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### CHARM Society

Is the unincorporated supporters' group, meets monthly online, first Tuesdays 6.30pm

Contributions to this magazine welcomed, may be edited for length and access.

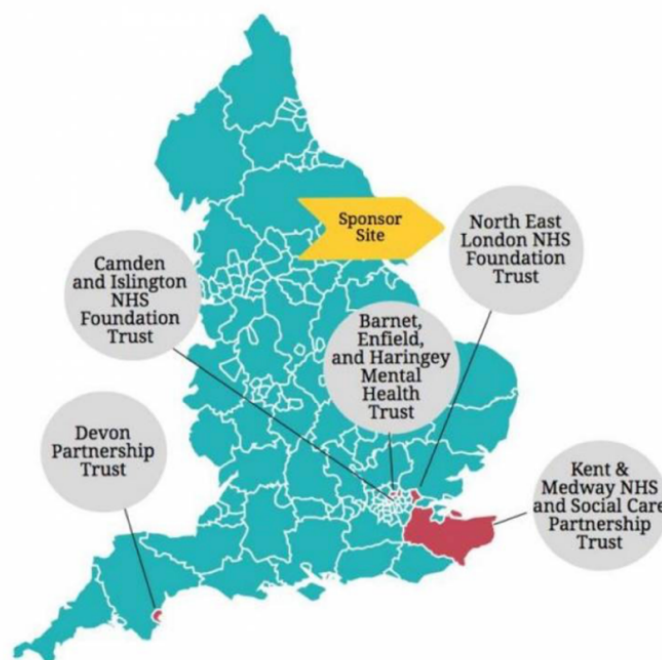
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CHARM Projects CIC  
Co. number 14437077

## Open Dialogue comes to Manchester

*“more effective than traditional psychiatric care”*

On pages 2, 3 and 4 we look in detail at the new methods of Open Dialogue, and the 19 March event below will be a great introduction to this new way of working. The University College London project in parts of London, Kent, and Devon is detailed.



## Manchester's broken care model

On pages 5 to 7 we look at new research and data on the shocking state of the Community Mental Health Teams, especially those based in Manchester.

## Diary shorts

- **Weds 19 Mar**, 9-5pm, *Open Dialogue and Peer Support*, free but pre-booking required, Manchester Deaf Centre M13 9GH. Details: <https://opendialogueCHARM.eventbrite.co.uk> Two workshop days follow.
- **Tues 1 April**, 6.30pm, monthly CHARM Society meeting, online
- **Mon 14 - Sun 27 April**, Norwich, *Not Safe for Treatment*, exhibition.
- **Sat 26 April**, Norwich, *National Conference for Grassroots Mental Health Campaigns and Campaigners*.

# Open Dialogue, an introduction

**The Open Dialogue system is a new mental health care approach, and it is more effective than traditional psychiatric care.**

It focuses on open communication, on family and social network involvement, and uses early intervention. It has gained international attention for its promising outcomes, particularly around psychosis.

## Key principles, especially number six

1. **Immediate help:** Response to someone's mental health crises is rapid.
2. **Social awareness:** The approach involves the person's family, friends, and other key social contacts in the treatment process.
3. **Flexibility in the community:** Services are adapted to the needs of each individual, often provided in home settings rather than hospitals.
4. **Continuity of care:** The same team remains involved throughout the person's care, and by working with the same clinicians over time, it fosters trust and better therapeutic relationships.
5. **Tolerance of uncertainty:** Practitioners avoid early diagnosis or prescribing medication too quickly, instead focusing on dialogue to understand the person's experiences.
6. **Dialogue-centred approach:** The emphasis is on open discussions where all participants' voices are valued equally.

## Outcomes and evidence

Studies in Finland suggest that Open Dialogue has led to better recovery rates for people with first-episode psychosis, with many avoiding long-term medication use.

Research has also shown reduced hospitalisation rates, lower use of antipsychotic medication, and a third better long-term social functioning (including return to work and study) compared to standard psychiatric care. There has been growing international adoption, including in the UK, the US, and several European countries, with pilot programmes testing its effectiveness.

## Challenges

It requires a significant shift in mental health professionals' training and mindset. It can be resource-intensive at the beginning, as it involves regular multi-professional meetings with families or networks. Yet the current broken mental healthcare systems are also expensive to run and they have poorer outcomes leading to more resource need.



## Open Dialogue in the UK

The NHS has been piloting Open Dialogue in various regions, aiming to integrate it into community mental health services. The **Open Dialogue Trial (ODDESSI)** is the largest UK-based study assessing its effectiveness compared to standard care: <https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/oddesi/oddesi-trial> (map on front page)

Their email is [oddesi@ucl.ac.uk](mailto:oddesi@ucl.ac.uk)

# Five features of open dialogue

## 1. Listening Without Preconceptions

Instead of diagnosing or interpreting immediately, professionals actively listen to the person in distress and their social network. There is no rush to find a solution; instead, space is given for different perspectives to emerge.

## 2. Polyphony (Multiple Voices)

Every participant's voice is equally important, including the person in distress, their family, and professionals. There is no single correct narrative; all viewpoints are acknowledged and valued.

## 3. Avoiding Premature Conclusions

Unlike traditional psychiatric settings, where labels and diagnoses are assigned quickly, dialogical communication tolerates uncertainty and allows the meaning of a person's experiences to develop over time. Medication decisions, if needed, are often delayed to prioritise dialogue.

## 4. Reflective Conversations

Practitioners openly discuss their thoughts and reflections in front of the patient and their family rather than making decisions behind closed doors. This transparency builds trust and encourages collective decision-making.

## 5. Focus on Relationships and Meanings

The emphasis is on how people relate to each other rather than focusing solely on individual symptoms. Mental distress is seen as a shared experience within a person's social context, rather than just an internal disorder.



(image: ODESSI trial)

## An example of open dialogue in practice

In an Open Dialogue meeting, a young person experiencing psychosis might describe hearing distressing voices. Instead of immediately pathologising this experience, the team would engage in a conversation like:

Practitioner: When did these voices first start appearing?

Person: A few months ago, when I was really stressed about work.

Family Member: I remember you seemed really anxious at the time, but I didn't know you were hearing voices.

Practitioner (reflecting to colleagues, in front of the group): I wonder what the voices might be communicating. Could they be related to the stress they've mentioned?

Rather than assuming the voices are symptoms of illness, the dialogue explores their possible meanings, helping the person integrate them into their life experience rather than simply eliminating them.

## Why is open dialogue important?

1. It empowers the person in distress rather than making them a passive recipient of treatment.
2. It reduces coercion in mental health care, because decisions are made collectively.
3. It creates long-term recovery pathways by addressing underlying social and emotional realities.

If you want to find out more about it:

“Dialogical communication” is at the heart of the Open Dialogue approach.

It is a way of interacting that emphasises mutual understanding, openness, and the co-creation of meaning rather than imposing fixed interpretations or solutions. It is rooted in the philosophy of dialogism, influenced by the work of Russian philosopher Mikhail Bakhtin, who argued that meaning emerges through interaction rather than being predetermined by one person.

The Open Dialogue system is a mental health care approach developed in Finland in the 1980s, particularly in Western Lapland, as an alternative to traditional psychiatric care, and is gaining international attention.

### **Books:**

1. Open Dialogue for Psychosis: Organising mental health services to prioritise dialogue, relationship and meaning. 2021. edited by Nick Putman and Brian Martindale.
2. Open Dialogues and Anticipations: Respecting otherness in the present moment. 2013. by Jaakko Seikkula and Tom Erik Arnkil.
3. Dialogical Meetings in Social Networks. 2018. by Tom Erik Arnkil. Describes two practices: Open Dialogue for use in mental health crisis situations, and Anticipatory Dialogue for use in less acute situations such as an inter-agency muddle where systems are stuck.

### **Article:**

Seikkula, J. and Olson, M.E., 2003. The open dialogue approach to acute psychosis: Its poetics and micropolitics. *Family process*, 42(3), pp.403-418.

### **Blog:**

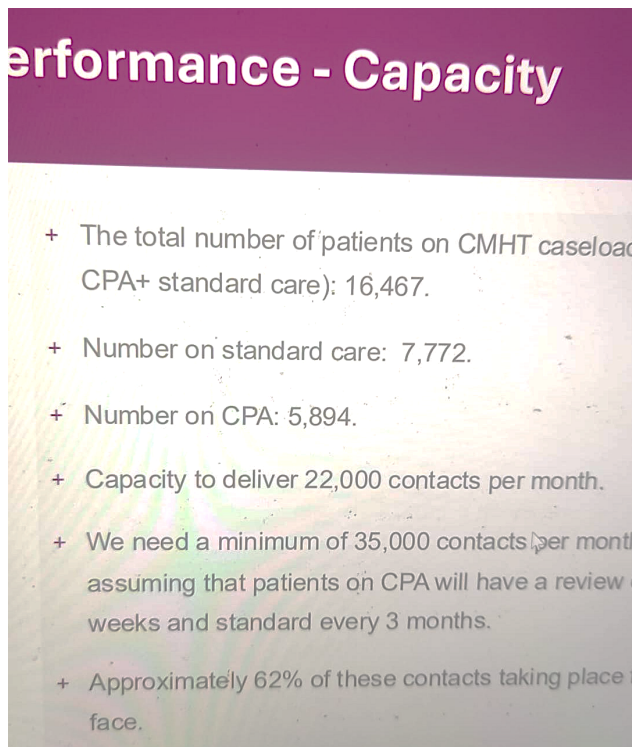
[What is Open Dialogue Today? - Mad In America](#)

### **Podcast:**

[Open POD pod RSS Feed](#). Explore! (Suggested: Episode 1, Episode 2.2)

# Shocking figures of casework overload and high sickness rates in Community Mental Health Teams

Recently received information reveals that, of the five local authority areas covered by the community teams, the highest caseload is in Manchester (44%, Table 2) and the local teams there are overwhelmed with sickness rates of nearly 20% (Table 4). This high pressure is costing around £2.28 million a year (Table 5) in cover staff (all reasons) from commercial agencies and bank staff (“bank” is like an internal agency within the NHS), and sickness cover is said to add up to around £1.6 million (Table 4).

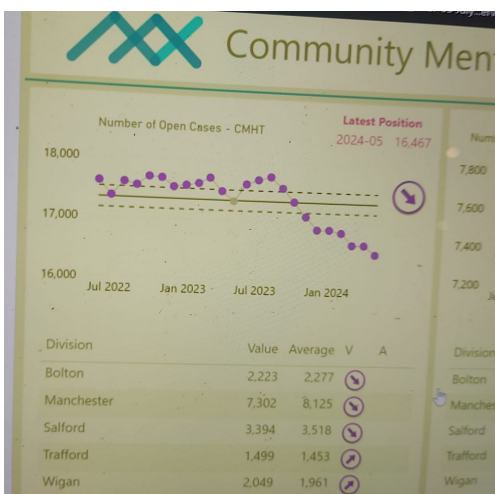


## Performance – Capacity

- The total number of patients on CMHT caseload ... CPA + standard care): 16,467
- Number on standard care: 7,772
- Number on CPA: 5,894
- Capacity to deliver 22,000 contacts per month.
- We need a minimum of 35,000 contacts per month ... assuming that patients on CPA will have a review on ... weeks and standard every 3 months.
- Approximately 62% of these contacts taking place [face to] face.

[ CPA = care programme approach, multi-agency, being replaced by Personalised Care Planning; Standard care = single agency ]

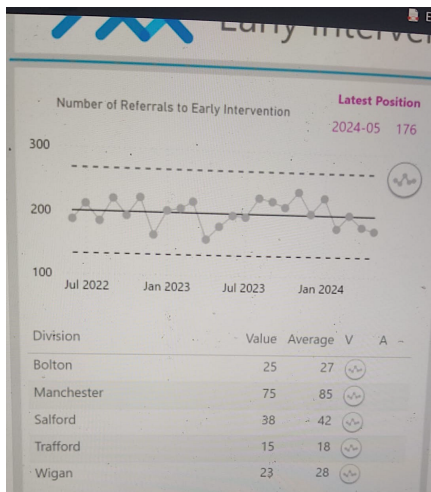
Table 1: CMHT Performance Capacity



Number of Open Cases – CMHT  
Latest Position, [May] 2024: **16,467**

	Value	Average
Bolton	2,223	2,277
Manchester	7,302	8,125
Salford	3,394	3,518
Trafford	1,499	1,453
Wigan	2,049	1,961
[ Totals	16,467	17,334 ]

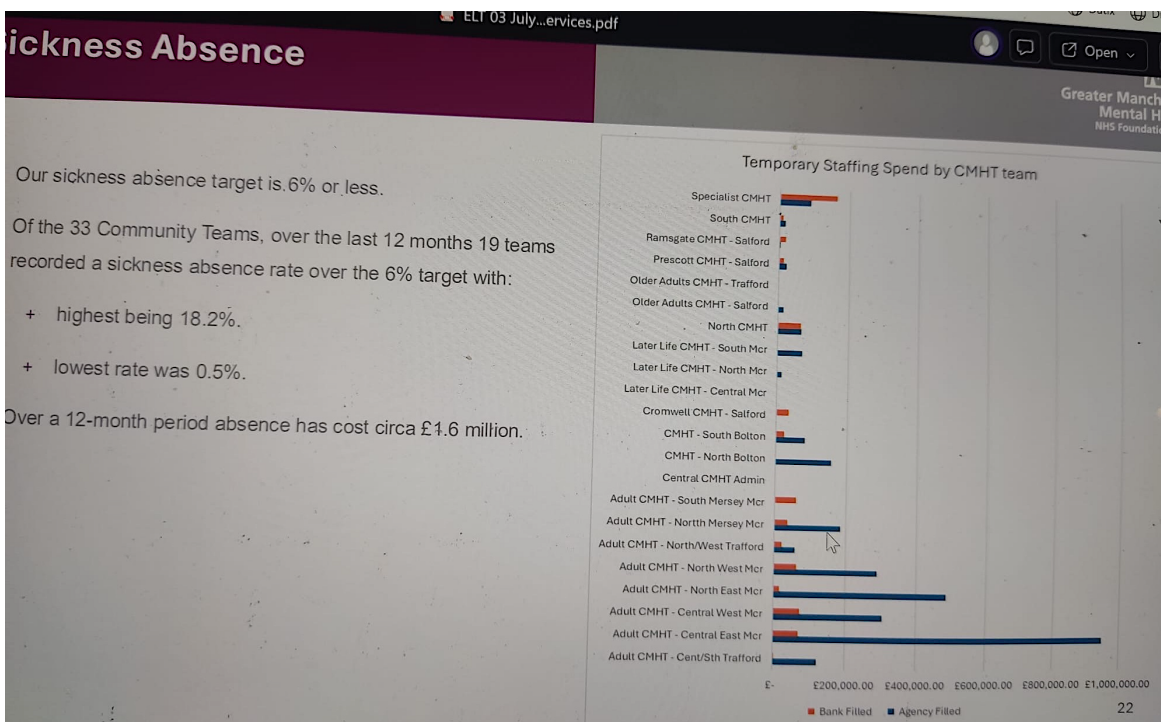
Table 2: CMHT Open Cases



**Number of Referrals to Early Intervention Latest Position, [May] 2024: 176**

	Value	Average
Bolton	25	27
Manchester	75	85
Salford	38	42
Trafford	15	18
Wigan	23	28
[ Totals	176	200 ]

**Table 3: CMHT Referrals to Early Intervention Teams**



**Sickness Absence**

Our sickness absence target is 6% or less.

Of the 33 Community Teams, over the last 12 months 19 teams recorded a sickness absence rate over the 6% target with:

- highest being 18.2%
- lowest rate was 0.5%.

Over a 12-month period absence has cost circa £1.6 million.

**Table 4: CMHT Sickness Absence**

**Temporary Staffing Spend by CMHT team**  
[ bank & agency ]

[ only showing here the teams with over £ 200k ]

Adult CMHT – North West Mcr	c. £380k a year
Adult CMHT – North East Mcr	c. £500k a year
Adult CMHT – Central West Mcr	c. £400k a year
Adult CMHT – Central East Mcr	c. £1m a year
Lowest of the 22 teams was:	
Central CMHT Admin	£0

**Table 5: CMHT Temporary Staffing Spend**

# Background on our Community MH Teams

Community MHT refers to Community Mental Health Teams. These are multi-disciplinary teams within the NHS that provide specialist mental health support in the community for adults with “severe and enduring” mental health conditions. They offer assessment, treatment, care coordination, and crisis intervention. The aim is to reduce hospital admissions and help people manage while living at home.

## Structure and Areas Covered

The Community MHTs are divided geographically, covering the five of the ten the district councils served by the Greater Manchester Mental Health NHS Foundation Trust (GMMH). Because Manchester is the largest district and has the highest levels of need, the city of Manchester is covered by several local teams. All the team boundaries are meant to match with those of their local GP practices.

## Failings of Community MHTs

For five years we have complained about the failings of community mental health teams. They could not cope with the caseloads that they needed to respond to. It has led to staff leaving and going sick. They have tried to manage their way out of the situation by employing more managers and by creating an unallocated hub, which they euphemistically call ‘the waiting well’. People have been discharged when they in fact need care. We feel this has been done cynically to reduce numbers.

## Staffing Pressures and Morale

The Independent Review of GMMH, published in January 2024, revealed concerning insights into staff experiences.

- In 2022, 57% of GMMH staff disagreed or strongly disagreed with the statement that “there were enough staff to perform their duties effectively”. This percentage was notably higher than both the regional and the national averages.
- The independent review indicated a decline in staff morale and engagement, with GMMH scoring below regional and national averages in these areas.
- The same review underscored the adverse impacts of staffing shortages on service delivery. The shortages come from many staff leaving and being off sick.
- Staffing shortages contribute to prolonged waiting times for patients requiring mental health services, making the existing service backlogs even worse.



## Integrated Care Boards (aka Partnerships, Systems)

A report to the Health Scrutiny Committee in January 2025 detailed Manchester’s collaboration with NHS Greater Manchester (NHS GM) to enhance governance, partnerships, and financial arrangements. This restructuring aimed to address systemic issues, including those affecting Community MHTs.