

Open Dialogue as transformation of the system of care

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21.06.2018

Dear Jaakko, we met in Madrid, November 2016, in a formation of "Open dialogue" in a old medical college hall. In the supper, we had a conversation about the possibility to make "Open dialogue" in my Center of mental health in Badalona (a city beside Barcelona). I believed that you try to encourage me to made an experience.

Well, I did it. We began the first of the cases in November 2016. **A young woman who recently suffered their first psychotic episode. The team has been: a social worker, a male nurse and me. In some meetings also a psychologist. We have made 20 meetings of treatment with the patient, her family and some friends. The result is absolutely shocking. We gave up the antipsychotic in 4 months (20 mg olanzapine). She found a new job in 3 months, she obtain the drive license and recently she began to study in an university.**

We are working with Open dialogue in 8 cases. The different teams involves 2 social workers, 2 nurses, 2 psychiatrists and one psychologist. **We all are very satisfied and interested to carry on the experience.** We have also a psychologist senior in Family therapy, to supervise the work. Recently, the team has presented a communication about the experience in a National Congress of Nursery in Mental health. This letter is made to know if you (your team and colleagues) are interested in share the experiences, or maybe there is a kind of net of Teams, who work in a similar experiences. How we can learn more about your system?

Jordi Marfà V.

Origins of open dialogue

- Initiated in Finnish Western Lapland since early 1980's
- Need-Adapted approach – Yrjö Alanen
- Integrating systemic family therapy and psychodynamic psychotherapy
- Treatment meeting 1984

Finnish national schizophrenia project 1982 - 1989

Two recommendations:

- 1) Recommendations for acute psychotic crises:
"Psychosis teams for every hospital district" (N=21)
- 2) Dissolving the beds in asylums for the long term patients and creating community services

Happened at the 90's

Before Open Dialogue in Western Lapland

- Treatment meetings in the hospital 1984
- Admission meetings in the hospital since 1988
- Need for hospitalization decreased radically – crisis intervention teams and home visits since 1990
- Comprehensive community care since 1990
- Research project 1994 – 1995 (Jukka Aaltonen)
Main elements of optimal treatment – Open Dialogue

What is Open Dialogue?

- Guidelines for clinical practice
- Systematic analysis of the own practice.
 - In Tornio since 1988: Most scientifically studied psychiatric system?
- Systematic psychotherapy training for the entire staff.
 - In Tornio 1986: Highest educational level of the staff?

MAIN PRINCIPLES FOR ORGANIZING OPEN DIALOGUES IN SOCIAL NETWORKS

- IMMEDIATE HELP
- SOCIAL NETWORK PERSPECTIVE
- FLEXIBILITY AND MOBILITY
- RESPONSIBILITY
- PSYCHOLOGICAL CONTINUITY
- TOLERANCE OF UNCERTAINTY
- DIALOGISM

IMMEDIATE HELP

- First meeting in 24 hours
- Crisis service for 24 hours
- All participate from the outset
- Psychotic stories are discussed in open dialogue with everyone present
- The patient reaches something of the “not-yet-said”

SOCIAL NETWORK PERSPECTIVE

- Those who define the problem should be included into the treatment process
- A joint discussion and decision on who knows about the problem, who could help and who should be invited into the treatment meeting
- Family, relatives, friends, fellow workers and other authorities

FLEXIBILITY AND MOBILITY

- The response is need-adapted to fit the special and changing needs of every patient and their social network
- The place for the meeting is jointly decided
- From institutions to homes, to working places, to schools, to polyclinics etc.

RESPONSIBILITY

- The one who is first contacted is responsible for arranging the first meeting
- The team takes charge of the whole process regardless of the place of the treatment
- All issues are openly discussed between the doctor in charge and the team

PSYCHOLOGICAL CONTINUITY

- An integrated team, including both outpatient and inpatient staff, is formed
- The meetings as often as needed
- The meetings for as long period as needed
- The same team both in the hospital and in the outpatient setting
- In the next crisis the core of the same team
- Not to refer to another place

TOLERANCE OF UNCERTAINTY

- To build up a scene for a safe enough process
- To promote the psychological resources of the patient and those nearest him/her
- To avoid premature decisions and treatment plans
- To define open

DIALOGISM

- The emphasize in generating dialogue - not primarily in promoting change in the patient or in the family
- New words and joint language for the experiences, which do not yet have words or language
- Listen to what the people say not to what they mean

The way to genuine dialogue

- Respecting and accepting the voice of the other without conditions

Variations: Acute Team in Tromsso

- Dr. Magnus Hald and Annrita Gjertzen
- Acute team in connection with the acute ward
- Good strength (n=15/70 000), work from 8 a.m. to 8 p.m. every day, night duty in the ward
- All contacts to acute psychiatry via the team
- Reflective processes as the form of dialogues – one interviews, the other one(s) listening and commenting later on
- Two years training for the staff ("Relation and network education")

Variations: Children and Adolescent Psychiatric Unit in Gällivare, Schweden

- Dr. Eva Kjellberg
- Serves large area with 200 000 inh
- Nearly connected to social care
- After referral always the first meeting together with the family, the referred authority and relevant others
- Need for further treatment decreased rapidly when the network mobilized
- Reflective processes as the form of dialogue
- Two years training

Variations: Home Treatment Teams in Germany

- Dr. Volkmar Aderhold and Nils Greve
- Ambulatory services for acute patients in the psychiatric units (population can be e.g. 200 000 to 300 000)(N= 22 teams at the moment)
- Insurance driven practice – specific agreement with insurance companies of a project period – evaluation started
- One year training programs

Variations – three US projects

- Umass Medical School: Key elements of Open Dialogue
- New York: Parachut project – 5 teams
- Advocates Framingham Massachusetts
- Vermont state
- 1 to 2 years education programs for clinicians and peers

Peer supported Open Dialogue

1) UK – several Mental Health Trusts

- OD principles including peers as resources
- Foundation training of Open Dialogue – 20 days

2) Open Dialogue certificate three years training (60
ect)

- Including trainers in training
- Peers

Open Dialogue in Italy

- 8 provinces
- 80 professionals training – 16 days + supervision
- Research on the effectiveness and processes

1:GUARANTEERING JOINT HISTORY

- Everyone participates from the outset in the meeting
- All things associated with analyzing the problems, planning the treatment and decision making are discussed openly and decided while everyone present
- Neither themes nor form of dialogue are planned in advance

2: GENERATING NEW WORDS AND LANGUAGE

- The primary aim in the meetings is not an intervention changing the family or the patient
- The aim is to build up a new joint language for those experiences, which do not yet have words

3: STRUCTURE BY THE CONTEXT

- Meeting can be conducted by one therapist or the entire team
- Task for the facilitator(s) is to (1) open the meeting with open ended questions; (2) to guarantee voices becoming heard; (3) to build up a place for among the professionals; (4) to conclude the meeting with definition of the meeting.

4: BECOMING TRANSPARENT

- Professionals discuss openly of their own observations while the network is present
- There is no specific reflective team, but the reflective conversation is taking place by changing positions from interviewing to having a dialogue
 - - look at your collegian – not at clients
 - - positive, resource orientated comments
 - - in form of a questions – “I wonder if ...”
 - - in the end ask clients comments
- Reflections are for me to understand more – not a therapeutic intervention

5 years follow-up of Open Dialogue in Acute psychosis

(Seikkula et al. Psychotherapy Research, March 2006: 16(2),214-228)

- 01.04.1992 – 31.12.1993 (API)
- 31.03.1997 (ODAP) in Western Lapland, 72 000 inhabitants
- Starting as a part of a Finnish National Integrated Treatment of Acute Psychosis –project of Need Adapted treatment
- Naturalistic study – not a randomized trial
- Aim 1: To increase treatment outside hospital in home settings
- Aim 2: To increase knowledge of the place of medication – not to start neuroleptic medication in the beginning of treatment but to focus on an active psychosocial treatment
- N = 80 at the outset; n=80 at 2 year; n= 76 at 5 years
- Follow-up interviews as learning forums

Dialogical practice is effective

Open Dialogues in Tornio – 5 years follow-up 1992-1997 (Seikkula et al., 2006):

- - 35 % used antipsychotic drugs
- - 81 % no remaining psychotic symptoms
- - 81% returned to full employment

COMPARISON OF 5-YEARS FOLLOW-UPS IN WESTERN LAPLAND AND STOCKHOLM

	ODAP Western Lapland 1992-1997 N = 72	Stockholm* 1991-1992 N=71
Diagnosis:		
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	33 %	93 %
- ongoing	17 %	75 %
GAF at f-u	66	55
Disability allowance or 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.

Outcomes stable 2003 – 2005 (Aaltonen et al., 2011

and Seikkula et al, 2011):

- - DUP declined to three weeks
- - about 1/3 used antipsychotic drugs
- - 84 % returned to full employment
- - Few new schizophrenia patients: Annual incidence declined from 33 (1985) to 2-3 /100 000 (2005)

20 year follow-up of Open Dialogue in Western Lapland (Tomi Bergström et al, 2017)

- 65/ 99 were living all their life in Open Dialogue treatment area in Western Lapland
- More severe problems compared to those moved away
- 26% neuroleptic at start; 34% at the follow-up
- Mean 5 years, variation 2 to 8 years

Long term follow-up- Initial observations (not to be referred)

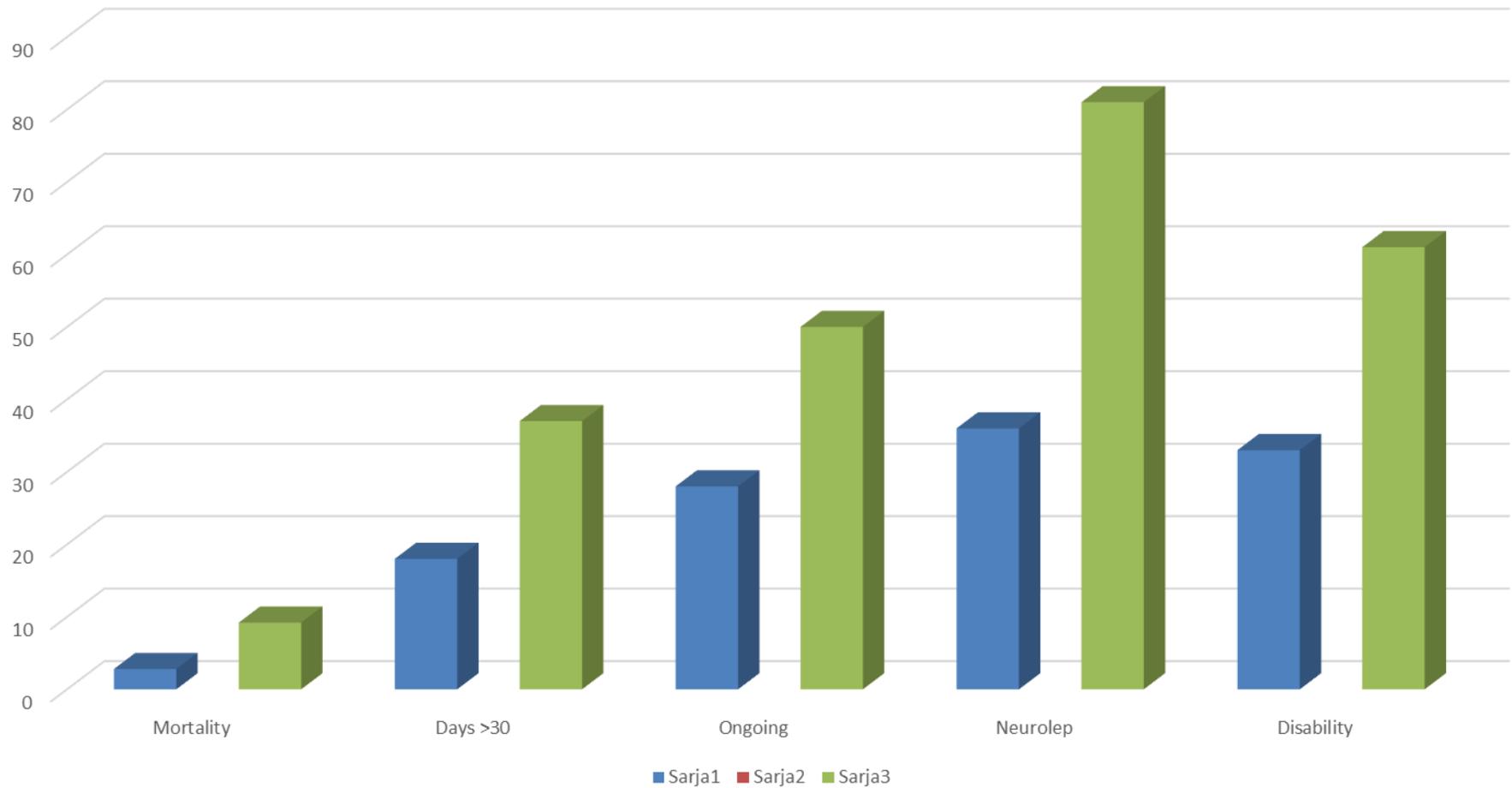
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OD N=108 TAU N=1763 /%

- Mortality by illnesses (not age controlled)
- Hospital days (over 30)
- Ongoing contact after 20y
- On neuroleptic
- Disability allowance

19 year follow-up: Open Dialogue Western Lapland (N=108) vs TAU Finland (N=1763)

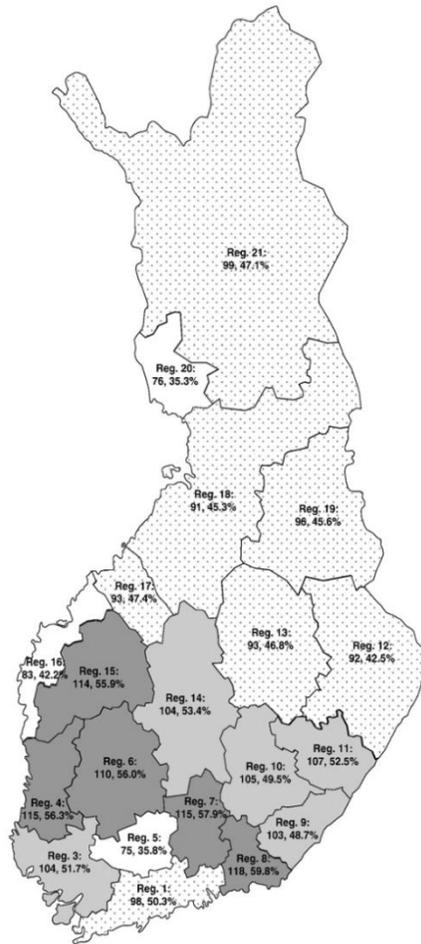
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Long term follow-up- Initial observations (not to be referred)

–	OD N=108	TAU N=1763 /%
• Mortality by illnesses	2.8	9.2
• Hospital days (over 30)	18	37
• Ongoing contact after 20y	28	50
• On neuroleptic	36	81
• Disability allowance	33	61

Disability pensions of schizophrenia patients — WL 35 %, (1995 -2001; Kiviniemi, 2014)



Why the dialogical practice can be effective?

1. Immediate response –taking use of the emotional and affective elements of the crisis
2. Social network included throughout and thus polyphonic in two respect: both horizontal and vertical
3. Focus on dialogue in the meeting: to have all the voices heard and thus working together
4. Avoiding medication that alter central nervous system – antipsychotic medication related to shrinkage of brain (Andreassen et al., 2011) and to decrease of psychological resources (Wunderink, 2013)

“Love is the life force, the soul, the idea. There is no dialogical relation without love, just as there is no love in isolation. Love is dialogic.”

(Patterson, D. 1988) Literature and spirit: Essay on Bakhtin and his contemporaries, 142)