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ORIGINAL ARTICLE

Negotiating the Practical Meaning of Recovery in a Process of Implementation

An Empirical Investigation of How a Participatory-Inspired Research Approach to Implementation Might Facilitate a More Recovery-Oriented Practice: The Case of RENEW-DK

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Abstract
As implementation of recovery-oriented practices has proven difficult, this study investigates whether a participatory-inspired approach to implementing and adjusting a recovery-oriented model, RENEW-DK, might facilitate a more recovery-oriented practice among the professionals in public sector services. Ten narrative interviews with professionals was analyzed from a Science and Technology Studies perspective, and special attention was devoted to the concepts of distortion and stigmatization. Despite a one-year participatory process of model adjustment and implementation, professionals experienced RENEW-DK as a distortion and thus shaped their practice of RENEW-DK according to organizational requirements and professional beliefs instead of making their practice more recovery-oriented. The study calls attention to the need to acknowledge contradictions between intentions in general models and values in specific organizations with local norms and practices.

Keywords Recovery-oriented practices · Implementation · Co-development · Mental health · Young adults · Professionals · Employment · Education · Psychiatry · Narrative interviews

Introduction

Implementing recovery-oriented practices[1] in services for people with mental health difficulties is a political priority (Amering and Schmolke 2009; Davidson et al. 2005; Shepherd et al. 2008; Slade 2010), with policies being formally employed in several countries including Denmark (Ramon et al. 2009; Sundhedsstyrelsen 2009). Thus, politicians and managers have tried to change staff attitudes as well as organizational structures (Gilburt et al. 2013; Jacobsen and Curtis 2000; Park et al. 2014; Shepherd et al. 2010). Nevertheless, studies continue to demonstrate that implementation of recovery-oriented practices is challenging (Delaney 2012; Shera and Ramon 2013; Waldemar et al. 2016), and mental health consumers do not necessarily experience services as recovery-oriented (Jaeger et al. 2015; Waldemar et al. 2018b). Le Boutillier et al. (2015) found a main concern voiced by professionals to be that competing structural and organizational priorities take precedence over the provision of recovery-oriented care. They describe that professionals

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[1] Many definitions and understandings of recovery-oriented practice exist, but we refer to the framework presented by Le Boutillier et al. 2011 containing four domains: (1) promoting citizenship, e.g. social inclusion and meaningful occupation; (2) organizational commitment, e.g. that services and organizational structures should be flexible in meeting the needs of the service user; (3) supporting personally defined recovery, e.g. peer-support, strengths focus and a holistic approach; and (4) a working relationship entailing partnership and inspiring hope.

and managers longed to reach a shared understanding of recovery and how to best implement it.

One approach to reaching a shared understanding is to engage professionals in a process of participatory research (Ness et al. 2014; Rowe et al. 2012; Wallerstein and Duran 2006). Mance et al. (2010) for example, describes how a community-based participatory approach in the adaptation of a mental health intervention for urban African American young people created a shared understanding of the intervention curriculum. Furthermore, it has been demonstrated that participatory action research (PAR) might enable practice change through reflecting on practice (Borg et al. 2010; Lincoln et al. 2015; Olesen and Nordentoft 2013). We were therefore interested in examining whether a PAR approach to implementation of a model with recovery-oriented values could facilitate more recovery-oriented practices.

Thus, we engaged in a PAR-inspired process[2] with professionals from a mental health facility (MHF) and an employment center (EC)[3] in Denmark where the professionals and the first author collaborated on adjusting the RENEW model[4] to make it correspond with professionals' needs. However, after the PAR-process had concluded, we found great discrepancies between the descriptions in the RENEW manual, and descriptions of the practice of RENEW presented by the professionals and the young adults enrolled in RENEW (elaborated in Hoej et al. submitted).

Inspired by Vohnsen (2017), we argue that simply describing these discrepancies as 'implementation gone wrong' is an oversimplification. By demonstration of the complexity of the labor market, Vohnsen argues that implementation is never straightforward; we need to understand it in light of the contexts. In relation to this, the crucial influence of context on implementation of recovery has also been called to attention in recovery-research (Slade et al. 2014; Storm and Edwards 2013).

The aim of this study is therefore to investigate the implementation of RENEW through a PAR-inspired approach in the two different contexts. We have demarked the focus of the study on exploring how contextual factors in themselves influences professionals' perspectives on adjusting and implementing RENEW; thus, the focus is not on comparing how an employment versus a mental health sector might influence the process of implementation.

Through the concept of distortion, we will demonstrate how professionals experienced the implementation of a new and different approach, and how they tried to connect this with their existing practice. Furthermore, by employing a Science and Technology Studies perspective, we will demonstrate how professionals made sense of RENEW in their own context by both reshaping their own perceptions and practice, as well as reshaping the components of RENEW.

The study contributes to existing knowledge by providing a clearer understanding of the processes of implementing recovery-oriented models in public sector services, and it provides methodological perspectives on how PAR approaches are important in endorsing recovery-oriented practices.

The Intervention RENEW

We chose the American RENEW model (Rehabilitation for Empowerment, Natural Supports, Education, and Work) (Malloy 2013) as a model for this study, since it provides a recovery-oriented framework for supporting young people with mental health difficulties. RENEW targets youth aged 18–30 with behavioral and emotional difficulties and addresses issues related to transitioning into adulthood, focusing particularly on building self-determination, empowerment and social support (Malloy 2013). As described above, we adapted RENEW to correspond to a Danish context in collaboration with professionals with the largest adjustment being the addition of a peer group. The elements of the Danish RENEW process as described in the amended manual are illustrated in Fig. 1.

To develop a peer group was an expressed wish by management and practitioners in both the MHF and the EC. We intended to establish a platform where youth could meet, share experiences and support one another, while also establishing connections with the local community through excursions to, e.g., community sports or youth centers. For a detailed presentation of the peer group structure and composition, please refer to Andreasen et al. (2019).

As demonstrated in Fig. 1, the network meetings are central in the RENEW process. Inspired by wraparound approaches (also described in Bruns et al. 2011), the intend is to empower and improve self-determination of the young

[2] In standard PAR processes, practitioners collaborate with the researcher on determining the purpose of the research and development process. However, in our study, we intended to give professionals more influence on the implementation process through methods from PAR. Thus, in PAR processes, it is not tradition to departure a development process from the basis of a model, because it can be argued that a predetermined model will instigate an inappropriate power balance thereby not allowing the practitioners to have the desired voice in the process.

However, we have flipped this script by using PAR approaches as a means to try to empower professionals in implementation processes and to investigate whether such an approach might be valuable in implementation of recovery-oriented models when aspiring for a more recovery-oriented practice. Since our approach thus differs from traditional PAR, we have chosen to term our approach'*participatory action research-inspired*' to avoid any unfortunate confusion.

[3] Reasons for choosing these sites are offered in the section "Implementation process and context".

[4] Reasons for choosing this model, and a description of its content, are offered in the section "The intervention RENEW".

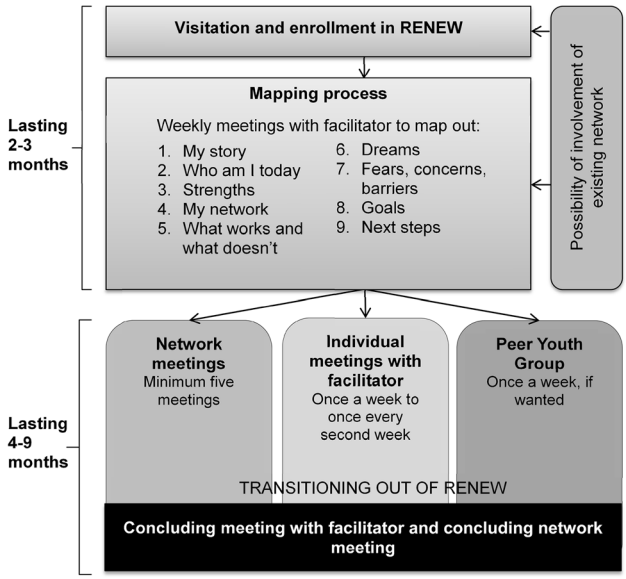

Fig. 1 The RENEW process

adults by giving them responsibility of preparing their own agenda and inviting people to the meetings to help them reach their goals (Malloy 2013; Malloy et al. 2012).

The term'network meetings' is, however, also applied in routine mental health services where it typically characterizes meetings arranged by professionals with the purpose of informing family about the treatment, and/or coordinating interprofessional care. Thus, though 'network meetings' is used both in the RENEW manual and in mental health services, the structure and content differ substantially by the emphasizing of the importance of young adults themselves chairing the meetings and deciding the agenda in RENEW.

Process of Implementing Through PAR and Description of Contexts

The RENEW manual was developed in 1996 in New Hampshire. It was translated into Danish in 2013, and professionals from an employment center and a mental health facility were trained as RENEW mentors in December 2014 by the American developers of the model as preparation for the consecutive PAR-inspired process in 2015, focusing on adjusting it to the Danish contexts. We chose to collaborate with professionals from these genuinely different public service contexts, since this would enable very different contextual perspectives from the professionals in the PAR process, inferring that this would enable a clearer account of how the contexts influenced the PAR/implementation process. A description of the mental health and employment setting is found in Table 1. Please note that this overview is provided for the reader to be able to discern the contextual factors affecting professionals in the process of adjusting and implementing RENEW; thus, the intent is not to compare the two places.

Recruitment for the project took place in 2014, where professionals were recruited out of the existing workforce by managers inquiring professionals if they wished to participate. Thus, participation was voluntary. The main criterion for enrollment was experience of working with people with mental health difficulties. Ten professionals signed up to participate in the project; five from each sector. The recruitment process is important, since this approach implicates that professionals were already shaped by the organizational context from the outset, influencing their shaping and understanding of RENEW-DK. However, recruiting from the existing workforces in two different public sector services also allowed us to explore how existing professional understandings, work practices, and organizational contexts influenced the process of implementing RENEW-DK.

Throughout 2015, after initial training, the professionals and the first author engaged in a collaborative PAR-process of adjusting and further developing RENEW; meanwhile professionals also worked with young people in a RENEW process (see Fig. 2).

The aim of the process was not only for the model to make sense for practitioners, but also to facilitate ownership and to achieve a more recovery-oriented practice. The collaborative process consisted of weekly one-hour methodological meetings and the actions described in Table 2.

By the end of 2014, the PAR-inspired process was concluded, and an amended manual, *RENEW-DK*, was generated. After this, professionals continued to work with RENEW-DK throughout 2015.

Method

This section provides descriptions of the methodological and analytical choices, and theoretical framework while also discussing study limitations in relation to the implications for the findings.

Participants and Empirical Data

The study was approved by the Danish Data Protection Agency, and the primary empirical data consists of ten interviews conducted in the fall of 2015 with MHF and EC professionals working as RENEW mentors. The interviews were conducted and analyzed narratively (Davidson 1993, 2003; Davidson and Strauss John 1992; Strauss 2011); thus questions were semi-structured and open-ended, focusing on exploring the professionals' experiences of implementing RENEW-DK in their own practice (Kvale 2007). The first author conducted the interviews, each lasting approximately one to one-and-a-half hour, with a focus on allowing the

Table 1 Description of RENEW settings in Denmark

	Primary institutional purpose	Professional composition	Further details
Municipal employment center (EC)	Helping young adults on public benefits (18–30 years) move closer to or enroll in education	Most professionals work as mentors and counsellors with very differentiated backgrounds; e.g. teachers, social workers, nursing assistants etc.	Young people are obliged to attend meetings in the EC as a prerequisite for receiving their social benefits. Should they fail to do so, benefits are reduced depending on amount of no-shows
Out-patient treatment in a regional mental health facility (MHF)	Providing treatment through psychotherapy and medicine for patients with depression, personality disorders, anxiety, and PTSD	Psychiatrists, psychologists, specialized mental health nurses, social workers, physiotherapists, etc.	To be able to receive treatment in the MHF, patients must have referral from their general practitioner. MHF professionals are responsible for further referral to different services, if they assess patients to not be profiting from treatment

professionals to describe their experiences as freely as possible; however, if the professionals did not themselves talk about the topics presented in Table 3, the first author asked about them.

The MHF professionals were specialized nurses or psychologists, while the EC professionals were nursing assistants, nurses, psychologists, and one professional had a master's degree in social work; we use pseudonyms to protect confidentiality. At the time of the interviews, two of the professionals had stopped working as RENEW facilitators, and one was temporarily on a break from working with RENEW-DK and was tending to other work assignments.

The data also consists of twelve interviews with young people (for details please refer to Hoej et al. submitted), video and audio recordings from the PAR-process, and field notes from observations conducted at the two sites (for details please refer to Hoej et al. 2017). All RENEW-DK professionals were conveniently sampled to participate in the interviews, and the first author conducted the interviews. The first author was also employed by the two organizations in which RENEW-DK was implemented, and, as described, she partook in the PAR-process. This allowed for a profound understanding of the institutions, which helped frame relevant interview questions, and provided contextual understandings when analyzing the professionals' experiences (Johansen 2018). However, being employed by the place where one also researches and participates in PAR-processes also presents some dilemmas (Humphrey 2013; Kragelund 2007). Thus, we would like to address the first author's personal involvement with the professionals and the risk of asymmetrical power structures in this relationship (Olesen and Nordentoft 2013; Olesen and Pedersen 2012); being positioned as "a researcher" and an "implementation leader" of RENEW-DK might have engendered professionals to perceive the first author as a RENEW expert, making them reluctant to suggest profound changes to the model in the PAR-process. Furthermore, the close collaboration between professionals and the first author could potentially have led to professionals feeling a breach of trust when reading the analysis, if they lost sight of the first author's primary role as a researcher (Alvesson 2003). In consideration of this, professionals were asked for their informed consent to participate several times throughout the PAR-process, as well as just before conducting the interviews.

Theoretical Framework and Analytical Strategy

This study takes off from a social constructivist epistemology; thus, we acknowledge how reality continuously shapes and is shaped by context, and the interactions playing out in it (Esin et al. 2013; Holstein and Gubrium 2013). Context is therefore understood as a dynamic entity

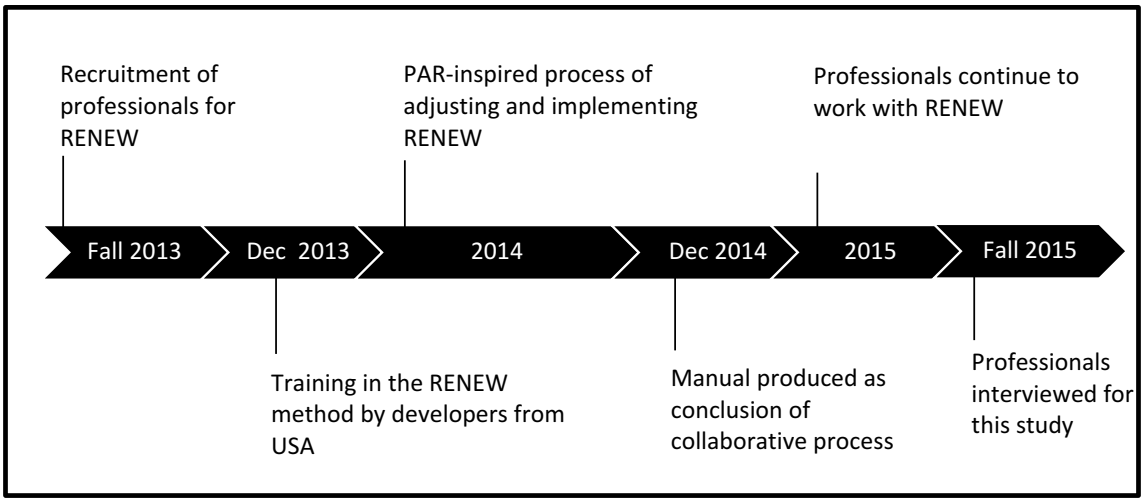

Fig. 2 Timeline of RENEW project

Table 2 Description of PAR-inspired process

Activity	Content	Participants	Location
RENEW Training December 2014	Training of Danish professionals by American developers of the model	• Model developers • Professionals • First author	EC
Workshop I (½ day) January 2015	Introduction and sharing of experiences	• Professionals • First author	MHF
Observation periods by researcher February 2015	First author learning about professionals' practice	• First author	EC and MHF
Workshop II (1-day) February 2015	Presentation of February observations and reflections on these	• Professionals • First author	EC
Intersectoral observations March to May 2015	Professionals observing how professionals from 'the other' sector worked.	• Professionals	EC and MHF
Workshop III (½-day) July 2015	Reflections on intersectoral observations and goal setting for PAR-process	• Professionals • First author	EC
Peer group development meeting (½-day) September 2015	Creation of a framework for the new peer group element.	• Two EC and two MHF professionals • First author	MHF
Four focus groups + consecutive interviews with participating facilitator October 2015	Focus groups of 2-3 h investigating young adults' perspective observed by one professional from the 'opposite' sector of the young adults.	• Facilitation: first author • 3–5 young adults in each group • One observing professional	EC and MHF
Workshop IV (1-day) End October 2015	Presentation of focus group findings; discussion and reflection on these	• Professionals • First author	EC
Workshop V (1-day) November 2015	Reflections on study approach and peer group manual	• Professionals • First author	EC
Workshop VI (1-day) December 2015	Presentation and discussion of adjusted RENEW-DK manual, sharing of experiences	• Professionals • First author	MHF

conditioned by interactions, positionings, and understandings occurring in it (Lund 2011).

The analysis comprised of the first author condensing the transcribed interviews into 1–2 page summaries in 1st person pronominal language in accordance with the method described by Sells et al. (2004).

The first author commenced by reading each narrative to grasp the entirety. This was followed by a second read where

Table 3 Overview over interview topics and example of questions

Interview topic(s)	Example of question
How did professionals experience the different phases? (The mapping phase, the individual meetings, the network meetings, and the youth groups	You have worked with the RENEW model, what has that been like? How have you experienced RENEW to be different, since the youth group was added to the model?
Collaboration with the young adults and social relations	How have you experienced working with the young adults, who are the target group of RENEW?
How did RENEW-DK correspond to the contexts?	Which elements of working with RENEW have you found particularly difficult?
The intersectoral collaboration	How has it been, working with professionals from a different sector? How is your work different from theirs?
Professionals development process	Is there anything from your experiences of working with RENEW that you feel you can use in other work assignments? What do you feel you have learned in this project?

important quotes capturing each young adult's experiences were highlighted. These highlighted sections were then transposed to a new document. During the third and final read, the focus was on condensing the narrative even further and the excerpts was rearranged to represent the narrative as a coherent whole. This approach presents a limitation, because, ideally, two people should have collaborated on this to compare and validate the summaries. However, due to financial and temporal constraints, this was not possible.

Following condensation, we discussed all the summaries one by one in the author group, while simultaneously writing up each interview's most important themes on a whiteboard, paying attention to themes that reoccurred in the interviews. In this process we realized, for example, that the different professionals used dissimilar, sometimes even contrasting, vocabulary to describe their work with RENEW-DK; e.g. RENEW was therapy/not therapy/coaching/a clarification process/etc., and use of terminology especially differed between the MHF and the EC. This led to a focus on how professionals categorized their work differently.

We would have liked to involve professionals more thoroughly in this process (Cahill 2007). However, we were only able to involve them in analysis in the early stages of the PAR-inspired process; not in the analysis of the interviews presented in this study. Accordingly, we carefully considered how to portray the predicaments encountered by the professionals in choosing excerpts and presenting the analysis.

We concluded by agreeing on three pivotal themes: (1) different perceptions and conceptualizations of RENEW-DK, (2) experiencing RENEW as a distortion in their work lives, and (3) contrasts between descriptions of RENEW-DK practice and descriptions in the manual.

The themes provided the foundation for writing up the analysis, and therefore the analysis comprise three sections; each representing one of these themes. The themes correlate to the research question by illustrating how RENEW-DK's boundaries were negotiated and contextualized as a result of it presenting as a distortion. We will demonstrate these processes in the analysis by depicting how RENEW-DK was practiced very differently from facilitator to facilitator, and we will illustrate how these practices were not necessarily in agreement with recovery-oriented principles, as intended in the model.

In the analytical framework, we take inspiration from Science and Technology Studies (STS) in analyzing the interaction between the context, the professionals, and the RENEW-DK model (Hackett 2008; Law 2008); thus conceptualizing RENEW-DK as a social technology (Derksen et al. 2012). The STS perspective represents a broad scientific approach, covering multiple methods and epistemologies (Law 2008), and it "invites [focus] on the sociomaterial construction of such technologies, the tinkering involved, and their modes of deployment and circulation" (Derksen et al. 2012). Thus, by conceptualizing RENEW-DK as a technology we can analyze how it was employed and materialized in practice, and how professionals "tinkered" with it to make it comply with their context. It thus provides a framework for analyzing the professionals' experiences of implementation of RENEW-DK, while also providing possible explanations for why implementation of recovery-oriented practices might be less straightforward than policy makers would like it to be. Inspiration is drawn from two strands within the STS-approach:

(1) The actor-network theory (ANT), which understands technology itself as an actor, and which focuses on how actors are both constituted by and are constitutors of networks (Law 2008; Nielsen 2010). This perspective enables an investigation of what happens to RENEW-DK during the transition from intention to practice by investigating how the embedded intentions in the technology are practiced (Akrich 1992). From this perspective, the concept of *fluidity* is applied to illustrate the ambiguity of RENEW-DK; it describes how

a technology's "boundaries and constitutions vary and its success and failure, instead of being clear-cut, are a matter of degree" (De Laet and Mol 2000, p. 248). We employ it in the last analytical section, where we depict how the practice of RENEW-DK unfolded differently from facilitator to facilitator. We also employ it in the first analytical section, where it allows for discernment of how RENEW-DK permitted different conceptualizations when adapting it to match the purpose of the organizations.

(2) The second strand is motivated by the symbolic interactionist STS perspective (Clarke and Star 2005; Law 2008; Star 1996) where special attention is devoted to the constitutive role of social interactions (Clarke and Waring 2018); thus the things that might seem straightforward and unambiguous on the surface, such as guidelines in a manual, might prove to be complicated and unclear when taking a closer look (Vikkelsø and Vinge 2004). For example, in the first analytical section, we focus on how professionals perceive and negotiate the conceptual boundaries of RENEW-DK differently depending on their professional background and their organizational belongingness. This unveils some of the ambiguities within RENEW-DK, while enabling an investigation of how professionals deal with them (Bowker and Star 2002; Jenkins 2000; Star and Strauss 1999).

Furthermore, we suggest that the implementation of RENEW-DK can be understood as a *distortion* (Rapport 2018), provoking professionals to discern established practices and to identify a place for the RENEW-DK-practice within these. Although not an STS concept, the notion of distortion is included, because it conceptualizes how the professionals experience being challenged by RENEW-DK while also having to respond to organizational demands and regulations. Hence, the concept provides an explanation for why the professionals insert different meanings and interpretations into the functioning of RENEW-DK. We follow Rapport's definition of distortion as…:

> …the ways and extends to which plans, intentions, expectations, foretellings, patternings fail to achieve particular outcomes. (…) 'Distortion' describes those processes where an input or starting condition (such as a set of intentions) is subject to a mutation or radical interference such that ensuring or emerging conditions, or outputs, are radically different in nature. Something transpires that is inexplicable: *neither anticipated nor anticipatable, unintended, revolutionary not evolutionary, random not formulaic, arriving seemingly from nowhere.*
>
> (Rapport 2018; iterations are shown as in reference).

Thus, by employing the theoretical concepts described above, we set out to explore whether the process of implementing RENEW-DK facilitates a more recovery-oriented practice, while also suggesting possible reasons for differences between intentions in the RENEW-DK manual and professional practice.

Analysis

The analysis is divided into three parts. In part I we illustrate, through the symbolic interactionist STS perspective, how different perceptions and conceptualizations of RENEW-DK allowed professionals to make sense of the model across different perspectives and contexts; thus demonstrating RENEW-DK's fluidity. In part II we focus on distortion by depicting how the descriptions set out in the RENEW-DK manual seem to clash with existing practices and understandings; especially in the MHF. In part III we focus mainly on the ANT perspective by illustrating how professionals dealt with discordances between the descriptions in the model and their existing practice by absorbing RENEW-DK into existing procedures.

Part I: Negotiating RENEW-DK—Different Perceptions and Conceptualizations

Although categories seem objective and undebatable in their structuring of life and work, they are subject to interpretation and negotiation rather than being clear-cut (Bowker and Star 2002; Jenkins 2000). An excerpt from the summary of the interview with MHF nurse Jane for example illustrates how MHF professionals negotiated RENEW-DK's boundaries by describing it as pre-treatment for youth who were not quite "therapy-ready":

It's really great [for the young adults] to go to RENEW first and then maybe afterwards go to a treatment package,[5] because then you will know what going to therapy is about, you will know something about your illness, and you will know yourself better …, [and] you will be much more motivated. … Going to therapy … can be hard, if you've never done it before. So, I can imagine them getting anxious and not showing up. … If they're not therapy-ready now, maybe they will be in five years, but at least they have been clinically assessed, so they know what's wrong. … In a way, what we do is prevention … because then they aren't tossed back

[5] In Denmark, out-patient treatment for non-psychotic disorders is organized and restricted through so-called 'packages', whereby a certain number of services are provided depending on diagnosis, e.g., patients with anxiety and social phobia receive a standardized 15-h package containing, among other things, a medical evaluation and therapy (Danish Regions 2014).

and forth between different services; … we keep them until we know what's wrong with them.

Jane describes RENEW-DK as a form of pre-treatment where young adults can get ready and motivated for therapy. She also believes it to be preventive, because it accommodates a thorough clinical assessment; thus facilitating easier and better referral (and avoiding inappropriate referral) for the young adults later on. Thus, she does not understand RENEW-DK – as intended in the manual – as a process that continues until the young adults do not need support anymore, and she constitutes it within the framework of the existing mental health organization by shaping it as assessment and pre-treatment.

Negotiations on interpretations of whether RENEW-DK was or was not treatment and/or therapy are frequently represented in the empirical material; Brian from the EC, for example, stated:

> It is difficult to separate; when is it therapy? So, I guess doing these interviews [with the young adults], with these headlines, quickly makes it some kind of therapeutic work; when you ask about hopes and dreams, and make them think really hard about it, right.

The EC professionals clearly explicated that they could not categorize RENEW-DK as treatment, since their organization was not authorized to provide treatment according to governmental delegation of areas of public sector service responsibility. On the other hand, MHF professionals were obliged to provide treatment, and thus they needed to conceptualize it within such a framework. As a consequence, RENEW-DK was understood as coaching or mentor support in the EC. In these negotiations, some professionals also expressed concern about having to draw such a clear-cut line between what was therapy, and what was not.

In addition to investigating negotiations, the symbolic interactionist STS perspective also calls for analyzing professionals different descriptions of RENEW-DK as an attempt to structure RENEW-DK into their work-lives. Thus, they used different vocabularies, clearly influenced by their workplace belonging when describing RENEW-DK. The MHF professionals thus articulated their RENEW-DK practice as "*strength-based*", "*holistic*" and "*recovery-oriented*". This resonates with the focus on recovery in Danish mental health policies in general (Korsbek 2017), illustrated by a focus on strengths (Anthony 1993; Shepherd et al. 2008). Contrarily, as exemplified by this excerpt from John's summary, language used by the EC professionals were more occupationally or teaching inspired, focusing, for example, on internships:

> The method brings [the youth] an opportunity to (…) narrow in on the things they are good at, that they are interested in, and that they'd just might possibly have a talent for. (…) And then we can, for example, talk internship with them, so they can check out the course that they have a feeling they'd maybe like to enroll in. (…)

Thus, EC professionals aimed attention on identifying the strengths of youths to be able to suggest suitable education. Articulating their practice as "strength-based" was not, however, part of their professional vocabulary; rather, it was a natural element of their work. Hence, as required by organizational demands, professionals adjusted RENEW-DK's framework to correspond to their context and their perceptions of what their work assignments and responsibility constituted.

Seemingly, RENEW-DK was fluid enough for professionals to interpret different perceptions and conceptualizations into its framework; in this manner, their perceptions and practices were not necessarily profoundly challenged by RENEW-DK. However, in the interviews, the professionals explained that working with RENEW-DK had changed their perspective. They acknowledged how involving the youths more profoundly in the decision-making process provided a sense of ownership for the young adults, which facilitated more engagement. The summary from Jane, a MHF nurse, illustrates her change in perspective:

> I have learned to also focus on resources and (…) the wholeness of the patient. (…) And also [the importance] of involving the family. Many factors need to be considered if a patient is to recover or get better. (…) [And] focusing on getting into employment or education also adds something for them, you know, it's about creating an identity and feeling like you are something. (…) I believe I have become more knowledgeable; more knowledgeable with regard to seeing the whole patient in a wider perspective instead of (…) [only focusing] on the illness that needs to be fixed. Of course, that is important too. I do that too, but through involving the network and these things.

The excerpt provides an example of the change of perspective experienced by professionals; they described a newfound ability to grasp the importance of looking at all aspects of the young people's lives and the benefit a strength-based approach. However, in the final section of the analysis we will demonstrate that despite experiencing changes in perceptions, the professionals were not necessarily able to translate these into practice. Before doing so, we will continue the analysis by illustrating how RENEW-DK was experienced as a distortion with its different knowledge paradigm, and how professionals tried to make sense of it within their professional contexts.

Part II: The experience of distortion

A PAR-inspired framework invites a change process with active engagement of professionals and the researcher (Bradbury and Reason, 2003). Change processes occur when old, existing knowledge regimes are challenged and perhaps replaced by new and different ones (Cunliffe 2002; Dalgaard et al. 2014; Karlsen and Larrea 2014). The intent of collaborating with professionals on adjusting RENEW-DK was thus to try to challenge old practices. In the following, we describe how professionals experienced the new knowledge regime, represented in RENEW-DK.

Professionals were asked how RENEW-DK differed most from their former practice, and John from the EC replied:

> What is most different is how it's structured – that this is a structured process; that there are all these maps we have to go through, followed by working with the network and endurance. So, I would claim that the structure is one element that is very characteristic of this way of working.

Thus, for John, working with RENEW-DK presented a new systematic approach to his work-life. In contrast to this, the MHF professionals found the structure to be loose and difficult to understand. Christine, an MHF nurse, explained how she experienced working with RENEW-DK at the beginning:

> I didn't understand where it was going. We had these maps … and the structure just wasn't transparent to me; what were they doing in the group and what kind of a group was it and what was it all, really? … Maybe I'm just not really great at working in a field where I'm not in control over what will happen; I mean, I would really like to know why I say what I do, and to begin with I thought, 'This thing is just too loose.'

Thus, in contrast to John, Christine experienced RENEW-DK as unstructured, and she could not make sense of the purpose, if it did not involve working with diagnoses, therapy, and medical treatment. We suggest relating her experience to Rapport's concept of *distortion*; a commonplace human experience where the outcome of a certain input cannot be predicted (Rapport, 2018, p. 18). Christine's experience of distortion was thus prompted by the implementation of RENEW-DK.

These converging perceptions can be understood in the light of the organizational structures of the two contexts: the MHF professionals routinely worked with standards (diagnoses) determining treatment paths described in guidelines, and they found it difficult to integrate RENEW-DK into this framework. Contrarily, the EC professionals experienced RENEW-DK structured, because their work was not organized by treatment regimens determined by diagnoses. Indeed, no categorization of the young adults' situations occurred in the EC,[6] and thus, before RENEW-DK, they could not rely on guidelines to structure their work-lives.

Furthermore, though all professionals were appreciative of working with RENEW-DK, its recovery-oriented framework presented challenges, especially for the MHF professionals. Thus, the strength-based focus collided with organizational requirements of being attentive to symptoms and signs of self-harm or suicide (Waldemar et al. 2016). Sofia, a MHF psychologist, reflected on her process of integrating the mapping process of RENEW-DK into her therapy sessions with youth:

> I have found it challenging: 'so, ok, now we have to focus on the maps, but you have these suicide thoughts.' So, then I'm like: ok, now I'll go back to being a psychologist again.

Distortions can be experienced when different intentionalities meet (Rapport 2018), and by representing a different knowledge-regime, RENEW-DK's recovery-oriented approach challenged the established practices and beliefs. Therefore, in the MHF, an extensive process of negotiation occurred concerning how RENEW-DK could be practiced in accordance with established therapy and treatment, and what role and responsibilities practitioners should take as RENEW-DK facilitators. In the next section, we will depict the practices of RENEW, as they were described by professionals, and we will discuss the implications RENEW-DK being experienced as a distortion; more so for some professionals than others.

Part III: RENEW-DK as a Facilitator for Recovery-Oriented Practices?

Some professionals found it natural to carry out the activities prescribed in the manual, while others struggled. From the methodological meetings (described in the section *Process of implementing through PAR and description of context*), we discerned that some of the MHF professionals, in particular, found it difficult to integrate their professional obligations with RENEW-DK. Throughout the empirical data from the development phase and in the interviews, professionals negotiated the constitution of RENEW-DK by, for example, describing that they allowed for its "pausation" when dealing with urgent problems like anxiety attacks or home evictions. Again, the concept of fluidity contributes with insights on how professionals shaped

[6] Typically, in traditional employment centers a categorization process does take place. But in the EC where this study was conducted, this process of categorization of the young adults took place before enrollment. Thus, this was not part of the professionals' duties in this study.

RENEW-DK in practice; for example, in the mapping process. Some mostly drew icons, and some added written cues; and where the EC professionals used flip-charts and hung maps on the walls, the MHF professionals used whiteboards or paper – mainly due to a lack of wall space. The order of the maps (illustrated in Fig. 2) was also questioned, and John from the EC described that he would alter the order, because he found it too intimate to begin with the young adult's story. Furthermore, despite the manual's description of the mapping processes as ongoing, only a few professionals used the maps beyond the first two months. However, all professionals agreed that the maps provided a valuable understanding of the young people, and the mapping process was described as clarificatory, for example, the following excerpt is from EC professional Victoria's summary:

> By us having these maps up every time, suddenly [the young adults] are able to look at themselves differently (…) and we can laugh a little bit and figure out what happened and why. (…) [The young adults] have all said: "'it has given me an overview over my life', and that has been positive. There is (…) a structure, you need to stick with, ensuring that [the process] doesn't just fade out.

The intent with the network meetings were for the young adults to be in charge, draw benefits from the capacities in their social network, and receive support in reaching their goals. However, fulfilling these aims posed a particular challenge.

In the EC few network meetings were held, because professionals found it difficult to motivate the young people to participate. The young adults—as did some of the professionals—found it very difficult to involve family or friends in their RENEW process; corresponding with scientific concerns raised elsewhere (LaPorte et al. 2014). They described that they felt reluctant to burden their social network with their difficulties, and they were not interested in involving their social network in issues related to them receiving social services benefits. Some facilitators also explained that they found the individual meetings more valuable than the network meetings, which also explains them being less inclined to work hard on motivating the young adults. The few network meetings held in the EC were, however, described as beneficial, because the young adults felt supported by their network, and some gained new insight about family relationships (Hoej et al. submitted).

In contrast to the EC, after a couple of months of working with implementation, network meetings in the MHF corresponded in frequency to the instructions in the manual, and, in the interviews, the professionals described how they could appreciate the benefit of them. The following excerpt from MHF nurse Jane's summary describes this:

> We have a lot of network meetings; (…) minimum four-to-five. (…) Family participates and helps the youth, (…) making them take a little responsibility. (…) And we can tell, I mean the quicker we set up a network meeting, the better the outcome for that patient; there's a better turn-up, and there are more positive going-back-to-work and -education outcomes.

This was despite the fact that MHF professionals to begin with struggled immensely to decipher their role as meeting facilitators. However, they described, for example, that the network meetings reduced non-attendance, because meetings yielded a platform from which to express expectations to the youths, while also getting parents on board (this is elaborated in Hoej et al. 2017). The professionals found it beneficial to have well-informed parents who, in turn, were very pleased to be involved. Meetings were, however, not conducted "completely in the spirit of JoAnne [Malloy, the instigator of the American RENEW model]", as Christine from the MHF described. Rather, they were practiced more as routine network meetings where it was "less about who could help with what, [and] more about summarizing and planning, and if someone had had an incredible amount of no-shows, then kind of, 'wake up—what do you wanna get out of this [being in treatment]?'"

The patient's network, the social worker and the clinic's psychiatrist routinely participated in the MHF meetings, and, contrary to manual descriptions, professionals coordinated the meetings and sent out invitations. How the meeting was planned depended on the individual facilitator; Christine, for example, planned the content and wrote the agenda, whereas others explained that they normally suggested and discussed an agenda with the youth, while still others said that the agenda was completely defined by the patient.

A likely explanation for MHF professionals' appreciation of the network meetings is that RENEW-DK's fluidity allowed them to shape the content to correspond with what they believed to be important; and for the MHF professionals this was providing information to parents, aligning expectations with regard to attendance, and coordinating treatment plans.

The circumstance that RENEW-DK could be shaped most likely also contributed to the change in Christine's perception from being unable to understand it to endorsing it in the narrative interviews:

> The reason why I ended up being really happy with RENEW was that I had so much resistance at the beginning. … I made quite a U-turn with regard to the things I simply couldn't make sense of at the beginning, where I then thought: 'No, this does make sense!'

Christine explained, as did the other MHF professionals, how things got back "on track" for her when she understood

RENEW-DK as a pre-treatment service, preventing dropout. As follows, RENEW-DK could be combined with her perspective of what the mental health service comprised. Christine thus articulated and reframed its purpose to deal with a concern previously occurring in her work-life: that some patients were not ready to receive therapy when starting treatment.

Notably, we found portrayals of the role of the peer group very similar in the MHF and the EC. We find this remarkable, because at the time of the interviews the EC professionals had recently begun working with peer groups, and only about 10–12 young people had thus far participated, whereas in the MHF all the patients in RENEW-DK took part. Possibly the similarities had to do with the constitution of the group, which, according to MHF professionals, was more educational than therapeutic, corresponding with practices in the EC. The professionals described the peer group as a safe and inclusive environment, focusing on youth sharing experiences and building peer-to-peer relations. Furthermore, the MHF professionals found that meeting the young adults every week for a continuous time period was convenient, because it allowed them to observe for signs of relapse.

In the following section, we will discuss the findings in relation to research on implementation and recovery, commencing with a discussion on what happens when a predesigned model is transferred from one context to another.

Discussion

Nielsen 2010 points out that a model's failure or success when transferred across contexts or borders depends on how well the embedded values correspond to the contextual demands. Furthermore, technologies are often designed in light of anticipations of practice which are not necessarily in accordance with actual practice (Akrich 1992). In the case of this study, RENEW-DK was developed in the USA, so the initial anticipations did not take into account Danish contextual factors. This could potentially explain some of the challenges of understanding and implementing it; American values relating to supporting young adults with emotional difficulties might differ from those of the two Danish public sector services in this study. We demonstrated how especially the MHF professionals were challenged by integrating the model into their context. Nielsen's assertion helps decipher this finding, since the core value in RENEW-DK of supporting young adults' road to education was immediately more aligned with the EC's organizational purpose of getting youth closer to or enrolled in education (see Table 1).

Nevertheless, attention *was* paid to the challenges of transferring a technology from one context to another, wherefore the year-long PAR-inspired phase was instigated. Despite the PAR efforts, the organizational requirements, the contextual demands, and the preferences and knowledge of professionals influenced the practice of RENEW-DK, leading to a profound variation in practice from one professional to the next. Therefore, our study adds by demonstrating how difficult it was to create a practice change despite efforts to consider context when implementing and adjusting RENEW-DK. As follows, RENEW-DK was conceptualized as a distortion because it represented a different set of values and approaches compared to those the professionals were familiar with, and also because it to some extent contradicted organizational structures, especially in the MHF. Rapport 2018 states how: "world-views, substantive relationships, institutional contexts, [and] social systems are transformed [as a result of distortions] and something new emerges—unintended, unplanned, unplannable—and with its own natural ramifications". We have demonstrated how RENEW-DK facilitated a change in professionals' perspectives, or "world-views" as Rapport terms it. However, we have also depicted how the practice of RENEW-DK was shaped in unintended and unplanned ways, despite efforts and plans to counter this process. And, especially for the MHF professionals, it appears that RENEW-DK called for a, perhaps unwanted, transformation of their role, for example by requiring them to surrender control to the young adults. Therefore, conceivably the conceptualization and practice of RENEW-DK in alignment with the organizational responsibilities and assignments was a manner of creating coherence. Thus, RENEW-DK came to be shaped out of the established routines and the context, meaning that, in many respects, professionals could retain earlier work practices. However, this was at the expense of the recovery-oriented intentions of involving and building social networks and giving the young adults more control.

Fidelity measurements based on observations are often used to try to ensure adherence to the intentions behind interventions. Corresponding to this, Fixsen et al. 2005 present framework for adapting and measuring behavioral interventions as an effort to ensure contextual fit. However, we invited the professionals to change the model to through the PAR-inspired process; thus, our focus was not on ensuring fidelity, but rather on exploring professionals' perspectives on the change process and how they made sense of the model in their context. And arguably, RENEW-DK might have seemed less fluid if professionals had been continuously challenged through observations followed by a critical questioning making them reflect over why they favored established practices over the ones described in the manual (Cunliffe 2002). However, professionals were not adequately made aware of how they, to a large extent, shaped their practice to comply with old ones, and therefore they were not given the opportunity to act on this. Therefore, it would have been a valuable contribution if observations of professionals' practice had been conducted concurrently

with the interviews. This would have provided a more complete portrayal of the professionals' practice than the one we were able to subtract from professionals' descriptions of their practice which we would have then been able to present to the professionals thus explicating the dissonance between the recovery-oriented values embedded in RENEW-DK and the organizational values or professional's preferences. Conceivably, this might have facilitated more reflections over their own practice (Cunliffe 2002; Dalgaard et al. 2014), enabling a shared understandings of how to practice RENEW-DK, which presumably would have introduced a more recovery-oriented practice. Accordingly, Le Boutillier et al. (2015) elaborate that the dissonance between intentions to promote recovery-oriented practices and the capacity to operationalize might be resolved if a change in professionals' perceptions of recovery is instituted, and a shared understanding is reached. Thus, supervision with a focus on reflections on practice (unlike case supervision), inspired by PAR, might be a valuable approach in promoting recovery-oriented practices (Borg et al. 2010; Park et al. 2014).

In our findings, it was conspicuous that the peer group was most similarly described, also across the sectors. This is remarkable because this was the one RENEW-DK component *not* originally developed in the USA. One possible explanation might be that the young participants, by virtue of the formation of a community within the group (Hoej et al. submitted), became a constituent factor in the group's practice, thus carrying the group culture themselves, making their practice relatively more important than the practitioners'. Another plausible explanation is that, despite working with different institutional purposes, the professionals' involvement in the development of the peer group facilitated a shared understanding for practitioners. Thus, if the aim of implementing a model is to create shared understandings and shape practitioners' practice in a particular direction, for example towards a more recovery-oriented practice, this study substantiates that a recommendable approach is to involve professionals in the development of the model while providing a possibility to discuss aims and values (Borg et al. 2010; Mance et al. 2010; Ness et al. 2014).

Lastly, we find it important to reflect on the implementation of recovery-oriented practices in public sector services. As we have indicated, the transformation of public sector services towards becoming more recovery-oriented cannot happen simply by implementing a single intervention or model (Karlsson and Borg, 2017). Rather, for change to happen in organizations, it is necessary to also address organizational structures which might impede (or facilitate) such changes (Davidson et al. 2006; Slade et al. 2014; Waldemar et al. 2018a). However, we have demonstrated the perspectives of working with PAR-inspired approaches when implementing recovery-oriented models by demonstrating how PAR can facilitate critical reflections, leading to a change in perceptions, which arguably have the potential of bringing about more practice changes than we accomplished in this study.

Conclusion and Perspectives

The process of moving from intentions to practice when implementing recovery-oriented approaches through descriptions of experiences with RENEW-DK has been unpacked in this study. Thus, we have demonstrated that the values entailed in RENEW-DK prompted professionals to perceive it as a distortion making it difficult for them to navigate between the prescribed practice in the model, their own professional convictions and the institutional structures.

The study was designed with special attention on contextualizing RENEW to the MHF and the EC in which it was being implemented, through a PAR-inspired process. Nevertheless, no profound alterations was made to the RENEW-DK model, besides adding a peer group module; maybe because the institutional structures did not typically allow for professionals to critically examine described practices; rather, they were accustomed to having to follow described procedures without questioning them.

Thus, despite the effort of contextualizing RENEW-DK, we found that professionals still experienced RENEW-DK as a distortion; also after the conclusion of the PAR-inspired phase. Thus, possibly as a means to make sense of RENEW-DK, professionals ascribed different purposes to it, and descriptions of RENEW-DK varied according to each professional's personal beliefs and their organizational belonging. Accordingly, RENEW-DK's fluidity made it applicable in two quite different contexts, and it made it meaningful for professionals. Furthermore, both EC and MHF professionals experienced RENEW-DK as a valuable approach due to its strengths-based focus.

Nevertheless, in the interviews, professionals described how they continued with earlier routines by 'inserting' old practices into the framework of the model, shaping their practice in alignment with existing routines. Thus, we could not identify descriptions of practices indicating that they had become more recovery-oriented.

It did, however, seem that RENEW-DK had—to some extent—shaped or altered the professionals' perceptions; maybe because they were given the opportunity to reflect on their practice during the PAR-inspired process of implementation. Thus, despite some MHF professionals initially being very critical of the educational framework presented in RENEW-DK, they came to see how it could be beneficial in a treatment setting as well.

This study contributes with perspectives on understanding the implementation of recovery-oriented initiatives as distortions: On the one hand, a certain element of distortion

is called for when asking professionals to change practice; on the other hand, if the distortion is too extensive and the value set within the intervention is too far from what professionals know and understand, change might not occur. A feasible solution to this might be to create reflection spaces, for example through supervision sessions where professionals are given the opportunity to reflect on their own practice, in addition to traditional case supervision, in which new recovery-oriented practices can be acknowledged as distortions, thereby also acknowledging professionals' frustrations.

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Data Availability The empirical material generated in this project will not be publicly available due to the rules of the Danish Data Protection Agency. It will, however, be available from the corresponding author, after publication, upon reasonable request and following a signed confidentiality agreement with the Danish Data Protection Agency in the Capital Region of Denmark.

Compliance with Ethical Standards

Conflict of interest As stated, Michaela Hoej was employed by the two organizations in which this study was conducted. Otherwise, the Authors declare no conflict of interest.

Ethical Approval The project was approved by The Danish Data Protection Agency (journal number 03610 and ID-number: RHP-2015-006). The Regional Committee on Research Ethics was also contacted for approval (Protocol number: H-7-2014-FSP15), but the project was not liable to notification, because no biological material was included in the research. Hence, no approval was necessary. Furthermore, the Danish National Board of Health was contacted (Case number 2014111813), but the project was not liable for notification here either.

Informed Consent Informed consent was obtained from all individual participants included in the study.

Statement of Human Rights The study was conducted in accordance with the Code of Ethics of the American Anthropological Association (http://s3.amazonaws.com/rdcms-aaa/files/production/public/FileDownloads/pdfs/issues/policy-advocacy/upload/AAA-Ethics-Code-2009.pdf).

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