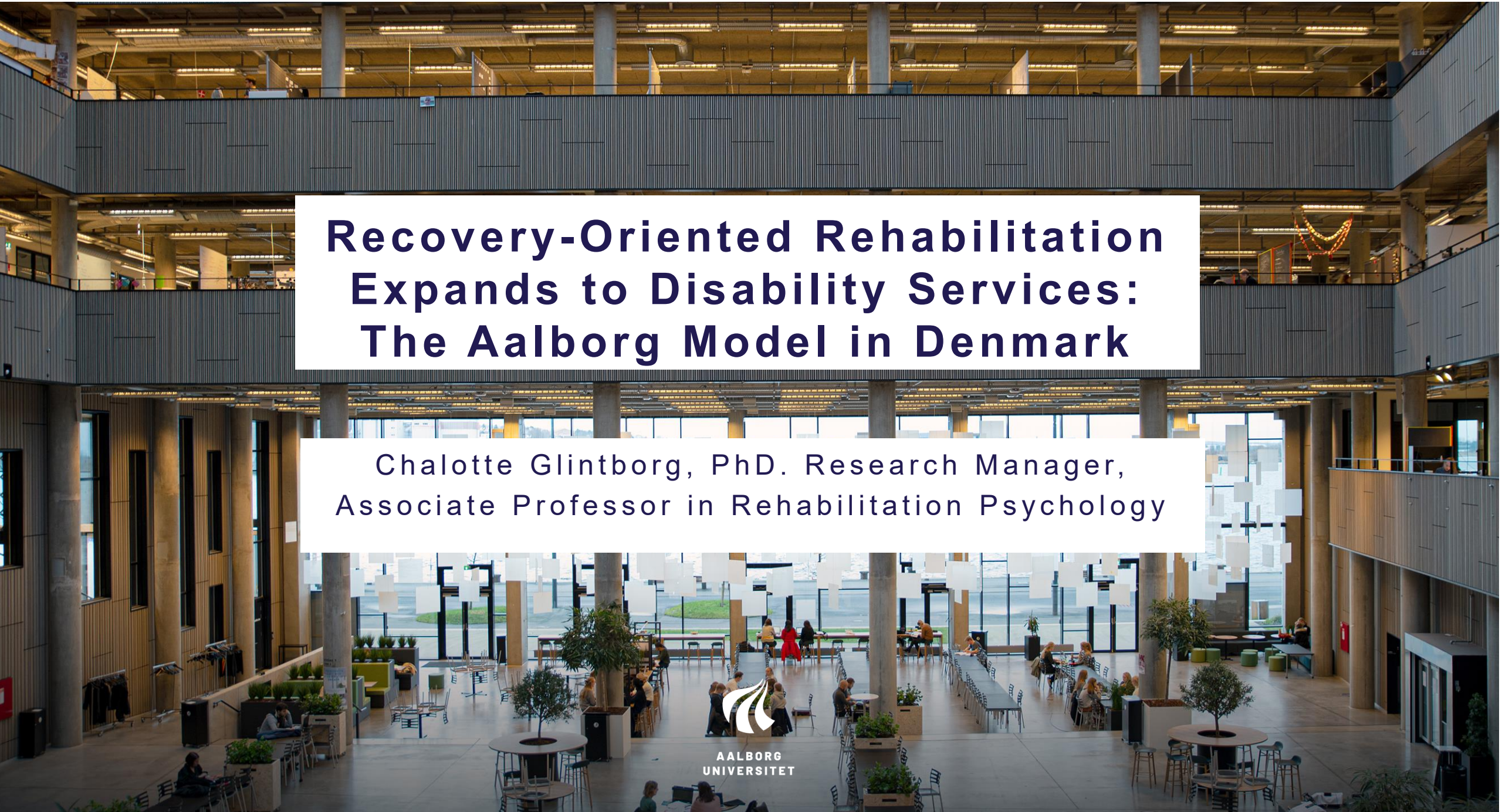

Recovery-Oriented Rehabilitation Expands to Disability Services: The Aalborg Model in Denmark

Chalotte Glintborg, PhD. Research Manager,
Associate Professor in Rehabilitation Psychology

AALBORG
UNIVERSITET

Presentation – my recovery journey

- **Since 2012**: Researcher at Aalborg University, Department of Psychology
  - Research in ROR
- **2011-2012**:Consultant, National Resource Centre for Disability and Social Psychiatry, National Board of Social Services
- **2001-2011**:Rehabilitation Professional, Manager & Organizational Consultant, Mental Health, Aarhus
  - Head of Implementation of the Masterplan for Recovery-Oriented-Rehabilitation (ROR) in Aarhus Municipality
  - Trained as a CARe instructor in 2007
- Trained more than 100+ employees in Aarhus Municipality in the CARe model + ROR

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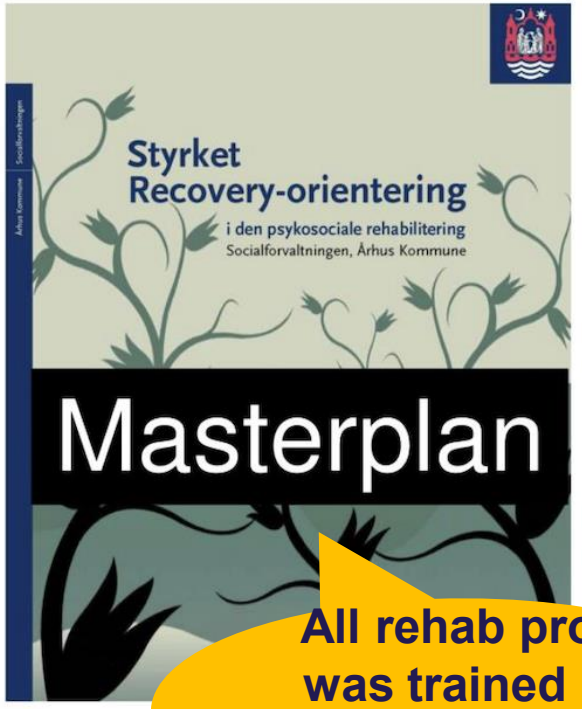
Background: Denmark's Recovery-Oriented-Rehabilitation Journey

2001



All rehab prof. was trained in the CARe model 2007-2009

2010+

Systematic Expansion

Evidence-based ROR
spread nationally at policy level

The Aalborg Model of ROR

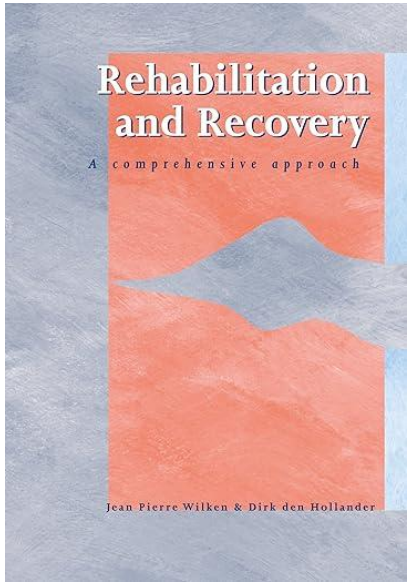
ecovery principles now applied across all disability service sectors

WHO (2019). Recovery and the right to health.

It is important to note that recovery do not apply only to people with psychosocial, intellectual or cognitive disabilities. Everyone is recovering or has recovered from something in their lives. Therefore, these recovery factors may apply to ***everyone****.*

Experiences from Aarhus with the CARe model

- The Aarhus of the CARe model drew criticism because what professionals received in practice was an extensive mapping system (big toolbox) — but no methodological language for the human dimension of rehabilitation work. The first CARe model treated the relationship as a means to an end. No cultural adaption to DK.
- Moreover the four core values from recovery – and the recovery research was not part of the initial training (person orientation, person involvement, authonomy, hope)
- However, the CARe model became a stepping stone in an already ongoing process and Aarhus
- The later model (2019+) represents a substantive theoretical advance. Where Version 1 operationalized the *what* of rehabilitation, the revised model foregrounds the *how*: **the relational stance**, the quality of presence, and the professional use of self. The four core actions— *connecting, understanding, securing,* and *strengthening* — are not procedural steps but relational dispositions. The model draws explicitly on relational care ethics, presence theory (Baart), attachment-informed thinking, and positive psychology.
- But do we need a model?



The Paradox of Formalizing Recovery

- Recovery is, by definition, a deeply personal, non-linear, and self-directed process. When we attempt to capture it within a formal model — with stages, tools, domains, and measurable outcomes — we risk enacting a fundamental contradiction: we systematize the unsystematizable.

The recovery term – from user driven grass root movement to a professional project?

Five critical tensions in the formalization of personal recovery

01 AGENCY

Recovery becomes a professional project

When mapped and monitored by professionals, the locus of agency shifts. The person is no longer the author — they become a participant in someone else's methodology.

02 SINGULARITY

Standardization conflicts with individuality

Recovery is irreducibly individual. Its meaning and pace cannot be standardized without distortion. What counts on the form may count for very little in the person's actual life.

03 DRIFT

The form becomes the goal

Documentation gradually replaces actual support. The relational encounter shrinks to fit the time left after administration.

04 LANGUAGE

Recovery language gets colonized

Once recovery enters formal systems, its radical origins — rooted in survivor movements — are quietly domesticated. The language remains, but the politics disappear.

05 MEASUREMENT

Measurement produces its own subject

Operationalized indicators shape what gets noticed and valued — often privileging institutional logics over lived experience.

Recovery cannot be delivered. It can only be supported — and that support is fundamentally relational, contextual, and resistant to full formalization. ***The map is not the territory.***

What is recovery? Getting the terminology right

Personal recovery (applies across all target groups including you and me)

- Recovery is, by definition, a deeply personal, non-linear, and self-directed process. When we attempt to capture it within a formal model — with stages, tools, domains, and measurable outcomes — we risk enacting a fundamental contradiction: we systematize the unsystematizable.
- *The individual person defines the goals of the intervention themselves, based on what gives them well-being in life. With a focus on an experienced Good Life. If professionals want to know what personal recovery means, they must therefore listen to each individual person. What the person experiences as providing well-being, hope, meaning and control in their own life defines personal recovery in that particular persons' perspective. All people have their own idea of well-being in life and the good life. Personal recovery is therefore concretized in a multitude of ways.*

Recovery-oriented-rehabilitation

"Recovery-oriented rehabilitation is about supporting persons' own process of realizing hopes, wishes and dreams for the future, creating meaning in their lives and shaping the life they themselves desire. The professional must focus on the fact that the person can recover. That means coming to thrive and live a satisfying and meaningful life, regardless of the challenges the persons experience, and whether or not they continue to have symptoms."

Danish Authority of Social Services and Housing, *Guidance for Practice.*

Juliussen, FB (2021) *Recovery-Oriented Rehabilitation*

.

The Aalborg Model – from mental health to *all* disability services

- Action research project (Collaborationg team (managers, researcher, consultants, service users)
- Implementation team (every site has an implementation team consisting of service users, rehabilitation professionals and the manager)
- Anthroprological visits in practice during the whole process
- Workshops
- Evaluating interviews with service users
- Quantiative meassures rehabilitation professionals and service users (Brief Inspire, WHO-5 QOL)

The Aalborg Model — Key Innovations

🧭 CHIME/Brief INSPIRE/WHO5

Standardised tools to monitor implementation and outcomes — adapted specifically for disability populations with systematic preparation before, during and after.

🤝 Relational Competencies

"Practicing presence" and relational attentiveness as core professional skills — grounded in Baarth's theory of presence and relationality

👤 Person-Centred Preparation

Structured support for service users before, during, and after recovery workshops — ensuring meaningful participation across disability types

📊 Practice Research

Data-driven quality development and wellbeing measurement across 8 disability services

Workshops

Brief INSPIRE – O, med illustrationer

Udsagn	Slet ikke	Lidt	I nogen grad	En hel del	Rigtig meget
Jeg føler mig godt støttet af andre mennesker 	1	2	3	4	5
Jeg har håb og drømme om en god fremtid 	1	2	3	4	5
Jeg trives og har det godt 	1	2	3	4	5
Jeg laver ting, som jeg godt kan lide 	1	2	3	4	5
Jeg kan bestemme i min hverdag 	1	2	3	4	5

Adapted Brief-Inspire-O with pictograms

The Sun. Your dreams and hopes

- What do you wish for in your life?
- What makes you happy?
- You can say it out loud, point to pictures, or draw.

Path, peaks, slopes and plateaus

- Highs, lows, standstill

Tailwind. What helps you

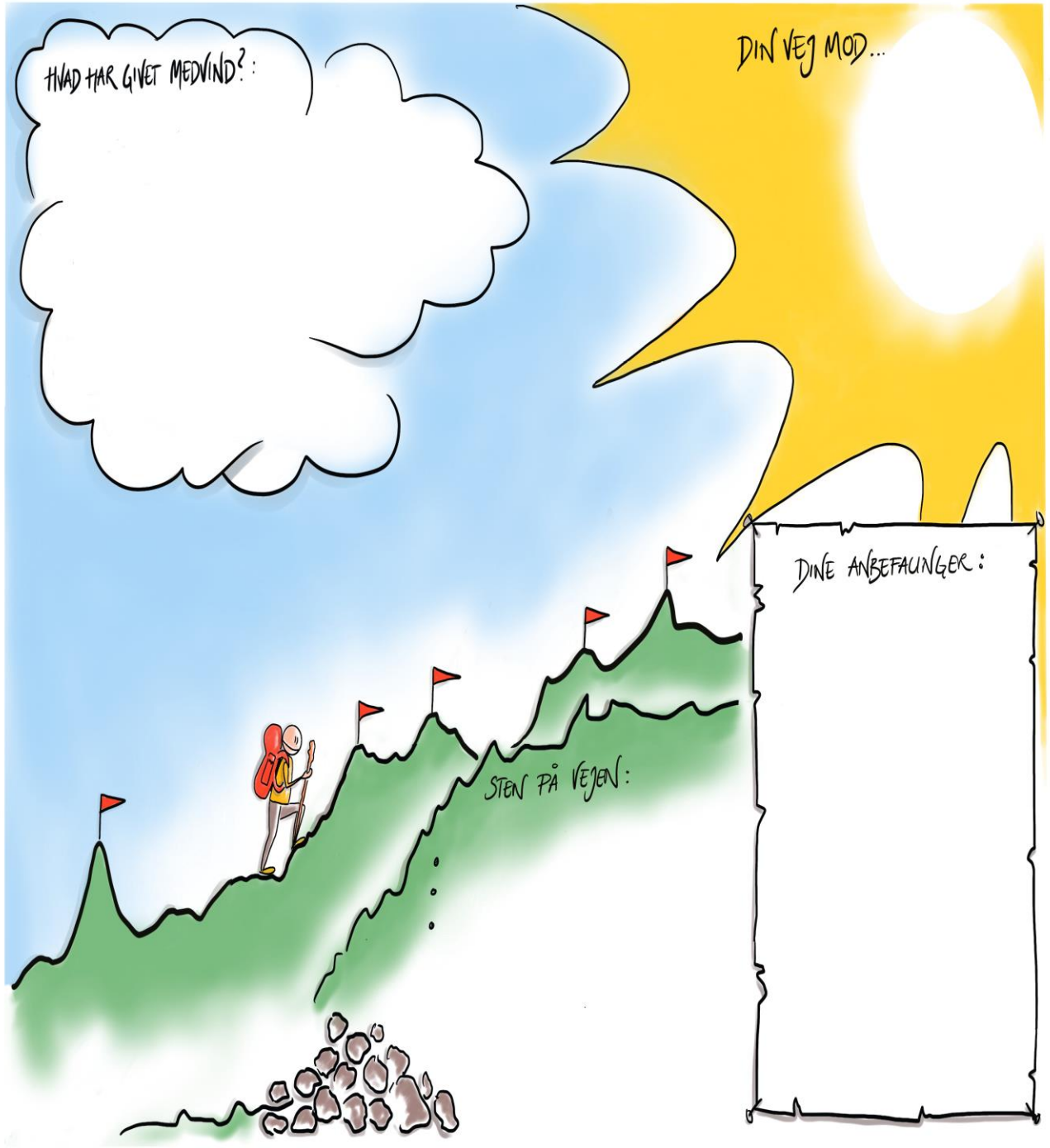
- Look at the highlights you have described.
- Why has it gone well?

Stones. What is difficult

- What can stand in the way of your dreams?
- Is there anything that makes you sad or uneasy?

Your next steps. New dreams?

- What would you like to try doing now?
- Who can help you with that?



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Recovery dictionary made by service users

ROR – ORDBOGEN

Recovery-Orienteret Rehabilitering på dansk

Perlen-gruppens oversættelse af ROR

- Vi arbejder med mine håb, ønsker og drømme
- Vi arbejder med de ting, jeg kan
- Vi skal bruge min familie, mine venner og fællesskaber
- Vi behandler hinanden med åbenhed, tillid og respekt

DU sætter kursen i DIT liv

Hvad betyder det for dig og mig?

Dem, du arbejder sammen med, skal støtte dig i at:

- Sætte fokus på dine drømme og håb
- Få øje på de ting, du kan
- Finde fællesskaber, der giver dig mening
- Skabe det liv, du vil have

Og dem, du arbejder sammen med:

- Øver sig i at spørge, hvad der er vigtigt for dig; hvad er dine håb og drømme?
- Taler med dig og lytter til, hvad du siger
- Lader dig selv sætte dine mål
- Sørger for at alle planer laves sammen med dig

8 principles in recovery-oriented-rehabilitation – working with the 1-3 (the culture change)

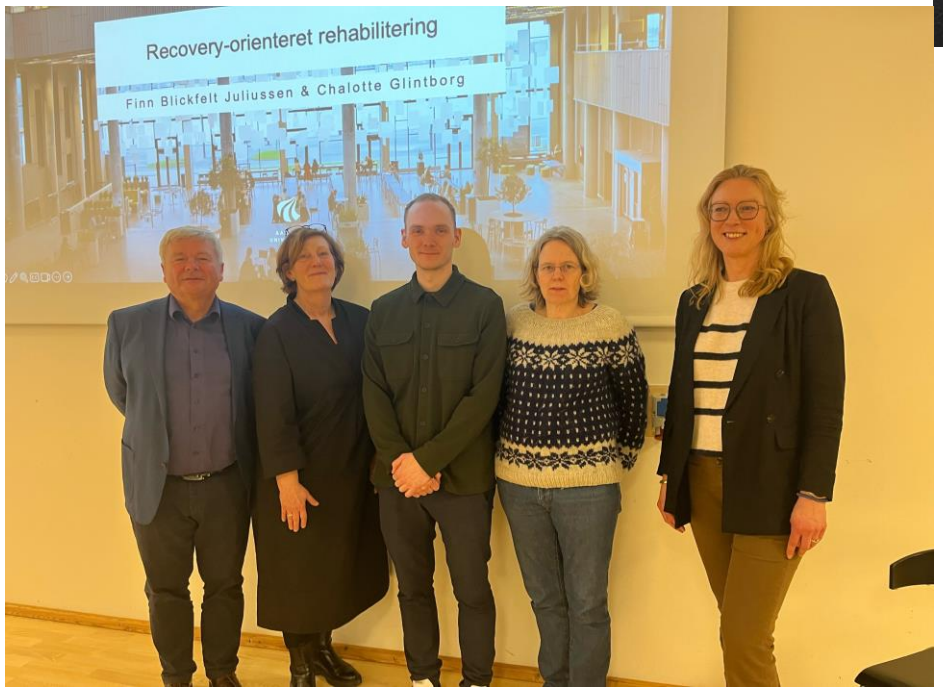
- Take the persons' hopes, wishes and dreams as your starting point
- Focus on the persons' resources
- Involve the persons' networks and the general communities
- Meet the persons with [illegible] respect
- Help the persons as early as possible
- Work in a coordinated way with the persons' overall life situation
- Follow up to ensure the intervention is always the right one
- Use knowledge and methods that work

Workshop 1

- Kick off: What is recovery-oriented-rehabilitation?

Feedback/learning from service users:

- Too long
- Presentations were hard to grasp
- The location was to big

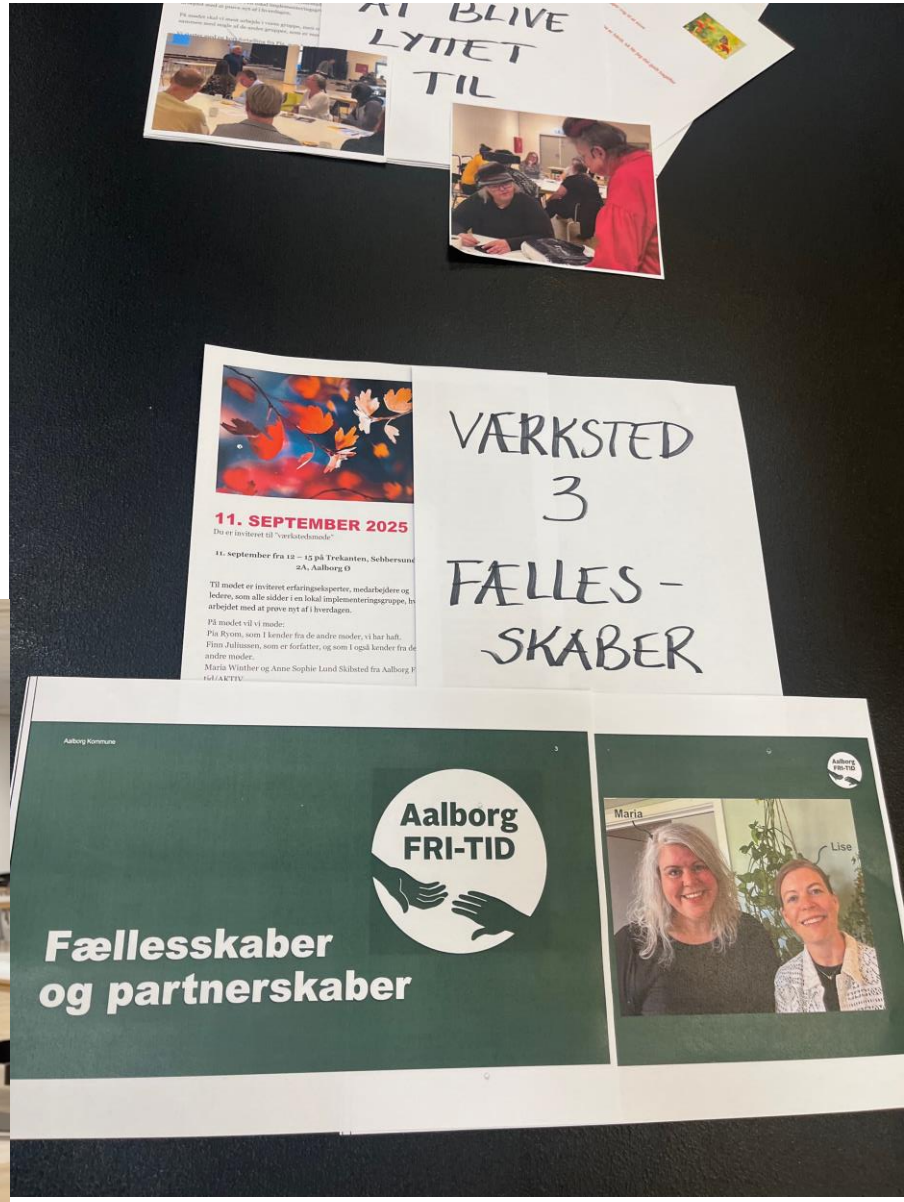


Workshop 2

- Being listened to – what does that mean?

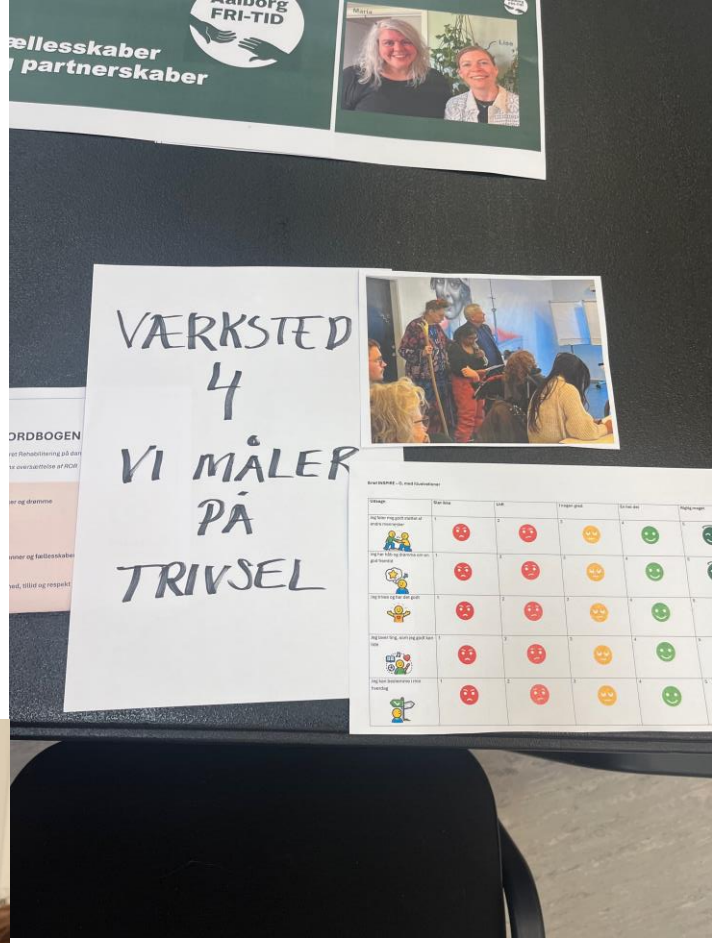
Workshop 3

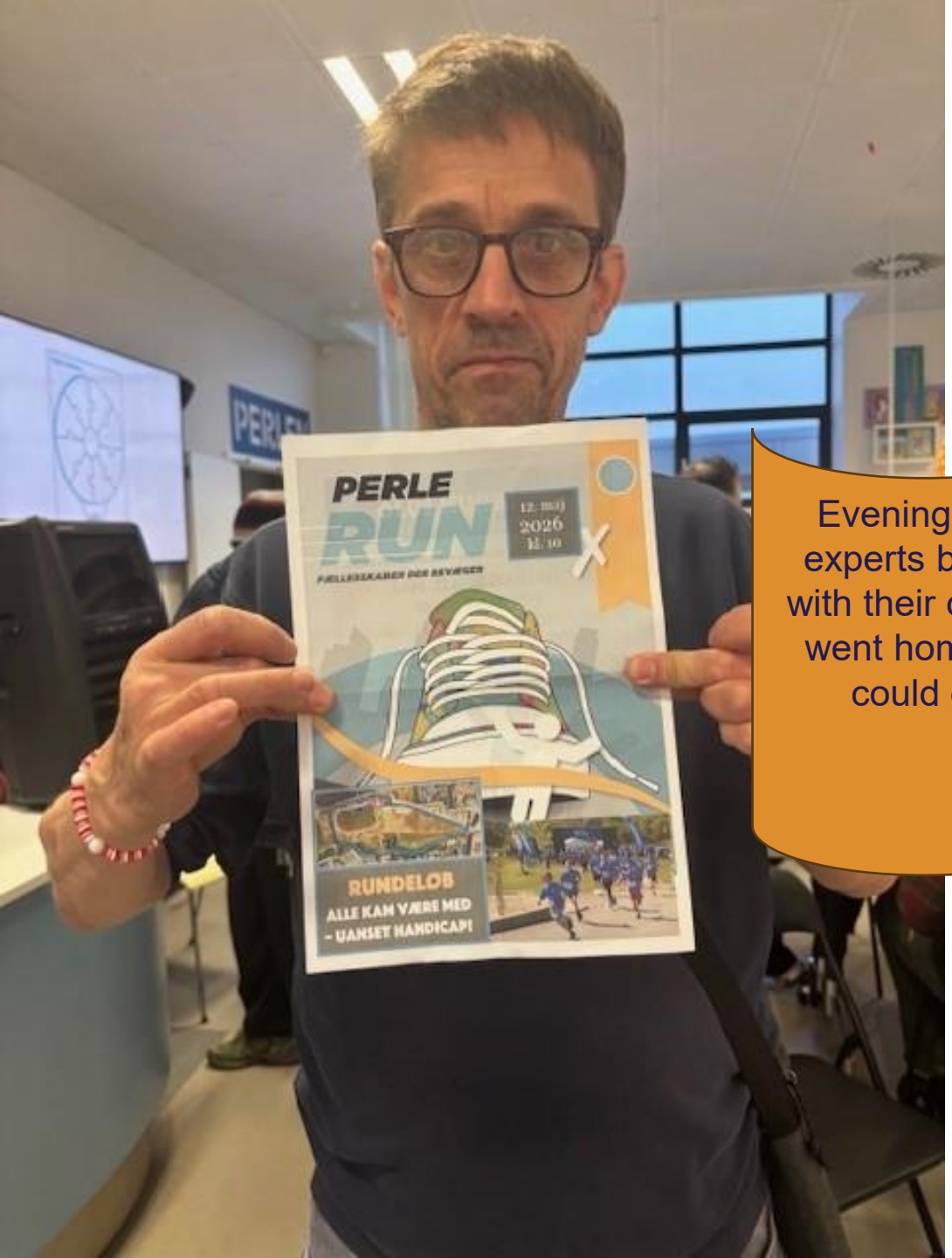
- Beloning/communities



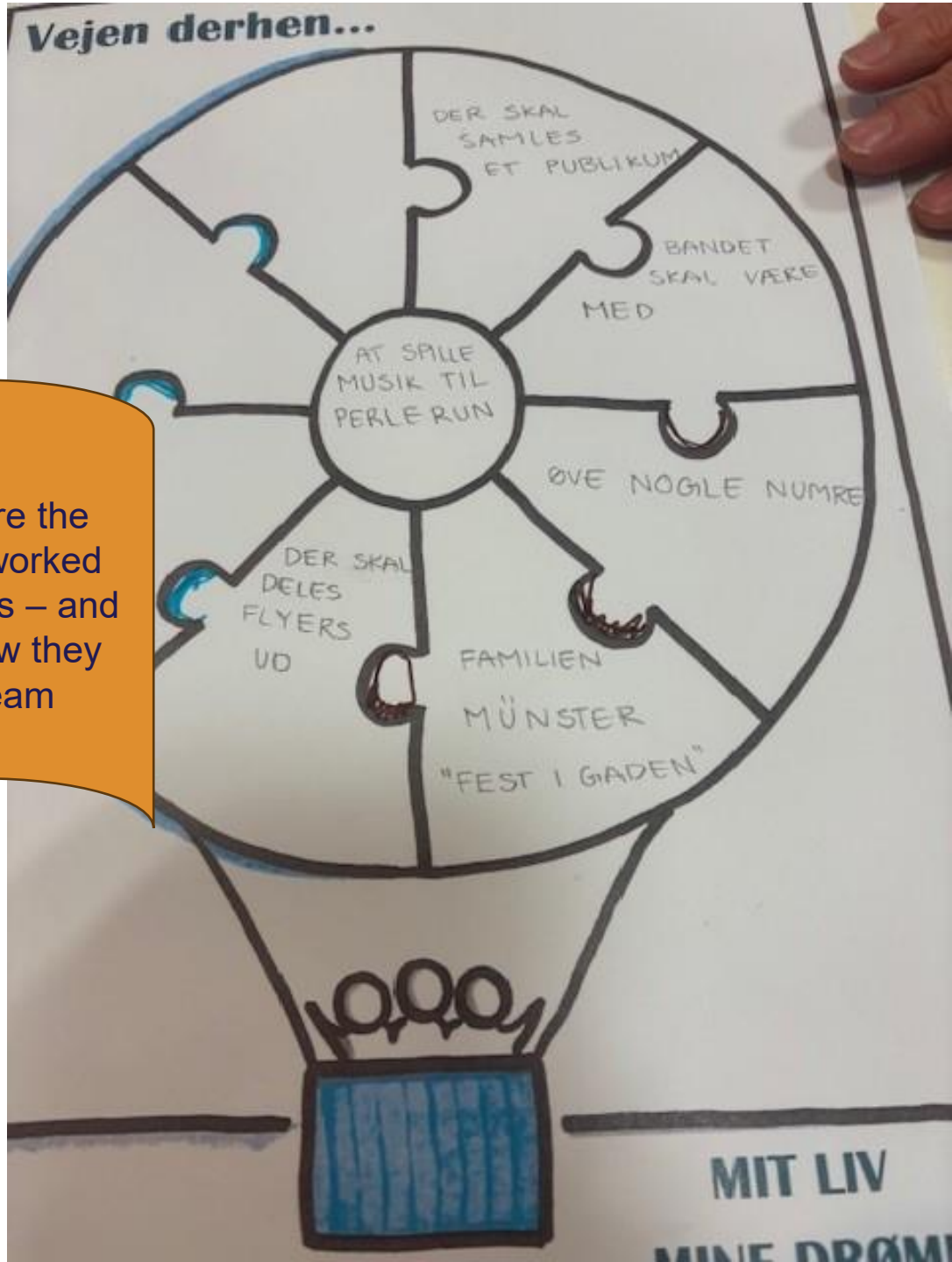
Workshop 4

- Measuring well-being in both persons with disabilities and rehabilitation professionals





Evening evet at Perlen, where the experts by experience each worked with their own concrete dreams – and went home with a plan for how they could get closer to that dream




AT LÆRE NOGET NYT
AT OPLEVE NOGET SÆRLIGT
AT GØRE DET JEG ELSKER
AT.....
MIT LIV
- MINE DRØMME

Recovery Outcomes Measurement

- Preliminary results from participating sites January 2026

Service users (n=14) · Professionals (n=17) · Control group (n=7)

Background & Methods

Instrument

Brief Inspire O measures recovery across 5 dimensions on a 0–5 scale (max sum: 25).

Sites

8 participating residential sites measured in January 2026.

Respondents

14 service users and 17 professionals rated the same 5 questions independently.

Control group

7 service users from comparable non-participating sites measured Feb–Mar 2026.

The 5 dimensions:

1. Support from others
2. Hope & dreams
3. Wellbeing
4. Doing things I enjoy
5. Autonomy in daily life

Figure 1 — Total Score by Site: Service Users vs. Professionals

Average total score (0–25) per respondent, grouped by site

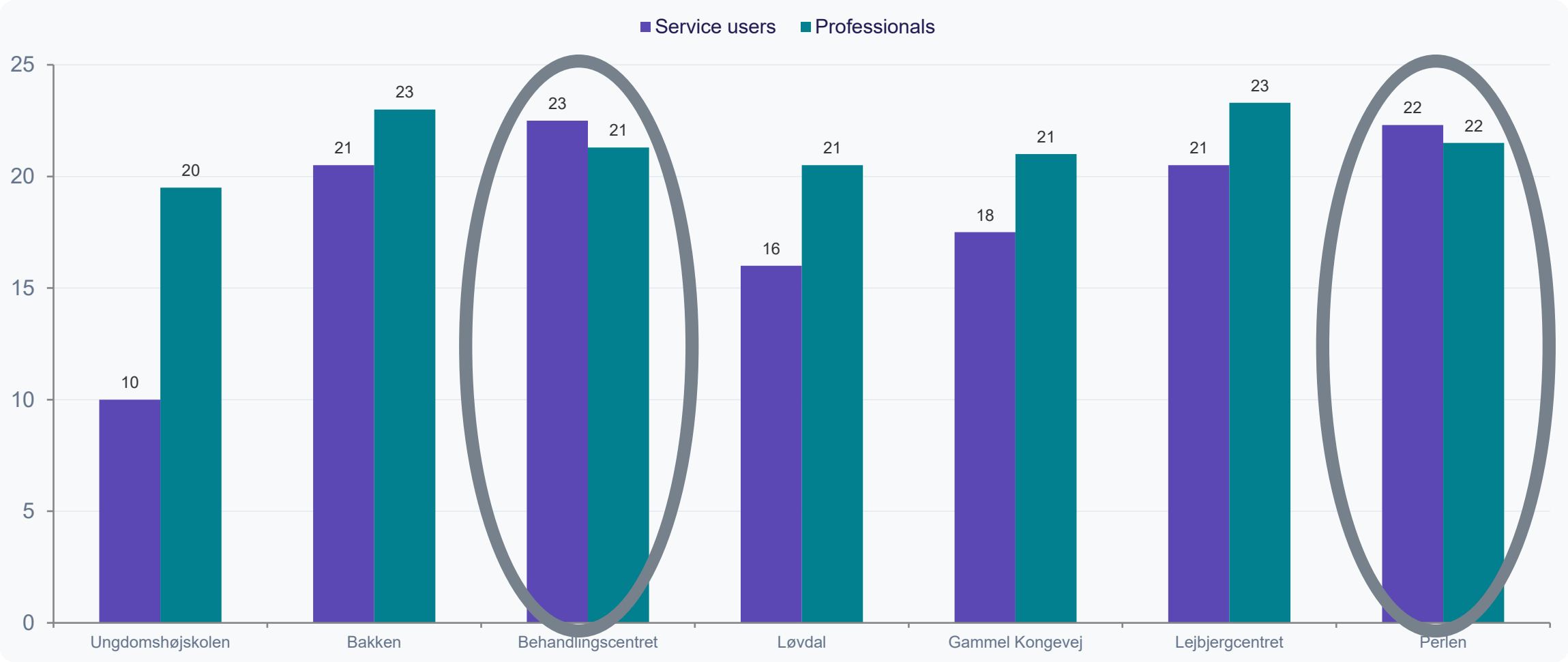


Figure 2 — Service Users: Mean Score per Question by Site

Scale 0–5 · January 2026 · n=14

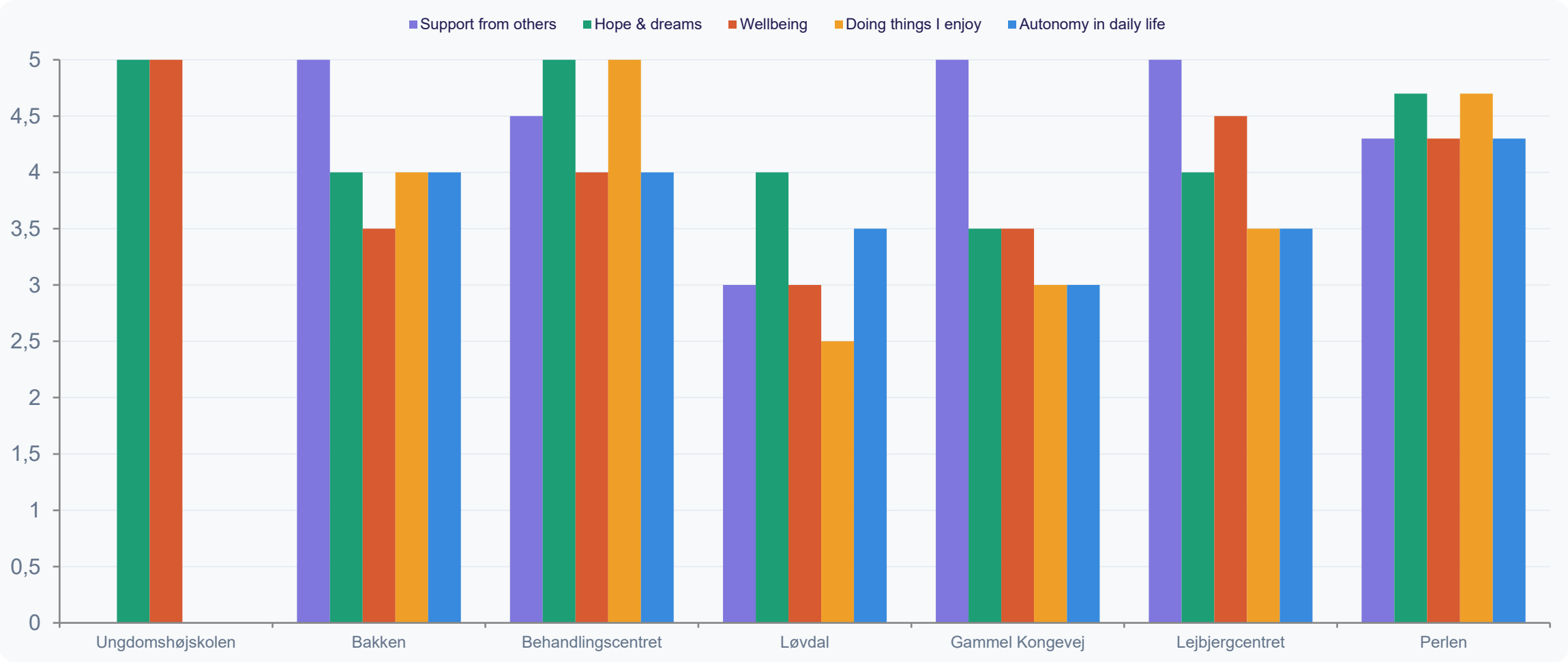


Figure 3 — Professionals: Mean Score per Question by Site

Scale 0–5 · January 2026 · n=17

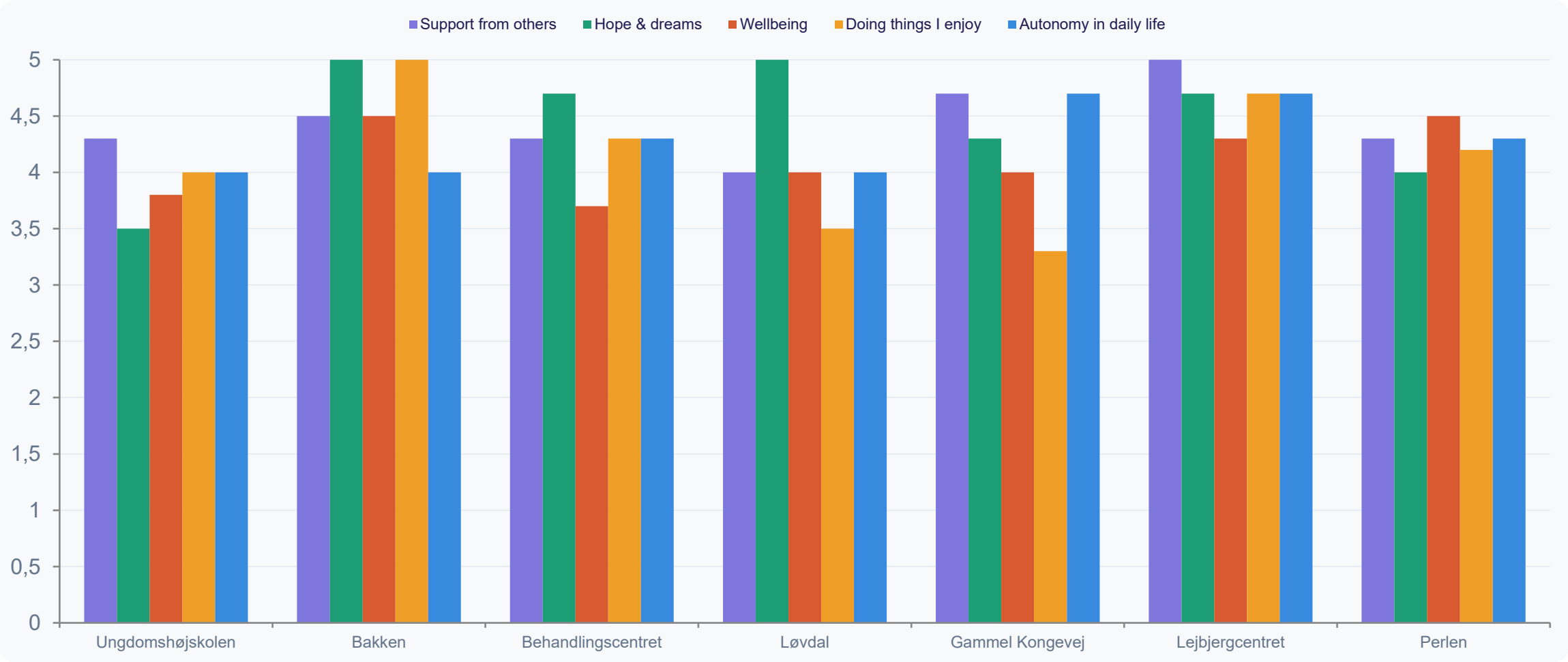
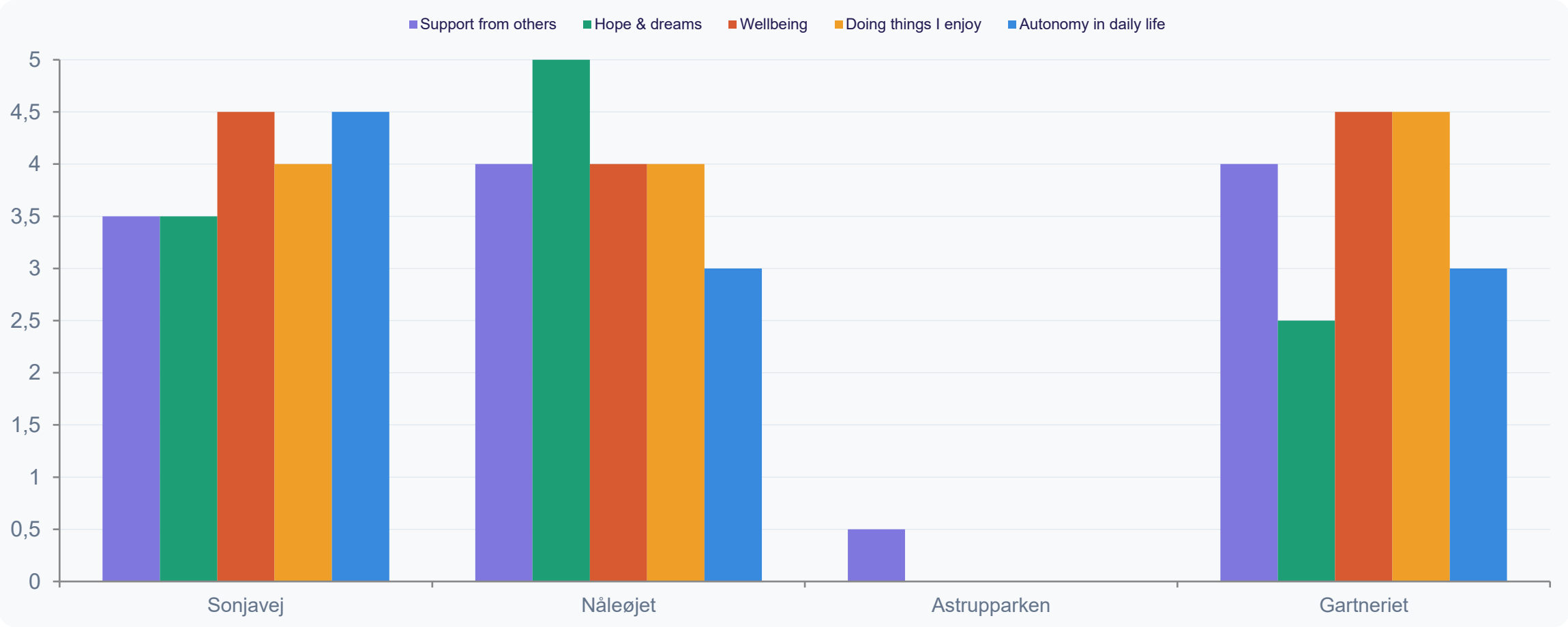


Figure 4 — Control Group: Mean Score per Question by Site

Scale 0–5 · Feb–Mar 2026 · n=7 (incl. 2 non-responding from Astrupparken scored as 0)



⚠ *Astrupparken: both service users declined to participate; scores recorded as 0.*

Statistical Comparison: Project Sites vs. Control Group

Mann-Whitney U test (preferred for small, skewed samples) · α = .05

Measure	Project (n=14)	Control (n=7)	Difference	M-W p	Interpretation
Total score (0–25)	19.4	14.0	+5.4	.260	No significant diff.
Support from others	4.14	2.86	+1.28	.059	Trend (p<.10)
Hope & dreams ✓	4.29	2.43	+1.86	.037	**Significant (p<.05)**
Wellbeing	3.93	3.14	+0.79	.669	No significant diff.
Doing things I enjoy	3.50	3.00	+0.50	.786	No significant diff.
Autonomy in daily life	3.50	2.57	+0.93	.262	No significant diff.

Note: Mann-Whitney U used due to small samples and non-normal distribution (Astrupparken zeros). Sample sizes are small — interpret with caution. Welch t-test p-values are consistent with M-W results.

Take away messages

01

Hope & Dreams — the strongest signal

Project site service users scored significantly higher on 'Hope & dreams about a good future' compared to the control group (4.29 vs. 2.43, p=.037).

02

Support from others — a consistent trend

Project site users also tended to report stronger social support (4.14 vs. 2.86, p=.059), approaching significance.

03

Professional ratings are generally higher

Professionals scored higher than service users — particularly on 'Hope & autonomy' dimensions.

04

Interpret with caution

Small sample sizes thus limit statistical power. Findings are promising but not conclusive.

Practice visits across 8 sites. Summer 2025 – Spring 2026

7 themes from field notes on recovery in practice

Seven Key Themes from Practice Observations

Observed across site visits — connecting to Brief Inspire O dimensions

1. **Hope & dreams as concrete drivers**
2. **Communities of all sizes**
3. **Autonomy & self-determination**
4. **Sensory environment as recovery tool**
5. **Staff culture change as prerequisite**
6. **Vulnerability in implementation**
7. **Citizen-driven innovation**

From Dreams to Action — and Community as ROR

Theme 1 — Hope & Dreams as Concrete Driver

- **Hope & dreams is the only dimension with a statistically significant difference between project and control group (p=.037).**
- **Field observations show why: dreams are translated into action.**
- *Løvdal: herb garden, Indian cooking, internship placement*
- *Behandlingscentret: citizen-initiated evening workshops, sewing circle*
- *Bakken: citizen-invented relay race with wheelchairs*
- Consistent across sites: staff ask better questions → concrete plans emerge

Links to Brief Inspire O: "Hope & dreams about a good future"

Theme 2 — Communities of All Sizes

- **Sites learnt to value small and large communities equally.**
- "It doesn't have to be for that many — a community can be 2–3 residents." (Attruphøj)
- *Katrine reading aloud to Heine in their shared living room*
- *Two residents from different floors bonding over building a computer game together (Gammel Kongevej)*
- *Larger communities: swimming, music therapy, cinema outings, bowling — organised by residents*
- Links to "Support from others" (p=.059, trend toward significance)

Links to Brief Inspire O: "Support from others" & "Wellbeing"

Self-Determination and a Changing Staff Culture

Theme 3 — Autonomy & Self-Determination

- **A cultural shift from staff-controlled to resident-driven — described as slow but real.**
- *"We are past the structured — now the residents decide." (Attruphøj)*
- Perlen: residents define the goals and terms of their own support.
- Behandlingscentret: residents initiate and run their own evening events.
- Observation: "Autonomy in daily life" shows no significant difference yet (p=.262) — autonomy takes time to grow and measure.
- Residents report feeling meaningful when they have responsibilities and tasks.

Theme 5 — Staff Culture Change as Prerequisite

- **Across sites, staff describe a fundamental shift in mindset.**
- *"We have parked everything we used to think we had to do — now we follow the resident." (Løvdal)*
- *"Staff now dare to take time to remove old habits and follow the resident." (Løvdal)*
- Bakken: peer learning day on ROR.
- Culture change is slow, fragile and context-dependent.

Links to Brief Inspire O: "Autonomy in daily life" & "Doing things I enjoy"

Environment, Vulnerability & Citizen-Driven Innovation

Theme 4 — The Sensory Environment

- **Physical and visual space matters for continuity and memory.**
- *Løvdal: visual planners, photos after events, a rainbow-and-glitter noticeboard designed by Katrine.*
- *Attruphøj: systematic photo documentation of all activities.*
- Serves residents with memory challenges — keeps recovery gains visible.

Theme 6 — Vulnerability in Implementation

- **Recovery-oriented practice is fragile under structural pressure.**
- *Løvdal (Feb 2026): no leader, negative narratives about resident while the resident is present.*
- *Gammel Kongevej: long-term sick leave + residents whose memory resets each visit.*
- Finding: implementation depends on stable leadership and protected time.

Theme 7 — Citizen-Driven Innovation

- **The 'Blomstringssamtale' (flourishing conversation) was invented by a resident at Bakken.**
- *It has since spread organically across sites as best practice.*
- *Residents also initiated: own stafet race, evening workshops, news discussion group.*
- Matches recovery literature on co-production — residents as knowledge producers.

Connecting Observations and Measurements

How field observations contextualise the quantitative findings

Hope & dreams ✓ (p=.037)	**Dreams are translated into concrete everyday actions at all sites — herb gardens, internships, relay races, workshops.**
Support from others (trend, p=.059)	**Communities — from two friends reading together to cross-site outings — are actively cultivated.**
Autonomy in daily life (n.s.)	**Cultural shift observed, but staff note it is still in progress. Autonomy takes years, not months.**
Professionals score higher than residents	**Staff are early in the culture change and see possibilities — residents may not yet internalise the same hope.**
Implementation vulnerability	**Leadership changes and staff shortages visibly interrupt recovery-oriented practice — a methodological risk for future implementation.**

What worked — and what did we learn from the gap?

✓ What worked	→ What we learned
All services established implementation groups with citizens	Local implementation plans did not materialise as planned → process was adjusted
No service excluded experiential experts from participation	Professional language creates barriers — translation is ongoing work
All groups chose a leading principle and got started	Context and daily form are decisive in wellbeing measurement
Strong cross-service engagement and peer inspiration	Cultural change is slow — but leaves clear, visible traces

Lessons Learned & Next Steps

✅ What works

- ROR transfers well to disability context with structured adaptation
- CHIME/Brief INSPIRE provides reliable data when citizens are well-prepared
- Relational competencies are trainable and measurable
- Cross-sector collaboration (municipality + university) strengthens fidelity

🔭 Looking ahead

- Scale measurement across more services and over time
- Increase citizen involvement in planning everyday activities
- Disseminate the Aalborg Model nationally and internationally

A cultural change

“We have set aside everything we thought we should be doing. Now we follow the citizen."

(Staff member, Løvdal)

"It's a cultural shift — two years ago, residents didn't know they were allowed to wish for things”.

(Manager, Attruphøj)

Transfer from mental health to disability

01 Equity requires structure

Citizens participate as equals when the frame is designed for it: clear roles, plain language, 1:1 support before, during and after meetings.

02 Honesty about process builds credibility

Not everything goes to plan — and that is an important part of the story. Frustration and healthy scepticism are normal phases, not failures.

03 Cultural change is slow and visible

Two years in, clear traces are emerging: citizens know they can wish for things, staff follow the citizen rather than the plan, managers let go.

04 Citizen voice is data and driving force

The stories, wishes and initiatives of experiential experts are not just illustrations — they are the primary source of knowledge about what works.

The Aalborg Model demonstrates that recovery-oriented-rehabilitation can and must extend beyond mental health to alle disability services.

Questions?