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.

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Open dialogue in Somerset?

Frank Burbach, Chris Sheldrake and Estelle Rapsey

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

service. Family members are well supported by a readily accessible worker who coordinates their ongoing care and invites in rather than refers on to other professionals or services to help with a wide range of needs. Family members experience a seamless service rather than being subject to internal referrals, delays and having to tell their story repeatedly. This is consistent with the Think Family initiative of a 'no wrong door' to services. Other services still rely on internal referrals that do not address sufficiently the needs of the support network.

In fact, our individual pathology-focused approach often further distances the person with mental health problems from their support network, and increases dependency on mental health services.

Where next for Somerset? – Possible service developments

Our mental health trust recently acquired community health services and is facing the twin challenges of integrating physical and mental health services whilst saving money. With the increasing momentum of open-dialogue approaches in the UK, we saw this acquisition as an opportunity to submit a proposal to redesign services emulating the approach in Western Lapland.

Although the network approach could be applicable to all mental health referrals, we particularly felt it was appropriate for multiple (physical and mental health) conditions and youth (0-25) services.

We proposed a network-coordinated approach with the aim of eliminating boundaries between teams. We suggested that, as in Western Lapland, all referrals would be allocated to a network coordinator who would be responsible for convening networks meetings for the duration of the client's contact with the service. If the client is referred back to the service at a later date,

wherever possible, the same clinician would return to the position of network coordinator. This clinician would work with the network in the community, and in hospital if necessary, 'inviting in' any specialists that were required ('needs specific' approach). These specialists (psychiatrists, employment, housing etc) would join the network meetings by mutual arrangement rather than referral, and then arrange any subsequent appointments as required, thereby fostering continuity during different phases of treatment. There would be an emphasis on building a collaborative shared understanding (or formulation) of the relationship between the presenting problem, the clients' experiences and the way these interacted with their environment and wider network. Integrating different therapeutic methods into a joint treatment-process would also enhance psychological continuity: i.e. if individual therapy is indicated, one of the network team would act as the therapist or be invited to network meetings, as appropriate. Such continuity is also more efficient as it enables therapeutic progress to be built upon, positive outcomes to be reached sooner and discharge to be facilitated earlier.

Our proposal also emphasised the principle of the provision of immediate help. Apart from the early intervention in psychosis and crisis teams, access to many services can be difficult and have long waiting times. We argued that intervening early helps people preserve their existing social resources such as keeping places at college or maintaining jobs, family and social relationships. It can stop a mental health problem from becoming acute, chronic or habituated. It can reduce risk and other associated problems such as concurrent substance misuse, crime, homelessness and physical

health problems. It may reduce the need for further services or inpatient bed days.

We proposed a single point of access that would be open to any source of referral including self-referral. First contact would be made over the phone by a senior clinician who would triage the referral and make a decision about the urgency of the case based upon factors such as concern about lack of sleep, risk, level of distress, disability or dysfunction or first episode or early onset of a new problem. The service would aim to see the individual and members of their social network within 24 hours, and would offer frequent initial meetings, daily if required. There would be less emphasis on an assessment that served the needs of the service and more emphasis on being immediately helpful and therapeutic. Even if the client were acutely unwell, clinicians would see the crisis as an opportunity to help the client and social network increase their understanding and open up dialogue about what has happened and the meaning they have drawn from their experiences. Crises would be seen as opportunities in which the emotions and issues are revealed and available to be addressed in therapeutic interventions.

Decreasing dependency on services and fostering agency in clients and their networks

Developing open-dialogue services involves a subtle but significant shift in the relationship between service users and professionals. Although the network coordinator organises meetings and involves resources within the services, their task is also to activate the clients' sense of agency and motivate the network to share the responsibility and tasks required to manage the clients' problems. The culture change involves an explicit emphasis on giving responsibility to the person and network wherever possible. Risks are held and managed by the network; risk management becomes a shared responsibility. In cases where this is not possible, services would remain able to manage care and risks in a proactive manner, but an emphasis in the meetings would be discussions about handing back responsibility in a timely and manageable way. This principle would be adhered to in all cases and would be part of care planning with acutely unwell or detained patients. In this way, if there were adverse incidents, the responsibility would be shared by everyone

> **In an ideal world we would undertake service-wide reform, reconfiguring the existing teams to eliminate wasteful internal referrals, mobilise the individual's support network and intervene early with all referrals**

who had attended the network meetings and contributed to decision-making. This should enable clinicians to feel less defensive about their practice.

Reflections on the challenge of developing dialogical practice in Somerset

As with most mental health services world wide, our practitioners in Somerset have been significantly influenced by models of mental distress that site the problem within the individual or their brain. These include the medical model, individual therapies and behavioural family therapy. Systemic family therapy and narrative approaches are also influential in Somerset and go some way towards influencing a more relational, psychosocial and therapeutic view, although this can also lead to a temptation to site the problem within other family members instead of the individual. The dialogical approach focuses primarily on the language used and dialogue within the network rather than trying to change the family system (Seikkula, 2003). This absolute loyalty to how the members of the network speak and respond to each other remains a somewhat radical approach compared to regular practice in Somerset. We can assume that, within the tens of thousands of mental health appointments that happen each year here, there must be great examples of dialogical working, and many staff within Somerset exposed to the approach claim they are already doing it!

However, we also have obstacles in our daily practice due to the expectations of the system. For example, many teams use manualised assessments at first contact. These assessments allow for gathering wide and varied information very quickly but can close down dialogue and become a box-ticking exercise. In Western Lapland, they have managed to achieve a high degree of team consistency through high-level training for all staff and a cohesive service-structure that enables all workers to practise dialogically. We recognise that we have a long way to go but dialogical theory is being disseminated at present and we hope to incorporate this into training programmes within the trust.

Conclusions

Somerset is a leading county in terms of having already established family-inclusive services and continues to make good headway with the 'triangle of care'.

Frank, Estelle and Chris (L to R) are photographed near Burrowbridge on the Somerset Levels following a team-training day. The flood defences appear to be working this year!

This initiative broadens the patient – professional relationship to include families and carers, but the inclusion of significant others is often limited and thus falls far short of open dialogue.

In contrast, the open dialogue and systemic approaches recognise that no one exists in isolation. Most people's lives are defined by their networks and relationships, and problems and solutions are socially constructed through shared language and understandings. We recognise that, if we can develop an open-dialogue approach, we would be able to harness the most important resource for the client's recovery, their personal network.

At the time of writing, it is still unclear whether we will be able to develop services closer to the ideal. Part of the challenge will be to enable trust management to recognise this flexible, therapeutic but intensive work with family networks is actually more cost effective!

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Please note that most of the papers by Burbach, Stanbridge and colleagues are available in Burbach, 2013, and are therefore not detailed here.

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Open dialogue in Somerset?