Title: A text on which the ink never dries.

Summary of Manuscript

- Considerable emphasis has been placed on the value of producing high quality care plans. In practice they often fall short of the mark and are largely constructed with the needs of the organisation and not the service user in mind.
- Whilst nurses support the concepts of positive risk taking they are concerned about protecting themselves and their employers from blame. Risk averse practices direct nurses away from a more recovery centred engagement to one of medication and hospitalisation.
- ‘Open Dialogue’ is an innovative approach to acute psychiatric crisis based on a family and social network approach. Open dialogue emphasizes listening and collaboration and uses professional knowledge with a ‘light touch’. It comprises of both a way of organising a treatment system and a form of therapeutic conversation, or Dialogic Practice, within that system.
- The paper is original in that it looks at care and treatment planning as part of the open dialogue process and how this might address some of the perceived shortfalls currently associated with constructing care plans in clinical practice.
Abstract

Background
Care and treatment planning are often seen as bureaucratic exercise in which the needs of the service user are overshadowed by the needs of the organization. The authors suggest that dialogism can radically unsettle current approaches to care planning and lead to a much more responsive model of care.

Aim
To provide an appreciative and critical examination of Open Dialogue in relation to care and treatment planning within a Crisis Resolution & Home Treatment Service

Method
The paper is a reflective account of the use of Open Dialogue by the first author and includes the use of a case study to illustrate key concepts and understanding.

Conclusion
Our experience to date indicates that dialogical approaches decentre care planning away from its traditional documentary locus towards a plan that is primarily discursive and co-created through conversation between people. The dialogue is premised on valuing the present moment, transparency, difference and shared decision making. Whilst these values are shared by many mental health nurses they are inimical to many of the tenets of a contemporary mental healthcare that seek to manage and control uncertainty.

Introduction
Open Dialogue is a model of mental health care that was first used in Finland in the mid-1980s in the treatment of early onset psychosis. It has now been used in countries such as America, Germany and the United Kingdom with reported success. It involves a social network approach to care in which regular meetings are conducted with the service user, their family and support. Decisions and treatment planning are a collaborative activity involving all parties with empowerment at the heart of the therapeutic process. It is different from traditional approaches to care which focuses more on individual deficiencies instead of strengths; stabilization instead of recovery; connections to the treatment system instead of the community, and compliance with the regimes mandated by treatment authorities instead of individuals taking an active part in their treatment and in directing their own affairs. Through Open Dialogue planning itself becomes a central therapeutic modality in its own right rather than the precursor to other treatments. The following paper provides an appreciative and critical examination of Open Dialogue in relation to care and treatment planning. The paper is centered on the experiences of the first author when
introducing Open Dialogue within a Crisis Resolution and Home Treatment Team as part of a local innovation supported by his employing organization. It incorporates the use of a fictionalized case study to illustrate key points and reflections. By engaging in this process, the two authors are able to present an overview as to the use of open dialogue in clinical practice, and the dialogical process in formulating a plan of care.

**Background: problematizing care and treatment planning**

Care and treatment planning has been an integral part of mental health nursing for four decades. During this period patients have been constructed as ever more complex and frequently multiple systems are involved in their care. Care planning is proposed as a rational response to coordinate interventions and to delineate responsibility (Department of Health, 2008). Written care plans can be well received by service users; giving goals and a trajectory for recovery (Palmer, 2014). It seems that they want plans that are flexible, dynamic and relevant to their circumstances at that moment in time (Grundy et al, 2016).

Considerable emphasis has been placed on the value of producing high quality care plans. The requirement to undertake care plans is invoked through local and national policy (Department of Health, 2008) and can even be enshrined in law (Welsh Government, 2010). Yet despite these aspirations there appears a disjuncture between ideology, strategic intent and service user hopes that is played out in the everyday practices of care and treatment planning (Brooks et al, 2015).

Within crisis services huge amounts of nursing time are spent writing care plans in an effort to keep pace with rapid changes in a person’s presentation and circumstances. For such a structured and labour intensive method there is remarkably little evidence to suggest it is effective. Simpson et al (2016) suggest care plans are rarely referred to by service users or clinicians. This might say something about their diminished utility to informing day to day mental health care.

In the UK a worrying proportion of service users and carers report not being as involved in their care as much as they would like (Atkin et al, 2014; Care Quality Commission 2015; Cree et al 2015). Mental health workers often bemoan care planning as a largely bureaucratic exercise and an encumbrance to therapeutic engagement (Simpson et al, 2016). Whilst nurses support the concepts of positive risk taking they are concerned about protecting themselves and their employers from blame. Risk averse practices direct nurses away from a more recovery centred engagement (Coffey et al 2016, Downes et al 2016). Consequently care plans can overly focus on “managing problems” than inviting risk and difference.

Given these difficulties it is unsurprising that care planning has attracted the attention of academics with ideas on how it might be improved. Simpson et al (2015) have investigated the practices of
assessment and care planning. This is with the aim of enhancing recovery focused, collaborative care planning. Bee et al (2016) have developed a tool to measure service user and carer involvement in care planning. Meanwhile Bower et al (2015) have investigated efforts to train practitioners to develop service user involvement in care planning. Simpson et al (2016) call for greater flexibility, openness and shared working in care planning. Bradley (2015) argues for a more radical approach involving both service users and carers as active agents and in which professionals relinquish power and control in favour of a more facilitative role.

The solution can be the problem!

For the authors the problems of care planning extend well beyond technical considerations. Even more research and training about how to do it better does not seem an entirely helpful solution. The authors themselves have previously been part of a project to educate staff to enhance care and treatment planning (Jackson et al, 2012) In a sense these efforts might, at best, amount to a superficial first order change (Watzlawick et al, 1974) in which procedural shifts leave the overarching system and culture largely unchanged. Our point of view is that recovery focused work will require far more than well-crafted assessments and care plans. Care planning in this more formalistic sense could even represent part of the problem.

Mental health systems are predicated on defining and responding to “problems” (Anderson and Goolishian, 1988). Much of the power of mental health professionals emanates from their expertise to pronounce upon mental health problems and to propose solutions (Brooks, 2014). Despite ideas of recovery focused planning there is little to suggest much progress in this regard. Part of the process of mental health care still involves life experiences being reified and encoded into a language of problems, goals and actions. Whilst this can mobilize help, it can do so at the cost of concretizing problems and planned outcomes. Whilst plans are arguably open to review they tend to take on a reality of their own as different perspectives are collapsed into an invariant definition of the problem or goal. Even in circumstances where the identified patient, social network and clinical team offer wholesale agreement this can rapidly foreclose on opportunities to constructing new meanings (Anderson and Goolishian, 1988). Once we believe that we “know” something about the problem and commit this to a care plan our curiosity and openness to fresh understandings can diminish. By circumscribing outcomes and activities, particularly those at the SMART end of the care planning spectrum, we sharply position our relationships as predictable, linear and goal directed rather than something fluid and emergent. Whilst this can tame worries by labelling them it hampers meaning making. The anxiety of unknowing is expunged by recourse to the language of certainty (Wilson, 2015).
Care plans often seem to benefit hierarchies more than service users or front line clinicians. They provide an auditable surface on which to adudge the quality of care planning. These measures tend to focus on objective data such as correct completion rather than the aspects that are felt important by service users (Bee et al, 2016). This can easily lead to care plans being written with an audience of managers or the Care Quality Commission in mind rather than the recipients of care. Such care plans could be understood as fabrications (Ball, 2003); something to be interrogated as a part of audit culture (Webb, 2006) rather than a document that informs care. The notion that “if it is not written down it didn’t happen” is an absurd summation that the reality of clinical work is found in written representation rather than in lived experience. This concern with the power of written texts can create an impression management whereby nurses are consumed by defensive documentation rather than actively engaging in authentic human relationships.

The Dialogical Turn

The last few years have seen growing interest in dialogical approaches (Lakeman, 2014). The work emanated in Finland where it has claimed significant results in promoting recovery compared to more orthodox psychiatric care (Gromer, 2012; Seikkula and Arnkil, 2014). The work has spread with the emergence of training and dialogic practices in other countries. As part of this the first author [PB] is undertaking a 3 year training in Open Dialogue largely following the programme used in Finland and taught by progenitors of the approach.

The practice of Open Dialogue involves efforts towards mobilizing service users, their families and social networks into treatment meetings. It is through these meetings that the presenting issues are explored and efforts made to generate new insights and understandings. The meetings afford opportunity to facilitate a distinctly democratic form of conversation in which contrasting points of view are heard and responded to (Olson, Seikkula & Ziedonis 2014: 2). Unlike more conventional care planning meetings there is no attempt to resolve or arbitrate different points of view (McNamee, 2015). Instead these unique perspectives are listened to with attempts to understand them. In open dialogue practitioners become enjoined in ongoing work on negative capability and a non-controlling orientation towards others (Razzaque and Wood, 2015). We openly reflect on our thoughts and feelings with each other and invite further responses from participants (Seikkula and Arnkil, 2006). Full consideration is given to what might be helpful, not only during the meeting but in the period immediately beyond it. Alanen (1997) proposes that planning interventions is a key function of network meetings. In this sense Open Dialogue is not a therapy but an integrative approach to organizing care and treatment. Those professionals or others involved in care can be included in the meetings as part of a social network web that is adapted to meet the needs of the family (Olson, Seikkula & Ziedonis 2014; Seikkula & Arnkil 2014).
Dialogic care planning represents a paradigmatic shift away from the linearity of traditional nursing process of assess-plan-implement-evaluate towards a dynamic model in which these dimensions elide in the discussion of a network meeting (Seikkula and Arnkil, 2014). Dialogue assumes that many participants have pieces of an answer and that together they can put them into a workable resolution. The dialogue between clinicians and the social network is spontaneous and generates a plan in response to what is expressed in the moment. Attempting to plan for all possibilities in a single document is both impossible and unnecessary. Any plan has immediacy to it both in the sense that it is generated from the dialogue but also in that it focuses on “what you do with whom next” (Arnkil, 2014). The life span of the plan is only until the next meeting which is rarely more than a few days within the crisis service.

Within meetings less attention is afforded to identifying problems or considering how they might be corrected. There is a move away from prescriptive care planning to one of more flexible working in response to emerging themes. We purposefully avoid prefabricated ideas or solutions; such as searching out examples of pathology or peremptory deciding the person requires a certain treatment. Things become slower and looser through inviting reflections and responses. Our efforts are not to decode, translate or even to assume we can understand the utterances of the other. Instead we share with the other participants something of what those words might mean or feel to us, in that moment (Shotter, 2009). As much as dialogic practitioners avoid problematizing they equally eschew over simplifying solutions. Consequently it is difficult to generate concrete goals. Dialogically the goal is often simply to create the space and opportunity for conversation. All discussions about planning are openly held in the presence of the network. The ideas of professionals are seen as they as material for discussion rather than recommendations (Olson et al., 2014). Care planning becomes an ‘ongoing process of communication, integrated into the person-centered care routine and appropriately staged to the individual’s state of health’ (Forlina, 2014: 2). This ongoing process allows for the possibility that individual preferences might change over time as health status worsens due to chronic illness or an acute episode. The focus of the dialogue is in the observed and its meaning. In this way, treatment planning needs to become responsive to what is happening often over quite short spaces of time, with every meeting potentially generating a change in plan. An approach that invites people to separate ‘self’ from ‘problem’ and highlights competencies and abilities can be empowering for both service user and clinician.

Open dialogue requires the clinician to analyze, deliberate and advance informed judgments from an array of perspectives. This can be unsettling for some and demonstrates the complexities of such an exchange. Because each meeting can present a dilemma and are open ended, they tend to simulate different reactions among members of the group. Yet the meetings also permit those involved to be more open because it is one conducted in trust. We can share our uncertainty as
well as our knowledge and experience. Adapting the therapeutic response to the specific and changing needs of the client/family, using therapeutic methods that best suits, ensures that ‘a whole person approach’ is adopted and that people are listened too. Dialogue therefore is not limited to the mere exchange of opinions but rather is imaginative and open to many ideas.

Whilst aspects of our work have been seen as unconventional we operate within the strictures of safe and effective governance. For example care is still documented. The difference within our practice is that the linearity and separateness of the nursing process is collapsed into a hopefully more dynamic document contained within the running notes. Service users and network members are not routinely given paper copies of care plans. However they “have” or “get” the plan in a psychological sense. This is because the immediate plan is generally a few key points pertaining to any actions required over the next few days. This is summarized and agreed towards the end of the meeting. Our experience is that people are generally good at knowing what the plan is and are able to enact it when it is relevant, simple and contemporaneous.

In addition more static or standard aspects detailing what the crisis resolution and home treatment service provides and any contact arrangements are provided by a team leaflet. Where there might be uncertainty about a specific plan or when members of the network are absent a short letter can be prepared and sent or given. This letter is usually largely derived from the entry in the patient running record to save duplication of effort. Similarly at the end of a treatment episode a summary letter detailing our involvement and any agreed ideas about further actions is sent to the service user and others copied in as appropriate. Generally the running records also provide information to other team members.

Case Study

To illustrate our way of working the authors offer some short passages from fictionalized case study. This is based on the first author’s experiences of developing dialogical practices within a crisis resolution and home treatment service.

Preparing to meet Daisy
Daisy is a young woman in her early twenties. Her relationship to her partner recently broke down.

She describes the partner as “emotionally abusive.” She is referred to the Crisis Resolution and Home Treatment Team by her GP. At assessment the team note that she is “reporting command hallucinations telling her that she is worthless and instructing her to end her life.” She was offered rapid access to a psychiatrist who has prescribed antipsychotic medication however Daisy is refusing to take this.
The team discuss Daisy at their daily meeting. They discuss a belief that she is “psychotic,” that her Mum believes she is getting worse. This provokes a short but animated discussion on the need to “have a plan” and in which various team members readily surrender ideas about what this should be. Many concur that admission to hospital or possible assessment for detention under the mental health act might be required if Daisy remains “non-compliant.” Another colleague asks “what’s the risk?” and there is passing reference to her being “tortured by the voices” One member offers that “she might be PD” There is also a suggestion that she might need to be referred to the Early Intervention for Psychosis pathway. Given the different perspectives. I am asked by the team to give an opinion. I am feeling uncomfortable about being entrained in a discussion about somebody who I only know through a few entries in her written records and the views of a couple of the team members who have seen her. I offer a few words to recognise their thoughts. My desire to be congruent with open dialogue lends me to suggest that it might be best to discuss any treatment options with Daisy before we start arriving at a decision. The team seem satisfied. A colleague (“Jane”) and I arrange to meet with the psychiatrist (Dr Duggan), Daisy, Her Mother (Dianne) and Stepfather (Mick) the next morning for a network meeting. When I speak to Daisy on the telephone to arrange the appointment she seems confused about the purpose of meeting. My efforts at explanation border on the expansive and seem to cause further confusion. However she agrees to meet and invites her family during the course of the conversation.

We gather together the next day. Daisy and the family are held up in traffic. The psychiatrist, Dr Duggan, asks what the key things are that we need to discuss. This develops into him expressing concern about Daisy’s psychosis and that it is “untreated” He is a genial man, but one who I sense wants me to concur. I attempt to explain that Open Dialogue avoids stage managing the meeting by setting any agenda and working with what emerges. This draws a seemingly bemused reaction. However the conversation is drawn into the doctor’s views on how open dialogue would only really work in Scandinavian nations and, despite being well intentioned is ill-suited to our culture. This conversation is interrupted by the arrival of Daisy and her parents.

Following brief introductions the family join us in a circle around a small table. I open by asking each family member their understanding of the meeting and how they would like to use our time together. The bulk of the meeting is then devoted to exploring the family’s understandings. During this time Jane, Dr Duggan and I reflect with each other about our responses to what is being discussed. Usually this is a brief comment or question to each other. At one point we have a more formal reflection when we ask the family to listen to our short discussion concerning our current ideas about them. The reflections are owned by us as speakers and offered tentatively (“I felt: I am curious: I’m thinking; I’m reminded about”) .The family are then invited to respond to what we have said.
As the meeting ensues discussion seems to naturally turn towards what might need to happen following the meeting. Again a gentle approach is taken by asking “what might be helpful beyond here?” with purposeful effort to avoid telling or advising the family.

As the meeting concludes. We ask the family to give feedback on the meeting using Session Rating Scales (Duncan et al, 2003). These scales help to support and gauge the therapeutic relationship. These measures are reviewed and a brief discussion held on what was helpful and what we might need to do to be more helpful to them.

Following the meeting an entry [below] is placed in Daisy’s records. This is both a record of the session and a summary of the current plan and how it was arrived at.

Date: 30.6.16
Social network meeting 1500-1615h at base. Purpose of meeting and agenda agreed at commencement of session. Daisy wants to be less troubled by voices and to be able to sleep. Both parents say they want to know more about her illness and how they can help her.

In attendance

- Daisy
- Dianne [Mum]
- Mick [Stepfather]
- Dr Gerard Duggan [Consultant Psychiatrist, CRHTT]
- Jane Black [Nurse CRHTT / Facilitator]
- Paul Barrett [Consultant Nurse / Facilitator]

Dialogic Discussion- Key Themes

- Daisy starts by saying she is “broken, and has been broken as long as she can remember. She “hates” hearing two female voices commenting on her appearance. It keeps her awake at night. Conversation indicated that they remind Daisy of being bullied at secondary school. Another voice is male and friendly called “Tom”. He sometimes tells her to think about ending her life.

- Daisy said she does not like voices. At times she trusts “Tom” however she thought that ending her life was wrong. She did feel desperate but had not made any actual plan to end her life. She wants to “get better.”
Discussion and team reflection on importance Daisy felt on being understood now as being “broken.” Also a sense of parents wanting to help and of Daisy wanting them to understand. Tom is more dominant and appealing when others “tell me how well I am doing”

Curiosity about being broken—what might this word mean? Daisy related this to having experiences of bullying around her appearance during secondary school that “mentally smashed me.” Dianne said she was surprised by this as she thought Daisy coped well with the bullying. Daisy suggested her Mum had done little to end the bullying and instead tried to encourage her to lose weight to try to prevent comments. She no longer knew who she was or what she wanted “I’ve been broken in bits.”

Dianne “devastated” by this—became tearful explaining that she too had also been bullied at school about her weight and that she wanted Daisy to lose weight to stop this. She said she had also spoken to the school about her concerns and Daisy was moved to another form. She felt she had “done the right thing” by contacting school and trying to help Daisy to lose weight. She said she was upset by Daisy’s charge. “She’s saying it’s my fault.”

Daisy said she was not accusing Mum but wanted her to know what it had done and asked that she thinks less about outward appearances. “Be less obsessed by weight.” She acknowledged this might be difficult given her Mum’s own experiences.

Mick said he had been busy at work to support the family. He wondered now whether he should have done more. Daisy suggested he had always shown her love and had not seemed bothered about her weight. She valued this. However she said that he usually tended to “pretend everything’ alright.” She reflected this made her voice Tom worse as only he knew how broken she was.

Generating a plan

Our worries about Daisy being able to stay safe discussed. She says she has never obeyed the voice and had no intention of doing so. She said thought of dying was a “comfort blanket” but that she wanted to get better and saw hope of this. Both parents said that they checked regularly on her throughout day. They would continue to do this.

Daisy said she hoped to resume her apprenticeship as soon as she was able. She said her employers were understanding. Diane had spoken to them and said their concerns were largely around when Daisy might be able to return to work. We suggested it might be helpful to invite them to a network meeting and Daisy and Dianne agreed to speak to them about this and feedback at the next meeting.
• Daisy said contact with CRHTT was helpful – “time to talk” she finds being seen later, ideally late afternoon or early evening would be more helpful. Daisy and parents said they knew how to contact the team if they require support outside of planned contacts. Next Home visit 1800 1.7.2016 by Robert Dean

• Dr Duggan is concerned that Daisy is psychotic and discussed medication options with meeting. Mum thought Daisy needed to take antipsychotics. “These voices aren’t right.” Daisy did not want antipsychotics but something to help her sleep. Mick thinks this is a good idea and didn’t like antipsychotics after seeing how his brother had responded to them recently. Dr Duggan agreed to prescribe 7 days’ supply of Zimovane 7.5mg and would like to see Daisy next week at a network meeting. He has given a pharmacy information leaflet.

• Jane reflected that family members held different points of view and that we thought this could be a consideration for further discussion.

• Daisy and parents asked if we could meet again. Jane and I have arranged to conduct a further network meeting at home 1700 on 4.7.2016

Outcome
SRS Completed
Daisy: 38- “most I’ve said. I wasn’t planning to say much.”
Mick: 38 “feel I’ve learned something”
Dianne: 33- “helpful” but was concerned that a diagnosis had not been discussed. Dr Duggan explained that he understood experience as psychosis and what this might mean but he needed to learn more before reaching a conclusion. Jane and Dr Duggan reflected briefly on whether diagnosis was helpful. Daisy did not think it was. All agreed that perhaps this could be spoken about more next time if it feels important?

Reflection
Working with people and their networks during periods of crisis can be extremely challenging. Concerns and objections run high; so much so that the temptation to invoke power and monologue is sometimes palpable. However sometimes fears around assuming more personal responsibility within existing NHS organizational culture can militate against Open Dialogue (Razzaque and Wood, 2015). On one occasion a suggestion that we might be exacerbating a service user’s problems and that we needed to exert control was levelled at our high tolerance of a particularly difficult and confusing situation. This statement although seemingly damning, equally needs to be given space. We do not want to escape the moral, legal and professional responsibilities placed
upon us which are other, sometimes compelling, voices operating in our dialogues. Being in language does not deny the materiality of power and suffering. Nor is it beyond the curtilage of care and protection. However I am uncomfortable to unreflectively default to spurious legalistic or organizational excuses (Warne, 2015) that hamper connection. Our implacable orientation, in even the most challenging circumstances, is towards maintaining or reopening dialogue (Wilson, 2015). One way we introduce this is to share our concerns or conflicts, for example, about a person’s safety openly with them in the meeting. This seems to feel more honest and enables a much more enlivened and relevant plan about how to respond to any identified risk.

Within this more co-produced framework of care planning we rely heavily on people being active agents. We have encountered situations in which people can be reluctant to assume agency. Generally we have trusted in them and the dialogic process enough to see them starting to find a voice to participate in conversation. We have sometimes discovered that their reluctance was because they felt silenced in previous encounters with acute mental health workers by not being listened to or respected (Mind 2011; Whittall & Allie, 2011).

In other instances there has been a frustration and sense of urgency about the pace of dialogue. This seems to relate more to financial considerations and service exigencies. Although our innovation is supported by our employing organization some managers have expressed alarm about whether this perhaps slower and labour intensive approach might increase service costs. It is early days but we are finding that many patients make considerable progress I sometimes only a couple of meetings. This suggests it is time well spent. Sometimes people can take longer to come to dialogue. Unfortunately mental health services are rarely configured around patients’ needs consequently there is a considerable shifting of responsibility between different teams and agencies. I reflect that a more “whole team” approach in which the patient journey is followed by the same team through to resolution would be more therapeutic and cost effective. However we are currently far removed from such a needs-adapted model and will need to engage in meaningful conversations with our management colleagues about how we best work within existing structures.

These real world difficulties are not deterents and I do not feel discouraged. As a nurse who is approaching the end of my career I have felt that the approach is perhaps the closest I have come to living out my values. More importantly I am hearing similar sentiments from nursing colleagues and students who have become involved in our work.

I believe that there is an affinity between holding a dialogical position and many mental health nurses. It seems to fit better with the ethos of nursing which is often to respond to the immediacy personhood of the patient rather than more technical evidence based considerations (McSherry et
We would further argue that this potential towards inviting and responding to experience might be an innate nurturance (Trevarthen 2011a, 2011b) and akin to the tradition of healing rituals that invoke a gathering and listening (Attneave, 1969, 1990; Mehl-Madrona and Mainguy, 2014). These are human processes that so many have found helpful for millennia. Unsurprisingly they are not reliant on generating endless reams of meaning-less paperwork. There might be learning for all there.

Not the Final Word

This paper aspires to dialogic principles and practices. We have set out our thoughts and feelings about dialogical approaches. In doing so we are aware that they are the words of this particular moment and circumstance……..something that is always becoming and not the final word. In this vein we warmly invite responses from readers so that we may learn more of your reflections on the flow of our work.

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