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Peer-supported Open Dialogue: a thematic analysis of student views on the approach and training

Abstract

Background Open Dialogue (OD) is a Finnish social network based model of care, with practice and organisational aspects. Peer-supported Open Dialogue (POD) is a UK version involving peer workers, whose contributions include building on fragmented social networks. 54 NHS staff undertook the first training in POD between 2014 and 2015. The training course was organised as four separate residential weeks, together with reflective sharing on an online platform.

Aims This study aimed to explore the perspectives of the POD trainees on the training and the POD approach.

Method At the end of the training year, four focus groups were conducted using a semi-structured interview measure examining trainees' perspectives on the training and POD approach. A thematic analysis was performed on the transcripts to analyse data.

Results Four superordinate themes emerged: personal experience, practice development, principles of POD, and pedagogical issues, each with a variety of subordinate themes.

Conclusions The course was widely reported as a positive experience, with substantial changes in attitudes and approaches to clinical work arising thus. Across the four superordinate themes, participant responses described a highly experiential course, experienced as an emotional journey which enabled them to embody the principles of POD, as well as use them at work.

Declaration of interest

None

Key words: Mental Health, Peer-supported Open Dialogue, focus groups, staff perspectives, education programme

Introduction

Open Dialogue (OD) is a mental health service intervention developed in Finland, which has its roots within family therapy (FT; Seikkula & Olson, 2003). It can be distinguished from other FT approaches due to it being an organisational level intervention (Seikkula et al, 2003).

OD is defined by seven core principles. Five are organisational: a social network perspective, the provision of immediate help, flexibility and mobility around the provision of care, responsibility of the clinician with first contact for the treatment process until conclusion, and psychological continuity throughout the care pathway (Seikkula et al, 2006). Treatment revolves around meetings involving the patient, their chosen social network, and clinicians. These 'network meetings' operate on two practice related principles: dialogism, the facilitation of a non-hierarchical dialogue in which all participants are able to communicate their perspective without judgement, with the aim of developing a new shared understanding of the difficulties; and tolerance of uncertainty, the development of trust and safety with a reduced emphasis on reflexive professional led intervention and focus on the empowerment of the patient and their network to understand and address the difficulties (Seikkula et al., 2003). Finnish nonrandomised OD trials have demonstrated promising outcomes in the alleviation of psychosis symptoms and improving quality of life. Over 70% of patients with a first episode psychosis treated via the OD approach returned to study, work, or work seeking within 2 years, despite lower medication and hospital use compared to treatment as usual, with outcomes stable after 5 years (Seikkula et al., 2006; Seikkula et al., 2011a).

Peer-supported Open Dialogue (POD) is a UK-developed modification of the OD approach (Razzaque & Stockmann, 2016). It employs the principles outlined above, and in addition, involves peer workers to bolster or create social networks and to enhance the democratic nature of network meetings. POD practitioners are required to complete a foundation diploma training course to practice. POD is a novel project, with the completed training being the first of its kind in the UK. Effective training will be vital for an expansion within the NHS. Examining staff experiences of POD training and the approach in general will be crucial, as changes to clinicians' working practices and existing organisational systems will be required.

To date, only handful of qualitative studies examining student's experiences of FT based training have been conducted. In one study, six trainees were asked for their views on how FT training had affected their personal, relational and professional identities (Nel, 2006). Trainees emphasised the significant demands of training, which had been a challenge and an opportunity for reconstructing personal and professional identities. Trainees often found themselves redefining their relationships with their own families, client families and professional teams. In similar study, thirteen marriage and family therapist trainees described positive reciprocity between personal and profession development (Paris, et al., 2006). Personal experiences, such as relationships and spiritual beliefs, contributed to professional growth – including building of knowledge/skills. Professional experiences, such as supervision, systemic theories and teamwork, contributed to personal growth – including open-mindedness and communication. Self-awareness, perspective, and 'letting-go', were identified as growth common to both domains.

In a more recent study, involving twenty-four FT trainees, focused on the effects of aspects of training designed to foster personal reflection and growth (Rhodes, et al., 2011). Consistent with previous studies, trainees reported deepened personal and professional relationships. Shifts towards systemic thinking led to reflections on relationships. Personal reflection, which tended to be driven by negative rather than positive training experiences, led including heightened compassion and empathy. Key contributory aspects of training involved "doing" relationships rather than learning theory/skills, such as personally challenging experiences, supervisors embodying the approach, a safe supervisory space, and trusting peer relationships.

Collectively, these studies demonstrate value of examining students' subjective experiences of FT training programmes and the personal and professional development which can occur. Therefore, the aim of this study was to examine students' subjective experience of undertaking POD training which has not been explored in previous research.

Method

POD Foundation Diploma Training Course

The course was co-facilitated by NELFT and the Norwegian University of Science and Technology. The curriculum and learning methods are based on established OD training programmes in Finland, Norway, and Massachusetts (Hopfenbeck, 2015). It was a part-time, four weekly modular residential course across a 12-month period. Various learning activities were used, designed to encourage personal and professional growth, including the development of a reflective practitioner who respects the contributions of others. Such activities included experiential exercises, practice in reflective processes, self-disclosure tasks, family-of-origin activities, role-play, lectures, yoga and mindfulness. There was also an online platform (Fronter), where students were required to regularly contribute to reflective discussions and to submit written assignments. The course aimed to make students aware of how to support the recovery process more effectively for people experiencing mental health difficulties, their families and the private and professional networks of which they are part. This course was also required each trust to consider the initial implementation of POD. The training modules and content are in Table 1; Table 2 lists the intended learning outcomes.

[INSERT TABLES 1 AND 2 HERE]

Focus groups

Participants were recruited opportunistically from a sample of POD foundation diploma students. The sample was taken from the first cohort of 54 who undertook the training between October 2014 and October 2015. Participants were recruited from four trusts. Table 3 shows further details.

[INSERT TABLE 3 HERE]

Focus groups are “a form of group interview that capitalises on communication between research participants [to] generate data” (Kitzinger, 1995), and therefore ideal to understand dialogue and shared meaning making between a group of people. Furthermore, focus groups capture multiple forms of dialogue that is not captured in an interview format which is reflective of the OD approach (Markova et al, 2007). The focus groups were conducted using a semi-structured schedule, developed collectively by the

research team and following guidance from Krueger (2002) to maximise the dialogue produced. The interview schedule examined four key areas: experiences of training, barriers/facilitators to implementing POD, personal development and professional development (Appendix 1). Individual focus groups were conducted with each of the four trust groups, by three of the authors (TS, LW, LG) and one POD trainer, who were trained and experienced in qualitative research data collection methods.

Analysis

Interviews were recorded and transcribed verbatim by TS and LW. Quality checks of transcription were undertaken by TS and LW by checking one another's transcripts. Analysis was conducted using thematic analysis procedures outlined by Braun and Clarke (2006). A realist approach was adopted, which assumes a directional relationship between meaning, experience and participants' language. Themes were extracted inductively and were strongly embedded within the data. Themes were identified by examining the explicit meaning of the data and not looking beyond what the participant has said. TS and LW individually coded two focus groups and crosschecked coding. Initially 528 codes were identified, and then collapsed with overlapping codes to form 21 potential themes. These themes were reviewed and finalised within a triangulation meeting, where individual themes were discussed and grouped together to form superordinate and subordinate themes, before a final thematic structure to represent study findings was decided.

Results

Analysis identified 19 subordinate themes, organised into four superordinate themes, shown in Table 4. All themes reflected experiences of POD, whether it be the training specifically or the therapeutic approach more broadly. Superordinate and subordinate themes are outlined, below with illustrative quotes.

[INSERT TABLE 4 HERE]

Personal experience

This superordinate theme outlines the personal effects of the training on individual trainees, which ranged from personal development to the exploration of spirituality.

Emotional experience

Powerful emotions were experienced during the training. These were often considered valuable, even when unpleasant, "*I guess I have extended my awareness and that's been quite painful but it feels as though it's helped me as a human being" (Participant 06).* The same participant described the exploration of personal and professional relationships as a common source of emotion, and reflected on experiencing emotion as experiential learning. *"The journey that we have all done together has been productive and rich process, but yeah extremely challenging at times, both in terms of the content, emotional sort of connectedness with people and sort of personal issues…I think you sort of live OD through the training, in the reflections you make with your fellow trainees."*

Personal development

Despite initial scepticism, many participants described personal development throughout the training, *"Mark [trainer] in the very first module said 'it's [OD] a way of life' [Seikkula, 2011b]. What the hell is he talking about, what kind of cult did I join? (group laughter) But it is, and it kind of did change my life" (11).* Changes noticed included improved clarity of thought and communication, being a "*better person"* (08), and increased self-compassion. Whilst many accepted that *"transformative"* (09) changes had

occurred, they were uncertain why, *"I can't quite get how doing so little can affect so much…change my life and all?" (14).*

Relationships

Participants described positive changes in their relationships following the training, *"It can potentially make you a better person, can't it? Maybe a better partner, better father or whatever, a better friend" (09).* Changes included listening skills and compassionate understanding of others' perspectives, *"I've been to conferences where service users are present and I've felt very attacked on a personal level. And, by the end of that week I saw them as a wonderfully charismatic group of a very kind, loving people who had a very strong voice, but important voice that hadn't been there before" (06).*

Spirituality

The inclusion of spirituality was appreciated by several participants, *"I think an integration of mind, body, spirit as well, I think is very important" (08)* and was contrasted by some to previous professional experiences, *"I really liked the idea of moving from the notion of psychotic breakdown to, to, um, a kind of, what was it? A kind of spiritual enlightenment." (02).*

Practice development

Practice development draws together themes which reflected changes in professional conduct and methods of practice resulting from POD training. It also drew attention to the significant differences between POD and current NHS practice.

Professional development

Participants noted improved interactions with colleagues and, especially, patients, *"A lot of us have aspired to work or think we're working this way, and talking is easy and that is part of our jobs and what we do as human beings, but there have been a few occasions when I've been with clients that I've felt a different connection and I've felt a different response, and I've felt is it because I'm doing this course" (08).* As well as a sense of returning to original ideals, there was unexpected insight into limitations of individual practice, "*I like to think that I am not just somebody who just prescribes medication, but that*

listens and tries to understand people's experiences…It's been quite humbling actually finding out that there is a whole new, a whole another level to that that I don't do" (06). Greater job satisfaction and personal wellbeing following the training was also mentioned, *"I was very close to being burnt out…I'm in a very different place now. I've got a passion back" (12).*

POD compared to usual treatment

POD was largely seen to re-humanise practice compared to traditional treatment, *"It's like OD provides a framework where expressing your humanistic side is allowed" (05).* The approach was described as natural to clinicians, but discouraged by a system prioritising a technical approach, *"This is the way I wanted to work with people, but because of the restrictions in the system…we become very sort of clinical and sort of 'chchchch' [completing a checklist]" (05).* Some participants spoke of the emotional burden of reconciling humanistic intentions with an opposing system, *"The disillusion which has always been there for me, is stronger because I have been here and because I so want it to be different, that it feels more painful in some ways having to be working in the ways I am having to work" (06).*

Changes required for POD to work in the NHS

The challenges of overcoming limited financial resources and achieving a necessary shift in the existing system were deemed fundamental. It was emphasised that barriers were systemic, rather than individual, and a split between POD and non-POD staff should to be avoided. There was a degree of pessimism about achieving meaningful system change, although others expressed optimism.

Team working

Some spoke of making valuable interpersonal connections during training. A sense of community was seen to aid learning through increasing perspectives making the training and practice less daunting, *"A great sense of looking after yourself and looking after each other, um, when you're doing some very difficult work…it all feels more possible" (02).* Learning about other trainees appeared to help empathetic understanding of others' circumstances and generated trust, which in turn allowed for some trainees to disclose more difficult aspects of themselves. This was viewed as positive as it mirrored the expectations of patients and families within services, *"People here really love each other basically, and can share really*

private things without falling apart cuz they know they have their whole group holding them when they're talking" (12).

Peer-supported Open Dialogue principles

Participants highlighted the importance of the core principles and peer-support in making positive change towards their practice. Some principles were identified as most important by participants.

Balancing power

Participants highlighted the aim of avoiding judgement and imposition of a clinician's agenda, in favour of a democracy of voices, *"Making those statements which completely, you see now, it closes people off; it creates that barrier and that judgement as well… just being really aware of, of how you are with people and having more equality" (03).* There was agreement about considering issues of power and hierarchy within the POD teams themselves, *"because that is what POD does" (15).* This was seen as a considerable challenge. Existing organisational structures were identified as the most significant barrier. Some advocated a pragmatic approach, *"There are points where the POD team will interact with the treatment as usual or not treatment as usual but the organisational, structural stuff which will not flex to make everything dialogical" (13).*

Dialogism and polyphony

Participants highlighted the benefits to both clinicians and patients. Value was seen in hearing all perspectives in a crisis. The importance of allowing quiet and challenging voices to be heard was emphasised. Also raised was the value of allowing patients their personal narratives and meanings, rather than imposing an expert view, *"The majority of people know that at some level smoking isn't good for you, but they've created stories around smoking and what it does, why they do it, and it's to unravel those stories" (02).* Some professionals described how experiential learning helped them to deeper understanding dialogism and polyphony, *"Just spending time with so many different voices and people that all have so much for me to learn from, that's been just really humbling." (06).*

Uncertainty

There was a general uncertainty amongst the trainees early in the training. There were complaints about insufficient explanations and feedback. This frustration reduced as the training went on, with increased understanding that the learning process was continuous. Some saw learning to tolerate uncertainty as useful experiential learning, *"The frustration is part of that, but you know, a lot of it is about space as well, to sit with that uncertainty, and even myself in reflection, you know, sort of looking at that process, to try to get that concept, understanding the model, and trying to get your head around the fact that it's not a model…it's a way of being. So the frustration kind of abated a bit as the course went on" (03).*

Mindfulness

Participants noticed personal and professional benefits, often unexpected, including an improved ability to maintain focus on the patient and not be distracted by one's own agenda or preoccupations. Some disclosed difficulty maintaining a regular practice. Mindfulness was linked to the development of self-compassion, *"It's taught me to be kinder to myself actually, in a lot of ways. And actually listen to myself and the internal sometimes the battles that go on in my head you know when I've had a difficult time, I've actually been able to sit with that a little bit more and listen instead of trying to block it out" (03).* Further benefits described were self-awareness, and the aiding of compassion for others and an ability to allow a free-flowing dialogue.

Peers

There was agreement that hearing accounts of lived experience within training helped promote empathic understanding of alternative perspectives. The voices of patients and families were also seen as vital for demonstrating the benefits of POD, *"I'm most moved when I hear the voice of a family or a person who's had that experience...You know, it shifts things more in some ways that you know words from an expert could" (06).*

Pedagogical aspects

This theme highlighted the important educational processes underpinning the course. The sub-themes reflect on how the way the course was run was almost as important as the content being taught.

Importance of supervision

Increased supervision was highlighted as an important element to training, particularly for managing difficult emotions, *"You had to get in quite deep in your own psyche and it's just I found it rocks you a bit. And so I think maybe if there's more support brought in to that that would be good" (09).*

Reflective space

Space to reflect was regarded as helpful for self-learning, *"I think there's been the space, again, in an Open Dialogue sense, to find your way with it" (01).* The presence of such space was sometimes contrasted to a lack in participants' working lives, and facilitated by the peaceful environment, as well as a product of a caring environment where individuals did not feel overwhelmed by dominating voices.

Training community

The training was seen to have created a community, which was thought to be crucial for learning. The residential aspect, and the time spent together, were emphasised. Some trainees connected more deeply by sharing personal aspects of their lives, *"It's felt a very shared experience. Talking about, I guess your own experiences and, your family of origin, families cycle posts, sharing that with other people, um, kind of changing perspective on things really" (19).* Having a sense of space, both physical and mental, was cited as important for this. The peace and beauty of the setting was appreciated, as was separation from work pressures. The feeling of being supported by others also helped. Some saw their experiences of relating to both themselves and others as a form of experiential learning.

Learning process

Expert trainers came from various countries with different dialogic practice traditions, and had diverse approaches to teaching. Some participants found less directive teaching anxiety provoking and preferred more instructive trainers. However, they did think it important to leave room for self-learning, and that experiencing uncertainty was helpful experiential learning. Some described initial surprise at the training methods, with more *"chalk and talk" (02)* teaching expected, before later realising that learning had taken place somewhat unexpectedly, *"at the time I didn't really know, as you think 'we do it anyway you know' but actually I feel that does need to be there because you get a new perspective on it later on as you grow" (16).*

'Fronter' - the online training platform

Several participants found the lack of feedback on Fronter frustrating and fluctuating interest was common. Some described initial scepticism which reduced over time. Positive comments included that Fronter provided an experiential lesson in shared leadership and responsibility, *"I really valued the idea that each and every one of us has made this, and that's been valuable. And I think that's been a good lesson" (21).*

Fidelity criteria

Whilst these were generally viewed as important, some envisaged problems, mainly the encouragement of an overly technical emphasis to learning, rather than, for example, an *"experiential exercise" (02)* or *"reflective process" (05). "The way it's been facilitated has been about embodying OD and being OD, and the danger to having…the fidelity criteria is that it becomes much more intellectual, like consciously thinking: 'Am I doing this? Am I doing that?'" (05).*

Discussion

This study aimed to explore participants' experiences of POD training using semi-structured focus groups. Four superordinate themes were identified, reflecting personal experience, practice development, POD principles and pedagogical experiences.

Regarding personal experience, participants reported positive changes in personal attitudes towards their clinical work. Findings were consistent with FT studies. For example, Rhodes et al. (2011) found that training led to increased personal reflection, and behavioural change within significant relationships. Our findings of a cross-over between personal and professional growth were also consistent (Paris, et al. 2006 & Rhodes, et al., 2011).

There was an emphasis on emotions, with students describing an emotional journey of self-awareness and self-growth, combined with deepening of interpersonal connections. Emotions, linked to embodiment and self-regulation, are key elements of the POD training (Hopfenbeck, 2015), and are thought to underlie the therapeutic effect of OD (Seikkula & Trimble, 2005). Emotional experiences were seen as a form of experiential learning, for example: tolerating distressing emotions evoked by discussing painful experiences, or appreciating the effect of expressing emotional reactions within a dialogue or in reflections on someone's story.

Participants described significant changes in their approaches to clinical work, identified in the practice development and POD principles themes. Participants spoke of a shift to dialogic thinking, similar to a switch to systemic thinking described by Rhodes, et al. (2011). Across the studies, this change contributed to both personal and professional benefits, particularly concerning relationships.

A widely-expressed view was that POD allows for a more intuitive, humanistic practice than currently, comparable to 'post-technological psychiatry' outlined by Bracken et al. (2012), with increased emphasis on meanings, values and relationships. This supports previous research which has demonstrated that shared meaning making and positive therapeutic relationships are two of the most important factors to patient care (Ardito & Rabellino, 2011; Eliacin et al., 2015; Ljungberg, et al., 2016).

Participants explained that the use of some POD principles required challenging changes to practice, and some required development in POD competencies. FT trainees emphasised the discomfort of feeling deskilled (Nel, 2006), perhaps similarly to uncertainty about learning in our study.

In our study, promoting dialogue, not change, was something that participants struggled with. Promoting dialogue empowers the individual and their network to generate meaning, reconstruct problems and form new understandings (Andersen, 1995). This also requires a tolerance of uncertainty, which participants found difficult and in conflict with routine practice, for example risk management procedures. Learning to tolerate uncertainty was, however, commonly viewed as useful experiential learning.

The idea that difficult training experiences result in helpful experiential learning, and positively affect personal and professional relationships, was common to FT training studies (Nel, 2006). The culture within FT training aims at developing relational ability, rather than merely technical skills, this is thought to be a significant factor in growth (Rhodes, et al., 2011). Similarly, the POD training was designed to be highly experiential, including a continual process of reflecting and self-growth (Hopfenbeck, 2015), as highlighted in the theme pedagogical aspects, which identified important learning components of the training. Experiential learning has been identified as the most effective postgraduate method of learning (Samarakoon et al., 2013). The sub-themes of supervision, reflective practice and training community reveal further similarities with FT training studies, concerning the key contributors to learning and development.

Limitations and strengths

To the authors' knowledge, this is the first study to examine staff experiences of any form of OD training. Participants were recruited opportunistically and only included students who completed the four course modules, which may limit the generality of views. However, the number of the participants was high; sufficient to achieve theme saturation (Guest et al., 2006). Multiple professions and positions were represented, increasing the range of responses. Efforts were made to minimise researcher effect on outcomes: interviewers relied on brief interventions from the schedule only; and steps were taken during analysis, as detailed in the Methods.

Word count: 3988/4000

Appendix 1 – Focus group interview schedule

Experience of training (allow 20 minutes)

1. **What has your experience of training been like?**
2. **What were your expectations for training? Did it differ?**
3. **What have been the difficulties/ struggles?**
4. **Has anything surprised you?**

Prompts

- Fronter, Back in clinical practice, Mindfulness, Weekly modules

Barriers and facilitators (allow 20 minutes)

1. **What are the barriers to implementing OD?**
2. **What are the facilitators to implementing OD?**

Prompts

- The NHS system, Staff, OD colleagues, Skillsbase, Personal /Professional

Professional and personal development (allow 20 minutes)

1. **How was OD impacted on your professional development?**

Prompts

- Therapeutic relationship, Relationship with colleagues, Working within the system, Job satisfaction, Professional self-image, Professional identity

Personal Development

2. **How has training impacted on your personal development?**

Prompts

- Mindfulness, Personal identity, Personal self-image, Personal relationships

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http://apopendialogue.org/open-dialogue-course/ (retrieved Dec 2016)

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Tables *(4 in total)*

Table 1 – Module Content of POD training

Module	Module Content
Module 1	Introduction to the course, family therapy, Open Dialogue and self-work • The history of systemic practice • Social constructionism and the importance of context • Open Dialogue as approach and attitude • Reflecting processes • The family life cycle • The importance of research and involving the family and networks
Module 2	Deepening Open Dialogue practice & self-work + introducing trauma-informed and recovery-based approaches to mental health care • Recognising and responding to trauma • Working with children • The therapeutic relationship • Working towards recovery; empowerment, connectedness and identity • Ethics and working with families and networks
Module 3	Applied open dialogue practice, peer support & integration of the two • The power of peers • Co-creating peer-supported services • Sharing stories and decisions in person-centred care • Dialogue and client-driven service development

Module 4	Holistic approaches to mental health and personal development; reflections and final assessments • Emotions, self-regulation and the body • Psychosocial, cultural and spiritual aspects of mental illness and recovery • Acceptance and compassion in professional practice • The use of self in Open Dialogues

Table 2 – POD Training: Intended Learning Outcomes

Learning Outcomes	At the end of the course students should be able to demonstrate: • an understanding of the Peer-supported Open Dialogue model and the relationship between its different components • an ability to place the development of POD into a historical context • an understanding of peer-support and the role of peers in service delivery • an understanding of how the local community can facilitate peer-support • an understanding of the differences between traditional and recovery-focused services • an understanding of the systemic approach to family and other relationships • a range of practical abilities in social network and relationship skills through role play • an ability to evaluate theory critically and to explore ideas and their application to different contexts • an appreciation of the need for feedback and client-driven service evaluation and

development

• an awareness of the impact of the wider social context especially in respect of race, class, religion, culture, gender, sexual orientation, age and disability

• an understanding of childhood adversity and trauma and their relationship to mental health

• an understanding of a person-centred approach to mental health care

• a willingness and ability to be mindfully and compassionately present in their private and professional lives

• an understanding of how the fulfillment of spiritual needs can contribute to hope, a new sense of meaning and personal growth

• an understanding of how spiritual interpretations of mental health difficulties can have a powerful, healing and often transformative effect for many people

• an ability to consider their own family and cultural experiences and their influence on personal and professional development

• an ability to explore and give an account of their personal learning process over time.

• a commitment to ethical and anti-discriminatory practice

(Ref: http://apopendialogue.org/open-dialogue-course/)

Table 3 – Focus group details

Date	October 2015
Location	Within the residential location of the final POD training module
Number of participants	26 (groups of 10, 7, 6, and 5)
Inclusion criteria	POD trainees who attended the last module of training, willingness to take part in the evaluation
Exclusion criteria	Any involvement in the implementation of the training

Participant roles	4 peer workers, 1 carer, 6 community psychiatric nurses, 2 support workers, 1 chaplain, 4 psychologists, 3 occupational therapists, 1 manager, 4 consultant psychiatrists
Average duration (range)	63:44 minutes (58:08 – 69:58)

Table 4 – Results: Themes

Superordinate themes	**Subordinate themes**
Personal experience	Emotional experience Personal development Relationships Spirituality
Practice development	Professional development POD compared to usual treatment Changes required for POD to work in the NHS Team working
POD principles	Balancing power Dialogism and polyphony Uncertainty Mindfulness Peers
Pedagogical aspects	Importance of supervision Reflective space Training community Learning process Fronter (online learning and discussion platform) Fidelity criteria (Olson et al., 2014)