a way of living a satisfying, hopeful, and contributing life, even with limitations caused by illness*” (Anthony, 1993, p. 15). In line with Deegan’s definition, Anthony emphasizes the individual and processual nature of recovery, focusing on the ongoing experience of recovery rather than biomedical symptom reduction, which has later been captured in the distinction between “*personal*” and “*clinical*” recovery (Slade et al., 2008).

Based on systematic reviews of the recovery concept, the CHIME-model (Leamy et al., 2011) presents a broader definition of *personal* recovery that depends both on individual and social factors. Thus, recovery is, as Topor et al. (2011) have argued, “*not just an individual journey*” but rather “*a deeply social, unique, and shared process in which our living conditions, material surroundings, attitudes, values, feelings, skills, and/or roles are changing*” (2020 p. 4) and a *relational* process (Price-Robertson et al., 2017) influenced by a multitude of socially embedded dynamics (Klevan et al., 2021). To extend this perspective on recovery as a *social/relational* process encompassing changes to the individual’s social identity, a parallel can be drawn to the “*social identity model of recovery*” (SIMOR) (Best et al., 2015). It suggests that the individual’s recovery from substance use is best understood as a socially embedded process of successful identity transition that occurs through changes in social networks and related meaningful activities.

2.2. Recovery as a political concept

Starting out in activism being a collective rebellion against the established psychiatry and standardized rehabilitation services, recovery has gradually been taken up by policymakers and professionals in the global west to transform the basis for mental healthcare (Karlsson

et al., 2022). This politicization and professionalization of recovery have been described in several well-developed critiques pointing to the co-option, hijacking, colonization, etc. of the concept, implying a realignment of recovery with (bio)medical models of mental healthcare and the neoliberal present, far-removed from the concept’s original call for social justice, de-medicalization, and experience-based knowledge (De Ruysscher et al., 2019; Howell and Voronka, 2012; McWade, 2016; O’Donnell and Shaw, 2016; Rose, 2014).

Recovery was designated the overarching model of mental healthcare in the USA in 1999 (Department of Health and Human Services), and has since been an increasingly recommended ideal internationally in both mental health and substance use policies (Harper and Speed, 2012; OHCHR, 2020; MH, 2022a). In Denmark, the notion of recovery was introduced in 2004 based on research by Topor (2002) and the strategic work in a recovery project supported by the Danish Government (Jensen et al., 2004). In a Danish context, the term “recovery” exists as an Anglicism, which since 2009 until today has been a significant ideal in the Danish mental health discourse (e.g. DG, 2014, 2018; SWA, 2020; HA, 2018).

However, the political use of the recovery concept seems to reflect entangled ideals of what we have called “optimization” and “emancipation” related to the transformation of the Danish Welfare State into a “*Competition State*” (Pedersen, 2011). Representing a crucial ideological shift within the global political discourse and organization of Western welfare systems since the 1990s, characterized by neoliberal ideals such as autonomy, empowerment, user involvement etc., New Public Management, and austerity politics (McPherson and Oute, 2021), the *Competition State* primarily seeks to mobilize international, economic competitiveness and dynamic development, resulting in an increased demand for efficiency of the welfare sector and a new way of governing (Pedersen, 2011). By sociological scholars, this neoliberal way of governing has been conceptualized as self-governance (Foucault et al., 1988; Rose, 1999), which in welfare practices, such as recovery-oriented rehabilitation, has resulted in a fundamental “*dilemma of governing*” (Villadsen, 2003, p. 195) between respecting the autonomous individual on one side and intervening to create changes for the same individual on the other, at once contributing to individual emancipation and optimization.

2.3. Recovery research

Albeit the ambiguity of the recovery concept is well-known, and similar points have been made in previous post-structural as well as ethnographic studies of recovery in different institutional contexts of mental healthcare or DD-treatment (Brekke et al., 2018; Johansson and Holmes, 2023; Jørgensen et al., 2020; Le Boutillier et al., 2014; Lloyd et al., 2008; Motta-Ochoa et al., 2021; Oute and Jørgensen, 2021; Waldemar et al., 2019), to our knowledge, no previous anthropological studies have explicitly examined the conceptual unclarity of recovery-oriented rehabilitation in the context of Danish DD-treatment policy and practice.

Danish reviews investigated to what extent a recovery-oriented approach is an integrated part of in-patient mental healthcare settings by analyzing interactions between patients/DDPs and professionals (Jørgensen and Rendtorff, 2018; Waldemar et al., 2016). In a Norwegian context, Brekke et al. (2017, 2020) addressed the experiential dimensions of recovery, including dilemmas from a first-person perspective of DDPs and professionals, and an international review of “*dual recovery*” summarized how recovery from co-occurring mental health and substance use problems are facilitated or inhibited by systemic, interpersonal, and individual circumstances (Ness et al., 2014). Similarly, a review of DDPs’ perspectives on recovery suggests that social support, communal participation, holistic and individualized treatment, personal beliefs, as well as meaningful, structuring, and motivating activities assist dual diagnosis recovery (De Ruysscher et al., 2017).

However, the reviewed studies are dominated by an analytical focus

on first-person experiences/perspectives of DDPs or professionals. This emphasis on methodological individualism in the existing body of research often explain inadequate help and poor service provision as matters of personal choice and intentionality, which tends to downplay the political and institutional contingency of recovery-oriented care. This calls for more social constructivist studies to understand the conceptual *fluffiness* related to recovery-oriented rehabilitation. Specifically, we wish to examine how competing models of recovery-oriented rehabilitation are represented in DD-treatment.

3. Analytical framework

To scrutinize competing representations of recovery-oriented rehabilitation, we adapt a social constructivist perspective inspired by Foucault's (1984) and Rose's (1999) analytical gaze on governmentality and problematizations. In accordance with this perspective, we draw on the post-structural analytic strategy "What's the Problem Represented to be?" (WPR) (Bacchi, 2009). In contrast to conventional policy studies characterized by the idea that policies are rational responses to existing problems waiting to be "addressed" (Bacchi and Goodwin, 2016, p. 14), the WPR approach incorporates adaptations of the Foucauldian study of problematization which involves examination of the relationship between power and knowledge, i.e. approaches/technologies through which policy problems are discursively constructed, by interrogating the assumptions which make certain problems possible (Houborg et al., 2020).

Previously, the WPR approach has been used to explore how specific welfare rationalities are adopted to govern and reform mental healthcare in Danish mental health and drug policies between 2006 and 2019 (Bjerge et al., 2020; Oute and Johansen, 2021), with a focus on how target groups of mental health services are represented and problematized, which techniques/tools are presented as means to "fix" the problem, and how these measures are legitimized. The same approach has been used to study how DDPs' problems are represented and how clinical measures are legitimized in digital health records drawn from integrated DD-treatment (Oute et al., 2022). However, in this article, we elaborate on the above WPR studies by including representations articulated by professionals working with and influencing the implementation of policies in practice. As demonstrated by Nygaard-Christensen and Bjerge (2021), constituting elements of alignments as well as discrepancies are not alone to be found between the level of policy and practice as they are inherent within all articulated concerns, which makes it methodologically relevant to include representations, from both policy and practice. Rather than operating with an analytical distinction between macro-level policy and micro-level practice, by focusing on structures in articulations across policy and practice, we access the rhetorical space of possibility in which professionals act (Shore and Wright, 2011, pp. 1–2).

A similar analytical approach has been presented by Jöhncke et al. (2004), who argue for an empirically founded approach to the study of "modes of solutions," understood as conceptual frameworks such as recovery-oriented rehabilitation. Referring to governmentality and discourse studies, they consider how *modes of solutions* work as "social technologies," which create certain spaces of action and thought where problems are produced in unity with already imagined solutions (ibid.: 385–386). Comparable to Bacchi's argument that problem representations construct certain problems, the rationality presented in any *mode of solution* reproduces the problem it intends to solve, and this way anticipates the answers to the questions of what is possible and worth knowing about a problem (ibid.). In supplement to Bacchi's approach to the study of policies and similar to Lipsky's (1980) concept of "street-level bureaucracy," Jöhncke et al. stress the importance of examining the ongoing negotiations through which *social technologies* are enacted in practice, creating certain "problem carriers" and "problem solvers," i.e., subjects who understand themselves by the rationale of the *social technology* (2004).

Inspired by perspectives from the Anthropology of Policy (Shore and Wright, 1997, 2011), we use the WPR framework to understand policy production and implementation as a dialectic process, which allows us to explore how recovery-oriented rehabilitation is represented across policy and practice by applying Bacchi's (2009) notions of problematizations, tools/measures, and legitimization. In this sense, we consider different representations of recovery-oriented rehabilitation as social constructions and show how these reflect convergences between competing and, at times, conflictual ideals and rationalities, which might explain the *fluffiness*, discrepancies, and dilemmas articulated by professionals in DD-treatment practice.

Finally, by drawing a parallel to broader post-modern debates within social sciences and humanities, we discuss how the conceptual *fluffiness* can be seen as a product of more general epistemological and ideological ambiguities within the mental health and political discourse, and how recovery-oriented rehabilitation works as a *social technology* by facilitating certain rationalities, creating certain problem subjects/"objects," and reproducing certain ideals within post-modern welfare work.

4. Data and methods

The empirical foundation for the analysis consists of two types of data, collected and examined by the first author as part of a larger qualitative ethnographic field study at a Danish, in-patient rehabilitation unit termed a "Special Unit," targeted people with severe mental illness, co-occurring substance use, and externalizing behavior (DG, 2018, p. 40), i.e., people often referred to as DDPs. Danish DD-treatment is generally divided between health-oriented, regional psychiatric institutions and community-oriented, municipal welfare institutions including substance use treatment, governed by the Danish Health and Social Welfare Authorities, respectively (Johansen, 2018). In 2018, with an aim of providing integrated psychiatric and substance use treatment and rehabilitation services (Kapitel 12 a. § 42a. Stk. 2. MH, 2022b), five cross-institutional Special Units were established. The units are physically located within regional psychiatric hospitals which hold the operational responsibility for everyday treatment practice, while the municipalities hold the responsibility for referrals and setting overall goals of rehabilitation (HA, 2018, p. 53).

4.1. Policy-collection

First, inspired by previous studies (Bjerge et al., 2020; Oute and Johansen, 2021), all national policies relevant to contemporary DD-treatment practice (i.e., legal acts, guidelines, proposals, and recommendations published by the Danish Government and Health-/Welfare Ministries/Authorities between 2009 and 2023) (see Table 1), were collected. Extended by the inclusion of most recent policies, as well as updated and/or reassessed versions of previous policies, the collection overlaps with earlier analytical collections of Danish psychiatric and substance use policies from 2006 to 2016 (Fig. 1 in: Bjerge et al., 2020) and mental healthcare policies from 2009 to 2019 (Table 1 in: Oute and Johansen, 2021). However, since we aim to examine competing representations of recovery-oriented rehabilitation in DD-treatment, we only included policies institutionally relevant at the Special Unit, policies addressing the recovery concept, as well as legal acts more generally presenting the governing principles within mental healthcare. This involves exclusion of national clinical guidelines, research strategies, and policies by political actors such as regional, municipal, professional, or user organizations, which might be relevant to include in broader examinations of the public health/welfare discourse; however, outside the scope of this article.

4.2. Interviews

Secondly, 23 qualitative semi-structured interviews were conducted with health/welfare professionals employed at the Special Unit in the

Table 1
Included policies

MH [Sundhedsministeriet] (MH, 2023)	"Act on Health"
MH [Sundhedsministeriet] (2022b)	"Act on the use of coercion in psychiatry etc."
HA [Sundhedsstyrelsen] (2021)	"Recommendations for reduction in coercion for people with mental illnesses"
SWA [Socialstyrelsen] (2020),	"National guidelines for the social substance misuse treatment"
DG [Regeringen] (2018)	"We perform together: A complete action plan for psychiatry towards 2025."
HA [Sundhedsstyrelsen] (2018)	"Strengthened services for people with mental illnesses: A professional proposal for a complete plan for the development of psychiatry."
MH [Sundheds- og Ældreministeriet] (MH, 2017)	"Act on a comprehensive plan for patients hospitalized at a Special Unit at the psychiatric ward."
DG [Regeringen] (2014)	"Equality – A new focus on services towards persons with mental illnesses: A long-term plan"
HA and SWA [Sundhedsstyrelsen og Socialstyrelsen] (HA and SWA, 2014)	"Guidelines for co-coordinated action plans"
DG [Regeringen] (2013)	"A modern, open, and inclusive strategy towards persons with mental illnesses: Report from the Governmental Committee on Psychiatry"
HA [Sundhedsstyrelsen] (2009)	"National Strategy for psychiatry"

MH: Ministry of Health, HA: Health Authorities, DG: Danish Government, SWA: Social Welfare Authorities.

Table 2
Informants

Profession	Interviews
Nurses	7
Social and healthcare assistants	4
Occupational therapists	2
Physiotherapists	2
Doctors/psychiatrists	2
Clinical psychologist	1
Caseworker	1
Social worker	1
Drug- and alcohol consultant	1
E-sport instructor	1
Music therapist	1

fall of 2021. The informants include the wide variety of treatment-oriented and care-oriented professions represented at the unit (see Table 2); in the analysis, all referred to as "professionals" to secure anonymity. The interviews were semi-structured to facilitate the interviews while leaving space for the professionals' conceptualizations (Brinkmann and Tanggaard, 2010). Based on initial fieldnotes and existing literature, an interview guide was developed including open questions and themes, not explicitly referring to policies, such as the professionals' experiences of the overall purpose of the unit, perceptions of ideals and approaches characterizing the DD-treatment, and understanding of recovery and/or rehabilitation related to their daily practice. Each interview lasted approximately 1 h and took place in a conference room at the unit. All interviews were recorded and transcribed verbatim to secure exact representation. All interviewees gave informed, written consent to participate, and all sensitive information about mentioned DDPs was removed or anonymized.

4.3. Coding

Initiated by a processual, thematic coding strategy (Braun and Clarke, 2006) and basic explorative ethnographic principles (Hammerley and Atkinson, 2007), instead of using pre-defined categories, policy documents and transcribed interviews were read thoroughly while taking notes of cross-cutting appearing themes and keywords related to the research issue. Subsequently, these themes/keywords served as foundation for a more systematic coding of policy documents and interviews, separately, using Nvivo 12 software. Informed by the

emic notion of *fluffiness* as exemplified in the introductory quote and the WPR-inspired approach outlined above, this was done with analytical attention to representations of recovery-oriented rehabilitation which were identified within the categories: 1) problematizations of dual diagnosis, including subject positions of DDPs as *problem carriers* or *problem solvers*, 2) techniques/tools for recovery-oriented rehabilitation services, and 3) legitimizations i.e. assumptions and ideals embedded in these services.

5. Competing representations of recovery

The coding revealed a complex relationship between competing representations of recovery-oriented rehabilitation across policy and practice, constituting the conceptual *fluffiness* captured in the following interview excerpt:

Interviewer: *If you were to describe the main ideals that characterize your work, how would you do that?*

Informant: *That is a difficult one.*

Interviewer: *Yes, it is a bit broad [question]. But I have, for example, noticed a lot [of your colleagues] talking about you being a rehabilitation unit.*

Informant: *And what else do they say? Because I think that none of us actually have a clue about what that means. [...] I think it is more words than action [...].*

Interviewer: *But at the same time, it is a part of the purpose [of the unit] like you have also described it yourself [previously in the interview].*

Informant: *Yes. We are a rehabilitation unit, at least on paper.*

Despite being the main ideal *on paper*, it is far from clear what (recovery-oriented) rehabilitation means in practice. Rather, it creates different articulated dilemmas and discrepancies reflected in three analytical themes: "rehabilitation vs. recovery," "experience vs. evidence," and "optimization vs. emancipation," which will be unfolded below.

5.1. Rehabilitation vs. Recovery

5.1.1. Representations in policy

In policy, the notion of recovery is closely linked to the concept of

rehabilitation, presented as the basis for the service provision in combinations like “*recovery and rehabilitation*” (SWA, 2020; HA, 2009), “*rehabilitation/recovery*” (MH, 2022a), or “*recovery-oriented[/-supportive] rehabilitation*” (DG, 2013; 2014; SWA, 2020; MH, 2022a). When defined separately, recovery refers to the possibility and subjective experience of restoring and living a meaningful, independent, and satisfying life with active participation in society despite limitations of mental illness (DG, 2013; 2014; 2018; SWA, 2020). Rehabilitation is directly related to the notion of health and the bio-psycho-social realm of understanding, referring to professional services, knowledge, and methods/tools used to recreate and maintain the best possible functionality of the individual, which besides a biomedical focus on reducing symptoms and clinical recovery requires a focus on psychological and social aspects and involvement of the individual (DG, 2013; SWA, 2020). Thus, recovery-oriented rehabilitation represents professional services through which *personal* recovery is facilitated, i.e., the individual’s experience of being helped by professional rehabilitation interventions.

5.1.2. Professionals’ representations

This representation of recovery and rehabilitation was echoed in practice as it becomes clear from one of the professional’s explanations of the concepts:

“As I see it, recovery is something you always have with you. It is not the same as rehabilitation but still something that kind of goes hand in hand. Because to achieve recovery, you must get rehabilitated in one way or another, right? You must be able to do something on your own; you must have reached a point where you have an acceptance of your medication, your way of living, or the like, which makes it possible to feel almost without illness.”

Here, rehabilitation is considered a precondition for *personal* recovery, and the two concepts are merged to describe and legitimize clinical interventions like medication. As another professional puts it, recovery represents “*a personal and a functional development.*”

However, the recovery concept was rarely used directly in practice, even though it was considered an implicit part of rehabilitation. As one professional said: “*I actually don’t think I use the word recovery that often when I talk about it. Most often it is rehabilitation, but without noticing it, it is a part of it*”, and most professionals seemed more concerned about practice than conceptual nuances. The merge of the two concepts and dominance of “rehabilitation” over “recovery” when distinguished might reveal a professional legitimization of rehabilitation as the clinical standard intervention.

At the same time, other professionals differentiated between recovery and rehabilitation, for example, by doubting the DDPs’ ability to recover. One of the professionals said, “*Well, we usually say that it is not recovery that we do here and that we stick to rehabilitation. [The patients] are not well enough for anything else.*” This argument was supported by other professionals’ comparison of the unit with a highly specialized neurorehabilitation unit, both providing services to regain deficient biological, psychological, and social functionality following mental illness and long-term substance use or brain injury. Thus, *clinical* recovery subordinates *personal* recovery, in accordance with the existing bio-psycho-social treatment model.

However, the co-existing representations of *personal* and *clinical* recovery in practice seem to create an epistemological dilemma expressed in the following reflection: “*Well, you can’t rehabilitate someone who has not previously had the kind of behavior you want them to have. It’s not called rehabilitation, but I think we lack some kind of word for what it actually is.*” Another professional expressed this dilemma by pointing to a discrepancy between restoration and creation in a reflection about the prefix “re” included in both *recovery* and *rehabilitation*. As she explained, the prefix implies restoring something previously existing, but rhetorically asked: “*Can’t it also be about moving on? So, not about returning to what were, but to create something new.*” While most professionals represent dual diagnosis as a bio-psycho-social concern from which one can

recover through restoration of bio-psycho-social deficits through rehabilitation, these reflections suggest another solution, namely recovery as *something new*, a new sense of self and purpose, arguably representing *personal recovery* which might be the lacking word requested in the quote above. This depicts an ambiguity in identifying recovery-oriented rehabilitation by clinical or personal measures.

5.2. Experience vs. Evidence

5.2.1. Representations in policy

In line with *personal* recovery, at policy level, the individual’s subjective recovery experience is emphasized as the knowledge-basis for intervention. For example, it is stated: “*An essential precondition for recovery-oriented service provision is the professionals’ knowledge about the citizen’s own experience of meaningfulness and interpretation of well-being in life*” (SWA, 2020: 52). People having lived recovery-experience are acknowledged as a “*unique resource*” and “*experts by experience*” with essential knowledge about personal dreams, goals, and needs for intervention (DG, 2014; 2018; SWA, 2020). Additionally, it is stated that: “*The basis [for the service provision] must be the human, rather than the diagnosis. This requires a holistic approach*” (DG, 2014: 13), which represents a broader ideal of an integrated, flexible, and coordinated approach centered around “*whole persons*” and their unique life situations, goals, and needs (DG, 2013; 2014; SWA, 2020; MH, 2017; 2022a). This positioning of the individual as the primary subject of knowledge represents the original, experience-based concept of recovery defined in opposition to evidence-based biomedical knowledge.

Simultaneously, a politically presented ideal is to determine a national goal of rehabilitation to promote the possibility of living an independent life through recovery-supportive methods with documented effects (DG, 2014). This ideal represents recovery-oriented rehabilitation as the basis for effective and qualified services, which must be secured through strengthened knowledge, evidence-based environments, and a comprehensive improvement of professional qualifications and competencies (DG, 2014; 2018; SWA, 2020; MH, 2022a). More specifically, this is described to be reached through the continual development, implementation, and use of national guidelines, clinical quality databases, specialized screening tools, and diagnostic manuals (DG, 2014; SWA, 2020; MH, 2022a; MH, 2023), founded in professional/clinical standards and evidence, rather than experience.

5.2.2. Professionals’ representations

The representation of DDPs as primary subjects of knowledge and intervention also appeared in practice. For example, in an interview, one professional said:

“We try to include the patient as much as possible and to make them the experts in their own way of life. And well, also based on the idea that the goal is not necessarily to remove their diagnoses, because that is probably not going to happen, but they are able to live a well-functioning and good everyday life with what they have.”

Rather than focusing on diagnosis and symptom reduction, i.e., *clinical* recovery and DDPs as “objects” of biomedical standards and evidence-based knowledge, the focus is on DDPs as experts with experience-based knowledge of how to live a well-functioning and good life. Another professional said, “*[I think] we have become better at navigating according to each individual patient, and that is rehabilitation, and rehabilitation within the scope of recovery, too, because it is based on each individual patient.*” Thus, when based on individual needs and wishes, rehabilitation is considered recovery-oriented, and the first step becomes to identify subjective experiences and interests without letting certain normative standards influence the approach, as expressed in the following reflection by one of the professionals:

“What is a life worth living? I think this [question] is very recovery-related. You can’t expect to be cured, but you can easily get a life

worth living with your illness [...]. Focus is very much [on progress], but where does the patient actually want to be? [...] Even if the norm is that they must have an apartment, a coffee machine, or the like, it is just too much.”

At the same time, the professionals worked towards a standard clinical ideal of stabilization, which created a dilemma between two competing epistemological approaches. One of the professionals expressed it as follows: “the goals are different depending on the patient, but we still work towards goals of rehabilitation and stabilization.” A similar discrepancy appeared in another professional’s reflection: “I think, it can be difficult for many [patients] to express what is important to them. [For example], if you are feeling very bad in a period, I think it can be very abstract to think along those lines of recovery.” The reflection shows how representations of *personal* and *clinical* recovery create an epistemological ambiguity, as the professionals, on the one hand, position DDPs as subjects of experience-based knowledge, in policy presented as *experts by experience*, and on the other hand as periodically incapable of expressing personal wishes and needs, and thus “objects” of standardization.

5.3. Optimization vs. Emancipation

5.3.1. Representations in policy

Politically, recovery-oriented rehabilitation focuses on supporting the individual’s coping and control in the everyday life with an illness, as recovery is considered a personal process of creating a meaningful life defined and governed by the citizen him-/herself (DG, 2013; HA, 2021; SWA, 2020, MH, 2022b: 16). Generally, ideals such as independence, active participation, and user involvement are presented as both pre-conditions for rehabilitation and/or recovery, and crucial for optimizing the quality of provided services (DG, 2014; SWA, 2020; HA, 2021). One way to support recovery is by involving the individual in setting goals based on personal hopes and dreams (2018; HA and SWA, 2014; SWA, 2020). This is, for example, done through a legal requirement of a “comprehensive plan” (MH, 2017) for DDPs hospitalized at a Special Unit, formulated in collaboration between the individual and the involved professionals.

Concurrently, recovery-oriented rehabilitation is related to an ideal of emancipation embedded in values such as inclusion and equality (DG, 2013; 2014; HA, 2021; MH, 2022a). It is stressed that people with mental illness are to be included and given equal status as “citizens” with equal opportunities to contribute and participate within society and live an active and independent life, including the possibility of education and employment, on the same terms as everyone else (DG, 2013; 2014). Further, it is noticed that a large part of the recovery process takes place after discharge from the hospital (HA, 2021) because participation in local communities, social networks, and collaboration with actors of civil society constitute an important supplement to treatment in assisting the recovery of the individual (DG, 2013; 2014; SWA, 2020; MH, 2022a).

5.3.2. Professionals’ representations

In an interview, when asked how to provide recovery-oriented rehabilitation, a professional a bit ironically answered: “Well, you do so by letting them do things themselves.” To give an example, she imitated a dialog with a previous patient who rarely got lunch while hospitalized:

Professional: “Why don’t you come for lunch?”

Patient: “No one woke me up.”

Professional: “No, but you [...] do very well know that lunch is between 12.00 and 12.30 p.m., so you must set an alarm on your phone. What would you have done at home?”

Also, other professionals expressed a focus on supporting DDPs in becoming “as self-supporting as possible,” for example, through “coping strategies,” which were presented as useful tools in avoiding re-

hospitalization or reducing substance use. According to the professionals, an important part of rehabilitation was to avoid violating the DDPs’ independence and level of functioning by “making them poorer than they really are,” as one expressed. Instead, active participation was perceived as a premise for rehabilitation, as expressed by another professional: “There are just some things that [the patients] must be able to participate in for us to be able to rehabilitate them.” This implies that some characteristics of DDPs make it difficult to facilitate rehabilitation: “Especially, when we get patients who lack motivation or have relatively low IQ, then it can be very difficult to drive the rehabilitation [...]. At least if we would like them to start a development.” The same representation put in a nutshell, was expressed by another professional who said: “I think that we cannot do rehabilitation when they abuse.” The quotes show how motivation, cognitive functions, and abstinence were considered necessary individual abilities in optimizing rehabilitation.

Nevertheless, this representation was not univocal. During an interview one professional stated: “I also think that the general picture is that when we are at a hospital, then a little, kind nurse will come and do things for me. And I think [this picture] is difficult to remove, especially because our patients are very ill with [substance] abuse.” This indicates a paradoxical dual perspective on the DDPs, who, on the one hand, are represented as autonomous subjects considered experts in their own lives, i.e., *problem solvers*, emancipated, motivated, and responsible for fixing their problems, and on the other hand as very ill patients/“objects” of disease i.e. *problem carriers*, who because of their dual diagnosis need services provided by *the little, kind nurse*, i.e., *the problem solver*.

In practice, many professionals also expressed frustration about lacking possibilities of facilitating rehabilitation due to the hospital’s structures, for example: “I actually think that our patients are good [at doing things themselves], but this is challenged by the fact, that they are at a hospital, where you need a [key]card to open the door to the laundry room and kitchen. You can’t just [do it], right? [...] It is not rehabilitation.” Similarly, another professional suggested that what they offer at the unit should rather be called “pre-rehabilitation,” understood as preparation for actual rehabilitation “out there” as part of society, based on the supposition that rehabilitation cannot take place within a “protected environment” like the hospital. Here, both professionals represent recovery-oriented rehabilitation as a *social* and *relational* process limited by the clinical setting of the hospital, in which individual optimization and/or emancipation seems difficult.

6. Concluding discussion

Previous research has shed light on dilemmas faced by professionals in recovery-oriented treatment without conceptualizing why they appear and their unintended consequences (Brekke et al., 2018; Le Boutillier et al., 2014; Waldemar et al., 2016). Inspired by Bacchi’s WPR approach (2009), this study helps to close the gap by elaborating the understanding of the contextual conditions, the different epistemological and ideological assumptions and discrepancies, which explains the dilemmas and conceptual *fluffiness* faced and reproduced by professionals in the field. In the face of mental health being notably absent in anthropological policy studies, our consideration of the *fluffy* political-professional representation of recovery-oriented rehabilitation across policy and practice conveys a new contribution to previous work on technologies and identity politics (Shore and Wright, 1997, 2011).

In the following discussion, we suggest that the conceptual *fluffiness* associated with recovery-oriented rehabilitation can be understood in parallel to more general epistemological and ideological debates brought up within humanities and social sciences as part of a post-modern turn in the 1980s, characterized by increased reflexivity, questioning of universal concepts, and general distrust in authorities. Within anthropology, this manifested in recognition of the fact that any attempt to represent the social reality of others, like policymakers’ and professionals’ representation of DDPs and their experiences, unavoidably involves a certain kind of sense-making (Marcus and Fischer, 1999,

pp. 7–9). In other words, “*problems of description became problems of representation*” (ibid., pp. 9), which was further problematized by the political and ethical question of the “*West’s*” authority to represent “*the exotic other*” (Said, 1978), similarly to DDPs constituted as the “*objects*”/subjects of intervention. Later, in the rise of the Competition State, the *problems of representation* have arguably developed into a neoliberal distrust in the sovereign expertise and effectiveness of welfare professionals and standardized services such as rehabilitation, as all citizens, including DDPs, are considered autonomous subjects with the knowledge and power to decide what is best for themselves (Villadsen, 2003; 2004, pp. 238–239).

6.1. Epistemological fluffiness

As the analysis has shown, *fluffy* representations of recovery-oriented rehabilitation are re-produced and legitimized through the gaze of a bio-psycho-social model, which has been commonly adopted within the biomedical rationality of Western psychiatry (Oute and McPherson, 2023). This common outlook underscores why the dominating representation of recovery-oriented rehabilitation in DD-treatment policy and practice has become a merge of *personal* recovery and bio-psycho-social rehabilitation, despite the recovery concept’s original call for experience-based rather than evidence-based, biomedical knowledge (Deegan, 1988), and its later redefinition as *social* and *relational* process (Price-Robertson et al., 2017; Topor et al., 2020) not taking place in the clinical context of the hospital. The merge leaves the professionals in a difficult epistemological position between humanism and biomedicine. Rather than being experts, they become facilitators of subjective, experience-based expertise (Järvinen and Mik-Meyer, 2012), which is not always compatible with biomedical, evidence-based knowledge, clinical standards for rehabilitation, and what DDPs need to recover.

As mentioned previously, humanistic and social scholars have addressed this issue through methodological individualism, trying to empower DDPs in the academic and political debate and qualify the recovery concept by mapping patterns in first-person experiences (Brekke et al., 2020; De Ruyscher et al., 2017; Leamy et al., 2011). However, the paradigmatic discussion about biomedicine and humanism intrinsically linked to the representations of recovery is still ongoing. This is reflected in the United Nations’ recent guidance for global changes in the organization, economic resources, and service provision within mental healthcare (OHCHR, 2020). This guidance points to the dominance of biomedicine as an obstacle to the emphasized necessity of recovery- and community-based services in line with human rights. In the global response of medical and psychiatric organizations to this request, the bio-psycho-social model is arguably used discursively as a “*unifying trope*” (Oute and McPherson, 2023, p. 18), representing the established psychiatry as a united profession and institution without any competing or conflictual ideals, epistemological challenges, or needs for changes. This concern about the potential of the recovery-orientation to overcome the hegemonic position of biomedicine within mental healthcare and its representation of recovery as a nice but not necessary add on to the existing breadth of mental health services might increase the conceptual *fluffiness* of recovery and invalidate its importance (ibid., Karlsson and Borg, 2022).

6.2. Ideological fluffiness

Besides competing epistemological positions, conceptual discussions about recovery reflect wider ideological debates about the purpose of mental healthcare and the authority to define recovery (Harper and Speed, 2012; Howell and Voronka, 2012; Rose, 2019). Certain representations seem more prominent than others depending on the dominating ideology. This points to recovery-oriented rehabilitation as a *social technology* (Jöhncke et al., 2004) that exists as a product of not only an epistemological but also an ideological *fluffiness*, facilitating certain ways of thinking and acting in practice.

In the wake of the ideological shift from the Nordic Welfare State to the Competition State, there has been a widespread political debate about welfare dependence (Vike, 2018). Welfare professionals have been accused of creating passive clients dependent on long-term welfare services, articulated as ineffective and counterproductive for personal freedom, conflictual with the neoliberal ideal of post-modern welfare work (Järvinen and Mik-Meyer, 2012). As previous studies have shown, the recovery concept’s celebration of autonomous individuals’ active involvement and responsibility in solving problems of their own fits perfectly with the ideals and technologies of the neoliberal welfare state and its measurable standards of development (Harper and Speed, 2012; McPherson and Beresford, 2019; Rose, 2019). Informed by the neoliberal ideology, recovery has arguably come to work as a *self-technology* (Foucault et al., 1988) that primarily seeks to optimize the citizen’s self-governing, for example, by involving DDPs in setting their own goals. As the analysis shows, DDPs are predominantly represented as *problem solvers* with the authority and experience-based knowledge to define and govern their own recovery process, emancipated from the objectifying psychiatric treatment system and authoritarian expertise of the professionals. However, within the ideological landscape of the Competition State this seem to imply a certain kind of emancipation, namely the optimization of individual motivation, potential, and responsibility to undergo personal development (Brinkmann, 2008). In line with previous studies (McWade, 2016; Vandekinderen et al., 2012), this points to an individualization of responsibility through a neoliberal co-option and professional reframing of the social aspects of recovery and emancipating ideas of the C/S/X movement.

Following this argument of co-option, politization, and professionalization of recovery, the conceptual *fluffiness* expressed by the professionals might not only be considered a consequence of ambiguous, competing representations but also a political and professional strategy of resistance used to maintain authority and expertise (Howell and Voronka, 2012; O’Donnell and Shaw, 2016).

7. Limitations and future perspectives

While we have aimed to analyze competing political-professional representations of recovery-oriented rehabilitation in Danish treatment for DDPs, our analysis neither considers itself nor first-person representations of experienced recovery. It is further limited by not including ethnographic field observations describing how different representations are competing, negotiated, and prioritized in practice and why, or any “*thick*” ethnographic descriptions (Geertz, 1973) of the institutional space of action constituted by organizational, local and/or individual characteristics of the specific unit, professionals, and DDPs.

Yet, the present article offers a conceptual framework and theoretical backdrop for future research examining how competing representations and dilemmas following from different epistemological and ideological positions are enacted and negotiated among professionals, peers, users, and/or relatives in and beyond DD-treatment practice, and continuously create new social relations, realms of understanding, and political spaces of actions (Shore and Wright, 2011).

Statement – ethical approval not required

In Denmark ethical approval of qualitative data collected from human subjects which is not a part of a clinical/medical research project is not legally required.

CRediT authorship contribution statement

Natja Bech Kjeldsen: Writing – original draft, Project administration, Methodology, Investigation, Formal analysis, Conceptualization. **Tine Holm:** Writing – review & editing, Resources, Methodology. **Jeppo Oute:** Writing – original draft, Supervision, Methodology, Investigation, Formal analysis, Conceptualization.

Data availability

Policies are publicly available, however data from interviews are confidential.

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