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**Recovery and care continuity experiences of people in mental healthcare: a conciliatory approach to the challenge of implementing recovery-based services**

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# **Recovery and care continuity experiences of people in mental healthcare: a conciliatory approach to the challenge of implementing recovery-based services**

## **Abstract**

This study investigates recovery and care continuity experiences of people with serious mental illness negotiating transforming services in the wake of recovery-based policy implementation. Data were collected in two phases involving ( $n=16$ ) service users who had transited from secondary to primary care and ( $n=16$ ) supporting workers. A qualitative methodology employed semi-structured interviews and thematic discourse analysis generating three themes. First, participants' expectations were misaligned with transforming services. Second, participants constructed competing versions of recovery in their talk. Third, analysis revealed care discontinuities concentrated at the primary care level. A singular notion of top-down recovery, a proliferation of bottom-up, competing recovery versions, and misaligned expectations of transforming services are closely allied with escalating service system complexity and fragmentation. This has detrimental implications for care continuity. Top-down, policy-based recovery implementation is viewed as a neoliberalist colonization of the recovery concept, understood in the Habermasian sense of colonization of the lifeworld. The detrimental effects of recovery colonization should not lead to repudiation of the concept altogether. Rather, the original radical idea of recovery should be reclaimed as a central concept within mental healthcare. This can be achieved by a conciliatory policy approach seeking to balance top-down and bottom-up forces of recovery appropriation.

**Word count: 8,497**      **(additional 500 words permitted by editors)**

## **Introduction**

Recent service structure transformation in Wales, UK, surrounding a key piece of legislation called the Mental Health (Wales) Measure 2010, has led to greater movement in both directions between specialist, secondary services and primary care (Gofal 2014; ORS,2014). This article reports on a study which sought to investigate recovery and care continuity experiences of service users with serious mental illness (SMI) negotiating transforming services which have been impacted by national legislation. Recovery is the focus of contemporary mental health policy both at national and international levels since it is the current, dominant paradigm shaping mental health policy and services (Braslow 2013; Edgley et al. 2012; Gilbert 2013; Morrow 2013; van Weeghel et al. 2019). Recovery-based services have been implemented in many countries including the USA, Canada, New Zealand and the United Kingdom (Gilbert, 2013). Contemporary mental health policy in the UK is now predominantly conceived as recovery-based, and the Measure can be viewed as a key instance of such a policy-conception (Braslow 2013; Morrow 2013; Welsh Government 2014). The Welsh Government has opted to use legislation as the primary driver for policy seeking to improve and restructure core mental health services, both at primary and secondary levels of care (Glasby and Tew 2015). The Measure has tidied up pre-existing legislation to produce a formal and comprehensive statutory framework for mental health services underpinned by recovery principles (Welsh Government 2014). This policy initiative focuses on augmenting mental health delivery at the primary level whilst consolidating secondary level care delivery by mandating a specific template for recovery care planning called the Care and Treatment Plan (CTP) (Welsh Government 2011; see <http://www.hafal.org/pdf/publications/My%20recovery.pdf>).

The Mental Health (Wales) Measure may be considered to be underpinned by recovery values according to two rationales. Part 1 of the Measure emphasises self-management and independence though increased treatment within primary care, along with reduced dependency upon secondary services (Welsh Government 2014). Part 2 of the Measure emphasises self-management and co-

production in collaboration with a care coordinator, according to the holistic recovery approach provided in the form of the CTP (Welsh Government 2011). Since the emphasis is on moving increased numbers of patients to primary care, the first of these rationales can be seen as the mainstay of recovery-implementation under the Measure. An increased service focus on primary mental healthcare delivery may be related to a particular interpretation of the recovery approach aimed at reducing specialist service dependency and provision coupled with the expectation of increased responsibility and self-reliance for people with mental illness (Lester and Gask 2006; Pilgrim and McCranie 2013; Ramanuj et al. 2015). This, however, can be seen as a very narrow interpretation of the notion of recovery, which may produce a limited set of care and treatment options in comparison to the very wide number of interpretations of recovery provided both in practice and in supporting literature (Pilgrim and McCranie 2013; Ramanuj et al. 2015). These include fostering hope and therapeutic optimism, encouraging better relationships and social inclusion, finding greater authenticity and meaning in life, and embarking on a personal journey through life, despite the limitations caused by mental illness (Anthony 1993; Deegan 1988; Pilgrim and McCranie 2013).

A lack of consensus about the nature of recovery and specific core features which can be attributed to the concept, has led to it being called a 'polyvalent' concept (Pilgrim 2008), meaning that it has many different forms and functions with little or no agreement about its precise identity. This can be seen as a strength or weakness of the concept depending on one's point of view. Some commentators view recovery as being a vague and simplistic concept, which Hopper (2007) has adroitly summarised as a "co-opted, near-toothless gospel of hope" (p.877). However, other commentators regard this lack of clarity as an opportunity for diversity in constructing new understanding, approaches and strategies for tackling the problems of mental illness, placed under the banner of the recovery label (Hopper 2007; Mind 2008; van Weeghel et al. 2019). According to this view, the notion of recovery in all its varied forms serves as a rallying point for different groups with various agendas on how to tackle the challenges posed by mental illness (Pilgrim and McCranie 2013). In this context, the narrow interpretation of recovery underpinning the Measure, based on self-sufficiency and reduced service

dependency within the context of primary care, might be seen to confound the potential for diverse interpretations of this polyvalent concept.

Given the controversies surrounding the concept of recovery and its implementation, it is unclear what the impact of the Mental Health (Wales) Measure might be at the ground level. This inquiry therefore sought to investigate patient experiences of care continuity, in the context of this policy implementation, as a key element in appraising provision of recovery-based mental health services in Wales. Good care continuity has been defined as “the long-term delivery of care that is coordinated among services and is appropriate to a patient's current needs” (Puntis et al. 2014, p.1). It is widely considered to be a cornerstone of modern healthcare and critical to achieving effective treatment (Weaver et al. 2017). The study therefore aimed to fill a gap in knowledge about patient and worker experiences which have been impacted by service changes in these two key areas of recovery and care continuity. This has implications for policy and practice beyond the Welsh locality, given the widespread influence of the paradigm, particularly in settings where recovery implementation is policy-led.

## **Methodology**

### **Study design**

The research question for the study was:

*“What are the experiences of care continuity and recovery for people at the interface of primary and secondary care in local mental health services?”*

A qualitative approach was adopted employing analysis of in-depth, semi-structured interview transcripts. Data were collected both from service users and mental health workers such as managers, third sector support workers and General Practitioners. Recruiting both service users and workers

allowed the principal researcher (author) to collect data generated from two main perspectives, supporting a multiple perspectives paradigm for the study (Heaton et al. 2012).

### **Sampling and data collection**

Data collection was carried out in two phases. Phase 1 involved in-depth, semi-structured interviews of service users ( $n = 16$ ) with a history of SMI transiting between secondary and primary mental healthcare levels in West Wales. These people were recruited by the principal researcher during 2017 to 2018 through a variety of third sector organisations and day centres at various locations in West Wales, to access individuals with SMI who had been discharged to primary care. Inclusion criteria necessitated that participants had been discharged from secondary adult mental health services to primary care within the past three years, and so would have the option to self-refer back to secondary services under Part 3 of the Measure. Participants could therefore be viewed as having care trajectories (Hannigan and Allen 2013) directly impacted by the implementation of the Measure. Phase 2 involved in-depth, semi-structured interviews of mental health workers ( $n = 16$ ) who had provided care and support for service users fulfilling the inclusion criteria for Phase 1. A total of  $n = 32$  participants were therefore recruited for the study. The sampling strategy was a purposive maximum variation approach to ensure heterogeneity of the sample.

This research project was conducted according to ethical standards for all health-related research, set out by the Declaration of Helsinki (WHO 2001). Evidence gathered was protected by anonymisation and other strategies which obstruct the identification of participants, to ensure confidentiality. Participants provided informed consent based on a description of research protocols in a participant information sheet. An application for ethical permission to conduct research was successfully made to the Swansea University College of Human and Health Sciences Research Ethics Committee.

## **Data analysis and findings**

The qualitative approach employed Braun and Clarke's (2006) thematic analysis combined with discourse analysis (Jørgensen and Phillips 2002) merging discursive psychology (Edwards and Potter 1992), critical discourse analysis (Fairclough 2003) and the poststructuralist approach of Laclau and Mouffe (1985) as a key element. I use the term 'thematic discourse analysis' coined by Singer and Hunter (1999) to describe this integrated approach. Themes were generated by the principal researcher through discourse analysis of key data extracts located in the dataset, whose selection was guided by concept maps formed out of coded transcripts of the interviews. In this way both comprehensive and fine-grained analysis of the dataset was performed. Discourse analysis was adopted primarily because it accords with the constructionist philosophical underpinning of the study which views language as a precondition for thought and reality, rather than arising as a consequence of thought and reality (Burr 2003). Analysis was conducted in the spirit of reflection since my cultural biases, values and interpretations, particularly those associated with my professional role as a registered mental health nurse, affected application of theories I deemed to be relevant to analysis. According to the constructionist paradigm, this positionality contributed to the process whereby new meaning and knowledge about the world was constructed, generating study findings.

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'
- 'Experienced discontinuities within primary mental healthcare'

In the following sections I provide details about how thematic discourse analysis generated these three themes.

### **Misaligned expectations in negotiating transforming services**

Misaligned expectations were particularly manifest in analysis of participants' talk about experiences of negotiating the interface between primary and secondary care, a boundary which had shifted due to the impact of the Mental Health (Wales) Measure. Discourse analysis and concept mapping revealed a prevalence of talk about barriers facing negotiation of the primary-secondary interface in both directions: either discharge from secondary to primary care or referral from primary to secondary care. According to concept mapping analysis, 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.

Since this study used a qualitative approach, I was agnostic about whether perceived barriers were indicative of the presence in actual fact of real impediments to negotiating the primary-secondary interface (Dingwall 1997). Rather my analysis led to the conclusion that could more properly be established on the basis of qualitative investigation, which was that expectations were misaligned with the nature of services. On this basis, it seemed a credible supposition that service transformation had led to an incongruence between patient or professionals' views and the new behaviour of services.

In-depth discourse analysis of talk provided greater insight into the nature of misaligned expectations. Katy, a service user in her mid-thirties suffering from social anxiety, whom I interviewed at a third sector day centre, expressed strongly her view that she should have been accepted back into secondary services after making a self-referral under Part 3 of the Measure, when instead her referral had been rejected:

27. Katy: I became ill  
28. again, but I didn't go back until...  
29. I tried to cure myself first, so I went back when I was really  
30. ill again because they told me I could go back. Then, I went  
31. back and explained to them that I'd just come down again,  
32. that I was shutting myself away again, and that it was the  
33. same process over again. They didn't want to take me  
34. back because they said to me that they thought it would be  
35. a setback for me, but I didn't understand that because I  
36. didn't know how much more set back I had to be to be  
37. taken in by them. You know? It made me feel like, "I don't  
38. even want to go back there anymore for the help", because  
39. they made me feel like I was just not ill enough. They said  
40. to me that I was contradicting myself, so I don't really want  
41. to go back and be told that again.

[Katy, Service user 4]

In lines 37 to 41 it appears that Katy has been deterred from further help-seeking via secondary care. The perception is conveyed in her language that workers have broken their promise that secondary services would be available to her should she need them, resulting in a breakdown of trust. To do this, her discourse employs a number of discursive and rhetorical devices to construct her account. For instance, Katy employs an emotion category (Wiggins 2017) in lines 37 to 39 to invoke sympathy in the listener: "It made me feel like, 'I don't even want to go back there anymore for the help,' because they made me feel like I was just not ill enough." An emotional category is a discursive device which enhances a speaker's position by adding an emotional resonance and force to the worldview being promoted in the account (Wiggins 2017). This emotional report is enhanced by additional rhetorical

devices such as re-iteration of the phrase “made me feel” (line 37 and line 39), and, more subtly, the use of passive voice to describe her relation to the emotion category. This to an extent expunges her of agency in relation to the emotional state, and therefore her responsibility for it, enhancing the idea that the difficulties she has encountered are both real and objective and that such an emotional response is appropriate. The discursive effect of her account therefore is to paint a picture of Katy as an unfortunate, innocent and powerless victim of discriminatory treatment at the hands of an implacable, impersonal and uncaring medical organisation.

Katy’s (misaligned) expectation is that because of her self-referral she will automatically be accepted back into services. However, psychiatrists are the sole profession with the authority to diagnose SMI suitable for specialist treatment, using diagnostic manuals such as the DSM-5 and the ICD-11 (APA 2013; WHO 2017). Arguably, the continued entrenchment of this gatekeeping role with regard to the determination of psychiatric disorder runs counter to greater service user autonomy facilitated by recovery values and policies enshrining them, such as the Measure. At the same time, the initiative to move Katy to primary care also runs counter to her intentions to continue to be supported by services. This misalignment of expectations, manifest in Katy’s discourse, can be understood in the light of complexity theory (Luhmann 2012a; 2012b) as a type of complex systems effect called a ‘wave of consequence’ (Rittel and Webber 1973), emanating from implementation of the Measure. According to this view, mental health services are seen as a complex system and, more specifically, as possessing the features of a ‘wicked problem’ whose solutions are intractable and potentially counter-productive (Hannigan and Coffey 2011; Rittel and Webber 1973). In this instance, top-down policy-based recovery implementation such as the Measure may produce unexpected and counter-productive effects (Hannigan and Coffey 2011; Hannigan 2013). These effects have been called “waves of consequences” (Rittel and Webber 1973, p.163), describing the way in which unexpected, and potentially undesirable, complex system effects emanate from the source of proposed solutions to wicked problems. A key ‘wave of consequence’ emanating from the implementation of the Measure is a mismatch between service user or worker expectations and the new behaviour of services. Discourse analysis of Katy’s

talk indicates that this unexpected and undesirable ‘wave of consequence’ occurs at the point of her discursive positioning in relation to changing service structures. Katy’s discourse can therefore be considered to be a focal point for this complex systems effect. More generally, discourse within the dataset was frequently the location of such complex systems effects. This highlights the way in which discourse can be the vessel for complexity, which is particularly discernible when discourse analysis is conducted through a poststructuralist lens, as with this inquiry (Cilliers 1998; Laclau and Mouffe 1985).

The account of a supporting worker participant, Alex, a General Practitioner working in primary care, provides further support to the theme of misaligned expectations of services:

21. Alex: There’s
22. not a plan for their future, there’s not you don’t often
23. see a strapline if things go wrong - if things go badly
24. wrong, if things are struggling just, just you can contact us
25. on this number or we can get them seen very easily or this
26. is what we want done with the medication if this happens
27. so there’s less of a long-term plan. And, of course, then as a
28. GP when those eventualities occur, you don’t have many
29. options other than picking up the phone which doesn’t
30. always reap rewards ‘cause you can’t get through to
31. somebody or you have to refer back through the whole
32. system.

[Alex, Supporting worker 15]

Alex’s criticism, made chiefly in this data extract, is that there is a lack of clear guidance in discharge documentation about potential re-referral to secondary care in the future. This lack of a “long-term plan” (line 27) for the service user is associated with difficulties in accessing secondary services through referral. Once again, approaching this account with a certain agnosticism about the objective

certainty of these statements, I regarded it as taking the discursive form of a 'complaint', which Edwards (2005) argues provides insight into the positionality of the speaker. Here, this positionality is indicative of tensions between professional groups which have resulted from shifted roles and responsibilities in an increasingly complex and fragmented "system" (line 32). Alex's expectations of services are therefore misaligned in a similar way to Katy's in the wake of service alteration due to the Measure, specifically involving an increased emphasis on primary care led treatment and recovery.

### **Competing versions of recovery in participants' talk**

Data analysis confirmed the notion of recovery as a 'polyvalent concept' (Pilgrim 2008). Participants' talk indicated a variety of competing versions of recovery, tallying with the notion that it is a contested concept lacking clarity, which may be appropriated in different ways to suit and fulfil a particular agenda such as rehabilitation, cost-cutting services or a shift to primary care (Deegan 1998; Mind 2008; Ramanuj et al. 2015; Weaver 2020). This process of appropriation has been described as 'colonization' by some commentators (Barker 2003; Ingleby 2006; Mind 2008). A key feature of my analysis was the identification of multiple instances of recovery colonization in participants' talk, which was understood to be the main driver for construction of new and competing versions of recovery. 'Empowerment and self-management' was the most prevalent construction in the dataset, represented both by ( $n = 6$ ) service users and ( $n = 4$ ) supporting workers. One service user, Dylan, expressed apparent commitment to this single version of recovery yet simultaneously constructed multiple competing versions of recovery within his talk. Dylan's verbal dexterity, experience as a support worker and high level of awareness about the nature of mental illness and services resulted in his talk being an exemplar of the polyvalent nature of the recovery concept. Dylan is a service user and support worker with bipolar disorder in his fifties providing service user training for people with SMI in a variety of third sector settings. The following data extract follows on from interviewer questions about the nature of the training he offers for self-management skills:

160. Dylan: Self-management is the key to recovery,  
161. and I don't know, it's a bit ambiguous that word, isn't it because  
162. you know I'm fifty-two now, thirty years on from when I was first  
163. diagnosed and here I am now and I'm still managing this  
164. condition. So I cannot pretend to say to you that I'm symptom  
165. free because I'm not. And if took my, erm – what's the right  
166. word - and if I took my foot-off-the-clutch then I'd be stuffed  
167. really – I've got to make sure that every night I get my sleep  
168. properly. It's a holistic approach. There's nothing difficult  
169. about this really. It's about eating properly, sleeping properly,  
170. exercise – something I struggle with to be honest; connecting  
171. with people, engaging with people, routine, but also I think for  
172. me – work – I find a lot of meaning and purpose in work, as  
173. well, and it really helps to keep me well as well. Appropriate  
174. work, mind, and that's been a struggle to find appropriate  
175. work, in all of that as well, erm, but it's like a jigsaw I guess,  
176. it's making sure all the pieces are together and I will say to  
177. you I still take medication, I still take lithium a mood stabiliser,  
178. albeit a very small amount now. I see the value of medication  
179. stabilising people but it isn't all about medication, I think the  
180. health service needs to practice what it says in theory but it  
181. doesn't do it in reality, and that is a whole person approach,  
182. you know.

[Dylan, Service user 2]

Dylan at first states clearly his apparent view that “Self-management is the key to recovery” (line 160). He then goes on to describe himself as “still managing this condition” (lines 163 to 164) thirty-two years on from when he was first diagnosed (lines 162 to 163). The use of the metaphorical phrase “foot-off-the-clutch” (line 166) implies a sense of remaining in control of one’s life as one would when driving a vehicle. Metaphors are used in discourse to encode people’s culturally embedded values, revealing particular ways of looking at the world (Coffey and Atkinson 1996). Dylan’s talk here can be interpreted as encoding the meaning that he needs to continue to self-manage his mental health and recovery on a daily basis, without taking his foot off the clutch, figuratively speaking. Recovery is “a bit ambiguous” (line 161) since while it may be conventionally understood as cure, here it is presented as an ongoing commitment to self-management and maintenance despite the continuation of illness. According to this understanding promoted in Dylan’s talk, recovery can occur even though symptoms persist, since the focus is less on alleviation of symptoms, and more upon reducing the degree to which symptoms interfere with an otherwise fulfilling and meaningful life (Repper and Perkins 2003).

In addition to these two competing versions of recovery, Dylan also talks about an “holistic approach” (line 168), which is supported rhetorically by the introduction of another metaphor, “jigsaw” in line 175 and the accompanying phrase, “making sure all the pieces are together,” in line 176. Holism often features within a person-centred recovery approach aimed at achieving personal integrity and wholeness (Gilburt 2013). Bethany, the manager of a third sector day centre, points out in her interview that the CTP approach promoted by the Measure can also be viewed as promoting an holistic, person-centred recovery approach (Welsh Government 2014; 2016). Recovery in this sense is closely related to the global phenomenon of holistic, person-centred care which has been highly influential in a wide range of healthcare settings (Stewart et al. 2014).

Another version of recovery may be discerned through analysis of Dylan’s talk, based on a critique of services (Pilgrim and McCranie 2013), which he begins to outline in lines 179 to 182. This critique is developed further on in the interview when he recounts a traumatic experience whilst in hospital

when he received coercive intramuscular administration of anti-psychotic medication. Recovery as critique of services and recovery as self-management are closely related since the former situation creates the context in which a more self-reliant approach might be preferable. If services are unhelpful or even harmful, they are to be avoided, leaving self-management as the only viable alternative. A notable contrast can be made between Dylan's self-management recovery version, with emancipatory connotations of finding freedom from coercive services, and the type of self-management recovery approach promoted by the Measure. In the latter case, the underlying driver behind promotion of self-management in the context of primary care is a neoliberalist policy concern with financial constraints and cost-cutting. The Measure can be seen as a narrow interpretation of recovery based on greater self-management in the context of primary care, accompanied by a strategy of reducing the number of patients in secondary care to a more select group (Gofal 2014; Lester and Gask 2006; Pilgrim and McCranie 2013; Ramanuj et al. 2015). An implicit neoliberalist strategy can be discerned beneath the surface of this recovery-based policy programme, where the intention is to get newly discharged service users back into work and reduce their dependency on services (Braslow 2013; DoH 2009; Mind 2008; Morrow 2013). 'Work-as-recovery', in this sense, can be seen as a highly colonized version of recovery (Barker 2003; Mind 2008), which has been co-opted by an agenda associated with neoliberalism (McKeown et al. 2017).

The view that the polyvalent recovery concept is vulnerable to neoliberalist colonization, is an application of the notion of 'psychiatric colonization' introduced by Thomas Szasz (1974) within the radical antipsychiatry critique, in turn based upon Frantz Fanon's critique of colonialism, which in this context took the form of institutional psychiatry (McKeown and Wainwright 2020). 'Colonization' may also be understood in the sense of 'colonization of the lifeworld' proposed by Habermas, where the systemic sphere, chiefly involving capitalist and associated policy drivers in this application, has become uncoupled from the lifeworld and now threatens to re-enter and dominate the domain of the lifeworld (Crossley 2005; Habermas 1984; McCarthy 1984). The concept of the lifeworld has its origins in the theory of Alfred Schütz (Schütz and Luckmann 1974) and can be defined as the context-forming

horizon of social action and consciousness; the site of symbolic interaction or communicative action which occurs between individuals on the basis of mutual, pre-reflective understandings, norms and values (Crossley 2005). The systemic sphere, on the other hand, describes a dominant hegemony (Day 2004; Gramsci 1971) of functionalist activity oriented towards maximum efficiency or strategic action, typically manifesting in the form of capitalism or bureaucracy (McCarthy 1984; Habermas 1984). Dylan's emancipatory, self-management version of recovery represents the lifeworld within this theoretical understanding, since it is rooted in the domain of lived experience, whose conceptual framework is referred to by Habermas as 'discourse ethics' (Habermas 1998). The related concepts of discourse ethics and the lifeworld have been applied theoretically by Fardella (2008) as a way of understanding emancipatory forms of recovery, as expressed by Dylan and others (Anthony 1993; Deegan 1988). Within the context of 'discourse ethics', intersubjective consensus and human betterment is achieved through undistorted communicative action which develops and enriches the lifeworld. Particularly in the context of peer support settings, which may provide an optimal environment for discourse ethics and communicative action, there is the greatest potential for new forms of intersubjective understanding and emancipatory recovery versions to be developed (Davidson et al. 2012).

Fardella's (2008) theory of recovery in the lifeworld is built upon here by emphasising the systemic sphere as a venue for colonization of recovery. The key dichotomy between system and lifeworld identified by Habermas therefore illuminates a major tension across the landscape of recovery versions. Woods and colleagues (2019) and Recovery in the Bin (2019) have signalled this key dichotomy, without explicit reference to Habermas, by contrasting 'top-down,' policy versions of recovery, or 'neorecovery', with 'bottom-up' or 'grassroots' versions of recovery. Top-down, neorecovery primarily refers to the narrow and limited notion of freedom encompassed in systemic forces of neoliberalism, transposed to the mental health arena (Curtis 2007; Edgley et al. 2012; Harvey 2005; McKeown et al. 2017). It may also involve associated systemic forces such as bureaucratic structures, policy programmes and biomedical psychiatry (Habermas 1984; Ingleby 2006).

Neorecovery can be contrasted with the broader understanding of liberty promoted by the original radical, emancipatory idea of recovery (Anthony 1993; Deegan 1988), or grassroots recovery. Here, the aim is to free the person from subjection to disempowering and potentially coercive services, as Dylan expresses in his discourse. Grassroots recovery represents the much wider and richer diversity of emancipatory recovery conceptions, rooted in the lived experience of the service user, and the domain of Habermas' discourse ethics. However, systemic neorecovery threatens to colonize and diminish the space for healthy expression of discourse ethics, or grassroots recovery within the sphere of the lifeworld.

### **Experienced discontinuities within primary mental healthcare**

Analysis of talk also revealed experiences of discontinuities in multiple dimensions according to the multi-dimensional model of care continuity which was adopted for this study (Weaver et al. 2017). Talk about discontinuities of care was concentrated in accounts of experiences of mental healthcare at the primary level and at the point of discharge from secondary to primary care. Service user participants talked about experiences of care discontinuities whilst attempting to self-manage within primary care after having been discharged from specialist treatment. One example is Bernadette, a service user in her forties diagnosed with bipolar disorder:

227. Researcher: Another thing I'm  
228. interested in is actually getting an appointment with your  
229. GP, for mental health, because you -  
230. Bernadette: That's hard. That's hard. Because  
231. you've got to phone up to half past eight, and then  
232. sometimes they'll say, "A nurse will phone you back",  
233. when, you know, you're desperate sometimes. You need to  
234. see a doctor, and sometimes you can be desperate. Well, it  
235. just puts you off phoning the GP because they'll say,

236. “Somebody will phone you back”, or sometimes you have  
237. to wait in a queue. Like, if you phone on a Monday, it’s so  
238. busy with patients that you can’t see a doctor, you know,  
239. and what happens when you’re really ill?

[Bernadette, Service user 3]

In this data extract, emotional category terms are employed such as “desperate” (lines 233 and 234) and “hard” (line 230) to describe the difficult experience of being mentally unwell whilst having to adhere to highly structured appointment-making protocols. According to Bernadette, this involves the requirement to phone the practice for an appointment before 8:30am in the morning and wait for the practice nurse to phone back even after contact has been made.

Arguably, the presence and severity of such barriers is aggravated for individuals with SMI. Conditions such as anxiety and depression may lead to heightened negative responses to obstacles, which can be debilitating. Additionally, serious mental health conditions can deteriorate very quickly without early intervention leading to a point of crisis (Becker et al. 2019). Consequently, it seems likely that the sorts of impediments to accessing primary care described by Bernadette may have a disproportionate effect on people with mental health problems, leading to enhanced experiences of care discontinuities whilst self-managing under the GP.

## **Discussion**

The analysis and findings outlined in the previous three sections contribute to an emerging picture of Welsh mental health services characterised by misaligned expectations of services, multiple care discontinuities concentrated at the primary level, a lack of cohesion between diverse and competing recovery approaches and escalating complexity. The implementation of recovery-based services may lead to a variety of disparate care trajectories which are difficult to coordinate and do not provide easy opportunities for care continuity experienced as a continuous and seamless whole (Weaver et al.

2017). Thus, a connection can be made between misaligned expectations and competing versions of recovery on the one hand and participants' experiences of care discontinuities on the other. The relationship between recovery and care continuity is therefore not straightforward. Whilst it is generally assumed that a recovery-based approach will contribute towards good care continuity, this study has shown that, on a service-wide level, a proliferation of competing recovery versions will actually be a factor for fragmentation, consequent care discontinuities and a plethora of complex pathways escalating service system complexity (Gilburt et al. 2014). This is an important consideration for attempts at service engineering which seek to implement recovery-based services, such as the Measure, since escalating complexity may not be a desirable outcome given the implications of service fragmentation and care discontinuities.

The poststructuralist perspective of Laclau and Mouffe (1985) incorporated as a key element within discourse analysis is a major contributor to this complex systems perspective. In analysis of Katy's talk for instance, misaligned expectations were expressed in discourse as a focal point for this complex systems effect. This poststructuralist perspective has important post-Marxist implications for theoretical analysis. Laclau and Mouffe's 'Hegemony and socialist strategy' (1985) may be considered to be a seminal text on post-Marxism which moves beyond the traditional Marxist ground of explanation in the economic base to a new form of radical or cultural identity politics (Epstein 1996; Maund 2012). Laclau and Mouffe (1985) grafted poststructuralism onto Marxism, with the result that the original fault-line of contention and conflict between capital and labour is shifted to a fault-line between diverse groups attempting to appropriate key meanings and signs within the field of ongoing discursive struggle (Crossley 2005). New social movements such as 'Black lives Matter', environmentalists, feminists and pacifists are the key activists within this poststructurally conceived landscape of contention (Crossley 2003; Habermas 1984). These groups are involved in an ongoing discursive struggle for a recognition of difference in the face of a dominant, colonizing hegemony that asserts the norm of the 'sane', white-Anglo middle-class male, accompanied by capitalist military industrial complex (Fraser 1997). In the field of mental health, new social movements championing

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this discursive struggle are represented by user/survivor groups such as Mad Pride, Recovery in the Bin (<https://recoveryinthebin.org/>), the 'National Survivor User Network' ([www.nsun.org.uk](http://www.nsun.org.uk)), or more locally, West Wales Action for Mental Health (WWAMH; <https://wwamh.org.uk/>). These groups have arguably carried out a defence of grassroots recovery, representing pluralism, emancipation and cultural diversity, against the encroachment or colonization of a singular notion of neorecovery. This theoretical perspective provides a post-Marxist context for understanding the key point of contention between grassroots recovery, promoted for instance in Dylan's talk, and a hegemonic neorecovery promoted in policy implementations.

Habermas' (1984) proposal of a dichotomy between system and lifeworld further enriches the post-Marxist perspective provided by Laclau and Mouffe. Analysis of Dylan's talk indicated that the systemic sphere of neorecovery underpinned by neoliberalist policy principles threatens to colonize the lifeworld domain of grassroots recovery and diminish the scope for discourse ethics in this arena (Fardella 2008). The product of this colonization is a limited, culturally impoverished form of recovery within the mental health field, resulting from the distortive, pathological consequences of colonization (Habermas 1984; Ramanuj et al. 2015; Recovery in the Bin 2019). This depletion of the meaning and value of recovery has led to calls for abandonment of the term altogether by groups such as Recovery in the Bin (2019). However, I would argue that whilst the recovery concept has been highly colonized and reified, this has not yet occurred to the point that the essential value of the concept has been lost, which is visible in the valid concerns of participants' grassroots recovery constructions. The original radical idea of recovery should therefore be re-appropriated and reclaimed within the sphere of the lifeworld, with user/survivor groups as key actors for this cause.

Additionally, colonization of recovery may be a contributory factor for escalating complexity, leading to service fragmentation and widespread care discontinuities. A limited, reductionist neorecovery, based on discharging people to primary care, may act as a catalyst for complexity because it is not committed to encouraging authentic and emancipatory generation of recovery versions at the

grassroots level. The result, indicated by data analysis, appears to be a free-for-all for co-option, since a mandate for ownership of recovery by individuals and groups at the grassroots level is not properly promoted in policy implementation. Neorecovery is irrelevant or even a barrier to what needs to be done at the ground level in order to tackle problems of mental illness, as is shown in Alex's discourse when he rails against the "system" (line 32). Consequently, a kind of disconnect has arisen between policy implementation and the realities of what is achievable by individuals and groups at the grassroots level. Singular notions of top-down recovery, as with the Measure, do not provide good guidance or governance for grassroots endeavours. The result of this, as data analysis has shown, is a kind of anarchy of disparate recovery behaviours. The paradoxical effect of reductionist top-down recovery implementation may therefore actually be to stimulate generation of competing versions of grassroots recovery in a way that escalates complexity and fragmentation.

A less polarised policy-approach might yield better results, where there is commitment to incorporating a richer notion of what recovery might be other than just the simplistic notion of discharge from services. This might remove oppositionality between policymakers and campaigning user/survivor groups, leading to a more constructive consensus about recovery. It should also involve a commitment to better resourcing of the third sector and opportunities for collaboration with user/survivor and peer support groups. There might be greater potential in such a service culture to develop new opportunities for reciprocal alliances between service users, supporting workers and policymakers. This would constitute genuine dialogue and communicative action, in the Habermasian sense, intended to liberate service users from psychiatric colonization in its contemporary form of neorecovery.

In parallel theorising, Richard Day (2004) has outlined the 'logic of affinity' as the basis for activism that might combat forms of hegemony hoisted upon society by colonization of emancipatory movements, such as recovery in the mental health field. Reciprocal alliances, communicative action and discourse ethics, spearheaded by new social movements, might be seen as falling within the ambit

of the 'logic of affinity', according to Day's analysis, with the purpose of confronting more subtle forms of hegemony which spring from emancipatory movements themselves. Policy seeking dialogue between alienated elements should therefore pursue a conciliatory approach which balances the colonizing effects of top-down, neorecovery and a proliferation of grassroots recovery versions. Such an approach would aim to set the alternative spheres of the system and the lifeworld to act as mutual balancers rather than as exacerbating factors for one another. This describes in Habermasian and social theoretical terms Hopper's (2007; 2008) idea of a 'working misunderstanding' between the emancipatory and neoliberal valences of recovery (Pilgrim and McCranie 2013). Such a reconciliation would create conditions for optimal levels of recovery diversity whilst at the same time limiting unhelpful proliferation. Using the balanced and conciliatory approach suggested here, policymakers would be able to set optimal cultural and communicative conditions for grassroots recovery-construction by employing neorecovery in a limited yet pro-active manner. Unhelpful polarisation towards neorecovery would be achieved by better support for grassroots recovery. Unhelpful polarisation towards proliferate grassroots recovery would be achieved by more limited and pro-active implementation of neorecovery.

A concern might be that efforts at reconciliation between lifeworld and system elements would merely open the door towards further colonizing incursions. However, this perspective reflects Habermas' acknowledgement that a certain level of systematisation is irreversible and desirable since modern mass society cannot rely completely upon communicative action within the sphere of the lifeworld. As Chouliaraki and Fairclough (1999) put it, "If societies had to constantly reach consensus over everything through argumentation, they could not function" (p.85), implying that recovery cannot be articulated purely at a grassroots level in modern mass society. Additionally, insofar as system-lifeworld reconciliation is cast within the logic of affinity, this should guard against new iterations of colonization, since this theoretical perspective is specifically focused upon this threat.

## Conclusion

This study provides initial, exploratory evidence for a circuitous relationship between recovery and care continuity, an understanding of which could be developed further by research aimed at clarifying the relationship between recovery approaches and care continuity. A limitation of this study was that it covered a relatively small region within Wales, and a broader study over a larger geographical area with a larger sample size might provide stronger support for conclusions. Potential critiques of the epistemic value of qualitative research (Ritchie et al. 2013) might be overcome by building on this inquiry with quantitative or mixed methods investigation of the relationship between recovery implementation and care continuity experiences.

As this study has shown, questionable recovery appropriation has the potential to generate escalating complexity and care discontinuities across services in Wales. This has led to the proposal of a more balanced and conciliatory implementation of recovery-based services to engineer healthy recovery pluralism rather than leaving a vacuum within which chaotic proliferation occurs. Given the prevalence of the recovery paradigm in the mental health services of developed countries around the world (Gilbert 2013), this balanced approach might serve as a point of guidance for policy makers wishing to implement recovery-based services in other settings. Recovery-based services, both in the Welsh context and beyond, must therefore be implemented in a conciliatory manner, where the mainstay of grassroots recovery is properly acknowledged and supported. This should leave room for the recovery paradigm to develop organically from within the hermeneutic and intersubjective dimension of service users' lives. This would involve a more substantive commitment than mere 'virtue-signalling' (Bartholomew 2015) in policy rhetoric or simply cutting costs by limiting service access in response to an underlying neoliberalist agenda. Otherwise, if the ill-effects of poor implementation are left unchecked, scepticism will rightly overtake an impoverished yet dominant form of neorecovery, leading to a repudiation of the concept of recovery altogether. Societies seeking to develop effective

mental health services will then lose this vital and fundamental concept intrinsic to the task of tackling mental illness.

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