Performance Management of the NHS’ Mental Health Care Service Delivery in England: The Role of the Service’ Actors’ (Clients) Collaboration through Dialogism

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Abstract  A welfare state has a responsibility to provide health and social services to the citizenry. The state delegates that responsibility to a number of actors, each of which has its own performance management criteria. To ensure coherence, it is important to manage their performances collectively taking into consideration all the actors’ inputs rather than only that of government or its agent, the NHS. This turns out to be a difficult task especially that of the mental health care services. The author will be looking at a possible solution to this problem based on the assumption that it is possible to change the way the actors present their stories by bringing them together to share their purposes and common action through the notion of dialogism as way of maintaining plurality of logics: different voices (polyphonic), styles (stylistic), space-time conception (chronotopic), inter-animating discourse (architectonics) and the dynamic interplay of these different dialogisms (polypi). It is this process of plurality of logic that the researcher termed, the Third Cybernetics Evolution, as a way of sequential processes from the First Cybernetics through the Second Cybernetics to the Third Cybernetics. It is argued that implementing these, allows for improved communication among actors, as a way of achieving high quality service. It is suggested that implementation of these concepts and processes implies the use of storytelling as a facilitatory system. It is shown that all actors in the mental health care services delivery make use of this system, albeit often inefficiently. Therefore this may lead to dissipation of the system in the future. To prevent such dissipation, the existing structure needs to be improved through spiral relationships via communication and collaboration through dialogism. The paper aims at flagging the important role played by the weaker actors in collaboration with stronger actors in improving performance management of the NHS’s mental healthcare service delivery through Actors-di alogism-system. The paper also focuses on proposition of a system to address issues affecting collaboration among the actors of the mental healthcare service in England.

Keywords Third Cybernetics Evolution, Mental Health Care System, NHS, Collaboration and Dialogism

1. Introduction

In qualitative research, one of the issues is how to explore the meaning that actors bring and generate within social interactions. However, in most research on mental health care services, the concentration has been on the inputs of the strong actors namely the government, the NHS and some voluntary organisations with less attention to the weaker actors like service users, the family, or relatives, carers and advocates. This paper will focus not only on moving the ‘gear’ to higher level of service users’ controlled and ‘emancipatory’ approach to research but further to the level of dialogism where all stakeholders are involved in a collaborative effort.

The state through its agent, the NHS, is responsible for ensuring that the health needs of the citizenry are adequately met. The NHS sometimes sub-contracts some of its services to other organisations or actors (in this case, they are also clients) like the voluntary sector organisations, private organisations etc. The government provides the resources in terms of equipment, funds, facilities and personnel needed to deliver the services to the patients. The government in the process of resourcing the NHS sets targets through the Department of Health for health and social service providers. But for the health care system to be effective in meeting the local needs and expectations, it has to include the inputs of the clients and patients. According to some clients (patients) interviewed in Lincolnshire in England, the system is not performing because some of their colleagues had to go back to the hospital after their medical treatment because the ‘system’ has no adequate provision for social integration and social needs of the patients. It is argued that, where such provisions exist, the government decides what is needed and the criteria for measuring and managing the performance without considering the local needs of the citizens which may be different from one locality to another. The clients (patients) claimed that where the system seems to give
attention to their needs, the government thinks the system is not performing because it is not meeting the targets set and therefore closes down such hospitals or departments in the hospitals even when the citizens protest.

It must be stated that in recent times Governments policies on health delivery since the creation of the NHS in England had changed from focusing mainly on service providers to include all stakeholders’ interest. The Government during the Labour (years) administration through reforms initiated policies aimed at bringing on board patients views and interests. These reforms shifted the focus of health care delivery including mental healthcare from an agenda based on managerialism, marketisation and bureaucratic expertise to service users’ experiences, expectations, desires and wishes (Titter, 2009). This ‘wind’ of reform in NHS is what the Labour government termed the Patients and Public Involvement (PPI).

The concept of PPI aimed at empowering patients and the public to be involved in decision making processes. This process can also be termed ‘Participatory governance’ by the actors of the health care services (Turnhout, Bommel and Aarts, 2010). It is expected that through the process of dialogism, the Actors-dialogism-system, service providers would be accountable to patients and the public but not only to the Government.

It is being argued that mainstream mental health care research tends to be clinically dominated, reflecting the linear and hierarchical approaches of medical professionals who based their analysis on quantitative and experimental testing with less attention to qualitative research. One of the focuses of the paper therefore is to give attention to qualitative research in mental health care services by analysing how when given audience to and manage service users, carers, the family and the community’s inputs through the Actors-dialogism-system will improve the quality of the service.

The paper begins with brief historical explanation and the development of mental disorders and how the UK Government have tried to improve the quality of the service via Community Care Act. This was followed by the methodology and design adapted to investigate the issues coming from the collaboration among the actors of the mental health care. The paper further looked at the way forward to improve the quality of the service by analysis of the service delivery via First, Second and the Third Cybernetics (dialogism) and finally, the conclusion of the paper.

2. Mental Health Care Services in UK

Mental health problems account for significant proportions of diseases in UK. However, access to treatment though available is not being fully utilised because of a number of issues in which re-organisation of the service is urgently needed. The issues of mental health care have become important because of its significant burden on the government and the community. It is argued that, it accounts for nearly 12% of the global burden of disease and will hit the target of 15% of disability adjusted life years lost to illness by 2020 (WHO, 2003).

The economic and social costs to the state and the community have increased with the development of science and medicine. Before the 17th century, issues of mental disorders were attributed to spiritual explanation and therefore its treatment. However, with the development in science and medicine, secular explanations were given to the mental disorder as a physical state of the mind leading to the confinement of such people in secured places.

During the first part of the 18th century however, the dominant view of mental disorders being incurable and the justification of being sub-humans and therefore their status, living conditions and physical restraints to places of confinement changed.

The pressure from society and humanitarian groups about the human rights of people with mental disorders led to a call for reforms in the treatment of mental patients and therefore the introduction of moral treatment programmes. This led to deinstitutionalisation or de-hospitalisation of the service delivery aimed at creating the opportunity to implement some of the ideas developed on social network and community support system as alternatives outside psychiatric institutions.

However, the way mental health care service delivery is organised determines the effectiveness of the interventions and the ultimate fulfilment of the objectives of the service. The quality of the service determines the likelihood of one achieving the desired outcome of becoming employable, independent, self organised and part of the community. The quality of the service delivery is important because it ensures that service users receive the care and support they require; it also ensures that there is improvement in their daily life activities and living; it provides an acceptable and relevant clinical and non clinical care in order to reduce the impact of mental health problems; and finally, to make efficient and effective use of resources available to the service providers (Murray and Lopez, 1996).

In UK, the government’s policy on community care services was strongly developed with the third sector in mind. This is evidenced in the Community Care Act (Department of Health, 1990) which embraces the full involvement of other actors in mental health care services in particularly, the Third Sector. Despite this policy however, the collaboration between the statutory organisations and the other actors, particularly, the voluntary sector organisations to improve the quality of the service is weak (Simpson, 1996) and problematic, (Adams, 1990). The weakness of this collaboration has been attributed to lack of understanding of each other’s objectives, missions or vision and organisational practices, methods and significantly, differences in respect of their structures, resources (Wilson, 1994) and their value systems (Mosher and Burti, 1994). There is also an issue of confidence and trust by the professionals of the formal sector about the capabilities of
semi skilled personnel of the Third Sector and the private sector. Gratham (1995) surveyed 55 general practitioners in his area and found that only 18 per cent had made some referral to the Alzheimer’s disease Society. Some professionals even see any sharing of skills, knowledge and experiences with the non-professional as a threat to their profession (Gussow and Tracy, 1976). The paper aims at proposing a system of resolving the problem of collaboration among the actors through participatory communication (dialogism), the Actors-dialogism-system.

We will now look at the methodology used in this research to identify the problem of limited collaboration among actors of the system, the way forward to improve the interaction and therefore the communication among all the actors of the mental health care system in England. It is expected that this will ensure maximum use of all resources including inputs from the weaker actors.

3. Methodology and Design

The study is intended to expand on our understanding of how to improve performance or improve the quality service through increase of interaction among the stakeholders in health service delivery, particularly in mental health care delivery system. A phenomenological method was used in this research because it is one of the methods which helps to identify phenomena through the perspectives of the actors in the situation. In human interactive situations like the mental health care delivery, it enables the researcher to gather in-depth information and perceptions through qualitative methods of interviewing and focal group discussions (Gerber, 2001).

Phenomenology could be looked at as a philosophy, but also as a research method for gathering and analysing data (Goulding, 1999). As a method, phenomenology allows for the discovering of people’s ‘world views’, thus capturing their subjective experiences. In all, eighteen (18) managers from the Lincolnshire Partnership Foundation Trust (LPFT), Lincoln County Council (LCC) Lincoln County Hospital (LCH) and some voluntary sector organisations in Lincolnshire were interviewed. In addition two focal group discussions were also conducted.

Using the phenomenological methods of interviews and focal group discussions, the experiences of the participants were organised by means of storytelling and interwoven with living story method. The living story theory, which is the bedrock of living story method is defined as the emergence, trajectory, and morphing of living story from ante-narrative-conception to the end of decomposition of a story (Boje, 2008; 2013). A living story is a story which lies in-between dead and alive narrative and between forgotten and revitalised story. It is therefore a critical ante-narrative, where a living story traces and pre-deconstructs an ongoing interweaving living story narrative and ante-narrative to become self-deconstruct. In the process of deconstructing stories, some stories die and others rejuvenate or emerge and better still some revolve. The living story method is therefore interplay of dead (ended) narratives with living emergent stories. It tells the emergent stories in the context of fragmented dead narratives.

The data collected were transcribed and analysed by reading and analysing the data in depth to search for differences and patterns of suggestions (stories) in relation to how to improve service delivery. Each interview was used to probe into issues which were not clear from the previous interviews, in order to create a ‘rich picture’ of the situation. The data were interpreted, continuously revised and the context broadened using the notion of ‘Ideal interpreter’.

Interpretivism is assumed to be a mental content judgement-dependent; that is, the facts about propositional attitude of people are what is being captured by the judgement of the Ideal Interpreter (Johnston, 1993a). However, for Dennett and Davidson (sited in Wright, 1989), the Ideal Interpreter is a third-person who interpreters someone else. The interpreter can also be a first-person account where the interpreter is taken to be the subject of interpretation. Dennett’s and Davidson’s version of interpreter is however, formulated on the thesis of biconditional: that X belief Q, therefore if there is an informed Ideal Interpreter, the Ideal Interpreter would be disposed to attribute to X, the belief that is Q. There is however, a problem with this line of argument of interpretivism. There is no a priori guarantee that the Ideal Interpreter will find answers to all the meaning of the subjects’ beliefs particularly those that are linguistically expressed. It is therefore necessary that some sufficient conditions are held as a constraint to strengthen this identified weakness of interpretivism, that is, there is an appropriate informed Ideal Interpreter who would be disposed to attribute X, the belief that Q. Interpretivism presupposes therefore that facts or believes given by the Ideal Interpreter will be the facts participants believe in an ideal situation, that is the assumption.

For the purposes of this research, the Ideal Interpreter is assumed to have a sufficient database of non-intentional and intentional sources of information, knowledge and experience to interpret the subjects’ meanings, believes, experiences and desires. The Ideal Interpreter uses daily life application of intentions in addition to scientific minded observations and experiences of non-intentional in order to arrive at the best possible meanings of the participants’ experiences and believes in order to detach the meanings of the participants’ experiences at the individual level.

The next section looks at how interaction among the actors through participatory communication will help to achieve the ultimate level of collaboration that will encourage improvement in the quality of the service delivery system. It does that by analysing the data collected from the perspectives of the First and Second Cybernetics and a further extension of the analysis into dialogism of polyphonic, stylistic, chronotonic, holographic and finally, architectonic from the perspective of Boje (2008). This, the author termed it the Third Cybernetics.
4. Actors’ Collaboration: Way forward to Improve the Quality of Service

It is proposed that to improve the quality of service, collaboration among all interested parties of the mental health care delivery system is necessary in order to meet the needs and expectations of clients. One can say therefore that, the collaboration among the stakeholders is not happening because of communication problems among the actors of the service delivery system. This was identified and confirmed from the data collected and organised as per the emerged sub themes (namely: state control of the mental healthcare system; organisational culture; service delivery as continuous process; service users needs and expectations; and participatory communication) from interviews conducted among managers and directors from the Lincolnshire Partnership Foundation Trust (LPFT), Lincoln County Hospital (LCH), Lincoln County Council (LCC), some voluntary sector organisations and some service users from the county, (these are some of the actors of the mental health care system).

There are a number of possibilities to resolve the problem identified:

One possibility is to focus on information overload in the organisation of the NHS. It is proposed, by increasing the level of interaction among all the interested parties via the use of participatory communication after a suitable destabilisation of the existing communication system, the quality of service will be improved.

Another possibility is the proposal to use the method of ‘information overload’, i.e. an intentional increase in information through the communication channels of the NHS, as a way to support a suitable destabilisation of the interaction among all the interested parties to stimulate self-organised improvement.

The third possibility, the one that is the paper’s focus is the possible improvement in the organisation of the mental health care system within the NHS. It is proposed therefore that the use of ‘information overload’, a process to achieve participatory communication is necessary in order to increase the level of interaction among all the interested parties and also to stimulate self-organisation of the system using the dialogism approach. It is when the level of interaction in the decision making process is increased and more attention given to the beneficiaries of the system through the supporting groups’ representatives that the system may attain optimum performance and meet clients’ needs, expectations and in fact satisfy the needs of all stakeholders, that is achieve ‘complete collective satisfaction’.

One theme that emerged from the interviews conducted was the organisational culture of the NHS, which mainly is about professionalism of work, staff and the way task is undertaken or service is rendered. The NHS: PCT and LPFT staffs have the idea that work should be based on specialisation of tasks leading to the departmentalisation and training of staff accordingly.

To deal with the culture of professionalism and also to improve the services delivery, there is the need for collaboration, because after medication and discharge from hospital, service users may need the social support mainly provided by other actors including the Third Sector. It is a fact that the majority of mental health patients preferred to work with and receive help from the non-professionals than from the mental health professionals (Barker et al, 1990). Research has proven that, for mental health problems in particular, the benefit of social support cannot be swept under the carpet especially at the time of discharge from hospitals and that social networks has been very influential in the improvement of quality of life of service users. (Green et al, 2002).

It is therefore important that collaboration is encouraged among all stakeholders to achieve complete collective satisfaction. This is necessary because no single organisation can meet the needs and expectations of mental health service users on its own, therefore a multi-agency model (Actors-dialogism-system) should be explored via collaboration; training of self help groups, sharing information, collective service evaluation and feedback to improve services. It is also important to incorporate other methods used by the Third Sector staff to strengthen the collaboration between the third sector and the formal sector (Simpson, 1996).

It is important to note that in order to evaluate or manage the performance of the service delivery in mental health care and to improve the quality, one need to go beyond the medical model, diagnosis of symptoms, treatment and side effects of disease. This may involve input/output system performance evaluation. This system of input/output evaluation is what the researcher calls the First Cybernetics (Boje, 2008). However, for total treatment of mental problems, the inclusion of social well being of patients (service users) is necessary. This in a collective term is referred to as Health-Related Quality Of Life (HRQOL). The HRQOL generally includes the domains of physical functioning, psychological, well being (e.g. level of anxiety, depression, fear of recurrence, etc); and social functioning of the patients. However, the process of evaluating the performance of the mental service delivery system goes beyond the medical model, input/output approach, to include the system’s environment (open system approach).

Cybernetics at the level of input/output approach is about negative feedback within self-stabilising loops that lead to a regulation of a system, in order to generate a state of equilibrium (Ashby 1957). When Cybernetics is related to external and centralised control of black boxes and goal-oriented behaviours, in order to sustain complex interactions with the environment over time (Beer, 1966 p.257), then, the system turns to become an ‘open system’ a Second Cybernetics system or approach (Boje, 2008; 2013). Cybernetics might also manifest itself in connected networks of components in interaction. As a result of such interconnectedness, multiple feedback loops may be formed.
within the networks, which allow for self-regulation and the production of ‘global’ order. This implies that a system can also have distributed control, which does not depend on an external centralised control unit (Ashby, 1957), this is termed the First Cybernetics.

The concept of negative feedback is crucial for achieving stability band adaptation. Negative feedback is a necessary corrective action, which when implemented produces a specific outcome by modifying a course of action. The consequence of this arrangement is that, the input of the loop is affected by its own output. Hence, a satisfactory outcome can be achieved following a negative feedback process, indicating whether the system has achieved its goal or fallen short. It does this by providing backward information on the resulting outputs, in order to be used for the manipulation of the inputs of the system (Ashby 1957 p.53-54). This is what is expected from a participatory communication process via dialogism of actors’ interaction if fully implemented.

The First Cybernetic approach as described above is not very suitable for a complex system like the mental health care system. The reason being that as adaptation and stability is achieved; the system is bound to dissipate (dysfunction) with time because of the continuous changes and constant increase of the variety in its environment, which may exceed the capacity of the input/output cybernetics system. This is in line with the reverse interpretation of the Ashby’s Law of requisite variety. Therefore one needed to go beyond this level of abstraction to the Second Cybernetics system which is the open system thinking. It is an open system because it receives its feedback not only from within the system but also from the system’s environment. Again being an open system, it means the system does not only exchange energy with its environment but also ‘matter’ from the environment. However, in both the First and Second Cybernetics approaches of improving performance or quality of service, there are elements of linearity and hierarchy, which in themselves create problems.

The mental health care system, as a human institution with different people with different needs and preferences, it is expected that the capacity of its meta-system transition (co-ordinated process) will not be able to cope with the variety of needs and preferences from both inside and outside the system and therefore dissipation is bound to still happen. This is what has resulted in various forms of reforms all aimed at resolving the problems associated with increase variety of needs and preferences by the various actors. One cannot avoid the dissipation because all the actors have their own different goal-oriented values which are not static but grow together with a diversifying environment, which may be different from the government’s target. The only way to resolve the problem in order to achieve the desired high quality of service delivery (complete collective satisfaction) is to move to a higher level of co-operation among the actors where the relationship between them or the functional imperative is neither a linear nor hierarchical but spiral relationship of polypi dialogism. This is an inter-co-ordinated system function of various dialogisms, namely the polyphonic, stylistic, chronotonic and architectonic. Let us now look at dialogism in a bit detail as per its application in the investigation conducted.

5. Dialogism

A polyphonic is a written, visualised or orally told stories by all the stakeholders of a system as opposed to mono vocal narrative or written strategy by an expert or a dominant actor (Boje, 2008). It is a construction by many embodied voices, logics and perceptions. It could be visual arts, photos, décors, drama or oral storytelling that communicates through interaction. It involves getting stakeholders to engage in storytelling through the sharing of ideas, experiences, knowledge, skills such that each and every one’s voice and logic get enunciated and subjected to questioning until a form of understanding is reached on the particular issue and how to deal with it.

It is this process of interaction among the actors of the healthcare service that is none existent and therefore affecting the quality of the service being provided to mental patients in England. It is the belief of the author and interviewees of the investigation that if the process is initiated and implemented it will increase the level of interaction and ultimately improve the quality of the performance and the quality of the service.

However, the interaction or communication among various actors is not necessarily a function of producing a consensus but usually results in open situation where the issue is being accepted or rejected. The actors in the process therefore reach a point, which bifurcates into further alternatives. The process of bifurcation itself is a process of reducing complexity of the issues that come to the ‘floor’ of the dialogue into simple terms and meanings.

The Stylistic is a dialogue; it is an orchestration of image or dialogism among various means of dialogue or communication namely oral telling of stories, print and video media, internet, gesture-theatrics, décor and other architecture modes of image expressions. It is a juxtaposition of varied styles for interaction. It can also be described as the interactivity of various modes of expressions of organisational image.

For Weick (1995), sense making could be a way of looking at stylistic on the basis of public sense making control. Sense making is about the act of or the process of placement of items into frameworks, comprehending, redressing and constructing meanings from the frame such that interacting with it generate mutual understanding and patterns. This form of framing and reframing (producing and reproducing) is a stylistic feature. When this participatory communication is initiated in the system, it will create an environment for the weaker actors’ meaning or sense making of what they see as the quality of service being recognised and incorporated in the policy initiatives of the Government. It also determines the style of delivery of the services and where necessary the revision of the style to meet certain
moral obligations. The power of stylistics is in the way that stylistics is able to connect or depend on the working interplay of the roles of all stakeholders in the service delivery to achieve a common purpose.

Chronotonic is a relativity of time and space, in terms of functions; it is like Einstein’s theory of relativity, with time being the fourth dimension of space. Chronotopic dialogism can also be described as a holographic relation of centring (centripetal of chronotopes) and amplifying (centrifugal of chronotopes).

Holographic is storytelling that runs from one dimension (monogram) to multiple complexities. Storytelling is holographic in the sense that it can interrelate to more than one complexity. Storytelling is infectious and can be tracked across space-time. It is the input from patients and the public through the PPI concept as introduced by the Labour Government that the author of the paper believes has elements of holographic storytelling. However, in England the participation of the public in governance of health care has been of diverse nature with participants being recognised as service users or the public rather than as citizens whom service providers are accountable to. This indicates the complexity of the interaction among the actors and therefore the sense of the holographic nature of the Actors-dialogic-system as would be introduced. It interrelates to more than just one complexity of collaboration. It also leads to improvement in the quality of service via accountability to the users of the service.

Architectonic is the orchestration of ethics in relation to aesthetic and cognitive storytelling. Architectonic dialogism mainly focuses on the interaction of several societal discourses that affects organisation’s performance. The three basic discourses are ethics, aesthetic and cognitive which are answerable to one another. Kant (1993) and Bakhtin (1981) described architectonic as societal discourses. However, each author has his own divergent views on this notion. Kant invented the ‘cognitive architectonic’. For him architectonic is the art of constructing a system. He argues that reason cannot permit our knowledge to remain in an unconnected and rhapsodistic state, but requires that the sum of one’s cognitions constitute a system. Kant sees architectonic as cognitive notion deeply implicated in the construction of systemicity. Bakhtin preferred the term ‘consummation’ to construction and was careful not to assume a monophonic or monologic or mono language system. He looked at a system as ‘systemic’, that is unmergedness and unfinalisability of a system.

This is the way forward for the proposed mental health care system, where there is no room for homeostasis state or dissipation because the process of ‘polyphi’ is ‘unmergedness’ and unfinalisation’. Bakhtin went further from Kant’s cognitive architectonic discourse to add ethical and aesthetic discourses. He defined Ethics discourse as the notion of ‘answerability’ which is a description of how one domain of discourse is answerable to another. The Aesthetic is about how and for whom a given systemicity is constructed or designed.

One last concept to mention is the Polypi. Polypi is the inter-dialogism of polyphonic, stylistic, chronotopic and architectonic. It is a multi-dialogised complexity where the four (4) notions collide. The polypi is therefore a coordination system of the dialogism. Polypi is the ‘NHS’ as per the mental health care system which has the responsibility of coordinating the roles played by all the various actors to ensure that the process result in performance improvement and therefore the quality of the service to service users, the family and the community in general.

6. Conclusions

The complexity of dialogism, the polypi, which explores multiple of dialogisms, is in line with Letches’s (2000) phenomenal complexity and also Stacey’s (2006) emergent complexity. The properties of the complexity are cumulative rather than successive. In cumulative, all the lower orders of phenomenal complexity (polyphonic dialogism) interrelate with higher orders of dialogism (of fragmented ante-narrative and petrified narratives that follow Aristotelian structures of wholeness and coherence of beginning middle and end in storytelling.

Weick (1995) looks at the complexity in retrospective sense making of experiences and narrative of coherence and control by people whose current experiences fit into past meaning structures. This I think offers a revolutionary breakthrough in complexity thinking or approach. This approach is not only compatible with phenomenal complexity theory, but also provides a way to overcome a major crack or gap in knowledge creation. The same argument applies to synchronous and diachronous approaches to storytelling organisation. The synchronous approach (being the current experienced story) looks at storytelling organisation at a particular point in time, rather than over time while the diachronous approach (being narrative) looks at storytelling organisations in historical development. Therefore in order to achieve the wholeness, one has to bring both approaches together through the phenomena, the ‘polypi’ which is the dialogism of history or background of current issue(s) plus current experiences of users of the mental health care delivery system.

A typical and familiar example of narrative and emergent stories of dialogism is the death of Michael Jackson, the pop star. A network of organisations constructed narratives along side stories of Michael Jackson’s death. In the narrative and emergent stories of his death, the polypi of dialogism is contentious: polyphonic logics struggle to converge or agree; the multiple stylistics of verbal, written and posters or pictures contrast; the multiple chronotopes of varying temporalities and partialities diverge, and the ethical discourse of architectonic questions reverberates into many other discourses. It indicates therefore that the complexity of the narratives and emergent stories of Michael Jackson’s death is unmerged and ‘unfinalised’ if one wants to get to the
Dialogue in practice.

Dialogue is a complex notion, it is a weave of many storytellers and listeners who together co-construct the meanings of a dynamic that reduce living story into complete collective meaning as a necessary outcome as opposed to antenarrative amplification (Boje, 2008).

The contribution of this paper to knowledge is the proposal that although linearity or hierarchical approaches to knowledge creation is making impact in society, the impact will be great and more beneficially however, if the interaction among the actors is on a spiral relationship, that is on a collective level by way of collaboration to resolve the problems identified collectively in order to achieve ‘complete collective satisfaction’ particularly in the service delivery system.

In the case of mental health care delivery system ‘Complete collective satisfaction’ is achievable only if the mental health care system moves from the level of abstract categorisation such as planning or reforms to the level of collaboration. This means that the way forward is therefore, the re-organisation of the system which is exclusive to the NHS or government (target setting) to a level of multifunctional and interdependent interaction where consideration is given to the environment, other service providers, clients, financiers, the public and in fact all stakeholders.

Although the research methodology is of a practical nature, that is, can be applied in a practical situation, the system design and the operational functioning of the Actors-Dialogism-System seems to be abstract in nature. It will be of interest how the model and the knowledge gained can work in practical situations. It is important, therefore, that in the future, the author explores how this will work in a typical organisation. This will open the opportunity to explore what promote self-organisation, self-evolution and match to purpose interaction between an organisation and its environment in practice.

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