

The Kent and Medway NHS and So Supported Open Dialogue service:

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In February this year, the Kent and Medway NHS and Social Care Partnership Trust began accepting individuals onto its Peer-Supported Open Dialogue service, modelled on the open dialogue approach from Finland. The approach is a form of family-focused therapy that incorporates other social network members and has a number of remarkable features such as the same individual clinicians attending every meeting, the frequency and duration of which are set by members of the social network, with an emphasis placed on all voices being heard.

Working alongside the more traditional crisis and community teams, each week the service is helping more people who are experiencing a mental health crisis by arranging an immediate treatment meeting with everyone involved. The only necessary criteria are that it is a new episode of care and the individual is between 18 and 65 years of age. This service is characterised by features that have not traditionally been encompassed in mental health care; for example, continuity of care staff, all decisions and discussions regarding care taking place in front of the service user with their family or social network, tolerating uncertainty, listening to multiple perspectives, and an emphasis on recognising the distress as being understandable within its own context.

In the spirit of open dialogue and the emphasis on hearing multiple perspectives, here we present a selection of views on the creation of the service, some of its key features and some thoughts on the future of the approach within the NHS.

The origins of the service

Catherine Kinane (executive medical director): My chief executive first mentioned open dialogue to me. I knew nothing about it but we decided we would check out what it was about. I approached the medical director of the North East London NHS Foundation Trust and was introduced to Russell Razzaque by him, and then Russell and I became involved jointly in relation to the development of open dialogue. I thought, *"This is certainly something that I can buy into; this is something that I can see will make a big difference to patients"*. The other thing that happened around that time was that I got to know Annie Jeffery and understand some of her concerns about what she felt needed to change. As a carer, she felt continuity of care was absolutely key, and that struck a chord with me, Annie's views of what would help chiming with my own views of what were the problems.

Annie Jeffrey (carer lead): My son had found it really difficult with current services so fragmented; constantly seeing different people, he found it so unhelpful that he disengaged from services. I think constantly telling his story and going over everything actually made it worse for him. This is why I was trying to find a service that allowed for continuity of care.

Catherine: I had the opportunity to visit the Parachute Project in New York. That project was inspirational. They talked about the fact that, as peer workers, they were able to offer something unique and individual to people

who used the service, which was additional to a traditional, professional input. They were reducing the cost of mental health episodes and had reduced admissions in mental health cases.

Creating the new service

James Osborne (clinical lead): The motivation to move ahead with the new service came from the recognition that we needed to do something different in mental health. We wanted to ensure good care, immediate responses, taking place close to home, and not just individualised care but family care. Also, to relocate the resources, the internal psychological resources, back in the patient and the family when traditional services would often absorb or take on responsibility for keeping people safe and getting better. A further motivation was to increase staff wellbeing and happiness.

Teresa Barker (assistant director lead): Creating the new service was always going to be a challenge, because the model doesn't sit neatly in any individual part of our organisation. It requires a complete paradigm shift (or expert staff that can bravely navigate current systems!) as there is currently no UK evidence-base that would convince stakeholders this would work in the NHS.

Catherine: It's been a tough job and a challenge. A group of people came together who were committed and believed the open dialogue model might hold something precious that we should be exploring for our

patients, and it's because of the strength of that group and beliefs of that group that the challenges have been overcome.

The first challenge was to get over some of the feelings psychiatrists had that this was quite an anti-psychiatry model and quite an anti-medication model. Then, there was the hurdle of writing all of the documents, a huge amount of preparation that was needed, and getting business people on board who would be able to fund and cost the training, asking the trust for the first round of funds. I would say, if it hadn't been such a cohesive group of people sharing a goal, it might have been impossible.

James: There was some consternation in the organisation about funding a group of staff to do the four-week residential training. However, the biggest of the challenges was the transformational piece of work to release staff from their day jobs into a stand-alone team, with no extra money.

Annie: I'm enormously excited a team has got going just in the last few weeks; I never underestimated how difficult this would be to try and run a service in par or with all the existing services. I think the fact we had buy-in from all levels of the trust is one of the reasons we've managed to get this far, but there have been huge challenges from many different aspects. I think mental health services, at the moment, are very much focused on the medical model and I think we need something that is a lot more holistic and is actually listening to what people want.

Social Care Partnership Trust Peer Perspectives from the team

Waddingham, Ben Sanders and Catherine Kinane

What is important about peer-supported open dialogue?

Catherine: Two things that struck me as very important were dialogicity and the involvement of the social network. At the various carers' events we had held in Kent, I had heard carers say that they felt excluded. The dialogical approach was attractive to me because I'd always thought taking a history from a patient was somewhat one-sided; the individual's perception of receiving any kind of health input can be that it's very much a 'done-to' experience. That's not to say the health care would not be provided with respect and politeness, or that it would not be a positive experience. The service user may get the outcome that they wanted, which is the treatment needed in order to get better, but it could still be felt as a 'done-to' experience and within mental health care this is sometimes perceived by patients as very frightening. Through being dialogical and hearing more of the patient's and others' voices about how the problem is being experienced, we would be able to defuse the fear factor and actually, in working with open dialogue, that has been my experience; their fear becomes entirely diminished almost from the first two or three sessions.

Michael Bowley (team member): Bringing the social network into the treatment helps because the different voices allow different viewpoints to be aired, you can hear it from a different perspective. I think it helps the client to hear their trouble, their mother's and father's issues or their family's issues as well, so it helps them to understand what's going on and get a better picture of how they can help themselves, help the family and help the network.

Teresa: The service is different from other treatments. Network meetings enter the service-user's world rather than vice versa. The service is there to support what the service user and their family say they need and respect the expertise of all contributors. There is a great sense of shared responsibility and the care offered is consistent.

James: I was very aware that, in mainstream psychology-services, we were treating people psychologically a number of months if not years after their first presentation, so people had what I call 'sealed-over', developing different kinds of defence and coping mechanisms that often needed to be unpicked in psychological treatment and I was very attracted to this first window of opportunity, within 24 hours to reach the person psychologically, at the point of crisis. A further key benefit is the continuity of person, the same face, to develop a relationship and lay down a memory of the situation and events. By having the same people involved, what evolves is a shared narrative and a sense of trust. I think this is one of the most important things. I consider it to be very different to 'treatment as usual', particularly at the point of crisis. It is at that point when people get passed around the most.

Ben Sanders (team member): In terms of impact on families I think it's absolutely fantastic; we've had some really positive feedback, which is encouraging; people really appreciate the consistency of staff and the shared understanding and shared decision-making processes within open dialogue. We're in a totally different situation now where we consciously try not to formulate, or develop hidden impressions; we look to respond through reflective practice, our immediate physical, emotional and psychological responses to the here and now. The primary intervention is the developing dialogue itself, which seems to allow for solutions to arise but, naturally, it requires all parties to tolerate varying levels of uncertainty. I think the fact we work with people from the point of crisis through to recovery reduces a service-led provision of care, so it's very much led by the individual and their families – they determine when we meet, who is going to meet, and they pretty much lead the content of the dialogues; so we don't come with an agenda.

Annie: I was always frustrated by the constant change of people, even within

the crisis team, you saw different people every time and you were told the system did not allow for continuity. In this service, everybody is included right from the beginning and people aren't talked about outside meetings. I've sat outside a meeting of professionals with my son, Tom, whilst our family was discussed by people who didn't know us and never saw us again and I question how that is supposed to help anybody.

Involving families in treatment

Ben: I strongly believe people, families and their network have the resources within them to resolve a crisis, and I think those resources are often not utilised to the best ability. Often, we work objectively, in terms of looking at symptoms and how can we manage symptom relief rather than getting a collective understanding and pulling people together at that time in order to resolve the crisis. Plus, I don't think I can emphasise enough the value of everyone's perspective within a social network. I think there can be challenges to involving the whole family; families can be quite complex; getting people together at certain times with different people's responsibilities and roles and finding an environment to meet in. It can become heated in the first sessions, but I feel it is important to allow that tension to come out and not to intervene or try to police what is happening – allowing this just to play out can feel quite alien at first, but I've even been able to see how it can be an important point of reflections in later meetings; it can give a sense that the family exercised the regaining of control, which can be empowering, in contrast to a professional facilitating this.

James: I think it's really difficult to quantify just how important the involvement of families in treatment is. What develops, I think, is a sense of containment and solidarity, of not being alone in the point of crisis, hearing everyone's voice and offering a space for a new narrative to develop in the family. A point often raised is that of confidentiality or risk-issues increasing

as a result of more open discussions, particularly if there is potential abuse in families. However, my sense is there is often a part of people that feels relieved by some expression of that as long as it is done carefully and sensitively.

Catherine: We know, for some individuals, there can be an aspect of the family network that contributes to or perpetuates the distress they feel, and I am mindful of that in thinking about the social network. It's much better to work with the family within that context and endeavour to make that context better for the individual. I think there can be some potential problems with bringing a family in to mental health care but, with skill and listening, it is possible to deal with most of those problems. Most of the time, the approach of listening and allowing all the voices to be heard will help to defuse any problems.

Michael: The network and possible family can provide great help and support for the person at the centre of concern. If they feel the family could be a hindrance, this invites dialogue and we can explore this issue. A good supportive network for the individual can help and promote lifelong recovery and better mental wellness. Through help of the network, it allows the person at the centre of concern to manage their own difficulties and become less dependent upon mental health services.

Rachel Waddingham (team member): Families and social networks can be massively important. That might not be someone's biological family; it could be their friends or their partner, the family you choose. I think mental health services have historically individualised things, locating the problem within a person rather than seeing it as something that exists in the space between us as human beings. Services have often had an ambivalent relationship with families, both wanting their help in supporting the person in crisis and feeling the need for space in order to assess them. By actively involving the person's network from day one, we're trying something different.

The 'P' in peer supported open dialogue: Peer support

Rachel: I've been impressed by the trust's commitment to involving those of us with lived experience as valued members of the team. It feels like we have a good foundation but, for me, there is still a big question mark as to what the 'P', the peer, truly means.

Peer is a word that cannot exist in isolation – it's inherently relational and is about a mutual relationship between two or more people with some shared experience. So, if I were engaging in peer support, I would be connecting with a person (or group) through the lens of my lived experience in an atmosphere of mutuality. As an open dialogue practitioner, I'm using my lived experience – but it's not peer support. I am not just engaging with the person who is in crisis and prioritising their perspective; like my colleagues, I'm trying to attend to all members of the network. I share my experience and use it explicitly, but I'm there as an open dialogue practitioner not a peer. Across the world, different iterations of open dialogue have approached this challenge in different ways – including Peer Support Workers in Advocates, Massachusetts, making the decision to not train as practitioners and attend meetings as peers, with a clearer focus on the person who is at the centre of concern. If we want more P in the approach, I'm hoping we can explore more ways of connecting with people as peers ... peer support groups, perhaps, or community bridging. There are lots of different opportunities to develop our approach, and I'm glad to be working with a team that's open to this.

Michael: I think my personal experiences with services have helped me to add reassurance to service users I've worked with and really, just through my lived experience, be a base and a resource for clients and service users to use to help them through their times really.

Difficult aspects of the service

James: In terms of the dialogic network meetings, the reflective practice carried out by the clinicians can potentially be disconcerting for the service user or the family. We find that more with people who have been involved in the mental health system before or up to that point, and so they get used to a monological type of interaction. What we are starting to see with the new team is that we are seeing some people who have never been involved with services at all so, in some ways, it's less new to them. For some, however, it seems a bit bizarre and odd; people do say, "Are you going to do your weird thing again?" or, "Should I go, should I leave you to it?" or, "I'll just go and make a cup of tea". Or they might not say that, but actually migrate out of the room. My experience is, over time, of

regularly doing that, people just get used to it and certainly start to see the benefit of it.

Ben: I own some anxieties about our team not being fully formed yet, and the service being in its infancy, and in the process of forming systems and processes that help to keep everyone safe. We're finding out things as we go and that is standard for any new service, but I'm keen to make sure we develop our ways of practicing that enable us to stay on model but, as I say, keep everyone safe in the process.

Being dialogical

James: I think the type of dialogic therapeutic-conversation is starkly different to 'treatment as usual', that welcomes all voices unconditionally rather than an advice giving or a risk checklist; that's starkly different – the type of therapeutic discussion. For me, a dialogical meeting is the encouragement of hearing all voices. This is facilitated by a promotion of further clarification by all voices rather than a response or an answer to, or an advice of what's been clarified or even an interpretation or formulation of what has been said. So, the dialogic meetings are very much about encouraging all voices to come to the fore. Another key thing is including the psychotic utterances and normalising that. I think the other key aspect is the reflection in the meeting so that the voices of the clinicians are heard openly and not leaving to discuss the case outside, in the car or back at the base. For me, dialogic meetings are very much about being transparent about one's thoughts and feelings in the presence of the family.

Ben: Traditionally, service delivery can be clinician-led, where an individual is interviewed as a way of assessing their mental state, risk, and to explore possible treatment options. Open dialogue allows for a sense of 'not knowing', not initially coming up with the answers and solutions. Through having time and space for narrative to emerge, with a view of having all voices heard, a shared understanding develops, which has a natural flow to it, and appears to progress and grow, which is assisted by having consistent practitioners and, currently, more time to enable this. I am interested in the idea of not minimising or reducing people's experiences before we fully understand them.

Rachel: We use the word 'dialogical' a lot and it becomes as if we are saying dialogical good, monological bad! What does



dialogical mean? The only way I can make sense of it, at the moment, is responsivity so, in a dialogue, I won't be introducing questions or topics of my own. For me, the dialogical part is when someone says something and I stick with that and might repeat just a bit of what they say or ask a bit about what they said, to try and understand it more or just move my body in a way that responds to something that's said. Dialogical is that way of responding which promotes dialogue and it is really nuanced and complicated and hard, because it's much easier to think of a really cool question that seems useful, because then I've got control of the conversation in some way, whereas dialogical in a way is relinquishing some of that control.

Michael: Being dialogical is basically about hearing and allowing all voices to come, to be present in the meeting and for everyone to be able to share their own issues and worries and, hopefully, then together as a network you can work on these issues and come up with ways to move on from crisis into recovery.

The future of open dialogue in the NHS

Catherine: What advice would I give a trust wanting to start an open dialogue service? I'd give them the same advice I would give

about a trust wanting to make any change. You have to have engagement from the top to the bottom of the organisation; you have to have influence and credibility for the change you want to make, at every level in the organisation. In the future, I think it's important we develop the opportunity to allow other professionals to visit the team, from within the organisation, within the wider health economy and more widely both nationally and internationally. We need to make sure we're ready to have people come to visit us and I'd say that is the next thing I would like to see nurtured to existence; the opportunity to host visits and the infrastructure that will allow us to do that.

James: There is no doubt that the peer supported open dialogue service we have opened here in Kent could be started up by other NHS trusts. Along with committing to training up a whole team, or teams, of clinicians, what shouldn't be underestimated is the willingness to transform and challenge current practices to ensure the continuity of care. The clinicians need to receive referrals at the point of crisis and see them through to the end of any need for care, and this is no small feat in the current setup of teams. Building this within the current systems of care requires a strong commitment to pilot or try this, and work through the interface

challenges that inevitably remain. The other key challenge is holding uncertainty while not seeking to reduce symptoms at the point of crisis, but instead, trying to increase safety and psychological resources in the individual and their family. We've only achieved it, I believe, because we've had sign-up at all levels and really strong backing from our chief executive and medical director.

Catherine: My hope is very much that the small start we have made in terms of delivering a service will grow, that practitioners will be attracted to working in that model and it becomes self-sustaining through practitioners hearing about how positive it is and the compliments the team are receiving. I think most mental health professionals are attracted to doing something that feels like it really matters and can be seen to work. The team at The Kent and Medway NHS and Social Care Partnership Trust are making a real difference and I think, with a bit of luck and a fair wind, the service will acquire its own impetus and continue to grow.

Contributors:

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Michael Bowley is a peer support worker within the service.

Rachel Waddingham is an open dialogue practitioner with lived experience of mental distress working within the service.

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Marcus Colman is a member of the trust's research and development team and carried out the interviews for this article. Email Marcus.Colman@kmpt.nhs.uk for more information on the research being carried out to build an evidence base for the service.

For more information about the Kent and Medway NHS and Social Care Partnership Trust Peer Supported Open Dialogue service, contact the service manager, Yasmin Ishaq (Yasmin.Ishaq@kmpt.nhs.uk) or phone 01227 812044.

A course within a course a systemic foundation course multidisciplinary staff

Catherine Butler and Jo Black

The contexts of systemic therapy training are shifting, influenced by programmes such as Children and Young Persons Improving Access to Psychological Therapy (CYP-IAPT), training staff to the equivalent of Intermediate level, and an increasing number of professional training courses developing their systemic teaching to meet the AFT requirements for foundation. Greater attention is also being paid to 'shared learning' in professional education, based on the belief that effective client-care will be achieved through collaboration within and between professional teams. An increased knowledge and understanding about the role of other professionals can increase trust, dispel stereotypes and improve working relationships (Jones, 1986). Parsell *et al.* (1998) propose that removing discipline-based education is one way to achieve this end.

However, shared learning comes with its challenges. These include practical issues such as discrepancies in the number of students from different professional groups and contrasting learning and assessment methods (Horsburgh *et al.*, 2001.) Students' attitudes to shared learning also has a large impact on its success; influenced by prejudice about other professional groups and a lack of knowledge about their approach to client care (Parsell & Bligh, 1988). Carpenter and Hewstone (1996) propose a 'contact hypothesis' whereby shared learning provides a forum for multi-professional groups to interact towards a shared goal and so break down potential hostilities and increase knowledge and positive attitudes towards each other.

While multi-disciplinary learning is a common feature on systemic training, it is not routinely offered on clinical psychology training-programmes. The current study is an evaluation of such an opportunity, conducted on a new foundation course in systemic theory and practice started at the

University of Bath. The clinical psychology doctorate started in 2011 and contained an element of systemic teaching within it, spread over three years. The revised British Psychological Society accreditation guidelines (BPS, 2015) specified courses name two therapy modalities that students would become competent and confident to deliver by the end of training. The society specified that one of these would be cognitive behavioural therapy, and the University of Bath course made a commitment to the second strand being systemic therapy. Work began on developing the existing training to create a foundation course to run during the first year of the three-year doctorate. With an emphasis on valuing multiple perspectives, the nine systemic teaching days, one a month, were opened up to external continued professional development students to join the clinical psychology trainees (hereafter referred to as 'trainees'). The course began in 2014 with an intake of 13 professional development students and 17 trainees.

The study was granted ethical approval by the University of Bath and funded by the AFT's David Campbell Fund.

Method

Students were asked to complete the modified version of the The Readiness for Inter-professional Learning Scale (Parsell & Bligh, 1999) at three time points over the course. The scale is a 19-item self-report scale designed to assess students' readiness to engage in shared learning.

At the end of the teaching series, students were invited to take part in a focus group, one for professional development students and one for trainees; separate groups were used so that if students wished they could talk about the other students freely.

Results

Total scores were calculated for all participants with data at one or more time