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Letter to the Editor

Open Dialogue: a rights-based approach to treatment in mental health care

Emer Rutledge

Navan Community Mental Health Care, HSE Dublin North East, Navan, Ireland

The tectonic plates of mental health care and psychiatry practice may be shifting. Over recent decades, the biomedical model has been dominant, eroding the previous influence of psychoanalysis. The United Nations in recent years has made a substantial critique of mental health service provision and called for the shift of modern psychiatry away from coercive practices towards a people-centered and rights-based approach (UN Human Rights Council, 2017). The Committee on the Rights of Persons with Disabilities and the QualityRights Initiative are advocating an end to involuntary treatment altogether (Hoare & Duffy, 2021). Countries which ratified the UN Convention on the Rights of Persons with Disabilities (CRPD) (this includes Ireland in March 2018) are now facing pressure to implement far-reaching changes that challenge fundamental principles of mental health care and treatment hitherto widely accepted as satisfying human rights norms (Freeman *et al.* 2015). Open Dialogue convincingly presents a way of organising public mental health services for persons experiencing the most serious mental health issues with minimal necessity for coercion and due regard for legal capacity; the human rights based approach as advocated by the UN CRPD (Puras, 2021).

Open Dialogue is both a therapeutic intervention and a way of organising services. It is a form of therapeutic engagement with patients and families which was developed during the 1980s in Finland's Western Lapland region (Alanen *et al.* 1991). It is an integrated approach involving systemic family therapy and incorporating some psychodynamic principles. It promotes a network perspective, bringing together both social and professional networks to provide continuity of psychological care across the boundaries of (traditional) services. It encourages the patient and family to meet immediately and frequently after referral to openly explore acute mental health crises. This approach aspires to create a space where decision making is transparent. Open Dialogue gives the patient the space to consider what they really want and the role of the clinicians is to respond to that; that is to be directed by the views and wishes of the person using the service. The ordinary language of the family is used, not clinical diagnostic terms. Thus, the whole intervention aims to promote respect for the decisions, values and priorities of the person involved. Open Dialogue attempts to promote the patient's potential for self-exploration, self-explanation and self-determination. Therapeutic plans can emerge from this dialogue. Issues of risk are addressed too by the network meeting. This is a form of shared risk management. The focus of the staff in Open Dialogue is to move away from a monological discourse, the aim of which is to remove symptoms and towards a dialogical focus on finding a shared way of talking about what is frightening people (Hoffman, 2006). Seikkula suggests that it is through dialogue that meaning develops and change arises (Seikkula *et al.* 2006).

Open Dialogue is endorsed by WHO's new 'Guidance on community mental health services: promoting person-centred and rights-based approaches' as an example of a service which engenders a human rights based approach (World Health Organisation, 2019). Intrinsic to the model of treatment is a respect for an individual's legal capacity (i.e. the right to make decisions about their treatment and life).

Early Intervention Programmes (EIP) share service level features with Open Dialogue, providing a comprehensive package of care and support for families. In EIP services, the emphasis remains on individual care with enhanced support given to families. Perhaps the biggest difference is that most EIP programmes offer cognitive behavioural-based approaches to individual therapy, in contrast to Open Dialogue, in which systemic, dialogical and psychodynamic principles are embedded in all components of the service and inform the primary approach to the psychotherapy delivered. Future studies should address this question of whether Open Dialogue can offer additional benefits to those offered by EIP services for this first episode psychosis group of individuals.

The overriding criticism of Open Dialogue is the lack of robust evidence. There is a dearth of good quality empirical publications evaluating Open Dialogue (Freeman *et al.* 2019). Much of the quantitative data regarding treatment outcomes for Open Dialogue has come from the previously mentioned region in Lapland. Seikkula *et al.* (2003) and (2006) reported outcomes from a 2-year and 5-year follow-up of two groups of first episode non-affective psychotic patients. These results indicate that those treated with Open Dialogue are more likely to be free of psychotic symptoms, more likely to return to study or work full time and less likely to be living on disability allowance and the Open Dialogue group required less psychotropic medication compared to the acute psychosis comparator group. A 19-year observational follow-up study suggested sustained improvements in outcomes over time (Bergstrom *et al.* 2018). Although these findings are promising, the lack of a robust study design is apparent. There was substantial variation in the severity of the presentations included in

Address for correspondence: Dr E. Rutledge, Navan Community Mental Health Care, HSE Dublin North East, 1st Floor Beaufort House, Old Athboy Road, Navan, Co Meath, Ireland. (Email: emer.rutledge@hse.ie)

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each cohort, which was not adequately accounted for in the interpretation of the findings (Freeman *et al.* 2019).

A large multi-centre randomised controlled clinical trial is underway in the UK to consider the effectiveness of Open Dialogue for severe mental illness. The ODDESSI clinical trial (Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness) funded to the tune of £2.4 million, by the National Institute of Health Research began in 2017. ODDESSI will run for 5 years until 2022 in five NHS Trust research sites with results of this clinical trial to follow in 2 years time.

Open Dialogue is an organisational intervention as much as it is a treatment built on building social networks, dialogue and relationships. It is a significant change in treatment approach for the mental health professional, one that requires training, ongoing supervision and a reflective practice. Its introduction brings about the need for an organisational change or a change to the systems of treatment as normal. In Community Health Organisation Area 8, 18 mental health professionals have completed a year-long training in Open Dialogue. Ten of these professionals are working in a team in Navan, Meath and embarking upon this change in practice. We plan to record and evaluate the effects of this change in practice, its effects on patients, their families and indeed ourselves.

Conflict of interest. The author has no conflict of interest to declare.

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