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Recovery in Austria: Mental health triologue

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Abstract

The active involvement of service users and relatives and friends is essential for the development of recovery-orientated mental health practice and research. However, accepting each other as equally entitled experts is still a challenge. In triologue groups users, carers and friends and mental health workers meet regularly in an open forum that is located on 'neutral terrain' – outside any therapeutic, familial or institutional context – with the aim of discussing the experiences and consequences of mental health problems and ways forward. Trialogues offer new possibilities for gaining knowledge and insights and developing new ways of communicating beyond role stereotypes. They also function as the basis and starting point for trialogic activities on different levels, e.g. serving on quality control boards or teaching in trialogic teams, and different topics, e.g. a task force on stigma busting or a work group on trauma and psychosis. In German-speaking countries well over a hundred triologue groups are regularly attended by altogether about 5,000 people. International interest and experiences are growing fast. Trialogues facilitate a discrete and independent form of acquisition and production of knowledge and drive relevant changes in forms of communication as well as in structures.

Introduction

Mental health reform efforts in Austria have since the 1970s had considerable impact with regard to dehospitalization and a move to community orientation of mental healthcare. However, the incentive structure of the fragmented and federalized financing system and the lack of coordination still pose serious obstacles to the full implementation of systems of integrated care with a flexible and person-orientated approach (Meise et al., 2008). These facts as well as inequalities between different regions and between mental health and health services in Austria are in line with what the US Department of Health and Human Services lists as main obstacles to recovery orientation of mental healthcare (Amering & Schmolke, 2009) despite otherwise big differences between the two countries' health systems. The other notable constant as impediment to recovery across many different care systems and cultures are stigma and discrimination. The fight for better mental healthcare and against stigma and discrimination in Austria profits from a 30-year tradition of a strong national family organization. The user movement is quite established and influential in some parts of Austria but not in others, and there is no national user organization. In recent years, the beginning of

a shift from the traditional paternalistic medical culture towards a culture of partnership and empowerment clearly highlights the need for further developments in this direction. In Austria as well as in Germany, the topics of power, empowerment and recovery in mental health carry some special and especially painful connotations because of the terrible crimes of psychiatry during the Third Reich. Thus, discussions about empowerment and recovery cannot be led or viewed without considering this context.

History, a life story and a legacy

A pivotal moment for the World Psychiatric Association (WPA) and for the participants of a WPA Thematic Conference on Coercive Treatment in Psychiatry occurred in June 2007. Dorothea Buck, then 90 years old, gave her keynote speech '70 years of coercion in German psychiatric institutions – experienced and witnessed' (Buck, 2007). The large audience shared a moment where we were not ashamed to have tears in our eyes or running down our cheeks. Dorothea Buck spoke about her youth in the Weimar Republic and her five psychoses in the 1930s, 40s and 50s of the last century. She spoke

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about the meaning her psychoses had and their importance for her personal development to be who she is today – a highly decorated citizen, a pioneer of the user/survivor movement, a woman who is on speaking terms with political prominence as well as with the angriest young men of the anti-psychiatric movement. She has been an inspiration to so many of us in the world of psychiatry, allowing insights into very many different perspectives and experiences, and can certainly be considered the ‘mother’ of the user movement. The fact that she has no biological children is due to the fact that Dorothea Buck was sterilized against her will in a psychiatric hospital in 1936. At that time she was one of many people in psychiatric care with such a terrible fate – not only in Germany, but pretty much worldwide. What was unique to Germany and Austria was the truly murderous consequences of a ‘scientific’ discourse on eugenics under the Nazi regime. It is quite overwhelming to take in all the meanings that the term ‘survivor’ carries when confronted with her.

For the first time only in 2010, during its annual congress in November, did the German Association for Psychiatry and Psychotherapy ask the victims and relatives of the victims for forgiveness (www.dgppn.de/english-version/history/psychiatry-under-national-socialism.html). In his speech the President of the Association, Frank Schneider, said among many other things:

I stand before you today as President of an Association that has taken nearly 70 years to end this silence and recall the tradition of enlightenment through science in which it stands ... At this point I would like to express my admiration for Dorothea Buck. The sculptor and author, who was herself one of the victims, co-founded the ‘Federal Organisation of (Ex-) Users of Psychiatry’ in Germany. She has tirelessly dedicated herself to raising awareness of the issues and to ensuring that they are not forgotten ... In the name of the German Association for Psychiatry and Psychotherapy, I ask you, the victims and relatives of the victims, for forgiveness for the pain and injustice you suffered in the name of German psychiatry and at the hands of German psychiatrists under National Socialism, and for the silence, trivialisation and denial that for far too long characterised psychiatry in post-war Germany.

In Austria the similarly difficult process of ending the silence following the same atrocities was greatly enhanced by the efforts of Harald Hofer, a prominent user/survivor activist. He focused in a commemorative speech in 1995 on a ‘conspiracy of indifference’ as the obstacle to recognizing victims of

discrimination and exclusion not only historically but also today (Hofer, 1997, pp. 35–38).

Dorothea Buck talks about how she ‘experienced the psychiatric system as so inhumane, because nobody spoke with us. A person cannot be more devalued than to be considered unworthy or incapable of conversation.’ This very notion brought it about that in the 1980s Mrs Buck shared with Thomas Bock and Ingeborg Esterer her ideas about the need to prevent such inhumane conditions, and that is how the trialogue was born (Bock et al., 2000). ‘Triologue’ stands for communication among and between the three main groups of individuals who deal with psychiatric problems and disorders and with the mental health system – people with experiences of severe mental distress, family members/friends and mental health professionals. Trialogue encounters occur under special conditions – outside familial, institutional and therapeutic hierarchies and clinches. Trialogue group participants meet on neutral ground and communicate on equal footing.

In trialogue groups, users, carers and mental health workers meet regularly to have an open discussion with the aim of communicating about, and discussing the experiences and consequences of, mental health problems and ways to deal with them. The groups also function as a basis and starting point for trialogic activities at different levels, e.g. serving on quality control boards, and different topics, e.g. a work group on religion and psychosis, and activities, e.g. a trialogic training day for police officers.

In German speaking countries trialogues and ‘psychosis-seminars’, which follow identical principles, are regularly attended by altogether more than 5,000 people in over 150 trialogue groups in urban and rural areas (Bock & Priebe, 2005). Austria was one of the pioneers concerning the trialogue model. Following the World Congress of Social Psychiatry in 1994 in Hamburg, Austria took up the idea by hosting the first Vienna trialogue organized by a psychiatrist and a community service manager, the legendary user/survivor activist Harald Hofer, and Ingrid Rath, who at that time was the president of the Austrian family organisation (Amering et al., 2002).

The trialogue movement has brought about concepts and language different from the still widely prevalent narrow discourse of the medical model of mental health and illness. It is a new and exciting form of communication, an opportunity to gain new insights and knowledge, a chance to interact beyond role stereotypes, and a training ground for working together on an equal basis. Participants learn to accept each other as ‘experts by experience’ and ‘experts by training’. In other words trialogue participants acquire skills that are well suited to recovery-orientated work as well as to participatory approaches in therapeutic and service development decisions (Amering, 2010a; Slade et al., 2008).

Recovery, empowerment, and triadology

In international mental health, the issue of recovery has taken on a rather urgent dynamic in recent years (Slade et al., this issue, pp. 1–4). Recovery is government policy in English-speaking countries such as Australia (Oades & Anderson, this issue, pp. 5–10), Canada (Piat & Sabetti, this issue, pp. 19–28), New Zealand (O'Hagan et al, this issue, pp. 56–63), Scotland (Bradstreet & McBrierty, this issue, pp. 64–69), the USA (Ostrow and Adams, this issue, pp. 70–78) and England (Perkins & Slade, this issue, pp. 29–39), which traditionally impact considerably on other parts of the world, especially concerning mental health service and policy development. We do not know yet, whether languages other than English will have a term they want to use or whether they will adopt the English term into their language. In German speaking countries the English term has been well accepted and the interest for the concept is considerable and growing. Amering and Schmolke's book on recovery was first published in German in 2007, in English in 2009, and its fifth edition in October 2011 (Amering & Schmolke, 2009; Amering & Schmolke, 2011). For other parts of the world it will be interesting to see whether languages will come up with a translation that fits the meaning – or meanings – of recovery in its current use in English.

In any case, important aspects of the 'vision of recovery today' with its values of 'person orientation, person involvement, self-determination, choice and growth potential' (Farkas et al., 2005) are expressed in different European languages in the 2005 Action Plan endorsed in the Mental Health Declaration for Europe by Ministers of Health of the member states in the World Health Organization (WHO) European Region (WHO, 2005). This Action Plan identifies as one of five priorities for the next ten years the need to 'design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery'. It prominently includes a call to 'recognize the experience and knowledge of service users and carers as an important basis for planning and developing services' and collectively 'tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process.'

User empowerment

The essential element of what started out as the recovery movement in the 1980s is the voice of the user movement that was pioneering and instrumental in creating the concepts and language for recovery. Whereas Germany has had a national

user organization since the 1970s, the Austrian movement is more fragmented, with activities growing autonomously as well as in cooperation with mental health services and government bodies in different regions and at a national level. As a salient component, the Hearing Voices movement is active in Germany as well as in Austria. Monika Mikus, in collaboration with the Hearing Voices movement in Linz, the capital of Upper Austria, is the most prominent Austrian activist, propagating the concept of hearing voices in a broader context than the medical model. She is also an important supporter of triadology in Austria. She actively participates in many triadologic activities and is well connected to the international networks of voice hearers. Her own recovery story can be read on her website (www.stimmenhoeren.info) and she and her collaborators from Intervoice in Upper Austria (www.intervoiceonline.org) are engaged in preparing for the World Hearing Voices Day on 14 September 2012 under the motto of 'Hearing Voices and Recovery'.

The current convergence of the interests and activities of service users and their families and friends and those of mental health professionals is a central element in coming to an understanding of these new developments. These would not have been possible other than as an extension and logical consequence of the achievements of the consumer movement. What is new in the role that recovery plays today is the increasing readiness and expertise of those users and mental health professionals who are engaged in collaborative efforts. The fact that empowered service users and family carers have been successful in finding ways to understand and influence the professional mental health system, is key for any current developments towards recovery. Most conceptual and political considerations and decisions have evolved from collaborations between people with and without a lived experience of mental health problems and services and the psychiatric service system. Many of the most influential publications on this recovery have been written by users and ex-users of services and work-groups that have brought together individuals with and without personal experiences of services.

However, part of the user/survivor movement is sceptical and have voiced concerns along the lines of the 'risk of professional colonization of this very special and very different knowledge-base' (Glover, 2005, p. 2) and co-option of the recovery movement and dilution of its challenges by the mental health system.

Family/carers empowerment

Due to the fact that family members are the most common carers for people who are affected by severe

mental illness, empowerment of these carers seems to be of utmost importance. The support they need to give is very complex – emotional as well as practical. Empowering carers is a very broad concept. It means developing confidence in their own capacity, developing the skills of self-sufficiency, becoming self-advocates by taking control of their own lives. Carers only need professionals as guides and coaches rather than allowing them to take a paternalistic role.

Empowerment has a fundamental aim of ensuring that users and carers not only have more say, but more power in policymaking processes. The WHO/Europe partnership project on empowerment (www.who.int) with its best practice examples and empowerment indicators speaks a clear language in this respect. The European Federation of Families of People with Mental Illnesses (EUFAMI) (www.eufami.org) is a member of the project advisory board. The Mental Health Declaration for Europe and the Mental Action Plan for Europe identify the empowerment of people with mental health problems and those who care for them as a key objective for the next decade.

Empowerment can be divided into three general attributes:

- self determination,
- social engagement,
- sense of personal competence.

But how exactly does the process of empowering carers work? In reality it means getting information about mental health problems and different ways of treating and dealing with them. It means giving options to choose from and at the same time increasing the ability to sort out right from wrong as well as giving hope that changes can be made. It helps by increasing the carer's positive self-image, keeping their own identity, recognizing their own emotions and needs and setting the required boundaries to support their own well-being and identity.

EUFAMI has been in the forefront of empowering its members through various courses, conferences and congresses organized over the last years. One example is the Empowerment through Prospect programme. The Prospect family and friends training programme addresses the needs of carers. It implies that family members have rights and needs of their own. It enables them to gain confidence, improve skills, regain control and improve their quality of life. Participants demonstrate increased empowerment and reduced displeasure and worry.

Family members from 14 different European countries have been empowered through the Prospect programme so far.

- They push for improvement in making care comprehensive.

- They promote best practice in prevention, diagnosis and treatment.
- They contribute to remove the stigma that surrounds mental illness.
- They lobby for greater equality of mental health legislation throughout Europe.
- They highlight examples of good practice in the field of mental health.
- They act jointly at a European level combining their efforts and sharing experience.
- They promote and support further research.

Empowered relatives call for a change in training and training methods for psychiatrists, and a shift from a medical focus to person-centred training, and are able and willing to play their role in the training of mental health workers.

EUFAMI (2003) has endorsed the triadialogue from early on, and family carers are regular participants in triadialogue groups and other triadialogic activities.

Empowerment of mental health workers

In the framework of recovery orientation it is understood that mental health services can be helpful if they succeed in fostering control, choice and hope, but harmful if they undermine self-determination and convey pessimism and hopelessness. Empowerment and recovery orientation promote new roles and responsibilities for service users in their treatment with a focus on individual choice and shared decision making. The resulting challenges and changes in the therapeutic relationship confront mental health professionals with areas of conflict. The 'top ten concerns about recovery encountered in mental health system transformation' (Davidson et al., 2006, p. 640) not only prominently address the issue of resources, but also focus on issues of risk. Client choice appears as a possible source of 'neglect under the banner of recovery' (Meehan et al., 2007) as well as a source of provider risk – 'If recovery is the person's responsibility, then how come I get the blame when things go wrong?' Specific obstacles highlighted often include a funding system that is aiming at programmes for user populations and does not allow individualized packages and services' prognostic pessimism. Concerns by mental health professionals are often expressed in terms of fear of misunderstandings and illusionary hopes and expectations, lack of clear definition and lack of scientific evidence (Roberts & Hollins, 2007). Worries also concern the possible misuse of the concept in order to cut services (Roberts & Hollins, 2007), which would be a cynical further aggravation of an already deplorable situation of inequity and inefficiency of resources for mental healthcare and the protection of the human rights of

people with mental health problems all over the world. On the other hand, there is an understanding that through successful cooperation between different stakeholders the essential expertise through lived experience and the results of user-led and user-controlled research (Wallcraft et al., 2009) should provide the mental health field with a multi-perspective evidence base for policy and development (Rose et al., 2006) in order to strengthen the position of mental health in society.

A recent focus group study of triologue participants with a background as professional mental health workers indicates professionals' surprise at many new insights, but also their sympathy for themselves in their ability to interact without the pressure and the obstacles encountered in their everyday work situations, which make it difficult for them to bring out their capacity for a partnership approach to their work (Munk, von Peter, Schwedler, Amering, personal communication). In an Austrian survey of mental health workers' attitudes towards service user involvement in therapeutic and service delivery decisions professional service staff appear optimistic (Sibitz et al., 2008). The majority of respondents were supportive of user involvement and the expected benefit for clients and employees outweighed the anticipated risks. While there is still an inconsistency between this positive attitude and the actual lack of practical experience with such involvement in service planning and delivery in Austria, opportunities for new forms of collaborations are growing and triologue groups are certainly a good avenue of practising a communication style that allows interactions in new settings and beyond role stereotypes.

Triologue groups and psychosis seminars

Triologue facilitates communication about personal experiences in dealing with psychiatric problems and disorders and their consequences. Participants of diverse experience backgrounds – lived experience as users and carers as well as professional working experience in mental health services – strive towards giving up their isolation and lack of common language. Mutual understanding and necessary delimitation from the vast variety of the participants' different backgrounds concerning experience and knowledge are to be established. Trying to understand and share the complex and very heterogeneous subjective experiences leads towards establishing a common language, in which different forms of expertise and experience of participants of the three groups can be exchanged. For any particular topic of discussion a wealth of knowledge and experience is brought to exchange and provides a comprehensive resource for problem solving. Every participant has the chance to observe different interpretations of similar roles in participants of his or her own groups as well as of

the other two groups. Subjective views can be complemented by objective knowledge and put into perspective of different interpretations and handling of similar experiences. Thus a skill base for effective forms of collaborations can be acquired, which then extends its value into other situations, such as clinical encounters or problem-solving within family life.

Triologues and psychosis seminars usually take place weekly, bi-weekly or monthly and last between 90 and 120 minutes (often including a short break). Attendees vary between 10 and 60 people. Ideally there should be about an equal number of participants from each group of professionals, users, and carers. Community centres, education or communication centres are well suited locations. Triologue groups are moderated. Moderators can be recruited from all three attending groups. They can rotate or stay stable for some agreed time. Rules concern mainly that only one person should be speaking at a time and that personal information disclosed should not be spread outside the group. Participants may introduce themselves with their full name and identify themselves as belonging to one of the groups. However, this is not necessary if anonymity is desired. Characteristic topics covered in triologue groups include 'What is a mental illness?', 'What helps?', good and bad experiences with services, 'diagnosis as a trap – being put in a box', medication, crisis management, stigma and discrimination, work and social integration, power, powerlessness, and empowerment, spirituality and mental health, easy access to early help, recovery and social inclusion.

Research

One may conclude that triologue groups have been widely established with a wealth of practical experiences and anecdotal evidence for positive effects in all three participating groups and on their efforts to collaborate more successfully. Yet, the effects have not been systematically studied. One reason might be that they represent an unconventional setting, which is in line with neither the didactic approaches of psycho-education nor the usual rules of group psychotherapy. However, there are strong indications that all participants do gain in knowledge and that language and communication style develops and therapeutic effects can be documented.

Bock and Priebe (2005) described characteristics and possible effects of psychosis seminars and triologue groups:

- Many participants are characterized by a large amount of experience, often over many years.
- Main benefits for carers stem from gaining knowledge, sharing experience and being able to discuss concrete issues they struggle with within their

family with individuals, who know similar situations from their own experience, but with whom they are not intimately entangled through emotional and biographical bonds.

- Consumers benefit from respect for their individual experiences and a chance to make sense of psychotic and other experiences in their personal, social and biographical context.
- Professionals value not only the opportunity to gain new insights into the experience of psychiatric problems, but also review their role and their practices in new and comprehensive perspectives.
- Many attendants share the wish to improve current psychiatric practices and advance the concepts of mental illness and health.

Communication in trialogue groups is considerably different from communication in clinical encounters with role prescriptions, power balance and constant pressure to act. Clearly, trialogue facilitates a discrete and independent form of communication and acquisition and production of knowledge. The trialogue experience is indicative of our capacity for surviving and gaining from serious discussions of adverse issues. At the same time it highlights the great possibilities of cooperative efforts and coordinated action. Two important slogans around trialogue seem equally important: 'It's normal to be different' and 'Together we are stronger'.

Conflicts

Typical topics of controversial discussion and disagreement in trialogue are the boundaries between mental health and mental illness (Roe, this issue, pp. 48–55) and the concept of functional disability as well as different models of mental distress and disorder ranging from, for example, psychoanalytic and narrow biological concepts to normalizing approaches and anti-psychiatric notions – prevalent in considerable diversity in participants from all three different backgrounds. Rachel Perkins' statement that 'whether mental health problems are viewed in biological, social, psychological or spiritual terms, recovery is still a necessary process' (Turner-Crowson & Wallcraft, 2002, p. 249) best captures a consensus on recovery as a common sense concept that can be reached in trialogue groups after exciting disputes.

Another issue that prompts fruitful discussions is the question of how to assess and measure desirable outcomes of interventions. These discussions can be exemplified by the notions of social roles versus symptomatology and leading a meaningful life versus service use reduction and the need for research on individually defined outcomes.

Of course, matters surrounding the use of coercion in psychiatry often give rise to serious disagreements

and the expression of strong emotions and serious arguments. Many promising ideas concerning the reduction of coercive measures and mediating its negative effects receive attention during trialogue groups.

New insights for all as well as new concepts and formulations concerning the topic of compliance often arise from trialogue discussions. The complex notion and role of 'insight' – from 'adding insight to injury' (McGorry, 1992) to developing a workable model and language of distress and recovery for each individual – shape many rich controversies. Learning about participatory decision-making and formulations such as 'personal medicine' and shared decision-making (Deegan et al., 2008) are advantageous for all. Learning about data that show how only a small percentage of people with serious mental illness receive treatment consistent with evidence-based recommendations as well as about the scarcity of meaningful choice and access to alternatives (Stastny & Lehmann, 2007) are appreciated. Such discussions of course sometimes lead to shared feelings of powerlessness *vis à vis* the mental health resource situation and its future, but also often result in dedicated projects aimed at more successful lobbying for access and choice.

Another goal that is shared among many participants is to overcome prognostic negativism as can be summarized by the consensus statement of the WPA section on preventive psychiatry: 'Conventional illness-based clinical treatment should be broadened to a comprehensive, multidimensional approach to clinical care, based upon positive attitudes and reduction of prevailing skepticism regarding the possibility of cure.' (Lecic-Tosevski et al., 2003, pp. 307–315).

One main and constantly recurring topic is the commitment to honouring patients' and human rights and the necessity to combat discrimination and stigma. For trialogue, important progress has been made by professionals acknowledging that 'iatrogenic stigma begins with behaviour and attitudes of medical professionals, especially psychiatrists' (Sartorius, 2002, p. 1470). The fact that anti-stigma as well as anti-discrimination work is only successful if users and their families and friends are visible in the interventions targeting the public or the medical profession is salient knowledge. Trialogues are an important source for finding people that are willing and able to participate in such interventions. One example is the trialogic initiative organized by the Austrian family organization that regularly and with great success offers training for people working in the police force.

Today there are many different approaches to incorporate the 'trialogue idea' in psychiatric life in Austria. Trialogue events take place in its original conception in different federal states of Austria. Furthermore the idea of the trialogue can be

adopted within many different levels of mental health work. Thus, more and more psychiatric planning and also educational events are following the trialogue model and the idea of the trialogue model is generally encouraged for integration into psychiatric activities. This is why users and their relatives are more and more often invited to be a part of discussions or be a speaker in conferences and training. However, the implementation of the trialogue model into inpatient settings is not yet realized in the desired dimension.

International developments

Growing international interest has led to the recent establishment of trialogue groups in Poland, French-speaking Switzerland, France, and Ireland. The Mental Health Trialogue Network Ireland (MHTNI) is an exciting new community development initiative in Irish mental health and will also serve as a web base for international exchange on trialogue in the future (www.trialogue.co). The aim of the Irish Network was to 'empower communities in Ireland to become proactive in communicating about mental health through a powerful open dialogue and participatory process called Trialogue.' (www.trialogue.co) Project leaders talk about how 'in the past mental health was often seen as the domain of service providers, carers and the people who used the mental health services. However, within communities there is a huge diversity of knowledge and experience that can be used to transform our services.'

At the 2011 International Network Toward Alternatives and Recovery (INTAR) conference in Toronto (www.intar.org) Liam MacGabhann, Paddy McGowan and Michaela Amering presented the Irish Mental Health Trialogue Network and the workshop was greeted with great enthusiasm. The Toronto trialogue movement is growing, and plans were made for the implementation of trialogues in other areas of Canada and the US. INTAR is an organization that from the start in 2003 has gathered prominent user/survivors, family members, mental health professionals and advocates in an effort to establish collaborations in order to work together for new clinical and social practices towards recovery. Trialogue meetings in North America have in the past often been difficult due to long-standing conflicts between the user/survivor movement geared towards alternatives to the biomedical model and families looking for best practice professional help for their relatives. A commitment to trauma-informed language and communication styles for trialogues has been identified as an important prerequisite for talking openly to each other, especially

in the face of the growing database on the association of different diagnoses from the psychosis spectrum and traumatic life histories of people affected (e.g. Schaefer & Fisher, 2011).

Triologue experiences in other parts of the world have shown impressively how the trialogue setting has very similar effects in different cultures. Trialogue meetings at WPA congresses in recent years in Istanbul, Buenos Aires and Beijing (Amering, 2010b) invariably resulted in animated discussions that were characterized by an openness and mutual appreciation of diverse experiences and positions. Considerable interest and energy towards implementing and sustaining a setting that regularly allows such moving and richly informative exchanges were expressed.

This is in line with the WPA's work in its first trialogic working group within the framework of the WPA Action Plan 2008–2011. The Task Force on Best Practice in Working with Service Users and Carers under the leadership of Helen Herrman published its recommendations to the international mental health community in 2011 (Wallcraft et al., 2011). The ten recommendations call for a partnership approach on all levels of mental health policy and care and promote shared work worldwide to identify best practice examples and create a resource to assist others to begin successful collaboration. In consultation with the Task Force, the WPA Committee on Ethics drafted a paragraph based on these recommendations that has been unanimously endorsed as an amendment to its Madrid Declaration on Ethical Standards for Psychiatric Practice by the WPA General Assembly in 2011.

Conclusions

For Austria it has been formulated that in order 'to achieve a power-balanced mental healthcare, the establishment of participatory processes where all actors' representatives are included in decisions as to resource allocation and service development is a key requirement within the organizational structure' (Zechmeister et al., 2002, p 128). For the success of such processes collaborations according to the principles of trialogue with its focus on partnership on equal footing and communication between people with a lived experience of mental health problems and/or service use, their families and friends and professionals working in mental health beyond role stereotype are essential elements. Also, the prosperity of such collaborations bodes well for the emerging evidence-base for recovery orientation as it includes an urgent call for a partnership approach which allows all experiences and all forms of evidence to be used at all levels. Cooperative and coordinated efforts offer

formidable chances to reduce stigma, discrimination and social exclusion, which are currently seriously limiting clinical and other efforts towards recovery worldwide. While the task appears huge, the combination of the wisdom and energy of the user and carer movements and the current need of many clinicians – and academics – in psychiatry to overcome reductionistic and uninspired conceptual frameworks, might just work in favour of substantial changes now.

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