Implementing Open Dialogue & Dialogic Practice in new settings:
Opportunities for Improving Outcomes in First-Break Psychosis & Acute Psychiatric Crisis

Douglas Ziedonis, MD, MPH
University of California, San Diego (UCSD)
Associate Vice Chancellor, Health Sciences & Chief Academic Officer
Professor, Department of Psychiatry
DZiedonis@ucsd.edu
Excellent Finnish Outcomes in Open Dialogue Studies

- 5, 10, and 20 year follow-ups
- Less hospital days
- Less psychotic symptoms (82% less)
- Fewer on disability insurance (14%)
- More in school or work (86%)
- Fewer relapses (17% @ 2 yrs & 19% @ 3 years)
- Less neuroleptic medication (29 - 50% used)
What is Open Dialogue?

7 PRINCIPLES FOR ORGANIZING DIALOGUES IN SOCIAL NETWORKS

1. IMMEDIATE HELP
2. SOCIAL NETWORK PERSPECTIVE
3. FLEXIBILITY AND MOBILITY
4. RESPONSIBILITY
5. PSYCHOLOGICAL CONTINUITY
6. TOLERANCE OF UNCERTAINTY
7. DIALOGISM
Why Implement Open Dialogue?

* Addressing Gaps in Practice

- Standard Treatment Outcomes Not Good Enough
- Patient’s Network / Social Context Left Out
- Requires dignity, respect, and engagement
- Need for Shared Decision Making = More Trust
- Supports Recovery Movement
- Reduces Staff Isolation -> burn out
D&I Studies in Global Settings:

Addressing Dissemination & Implementation Gaps:
Training Programs, Fidelity Tools, & Technical Assistance for Organizational Change
4 Stages of NIDA Psychosocial Therapy Development

- **Stage I: Demonstrate Premise.** Develop manuals, adherence scales, training program, assess feasibility
- **Stage II: Demonstrate Efficacy.** RCT, component analysis (e.g. dismantling, predictor/matching, and optimization)
- **Stage III: Demonstrate Generalizability** across patients, therapists, and sites.
- **Stage IV: Technology Transfer.** Large Scale Training. Demonstration research
Current UCSD Studies (range of study designs):

- **PSYCHOSOCIAL DEVELOPMENT INTERVENTIONS**
  - NIH Staging model (1a/b, 2, 3, 4)
    - Dialogic Practice (DP) Guide & Fidelity Tool:
    - OD Organizational Change Guide & Fidelity Tool:
    - Briefer Training Curriculums

- **D&I PILOT STUDIES** (lots of Stakeholder Engagement):
  - APTOC Organizational Change Model (for Technical Assistance)
  - Peer-support Networks
  - Participatory Research
  - Adapt for local cultures
**Dialogic Practice (what happens in the network meetings)**

- Anthropologist in Clinical / Home Visit setting

- Deep Listening
  - Use patient’s words / stories

- Engage Family / Network

- Reflections

- Pauses

- Shared decision making
  - all treatment decision making with the patient present

- Meeting location also in the community / homes
Open Dialogue Denmark
- a historic View

[Map of Denmark with various labels and locations marked, including cities, towns, and facilities.]
The 12 Key Elements of Dialogic Practice in Open Dialogue

**Two Structural Elements**
1. Two (or More) Therapists in the Team Meeting
2. Participation of Family / Individual’s Support Network

**Ten Clinician Dialogue Elements**
3. Using Open-Ended Questions
4. Responding To Clients’ Utterances
5. Emphasizing the Present Moment
6. Eliciting Multiple Viewpoints
7. Use of a Relational Focus in the Dialogue
8. Responding to Problem Discourse or Behavior in a Matter-of-Fact Style and Attentive to Meanings
9. Emphasizing the Clients’ Own Words and Stories, Not Symptoms
10. Conversation Amongst Professionals (Reflections) in Meeting
11. Being Transparent
12. Tolerating Uncertainty

*(Olson, Seikkula, and Ziedonis, 2014)*
Patronizing or disrespectful utterances:

A. Classifying clinicians’ utterances

Start

What kind of utterance did the clinician make?

Monologic

Closed-ended question

Clinical assessment (e.g. medication, symptoms, exam):

Other:

Statement/open-ended question

Unsolicited advice, information:

Other:

Dialogic

Open-ended question

History of idea of meeting:

How to use the meeting:

Open-ended question

Inner or outer polyphony:

Relational or circular question:

Other:

Other statement or closed-ended question, (includes 1 clinician “reflecting” directly to the person or family”):

Significant silence of 3 seconds or more:

Reflection (a dialogue between 2 or more clinicians which includes creating opportunity for family to respond):

Circle: Norwegian (unique reflecting team) or Finnish (reflections by network clinicians) approach

Proportion of dialogical utterances= \( \frac{b}{(a+b)} = \) 

Total # dialogic utterances [“b”]: ____

Total # monologic utterances [“a”]: ____

How to use the meeting:

Patronizing or disrespectful utterances:
Survey of Programs Implementing Open Dialogue (mixed methods)

- Why adopt OD?
- How adapt OD?
  - What were the steps and big goals?
  - How engage physicians and peer support?
- What were the barriers / facilitators?
  - Funding / reallocation of resources?
  - Skills and Knowledge?
- How well did you sustain change?
- Lessons learned?
10 Organizational Criteria

1. Network Centered Care
2. Respect, Authenticity & Collaboration Values
3. Clinical teams with multiple providers in meetings
4. Staff skilled in respectful communication and network engagement
5. Create a welcoming environment with a focus on customer experience
6. Provide and connect services in clinical and community settings
7. Practice 12 Key Elements of Dialogic Practice
8. Provide immediate support and access to needed services
9. Shared decision-making process
10. Use Open Dialogue as a mindful way of being
Addressing Problems Through Organizational Change (APTOC)

- Training & Technical Assistance
- Patient, Staff, and Environmental Goals
- Organizational Change Strategies
  - 3 Phases & 10 Steps
    - Plan, Implement, & Sustain
- Leadership: Vision and Support
  - Champion Model
- Communication
- Monitoring Change Process & Outcomes
  - Environmental Scan
  - QI
RE-AIM Model:

* Reach
* Efficacy/Effectiveness
* Adoption
* Implementation
* Maintenance

http://www.dissemination-implementation.org
USA D&I Feasability projects

- UCSD
- Emory / Grady Health Care
- Advocates Framingham MA
- New York: Parachute project
- Vermont State – DMH
- Boston programs
How we’re missing the real story on mental health in Massachusetts

By Sara Davidow | AUGUST 12, 2016

The average citizen has now heard (and heard) the story of people with psychiatric diagnoses who are slipping through the state’s cracks, how their families are desperate but lack resources, and how the mental health system is failing us all. Yet there are two related stories that are hardly getting told: one good, and the other very, very bad.

New Approach Advised to Treat Schizophrenia

By BENEDICT CAREY | OCT. 20, 2015

Care Without Labels

The New York Times, Tuesday, August 9, 2016

Continued from page 1.

New open approach to mental healthcare

by Ken Picard

Burlington’s Howard Center Tries a New Approach to Treating Mental Illness: More Talking, Fewer Meds
Open Dialogue in Italy

- 8 MHDs in 6 different regions
- Financed by National Ministry of Health
- Open Dialogue training for 80 professionals and 1 researcher
- Comparing two matched areas (intervention versus control)

Latvia

* Riga Stradins University & Zelda
The research aims:

- Can services be reorganized to evaluate OD?
- How effective is staff training?
- Can OD be used to treat people in crisis?
- Will service users, families and staff have a positive experience?
- Can OD become part of routine care?
- Is OD better than usual crisis care?
- What changes are needed to integrate into routine care?
- How much is the cost and is a good value versus usual care?

- Many OD Teams / Open Dialogue UK
- University College London
  - Centre for Outcomes, Research & Effectiveness
    - Steve Pilling & Russell Razzaque
Lessons Learned:

- Need the Tools to Help D&I
- Positive Experience and Outcomes
  - Patient (PCC)
  - Family / Network
  - Staff
- Needed Adaptations Vary:
  - Resources / Finances
  - Structure / Organization
  - Treatment Orientation / Values
  - Culture – of Country, Agency, & Programs
  - Role of Peers and Physicians
- Transformative change on an organizational, clinical & personal level

- Next Steps