Open Dialogue (OD) Notes

7 Principles – 1) Immediate Help, 2) Social Network Perspective, 3) Flexibility & Mobility, 4) Psychological Continuity, 5) Responsibility, 6) Tolerance of Uncertainty, and 7) Dialogism

12 Elements - 1) Two or more therapists, 2) Participation of family and/or network, 3)Open-ended inquiry, 4) Responsiveness, 5) Emphasis on present moment, 6) Sustains and integrates multiple viewpoints, 7) Sees behavior as meaningful, 8) Relational focus, 9) Emphasis on stories not symptoms, 10) Reflecting conversation among professionals, 11) Transparency, 12) Tolerance of uncertainty

General Overview of Parachute New York

~ Challenges diverting people to Parachute Projects

~ Focus on trying to understand what is going on with the person vs. medication

~ Need Adapted Treatment Model (NATM) is an adaptation of OD. In NYC, some psychiatrists on the teams are still more likely to use medication as a first intervention

~ OD is very important and we need more educational access to it. We need to contact Mary Olson regarding the next stage of training access; people need to know about it, people in the schools as well, then they would seek training. Spread the work through peer organizations.

~ Nick from UK shares that OD training is in the beginning stages, so ramping up trainings too fast could result in watered-down versions and result in poor practitioners.

~About 70 people have been trained in OD so far. IN NYC, Parachute New York is being federally funded and they are doing careful research to synthesize best practices so that what they do can be the basis and strong foundation of spreading it further in the US.

~Therefore, we have time now to educate people and get the word out and plan for more widespread training availability.

~Those here at this conference can start getting the word out in our home areas.

~We need to contact and request collaboration with Mary Olson and inform her of the upswell of desire at the conference that we want the next stage of blooming of OD awareness and more accessible OD training.

~ OD training must also be accessible to low-income providers so there is not a two-tier system – from the beginning.

~ OD training needs to get into university and licensure programs.

~Lay people need to spread information about OD in their schools.

~Faculty awareness is key to getting OD into schools. Approach individual faculty in an attuned way.

~Inform the media and journalists about it. Submit articles to the local and mass media press.

~Parachute New York is doing at adaptation of OD. Nick and Ed, from Parachute New York, were both present, and were asked how they see OD evolving? Answer: Well, having a small part of the mental health system using OD builds awareness and trust, it is seen that it is a more effective response towards the vulnerable, and because of this, the mental health system will change over time. The OD approach and results (less meds and hospitals, more respect of people and families, more people able to re-enter life more fully and be part of the workforce) – this is what is beginning to happen in NYC. We are talking small steps, as Parachute NY is just a small slice of the mental health system in NY. But if it is shown to improve results in the mental health system, it will catch on and grow.

~ Support for helping people get and keep employment is key to recovery. Employment is vital. Not in the adapted New York model at this time.

~Here in the US, we cannot do this piece, or maybe any piece, exactly like they do it in Finland, it is flexible. It must at attuned to each country's culture, needs, constraints. Even county to county, even with counties, needs vary. Politics are key. Need to be aware of issues of power, changing power dynamics among stakeholder is tough. Change is uncomfortable, especially because of loss of power of people in the conventional mental health system. Local needs will drive adaptation of OD – balanced but not water down, locally attuned but not wated down – must be the goal.

~The NYC Needs Adapted Treatment Model training was 1 year. Mary Olson's training is open to clinicians and non-licensed folks working the field. What about the NYC NATM training?

`A question arose about OD and psychosis. Mia, on Skype from Finland, said that they have a dialogue about meaning making when the individual and the network don't have shared reality. Reflections are used. In Parachute program, peers with lived experience can relate to individuals, and there is a valuable place in the network for peer connection/expertise. Being able to relate about a shared experience of hearing voices, for example, breaks down the fear and is reassuring. It is found that because the team makes it a priority to listen to the individual's story, family members and other members of the gathered social network do not feel like their loved one, who is the "person of concern" in the social network, has to live in isolation/marginalization/exclusion.

~ We observed 5 trained people engage in an Open Dialogue about Open Dialogue (Dan Fisher, Sandra Steingard, Amy (from Advocacy, Inc.), Mia (Skyped in from Finland), and Woman (from Parachute NY). Here are some of their comments:

> ~The answer comes from the process.
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> ~We are story listeners.
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> ~OD is about how you deal with power.
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> ~I'm concerned that OD has become glamorized – then shares recent painful vulnerable experience from provider perspective of a recent forced hospitalization/medication of client.

~Mia refocused group with the question: How do you experience/feel yourself in this dialogue? They all answered, sharing personal experience of the training. Mia asked them to think of power as a feeling, and then think of themselves without that feeling of power. They discussed that.

~ Who can do OD? Clinicians only, or also peers? Also, how can we get OD into the conventional system?

~OD vs. conventional system. OD is similar to good parenting, reverential care for other. OD is part of a larger movement of attunement-based work and care. Conventional forced treatment generates great loss and grief. Akin to ending a pregnancy due to a mother's natural labor pains. This is what conventional forced care does, and time to grieve and rest is the healing agent.

~Do team members self-disclose? Training includes therapy for team members. Every individual chooses what/how to share their experiences with the network. So, it varies from person and person. The training gives the message that we need to look at ourselves all the time. If team members share something, it is going to help the dialogue.

~Members from the person's religious affiliation are invited into the network if that is helpful.

~If a person doesn't want someone in their network, they have that say.

~The issues in NYC or US may not be the same as those in Finland. Mia said that involuntary commitment does happen in Finland.

~ For individuals in altered states, the same principles of OD apply. OD has the same approach for everybody.

~ In Finland, they usually start with anxiety medicine for sleep. (Benzos).

~ Persons know to call before things become "chronic".

~ People can be in individual therapy in addition to network meetings.

~Why is OD so successful? Finnish authorities have come to Western Lapland to enlarge OD to the rest of Finland.

~Rates of psychosis higher in immigrant population. And in NYC there are cultural differences.

~Integration of peers and non-peers. In NYC, by talking with the caller they arrange with whom the team needs to meet. Team members then ask the network whom to meet. The person who is in crisis has the say about who is in the network. Network members can be anyone who is significant in the person's life and who the person's wants in the network. There are always two team members in the meeting.

~People can continue with psychotherapy after the NATM approach.

~How does OD hold and negotiate big feeling? Does OD help with de-escalation of big feeling?

At the very beginning of OD, people try to dictate the process and there is more monologue. The team sticks to themes and ideas that the network brings to discussion. Sometimes reflections are about strategies to allow people to be heard. There might be 2-3 reflections in an ideal meeting. Ideally, these are emotionally connecting/sharing moments between the network members and team members.

More untold stories come up once that process unfolds and healing begins. The process will come to a climax, then more there will be silence, then it unfolds again and will come to a climax, in small steps.

~In Brooklyn they tried to have separate meetings when domestic violence was present in the family. How to address domestic violence and abuse is still a work in progress.

~Primary physicians, doctors, etc. call with the person on the OD cell line in Finland. However, it varies with the doctors.

~Psychiatrists get trained in Open Dialogue and Family Therapy.

~In NYC, peer support workers are trained in Intentional Peer Support and the Need Adapted Treatment Model. 50% of their participants are from an inpatient unit.

1-800-LIFENET.

Contact Amy Morgan, amorgan@advocatesinc.org 508-612-5780

~It would be nice to have a distance learning program for OD. Could OD practitioners travel to train? Contact Mary Olson regarding creating the next steps of training access. People need to know about it. A large conference is coming next year. People in the schools need to be exposed to it, because then they would seek training. We can spread the work through peer organizations.

Nick cautioned that we are in the foundational stages and there need to be safeguards against watered down versions being spread.