Open Dialogue From Theory to Practice

Jane Hetherington
- Background
- Open Dialogue Model
- What we are doing in Kent
- Research
- Ways forward and challenges
- Questions and dialogue
3. Listening to what service users and their families want

Compassionate
Safe
Effective
Continuity
Communication
Consistency

Open Dialogue

11/02/16
Poor network involvement…

“A family member or someone close to me was involved as much as I would like” 55%

+ Poor therapeutic relationships…

“I definitely agreed with someone in NHS MH services on what care I’ll receive” 43%

“Mental health services understand what is important in my life” 42%

“Mental health services help me with what is important” 41%

“mental health services help me feel hopeful about what is important” 38%

*16,400 SU respondents from 51 MH Trusts
Origins of Open Dialogue

- Initiated in Finnish Western Lapland since early 1980’s
- Need-Adapted approach – Yrjö Alanen
- Integrating systemic family therapy and psychodynamic psychotherapy
Open Dialogue...
A Relational & Network Based Approach

- All MDT staff receive rigorous training in family therapy and related social network engagement skills

- This is therefore knitted into the very fabric of care – not an additional intervention offered on the side

- Every crisis is an opportunity to rebuild fragmented social networks (friends & family, even neighbours), by instilling a sense of group ...
• The patient’s family, friends and social network are seen as "competent or potentially competent partners in the recovery process [from day one]" (Seikkula & Arnkil 2006)

• There is an emphasis on building deep & authentic therapeutic relationships from the start
Social Network Perspective (asset based)

- To develop their own vision for a good life
- To recognise their own strengths and real wealth
- To get information about what is available that they can use on their own
- To make use and build on their own networks
- To strengthen their own voices
- To take their own practical actions for change
- To create new opportunities of their own within the community
Open Dialogue…
A Different Approach

- **Dialogism**: promoting dialogue is primary and, indeed, the focus of treatment. “the dialogical conversation is seen as a forum where families and patients have the opportunity to increase their sense of agency in their own lives.”

- This represents a fundamental culture change in the way we talk *to and about* patients. All staff are trained in a range of psychological skills, with elements of social network, systemic and family therapy at its core.
Open Dialogue…
Making a Mindful Connection

- **Being In The Present Moment**: “Therapists… main focus is on how to respond to clients’ utterances from one moment to the next” (not using a “pre-planned map”)
- “Team members are acutely aware of their own emotions resonating with experiences of emotion in the room.”
- **Mindfulness** is a major aspect of training (studies show how it improves therapeutic relationships)
Global Take Up

Rapidly increasing interest internationally and at home…

- First Wave:
  Finland, Norway, Lithuania, Estonia and Sweden

- Recent Years:
  Germany, Poland, New York, Massachusetts, Vermont

…training evolving and improving, becoming more accessible and focused.
Outcome data

- Open Dialogue
  - 14 bed days over 2 yrs
  - 33% using neuroleptics
  - 24% had some relapse
  - 81% returned to work

- Comparison with TAU
  - 117 bed days over 2 yrs
  - 100% using neuroleptic
  - 71% had some relapse
  - 43% returned to work

Incidence of Schizophrenia in Western Lapland reduced from 33 per 100,000 in 1985 to 2-3 per 100,000 in 2005
• “Having friends (& a social network) is associated with more favourable clinical outcomes and a higher quality of life in mental disorders” (Giacco et al., 2012)

• “A systematic review of Randomised Controlled Trial (RCT) evidence suggests that family therapy could reduce the probability of hospitalisation by around 20%, and the probability of relapse by around 45%” (Pharoah et al., 2010)

• “The estimated mean economic savings to the NHS from family therapy are quite large: £4,202 per individual with schizophrenia over a three-year period”
The Therapeutic alliance and its relationship to outcome in short-term inpatient psychiatric care (Hansson L, Berglund M 1992). “The main finding was that a better therapeutic alliance… was related to a greater improvement in symptoms during treatment.”

“Evidence suggests that these interpersonal processes also have a direct therapeutic effect. Thus, depending on the conceptual model of therapeutic processes they may be seen as therapy in itself.” (Priebe & McCabe 2008).

In patient surveys, the therapeutic relationship has repeatedly and in different settings been reported as the most important component of care (e.g. Johansson & Eklund, 2003).
MAIN PRINCIPLES FOR ORGANIZING OPEN DIALOGUES IN SOCIAL NETWORKS

• IMMEDIATE HELP
• SOCIAL NETWORK PERSPECTIVE
• FLEXIBILITY AND MOBILITY
• RESPONSIBILITY
• PSYCHOLOGICAL CONTINUITY
• TOLERANCE OF UNCERTAINTY
• DIALOGISM
• Discussion with your neighbour for five mins

• Feedback
THE KEY ELEMENTS OF DIALOGIC PRACTICE
IN OPEN DIALOGUE: FIDELITY CRITERIA

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Clinical fidelity criteria

1. Two (or More) Therapists
2. Participation of Family and/or Network Members
3. Use of Open-Ended Questions
4. Responding To Clients’ Utterances
5. Emphasizing the Present Moment
6. Eliciting Multiple Viewpoints: Polyphony
7. Creating a Relational Focus in the Dialogue
8. Responding to Problem Discourse or Behaviour as Meaningful
9. Emphasizing the Clients’ Own Words and Stories - Not Symptoms
10. Conversation Among Professionals in the Meeting: The reflecting process, making treatment decisions, and asking for feedback
11. Being Transparent
12. Tolerating Uncertainty
1. Person, Family and Support Centered Care Approach
2. Culture demonstrates respect, authenticity and collaboration
3. Teams meet routinely with person and network
4. Staff trained in dialogic practice and network engagement
5. Welcoming environment focusing on client experience
6. Connect services in clinical and community settings
7. Practice 12 Key Elements
8. Provide immediate support and access to services
9. Shared decision making process
10. Use OD as a mindful way of being
• Discussion with your neighbour for five mins

• Feedback
The Kent Team

- OTs
- CPNs
- Carers
- Psychiatrists
- Support workers
- Social Workers
- Peer Support Workers
- Psychological practitioners

Families have been identified from the Early Intervention in Psychosis Service

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What is different?

- In statutory services treatment adherence is seen as core to successful outcomes
- Networks are decision making forums and the relationship is the core intervention for change
- Agenda set by individual and family/network
- Frequency and length
Being with rather than being about

- No pre planned agenda
- Follow flow of network dialogue
- Inquisitive and curious
- Relationships are the Immune System of society
Supervision

- Monthly supervision
- Peer supervision
- Use of reflective practice
- Interface with other parts of the organisation
Cohort 2

- Currently recruiting for cohort 2 across CMHT and CRHT/Inpatient to create a team that can be responsive at the point of crisis and maintain continuity throughout pathway of care.
- Course participation and service design through 2015 and 2016.
- Participation in pilot/research trial 2016 - 2017
In a multicentre cluster RCT and related work streams we will seek to answer the following:

- Is OD more effective than usual NHS crisis care in reducing service user relapse?
- Is OD more effective than usual NHS mental health crisis care in improving service user social network extent and quality, and does this mediate service user relapse?
- Is OD a more cost-effective service than usual NHS crisis care?
- What are service users, carers and clinicians experiences of OD delivery?
- What organisational changes are required within NHS services for to support the effective implementation of OD?
“Peer Support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on a psychiatric model and diagnostic criteria. It is about understanding another’s situation empathetically through the shared experience of emotional and psychological pain.” (Mead, 2003)
The Kent Perspective

Challenges for Practice

Dialogic practice needs to be brought about by many actors

Support

...there is a need to develop a dialogue friendly environment that addresses the worries of others

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The NHS Five Year Forward View: New Care Models

Focus on meeting local population need

Investment and flexibility

Dissolve traditional barriers to manage systems of care

Co-design services and apply learning across health systems

Focus on the quality of the transaction

Clinical Engagement

Patient Involvement

Local Ownership

National Support

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Any questions?