Summary of Peer Supported Open Dialogue Principles

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	Open dialogue approach, *n* = 23	Treatment as usual, *n* = 14
Mild/no symptoms	19 (82%)	7 (50%)
Relapse	6 (26%)	10 (71%)
Studying, working or job seeking	19 (83%)	4 (30%)
Antipsychotic use	8 (35%)	14 (100%)
Mean hospital admissions, days	14.3	116.9

Two-year outcomes for first-episode psychosis treated with open dialogue in Finland

Core principles of the open dialogue approach

1. Social network perspective
2. Provision of immediate help
3. Responsibility
4. Psychological consistency
5. Flexibility and mobility

The practice-related principles of open dialogue

6. Dialogism and polyphony
7. Tolerance of uncertainty

1. Social network perspective

The social network perspective is fundamental to the open dialogue model. Patients' families and other key members of their social network are always invited to network meetings. Other key members may include official agencies such as Social Services and local employment agencies – to support vocational rehabilitation – as well as fellow workers and any other associates or carers that may be involved. The network meeting also incorporates at least a couple of team members, and all key discussions about care take place within the network meeting. The meeting functions in a very person-centred way, which is more collaborative and less hierarchical than ordinary clinician–patient interactions. This is elaborated further under the key practice parameters outlined in the next section.

Conversations between clinicians will also take place in front of the entire network, and all present are invited to comment on them, so that a dynamic of openness and reflection is established from the outset (Andersen 1995).
The location and composition of network meetings depends on the wishes of the patient. Often, they will be held at the patient's home. According to Finnish research, home meetings may help to prevent unnecessary hospital admissions, by rendering the family's own resources more accessible (Keränen 1992).

2. The provision of immediate help

Providing a rapid response, usually within 24 hours, at the point of referral is at the core of the model. The patient will be present from the start, even through the most intense phases of presentation – including psychosis – so as to create a sense of security from the outset and thus bring about a firm foundation for community and network meeting-based care.

3. Responsibility and psychological continuity

The first team members to be involved in the initial meeting will remain involved throughout the care pathway. This means that the same team is responsible for the treatment for as long as it takes in both out-patient and in-patient settings. Throughout treatment, the network meeting is seen as the 'sovereign' decision-making body. There will be at least two clinicians in the network meetings, who may be medical staff, depending on the nature of the case. If support for a change in medication becomes necessary, then doctors (or non-medical prescribers) can be co-opted onto the network meetings at a later stage, if there is not already a team member with the appropriate background. In addition, other modes of treatment – such as occupational therapy groups and psychotherapy – can take place between the network meetings, enabling various methods of treatment to be combined as part of an integrated process.

4. Flexibility and mobility in the provision of care

Flexibility around the treatment provided is vital. All conceptualisation around what is and is not appropriate or necessary is left at the door, so as to allow appropriate responses and interventions to evolve in a need-adapted way through the meetings. In psychotic crises, for example, allowing the possibility of meeting every day for up to a couple of weeks may often be necessary to generate an adequate sense of security around the crisis. Other forms of treatment and therapeutic methods are chosen depending on what best fits the patient's problems.

Additional possible interventions such as medication should, wherever possible, be discussed at several network meetings before decisions are made. This is to maintain a consistently democratic and reflective process that then facilitates the continued cultivation of a powerful sense of agency for non-clinicians when it comes to both decision-making and 'meaning formation' (see 'Cultivating agency' below) from the outset.

For the group to function in such a truly democratic and effective way, the practice of the meetings themselves will need to be guided by a set of key principles.

5. Core principles of practice

The practice-related principles of open dialogue form the backbone of the network meetings. These principles include dialogism and polyphony, and tolerance of uncertainty (Reference Seikkula, Aaltonen and RasinkangasSeikkula 2003).

6. Dialogism and polyphony

The term dialogism was first coined by Russian philosopher Mikhail Bakhtin in his work of literary theory, The Dialogic Imagination (Reference HolquistHolquist 1981). The term refers to the way in which all language and thought is a process of evolution, in which every discourse/thought is a product of all the discourses/thoughts that went before it. For a dynamic to be dialogical, therefore, it must start without fixed objectives, within certain parameters, so as to allow for a free exchange that builds up layer by layer, via each contribution made, into new terrain. In addition, unlike the dialectical dynamic, there is no goal of a merging of viewpoints in order for a shared perspective to be reached. Each person can maintain their own perspective, and each perspective can hold more salience in particular circumstances – depending on the needs at the time. As a result, the group can ultimately function in a wholly pragmatic manner, enabling empowered and innovative problem-solving and decision-making, with each member having an equal right to contribute and to affect the future direction, to acquire a greater sense of agency in their own life (Reference HaarakangasHaarakangas 1997).

Such a dynamic can have a therapeutic effect from the outset, enabling a sense of personal independence, as well as interdependence, to be experienced by each member of the network. As Reference Olson, Seikkula and ZiedonisOlson et al (2014) add:

‘[…] the starting point of a dialogical meeting is that the perspective of every participant is important and accepted without conditions. This means that the therapists refrain from conveying any notion that our clients should think or feel other than they do. Nor do we suggest that we know better than the speakers themselves what they mean by their utterances.’

Open dialogue allows each person to enter the conversation in their own way. The primary focus is on promoting dialogue (more so than promoting change in the family), and the goal of the dialogue is not agreement, but for everyone to be heard. This multiplicity of accepted voices is known as polyphony:

‘The team cultivates a conversational culture that respects each voice and strives to hear all voices […] Listening intently and compassionately as each speaker takes a turn and making space for every utterance, including those made in psychotic speech’ (Reference Seikkula and TrimbleSeikkula 2005).

Each person in the dialogue constructs the problem using their own voice. For the clinician, listening to and responding to these voices takes precedence over interviewing techniques (Reference AndersonAnderson 1997). Through the resulting dialogue, problems may be reconstructed and new understandings formed (Reference Andersen and FriedmanAndersen 1995).

7. Tolerance of uncertainty

Uncertainty, on the part of both the patient and the clinician, pervades the experience of mental illness and psychological distress. The open dialogue approach explicitly acknowledges this from

the outset. According to the model, however, the reflexive desire to remove the uncertainty is often the very thing that compounds it. Meetings are therefore facilitated to avoid premature conclusions or decisions about treatment (Reference Anderson, Goolishian, McNamee and GergenAnderson 1992). Connection to the distress being experienced is key, and this means not acting too rapidly to bring about change. If this kind of tolerance is constructed, more possibilities emerge for the family and the individual, who can then become agents of change themselves, having more robustly evolved a language to express their experience of difficult events in the intervening period. For this reason, questions are kept as open-ended and as relationally focused as possible, to enable the collective dialogue itself to produce a response or, alternatively, dissolve the need for action altogether.

Focusing on connection – as opposed to direction – from the outset is also a means by which safety is fostered within the meeting. Creating a safe space where everyone can be heard and respected on an ongoing basis opens up a new means by which a sense of safety can be instilled within the group. However, as Olson et al recognise, this new way of working can present a significant challenge for clinicians: ‘This therapeutic position forms a basic shift for many professionals, because we are so accustomed to thinking that we should interpret the problem and come up with an intervention that counteracts the symptoms’ (Reference Olson, Seikkula and ZiedonisOlson 2014).

A mindful approach

Being in the present moment

Clinicians often approach their work with a set of templates and internal algorithms that help them make decisions about how to respond. Unfortunately, one of the consequences of this is that patients and carers can be left feeling unheard. The interaction becomes about extracting or imparting information (‘doing to’), rather than ‘being with’ the patient and whatever is happening in the present. This moment-to-moment connectivity is a core aspect of mindfulness, and studies have shown that the ability to engage in this way has a positive effect on the therapeutic relationship (Reference Lambert, Simon, Hick and BienLambert 2008; Reference Razzaque, Okoro and WoodRazzaque 2015). Lambert & Simon add that mindfulness training, by potentially fostering an attitudinal change in clinicians towards greater acceptance and positive regard for self and others, represents ‘an extremely promising addition to clinical training’ (Reference Lambert, Simon, Hick and BienLambert 2008).

A key practice in open dialogue, therefore, is to respond to the patient's utterances as they occur and keep the focus on what is happening in the here and now. According to Reference Olson, Seikkula and ZiedonisOlson et al (2014),

‘The clinician emphasizes the present moment of meeting. There are two, interrelated parts to this: (A) responding to the immediate reactions that occur in the conversation; and (B) allowing for the emotions that arise’.

The focus, therefore, is wholly on the patient and those around them, and on what is happening now. As Reference SeikkulaSeikkula (2011b) explains,

‘Therapists are no longer interventionists with some preplanned map for the stories that clients are telling. Instead, their main focus is on how to respond to clients’ utterances’.

Attention to the present moment is also a gateway through which connections can be established at a pre-verbal level. This is another way in which open dialogue is a mindful approach; all levels of

presence and connection – not just the verbal – are seen as vital, and cultivating an awareness of and sensitivity to them is key. Reference SeikkulaSeikkula (2011b) talks of:

‘moving from explicit knowledge to the implicit knowing that happens in the present moment as embodied experience, and mainly without words – that is, becoming aware of what is occurring in us before we give words to it. We live in the present moment lasting only [a] few seconds. This refers to the micro aspects of a dialogue in the response and responsiveness of the therapist to the person before anything is put into words or described in language; that is, in being open to the other’.

As in mindfulness, the embodied connection with the other is thus believed to be as important as the verbal one: ‘Therapists and clients live in a joint, embodied experience that happens before the client's experiences are formulated in words. In dialogue an intersubjective consciousness emerges’ (Reference SeikkulaSeikkula 2011b).

Acceptance of thoughts and emotions

Mental health professionals can often see it as their job to remove difficult thoughts and emotions. In open dialogue, however, a key skill is the ability to accept and allow whatever thoughts and emotions are happening in the present moment – as long as there is no immediate threat – to emerge and be experienced. As articulated by Reference Olson, Seikkula and ZiedonisOlson et al (2014),

‘When emotions arise such as sadness, anger, or joy, the task of therapists is to make space for their emotions in a safe way, but not give an immediate interpretation of such emotional, embodied reactions’ (Reference Olson, Seikkula and ZiedonisOlson 2014).

When this occurs, clinicians can also be ‘transparent about being moved by the feelings of network members, [thus] the team members’ challenge is to tolerate the intense emotional states induced in the meeting’ (Reference Seikkula and TrimbleSeikkula 2005).

Cultivating agency

Fostering agency in the patient and their social network underpins the entire model. Agency is cultivated through the milieu that is maintained and the way decisions are made, and, as a consequence, through the way in which meaning is generated.

A key objective of working with people in this way is to enable the individual concerned to generate meaning around the experience through dialogical interaction with their social network. This more endogenous ‘meaning formation’, as it were, can be considered more powerful, and thus more valid and sustainable, than what could be termed exogenous meaning formation, in which outside bodies or professionals take on sole responsibility for defining the experience. By allowing for polyphony, tolerating uncertainty and connecting with the network in this way, clinicians go from being enforcers of meaning to enablers of endogenous meaning formation, therefore enhancing the sense of agency that the process itself begins to instil. In many respects, this can be seen as a core mechanism of change within the process.

Risk and governance

Risk assessments in a dialogical approach are completed and documented as in treatment as usual; however, they are compiled differently. Whereas the clinician would usually go through a checklist

of questions pertaining to key elements of risk, the broader discussion in a network meeting is by definition less goal-directed. However, this wider-ranging dialogue among the many parties concerned means that issues of concern/risk – or lack thereof – arise inevitably during the course of the meeting. In this process, a far richer exchange and exploration takes place. It has been the experience of clinicians in both the UK (within the pilot teams) and abroad that by the end of a network meeting, all the items that would have been covered via direct questioning in a formal risk assessment have emerged through the dialogical interaction. Relevant details are then logged as progress notes in the appropriate formats.

A similar process has been operated and found to work effectively for other formal assessment and governance requirements such as the Care Programme Approach (CPA).
If risk arises during or around the time of the network meeting, this must be expressed in the meeting and any necessary action must be taken, whether that relates to safeguarding protocols or the Mental Health Act. This has been the practice in Finland and other countries where open dialogue or similar services operate; however, utilisation of such measures – especially detention – are reported to be required much less frequently. For this reason, whether it be in such circumstances, or for broader reasons such as prescribing medication, performing activities of daily living (ADL) assessments, engaging in supportive/recovery-oriented work and visits, or commencing one-to-one psychotherapy, the specific expertise of the individual clinician may still be called upon at any time.

Should hospital admission ultimately be required, then network meetings would still continue for the duration of the admission and after discharge. Throughout the care pathway, network meetings remain the primary decision-making forum when it comes to key aspects of care.

Clinicians in an open dialogue team are thus not required to abandon their area of expertise altogether. However, in a dialogical service, this expertise would normally be applied in a more discriminating, need-adapted way, within the context of a generally more democratic, less hierarchical environment.

Peer support

Peer support is recognised as an important facilitator of individual mental health recovery (Department of Health 2008) and is currently used across a variety of mental health services (ImROC 2013; Reference Gillard and HolleyGillard 2014; Reference Mahlke, Krämer and BeckerMahlke 2014; www.hearing-voices.org). Reference Repper and CarterRepper & Carter (2011) described a range of benefits for peer workers, patients and mental health services that peer worker roles offer (Box 2).

Conclusions

The open dialogue approach is the result of an extensive, collaborative development process over several decades. Promising outcomes in Western Finland have led to the export and local modification of the approach internationally, including in New York and Berlin. POD is a further development of the approach for the NHS in the UK.

POD is a model of care that is based on strong humanistic, person-centred values. A premium is placed on establishing connections between clinicians and patients, as well as between the patient and their social network. The network meeting is seen as the crucible within which this occurs and, as a result, the clinician's role from the outset focuses more on relationships than would be the case

in traditional settings. This requires a mindful, tolerant and compassionate approach to care, and it is one that will involve some personal cultivation and development on an ongoing basis. This commitment to forging a profoundly empathic connection is further enhanced by the integration into the model of peer support workers, who will contribute to a flattening of the hierarchy and, through a process of co-supervision with clinicians, enhance the patient-centred nature of the service provided.

The ultimate goal is to facilitate the emergence of a sense of agency between the patient and their social network, by allowing a dialogical milieu to form. Allowing the people most affected by the mental health concern to make sense of the experience themselves through such a dynamic becomes a key accelerator of the recovery process, and one that has the potential to create longer-term stability and ultimately promote independence from care systems and services.