Open Dialogue - Putting relationships at the heart of a public mental health service.

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open dialogue uk

Related organisations/approaches

R. D. Laing & Philadelphia Association

Richmond Fellowship

Soteria

Arbours Association

Hearing Voices Network

Windhorse

Values

‘Being with’ (Not ‘doing to’)

Phenomenology

There is meaning in ‘madness’

Community

A place of safety

Agency, capability

Ordinary life/language

Open Dialogue - Geography

Western Lapland
Population 63,000

- Two towns: Kemi and Tornio - almost 70% live here.
- Remainder of population are quite dispersed over a rural area.
- One hospital (one ward) and several outpatient clinics, in the towns and municipalities.
- Staff consist of nurses, psychiatrists, psychologists, rehabilitation workers, social workers and peer support workers.
- High level of collaboration with other public agencies.

Open Dialogue - History

- In the early 1980s a group of professionals, some trained in family therapy, were looking for **ways to improve** services in Western Lapland.
- **Network meetings** since 1984.
- **Systematic research** on the approach since 1988.
- **Systematic 'family therapy' training** for almost the entire clinical staff since 1989 - at one point 90% of all staff in the Western Lapland service were trained to this level.
- **Practice first**, theory later.
- **Learning from mistakes** and being guided by feelings of **comfort and discomfort** - continual reflection, which includes research.

Two key aspects to Open Dialogue

(and 7 principles)

A way of organising services

1. Immediate Help
2. Social Network Perspective
3. Flexibility and Mobility
4. Responsibility
5. Psychological Continuity

A way of being with people

6. Tolerance of Uncertainty
7. Dialogism

12 key elements of dialogic practice

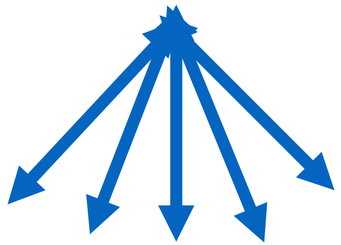
1. Two (or more) therapists in the team meeting
2. **Participation of family and network**
3. Using open-ended questions
4. Responding to clients' utterances
5. Emphasising the present moment
6. Eliciting multiple viewpoints
7. Use of a relational focus in the dialogue
8. Responding to problem discourse or behaviour as meaningful
9. Emphasising the clients' own words and stories, not symptoms
10. Conversation amongst professionals in the treatment meetings (reflections)
11. Being transparent
12. **Tolerating uncertainty**

Olson, M., Seikkula, J., & Ziedonis, D. (2014). The key elements of dialogic practice in open dialogue: Fidelity criteria. Worcester, MA: The University of Massachusetts Medical School.

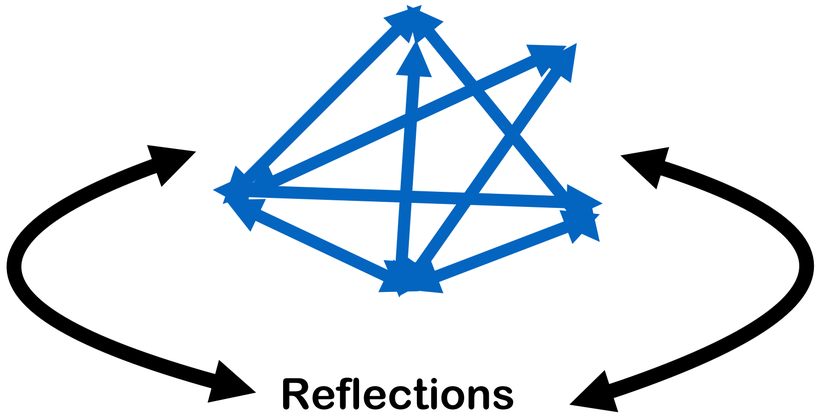
Network Meeting

Welcome Seating Introductions Timeframe Introduce Reflecting?

History of the idea of this meeting? How shall we use our time?



All topics are important. How shall we begin?



Anything else? Decisions? Safety? Next Meeting?

From division to difference

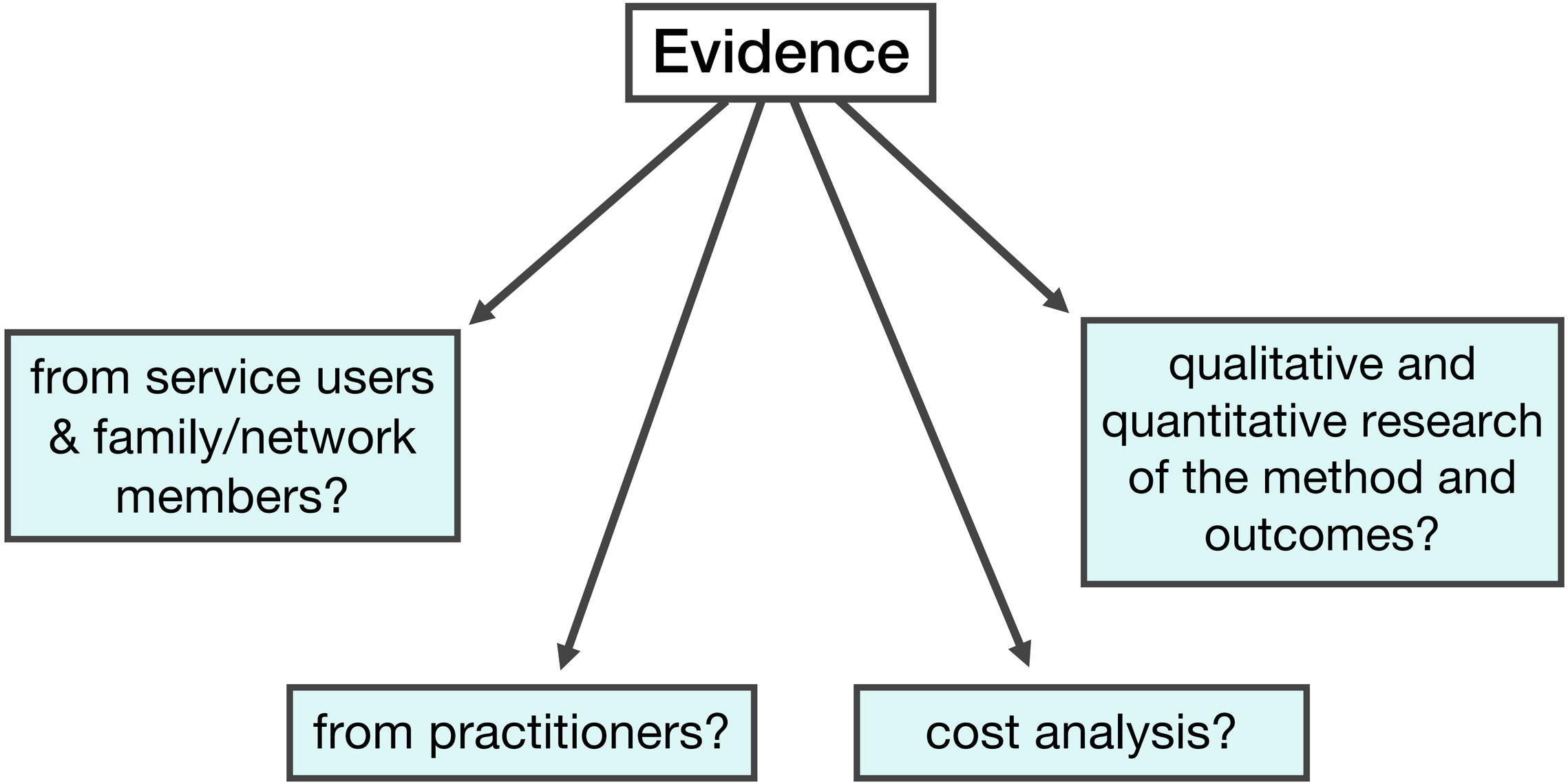
- A key aspect of our role as Open Dialogue practitioners is to create and hold a space in which network members can start to more freely express themselves and to listen more to themselves and each other.
- If this proves possible, network members are likely to have a fuller understanding of the differences that exist both between them and within them and, in time, a greater ability to embrace/live with these differences.
- If the network can respect their inner and outer polyphony in this way, they have more chance of being able to move forward together and to make any necessary decisions.

Process notes

- With all the families we have worked with at Open Dialogue UK it has turned out to be the case that it is not just the person at the centre of concern who is suffering.
- There is often trauma in the histories of people experiencing ‘psychosis’ and the family more generally, and network meetings can be a setting in which to address such experiences.
- Open Dialogue is a creative process, founded on social constructionist roots. The process has the potential to be transformative for the family/network, as they are able to address issues in a way that hasn’t been possible before.
- The process also has the potential to cultivate ‘social capital’, but of course some people are very isolated and so we may need to be creative in the way we build community.

Open Dialogue and TC principles (Rapaport, 1960)

	Therapeutic Communities	Open Dialogue
Democratisation	Flattened hierarchies. Emphasis on the capability, agency, responsibility and lived experience of community members. Therapists are not experts. Transparency about decision making/limit setting.	Flattened hierarchies. Emphasis on the capability, agency, responsibility and lived experience of community members. Therapists are not experts. Transparency about decision making/limit setting.
Permissiveness	Behaviours and attitudes/beliefs that would not be tolerated in other settings, because they are considered too problematic or unusual, are permitted in TCs, providing they do not damage community members.	An invitation to network members to express themselves authentically, to share more about their experiences/perspectives, however strange these may seem to others or difficult it may be for others to hear.
Reality confrontation	Reality confrontation counterbalances permissiveness, allowing TCs members and staff to give each other constructive/thoughtful feedback on how they see and effect one another, in the spirit of furthering understanding.	Practitioners help those present to share more about their perspectives on each other and their relationships. There is not a deliberate attempt here to change any particular behaviour, but rather there is a trust that, the more network members can share in this way, in a dialogical process, the more likely the experience will be transformative.
Communalism	A "tightknit, interconnected, warm and intimate" network of relationships. In residential TCs the everyday experience of living together is considered to be as significant as specific meetings, and so considerable attention is given to the milieu.	Facilitators of network meetings leave space for participants to address **their** issues with each other. DIFFERENCE – when working in the community professionals usually only have the opportunity to be with the network during network meetings, but in these meetings participants are reflecting on day-to-day life.


Evidence
from service users & family/network members?
from practitioners?
cost analysis?
qualitative and quantitative research of the method and outcomes?

ISPS book on Open Dialogue and Psychosis

- Edited by Brian Martindale & Nick Putman
- Published in 2020.
- Around 100 contributors from 12 different countries, including sections on introducing the approach, examples of the work co-written by family members and practitioners, training, service development, comparisons with other approaches to psychosis and research.

Satisfaction - Service Users/Families

- The value of being **listened to**.
- The appreciation of **everyone's perspectives** and **collaborative** decision making.
- Mutual support, **understanding**, and **connection**.
- The **relationship** that develops with practitioners.
- A **safe** space to say the otherwise unsayable.
- Making **meaning** of the experience of psychosis in **human terms**.
- Support to **avoid hospitalisation**.

Satisfaction - Practitioners

- Open Dialogue resonates with their **values**, and the reasons they chose their career.
- Significant **changes in attitude** in the workplace, as well as **language** and practice.
- A sense of a “**culture shift**”.
- Developing **trust** in their coworkers.
- Feeling that they **grow** as people through the processes in this work.
- The in-depth **training** processes are a unique and valuable experience.

Countries where Open Dialogue is actively being developed

Finland
Denmark
Germany
USA
UK
Italy
Australia
Norway
Sweden

Ireland
Greece
Lithuania
Poland
France
Japan
Holland
Switzerland
Belgium

Cost Savings (based on outcomes - 5 year follow-ups)

- Unpublished report showing that Open Dialogue service is **cheaper** to run than other psychiatric services in Finland.
- When meeting with the whole family/network (and any other agencies involved) **less intervention is needed** (an efficient way of working).
- Less **hospitalisation** (mean of 16.7-42.4 days)
- Less **medication** (17-24% using neuroleptics)
- Lower **relapse rates** (19-32%)
- Less need for **disability allowance** (14-27%)
- Higher levels of **study/employment** (70-76%)
- Better **inter-agency collaboration**

Ongoing research

- **UK -** ODDESSI is a 5 year research programme evaluating the development of Peer supported Open Dialogue in several NHS trusts - an RCT along with qualitative evaluation of the experience of staff and families (due to complete in 2022).
- **Italy** - ongoing evaluation of a national project to develop Open Dialogue in 8 districts across the country.
- Ongoing research in a number of other countries.
- **HOPEnDialogue** - a new international project to research several international sites - hope is to build on the ODDESSI trial.

A simple proposition about outcomes

Where the service user, their family/network and professionals are committed to this way of working, and have the opportunity to engage in the work for as long as needed, the outcomes are likely to be positive.

Research/service development issues

- There is an understandable reluctance to invest significantly in the development of Open Dialogue services until there is more evidence of the effectiveness of the approach in different settings, but significant investment over several years is needed to develop a service of sufficient quality in order to truly research effectiveness (“catch 22”).

- In many settings where Open Dialogue is being developed, adaptations are being made, including shorter trainings, and there is a pressure to show positive outcomes quickly, which is likely to have an impact on the quality of the therapeutic processes as well as the outcomes.

Other challenges

- Frequent **changes in management** structures and policies. **Not enough support** from management.
- **Lack of finance** available to invest in training/service development.
- **Resistance to change** from highly qualified staff and those with a strong belief in an alternative model, e.g. biochemical, CBT.
- What proportion of staff have the **capacity/interest** to work dialogically, to be **open/flexible** and to **share expertise**?
- Struggle with **continuity** - staff turnover, shift work and the absence of teams dedicated full-time to Open Dialogue.
- Outcomes may be poorer where there is aggressive behaviour at the onset of a crisis.

Open Dialogue Training

- **Foundation training** - 1 year (20 days) – October 2019 & in-house in NHS
- **‘Full’ training** - 3 years (60 days) - 2020
- **Mixture** of exercises and role plays, large group and small group discussions, as well as presentations on theory and practice.
- **Emphasis is on practice.** The learning is **embodied** as well as conceptual.
- **Supervision** - video recordings of network meetings and live family meetings.
- **Family of origin** work - exploring one’s own family background.
- Explore issues related to **service development**.

Feedback from training participants

- “I could have read thousands of books and still not have learnt what I have learnt during this educational journey.”

- “Walking through the Open Dialogue path is an inspiring way of re-thinking and refreshing our professional and life perspectives. The Open Dialogue foundation training is a gem in the international mental health panorama that highlights and spreads around a deep sense of respect for others.”

- “The programme will stretch you and encourage you to change how you communicate with others as well as yourself…I would thoroughly recommend it to anyone with any interest in the care of others. At every professional level it will make an impact should you allow this process to change you”.

Open Dialogue raises a number of key questions

- What do we want the foundation of our mental health services to be?
- What do we think our initial response to someone experiencing ‘psychosis' should be?
- To what extent do we want our mental health services to be divorced from society as a whole, i.e. a specialised service?
- Is there room for common sense, amidst the ‘expertise’?
- Does using ordinary language make us any less useful/skilful?
- Do we need to look for patterns in human behaviour in order to know how to proceed?
- Can those governing our services acknowledge that there is a good deal of uncertainty in the work and support us to be in this uncertainty?
- Can we ourselves trust in uncertain processes?

Thank you!

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