GUIDANCE ON REMOTE WORKING FOR SECONDARY MENTAL HEALTH TEAMS IN THE ODDESSI RESEARCH PROGRAMME

Produced by the ODDESSI Remote Working Guidance Group

With contributions from:

Professor Stephen Pilling

Dr Russell Razzaque

Catherine Thorley

Mark Hopfenbeck

Dr Thomas Cant

Yasmin Ishaq

Professor Jaakko Seikkula

Annie Jeffrey

Katherine Clarke

Georgie Parker

Benjamin Brandrett

Rosie Powell Davies

The ODDESSI Lived Experience Advisory Panel

Contents

Summary

This document aims to provide guidance on remote delivery of care for the secondary mental health teams involved in the ODDESSI programme in light of the coronavirus pandemic and resulting restrictions on patient contact. More information about the ODDESSI programme, and the knowledge base from which this guidance was developed, is outlined in the Background section of this document. This is followed by three sections of guidance. Teams have both national and local guidance and procedures to follow, but this document focuses on any additional considerations for crisis and community mental health teams (in Section 1) and Open Dialogue teams (in Sections 1, 2 and 3) who are part of ODDESSI.

Section 1: Guidance on remote delivery of secondary care mental health services
This section provides guidance on service delivery relevant to all secondary mental health teams involved in ODDESSI. As part of the research programme, we measure how services adhere to their intended model of care (through 'fidelity' assessments), and this section is intended to highlight any additional considerations for fidelity when working remotely. It will be of particular relevance to leads and decision-makers within crisis and community mental health teams, and Open Dialogue teams.

Section 2: Guidance on remote delivery of an Open Dialogue Service
This section provides guidance on maintaining fidelity to Open Dialogue in terms of service delivery (and relates to the Open Dialogue elements of the fidelity assessments). Open Dialogue team managers and senior staff supporting Open Dialogue service delivery may find this section particularly relevant.

Section 3: Guidance on remote network meetings
This section provides guidance on maintaining adherence to the key principles of Open Dialogue within network meetings when conducting them remotely, and as such is relevant to all practitioners who deliver network meetings. As part of the research programme we assess this 'adherence' through rating audio recordings of network meetings.

Background

ODDESSI Programme

ODDESSI (Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness) is a large-scale NIHR-funded programme of research into crisis and continuing mental health care within the NHS, running from 2017–22. It includes a large multicentre cluster randomised controlled trial that seeks to examine the clinical- and cost-effectiveness of Open Dialogue in comparison with 'usual care', and whether Open Dialogue is acceptable to staff and service users.

Study participants in the intervention arm of the trial are offered Open Dialogue, a social network model of crisis mental healthcare that is person-centred and recovery focused. It was originally developed in Finland in the 1980s by staff trained in family and systemic therapies. Open Dialogue teams work systemically to enable an individual and their social network to utilise their own resources and give rise to a sense of agency (Razzaque & Stockmann, 2016). The model is designed to provide a collaborative and non-hierarchical approach to care. Both social and professional networks of the individual in crisis are brought together in network meetings to make decisions about treatments and interventions (Olson et al., 2014). These meetings aim to provide continuity of care (Freeman et al., 2019), as Open Dialogue is both a community-based integrated system of care and a therapeutic intervention centred around therapeutic conversations (Olson et al., 2014).

Participants in the 'usual care' arm receive existing NHS care, which might include psychological therapies and/or drug treatments. Support is provided by doctors and other healthcare professionals from various services, including crisis resolution home treatment teams and community mental health teams.

The coronavirus pandemic and resulting lockdown restrictions have required mental health services in the UK to change the way care is delivered since April 2020. The NHS has encouraged a move to remote delivery where possible and this has been enacted in many community-based mental health teams, including the usual care and Open Dialogue teams in the ODDESSI trial. In this guidance, we use the term 'remote delivery' to refer to mental health care delivered over the phone or via video conferencing software.

Remote delivery of complex interventions

Remote delivery of complex interventions is an important way of ensuring that mental health care can still be provided while face-to-face contact is restricted. It has previously been seen as a way to embrace the pervasiveness and influence of digital technologies, as well as a way to circumvent barriers which may typically impede access to therapy. There are several examples of projects seeking to harness digital platforms, including tablets, smartphones, apps, and wearable devices to inform and enhance clinical care (Biagianti et al., 2017).

A systematic review by Hubley et al. (2016) conducted with a general psychiatric population found that remote delivery was reliable for conducting clinical assessments, produced equivalent treatment outcomes and was as cost-effective as face-to-face sessions. Furthermore, a number of case studies and small trials suggest that family therapy via telehealth is effective and well-received by patients and providers (Hill et al., 2001; Dausch et al., 2009; Comer et al., 2017). Because these studies were conducted before the coronavirus pandemic, they tended to focus on specific communities with limited physical access to services, such as those in rural and remote settings (Shore, 2013), rather than the now widespread need for remote delivery of clinical services.

Remote delivery of Open Dialogue

Open Dialogue has been delivered both in person and remotely since its inception. The original developers of Open Dialogue continue to conduct remote network meetings with individuals internationally. 'Dialogue First', a peer-supported Open Dialogue service based in North-East London Foundation Trust (NELFT), regularly delivers remote sessions. They accept referrals from across the country, and so have clients from a large geographical area where travel to network meetings would be a significant barrier to access. Although until recently Open Dialogue teams in the ODDESSI programme have predominately delivered care 'in person', they have rapidly adapted to also deliver Open Dialogue remotely.

Remote Working Guidance Group

An ODDESSI Remote Working Guidance Group made up of Open Dialogue practitioners, peers, trainers, and researchers was established to support teams working remotely. The objectives of the Remote Working Guidance Group are to:

1. provide guidance to all Open Dialogue and usual care teams in the ODDESSI programme on remote working
2. provide guidance to Open Dialogue teams on service structure considerations when adapting to increased remote working
3. provide guidance to Open Dialogue teams on remote delivery of network meetings
4. gather experiences of remote Open Dialogue delivery from staff and service users.

This document has been produced to provide advice for Open Dialogue and usual care practitioners within ODDESSI, and is intended to be used alongside relevant guidance provided by the NHS and other organisations (NHS England & NHS Improvement, 2020; NHSx, 2020; British Association for Behavioural and Cognitive Psychotherapies [BABCP], 2020). This document has been created in consultation with service users, families, teams, Open Dialogue trainers, and a Lived Experience Advisory Panel, whose contributions can be found in indented paragraphs throughout.

Following the dissemination of this guidance, we will continue to collect the experiences of Open Dialogue practitioners and service users. It is hoped that this will result in a rich body of knowledge that can be disseminated more widely to support services that are remotely delivering other complex psychosocial interventions.

Section 1: Guidance on remote delivery of secondary care mental health services

In light of the coronavirus pandemic, several remote working guidance documents have been produced for healthcare workers and practitioners (NHS England & NHS Improvement, 2020; NHSx, 2020; BABCP, 2020). These are useful resources for all ODDESSI Open Dialogue and usual care teams, and should be reviewed alongside local and model-of-care-specific documents. Some key points from these documents are summarised below.

NHS England and NHS Improvement (2020):

- Outline the potential communication options to patients before treatment begins, along with clear, reasonably adjusted information on how treatment will be delivered remotely.
- Try not to assume delivery methods such as video calls are unsuitable for certain groups, for example older adults.
- Ensure working from home spaces are suitable (and free from confidential information).
- Encourage and use good lighting when engaging in video calls (for example, try not to have bright light sources behind individuals).
- Ensure alternative plans are in place should technology fail.

BABCP (2020):

- Practice using unfamiliar technology and allow plenty of time to log on before meetings start.
- When choosing a platform for video calls, consider its security. Does it have end-to-end encryption? Are videos recorded? If so, where are they stored and who owns them?
- If taking notes during a meeting, consider using paper because typing can be loud and distracting for others.

NHSx (2020):

- Make sure internet access is secure: use a private network and avoid public Wi-Fi.
- When using own devices, consider setting a strong password and only using secure channels.
- NHSmail and MS Teams are recommended for communication between colleagues.

ODDESSI

Within ODDESSI, we measure levels of fidelity (delivering the service according to the intended models of care) in all teams. The ODDESSI measure of fidelity (see Appendix A) remains unchanged, yet some additional areas of focus following the increase in remote delivery are provided below.

Training

If a service is rapidly increasing levels of remote delivery, managers should consider holding a period of more intensive training or workshops followed by regular check-ins. Additional knowledge and skills will become essential, such as knowledge of updated policies and procedures, and skills to use technology effectively. Training should be based around local need, but we suggest focusing on:

- locally recommended or approved technologies: how to use them, how to help service users use them, and relevant data protection or security considerations
- making adaptations to face-to-face sessions, such as use of personal protective equipment or distancing
- the personal impact of increased working from home: benefits and challenges, practical advice on managing distractions, structuring time and taking breaks.

Remote service capacity

Appropriate access to technology is essential to ensure service capacity with increased remote working. This will most often be personal access to phones and laptops that support contact with service users and colleagues, and that enable access to secure NHS systems. Shared equipment or accounts may disrupt the ability to respond promptly to service users when necessary (for example, when there is a safety concern with associated 'expected response' times).

> *Open Dialogue trainers advise that multiple video conferencing or teleconferencing 'accounts' are needed for each team using them. This ensures staff can arrange meetings efficiently.*

Focus groups held with staff and service users have indicated a preference for platforms that are easy to navigate and are used more broadly than within health services. However, the digital platform available to mental health teams will likely depend on trust policy and local information technology department support rather than their own preference. Local guidance should be sought on particular considerations for the platform. For example, Microsoft Teams displays practitioner email addresses to others in the call, so teams should consider any implications of this and how it should be managed.

Risk management and safeguarding

Risk management and safeguarding policies should be updated to cover remote working, and any changes should be openly discussed within the team. Managing risky situations remotely is a particular concern for staff; in particular, what to do when a person does not engage in a video or telephone call. In some instances, face-to-face contact should be prioritised because of concerns. Within sessions, some staff have found it useful to ask questions about who else is present and whether they feel able to talk openly, or to use the 'chat' function on some video platforms.

> *One member of staff mentioned the relief they felt when they learnt that a service user was not alone at home and would have support after the call had ended.*

Access to service

Decisions about in-person or remote delivery

It is important that each service user is involved in decisions about whether meetings should take place remotely, the method of remote delivery, or the location and conditions of an in-person meeting. These choices should include a consideration about service users' needs and preferences as well as any other restrictions the mental health teams are working within.

Monitoring equality of access

Services should attempt to examine and monitor whether increased remote working is impacting the accessibility of the service: assessing whether the time taken to process referrals has changed, and whether certain groups (such as those who are most unwell) are less likely to use the service. Avoiding calling from a blocked or withheld number, asking for help with contact from friends or relatives of the person, and prioritising face-to-face meetings may help access.

> *Some relatives of our contributors experience mistrust and paranoia around telephones when unwell, making remote access to services difficult or impossible at a time where it is particularly important.*

Access to remote meetings

When service users do not have the means to participate in video calls but wish to, efforts should be made to support access: perhaps through exploring any community services that loan technology (such as 'community hubs'). Clear information is also needed, in advance, about how to connect to meetings, as well as an alternative phone number to use in case of any difficulties connecting. Wherever possible, services should ensure costs of phone and video calls are borne by the service.

Section 2: Guidance on remote delivery of an Open Dialogue Service

The core principles of Open Dialogue service delivery (immediate help, a social network perspective, flexibility and mobility, responsibility, and psychological continuity; Seikkula et al., 2003) remain when working in person or remotely. Here we detail some key considerations to maintain fidelity of Open Dialogue service delivery with reduced face-to-face client contact.

Intervision and self-work

Weekly intervision remains vital for staff to feel supported and to manage risk.

> *Staff have reported that, although it can be hard to find time, intervision feels particularly important while working remotely, and gives staff the time to reflect.*

Both Open Dialogue trainers and staff in focus groups felt that a video connection (rather than just audio) is strongly preferred for intervision, and staff must be provided with access to this wherever possible. To support equality of voices and reduce technical problems (like audio-feedback) it can be useful to sit in separate spaces (or use earphones/headsets) and connect using individual devices. Teams will continue to develop creative ways to use technology to support intervision:

> *Team members who are not taking part in a reflection could turn off their video and audio, leaving those who are reflecting with their camera and sound on.* This mirrors the physical separation that happens during a 'fishbowl', when some team members move into a separate physical space to reflect while others observe.

It is important that staff continue with a regular schedule of self-work, which could include a focus on increased working from home, the suitability of their physical work space at home, any feelings arising from personal spaces being shown, and being able to see your own face during video meetings. Informal catch-ups are also important, helping to boost morale and keep the team connected.

> *Some teams have a video catch-up at the end of every day to check in with each other. These focus on talking about their own wellbeing, and not work tasks.*

For some, delivering Open Dialogue remotely has meant more flexible and convenient appointment times and a large reduction in time needed for travel. The impact of back-to-back meetings on practitioners should be actively considered, with particular attention paid to how many meetings practitioners participate in each day, and whether there is sufficient time for rest and for other tasks.

Assertive engagement

It is advised by Open Dialogue Trainers that at least the first network meeting take place in person before moving to remote working, in order to build familiarity and trust and to help later recognition of voices. However working in a flexible and collaborative way to engage the network is key.

> *It has been difficult to know who is talking when meetings have taken place over the phone with a network who are new to each other.*

Remote delivery has allowed some networks to expand, although others have been uncomfortable using group calls and so engage with more one-to-one sessions. Flexibility and responding to individuals' needs to increase engagement continues to be paramount.

Flexibility of response and community links

It is important that teams continue to respond flexibly to service user's needs and 'signpost' to a range of other services, bearing in mind that the coronavirus pandemic may have changed the needs of some people (because of increased isolation or lack of technology), and changed access to previous provision of community support (with some services restricting physical access).

Section 3: Guidance on remote network meetings

The key elements of a network meeting remain, whether delivered in-person, over video or over the phone. A measure of adherence (see Appendix B) has been developed, which is based on the 'twelve key elements' of Open Dialogue (Olson et al., 2014). To meet good adherence to the model, this section describes important considerations, from arranging an initial meeting, to during and ending a meeting.

Arranging a network meeting

The initial conversation between practitioners and people who have been referred to them often includes an open conversation about how and when they might arrange a meeting, and who should be invited to that meeting. It is now important to include in this conversation the additional options that might be available, such as meeting via a video-conferencing platform, and explore questions that arise from this. The same principle of flexibility remains, and practitioners will continue to respond to the needs of each network. Adaptations might be useful, such as arranging a 'practice run' connecting to a video network meeting to help them feel more comfortable using the technology.

Practitioners should share information about any restrictions on face-to-face meetings (such as wearing PPE, social distancing or temperature testing). Focus groups held with staff have revealed the difficulties in engaging in network meetings while wearing PPE, because of feeling uncomfortable, finding it hard to hear one another and missing feedback from facial expressions.

> *Open Dialogue teams have reported that having an open and collaborative conversation with the network before remote meetings commence is helpful. This has allowed them to hear the networks views and preferences for conducting remote sessions.*

Practitioners should aim to ensure that they are able to be 'present' during remote network meetings, when there might be distractions. Using earphones or a headset can help to block out external noise. Practitioners may also be able to look at ways to remove likely distractions. For example, they might set email and other messaging platforms to 'Do Not Disturb' or close them down, so there are no audio or pop-up notifications during the meeting, and put phones away from sight.

Beginning network meetings

Beginning the meeting with an 'arrival period' sets aside time for technical and connectivity issues to be resolved. This might mean starting the remote meeting connection at a certain time but explaining that you won't expect to start for ten minutes after that. Remote meetings can feel less personal, so a more informal beginning can help members of the network become more familiar with one another.

> *An arrival period at the beginning of remote sessions, with the space for small talk and checking everyone has a cup of tea that wants one can really help everyone to 'settle in'.*

During network meetings

Pauses and silences are an important part of network meetings, but have been identified as more difficult when meeting remotely, particularly if connecting via audio only. However, with increased practice in delivering remote network meetings, this difficulty seems to reduce.

> *One Open Dialogue trainer said that silences during remote meetings can be misconstrued as problems with network connections and thus be interrupted. It is important, therefore, that silences are spoken about openly within the network.*

When members of the network are not in the same room, reading body language or visual cues is more difficult or not possible. Practitioners may need to say individuals' names more to direct a question and **elicit multiple viewpoints**. They could also ask the person at the centre of concern or their network to describe visual information.

> *One Open Dialogue practitioner described asking questions such as "If I were with you what would I be seeing?" or "Would I be seeing tears if I were with you?" when conducting network meetings on the phone.*

It is important that practitioners share their own experiences during remote network meetings, where appropriate, in the same way as they would in a face-to-face meeting, because it will improve the flow of dialogue and polyphony.

> *Dialogue First practitioners noted that sharing their own experiences helped build the connections between themselves and the network, and allowed them to continue being authentic while working remotely.*

However, it should be noted that some practitioners have also noticed networks sharing more in this remote context than they had previously in face-to-face meetings. Video network meetings can provide the opportunity for network members to pick up on subtle visual cues, because faces are viewed more in close-up on the screen than they might be in a large room. This can allow for more responsive conversations and elicit more viewpoints.

> *Dialogue First practitioners and trainers have described how it is easier to pick up on facial expressions or reactions which might be missed if the meeting took place in a large room.*

Practitioners have found **holding reflections** within remote network meetings challenging, particularly initially. They have found themselves explicitly introducing a reflection more often than they have in person. Technology can be used in creative ways to promote the principles that underpin Open Dialogue. It may be that teams need extra equipment to explore these options.

> *One Open Dialogue practitioner has tried placing a detached webcam above the person of concern on their screen. This means they are looking more directly at the person when talking with them, while looking more away when, for example, carrying out a reflection with other practitioners.*

> *Dialogue First practitioners have sometimes felt that using the mute button feels like disconnecting from the network, and so often agree with the network to avoid this.*

Ending network meetings

Practitioners may want to set aside 5 or 10 minutes at the end of a network meeting in which more informal conversations might happen, such as asking the network about their plans for immediately after the meeting. It could be useful to allow the individual of concern or their family to take charge of ending the session, where possible, so that the meeting is ended on the network's terms, rather than an abrupt, practitioner-led decision.

> *Open Dialogue practitioners and service users have described finding the end of remote network meetings, where the video call 'ends' and disappears, as abrupt and sometimes unsettling.*

If possible, practitioners could leave the video connection running for a few moments, allowing the remainder of the network to speak with one another before deciding to leave the connection when they feel ready and have said their goodbyes.

Conclusion

This document outlines staff and service user experiences of remotely delivered Open Dialogue as part of the ODDESSI programme. It also provides guidance on ensuring fidelity and adherence are maintained in Open Dialogue and usual care teams while working remotely. This guidance has been shaped by the ODDESSI Remote Working Guidance Group, and incorporates input from focus groups held with staff and service users who have engaged in remote network meetings. We plan to continue gathering experiences of staff and service users over the coming months, and incorporate these into future guidance. We hope that by continuing to gather the experiences of staff and service users, we can begin to describe the differences and similarities in mental health care when delivered in person or remotely. This knowledge base can then be used to inform interpretation of the ODDESSI trial outcomes and be used to support others offering remote mental health care.

References

Biagianti, B., Hidalgo-Mazzei, D. & Meyer, N. (2017). Developing digital interventions for people living with serious mental illness: perspectives from three mHealth studies. *Evidence Based Mental Health*, *20(4)*, 98-101. doi: 10.1136/eb-2017-102765

BABCP. (2020, July 03). *Tips related to remote therapy provision.* Retrieved from https://www.babcp.com/Therapists/Remote-Therapy-Provision.aspx

Comer, J. S., Furr, J. M., Carpenter, A. L., Kerns, C. E., DeSerisy, M., Myers, K. M., … & Chase, R. (2017). Remotely delivering real-time parent training to the home: An initial randomized trial of internet-delivered parent-child interaction therapy (I-PCIT). *Journal of Consulting and Clinical Psychology*, *85(9)*, 909-917. doi:10.1037/ccp0000230

Dausch, B. M., Miklowitz, D. J., Nagamoto, H. T., Adler, L. E. & Shore, J. H. (2009). Family-focused therapy via videoconferencing. *Journal of Telemedicine and Telecare*, *15(4)*, 211-214. doi: 10.1258/jtt.2009.081216

Freeman, A. M., Tribe, R. H., Stott, K. C. & Pilling, S. (2019). Open Dialogue: A review of the evidence. *Psychiatric Services*, *70*, 46-59. doi:10.1176/appi.ps.201800236

Hill, J. V., Allman, L. R. & Ditzler, T. F. (2001). Utility of real-time video teleconferencing in conducting family mental health sessions: Two case reports. *Telemedicine Journal and E-Health*, *7*, 55-59. doi:10.1089/153056201300093930

Hubley, S., Lynch, S. B., Schneck, C., Thomas, M. & Shore, J. (2016). Review of key telepsychiatry outcomes. *World Journal of Psychiatry*, *6(2)*, 269. doi: 10.5498/wjp.v6.i2.269

NHS England & NHS Improvement. (2020, July 03). *IAPT guide for delivering treatment remotely during the coronavirus pandemic.* Retrieved from https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/Final-C0042-MHLDA-Covid-19-Guidance-IAPT-.pdf

NHSx (2020, July 03). *COVID-19 information governance advice for staff working in health and care organisations.* Retrieved from https://www.nhsx.nhs.uk/covid-19-response/data-and-information-governance/information-governance/covid-19-information-governance-advice-health-and-care-professionals/

Olson, M., Seikkula, J. & Ziedonis, D. (2014). The key elements of dialogic practice in Open Dialogue. The University of Massachusetts Medical School. Worcester, MA.

Razzaque, R. & Stockmann, T. (2016). An introduction to peer-supported open dialogue in mental healthcare. *BJPsych Advances*, *22(5)*, 348-356. doi:10.1192/apt.bp.115.015230

Seikkula, J., Alakare, B., Aaltonen, J., Holma, J., Rasinkangas, A. & Lehtinen, V. (2003). Open Dialogue: Treatment principles and preliminary results of a two-year follow-up on first episode

schizophrenia. *Ethical Human Sciences and Services*, *5(3)*, 163-182. doi: 10.1891/1523-150X.5.3.163

Shore, J. H. (2013). Telepsychiatry: videoconferencing in the delivery of psychiatric care. *American Journal of Psychiatry*, *170(3)*, 256-262. doi:10.1176/appi.ajp.2012.12081064

Appendices

Appendix A: The CoMFideS measure of Fidelity

Community Mental Health Fidelity Scale (CoMFideS)

This **Co**mmunity **M**ental Health **Fide**lity **S**cale (**CoMFideS**) is designed to measure the programme fidelity of the Open Dialogue and standard crisis and community care.

The scale addresses four aspects of service provision:

1. Team structure and culture
2. Access and engagement
3. Delivery of care
4. Community support

Additionally, an Open Dialogue addendum evaluates the extent to which Open Dialogue teams as a whole support and enact specific dialogical operational principles.

TEAM: _____	☐ **CAU** ☐ **OD**	☐ **Managers** ☐ **Practitioners**

DATE: _____/_____/_____ **RATED BY (INITIALS): _____**

TEAM STRUCTURE AND CULTURE	1 Limited evidence	2 Somewhat present	3 Mostly Present	4 Fully present
1. Team ethos and comprehensiveness Comprehensive, well-articulated, and shared model of care.				
2. Staff training Staff are trained and competent for their role, and their training needs are addressed and reviewed.				
3. Supervision There is a clear supervision model and all team members receive regular supervision.				
4. Staff roles Composition of the team is consistent with core team functions, and there are clearly defined roles and responsibilities within the team.				
5. Staff Satisfaction & Team Cohesiveness Staff feel well supported, valued, and part of a team.				
6. Team capacity Staffing levels are sufficient to effectively meet the needs of the team caseload.				
7. Safety Policies for risk management and protecting people at risk of harm (for clients, their families, and staff members) are in place and are openly discussed within the team.				
8. Client involvement in co-production Clients are involvedin the development, planning, and evaluation of the team.				

ACCESS AND ENGAGEMENT	1 Limited evidence	2 Somewhat present	3 Mostly Present	4 Fully present
9. Access to the service Referral criteria and population served are explicit and understood by all staff members.				
10. Providing information Clients are provided with clear information about the ways of working and interventions provided by the team.				
11. Prompt action The team is able to respond to new referrals and emergencies within its specified response times.				
12. Identification of support systems Client's support systems are identified, considered and engaged where appropriate.				
13. Flexibility of response Care provided is adapted to individual needs and circumstances (including health, education, social and employment).				
14. Assertive engagement Team makes any reasonable effort to engage with the clients, including attempting contact through friends/family, professionals and communities.				

DELIVERY OF CARE	1 Limited evidence	2 Somewhat present	3 Mostly Present	4 Fully present
15. Outcome monitoring Formal individual or service-level data (such as individual mental health assessments and/or service use metrics) is used to evaluate the work of the team.				
16. Continuity of care Systems are in place (e.g. individual staff members, joint working arrangements, clinical records) to ensure that continuity of care is provided				
17. Meetings with clients The client is actively involved in determining the timing, location, and agendas of meetings.				
18. Shared decision making Decisions regarding care and treatment are developed in collaboration with the client, and where decisions are made without the them (e.g. to ensure safety), the team is inclusive in their process and explanation with the client.				
19. Information-sharing and communication The content of records and written communication are shared and reviewed in collaboration with the client.				
20. Coordination of care Systems are in place to support the proper coordination of care, which are monitored and reviewed through appropriate service structures (e.g. electronic patient records, team meetings, delegation of responsibility to an individual tracking this)				
21. Client involvement in delivery of care People with current or past lived experience of mental health problems are involved with the team in the provision and/or advocacy (e.g. volunteering, peer support).				

COMMUNITY SUPPORT	1 Limited evidence	2 Somewhat present	3 Mostly Present	4 Fully present
22. Team links The team has effective links with a range of other mental health, social, and care services, and the team enables the access and utilisation of these links				
23. Community engagement The team actively engages with the client's support system in order to enhance access to the use of other care services.				
24. Carer involvement and support Family/carer's needs and support are considered and addressed including the provision of information about local support services for families and carers (e.g. carers groups, welfare advice, child support).				
25. Discharge and aftercare Care coordination/ or meetings include discussion and agreement of end of care, including referrals to other health and social care services, which is supported by a social support system or network.				

OPEN DIALOGUE ADDENDUM	1 Limited evidence	2 Somewhat present	3 Mostly Present	4 Fully present
1. Transparency - All discussions about the client and their network occur with them present. - There is a culture of 'nothing about them, without them' and neither the client nor members of their network are talked about when they are not present.				
2. Self-disclosure Professionals share their own lived experiences (self-disclosure) in both intervision and network meetings if deemed relevant and appropriate.				
3. Intervision frequency All members of the team meet at least weekly for intervision (or group supervision)				
4. Intervision content and structure -Intervision focuses on adherence to the key principles of Open Dialogue and the clinicians' own emotions and reactions, while minimising content of the actual case wherever possible. - Intervision includes team members sharing personal reflections in pairs/groups, reflections on which are then shared with team members.				
5. Team self-work - A regular programme of self-work is on-going within the team where such work is engaged in by all team members - Team members are encouraged to maintain a regular individual self-work practice				
6. Open Dialogue training All team members have completed or are undergoing an accredited Open Dialogue training.				
7. Open Dialogue continuing professional development (CPD) Team members attend regular (at least annually) CPD delivered by accredited Open Dialogue trainers.				

Open Dialogue Adherence Scale

A. Classifying Practitioners' Utterances Rating Tool		
MONOLOGIC	Clearly patronizing or disrespectful utterances that cause offence or hurt:	
	Clinical assessment (e.g. medication, symptoms, exam):	
	Other closed-ended question: Interpretations, hypotheses, labels, judgements. Needs to be imposing or technical	
	Unsolicited advice, information: Insensitively introduces new themes without asking, dominates conversation, a major break in topic	
	Misses/ignores important words or emotions, goes either forward too quickly or is too passive:	
DIALOGIC	History of idea of meeting/How to use the meeting:	
	Inner or outer polyphony: Refers to different roles, asks for alternative views, shares own inner thoughts, all voices are heard	
	Relational focus: Asks to reflect on others experiences and perspectives, encourages empathy, mutual understanding	
	Significant silence of 3 seconds or more: Goes slow, is patient, dwells on important themes, creates space for network to reflect	
	Normalising symptoms: Explores meaning, self-disclosure, relates present experiences as part of coping with previous experiences/traumas	
	Emphasising client's own words, responsive listening: Picks up on key words/emotions, mirrors, attunement using paralanguage, includes mm's and aah's (only count mm or aa when in response to a new notion or subject)	
	Emphasising present moment: Focuses on current thoughts, sensations, emotions, stays with whatever arises in the moment	
	Being transparent: Relevant information regarding decisions is offered, reasoning behind potential decisions is shared	
	Reflections: Non-interpretive, emotional focus, uses network's own words, validating, sensitive to what is important, tentative	
	Tolerating uncertainty: Acknowledges 'not-knowing', supports expression of and being with uncomfortable emotions and conflicting perspectives	
	Other dialogical (open- or closed-ended questions) utterances: Shows interest, engages in a natural, non-clinical conversation	

Total (M/D+M): _____

B. 12 Key Elements of OD Rating Scale	Not at acceptable level	Acceptable	Good	Excellent
1. Two (or More) Practitioners in the Team Meeting:				
2. Participation of Family and Network				
3. Using Open-Ended Questions				
4. Responding to Clients' Utterances *Responsive Listening, Simple Responses to Continue Conversation, Using client's words*				
5. Emphasizing the Present Moment *Respond to immediate reaction, respond to emotions but not interpret*				
6. Eliciting Multiple Viewpoints *Outer and inner polyphony*				
7. Use of a Relational Focus in the Dialogue *Focus on the relational aspects of the spoken stories*				
8. Responding to Problem Discourse or Behavior in a Matter-of-Fact Style and with Meaningful Dialogue *See symptoms as "natural" responses to stressful life situations*				
9. Emphasizing the Clients' Own Words and Stories, Not Symptoms *Help client find words to communicate more clearly? Pay attention to one word or sub-sentences?*				
10. Conversation Amongst Professionals (Reflections) in the Treatment Meetings				
11. Being Transparent *Shared Decision making. Disclose info on all discussions at the treatment meeting to all members present? Shared what practitioners do know and don't know?*				
12. Tolerating Uncertainty *No hasty judgments about symptoms, diagnosis or treatment? Understand and respond to whole person in context, rather than reacting to isolated behaviors?*				

C. Overall Quality Rating

	Yes	No
1. Was the proportion of dialogic statements (m/d+m in Section A) at least two-thirds (0.67)?		
2. Were at least 10 of the 12 fidelity items in Section B at the level of "Acceptable" or higher?		
3. Were there fewer than two instances of patronizing or disrespectful statements from the red box in Part A?		

Final Appraisal

Was the answer "yes" to all three items in C. Overall Quality?

☐ **Yes (quality and fidelity were acceptable)**

☐ **No (quality and fidelity were not acceptable)**

Notes