

# Yale Symposium: New Data and New Hopes Call for New Practices in Clinical Psychiatry

## Open Dialogue: The Advocates Experience

### *The Collaborative Pathway and Open Dialogue in Community-Based Flexible Supports*

April 24, 2015

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# From Tornio to Framingham?



# Open Dialogue seemed like a natural fit for Advocates, Inc.

- ▶ Non-profit provider of full services for people with psychiatric as well as other life challenges
- ▶ 24/7/365 mobile crisis team
- ▶ Outpatient services
- ▶ Robust community based, residential supports
- ▶ Employment and other outreach supports
- ▶ Very holistic, strength-based, and person-centered clinical philosophy
- ▶ If we can do it here....

# Crisis Psychiatry and Open Dialogue

- Open Dialogue uses a crisis model, not a disease model.
  - Crises resolve; crises are opportunities; people in crisis need support.
  - Things often look better in the light of day, when we include family and other resources.
  - 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.”
- The voice of the person at the center of concern *must* be heard.

# 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.

# We had great training



- 35-member team trained in Open Dialogue under the direction of Mary Olson, PhD, Founder and Executive Director of the Mill River Institute for Dialogic Practice in Haydenville, Massachusetts.
- Her faculty includes the founders of Open Dialogue and current practitioners.
- *It is an absolutely fantastic experience; this is THE way to learn Open Dialogue!*

# Collaborative Pathway

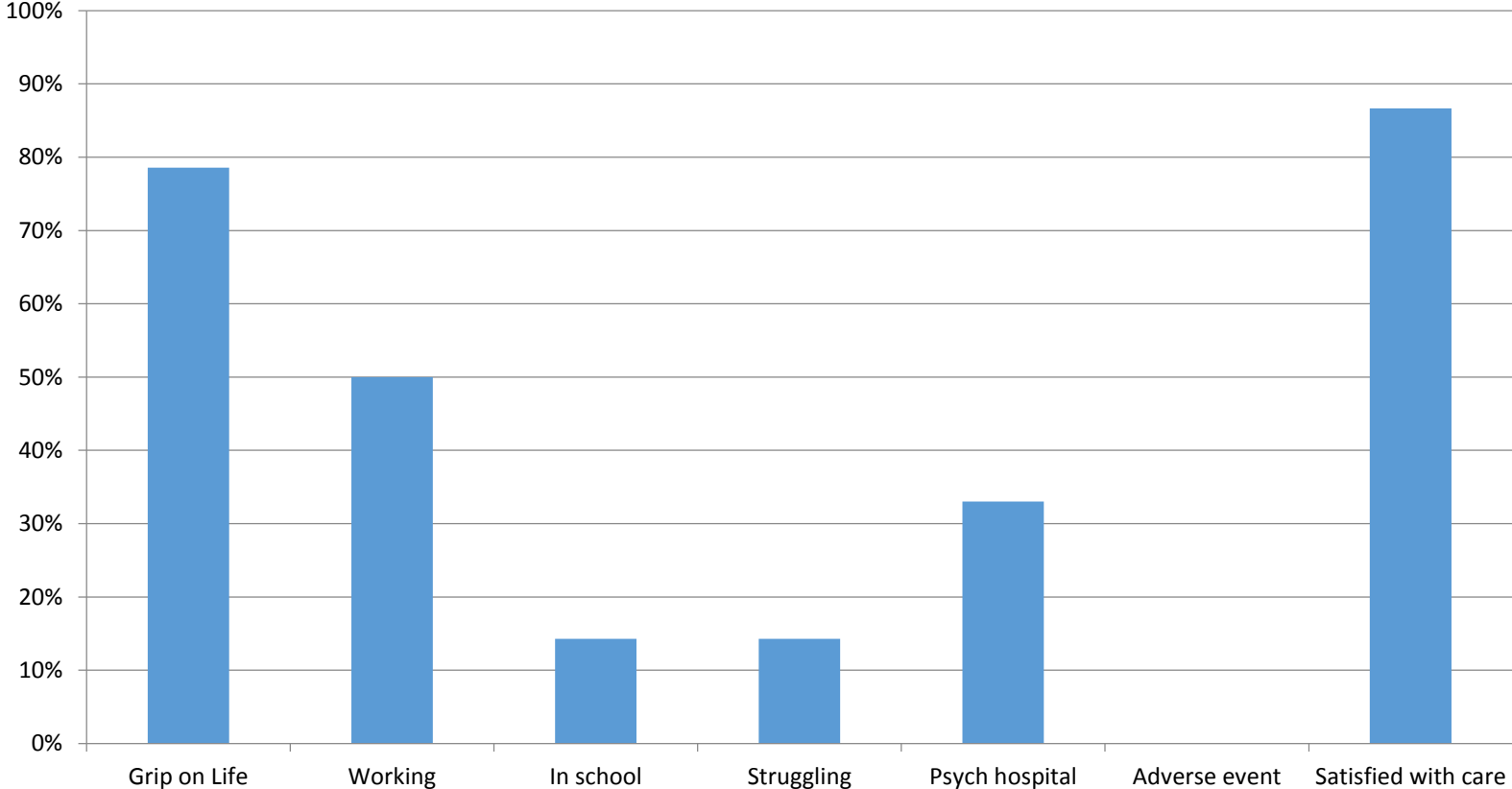
- Young people hopefully early on in psychiatric experience (ages 14 – 35)
- With support of families
- Without severe risk factors or severe substance use
- Psychosis from any diagnosis

# Collaborative Pathway: Preliminary Findings

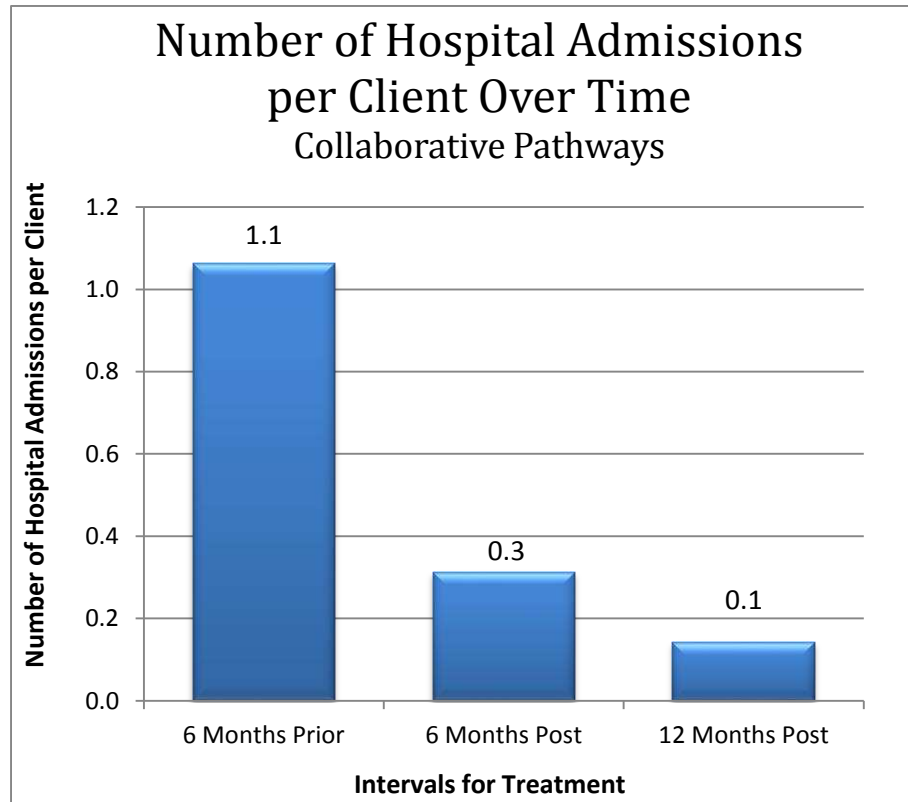
- 15 families served
- No significant adverse events other than psychiatric hospitalizations (30% of families)
  - No suicide attempts
  - No acts of violence
- For 70% of the families, whether or not to take medications was a central issue at the start of engagement
- Of those who did engage, at or 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



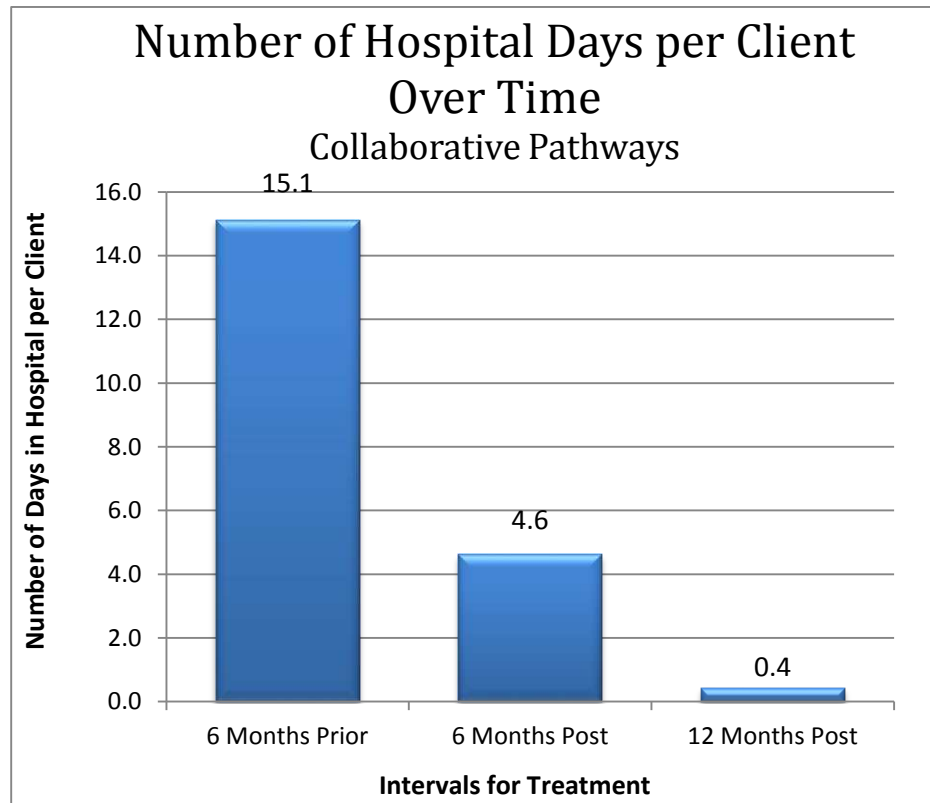
# Collaborative Pathway: one year outcomes



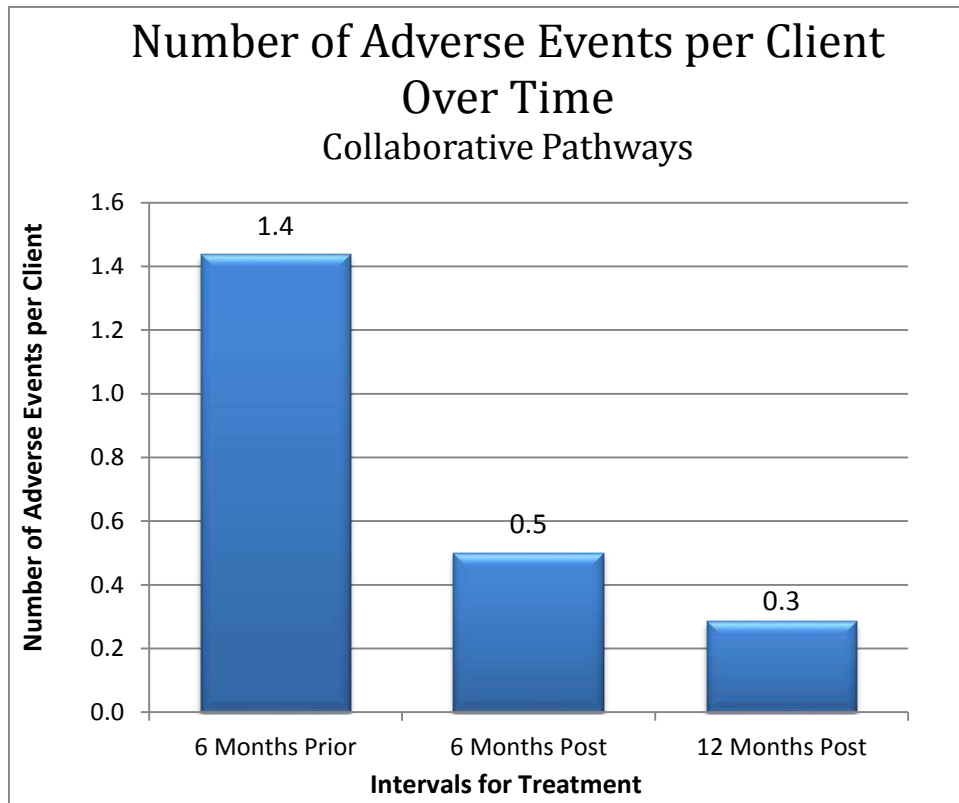
# Hospital Admissions per Client



# Hospital Days per Client



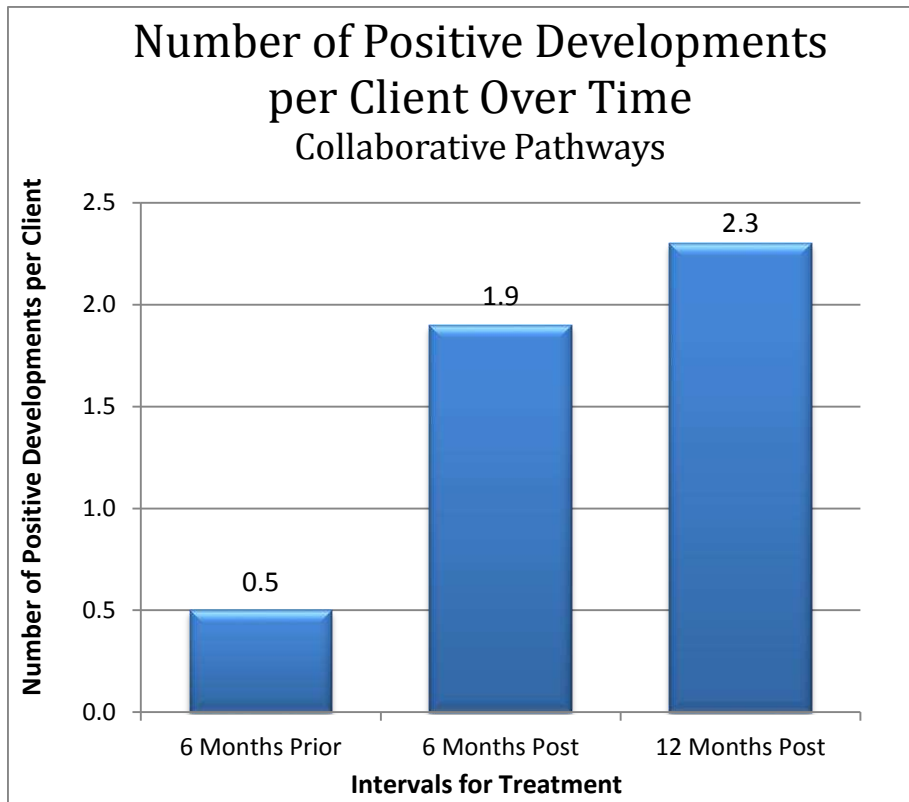
# Adverse Events per Client



## Adverse Event Criteria:

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

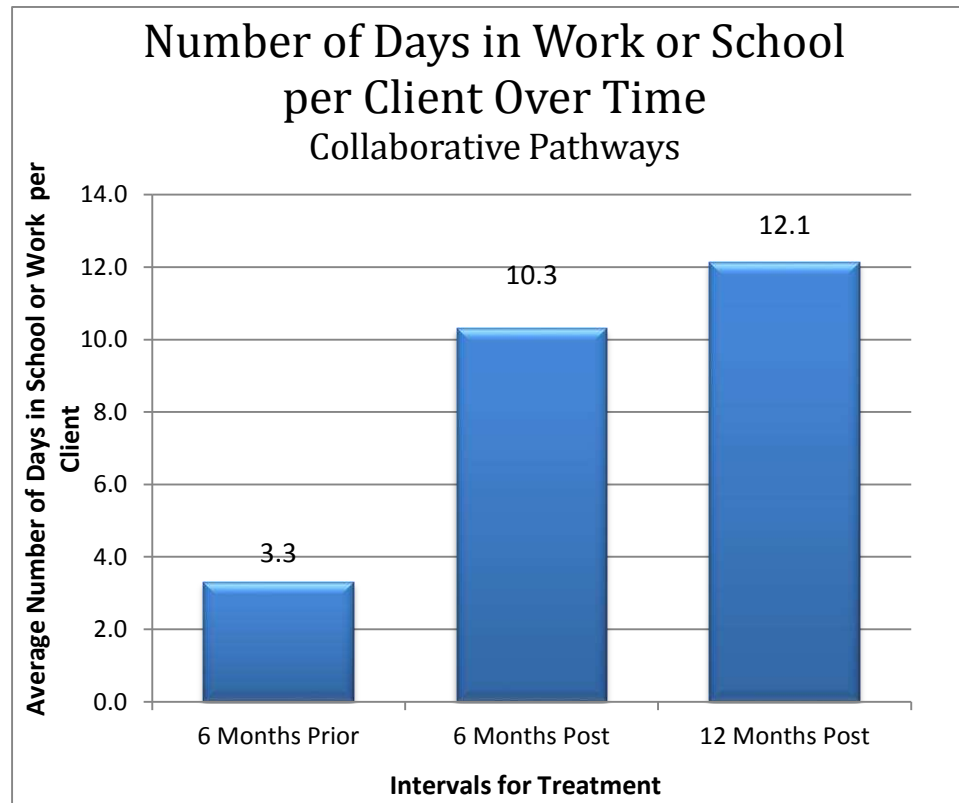
# Positive Developments per Client



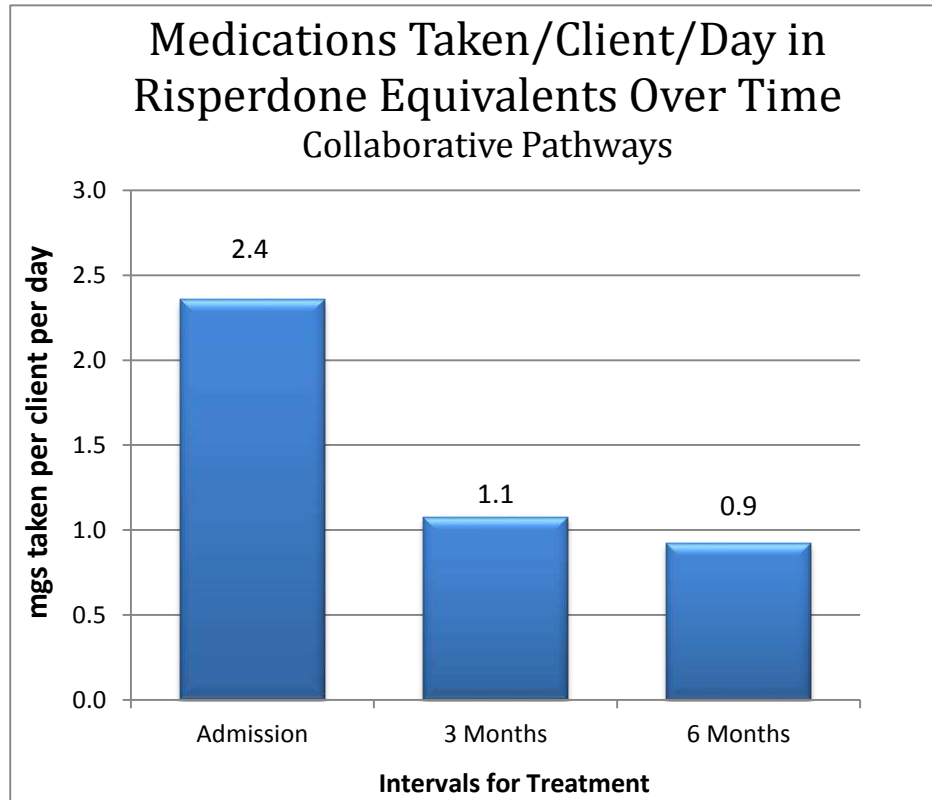
## Positive Developments Criteria:

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

# Days in Work/School per Client

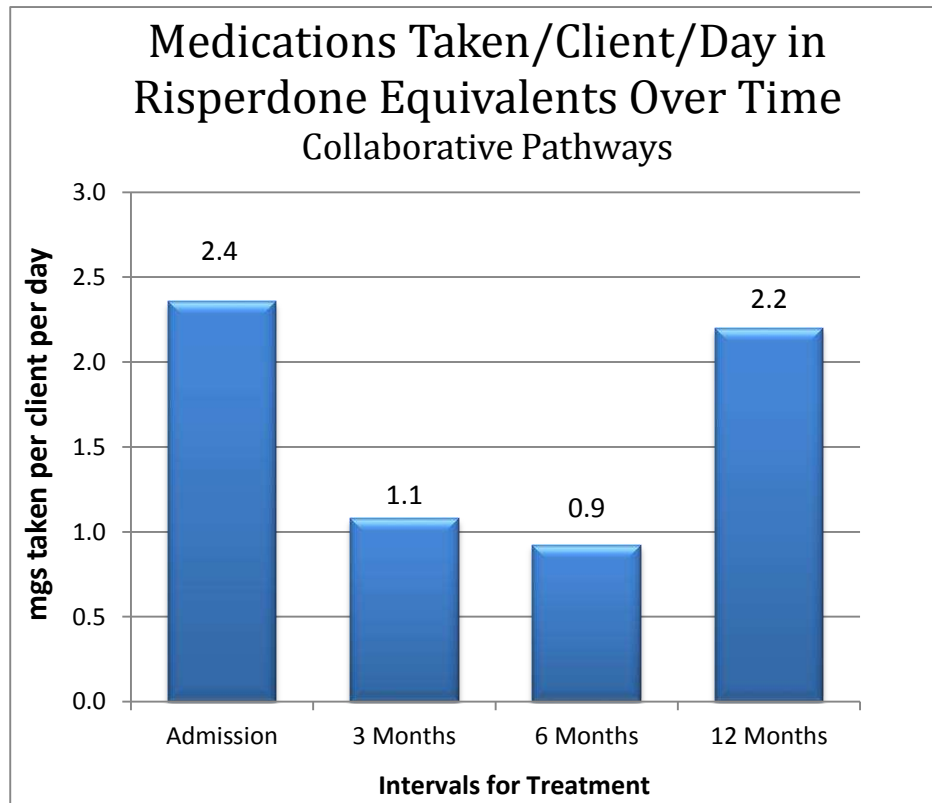


# Dosage, Risperdone Equivalents: Clients Completing 6 Months in Program (n=13)



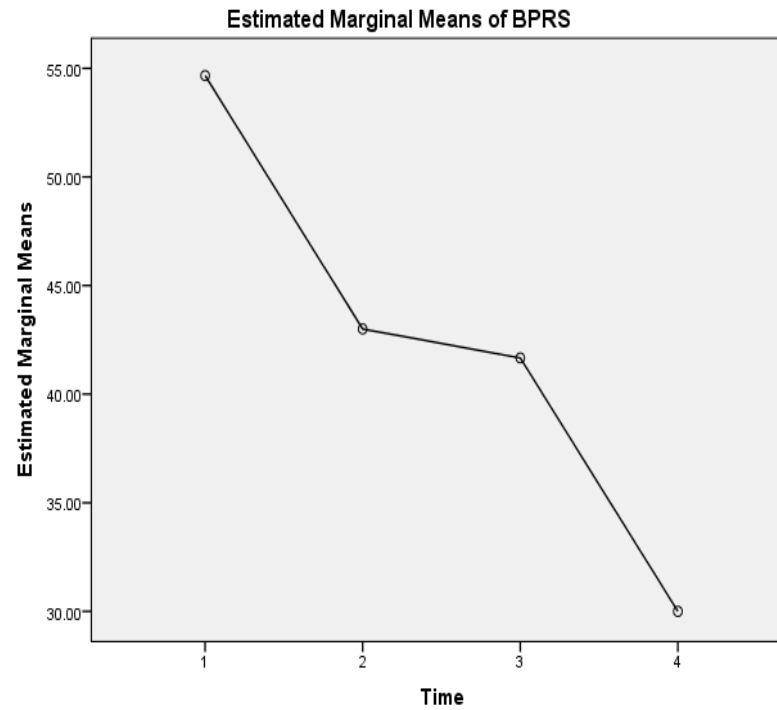
# Dosage, Risperdone Equivalents:

Clients Completing 12 Months in Program (n=10)

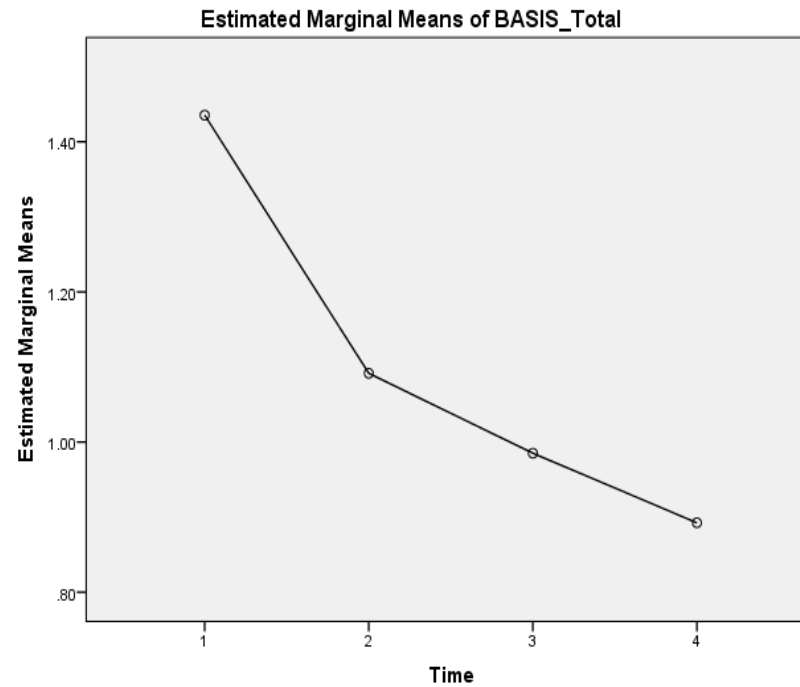




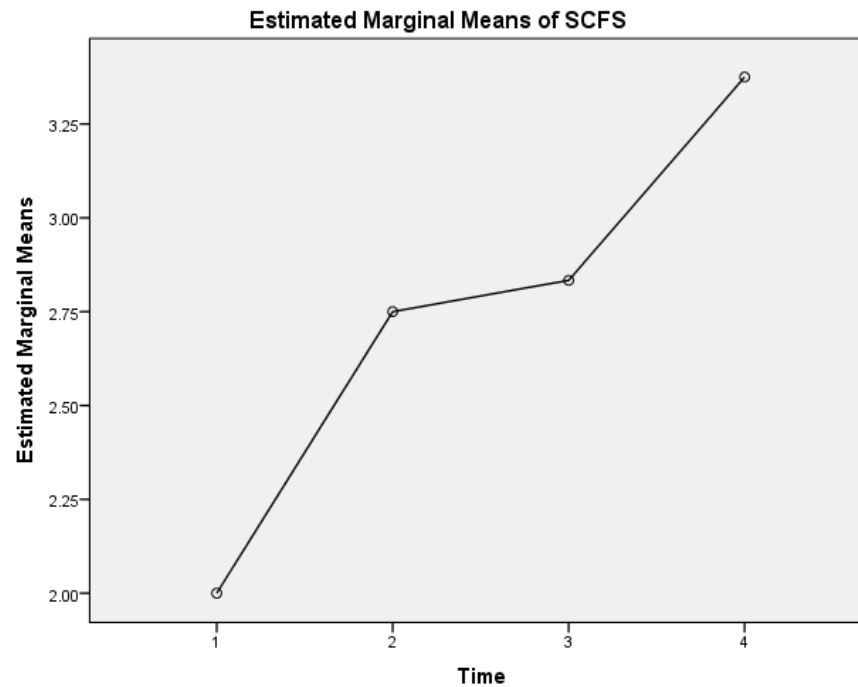
BPRS Scores over time (lower score is better)



# BASIS Scores over time (lower score is better)



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

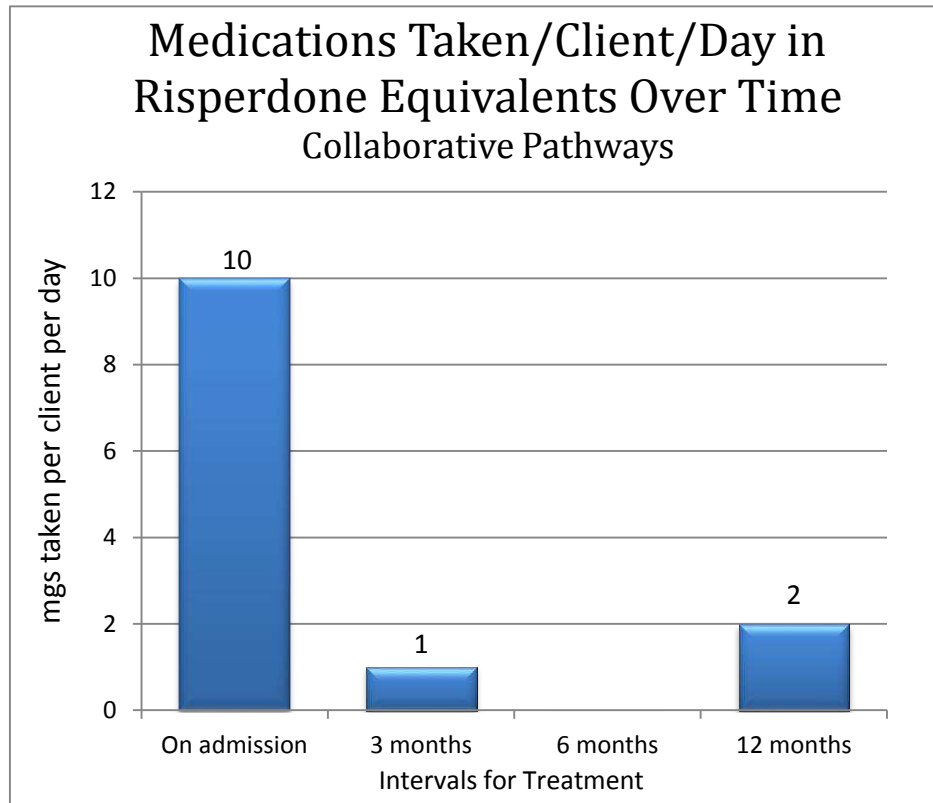


# Decision Self Efficacy Scale

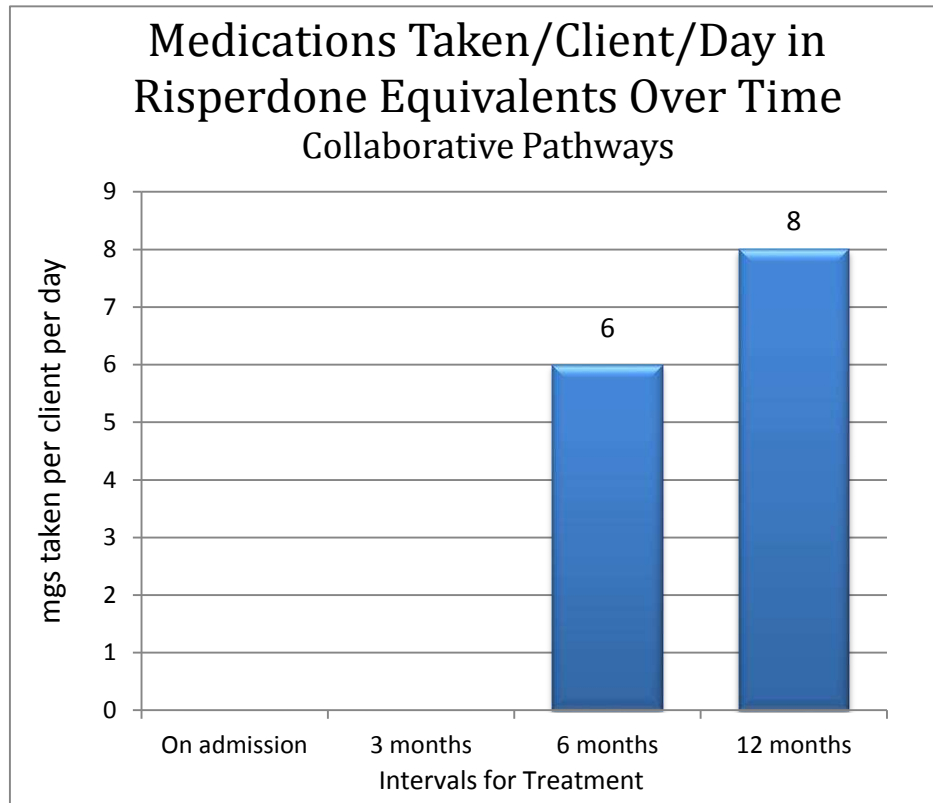
The 'Decision Self-Efficacy Scale' measures self-confidence or belief in one's ability to make decisions, including participate in shared decision making.

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

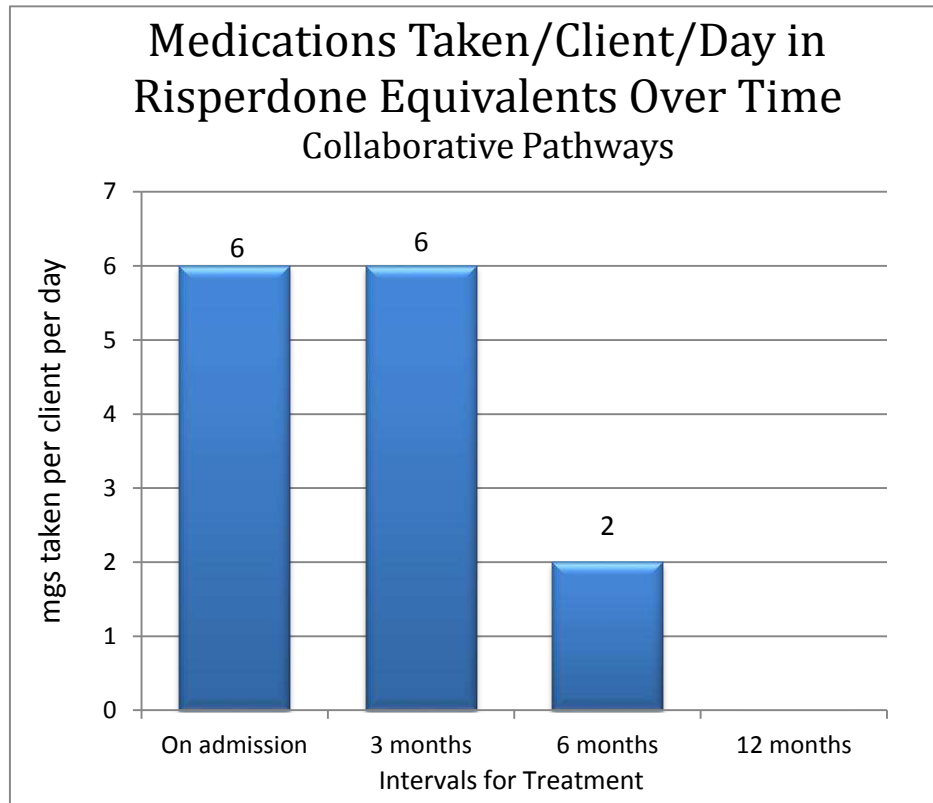
# Client 0876: reducing antipsychotics



# Client 5636: finding an acceptable med



# Client: 6873: tapering to zero



# Open Dialogue in Community-Based Flexible Supports (CBFS)

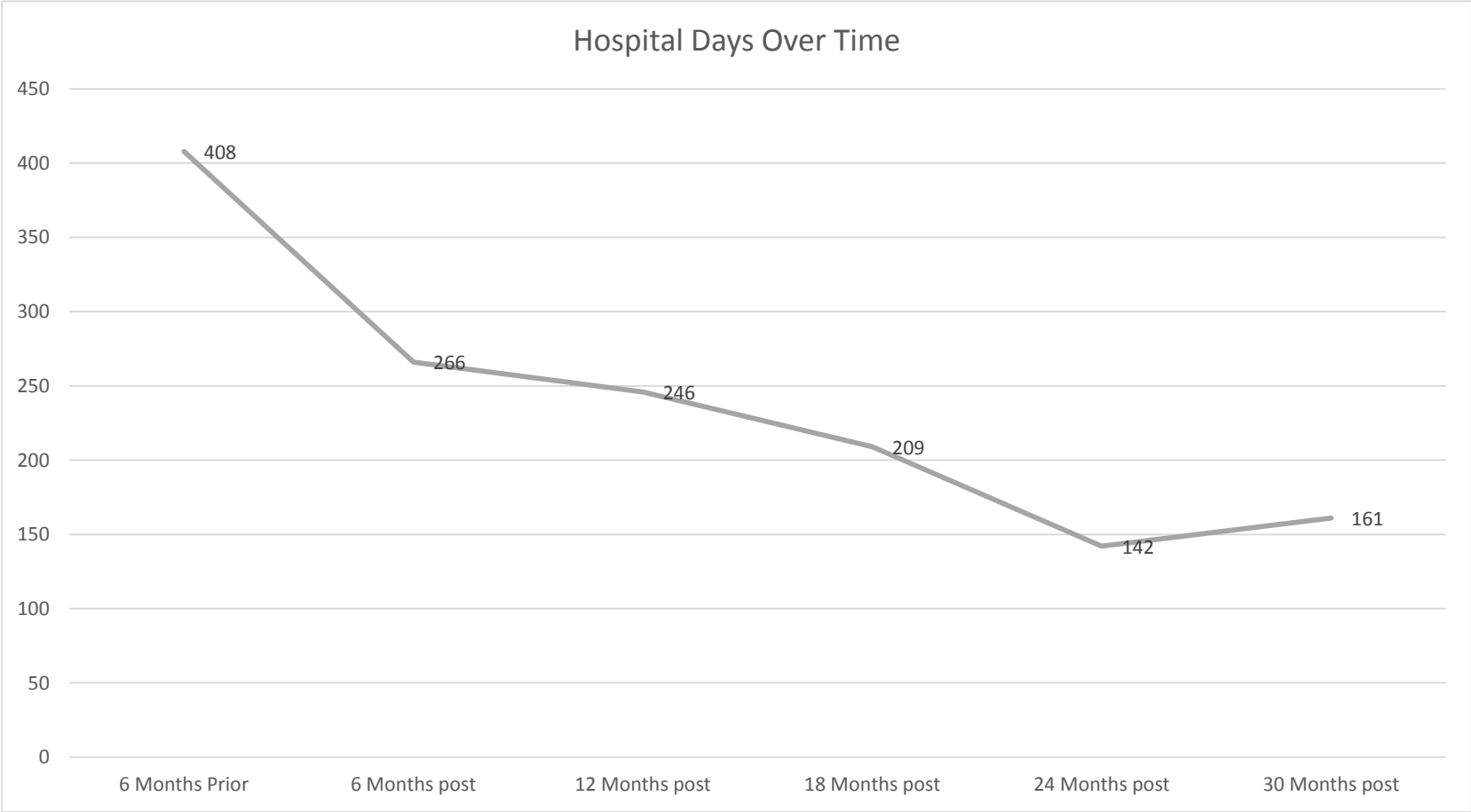
- People who were unhappy with treatment in CBFS
- People with frequent hospitalizations and “not doing well” clinically
- People new to DMH, with hope to avoid life long services
- Others who requested Open Dialogue services
- Two families who did not meet criteria for Collaborative Pathway
- The person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



# 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

# Open Dialogue in CBFS

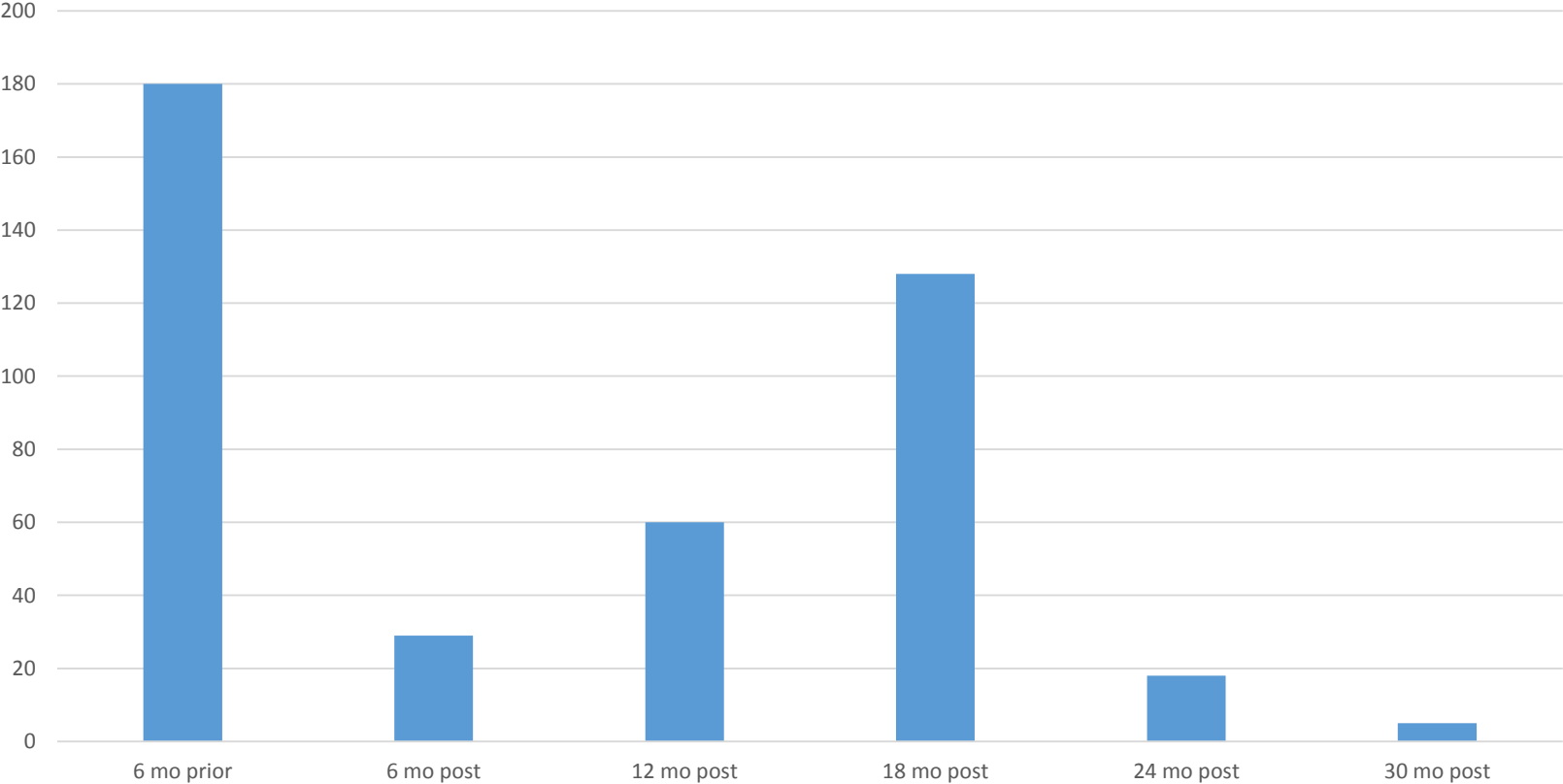


# OD in CBFS: some positive outcomes

- 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.

# Client 457

Hospital days

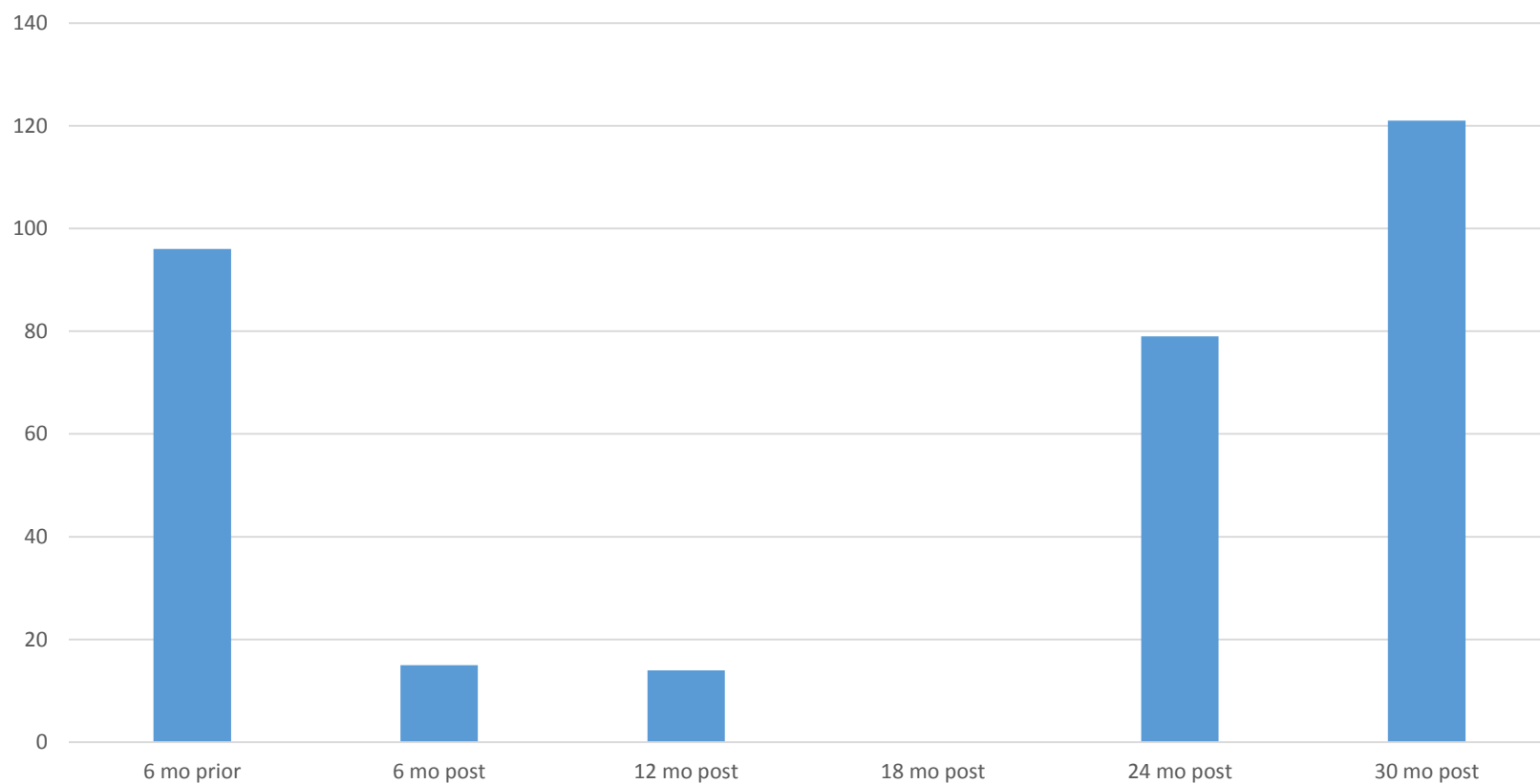


# OD in CBFS: some poor outcomes

- 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.

# Client 843

Hospital days



# 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 – a deviation from 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.

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



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

# 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.

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

- DBT
- Employment supports
- Psychopharmacological options
- Other psychotherapy

# 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 process.

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.

# Lessons learned: it's not magic

- Psychosis does not “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 our tools and efforts are puny and ineffective.

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