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Mental Health Commission of New South Wales

Open Dialogue: A Recovery-Oriented Practice

The Collaborative Pathway

and

Open Dialogue in Community-Based Flexible Supports

at Advocates

Christopher Gordon, MD

Medical Director, Advocates

Associate Professor Psychiatry, Part-Time

Harvard Medical School

cgordon@advocates.org

Brenda Miele Soares, MSW, LICSW

Vice President, Behavioral Health, Advocates

bmiele@advocates.org

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Who we are and why we're here

- Learned about Open Dialogue from Robert Whitaker in 2009, and have been working to adapt this model to our agency since then.
- We've developed two programs – one for people in acute psychiatric crisis, the other for people with longstanding conditions – and we would like to share our experience and lessons learned so far.
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  - Residential services; Outpatient services; Crisis services
  - A holistic, strength-based approach, working with people with serious challenges
- Discouraged by standard care
  - Low rates of functional recovery
  - High rates of "chronification"
  - Appalling rates of early death
  - Frequent complaints from people receiving services
  - Disturbing findings regarding the pharmaceutical industry and academic psychiatry
- Awakened to new possibilities by the advent of the Peer Specialist movement in the US
  - The multiplicity of paths to recovery
  - The critical importance of empowered voice in many paths
- Bottom line: we are impressed with this model but it's not magic

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What is Open Dialogue?

- In some ways, it's back to the future – the very best of Crisis Intervention.
- A way of working with people in **psychiatric crisis** developed in Tornio, Finland, over the last 30 years.
- A **system of care** that includes crisis services, inpatient services, outpatient services, psychiatrists, nurses, therapists.
- The person is seen rapidly, in the most normal circumstances possible – ideally at home – with family and other supports.
- The network and the clinical team together try to figure out what would be best to do and not do.
- The team sticks with the person and the family, wherever the need takes them, for however long is required.
- Neuroleptics are used sparingly, at low doses if possible and for shorter periods of time if possible than is typical in the US.

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7 principles of Open Dialogue

- Immediate help
- Social network perspective
- Flexibility and mobility
- Responsibility: team provides what's needed
- Psychological continuity: team follows patient
- Tolerance of uncertainty (slow to diagnose/slow to explain)
- Dialogism (including professional transparency)
- PLUS: "gentle psychopharmacology"

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Some distinguishing features

- More than one clinician
- All decisions made in front of the family/network
  - "staff meeting" in front of the family
  - Family welcome to respond
  - Not a democracy, but very egalitarian
  - Two modes of professional speaking
    - Reflection
    - Ordinary discourse
  - "Sitting around a kitchen table"
  - More of an emphasis on what happened, not what's wrong
  - Stories over symptoms
  - Super-Shared Decision Making
- For definitive paper, see Olson, M, Seikkula, J. & Ziedonis, D. (2014). The key elements of dialogical practice in Open Dialogue. The University of Massachusetts Medical School. Worcester, MA

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Extraordinary Results

	ODAP Western Lapland: 1992-1997	Stockholm: 1991-1992
Diagnosis:	N=72	N=71
Schizophrenia	59%	54%
Other non-affective psychosis	41%	46%
Mean age years		
female	26.5	30
male	27.5	29
Hospitalization: days/mean	31	110
Neuroleptic used-ongoing	17%	75%
GAF at follow-up	66	55
Disability allowance/sick leave	19%	62%

**Svedberg, B., Mesterton, A. & Cullberg, J. (2001). First-episode non-affective psychosis in a total urban population: a 5-year follow-up. Social Psychiatry, 36:332-337.*

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Five and ten year follow up

	ODAP 1994-1997	ODAP 2003-2005
Diagnosis:	N=42	N=18
Schizophrenia	41%	22%
Other non-affective psychosis	22%	22%
Mean age years	26.8	20.2
Hospitalization: days/mean	9.3	13.6
Neuroleptic used-ongoing	11%	28%
Employment Status		
Studying or Working	78%	72%
Unemployed	13%	12%
Disability allowance/sick leave	9%	16%

*Seikkula, J., Alakare, B., Aaltonen, J. (2011). The Comprehensive Open-Dialogue Approach in Western Lapland: II. Long-term stability of acute psychosis outcomes in advanced Community care.

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Generating tremendous interest

- Could it be possible to bend the clinical curve away from chronicity?
- Could it be possible to use less neuroleptic medications?
- Could it be possible to decrease the sense of alienation and polarization that so often occur?
- This leads to great interest, and maybe some unrealistic expectations…

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A bit of the history of Open Dialogue

- Open Dialogue began in a process of “de-institutionalizing” a chronic hospital.
- This involved moving people with longstanding psychiatric conditions to the community, and helping them to remain there.
- It involved creating flexible, mobile, multidisciplinary crisis teams.
- And the creation of a network of outpatient supports.
- It occurred at a time of great interest in working with families.
- It incorporated pioneering work by Tom Anderson, Magnus Carlson, Jaakko Seikkula, and others, especially the work on Need-Adapted Treatment by Yrjo Alanen.
- Need Adapted Treatment is very much based on the bio-psycho-social model, without privileging any one model over another.
- This meeting people where they are, using whatever lens best makes sense, is at the heart of Open Dialogue.
- Note that this arose in the same era as the pioneering, early intervention work in Australia by Pat McGorry and others, but comes at early intervention through a bit of a different paradigm, I think.

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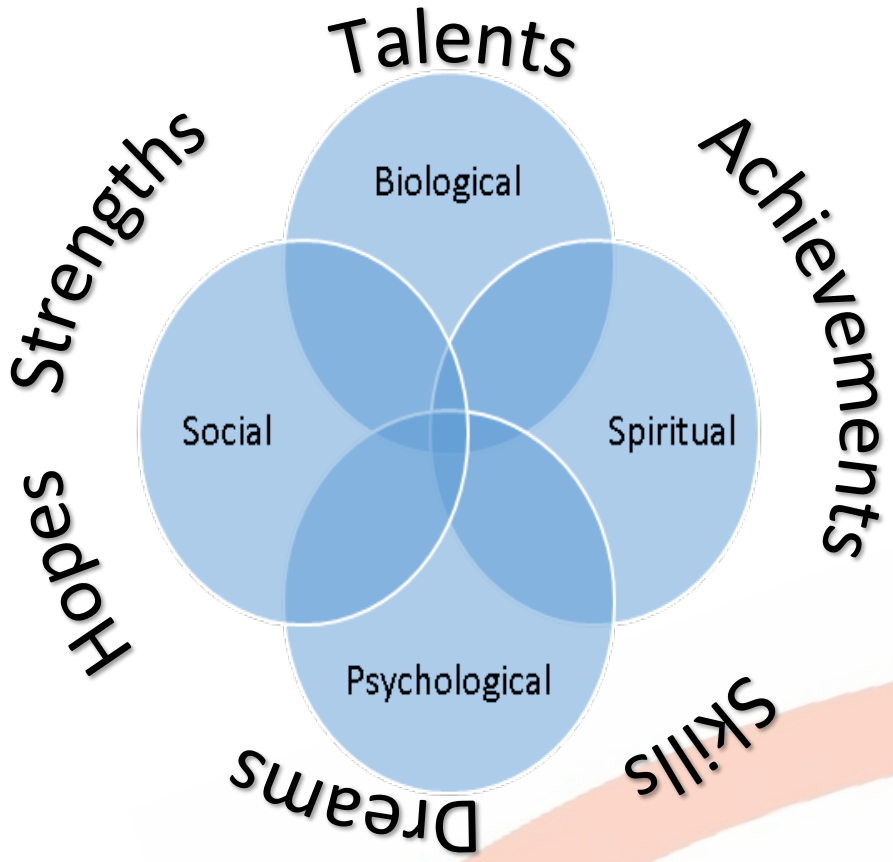
The Bio-psycho-social-spiritual Model



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Pernicious certainties – biological

- Disease focused paradigm in the US.
- Schizophrenia seen as a well understood, progressive, neurodegenerative disease[2]
- Schizophrenia seen as having a grim prognosis absent antipsychotic treatment[3]
- Psychosis seen as neurotoxic, akin to “kindling”[4]
- And antipsychotic seen as neuroprotective[5]
- Declining or refusing antipsychotics tends to be equated with anosognosia.
- Therefore shortening DUP with antipsychotics and preventing noncompliance are keys to good outcome

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In this setting

- We may alienate the person at the center of concern.
- We can diminish the agency of the person.
- We may “freeze” the situation and inadvertently block natural resolution.
- We may use inadvertently grim, “violent” language.
- We may oversell antipsychotics.
- Results in high rates of noncompliance, often surreptitious.
- Results in polarization/alienation/chronicity.

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Open Dialogue uses a crisis model, not a disease model.

- Crises resolve; crises are opportunities; people in crisis need support.
- Diagnoses can “freeze” situations and impede resolution and recovery.
- We have always known that many people can recover from a psychotic episode: this model seeks to optimize the chances for such recovery.
- Therefore,
  - be *slow to diagnose,*
  - *slow to explain;*
  - *Provide practical, helpful support;*
  - *beware of psycho-education that implies more certainty than is warranted.*

- Open Dialogue involves modest goals: restoring the “grip on life.”
- Open Dialogue is not a “sticky system.”
- The voice of the person at the center of concern *must* be heard.

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Crisis Psychiatry: general principles

- Feeling welcomed, safe, included in all decisions, and *understood as you understand yourself* promotes better outcomes.
  - If you feel like the doctor, nurse or therapist "gets it" as you understand the situation, it helps.
- Things often look better in the morning, and often better when we bring the family together.
  - Time helps.
  - Time together helps.
  - Getting more input helps.
- Crisis really does = danger + opportunity.
- We want to optimize chances for a good outcome, and do what we can to avoid a bad one. There are risks from under-treatment and risks from over-treatment.

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Positive aspects of Open Dialogue

- Conveying deep welcoming, “normalizing” and respectful engagement
- Demystifying the clinical process
- Avoiding or minimizing the “clinical gaze”
- Delaying diagnosis
- Making space, time, and opportunity for natural resolution, healing and growth
- Minimizing toxic interventions and treatments
- These are elements that also characterize many other early intervention programs.

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However…

- Even Open Dialogue can be susceptible to its own pernicious certainties!
  - "Psychosis is something between people"
  - "Psychosis is socially constructed"
  - As opposed to "can be…"
  - Can lead to romanticizing the experience of psychosis, and underestimating the dangers and risks.
  - Can lead to the belief that anosognosia does not exist.
  - Can lead to demonizing medications.
  - This in turn can lead to unrealistic hopes and expectations for some people and their families.

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A few caveats about Open Dialogue as we see it.

- Open Dialogue is not anti-psychiatry
- Open Dialogue uses diagnostic language
- Open Dialogue is not anti-medication
- Open Dialogue is not against people using hospitals
- Open Dialogue is not the answer for everybody
- Open Dialogue does not enable everyone to go off of neuroleptics

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Open Dialogue seemed like a natural fit for Advocates

- Non-profit provider of full services for people with psychiatric as well as other life challenges
- 24/7/365 mobile crisis team
- Robust outpatient services
- Robust community based, residential supports
- Employment and other outreach supports
- Very holistic, strength-based, and person-centered clinical philosophy

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Open Dialogue at Advocates: Two Programs

- The Collaborative Pathway
  - Based on emergency services/outpatient platform
  - Intended to serve individuals more at the start of their psychiatric experience
  - Hoping to bend the clinical curve away from chronicity

- Open Dialogue in Community-Based Flexible Supports
  - Serving individuals receiving CBFS services
  - Department of Mental Health connected
  - Not at the start of their psychiatric experience

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We received grant and research support for two programs

- **Foundation for Excellence in Mental Health Care** provided funding for **Collaborative Pathway**.
  - We partnered with The **Boston University Center for Psychiatric Rehabilitation**, with Sally Rogers and Vasuda Gidigu
- The **Department of Mental Health** provided funding for **Open Dialogue in CBFS** (Community-Based Flexible Supports).
- And have joined the **University of Massachusetts Open Dialogue Project** with Professor Doug Zeodonis, and Mary Olson and their team.

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Our Training

- 35-member team certified in Open Dialogue under the direction of Mary Olson, PhD, Executive Director of the Mill River Institute for Dialogic Practice in Haydenville, Massachusetts, in partnership with Jaakko Seikkula, PhD.

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Collaborative Pathway

- Young people hopefully early on in psychiatric experience (ages 14 – 35)
- With support of families
- Without severe risk factors or severe substance use
- Psychosis from any diagnosis

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Collaborative Pathway: Preliminary Findings

- 14 families served
- No significant adverse events other than psychiatric hospitalizations (30% of families)
  - No suicide attempts
  - No acts of violence
- For 70% of the families, whether or not to take medications was a central issue at the start of engagement
- Of those who did engage, at or near a year of treatment
  - 9 of the persons at the center of concern are working or in school
  - 11 have significantly improved family connections
  - 8 are on no antipsychotics and are doing well
  - 3 are on reduced on antipsychotics and are doing well
  - 4 are on antipsychotics of their own choice

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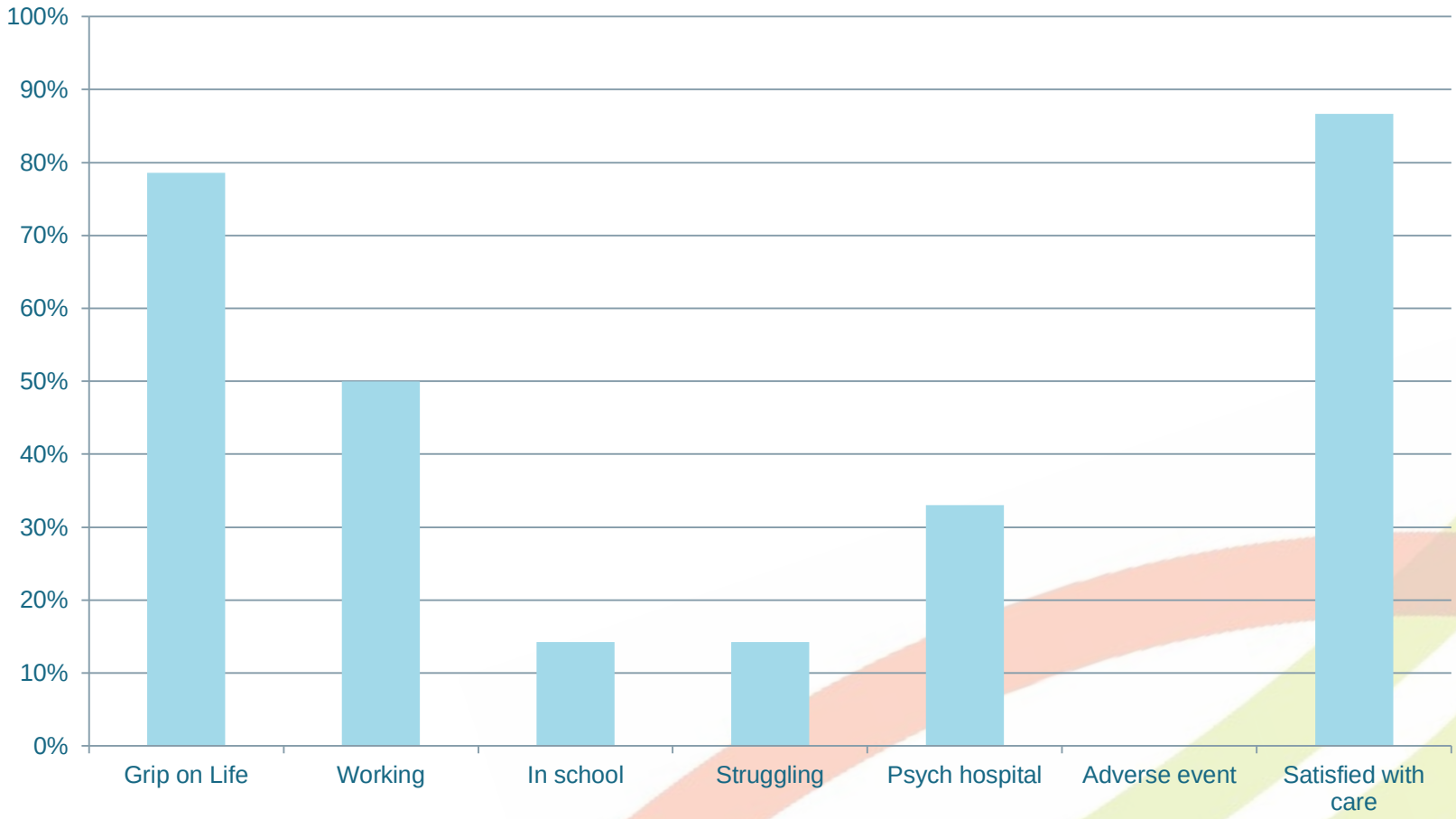
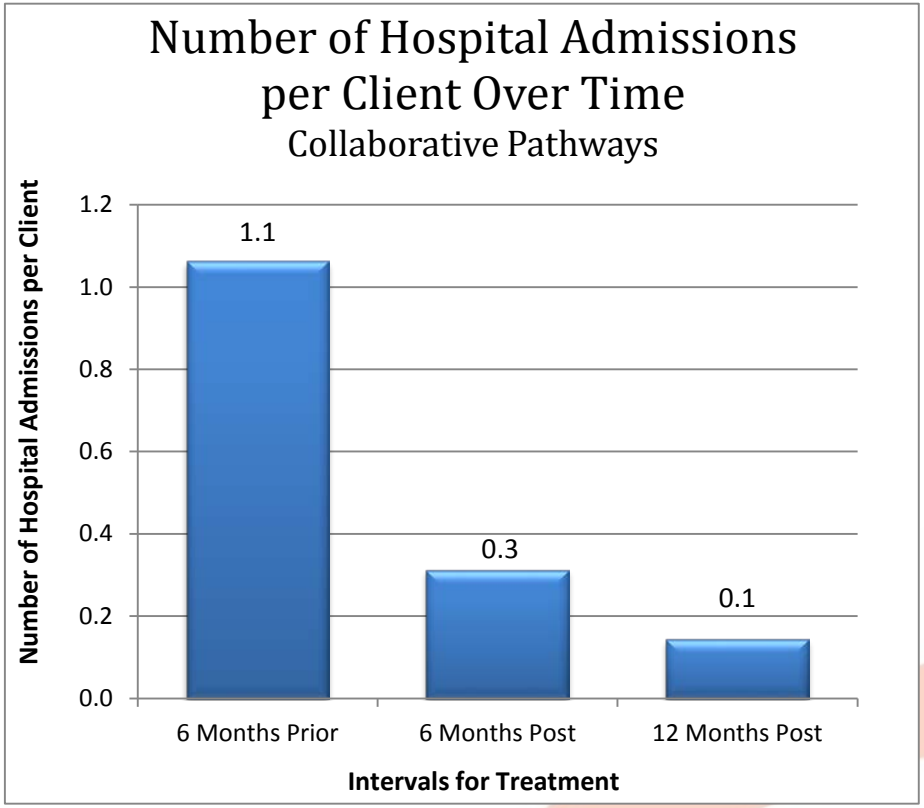
Collaborative Pathway: one year outcomes



Hospital Admissions per Client



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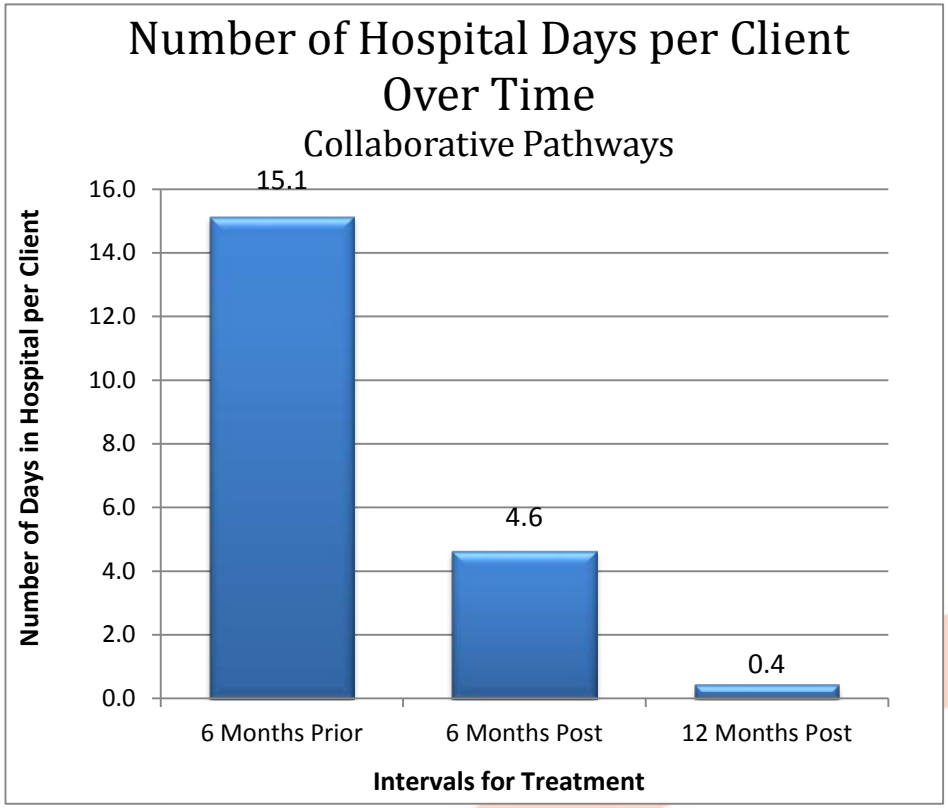
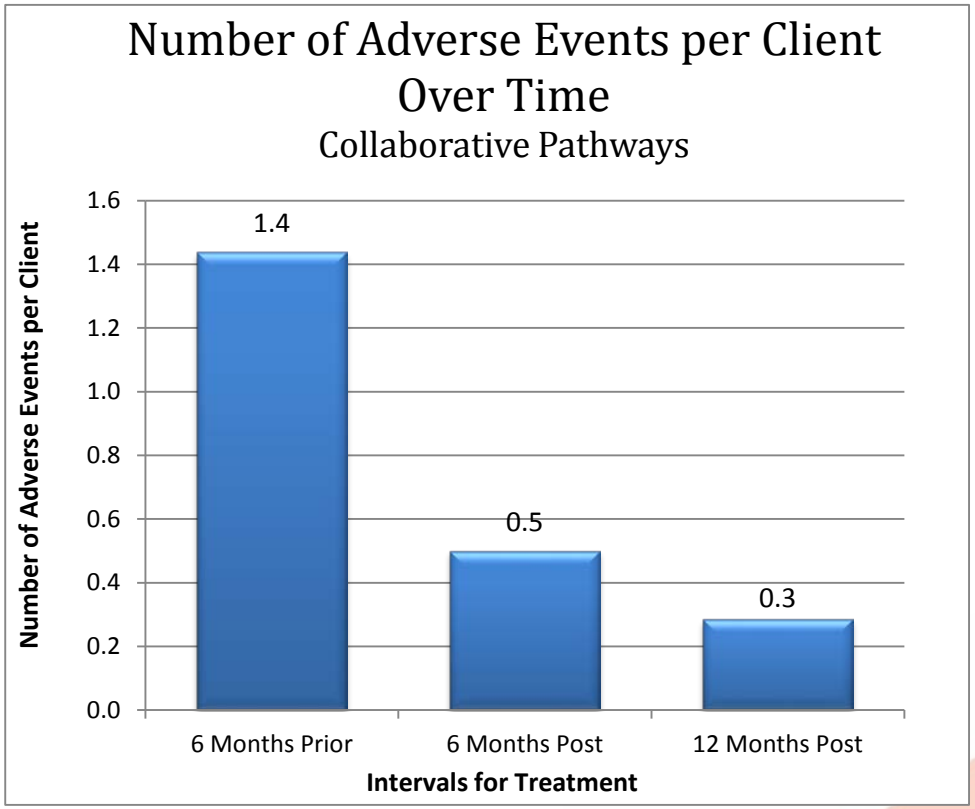
Hospital Days per Client



Unplanned Hospitalizations and Adverse Events



Adverse Event Criteria:

- Suicide attempt (0)
- Violent/Assault (0)
- Police involvement/Arrest (0)
- Other violent or disruptive events (0)
- Unplanned psychiatric admissions

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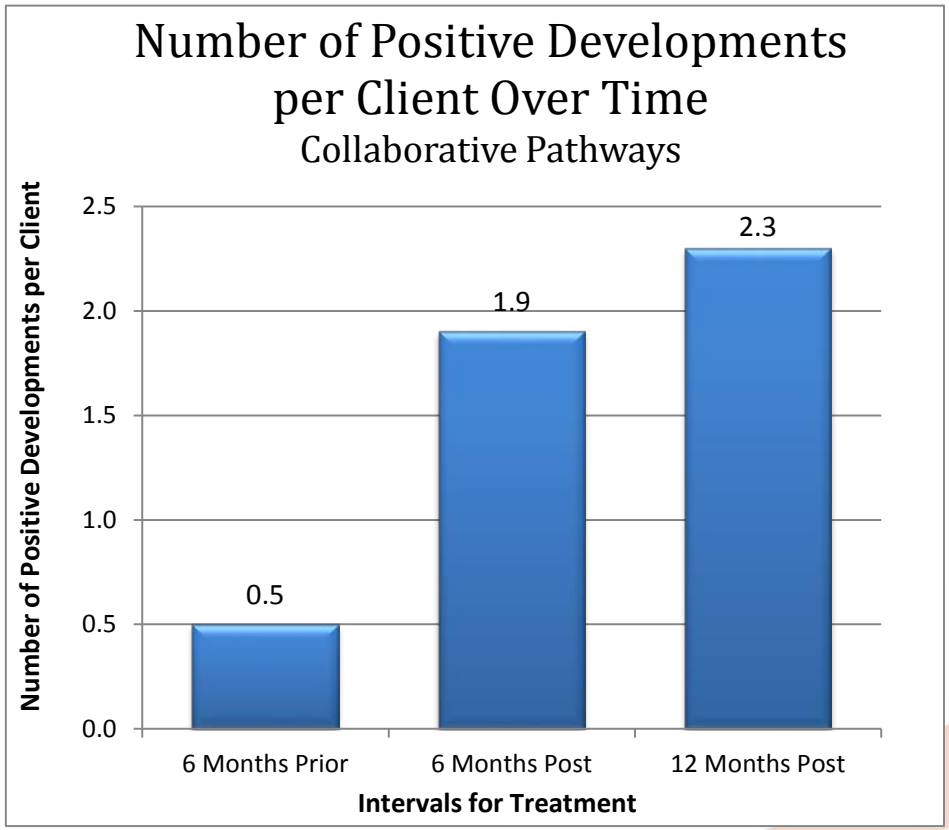
Positive Developments per Client



Positive Developments Criteria:

- Starting to work or attend school
- Substantially improved or new relationship
- Other engagement in living
- Any other meaningfully positive improvements

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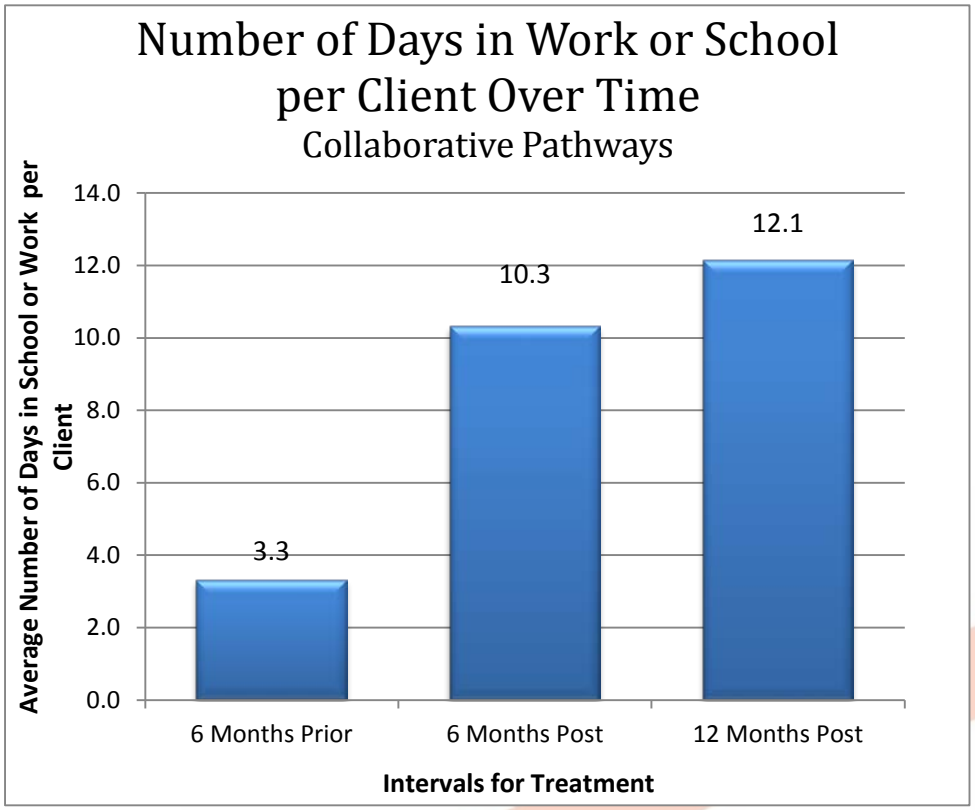
Days in Work/School per Client



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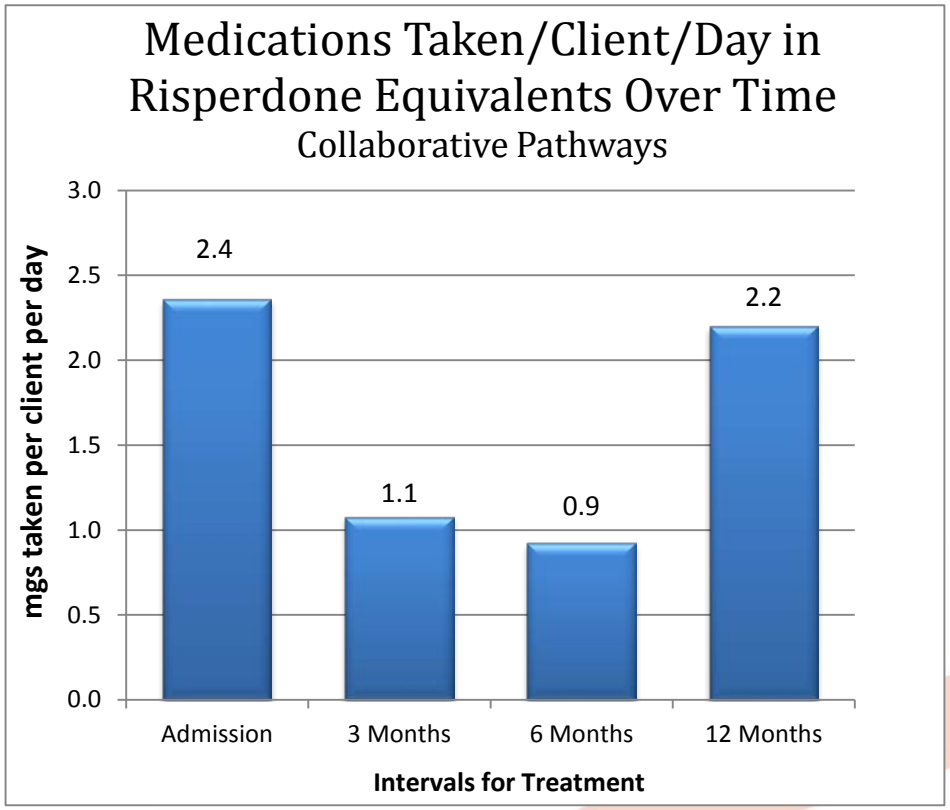
Dosage, Risperdone Equivalents:
Clients Completing 12 Months in Program (n=10)



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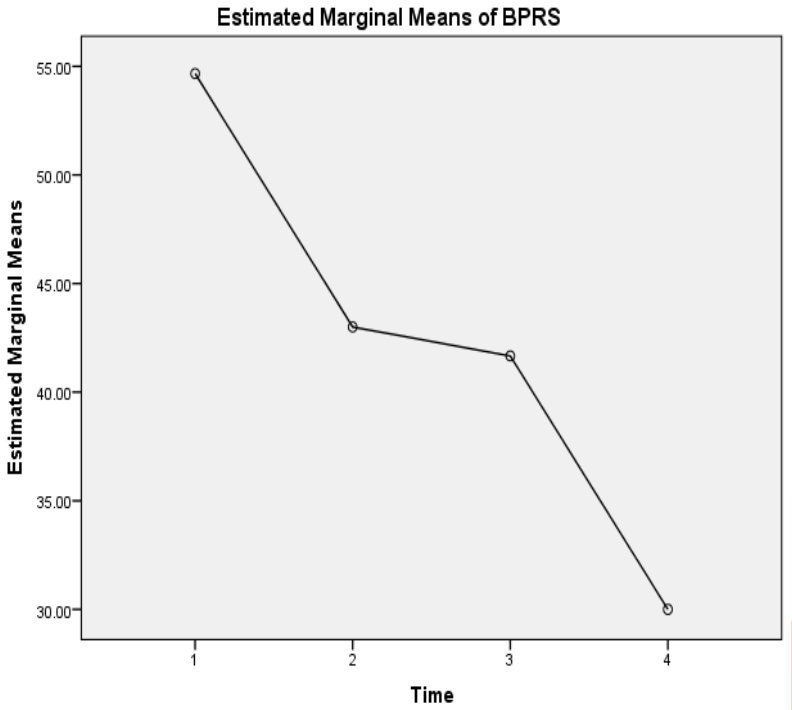
BPRS Scores over time (lower score is better)



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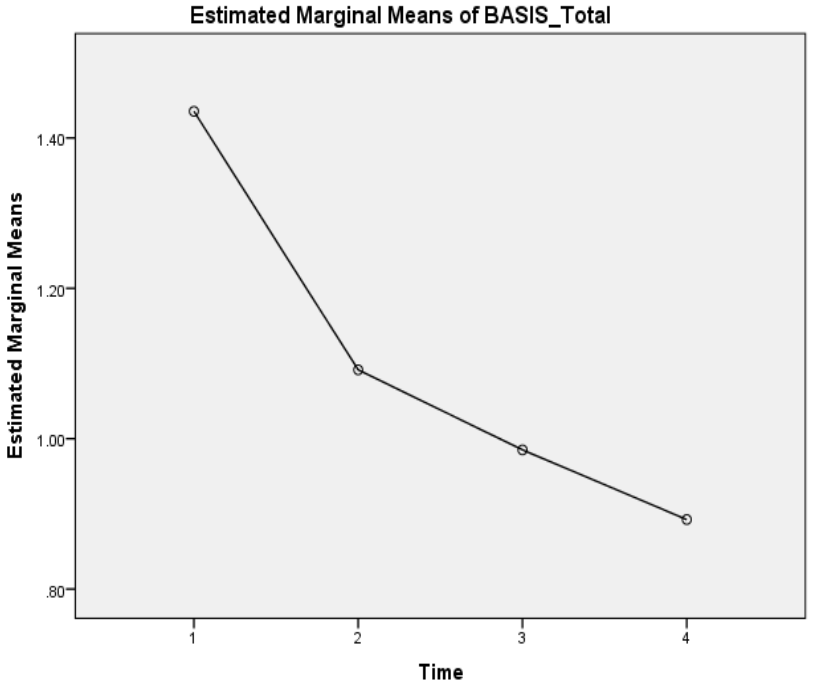
BASIS 24 Scores over time (lower score is better)



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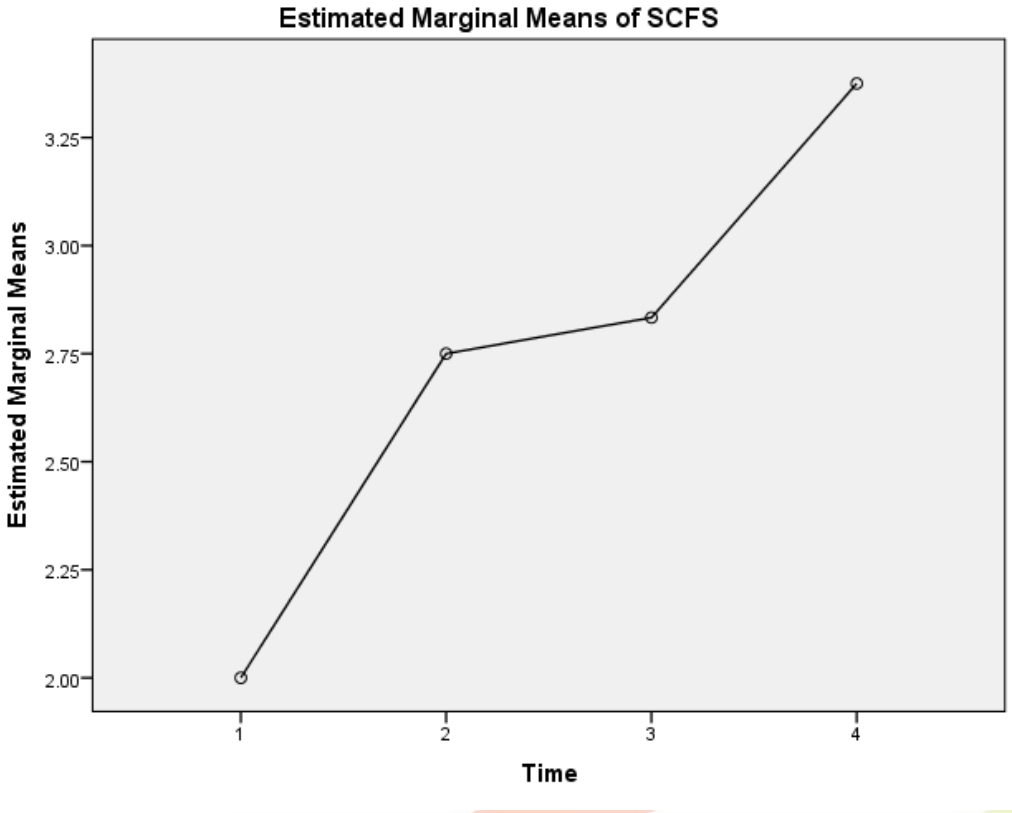
Strauss Carpenter Functioning Scale- Scores over time (Higher scores are better)



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Decision Self Efficacy Scale

The ‘Decision Self-Efficacy Scale’ measures self-confidence or belief in one’s ability to make decisions, including participate in shared decision making.

DSES showed a trend in the positive direction but this change was not statistically significant.

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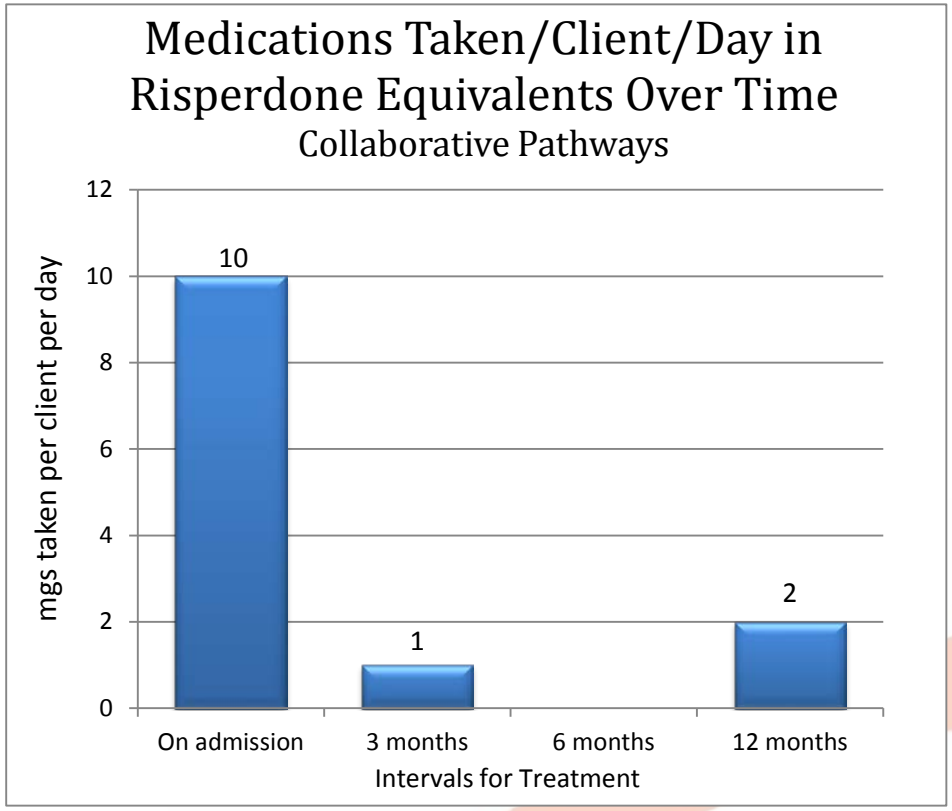
Client 0876: reducing antipsychotics



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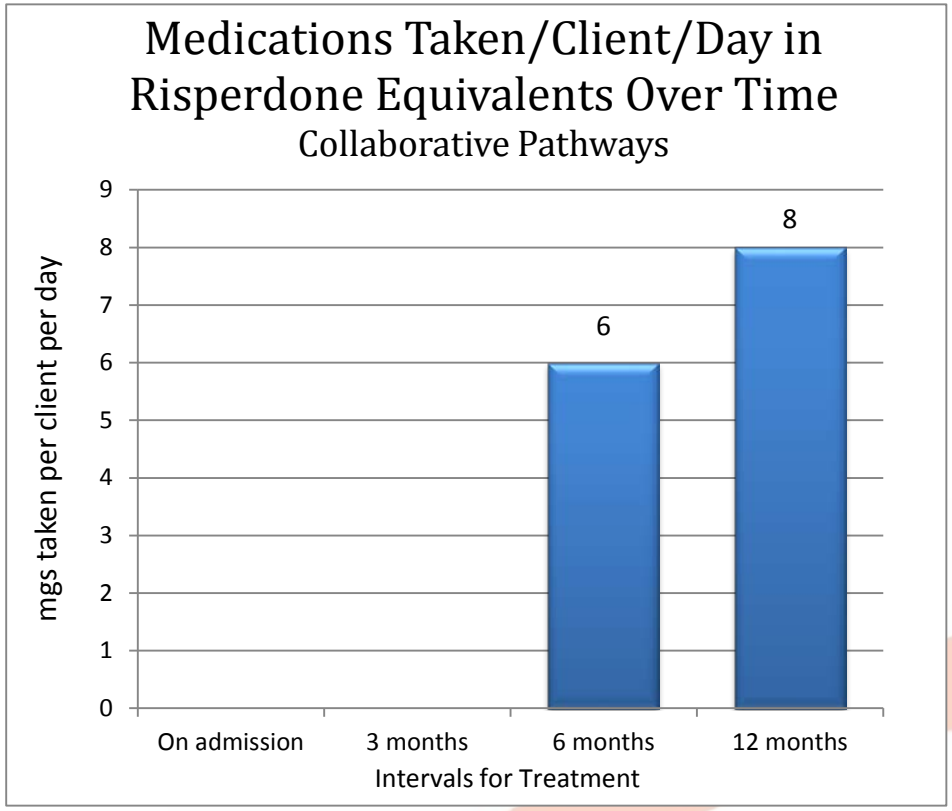
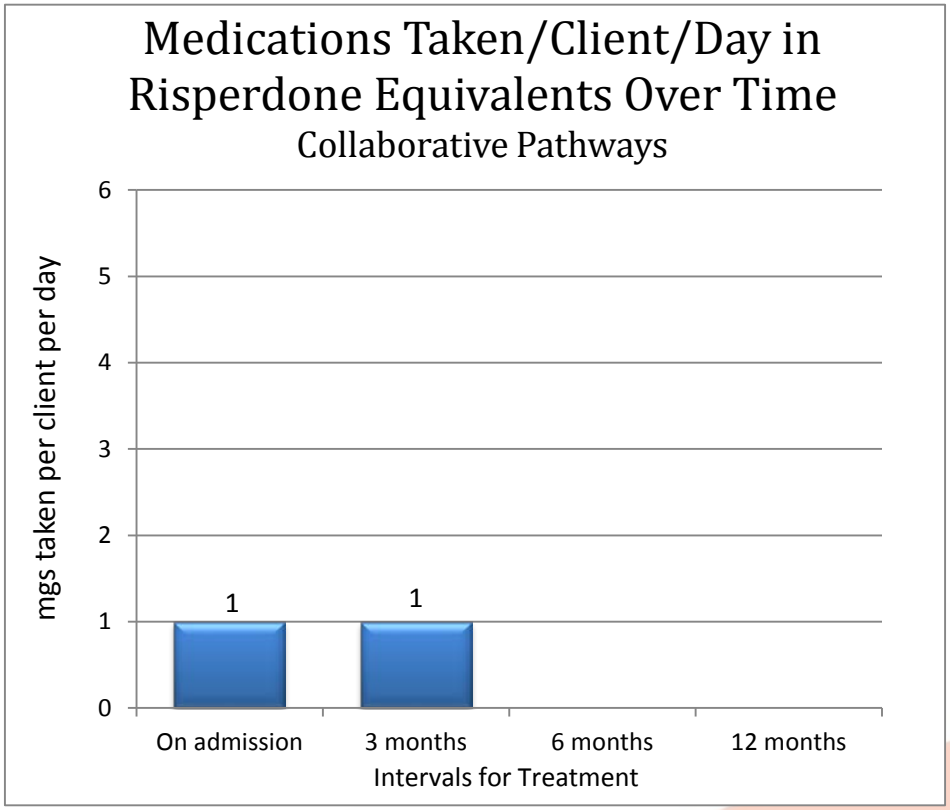
Client 5636: finding an acceptable med



Client: 3764 tapering to zero



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Open Dialogue in Community-Based Flexible Supports (CBFS)

- People who were unhappy with treatment in CBFS
- People with frequent hospitalizations and “not doing well” clinically
- People new to DMH, with hope to avoid life long services
- Others who requested Open Dialogue services
- Two families who did not meet criteria for Collaborative Pathway
- The person could have any diagnosis but were experiencing psychosis

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Open Dialogue in Community-Based Flexible Supports (CBFS)

- 15 People/families served:
- 9 individuals experienced positive outcomes as a result of Open Dialogue.
  - Less hospital days
  - Greater sense of being heard; great alliance
  - Improved involvement of networks of support
  - Treatment plans much more acceptable to the person at the center of concern
- 3 individuals experienced poor outcomes
- 3 more equivocal outcomes

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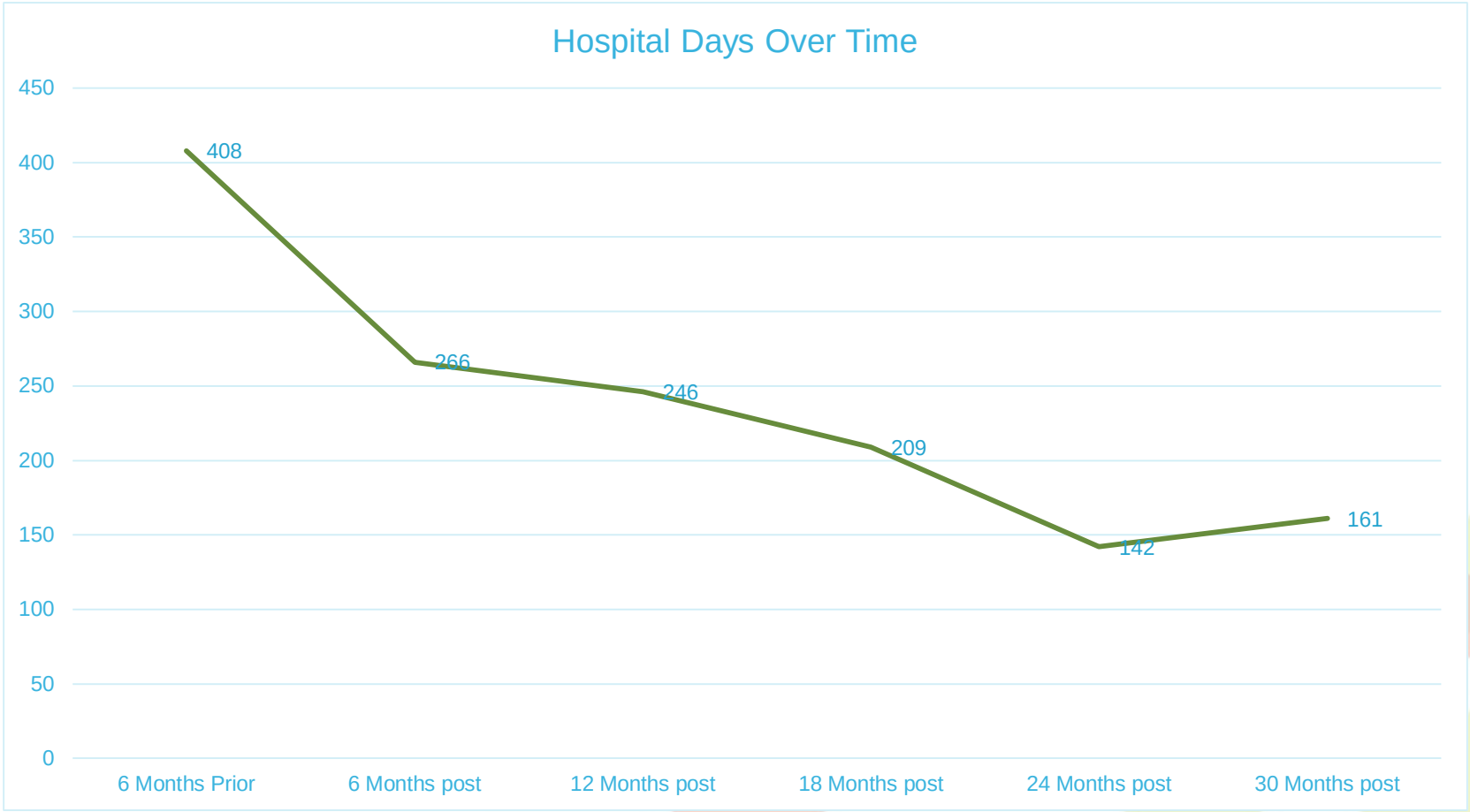
Open Dialogue in CBFS



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OD in CBFS: some positive outcomes

- Person at center of concern felt heard, respected, and better understood.
- Families often felt radically more engaged in being part of a helping team.
- One person's relationship with her staff shifted such that she and the team could "hold" her suicidal feelings with less action and less distress
- One person was able to engage with their family in a new and radically more satisfying way
- Sometimes medications were able to be adjusted in ways more acceptable to the person's wishes.
- In one instance the person became more trusting of the team and actually utilized hospitalizations **more**, to his benefit.
- In one instance, when the storms of psychosis returned with full force, this approach enabled the team and family to bear it together.

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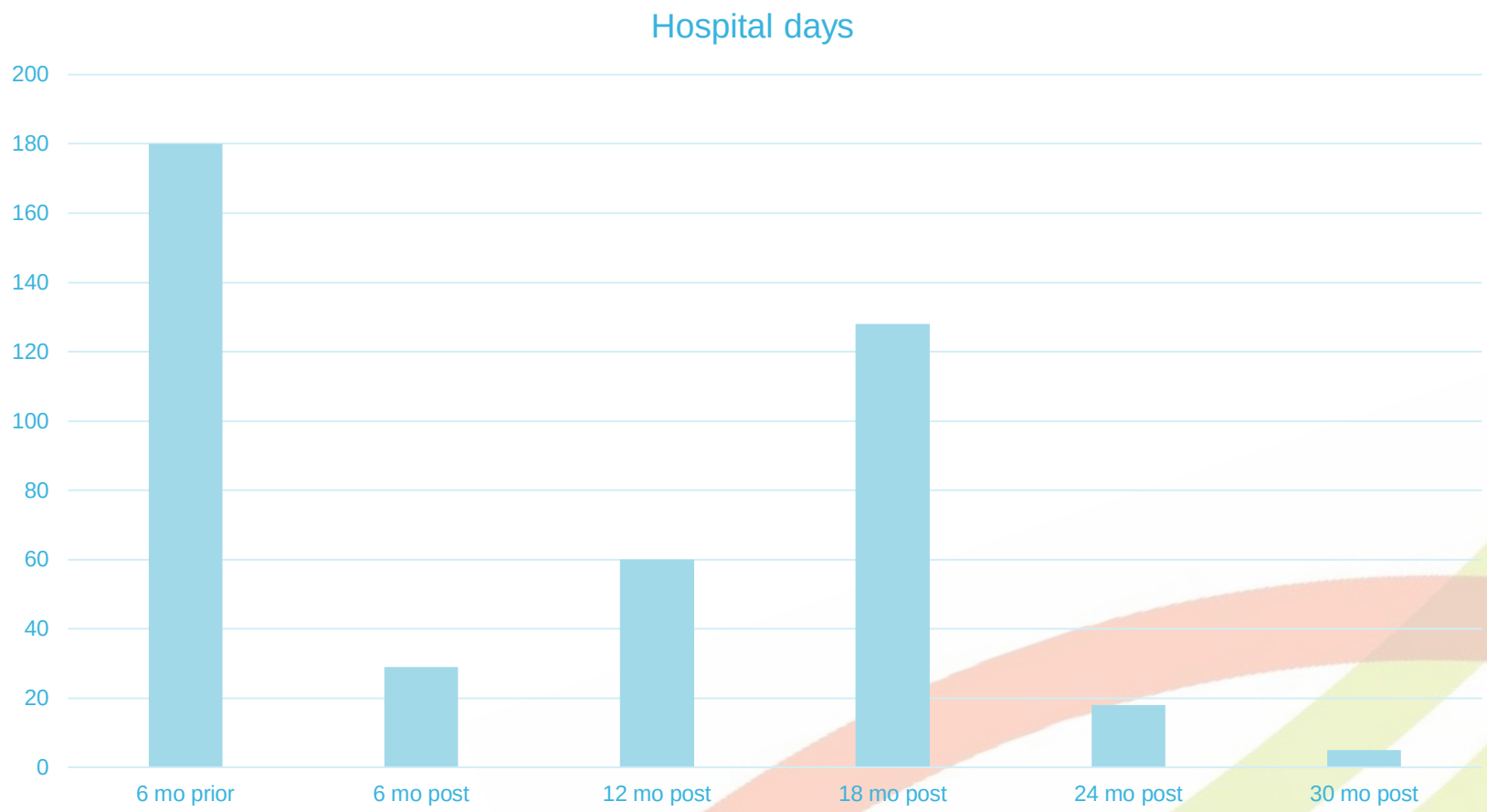
Client 457



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OD in CBFS: some poor outcomes

- Some families came in with very high hopes that Open Dialogue would **eliminate or replace the need for all psychiatric medications**.
- In some instances in which families hoped to stop all medications, it seemed too dangerous, and to involve too much suffering to do so.
- In some instances, the people at the center of concern had traveled a long way for treatment, leaving their network behind.

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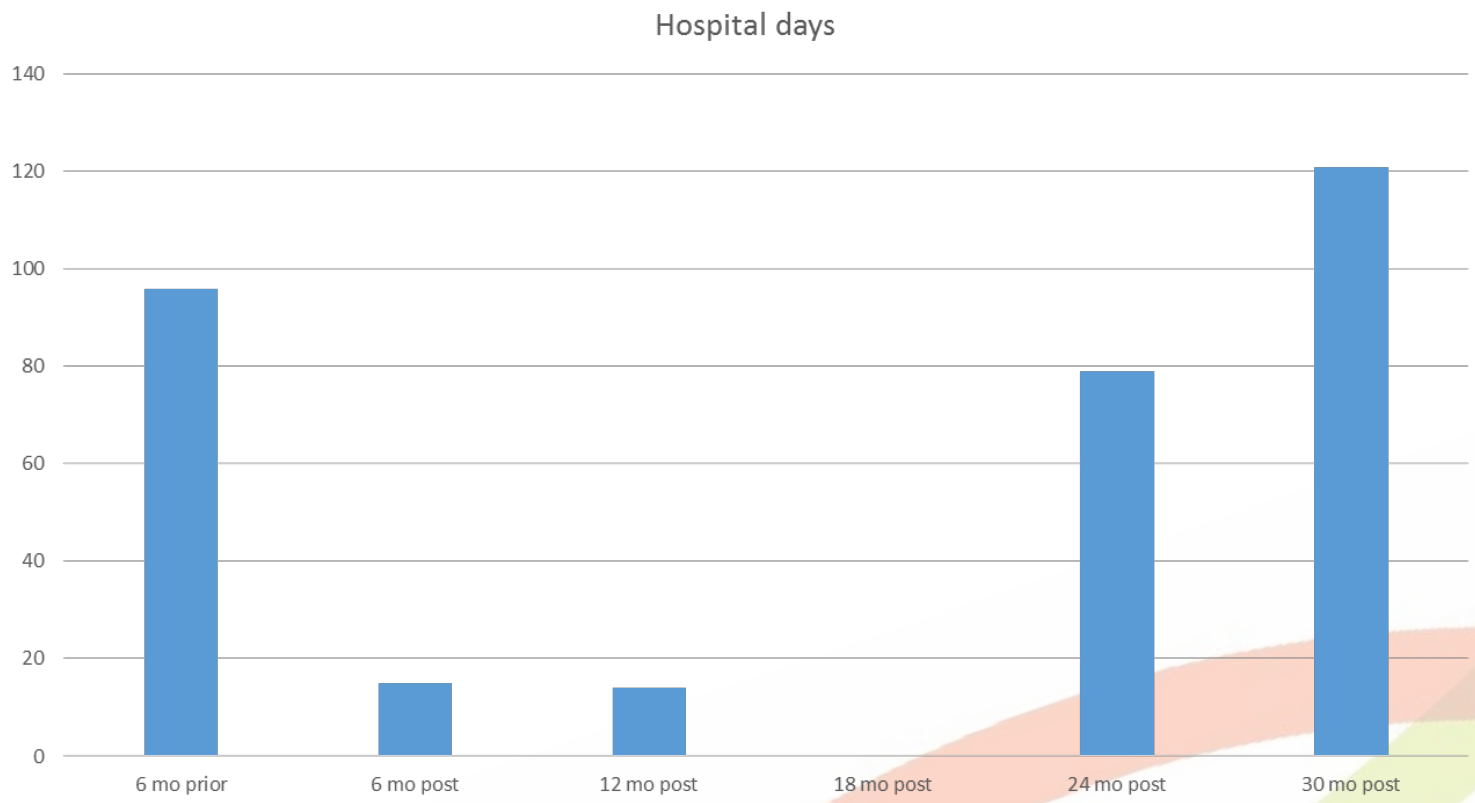
Client 843



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Lessons Learned: Open Dialogue can be provided safely in a US context

- This method can be done with relative safety, if there is
  - careful assessment up front – a possible modification of Finnish practice;
  - proactive crisis planning;
  - buy-in by the family and person at the center of concern; and
  - real 24/7/365 availability of help.

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Lessons learned: By and large, people love this process.

- People at the center of concern and families like this process
- Decreases isolation – of both the person and the family
- Makes the clinical processes transparent and understandable
- Elicits creativity and engagement
- Opens pathways for staying connected
- Protects the dignity and autonomy of the person at the center of concern

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Lessons learned: Open Dialogue creates a very good environment for people and families to engage the question of the use of medications.

- Promotes shared decision making
- By giving and respecting real options, space is created for the person at the center of concern and the family to hear each other's concerns
- The way the problem is defined, the various paths for dealing with the problem are open for mutual examination
- This model seems to decrease the toxicity of the language and process of diagnosis and treatment

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Lessons learned: Open Dialogue creates a good space for processing setbacks and conflicts

- Safe exploration of differences.
- Steadying place to regroup, learn from what occurred.
- Defends and protects the relationship.
- A good space for exploring alternative approaches to stuck communication.

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Lesson learned: slow diagnosis can be helpful

- Leaving open the issue of diagnosis can sometimes make room for natural resolutions, and family-centered paths to recovery and care.
- Taking time with diagnosis sometimes clarifies issues that move the diagnosis away from schizophrenia, and toward other possibilities.
- Leaving open the issue of diagnosis seems to diminish the toxicity of language and the power differentials which often accompany more conventional medical practice.

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Lessons learned: sometimes the Open Dialogue process connects people with resources.

- Peer Specialists
- DBT
- Employment supports
- Psychopharmacological options
- Other psychotherapy

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Lessons learned: radical hospitality, radical humility promote partnership

- In deviation from Finnish practice, I tend to explain everything. This is not universal on our team.
- In solidarity with Finnish practice, we all hold our ideas lightly.
- There are many paths to recovery, some surprising and unpredictable.
- Shared decision making means sharing ideas and information and uncertainty. The treatment team's honesty, clarity and humility promote this is process.

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Lessons learned: at least two clinicians, in the home if at all possible.

- It takes a village.
- Reflective speaking deepens dialogue.
- Being a guest changes everything for the clinical team.
- It's fine for the MD not to be there.

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Lessons learned: it's not magic

- Psychosis does not usually "melt," "dissolve," or "evaporate" with dialogue.
- On the other hand, when any of us feels heard, safe, and respected, problems that are intensified by stress can soften or fade, including psychosis.
- Moreover, when we make a space for the experience of the person having an extreme state, we, they and the family often find meaning and understand the person in important ways that otherwise might not be heard.
- Psychosis in its most violent and dangerous forms, is like a terrible force of nature – like a tsunami or a cyclone – and sometimes all of our tools and efforts are puny and ineffective.

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Lessons learned: this is the treatment model we'd want for ourselves.