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Escalating complexity and fragmentation of mental health service systems: the role of recovery as a form of moral communication

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Escalating complexity and fragmentation of mental health service systems: the role of recovery as a form of moral communication

Abstract:

Design/methodology/approach

Recent mental health service transformation in Wales UK has been stimulated by a policy programme underpinned by person-centred recovery values. This paper offers analysis informed by the perspectives of Niklas Luhmann and other noted theorists to examine escalating service system complexity related to this transformation. Analysis builds upon the findings of a qualitative study employing thematic discourse analysis of talk of people with mental illness and associated workers.

Purpose

Theoretical generalisation provides the basis for tackling problems of service complexity, fragmentation, and disrupted care pathways.

Findings

Three themes were constructed in participants' talk: 'Competing versions of recovery', 'Misaligned service expectations' and 'Disrupted care pathways.' Recovery may be understood as a form of moral communication and autopoietic meaning-making activity, according to Luhmann's radical constructionist epistemology. This has the potential to generate competing versions of recovery, a key contributor to escalating complexity.

Research limitations/implications

Findings could be developed further by continued investigation of the relationship between recovery implementation and service fragmentation.

Social implications

A more judicious, balanced policy-implementation may cultivate optimal conditions for recovery pluralism by avoiding polarisation towards either top-down, policy-based recovery implementation or a proliferation of approaches at the grassroots level. Findings have implications for healthcare settings beyond the scope of mental healthcare, given the prevalence of person-centred care internationally.

Originality/value

A simplistic view of recovery implementation should be challenged. Recovery should not be considered a 'magic bullet' for mental healthcare delivery. Haphazard recovery-implementation may have detrimental effects of escalating complexity, service fragmentation and disrupted care pathways.

1. Introduction

Despite the application of complex systems theory to mental health services, Niklas Luhmann's theory of society has rarely been engaged with in this field. However, a qualitative study of the recovery experiences of people with mental illness in Wales, United Kingdom, reveals the potential for this social theoretical perspective to provide a greater understanding of contemporary services. This paper offers analysis informed by Niklas Luhmann's social systems theory (1996; 2012a; 2012b), illuminating the nature of escalating complexity within Welsh mental health services. Such complexity and fragmentation of services may have a detrimental effect on the care pathways of people with mental health problems as they seek to navigate services and engage in recovery.

Recent service systems transformation in Wales UK, surrounding a key piece of legislation called the Mental Health (Wales) Measure 2010, has aimed at implementing services underpinned by recovery principles. Recovery can be considered to be the current, dominant paradigm shaping mental health policy and services, and is highly influential at both national and international levels. (Braslow, 2013; Edgley et al., 2012; Woods et al., 2019). Policy implementation of recovery-based services has become increasingly prevalent in many countries including the USA, Canada, New Zealand and the UK (Gilbert, 2013). At its heart, recovery centres on the notion of a person being empowered to reclaim autonomous control of their life and how their mental illness is managed (Glasby & Tew, 2015). Recovery is therefore closely related to the wider, global phenomenon person-centred care which affects a panorama of healthcare settings (Rossiter et al., 2020; Stewart et al., 2014).

The Mental Health (Wales) Measure 2010 can be seen as a key local example of this movement, enshrining person-centred recovery in policy-form in the context of devolved healthcare administration (Braslow, 2013; Welsh Government, 2013; 2014). 'Devolution' describes the delegation of certain legislative powers by the UK Parliament at Westminster to the national administration of Wales, the Welsh Government. Along with the national governments of Scotland and Northern Ireland, this semi-independent legislative body has been given limited primary law-making powers,

including health service delivery. Devolution has opened up the prospect of greater autonomy for the UK countries to develop their own policy approaches for mental health service delivery. Unlike England, Scotland and Northern Ireland, however, the Welsh Government has implemented statutory legislation as the primary driver for improving and restructuring mental health services according to recovery values (Glasby & Tew, 2015; Welsh Government, 2014). Within this policy context, the central aim of the recovery conception underpinning the Measure is a shift to mental healthcare provision at the level of primary care. This is the stated aim of the Measure since “discharge from specialist care (such as secondary mental health services) is regarded as a key outcome of the recovery model within mental health” (Welsh Government, 2010, p.42; 2013, p.11; 2014, p.15).

The Mental Health (Wales) Measure is divided into four main parts. Part 1 of the Measure emphasises self-managed recovery and a greater level of individual responsibility in the context of discharge to primary care (Welsh Government, 2010; 2014). This may be seen as an instance of the wider, international movement towards primary mental health care integration in which context person-centred care is foundational (WHO, 2008). To achieve this, the Measure enhances local primary mental health services by making available comprehensive mental health assessments, short term treatments such as brief Cognitive Behavioural Therapy (CBT), better facilitation of signposting to other services and greater support for referral to secondary services (Welsh Government, 2011). Primary care is the first point of contact in the healthcare system and not traditionally the mainstay of treatment for people with serious mental illness (service users). The shift of emphasis towards primary care is therefore a transformative step in delivering person-centred mental healthcare, which by implication entails a reduced dependency upon secondary services. Part 2 of the Measure introduces a mandatory, national template for care planning in the form of the Care and Treatment Plan (CTP), with the requirement that all people within secondary mental health services should have a clearly identified care coordinator (Welsh Government, 2011). The introduction of this new regulatory standard has arguably been a factor behind an increase in the number of discharges from secondary services. Previously, not all patients within secondary care had a care coordinator so the new legal requirement for this placed a significant additional burden on Welsh community mental health teams. In order to cope with increased caseloads, it appears that there was a drive towards discharging people to primary care (Gofal, 2014; ORS, 2014; Welsh Government, 2014). This accompanied a new strategy of retaining a more select group of people with the most severe mental illness to be care coordinated within secondary services. The reduction in the number of people within secondary care tallies with enhanced primary mental healthcare delivery under Part 1 of the Measure, which makes greater provision for newly discharged service users.

Part 3 of the Measure also accompanies the strategy of shifting patients to primary care by introducing a 'safety net' for people who have been discharged from secondary services (Welsh Government, 2014). Underlying this is the concern that some patients may once again require specialist treatment and, if this is too difficult to access in a timely manner through usual referral routes, fall into a 'gap' between primary and secondary levels. Individuals falling into this gap would have mental healthcare needs exceeding the scope of primary care, notwithstanding enhanced provision under Part 1 of the Measure. The option is therefore provided under Part 3 for individuals to self-refer back to secondary services within three years of discharge, without needing to circumvent potential boundaries which might present upon the primary care referral route.

Part 4 of the Measure provides an expanded statutory scheme of mental health advocacy, to include those in hospital informally (Welsh Government, 2011). Taken together, the four main parts of the Measure may be viewed as an implementation of 'Prudent Healthcare Principles', which underlie devolved healthcare policy and strategy in Wales (see <https://www.bevancommission.org/prudent-healthcare>). Prudent Healthcare Principles capture person-centred care values since the intention is for patients and providers to be equal partners through co-production. Additionally, in a climate of austerity where financial stringency has been a priority, a key aim of Prudent Healthcare Principles is to focus treatment resources on individuals with the greatest need, making savings in other areas. Within mental healthcare, a refocusing of resources under the Measure certainly appears to have been achieved through prioritising those with the most serious mental illness to receive expensive secondary care, whilst discharging others to primary care.

This overall strategy, in its particular manifestation in the form of the Measure, may be related to a narrow, neoliberalist interpretation of person-centred recovery (Ramanuj et al., 2015). Here, the aim is to increase autonomy and responsibility for people with mental illness, coupled with reduced service dependency (Lester & Gask, 2006). Policy-based implementations such as the Measure have been called 'top-down' recovery by Woods and colleagues (2019), or 'neorecovery' by the mental health campaigning group, Recovery in the Bin (2019). These labels refer to top-down, systemic forces shaping the nature of recovery such as bureaucracy, policy programmes and biomedical psychiatry, but neoliberalism in particular (Double, 2006; Habermas, 1984). The latter systemic force is associated with a drive towards greater financial efficiency and, in its application to recovery, the objective of getting people with mental illness back to work (Becker et al., 2010; Curtis, 2007; Edgley et al., 2012; McKeown et al., 2017). This may be contrasted with the broader notion of liberty promoted by the original, radical and emancipatory idea of recovery (Anthony, 1993; Deegan, 1988). This is manifest in

the wide diversity and plurality of interpretations of recovery available in theory and in practice (Leamy et al., 2011; van Weeghel et al., 2019; Woods et al., 2019). The term 'grassroots recovery' has been coined by Recovery in the Bin (2019) to contrast this bottom-up generation of recovery approaches at the grassroots level of society with top-down, neorecovery. This study focuses on the interplay between top-down and bottom-up recovery approaches experienced by service users in Wales. This analysis has wider implications for healthcare at an international level, characterised by the global phenomena of person-centred care, recovery and a shift to primary care.

2. Study outline

A qualitative study set out to investigate patient and associated healthcare workers' experiences of the prevalence and impact of either top-down, policy-based neorecovery, or bottom-up, grassroots recovery initiatives and related experiences of care provision. Data were collected in two phases through in-depth, semi-structured interviews of service users with mental health problems ($n=16$) and then mental health workers ($n=16$) such as managers, support workers and General Practitioners (GPs: doctors working within primary care surgeries). These people were recruited by the principal researcher (author) during 2017 to 2018 through a variety of third sector organisations and day centres at various locations in West Wales. Service users fitted inclusion criteria that they had been discharged from secondary services within the past three years and so had the option to self-refer back to secondary services under Part 3 of the Mental Health (Wales) Measure. They could therefore be viewed as having care and recovery experiences which had been impacted by the implementation of the Measure. Workers recruited in phase two provided care and support for individuals impacted by the Measure. The sampling strategy was a purposive maximum variation approach to ensure heterogeneity of the sample.

Thematic analysis (Braun & Clarke, 2006) was combined with an integrative method of discourse analysis (Jørgensen & Phillips, 2002). This drew upon discursive psychology (Edwards & Potter, 1992), critical discourse analysis (Fairclough, 2003) and the poststructuralist perspective of Laclau and Mouffe (1985). I use the phrase 'thematic discourse analysis' coined by Singer and Hunter (1999) to describe this hybrid approach which was applied to interview transcripts. Specifically, themes were generated through discourse analysis of key data extracts, whose selection was guided by concept maps developed from coded interview transcripts. In this way, both comprehensive and fine-grained analysis of the dataset was achieved. Full methodology is provided in Weaver (2020) along with details of ethical standards and permissions.

Thematic discourse analysis of ($n=32$) interview transcripts led to the generation of three themes:

- 'Misaligned expectations in negotiating transforming services'
- 'Competing versions of recovery in participants' talk'
- 'Disrupted care pathways concentrated at the primary mental healthcare level'

Misaligned expectations of services were a key feature within analysis of talk about experiences of transiting between primary and secondary care. The boundary between primary and secondary levels had shifted due to the impact of the Measure, which meant that previous expectations about service accessibility were now being challenged by new service realities. This occurred in both directions of travel across the primary-secondary interface, either discharge from secondary to primary care or referral from primary to secondary care. Only $n=6$ participants spoke about positive experiences of discharge from secondary care whereas $n=19$ participants spoke about negative experiences of discharge, including not wanting to be discharged, not being informed about discharge and a perceived lack of care planning or coordination at the point of discharge. In the direction of referral to secondary care, $n=10$ participants talked about their difficulties and frustrations in accessing secondary services, either by GP referral or through self-referral under Part 3 of the Measure.

Participants' talk indicated a proliferation of disparate and competing versions of recovery, tallying with the observation in the literature about a wide diversity of recovery approaches at the grassroots level (Leamy et al., 2011; van Weeghel et al., 2019). These versions included empowered recovery ($n=10$), recovery which is person-centred rather than illness-focused ($n=4$), holistic care implemented through the use of the CTP ($n=3$) and provision of an appropriate social space for peer support ($n=8$). One participant, Dylan, actually constructed multiple competing versions of recovery within his talk, covering these areas with a particular emphasis on self-management.

Finally, analysis illuminated multiple experiences of disrupted care pathways within talk. These were concentrated in accounts of experiences within primary care and at the point of discharge from secondary to primary care. One participant, Luke, a third sector day centre manager in his thirties, talked about how individuals may even be lost to services when they are discharged to primary care because they are not deemed unwell enough to be accepted back into secondary services:

373. Luke: What I'm finding is perhaps as I stated earlier that
374. individuals are perhaps not deemed unwell enough. That
375. is the worry then where if they're not deemed unwell
376. enough, whether then it's just solely back to the primary level
377. or if they're unaware of what other support networks are
378. around that you lose that individual.

[Luke, Supporting worker 10]

A person being completely lost to services in this way would represent a profound disruption of care and recovery. It also highlights that people falling into the 'gap' between primary and secondary services are not always being captured by the 'safety net' of Part 3 of the Measure, designed to give them speedy re-access through self-referral if their needs became too great for primary care. Analysis of participants' talk such as this, and theoretical argument developed on this basis in the following sections, reveals disruption of recovery and care provision under the Measure in services that are increasingly complex, fragmented, and difficult to navigate.

3. Parameters of theoretical analysis

I now proceed to develop theoretical analysis and generalisation, described by Mitchell (1983), to build upon thematic discourse analysis. The "cogency of the theoretical reasoning" (Mitchell, 1983, p.207) is the key element in this approach and the basis for validity of theoretical analysis presented in this paper. Complexity theory is a particularly apt theoretical context within which to interpret the changing nature of Welsh services and related healthcare experiences of participants. Complex systems theory has been developed into various comprehensive frameworks for describing the world and society (Forrester, 1968; Luhmann, 2012a; 2012b; Maturana & Varela, 1991; Wiener, 1948). The most all-encompassing and sociologically formidable contribution of these is the social systems theory of Niklas Luhmann (2012a; 2012b), which provides fertile ground to develop theoretical generalisation and analysis of findings.

I shall first describe the way in which Luhmann's systems theory facilitates an understanding of mental health services as a complex system. Recovery implementation is then viewed as a key stimulus for complexity escalation. Second, I shall apply Luhmann's (1996; 2006) radical constructionist epistemological theory specifically to recovery approaches, revealing this activity to be a form of

‘moral communication’ (Luhmann, 1991; 2012a). This activity is also shown to feed into escalating service complexity and fragmentation.

4. Complex systems theory as a framework for analysis of recovery implementation

Complex systems theory underlies the depiction of the UK National Health Service (NHS) by Plsek and Greenhalgh (2001) as a “complex adaptive system” (p.625). Building on this work, Hannigan and Coffey (2011), have applied complex systems analysis to mental health services in the UK, highlighting how a succession of top-down, recovery-based policy implementations has had the overall effect of acting as a stimulus for escalating complexity. The Mental Health (Wales) Measure is the latest in a series of policy implementations applied in Wales and so it seems plausible to infer that this has contributed to escalating complexity in services. The precise nature of this effect is the focus of the following analysis.

A complex system is characterised by the disparity and functional differentiation of its component parts (Cilliers, 1998; Luhmann, 1996; Osterberg, 2000). This means that the system will be highly flexible and adaptive, prone to unpredictability and disequilibrium (Cilliers, 1998; Osterberg, 2000; Plsek & Greenhalgh, 2001). Cybernetics systems theory is employed by Luhmann to model this structural complexity, after the influence of Talcott Parsons (1951; 1961). In his structural-functionalism, Parsons employs a cybernetic systems model which tends towards stability and equilibrium. Luhmann employs cybernetics in a different way to Parsons to model a system which is complex and may tend towards disequilibrium. Dimensions of reflexivity and functional differentiation are factors which have the potential to increase complexity through positive feedback loops (Osterberg, 2000). Cybernetic systems theory articulated in this way by Luhmann therefore exemplifies the structural features of a complex system.

This perspective can be enhanced by highlighting that, in addition to its application to mental health services, complexity may be associated with the phenomenon of mental illness itself (Bracken et al. 2012). Good mental healthcare engages actively with the complex nature of mental health issues which are rooted in social determinants and inequalities occurring across the lifespan (WHO, 2014). Consequently, mental illness should be understood on a more complex, hermeneutic basis, and not just in terms of a reductionist, psychiatric orthodoxy dominated by a biomedical model (Double, 2006; Keen, 1999). This alternative, interpretivist view of psychiatry, promoted in particular by Karl Jaspers (1997 [1913]), emphasises a person’s phenomenological experience of mental illness and recovery (Stanghellini et al., 2013). The idea of the intrinsic complexity of mental illness, based on this

hermeneutic understanding of psychiatric disorder, has direct implications for the nature of recovery. Recovery has been identified as a 'polyvalent' concept (Pilgrim, 2008), meaning that it has many different functions, forms or facets with little or no consensus about its precise identity. The concept of a 'floating signifier' provided by Laclau and Mouffe (1985) is helpful in illuminating this notion of polyvalency. Regarded as a floating signifier, the meaning of recovery is not fixed but is instead polyvalent as competing parties attempt to appropriate the concept. This competing stems from their disparate and unique perspectives on mental illness.

This understanding of recovery as polyvalent and a floating signifier is rooted in Laclau and Mouffe's (1985) poststructuralist view of society as an ongoing discursive struggle between different individuals and groups trying to fix meanings within language (Jørgensen & Phillips, 2002). According to Cilliers (1998), a poststructuralist perspective promotes a view of language and discourse as an 'open' system rather than the 'closed' system described by structuralism (Derrida, 1976; 1978; Saussure, 1974). Within this 'open' system, meaning is not given in a determinant manner but rather on the basis of the unlimited potentialities of 'différance', leading to a linguistic system which generates an unlimited succession of new significations. Cilliers (1998) proposes that language understood poststructurally must fundamentally be understood as a complex, communicative system since it is constantly driven towards disequilibrium by the meaning-making principle of 'différance'. A central conclusion provided by this theoretical perspective is that discursive differentiation surrounding recovery as a floating signifier engenders conditions of complexity escalation within mental healthcare.

Tallying with this theoretical argument, discourse analysis identified 'Competing versions of recovery' as a key theme within participants' talk. According to this theme, participants promoted disparate versions of recovery based on their individual perspectives and self-oriented agendas. Recovery is often defined precisely in terms of it being a self-oriented, person-centred approach to tackling mental illness (Anthony, 1993; Davidson, 2005; Edgley et al., 2012). Here, newly empowered individuals are freed to release their own resources of social capital through increased self-efficacy (Tew et al., 2011). Tricia is one participant who talks about this new autonomous state:

470. Tricia: I feel quite happy to be discharged.

471. I felt it was an achievement after 25 years, to be

472. discharged, if you know what I mean?

473. Researcher: Why do you feel it's an

474. achievement?

475. Tricia: Because, I'm in control of my own

476. illness now.

[Tricia, Service user 6]

Such potential for individual self-determination is indicative of the high level of interpretative input which can be employed to appropriate recovery. Recovery should therefore be centrally understood as a person-centred meaning-making activity, or floating signifier, conveying the interpretation an individual wishes to adopt for their approach to tackling mental illness. On this basis, recovery may best be understood as a rhetorical vehicle or form of moral communication (Luhmann, 1991; 2012a) for promoting the values of mental health progression, favoured by the individual or group appropriating the concept. Recovery in this sense may be understood in the context of Luhmann's (1991) sceptical position of 'negative ethics', since it is not grounded in an authoritative approach of bio-psychiatric orthodoxy (Double, 2006; Keen, 1999) but rather based upon principles established by autonomous individuals. According to this application of Luhmann's theory of moral communication, the 'right' (or 'esteemed') approach to tackling mental illness is grounded in individual communicative scenarios and not in some authoritative, universalist basis for right practice imposed upon the mental health arena (Luhmann, 1991).

The potential for generation of diverse, person-centred recovery approaches, rooted in differentiated forms of moral communication, can therefore be seen as a key factor for escalating complexity within mental health services. Additionally, top-down policy programs such as the Measure arguably act as a stimulus for individual appropriations of recovery, contributing further to escalating structural complexity. This additional understanding is developed in the next section by application of Luhmann's radical constructionist epistemological theory.

5. Radical constructionist epistemology: an explanation for fragmented, recovery-based services

In this section, I apply Luhmann's radical constructionist epistemological theory (1996; 2006) to provide an explanation for a key mechanism of complexity escalation in mental health services. This perspective has its roots in both cybernetics and autopoietic systems theory (Maturana and Varela, 1991; Von Foerster, 1981). The term 'autopoiesis', from the Greek 'auto-' meaning 'self' and '-poiesis' meaning 'creation', refers to a system capable of maintaining and reproducing itself. Luhmann's application of the concept of autopoiesis, drawing on Maturana and Varela's (1991) theory of cognitive biology, is critical for understanding his systems theory, and how it differs from earlier stable systems theories such as that of Talcott Parsons. The key distinction between Parsons' and Luhmann's

systems theories is that in the former, functionally differentiated components are integrated into the entire social system and contribute to the maintenance of society as a whole (Parsons, 1961). With Luhmann, each component is a functionally differentiated autopoietic system, communicating according to its own code or meaning. The overriding purpose of components of the social system is that of their own self-maintenance, and not the perpetuation of the whole social system, as with Parsons. This is a key point at which complexity is introduced, since individual components are autonomous and have no awareness of the function they play in relation to the whole social system. Increased complexity therefore stems from the functional differentiation of components acting independently from the system as a whole (Osterberg, 2000). The high level of flexibility and adaptivity of social systems gives rise to the potential for unpredictability and disequilibrium, which are characteristic features of complex systems (Cilliers, 1998; Plesk & Greenhalgh, 2001).

This view forms the basis for application of Luhmann's radical constructionist epistemology (Luhmann, 2006). Communication and meaning within this social systems perspective constitute "a recursively closed, autopoietic system, and actually as a structurally determined system that may be specified only by its own structures and not by states of consciousness" (Luhmann, 1996, pp.263-264). This is constructionism through systems theory since meaning is constructed through the structurally determined system of language and human interaction (Berger & Luckman, 1991; Blumer, 1986). Knowledge and meaning are therefore systemically constituted and not composed in a zone of subjective cognition or conceptualisation residing within individual communicators.

Theoretical analysis related to the themes 'Competing versions of recovery', and also 'Misaligned expectations of services', may be developed further with reference to Luhmann's radical epistemology (Luhmann, 2006). In promoting a greater level of autonomy and self-sufficiency for individuals managing their mental health conditions, person-centred recovery versions engender a greater amount of information to be inputted into autonomous, autopoietic subsystems or components, representing the epistemological state of service users. In a system which is functionally differentiated, introducing a greater level of autonomy for independent subunits (service users) has the potential to initiate an imbalance between the information levels of the subunit and its systemic environment. Since subunits are autonomous and unconcerned with the function they play in relation to the whole social system, this imbalance has a dynamic effect disseminating increased complexity and disequilibrium throughout the entire mental health service system.

Recovery implementation, either as a top-down policy programme or as a proliferation of recovery versions generated at the grassroots level, has the potential to escalate system-wide complexity through this mechanism. Luhmannian epistemology therefore sheds light on this process of systemic complexity escalation as a process of moral communication of new knowledge about recovery (Luhmann, 1991; 2012a). Through this process of moral communication, person-centred versions of recovery are constructed and then disseminated as complex factors throughout the mental health service system.

This theory may also be related to the study theme of ‘Misaligned expectations in negotiating transforming services.’ This theme can be seen as a further manifestation of recovery as moral communication, escalating complexity in response to the stimulus of the Measure. Greater levels of autonomy and autopoiesis encouraged by this recovery implementation are related to greater resistance to changing service behaviour, which is ironically the result of the policy programme. The key point is that it is the impact of the Measure in stimulating person-centred recovery which generates a more complex and disjointed system, characterised by a proliferation of highly individualised recovery versions and related misaligned expectations. A pronounced instance of autopoietic recovery within the dataset is provided in Ian’s talk, a person in his thirties with PTSD (Post Traumatic Stress Disorder). Having struggled with a succession of care disruptions and iatrogenic experiences of medical and psychological interventions, he now avoids services altogether. In response to my question about how previous care provision has helped him, he says:

608. Ian: Other than giving me an appreciation that
609. anything that’s going to improve the situation must come from
610. me, because it’s not going to come from anybody else,
611. nothing. It’s done nothing at all.

[Ian, Service user 16]

This extreme case of zero expectations, autonomy and alienation from service provision is perhaps one of the starkest illustrations in the dataset of the disconnect which can occur between the individual and the mental health service context.

6. Postpsychiatry and liquid modernity

The development of various theoretical strands related to Luhmann's systems theory in this paper contributes to what I argue is an emerging picture of Welsh mental health services that are complex, disconnected and fragmented. This accords with contemporary discussions on the fragmented nature of contemporary mental health services (Hannigan & Coffey, 2011; Gilbert et al., 2014). This Luhmannian perspective on recovery as a form of moral communication may be allied with the postpsychiatric view of mental illness and psychiatric services. The postpsychiatric school of thought promotes the notion that the inherent complexity of mental illness and recovery is rooted in the personal and subjective dimension within which mental illness may properly be interpreted (Bracken et al., 2012). There is therefore a greater need to negotiate the "tangled nature of relationships and meanings" (Bracken et al., 2012, p.433) which generate complex, shifting service pathways and interfaces. Recovery, as a form of moral communication with the capacity to generate an unfettered proliferation of approaches, may be centrally situated within the sociological and cultural conditions of postpsychiatry. This means that the recovery paradigm has characteristically postmodern implications of service fragmentation and discontinuity (Fuat Firat & Schultz, 1997; Gilbert et al., 2014).

Taking a broader view, it may be argued that whilst progress has been achieved in moving beyond a modernist position for mental healthcare, with associated problems of institutionalisation, positivist biomedicine and paternalistic psychiatry (Double, 2006), the emergence of the recovery paradigm has introduced new problems associated with postmodernism, such as complexity and fragmentation (Braslow, 2013; Edgley, 2012). In the light of Bauman's (2000) work on 'liquid modernity', which can be seen both as a continuation and superseding of postmodern social analysis (Lee, 2006), the emergence of the recovery paradigm may also represent a shift from 'heavy' to 'light' modernity. Applying this sociological theory to the field of mental healthcare, the modernist solutions of orthodox psychiatry (Keen, 1999) have been replaced with the 'caravan park' of isolated, individualistic recovery journeys. According to Bauman's (2000) metaphor of the 'caravan park', people within contemporary society do not operate with an awareness of the entire social system but only in an interactive, non-committal manner with other adjacent 'caravan dwellers'. This perspective has parallels with the Luhmannian perspective on autopoietic recovery, wherein people-in-recovery operate autonomously, without reference to whole system approaches. However, under conditions of liquid modernity, the questionable stability once afforded by a monoglot bio-psychiatric orthodoxy (Double, 2006; Keen, 1999) is eclipsed not so much by complexity but by fluid and contingent conditions of social life for the service user in recovery. This perspective also suggests a counterproductive state of affairs

characterised by uncontrollable flows of recovery proliferation and isolated care pathways, whose prevalence has been indicated by this study.

7. Conclusion and policy implications

In this paper, I have primarily applied Luhmann's complex systems theory to illuminate how person-centred, self-management-oriented versions of recovery may generate escalating complexity within the mental health service landscape of Wales. This is accompanied by fragmentation of coherent care pathways for service users. It should be noted that this view may also be speculatively applied to other western psychiatric systems situated within the recovery paradigm, particularly where great reliance is placed upon top-down policy implementation. A broader application of findings and theory might be advanced by subsequent quantitative or mixed methods investigation into the relationship between recovery implementation and service fragmentation. This might circumvent some of the limitations associated with this study, such as a relatively small geographical area and sample size for data collection, and the various critiques of the epistemic value of qualitative research (Ritchie et al., 2013). Further development of findings may have implications for healthcare settings beyond the arena of mental health services in Wales, given the widespread nature of person-centred care both at home and abroad.

The perspective developed in this paper runs counter to the prevailing view of person-centred recovery as an infallibly beneficent notion, whose application in any manner, no matter how imprecise or insincere, is regarded as a necessarily benign endeavour (Edgley et al., 2012). I would argue that this simplistic view should be challenged, especially considering the impact of recovery implementation at a service-wide level. Theoretical analysis has indicated that haphazard recovery implementation can act as a key catalyst for escalating complexity of care pathways. Consequently, recovery should not be considered as a panacea or 'magic bullet' for tackling all the challenges of delivering effective mental healthcare. Neither should recovery be considered a rubber-stamp endorsement for any apparently worthwhile activity in this area.

On this basis, a more measured policy-implementation of recovery than the current approach in Wales might be achieved through a deliberate strategy of balancing top-down and bottom-up versions of recovery within services. This paper has shown how both top-down and bottom-up recovery versions have the potential to escalate complexity. Indeed, a polarisation towards either side of this dichotomy has the potential to generate an unbalanced system leading to unsustainable complexity and

fragmentation of services. Luhmann (1991) highlights that a key problem with moral communication is its tendency towards polarisation, which occurs with an unbalanced system. Policy which seeks to optimise recovery-oriented services should therefore seek to strike a balance between the limiting and complexity-stimulating effects of dominant neorecovery on the one hand, and unfettered proliferation of person-centred, bottom-up recovery versions on the other (Hopper, 2008; Pilgrim & McCranie, 2013). This balance would create conditions for optimal levels of recovery pluralism as opposed to the kind of unbridled proliferation which has been critiqued in this paper. Recovery pluralism might be propagated by the variety of third sector mental health support groups available in the study locality, such as Hafal (<http://www.hafal.org>), Links (<http://links.uk.net/>), or Mind (<https://www.mind.org.uk>) at a national level. Such groups provide venues for peer support activities to defend and cultivate legitimate recovery values rooted in the lived experience of service users (Davidson et al., 2012). Peer support facilitated by such groups may be a fruitful venue for construction of recovery versions, in the context of appropriate governance.

This policy approach, which could be regarded as a more judicious implementation of recovery-based services, would involve a limited top-down policy programme aimed at setting optimal parameters in which recovery versions may be constructed. These optimal cultural or communicative conditions would establish the right systemic environment to encourage the ongoing activity of grassroots recovery-construction, without overstimulating component subsystems so that they generate an insurmountable proliferation of recovery versions. In this way, top-down neorecovery policy is employed not so much as a driver for recovery-based services but as a set of delimiting parameters within which more authentic and emancipatory versions of grassroots recovery are given room to thrive. This therefore is not neorecovery as an end-in-itself, subsumed within an agenda of fiscal stringency. Rather, it is a deliberately constrained implementation of neorecovery as a means-to-an-end of providing the best context for flourishing, grassroots, recovery-based services. Given the unique status of Wales within the UK in seeking to implement recovery-based services, this strategy might serve as a point of guidance for policy makers in other settings who are serious about implementing person-centred care underpinned by recovery values.

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