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Escalating complexity and fragmentation of mental health services: the influence of recovery as a form of moral communication

Abstract: Despite the application of complex systems theory to mental health services, Niklas Luhmann's thought has rarely been engaged with in this field. 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. Top-down policy implementations of recovery, such as the Measure, have emphasised the values of increased self-reliance and reduced dependency on services, mirroring neoliberal thinking on welfare reform and poverty. An expectation of self-management after discharge to primary care under the Measure has led to greater movement across the interface between primary and specialist care, which may cause disruptions to recovery trajectories and escalate service complexity.

The recovery concept has become one of the most important paradigms within contemporary mental health services. However, it has been called a 'polyvalent' concept subject to a wide range of applications. Such interpretative diversity indicates that recovery may best be understood as a rhetorical vehicle or form of moral communication for promoting values favoured by the individual or group appropriating the concept.

A qualitative study, employing in-depth, semi-structured interviews, set out to investigate patient and associated healthcare workers' experiences of the impact of service changes on recovery and care provision. Complex social systems theory, as exemplified by Luhmann, provides a key perspective for theoretical generalisation on the basis of discourse analysis of interview transcripts. Complexity was most manifest in the discursive practices, positionings and constructed meanings of talk spoken by individuals seeking to negotiate transforming service structures and interfaces. In particular, participants' expectations were misaligned with the new behaviour of services triggered by policy implementation. Applying Luhmann's epistemological theory, the meaning inherent in misaligned expectations is the product of autopoietic, information-processing components which are autonomous and functionally differentiated from the entire social system. This therefore is a key point at which complexity escalates through mechanisms of reflexivity and differentiation in response to top-down systemic stimuli.

Additionally, discourse analysis elucidated a proliferation of competing versions of recovery. This tallies with the notion that recovery in mental health is a contested and polyvalent concept, suitable for highly individualised, deeply personal discursive appropriations and interpretations of its meaning. This is testified to by the variety of self-oriented versions of recovery constructed in analysis of participants' discourse. Recovery should therefore be centrally understood as a person-centred meaning-making activity conveying the interpretation an individual wishes to adopt for their approach to tackling mental health. Such self-oriented interpretations of recovery will be diverse, and potentially competing, understood as various attempts to fix the meaning of recovery within the ongoing discursive struggle constituting the complex mental health service system.

This perspective of a plethora of autonomous, self-oriented recovery versions may similarly be related to Luhmann's complex systems theory. In promoting a greater level of autonomy and self-sufficiency for individuals managing their mental health conditions, embracing recovery engenders a higher amount of information to be inputted into autonomous, autopoietic subsystems or components. Introducing a greater level of autonomy for independent subunits has the potential to escalate complexity within a social system, since disequilibrium has been introduced between the information levels of the subunit and its systems environment. Since individual components are autonomous, this imbalance may have a dynamic effect whereby increased complexity and disequilibrium are amplified throughout the entire social system of mental health services. In this way, promoting a person-centred approach to mental health, based on a self-management recovery ethos, has the potential to generate escalating systems-wide complexity coupled with increased service fragmentation.

This analysis may be expanded by considering the debate between Luhmann and Jürgen Habermas in 'Theorie der Gesellschaft oder Sozialtechnologie: Was leistet die Systemforschung?' Whilst Luhmann's social theory can be seen as an appropriate theoretical framework for contextualising participants' experiences and discourse within a complex systems perspective, Habermas' critical theory provides an additional historico-hermeneutic dimension, rooted in human agency and the lifeworld, which he argues is lacking in complex systems theory. This added dimension enables the recovery concept to be grounded in the lived experience of services users, reconnecting it with the original radical, emancipatory idea of recovery based on an agenda of liberation from coercive and iatrogenic psychiatric services. Additionally, the Habermasian conception of colonization of the lifeworld may be applied to the case of top-down policy implementations such as the Mental Health (Wales) Measure, involving a neoliberalist colonization of recovery. Here, the systemic reification of recovery leads to colonization of the lifeworld by system elements that lead to distorting and complexity-generating repercussions for the wider social system. This provides a further explanation, compatible with Luhmannian theory, of how colonization and systematic distortion of an emancipatory form of moral communication, originally rooted in the lived experience of the patient, may be a factor for escalating complexity.

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 health issues using services in Wales, United Kingdom reveals the potential application of this social theoretical perspective. Wales is a country within the United Kingdom which also enjoys a limited degree of political autonomy from England in certain fields including healthcare, described as devolved administration under the Welsh Government. This paper will outline this study and describe how theoretical generalisation (Mitchell, 1983) based on study findings may involve Niklas Luhmann's social systems theory (1995; 1996; 2012a; 2012b) as a key component of analysis, shedding light on the nature of escalating complexity within services. Such complexity may have a detrimental effect on trajectories of mental health care provision as people with serious mental health issues seek to navigate services and engage in their 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 is the focus of contemporary mental health policy since it is the current, dominant paradigm shaping mental health policy and services (Braslow, 2013; Edgley et al., 2012; Hannigan et al., 2018; Morrow, 2013). Contemporary mental health policy is now predominantly conceived as recovery-based, and the Mental Health (Wales) Measure can be seen as a key local example of such a policy-conception, within the devolved healthcare administration of Wales (Braslow, 2013; Morrow, 2013; Pilgrim and McCranie, 2013; Welsh Government, 2010a; 2013; 2014). The stated aim of this recovery-conception is a shift to primary care[1] mental health delivery 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, 2010b, p.42; 2013, p.11; 2014, p.15). An increased service focus on primary mental healthcare delivery under the Measure may be related to a narrow interpretation of the recovery approach aimed at reducing specialist service dependency and provision coupled with the expectation of increased responsibility and self-reliance for individuals with mental illness (Lester & Gask, 2006; Pilgrim & McCranie, 2013; Ramanuj et al., 2015). Arguably, it achieves not only the goals of a particular brand of recovery model, but also accomplishes the purposes of financially motivated agendas stemming from implicit neoliberalist ideologies governing

[1] Primary care services are the first point of contact in the healthcare system including general practice, community pharmacy and local primary mental health support services (LPMHSS). Traditionally, the role of primary mental health care has been that of gatekeeping for specialist secondary mental health services. Secondary mental health services provide specialist support for people with complex mental health issues either through hospital or the community mental health team (CMHT).

the actions of policy-makers (Braslow, 2013; Morrow, 2013; Recovery in the Bin, 2019; Woods et al., 2019). These agendas include cost-cutting, a drive towards achieving greater efficiency, and getting people with mental health issues back to work. The Measure can therefore be situated within the neoliberal consensus of policy-makers on recovery, and can be seen as an instance of this kind of colonized recovery version (DoH, 2009; Recovery in the Bin, 2019; SAMHSA, 2004). Here, 'colonization' may be understood in the sense of 'colonization of the lifeworld' proposed by Habermas, where the systemic sphere of capitalism has become uncoupled from the lifeworld and now threatens to re-enter and dominate the domain of the lifeworld (Crossley, 2005; Habermas, 1984a; Habermas, 1984b; McCarthy, 1984) (see section 6 below). Policy-based implementations of recovery such as the Measure have been called 'top-down' recovery versions by Woods and colleagues (2019), or 'neorecovery' by the service user/survivor campaigning group, Recovery in the Bin (2019; see also: Recoveryinthebin.org), fusing in this pejorative label the terminology of neo-liberalism and recovery. Neorecovery in this sense describes the narrow and limited notion of freedom embodied in neoliberalism, transposed to the mental health arena (Curtis, 2007; Edgley et al., 2012; Harvey, 2005; McKeown et al., 2017). This may be contrasted with the much broader notion of liberty promoted by the original radical, emancipatory idea of recovery (Anthony, 1993; Deegan, 1988). To describe this, the term 'grassroots recovery' has been coined by Recovery in the Bin (2019), where the aim is to liberate the individual from subjection to devaluing and disempowering services that may be coercive or even iatrogenic (Edgley et al., 2012; O'Keeffe et al., 2018; Repper & Perkins, 2003; Tew et al., 2011). The qualitative study, employing in-depth, semi-structured interviews and discourse analysis, 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.

2. Study outline

A qualitative approach was selected for the study, employing analysis of in-depth, semi-structured interview transcripts. Data were collected in two phases both from service users with mental health problems (*n = 16*) and mental health workers (*n = 16*) such as managers, third sector[2] support workers and General Practitioners (or GPs: doctors working within primary care surgeries). Analysis employed thematic analysis (Braun & Clarke, 2006) combined with an integrative method of discourse analysis (Jørgensen & Phillips, 2002) drawing on discursive psychology (Edwards & Potter, 1992), critical

[2] The third sector or voluntary sector is an umbrella term that covers a range of different organisations that occupy the 'third' sector after the public and private sectors. These organisations are non-profit-making and motivated by charitable concerns or a desire to create social impact such as in areas of mental health support and recovery.

discourse analysis (Fairclough, 2003) and the poststructuralist viewpoint of Laclau and Mouffe (1985). I use the phrase 'thematic discourse analysis' coined by Singer and Hunter (1999) to describe this hybrid approach. Thematic discourse analysis of (*n = 32*) interview transcripts led to the generation of three themes:

- 'Competing versions of recovery in participants' talk'
- 'Misaligned expectations in negotiating transforming services'
- 'Experienced care discontinuities[3] concentrated at the level of primary mental healthcare'

I then proceeded to develop analysis and subsequent findings theoretically, employing theoretical generalisation as described by Mitchell (1983). Theoretical generalisation is described as a form of 'theory-building' where "conclusions are drawn from features or constructs developed in a 'local' or single study which are then utilised in developing wider theory which is or can be applied to other settings" (Ritchie et al., 2013, pp.38-349). The "cogency of the theoretical reasoning" (Mitchell, 1983, p.207) is a key goal of this approach and the basis for validity of findings and arguments which I sought to develop by drawing on various strands of social theory, including that of Niklas Luhmann.

3. Theoretical generalisation on the basis of study analysis

Complex social systems theory, as exemplified by Luhmann, provides a key perspective for theoretical generalisation on the basis of thematic discourse analysis of interview transcripts produced in this study. I employed the systems theory of Niklas Luhmann (1995; 2012a; 2012b) as a key component of theoretical generalisation since I viewed it as the most fully developed and sociologically insightful version of complexity theory. Complex systems theory has been developed into various forms of comprehensive philosophical frameworks for describing the world and society (Forrester, 1968; Luhmann, 1995; Luhmann, 2012a; Luhmann 2012b; Maturana & Varela, 1991; Walby, 2007; Wiener, 1948). The most all-encompassing of these is the social systems theory of Niklas Luhmann (2012a; 2012b). This systemic theory incorporates other comprehensive complex systems theories such as cybernetics (Forrester, 1968; Wiener, 1948) and autopoiesis (Maturana & Varela, 1991; Von Foerster, 1981; Von Foerster & Zopf, 1962). As well as being one of the most well developed and widely cited

[3] 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 health care and considered to be critical to achieving effective treatment (Biringer et al., 2017; Burns et al., 2009; Sweeney et al., 2012; Weaver et al., 2017).

examples of complex systems analysis (Delanty, 2005; Walby, 2007), Luhmann's theory is considered to be a formidable contribution to the field of sociology in its own right (Holub, 1991; Wagner, 1997). In this sense, Luhmann provides the most complete theory of sociology with direct reference to complex systems theory. I decided that this was therefore an appropriate way to develop analysis based on the three major themes generated by thematic discourse analysis in the study.

The overall paradigmatic context for the study was that of constructionism, a broad philosophical position closely allied with discourse analysis (Burr, 2003), which also underpinned my methodology both in terms of epistemology and ontology. Epistemology may be defined as referring to the 'knowability' of the social world, and the relationship between the knower and what is known (Epstein, 2011; Ritchie et al., 2013). Ontology, on the other hand, concerns the nature or composition of the world, or that part of the world that is known in a specific context (Epstein, 2011; Guba & Lincoln, 1994; Scruton, 1994). Since ontology and epistemology are critical dimensions within philosophy, and clearly articulated as aspects of my methodology (Weaver, 2020 – see http://cronfa.swan.ac.uk/Record/cronfa53686), I chose to expand my analysis theoretically along these lines. I shall first describe the way in which Luhmann's systems theory expands the ontological stance of constructionism, and how this provides a useful framework for understanding the nature and composition of mental health services in Wales, as experienced by participants and service users in general. Following on from this, I shall describe how complex systems theory may be understood as a development of constructionist epistemology. Recognition of complexity theory as an epistemological system enables an application of this theory more directly to participants' experiences of recovery, since experiences and intentions occupy the epistemological dimension of these individuals' knowledge of the world.

4. Complexity systems ontology modelling recovery experiences and expectations

A complex systems ontology may be considered a natural development of constructionist ontology which articulates the world in terms of local and specific constructed realities (Guba & Lincoln, 1994). Similarly, complex systems ontology is characterised by disparity and functional differentiation of its component parts (Cillers, 1998; Luhmann, 1996; Osterberg, 2000). This fragmented ontological nature is the basis for the system's complexity. Disparate components may operate in a manner which is independent of the whole system. This means that the system will be highly flexible and adaptive, prone to unpredictability and disequilibrium (Cillers, 1998; Osterberg, 2000; Plesk & Greenhalgh, 2001; Rittel & Webber, 1973). Cybernetics systems theory is employed by Luhmann to model this ontological complexity, after the influence of Parsons (1951; 1961). In his structural-functionalism,

Talcott Parson's employs a cybernetic systems model which tends towards stability and equilibrium (Craib, 1992). Equilibrium is maintained through feedback loops based on the 'AGIL' paradigm[4] distributed throughout the entire system (McClelland & Thomas, 2006; Parsons, 1951). Luhmann employs cybernetics in a different way to Parsons to model a system which is complex and may tend towards disequilibrium. Additional dimensions of reflexivity and functional differentiation are also introduced into his systems theory (Holub, 1991; Luhmann, 1995, Osterberg, 2000). These factors have the potential to preserve or even increase complexity through positive feedback loops (Cilliers, 1998, Holub, 1991; Segre, 2014). A complex cybernetic systems model articulated in this way by Luhmann therefore exemplifies the ontological nature of complex systems theory.

Complex systems theory considered ontologically in this manner can be seen in the application by Plsek and Greenhalgh (2001) to modern healthcare systems in their depiction of the UK National Health Service as a "complex adaptive system" (p.625). Building on this work, Hannigan and Coffey (2011) apply complex systems theory specifically to mental health services. In addition to its application to mental health services, complexity can be associated with the phenomenon of mental illness itself (Bracken et al. 2012). Good mental health care engages actively with the complex nature of mental health issues which are rooted in social determinants and inequalities occurring across the life span (Bracken et al. 2012; WHO, 2014). Patients with mental health issues often have complex needs requiring treatment and support from a variety of specialist service points dispersed throughout the community (Crawford et al., 2004; Durbin et al., 2004). The notion of mental illness has been contested by the antipsychiatry movement, adding to a complex ontological picture of mental illness. Thomas Szasz, who was a leader of the antipsychiatry movement, questioned the objective reality of mental illness, describing the 'myth of mental illness' as the psychiatric construction of diagnostic labels out of everyday 'problems of living' (Szasz 1974). This critique has softened within recent decades as the antipsychiatry movement has given way to critical psychiatry (Double, 2006; Double, 2009; Ingleby, 2006). However, this subsequent movement retains the assertion that mental illness should be understood on a more complex, hermeneutic basis, and not just in terms of reductionist, positivist biomedicine (Jaspers, 1997; Stanghellini, 2013). The critical psychiatry movement, and the related school of postpsychiatry, have promoted the notion that the inherent complexity of mental health and illness is rooted in the personal and subjective nature of mental disorder.

[4] Parson's theory stipulates that every system must satisfy four functional prerequisites for its continued survival. It must adapt (A) to its external environment, attain goals (G), achieve systemic integration (I) and reproduce latent cultural patterns (L) (Crossley, 2005; Parsons, 1951).

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. The recovery concept has been identified as a 'polyvalent' concept (Pilgrim, 2008), or even a 'floating signifier' (Laclau & Mouffe, 1985; Weaver, 2020) whose meaning has not been fixed and which competing parties attempt to determine according to their disparate interests and agendas. Recovery may therefore have different meanings for different people because of the highly subjective, individualised nature of mental health and illness (Edgley et al., 2012). This view of psychiatry, promoted in particular by Karl Jaspers (1997), which emphasises a person's existential orientation and phenomenological experience of mental illness, is seen as the basis for person-centred, recovery-oriented care in the schools of value-based practice (Stanghellini et al., 2013) and postpsychiatry (Bracken et al, 2012; Middleton, 2007). This person-centred stance has the potential to generate multiple, competing versions of recovery, rooted in individual experiences and agendas. Along these lines, study analysis identified competing versions of recovery as a key theme in analysis of participants' talk, who promoted their own versions of recovery based on self-interested agendas. Recovery is often defined precisely in terms of it being a self-oriented and personal approach to tackling mental illness (Anthony, 1993; Davidson, 2005; Edgley et al., 2012; Repper and Perkins, 2003), and a facilitation of individual resources of social capital through empowerment and increased self-efficacy (Amering and Schmolke, 2009; Bonney and Stickley, 2008; Leamy et al., 2011; Tew et al., 2011). The variety of recovery approaches encountered in this study are rooted in the personal situations and interests of these individuals related to their particular perceptions of mental illness and its resolution. Such interpretative diversity rooted in individuals' perspectives indicates that recovery may best be understood as a rhetorical vehicle or form of moral communication (Luhmann, 1990; 2012a) for promoting the values of mental health progression, favoured by the individual or group appropriating the concept. Since this is not grounded in an authoritative approach within psychiatry but rather based on autonomous self-empowerment, recovery in this sense may be understood in the context of Luhmann's (1990) sceptical position of 'negative ethics'. Applying this position to recovery in mental health, the 'right' (or 'esteemed') approach to tackling mental illness is grounded in individual communicative instances and not in some authoritative, universalist basis for right practice imposed upon the mental health arena (Luhmann, 1990).

The potential for generation of diverse recovery approaches, rooted in individual perspectives and communicative practices, is one key basis for the formation and cultivation of a complex ontological structure of competing versions of recovery. Indeed, thematic discourse analysis elucidated a proliferation of competing versions of recovery talked about by participants. This tallies with the notion that recovery in mental health is a contested and polyvalent concept (Pilgrim, 2008), suitable

for highly individualised, deeply personal discursive appropriations and interpretations of its meaning. Recovery should therefore be centrally understood as a person-centred meaning-making activity conveying the interpretation an individual wishes to adopt for their approach to tackling mental health. This individuality is understood in a non-Cartesian sense where the subject is co-equal with communicative functionality in line with Luhmann's systems theory (Luhmann, 2012a; 2012b). In a parallel sense, Laclau and Mouffe (1985) view the individual as composed discursively. Their theory of society may be described as a kind of discursive universalism wherein everything "constituted as an object of discourse" (p.108), which has parallels with Luhmann's communicative systems theory. Such self-oriented interpretations of recovery understood according to both these schemes will be diverse, and potentially competing, understood as various attempts to fix the meaning of recovery within the ongoing discursive struggle constituting the complex mental health service system. This analysis draws on Laclau and Mouffe's (1985) view of society as an ongoing discursive struggle to fix meaning within the linguistic system between various individuals and groups (Jørgensen & Phillips, 2002). According to Cilliers (1998), this type of poststructuralist (or complex communicative) view posits discourse as an 'open' system rather than as a 'closed' system indicated 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' in an unlimited system of new significations. Cilliers (1998) proposes that this may be understood as a complex communicative system which is constantly driven towards disequilibrium by the meaning-making principle of 'différance'. Applied to participants' talk, and by implication to mental health services in Wales, underpinned by the recovery-implementation of the Mental Health (Wales) Measure, such discursive diversity surrounding recovery reveals a service landscape ontologically characterised by escalating complexity and service fragmentation. This accords with contemporary discussions on the complex and fragmented nature of contemporary mental health services in the UK (Coffey & Hannigan, 2011; Gilburt et al, 2014).

5. Complexity theory as an epistemological framework for analysis

In this section, I examine the ways in which complex systems theory may be understood as a potential development of a radical constructionist epistemology, an understanding which is more directly allied with Luhmannian social theory (1996; 2006). This opens the way for further analysis of data, findings and accompanying theoretical generalisation. The epistemological position of radical constructionism has its roots in both cybernetics and autopoietic systems (Delanty, 2005; Von Foerster, 1981; Von Foerster & Zopf, 1962), which in turn form the basis for Luhmann's systems theory. Knowledge is understood in cybernetic theory as a system which is structured as an information-processing entity (Luhmann, 1995; Wiener, 1948). To this Luhmann adds the notion of autopoiesis, or self-autonomy,

in which society is composed of independent subsystems, which reproduce themselves distinctively from their environment (Delanty, 2005; Segre, 2014). The term 'autopoiesis', from the Greek 'auto-' meaning 'self' and '-poiesis' meaning 'creation' refers to a system capable of maintaining and reproducing itself. The concept was first developed into a complex systems theory of cognitive biology by Maturana and Varela (1991).

Luhmann's application of the concept of autopoiesis drawn Maturana and Varela's (1991) cognitive biology is critical for understanding his system theory, and how it differs from earlier stable systems theories such as that of Talcott Parsons. The key difference between Parson's and Luhmann's systems theory 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 (Osterberg, 2000; Parsons 1961). In Luhmann's system, each component is a functionally differentiated autopoietic system, communicating according to its own code. A code is a guiding distinction of a system, by which it identifies itself and its relation to the world (Segre, 2014). The overriding purpose of components of the social system is therefore that of their own self-maintenance, and not to 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 may play in relation to the whole social system (Cilliers, 1998). Complexity is therefore fundamentally the result of the rich interaction of component elements that respond only to the limited information they are presented with. Osterberg (2000) sums up this state of affairs as follows:

"Generally, modern society is characterized by advanced functional differentiation: each differentiated subsystem has its function within the system as a whole, which makes the system as such highly flexible and adaptive." (p.19)

The high level of flexibility and adaptive nature of a social systems gives rise to the potential for unpredictability and disequilibrium, which are characteristic features of complex systems (Byrne, 1998; Cillers, 1998; Plesk & Greenhalgh, 2001; Rittel & Webber, 1973).

In epistemological terms, Luhmann's theory may be considered to be a type of radical constructionism under the influence of cognitive biology and cybernetics (Delanty & Strydom, 2003; Luhmann, 2006). Communication and meaning in this understanding of the social system is "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;

Mead, 1934). Knowledge is situated in the system regarded as an information-processing entity, rather than finding its source in the subjective thoughts and concepts of individual communicators (Burr, 2003; Delanty & Strydom, 2003). Cybernetic, autopoietic systems theory, as exemplified in the work of Luhmann, is a clear way of conceptualising the constructionist notion of epistemology, since it provides a model for describing the way in which structurated meaning-making as communication is prioritised over the human individual. Consequently, Luhmann's systems theory is a radical form of constructionism which asserts that structurated and systemic "meaning is constitutive of the subject rather than the other way round" (Holub, 1991, p.109).

Analysis of competing self-management-oriented recovery versions and misaligned expectations of services can be developed further by shifting from an ontological to an epistemological theoretical framework along these lines. Talk related to experiences of self-managed recovery after discharge to primary care, in line with implementation of the Measure, is analysed in the accounts of (*n = 2*) participants, revealing discontinuities of care concentrated in this service area. This type of analysis led to the construction of the theme 'Experienced care discontinuities concentrated at the level of primary mental healthcare', which articulates the presence of discontinuities of care in participants' experiences of services. This analysis also indicates one type of self-oriented recovery version at the primary level. I considered this recovery version to be a fairly colonized type of recovery (or neorecovery) since it is situated conceptually within the narrow interpretation of the recovery approach under the Measure, aimed at reducing specialist service dependency and increasing the focus on primary mental healthcare delivery. Competing with this are other less colonized self-management versions of recovery, such as the one provided by one participant, Dylan, which is more rooted in an emancipatory critique of services and the service user's lived experience (Anthony, 1993; Deegan, 1988; Pilgrim & McCranie, 2013). Supporting these elements of the theme 'Competing versions of recovery', notions of autonomy, self-management, empowerment and emancipation are found throughout the theoretical literature on recovery (Amering & Schmolke, 2009; Bonney & Stickley, 2008; Keetharuth et al., 2018; Leamy et al., 2011; Slade, 2009), and in policy frameworks for recovery (Department of Health and Human Sciences, 2003; DoH, 1999; DoH, 2009; Gilburt, 2013). The latter recovery versions, however, are arguably more colonized by a neoliberalist agenda (Becker et al., 2010; Mind, 2008; Recovery in the Bin, 2019). A self-management version of recovery is promoted in the literature surrounding the implementation of the Measure which seeks to maximise the independence of the service user after discharge from specialist care (Welsh Government, 2010b; 2011; 2014).

These various forms of recovery, exhibiting varying degrees of colonization, may be fitted into Luhmann's complex systems theory of epistemology. Indeed, Luhmannian epistemology can be put forward as a theory to encompass the systems-effects of autonomy-promoting versions of recovery, and the way in which they can contribute to service complexity. In promoting a greater level of autonomy and self-sufficiency for individuals managing their mental health conditions, self-oriented recovery versions engender a higher amount of information to be inputted into autonomous, autopoietic subsystems or components, representing service users. As has already been mentioned, in a system which is functionally differentiated, introducing a greater level of autonomy for independent subunits has the potential for constructing higher complexity in a social system. In cybernetic terms, an imbalance has been created in the information levels between the subunit and its systems environment. Since subunits are ignorant of the function they may play in relation to the whole social system, this imbalance may have a dynamic effect whereby increased complexity and disequilibrium is amplified throughout the entire social system of mental health services (Hooker, 2011). The equalisation of complexity between the subsystem and its environment, requisite for the construction of recovery knowledge, will occur through an increase in the complexity of the mental health service system, since greater complexity is being inputted into the domain of the autonomised individual. Creating a more person-centred approach to mental health, based on a self-management recovery ethos which is either neoliberalist or emancipatory (top-down neorecovery or bottom-up grassroots recovery), has the potential therefore to generate increased, systems-wide complexity, when service systems are understood according to a Luhmannian constructionist epistemology. The application of an epistemological understanding of Luhmann's complex systems theory to data analysis in this way provides a theoretical basis for understanding self-management versions of recovery and their complexity-inducing impact on the service system. Since this is a complex systems theory, it also provides an appropriate theoretical context for explaining how a stimulus for recovery approaches such as the Mental Health (Wales) Measure can escalate complexity within a cybernetically understood system.

The critical point to grasp is that actual versions of recovery are generated within the subjectively-oriented lifeworld of service users and workers. An additional argument may be made that misaligned expectations are actually just another example of a recovery version generated in response to implementation of the Mental Health (Wales) Measure 2010. The increased recovery-oriented self-sufficiency stimulated by the Measure actually encourages greater autonomy amongst individuals and consequently greater resistance to changing service behaviour, in terms of what they think is the right approach to recover. This can be considered to be a specific instance of autopoiesis generating complexity in a differentiated system. The key point is that it is the impact of the Measure in

stimulating a greater orientation towards recovery amongst groups and individuals which generates a more complex and disjointed system, for instance in the case of misaligned expectations about the new behaviour of services, and more widely with regard to a proliferation of competing recovery versions. I argue that this diversity of competing recovery versions has the capacity to introduce divergent care trajectories (Hannigan & Allen, 2013) involving greater informational input into autonomous, autopoietic components, representing service users. Consequently, the impetus towards increasingly recovery-based services under the Measure involves the introduction of greater informational complexity into the service system, resulting in increased services fragmentation and discontinuities of care. The counter-argument could be proposed that not all recovery versions and ensuing care trajectories would necessarily be competing and that there could, for instance, be complementary versions, parallel or closely aligned versions. However, the weight of the evidence presented in data analysis and constructing the key theme 'Experienced care discontinuities concentrated at the level of primary mental healthcare' strongly implies the absence of such cohesion and the presence of disharmony between recovery versions.

Furthermore, the Mental Health (Wales) Measure may be considered to be a dual-pronged implementation of recovery giving rise to an underlying structural dichotomy of two key recovery versions. As is described above, 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, 2010a; 2013; 2014), which may be classed as a type of neorecovery. On the other hand, Part 2 of the Measure emphasises self-management and co-production in collaboration with a care coordinator, involving an holistic recovery approach (Welsh Government, 2010b; 2014; 2015) under the eight areas of the Care and Treatment Plan[5] (Hafal, 2012; Welsh Government, 2015; 2016), which is closer in character to grassroots recovery. This dual-pronged nature of the Measure's recovery implementation potentially accentuates the 'gap' between primary and secondary levels which would be felt keenly by individuals once they have been discharged to primary care, or if attempting re-referral back to specialist services. This service gap then becomes a care pathway boundary and point of care discontinuity which service users have to face, and this was talked about by participants emerging in analysis as a contributor to the theme, 'Experienced care discontinuities concentrated at the level of primary mental healthcare'. It is also the

[5] The Care and Treatment Plan (CTP) is a national template in Wales for a care plan which under the Mental Health (Wales) Measure 2010 is a mandatory requirement for coordination and planning of care for people within secondary services. The template is divided up into eight areas which are accommodation; finances; spiritual/cultural/social activities; work and occupation; medical and other treatments including psychological therapies; parenting and caring relationships; education and training; and personal care and physical wellbeing.

point at which the complex effect of misaligned expectations occurs since participants struggle to cope with the shift to primary-level care which is the stated aim of the Mental Health (Wales) Measure (Welsh Government, 2010b, p.42; 2013, p.11; 2014, p.15).

In sum, 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; Gilburt et al., 2014). Thematic discourse analysis and theoretical generalisation laid out in previous sections has identified concentrations of meaning-making or knowledge-constructing activity and recovery trajectories as the key conduits for escalating complexity. This meaning-making activity, which surrounds appropriation of the concept of recovery, promotes a higher amount of autonomy for autopoietic subsystems or components, contributing to functional differentiation and escalating complexity within the mental health service system. This may lead to a proliferation of competing versions of recovery, which has the potential to contribute to escalating complexity, service fragmentation and discontinuities in mental healthcare and service user experiences.

6. Consideration of Habermas' historico-hermeneutic perspective

The overall theoretical perspective which has been built in this paper may be expanded yet further by examining Jürgen Habermas' critique of Niklas Luhmann's complexity theory (Luhmann & Habermas, 1971; Holub, 1991) which emerges from the debate between these two scholars in *'Theorie der Gesellschaft oder Sozialtechnologie: Was leistet die Systemforschung?'* (Luhmann & Habermas, 1971). Consideration of Habermas' philosophical position contrasting strategic and communicative action, or system versus lifeworld (1984a; 1984b), enables the incorporation of a critical sociological perspective which was expounded by Habermas (Craib, 1992; Hanssen, 2014; Kincheloe & McClaren, 1994; Layder, 2005). Whilst Luhmann's complexity theory can be seen as an appropriate theoretical framework within which to comprehend and describe service experiences of participants in the context of escalating service system complexity, Habermas' critical perspective throws into sharp relief the need to attain a supplemental theoretical dimension, in order to better elucidate the central issues concerning recovery and care continuity highlighted by study analysis. Indeed, issues of colonized, competing versions of recovery and service fragmentation can best be understood in the light of Habermas' requirement for an additional historico-hermeneutic dimension, rooted in human agency and the lifeworld (Schutz & Luckmann, 1974), which he argues is lacking in complexity theory and functional systems theory (Habermas 1984a; Habermas 1984b; Holub, 1991; Luhmann & Habermas,

197). This does not necessarily mean a return to essentialist subjectivism, which Luhmann is keen to avoid (Luhmann, 1994), if Habermas's position is interpreted as articulating a weak rather than a strong view of the lifeworld. This weak view is influenced by a Schutzian perspective on the lifeworld which focuses on intersubjectivity, as opposed to the strong view which traces its roots to Gadamer and Heidegger where the lifeworld's pre-subjective character is more heavily emphasised (Dallmayr, 1981). Introduction of the historico-hermeneutic dimension through Habermas' critical social theory and an intersubjective conception of the lifeworld, opens the door to grounding the recovery concept in the lived experience of service users, whilst avoiding subjective essentialism, yet nevertheless returning it to its roots at the grassroots level of the service user, and their interest in movements of protest, emancipation and critique of medicalised, even oppressive psychiatric services (Bracken et al., 2012; Conrad, 1992; Conrad, 2008; Edgley et al., 2012; Ingleby, 2006; Middleton, 2007; Pilgrim & McCranie, 2013). Colonized versions of recovery, such as neorecovery, can be seen in this light to conflict with person-centred, emancipatory recovery approaches founded upon the principles of values-based practice (Fulford, 2004; Fulford, 2008; Fulford, 2013; Stanghellini et al., 2013; Sullivan, 2003). Complexity theory therefore becomes not just a way of describing service behaviour but also of embodying the complexity-escalating and fragmentary effects of manifold versions of recovery or neorecovery (Habermas 1984a; Ingleby, 2006; Middleton, 2007). The prevalence of such complexity across Welsh mental health services raises the question of how best to navigate a complex landscape of care trajectories (Hannigan & Allen, 2013; Strauss, 1985) based on competing versions of recovery, and how to find common ground to facilitate collaboration between primary and secondary levels or with the third sector. My argument is therefore that the critical theory of Habermas is one way to steer a pathway through a "plethora of complex pathways" (Gilburt et al., 2014, p.13) of recovery approaches, by grounding the approach in the lived experience of service users and the lifeworld (Schutz & Luckmann, 1974). In so doing, employing a critical theoretical approach is intended to provide guidance for navigating and coordinating a complex landscape of care trajectories, and elucidating underlying value-based principles (Fulford, 2004; Fulford, 2008) to establish common ground for collaboration and recovery.

This added dimension enables the recovery concept to be grounded in the lived experience of services users, reconnecting it with the original radical, emancipatory idea of recovery based on an agenda of liberation from potentially coercive and iatrogenic psychiatric services (Edgley et al., 2012; O'Keeffe et al., 2018; Pilgrim 2008; Pilgrim and McCranie, 2013; Repper and Perkins, 2003; Tew et al., 2011). This also affords a basis for shielding the notion of recovery from the distortive effects of colonization, particularly in the form of neorecovery. Colonization of grassroots recovery in the form of neorecovery is arguably a contributory factor for escalating complexity. The systemic sphere, according to

Habermas (1984a; 1984b), refers to those areas of life that have become so complex and specialised that they have become uncoupled from the hermeneutic site of symbolic, intersubjective interaction within the lifeworld. With recovery, the systemic reification of recovery leads to colonization of the lifeworld by system elements that lead to distorting and complexity-generating repercussions for the wider social system. Colonization therefore overloads the lifeworld with system elements that have a distorting and complexity-generating effect on social practice and discourse (Layder, 2005). This can be seen as a further instance of inputting into autopoietic subsystems, as individuals have forms of neorecovery increasingly imposed upon them, with consequent ramifications for escalating systemic complexity[6]. The impact of the Mental Health (Wales) Measure as top-down or neorecovery can therefore be seen as a catalyst for escalating complexity in a way which accompanies its effect of stimulating diverse and competing, person-centred versions of recovery at the grassroots level. This provides an explanation, compatible with Luhmannian theory, of how colonization and systematic distortion of an emancipatory form of moral communication, producing neorecovery, may be a further factor for escalating complexity.

7 Conclusion

In this discussion paper, I have applied Luhmann's complex systems analysis both ontologically and epistemologically to indicate how person-centred, self-management-oriented versions of recovery may generate escalating complexity within the service system landscape, which is accompanied by discontinuities of care. This constitutes an application of a reflective, as opposed to a universalist, theory of morality, after Luhmann. I have added to this Habermas' perspective on systemic colonization of the lifeworld to inform the notion of neorecovery. This provides a further explanation for escalating complexity due to the distortive and fragmentary effects of the systemic sphere as it intrudes into the domain of the lifeworld. The Mental Health (Wales) Measure 2010 can therefore be seen as a factor for increased service complexity, because it attempts to stimulate greater orientation towards recovery-based services, which may be grassroots or top-down, both of which may be complexity-inducing. Furthermore, it has been argued that both types of recovery are implemented

[6] A narrow and reductionistic version of recovery represented by neorecovery may appear on the face of it to be simpler for the individual and therefore not complexity inducing. However, the implication of reductionist neorecovery for the wider service system is that of complexity escalation since, as study analysis has shown, the fragmentary effect this has on care continuity experiences leads to a plethora of complex care pathways. The imposition of a simplistic form of recovery therefore has the capacity to induce a further proliferation of recovery versions, for instance in the case of misaligned expectations of services. A similar effect is seen with the colonization of the lifeworld by the free market or by bureaucracy, both of which are reductionistic for the lifeworld and yet engender global or national structures which are spectacularly complex (Habermas, 1984a; 1984b).

by Part 1 and Part 2 of the Measure at the primary and secondary levels respectively, and this may engender a key structural dichotomy or 'gap' at this point of interface, whether experienced as discharge to the GP or re-referral back to secondary services. Services characterised in this way by increased complexity and fragmentation may lead to a greater level of care discontinuities and barriers to collaboration, which were also central features in analysis of participants' talk, leading to generation of the theme, 'Experienced care discontinuities concentrated at the level of primary mental healthcare'. Since care continuity is a cornerstone of positive care delivery (Biringer et al., 2017; Weaver et al., 2017), escalating complexity stemming from increased diversity of recovery implementation and appropriation can be seen as a detrimental force within contemporary services.

This runs counter to the prevailing view of recovery as a broadly beneficent notion within mental health care and services, where appropriation and application of the concept in any form, no matter how imprecise or insincere, is viewed as a necessarily positive initiative. However, I would argue that this is not necessarily the case, especially when the impact of recovery implementation is considered at a service-wide level. Analysis and theory developed in this paper indicate that a haphazard and imprecise implementation or appropriation of recovery can act as a key catalyst for escalating service complexity, fragmentation and care discontinuity. On this basis, recovery should not be considered, as it often is, as a panacea or magic bullet for tackling all the challenges of delivering effective mental health services. Recovery must be implemented with care, giving room for the paradigm to develop organically from within the historico-hermeneutic and intersubjective dimension of service users' lived experience. This may provide an anchor point from which to stymie escalating complexity, and also to successfully navigate existing complexity. One potential way in which this more considered implementation might be achieved would be to balance top-down and bottom-up versions of recovery within services, since this paper has shown how polarisation towards either side of this dichotomy has the potential to generate escalating complexity and fragmentation in services. Luhmann (1990) points out that a key problem with moral communication is its tendency towards polarisation which in this case can be seen to have a detrimental effect of escalating complexity and service fragmentation. Policy which therefore seeks to optimise recovery-oriented service delivery should therefore seek to strike a balance between the distortive and constricting effects of dominant neorecovery on the one hand, and an escalating proliferation of self-oriented, bottom-up recovery versions on the other. This reflects Habermas' acceptance that a certain level of systematisation is irreversible and not inherently negative since the viability of modern society depends on it. As Chouliaraki and Fairclough (1999) summarise, "If societies had to constantly reach consensus over everything through argumentation, they could not function" (p.85). Such an accommodation of the systemic sphere also preserves Luhmann's stipulation that communicative systems rather than individual subjects are the basis for

society, which is also congruent with the weaker, Schutzian sense of the lifeworld as intersubjectivity being adopted in this paper. This balance would create conditions for optimal levels of recovery diversity whilst at the same time limiting potentially damaging complexity and fragmentation, and the sort of misaligned expectations of services expressed in the talk of participants. This 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 for the social system within which recovery versions could be constructed by service users and groups. These optimal cultural or communicative conditions would set the right systemic environment within which to encourage the ongoing process of grassroots recovery-construction and associated expectations, without overstimulating subsystems to produce a proliferation of recovery versions. In this way, top-down neorecovery is not used so much as a driver for recovery-based services but as a set of delimiting parameters within which more authentic and emancipatory versions of recovery, rooted in the lifeworld of people with mental health problems, are given room to thrive. This therefore is not neorecovery as an end in itself and as a programme for fiscal stringency, as is so often the case with policy implementations. Rather, it is a consciously constrained implementation of neorecovery as a means to an end of providing the best context for flourishing recovery-based services, where grassroots recovery initiatives are well-resourced.

References

Amering, M., & Schmolke, M. (2009). *Recovery in mental health: reshaping scientific and clinical responsibilities* (Vol. 7). John Wiley & Sons.

Anthony, W. A. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11.

Becker, E., Hayllay, O. & Wood, M. (2010) *Pathways to Work: programme engagement and work patterns*. London: Department for Work and Pensions.

Berger, P. L., & Luckmann, T. (1991). *The social construction of reality: A treatise in the sociology of knowledge*. London: Penguin.

Biringer, E., Hartveit, M., Sundfør, B., Ruud, T. & Borg, M. (2017). Continuity of care as experienced by mental health service users - a qualitative study. *BMC Health Services Research, 17*(1), 763. doi: http://dx.doi.org/10.1186/s12913-017-2719-9

Blumer, H. (1986). *Symbolic interactionism: Perspective and method*. University of California Press.

Bonney, S., & Stickley, T. (2008). Recovery and mental health: a review of the British literature. *Journal of psychiatric and mental health nursing*, 15(2), 140-153.

Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C., Bhunnoo, S., Browne, I., Chhina, N., Double, D. & Downer, S. (2012). Psychiatry beyond the current paradigm. *The British Journal of Psychiatry, 201*(6), 430-434.

Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi: http://dx.doi.org/10.1191/1478088706qp063oa

Braslow, J. T. (2013). The manufacture of recovery. *Annual review of clinical psychology, 9*, 781-809. doi: http://dx.doi.org/10.1146/annurev-clinpsy-050212-185642

Burns, T., Catty, J., White, S., Clement, S., Ellis, G., Jones, I. R., Lissouba, P., McLaren, S., Rose, D. & Wykes, T. (2009). Continuity of care in mental health: understanding and measuring a complex phenomenon. *Psychological Medicine*, *39*(2), 313-323.

Burr, V. (2003). *Social constructionism* (2nd ed.). London: Routledge.

Byrne, D. (1998). *Complexity theory and the social sciences: An introduction*. London: Routledge.

Chouliaraki, L. and Fairclough, N. (1999). *Discourse in late modernity: Rethinking critical discourse analysis*. Edinburgh University Press.

Cilliers, P. (1998). *Complexity and postmodernism*. London: Routledge.

Conrad, P. (1992). Medicalization and social control. *Annual review of sociology, 18*(1), 209-232.

Conrad, P. (2007). *The medicalization of society: On the transformation of human conditions into treatable disorders*. JHU Press.

Craib, I. (1992). *Modern social theory: from Parsons to Habermas* (2nd ed.). Edinburgh: Pearson Education.

Crawford, M. J., de Jonge, E., Freeman, G. K. & Weaver, T. (2004). Providing continuity of care for people with severe mental illness- a narrative review. *Social Psychiatry and Psychiatric Epidemiology, 39*(4), 265-272. doi: http://dx.doi.org/10.1007/s00127-004-0732-x

Crossley, N. (2005). *Key concepts in critical social theory*. London: SAGE.

Curtis A. (2007). *The Trap*. BBC TV Documentary Series.

Dallmayr, F. (1981). *The twilight of subjectivity: contributions to a post-individualist theory of politics*. Amherst: University of Massachusetts Press.

Davidson, L. (2005). Recovery, self management and the expert patient: Changing the culture of mental health from a UK perspective. *Journal of Mental Health, 14*(1), 25-35.

Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*(4), 11.

Delanty, G. (2005). *Social science: philosophical and methodological foundations* (2nd ed.). Maidenhead: Open University Press.

Delanty, G., & Strydom, P. (Eds.). (2003). *Philosophies of social science: The classic and contemporary readings*. Maidenhead: McGraw-Hill.

Department of Health and Human Sciences. (2003). *Achieving the promise: Transforming mental healthcare in America, President's new freedom commission on mental health*. Rockville, MD: Department of Health and Human Sciences.

Derrida, J. (1976). *Of Grammatology*. Baltimore: Johns Hopkins University Press.

Derrida, J. (1978). *Writing and Difference*. Chicago: University of Chicago Press.

DoH: Department of Health (1999). A national service framework for mental health. London: Department of Health.

DoH: Department of Health. (2009) *New Horizons*. London: Department of Health.

Double, D. B. (2006). Critical psychiatry: Challenging the biomedical dominance of psychiatry. In D. B. Double (Ed.), *Critical psychiatry: the limits of madness* (pp. 3-15). New York: Palgrave Macmillan.

Double, D. B. (2009). Critical psychiatry seeks to avoid the polarisation engendered by anti-psychiatry. *Psychiatric Bulletin, 33*(10), 395-397.

Durbin, J., Goering, P., Streiner, D. L., & Pink, G. (2004). Continuity of care: Validation of a new self-report measure for individuals using mental health services. *Journal of Behavioral Health Services & Research, 31*(3), 279-296.

Edgley, A., Stickley, T., Wright, N., & Repper, J. (2012). The politics of recovery in mental health: A left libertarian policy analysis. *Social Theory & Health, 10*(2), 121.

Edwards, D. and Potter, J. (1992). *Discursive psychology*. London: SAGE.

Epstein, M. (2011). Introduction to the Philosophy of Science. In C. Seale (Ed.), *Researching society and culture* (pp. 7-28). London: SAGE.

Fairclough, N. (2003). *Analysing discourse: Textual analysis for social research*. London: Routledge.

Forrester J. (1968). *Principles of Systems*. Cambridge: Pegasus Communications.

Fulford, B. (2004). Facts/Values - Ten Principles of Values-based medicine. In J. Radden (Ed.), *The philosophy of psychiatry a companion* (pp. 205-350). New York: Oxford University Press.

Fulford, K. W. M. (2008). Values-Based Practice: A New Partner to Evidence-Based Practice and A First for Psychiatry? *Mens Sana Monographs, 6*(1), 10-21.

Fulford, K. W. M. (2013). Values-based practice: Fulford's dangerous idea. *Journal of Evaluation in Clinical Practice, 19*(3), 537-547.

Gilburt, H. (2013). Promoting recovery-oriented practice in mental health services: A quasi-experimental mixed-methods study. *BMC Psychiatry*, 13.

Gilburt, H., Peck, E., Ashton, B., Edwards, N. & Naylor, C. (2014) *Service transformation: Lessons from mental health*. London: The Kings Fund.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 163-194). London: Sage.

Habermas, J. (1984a). *The theory of communicative action: Vol. 1. Reason and the rationalization of society*, trans. T. McCarthy. Boston: Beacon Press.

Habermas, J. (1984b). *The theory of communicative action: Vol. 2. Lifeworld and system: a critique of functionalist reason*, trans. T. McCarthy. Boston: Beacon Press.

Hafal (2012). *Hafal - CTP and recovery promotional leaflet*, viewed 10 July 2018, http://www.hafal.org/pdf/publications/My%20recovery.pdf

Hannigan, B., & Coffey, M. (2011). Where the wicked problems are: the case of mental health. *Health policy, 101*(3), 220-227.

Hannigan, B. and Allen, D. (2013). Complex caring trajectories in community mental health: contingencies, divisions of labour and care coordination. *Community Mental Health Journal, 49*(4), 380-388. doi: http://dx.doi.org/10.1016/S0277-9536(02)00375-1

Hannigan, B., Simpson, A., Coffey, M., Barlow, S. & Jones, A. (2018). Care coordination as imagined, care coordination as done: findings from a cross-national mental health systems study. *International Journal of Integrated Care, 18*(3).

Hanssen, B. (2014). *Critique of violence: between poststructuralism and critical theory*. London: Routledge.

Harvey, D. (2005). *A brief history of neoliberalism*. Oxford University Press.

Holub, R. C. (1991). *Jurgen Habermas: Critic in the public sphere*. London: Routledge.

Hooker, C. (2011). 'Introduction to philosophy of complex systems: A: Part A: Towards a framework for complex systems' in C. Hooker (ed.), *Vol. 10: Philosophy of complex systems* (pp.3-90). North-Holland. Boston: Elsevier/Academic.

Ingleby, D. (2006). Transcultural mental health care: The challenge to positivist psychiatry. In D. B. Double (Ed.), *Critical psychiatry: the limits of madness* (pp. 61-78). New York: Palgrave Macmillan.

Jaspers K. (1997 [1913]). *General Psychopathology*, trans. J. Hoenig and M. W. Hamilton. Baltimore, MD: Johns Hopkins University.

Jørgensen, M. W. and Phillips, L. J. (2002). *Discourse analysis as theory and method.* London: SAGE.

Keetharuth, A. D., Brazier, J., Connell, J., Bjorner, J. B., Carlton, J., Buck, E. T., . . . Croudace, T. (2018). Recovering Quality of Life (ReQoL): a new generic self-reported outcome measure for use with people experiencing mental health difficulties. *The British Journal of Psychiatry, 212*(1), 42-49.

Kincheloe, J. L., & McLaren, P. L. (1994). Rethinking critical theory and qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 138-157). London: Sage.

Laclau, E., & Mouffe, C. (1985). Hegemony and socialist strategy. London: Verso.

Layder, D. (2005). *Modern social theory: Key debates and new directions.* London: Routledge.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry, 199*(6), 445-452.

Lester, H. and Gask, L. (2006). Delivering medical care for patients with serious mental illness or promoting a collaborative model of recovery? *British Journal of Psychiatry, 188*, 401-402.

Luhmann, N. (1990). *Paradigm lost: Über die ethische Reflexion der Moral: Rede anläßlich der Verleihung des Hegel-Preises*, 1989. Frankfurt/Main: Suhrkamp. (English translation: 1988. *Paradigm lost: on the ethical reflection of morality. Speech on the Occasion of the Award of the Hegel Prize*, trans. D. Roberts. *Thesis Eleven 29*:82-94.)

Luhmann, N. (1994). 'How can the mind participate in communication' in *Materialities of communication*, H. U. Gumbrecht and K. L. Pfeiffer (eds.) (pp.371-387), trans. W. Whobrey. Stanford University Press.

Luhmann, N. (1995). *Social systems*. Stanford University Press.

Luhmann, N. (1996). On the scientific context of the concept of communication. *Social Science Information, 35*(2), 257-267.

Luhmann, N. (2006). 'Cognition as construction' in H. Moeller, *Luhmann explained: from souls to systems*. Chicago and La Salle, IL: Open Court.

Luhmann, N. (2012a). *Theory of Society, Volume 1*. Stanford University Press.

Luhmann, N. (2012b). *Theory of Society, Volume 2*. Stanford University Press.

Luhmann, N. & Habermas, J. (1971). *Theorie der Gesellschaft oder Sozialtechnologie: Was leistet die Systemforschung?* Frankfurt/Main: Suhrkamp.

Maturana, H. R., & Varela, F. J. (1991). *Autopoiesis and cognition: The realization of the living* (Vol. 42). Springer Science & Business Media.

McCarthy, T. (1984). 'Translator's introduction' in J. Habermas, *The theory of communicative action: Vol. 1. Reason and the rationalization of society* (pp.vii-XXXiX). Boston: Beacon Press.

McClelland, K., and Thomas J. (2006). *Purpose, meaning, and action: control systems theories in sociology* (Eds.). New York: Palgrave Macmillan.

McKeown, M., Wright, K. & Mercer, D. (2017). Care planning: a neoliberal three card trick. *Journal of Psychiatric and Mental Health Nursing, 24*(6), 451-460.

Mead, G. H. (1934). *Mind, Self and Society*. Chicago University Press.

Middleton, H. (2007). Critical Psychiatry. *Mental Health Review Journal, 12*(2), 40-44.

Mind. (2008). *Life and times of a supermodel. The recovery paradigm for mental health. MindThink report 3*, viewed 12 September 2018, https://www.bl.uk/britishlibrary/~/media/bl/global/social-welfare/pdfs/non-secure/l/i/f/life-and-times-of-a-supermodel-the-recovery-paradigm-for-mental-health-001.pdf

Mitchell, J. C. (1983). Case and situation analysis. *The sociological review, 31*(2), 187-211.

Morrow, M. (2013). 'Recovery: Progressive paradigm or neoliberal smokescreen?' in B. A. LeFrancois, R. Menzies & G. Reaume (eds.), *Mad matters: a critical reader in Canadian mad studies* (pp.323-333). Toronto: Canadian Scholars' Press.

O'Keeffe, D., Sheridan, A., Kelly, A., Doyle, R., Madigan, K., Lawlor, E. & Clarke, M. (2018). 'Recovery'in the real world: service user experiences of mental health service use and recommendations for change 20 years on from a first episode psychosis. *Administration and Policy in Mental Health and Mental Health Services Research*, *45*(4), 635-648.

Osterberg, D. (2000). Luhman's general sociology. *Acta Sociologica, 43*, 15-25.

Parsons, T. (1951a). *The Social System*. Glencoe, IL: Free Press.

Parsons, T. (1961). *An Outline of the Social System*. University of Puerto Rico, Department of Social Sciences.

Pilgrim, D. (2008). Recovery and current mental health policy. *Chronic illness, 4*(4), 295-304.

Pilgrim, D., & McCranie, A. (2013). *Recovery and mental health: A critical sociological account*. New York: Palgrave Macmillan.

Plsek, P. E., & Greenhalgh, T. (2001). The challenge of complexity in health care. *British Medical Journal, 323*(7313), 625.

Puntis, S., Rugkasa, J., Forrest, A., Mitchell, A. & Burns, T. (2014). Associations between continuity of care and patient outcomes in mental health care: a systematic review. *Psychiatric Services, 66*(4), 354-363. doi: http://dx.doi.org/10.1176/appi.ps.201400178

Ramanuj, P. P., Carvalho, C. F., Harland, R., Garety, P. A., Craig, T. K. & Byrne, N. (2015). Acute mental health service use by patients with severe mental illness after discharge to primary care in South London. *Journal of Mental Health, 24*(4), 208-213.

Recovery in the Bin. (2019). *Neorecovery: a survivor led conceptualisation and critique*. In *Proceedings of the International Mental Health Nursing Research Conference*. RCN Headquarters, London.

Repper, J. and Perkins, R. (2003). *Social inclusion and recovery: a model for mental health practice*. London: Elsevier Limited.

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2013). *Qualitative research practice: A guide for social science students and researchers*. London: SAGE.

Rittel, H., & Webber, M. (1973). Dilemmas in a general theory of planning. *Policy Sciences, 4*(2), 155-169.

SAMHSA: National Consensus Conference on Mental Health Recovery & Mental Health Systems Transformation. (2004). *National Consensus Statement on Mental Health Recovery*. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Saussure, F. (1974). *Course in General Linguistics*. London: Fontana.

Schutz, A. and Luckmann, T. (1974). *The structures of the lifeworld*, trans. R. M. Zaner and H. T. Engelhardt Jr. London: Heinemann.

Scruton, R. (1994). *Modern philosophy: a survey*. London: Sinclair-Stevenson.

Segre, S. (2014). *Contemporary sociological thinkers and theories*. Farnham: Ashgate Publishing.

Singer, D. and Hunter, M. (1999). The experience of premature menopause: a thematic discourse analysis. *Journal of Reproductive and Infant Psychology, 17*, 63-81.

Slade, M. (2009). *Personal recovery and mental illness: A guide for mental health professionals*. Cambridge University Press.

Stanghellini, G., Bolton, D. & Fulford, W. K. (2013). Person-centred psychopathology of schizophrenia: building on Karl Jaspers' understanding of patient's attitude toward his illness. *Schizophrenia Bulletin, 39*(2), 287-294. doi: http://dx.doi.org/10.1093/schbul/sbs154

Strauss, A. L. (1985). *Social organization of medical work*. London, IL: University of Chicago Press.

Sullivan, M. (2003). The new subjective medicine: taking the patient's point of view on health care and health. *Social Science & Medicine, 56*, 1595-1604.

Sweeney, A., Rose, D., Clement, S., Jichi, F., Jones, I. R., Burns, T., Catty, J., Mclaren, S. & Wykes, T. (2012). Understanding service user-defined continuity of care and its relationship to health and social measures: a cross-sectional study. *BMC Health Services Research*, *12*(1), 145.

Szasz, T. S. (1974). *The myth of mental illness: foundations of a theory of personal conduct* (rev. ed.). London: Harper & Row.

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J. & Le Boutillier, C. (2011). Social Factors and Recovery from Mental Health Difficulties: A Review of the Evidence. *British Journal of Social Work 42*(3), 443-460.

Von Foerster, H., 1981. *Observing systems, the systems inquiry series*. Salina, CA: Intersystems Publications.

Von Foerster, H. & Zopf, G.W. (1962). Principles of self-organization, In *University of Illinois Symposium on Self-Organization (1961: Robert Allerton Park)*. New York: Pergamon Press.

Wagner, G. (1997). The end of Luhmann's social systems theory. *Philosophy of the social sciences, 27*(4), 387-409.

Walby, S. (2007). Complexity Theory, Systems Theory, and Multiple Intersecting Social Inequalities. *Philosophy of the social sciences, 37*(4), 449.

Weaver, N., Coffey, M. & Hewitt, J. (2017). Concepts, models and measurement of continuity of care in mental health services: A systematic appraisal of the literature. *Journal of Psychiatric and Mental Health Nursing, 24*(6), 431-450.

Weaver, N. (2020). *Experiences of care continuity and recovery for people at the interface of primary and secondary mental health care in Wales: a thematic discourse analytic approach.* Doctoral thesis, Swansea University. http://cronfa.swan.ac.uk/Record/cronfa53686

Welsh Government (2010a). *Mental Health (Wales) Measure 2010*. Cardiff: Welsh Government.

Welsh Government (2010b). *Explanatory memorandum incorporating the regulatory impact assessment, explanatory notes and delegated powers memorandum*. Cardiff: Welsh Government.

Welsh Government (2011). *Implementing the Mental Health (Wales) Measure 2010: Guidance for Local Health Boards and Local Authorities*. Cardiff: Welsh Government.

Welsh Government (2013). *The duty to review inception report: post-legislative assessment of the Mental Health (Wales) Measure 2010*. Cardiff: Welsh Government.

Welsh Government (2014). *The Duty to Review Interim Report: Post-Legislative Assessment of the Mental Health (Wales) Measure 2010*. Cardiff: Welsh Government.

Welsh Government (2015). *The duty to review final report: post-legislative assessment of the Mental Health (Wales) Measure 2010*. Cardiff: Welsh Government.

Welsh Government (2016). *Research to support the duty to review the implementation of the Mental Health (Wales) Measure 2010 - Part 2: Coordination of and Care and Treatment Planning for Secondary Mental Health Users*. Cardiff: Welsh Government.

WHO: World Health Organisation (2014). *Social determinants of mental health*. Helsinki: World Health Organization.

Wiener, N. (1948). *Cybernetics: Or Control and Communication in the Animal and the Machine*. Cambridge, Massachusetts: MIT Press.

Woods, A., Hart, A. & Spandler, H. (2019). The recovery narrative: politics and possibilities of a genre. *Culture, Medicine, and Psychiatry*, 1-27.