

Getting on with it: *The Early Network Response trial in Leeds*



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Aspire early intervention in psychosis service is currently running a small trial based on open-dialogue principles. Below is a description of the development of the trial and what we have learned so far.

After many years of talking about open dialogue to anyone who would listen, I was becoming despondent. Then, in 2011, my supervisor said to me, “*Why don’t you just get on with it?*” So, this is an account of what happened when I did just that.

I invited Jaakko to run a two-day workshop in Sheffield, attended by early intervention in psychosis teams. The enthusiastic response to the workshop led our manager to suggest we conduct a trial in Leeds. We formed a team of seven members of staff, some of whom had personal experience of mental health difficulties. It included a psychologist, occupational therapist, registered mental health nurse, psychiatrist and two case coordinators without professional qualifications (but one with a foundation and the other with an intermediate level of family therapy training), and me, a family therapist. Over an 18-month period, we spent several days in training, held weekly meetings to practice role-plays and discuss protocols, particularly in relation to risk assessment and other statutory requirements. We worked with families not in crisis using a dialogical approach, and attended several first meetings with families to gain an understanding of the emotional context of early contact.

As I am a part-time member of staff and with the service as a whole under threat of reduced funding, our aim was to conduct the trial with two families without extra resources and discover whether we could practice in this way.

Our consultant psychiatrist, never critical of the ethical stance of open dialogue, was initially sceptical of the feasibility of implementing the approach locally. He became an active supportive member of the team, realising that the trial protocol was within NICE guidelines, which includes options for those not

wanting to take medication (NICE, 2014). Open dialogue is not against medication, but aims for shared decision-making in regard to its use. Having a psychiatrist on the team was an important addition, enabling us to offer a wider range of support within a collaborative framework.

Staff changes during this period were challenging, as new staff had not been part of the collaborative process of training and decision-making, and perhaps this mirrors the relationship of client and staff member, when clients are referred to other services, often within short periods of time. The embodied experience (Shotter, 2010) of being present from the beginning is never repeated and the lack of continuity undermines the responsiveness between listener and speaker, “*Dialoguing participants cannot be randomly replaced by other people, building mutual understanding presupposes the participation of those very individuals that are personally connected to the case*” (Seikkula 2014, p. 90).

The aim was to have:

- Up to six network-meetings in the first two weeks
- Thereafter, as required for one year
- Other therapies as required
- Treatment as usual after one year.

On 18 June 2014, we met with our first family, the client being a 23-year-old woman, living with her sister, two brothers, parents and a grandmother. She had attended the local accident and emergency department alone, complaining she had been unable to eat and was vomiting. The liaison psychiatry-team met with her and noted the presence of some unusual beliefs. She was referred to our service, and we arranged to meet with the family within 48 hours.

The following is an edited transcript from the first meeting. Present was Alex, our psychologist, Adam, the care coordinator, the client, Katy (name changed), her sister, her cousin, her mother and her grandmother, who came into to the room for a short while, and me. Our team aimed to respond dialogically, acknowledging the family’s comments either verbally or

in a spontaneous embodied way. Although invited, none of the male members of the family joined us.

Adam: *Who would like to tell us what’s been happening?*

Katy: *I don’t feel well.*

Alex: *Don’t feel well?*

Val: *Can you explain a bit more what it is you are feeling?*

Katy: *I can’t sleep and I can’t eat properly.*

Val: *You can’t sleep. And you can’t eat.*

Katy: *I don’t remember things.*

Sister: *Because she is stressing and over-thinking, which is impacting on her food so everything she eats she ends up puking it back up and her appetite is not right.*

Val: *OK.*

Sister: *I think she over-thinks.*

Katy: *No, no, I don’t even stress but it’s like I’m right at the bottom now, I’ve forgotten everything.*

Sister: *You’re not right at the bottom, Katy.*

Katy: *I am.*

Val: *Can you just explain what you mean by that?*

Katy: *I don’t remember how to eat....*

Sister: *I feel as if she does know how to eat – I’ve seen her; she can eat some things; you know when you are stressed and you over-think, it affects your eating as well, doesn’t it?*

Val: *I’m not sure if I really understand what that’s like.*

Alex: *It was something that you could do before, but you can’t do it now?*

Katy: *Yes.*

Sister: *It has been quite a long time but it’s like some meals she can eat.*

Cousin: *I think that was more of a problem at home, at your house wasn’t it? It’s because they are getting the house done and Katy and her Mum are actually staying at my house, from what I’ve seen at my Aunties house as well and from everyone saying she is eating fine there and she’s eating fine here as well. She’s not puking it up. So it is more of a problem at home.*

Mum says she likes eating burgers or chicken from outside, get whatever she wants, as long as she eats, her brother’s, like ... get

her food and stuff from outside but, whenever we're at home, you don't like home-cooked food much, do you Katy?

As we can see from this transcript, the first responses to our initial enquiries began to expand as other family members started to offer their ideas that developed different contexts around Katy's eating problem.

This was achieved by acknowledging the comments made and by asking questions that elicited more information based on these comments. No attempt was made to develop new ideas that staff may have had at this stage, or follow an assessment process.

Val: *Your cousin was saying that, in some places, it's harder to eat and in other homes it's easier?*

Adam: *Have you had any thoughts of why this might be happening, Katy?*

Katy: *It's because of my Dad, that's why. He was doing everything and that's why I have stopped eating and I've forgotten how to eat. He shouldn't be living with us.*

Sister: *She thinks that my Dad is after her but, to be honest, my Dad's got his own illness.*

Katy: *How is he ill – he's not ill.*

Sister: *He's got his medical notes. He's got a hole in his throat ... He pukes up his food ... he got really ill in January, he was in hospital for three weeks. My Dad lost his business two years ago; he did have anger problems when I was younger. He had like ... stuff with my Mum.*

Val: *Sounds like having your Dad come to meet with us, would that be helpful?*

Katy: *I don't want him to come, never.*

Sister: *We can try it but then she will think that the whole world is against her.*

As the dialogue continued, new narratives developed, one involving Katy's father. Attempts had already been made to invite other, absent voices into the meeting, by asking everyone what they thought the brothers might say if they had joined us.

By this time, we had already heard Katy was having suicidal thoughts so, as a team, we turned to each other to reflect on this, highlighting what we thought we had heard, but also introducing the possibility of connections, such as Katy's relationship with her father. Adam, as the care coordinator, felt a particular responsibility to explore the issue of safety and risk.

Reflection

Adam: (to Alex and Val) *Is she trying to let us know how she feels?*

Alex: *She's desperate.*

Adam: *Yeh, she was actually saying she feels like killing herself... from my point of view, she*

has mentioned a few things that concern me a little, about safety, really; we have to mention these things between us, yourselves and your family about how to keep her safe, really...

Outcome

In total, there were four meetings in the first 18 days, and Katy also met with her care coordinator. After two network-meetings, the potential for psychotic experiences, although initially high, seemed to have diminished. Katy was more relaxed, said she did not feel like killing herself anymore and the family, pleased with the progress, asked that the meetings should discontinue. Attempts were made to maintain phone contact and individual sessions with Katy, but these also were avoided. Eventually, Katy made an attempt on her life, spent time in hospital and was prescribed medication. The family was still reluctant to continue with meetings.

What have we learned so far?

The early network response team and the service were shocked by Katy's attempt on her life. Clearly, the outcome was one that wasn't hoped for or expected. However, the learning opportunities offered to us because of this were extremely valuable and included:

• Our need to understand is secondary to fostering communication

As the problem, whatever that may be, is the client's struggle to find words to express their distress, more time may be required to explore their understandings. The challenge at the first meeting was to balance the family's desire to tell their stories for the first time, and to ensure Katy was heard too. The family stories about her eating problems were intriguing, and led us to hearing narratives that made sense. In hindsight, we would have spent more time discussing the difference of opinion and what this meant to Katy, rather than us trying to understand the meaning of "can't eat, don't remember how to eat". Perhaps, following the emotion, rather than or as well as the narrative, was an important lesson to learn.

• Being there from the start

Not only does this create a consistency and continuity that is crucial to the approach, it has meaning for staff as well as clients. The sense of responsibility and commitment to the situation is dramatically increased by hearing stories from the beginning. The emotional, embodied response will never

be the same, and cannot be transferred to others, either verbally or electronically.

• A crisis presents a (narrow) window of opportunity

After 5 meetings over 18 days, the crisis was over, and the momentum for change was lost. Perhaps more frequent meetings in the first 7 to 14 days may have been acceptable and prevented the hospital admission.

• Working this way is exciting, challenging and scary.

Without the training and a committed supportive team, this would have been a very difficult experience.

• The challenge of combining the statutory processes within unstructured meetings.

The care coordinator had a sense that statutory requirements, risk assessments and so on were incomplete and he felt unsure of his role. For me, this confirmed the need for repeated role-plays of network meetings as part of the preparation. Having since discussed this many times, despite the conflicting pressures of the role, we all feel more comfortable in addressing these issues directly, usually at the end of the meeting.

• The network meetings are only part of the process.

Network meetings were particularly important, initially, but then the focus must be on the needs of the client and family, which may be individual work, CBT, social recovery, family therapy. It can be easy to forget that much of what happens between the meetings lies within the elements of a flexible needs-adapted approach. As Seikkula (2006) has discussed, the therapeutic response is adapted to the specific and changing needs of each case.

• Shared thinking space

Members of the team without prior family therapy experience were particularly struck by the richness of the stories presented during the network meetings, and resolved to involve families earlier, particularly during crises. Feedback from the family suggested to us that the younger family members thought this was a much better approach ("It got to the heart of the problem"), but Katy's mother found it challenging and perhaps rather intrusive into family life. As siblings and cousins don't have the same sense of responsibility for the client, perhaps this gives a freedom to explore sensitive issues, a process that is more difficult for parents.

So what happens now?

Without extra funding, we have hopes for introducing incremental changes to our service. This may include changing the structure of care-programme-approach meetings, the first contact (usually a phone call) with the client, the first meeting, and earlier availability of psychological therapies. A dialogical conversation is a challenge for the first meetings in a service that is diagnosis dependent, but one that we should still confront. The impact of Katy's admission to hospital led us to meet with hospital staff and engage in different conversations, ones the ward staff participated in. This gave me hope that new conversations could also take place with other services, such as the crisis team, home-based treatment team and so on, on a case-by-case basis.

Hopes for the future

Having been in a place of despondency in 2011 with little hope for open dialogue in the UK, I now believe a trans-diagnostic or diagnosis-free service, although still a distant hope, is one that is achievable, creating the space for the continuity of care that could truly make a difference to people's lives. This needs on-going training and supervision if we are to see any of the remarkable results seen in Lapland. Our six-person team succeeded in offering a crisis-led dialogical approach with one family therapist and one psychologist with limited open-dialogue training and supervision. Although training all staff as family therapists might achieve the best outcomes, I do believe we can create a much more humane service in the UK, one that is long overdue.

References

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Open dialogue in Somerset?

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In Somerset, we have been developing systemically orientated mental health services for the past 20 years (Burbach, 2013). This has involved the development of a range of services and large-scale staff training programmes (Stanbridge & Burbach, 2014). We now have many services that are family-inclusive or family-focused and are being carried forward under the 'triangle of care' umbrella (Worthington *et al.*, 2013).

In this paper, we reflect on the similarities and differences between the Somerset and Open Dialogue (Western Lapland) approaches and services, and consider how we might take further steps to develop our NHS mental health service to be as close as possible to the 'gold standard' Western Lapland service.

Our approach developed independently of open dialogue but at a two-day workshop in Leeds (2007) where Roger Stanbridge and Frank Burbach presented the Somerset model alongside Jaakko Seikkula, it became very clear we had developed a similar therapeutic approach. This is not surprising as both approaches are influenced by 'third-phase' systemic ideas (Dallas & Draper, 2000).

The difference is that in Somerset we developed our approach for a tertiary family-interventions service, (The 'Family Service for Psychosis') with staff undergoing a year long training programme. However, this is only able to offer family sessions to a select number of families. Although effective, we realised the front line inpatient and community teams were largely focused on the individual and families often felt excluded. A tragedy that might have been prevented if staff had listened to the concerns expressed by family members resulted in trust management asking us to develop more family inclusive frontline-services. We developed a trust wide strategy to Enhance Working Partnerships with Families and Carers, and a short (two-to-three day) whole-team training programme which we have been implementing since 2002 (Stanbridge & Burbach, 2004, 2007).

Despite considerable attitude-change, we realised ward staff needed more help and encouragement to begin to involve families more actively in the assessment process and care planning. We therefore developed the family-liaison service, whereby a staff member with systemic training joins the ward for up to one day per week to jointly hold family meetings. This service has been very successful in enabling family and network meetings to become part of the routine ward processes (Stanbridge, 2012), but we also continue to work closely with 'ward champions' whose role is to help colleagues maintain a focus on family inclusive practice.

We began to consider how we might further develop our service to approach the open-dialogue ideal. This focus was sharpened through our attendance at the three weekend seminars on the approach, in London (2014) and a local two-day workshop for Somerset staff with Val Jackson, Alex Perry and Mark Hopfenbeck. This has resulted in considerable enthusiasm to try out 'open dialogue proper', and two or three workers drawn from the early intervention in psychosis team, crisis resolution and home treatment teams, and other community teams, are now being created around particular families to try to deliver all the principles of the approach. We intend to evaluate these case studies in order to make a case to further develop it. In addition, we are changing our two-day family-inclusive-practice training to incorporate ways of inviting the wider network, together with promoting more network-inclusive practice in our crisis teams and community mental health teams through an adapted family-liaison service.

The wider system – mental health service structure in Somerset

Whilst we have a number of services in place that attempt to work in a more relational, network-orientated way (as previously described), of these, only the early intervention team offers a flexible