

## **Dialogical Supervision in an NHS Open Dialogue service**

**James Osborne, Yasmin Ishaq, Marcus Colman, Ben Sanders and Michael Bowley**

### **Introduction**

“Jaako Seikkula and his colleagues in Finland developed what they called Open Dialogue, as a relational approach to working with severe mental illness. The approach is theoretically and ethically compelling, and startlingly effective in practice.”

(Editorial, Context, Issue 138)

At the beginning of February this year the first NHS Peer Supported Open Dialogue service was launched in Kent, described in Context, 152 by Osborne *et al.*

Open Dialogue is offered as a crisis intervention for families and has some unique features, including consistency of clinical staff, equal importance given to all voices (including psychotic voices), the avoidance of quick treatment decisions and a form of therapeutic interaction known as ‘dialogic practice’ (see Context, 138). This new team has sought to remain faithful to the Finnish model of Open Dialogue while developing its own governance and supervisory processes fit for the NHS. Along with quotes from clinicians, Yasmin Ishaq and James Osborne provide some reflections on the model of supervision developed and co-produced by all team members.

### **Supervision in the Open Dialogue service**

“The supervisions are challenging, yet effective. They are an important space to explore how it feels for us to work in this way, our relationships with each other, and to hear others responses to this. It is important for us to not overly focus on content but also for us to feel able to offload difficult experiences, and difficult things we have heard and felt, so balance and relevance are key.” (Ben, Open Dialogue clinician)

As with any therapeutic intervention clinical supervision is an imperative place of support for the clinicians, but it also allows us to monitor the progress of the service through the difficulties that the team is experiencing. The service has to deal with some thorny issues regarding the extent to which the clinicians can tolerate the uncertainty of a situation, and how the team manages those feelings of wanting to jump in and offer a treatment intervention, or when to hold back. In supervision everyone comes from a different perspective in terms of what they feel and think and so through supervision we seek to understand what’s happening in our own internal dialogues and how our own internal dialogue is informing our decision making.

During the supervision there is a focus on issues that resonate for the clinicians whilst working with an individual and their family; this is not just about the problems that service users present. Sometimes difficult feelings can arise and this approach does not always apportion those difficult feelings to our clients; it makes us consider, 'why I am feeling that this is a difficult situation?', and the more that we understand about each other the more we get a greater picture of how everybody is operating in this situation.

Bringing together clinicians from all disciplines including health professionals, social care staff and peer support workers into one team we were aware that there were almost as many different models of supervision as there were disciplines. The Open Dialogue training, and its focus on family therapy origins, therefore enabled us initially to develop a shared understanding in the team around the importance of supervision in the clinical work. This uniting factor then helped us to develop an effective, albeit evolving, model of weekly, whole-team supervision which is described below.

### **Mindfulness meditations**

Before we begin each supervision session we have a short mindfulness meditation. This is helpful because we all have busy lives and busy minds and returning to the breath in meditation helps to ground us bring us to where we are in time and place with our colleagues. For five minutes at the start of supervision meetings we have found it to be a useful way to focus us on what we are here for and to assist us in attending to our own inner thoughts during supervision.

### **Fishbowl dialogues**

During any one supervision session a number of clinical discussions occur. All clinical discussions take place in what are called 'fishbowl dialogues', whereby the clinicians directly involved in the clinical case sit together in an inner circle. This includes any clinician who has previously been present at a network meeting. The rest of the team then create an outer circle around the 'fishbowl' to listen in to the discussion in the centre. Similar to the reflective processes (Anderson, 1991; 1995) that occur in the Open Dialogue family network meetings, the benefit of fishbowls in supervision allows both circles in turn to have space to attend to their own reflections while listening to comments from the other circle.

Within the centre of the fishbowl there are reflections on what has happened in a network meeting or meetings, what has happened between the clinicians in that meeting and what feelings they have been left with including what has resonated for them. Having people who are not part of that network, to sit and listen and reflect on what's been heard in a 'not knowing' position (Anderson & Goolishian, 1992) can be helpful for the clinicians in the centre because when you are in the midst of a situation it can be hard to see the wood for the trees. Feelings and thoughts will resonate for members of the outer circle which could be helpful to members in the centre; these might be things that they have not have considered. The reflections don't necessarily take away worries that people have, reduce the risk, or let them know if they are proceeding correctly, but just to hear more voices, views and opinions can sometimes open up other possibilities for that team to think about.

By being sensitive to their own powerful emotions in a family network session clinicians learn to use their inner feelings and inner dialogue 'as a tool that may be used to further the therapeutic process' (Roper, 2010). Therefore, holding this space open in supervision for reflection on what is happening in the moment becomes important to enabling new meaning and understandings of the situation for clinicians. We believe that this recursive process in supervision then further helps the clinicians tolerate the uncertainty of the clinical picture.

In our experience however, sometimes people can feel a bit lost in the fishbowl dialogues. We attempt to focus on the 'process' of network meetings and the feelings evoked in us by both the family and our co-therapists. For supervision, in seeking to migrate away from a content driven account of meetings, clinicians are challenged to access in themselves those feelings that the content and the interactions in the meetings brought up for them.

This form of supervision, while a more lengthy process than perhaps traditional supervision, seems to fit more closely with a dialogical way of working which prioritises reflection on both outer and inner voices. It also parallels the reflective process which clinicians undertake in the presence of family members during the network meetings. We are in our very early days of developing our supervision and our work is ongoing to find the most suitable structure. For example, one variation that we are considering would position the reflecting team members to attend solely to one therapist's position instead of the whole clinical team, thereby increasing the experience of support to each therapist. As with the evolution of family network meetings this kind of supervision should always be evolving and developing to fit the need of the team that are working together.

## **Team Development**

With a new Open Dialogue service, and therefore new team, we have been committed to developing the working relationships in the team and have begun to notice that this is having a positive impact on supervision. In Open Dialogue training all clinicians have undergone their own family of origin work using genograms to explore their family background. As part of our team development we have sought to continue this among colleagues by sharing family of origin work within the team itself. This sharing of our own family influences has enabled a deeper understanding between us of the lens and influences that shape our experience of the work. Developing this degree of vulnerability and trust within the team has brought about a real openness and honesty in supervision. We have found clinicians being able to reflect both on why a specific family narrative has raised specific feelings as well as feelings triggered by our co-therapists in network meetings. At times this has led to some difficult and uncomfortable conversations in the supervision but with the consistency of the supervision membership and a regularly weekly space clinicians have spoken about finding the honesty liberating and ultimately supportive.

### **Evaluating the service**

While there is some individual supervision that takes place, the weekly team supervision serves both to explore clinical issues and provide an overview for evaluation of the service. Although there is a current formal research project examining the Open Dialogue service in Kent which will provide data on clinical effectiveness, the weekly team supervision allows us to keep track of any issues that come up for clinicians when delivering this new way of working within a traditional mental health system. Specific examples include questions such as, 'how do we remain dialogical when interfacing with a monological service provision such as psychiatric wards, or using the mental health act?', or, 'how do we meet the national targets for Early Intervention for Psychosis in an Open Dialogue model?'.

One of our key areas of monitoring in supervision however, has been our fidelity to the 12 key elements of dialogic practice in Open Dialogue (Olson et al, 2014). As clinicians relatively newly trained in Open Dialogue we use supervision to check our adherence to the model by taking one key element each week and attending to this while we go through the supervision session. For example we might take 'use of a relational focus in the dialogue' or 'reflections among professionals in the treatment meetings' as a central theme in the supervision. Just by reminding ourselves of each of these key elements and keeping them central in our mind we hope to develop the team skill in delivering this intervention.

“These sessions are important for so many reasons. They create a space to offload and speak out loud our own internal dialogues. The work can be very heavy at times and we do absorb a lot of the emotions and thoughts of the people we work with. These sessions help us grow and understand ourselves, each other and the people we work with.” (Michael, Open Dialogue Peer Support Worker)

We are aware that these thoughts on team supervision may represent a departure from the type experienced in traditional inpatient teams, crisis teams or community mental health teams. For most of our multidisciplinary clinicians who have come from such teams, not only getting to grips with the dialogic therapeutic intervention, but then this different style of supervision has been a challenge. What we have noticed however is that clinicians protect the supervision time, value the space to reflect and feel supported by it. Beyond this, it seems to grow a sense of team cohesiveness and shared experience, which has been particularly valuable in these early stages of forming the service.

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