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Peer-supported open dialogue

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In October 2014, a number of NHS trusts initiated a foundation diploma course 'peer-supported open dialogue, social network and relationship skills'. This article sketches the development of the course and describes the initial work being done to implement this approach within the participating trusts.

The Norwegian context

During the past ten years at Gjøvik University College, Norway, I have been the director of a post-graduate programme in network meetings and relational competence, based primarily on open dialogue. The history of network approaches to mental health care in Norway goes back almost thirty years. Much of the initial impetus was based on the work of Tom Andersen, who helped establish a training programme in relationship and network interventions in 1987. Jaakko Seikkula and his colleagues, who were developing the open-dialogue approach in Western Lapland, visited Andersen for the first time in 1988. This became the start of an intense collaboration between the Norwegian and the Finnish groups during the 1990s. The Western Lapland project also paralleled work in Oslo under the guidance of Live Fyrand who had introduced social-network therapy in Norway. Both the Norwegian and the Finnish groups had visited the Nordic Network Project in Stockholm. This group had worked closely with the American psychologist, David Trimble, who in turn had studied under Ross Speck and Carolyn Attneave. Speck and Attneave are (together with Uri Rueveni) considered the originators of social-network therapy and had in 1973, published *Family Networks* describing their approach. In it, they state their most fundamental principle is "Any help, to be useful, must be part of the social context of the person in distress".

This was the background and inspiration for a number of clinical groups in Norway to establish open-dialogue projects in the late 1990s. In 2002, the project group in Valdres, central Norway, with representatives from

the regional trust, the municipal mental health care-services and national service-user and carer associations, contacted Gjøvik University College regarding the possibility of collaborating on a post-graduate programme. The first group of students started in January 2005 and we have been further developing the programme since, in the past five years in cooperation with Akershus University Hospital Trust.

After the first ten years of the Valdres project, it was evaluated by the Norwegian Institute for Public Health and the results showed that service users, carers and staff reported that the method had contributed positively towards involving clients actively in shaping their own treatment programme; encouraging open communication between patients, network members and professionals; increasing insight into clients' problems; promoting social support; enhancing the ability to cope; and contributing to the improved cooperation between professionals from primary and secondary care (Holloway *et al.*, 2009).

Despite this relatively long Norwegian and Nordic tradition, and the positive evaluation, the spread of the open-dialogue approach has been slow. I was therefore very excited when I was contacted in January of 2014 by psychiatrist, Russell Razzaque, associate medical director at North East London NHS Foundation Trust, regarding training for a national multi-centre open-dialogue pilot that would seek to transform the model of healthcare provision for persons with major mental health problems in the UK. Razzaque, together with family therapist and trainer, Val Jackson, and I, started work on adapting the Norwegian model and syllabus for use in the UK.

The model

The Valdres model that I have worked with was based on continuous service-user and carer involvement, community integration and peer-support and we therefore chose to name our approach 'peer-supported open dialogue'. The model



is based on a number of central elements including systemic family therapy, reflective processes and open dialogue as well as:

• Value-based practice

Value-based practice is based on the premise that core values should be made explicit and described as they guide both our perception, our practice and our ability to form positive, supportive interpersonal relationships (Farkas & Anthony, 2006). Core values in our approach include openness, authenticity and unconditional warmth.

Openness is based on a fundamental respect for others' autonomy and integrity. The recovery movement has used the phrase "*Nothing about us, without us*" as a rallying cry for increased transparency. Such explicit openness is dependent upon an acceptance of a certain degree of uncertainty and unpredictability as well as a trust in the healing process. Openness implies authenticity, which always entails a certain risk; a risk of being rejected or ignored.

Therefore, it is important the professionals take the first step and are willing to 'expose' themselves through self-disclosure as fellow human beings (Burks & Robbins, 2012). Gelso (2009) calls this a "*real relationship*" and forms the basis of a therapeutic relationship that is associated with a positive outcome of treatment (Ardito & Rabellino, 2011).

In addition to openness and authenticity, unconditional warmth is perhaps not only the most important thing we take with us into an open dialogue, but also the most challenging. Unconditional warmth implies an appreciation of the other by virtue of their humanity. To achieve this, we must cultivate the same unconditional warmth for ourselves by developing self-awareness and self-compassion. The more this way of being is developed in us, the more we can be fully present for the other and thus contribute to positive growth and health. Establishing a practice of mindfulness can make an important contribution to this process.

• Mindfulness and self-work

The quality of the interaction between provider and service user is dependent on a practitioner's ability to be fully present in the meeting, with an open mind and an open heart. The goal, then, is to facilitate the development of these qualities and abilities – but it is a challenging task:

... therapist attitudes characterized by warmth, unconditional positive regard or acceptance, and genuineness have proved quite difficult to teach as a skill ... In this regard mindfulness training may be an extremely promising addition to clinical training because it may indeed foster attitude change (internalization) toward greater acceptance and positive regard for self and others (Lambert & Simon, 2008, p. 26).

Mindfulness represents a unique and valuable source of improved clinical practice in general (Bruce *et al.*, 2010) and for open dialogue in particular (Razzaque, this issue).

• Person-centered care

Person-centered care is a holistic, non-directive approach, as opposed to a profession-centered, disease-focused care and is increasingly seen as a guideline for how health services should develop in the future. Central to this approach is "*an extraordinary trust in the client and in the potential of human beings to grow, heal and find their own path towards psychological health, given the right conditions*" (Freeth, 2007, p. 20).

• Trauma-informed approach

It is estimated that over 90% of public clients with severe mental illness in the United States have been exposed to childhood physical and/or sexual abuse (Adams, 2004). According to the *Substance Abuse and Mental Health Services Administration Guidelines* (2014), a "*program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization*" (p. 9). Our peer-supported method represents a trauma-informed social approach to mental health care in its recognition of the impact of traumatic events for each unique life history and path towards recovery.

• Recovery-oriented services

Recovery-oriented services are based on an everyday-life perspective, including the concrete social context people are living in. A recovery approach also includes the understanding that, despite the personal

distress of mental health problems at the individual level, recovery is a social process and, by mobilising resources in oneself and one's social network, it is possible to bridge the social barriers of stigma and discrimination and regain a greater sense of well-being, autonomy and belonging (Kennedy & Horton, 2011).

• Holism and spirituality

Recovery is a personal, social, cultural and spiritual process, unique for any given individual. At its core is the existential endeavour to create meaning and make sense of life, despite its apparent chaos and arbitrariness. For many persons, spirituality is synonymous with personal growth, purpose and the attainment of insight and wisdom. In our approach, cultural systems of communion, ceremony and ritual are recognised and appreciated as resources that persons and networks can draw on for support and aids towards recovery (Razzaque, 2014).

• Emotions, embodiment and self-regulation

Emotions are essentially embodied processes of self-regulation, but they are also relational and regulate social dynamics through experiences of love, hate, shame, sadness, anxiety, etc. Emotions are fundamental to how we experience each other and ourselves and yet, generally, we give very little attention to understanding them. Seikkula and Trimble see emotional exchange between the network members as being the core driving force towards either health or illness (2005). In peer-supported open dialogue, the 'primacy of affect' is acknowledged so that open dialogues are not so much a 'talking cure' as an 'affect communicating cure'.

• Peer-support

A further core element of the model involves the inclusion of peer workers within each team, trained specifically in intentional peer-support (Mead, 2005). Peer workers are experts in their own right and, through the 'intentional peer support' training (see www.intentionalpeersupport.org), will receive training jointly with staff in crisis care and holistic models of support as an integrated aspect of the model. Peer-support also entails a closer collaboration with the many service-user movements and the development of local supportive-networks.

These various themes are complex in themselves and their integration within one model requires a considerable investment of time coupled with an optimal pedagogical framework. Based on ten years

of quality development, we have attempted to create a syllabus that facilitates the professional and personal development necessary to peer-supported open-dialogue services.

The syllabus

The course entitled 'foundation diploma in peer-supported open dialogue, social network and relationship skills' comprises four five-day residential modules over approximately twelve months. The students receive training in both yoga and mindfulness in addition to a variety of experiential exercises, family-of-origin activities, lectures, practice in reflective processes, self-disclosure tasks, etc. In addition to the work done at the residential modules, the students have written assignments on a net-based virtual learning-environment, Fronter. These contribute to a continual process of writing, reflecting and self-growth.

Getting started

This foundation course is designed as an introduction and is a prerequisite to the trainers' training course, which is currently being planned. As an integral part of the course, participants from the individual trusts will carry out a project which includes establishing and participating in local peer-support groups that will receive training. These groups will develop locally adapted models of peer-supported open dialogue within their respective services.

The four participating trusts, North East London, North Essex, Nottingham and Kent and Medway, will establish teams during 2015, which will form the basis of a large multi-centre controlled trial headed by a research team at University College London. In addition, an award-winning TV production company is following the project, and will document the training, implementation and experiences of those receiving the services.

As I write this article, the students have completed the first module and are posting their reflections on the discussion forum. There is an intense, sometimes apprehensive, sometimes jubilant, sense of change and renewal in their writings. Together, we have started on a journey whose final destination is not wholly certain. Yet it is, we feel, a crucial first step towards transforming services and creating a real paradigm shift for mental health care in the UK.

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