Discussion and Strategy Document on Open Dialogue

The Key Principles and Development of Open Dialogue in Nottinghamshire Healthcare NHS Trust Adult Mental Health Services

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Background and Focus of the Document

Open Dialogue is an innovative approach to psychosis from Western Lapland in Finland, which has shown very impressive results and rates of recovery in comparison to other parts of the Western world. With first episode psychosis they have 78% returning to work or studying and only 14% on disability allowance, reductions in hospitalisation and only 19% had relapsed within 5 years (Seikkula et al. 2006). The impressive results have shown long-term stability over a 10 year period (Seikkula, Alakare & Aaltonen, 2011). These results are achieved in the context of significantly lower use of antipsychotic medication at entry into services and during follow-up, for example in one cohort only 17% were taking neuroleptics at 5 years (Seikkula et al. 2006).

Open Dialogue is not a discrete intervention, but a whole system philosophy and approach, which has been developed over a number of years; in essence, in Western Lapland, Open Dialogue is the psychiatric service. These systemic and innovative changes in services developed during a period of economic downturn and lowered funding to mental health services. A documentary of the service has started to popularise the ideas across the world (Mackler, 2011), for example services in Vermont, USA are trialling the approach; as yet, there are no results, but anecdotal accounts have been positive.

The extremely positive results achieved by Open Dialogue strongly suggest that the ideas and practice should be carefully examined and learnt from in the UK. Nottinghamshire Healthcare NHS Trust innovative adoption of Recovery principles and practices, as well as early adoption of strengths based working suggest it has the foundations to develop and adopt Open Dialogue. This document gives an overview of Open Dialogue; the potential and existing resources, as well as barriers, to the development in Nottinghamshire; and the next steps towards Open Dialogue.

Overview of Open Dialogue

Open dialogue has been extensively researched and written about. Some of its key components are: a focus on the social network, seeing psychotic reactions as meaningful, creating space for everyone's voice to be heard and responded to, and immediate provision of help in a crisis in a person's home setting. (e.g. Aaltonen, Seikkula & Lehtinen, 2011; Seikkula, 2002; Seikkula, 2011; Seikkula et al. 2006; Seikkula & Alakare, 2007; Seikkula, Alakare & Aaltonen, 2011; Seikkula et al. 2003; Seikkula & Olson, 2003; Seikkula & Trimble, 2005;) The following is based on this body of work. Below gives an overview of the core philosophy and the practice of Open Dialogue, as well as the training provided to staff in Finland.

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Philosophy

1. The approach is based on social network model of mental health. A person's social network is seen as crucial to successful resolution of mental health crises.
2. Mental health issues, including psychotic reactions, are seen as meaningful in relation to difficult experiences and dilemmas in a person's life.
3. Open dialogue attempts to make sense of psychotic crises. This understanding is developed through developing a shared language within the family and social network.
4. An ongoing dialogue is seen as essential to the therapeutic process, where everyone's voice is listened and responded to.
5. The client and family are seen as active agents in the understanding and solution of problems.
6. The meaning of experiences and the crisis is constructed in between people rather than transmitted or imposed from one person to another.
7. A point of crisis and expression of unusual experiences is seen as a crucial period and opportunity to understand psychotic experiences and crises in the network.
8. It is seen as important, where at all possible, not to suppress powerful emotions during a crisis, but instead to contain and make sense of them.

Practice

9. The key format for treatment is social / family network meetings, which the mental health team has the responsibility to arrange.
10. Discussions and all treatment decisions are made with and in the presence of the family and the service users. This reflects core values of openness, transparency and fairness.
11. The first meeting is held within 24 hours of the initial contact.
12. The person who responds to the crisis takes responsibility for arranging the meeting, and where possible there is continuity in those supporting the person and network.
13. The mental health team work in at least pairs. Working as a team increases the possibility of everybody feeling heard and is a prerequisite in a crisis to help contain intense emotions.
14. These meetings try to: gather information about the problem; build up a plan based on what is discussed in the meeting; and generate a therapeutic dialogue.
15. Within the meeting attempts are made to ensure everyone has a voice and all utterances are responded to, so to create and maintain a dialogue.
16. Preformed ideas are not imposed on the network by the treating team, but the meaning and actions are creating within the meeting.
17. The staff team's role is to allow and facilitate the client's social network to take the lead in making sense of the crisis and actions to be taken.
18. Staff members move between questions, acknowledging others' utterances as well reflective conversations between staff members.
19. A process of continual dialogue in a deliberating atmosphere is central. Teams need to listen carefully and respond to the themes in a client's speech, so to create a safe atmosphere.
20. Actions do not have to be decided at each meeting, but are summarised at the end if they are.
21. Psychiatric Medication
    a. Psychiatric medications are avoided in the initial stages of service provision, and when used in the early stages, there is a greater use of anxiolytics.
    b. There is open discussion regarding medication use for at least 3- 4 meetings prior to use.
    c. Overall use of neuroleptics is significantly lower than most other psychiatric service provisions.

Training
Open Dialogue has a systematic training programme and supervisory support system. The form of family therapy training employed is broader than the Behavioural Family Therapy approach emphasised in England; however, as part of their training they encourage a diversity of therapeutic approaches, such as individual psychotherapy. This training programme started in 1989 and Aaltonen, Seikkula & Lehtinen (2011) reported that 90% of staff had received substantive family therapy training. Principal trainers and supervisors are members of psychiatric staff, and provide training and supervision as part of their day to day work.

Barriers to the Development of Open Dialogue in Nottinghamshire
The significant success of Open Dialogue suggests the need to learn from this model, however, there are barriers and unknowns to overcome. Some of the key factors are:
1. The majority of staff in Finnish Open Dialogue have a Family Therapy and / or Psychotherapy qualification, this is not the case in Nottinghamshire Healthcare NHS Trust.
2. The social / network model is not the dominant paradigm in current mental health provision.
3. The dominant model in UK services, though it incorporates ideas of collaboration and recovery, is one of service expertise and transmission of knowledge to service users.
4. By its very nature, full implementation of Open Dialogue requires whole systems change.
5. Open dialogue was developed in a specific cultural and regional area; therefore it is unknown whether specific aspects of Finnish culture of the region are necessary components to successful implementation. However the outcomes for people with a diagnosis of Schizophrenia in Finland as a whole are generally poor. This suggests the outcomes in this region of Finland are not simply the result of Finnish culture[2].
6. It is unknown whether factors such as substance misuse, housing shortages, job market, community cohesion etc are equivalent between Lapland and Nottingham, though Open Dialogue was implemented during a time of economic downturn.

Resources and Potential to Development
The Trust has a number of resources, which will aid the implementation of Open Dialogue, such as its recovery ethos and investment in training.
1. The Trust's adoption of a recovery ethos has placed an emphasis on personal meaning and service users as active in their recovery.
2. This ethos and Peer Support workers have increased the voice of service users in services, and increased the importance of service user knowledge and experience.
3. There have been some staff trained in Family therapy and other psychotherapy approaches.
4. Open Dialogue developed out of a pre-existing Needs Led Approach, which has some similarities to approaches practised in Assertive Outreach.
5. Psychological models and approaches have been disseminated within the Trust for a number of years e.g. Clinical Psychology Bite-Size, Trust training events and conferences.
6. There are a number of teams and individuals receiving psychological supervision.
7. There is a growing network of people with an interest and knowledge of Open Dialogue within services.
8. NICE recommends Family Therapy approaches, and there has been a successful bid to support training in Behavioural Family Therapy.

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[2] For example, see Seikkula et al. (2003). Furthermore, future research results from other areas of the world, such as the USA will add to our knowledge regarding cross-cultural implementation of Open Dialogue

9. There was also a successful NICE bid for supporting psychological approaches to psychosis, which conceives these experiences as meaningful.
10. The Trust has a well established Learning and Development Department which could support training needs in Open Dialogue

Next Steps
1. Dissemination of Open Dialogue ideas to Trust staff. Such as:
   a. Purchase of additional copies of Open Dialogue Documentary DVD. To arrange via service managers and team leaders showings of Open Dialogue DVD in team meetings.
   b. Presentations to teams on Open Dialogue from knowledgeable Trust staff.
   c. Dissemination of a short, accessible summary of Open Dialogue to Trust staff.

2. Supporting and expanding existing skills, knowledge and therapeutic models and approaches that emphasise the construction of meaning and systemic thinking.
   a. Dissemination of information on systemic and social network models and ways to make sense of psychosis.
   b. Short information / training sessions on these approaches through team meetings.
   c. Arrange half and whole day training sessions for staff with a particular interest. These staff could then disseminate ideas to colleagues.

3. For the Trust to set up an internal network of people with an interest in Open Dialogue, this could be an e-mail distribution list where key articles on Open Dialogue could be disseminated.

4. To increase links with local people outside the Trust with an interest in Open Dialogue.

5. To develop a steering group to implement development of Open Dialogue.

6. To explore funding options for development and training through sources such as non-recurrent NICE bids and Learning and Development department.

7. Increase the number of people with specific family therapy and psychotherapy training and knowledge. Such as:
   a. Family therapy approaches - this could partially include Behavioural Family Therapy; however, adoption of Open Dialogue would require broader systemic models of family interventions.
   b. Psychotherapeutic approaches where voices and unusual beliefs are conceived as meaningful in relation to life experiences and dilemmas.

8. Arrange specific training and consultation on Open Dialogue from experts in the field.

9. Develop research links with organisation such as Institute of Mental Health so to evaluate quantitatively and qualitatively the implementation of Open Dialogue.

10. Exploration, consultation and modification of Trust medication protocols, so that they are in alignment with an Open Dialogue approach.

11. To trial aspects of Open Dialogue in teams that are oriented to Psychosis, such as Early Intervention and Assertive Outreach services, but may also include Crisis workers.

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