

# *The Finnish open dialogue approach to crisis intervention in psychosis: A review*

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The open dialogue approach to crisis intervention is an adaptation of the Finnish need-adapted approach to psychosis that stresses flexibility, rapid response to crisis, family-centred therapy meetings, and individual therapy. Open dialogue reflects a way of working with networks by encouraging dialogue between the treatment team, the individual and the wider social network. RICHARD LAKEMAN reviews the outcome studies and descriptive literature published in the English language associated with open dialogue in psychosis and considers the critical ingredients. Findings indicate that in small cohorts of people in Western Lapland the duration of untreated psychosis has been reduced. Most people achieve functional recovery with minimal use of neuroleptic medication, have few residual symptoms and are not in receipt of disability benefits at follow-up. Open dialogue practices have evolved to become part of the integrated service culture. While it is unclear whether the open dialogue components of the service package account for the outcomes achieved, the approach appears well-accepted and has a good philosophical fit with reform agendas to improve service user participation in care. Further large scale trials and naturalistic studies are warranted.

The 'Finnish open dialogue' method, sometimes known as 'Seikkula's open dialogue approach' to psychosis (Anderson, 2002) encompasses a range of practices and a philosophy of care that is radically different to the way mainstream mental health services work with people in crisis. Open dialogue has gained international attention because it is purported to have reduced the incidence of people with first episode psychosis developing chronic symptoms and associated disability with minimal use of psychotropic medication. The open dialogue approach to psychosis emphasises a rapid response to crisis with skilled therapy teams meeting people in their own homes where possible, co-ordinating all care until the crisis is resolved, engaging with the person's social and support network in open dialogue meetings, and the facilitation of intensive individual therapy.

Open dialogue is of particular interest to Australia which has invested heavily in specialist early intervention in psychosis teams, the cost effectiveness of which is being questioned (Raven, 2013). Recent controlled trials of specialist relapse prevention services compared to individual and family cognitive behavioural therapy have found that relapse rates are lower at twelve month follow-up for those receiving therapy and that psychosocial functioning actually deteriorated in the specialist service which may be an outcome of medication adherence (Gleeson et al., 2013).

In Australia over 90% of people diagnosed with a psychotic illness are prescribed medication, and poly-pharmacy is common (Waterreus et al., 2012). Nevertheless, there is increasing public disquiet about the impacts of increasing rates of antipsychotic prescription

(Heilbronn, Lloyd, McElwee, Eade, & Lubman, 2012) and increased mortality associated with their use (Weinmann, Read, & Aderhold, 2009). At the same time there is a burgeoning interest and optimism around the use of psychotherapy in psychosis (Rosenbaum et al., 2012) and a growing understanding of how it influences brain functioning (Barsaglini et al, 2013). An exploration of the factors in the open dialogue programme that might contribute to improved outcomes with minimal use of antipsychotic medication could usefully inform the development of specialist early intervention services and the improvement of general responses to psychiatric crisis.

The techniques of open dialogue are derived from family therapy and evolved in the context of service reform in Western Lapland, a small (~70,000 people) culturally homogenous community at the edge

of the Arctic Circle. It has come to international attention largely through advocacy and promotion by critical psychiatry networks, and service user movements. Whitaker (2010), in the epilogue to his best-selling book on the iatrogenic harm associated with an overzealous emphasis on medication in responding to mental distress in North America, offers 'open dialogue' as an example of a treatment system that has transformed the outcomes of those who present with psychosis. It has, he argued, improved outcomes to the point where at the end of two years, 84 percent of people with first episode psychosis had returned to work or school and only 20 percent were taking anti-psychotic medications. Contentiously, Whitaker also argues that schizophrenia (i.e., symptoms of psychosis lasting longer than six months) is disappearing from the region.

In one of his more moderate reviews of Whitaker's book Torrey (2011) objects and rhetorically asks why there are '*... almost no publications describing its results and nobody in Finland or elsewhere has tried to replicate it?*' Open dialogue has nevertheless taken hold of the collective imagination and a Google search limited to the exact phrase 'Finnish Open Dialogue' reveals more than 32,000 results (as at 30 April 2014), with a documentary film released in 2011 (Mackler, 2011) and widely promoted on the internet (over 25,000 views of the Youtube trailer<sup>1</sup>). Whilst, the academic interest in open dialogue appears modest and largely confined to family therapy literature there have been increases in citations of the primary sources for open dialogue since 2011. For example, according to Scopus there were a mere 15 citations for the main outcome study on open dialogue approach (Seikkula et al., 2006) from 2006 to 2011, but a further twenty citations in the two years following the release of Whitaker's book. Open dialogue has attracted editorial commentary in mental health related journals

<sup>1</sup> Dr Fuller Torrey may well be correct regarding the lack of academic interest in open dialogue as a treatment approach but the broader public interest is considerable. Dr Torrey's most watched Youtube clip had 3000 views as at the 30th April 2014.

(Lakeman et al., 2012; Sutela, 2012; Thomas, 2011; Trimble, 2002) but has had little exposure in English language psychiatric journals, although the latest Cochrane review on early intervention in psychosis cautiously endorses 'family

psychosis in Finland. The need-adapted model of care is a broader integrative treatment approach that has become more widely implemented as part of the deinstitutionalisation and mental health reform process in

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interventions' as one of the few specific intervention forms that currently might be considered helpful. No studies on open dialogue met their criteria for inclusion (Marshall & Rathbone, 2011).

Whilst 'open-dialogue' does not appear to have been evaluated or included as part of a wider systematic review of interventions in psychosis, Gromer (2012) undertook a review of studies relating to need-adapted and open-dialogue approaches to

Finland (Alanen, 2011; Alanen et al, 1991; Lehtinen, 1994). It emphasises adapting a therapeutic approach to changing individual and family needs rather than a diagnosis driven approach to problem identification and treatment, integrating family and individual therapy into treatment and responding with crisis-orientated family interventions delivered by responsive mobile teams of professionals.



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What probably distinguishes need-adapted treatment from other integrative treatment approaches and the now well-established need to engage with families, reduce expressed emotion (really ‘hostile intrusiveness’), provide psycho-education, and help

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people solve problems (Falloon et al., 1982), is the highly structured initial family therapy informed crisis network meeting that occurs as soon as practicable after the person engages with the service (Räkköläinen et al., 1991). Open dialogue represents a particular adaptation of how these treatment meetings take place with an emphasis on generating dialogue within the treatment system and families rather than attempting to change the family system (Seikkula et al., 2006). Gromer (2012) concluded that both forms of intervention appeared safe and conferred substantial benefits over previous models of care.

### Methodology

This review aimed to identify and describe the evidence base for open dialogue in psychosis, and second, to identify the critical ingredients of the approach so that it might be adopted and trialled in different service settings and health systems.

Electronic searches were carried out to identify resources on open dialogue and psychosis. The searches included the following databases: CinAHL with full text, PsychInfo, Medline with full text and PsycArticles. Search terms used were: ‘open dialogue’ or ‘dialogical’ or ‘need adapted’ AND psychosis OR schiz\* OR psychotic OR Crisis, limited to the English language and peer reviewed journals. Reference lists of those papers which directly addressed open dialogue were examined and relevant papers obtained.

The initial yield was 100 papers. A first review of the titles and abstracts for relevancy reduced the yield

to 48 papers including editorials, commentary and theoretical papers. The abstracts of these papers were read and the full text obtained for most. Whilst many did not deal specifically with open dialogue they did deal with salient theoretical and background

issues that assist in understanding the open dialogue process. For example a body of theory and research addresses how self-dialogue may be disrupted in psychosis (Holma & Aaltonen, 1998; Lerner, 2011; Lysaker et al., 2012; Lysaker & Lysaker, 2001, 2010, 2011). The evaluation and adaptation of the need-adapted approach was also useful background to understanding how open dialogue evolved as it did (Alanen, 1990; Lehtinen, 1993, 1994; Räkköläinen et al., 1991).

A total of twenty-five papers addressed open dialogue directly (excluding editorials). Four papers (Aaltonen et al., 2011; Seikkula et al., 2006; Seikkula et al., 2003; Seikkula et al., 2011) examined the outcomes associated with the open dialogue approach. Several additional papers have described open dialogue with detailed case examples in particular with illustrations of how the quality of the dialogue generated in network meetings differed between good and poor outcome cases (Seikkula, Alakare, & Aaltonen, 2001a, 2001b; Seikkula, 2002b; Seikkula, 2005). A further ten were theoretical and descriptive. Several books address open dialogue and summarise the research to date and outline the principles and process (Haarakangas et al., 2007; Seikkula & Alakare, 2012; Seikkula & Arnkil, 2006).

### The critical ingredients of open dialogue

The open dialogue approach is amply described in the literature with most research papers providing an elaborate description of the process

or principles. As an ‘entire network-centred treatment’ (Seikkula, 2011, p.184) open dialogue shares much in common with Needs Adapted Treatment. Seikkula et al. (2003) describes the main features of open dialogue as:

- *the provision of immediate help* with an initial network meeting convened within 24 hours of first contact at which the person with psychosis participates;
- *a social network perspective*—key members of the person’s social network such as family, friends, neighbours, employers or helping agencies are invited to the first meetings;
- *flexibility and mobility*—the therapeutic response is adapted to the specific and changing needs of the case. No firm treatment plans are made whilst the person is experiencing crisis. Network meetings are typically convened in the person’s home and during the crisis period may occur every day;
- *responsibility*—the staff member who is first contacted is responsible for organising the first meeting and the team is then responsible for the entire treatment process including in-hospital treatment if needed;
- *psychological continuity*—the team is responsible for treatment for as long as it takes and wherever it occurs. Different therapeutic approaches are combined as required (e.g., individual therapy or rehabilitation) to provide integrated treatment. All decisions about treatment are made with a family in the family meetings. Members of the person’s social network continue to meet in network meetings;
- *tolerance of uncertainty*—this is described as an active attitude on the part of therapists to avoid premature conclusions or decisions about treatment. The advisability of neuroleptic medication is discussed at least several meetings before implementation;
- *dialogism*—the primary focus of the network meetings are to promote dialogue and to build a new understanding between participants in the language of the family.

The open dialogue meeting draws on some techniques used in systemic family therapy such as the use of a reflective team (pausing to share their thoughts and observations—Seikkula, 2003), but philosophically it is more akin to narrative therapy which holds that reality is socially constructed through discourse or dialogue (Angus & McLeod, 2004). Unlike narrative therapy in which there is often an intent to ‘re-author’ the person’s story or create a preferred or more positive narrative, open dialogue proceeds without any pre-planned themes or forms to enable clients to construct a new language through which they can express the difficulties in their lives (Seikkula, 2003).

An emphasis on dialogism and tolerance of uncertainty distinguishes open dialogue from other programmes and needs adapted treatment (Seikkula et al., 2003). It is worth elaborating on the concept of dialogism as used as a treatment principle in open dialogue and, in particular, how dialogue relates to psychosis. Dialogue is a communicative process through which reality is socially constructed and problems are seen as reformulated in every conversation (Seikkula, 2002). Dialogism was coined by the philosopher Mikhail Bakhtin. Being in dialogue involves responding to what has been said before or in anticipation of what will be said in response. In contrast to a monologue, dialogue is relational, dynamic and produces new descriptions of the world and is considered a process that enables meaning to be generated. As Holma and Aaltonen (1998) note: *Any action, speech, or other action, is always in search of a narrative interpretation. This narrative interpretation has to be constructed socially and maintained in dialogue in relationships with others* (p. 262). They argue that if we attempt to understand experience through stories in which the meanings of experiences are already determined (monologues) then real dialogical conversation will not be created and the real needs of the patient and family will not be discovered and will remain unsatisfied. Dialogue, therefore is the primary means by which an individual’s needs might be revealed to others.

The person experiencing psychosis has not found a way to be in dialogue with the self or others so the monologue that is ‘*psychotic speech*’ becomes the only way of describing the experience (Anderson, 2002) or as Seikkula (2002) suggests in psychotic speech people talk about things ‘...*that do not yet have any other words than those of hallucinations and delusions*’ (p.265). Each person is considered to have their own voice in constructing problems and Seikkula et al. (2006) suggest that it is important to accept the psychotic hallucinations or delusions of the patient as one voice among others.

In open dialogue listening and responsively responding to what different members of the network say is more important than intervening or interpreting speech (Seikkula, 2011). Seikkula (2002a) suggests that relating to each other in a series of monologues constitutes the crisis experience and people are often seeking the certainty of a monological answer to their suffering, advice on what to do or an assurance about what is wrong. Prematurely offering monological responses may encourage dependence on the system, impede the emergence of a shared understanding of the meaning of the problem, and reduce the capacity of the network to draw on their shared resources to resolve the problem.

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How to listen and how to respond to or answer each utterance of the client is the treating team’s challenge and indeed the goal of therapy is the facilitation of open dialogue through responding to each utterance with a view to building up new understanding between the different participants. Seikkula (2002) suggests that it is pivotal that those nearest to the patient (their social network) are included in this process and that three is the optimal number of professional team members who participate in network

meetings (to enable one person to always be listening). The health professionals in the network meeting may engage in a reflective conversation amongst team members whereby they may share their thoughts about what others have said.

The procedures for network meetings and examples of meetings associated with good outcomes have been described in detail (see: Seikkula & Arnkil, 2006; Seikkula et al., 2001a, 2001b). It appears that open dialogue is the preferred way of engaging with networks and this form of engagement is considered therapeutic in its own right. In keeping with needs adapted protocols, the crisis meetings also serve the pragmatic purposes of gathering information about the problem, planning treatment on the basis of the diagnosis, making decisions about what is needed and facilitating concrete cooperation between relevant parties involved with the patient’s life and future (Seikkula et al., 2006).

#### **Open dialogue and outcomes**

Outcome data was collected for a small cohort of patients who received an early incarnation of open dialogue in 1992 and 1993 as part of a Finnish national multicentre study called the Acute Psychosis Integrated Treatment project (API) which sought to evaluate the Need-Adapted approach and to

explore the use of neuroleptics in the context of providing intensive psychosocial support in first episode psychosis (Lehtinen et al., 2000). Three sites that were deemed to have considerable experience in the provision of psychosocial treatment (including Western Lapland) used a minimal neuroleptic regime for all people who were consecutively admitted to hospital with first episode of psychosis (the experimental group). This involved deferring neuroleptic prescription where possible for three

weeks (using benzodiazepines to reduce anxiety if needed) and if improvement was noted at that time a neuroleptic was not prescribed. The control group also received a form of need-adapted treatment including family therapy but without a protocol relating to minimal neuroleptic use. A total of 106 patients were enrolled across six sites and it was found that 42.9% of the experimental group did not receive any neuroleptics during the two year follow-up (compared to 5.9% of the control group). The outcomes of the experimental group were as good or better than the control group at two years. They were more likely to have no psychotic symptoms during the last year and over 50% had spent less than two weeks in hospital over the past two years (compared to 25% of the control group). The good overall prognosis and outcomes associated with minimal neuroleptic use in itself challenges contemporary wisdom and provides empirical support for intensive psychosocial interventions in psychosis (Lehtinen et al., 2000).

Seikkula et al. (2003) explained that open dialogue at the time of the API project was in its infancy but the results were so impressive relative to the local historical outcomes for people with psychosis that they chose to continue the project in an attempt to sustain the positive results. Outcomes for the API cohort with a diagnosis of schizophrenia, schizophreniform or schizoaffective psychosis (n=22) was compared to a cohort of people consecutively admitted to the service with the same diagnosis between 1994 and 1997. This group received a more developed 'Open Dialogue Approach in Acute Psychosis' in which the principles of tolerance of uncertainty and dialogism had been established as working guidelines (ODAP) (n=23). Both groups were compared to a control group of consecutively admitted patients from a similar municipality who received a more conventional approach of need adapted treatment (n=14).

Compared to the comparison group, the ODAP group had fewer residual symptoms, better employment status and fewer relapses than the comparison group. There were few differences between the API and ODAP group.

Both received fewer neuroleptics, had more family meetings and had fewer days in hospital. The ODAP group had significantly fewer hospital days than the API group. However, Seikkula et al. (2003) notes that the API group had higher symptom severity as measured on the Brief Psychiatric Symptom Rating Scale (BPRS) and two individuals had particularly high scores. The small sample sizes (reflective of the small number of new psychosis cases in a small town) mean that results could be skewed relatively easily by one or two individuals. The ratings too, as Seikkula et al. (2003)

group recovered more slowly. However, there were no differences at five years at which point 82% of the ODAP group and 76% of the API group had no residual psychotic symptoms. At least one relapse occurred in 29% of the ODAP group and 39% of the API group over the five years with most occurring within the first two years. The majority of people had returned to work or study at five years (76% of the ODAP patients and 70% of the API group). Most differences between the groups were in favour of the more mature open dialogue approach but failed to reach statistical significance.

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notes, were undertaken by the authors who were not blind to treatment allocation and had developed the OD approach thus introducing potential bias. Thus the positive findings in favour of open dialogue ought to be treated cautiously.

Seikkula et al. (2006) examined data for the API (n=33) and ODAP (n=42) groups after five years. In this instance all people who were treated for first episode psychosis, could be reached at follow-up, and who provided consent were included in the analysis and thus the groups were larger. The duration of untreated psychosis (DUP) was 3.3 months in the ODAP group compared to 4.2 months for the API. The ODAP group had fewer hospital days during the first two years but there was no difference at the five year follow-up period. There were no significant differences between groups on the use of neuroleptics at five year follow up (17% of the ODAP group and 24% of the API group) or use of neuroleptics over the entire five year period (29% of ODAP and 39% of API). The API group had significantly higher BPRS scores at two years which Seikkula et al. (2006) suggested indicated that the

Seikkula, Alakare, & Aaltonen (2011) examined a second cohort of 18 people (ODAP2) with non-affective first episode psychosis who were consecutively admitted to the local service and received open dialogue between 2003 and 2005. This cohort at two years was compared to the previous groups and were found to be younger, single, and more likely to be studying rather than being in employment on first presentation. The DUP had declined to half a month in the ODAP2 group. There was no difference between the two cohorts of ODAP on the number of hospital days experienced by users although 50% of the ODAP2 group had taken neuroleptics and 28% were continuing to take medication (an increase relative to previous groups). The ODAP2 group had fewer residual psychotic symptoms than other groups but had higher overall BPRS scores. In the ODAP2 group 72% had returned to work or study at two years. Seikkula, Alakare, & Aaltonen (2011) included those who were unemployed and not on a disability allowance in the two ODAP groups (13% and 12% respectively) to conclude that in the last two periods

84% were studying, employed, or actively seeking employment at two years follow-up.

In relation to Whitaker's (2010) claim that the incidence of schizophrenia is reducing in Western Lapland Aaltonen et al. (2011) examined in detail the case notes of all first episode case of psychosis before the introduction of OD in the years 1985–1989 and after the introduction of OD from 1990–1994. A rich and detailed description of each case was written up by one of the authors who had not worked previously within the district and a consensus diagnosis was reached between the two principle researchers (sometimes after re-reading the full record). To prevent bias an expert independent psychiatrist who was blind to the consensus diagnosis read a randomised sample of complete records (with dates removed) from both periods and made a diagnosis. The kappa coefficient as a measure of diagnostic reliability was 0.6 ( $p < .001$ ) and the consistency of diagnosis was the same across time periods but with the researchers more likely to diagnose schizophrenia in the second period. It is unclear whether the authors adjusted their diagnoses where there were points of difference with the independent diagnostician.

Aaltonen et al. (2011) state that the incidence of all schizophrenic disorders (i.e., schizophrenia and schizophreniform psychoses) fell significantly (from 73 to 41 patients) or a mean annual incidence of 33.3 between 1985–1989 to 17.1 per hundred thousand between 1990–1994. The reduction in schizophrenia was offset in part by a small but significant increase in brief psychotic reactions (from 3 to 16 patients). Other non-affective psychosis and the incidence of prodromal psychosis essentially remained the same and overall the number of all first admission patients for any diagnosis increased from 173 to 216. Aaltonen et al. (2011) suggest this is evidence that the apparent decline in the number of psychotic patients was not due to an overall decline in the use of psychiatric services. They also note that no new long stay patients (those in hospital for longer than a year) had been admitted since 1992.

## Discussion

The service response in Western Lapland appears to have greatly reduced the duration of untreated psychosis (DUP) in the region. Engagement with the service system might broadly be considered 'treatment' as often this does not include pharmacotherapy. The relationship of DUP to prognosis is unclear and some have argued that a long DUP may be a proxy for a more severe clinical phenotype (Penttilä et al., 2013). To date it is not clear whether a longer duration of untreated psychosis causes poorer outcomes (Marshall et al., 2005). An examination of the relationship between duration of untreated psychosis and outcome 12 years after a first episode of psychosis in Ireland suggested that longer duration of untreated psychosis was highly predictive of more severe symptoms, poorer remission status, poor functioning and quality of life in Ireland. It was not, however, associated with gainful employment or independent living, which the authors suggest might be more related to socio-cultural factors and individual opportunity (Hill et al., 2012). Open dialogue as practiced in Western Lapland does appear to have demonstrated that it is possible to successfully engage with the person's social network to maximise the opportunities that exist. To what extent this can be replicated in other more heterogeneous cultures and different service systems remains to be seen.

On the face of it the changing incidence in new cases diagnosed with schizophrenia and the reduction in residual psychotic symptoms in those that are diagnosed is impressive. The incidence of schizophrenia (new cases per year) has been found to vary considerably across studies. McGrath et al. (2008) examined three systematic reviews on the incidence, prevalence, and mortality associated with schizophrenia in other countries and found a median incidence of 15.2/100,000 persons. The distribution of incidence was right skewed with many more estimates in the upper tail, studies based on higher latitudes having a higher median estimate, males having a slightly higher incidence, migrants having a higher rate and a

trend towards diminishing incidence over time. Suvisaari et al. (1999) has noted a dramatic decline in the age-specific incidence of schizophrenia in Finnish Cohorts born from 1954 to 1965, however these were still many times higher than the non-age specific incidence reported by Aaltonen, Seikkula and Lehtinen (2011).

There is little question that mental health services in Western Lapland appear to have achieved admirable outcomes for people presenting with psychosis in that small community and what they have done and how ought to be scrutinised carefully. It appears that there has been a sustained cultural shift towards a more responsive, psychotherapeutically orientated and community engaged service and a way of working with people in crisis that is largely accepted by the community and seems to work. The way of working has evolved over several decades and as Seikkula et al. (2003) notes the majority of staff working within the service (from all disciplines) are qualified psychotherapists with a minimum of three years postgraduate study in family therapy and/or open dialogue processes. Few services in the world would have available such a concentration of psychotherapeutically informed staff across the service system. This has inevitably contributed to their success.

The small numbers of patients involved in the naturalistic cohort studies point to good outcomes but do not provide compelling evidence about which elements of this integrated service system are pivotal. The differences in outcomes between the early cohort of patients who experience enhanced needs adapted treatment (API), and subsequent patients who received a more developed and proceduralised open dialogue approach are not so convincingly great that one might assume that the open dialogue element is the critical ingredient that has made the difference.

So few are the numbers of people likely to present with first episode psychosis in a small centre such as western Lapland that any number of confounding factors might impinge on outcomes. It would appear that this is a well-established and articulated system of care that needs to be scaled

up and exposed to a randomised controlled trial. However, open dialogue is not any one intervention, but rather a set of principles and practices. It is an approach that integrates other approaches to therapy and care according to need, which again makes it difficult to isolate the ingredients that are critical to success. It would seem that a professional might operate within such a system without necessarily subscribing to a social constructionist view of psychosis (this in itself might be considered one voice amongst many).

The open dialogue approach to psychosis may not presently enjoy overwhelming empirical support but its development has been carefully chronicled. It may be better to judge the philosophical fit of this approach with espoused public policy in relation to family and service user participation and mental health recovery alongside the evidence for its efficacy. In this respect it appears to be most consistent with a person or network-centred, recovery orientated philosophy which is largely an aspiration for many services. It and other dialogical methods are being trialled elsewhere (Ulland, Andersen, Larsen, & Seikkula, 2013) and are prompting the evolution of new ways to evaluate mental health treatment and the quality of therapeutic dialogue (Borchers et al., 2013; Olson et al., 2012; Seikkula et al., 2013). Open dialogue as conducted by committed and skilled practitioners appears to be safe and worthy of consideration for services seeking to become more congruent with extant public policy.

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