THE DIALOGIC APPROACH. AN EFFECTIVE MODEL FOR MENTAL HEALTH SERVICES

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ABSTRACT

The quality and effectiveness of therapeutic rehabilitative interventions represent a landmark in the field of mental health. The respect of human rights is strictly linked to health in general, and *these two aspects depend on how mental health services* guarantee the treatment pathway.
The focus of this study is on the international success of Open Dialogue (OD), once designed for those affected by schizophrenia, since it questions the traditional structure of mental health services. From the study of theoretical principles and the scientific evidences of the benefits of dialogic approach on *Services, the core of this contribution consists of how much dialogue can be found inside Services themselves. The field of work was characterised by the operators of two MHCs: Modena Polo Est and Pavullo. The inquiry focused on operators' behaviours and dispositions towards OD, regardless of the occupation of the workers, but selecting those with direct experience of Open Dialogue.*
Results highlight that dialogic approach is, in most cases, already adopted by operators, and that it positively affects their dispositions. Despite arduous to undertake, it can be inferred that tolerating uncertainty in its practical application and the reject of a medical-centred approach are *extremely necessary. Indeed, not only are they coherent with the dialogic approach, but they also bring improvement aside from the selected approach.*

INTRODUCTION

The *Open Dialogue Approach* (OD), was born in Finland in the mid-80s, when a team of the hospital of Keropudas renewed the way of hospitalizing patients. The new method, started in 1984, consisted of prearranged meetings between doctors, patients and their families before determining any therapeutic action towards acute psychotic crises. The intervention was characterised by a slight openness and transparency in its organisational and decisional processes. Over time, new practices allowed to create a more democratic psychiatric service. Patients and families, together with experts, became co-participant in the following therapeutic decisions, and even responsible for the change of the present, problematic situation (Aaltonen et al., 1997). Seikkula[1] and coll. theorised *seven fundamental principles*[2] of OD. Moreover, OD implies the *Dialogical Practice*, a precise structure of therapeutic conversation inside the abovementioned meetings. If the OD is ruled by seven basic principles, the Dialogical Practice is defined by *twelve keypoints*[3].

The seven principles of O.D.

1. Immediate support. The patient must receive assistance within 24 hours from the first request for intervention.
2. Perspective of social networking. From the early beginning, families and other relevant figures in the patients' social networking are appointed to give social support to the patient.
3. Flexibility and mobility. Usually meetings are hosted in patients' houses behind family consent.
4. Responsibility. Experts involved are responsible for the initial organisation of the multi-professional meeting with the patients and their families.
5. Psychological continuity. The same specialists persist being responsible for the entire treatment, not only in health structures but also in patients' domiciles.
6. Tolerance of uncertainty. Creating a sense of safety is essential for the therapeutic process. The OD aims at building relationships where everyone feels safe and at ease.
7. Dialogue (polyphony[4]). The last principle consists of the promotion of dialogue, and considers the patients and family's changes. Indeed, it is believed that, through dialogue, each participant becomes more conscious of his active interaction and power on their own lives' situations.

Twelve keypoints

1. Two or more therapists must be present in the team meeting.
2. Family and social networking participation.
3. Using open questions.
4. Answering to the patient.
5. Give emphasis to the present moment answering to immediate reactions of patients and families.
6. Encourage multiple viewpoint.

7. Relational focus adopted during dialogues.
8. Answering to dialogical and behavioural issues with a concrete and careful verbal style.
9. Give emphasis to words and stories recalled by patients, not symptoms.
10. Conversations between professionals during care-meetings should involve all participants to therapeutic meetings.
11. Be transparent.
12. Tolerate uncertainty.

In 2018, Tomi Bergström tested the effectiveness of OD by considering two main focus groups: one treated with Open Dialogue (OD) and one control group (CG) conventionally treated. The study lasted nineteen years and ended with a follow up. Results show that the percentage of patients treated with drugs at the end of the follow-up-phase is 46% for the OD group, while 97,3% for the CG. On average, each OD-patient had 3,2 hospitalisations, whereas the CG-patient 7. The days of hospitalisation usually were 63,1 for the OD, while 340,4 for the CG (T. Bergström et al., 2018).

The impressive results surprised the international community. Specifically, the Italian experience of the DSM[5] in Modena is generally considered a remarkable example to display. Modena was chosen by the Ministry of Health in 2015 to ascertain the transferability of OD, together with the DSM of Turin, Savona, Trieste, Rome and Catania. During this period of experimentation, a team was formed and started clinical work in 2017. "*Preliminary results of the actual experimentation in a Modenese MHC highlighted that the OD approach can be applied and that it gives positive outcomes."*[6] In the still-occurring experimentation, patients were accepted notwithstanding the diagnosis, and all types of crisis were treated. The experimental MHC continued with the usual treatment. After six months, a valuation was elaborated with the GAF[7] and CORE-OM[8] scales. A clinical improvement in OD patients emerged from the analysis. Moreover, the *dismissal rate*[9] of the service was strikingly higher in the experimental MHC. Another important characteristic was the decrease of pharmacological treatment, since more than half participants was treated without drugs, considering the opposite one tenth of the control group.

As a result, from the Italian experience two main outcomes seem to emerge. From one hand, the OD is revealed to be transferable; from the other hand, such approach can be generally employed inside the service (Mazzi F. et al., 2018).

However, it could be also stated that opposition against this untraditional method have appeared. In particular, those resistances arisen from individual mental health operators seem to be particularly noteworthy, since they are alleged to affect the efficacy in the spread of the OD approach. In this regard, Tibaldi and Bertani's work[10] is considered a cornerstone. In their contribution, resulting from the Torinese experience of transferability analysis of the aforementioned approach, the scholars reported favourable opinions and issues of untrained operators involved in OD sessions. Results highlight not only theoretical objections to such method, but also personal concern and concrete feelings. Indeed, the OD is believed to prevent the patient from having his own, indispensable space for the therapeutic path. Furthermore, it is generally accepted that, with the OD approach, an authentic and well-defined control is missed during the therapeutic meeting, and this risks exposing the patient to unpleasant situations (e.g. the reiteration of inadequate modalities adopted by families). An excess of freedom could influence the therapeutic element of the meeting, thus vanishing the therapeutic role of the expert.

Concerning the language, the main issue involves the adoption of a concrete, informal, everyday language. Moreover, it should be highlighted that the reflexive step could make patients feel unease, not only because of the effort of being authentic and sincere, but also because of the fear of 'cutting out' patients and their families. Thirdly, only nurses and professional educators manifested their difficulty in posing their voices as equal to their colleagues', in addition to their fear of prevailing among others (*Mental Health workers (without specific training) engagement in Open Dialogue meetings with some families in Turin*, Giuseppe Tibaldi and Sara Bertani, 2017, unpublished work).

The following research illustrates the dispositions of those working in the field of mental health, highlighting the differences between having or not a direct experience of OD. The first goal of this contribution is to investigate whether the Open Dialogue was effectively adopted by operators of mental health centres, notwithstanding of their personal experience. A realistic depiction of the current situation, based on the results of the study, will be provided.

Moreover, this research aspires to evaluate the disposition and behaviour towards a possible dialogical redefinition of mental health treatment inside services. From the analysis, eventual arrangement of efficient training and a consequent redefinition of therapeutic practices could be finalised.

METHODS

In this study were involved health experts of two MHCs: one in Modena Polo Est and the other in Pavullo. Professionals who were absent from work due to illness, injury, parental leave or leave for 104/92 Law were excluded from the administration of the questionnaire.

Sample

The sample was composed by operators with direct and no experience of dialogical practices objects of this study. Different job roles were taken into consideration: complex, operational unit directors, health-professions' coordinators, professional nurses and educators, art therapists and psychologists. The sample was collected on rational basis with the 'avalanche selection mode'. In particular, the Pavullo MHC was included with the aforementioned modality after some recommendations given by collaborators, who allowed the realisation of this research. The interviewee were 48, divided as follows:

The total amount of operators of the two MHC were obtained from the directors and coordinators of UOC[11]. The 79% of participation rate emerges from the data of the questionnaire, with a major participation of the MHC of Modena Polo Est.

It seems remarkable to highlight a substantial difference in the OD between the two interviewed groups.

Indeed, taking into consideration the 21st item in the questionnaire, 38% of operators of Modena's MHC declared to have direct experience of the OD, opposed to the 95% of Pavullo. Such disparity must be taken into account when analysing the answers inferentially.

Belonging MHC	Professionals interviewee/ All Professionals	Partecipation index
Group 1: MHC Modena Polo Est	26/27	**96%**
Group 2: MHC Pavullo	22/34	**65%**
	TOT: 48/61	TOT: **79%**

Tab. 1 - *Description of the sample*

Tool

To carry out this study, was adopted a questionnaire, composed by 22 multiple-choice items. 21 of the items was based on Likert scale, whereas the 22nd was a close-ended question with three possible alternatives.

To elaborate the questionnaire, the "*Recovery Knowledge Inventory (RKI)*" [12] was modified. The first step included the definition of the general topic, which affected the items in order to adapt them to the more decisive, dialogical approaches, meaning the seven OD principles and four key elements of the dialogical practice. The 21st item was necessary to separate the directly-experienced operator from the unskilled one. This element was added to investigate on the duration of the professional service of each interviewee.

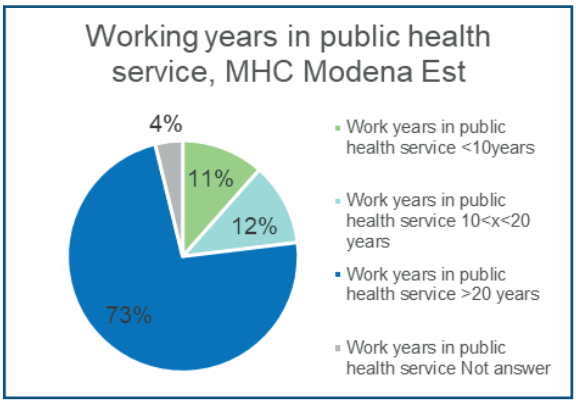
RESULTS

The sample was composed by operators with direct and no experience of dialogical practices, 48 professionals from two different Italian MHCs.

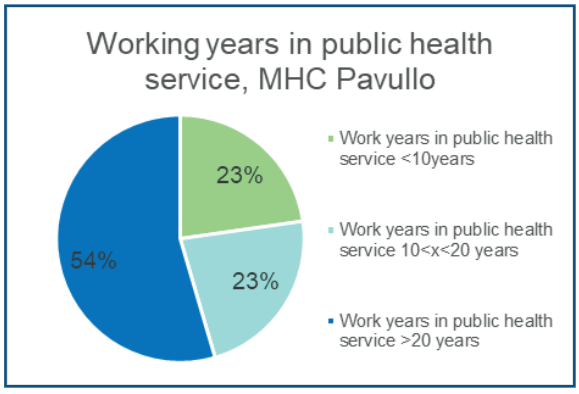
Based on the results of the 22nd item, the 55% of oper-

Rate the following statements on a scale from 1 to 4: put a cross based on how you feel disagree or agree.				
1 Completely disagree	**2 Disagree**	**3 Agree**	**4 Completely Agree**	
1 The therapeutic meeting with the patient, family, friends and professionals can be the main place where the therapeutic path begins.	1	2	3	4
2. An approach based on dialogue and relationship is not particularly effective for patients with schizophrenic disorder.	1	2	3	4
3. The center of treatment should be the meetings between the patient and the psychiatrist.	**1**	**2**	**3**	**4**
4. During psychotic onsets it is advisable to remove the patient from the usual place of life, even without real danger of harmful acts for himself or others.	1	2	3	4
5. Among the main objectives to be achieved, when a non-acute patient comes into contact with the services, there are overall diagnosis and pharmacological prescription.	1	2	3	4
6. The possibility of participating in therapeutic meetings in the presence of family members and care services must be guaranteed to all patients, even in hospitalization regime.	1	2	3	4
7. Patient's family and friends opinion can have the same importance as professionals in guiding the therapeutic process.	1	2	3	4
8. The care process for a person with a mental disorder tends to follow a predetermined path.	1	2	3	4
9. Only clinically stable patients can have the opportunity to actively influence the decision-making process.	1	2	3	4
10. After the first request for help, it is advisable, among the available interventions, to propose hospitalization in order to assess the situation in a protected and professional place.	1	2	3	4
11. Intervening within 24 hours from the first request for help can positively influence the course of a psychotic crisis.	1	2	3	4
12. It is good to adapt the therapeutic response to the specific patient, as a general recommendation.	1	2	3	4
13. Among the main goals to be achieved in the care of people with psychiatric disorders there is the involvement of significant relations and families.	1	2	3	4
14. Is preferable that a single team take care of patient for the entire duration of the treatment process, in favor of the effectiveness of the intervention.	1	2	3	4
15. If a good dialogue is established within the therapeutic meetings, it is good that patient's family opinion influences the treatment path.	1	2	3	4
16. Inviting to therapeutic meetings all the services that are taking care of the patient can promote the effectiveness of the intervention.	1	2	3	4
17. All participants in the therapeutic meeting can express themselves in front of the patient and family, including with regard to drugs and hospitalizations.	1	2	3	4
18. It is recommended that professionals respond to what the schizophrenic patient says by trying to relate to the person who he says he is.	1	2	3	4
19. At the end of the therapeutic meetings, it is advisable for professionals to reflect among themselves, in the presence of everyone, on their own ideas and feelings about the situation.	1	2	3	4
20. Among the primary purposes of the therapeutic meetings are the interpretation of the patient's needs and the evaluation of symptoms that will be used for diagnosis.	1	2	3	4
21. I have had direct experience of Open Dialogue meetings conducted by trained colleagues.	1	2	3	4
22. Working years in the public health service:	Less than 10 years. ☐	Between 10 and 20 years. ☐	More than 20 years. ☐	

Tab. 2 – *The questionnaire*



Tab. 3 – *Professionals' experience in public health service, MHC Modena Est*



Tab. 4 - *Professionals' experience in public health service, MHC Pavullo*

ators declares to have been working in public services for more than twenty years. Specifically, Modena Polo Est reaches a 73%, against an 11% of those with less than 10 years in the same field. By these data, it could be argued the plurennial experience of work in the public services of the sample and the full compatibility with the aim of this study.

Remarkable results are here displayed.

The third item requires further analysis. Its question regards the operators' behaviour towards the setting of the therapeutic path for someone affected by a mental disorder. The result is emblematic, since it reveals two opposite perspectives. The 55% of the interviewees believes that the treatment should not necessarily be focused on the classical conversation between patient and psychiatrist. A 43% could be described as more loyal to traditions, thus confirming the most recurrent practice among services. No statistically relevant differences appear to emerge from the distribution of answers between the two groups.

Item n. 5 recalls the mentioned concept of tolerance of uncertainty. The 48% declares that, when a patient comes to the service for the first time in a non-acute phase, the two main goals to reach are the diagnosis and drug-prescription.

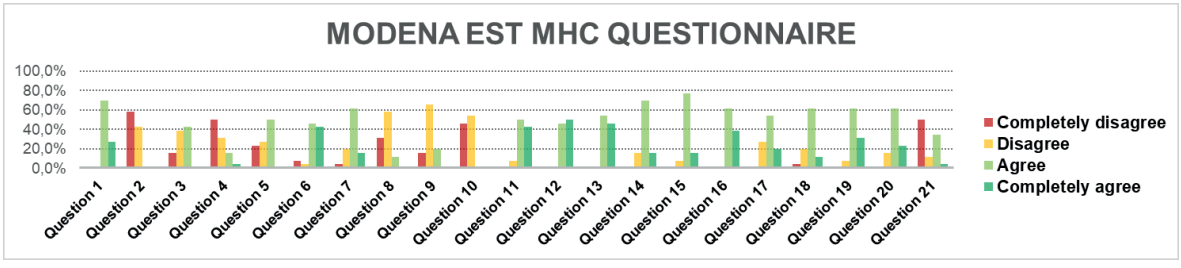
The 17th item highlights a consistent willingness to a free exchange of views concerning drugs and hospitalisations, despite the sensitive matter of cure, which is traditionally relevant for specialists. By contrast, it is also observed a minor discrepancy in the number of interviewees (31%), in addition to the differences between the two groups. Adding participants disagreeing or totally disagreeing within each group, the following percentages are produced: 27% for Modena Est and 36% for Pavullo.

DISCUSSION

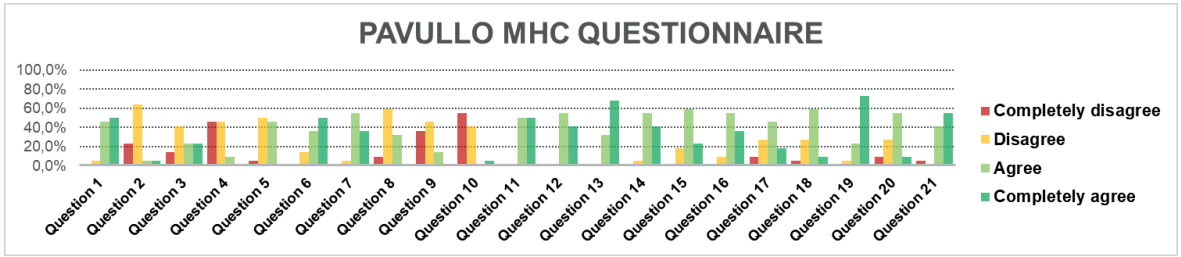
Health professionals involved in this study appear to have been working in the sector for more than twenty years, agreeing with the 19 years registered by the *Annual Count of Health workers 2018*[13] of the Italian Ministry of Economy and Finance. Experts in the field of mental health are usually older and it seems thought-provoking to consider their disposition towards the introduction of new approaches such as the OD.

Being an essential part of their job, dialogue and relationship are well-known concepts for insiders, in addition to the normalisation of symptoms and the emphasis to patients and families' polyphonic narration. The affirmation of dialogue in the Italian psychiatric world derives from Basaglia's experiences.

The network perspective is shared by broad assent and it is expressed through the involvement of families, of social networks and services within therapeutic shared meetings. Ideally, patients and their



Tab. 5 - *MHC Modena Est Results*



Tab. 6 - *MHC Pavullo Results*

families are allowed to actively participate in the decision-making process of the therapeutic path, even in the case of hospitalization. Results seem coherent with the research conducted by Giusti[14], who in 2017, using an original RKI[15] questionnaire, investigated mental health operators' attitude when recovering patients. The 70% of respondents admitted to be favorable to the direct involvement of the patient in the decision-making process of his therapeutic path, even in cases of clinical instability.

Insiders react flexibly to patients' needs, trying to adapt their therapeutic path to each case and sharing prompt action. This last disposition is not only coherent with the Dialogic Approach, but also with the *Recommendations of Emilia Romagna Region*[16] concerning the major efficacy of early interventions in treating early psychotic patients.

Continuity is acclaimed as a pivotal factor to be granted during the therapeutic path, and is established by the existence of a unique team responsible for each case.

Operators seem aware of the need to avoid exposed, automatized interventions such as hospitalisations and unfruitful home displacement. This ideas confirms the data gathered in the 2018 by the Mental Health Report[17], which registered an Italian psychiatric hospitalisation rate of 1,9 every 1000 inhabitants, a result that is slowly diminishing. The OHT[18] follows this negative trend: in Emilia Romagna 910 OHTs were registered out in 2018, in slight decreased compared to the 995 of 2016.

Continuity is acclaimed as a pivotal factor to be granted during the therapeutic path, and is established by the existence of a unique team responsible for each case.

During meetings, transparency plays a crucial role in conversations between professionals and patients and between operators. This element may represent the main turning point in the distribution of dialogical power.

Generally, differences emerge between operators who had experience of the OD and inexpert ones. The more OD-experienced MHC appears to prefer the Dialogic Approach, especially if compared to the untrained one. It should be emphasised that the trend linked to the application of OD switches in relation to the homogeneity of therapeutic paths, to the direct involvement of the families in the decision-making process and to considerations on elements dealt by experts (items n. 8, 15,17). Indeed, the Pavullo group is more conformed to the Dialogic approach compared to Modena's. As a result, an unexpected outcome was achieved.

The free expression of thoughts during the therapeutic meeting, the normalisation of symptoms, the emphasis on personal story, the need to interpret patient's needs and the evaluation of symptoms favourable to diagnosis (items 17, 18 and 20) remain for more than a quarter of operators. Their feelings, reasonably influenced by professional habits, remain partly centred on the diagnosis, on the greater weight of specialist's opinions and on the answers given in short time. This trend clearly emerges from the centrality of the interview with the psychiatrist and the tolerance of uncertainty (item 3, 5): the respondents split in two opposing sides.

As discussed above, the OD suggests a progressive detachment from the medical-centric perspective, and rather proposes a multidisciplinary approach, together with the full involvement of social networks around the patient. Being able to wait and listen to patients avoids automatized interventions, which could not leave time to the identification of patient and his network's needs. Allowing moments of dialogue when concerning the pharmacological treatment reveals that listening is the main goal and that answers follow. Half operators declared that the core of the treatment of a patient with mental disorder remains the conversation with the psychiatrist. Although not in an acute phase, the other part of participants admitted that diagnoses and pharmacological prescriptions continue to prevail. They are peculiar outcomes, inscribed within the long-standing dispute about the dysfunctionality of the medical-centric approach and the abuse of diagnoses and pharmacological prescriptions. In 2017, the British Psychological Society[19] suggested to go beyond this model and referred to previous scientific research. It stated that behaving in a one-dimensional and simplistic way with patients with multifactorial problems and complexes was unjustifiable, in addition to the stubbornly avoidance of the biopsychosocial approach of network.

In the same year, the NIMH (National Institute of Mental Health) declared that the actual system of diagnostic categories was relatively efficient in the improvement of patients' health and sensibly limited clinical choices[20]. Professionals, understaffed and underpaid, still result in being prone to bureaucratic and administrative mechanisms such as the justification of the drug, the legal-financial coverage and the strict deadlines dictated from the delivery setting of mental health services (NIMH, 2017).

To avoid mechanical answers it seems necessary to detach from the medical-centric model. This is possible through a right number of trained operators. In this regard, Starace affirms that two main advantages would derive from the increase in the number of operators in the Italian CSM. From one hand, it would diminish the workload, its consequent job-stress related syndromes and the number of antipsychotics (Starace F. et al., 2018). From the other hand, the total capacity of assistance in the MHC should increase. Today this capability stops at the 55,6% of the general demand of assistance (Starace F. et al., 2019).

The following limits were posed in this study in order to avoid influencing the results:

- Limited amount of sample (48 units);
- Restricted location as object of analysis (Modena, Pavullo);
- The questionnaire was built during this work on the basis of an already-existent tool. As a result, it was not validated by literature;
- Possible different interpretations of some questions by the interviewees.

CONCLUSION

After the analysis of the data and their results, it is possible to draw some conclusions:

- The Dialogic approach is already employed in the disposition and in the behaviour of mental health experts.
- Operators with DA experience appear favourable to its principles and key elements.
- Two main concepts, however highly debated,

emerge from the study: tolerance of uncertainty and the medical-centric model. These two aspects are aimed at redefining mental disorders inside the services from a dialogic perspective.

- Tolerating uncertainties, multi-professional interactions and the involvement of the social networks around the patient have a considerable relevance when curing mental disorders. Moreover, they regard theoretical trends and promote their adoption.

Firstly, this study implies that reorganising Italian MHCs is essential, especially basing on multi-professionalism, on social networks and on tolerance of the time needed. The final aim is to build relationships and dialogue between patients, networks around them and professionals.

Secondly, the concepts of network and tolerance of uncertainty should prevail in the dialogic formation of the staff.

In the following years, mental health services should invest wisely and coherently with the scientific evidence and the health needs. What is at stake are the quality and efficacy of intervention, together with patients and professionals' well-being.

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