PEER-SUPPORTED OPEN DIALOGUE

SOCIAL PSYCHIATRY CONFERENCE

DLOUHÉ STRÁNĚ
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Mark Hopfenbeck
Assistant Professor
Norwegian University of Science and Technology

Visiting Fellow
London South Bank University

‘Embracing a social paradigm could generate real progress…’

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Editorial

The future of academic psychiatry may be social

Stefan Priebe, Tom Burns and Tom K. J. Craig

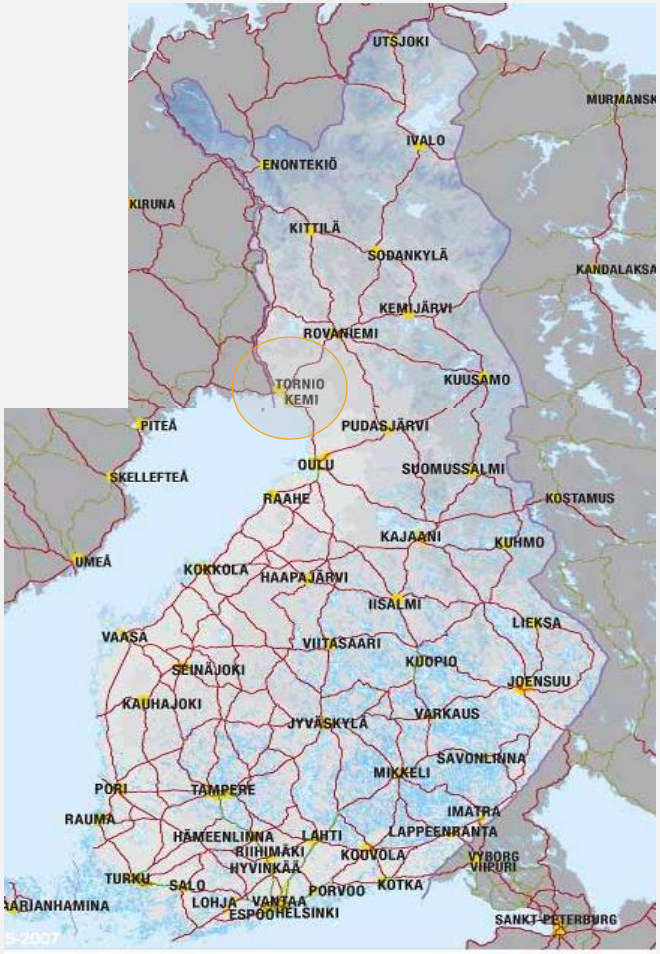
Summary
The past 30 years have produced no discoveries leading to major changes in psychiatric practice. The rules regulating research and a dominant neurobiological paradigm may both have stifled creativity. Embracing a social paradigm could generate real progress and, simultaneously, make the profession more attractive.

Declaration of interest
None.

“Tend to the social and the individual will flourish”

- Jonathan Rutherford 2008 p. 18

Where it all began



HISTORY OF OPEN DIALOGUE

- Practice came first, theory and explanations later during the studies
- Need-Adapted approach, integrating systemic family therapy, network therapy and psychodynamic psychotherapy
- Network meetings since 1984
- Systematic analysis of the approach since 1988 - ”social action research”
- Systematic family therapy training for the entire staff - since 1989

- *OD is not a strategy or a technique, but a way of thinking and relating to other people, ‘a way of life’.*

Becoming Dialogical: Psychotherapy or a Way of Life?

Jaakko Seikkula

University of Jyväskylä, Finland

After birth the first thing we learn is becoming a participant in dialogue. We are born in relations and those relations become our structure. Intersubjectivity is the basis of human experience and dialogue the way we live it. In this paper the dilemma of looking at dialogue as either a way of life or a therapeutic method is described. The background is the open dialogue psychiatric system that was initiated in Finnish Western Lapland. The author was part of the team re-organizing psychiatry and afterwards became involved in many different types of projects in dialogical practices. Lately the focus has shifted from looking at speech to seeing the entire embodied human being in the present moment, especially in multifarious settings. Referring to studies on good outcomes in acute psychosis, the contribution of dialogical practice as a psychological resource will be clarified.

Psychiatry Research
Volume 270, December 2018, Pages 168-175

The family-oriented open dialogue approach in the treatment of first-episode psychosis: Nineteen–year outcomes

Tomi Bergström [a], Jaakko Seikkula [a], Birgitta Alakare [b], Pirjo Mäki [c, d], Päivi Köngäs-Saviaro [b], Jyri J. Taskila [b], Asko Tolvanen [e], Jukka Aaltonen [a]

"FINDINGS INDICATED THAT MANY POSITIVE OUTCOMES OF OD ARE SUSTAINED OVER A LONG TIME PERIOD."

FAMILY/NETWORK IS KEY TO BETTER CARE & OUTCOMES

- "Having friends (& a social network) is associated with more favourable clinical outcomes and a higher quality of life in mental disorders" (Giacco et al., 2012)
- Risk of unnatural death reduced by 90% when there is family involvement from the start (Medical Research Council AESOP – 10 year Study, 2015)
- "A systematic review of Randomised Controlled Trial (RCT) evidence suggests that family therapy could reduce the probability of hospitalisation by around 20%, and the probability of relapse by around 45%" (Pharoah 2010)
- "The estimated mean economic savings to the NHS from family therapy are quite large: £4,202 per individual with schizophrenia over a three-year period"

Fundacja Polski Instytut Otwartego Dialogu

Leonardo Da Vinci Project 2013-2015

Education and Culture
Lifelong learning programme
LEONARDO DA VINCI

PROJECT PARTICIPANTS EVENTS ACTION PLAN MATERIALS CONTACT

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PROJECT

OBJECTIVES OF THE PARTNERSHIP

Our main objective is the build European partnership to spread the power of ODA practices in the healing process of the patients with psychosis. The project will be oriented to gather the existing knowledge, competences and experiences in the countries which started ODA in Europe (Finland, Norway, Denmark) and help these countries which joint the group later (Germany, Lithuania, Austria and Poland).

SPECIFIC GOALS

1. Improve the social network orientation in all participating countries and thus optimize the use of national resources, both professional and the patient and their network.
2. Organize different kinds of educational programs for professionals/employees in implementing ODA.
3. Create meetings and workshops concerning ODA to learn from each other and exchange experiences between the professional workers both national and international
4. Arrange a regional education programmes for employees
5. Arrange open workshops

NTNU

Global Initiatives
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Preparing the Open Dialogue Approach for Implementation in the U.S.

Recent News

*Check out our newly released first version of The Psychotherapy-Focused Fidelity Chapter entitled "**The Key Elements of Dialogic Practice in Open Dialogue: Fidelity Criteria**". The intent of this document is to help support the development of an Open Dialogue practice and way of relating in teams that can be used for "self-reflection" by an individual practitioner or whole team participating in Open Dialogue meetings, for supervision and training purposes, and for helping in systematic research. Please send your comments and feedback to Dialogic.Practice@umassmed.edu.*

Parachute NYC

Crisis Respite Centers | Mobile Treatment Teams | Support Line

Approaches to Care | In the News

What is Parachute NYC?

Parachute NYC provides alternatives to hospitalization for people experiencing emotional crises. Parachute NYC offers free, community-based options that focus on overall wellness, recovery, and hope. It is largely driven by peers - who themselves have had their own experiences with the mental health system.

In addition to home-based treatment, Parachute NYC offers crisis respite centers where people can stay overnight in a calm, open, and supportive environment. A **Support Line** (646-741-HOPE) is also available for those experiencing emotional distress.

Services are available in the Bronx, Brooklyn, Manhattan, and Queens to New Yorkers ages 18 to 65. In Brooklyn, home-based treatment services are available to people ages 16 to 30. Staten Island residents ages 18 to 65 can seek services in Manhattan. .

OPEN MINDS AWARD FLANDERS

POSITIVE PRACTICE AWARD ENGLAND

PLANETREE SERVICE AWARD HOLLAND

MYTHS OF OPEN DIALOGUE
OD IS NOT:

- Anti-medication
- Unsafe
- Threat to confidentiality
- Costly
- Exclusive to other methods

WHAT IS THE OPEN DIALOGUE APPROACH?

Poetics

Dialogism and polyphony

Tolerance of uncertainty

Micropolitics

Immediate help

Responsibility

Flexibility and mobility

Psychological continuity

Social network perspective

The Open Dialogue Approach to Acute Psychosis: Its Poetics and Micropolitics

JAAKKO SEIKKULA, Ph.D.
MARY E. OLSON, Ph.D.*

In Finland, a network-based, language approach to psychiatric care has emerged, called "Open Dialogue." It draws on Bakhtin's dialogical principles (Bakhtin, 1984) and is rooted in a Batesonian tradition. Two levels of analysis, the poetics and the micropolitics, are presented. The poetics include three principles: "tolerance of uncertainty," "dialogism," and "polyphony in social networks." A treatment meeting shows how these poetics operate to generate a therapeutic dialogue. The micropolitics are the larger institutional practices that support this way of working and are part of Finnish Need-Adapted Treatment. Recent research suggests that Open Dialogue has improved outcomes for young people in a variety of acute, severe psychiatric crises, such as psychosis, as compared to treatment-as-usual settings. In a nonrandomized, 2-year follow up of first-episode schizophrenia, hospitalization decreased to approximately 19 days; neuroleptic medication was needed in 35% of cases; 82% had no, or only mild, psychotic symptoms remaining; and only 23 % were on disability allowance.

Fam Proc 42:403–418, 2003

IN FINLAND, a network-based, language approach to psychiatric care, termed Open Dialogue, has been pioneered at Keropudas Hospital in Western Lapland. One of the authors (JS) worked as a member of the original team. Other team members who have been writing about this approach include Jukka Aaltonen, Birgitta Alakare, Jyrki Keränen, and Kauko Haarakangas (Haarakangas, 1997; Keränen, 1992; Seikkula, Alakare, & Aaltonen, 2001a). Recent studies suggest that this model has improved the therapy of people suffering from first-episode psychosis by significantly reducing the incidence of hospitalization, the rate of recidivism, and the use of medication (Seikkula, Alakare, & Aaltonen, 2001b). This approach has gained widespread recognition in Northern Europe where

* Both authors have equally contributed to the article and should be regarded as first authors.

Jaakko Seikkula, Ph.D., is Senior Assistant in the Department of Psychology at the University of Jyväskylä and Professor at the Institute of Community Medicine at the University of Tromsø, Norway. Send requests for reprints to Jaakko Seikkula, Department of Psychology, University of Jyväskylä, P.O.Box 35, FIN 40351, Jyväskylä. Email: seikkula@psyka.jyu.fi

Mary Olson, Ph.D., is on the faculty of Smith College School for Social Work and a research fellow at its Center for Innovative Practice. In the fall of 2001, she was Fulbright Professor to Finland in the Department of Psychology at the University of Jyväskylä.

A Fulbright scholar award to Finland supported the research for and preparation of this article. Grateful acknowledgment goes to the entire staff of about 100 professionals at Keropudas Hospital and local outpatient clinics.

DIALOGISM AND POLYPHONY

- Honesty and transparency
- "Nothing about us, without us!"
  - All conversations 'about' the person at the centre of care, occur with the person present as part of an ongoing dialogue
- Finding words and creating a new language, new meanings
- Making sure all voices are heard

TOLERANCE OF UNCERTAINTY

- An active attitude of being present with the network
- Being patient, taking the time to listen, to follow
- Avoid premature decisions and treatment plans
- Based on non-judgemental acceptance & trust
- Allowing for the expression of powerful and often painful emotions

THE PROVISION OF IMMEDIATE HELP

- First meeting arranged within 24 (or 72) hours of first contact
- The mobilization of resources during a crisis creates a window of opportunity involving significant others
- Responding immediately to another's need contributes to building trust (working alliance)

RESPONSIBILITY

- First contact takes charge of process organizing the first meeting
- “You’ve come to the right place”
- “We can help”
- ”You are not alone”
- Integrated, coordinated networks of care

FLEXIBILITY AND MOBILITY

- Radically person-centred
- Meetings occur anytime, anywhere, with anybody
- Non-directive, need-adapted, responsive, empowering
- Open, no agenda; 'How shall we use our time together?'; 'What is important to you right now?'
- Meeting every day if required

PSYCHOLOGICAL CONTINUITY

- The same transdisciplinary team is responsible for engaging with the social network for the entirety of the 'treatment' process
- Long term, 5 years ++
- Same core members in case of future crises
- Importance of sustainable relationships

A SOCIAL NETWORK PERSPECTIVE

- Families, carers, friends, colleagues & other members of the professional and private network can always be invited to the meetings
- "Who can help you right now?"

THE POD PARADIGM
POD = Peer-supported Open Dialogue

- The explicit integration of OD with;
  1. Value-based practice
  2. Mindfulness and self-work
  3. Relational skills
  4. Sociopolitical approach to recovery
  5. Trauma-informed care
  6. Peer-support

VALUE-BASED PRACTICES ARE EMPIRICALLY-BASED PRACTICES

«Value-based practice is based on the premise that core values guide and direct a particular intervention.. **Best practices also are value-based practices that have recovery values underlying the practice**; the values should be able to be described and measured."

- Farkas & Anthony (2006) System Transformation Through Best Practices. *Psychiatric Rehabilitation Journal*

WHAT ARE THE CORE VALUES OF POD?

- Openness
  - 'transparency' – 'Nothing about us, without us'
- Authenticity
  - Trust, equality, common humanity, vurnerability
- Unconditional warmth
  - Acceptance, compassion, empathic listening

DEVELOPING VALUE-BASED PRACTICE REQUIRES SELF-WORK

«.. a simultaneous exploration of one's inner world and private thoughts… When we begin training, we embark on two simultaneous journeys; one outward into the professional world and the other inward, through the labyrinths of our own psyches… **The more fearless we become in the exploration of our inner worlds, the greater our self-knowledge and our ability to help clients.»**

- Cozolino (2004) *The Making of a Therapist*

MINDFULNESS TO DEVELOP VALUE-BASED PRACTICE

Therapist **attitudes characterized by warmth, unconditional positive regard or acceptance, and genuineness** have proved quite difficult to teach as a skill. Training programs have either neglected these personal attitudes or relied upon personal psychotherapy, sensitivity training, and the like for their development. In this regard **mindfulness training** may be an extremely promising addition to clinical training because it may indeed foster attitude change (internalization) toward greater acceptance and positive regard for self and others.

- Lambert & Simon (2008) The Therapeutic Relationship: Central and Essential in Psychotherapy Outcome

RELATIONAL SKILLS

- 'Be flexible, honest, respectful, trustworthy, confident, warm, interested, open, explorative, reflective, note past success, interpret accurately, facilitate the expression of affect, and attend to the person's experience…
- … contribute positively to the therapeutic alliance'
  - Ackerman & Hilsenroth (2003) A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review,* 23, 1-33

SOCIOPOLITICAL APPROACH TO RECOVERY

"**A recovery-oriented paradigm** can not, and will not, be realized simply by changing what people do (i.e., their behavior). **It also requires changing the way that people feel and think (i.e., their hearts and minds).** As individuals and as a system, we must look inward and address the obstacles that linger in our own perspectives and worldview, and then we must talk with each other honestly and openly about what we see."

- Tondora, m.fl. (2005)

TRAUMA-INFORMED APPROACH

"A program, organization, or system that is trauma-informed

- **realizes the widespread impact of trauma** and understands potential paths for recovery;
- recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- and responds by fully integrating knowledge about trauma into policies, procedures, and practices
  - SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (2014)

LEARNING TO BE PRESENT WITH TRAUMA

- **Staff, therefore, need to be trained and supported to do work that can be emotionally difficult**;
- Coles (2014) has described "horror" as a barrier to practitioners embracing notions of trauma: "to stand as witness to the extent and horror of people's accounts of pain and suffering is to encounter and experience fear, despair, loss and rage."

PEER SUPPORT

- Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. **It is about understanding another's situation empathically through the shared experience of emotional and psychological pain.**
  - Mead, et al (no date) *Peer Support: A Theoretical Perspective*

OUR ROLE AS PROFESSIONALS…?

- Although professional support can be helpful, often the most important source of help and support is our network of relationships: friends, family and community. **A useful role for professionals is helping friends, family and self-help groups to support people**.
  - Cooke (Ed.) (2014) Understanding Psychosis, p.63

"**O**PEN **D**IALOGUE – **D**EVELOPMENT AND **E**VALUATION OF A **S**OCIAL NETWORK INTERVENTION FOR **S**EVERE MENTAL **I**LLNESS (**ODDESSI**)"
5 YEAR PROGRAMME,
NIHR PROGRAMME GRANT FOR APPLIED RESEARCH

- Program grant from NIHR for £2.4 million (70 mill CZK)
- Comprehensive evaluation with 5 work packages, including a multi-centre cluster RCT involving 634 patients
- Five NHS Trusts across UK signed up as study sites
- Programme milestones
- started July 2017
- review December 2018
- completion end of 2022

Professor Stephen Pilling PhD, University College London, UK
Research Department of Clinical, Educational and Health Psychology

Open Dialogue: A Review of the Evidence

Abigail M. Freeman, B.Sc., M.Sc., Rachel H. Tribe, B.Sc., M.Sc., Joshua C. H. Stott, D.Clin.Psy., Stephen Pilling, M.Sc., Ph.D.

Objective: Emerging evidence for Open Dialogue (OD) has generated considerable interest. Evidence comes from a range of methodologies (case study, qualitative, and naturalistic designs), which have not been synthesized as a whole. The objective of this review was to synthesize this literature.

Methods: A systematic search of the databases PubMed, CINAHL, Scopus, Web of Science and PsycINFO included studies published until January 2018. A total of 1,777 articles were screened. By use of a textual narrative synthesis, studies were scrutinized for relevance and quality.

Results: Tw
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designs and

precludes any conclusions about the efficacy of OD among individuals with psychosis. Qualitative studies also presented a high risk of bias and were of poor quality.

Conclusions: Variation in models of OD, heterogeneity of outcome measures, and lack of consistency in implementation strategies mean that although initial findings have been interpreted as promising, no strong conclusions can be drawn about efficacy. Currently, the evidence in support of OD is of low quality, and randomized controlled trials are required to draw further conclusions. It is vital that an extensive evaluation of its efficacy takes place because OD has
unity men-

"… ALTHOUGH INITIAL FINDINGS HAVE BEEN INTERPRETED AS PROMISING, NO STRONG CONCLUSIONS CAN BE DRAWN ABOUT EFFICACY."

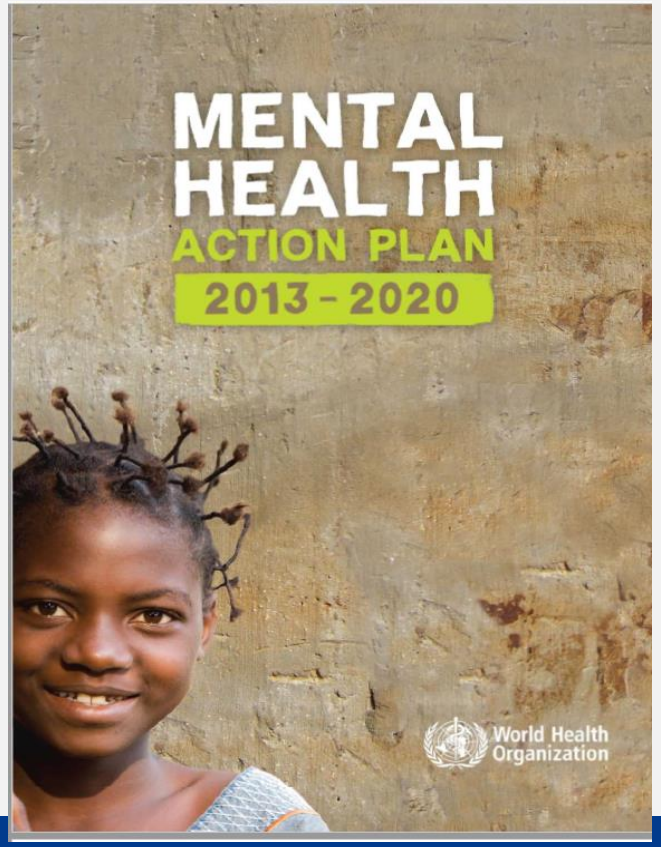
NHS TRAINING

- 4 x 1 week residentials
- Delivered by 12 trainers from 5 different countries – incl. Jaakko Seikkula, Mary Olson, Mia Kurrti
- Trained 300 staff from 9 Trusts to date from UK, Italy, France, Germany, Israel, Netherlands, Norway
- Certification to be accredited by AFT + University PGCert awarded by London South Bank University
- 2019:
  - 14th – 18th January, 1st – 5th April, 17th – 21st June, 30th September – 4th October

ZAHRADA 2000

- Open Dialogue method adaptation for Zahrada
- Training of staff and involvement of clients
- Creating an Open Dialogue organization and management philosophy
- Community development through anti-stigma work and social inclusion
- Creating regional support and collaboration

SUPPORTING RECOVERY
A GLOBAL AGENDA
(WHO, 2013)



…The ***core service requirements include: listening and responding to individuals' understanding of their condition and what helps them to recover; working with people as equal partners in their care; offering choice*** *of treatment and therapies, and in terms of who provides care; and the* ***use of peer workers and supports, who provide each other with encouragement and a sense of belonging, in addition to their expertise".***

THANK YOU…

Never underestimate the strength of one person's dream, the power of one voice, the wind from a butterfly's wing or the light from one dim candle. That tiny candle may be the bright light out of someone's darkness.

- *Kirsti Dyer*

mark.hopfenbeck@ntnu.no