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3 **Title: A text on which the ink never dries’.**
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8 **Summary of Manuscript**
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- 11 • Considerable emphasis has been placed on the value of producing high
12 quality care plans. In practice they often fall short of the mark and are
13 largely constructed with the needs of the organisation and not the service
14 user in mind.
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 - 16 • Whilst nurses support the concepts of positive risk taking they are
17 concerned about protecting themselves and their employers from blame.
18 Risk averse practices direct nurses away from a more recovery centred
19 engagement to one of medication and hospitalisation.
 - 20 • ‘Open Dialogue’ is an innovative approach to acute psychiatric crisis
21 based on a family and social network approach. Open dialogue
22 emphasizes listening and collaboration and uses professional knowledge
23 with a ‘light touch’. It comprises of both a way of organising a treatment
24 system and a form of therapeutic conversation, or Dialogic Practice,
25 within that system.
 - 26 • The paper is original in that it looks at care and treatment planning as
27 part of the open dialogue process and how this might address some of the
28 perceived shortfalls currently associated with constructing care plans in
29 clinical practice.
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1
2 **Abstract**
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5 Background

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

15 To provide an appreciative and critical examination of Open Dialogue in relation to care and
16 treatment planning within a Crisis Resolution & Home Treatment Service
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20 Method
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22 The paper is a reflective account of the use of Open Dialogue by the first author and includes the
23 use of a case study to illustrate key concepts and understanding.
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26 Conclusion
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28 Our experience to date indicates that dialogical approaches decentre care planning away from its
29 traditional documentary locus towards a plan that is primarily discursive and co-created through
30 conversation between people. The dialogue is premised on valuing the present moment,
31 transparency, difference and shared decision making. Whilst these values are shared by many
32 mental health nurses they are inimical to many of the tenets of a contemporary mental healthcare
33 that seek to manage and control uncertainty.
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38 Introduction
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40 Open Dialogue is a model of mental health care that was first used in Finland in the mid-1980s in
41 the treatment of early onset psychosis. It has now been used in countries such as America,
42 Germany and the United Kingdom with reported success. It involves a social network approach to
43 care in which regular meetings are conducted with the service user, their family and support.
44 Decisions and treatment planning are a collaborative activity involving all parties with
45 empowerment at the heart of the therapeutic process. It is different from traditional approaches to
46 care which focuses more on individual deficiencies instead of strengths; stabilization instead of
47 recovery; connections to the treatment system instead of the community, and compliance with the
48 regimes mandated by treatment authorities instead of individuals taking an active part in their
49 treatment and in directing their own affairs. Through Open Dialogue planning itself becomes a
50 central therapeutic modality in its own right rather than the precursor to other treatments. The
51 following paper provides an appreciative and critical examination of Open Dialogue in relation to
52 care and treatment planning. The paper is centered on the experiences of the first author when
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2 introducing Open Dialogue within a Crisis Resolution and Home Treatment Team as part of a local
3 innovation supported by his employing organization. It incorporates the use of a fictionalized case
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5 study to illustrate key points and reflections. By engaging in this process, the two authors are able
6 to present an overview as to the use of open dialogue in clinical practice, and the dialogical
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8 process in formulating a plan of care.
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10 Background: problematizing care and treatment planning

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14 Care and treatment planning has been an integral part of mental health nursing for four decades.
15 During this period patients have been constructed as ever more complex and frequently multiple
16
17 systems are involved in their care. Care planning is proposed as a rational response to coordinate
18 interventions and to delineate responsibility (Department of Health, 2008). Written care plans can
19
20 be well received by service users; giving goals and a trajectory for recovery (Palmer, 2014) It
21
22 seems that they want plans that are flexible, dynamic and relevant to their circumstances at that
23 moment in time (Grundy et al, 2016).
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26 Considerable emphasis has been placed on the value of producing high quality care plans. The
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28 requirement to undertake care plans is invoked through local and national policy (Department of
29 Health, 2008) and can even be enshrined in law (Welsh Government, 2010). Yet despite these
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31 aspirations there appears a disjuncture between ideology, strategic intent and service user hopes
32 that is played out in the everyday practices of care and treatment planning (Brooks et al, 2015).
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34 Within crisis services huge amounts of nursing time are spent writing care plans in an effort to keep
35 pace with rapid changes in a person's presentation and circumstances. For such a structured and
36
37 labour intensive method there is remarkably little evidence to suggest it is effective. Simpson et al
38 (2016) suggest care plans are rarely referred to by service users or clinicians. This might say
39
40 something about their diminished utility to informing day to day mental health care.
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43 In the UK a worrying proportion of service users and carers report not being as involved in their
44 care as much as they would like (Atkin et al, 2014; Care Quality Commission 2015; Cree et al
45
46 2015). Mental health workers often bemoan care planning as a largely bureaucratic exercise and
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48 an encumbrance to therapeutic engagement (Simpson et al, 2016). Whilst nurses support the
49 concepts of positive risk taking they are concerned about protecting themselves and their
50
51 employers from blame. Risk averse practices direct nurses away from a more recovery centred
52 engagement (Coffey et al 2016, Downes et al 2016). Consequently care plan can overly focus on
53
54 "managing problems" than inviting risk and difference.
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57 Given these difficulties it is unsurprising that care planning has attracted the attention of academics
58 with ideas on how it might be improved. Simpson et al (2015) have investigated the practices of

1
2 assessment and care planning. This is with the aim of enhancing recovery focused, collaborative
3 care planning. Bee et al (2016) have developed a tool to measure service user and carer
4 involvement in care planning. Meanwhile Bower et al (2015) have investigated efforts to train
5 practitioners to develop service user involvement in care planning. Simpson et al (2016) call for
6 greater flexibility, openness and shared working in care planning. Bradley (2015) argues for a more
7 radical approach involving both service users and carers as active agents and in which
8 professionals relinquish power and control in favour of a more facilitative role.
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14 The solution can be the problem!
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16 For the authors the problems of care planning extend well beyond technical considerations. Even
17 more research and training about how to do it better does not seem an entirely helpful solution.
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20 The authors themselves have previously been part of a project to educate staff to enhance care
21 and treatment planning (Jackson et al, 2012) In a sense these efforts might, at best, amount to a
22 superficial first order change (Watzlawick et al, 1974) in which procedural shifts leave the
23 overarching system and culture largely unchanged. Our point of view is that recovery focused work
24 will require far more than well-crafted assessments and care plans. Care planning in this more
25 formalistic sense could even represent part of the problem.
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31 Mental health systems are predicated on defining and responding to “problems” (Anderson and
32 Goolishian,1988). Much of the power of mental health professionals emanates from their expertise
33 to pronounce upon mental health problems and to propose solutions (Brooks, 2014). Despite ideas
34 of recovery focused planning there is little to suggest much progress in this regard. Part of the
35 process of mental health care still involves life experiences being reified and encoded into a
36 language of problems, goals and actions. Whilst this can mobilize help, it can do so at the cost of
37 concretizing problems and planned outcomes. Whilst plans are arguably open to review they tend
38 to take on a reality of their own as different perspectives are collapsed into an invariant definition of
39 the problem or goal. Even in circumstances where the identified patient, social network and clinical
40 team offer wholesale agreement this can rapidly foreclose on opportunities to constructing new
41 meanings (Anderson and Goolishian, 1988). Once we believe that we “know” something about the
42 problem and commit this to a care plan our curiosity and openness to fresh understandings can
43 diminish. By circumscribing outcomes and activities, particularly those at the SMART end of the
44 care planning spectrum, we sharply position our relationships as predictable, linear and goal
45 directed rather than something fluid and emergent. Whilst this can tame worries by labelling them it
46 hampers meaning making. The anxiety of unknowing is expunged by recourse to the language of
47 certainty (Wilson,2015).
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Care plans often seem to benefit hierarchies more than service users or front line clinicians. They provide an auditable surface on which to adjudge 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 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).

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2 Dialogic care planning represents a paradigmatic shift away from the linearity of traditional nursing
3 process of assess-plan-implement-evaluate towards a dynamic model in which these dimensions
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5 elide in the discussion of a network meeting (Seikkula and Arnkil, 2014). Dialogue assumes that
6 many participants have pieces of an answer and that together they can put them into a workable
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8 resolution. The dialogue between clinicians and the social network is spontaneous and generates a
9 plan in response to what is expressed in the moment. Attempting to plan for all possibilities in a
10 single document is both impossible and unnecessary. Any plan has immediacy to it both in the
11 sense that it is generated from the dialogue but also in that it focuses on “what you do with whom
12 next” (Arnkil, 2014). The life span of the plan is only until the next meeting which is rarely more
13 than a few days within the crisis service.
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18 Within meetings less attention is afforded to identifying problems or considering how they might be
19 corrected. There is a move away from prescriptive care planning to one of more flexible working in
20 response to emerging themes. We purposefully avoid prefabricated ideas or solutions; such as
21 searching out examples of pathology or peremptory deciding the person requires a certain
22 treatment. Things become slower and looser through inviting reflections and responses. Our efforts
23 are not to decode, translate or even to assume we can understand the utterances of the other.
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25 Instead we share with the other participants something of what those words might mean or feel to
26 us, in that moment (Shotter, 2009). As much as dialogic practitioners avoid problematizing they
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28 equally eschew over simplifying solutions. Consequently it is difficult to generate concrete goals.
29 Dialogically the goal is often simply to create the space and opportunity for conversation. All
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31 discussions about planning are openly held in the presence of the network. The ideas of
32 professionals are seen as they as material for discussion rather than recommendations (Olson et
33 al, 2014). Care planning becomes an ‘ongoing process of communication, integrated into the
34 person-centered care routine and appropriately staged to the individual’s state of health’ (Forlina,
35 2014: 2). This ongoing process allows for the possibility that individual preferences might change
36 over time as health status worsens due to chronic illness or an acute episode. The focus of the
37 dialogue is in the observed and its meaning. In this way, treatment planning needs to become
38 responsive to what is happening often over quite short spaces of time, with every meeting
39 potentially generating a change in plan. An approach that invites people to separate ‘self’ from
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41 ‘problem’ and highlights competencies and abilities can be empowering for both service user and
42 clinician
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52 Open dialogue requires the clinician to analyze, deliberate and advance informed judgments from
53 an array of perspectives. This can be unsettling for some and demonstrates the complexities of
54 such an exchange. Because each meeting can present a dilemma and are open ended, they tend
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56 to simulate different reactions among members of the group. Yet the meetings also permit those
57 involved to be more open because it is one conducted in trust. We can share our uncertainty as
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2 well as our knowledge and experience. Adapting the therapeutic response to the specific and
3 changing needs of the client/family, using therapeutic methods that best suits, ensures that ‘ a
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5 whole person approach’ is adopted and that people are listened too. Dialogue therefore is not
6 limited to the mere exchange of opinions but rather is imaginative and open to many ideas.
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9 Whilst aspects of our work have been seen as unconventional we operate within the strictures of
10 safe and effective governance. For example care is still documented. The difference within our
11 practice is that the linearity and separateness of the nursing process is collapsed into a hopefully
12 more dynamic document contained within the running notes. Service users and network members
13 are not routinely given paper copies of care plans. However they “have” or “get” the plan in a
14 psychological sense. This is because the immediate plan is generally a few key points pertaining to
15 any actions required over the next few days. This is summarized and agreed towards the end of
16 the meeting. Our experience is that people are generally good at knowing what the plan is and are
17 able to enact it when it is relevant, simple and contemporaneous.
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23 In addition more static or standard aspects detailing what the crisis resolution and home treatment
24 service provides and any contact arrangements are provided by a team leaflet. Where there might
25 be uncertainty about a specific plan or when members of the network are absent a short letter can
26 be prepared and sent or given. This letter is usually largely derived from the entry in the patient
27 running record to save duplication of effort. Similarly at the end of a treatment episode a summary
28 letter detailing our involvement and any agreed ideas about further actions is sent to the service
29 user and others copied in as appropriate. Generally the running records also provide information to
30 other team members.
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37 **Case Study**

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

49 Daisy is a young woman in her early twenties. Her relationship to her partner recently broke down.
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51 She describes the partner as “emotionally abusive.” She is referred to the Crisis Resolution and
52 Home Treatment Team by her GP. At assessment the team note that she is “reporting command
53 hallucinations telling her that she is worthless and instructing her to end her life.” She was offered
54 rapid access to a psychiatrist who has prescribed antipsychotic medication however Daisy is
55 refusing to take this.
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2 The team discuss Daisy at their daily meeting. They discuss a belief that she is “psychotic,” that
3 her Mum believes she is getting worse. This provokes a short but animated discussion on the need
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5 to “have a plan” and in which various team members readily surrender ideas about what this
6 should be. Many concur that admission to hospital or possible assessment for detention under the
7
8 mental health act might be required if Daisy remains “non-compliant.” Another colleague asks
9 “what’s the risk?” and there is passing reference to her being “tortured by the voices” One member
10 offers that “she might be PD” There is also a suggestion that she might need to be referred to the
11 Early Intervention for Psychosis pathway. Given the different perspectives. I am asked by the
12 team to give an opinion. I am feeling uncomfortable about being entrained in a discussion about
13 somebody who I only know through a few entries in her written records and the views of a couple
14 of the team members who have seen her. I offer a few words to recognise their thoughts. My
15 desire to be congruent with open dialogue lends me to suggest that it might be best to discuss any
16 treatment options with Daisy before we start arriving at a decision. The team seem satisfied. A
17 colleague (“Jane”) and I arrange to meet with the psychiatrist (Dr Duggan), Daisy, Her Mother
18 (Dianne) and Stepfather (Mick) the next morning for a network meeting. When I speak to Daisy on
19 the telephone to arrange the appointment she seems confused about the purpose of meeting. My
20 efforts at explanation border on the expansive and seem to cause further confusion. However she
21 agrees to meet and invites her family during the course of the conversation.

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

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36 Following brief introductions the family join us in a circle around a small table. I open by asking
37 each family member their understanding of the meeting and how they would like to use our time
38 together. The bulk of the meeting is then devoted to exploring the family’s understandings. During
39 this time Jane, Dr Duggan and I reflect with each other about our responses to what is being
40 discussed. Usually this is a brief comment or question to each other. At one point we have a more
41 formal reflection when we ask the family to listen to our short discussion concerning our current
42 ideas about them. The reflections are owned by us as speakers and offered tentatively (“*I felt: I am*
43 *curious: I’m thinking; I’m reminded about*”). The family are then invited to respond to what we have
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60 said.

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2 As the meeting ensues discussion seems to naturally turn towards what might need to happen
3 following the meeting. Again a gentle approach is taken by asking “what might be helpful beyond
4 here?” with purposeful effort to avoid telling or advising the family.
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8 As the meeting concludes. We ask the family to give feedback on the meeting using Session
9 Rating Scales (Duncan et al, 2003). These scales help to support and gauge the therapeutic
10 relationship. These measures are reviewed and a brief discussion held on what was helpful and
11 what we might need to do to be more helpful to them.
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15 Following the meeting an entry [below] is placed in Daisy’s records. This is both a record of the
16 session and a summary of the current plan and how it was arrived at.
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21 Date: 30.6.16
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23 *Social network meeting 1500-1615h at base. Purpose of meeting and agenda agreed at*
24 *commencement of session. Daisy wants to be less troubled by voices and to be able to sleep. Both*
25 *parents say they want to know more about her illness and how they can help her.*
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29 In attendance
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31 • *Daisy*
32 • *Dianne [Mum]*
33 • *Mick [Stepfather]*
34 • *Dr Gerard Duggan [Consultant Psychiatrist, CRHTT]*
35 • *Jane Black [Nurse CRHTT/ Facilitator]*
36 • *Paul Barrett [Consultant Nurse/ Facilitator]*
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41 Dialogic Discussion- Key Themes
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45 • *Daisy starts by saying she is “broken, and has been broken as long as she can remember*
46 *She “hates” hearing two female voices commenting on her appearance. It keeps her awake*
47 *at night. Conversation indicated that they remind Daisy of being bullied at secondary*
48 *school. Another voice is male and friendly called “Tom”. He sometimes tells her to think*
49 *about ending her life.*
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54 • *Daisy said she does not like voices. At times she trusts “Tom” however she thought that*
55 *ending her life was wrong. She did feel desperate but had not made any actual plan to*
56 *end her life. She wants to “get better.”*
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- 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

1
2 upon us which are other, sometimes compelling, voices operating in our dialogues. Being in
3 language does not deny the materiality of power and suffering. Nor is it beyond the curtilage of
4
5 care and protection. However I am uncomfortable to unreflectively default to spurious legalistic or
6 organizational excuses (Warne, 2015) that hamper connection. Our implacable orientation, in even
7
8 the most challenging circumstances, is towards maintaining or reopening dialogue (Wilson, 2015).
9 One way we introduce this is to share our concerns or conflicts, for example, about a person's
10 safety openly with them in the meeting. This seems to feel more honest and enables a much more
11 enlivened and relevant plan about how to respond to any identified risk.
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15 Within this more co-produced framework of care planning we rely heavily on people being active
16 agents. We have encountered situations in which people can be reluctant to assume agency.
17 Generally we have trusted in them and the dialogic process enough to see them starting to find a
18 voice to participate in conversation. We have sometimes discovered that their reluctance was
19
20 because they felt silenced in previous encounters with acute mental health workers by not being
21 listened to or respected (Mind 2011; Whittall & Allie, 2011).
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26 In other instances there has been a frustration and sense of urgency about the pace of dialogue.
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28 This seems to relate more to financial considerations and service exigencies. Although our
29 innovation is supported by our employing organization some managers have expressed alarm
30
31 about whether this perhaps slower and labour intensive approach might increase service costs. It
32 is early days but we are finding that many patients make considerable progress I sometimes only a
33
34 couple of meetings. This suggests it is time well spent. Sometimes people can take longer to come
35 to dialogue. Unfortunately mental health services are rarely configured around patients' needs
36
37 consequently there is a considerable shifting of responsibility between different teams and
38 agencies. I reflect that a more "whole team" approach in which the patient journey is followed by
39
40 the same team through to resolution would be more therapeutic and cost effective. However we
41 are currently far removed from such a needs-adapted model and will need to engage in meaningful
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43 conversations with our management colleagues about how we best work within existing structures.
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49 These real world difficulties are not deterrents and I do not feel discouraged. As a nurse who is
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51 approaching the end of my career I have felt that the approach is perhaps the closest I have come
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53 to living out my values. More importantly I am hearing similar sentiments from nursing colleagues
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55 and students who have become involved in our work.
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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

1
2 al 2015). We would further argue that this potential towards inviting and responding to experience
3 might be an innate nurturance (Trevarthen 2011a, 2011b) and akin to the tradition of healing rituals
4 that invoke a gathering and listening (Attneave, 1969, 1990; Mehl-Madrona and Mainguy, 2014).
5 These are human processes that so many have found helpful for millennia. Unsurprisingly they
6 are not reliant on generating endless reams of meaning-less paperwork. There might be learning
7 for all there.
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10 11 Not the Final Word 12

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

26 Anderson H, Goolishian, H.A, Human systems as linguistic systems: preliminary and evolving
27 ideas about the implications for clinical theory. *Family Process* 27 371-393
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29
30

31 Arnkil , T.E. (2014) *Boundary crossing, dialogues and facilitation*. Presentation Emilia-Romagna e
32 Brasile, partnership sulle politiche per la salute. 14th February 2014
33

34
35 Atkin , H., Brandon, T., Thomson, L. (2014) Is there a pathway to recovery through care
36 coordination: early findings from an emancipatory action research project. *The Approach* 3.18 12-
37 15
38
39

40
41 Attneave, C. L. (1969) Therapy in tribal settings and urban network intervention. *Family Process* 8,
42 192-210.
43
44

45
46 Attneave, C. L. (1990). Core network intervention: An emerging paradigm. *Journal of Strategic &*
47 *Systemic Therapies*, 91,3-10.
48
49
50

51 Bee, P, Gibbons, C, Callaghan, P, Fraser, C, & Lovell, K 2016, 'Evaluating and Quantifying User
52 and Carer Involvement in Mental Health Care Planning (EQUIP): Co-Development of a New
53 Patient-Reported Outcome Measure', *Plos ONE*, 11, 3, pp. 1-14, Academic Search Complete,
54 EBSCOhost, viewed 23 June 2016.
55
56
57
58

1
2 Bower, P, Roberts, C, O'Leary, N, Callaghan, P, Bee, P, Fraser, C, Gibbons, C, Olleveant, N,
3 Rogers, A, Davies, L, Drake, R, Sanders, C, Meade, O, Grundy, A, Walker, L, Cree, L, Berzins, K,
4
5 Brooks, H, Beatty, S, & Cahoon, P 2015, 'A cluster randomised controlled trial and process
6 evaluation of a training programme for mental health professionals to enhance user involvement in
7
8 care planning in service users with severe mental health issues (EQUIP): study protocol for a
9 randomised controlled trial', *Trials*, 16, 1, pp. 1-13, Academic Search Complete, EBSCOhost,
10 viewed 23 June 2016
11

12
13
14 Bradley E (2015) Carers and co-production: enabling expertise through experience? *Mental Health
15 Review Journal* 20 4 232-241
16

17
18 Bromley, D. B. (1986). *The case-study method in psychology and related disciplines*. Chichester:
19 John Wiley & Sons.
20

21
22
23 Brooks, H, Sanders, C, Lovell, K, Fraser, C, & Rogers, A (2015), 'Re-inventing care planning in
24 mental health: stakeholder accounts of the imagined implementation of a user/carer involved
25 intervention', *BMC Health Services Research*, 15, pp. 1-12, Academic Search Complete,
26 EBSCOhost, viewed 23 June 2016
27

28
29
30
31 Brooks, O (2014) 'Critical psychotherapy,' 'postpsychotherapy,' and the cult of technicism,
32 *European Journal of Psychotherapy & Counselling*, 16:4,331-347,
33

34
35 Care Quality Commission (2015) *Community Mental Health Survey: Statistical Release* (online)
36 Available at http://www.cqc.org.uk/sites/default/files/20151020_mh15_statistical_release.pdf
37 (accessed 15th February 2016)
38
39

40
41 Coffey, M., Cohen, R., Faulkner, A., Hannigan, B., Simpson, A. & Barlow, S. (2016). Ordinary risks
42 and accepted fictions: how contrasting and competing priorities work in risk assessment and
43 mental health care planning. *Health Expectations*
44 <http://onlinelibrary.wiley.com/doi/10.1111/hex.12474/epdf>
45
46
47

48
49
50
51 Cree, L, Brooks, H, Berzins, K, Fraser, C, Lovell, K, & Bee, P 2015, 'Carers' experiences of
52 involvement in care planning: a qualitative exploration of the facilitators and barriers to
53 engagement with mental health services', *BMC Psychiatry*, 15, 1, pp. 1-11, Academic Search
54 Complete, EBSCOhost, viewed 23 June 2016
55

1
2 Department of Health (2008) *Refocusing the Care Programme Approach*. London: Department of
3 Health.
4

5
6 Downes, C., Gill, A., LDoyle, L., Morrissey, J., Higgins, A. (2016) Survey of mental health
7 nurses' attitudes towards risk assessment, risk assessment tools and positive risk *Journal of*
8 *Psychiatric and Mental Health Nursing* 23 (3-4), 188-197
9
10

11
12 Forlini J, H and Goldberg, L (2014) Respecting Choices: A Case study for Incorporating Advance
13 Care Planning into Person and Family Centred Health Care Delivery. *Health Policy Brief* 9, 1 – 4,
14 National Academy of Social Insurance.
15
16
17

18
19
20 Gromer J [2012] Need-Adapted and Open-Dialogue Treatments: Empirically Supported
21 Psychosocial Interventions for Schizophrenia and Other Psychotic Disorder. *Ethical Human*
22 *Psychology and Psychiatry* 14.3 pp 162-177
23
24

25
26 Grundy, A., Bee P., Meade, O., Callaghan, P., Beatty, S., Ollevent NT, N. and Lovell, K., 2016.
27 Bringing meaning to user involvement in mental health care planning: a qualitative exploration of
28 service user perspectives. *Journal of Psychiatric and Mental Health Nursing*. 23 12-21
29
30

31 Jackson, C. McGonagle, I, Betts, A. Barrett, P. & Linsley, P. (2012) *Rhagoriaeth mewn Cynllunio*
32 *Gofal a Thriniaeth Llyfr Gwaith Hwyluswyr [Excellence in Care & treatment Planning: Facilitator's*
33 *Workbook]* Cardiff: Welsh Government
34
35

36
37 McNamee, S (2015) Radical presence: Alternatives to the therapeutic state, *European Journal of*
38 *Psychotherapy & Counselling*, 17:4, 373-383
39
40

41
42 Mehl-Madrona , L., Mainguy, B. (2014) Introducing Healing Circles and Talking Circles into Primary
43 Care. *The Permanente Journal*, 18.2 4-9
44
45
46

47 Mind (2011) Listening to experience: an independent inquiry into acute and crisis mental health
48 care. London: Mind [Online] Available at
49 http://www.mind.org.uk/media/211306/listening_to_experience_web.pdf [Accessed 4th July 2016]
50
51

52
53 Olson, M., Seikkula, J., & Ziedonis, D. (2014) *The key elements of dialogic practice in open*
54 *dialogue: fidelity criteria*. The University Massachusetts Medical School: Worcester: MA
55
56

57
58 Palmer, V, Johnson, C, Furler, J, Densley, K, Potiriadis, M, & Gunn, J 2014, 'Written plans: an
59 overlooked mechanism to develop recovery-oriented primary care for depression?', *Australian*

1
2 *Journal Of Primary Health*, 20, 3, pp. 241-249, Academic Search Complete, EBSCOhost, viewed
3 23 June 2016

4
5 Razzaque, R. & Wood, L. (2015) Open Dialogue and its Relevance to the NHS: Opinions of NHS
6 Staff and Service Users. *Community Mental Health Journal* 51 931–938

7
8
9
10 Seikkula, J. & Arnkil. T.E. (2006) *Dialogical Meetings in Social Networks*. London: Karnac

11
12
13 Seikkula, J. & Arnkil. T.E. (2014) *Open Dialogues and Anticipations. Respecting Otherness in the*
14 *Present Moment*. Tampere: National Institute for Health and Welfare.

15
16
17
18 Shotter, J (2009) Listening in a Way that Recognizes/Realizes the World of ‘the Other’,
19 *International Journal of Listening*, 23:1, 21-43, DOI:10.1080/10904010802591904

20
21
22 Simpson, A, Hannigan, B, Coffey, M, Jones, A, Barlow, S, Cohen, R, Všetečková, J, Faulkner, A, &
23 Haddad, M 2015, 'Study protocol: cross-national comparative case study of recovery-focused
24 mental health care planning and coordination (COCAPP)', *BMC Psychiatry*, 15, 1, pp. 1-13,
25 Academic Search Complete, EBSCOhost, viewed 23 June 2016.
26

27
28
29
30 Simpson, A, Hannigan, B, Coffey, M, Barlow, S, Cohen, R, Jones, A, Všetečková, J, Faulkner, A,
31 Thornton, A, & Cartwright, M (2016), 'Recovery-focused care planning and coordination in England
32 and Wales: a cross-national mixed methods comparative case study', *BMC Psychiatry*, 16, pp. 1-
33 18, Academic Search Complete, EBSCOhost, viewed 23 June 2016
34
35
36

37
38
39 Trevarthen, C (2011a) What is it like to be a person who knows nothing? Defining the active
40 intersubjective mind of a newborn human being. *Infant & Child Development* 20.1 119-135

41
42
43
44 Trevarthen, C. (2011b). Born For Art, and the Joyful Companionship of Fiction. In D. Narvaez, J.
45 Panksepp, A. Schore & T. Gleason (Eds.) *Human Nature, Early Experience and the Environment*
46 *of Evolutionary Adaptedness*. Oxford University Press.

47
48
49
50 Warne S (2015) Shared dilemmas, choice and autonomy in the management of psychosis: a
51 phenomenological analysis *Mental Health Review Journal* 20 4 256-266

52
53
54 Watzlawick P, Weakland JH, Fisch R. (1974) *Change: Principles of Problem Formation and*
55 *Problem Resolution*. New York: Norton,
56

1
2 Webb, S (2006) *Social Work in A Risk Society: Social and Political Perspectives*. Basingstoke:
3 PalgraveMacmillan.
4

5
6 Welsh Government (2010) *Mental Health (Wales) Measure 2010*. Cardiff: Welsh Government
7

8
9 Whittall,S & Allie, S. (2011) Using narratives on an acute psychiatric ward. *Counselling*
10 *Psychology Review*,26 3 34-44
11

12
13
14 Wilson, J (2015) Family Therapy as a Process of Humanisation: The Contribution and Creativity of
15 Dialogism. *Australian and New Zealand Journal of Family Therapy*36, 6–19
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
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