

The Comprehensive Open-Dialogue Approach in Western Lapland: II. Long-term stability of acute psychosis outcomes in advanced community care

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An open dialogue need-adapted approach was applied in Finnish Western Lapland by organizing three-year family therapy training for the entire staff, and by following the outcomes. Three inclusion periods of first-episode psychotic patients were compared. In a two-year follow-up of two consecutive periods during the 1990s (1992–3 and 1994–7) it was found that 81% of patients did not have any residual psychotic symptoms, and that 84% had returned to full-time employment or studies. Only 33% had used neuroleptic medication. A third inclusion period, covering 2003–2005, was organized to determine whether the outcomes were consistent 10 years after the preliminary period. Fewer schizophrenia psychotic patients emerged, and their mean age was significantly lower. Duration of untreated psychosis had shortened to three weeks and the outcomes remained as good as for the first two periods. It is therefore suggested that the new practice can be related to profound changes in the incidence of severe mental health problems. This is supported by the large number of local inhabitants participating in treatment meetings for crises. Professionals had learned to make early contact in the event of crisis, and by this means prevent problems from developing into more severe cases.

Keywords: first episode psychosis; community care; need-adapted approach; open dialogues

In this study, our aim was to determine the effectiveness of the Open Dialogue approach in the treatment of first-episode psychotic patients. Two research projects had already been conducted in Western Lapland, the first as part of the Finnish National API (Acute Psychosis Integrated Treatment) study (1992 to end-1993), with a continuation as the local Open Dialogue in Acute Psychosis (ODAP) project (1994–1997) (Seikkula et al., 2003; Seikkula et al., 2006). To determine how far the outcomes in the treatment of acute psychosis remained stable, a third study was conducted, examining the period 2003–2005. This paper reports on the outcomes of all these studies, focusing particularly on the longer-term stability of the outcomes. For ease of reference the periods in question will be referred to as API¹⁹⁹²⁻¹⁹⁹³, ODAP¹⁹⁹⁴⁻¹⁹⁹⁷, and ODAP²⁰⁰³⁻²⁰⁰⁵.

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The basic aim of community psychiatry is the integration of different approaches and treatment modalities during a continuous treatment process. The treatment should be adapted to the changing needs and sub-outcomes emerging during the process, forming an entity that will guarantee the best treatment for each patient (Alanen, Lehtinen, Rökköläinen, & Aaltonen 1991; Alanen, 2009). A criticism often leveled against the one-method designs mostly used in psychotherapy outcome studies is that they tend to incorporate a view of stable therapeutic needs – needs supposedly present from the very beginning of the treatment till the very end of it. Moreover, the need to have a reliable study design favors therapeutic interventions involving a similar treatment modality from case to case. This can be difficult to implement, for example in the public health sector, where patient characteristics, and treatment processes may vary from case to case, according to the specific needs of each patient and the specific context of the services.

Outcome studies in acute psychosis mostly consist of controlled designs, with the control making it possible to analyze one specific method of treatment. Few studies exist on outcomes in community psychiatry in which treatment is adapted to individual need, even if as long ago as the 1970s several (apparently well-functioning) community-based crisis intervention programs were reported (Perlmutter, 1986; Rhine, & Mayerson, 1971; Rubinstein, 1972). In recent years, assertive community treatment (ACT) has become the most intensively studied form of community psychiatry (Drake et al., 2001; Dixon, 2000; Marshall & Lockwood, 2004; Mueser, Bond, Drake, & Resnick, 1998; Verhaegh, Bongers, Kroon, & Garretsen, 2009). The model includes multidisciplinary team work, integrated care, and working within the community; it aims at adapting to everyday needs, quick crisis intervention, an assertive attitude, an individual approach, and continuity of care. Killaspy et al. (2009) found that staff members' experiences of their work showed differences compared to treatment within the usual setting. ACT team members described more varied and flexible approaches with their patients, for example in having general conversations with their clients, not only on matters related to treatment. Staff members experienced support from each other through working as a team. ACT has improved the outcomes of treatment by reducing hospitalizations and improving employment status. It has assisted in shortening the duration of untreated psychosis (DUP), and has been found cost-effective (Marshall & Lockwood, 2003). Nevertheless, not all studies have shown such positive outcomes, most notably in cases of low fidelity to the original ACT model (Bodén, Sundström, Lindström, Wieselgren, & Lindström, 2009). Fidelity appears to be important, at least in cases of first-episode psychosis (Verhaegh et al., 2009).

In these studies there are similarities to the need-adapted approach (NAA) described in this paper. In the NAA the basic aims do indeed resemble ACT in terms of stressing family-centeredness, home visits, and team work. The main difference is that the NAA integrates specific psychotherapeutic methods as a part of an overall integrated approach.

In the small Finnish province consisting of the south-western part of Finnish Lapland, community psychiatry has been developed since the beginning of the 1980s (Aaltonen, Seikkula, & Lehtinen, 2011). The outcomes and processes in the treatment of psychosis and other severe problems have been reported in many studies (Haarakangas, 1997; Keränen, 1992; Seikkula, 1994; Seikkula

et al., 2003; Seikkula et al., 2006). In the latest studies, concerning the outcomes in first-episode psychosis, discussion has focused on the exceptional five-year outcome in psychotic symptoms and employment status (Seikkula et al., 2006). Critical comments have centered on the methodology of the studies (Fris, Larsen, & Melle, 2003), insisting that not every psychotic patient could have been included, given that the outcomes are so (unrealistically) favorable.

In the study described in the first, accompanying paper (Aaltonen et al., 2011) we focused on the changes in the incidence of first-episode psychosis that took place after initiating the new approach. The aim in this second study was to determine whether the outcomes in the treatment of first-episode psychosis have remained consistent over a 10-year period.

Community treatment in western Lapland

Based on the need-adapted approach first initiated by Yrjö Alanen and his team (Alanen, 1997, 2009; Lehtinen, Aaltonen, Koffert, Rökkölöinen, & Syvälahti, 2000), a community psychiatric system was initiated in the south-western part of Finnish Lapland in the early 1980s. Progressing through a number of phases, the system has been developed to function in a consistent manner from the mid-1990s (Aaltonen et al., in press; Seikkula et al., 2003; Seikkula et al., 2006; Seikkula & Arnkil, 2006). In the community psychiatric system there are three central elements:

1. Family and Team-centeredness

The system of treatment is guided by seven main principles, established in a research project in the mid-1990s (Aaltonen et al., 1997, 2011). Hence:

- (1) the first meeting should be organized immediately, within 24 hours of contact being made with the mental health services;
- (2) the social network of the patient, including the family and the professionals working with this specific family, should always be invited to participate, from the outset and for as long as required;
- (3) the treatment should be flexibly adapted to the specific needs of the patient and the family, using the therapy methods most suited to the case in question;
- (4) the mental health systems should guarantee that specific persons/teams will take responsibility for the treatment, organizing a case-specific team that will make decisions together with the family concerning all the treatment planning and actions to be taken;
- (5) the team should aim to guarantee psychological continuity by inviting staff members from different facilities to collaborate, for as long as required;
- (6) the team should aim at promoting a sense of security, generating a therapeutic process that can tolerate uncertainty in order to mobilize the psychological resources of the family and the social network;
- (7) the team should focus on generating dialogue in the joint therapy meetings, in order to create new words and a new joint language for experiences that previously did not have words.

2. Psychotherapy Training for all Staff Members

The training of the staff consists of a one-year introductory program and a specific three-year program in family therapy (Aaltonen et al., 2011). In addition, staff members are encouraged to undergo other forms of psychotherapy training, such as individual psychodynamic or cognitive psychotherapy. The training format is based on early notions that the basic education of the staff did not give enough support to community-based and family-centered practice, with basic education being too much focused on individual treatment of the most severe mental health problems within an in-patient setting. For this reason, since 1989 the program has included multidisciplinary on-the-job psychotherapy training for the entire staff, including doctors, psychologists, nurses, social workers, and others. The group members in this training meet for one day every second week, focusing on theories, direct supervision, and working with their own family background. The trainers are mainly fellow employees in the system, people who have qualified as trainers after undergoing a total of six years of training in cooperation with the Finnish Association for Mental Health. Thus the aim has been to guarantee a training program that will allow trainers to use of the official title of Psychotherapist, in accordance with Finnish law. At the time of writing this paper the training has been going on for more than 20 years, with about 150 people in the province (population 70,000) having gone through it. The training program is organized in collaboration with the Department of Psychology at the University of Jyväskylä, where author JA acted as Professor of Family Therapy.

3. The Research Project

The ongoing research program was initiated during the 1980s, in such a way as to guarantee that the information for developing the local treatment system would be based on the systematic exploration and analysis of the outcomes and processes in the treatment (Aaltonen et al., 2011; Alanen, 2009). The most basic principle has been to focus on naturalistic designs in the real life of Western Lapland, rather than on randomized trials. The follow-up studies have been descriptive in nature, rather than aimed at identifying generalized explanatory factors for change (Seikkula et al., 2003; Seikkula et al., 2006). Throughout the studies, a variety of qualitative analyses of treatment processes have been conducted. These studies have provided important knowledge which has allowed the psychotherapeutic quality of the work to be developed (Haarakangas, 1997; Seikkula, 2002).

Study Design and Participants

The data for the present study were gathered over three periods, the aim being to determine whether the outcomes of first-episode psychosis have remained stable over a the period from 1992 until 2005 in Western Lapland. The first two periods, named (1) the API¹⁹⁹²⁻¹⁹⁹³ period (1 March 1992 until 31 December 1993; N = 36) and (2) the ODAP¹⁹⁹⁴⁻¹⁹⁹⁷ period (1 January 1994 until 31 March 1997; N = 46) have already been reported (Seikkula et al., 2002, 2003, 2006). These periods belonged to a multicenter research project, planned as part of a Finnish national project. The specific focus was on improving community treatment and increasing information concerning the place of medication in the treatment of psychosis. The project was jointly organized by the National Research and Development Center for

Welfare and Health (STAKES), Department of Psychology (University of Jyväskylä), and the Department of Pharmacology (University of Turku). It was carried out in six psychiatric treatment centers with a total catchment area of 600,000 inhabitants. One of these centers was the western Lapland catchment area.

The third period, referred to here as ODAP²⁰⁰³⁻²⁰⁰⁵ (from 1 February 2003 until 31 December 2005; N = 18), was specifically planned to gather information on first-episode psychotic patients in the daily clinical setting, with a view to determining the stability of the results after the earlier research projects. The local ethical committee gave permission for the study, and every patient gave informed written consent regarding inclusion.

The study included all first-episode patients between 16 and 50 years of age with non-affective psychosis (using DSM-III-R and DSM IV for the third period, ODAP²⁰⁰³⁻²⁰⁰⁵). The diagnosis was made in two phases. After the first meeting, the team, in conjunction with the responsible chief psychiatrist (author BA), formulated an initial hypothesis; then, after six months, having also interviewed the patients individually, the chief psychiatrist made the final diagnosis. To test reliability, an experienced psychiatrist from outside the region re-diagnosed the patients on the basis of the patient records. The diagnostic consistency of the schizophrenia diagnosis was 78% (Kappa = .453; p = .002).

The main sources of information were: (1) premorbid variables such as psychiatric and employment status at the outset, and duration of untreated psychosis (DUP) (defined as the time between first psychotic symptoms and the start of psychosocial intervention); (2) process variables, i.e. the registered number of hospital days, number of family meetings, and registration of the use of antipsychotic medication and individual psychotherapy; (3) outcome variables, i.e. registered number of relapses (defined as making a new contact for treatment after terminating the original treatment, or as an intensification of existing treatment because of new psychotic or other severe symptoms), employment status, and ratings of the mental state of the patients on the Brief Psychiatric Rating Scale (BPRS), the Global Assessment of Function Scale (GAF), and a five-category sub-scale of the Strauss–Carpenter Rating Scale (Strauss & Carpenter, 1972; Opjordsmoen, 1991). During the API and ODAP periods, the ratings were conducted jointly by two of the authors (JS and BA) using a consensus conference method. These authors worked as researchers, and were not involved as therapists in the treatment process. During the third study period, ODAP²⁰⁰³⁻²⁰⁰⁵, all the registrations and ratings were performed by an experienced nurse and author BA. The internal consistency (Cronbach's alpha) of the BPRS was .774 at the outset and .667 at the follow-up during the API¹⁹⁹²⁻¹⁹⁹³ period, and .783 at the outset and .735 at the follow-up during the ODAP¹⁹⁹⁴⁻¹⁹⁹⁷ period. During the ODAP²⁰⁰³⁻²⁰⁰⁵ period Cronbach's alpha was .730 at the outset, and .863 at the two-year follow-up.

All the ratings mentioned above were performed at the baseline and at the two-year follow-up. During the first treatment meetings, the family was interviewed to determine the duration of psychotic and prodromal symptoms prior to first contact. Author BA verified this during an individual interview with the patient. The follow-up interviews took place in the presence of both the case-specific treatment team and the family. The statistical analysis was conducted using the Pearson Chi-square in cross-tables, and a one-way analysis of variance (ANOVA) for comparison of the means of independent groups.

Attrition

Table 1 summarizes the reasons for exclusion in the follow-up interviews.

In the third ODAP²⁰⁰³⁻²⁰⁰⁵ period, more attrition took place, mainly due to emigration from the province. To some extent this illustrates a change in society, since during the 2000s there was more emigration than in the early 1990s, when the population was more or less stable. The population decreased from 72,000 in 1995 to 68,000 in 2005. The second possible reason for emigration is connected with the mean age of the patients: The patients were younger during ODAP²⁰⁰³⁻²⁰⁰⁵ and thus at an age when they might move for the sake of their studies. When one compares the variables of sex, age, employment status, diagnosis, and duration of untreated psychosis for (1) the entire “intention-to-treat” groups and (2) the patients reached in the follow-up, one significant difference can be observed. In ODAP²⁰⁰³⁻²⁰⁰⁵ the duration of untreated psychosis was higher among the dropout patients. Overall, it appears that in all three periods the groups analyzed are strongly representative of the entire “intention-to-treat” group of psychotic patients for the timeframe in question, except for a slight tendency in the third period to select for analysis cases with a shorter duration of untreated psychosis.

Results

Comparison of the groups at outset

Differences were observed in mean age, marital status, and employment status. In all these respects the group coming for treatment in 2002–2005 differed from the two groups who came in the 1990s. Psychotic patients were significantly younger in the third group; they also had a higher likelihood of being single and of studying instead of working.

Table 1. Reasons for exclusion from the study during the two-year follow-up period.

	API (01.04.1992– 31.12.1993)	ODAP(01.01.1994– 31.12.1997)	ODAP2(01.01.2003– 31.12.2005)	Total
Treatment started	39	51	27*	117
Treatment started in a unit outside OD	1	1		
Refused to participate	1	2	3	
Not reached at two-year follow-up	2	2	6	
Deceased	2	2	0	
–suicide	2**	1**	0	
– other reason	0	1	0	
Total sample at two-year follow-up	33	43	18	95

Notes: *Altogether 31 patient contacts were registered, but four were excluded because of only one treatment contact occurred and no possibility for verifying psychotic experience was realized. None of these responded to contacts for follow-up.

**All suicides took place in 1995 when a suicidal epidemic emerged in the province.

Table 2. Characteristics and premorbid adjustment at baseline of the patients reached in the follow-up within the three groups.

	API ¹⁹⁹²⁻¹⁹⁹³ (N = 34)		ODAP ¹⁹⁹⁴⁻¹⁹⁹⁷ (N = 46)		Chi-square (N = 18)	df	p
	19-38 26.6	17-43 26.8	16-42 20.2	ODAP ²⁰⁰³⁻²⁰⁰⁵			
Age							
Mean					t = 3.53	50	.001
Sex							
Male	16 (47%)	16 (35%)	9 (50%)				
Female	18 (53%)	30 (65%)	9 (50%)		1.8	2	NS
Marital status					9.7	6	NS
Single	20 (59%)	34 (74%)	15 (83%)				
Married, living together or divorced	14 (41%)	12 (26%)	3 (17%)		12.2	6	.057
Employment status					260	8	.001
Studying	11 (32%)	13 (28%)	12 (67%)				
Working	14 (41%)	24 (52%)	0				
Unemployed	3 (9%)	6 (13%)	2 (11%)				
Passive	6 (18%)	3 (7%)	4 (22%)				
Diagnosis/DSM-III-R					6.23	6	NS
Brief psychotic episode	5 (15%)	11 (24%)	7 (39%)				
schizophrenia (NOS)	7 (21%)	10 (22%)	4 (22%)				
Schizophreniform psychosis	9 (26%)	6 (13%)	3 (17%)				
Schizophrenia	13 (38%)	19 (41%)	4 (22%)				

Note: *Unemployed* means having been working during the previous two years, but at the moment unemployed and registered as job-seeking with the employment services.

Comparison of the groups at follow-up

Treatment processes

The duration of untreated psychosis (DUP) was 3.3 months during the first ODAP period compared to 4.2 months in the API period ($p = .069$), as shown in Table 4. It declined to half a month in the ODAP²⁰⁰³⁻²⁰⁰⁵ group, the longest time being three months. The ODAP¹⁹⁹⁴⁻¹⁹⁹⁷ group had fewer hospital days than the API group ($p < .001$), but no differences were found in a comparison between the ODAP¹⁹⁹⁴⁻¹⁹⁹⁷ and ODAP²⁰⁰³⁻²⁰⁰⁵ period. The number of family therapy meetings stayed about the same in all three periods. Neuroleptic medication was used in the first two groups in only a quarter of cases, but showed an increasing trend in the third group, in which 50% had taken and 28% were continuing to take medication (Table 3). However, this aspect may have been affected by the larger number of dropouts in ODAP²⁰⁰³⁻²⁰⁰⁵, since treatment had been terminated among those patients who were not reached at the follow-up, and according to preliminary information they were not using antipsychotic medication. In the two first groups, first generation neuroleptics were used as the antipsychotic medication, while in the third group, second generation antipsychotics were used.

Treatment outcomes

More than 70% of the patients in each period did not have a single relapse during the two-year follow-up period. Concerning residual psychotic symptoms, the ODAP²⁰⁰³⁻²⁰⁰⁵ group had significantly fewer psychotic symptoms at the two-year follow-up, but their BPRS score was higher compared to the ODAP¹⁹⁹⁴⁻¹⁹⁹⁷ group (Table 4; $p < .001$). In each group more than 80% of the patients did not have any

Table 3. Frequencies in treatment process and outcome variables in the three groups at the two-year follow-up.

	API ¹⁹⁹²⁻¹⁹⁹³	ODAP ¹⁹⁹⁴⁻¹⁹⁹⁷	ODAP ²⁰⁰³⁻²⁰⁰⁵	Chi-square	df	P
Use of neuroleptics						
Started	9 (26%)	12 (26%)	9 (50%)	4.47	4	NS
Ongoing	5 (15%)	5 (11%)	5 (28%)			
Individual psychotherapy						
Yes	12 (33%)	21 (46%)	12 (67%)			
No	22	25	6			
No of relapses						
0	25 (74%)	38 (83%)	13 (72%)	16.1	10	NS
1	6	5	0			
2	3	2	3			
>2	0	1	2			
Employment status at two-year follow-up				7.29	4	NS
Studying or working	21 (62%)	35 (78%)	13 (72%)			
Unemployed	4 (12%)	6 (13%)	2 (12%)			
Disability allowance	9 (26%)	4 (9%)	4 (16%)			

Table 4. Means of treatment process and outcome variables in the three groups at baseline and at the two-year follow-up, t-test.

	API ¹⁹⁹²⁻¹⁹⁹³ (N = 33)		ODAP ¹⁹⁹⁴⁻¹⁹⁹⁷ (N = 42)		ODAP ²⁰⁰³⁻²⁰⁰⁵ (N = 18)		t-value	P
	mean	sd	mean	sd	means	d		
Duration of untreated psychosis (DUP), months								
Mean	4.3	7.0	3.3	3.8	.5	.9	2.3	.001**
Range			0-13		0-3			
Hospitalization days								
Mean	25.7	44.2	9.3	18.3	13.6	27.8	.96	.001*
Range	0-124		0-89		0.83			
Number of family treatment meetings								
Mean	26.1	14.1	20.7	20.6	23.3	19.2	0.99	NS
Range	2-55		0-99		0-38			
BPRS								
Baseline	47.4	12.5	48.8	12.2	52.1	9.8	2.5	NS
Two-year follow-up	30.2	12.9	23.7	4.5	28.5	8.8	22.6	.001**
Residual psychotic symptoms								
Baseline	3.21	.64	2.98	.80	1.56	.64	.35	NS
Two-year follow-up	.50	.90	.30	.70	.17	.38	10.1	.003*

Notes: *pair comparison between API and ODAP²⁰⁰³⁻²⁰⁰⁵.**pair comparison between ODAP¹⁹⁹⁴⁻¹⁹⁹⁷ and ODAP²⁰⁰³⁻²⁰⁰⁵.

remaining psychotic symptoms. It was discovered that 27% of the API patients, 14% of the ODAP¹⁹⁹⁴⁻¹⁹⁹⁷ patients, and 16% of the ODAP²⁰⁰³⁻²⁰⁰⁵ patients, were living on disability allowance (Table 3). Thus in the last two periods more than 84% were studying, employed, or actively seeking employment. This result has stayed the same over a 10-year period involving different individual patients.

Discussion

The analysis was based on two different studies. The first study, covering the first two periods, has already been reported. The third period is a new one, selected for the purposes of this specific report with the aim of determining whether the outcomes obtained in the 1990s still held as the timeframe moved into the 2000s. For the most part it could be verified that this was the case, but some interesting changes were noted. First of all, the group of psychotic patients in the 2000s seemed to be different, in the sense that the patients were younger and included fewer schizophrenia patients (Table 2). The duration of untreated psychosis had declined to half a month, compared to 3.5 months during the 1990s. Second, differences occurred in the remaining psychotic symptoms, with fewer symptoms in the 2000s than in the 1990s. In other ways the outcomes – including the employment status – remained the same, so that more than 84% of the patients were capable of returning to active social life, or were in full employment, or studies. However, in the third period the relative proportion of brief psychotic episodes was higher than in the first two groups. Even taking account of this bias, the social outcome for non-affective psychoses seems to remain positive.

These results raise some interesting questions. What is the significance of the change in the configuration of the groups of first-episode psychotic patients? Western Lapland is a small province, and community mental health practice has been conducted within it since the late 1980s, i.e. covering a period of about 20 years to the end of the last inclusion period. Under the new system, the families are immediately invited to joint meetings in all cases of crisis. This has led to a positive change in the whole culture of using mental health services. This is reflected in a general trend towards earlier initiation of treatment. At the same time, the comprehensive training in both family therapy and individual therapy for all staff members has made the treatment system itself more willing to consider psychotic phenomena from a psychological and systemic viewpoint: the entire treatment system is more oriented towards the changing needs of patients, families, and their relational systems (Whitaker, 2010). All this has led a shortened duration of untreated psychosis, and to first contact tending to be made at a younger age. The overall result is that psychotic symptoms are less entrenched than is the case where psychotic patients may have been psychotic for a year before first contact (Aaltonen et al., 2011).

The second major aspect involves the importance of the social network functioning collaboratively. In each new contact those professionals who are seen as relevant are invited to joint meetings. As one element in this, the employment authorities are invited to joint therapy meetings, in order to plan rehabilitation support for clients if this should be necessary. The young patient is regarded as competent to remain in active social life, even if he/she experiences crises and possible symptoms. To a large extent this excludes the process of being “chronified” in illness – a process which is more likely when patients move to living on a disability

allowance. In psychotic crises there are particular dangers in the patient staying outside the social context, since he/she can easily interpret other people as being dangerous, and may thus try to avoid contact. In the open dialogue treatment system of western Lapland, young patients are encouraged to stay within the social context, and this seems to encourage a return to active employment and studies.

Over the 20-year period in question, the number of psychotic patients and the incidence of schizophrenia cases seem to have declined – which is an interesting phenomena in itself (Aaltonen et al., 2011). Some previous studies have indicated that the incidence of psychosis tends to show a particular increase in areas of immigration. It has been suggested that this is connected with increased drug abuse (e.g. Boydell et al., 2003). Nevertheless, other studies have shown a general decline in the incidence of psychosis and schizophrenia, especially in stable population situations. In western Lapland, the population statistics show no emigration, and in general terms the population has remained fairly stable. In Finland as a whole, the incidence of schizophrenia has once again recently started to show an increase (Salokangas et al., 2011). A small decline in the incidence of schizophrenia is not in itself surprising, but major questions arise concerning the proportion of patients who go on to develop schizophrenia among the first-episode psychosis group. This may be related to the long-term and comprehensive development of the public health treatment culture. The implication seems to be that in Western Lapland, population stability has only had minor relevance for a positive outcome, in comparison with the notable stability of the treatment culture. Continuous efforts have been made over several years to develop the culture according to the principles of the need-adapted approach, with open dialogue as an important constituent. It appears that the open dialogue, with its early engagement with mental health problems, and retention of family involvement and the social network, plays an important role in the prevention of further deterioration into schizophrenia.

In parallel with the above, some suggestions can be drawn that the long-term development of the system has changed the overall culture of the basic population in a more positive direction in relation to all psychiatric treatment. This is reflected in earlier initiation of treatment processes, often within prodromal phases, and in an increased openness in participating psychiatric treatment. In western Lapland a large proportion of the local population has participated in therapy meetings. Every year, about 1500 patients undergoing acute psychiatric crises are met, and in nearly all cases at least closest family members participate in the first meetings. It can thus be estimated that every year about 4500–7000 people participate in joint therapy meetings, amounting to as much as 5–10% of the population. In this kind of setting one needs to emphasize the staff qualities that Rosen (2006) saw as necessary. In the community setting one cannot rely on the kind of day-program routines that might schedule the course of the day within an in-patient setting. What is important are the personal qualities and ways of acting of the staff – a point which highlights the need for new forms of staff-training, as called for also by Rosen (2006). In addition, Rosen believes that mental health service users should be seen as *empowered* agents, with the focus shifting away from (merely) their disabilities. This once again calls for skills on the part of the psychiatrist, who requires expertise in transdisciplinary team work, and in orientation and relational work. He/she is not merely an expert in diagnosing and in prescribing medication – although these skills are needed as well. While visiting Western Lapland, Robert Whitaker (2010) noted some elements of the new culture.

Limitations of the study

Because of the aim that the findings should have as high a level of external validity as possible, the reliability of some elements of the research methods could not be optimally guaranteed. All the ratings were used as a part of everyday clinical practice. This being so, the ratings from GAF and BPRS should only be seen as approximate indicators of psychological status and symptoms. They merely support the information taken from more objective indicators involving the number of hospital days, the number of relapses, and the employment status. Another problem arises from Western Lapland being a relatively small province. With such low-incidence problems as psychosis, long inclusion periods are needed if one is to have sufficient observations. During such long inclusion periods, possible changes in the local culture cannot be standardized, meaning that conclusions are less firm concerning the factors that may be most important in causing changes.

On the other hand, the small size of the province can also work as an advantage. Because no other mental health services are available, we can be fairly confident that all psychotic problems fell within the system described in this paper.

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