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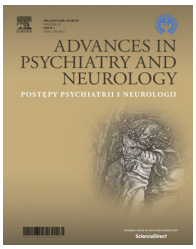

Review/Praca poglądowa

Open Dialogue as a contribution to a healthy society: possibilities and limitations

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ABSTRACT

This article proceeds from and explores the assumption that psychiatry has arrived at a crossroads, at which it has to choose, whether it will go on in the direction of neuroscience or turn back towards the individual, within its specific surroundings, with a focus on what the Open Dialogue Approach can contribute to the debate. Because of the comprehensiveness of this approach some changes should be expected in the treatment system. These affect the interests of many groups involved: patients, relatives, professionals and governmental agencies will profit in different ways, and some things might change that particular members of the different "lobbies" might see as a loss. Before getting close to a solution, the actual proceedings in Germany, based on experiences in Finland, are outlined, and finally some thoughts are shared on the difficulties of implementing the approach.

I want to start with a quote from an article by the Irish MD Pat Bracken, published just recently, in October 2014, in "World Psychiatry", the journal of the World Psychiatry Association [1]: "Psychiatry is currently going through a crisis of confidence. Some medical commentators have even questioned the very credibility of the profession. There are many indicators of this crisis. For example [there have been] [...] raised serious questions about the validity of the whole DSM [Diagnostical and Statistical Manual of Diseases] process [...]. It is clear that psychiatry has been a particular target of the marketing strategies of the pharmaceutical industry; strategies that have led to the corruption of evidence-based medicine in general. Much-heralded advances in antipsychotic psychopharmacology are now revealed as 'spurious'. Academic psychiatry's attempt to transform itself into a sort of 'applied neuroscience' has consumed enormous resources but delivered very little for patients".

Well, this is harsh criticism of scientific psychiatry, which in the years following the euphoria of the "decade of the brain" turned towards the idea of an almost complete neuroscience, in which expressions of human life are reduced to simple dysfunctions of neural circuits. That does not sound like a contribution to a healthy society.

He claims further that: "[...] meaning is not something that happens inside an individual mind or brain, but instead comes into our lives from the social practices that shape the world around us". "I contend, that good psychiatry involves a primary focus on meanings, values and relationships [...]."

This is a call for a hermeneutic approach towards mental health, based on the idea that the meaning of any particular

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experience can only be grasped through the understanding of the context, in which a person lives, and through which that particular experience has significance.

Comparing these quotes you find a description of very different views on the field, and it leads to a situation akin to walking through a minefield, in which it would be helpful to have some gap markers.

So what does Open Dialogue as a way of dealing with severely acute mental crisis, have to contribute to the discussion [2, 3]? The Open Dialogue Approach can be seen as something very new and revolutionary; but at the same time it is not at all new, but rather a collection of examples of best practice assembled to form a new pattern. It concerns the possible ways in which the creation of a treatment system meets the needs of patients, their families, professionals and the National Health Fund or (in other countries, e.g. Germany, insurance companies) – however widely these needs may differ.

Along with this approach goes a radical change in the system, so that from now on professionals will no longer have to meet the needs of patients and families or networks in their offices, but 'out there', in those places in which people's needs can be best met. This is in some way a real turnaround, but on the other hand best practice already exists in some places, where acute teams were created that were able to go in the direction of "home treatment", as for example in Finland, Norway and Sweden, the UK or nowadays also Germany. You heard something very profound about Open Dialogue and its development in Finland, and I want to point out that the results, having been researched over the years, are the best worldwide. Assertive Community treatment and Acute Crisis Teams have proven to be successful enough to prevent inpatient treatment. And yet there is a tendency these days to once again expand hospitals and increase the number of beds that can be used. This is, in spite of there being no evidence for the superiority of inpatient treatment compared to other forms. This is some kind of contradiction: the best results we claim for home treatment approaches, while again enlarging hospitals. Nowadays it is obvious why. It is a well-known rule that, if you want to know more about how things work, or how the cookie crumbles, follow the money. Not just in the field of health services. Everywhere in Europe we have, for historical reasons, a large number of bigger and smaller hospitals in each country. Hospitals are paid per bed. That is their only way to make money, so if they want to improve their economic situation they will ask for more beds. And the national boards of hospitals are certainly a strong force or lobby. But we also know that inpatient treatment is the most expensive kind when compared to any other approach [4]. And once again, there is no proof that this kind of standard care is successful in the long run anyway or, more importantly, superior to other forms of outpatient treatment. Much could be said about the findings of Robert Whitaker, a journalist, who investigated standard care outcomes worldwide. These findings cannot be reported here in more detail, but there is evidence that we should rethink large parts of our standard treatment system. Well, and that is what we have gathered here for.

So, "possibilities and limitations" are mentioned in the title of this lecture. These are present for all the different perspectives to be found somewhere in this field, which is hard to understand fully or even scrutinize because, whichever way we find into the future, some things will have to change and, with these changes, there will be winners and losers and at least some economic shifting. At the moment it is no more than a promise whether in the long run all of us would profit from new ways of cooperation.

Before I turn to opportunities and risks for the possible participants, a few words on the question of the limitations of the approach. When are you unable to, or in what kind of situation should you not try to work according to the principles and elements of the Open Dialogue? Though the approach has been developed for the treatment of networks, in which one member shows signs and symptoms of psychosis, it turns out that it is equally useful for other kinds of crises; and it depends more on the complexity of the situation, the needs of the patient or the network, if you fully employ these elements and principles. On the other hand, there is not always the need for a network meeting, because in a lot of personal crises it might be sufficient to ask for individual help. This is also meant, when we say: "follow the needs of the client" but it seems that the more anxious, irritated or disturbed a person gets, the more important it becomes to gather those people who are in some way involved and caring. Families tend to seclude themselves in moments of severe crisis, though the ground on which they stand is crumbly, slippery, hot and not at all sure for most of them. And here it can be helpful, if more people join in, to bring back some feeling of trust and safety. We have to admit, however, that there is as yet no research on this. As with every therapeutic approach there can arise the question of safety, force or danger for bodily or other kinds of harm. In such cases the way forward seems clear: it must be "safety first", otherwise trust will be destroyed. And then you will make use of anything that might help to prevent damage to persons or things. Close to this, in some way is the fact that a limitation always lies in ourselves. How much experience do we have? How safe do we feel? What do we, as moderators, need to feel safe and secure? This is a very intimate question that everybody has to answer for himself. The safety line is here the element of collaborativity, which opens the door for possible supporters or people who are experts in things we are not.

From isolation to inclusion

Now let us have a closer look at the opportunities and risks of the new approach, viewed from the point of view of all the participants in the field. First let us have a look at the patient or user. Is it a risk for a patient to follow his needs as embedded in his family or network? I cannot know this for certain. Maybe he or she wants to be left alone or undisturbed for some time, and then nothing and nobody will keep them from going into a hospital or a crisis apartment. Is there a risk if, in a network meeting, conflicts suddenly arise, taboos are touched and secrets disclosed? Or what about strong emotions that might erupt suddenly? Yes, there can be a risk, but isn't it then more a question how to deal with it? We see strong emotions as a driving

force behind whatever we do. The more we can share of these sometimes unbearable emotions, the greater the chance to carry the burden of them together.

It is the recovery movement that gives us an answer to this because if you read the principles of recovery-oriented approaches, as the SAMHSA (*Substance Abuse and Mental Health Social Administration*, USA) put it, you will find almost the same elements and principles that guide Open Dialogue. So there is huge complementary at the moment from that side. Follow them on [5, 6] http://www.madinamerica.com.

From exclusion to participation

The same might apply for family members, when the burden of disease has grown to be too much and they long for a period of separation. Mostly relatives nowadays complain that they are not invited, informed about or taken seriously as participants in the healing process. Here again, it is all a matter of discussing things. We as moderators will invite them, listen to them, give them information when necessary, but not decide what the next step will be. Our task is to moderate a network meeting in such a way, that a decision can be made by the network members. A risk or limitation might be that Open Dialogue and the hospital fail to follow the same rules of having a dialogue. So it can turn out to be frustrating to get stuck between two contrasting treatment approaches. That is why it is of great importance to involve a hospital in the region, in which OD is going to be implemented. And not only for reasons of treatment philosophy; is the economic aspect equally important. Certainly, the introduction of home treatment teams does cost money; but as we already know, it would help to reduce inpatient treatment. So what would the hospital do, realizing that fewer patients are coming in for treatment? They would have to recruit "new" patients, mostly those less severely ill, and we know by now that at least 30% of our patients would not be admitted if there a proper outpatient and crisis intervention programme did exist. So we had better think of a catchment area as a whole, starting perhaps with model regions in some districts, and then slowly but steadily introducing OD even to those, in which there is a reluctance to believe it can work.

From experts to "one of us"

In terms of a discussion of the risks and limitations for professionals, the hardest aspect of all seems to be that they can no longer act as all-knowing experts. This is true of doctors, but also for psychologists or other professionals whose education has suggested to them that all persons with a certain diagnosis act in a specific way. The fonder you are of these sorts of theories, the less you will be able to listen properly. This is especially true when you are a young professional, and happy to recognize something with which you are already familiar. Then after a time you cease to be curious – but we should always bear in mind that a situation may be different from anything we have known before. One of my late teachers once told me that "the longer I do this job, the more I am insecure about how things really could be". This is may be one aspect of Socrates' statement "I know, that I know nothing" – very wise.

Are there any more risks? Yes, there are. We are used to working with all kinds of professions in the home treatment teams. All staff members get the same education, and there is no reason not to have a nurse, an occupational therapist or a social worker side by side with psychologists or physicians as moderators in a meeting, if they want to participate in this way. I think you cannot force somebody to do this work. Nor can you force somebody to develop this kind of understanding of relational, respectful partnership. But you can invite them and offer them information and opportunities to experience the benefits before they will make a decision. But more of that later. We do not need a doctor or a psychologist all the time, and we do not have so many of them at our disposal. For the nurses, for example, it might really be a big step to become a moderator, instead of doing the usual daily work. For younger colleagues it might also, at the beginning, be frightening to do home visits, be a guest in a house and not the host in an institution. Here they have to be carefully educated, coached and supervised. This might be true for what we call responsibility or psychological continuity as well.

From closed wards towards the community treatment centre

In the hospital there may be more, although different, limitations, especially because you cannot offer training to all of the staff members at the same time. So there is a division between those who are already privileged through education and those who have to wait. Or if you don't take the leaders into the training at the beginning. If not, there will be discussions about the right strategy, and sometimes these will be frustrating for everybody. At the very beginning, the idea has to be implemented top-down, but after a while the implementation of a new everyday routine has to be bottom-up, and there is always someone in between, who will say something like: "Well, if the chief says 'go', I will go, but I cannot imagine it will work". These are all reasons why those people in charge have to be very careful to moderate this process; to support where support is needed, and wait where this seems to be appropriate. And leaders have to be engaged themselves; nothing is more convincing than what you as a leader do yourself.

There is another important issue to consider when introducing OD into an institution or region: sustainability. What we create is something like a "learning organization", and this task can be described as involving some "change management". This includes an ongoing input of knowledge and repetition of learning situations in everyday routine. Only by acknowledging this you can integrate newcomers and beginners, and support those already on the way. This is no easy task, and it is best to be aware of the challenges from the beginning.

Such are the institutional risks. But these are made up for by far by the advantages of introducing OD. The ways in which people talk to one another on a ward changes towards more respectful, and simply polite, behaviour. Acknowledging

that we are not responsible for changes in other people's lives, or decisions other people make for themselves, reduces personal stress. We learn to be curious about this, because behind every kind of behaviour always hides a very personal story, which has maybe never been told.

For each person involved in training or this kind of work there is the possibility of personal growth, through the power of dialogue, and this affects us as well as others. But it is always you who decides how to improve your health and well-being, how to lead a self-directed life and in which ways you will strive to reach your full potential. Isn't this a healthy concept for all people? This is also what the recovery movement suggests [5, 6]. So it is true that professionals can also recover. Working in the psychiatric system for many years can lead to a special kind of chronification: here is a way out.

The Open Dialogue Approach is very comprehensive. It is an approach that cannot be adopted by a lone practitioner: it requires a team and a surrounding context that is open enough to accommodate it. Otherwise there will be much frustration. The solution here may lie in the satisfactory reward, experiencing the difference between a therapeutic talk and a dialogue, which can be in itself fulfilling in normal life. But I guess it unfolds its full potential in the field that it was developed for – helping people experiencing severe crisis.

And then there is the fear of a director of losing beds and thereby being marginalized in his position and influence. The chance here lies in the reorganization of the hospital as a community psychiatric treatment centre, where all kinds of support is offered. The hospitals will have fewer beds, but not less staff, because the staff members will have to be those who go out into the community to provide home treatment. So there will be much more of a variety in a hospital. Isn't that a brilliant idea?

And your CEO might also ask you how you propose to earn the money needed to pay all the wages if you decide to treat as many people as possible with the home treatment approach. There is an economic risk, if there is not also the necessary change in the financing system.

Here it should be mentioned that the structural problem of dividing psychiatric treatment into two fields (National Health Fund and Community Psychiatry) and assign the costs to different ministries or organizations might provoke a “shovelling out” of some of the costs to each other's areas.

A turtle on its way

Now I want to say something about the way in which Open Dialogue has been implemented in Germany since 2007. There have been some local activities, due to some outstanding colleagues like Thomas Keller in Langenfeld or Volkmar Aderhold in Hamburg introducing need – adapted treatment elements via family therapy into clinical psychiatric practice [7]. It was in 2006 that I first met Birgitta Alakare and Tapio Salo from Keropoudas Hospital at a conference in Hamburg. They talked about the treatment approach in Tornio, Western Lapland, and I was so impressed that I started to discuss their approach with them. They invited me to a conference of the International Network for the Treatment of Psychosis that year, taking place in Falun, Sweden. After I came back, I must have been “glowing” somehow and was certain that this was it for me. In that year we had many meetings inside and outside the hospital and the department, until we decided unanimously: “Yes, we can make it”. We were lucky to be able to start with the education aspect in 2007, and we went 'out' to deliver home treatment in 2010, before we were halted for financial reasons. But in the meantime some other hospitals and regions (one of them the Psychiatric Department of the University-Hospital Charité in Berlin), in which community psychiatric teams were working, asked for education as well and now, in 2014, there are about 15 different areas in Germany where there are teams for crisis intervention and home treatment inspired by Open Dialogue. They have special financial options for this, mainly because one of the insurance companies offers a “flat rate” for patients endangered by chronification who can be treated that way. This flat rate rewards outpatient treatment and sanctions inpatient treatment, a solution which moves in the right direction [8]. The costs for those patients over one year have been reduced by 50%, which really is substantial and convincing. The disadvantage with this model, clearly, is that the local hospital is not involved.

The other type of model is the so-called “Psychiatric Regional Budget” [8]. The hospital, with its possibilities for inpatient, day care treatment and outpatient clinics, gets a certain amount of money per year with which to cover overall costs. It has to provide treatment for every person living in the catchment area, and can decide which treatment is most appropriate for every patient. Guess what happens? Inpatient treatment is reduced by 25%; adding home treatment to the therapeutic portfolio will increase this up to 50%.

From paternalism to cooperation

What are the possibilities and limitations for local, district and national authorities, National Health Funds or Insurance Companies? For those, for example, that have an agenda for the field of psychiatry that has a demand for:

- reducing the number of hospital beds
- supporting community psychiatric services
- public education?

To say it clearly: Although I am not a politician and am in no position to be responsible for organizing mental health services, I daresay the biggest interest here lies in these questions: How much will it cost? How can we reduce costs? Does it pay off? How do I know if it does? and What will voters say? And it is up to us to understand these things and find a proper language, which takes into account what and how those in charge think.

There is no convincing or sufficient answer to all of the questions, but there are some things we know (pretty much) for sure. For example:

- The most expensive, but by far not the most successful, treatment is inpatient treatment.
- Up to at least 30% of patients have to be treated in a hospital because of lack in outpatient treatment facilities.
- The contemporary treatment system “produces” costs through rising numbers of disability allowances (fourfold

in the last 20 years), although in other financial sectors, but society as a whole has to pay for it (R. Whitaker).
- Thinking about treatment systems for patients experiencing severe crises means thinking in periods of at least five to ten years.
- Thinking about costs for patients should make you think across the borders of National Health Funds and Social Security Funds that is "follow the person".
- A lot of people speak about prevention, but no one gets serious about this. We know that early intervention programmes can be very successful. OD can be such an early intervention programme, as it turned out to be in Finland [9, 10].
- To add new offers of provision to the existing ones will only lead to more costs. Introducing home treatment for people in acute crises only makes sense economically if, at the same time, you start to reduce the number of hospital beds.
- There is enough money in the system, we just have to spend it more "intelligently".
- Thinking about family therapy, the by far cheapest approach is that of home treatment, compared to sessions in institutions or offices [4].
- Regional budgets are able to reduce inpatient treatment, and in the long run costs, by reducing hospital capacities [8].
- Under certain conditions so-called "flat rate" can contracts reduce costs by 50%, if home treatment is used (TKK-Pinel-report).

To find out the best solutions for these emerging questions might be to consider the voice of the users or peers, relatives and professionals. Thus could begin a new age of cooperation.

Conclusions

Introducing Open Dialogue and implementing it in existing treatment systems is a real challenge. This kind of "grand practice", with its need for comprehensive action, affords an opportunity to engage people in the different fields of therapy, local and regional authorities, hospitals and organizations. It is itself very much a form of community building. There is no fast solution for this approach, and it seems more like a long – though nevertheless promising – road for all of those participating. The Open Dialogue Approach is not something you can force on anybody. It should be an offer, a proposition, and then everybody has to make up his own mind. So the process of implementation against a strong mainstream has to be carefully prepared and accompanied, allow for reliable cooperation of all actors in the field, and act as a restraint on competition and rivalry. Give it time to grow, beware of pushing it too hard.

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Ethics/Etyka

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