Co-creating a Path to Recovery in Mental Health Processes

A reflection on mental health recovery

Perth 2014 - 2015

This paper is a collaboration between
Michael Williams – A client referred to Partners in Recovery
Ariane Thirion – Support facilitator at Partners in Recovery
Neil Sullivan – Psychotherapist in Community Programs, PdPP

Co-creating a Path to Recovery in Mental Health Processes

A shared experience between Michael Williams – referee to Partners in Recovery, Ariane Thirion – Support Facilitator at Partners in Recovery and Neil Sullivan – Psychotherapist with the Community Programs of Psychoanalytic/dynamic Practitioners of Perth (PdPP).

Time: 2014 – 2016 Place: Perth Western Australia.

The idea of this writing was to document and reflect upon eighteen months over which Partners in Recovery WA organised a Needs-Adapted Plan for Michael Williams which would assist him in his recovery process toward attaining his goal of being a support worker in Mental Health. Along with this reflection we wanted to correlate our experience with the Finnish Open Dialogue approach to treating mental health, to see how it might influence and further our desires to attain the best solutions for people and families in need.

* * *

On the 20th of November 2015, I received an email from Ariane – sent to Michael and me:

> *"Michael and I have met this morning. The VERY GOOD NEWS is that Michael has been offered a job at UnitingCare West as a Support Worker, from 30th November. Congratulations Michael….your persistence and commitment have led you to this new door step…."*

History

Some events leading to this started in May 2014 when Michael was referred to the Partners in Recovery program in which Ariane was to be his Support Facilitator. Michael was thirty-three years old at the time. His social history is important:

Michael struggled socially and academically in primary school, with friends, with speaking in front of the class, and in high school with shared presentations. He feigned sickness in order to stay home when any of the difficult activities were known beforehand. This was despite the three years of speech therapy he received when he was young; "they told my parents that I had to go to a special school. It didn't really help much and also I got picked on a lot because I went to that school." He was bullied, beaten-up weekly, had his lunch stolen, but didn't disclose these events to his parents.

> *"The reasons why I didn't talk to my parents about what was happening was because I thought that they might not believe me because the Principal of school didn't believe me at the time. Also I didn't want them to worry about it because we were having issues within the family at the time." (Michael, Draft notes)*

Michael left school in year 10 and became involved with drugs and alcohol. He started an apprenticeship in welding for 6 months, but this working life plan was disrupted by being adversely affected by his own self-medication.

He called himself a "yes-man", and said it was this feeling that was stopping him from being able to take more control over his life and the aspects of it he wanted to change. He had auditory hallucinations – ones that were critical and demeaning, contributing to feelings of shame, embarrassment, to distraction and lack of confidence.

His deteriorating condition motivated a move to Sydney which only increased his anxiety; he became paranoid and suicidal. Through an altercation with the police he ended up in a psychiatric hospital where he was diagnosed as schizophrenic and medicated for that condition.

On returning to Perth at the encouragement of his parents, Michael was told by his psychiatrist that he would not be able to work again and he would have to spend the rest of his life on medication. He spent the next ten years struggling with life – his medication as the only mental health solution.

> "*I was 19 when I got unwell and I didn't work for 18 months. I started working again just before my 21st birthday. Over the years I mostly did warehousing and forklift driving. In that time I had bosses who said they would support me and they did. But I had bosses who said they would support me but never did and I had bosses who never supported at all. It wasn't till I quit my job in 2014 because I got really unwell that I decided to change careers. My GP gave me a medical certificate for Centrelink and I had 6 months off work. It was then that I got referred to PIR by Mirrabooka clinic." (Michael)*
>
> *"When the medical certificate ran out I got told I had to look for a job. It was then I made contact with a job agency. The lady who was supposed to be my case manager would never listen to me because she wanted me to get a warehousing job but I told her many times that I didn't want to do that sort of work anymore and that I wanted to became a support worker. That's when at my next appointment Ariane came with me and the lady got angry at us." (Michael)*

Partners in Recovery (PIR)

Funded by the Australian Commonwealth Department of Health, PIR was launched nationally in June 2013. It is now a program delivered through WA 360 Health and Community and supports people with severe and persistent mental illness with complex needs, as well as their carers and families. PIR promotes collective ownership and aims to provide effective and timely access to services and supports that sustain optimal health and wellbeing.

PIR's mission is to identify gaps in the mental health system. PIR Support Facilitators will work with participants to:

- set recovery goals and track their progress
- identify, coordinate, and access appropriate services and supports with a vision of long term recovery and consistent service provision.

Michael's support program

In one period of increased anxiety and suicidality, Michael attended the Mirrabooka Mental Health Clinic where he was told he needed to increase his

medication which would give him 'a boost' that was needed. Michael rationalised that the medication he felt had taken away his energy was not capable of giving him a 'boost'. He therefore refused the idea of an increase in the dosage. Subsequently Michael was referred to Partners in Recovery.

Through referral to the Partners in Recovery network, Ariane and Michael decided to meet on a weekly basis and design a program of activities. They utilised available local programs that seemed to have the potential to cater for Michael's needs in the realms of psychological, psycho-social and vocational activities. These helped in developing the confidence necessary to be able to follow his real interests. He was always challenged by the new engagements, sometimes feeling regression and the desire to stop, but resiliently taking up the challenge again when realising he was making progress in his communications with others in varying situations.

Ariane encouraged Michael to attend the Meerkat Mob program run by The Mental Illness Fellowship of Western Australia (MIFWA). The Program is a State Peer based physical and mental health program. The aim of the support provided is to give participants more self-confidence, self-acceptance and self-respect. This is achieved through being actively involved in one's own personal recovery.

The program was for two hours per week and run over an eight week period for people who want to learn about good nutrition; to reduce bad habits; and to learn stress management strategies.

Michael attended the MIFWA Meerkat Mob program. Some of his thoughts on his experience with the Meercat Mob were:

> *"I got a lot out of the Meerkat Mob program. The main things I got out of the program was how to reduce bad habits, how to manage stress and especially about neuroplasticity which I am really interested in learning more about. I met Joyce who is the program manager and I asked if I could become a volunteer at MIFWA, which I did. I went in once a week on Wednesdays and got a lot out of it. It helped me to get out of my comfort zone by talking to people who worked there and I really enjoyed volunteering there. I am now running the boot camp for the Early Intervention Recovery Program, EIRP." (Michael)*

Michael decided to move away from old 'friends' as he was looking for more meaningful friendships where there were no drugs and alcohol used for social interactions. As Michael's Support Facilitator, Ariane discussed alternative ways to create new friendships, resulting in Michael joining the 'Meet Up' social anxiety shyness group, through which he has made long term friends.

> *"When I first joined this group I was very nervous about going but I knew if I kept persisting, it would get easier for me, which it did. I challenged myself to step out of my comfort zone every time I went to meet up with the group. I made a few good friends from the group and we keep in regular contact with each other." (Michael)*

Partners in Recovery also funded a public speaking course. Michael was aware of the need to be able to speak in public and in group-work; from his past experience, and the future employment he was aiming for.

> *"I got a lot out of doing the public speaking course. I learnt about how to handle nerves, about writing a good speech and how to get the audience's attention." (Michael)*

Over the year there were a variety of relative areas that Michael investigated and that were supported by Partners in Recovery; there were also self-help plans – focussed reading and exercise – that he had created from the growing awareness through being able to plan and achieve, to keep in mind the many aspects of being himself in working toward the desired goal. Ariane stated:

> *"As his Support Facilitator it also showed Michael's wish to gain control over his life and his emotions/behaviours. He was able to learn about those skills by himself, he gained a sense of self confidence that he could handle himself better and better. There is nothing worse than feeling you are your own worst enemy, which is a sentiment experienced by a lot of people battling with their own mental health." (Ariane)*

During these twelve months, Michael and Ariane met in average once or twice fortnightly in 55 Central Crisis Accommodation Service, where PIR had one of their remote offices. 55 Central Crisis Accommodation Service is a specialist organisation that operates in the Perth inner-metro area and provides person-centred, evidence based services to people who are homeless or at risk of homelessness. 55 Central has a partnership approach to its case management delivery. To help its residents with mental health difficulties, 55 Central works with Partners in Recovery and also supports the Community Programs of Psychoanalytic/dynamic Practitioners of Perth through a visiting psychotherapist to whom case managers and support workers may refer clients.

Individual Psychotherapy

The 55 Central Crisis Accommodation Service in Maylands has had onsite psychotherapy for four years now, available for its residents and others who are supported by affiliated agencies. PdPP, an association of psychoanalytic therapists in Perth, uses Community Programs as a way of providing low cost therapy for people in need, mostly those whose only income is Centrelink payments. Case managers and support workers at the hostel refer residents to this service, which is accessed on site.

Ariane referred Michael to me for weekly sessions in June 2014, shortly after he was introduced to the Partners in Recovery program. Michael continued with the individual therapy sessions until July 2015.

> "*Before I got help from Neil I never spoke to anyone about the issues that I had gone through in my life, including getting bullied at school, in the workplace and my drug addiction I had in my teenage years. The sessions I had with Neil helped me in a big way to overcome these issues, so I could let go of the past and move forward in life." (Michael)*

The weekly sessions' program started with a general meeting of asking about Michael's reasons for wanting to commence sessions, and an explanation of the therapy process to confirm that it was a process that he would be interested in. After getting some general information about present arrangements for health and support, Michael agreed to a weekly fifty minute session.

The first session is generally about getting a brief history. This introduction to the life the client has experienced becomes the context for understanding many of the nuances of the present. It helps mutual understanding that can lead to a deeper investigation of aspects of the past that still have significance in the present. A different way of looking at current responses can evolve from the dialogue cocreated using the client's speech as the starting point, and the evolving history as a clarifying perspective.

Talking about the process of dialogue in analytic therapy Jacques Lacan states:

> *"It is false to think that an analysis comes to a successful denouement because the analysand consciously realizes something. . . . What is at stake is not a move from an unconscious level, plunged in darkness, to the conscious level, the seat of clarity, by some mysterious elevator. . . . What is at stake is not, in fact, a move to consciousness but, rather, to speech . . . and that speech must be heard by someone." (Lacan, 2001)*

I remember a Ghanian African drum teacher instructing how to play a new rhythm saying, "If you can say it, you can play it!" So we had to learn to say "Gun-dun pat-ta Go-do pat-ta, Gun-dun pat-ta Go-do pat-ta," which indicated the place on the drum head that you had to strike to create the Gun-dun, Go-do and Pat-ta sounds. The language created the action. Language that is communicated through the spoken word to another is our way of creating knowledge. Unless we put our thoughts into words spoken to someone else, we have no real knowledge, the unspoken remains an unverified concept that stays in our minds as a thought yet to be processed.

In Michael's psychotherapy, the words he chose to speak in describing what was on his mind, became the stimulus that activated my responses. The process of questioning, confirming and occasionally interpreting Michael's dialogue either stimulated more dialogue or precipitated moments of quiet contemplation that seemed positive in letting new perspectives establish themselves. This way of communicating utilizes two different dialogues that create new understandings for both parties through the 'intersection' of words, phrases and sentences – similar to the new understandings from literature that stimulates personal thought processes.

> *Mikhail Bakhtin . . . had introduced . . . the notions of alterity and dialogism. My conception of dialogism, of ambivalence, or what I call "intertextuality" – notions heavily indebted to Bakhtin and Freud. . . . issued from my reading of Bakhtin, encourages one to read the literary text as an intersection of other texts. (Kristeva, J. 2002)*

Julia Kristeva's intertextuality relates to the conscious and unconscious communication of psychotherapy, as much as it relates to Bakhtin's analysis of the text and the perception of the reader, adding a new way of considering the importance of language in the acquisition of new understandings in recovery processes.

The Open Dialogue System

Michael's program of involvement with Partners in Recovery and also with Community Programs' psychotherapy resulted in a natural intersection between these two facets of his recovery – Michael being the intermediary. Along with this, Ariane and my interest in the very successful Open Dialogue system began. OD was gradually developed in Finland by Jaakko Seikkula and the teams at the University of Jyväskylä and Keropudas Psychiatric Hospital. This retrospectively became the standard against which our work in Perth could be considered as a means of critical reflection, and toward development of methods relative to our particular local needs and resources.

Open Dialogue is a network-based language-approach to psychiatric care. The idea behind OD is the provision of psychotherapeutic treatment for all patients within their own personal support systems. This is done by generating dialogues within the treatment system and families. It involves mobile crisis intervention teams, patients, and their social networks in joint meetings.

> *Recent research suggests that Open Dialogue has improved outcomes for young people in a variety of acute, severe psychiatric crises, such as psychosis, as compared to treatment-as-usual settings. In a nonrandomized, 2-year follow up of first-episode schizophrenia, hospitalization decreased to approximately 19 days; neuroleptic medication was needed in 35% of cases; 82% had no, or only mild, psychotic symptoms remaining; and only 23% were on disability allowance. (Seikkula, J. & Olson, M. 2003, p403).*

Following on from this, 5-year follow up studies of first-episode psychosis in treatment-as-usual settings found that average hospitalization was 110 days; neuroleptic medication was needed in 93% of cases; generally, about 40% are considered to have improved; and 62% were on a disability allowance. In comparison, in an Open Dialogue setting, hospitalization was 25-40 days; neuroleptic medication was needed in 50% of cases; 76% had returned to their work or studies; and 14% were on a disability allowance. (Seikkula, Aaltonen &, Alkare et al, 2006)

The Open Dialogue approach was developed from the Milan Systemic therapy which first introduced circular questioning as a specific way of interviewing the family. The original principles of the Milan Systemic therapy of hypothesizing, circularity and neutrality (Selvini-Palazzoli, M. et al, 1980) were echoed and transformed in the development of the Open Dialogue approach by staff from the Keropudas Psychiatric Hospital in cooperation with the University of Jyväskylä.
(Seikkula, Aaltonen &, Alkare et al, 2006) (Seikkula, J., & Olson, M., 2003)

Mihail Bakhtin and Valentin Voloshinov created the idea of dialogism for describing a specific type of communication and interaction in which the participants in dialogue become co-creators of the shared reality. In family therapy their ideas were transformed into psychotherapeutic dialogue by the Open Dialogue team. (Seikkula et al., 2006, p216).

Open Dialogue is unique in that it is a "communal practice organized in social networks." It is embedded in the larger transformation of public psychiatric sources in Finland that were associated with a reform called "Need-adapted Treatment." (Seikkula J, Olson M.E., 2003)

In other words, Open Dialogue is successful because there is wider reform in the mental health system in Finland that supports the idea and its objectives. In many countries it seems that this integrated support and understanding is only at the level of systematic connections that can be contrary in their functioning, rather than having established a collaborative understanding in the best interests of the clients – in what is aptly called "Need-adapted Treatment".

> *The Bakhtinian idea of dialogue and its adaptation to the psychotic situation derive from a tradition that sees language and communication as primarily constitutive of social reality. Constructing words and establishing symbolic communication is a voice-making, identity-making, agentic activity occurring jointly "between people". The crisis becomes the opportunity to make and remake the fabric of stories, identities, and relationships that construct the self and a social world. (Seikkula J, Olson M.E., 2003)*

In psychodynamic psychotherapy the processes have a lot in common with the "tolerance of uncertainty" and "dialogism" of the Open Dialogue System (Seikkula, 1995) and are embedded in the practice as the therapist listens intently to the dialogue of the client and only relates to what has been heard when responding to that dialogue. Responding in a way that furthers the discourse of the patient rather than hindering it. The intention is to enable the client to reflect in various ways on the dialogue, and eventually also on what their role was in, and what their reactions were to, the events at the time.

A reflection upon the seven main principles of treatment in the Finnish Open Dialogue system that have emerged from the various training and research programs. These are considered against our local experience through Partners in Recovery.

Principle 1: The provision of immediate help. *The clinics arrange the first meeting within 24hr of the first contact, made either by the patient, a relative, or a referral agency (since 1987). In addition to this, a 24-hr crisis service exists (since 1992). The aim of immediate meeting is to integrate the outpatient treatment as soon as possible with the patient's everyday life and, in that case, even to prevent hospitalization in many cases. (Seikkula, Aaltonen &, Alkare et al, 2006, p215-216).*

This is undoubtedly of great importance. It necessitates being informed regarding the importance of a systemic process through which first contact persons are empowered to facilitate 'Need-adapted treatment'; in Australia, in general, this would require systemic change, as often the first response is to medicate, or sedate the patient before becoming familiar with their problem or seeing how the patient can be supported by assistance which empowers them to help themselves.

Doctor Karen Hitchcock, staff physician in acute and general medicine at the Alfred Hospital Melbourne Australia, writes in her book, "Dear Life":

> *"The delivery of health care is much more than a delivery of goods and services. The medical system is constructed from tacked together fragments – GPs, specialists, the hospitals, mental health services, community services – all of which have little contact with each other. We treat social and medical needs separately, although they are intricately entwined. Hospitals themselves are designed around a body fragmented into discrete organs. Often, our institutions serve clinicians, bureaucrats and cutting edge science better than those they are supposed to be serving." (Hitchcock, K. 2016, p2-3.)*

In Michael's case, his difficulties in social integration, self-confidence and self medication were, apart from some random individual support, not dealt with in any 'needs-based' way for a long time. In the institutions he came into contact with there was an almost total reliance on medication. However Michael remembers two people whose human interactions were in tune with his own needs.

He has a strong memory of a police sergeant who intervened in a situation with Michael and two young officers that was developing aggressively. The sergeant dismissed the officers and sat down to talk calmly to Michael. From this situation of empathy, he was then hospitalized in a psychiatric unit where sedation was the first response. Fifteen years later Michael could say of the sergeant "I'll never forget him!"

There was also a Salvation Army lady:

> *". . . she would come into the hospital that I was at and talked to the patients everyday. When I first meet her I was very unwell and paranoid but I had this feeling that I knew I could trust her and that she really wanted to help me There were times when I was really struggling and didn't want to talk to the nurses and doctors but I knew I could talk to her and she was very helpful and understanding."*

In contrast to these experiences, Michael's attempts to establish himself in the workforce where often very negative. Some of the bosses' comments he received were quite humiliating in front of other workers, and managing his mental health condition and vulnerabilities, together with job commitments was a big challenge for him.

> *"The medications I had to take made me drowsy and sleepy, and I was sometimes quite slow especially in the morning; some bosses understood*

that it impacted my performances at work, others did not want to know about it. It wasn't until I quit my job in 2014 because I got really unwell, that I decided to change careers."

Principle 2. A social network perspective. *The patients, their families, and other key members of the patient's social network are always invited to the first meetings to mobilize support for the patient and the family. Other key members may include official agencies, such as the local employment and health insurance agencies, to support vocational rehabilitation, fellow workers, or the employer, neighbors, and friends. (Seikkula et al, 2006).*

The first group meeting with family, friends and connected officials – a support group relative to the needs of the client – should establish its own logic and include a variety of people, some who will be important in the early recovery process, and others in the continuing long-term.

In PIR there are instances where a facilitator will work with parents and carers helping them to gain more insight into the process of recovery and possibly how they can work in a coordinated way to the same end, but it isn't necessarily a norm. The open-dialogue approach facilitates the integration of all those involved as a priority and as contributing voices in establishing the patient's needs in creating a plan. Having family and social connections involved in all decision making establishes a greater social awareness of how problems have developed and how they can be resolved; this partnership can help reduce the apprehension within the patient's environment which can exist through lack of information and experience in a complex supporting role. Carers, partners and relatives also often need to share their own needs for support, as it is a life journey for them as well. The sharing of knowledge through open dialogue can empower relationships in a mutually beneficial way.

The fact that Michael had continued living with his family was of inestimable support even if there were some communication difficulties. The OD system of early inclusion of family and friends in the group sessions would have had a positive effect on the inter-family relations and communications. It is difficult to assess and to communicate how families play a role in the problems of their children. It is in the best interests of the whole family when members are included and therefore find support in their difficult situation.

"I wanted to go back to work but definitely not to the same jobs. I had always been wanting to do youth work and peer support for people in mental health. So I thought this was my chance. I discussed a plan with my PIR support worker Ariane, and PIR together with my parents financially supported me going back to TAFE for 6 months. The job agency I was linked to made this process really difficult as the employment officer would never listen to me. This lady wanted me to get a warehousing job. I told her many times that I didn't want to do that sort of work anymore and that I wanted to become a Mental Health support worker. She questioned my choices and the idea of me going back to studying and not paying for my own studies. At my request, my doctor wrote a support letter explaining how destructive it would have been for me to go back to

warehousing. If it had not been for the faith my family, my doctor, Neil and Ariane had in me, this lady's responses to my goals could have led to me not pursuing them."

Principle 3. Flexibility and mobility. *These are guaranteed by adapting the therapeutic response to the specific and changing needs of each case, using the therapeutic methods that best suit each case. The meetings are often organized at the patient's home, with the consent of the family. (Seikkula et al, 2006).*

Both Ariane and myself were guided by a needs-adapted plan developed with Michael, whereby Michael met his needs for interpersonal growth through therapy and worked on improving the quality of his life exploring the practicalities of his social, financial and professional needs. We made sure that he was feeling safe at the emotional level so that he could take risks in "real life" to carry out his plans. Michael was building on each success to gradually grow in his self-confidence and exploration. Of his own accord he began to read self-help books, used journaling as a reflecting tool and started attending meditation classes at Nollamara Buddhist Centre.

Principle 4. Responsibility. *Whoever among the staff is first contacted becomes responsible for organizing the first multi-professional family meeting, in which decisions about continuation and site of treatment are made. The team then takes charge of the entire treatment process. . (Seikkula et al, 2006).*

Michael's supporting 'team' (including his parents in the background) was able to maintain its involvement through the time that was needed in order to establish a sustainable situation.

"After I got my Certificate 3 in 2015 the next challenge was for me to apply for jobs and always getting responses such as "you do not have enough working experience". I had to be very patient and develop faith that something would eventually happen. Again I needed support and encouragement from all my support network and eventually I got my first job. I now am hoping I can move on to the next step and go back to study to get my Certificate 4."

Principle 5. Psychological continuity. *The role of the team is not only to take care of the treatment as such but also to guarantee both the creation of new psychological meanings for symptoms and shared experience of this process. The team is responsible for the treatment for as long as it takes in both outpatient and inpatient settings. Members of the patient's social network are invited to participate in the meetings throughout the treatment process. The various methods of treatment are combined so as to form an integrated process. (Seikkula et al, 2006).*

The whole process needs to be underpinned by the continuity attained through the understanding and utilization of the dialogical process by all members of the team. This would of necessity be achieved through information and the process of dialogism training meetings with the team members, in preparation for engagement. Open Dialogue training and information is available in Australia.

In Michael's recovery journey though, very little connection was achieved by PIR with his Mirrabooka Clinical team, despite attempts to meet and engage in an Open Dialogue approach. There does seem to be a general intolerance from government clinical services to collaboration with community based support services and alternative holistic approaches. A general feeling is that it seems a "waste of time" to undertake more collaborative approaches. This may be through a pressure of getting the work done, and a lack of faith that collaborative practices may improve the mental health conditions of mental health patients in general. Most of the recipients of services are, in other ways apart from mental health conditions, dealing with difficult life situations. Quite often the communication difficulties in the system are precipitated by insufficient training in the whole Mental Health sector. Also a general climate of job insecurity and lack of recognition of the psychological difficulty of working with a population whose recovery progress can be very slow, can create a general sense of frustration or defeat for all involved – the patient, the carers and the service providers.

Principle 6. Tolerance of uncertainty. *Building a relationship in which all parties can feel safe enough in the joint process strengthens this. According to our experience, in psychotic crises, having the possibility for meeting every day at least for the first 10 to 12 days appears necessary to generate an adequate sense of security. By so doing, both the tolerance of uncertainty and a possibility for some certainty increase. After this the meetings are organized regularly according to a joint plan. Usually no detailed therapeutic contract is made in the crisis phase. Instead, all parties discuss as a routine part of every meeting whether and when the next meeting will take place. Meetings are conducted so as to avoid premature conclusions or decisions about treatment. For instance, neuroleptic medication is not introduced in the first meeting; instead, its advisability is discussed in at least three meetings before implementation. (Seikkula et al, 2006)*

This tolerance is an important part of the team's education process and would need to be experientially attained through the information and process of dialogism meetings. How to utilize uncertainty in the best interests of new information coming to the surface in group or individual meetings is fundamental to the recovery process. It should be paramount in the psychotherapeutic and support approaches used for group and individual therapy.

Principle 7. Dialogism. *The focus is primarily on promoting dialogue and secondarily on promoting change in the patient or in the family. In dialogue patients and families increase their sense of agency in their own lives by discussing the patient's difficulties and problems. A new understanding is built up in the area between the participants in the dialogue. Instead of having some specific interviewing procedure, the team's aim in constructing the dialogue is to follow the themes and the way of speaking that the family members are used to. The latter two principles (tolerance of uncertainty and dialogism) have been established as working guidelines during 1994 to 1996. . (Seikkula et al, 2006)*

The process of allowing dialogue to emerge freely from the group participants and for the responders to relate closely to the speech and content of the speaker, creates an importance of the dialogue used, and establishes a process where everyone involved can feel that something is achieved; there is the fact and feeling of co-creation in the process which is facilitated through the tolerance of uncertainty and respect for the words spoken, and not having any set agenda apart from discovery, at the start of the meeting

How we use language when communicating is an important consideration in any situation, it alters the mood of the moment, and therefore the response. The importance of language in communication and understanding is underestimated, and often not considered at all.

The specific agendas of behavioural processes in psychological and educational environments are still a major part of our culture, and in both these areas of community life, can be said to have contributed to a society that is quite judgemental and critical of difference, and it seems that this is reflected in many of the negative and anti-social elements embedded in the culture. The Open Dialogue approach and the resources it uses are based more, if not totally, on a developmental psychology. Change of this nature is essential in recovery processes which are dealing with the results of neglected and stalled areas of development in a patient's life.

Considerations

There can be no one solution to any of the problems within the Mental Health system as it should be an integrated part of the general Health System, in order for the whole system and its parts to be able to recognize and differentiate mental health problems from purely physical ones; and to recognize when both the mental and physical needs coexist in a diagnosed pathology. This integration needs to mirror the integration of the human person and for that to be its focus – body and mind; and to involve the patient and family at all stages of treatment.

"It is often more important to sustain the problem raised than it is to solve it."– Jacques Lacan

The Jacques Lacan quote seems to hold an answer in its primary objective of not needing a solution, but in sustaining an awareness through activity that can lead to greater learning and progress in the understanding of what advances have been possible.

Because some progress in the sector is being made doesn't mean the job is done. It should be an ongoing process of action, reflection, and re-adjustment – continuing to learn and to act from new knowledge. This is why the Finnish experience is valuable to the world and why some countries of the world are taking notice of the results; endeavoring to see how we can adapt our systems to be more open and inclusive – where one's training establishes an interest in learning from the patients or clients whom you encounter.

To accomplish this development, training systems would need to underpin an open dialogue methodology or use recovery models with similar proven

methodologies. Group treatment meetings, social support and psychodynamic therapy where needed, has now been proven to be a better way of patients being able to access rewarding occupations and social inclusion.

The treatment of the elderly, as described in Karen Hitchcock's book, and of mental health patients in our society describes systemic similarities. These groups are both over-medicated in a way that is the cause of a lot of their problems. This is due to "incomprehensible institutional requirements and service fragmentation."(Hitchcock, 2016). Services, in many health areas, and in agencies, seem to be under pressure to treat and discharge as quickly as possible, and medication facilitates that.

A sense of futility that is sometimes experienced within these sectors can lead to outcomes that seem to not be in the best interests of the patients, but that fulfill aims and quotas that are part of a business model rather than a focus that is humanistic and inclusive. Through reductions in hospitalization and medication in a "communal practice organized in social networks," (Seikkula, Olson, 2003) great financial savings are realized, and patients become more socially integrated.

In general there is a need for integration and care that allows the patients more choice and inclusion in environments that promote support, belonging, healing and ownership, rather that alienation. Open Dialogue methods could be included in all phases of process and decision making, providing social cohesion and care rather than just scientific and medical solutions.

Economics

According to a recent article (23/05/'16) in The West Australian newspaper, Rod Asbury, chief executive of the WA Association for Mental Health, which represents the community mental health sector, said community support services were the most under-resourced sector of WA's mental health system, with only 20% of demand met in 2014. He was responding to the budget report that there would be more than $6 million cuts to community mental health support services in WA over the year. He added:

> *"The alarming picture is that more and more people are accessing acute treatment and services and being discharged, going into the community without any community support. We're not preventing people getting unwell in the first place and we're not picking them up when they have accessed those services." (Pownall, Angela 2016,p5).*

The Federal Budget 2016 includes a number of new initiatives for mental health, but leaves ongoing uncertainty about how current reforms will be coordinated and integrated.

Mental Health Australia CEO Frank Quinlan said, "Following tonight's Budget, Australia still has no comprehensive plan to guide the very significant reforms changing the shape of mental health services."

While the funding for mental health is vital, some considerations can be made that should indicate that different strategies are needed to improve the current situation and not waste valuable resources:

> The Australian government Department of Social Services 2013 Report: *Characteristics of Disability Support Pension Recipients* indicates that over the past decade mental illness has become the number one reason people are receiving the disability pension; in 2013 more than 30 per cent of recipients suffered from psychiatric and psychological conditions. (DSS Report: CDSPR 2013, pp22)
>
> Also the same department in the *National Mental Health and Disability Employment Strategy* stated that "the number of people with disability in receipt of Disability Support Pension has increased by over 36% in the past 10 years." (DSS Report: NMHDES 2009)
>
> The report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing: *The Mental Health of Children and Adolescents,* by the Department of Health Canberra stated: The findings reveal that 14 per cent of children and adolescents in Australia have mental health problems. This is very similar to the prevalence identified in previous Australian and overseas surveys. [..] The survey also found that family doctors, school-based counsellors and paediatricians provide the services that are most frequently used by young people with mental health problems. However, only one out of every four young people with mental health problems receives professional help. (Lawrence D, Johnson S, et al, 2015)

It would be a tragedy if the money seen as necessary for the Mental Health System were to be spent supporting, in the same way, the practices that are part of a growing mental health problem. The Open Dialogue approach model embedded in Needs-Adapted Treatment "has improved the outcomes of people suffering from first-episode psychosis by significantly reducing the incidence of hospitalisation, the rate of recidivism and the use of medication." (Seikkula, Alkare & Aaltonen, 2001b).

The Open Dialogue system has been effective because it taps into the real needs of people in their lives. And to people with mental health problems their needs are more critical because during their development there has not been adequate environmental and social provision for those needs.

The practice of OD with its seven main principles of treatment makes sure that the best possible response to the crisis is always developed, keeping in mind the innate needs of each individual involved in the process.

The needs include the need to be taken seriously, to be cared for in an empathetic way, to be listened to intently, to be allowed to listen and speak to professionals who they know have concern for their wellbeing, to feel affection. To speak without being judged, and without being told what they should be doing – instead they need new information and activities to help expand their life choices.

The OD system is based on the human needs of all human beings. The rising toll of victims to suicide, mental health and disability pensions should give us some cause to look at our core cultural systems of education, child care, health and care of the elderly to see whether the basic human needs are being met. If they were, our society's problems would be on the decrease, and that is not the case.

Summation

"As his Support Facilitator, I observed that Michael was building up his level of self-confidence, together with his trust in people and in services; he was creating around him that network of support that he had failed to have for so many years. He was gaining enough hope and enough motivation that lead him to the next level of commitment: he felt he could enrol and study at TAFE, keeping in line with his true desire to be one day a peer support worker. I fully supported his vision and my PIR role was to encourage any steps in that direction, including financial support to help him achieve that vision of himself." (Thirion, A. 2015, draft notes).

Michael said: "I really struggled at TAFE with my anxiety and worrying about fitting in. There was a few people in my class that made comments that were not right but I never gave up and I continued to go to class and never missed a class. I continue putting in effort even though there were times I wanted to give up. It was a big achievement for me when I finished the course." (Williams, M. 2015, draft notes.)

Conclusion

The process of reflecting on Michael's eighteen month recovery process has lead to contemplating the broader field of recovery in mental health matters. It has become quite obvious that some serious thinking about the effects of the present system in its multiplicity of facets is a challenge we can't ignore.

There are already many ideas in circulation that could be seen as progressive in humanised naturalised methods. There are just as many different ways of keeping the security of the status quo and maintaining separate approaches. These two ways of working are entwined in the current system. We need to be aware of what is working, and what is not, and to listen more to those who need help and their social group, to actually gather that information. There is a need to re-assess the primacy of prescription medication for the mentally ill, and consider its use only if needed to support the priorities detailed in the Open Dialogue approach.

This has more to do with communicating and with assisting development than it is to do with changing behaviour and medicating. It is about working out what we need for the establishment of an Open Dialogue system where everyone involved in a treatment is working and learning together. Creating this Needs-Adapted treatment system is a challenge that our society needs us to accept.

Michael Williams • Ariane Thirion • Neil Sullivan

References:

Hitchcock, K. (2016). *Dear Life: on caring for the elderly*. Melbourne: Black Inc.

Kristeva, J. (2002) . *My Memory's Hyperbole.* In K. Oliver (Ed.), *The Portable Kristeva*, updated edition. New York: Columbia University Press.

Lawrence D, Johnson S, Hafekost J, Boterhoven De Haan K, Sawyer M, Ainley J, Zubrick SR (2015) *The Mental Health of Children and Adolescents*. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Department of Health, Canberra.

Lacan, J. (2001*) Autres écrits [Other writings].* Paris: Seuil.

Seikkula, J., Alkare, B., Aaltonen, J. (2001b) *Open Dialogue in first-episode psychosis II: A comparison of good and poor putcome cases*. Journal of Constructivist Psychology, 14, 267-284

Seikkula, Jaakko, Aaltonen, Jukka, Alakare, Birgittu, Haarakangas, Kauko, Keränen, Jyrki and Lehtinen, Klaus. (2006). *'Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies'*, Psychotherapy Research, 16: 2, 214 — 228

Seikkula, J., & Olson, M. (2003). *The open dialogue approach to acute psychosis: Its Poetics and Micropolitics.* Family Process , 42, No. 3, 403–418.

Selvini-Palazzoli, M., Boscolo, L., Cecchin, G., & Prata, G. (1980). *Hypothesizing–circularity–neutrality: Three guidelines for the conductor of the session.* Family Process, 19, 3–12.

Characteristics of Disability support Pension Recipients, June 2013. PDF available at: https://www.dss.gov.au/sites/default/files/documents/01_2014/dsp_characteristics_report_2013_final.pdf Australian Government Department of Social Services.

National Mental Health and Disability Employment Strategy. 2014. Available at: https://www.dss.gov.au/our-responsibilities/mental-health/programs-services/national-mental-health-and-disability-employment-strategy. Australian Government Department of Social Services.

Other readings used toward an understanding of dialogism within OD.

Seikkula. Jaakko. (2003). *Dialogue Is the Change: Understanding Psychotherapy as a Semiotic Process of Bakhtin, Voloshinov, and Vygotsky*. Human Systems: the Journal of Systemic Consultation & Management, Volume No. 14, issue 2, 2003, pp. 83-94.

Seikkula, Jaakko. (2011) *Becoming Dialogical: Psychotherapy or a Way of Life?* The Australian and New Zealand Journal of Family Therapy. Volume 32 Number 3 2011 pp. 179–193 *Available at:* https://www.power2u.org/downloads/becomingdialogiic_ANZJFT11.pdf

Schizophrenic Fellowship of New South Wales Web page. Available on 26/05/'16 at: http://www.sfnsw.org.au/Research-and-Publications/Open-Dialogue-Program

Whitaker, Robert. (2010). *Anatomy of an Epidemic.* New York: Broadway Books.