Open Dialogue Centre

Study Tour October 2022

Key Findings

Open Dialogue Centre Study Tour

November 2022

Final Report

Foreword

Between 26th September and 31st October we were privileged to have the opportunity to embark on a world-tour of Open Dialogue and person-centred practices as part of the establishment of the Open Dialogue Centre in Australia. The objectives of the tour were to:

- Explore ideas, thinking and evidence about the characteristics of success of Open Dialogue
- Learn about international approaches to training and implementation
- Learn about international approaches to impact and evaluation
- Share information with international colleagues about the Open Dialogue Centre and Australian Context
- Build strong international connections and explore what an international community of practice could be

We visited 4 Countries, 12 Cities and had 25 Conversations (some running over multiple days) and have returned inspired and profoundly impacted by the incredible work being undertaken across the globe to do something different in mental health care. All the services we visited were connected by a set of shared values:

- True respect for individuals with mental ill-health and recognising their right and role to make decisions about their care – really 'walking the walk' of 'no decision about me without me';
- A recognition of the importance of an individual's networks and community, and a strong therapeutic alliance, in improving their mental health;
- Hope for, and a commitment to, individuals meeting their goals for health and wellbeing and being able to live fulfilled independent lives; and
- Care and compassion for the health care team, working to support one another and respecting every member

It is our hope in returning to Australia, and in launching the Open Dialogue Centre, that we can find ways to embed these values across the Australian Mental Health system. The principles of Open Dialogue provide a practical framework that supports the embedding of these values.

Thank-you to the Open Dialogue Centre, GrantFamily Philanthropy, and all of our wonderful international hosts, who made this life-changing experience possible.

Pia Clinton-Tarestad

Rachel Barbara-May

Open Dialogue Centre

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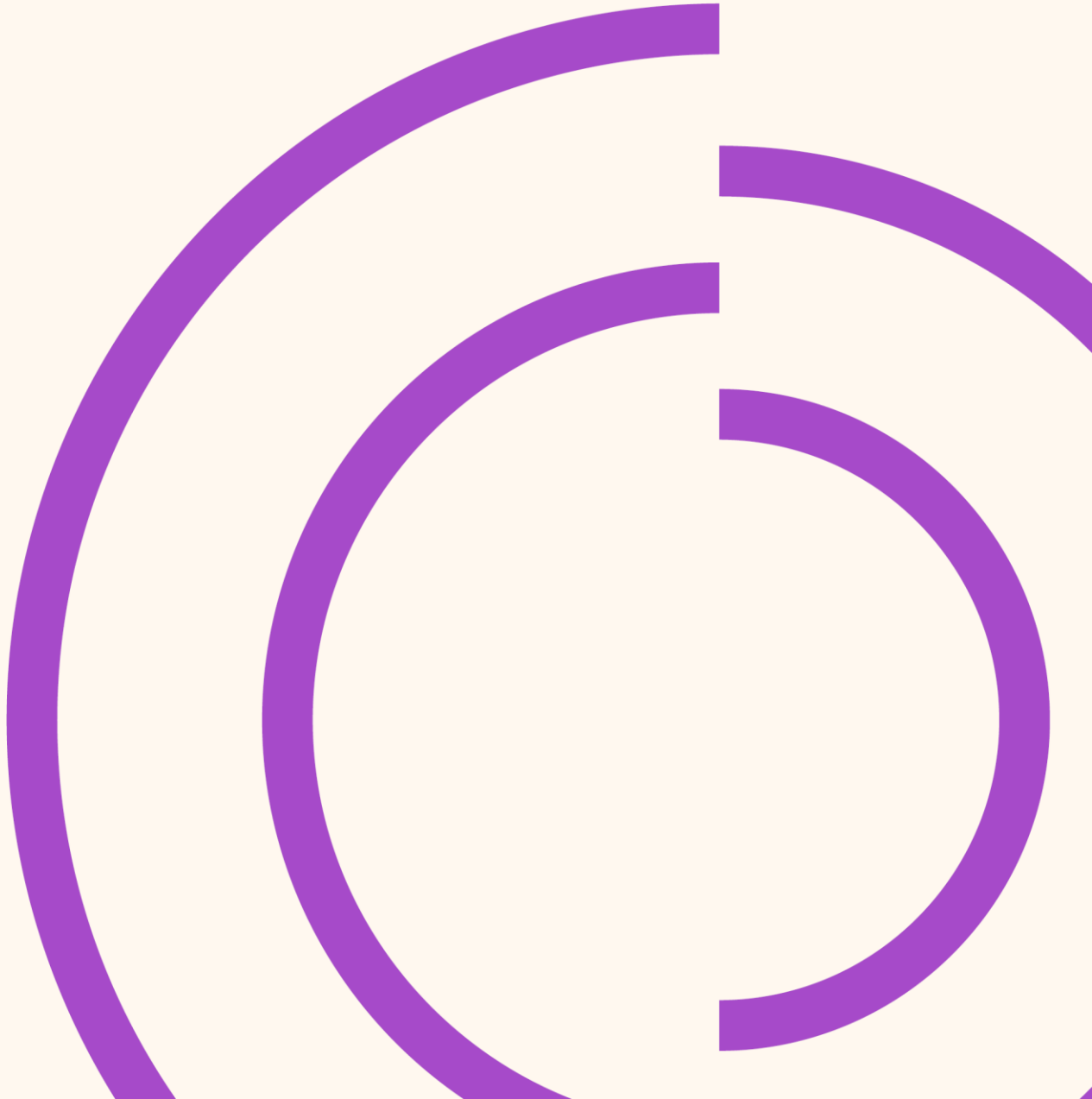
Key Themes



Characteristics of Success: What is Open Dialogue

What We Learned

- Much work has been done to define Open Dialogue, but at the same time, both proponents and detractors of the approach describe a certain ‘mystery’ or ‘nebulousness’. The reasons for this became clearer in our conversations:
- **Open Dialogue is a values set but not a belief system.** As outlined in the Foreword, there are a common set of values that we saw in every Open Dialogue service we visited, and which align to those of the Open Dialogue founders. The Open Dialogue Principles (see overleaf) provide a practical framework through which to embed these values.
- It is important to distinguish between these values and beliefs. We saw differences within and across countries in the underpinning belief systems of OD practitioners. Open dialogue can sometimes be perceived as anti-medicine/anti-psychiatry and there are undoubtedly some practitioners that hold these beliefs. Equally there are practitioners who believe strongly in the value of medicine and the importance of psychiatry. Open Dialogue, by design, allows for different belief systems to co-exist.
- The values that we saw in place across all of the services we visited are the foundation for successful implementation of Open Dialogue, and, perhaps more importantly, articulate the change we want to see in the mental health system.
- **Open Dialogue is an organisational intervention.** We saw how translating Open Dialogue practices into an organisation, including the training of teams, has a profound impact on the organisation’s culture, and drives significant improvement in staff morale. This aspect is often overlooked.
- The impact of Open Dialogue (organisational intervention) on staff satisfaction was also a strong theme throughout our conversations. We heard from a staff member in one of the UK teams that health professionals working in mental health go into the profession because they care, but become worn down by non-patient focussed protocols and procedures. Open Dialogue has provided a means to return to their core purpose and values.
- **Open Dialogue is a therapeutic approach.** Open Dialogue can be constructed as an intervention (as has occurred in the ODDESSI trial), an alternative way of treating individuals and their network. Substantial work has already been completed to describe the fidelity criteria of Open Dialogue as a therapeutic approach.
- A special feature of Open Dialogue is that it facilitates a combination of the above key elements in the design and delivery of mental health services.

Alignment of Intent, Values & Principles

What We Learned

Intent

- There was a strong focus, in many of the services we visited, on a human-rights based approach to thinking about mental health care.
- There was also consistent recognition amongst the services we visited that the way that mental health care is delivered needs to change to be more truly human-centred, empower the individual requiring support and recognise that there is likely complexity in the negative and positive drivers of their mental health.
- These drive the values we saw in place in the services we visited (see right), which are highly consistent with the intentions of Australia's National Mental Health Plan and the recent Victorian Royal Commission into the Mental Health System.

Values

- True respect for individuals with mental ill-health and recognising their right and role to make decisions about their care – really 'walking the walk' of 'no decision about me without me';
- A recognition of the importance of an individual's networks and community, and a strong therapeutic alliance, in improving their mental health;
- Hope for, and a commitment to, individuals meeting their goals for health and wellbeing and being able to live fulfilled independent lives; and
- Care and compassion for the health care team, working to support one another and respecting every member

Open Dialogue's 7 Principles

- Immediate Help: *Responsive to psychosocial crises and support initiated according to immediate need*
- A social network perspective: *The person's social network is involved, where desired*
- Flexibility & Mobility: *All therapy is adapted to the needs of an individual, including meeting them where they are at*
- Responsibility: *The 'front door' will accept responsibility and coordinate support*
- Psychological Continuity: *At least one person from the treatment team is consistent throughout*
- Tolerance of Uncertainty: *Acceptance that there may not be an 'answer'. Significant treatment decisions (medication/admission) are discussed at length*
- Dialogue (& Polyphony): *Language at treatment meetings is open-ended and focused on appreciative listening. Hierarchies are flattened – everyone has an equal voice*

Characteristics of Success: Models of Care

What We Learned

- We saw examples of Open Dialogue being used in a wide range of settings and cohorts across all ages. These models are described in more detail in our conversation summaries, but included:
  - Residential Facilities
  - Outpatient Programs
  - Assertive Community Outreach Programs
  - Specialist Inpatients
  - High Security Inpatients
  - Crisis Assessment & Intervention Teams
  - Developmental Services

- The degree of adherence to Open Dialogue fidelity criteria varied between services, but generally included:
  - All treatment discussions held with the client, not about them
  - Reflective practice
  - Efforts to soften or flatten hierarchies and create equal voices in meetings
  - Involvement of family/network – usually through network meetings
  - A core team of practitioners with some OD training

- There was no clear correlation between apparent 'fidelity' and perceived success of the programs, but a general view that implementation of Open Dialogue had improved client outcomes and staff satisfaction.

- There is often a misperception that Open Dialogue only works for those who are help seeking – this is not what we heard or observed in our discussions. If anything, we heard the opposite.

- There was some consensus that Open Dialogue was most effective for individuals in crisis, or where the individuals or clinicians were not achieving progress.

- The wide range of Models Of Care we observed highlighted the broad applicability of Open Dialogue values and approaches across mental health care, and indeed beyond. Given the breadth of international experience, prospective adopters in Australia do not need to start from scratch.

- Our conversations also identified the key drivers for changing to these Models Of Care, which tended to be either evolutionary (in services where person-centred values and practices were already embedded, and introducing Open Dialogue was a logical next step) or revolutionary in response to a crisis or intractable challenge (such as in the high secure unit in Norway).

Characteristics of Success: Culture & Workforce

What We Learned

- The vast majority of the services that we visited had been established (or redesigned to include Open Dialogue) due to the conviction and passion of one or a few individuals who had learned about Open Dialogue and become determined to implement it in their service.
- The typical pathway was for an individual to learn about the approach from either reading one of the seminal texts, or hearing a practitioner or lived experience perspective on the approach, then undertaking some level of external training, and then becoming a change maker in their organisation.
- We heard about some of the important team and cultural characteristics to make translation into an organisation work. The most consistent feature was having leadership support in place at both Department and Executive Level.
- We also heard that having a culture of person-centred care already in place was a huge advantage, although there were examples of strong leaders taking over programs with very different value sets and successfully transforming them to an Open Dialogue approach.
- We heard the importance of having or building trust within the team (primarily achieved through delivering on commitments made – 'doing what we said we would') so that practitioners feel safe in bringing their whole selves to work.
- We had a number of conversations about the importance of giving choice to the workforce in when and how to engage in Open Dialogue, through inviting them in to training and discussions, and inviting them to make changes in their own areas, as well as of having a learning mindset.
- The critical importance of a peer workforce was also repeatedly highlighted, and the importance of that peer workforce being respected and integrated members of the team, with clear roles and appropriate professional training. The importance of not relying on the peer workforce as the sole source of lived experience or openness & vulnerability was also highlighted.

Barriers to Adoption

What We Learned

Funding Flexibility

- We learned from our conversations that implementing Open Dialogue is not necessarily about more service investment – the vast majority of services we met had introduced Open Dialogue from within their existing budgets, however, it does require investment in training for practitioners, at sufficient scale to account for turnover, and it absolutely requires flexibility within funding envelopes to reorganise services.
- In particular the US Fee For Service system is a very significant barrier, as it prescribes service inputs. Financial structures that prescribe assessment approaches, diagnostic timelines or are diagnosis driven are also barriers to taking a more holistic view of the client and their network.
- We heard that in England there is now a shift away from activity-based-funding, to pathway or service funding that enables greater flexibility and local tailoring for population health. They key tenet of activity-based funding that the NHS are seeking to retain is good counting & coding practices, to support ongoing understanding of the costs of service delivery.
- There is much opportunity to learn from the experience of other countries, in how to allow funding flexibility for services to innovate, within a framework that supports cost-effectiveness and value of services.

Fear-Based Practices

- We had many conversations about the tendency towards fear-based practices in mental health as a significant barrier to implementing Open Dialogue (or indeed any approach which recognizes the autonomy of the individual). Fear of litigation, coroners court, or being blamed if something happens to a patient (causal effect of the service is implicit in the way incidents are reviewed through root cause analysis), has driven ever-increasing protocols, proformas and assessments, and contributes to high use of Involuntary Treatment Orders. This is exacerbated by workforce shortages limiting the availability of skilled practitioners who can work autonomously and confidently.
- Unfortunately fear-based practice is at the expense of being with clients human-to-human and persists even where evidence shows these practices do not impact the outcome or indeed cause harm (as in the case of self-harm risk assessments). Whilst of course structure and protocols are important, we seem to have gone too far at the expense of person-centred care and self determination.
- We heard amazing success stories of how person-centred values and practices have reduced the use of restraints and involuntary treatment orders, and had hugely positive impacts on staff. We also heard of the imperative for change – fear-based practices lead to coercive practices and the UN Convention on the Rights of Persons with Disabilities (which includes those with serious and enduring mental ill-health) is clear that coercive practices contravene the Convention.

Training

What We Learned

- Training is a critical success factor for implementation of Open Dialogue – all of the services we met had had at least one individual commence formal external Open Dialogue training prior to implementing changes.

- A wide range of approaches to training have been adopted globally, from entirely internal training by a very small number of individuals who had attended external training, to whole teams attending extended external training programs.

- We had conversations about the fidelity of training, and a number of important considerations emerged:
    - The advantage of having multiple people from each team attend training, to address turnover issues, and provide a safe space where individuals know they are not alone.
    - The value of offering taster sessions to give training participants a sense of what to expect, and allowing individuals to opt-in to more extensive training.
    - The importance of retaining family-of-origin work and small group work in foundational training for aspiring practitioners, as well as sufficient theory days (16-20).
    - The value of holding off-site training, to enable teams to properly immerse themselves in concepts.
    - The importance of moving from theory to practice and experiencing the work quickly after foundational training, even if it is outside practitioners comfort zone, and providing supervision and support.
    - The need for both external and internal training, to balance fidelity and affordability considerations.
    - The opportunity to collaborate with emerging providers of academically recognized Masters Courses in Open Dialogue, noting the importance of maintaining inclusive and affordable training options
    - The importance of supervision, and selecting the right external supervisor, who is experienced in Open Dialogue approaches

- We learnt that there is a need for plurality of training options, including:

    - Introductory sessions that include an insight into the experience participants would have if they committed to more substantial training

    - Foundational, Practitioner and Trainer training with high fidelity, for leaders and prospective leaders in Open Dialogue to attend – with the option for certification and/or academic qualifications

    - Training packages that can be delivered locally within services with established Open Dialogue expertise. Existing online courses (included in this report's references) could be adapted to provide useful materials for use by any service.

What We Learned

- The majority of Open Dialogue programs we visited were very limited in capacity and funding to undertake robust evaluation or research into their service outcomes. The ODDESSI trial is the notable exception to this, but outcomes are not yet available – recruitment has almost concluded, but was delayed due to COVID. A number nonetheless had manuscripts written or partially completed but not yet published.

- We heard of some amazing impacts from the services we visited:
  - Staff satisfaction and morale (this was almost universally cited as a major advantage of the approach)
  - Clients and families feeling more engaged with the service (very common)
  - Increases in productivity (the Grady Assertive Community Outreach experience when they stopped focussing on productivity and focussed on client needs)
  - Reduction in chronicity (the OO-CAMHS experience) although we also heard examples where this was expected but not achieved
  - Numerous case examples of individuals who had been 'written off' returning to fulfilled independent living.
  - Numerous case examples of individuals trajectory radically improving

- We had interesting conversations regarding what and how to research Open Dialogue, given that it is not just an intervention, but also a set of values and organisational intervention.

- If we acknowledge that Open Dialogue is more than an intervention (and in so far as it can be categorized in this way, the ODESSI trial will provide the evidence base needed for its efficacy), the focus of research may need to shift away from intervention based approaches (RCT as gold standard) to systems research, and 'before and after' impacts of introducing Open Dialogue into services.

- We also learned that no consistent data is being collected across Open Dialogue sites to enable aggregate comparisons of 'before and after'. Some of the data being collected include:

  - Client Outcomes, that are meaningful to the client themselves. There are two measurement tools widely in use: Inspire (5 [brief] or 27 questions) and the Outcome Rating Scale (4 questions)

  - Therapeutic Alliance (quality of the car provided) Inspire provides a measure of this. The Session Rating Scale (4 questions) is also used in a number of services.

- No consistent staff outcome measures were identified in use.

- No consistent health system measures were identified in use either, but the key areas of perceived benefit were in reduced chronicity (e.g. reduction in the number of long-term clients) and reduced hospitalisations.

Open Dialogue Centre

Conversation Summaries - Denmark

Open Dialogue Centre

Finn Juliussen
National Board of Social Services
Denmark, 26.09.22

Overview:

- The National Board of Social Services is a government agency under the Ministry of Social Affairs and Senior Citizens. Its role is to contribute to knowledge based social policy, and to support and influence municipalities to provide high quality services for vulnerable Danes, in keeping with the relevant legislation (the Act on Social Services). This legislation sets out guidelines for mental health service provision in the community. Municipalities receive funding for social psychiatry provision and have a significant degree of autonomy in both how much they spend (provided it is above a minimum level which is set) and how they organise services (provided they are in line with the legislation).
- Social Psychiatry in Denmark was established in 1989, as a result of the de-institutionalisation of individuals with mental health conditions. Politicians didn't trust that psychiatrists could deliver a non-medical model, so created a separate system focussed on inclusion and participation. The legislation is separate from that which governs healthcare provision and social psychiatry operates completely separately from healthcare, but there are legislative requirements on the two systems to work in partnership.
- The focus of social psychiatry and, more recently, in hospital psychiatry, is on recovery-oriented practice, including a network perspective. Social psychiatry allows for a number of methods that support this practice, including Open Dialogue (OD), Individual Placement and Support (IPS), Feedback Informed Treatment (FIT), Critical Time Intervention (CTI), Low Arousal (LA2), and Social Skills Training (SST). It is up to municipalities which approaches they use.
- Open Dialogue has been adopted in a number of municipalities, who have found it useful in both their day-to-day practice, and in supporting conversations and care coordination with hospital-based psychiatry.
- There are advantages and disadvantages to having a separate social psychiatry system. One key advantage is that the system has been able to adopt a recovery-oriented, non-medical model from the outset, as it is a non-medical model by design. One potential disadvantage is that there can be very different philosophies between the social psychiatry and hospital psychiatry systems in a geography, which can make handover/transition between services difficult.
- Looking forward, the social psychiatry and hospital psychiatry systems have developed a joint 10-year plan, which will move the whole system towards recovery-oriented practice, with financial incentives for hospital psychiatry to participate.

Finn Juliussen
National Board of Social Services
Denmark, 26.09.22

Key Themes

Outcomes

The National Board use **CHIME** as their focus for setting and measuring success, and the **Inspire** tool for data capture. CHIME is a model developed from a systematic review of first person narratives of recovery, and considers: **Connectedness** to others and community; **Hope**, belief in possibility, dreams & aspirations; **Identity**, positive sense of self; **Meaning**, in experience, life and social goals; and **Empowerment**, responsibility, strengths choice and control

Funding

The National Board does not fund municipalities, they receive funding directly through taxation. Poorer municipalities are subsidised by richer municipalities.

Model of Care

The National Board does not dictate the model of care that municipalities and services follow, this is decided bottom-up, provided it is within legislative guidelines.

If a person has a crisis, they go to the hospital psychiatry system. When the crisis is over, they transfer to social psychiatry. Social psychiatry also works with early intervention (including pre-diagnosis) and provides residential housing for those who need it.

Training

The National Board provides free training to municipalities on a range of recovery-oriented themes. In order for municipalities to access the training, they have to commit to sending leaders, as well as practitioners.

Implementation

There are four big municipalities in Denmark where OD is functioning well between hospital and social psychiatry – Aarhus is a leader in the area, with social and hospital psychiatry co-located.

The most significant influence on successful implementation in Denmark has been having the politicians committed to the approach.

Bjarne Vind, Bo Christofferson
Copenhagen Social Psychiatry – Residential Service – Skovvaenget
Denmark, 28.09.22

Overview:

- Met with Bo Christofferson, Chair of the Danish National Open Dialogue Trust and Bjarne and visited a residential unit, which is co-located (adjacent to) the hospital program, made up of 30-40 private residences (small, unfurnished bungalows).
- This is a long-term facility, for individuals with severe, complex and long-term mental health challenges, for individuals who can't cope with living fully independently, typically staying at least 10 years. It includes residents with significant forensic histories.
- The facility is open, with residents able to come and go as they please. The care team provide day-to-day living support, including a range of groups and programs, daily living supports and mentoring, and with staff on-site available around the clock
- In the Australian system, equivalent individuals are likely to be in a Complex Care Unit, a secure facility or on the street
- All residents have a formal network meeting every fortnight, with residents choosing who is involved – this would usually include the local care team, and the resident might invite their treating psychiatrist, their family members or others that are important to them.
- In addition to the network meetings, they apply dialogical practices – for example, care workers meeting with residents inbetween network meetings to have reflective conversations
- The way the team spoke to one of their residents was remarkable (not a network meeting) – treated with such humanity and respect and made that individual feel important. They didn't ask him about symptoms, they didn't ask him about risk, they didn't check that he was managing his life appropriately, they just listened. The quality of the dialogism was extremely high and was delivered by a non-clinician.

Bjarne Vind, Bo Christofferson & Elvira
Copenhagen Social Psychiatry
Denmark, 28.09.22

Overview:

- Bjarne, Bo & Elvira work in one of 3 residential facilities within the large capital region, providing support to residents under the Act on Social Services. The residential unit is for individuals with severe and complex mental health needs, who will typically stay for a minimum of several years.
- The facility comprises 30 apartments and there are 47 staff in total, including leaders, administration, clinicians and others.
- Open dialogue is embedded throughout the organisation and all of the staff have had at least 2 years of Open Dialogue training. They are also practicing FIT, but the staff prefer Open Dialogue.
- The introduction of Open Dialogue was first thought about in 2005 and implemented at the facility 3-4 years later, driven by a strong view that what was in place before wasn't good enough. In particular, alternative approaches to involving families as partners in care weren't working.
- The approach has, and continues, to evolve and the team have come to see this evolution as part of the nature of practicing Open Dialogue – this includes examples of Open Dialogue philosophy spreading into how individual clinicians practice and reflect. At the same time it is a very purposeful choice to continue working in this way, that requires ongoing commitment and effort.
- Critical incidents are inevitable. Within the last 8 years, 10 staff members have been killed and many more injured within social psychiatry, including one severe injury within the region two months ago - a staff member who was stabbed several times. Critical incidents are managed through significant reflection amongst the team using a dialogical approach, supported by professional help for individual staff members affected if required, in addition to root cause analysis, reporting and external review. To mitigate risks, staff are trained to use their instincts.
- For resident self-harm and suicide, within the dialogical approach it is accepted that these issues will come out during dialogue – there is no expectation on staff to monitor this risk in other ways. When critical incidents of this nature arise, they are treated as a learning experience with a no blame approach.
- There is no equivalent to this type of facility in Australia – residents would typically either be in a Community Care Unit, in Boarding Houses, or on the street.

Bjarne Vind, Bo Christofferson & Elvira
Copenhagen Social Pyschiatry
Denmark, 28.09.22

Key Themes

Outcomes

No formal measurement of outcomes – success is based on the individual feeling they can manage their life in their own way and having hope of independent living.

Funding

The facility is paid a fixed sum per resident per day. There were no changes to funding when Open Dialogue was introduced.

Model of Care

There are two types of network meeting in place:
- Planned meetings, where residents can identify who they would like to attend in advance – these are usual part of routine reviews and often include external participants
- Ad-hoc meetings – the team have worked hard to be able to respond within a couple of weeks when a resident requests a meeting – these are usually more internally focussed

The team are constantly adapting meeting structures as they learn what works best.

A fundamental tenet of the model of care is a shift away from problem solving, and control, to being a partner in conversation.

The team never have meetings about a resident without them being present and do not use agendas for meetings.

Training

All staff have had at least 2 years training in Open Dialogue, provided externally.

There has been a lot of learning regarding what works with supervision. It is critically important that Supervisors:
- Do not become overly familiar with the team and part of a group dynamic – this requires regular turnover of Supervisors
- Provide an open space for staff to explore issues
- Do not attempt to problem solve – the philosophy with complex problems is that they are to be discussed and handled, not solved

Implementation

Implementing and sustaining the service continues to be reliant on passionate individuals – this is a wicked problem in both sustaining the service and thinking about how to scale and systematize it.

There was fear at the outset of clinicians sharing their concerns and worries about residents with them directly, and that residents would find this difficult to hear, but the opposite turned out to be true.

Open Dialogue Centre

Mie Leer
Aarhus Eating Disorder Service
Denmark, 29.09.22

Open Dialogue Centre

Mie Leer
Aarhus Eating Disorder Service
Denmark, 29.09.22

Overview:

- Visited an adult eating disorders residential program and attended a network meeting with a resident, her team from the facility, the Open Dialogue leaders and the manager of the facility
- Set-up as a house, with a studio bedroom for each individual, with a small kitchenette and bathroom, with approximately 20 residents, aged 20-34. This is one of 3 or 4 facilitated houses in Aarhus, with this one the only one dedicated to eating disorders (others are mixed, to include eating disorders, psychosis and general)
- In the eating disorders house they have chef prepared meals and a heavy focus on supported mealtimes, but otherwise all treatment happens away from the facility (both medical and psychiatrist led) and residents have autonomy around their own actions
- The inclusion criteria and referral pathways into and out of the facility are not well defined – it is left to their treating doctor to determine whether or not they are appropriate for the facility
- Length of stay in the unit is highly variable, but typically between 2 to 4 years. This is in stark contrast to Australia, where supported housing doesn't exist for eating disorders – individuals are either in an acute setting for a short-stay, or at home. Residential programs are just commencing in Australia, but these are very treatment oriented and time bound.
- Quality of dialogism was incredibly high – slow, unstructured and responsive – opened the meeting with 'what are we going to talk about' and it went for 2 hours and covered dialogue that was very important to the individual. The client explained that they had been sceptical of family involvement initially, due to past experiences, but now they are able to talk together and listen to each other. She appreciated that staff do not overact and are not punitive and described feeling that consequences 'are my own'.
- The team are working very hard to engage the hospital psychiatry system, through 'learning circles' where they move to different parts of Aarhus and invite anyone from the hospital system to join a dialogical meeting – they keep promoting invitations for people to participate in dialogues about dialogue, and are having some success – they have noticed an increase in attendance of psychiatrists at network meeting and improving cooperation.

Mie Leer
Aarhus Eating Disorder Service
Denmark, 29.09.22

Key Themes

Outcomes

No formal measurement of outcomes were observed – focussed on an individuals wellbeing.

Funding

The facility is paid a fixed sum per resident per day. There were no changes to funding when Open Dialogue was introduced.

Model of Care

Weekly network meetings, which are focussed on relational healing and working on the relationship challenges created by the eating disorder (including trust, sense of identity and control).

Residents are encouraged to involve their families in the network meetings and can opt to have their hospital treatment team involved or not. The only mandatory attendees are the key care workers from the facility.

There is no coercion, punishment or control from the care team in how eating is managed – residents have autonomy.

There are regular community meetings.

Training

All staff have had at least 2 years training in Open Dialogue, provided externally through Mie's training program.

Physical Space

Old facility – nothing of note. In an urban area.

Research

Not discussed.

Implementation

The facility has transformed from having a very top-down process, where the manager would run meetings and the daily task of the house. Would previously have required residents to attend mealtimes, with consequences if not.

They would see themselves as still in a transition – their next task is to have more lived experience into the house.

Open Dialogue Centre

Birgitte Terese Falck-Jensen
Centre for Social Effort, Emergency Service, Akuttilbud
Denmark, 30.09.22

Overview:

- Visited a social crisis service led by the municipality (this includes mental health, AOD, housing, family breakdown) and includes a crisis helpline, a 24/7 drop-in centre, short-term housing, and community outreach
- In Australia, social crises would tend to be separate from mental health crisis – e.g. St Kilda crisis response
- The service will refer individuals to the appropriate service for ongoing care (this could include social psychiatry or hospital psychiatry) – they won't section individuals, but will call the police if required.
- The service appears to be well respected by the hospital psychiatry system, who will refer patients in crisis on to them. The municipality are proud of what they've achieved and the model is being implemented elsewhere.
- The team is run by 7 individuals covering the 24/7 service.
- They have developed tools that they use to support the network meeting and understanding of the network, including:
    - A network map
    - A crisis management plan, developed together during the network meeting
- The team is strongly grounded in a human rights and ethics philosophy in how they meet and support people. They do not subscribe to a mental illness model, but rather see psychological problems as relating to experiences in life (social determinants)
- They focus heavily on values in how they recruit and attract staff

Birgitte Terese Falck-Jensen
Centre for Social Effort, Emergency Service, Akuttilbud
Denmark, 30.09.22

Key Themes

Outcomes

No formal measurement of outcomes were observed.

Funding

Funded through the municipality on a block funding basis.

Model of Care

Use network meetings as first response as soon as they've received a call (including out of hours), for anyone who requires more than phone support.

The network meeting including anyone the individual would like. Involvement of family is encouraged.

The network will be organised around the specific crisis that has been identified.

Training

All staff have had at least 2 years training in Open Dialogue, provided externally.

The team all participate in monthly, team-based supervision, facilitated by an external psychologist, who is also a psychiatric survivor.

Every two weeks they have a four-hour team development session, where they look at practice (e.g. role plays / reflective practice).

Physical Space

Nothing of note.

Research

Not discussed.

Open Dialogue Centre

Conversation Summaries - Norway

Open Dialogue Centre

Ritva Jacobsen & Wendy Stavran Aas

High Security Psychiatric Ward, Akershus Hospital Norway, 04.10.22

Unit A 1 unit leader 1 assistant unit leader	• 1 psychiatrist. 1 psychologist, 1 physician in education, • 1 social worker • Daytime: 8 nurses and social workers • Evening: 6 nurses and social workers • Night: 3 nurses and social workers
Unit B 1 unit leader 1 assistant unit leader	• 1 psychiatrist, 1 psychologist, 1 physician in education • 1 social worker • Daytime: 9 nurses and social workers • Evening: 8 nurses and social workers • Night: 5 nurses and social workers
Unit C 1 unit leader 1 assistant unit leader	• 1 psychiatrist, 1 psychologist, 1 physician in education • 1 social worker • Daytime: 8 nurses and social workers • Evening: 6 nurses and social workers • Night: 3 nurses and social workers

Open Dialogue Centre

Ritva Jacobsen & Wendy Stavran Aas
High Security Psychiatric Ward, Akershus Hospital
Norway, 04.10.22

Overview:

- The Department of Specialised Psychiatry at Akershus University Hospital are one of the first globally to apply Open Dialogue within a secure psychiatric facility worldwide. Their work was noted as good practice for reducing and preventing coercion in mental health systems by the Council of Europe
- The service covers a catchment of 600,000, with ~80 admissions per year and is comprised of 3 units:
    - **A**: A 12-room unit for short-term treatment of people with psychosis, made up of 11 single rooms and 1 high intensive care unit. Length of stay is between a few days (crisis admission) and 3 weeks.
    - **B**: A 10-room including 2 high intensive care unit for the treatment of people with severe mental illness and violence, or who have been sentenced to treatment in a psychiatric ward by the courts, made up of 8 single rooms and 2 high intensive care units. Most patients on this unit are non-voluntary. Length of stay is from several months to several years.
    - **C**: A 12-room unit for longer term –treatment of people with psychosis, made up of 11 single rooms and 1 high intensive care unit. Length of stay is usually ~3 months.
- In the Norwegian system, forensic patients are sentenced to treatment, rather than punishment. Whilst the treating physicians need to liaise with the court prior to discharge and they continue to be followed by the court, their 'sentence' would never be commuted to prison. (In Australia and the UK you are serving your sentence in a psychiatric facility, and you are expected to serve a minimum sentence as part of this.)
- The unit has a considerable focus on safety and security, and a clear hierarchy within the professional team (Psychiatrists > Psychologists > Nurses > Social Workers)
- A unique feature is that nurses and social workers lead the meetings, not the responsible therapist. The responsible therapists find this liberating, as it enables them take part in the network meetings in a different way than if they had to lead the meeting themselves. The network meeting is very intentionally not decision making – this allows the facility to integrate traditional care (including a traditional MDT and diagnosis within 2 weeks) and Open Dialogue practice

Open Dialogue Centre

Ritva Jacobsen & Wendy Stavran Aas
High Security Psychiatric Ward, Akershus Hospital
Norway, 04.10.22

Key Themes

Outcomes

No formal measurement of outcomes were observed.

Funding

Funded through the state on a block funding basis.

Model of Care

Treatment is organised around a ‘mini team’ that meet at least once a week, comprising the patient, responsible therapist (psychiatrist or psychologist), responsible nurse and social worker. Each patient is discussed at a monthly MDT with all clinicians.

Network meetings involving whoever the patient wishes to invite are held as often as the network feels is required. The meetings are facilitated by two trained ‘network leaders’. Reflecting talks take place between the patient and network leader, with other participants listening – the discussion is paused at certain points and other participants invited to reflect.

Network meetings with the same network leader continue for up to 12-months post discharge as part of transition out the service for people who have been in the locked ward.

The team are also seeking to embed dialogical practices in their other patient interactions.

Training

Training is provided in-house by the Network Leaders. In addition, staff participate in a 10 day course in Open dialogue conducted once a year. This course is a collaborative between the hospital and the surrounding municipalities, and clinicians from in-patient and out-patient treatment participate together

The service have adopted the Meeting Aggression Problem (MAP) program, a 10-module national learning program with a focus on handling aggression and violence in the health and social sector.

Physical Space

Nothing of note.

Research

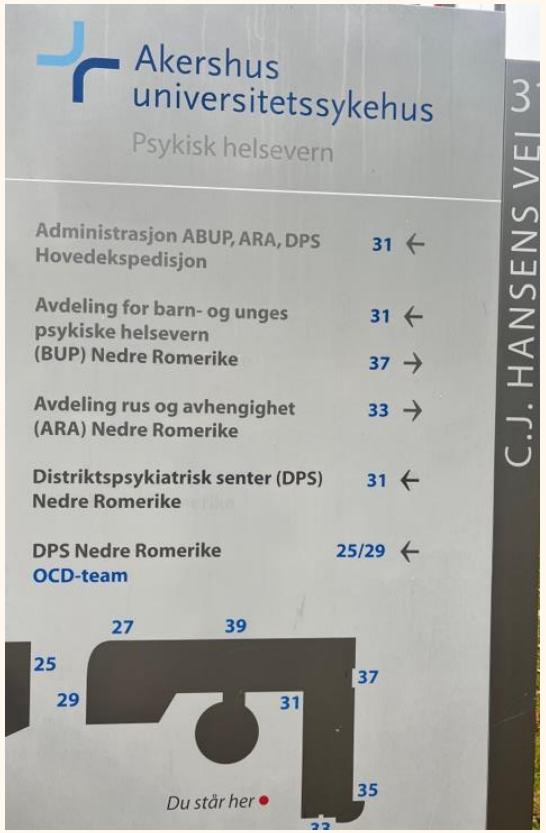
The service provided two case studies of individuals with chronic severe mental illness, including violence and/or extreme self-harm who had been fully rehabilitated back to independent living following admission to Akershus. They have also published an article based on interviews with staff and service users about their experience with the Open Dialogue approach.

Implementation

Open Dialogue was implemented at Akershus because there was a desire to increase user and family involvement in the treatment process. Open dialogue was introduced to unit B (high security ward) in order to try something different, instead of doing more of what wasn’t working when treating high security patients

Open Dialogue Centre

Bengt Erik Karlsson
Akershus University Hospital – Medication Free Unit
Norway, 05.10.22



Open Dialogue Centre

Bengt Erik Karlsson
Akershus University Hospital – Medication Free Unit
Norway, 05.10.22

Overview:

- Developed following legislation in 2015 requiring every Norwegian health region to have a medication-free mental health unit, providing alternatives to service users with severe mental illness (including psychosis)
- In practice all medication free units have incorporated the use of some medication, but there is a heavy focus on specialist alternatives, and on patient choice of treatment
- There has been debate in Norway on whether the current practice of compulsory medication (as is common in Australia and other countries) contravenes the UN Convention on the Rights of Persons with Disabilities (UN CRPD), with the UN CRPD Steering Committee view that coercive regimes need to be abolished and replaced with a system for supported decision making
- The unit admits up to seven clients at a time, with priority given to those with psychosis and bipolar disorder, for an 8-week admission. Admissions are Monday to Friday, with clients going hoe at the weekends. There are multiple preadmission meetings to establish the individual's hopes and goals, with an average waiting time of 3-6 months for admission.
- The unit is staffed by 0.5 FTE Doctor, 1 Social Worker, 2 Psychologists, 7 Mental Health Clinicians (including nursing, social worker, occupational therapy), 1 Physical Therapist, 1 Art Therapist

Key Themes

Outcomes

No formal measurement of outcomes were observed.

Funding

Funded through the municipality on a block funding basis.

Model of Care

A tailored treatment program for each individual based on their hopes and goals, which incorporates:

- Effect Integration Model
- Open Dialogue (network meetings)
- Reflecting team and processes
- Feedback Informed Treatment
- Illness Management Recovery
- Focus on what happens when you leave
- What has been helpful before you came

The work is primarily group based, with a greater focus on one individual in each week of the program

They also focus on one emotion each week

Training

TBC

Physical Space

TBC

Research

Not discussed.

Open Dialogue Centre

Ragnhild Andersland
Specialist Day Program, Bergen
Norway, 06.10.22

Overview:

- The outpatient program is a day-based program providing primarily group-based therapy to individuals with mental illness who require ongoing support greater than a weekly outpatient program. This includes referrals for patients being discharged from the acute hospital, or from the ambulance/acute team as an alternative to admission.
- One of their main programs is the ‘Day 1 Program’, a 4-week program where individuals attend 3 days a week for group therapy.
- Their interest in dialogue came from one of their Nurse Practitioners, Per, who had a special interest in the causal factors for mental ill-health and the degree to which these are internal versus relating to the relationships an individual has, and societal norms. He attended a special education program in Oslo and when he returned wanted to start an Open Dialogue practice.
- As a result they developed and designed a research project to incorporate Open Dialogue into treatment and assess it’s impact. That project commenced in 2017 and has now completed.
- The concept of bringing in a network was readily accepted by the clinicians in the service, as they already had a philosophy of ‘healing together’ through their group programs.
- The research project included 93 participants (out of 146 invited to take part) who opted to either continue with treatment as usual, or to add Open Dialogue network meetings to their treatment. 40 patients opted to have the network meetings – approximately half of them had one network meeting and the other half had 2.
- The project demonstrated statistically significant improvements for all participants (depression, anxiety and daily living scores) against 3 out of 7 measures, with statistically significantly greater improvement in the group that had network meetings.
- The service has continued to incorporate Open Dialogue into their practice since the research project, with every client offered a network meeting as part of their treatment.

Key Themes

Outcomes

Improvements in depression, anxiety and quality of life measured as part of a research project. Statistically significant improvements seen in those who had Open Dialogue.

Funding

No additional service funding was provided for the implementation of Open Dialogue, but there was funding (and time) provided to allow for training & supervision.

Model of Care

All individuals in the program are offered network meetings at 2 points during the program.

The client can choose who to invite to the meeting, with inviting family encouraged.

The meeting starts with the patient outlining their goals for the meeting and why they have invited their network.

The clinical team aim to maintain consistency with the principles of uncertainty, not having the answer, and asking open questions.

Training

The team member who introduced Open Dialogue had attended a special education program in Oslo. He went on to develop an internal training program for the staff in the service, which included reading recommendations, role play and coaching in running network meetings, and external supervision.

In addition, 2 of the team attended an education program in Oslo, delivered in short blocks of 2-3 days over a year.

The team also met with other sites using Open Dialogue within Bergen and in other municipalities (approximately 4x per year)

Physical Space

TBC

Research

- Quantitative research project complete and published – see overview.
- Qualitative research project complete, soon to be published.

The research has given the team confidence that the Open Dialogue approach is effective.

Øyvind Kalsås and Hege Hansen
Western Norway University of Applied Sciences, Bergen
Norway, 07.10.22

Overview:

Education

- The University have developed one two year training and an additional Masters program of family therapy and network meetings. The two-year training is well implemented and a popular program, and the first Masters cohort has commenced. Open Dialogue is planned as a 7.5 or 15 credits part of this Masters.

- In another Masters program on substance use and mental health, the University are working to include Open Dialogue / network meetings as part of the core curriculum, but this is still in process

Policy Context

- Municipalities are responsible for primary and social care, specialised health is responsible for in and outpatient treatment, with lots of room for overlap/gaps between the two. There is legislation that encourages the two systems to come together, but this isn't always working well. Individuals with complex, multi-morbid problems are most likely to be negatively impacted by this.

- There are also challenges in some of the attempts to address the gap that have been legislated for, for example the requirement to establish interprofessional, interorganisational teams (e.g. FACT), with the challenge that they overlap with existing services, which whilst not collaborating with one another, were otherwise working well. This is causing confusion and wastage.

- Municipalities are supposed to take the lead role on care coordination, but they often struggle with the hierarchy/stronger voice of the specialist system.

- The specialist system is still heavily focussed on the **bio** of the biopsychosocial model, although this is slowly shifting more towards the psychosocial. One project attempting to introduce Open Dialogue across the municipal and specialist teams ultimately failed. The specialist team were concerned about loss of control of the 'front door' as well as perceived loss of control of outcomes (noting that this control is never there).

- Whilst the project failed, and the specialist team have not adopted OD, they have become much more aware of the role and importance of family members. The municipal team has also continued and increased the adaption to OD principles after the end of the project.

Open Dialogue Centre

Conversation Summaries – United Kingdom

Open Dialogue Centre

Brian Campbell
Waltham Forest Community Recovery Team
London, 11.10.22

Overview:

- Waltham Forest Community Mental Health Team are the first community health team at North East London Foundation Trust to implement an integrated community mental health team, in line with the Community Framework and NHS Long Term Plan, which brings together community mental health with primary care and other key community services and partners.
- This includes a substantial expansion of the peer workforce, additional mental health practitioners and all staff being trained in trauma-informed care and Open Dialogue, as well as the creation of individualised care plans that can be shared beyond Trust boundaries. The goal of the new team is to remove barriers to access between primary and secondary care and to orient care towards recovery.
- The community recovery team provides specialist mental health services for adults aged 18 to 65 with serious and/or enduring mental health problems that fit CPA criteria (noting that the care programme approach is being phased out), including: interventions based on recovery and social inclusion; medication management; depot clinic; physical health screening; psychoeducation; access to psychological therapies focussed on relapse prevention, assertive outreach; and a Clozapine service
- The team have been using Open Dialogue in their practice for several years, focussed on providing network meetings for all individuals within the service, and adopting a more dialogical approach in day-to-day interactions, and in how the team work.
- Waltham Forest has a population of 277k residents, with very diverse backgrounds. 53% of the population are from a minority ethnic background and 94.2% of enterprises in Waltham Forest are micro businesses employing fewer than 10 people. The borough is currently ranked 82nd most deprived borough nationally (out of 309), a significant improvement in recent years.
- We observed the Intervision meeting, which is peer supervision, where the weekly peer supervision meeting for the full team.

Brian Campbell
Waltham Forest Community Recovery Team
London, 11.10.22

Key Themes

Outcomes

Not discussed

Funding

Block funded. No additional staffing to implement Open Dialogue.

Model of Care

All individuals in the program are offered network meetings, and the team aim to practice in a more dialogical way in day to day care.

Research

The team are one of the sites on the ODDESSI trial, a large multi-year, multi-centre trial examining the impact of Peer supported Open Dialogue (POD) versus treatment as usual.

Training

All team members had been through the Open Dialogue training program associated with the trial.

We observed the weekly Intervision peer supervision meeting. Membership included the whole team, including clinical staff, peer workers and administrator.

The team was held over Teams and technology was used to aid the structure of the meeting. Team members were asked at the outset of the meeting which cases they wished to discuss. Cases could either be discussed as a reflection (reflective practice on the impacts of the case on the team), or as an update (one team member providing an update on the case to the rest of the team if something of significance had occurred that week).

Reflections started with anyone who wasn't on the care team switching off their camera to listen to the dialogue. The care team then discussed their feelings about the case. There was an emphasis on avoiding discussing clinical management (as this should be reserved for network meetings with the client) and avoiding problem solving (as this is not consistent with reflective practices).

After the clinical team had reflected, they turned their cameras off, and the reset of the team were invited to reflect on the discussion. We were invited to participate. Again, the focus of this discussion was on the feelings of the clinical team.

Finally, the clinical team would switch their cameras back on and others switch their cameras off, to wrap up.

Open Dialogue Centre

Gareth Harry
Mental Health Implementation Director, NHS England
London, 12.10.22

Overview:

- NHS England have overall responsibility for the NHS in England, including the setting of strategy, policy and budgets for local areas.
- A long term plan for the NHS in England was published in 2019, a five-year plan setting out the key priorities for the health system. This included a significant focus on mental health, with a recognition that services were inadequate to meet the needs of the population. The plan set aside £2.3billion over 5 years to deliver substantial system improvements:
    - A focus on Years 1 and 2 on addressing gaps in crisis and urgent care. £1billion allocated to: Establish Intensive Home Treatment teams across the country (pilots having demonstrated a significant affect in reducing A&E attendances); Set-up a 24/7 helpline to provide a single point of access to services in every locality; and open access to Crisis Teams directly from that helpline
    - Years 3-5 are now focussed on transforming community mental health. £1.15billion has been allocated to deliver the Community Mental Health Framework, which involves: increasing capacity in community mental health teams, including a larger peer workforce; realigning teams to integrated health and social care teams with a broader multi-disciplinary team including a range of social supports; aligning those teams to primary care networks and other related service providers; the employment of mental health practitioners within primary care networks
- Local areas are now in the process of implementing their transformation plans, with substantial design decisions being left to local discretion, within the framework and funding expectations.
- The current fiscal environment is particularly challenging for the NHS with significant uncertainty in funding for this year and future years, and funding dependent on the conservative government budget, which has still to be finalised. This is occupying substantial leadership time and effort, at the expense of progressing other initiatives and developments.
- There has been a loss of focus on patient-centred care from an NHS leadership perspective, with no known efforts underway nationally to progress patient-centre models and philosophies of care. There has also been a loss of focus on outcomes, with the NHS Outcomes framework no longer extant.

Open Dialogue Centre

Allison Crane
Havering Community Recovery Team
London, 12.10.22

Open Dialogue Centre

Allison Crane
Havering Community Recovery Team
London, 12.10.22

Overview:

- Havering has a population of 261k residents. 76% of the population are from a white British background and has a lower population density than other London boroughs as large areas are parkland and 23 square miles is metropolitan green belt. There is considerable variation in the levels of deprivation in the borough, with much of the borough having low levels of deprivation, but some areas having very high levels of deprivation (worst decile)
- The Havering community recovery team is split across two sites and provides the same scope of specialist mental health services as the Waltham Forest recovery team and is part of the same organisation. Services are for adults aged 18 to 65 with serious and/or enduring mental health problems that fit CPA criteria (noting that the care programme approach is being phased out), including: interventions based on recovery and social inclusion; medication management; depot clinic; physical health screening; psychoeducation; access to psychological therapies focussed on relapse prevention, assertive outreach; and a Clozapine service.
- The team are about to implement their transformation plans, with consultation for staff now closed. Changes to be implemented include: bringing together the community recovery team and access, assessment and brief intervention teams, and aligning these to three geographically based multi-service teams in line with the Community Mental Health Framework; Delivering a single front door for primary and secondary care mental heath presentations; every mental health clinician will have a fixed caseload, reviewed through supervision regularly; Urgent referrals will be seen within 48 hours and routine referrals within 6 weeks; all team members will be trained in trauma-informed care and Open Dialogue and be supported to embrace both NICE Guidance and the Open Dialogue model; and improvements will be measured.
- The team have been using Open Dialogue in their practice for several years, focussed on providing network meetings for all individuals within the service, and adopting a more dialogical approach in day-to-day interactions, and in how the team work. There are 3 Peer Supported Open Dialogue teams under Allison's responsibility, each made up of a multi-disciplinary team including psychiatrist, mental health nurses, social work and occupational therapy. The peer support is provided through a partnership with the charity MIND

Allison Crane
Havering Community Recovery Team
London, 12.10.22

Key Themes

Outcomes

No emerging outcomes from the ODDESSI trial were available yet, but Allison noted a significant improvement in staff reported outcomes.

Funding

Block funded. No additional staffing to implement Open Dialogue.

Model of Care

All individuals in the program are offered network meetings, and the team aim to practice in a more dialogical way in day to day care.

Research

The team are one of the sites on the ODESSI trial, a large multi-year, multi-centre trial examining the impact of Peer supported Open Dialogue (POD) versus treatment as usual.

Training

All team members had been through the Open Dialogue training program associated with the trial, which comprises a foundation level qualification in family therapy and are all registered with the Academy of Peer-Supported Open Dialogue. The training involves aspects of family therapy as well as mindfulness and other approaches. The course is made up of 4 ‘residential’ training blocks across a 12 month period.

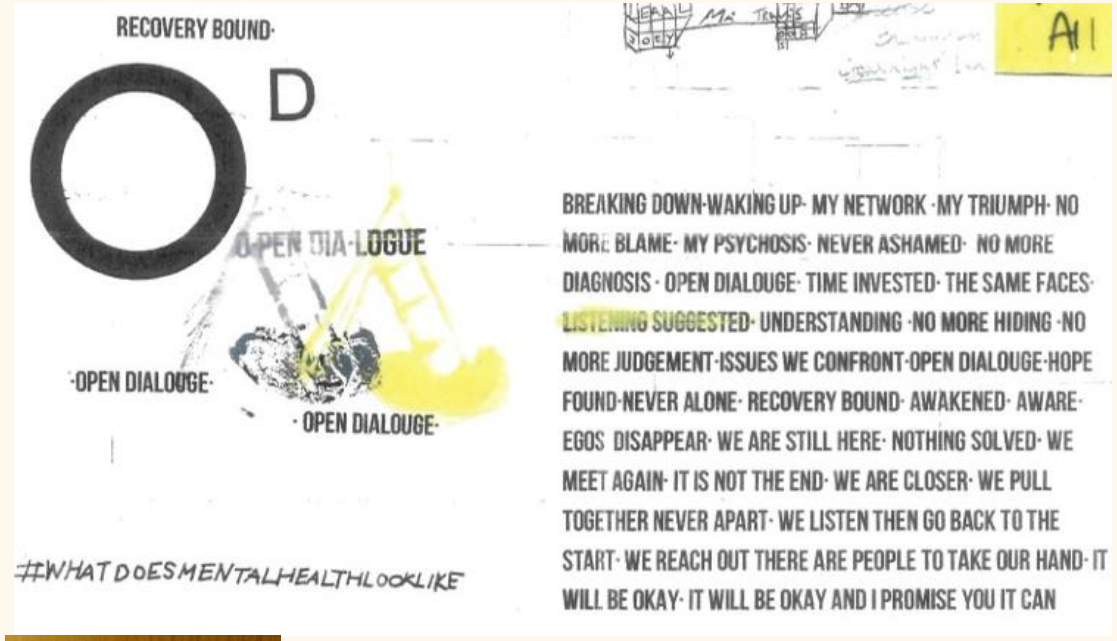
We observed the weekly Intervision peer supervision meeting. Membership included the whole team, including clinical staff, peer workers and administrator.

The meeting followed the same structure as that of the Waltham Forest (see page 34). Some differences were observed, including:

- The session started with a 6-minute mindfulness exercise
- Psychiatrists were absent from the session (due to staffing shortages and urgent issues)
- Reflections were timed, with a time limit set

Open Dialogue Centre

Annie Jeffrey
Kent & Medway Community Mental Health Team
Canterbury, 13.10.22



Open Dialogue Centre

Annie Jeffrey
Kent & Medway Community Mental Health Team
Canterbury, 13.10.22

Overview:

- The Peer Supported Open Dialogue Service in Canterbury provides services Peer Supported Open Dialogue for adults aged 18 to 65 with serious and/or enduring mental health problems including in: interventions based on recovery and social inclusion; medication management; depot clinic; physical health screening; psychoeducation; access to psychological therapies, assertive outreach; and a Clozapine service. The Canterbury & Ashford Community Mental Health service is providing 'treatment as usual' for these cohorts.

- The team are about to implement their transformation plans, with consultations for staff currently underway. Changes to be implemented include: bringing together the community recovery team and access, assessment and brief intervention teams, and aligning these to three geographically based multi-service teams in line with the Community Mental Health Framework.

- The team have been using Open Dialogue in their practice for several years, focussed on providing network meetings for all individuals within the service, and adopting a more dialogical approach in day-to-day interactions, and in how the team work. The POD team try to practice with a high level of fidelity to both the 7 OD principles and the 12 key elements of dialogical practice.

- Access to psychological therapy was difficult during COVID, requiring referral to Psychological Services for therapy, where there was limited staffing creating long waiting lists and significant access issues. This is less significant now. One of the advantages of the Open Dialogue approach is that it creates a therapeutic experience for all clients throughout their mental health care.

- If you receive POD treatment and support you can expect to be seen by POD practitioners within 24 hours if needed. All shared decision making happens in the network meeting, where the person, their family and others can all say what they think and what may be helpful. The meetings take place where the person decides is most comfortable. The person and network will see the same care team members every time. The meetings might last between one and two hours but that will depend on what is needed. The frequency of the meetings are agreed and reviewed at the end of each meeting.

Open Dialogue Centre

Annie Jeffrey
Kent & Medway Community Mental Health Team
Canterbury, 13.10.22

Key Themes

Outcomes

No emerging outcomes from the ODDESSI trial were available yet, but Annie noted a significant improvement in staff reported outcomes.

Funding

Block funded. No additional staffing to implement Open Dialogue.

Model of Care

The POD team provide a crisis response to those calling during business hours and commence network meetings immediately. They prioritise immediate help and psychological continuity. All individuals in the program are offered network meetings, and the team aim to practice in a more dialogical way in day to day care.

Research

The team are one of the sites on the ODESSI trial, a large multi-year, multi-centre trial examining the impact of Peer supported Open Dialogue (POD) versus treatment as usual.

Training

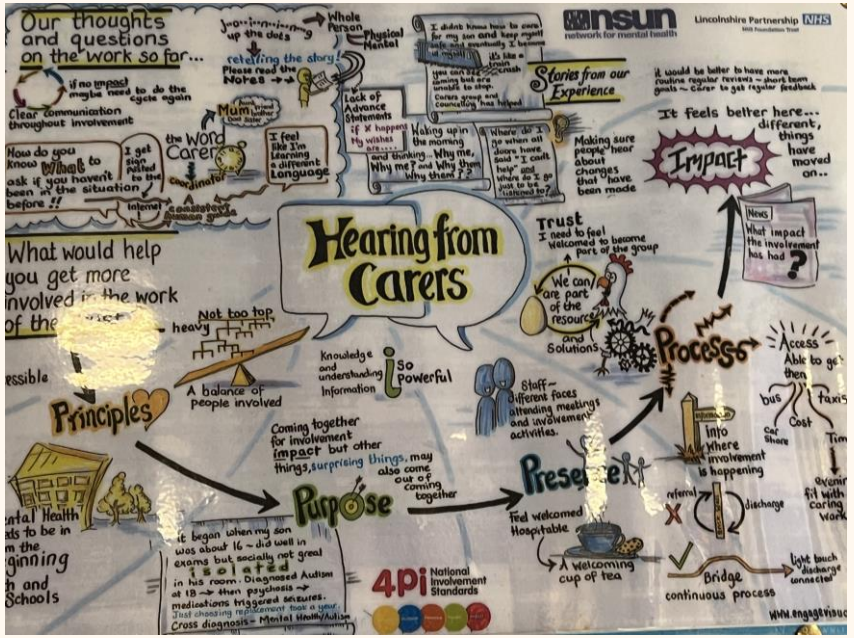
All team members had been through the Open Dialogue training program associated with the trial. Mentorship for new team members through the local team.

Supervision

Inter-vision meetings weekly. Membership includes the whole team, including clinical staff and peer workers. Current considerations about the value of bringing in external facilitator.

Open Dialogue Centre

Sami Timimi
Lincoln CAMHS Team
Lincoln, 17.10.22



Open Dialogue Centre

Sami Timimi
Lincoln CAMHS Team
Lincoln, 17.10.22

Overview:

- Sami's team developed a Model of Care for Lincoln's CAMHS team – Outcome Oriented or OO-CAMHS. This focussed on a common factors approach to mental health care, underpinned by four concepts: **C**onsultation – being mindful of the systemic issues that may be impacting a child (for example many are in the out of home care system) and involving their network, potentially seeing the network first; **O**utcomes – using a person-centred outcome scale (the ORS) to measure progress and incorporating goals, genogram and strengths from the outset.

- The team also introduced a 'stuck' clinic for stuck cases, defined as any not realising improvement within six sessions; **R**elationships – acknowledging the importance of the therapeutic relationship and building this into the team's core values. Also using the SRS as a measure of the quality of meetings; and **E**thics of Care – building a culture in the team where everyone will be listened to and is safe, and keeping the team healthy and supported.

- The team were recognized for their work and outcomes (see overleaf) and won some awards and funding, including an opportunity to roll the model out to other CAMHS services, however, this roll out never occurred, as a decision was taken to roll out a different program called CYP IAPT nationally, which is a treatment pathways model (matching diagnoses and treatments). This model of care is inconsistent with the OO-CAMHS holistic philosophy and approach, which has meant maintaining the model has been extremely challenging. The first review report for CYP IAPT in 2015 also showed that this approach had not been successful in improving outcomes.

- The team are now regrouping to look at ways they can get back to their previous approaches and philosophies through incremental change and improvement. This has included introducing brief intervention rather than an assessment approach when children enter the service (the standard model is to undertake an assessment, then add the child to a waiting list (which could be up to 12 months long) before providing any treatment), and continuing with the supervision/stuck clinics.

Sami Timimi
Lincoln CAMHS Team
Lincoln, 17.10.22

Key Themes

Outcomes

Halved the number of long-term cases (>2 years) through introducing Outcome Orientated (OO) -CAMHS and demonstrated significant outcome improvement.

More recently, implementing supervision clinics and therapeutic approach to assessment has halved the waiting list.

Funding

Block funded. Requirement to transition to CYP IAPT data capture and care model to maintain funding.

Model of Care

OO-CAMHS: Child-centred, network oriented and holistic approach to care, with active intervention for children not progressing after six sessions.

Outcome Orientated (OO) - CAMHS refers to the Client Directed, Outcome Informed (CDOI) approach. This approach requires services to relinquish expert models of practice and provide assistance in the areas that the client is seeking help and in a way that suits the clients preferences. The therapeutic relationship is prioritised and the clients difficulties are contextualised. The approach requires great collaboration and puts the person in charge of their care.

Research

The team published one paper on the OO-CAMHS model, as well as a service transformation toolkit book. (See References)

Training

This approach was based on the work of Scott Miller and Barry Duncan. An internal training program on CDOI was provided to all clinicians in the service

Chris Graham (CEO), Sally Sykes (Treasurer), Julia Levy (Trustee)

Picker Institute

London, 18.10.22

Overview:

- The Picker Institute in the UK was founded with the mission of helping people to have a voice in their experience of care. They were originally set up as a trading arm of the US Charity (since ceased), who had done a lot of work on developing tools to measure patient experience. The UK organisation was set-up around the time New Labour came into power in the UK, who had an interest in measuring patient experience and supported the early development of the patient survey. The organisation currently has 48FTE, the majority of which are focussed on data collection and cleansing for the national patient survey.
- Their biggest success was in getting the contract to develop and implement the patient experience survey around 2000. At that time they faced a lot of criticism, particularly from clinical disciplines, who didn't see value or validity in measuring patients' experiences of care. Since that time, they have seen the usage and acceptance of the patient survey measures grow, however, there hasn't been significant improvement in peoples' experience of care.
- This need for improvement is now the focus of their strategy, working with those Integrated Care Systems (ICS's – the new organising structures of the NHS, established on the 1st July 22) where the need for improvement has been identified and there is appetite from the ICS to improve. Picker Institute provide implementation support through a combination of their more senior staff, and a panel of freelancers.
- They also continue to play an advocacy role, with a focussed message of 'moving beyond measurement' of patient experience and focus their advocacy efforts on encouraging national organisations to drive and require change from the system.
- The organisation doesn't take a position on which approaches the NHS should deploy to improve patient experience (e.g. approaches like Open Dialogue).
- The organisation is fully funded through a fee-for-service model, with a substantial proportion relating to their preferred provider status for national programs. All work they take on must be align to their purpose and charitable mission.

Open Dialogue Centre

Conversation Summaries – United States

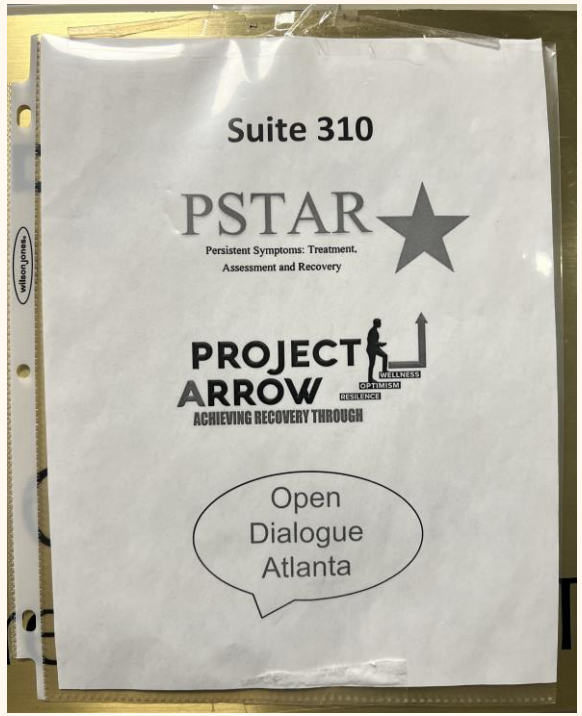
Rob Cotes and Justin Palanci
Grady Hospital Behavioural Health Centre
Atlanta, 20.10.22

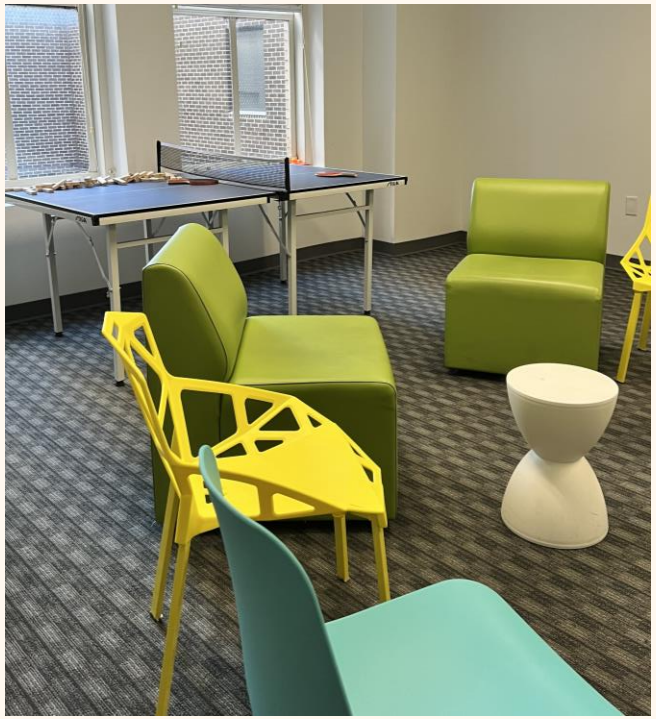
Overview:

- The Grady Hospital Behavioural Health Centre serves the whole catchment of Atlanta, but with the majority of mental health clients coming from the South and West of the city, and primarily from minoritized groups.
- It is a significant component of a large health system, which is very medically driven – this has made it challenging to get people within the organisation to understand the importance of recovery and connectivity to other community services.
- Open Dialogue started in Atlanta as a result of the interest of a philanthropist in the area, who through the Foundation for Excellence in Mental Health ('Open Excellence') approached Grady to see whether they would be interested in implementing an OD program. This led to the first project, Open Dialogue Atlanta, being established. In addition to funding for training, a dedicated staff member, and some research time, the Foundation funded Dr Doug Ziedonis to support the team with an organisational change model, adapted from a successful organisational change model for implementing tobacco free hospitals (ATTOC)
- Following the first project, Grady submitted a proposal for further funding to the Foundation for a new Open Dialogue program. At the same time they submitted a proposal to the State for available funding for early psychosis programs using the Coordinated Specialty Care model (a federally prescribed model of care). The team were successful in getting 2 pots of funding, which led to a decision to merge the CSC and OD programs into one, through hiring a brand new team and training them in both CSC and OD. This became known as Project Arrow.
- Having worked in the CSC team for some time, Justin moved into the Assertive Community Treatment (ACT) team and began implementing Open Dialogue Principles there.

Open Dialogue Centre

Rob Cotes and Justin Palanci
Grady Hosptial Behavioural Centre
Atlanta, 21.10.22





Key Themes

Outcomes
Adapted from the Advocates metrics and measured at baseline, 3 months, 6 months and 12 months.

Statistically significant improvements in BPRS and WHO-DOS.

88% of clients were taking meds at the outset, this had reduced to 66% at month 12 (movements in and out)

Funding
Fee For Service. Philanthropic funding was used for training, research resources and to fund a dedicated person exempt from productivity requirements.

Model of Care
Clients recruited from the inpatient unit who were being discharged to outpatients. 1-2 network meetings held on the IPU and then psychological continuity into outpatients. All clients were offered the Open Dialogue service, and later consented for research (sub-study).

100 networks were recruited in total – the configuration of network meetings was highly variable, with a psychiatrist present approximately 50% of the time. Frequency was guided by clients but typically weekly.

Fidelity checks of the quality of network meetings were undertaken as part of the research.

Training
15 People underwent a six month training program (7 days over 3 blocks) – a mixture of disciplines from across inpatient and outpatient teams.

There was a weekly team meeting similar to an Intervision session. Justin was also receiving external supervision.

Research
This project was undertaken as a research project – the outcomes are still being written up.

18 networks consented to participating in the research study.

Implementation
The logistics of organising network meetings was extremely difficult due to limited availability of trained team members.

The lack of role clarity in a deconstructed hierarchy was also challenging.

There was a long implementation timeline (2 months ramp-up, 6 months training, 4 months workflow changes) which was felt to be key to success.

A seclusion & restraint reduction initiative had preceded the Open Dialogue project, and the team had gone from 20 restraints per month to 0 over a period of 2 years. This had laid the foundation for a different philosophy.

Rob Cotes and Justin Palanci
Project Arrow (Achieving Recovery through Resilience Optimism and Wellness)
Atlanta, 21.10.22

Key Themes

Outcomes

Data currently under review.

Funding

State-funding for early psychosis CSC program. A new philanthropic grant. Funding combined to establish the program.

Model of Care

Combining Coordinated Specialty Care and Open Dialogue for early psychosis.

The CSC model is a surveillance model of care, with assertive outreach and follow-up for 2-years following first episode psychosis. To incorporate Open Dialogue participants are offered network meetings as one of the options available to them. There are no fidelity criteria or checks.

Project Arrow team meetings are dialogically informed.

Peer specialists are core team members.

70% of clients are in school or work and don't want to come in to attend meetings. The pandemic also resulted in a drop-off in network meetings, which in turn seems to have impacted levels of engagement.

Training

Mary Olsen provided 3 days of on-site training (although this was before the full team had been recruited)

An in-house training program has been developed which has just commenced – this comprises five 2-hour sessions, which cover: Introduction – being heard; Background to OD and key elements; How to run a network meeting; The reflecting process; and ways to implement.

There will be ongoing Intervision sessions. Attendance is voluntary.

Research

This program has been implemented as a research project – outcomes are not yet available.

Implementation

They attempted to implement the new model rapidly without an organisational change model, on the basis that it had been successfully done once before. This caused some challenges. The need to quickly recruit staff meant there was little focus on their interest/ability to work in an Open Dialogue approach.

It was an enormous ask on staff to train in both CSC and OD at the same time. Team cohesion was compromised, with factions appearing, and the OD lead being somewhat ostracized (they have since left).

Rob Cotes and Justin Palanci
Assertive Community Treatment
Atlanta, 20.10.22

Key Themes

Outcomes

Productivity improved. Multiple case study examples of individual improvements.

Funding

Fee For Service

Model of Care

The ACT Program is made up of ~50FTE staff, when fully staffed, split across 3 geographical teams, who each manage a caseload of approximately 75 individuals, who require more intensive support than can be offered in the clinic.

The ACT Program is a team-based approach (no individual case leads) and is moving to a therapy-based approach. Each team meets 4x per week to go through their caseload.

All teams are offering some Open Dialogue, with a focus on ensuring family meetings occur, rather than fidelity of approach, with an underpinning philosophy ‘the only bad family meeting is the one that didn’t happen’. Recovery-Oriented Cognitive Therapy is also offered.

Treatment Starts on Day 1 and you tell your story once.

Training

Only the Medical Director has been through external Open Dialogue training.

An internal ‘lunch & learn’ program was established.

There is supervision twice a week.

Research

Not discussed.

Implementation

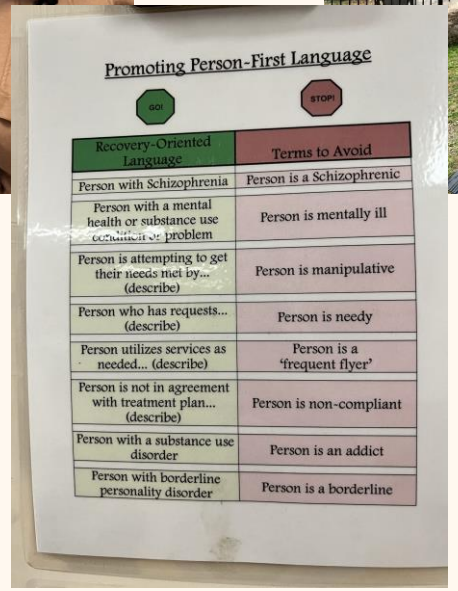
Having supportive leadership, who genuinely prioritised client needs was critical to being able to implement the approach.

Grady also used an organisational change model (adapted ATTOC model) with the support of Doug Ziedonis to implement Open Dialogue.

Philanthropic seed funding made the initial implementation possible.

Open Dialogue Centre

Joseph Stoklosa
McLean Psychiatric Hospital
Boston, 244.10.22



Open Dialogue Centre

Joseph Stoklosa
McLean Psychiatric Hospital
Boston, 244.10.22

Overview:

- McLean Hospital is a dedicated psychiatric hospital in the Boston suburbs. Joe became the Medical Director of AB2 (an inpatient unit within the Psychotic Disorders Division, which he is now Clinical Director of) in 2012. AB2 was a well-established academic unit with a high standard of excellence and academic mindset.
- Under Joe's leadership the unit progressed it's culture towards one of humanism and a recovery model. This included the introduction of pet therapy and spirituality groups, incorporating physical fitness equipment into the unit and fish tanks, and using quotes and slogans to emphasize the culture ('AB2 will get you through')
- One of Joe's residents approached him with the idea of introducing Open Dialogue on AB2 and he attended an international meeting and met Chris Gordon and Matt Bernstein and became very enthusiastic about the idea. He discussed the idea with his Head Nurse and Clinical Director and both were supportive, which led to implementation on the inpatient unit.

Open Dialogue Centre

Joe Stoklosa
Inpatient Unit AB2
Boston, 244.10.22

Key Themes

Outcomes
Ward rounds became shorter
Individuals who were dissatisfied with treatment as usual were most likely to benefit
Staff tended to much prefer the new way of working and feel it is more 'honest'
The approach seems to be most useful in times of crisis and high acuity and less useful for people who are help seeking

Funding
No change – a mixture of insurance, Medicaid and state funding for inpatient care. No additional funding was available for OD implementation.

Model of Care
A number of ideas came out of the brainstorming workshop (see Training):
1) Use first names for everyone (to soften the hierarchy)
2) Change ward rounds to do treatment planning in front of clients
3) Hold dialogic family meetings early on in a client's stay
4) Move all nurses station conversations into ward rounds (nothing about us without us)

Joe invited each of the 3 ward based teams to make at least 1 of them.

The ward rounds work by inviting clients into the rounding room, one by one, nursing notes are read out, the team talk with the client and then about them in the third person, with 7-10 minutes allocated per person

6 Teams covering 42 inpatient beds, with each team comprising an attending psychiatrist, resident, nurse and social worker. There are mental health specialists (graduate level), art therapists and peer specialists that work across teams.

Training
Three workshops of 1.5 hours were organised supported by Chris Gordon and Matt Bernstein.

Workshop 1 – What is Open Dialogue
Workshop 2 – Experiencing a Network Meeting
Workshop 3 – Brainstorming Implementation – What Could we Do Better

Internal training has just been rolled out of 3 hours per month plus 1.5 hours supervision – 13 people have signed up.

Research
A manuscript has been written but isn't published yet.

Implementation
Positioning Open Dialogue as incremental improvement and not as contrary to the medical model was a critical success factor, as well as giving teams choice over what to adopt.

Focussing on those who are interested and willing to try a different way of working was more time effective than trying to convince those who were opposed to it. One detractor said they would change when they saw the data, so much time was spent gathering the data, but it didn't make them change.

Rahel Bossonl
Program for Assertive Community Treatment (PACT)
Boston, 24.10.22

Key Themes

Outcomes
Not discussed.

Funding
Only available as a privately paid service

Model of Care
The PACT program has adopted Open Dialogue principles with clients seen as agents in their own recovery.

The program includes dialogic consults whenever clients are ‘stuck’ and not making progress. The primary carer (social worker) will present the dilemma, and then open to dialogue and reflection.

There is also lots of family work incorporated into the program, including family coaching and working with parents.

The program is open for 18—60 year olds but the majority are in the younger age group.

1 psychiatrist
3 social workers (caseload of 6/7 each)
1 nurse practitioner
1 resident
1 peer specialist
1 administrative staff

Training
The team have not yet been trained – this is an aspiration of the Program Director.

There have been 2 Intervision meetings so far.

Research
Not discussed.

Implementation
Not discussed.

Kirsten Bolton
Residential Program
Boston, 24.10.22

Key Themes

Outcomes
Not discussed.

Funding
Only available as a privately paid service - $800 per day.

Model of Care
The residential house has changed their rounding practices, going from 3 ward rounds per client per week (held without the client present) to one dialogically informed rounding meeting per client per week instead, with the client present.

The meeting format follows a consistent structure: the resident outlines what they want from the meeting; the team reflect; the resident reflects on what the team have said.

Some staff are now also offering dialogic meetings to residents and their networks, and dialogic consults are routinely used when needed.

These changes have led to fundamental changes in the culture of the program, with staff relinquishing control and recognizing the residents as agents in their own care.

1 psychiatrist
3 social workers (caseload of 6/7 each)
1 nurse practitioner
1 resident
1 peer specialist
1 administrative staff

Training
Kirsten has provided a twelve month in-house training program made up of six three hour modules and 1.5 hours of supervision on alternating months.

Research
Not discussed.

Implementation
Prior to implementing OD in the residential program, Kirsten had attempted to introduce OD in the early psychosis program. Ultimately this had failed due to lack of appetite for change from the Medical Director.

Prior to Kirsten taking over the residential program it had a poor reputation for coercive practices and non-progressive practices. Joe suggested introducing dialogic consults. One was done for a resident and Kirsten had staff members observe – they were so blown away by what they saw that they said they wanted to bring Open Dialogue to the unit.

Open Dialogue Centre

Chris Gordon and Michelle Goodwin
Advocates
Boston, 26.10.22

Chris Gordon and Michelle Goodwin
Advocates
Boston, 26.10.22

Overview:

- Advocates was founded on a commitment to person-centred care and social justice and this is in their DNA – this has provided a strong foundational culture from which to implement Open Dialogue. Their original practice was called ‘Intentional Care’, which emphasized being respectful of choice and dignity, and had a long history of supporting individuals with severe mental health in the community.
- Chris Gordon learnt about Open Dialogue from a service user, who would tell him off for not following principles of informed consent, and having the wrong understanding of his condition. He introduced Chris to Robert Whittaker’s book, following which Chris felt compelled to contact him. Robert introduced him to the annual Scandinavian Open Dialogue conference and he attended, and came back committed to adopting this practice.
- As a result, Advocates launched the Collaborative Pathway, to provide the option of Open Dialogue within their service. They opted not to use the language of Open Dialogue as they began implementing the pathway before their staff were certified in Open Dialogue.
- Advocates has a large residential program with 600 beds across 30 group homes, plus outreach services.

Chris Gordon and Michelle Goodwin
The Collaborative Pathway
Boston, 26.10.22

Key Themes

Outcomes
Evidence of reduction in chronicity wasn't seen
Clinicians love the approach
It enables families to communicate who weren't able to before

Funding
Fee for Service

Model of Care
The Collaborative Pathway is a treatment option to anyone in the crisis team with psychotic symptoms and anyone in residential care who isn't happy with the service, or where the clinicians felt stuck. However, whether it is offered, is highly dependent on whether a practitioner requests it, or in the crisis team, who is answering the phone.

The Collaborative Pathway is housed in Outpatients and offered as a service for internal and external referrals. Sometimes it is integrated into existing care (i.e. through the OD Program Lead facilitating network meetings with the referring clinician), otherwise it is offered as a stand-alone intervention.

Network meetings are offered until the client no longer requires them – this has caused some issues with 'stickiness' as the team get pulled into networks that are problem saturated.

Training
Two cohorts of clinicians from Advocate undertook Open Dialogue training through the Institute for Dialogic Practice – 35 in the initial cohort and 12 in the second cohort.

Supervision practice didn't change, but there is also now a monthly Open Dialogue meeting.

Research
Not discussed.

Implementation
The single greatest implementation challenge has been sustainability within a fee-for-service payment structure. The Collaborative Pathway was set up through heroic efforts of individuals working extra hours to be able to meet productivity targets and offer network meetings (where only one clinician can bill) but this isn't sustainable.

Another challenge has been reducing chronicity, with no significant improvements noted since introduction of the Collaborative Pathway. This may be due to Advocates often not seeing families as the first provider, the complexity/problem saturation of the networks seen and/or because networks (and potentially practitioners) are reluctant to discharge from the service.

Open Dialogue Centre

Per Eisenmann (Host)
Counselling Services of Addison County
Vermont, 27.10.22

Open Dialogue Centre

Per Eisenmann, Sandy Smith & Others
Counselling Services of Addison County
Vermont, 27.10.22

Overview:

- Counselling Services of Addison County in Vermont is the designated Community Health provider for the County, serving a population of approximately 40,000, with a total FTE of ~300 across all programs. The service provides secondary tertiary level mental health services for the community, including residential programs.
- 8-10 years ago the organisation made a conscious decision to start undertaking more family work, and found Open Dialogue as a mechanism to support this intent. The introduction of Open Dialogue has prompted a different way of thinking and influenced the culture of the organisation.

CAMHS

- The service comprises a Crisis Team, providing 24/7 support, and an Intake team for all other referrals, from which children are streamed into either clinic-based care or outreach (typically for higher acuity children). Families who may be suitable (Intake clinician discretion) are offered Open Dialogue at intake, but uptake is fairly low (total of ~10%). Open Dialogue is also considered if the treating clinician is struggling to make progress.
- There are significant limitations to expanding Open Dialogue more broadly, in particular capacity constraints (there is a long-waiting list for the service, with a current Intake list of ~50) and a fee for service model that only recompenses one clinician per session.

Adult

- Open Dialogue is most well established in the Community Rehabilitation and Treatment program (the long-term chronic adult program), which has been made possible through funding flexibility for this cohort (fixed sum of money per client supported). Open Dialogue is also used ad-hoc in crisis response, residential programs and day programs. Dialogic consults can be used when clients get ‘stuck’ in treatment.
- In addition there has been one example of an insurance company funding Open Dialogue for an individual on an exceptional basis, with a goal of avoiding hospital admission. This case has been very successful, with hospital admissions avoided and a positive change in trajectory for the client.

Per Eisenmann, Sandy
Counselling Services of Addison County (CSAC)
Vermont, 27.10.22

Key Themes

Outcomes
The service intuitively knows it is doing better (reduced chronicity and hospital admissions) but hasn't had the capacity or funding to undertake evaluation or research.

Funding
CAMHs - Fee for Service; Adult – Mixed. CRT program is a capitated model, which provides much greater freedom in how services are designed.

A State grant funded the Open Dialogue training for CSAC and other providers in the region.

Model of Care
Open Dialogue is a treatment option across the whole of CSAC, but with limited capacity and uptake in most services.

The CRT program is the exception to this, where funding flexibility allows for 2 clinicians as standard care, and Open Dialogue to be routinely used.

The number of network meetings is highly variable depending on the individual needs of the network and the care setting.

Training
A number of the team underwent a five-month period of training (2 days a week for five months), starting with members of the Youth & Family team.

There are fortnightly Open Dialogue meetings on Thursday mornings, for ongoing training and reflection.

Research
None underway – constrained by funding and capacity.

Implementation
A number of critical enablers for implementation emerged during discussion:
- Funding flexibility
- Workforce stability
- Training capacity
- Bringing the right network in early

Open Dialogue Centre

Sandy Steingard
Howard Centre
Vermont, 27.10.22

HOWARD CENTER
Help is here.

Sandy Steingard, Leslie Nelson, Beth & Ashleigh
Howard Centre
Vermont, 27.10.22

Overview:

- The Howard Center serves children, adults, families and communities as the designated provider for mental health and developmental disability services and the preferred provider for substance use services in Chittenden County (population 170k).

- The introduction of Open Dialogue into the region can be traced back to a series of events. In 2011 the Waterbury Hospital flooded, leading to a scramble to find solutions for the 51 residents who had been housed there and an influx of funding for associated programs and service innovations. At the same time Sandy and others in the region had become familiar with Open Dialogue and there was appetite for change.

- This led to the establishment of the START program – a mobile crisis team combining social work and peer support and founded on Open Dialogue principles. In addition the State provided monies to support training, which has become an ongoing funding commitment. The START program has since evolved into a peer support team, 2 of whom have completed Open Dialogue training and lead network meetings. The Coordinator of the START program, Leslie Nelson, is also the Coordinator of the Collaborative Network approach, who brings a powerful story of her lived experience.

- The Howard Centre chose to call the approach the Collaborative Network Approach, recognizing that it is an adaptation of the Finnish model, and to avoid any confusion regarding IP ownership or model fidelity.

- Training was made open to anyone with an interest in Open Dialogue, leading to uptake in developmental services, which is the first known example of Open Dialogue being used in developmental services.

- The Collaborative Network Approach is provided as an option across the service. Teams will refer into the CNA team where they feel they would benefit from this support. There are funding and capacity constraints in being able to provide the service, as it relies on individuals supporting client meetings without billable hours.

- Open Dialogue principles have been adopted in other parts of the service, for example, the Intensive Service Team (multi-agency meetings for complex cases) now use reflecting practice as part of their approach.

Open Dialogue Centre

Sandy Steingard
Howard Centre
Vermont, 27.10.22

Key Themes

Outcomes
A number of case examples of successfully unblocking and deescalating issues in developmental services.

Funding
Fee for Service

Model of Care
The Collaborative Network approach is a treatment option to anyone in the service, who can be referred in by their treating clinician.

Uptake is current high in developmental services, which is a cohort not typically associated with Open Dialogue. The team come in to support network meetings when the primary carers are stuck with a particular issue or resident.

The number of network meetings in developmental services tends to be shorter (usually 5-10), usually because the acuity of the crisis is lower.

Training
The team have learnt a lot about training, and have refined their programs over time.

First, a one-day experiential training is offered (voluntary) to allow practitioners to get a sense of whether Open Dialogue will suit them.

There are 2 levels of training:
- Level 1 (Foundation) – 15 days split across 3 blocks of five days. Approximately 10 days is allocated to theory and the cohort is then split into small groups for family of origin work (3 days) and supervision (2 days)
- Level 2 (Practitioner) – 6 days split across 2 blocks of three days with a 3 month gap in between for practice to occur, with 5 supervison meetings over the time period. This Level of training has been redesigned to place heavy focus on people doing the work – there is an expectation of a number of hours of practice between the 2 blocks of training

Implementation
There were a number of learnings in regard to training for successful implementation:
- Turnover – 3 people were trained originally, of which 2 subsequently left the organisation, leaving insufficient trained individuals
- The importance of individuals having a trusted colleague in the training with them so that they feel supported

In addition, the importance of having flexibility of schedules for trained facilitators is critical to them being able to respond to requests for network meetings.

Open Dialogue Centre

Carolyn & Trish
State Mental Health Department
Vermont, 28.10.22

Overview:

- Carolyn & Trish are highly experienced mental health clinicians and able to bring this experience to their policy work, with a strong focus on evidence-based practice and accelerating translation of innovations into practice. This is a huge advantage for Vermont State, and not commonly seen. Both are strongly values aligned to the principles of Open Dialogue, and have supported Open Dialogue training through using any funding flexibility they have (e.g. allocating the 10% of their mental health grant that is required to be used for early psychosis to Open Dialogue training).

- Otherwise funding constraints are very significant at the State level, with most State funding streams (Medicare and Medicaid, Mental Health Grant) being attached to specific spending requirements by the federal government. This hugely limits the ability of the State to innovate Models of Care and Delivery to meet local circumstances and needs. This was a surprising finding, and is significantly at odds with all other countries visited, even the UK NHS as a single system.

- There are also limitations to how far the State can influence providers, particularly hospitals, who are licenced nationally. The State are reliant on individual communities to drive the culture and approaches within their mental health providers that they wish to see, and there are significant variations amongst the Boards and Executives of Community Mental Health providers regarding the right approach to mental health care, with some still focussed on a more paternalistic model of care.

- At the same time, the supporting influence of the State Mental Health department has led to substantial uptake of person-led, self-determination approaches to mental health across most Counties in the State, including the establishment of peer-led recovery services.

- The State have undertaken an ethnographic study on early psychosis, which highlighted the importance of integration into community (including friends; employment; housing) and removal of ‘othering’ were key factors that support improvement.

- There is also some discussion beginning regarding the term ‘recovery’ and the degree to which this is truly inclusive, or is loaded with social norms that may unintendedly exacerbate ‘othering’ for some populations.

Sandy Steingard, Bill, Vicki, Keith & Paule
Washington County
Vermont, 28.10.22

Overview:

- Washington County are another County in Vermont looking to implement Open Dialogue. A number of their team members have completed or are in the process of completing their training.

- The team have greatly valued the Open Dialogue training and can see it's applicability in their setting. It has also changed their perspectives, which has influenced their individual therapy – examples include the ability to tolerate uncertainty (and recognizing the importance of this within work and life) and using dialogical practice to move away from binary thinking.

- One of the challenges discussed in the group is how you operationalise Open Dialogue, given funding & capacity constraints. We discussed a number of key considerations:
    - The need to be supported by leadership to 'take a leap of faith' that implementing the approach will deliver improvement and be manageable within workloads
    - To really ensure there is deep values alignment – and a shared understanding of what 'nothing about us without us' really means
    - Having access to high quality training
    - Seizing every service development opportunity as a way to design in Open Dialogue
    - Recognizing that Intent is a legitimate starting point, that in itself will impact how the team practice
    - To not let perfection be the enemy of good in implementing changes that will make a difference to clients and their networks

Open Dialogue Centre

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Open Dialogue Centre

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