

Increasing Collaboration and Transparency in Community Mental Health Systems Through Applications of Open Dialogue

Experiences from The Counseling Service of
Addison County in Vermont, USA

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For more about Open Dialogue:

Olson, M., Seikkula, J., & Zedonis, D.. (2014) *Key elements of dialogic practice in open dialogue: fidelity criteria. UMass Medical School*

Also – discussion of OD and rights:

(von Peter, S., Aderhold, V., Cubellis, L., Bergström, T., Stastny, P., Seikkula, J., & Puras, D. (2019). Open Dialogue as a Human Rights-Aligned Approach. *Frontiers in psychiatry, 10*, 387. doi:10.3389/fpsy.2019.00387)

Where we practice



Vermont is famous for...

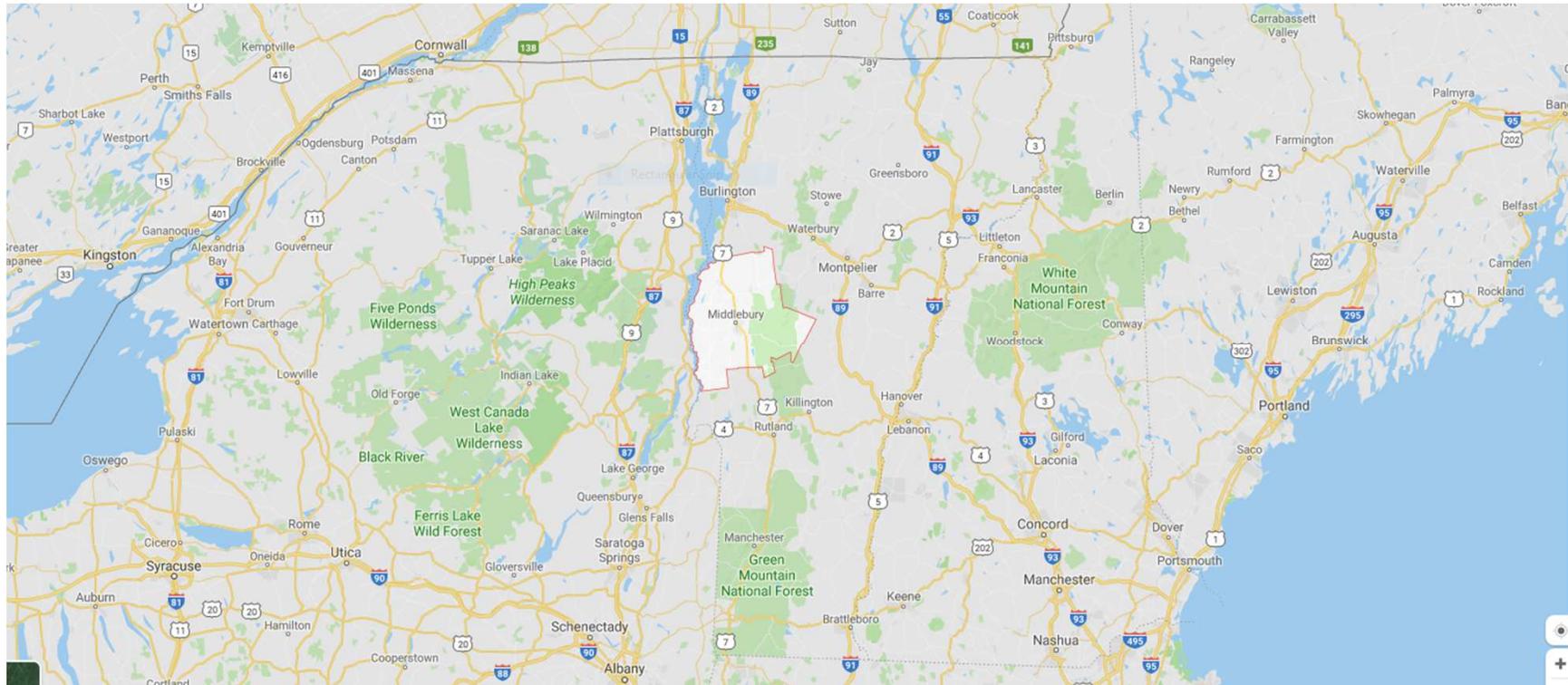


and...



Ben Cohen & Jerry Greenfield
Co-Founders, Ben & Jerry's

The region we serve in Vermont



Brief history of Vermont system of care

- Current population of Vermont 623,000.
- State hospital population in 1950's was 1300 before introduction of antipsychotics. Data kept on a cohort later followed up with by Courtenay Harding's landmark longitudinal study (Harding et al. ,1987).
- 10 regional "designated agencies" are responsible for all the publically funded mental health services in their counties.
- Vermont increased funding to community programs to support deinstitutionalization in late 1980's, fueling practices of staff intensive teaming and community-based support.
- Multiple efforts to reduce or close the state hospital got the inpatient population down to low 50's. These efforts included 4 staff -intensive residential recovery programs, and crisis bed programs at each of the 10 agencies.
- Tropical storm Irene triggered a flood that closed the state hospital in Aug. 2011. New 25 bed facility has since opened with increased involuntary capacity at other regional hospitals. As of 2018 Vermont has 45 involuntary "level 1" beds out of a total of 201
- 2018 rates of involuntary admissions approx. 83/100,000.
- Continued serious difficulties with long ER stays awaiting hospital beds.

About our setting

- The non-profit designated community mental health agency responsible for rural county of 36,776 people.
- Multidisciplinary staff including psychiatrists, nurses, psychotherapists, case managers and other community support staff including peers/experts by experience.
- For adult services we offer supported employment, recovery wellness day supports, help with finding housing and related benefits, DBT, Hearing Voices network support group, Wellness Recovery Action Planning, Intentional Peer Support, addictions treatment. We are developing new trauma treatment options including EMDR. We have 15 group home beds in 2 settings and run a 1-2 bed crisis bed program with 24/7 staffing coordinating with 24/7 crisis team; other psychiatric, psychotherapy, emergency and community support services. Also broad range of services in youth and family program. Comprehensive developmental service system.
- Closest psychiatric unit an hour's drive away.
- Primary funding is federal Medicaid managed by state government. As of 1/2019 we operate with a bundled payment for adult Medicaid to allow more flexibility, our payment system for children's services made this change a few years prior.

It is difficult to implement Open Dialogue in publically funded community mental health systems

- Staff intensive approach that is not funded by existing payment models.
- Intensive training is needed vs. high turnover of staff experienced by many public mental health programs.
- Does not fit in easily with diagnostically based treatment/payment paradigms that are often highly prescriptive, defined by individual pathology and treatment.
- User expectations are also oriented to individual models.
- Moments of crisis are important in OD to slow down and open the conversation, yet crisis screening systems are often highly time pressured.
- Coordinating with other providers who do not understand/value this approach.
- Can challenge existing decisional hierarchies in treatment settings.

Aspects of our history enabling applications of Open Dialogue

- Held a series of trainings and consultations with Tom Andersen and colleagues regarding reflecting process in late 1980's and early 1990's.
- Low turnover. Several staff from time with Tom Andersen are still at CSAC nearly 30 years later, including some senior leadership.
- Long held program values - relationship based, strengths based, person centered, interdisciplinary respect and collaboration.
- Vermont's support of innovative practice and flexible funding models.
- 2011 –Tropical storm Irene flooded the state hospital. The state directed new funds to the community programs and encouraged creativity in finding ways to hold or divert crises.

How we got started

- Formed a cross departmental planning team.
- Initially arranged training with Institute for Dialogic Practices.
- Used in house expertise in family therapy and reflecting process.
- **Partnerships and networking** with others working on OD **was essential** – 2 other pilot agencies in Vermont (Howard Center, United Counseling Services), Advocates, Project Parachute, Northern Europe network. We organized and hosted a regional meeting of practitioners which has now continued for 5 years.
- Developed training program in Vermont with support from Dr. Werner Schuetze, Mia Kurtti with a 15 day year 1 training and 10 day year 2. Affordable for publically funded service systems. Available to staff with diverse roles. Some hospital and community staff training together. We call this training “**Collaborative Network Approach**”.

How we've applied these practices

- Practicing OD with different kinds of problems across treatment populations we serve. Ranging from first time crisis presentations (including early episode psychosis) to applications with people we have worked with for a long time.
- In the office, client homes, residential programs, hospital units, a snowy driveway.
- In a flexible combination with more traditionally structured individual services.
- Some aspects of this model have been used with over 110 cases at our agency.

Findings that encourage us to broaden and deepen our implementation of OD

- ***With clients*** almost every dialogic network meeting has something happen that we couldn't anticipate, and these often lead to further positive shifts in the course of treatment.
- This has led to diverted hospitalizations, better treatment alignment with clients and with their personal networks, better coordination with other treatment providers, in some instances leading to better outcomes from hospitalizations at reduced length. Clients and their network members report feeling better heard and understood. We see more resilient ***personal networks***
- This has had notable impact ***on staff*** who describe getting better results not working alone, seeing more movement in meetings, more mutuality/less fix it pressure, sharing tolerance of uncertainty, being part of a broader practice network/community, more emotionally embodied co-presence with colleagues.
- OD readily ***aligns with other paradigm changing practices*** such as Hearing Voices Network and Intentional Peer Support that point to less focus on medical formulation and more on relationship, meaning making, and personal agency and empowerment in defining and coping with mental health challenges.
- OD seems to be a catalyst for us that triggers further improvements in our ***service systems*** and helps barriers to become more transparent.

Some challenges and drawbacks we've experienced

- Hard to manage the staff intensiveness of having 2 people leading meetings in the context of other workloads and caseload pressures.
- Changes in how we carry roles and expertise.
- Hard/intense work and no easy fixes.
- Existing assumptions about treatment for families and other providers.
- Some staff feeling alienated by the language and/or their work devalued.
- Many voices vs. need to have a clear next step.

Open Dialogue from a human rights perspective

- The approach emphasizes collaborative and transparent decision making about treatment.
- We hold back on using our “expert” authority and clinical formulations for defining experiences.
- Contextualizing and humanizing vs. pathologizing and distancing - Look for how the client and network members understand what is going on in the context of those experiences.
- Trying to keep people with early psychosis out of the harmful aspects of the disability system – protecting citizenship and community inclusion through building networks and fostering hope and possibility.

OD and human rights - continued

- We're working better with long held recovery values – clients leading the agenda, non-pathologizing language, client centered goal setting.
- 2 facilitators working dialogically – reduces pressures on staff and allows for more openness and less likelihood to react coercively.
- 2 facilitators working dialogically creates changes in the broader systems within which that work is occurring.
- Reduced discussion of clients when not present.
- Increased transparency in network meetings of external factors that can interfere with treatment.
- Results in reduced coercion.
- Colleagues at Howard Center find it helps support the voice of clients with developmental disabilities in processes of decision making.
- Reassessing the role of meds, how they're prescribed, and the meaning attached – also going slower with lower dosages. Assessing thoughtful approaches to tapering.

Possible difficulties with OD from a human rights perspective

- Client privacy – some people don't want their networks involved and want their treatment involvement kept very private.
- Client decision making – Similarly some may prefer to not have others in their personal network part of treatment decision making.
- We seek to not coerce participation, yet clients may experience differently due to power inequities and past experiences of coercion.
- In some settings being open might not be in client's best interest.

Possible future directions – our agency

- Continue to increase use of dialogic network meetings to reduce hospitalization and improve outcomes.
- Possible use of new flexible funding models to broaden applications.
- Study if increased network focus at the start of treatment reduces trajectories of long term service involvement.
- Increase use of dialogic networks /transparency when considering involuntary interventions as well as assessing alternatives to voluntary hospitalizations.
- Deepen capacity for engaging with clients and networks within 24/7 crisis systems.
- Use of these processes for collaborative utilization management.
- Continued strong emphasis on networking with other practitioners using these practices – including psychiatric hospital staff, other healthcare providers, primary care practices.
- Community Bridges Project – influenced by Fergusson and Trieste – creating new pathways for community connection and meaningful roles.
- Incorporating more from Trieste model in our crisis bed program.
- Research

Implications for future directions –in broader systems of care

- Broadening training in Vermont system of care – 4 of 10 CMHC's have begun training; 2 hospitals. Others are interested.
- Increase peer involvement and collaboration with Intentional Peer Support.
- Collaborative networks as gold standard practice for reducing treatment fragmentation
- Towards a vision of community systems that prioritize relational interconnectedness, meaning making, and personal agency.
- Could this path be easier in developing countries?

Thank you!

For more information and/or copy of this power point:

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References:

Harding, C.M.; Brooks, G.W.; Ashikaga, T.; Strauss, J.S.; Breier, A.: The Vermont longitudinal study of persons with severe mental illness: I. Methodology, study sample, and overall status 32 years later. (lead article) AMERICAN JOURNAL OF PSYCHIATRY, 1987, 144(6): 718-726.

*von Peter, S., Aderhold, V., Cubellis, L., Bergström, T., Stastny, P., Seikkula, J., & Puras, D. (2019). Open Dialogue as a Human Rights-Aligned Approach. *Frontiers in psychiatry*, 10, 387. doi:10.3389/fpsyt.2019.00387*