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Discursive paper

Open Dialogue, need-adapted mental health care, and implementation fidelity: A discussion paper

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Authorship statement

EW and NB had primary responsibility for conceiving the study and planning the literature review. All authors contributed to reviewing the literature, writing and revising the manuscript.

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Abstract

Open Dialogue is a need-adapted approach to mental health care that was originally developed in Finland. Like other need-adapted approaches, Open Dialogue aims to meet consumers needs and promote collaborative person-centred dialogue to support recovery. Need-adapted mental health care is distinguished by flexibility and responsiveness. Fidelity, defined from an implementation science perspective as the delivery of distinctive interventions in a high quality and effective fashion, is a key consideration in health care. However, flexibility presents challenges for evaluating fidelity, which is much easier to evaluate when manualisation and reproducible processes are possible. Hence, it remains unclear whether Open Dialogue and other need-adapted mental health interventions can be meaningfully evaluated for fidelity. The aim of this paper was to critically appraise and advance the evaluation of fidelity in need-adapted mental health care, using Open Dialogue as a case study. The paper opens a discussion about how fidelity should be evaluated in flexible, complex interventions, and identifies key questions that need to be asked by practitioners working in need-adapted mental health care to ensure they deliver these interventions as intended, and in an evidence-based fashion.

Keywords: Philosophy, nursing; mental health; implementation science; psychiatric nursing; evidence-based nursing.

Aims

The aim of this paper is to open a discussion on how fidelity should be evaluated in need-adapted mental health care. Fidelity has been defined as the extent to which an intervention is delivered as intended (Proctor et al., 2011), and the extent to which the delivery of an intervention is of high quality (Carroll et al., 2007, Dusenbury et al., 2003). Evaluating the fidelity to content and process of a therapeutic intervention can assist in explaining in part whether a lack of achieving desired outcomes is an issue related to the intervention or its application (Schoenwald et al., 2011).

To achieve our aim, we critique a number of proposals for evaluating fidelity in Open Dialogue, a recovery-oriented approach to mental health care, which is founded on need-adapted principles.

Background

In mental health nursing, many interventions are based on need-adapted principles, e.g. (Barker and Buchanan-Barker, 2005). Open Dialogue is one intervention based on need-adapted principles, and was developed in Western Lapland in Finland during the 1980s and 1990s (Haarakangas et al., 2007). Like all need-adapted interventions, it aims to build therapeutic dialogues that involve social networks as a psychosocial resource for a person experiencing crisis (Gromer, 2012). The original Finnish Open Dialogue project received documentary coverage that captured the popular imagination (Lakeman, 2014), and community demand for Open Dialogue was an important factor in the dissemination of
Open Dialogue across Australia, Europe, and the United States. Need-adapted interventions, such as Open Dialogue, naturally develop heterogeneous presentations as they meet the needs of different consumers; this has raised difficult issues when evaluating these interventions, as the heterogeneity makes it difficult to assess fidelity.

It is not the intention of this paper to describe Open Dialogue in detail; readers interested in a mental health nursing perspective on Open Dialogue are referred to Buus et al. (2017, Ong et al., 2019), or to Bellingham et al. (2018), published in this journal. However, for context, Open Dialogue is founded upon seven need-adapted principles described by Seikkula et al. (2001a, 2001b):

1. Immediate help: A meeting with the consumer and their network (network meeting) is established within 24 hours of first contact with the psychiatric system
2. A social network perspective: The consumer, relatives, and significant others are invited to the network meetings
3. Flexibility and mobility: Treatment is adapted to the specific needs of the consumer and includes outreach
4. Responsibility: The treatment team immediately takes responsibility for establishing and continuing network meetings and integration with other treatment processes
5. Psychological continuity: The consumer collaborates with at least one clinician who remains involved throughout the process
6. Tolerance of uncertainty: Treatment options are discussed at length to avoid premature decisions
7. Dialogism: Dialogue and collaboration within the family and network is promoted. Dialogue does not seek behavioural change or consensus, but increased meaning and understanding.

The first five principles primarily relate to service organisation with principles six and seven primarily relating to the particular dialogical therapeutic style. The processes used to establish these principles have never been reported in the literature, which is problematic because these principles have been used as the basis of several evaluations of Open Dialogue. The principles were not intended by the authors to define Open Dialogue, arguably because of the tension between the flexibility of the approach and the lack of flexibility inherent to practices of standardisation. Rather they have been classified as “research-based” guidelines for “treatment focusing on dialogue” (Seikkula and Arnkil, 2006, p. 53). Nonetheless, these principles have been used to develop fidelity criteria for distinguishing and evaluating Open Dialogue interventions.

When evaluating interventions in mental health, treatment manuals are generally used to make transparent the mechanisms by which a specific psychosocial treatment effects change, and therefore manualising a treatment contributes to the replicability of content and processes to ensure fidelity (Schoenwald et al., 2011). In keeping with the principle of flexibility, approaches to evaluating Open Dialogue approach have generally resisted manualisation, which is a process for developing treatment manuals that describe how to deliver an intervention with sufficient uniformity that it can be assured to have been delivered as intended (Blanche et al. 2011). This is important because if interventions are not delivered as intended, it is difficult to gather evidence on their efficacy and outcomes (Toomey et al.,

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The current approaches to defining Open Dialogue standards have not hitherto been compared or appraised to consider their relative benefits and shortcomings or to identify areas of future research. This paper aims to fill this gap in the literature, and in doing so, to open discussion about how need-adapted interventions in general should be evaluated for fidelity.

**Design**

This discussion paper contains a critical appraisal of ways in which fidelity has been approached in Open Dialogue, using the elements of fidelity identified by Carroll et al. (2007) to guide the critique. The use of this framework is inspired by the best practice guidelines promulgated by Toomey et al. (2020), which include the use of published frameworks to guide the evaluation of fidelity.

**Method**

We first identified approaches to describing Open Dialogue fidelity, which included research instruments and key statements (Olson et al., 2014, Eiterå et al., 2014, Rambøll, 2014a, Rambøll, 2014b, Alvarez Monjaras, 2019). These sources were identified through a previously conducted review of Open Dialogue studies (Authors 2017) and by contacting researchers we knew were currently working with research and implementation of Open Dialogue. Thereafter, we reviewed and appraised the identified approaches.

This critical appraisal was guided by the elements of fidelity developed by Carroll et al. (2007) who identified five issues that need to be appraised when evaluating whether interventions are delivered with fidelity. These five elements of fidelity can be divided into those that examine whether a unique intervention was delivered, allowing the attribution of outcomes and subsequent analysis of efficacy, and those that assess the quality of delivery, since not all interventions may be delivered equally well. In Table 1, these five elements are operationalised into specific questions to assess whether Open Dialogue is delivered with fidelity. The existing approaches to Open Dialogue fidelity were critically analysed as to whether they can answer these five key questions and subsequently, their ability to actually assess whether Open Dialogue is delivered with fidelity.

[Insert table 1 approximately here]

**Discussion**

**Part one: approaches to fidelity in Open Dialogue**

We identified five approaches to fidelity in Open Dialogue, which are briefly presented in the following sections, and then compared, contrasted, and critiqued using the questions from Table 1.

1. Eiterå et al.’s “markers” of the seven principles
Eiterå et al. (2014) approached fidelity in Open Dialogue by creating “markers” of the seven principles that can be used to “determine whether a practice can be called Open Dialogue” (p. 3). According to Eiterå et al. (2014), the individual markers should be further operationalised and manualised to ensure standardised implementation, but they do not explain how that should be done. Each principle was assigned between two and six markers. For example, Tolerance of uncertainty (principle 6) has six markers:

1. Access to the professionals when the citizen needs this
2. Do not give way to immediate solutions
3. Use reflection with your colleague when there is pressure to act
4. The professional gets involved in the work as a professional and as a personal presence
5. Take responsibility for ensuring that the situation is ethically correct
6. Do not talk about anything that has not been raised by the citizen/network – forget your own preconceptions.” (Eiterå et al., 2014, p. 15)

In general, the markers appeared to provide guidance for clinicians in their clinical practice rather than supporting clear assessment of fidelity. For instance, the first marker “access to the professionals when the citizen needs this” raises a need for clarification: Is there a threshold for determining when citizens need to access professionals, and if there is, who defines it? Moreover, as with the original seven principles, it is not clarified whether all or how many of the markers should be present before a practice can be determined as Open Dialogue. Conversely, if a clinician violated the sixth marker and raised a concern that was not introduced by the family, would that mean that Open Dialogue had not taken place? We also note that some of the markers seem only tenuously, if at all, connected to the underlying principle, such as the fifth marker concerning the clinician’s moral responsibility for the situation.

2. Ramboll’s operationalisation of the seven principles

As part of manualising an Open Dialogue approach and evaluating its fidelity, a Danish Open Dialogue implementation study included an operationalisation of the seven principles (Ramboll, 2014a, Ramboll, 2014b). In this study, an Open Dialogue approach was described as containing five elements in a recursive flow model: 1. Initiation and first contact with the citizen, 2. Network mapping, 3. Planning before network meetings, 4. Network meetings, and 5. Closure. Three data collection tools were provided for mapping citizens’ networks and for summarising outcomes from network meetings. While all seven principles were taken into account, the focus on organising and executing network meetings reduced the significance of some of the principles, for instance “immediate help”.

The manual included descriptions and a checklist for each of the five elements. For instance, “Network mapping”, which stated:

“As part of planning the citizen’s network, the professional/co-ordinator and the citizen should complete the following activities:

- Completion of a network overview (using tool)
- Continual updating of network overview

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• Completion of a network map (using tool)
• Continual updating of network map and use of the instrument.” (Rambøll, 2014b, p. 7).

Assessments of fidelity to the manual suggested that clinicians generally followed the manual, for instance, network overview and network map were completed before 60-70% of the first meetings. The stated high level of fidelity was largely attributed to the quality of the local training and supervision certification program (Lægsgaard, 2017, Lægsgaard, 2014).

3. Olson et al.’s 12 “fidelity criteria”

Rather than evaluating fidelity across all seven principles, Olson et al. (2014) focus on the particular dialogical style of therapy in Open Dialogue network meetings and proposed twelve “fidelity criteria” that “characterize the therapeutic, interactive style of Open Dialogue in face-to-face encounters within the treatment meeting.” (p. 4). The first two criteria concern the structure of meetings, and the other criteria relate to the presence or quality of dialogue.

1. Two (or more) therapists in network meetings
2. Participation of family and network
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 behaviour 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 the treatment meetings
11. Being transparent
12. Tolerating uncertainty (Olson et al., 2014).

These criteria are described as overlapping, and the publication provides extensive examples of the criteria. Parallel to Eiterà et al.’s markers (2014), it is not clear how to operationalise the criteria to formally evaluate fidelity.

4. Ziedonis’ modification of the 12 fidelity criteria

Ziedonis et al. (2018) modified Olson et al.’s (2014) 12 fidelity criteria and developed a manual for evaluating fidelity to Open Dialogue principles during network meetings. The tool has been widely publicised in the Open Dialogue community, and demands discussion in this paper; however, it has not to date been formally published in peer reviewed journals, but is available through the author. The fidelity tool contained in the manual was designed for ratings of recordings of network meetings and is ultimately used to determine if a session had acceptable “quality and fidelity”. This rating tool was the first to define a difference between “monologue” and “dialogue”, with the former being damaging forms of communication that can undermine the latter.
This tool is the first to employ a numerical rating (the monologue/dialogue ratio) to determine whether meetings contained the essence of Open Dialogue or not. The rating is three-parted: The first part is “Classifying clinicians’ utterances”, where an observer rates the number of “monologic” and “dialogic” utterances respectively. An example of a monologic utterance, “Unsolicited advice, information” is: “Interpretations, hypotheses, labels, judgements. Needs to be imposing or technical.” An example of a dialogical utterance, “Normalising symptoms”: “Explores meaning, self-disclosure, relates present experiences as part of coping with previous experiences/traumas.” The proportion of dialogic statements are then calculated (number of dialogic utterances divided by number of monologic + dialogic utterances). The second part is “12 key elements of fidelity”, where criteria 3-12 are rated from “Not at acceptable level” to “Excellent”. The third part is “Overall quality” where raters are asked: A. Is the proportion of dialogic statements at least two-thirds? B. Are at least 8 out of 10 key elements of fidelity rated as “acceptable”? C. Were there fewer than two instances of patronising or disrespectful statements amongst the clinicians’ utterances (rated in the first part)? If the answers to these three questions are “yes”, then quality and fidelity in the session are acceptable.

5. The Community Mental Health Fidelity Scale (COM-FideS)

Developed for use in the ongoing UK-based Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness (ODDESSI) trial, the COM-FideS scale incorporates items that assess fidelity to the principles of Open Dialogue both in programmatic delivery at the service level and at the therapist level (Alvarez Monjaras, 2019). The term “adherence” is sometimes used by the developer to distinguish therapist level assessment, with the term “fidelity” being reserved for the assessment of elements of program delivery.

The COM-FideS measure was developed through a multi-stage process. The Children and Young People – Resource, Evaluation and Systems Schedule (CYPRESS) (Gaffney, 2012) was used to compile an initial list of items that could be used to evaluate a complex mental health intervention, particularly at the service level. CYPRESS items were augmented by Open Dialogue specific items, informed by the original seven principles, the 12 criteria (Olson et al., 2014) and Ziedonis et al.’s (2018) rating tool, as well as by discussions with experts including Ziedonis and Seikkula. The finalised COM-FideS scale includes 25 items addressing service delivery in four domains (service structure and culture, access and engagement, delivery of care, and community support and engagement), plus an Open Dialogue “addendum” consisting of 7 items relating to the characteristics of therapists and therapeutic teams. The 25 service level items substantially overlap with the 21 items of CYPRESS (Gaffney, 2012). The seven items of the Open Dialogue addendum are unique as they do not refer to the seven principles, dialogism, or Network Meetings but are focused on the presence or absence of training, professional development, self-disclosure, transparency and intervention amongst therapists (Alvarez Monjaras, 2019).

The COM-FideS measure represents a significant break away from relying on the Finnish descriptions of Open Dialogue principles. But, like the other approaches, there is a pervasive idea that fidelity evolves organically when clinicians are trained/oriented appropriately in their practice. In a sense, fidelity is something that is determined a priori i.e., if a clinician’s practice is informed by the seven principles.
principles or other protocol, then the intervention will be delivered with fidelity. This is different to the notion of fidelity in the literature, which assumes that interventions are never delivered as intended, hence robust post hoc critique is required (often by independent evaluation) (Toomey et al., 2020). In this view, a priori commitments and self-evaluation are not enough as they are exceptionally susceptible to confirmation bias.

**Part two: critical appraisal of existing approaches to Open Dialogue fidelity**

All five identified approaches failed to address at least one of the five elements of fidelity operationalised in Table 1. Each of these elements will be discussed below.

**Element 1: Has Open Dialogue been delivered?**

The approaches of Rambøll (2014a, 2014b) and Ziedonis et al. (2018) both address this question. Rambøll (2014a, 2014b) provide a manual for the delivery of Open Dialogue, that must be followed by therapists in their program, and Ziedonis et al. (2018) determines that Open Dialogue has occurred if the monologue/dialogue ratio is acceptable. Of these approaches, the Rambøll (2014a, 2014b) manuals include a number of unique tools that draw on each of the seven principles of Open Dialogue to assess delivery. Contrary to this, Ziedonis et al. (2018) focus on dialogism almost exclusively. This is problematic, because not only are the other six principles neglected, but there are many other interventions that utilise similar approaches to dialogism; for example, dialectical behavioural therapy (Chapman, 2006), multi-dimensional family therapy (MDFT) and brief strategic family therapy (Rigter et al., 2010, Szapocznik et al., 2012). As such, it is apparent that instruments solely focusing on dialogism cannot be used to determine whether Open Dialogue has in fact been delivered.

**Element 2: How much and how often should Open Dialogue be delivered?**

Open Dialogue scholars and practitioners have been reluctant to prescribe optimal frequency or duration of network meetings. Instead, it is generally recommended that meetings occur as soon as possible and whenever needed, in accordance with principles 1, 3 and 5. Whilst they do not explicitly countenance the idea that a “dose-response effect” (Robinson et al., 2020) may exist for Open Dialogue, it can be argued that Open Dialogue practitioners do perhaps implicitly acknowledge that some relationship between length and frequency of therapy sessions and subsequent probability of improvement (Robinson et al., 2020) does exist for Open Dialogue, since practitioners acknowledge in theory that there is a point where it is appropriate to cease network meetings. Only the Danish Rambøll approach (2014a, 2014b) thus far has explicitly addressed this element of fidelity, and found in post-hoc analysis that participation in two or more network meetings equated with the delivery of Open Dialogue (Lægsgaard, 2017, Lægsgaard, 2014). Despite also collecting data on the extent of network participation in meetings, these authors did not consider whether there existed a critical network mass or extent that influenced the delivery of Open Dialogue. At this stage, there exists significant potential to further explore how network meeting frequency and composition should be measured in researching Open Dialogue fidelity.

**Element 3: Has Open Dialogue been delivered well?**

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Both Ziedonis et al. (2018) and Rambøll (2014a, 2014b) provide means of distinguishing between network meetings that have been delivered well and not so well. Ziedonis et al. (2018) proposes the monologic/dialogic ratio to assess whether networks meetings have been sufficiently dialogical. Rambøll (2014a, 2014b) provide a summary sheet to assess whether certain goals have been met at each treatment meeting, such as whether agreements or undertakings were made. Whilst not explicitly stating that these measures of quality are linked to therapeutic efficacy, it is clear that a supposition exists amongst these authors that quality relates to improved outcomes; otherwise, why should it be assessed? This is reflected in the literature, which acknowledges that not all network meetings have equally positive outcomes (Seikkula, 2002).

Assessing the quality of delivery at the service level is also an important part of assessing fidelity, and cannot simply be ascertained by studying network meetings, since Seikkula (2011) maintains that the Open Dialogue principles not only govern therapeutic encounters, but also health service delivery. To date, only the CoMS-Fides measure explicitly addresses service level delivery of Open Dialogue, by assessing the quality of training, support and intervision provided to therapists (Alvarez Monjaras, 2019). As yet, however, there is no evidence that this training is linked to improved outcomes in Network Meetings. Future work should explore whether service level measures and Network Meeting level measures are independently associated with participant experience and perceived quality of Open Dialogue.

Element 4: Does Open Dialogue meet consumers’ and networks’ needs?

This is a key question because in many countries, including Australia, consumer involvement in service delivery is a key policy goal (National Mental Health Commission, 2014, NSW Mental Health Commission, 2014, NSW Mental Health Commission, 2015). Open Dialogue is an attractive intervention within this context, since there is ample evidence that Open Dialogue is acceptable to both consumers and their support networks (Buus et al., 2017). Of the five identified approaches to fidelity, none collect information on the acceptability of the intervention to consumers. However, several collect information on the presence or absence of social supports at network meetings (Olson et al., 2014, Eitzen et al., 2014, Rambøll, 2014a, Rambøll, 2014b), which might be regarded as an indication of acceptability. In addition, Rambøll (2014a, 2014b) requires characterisation of the breadth of available social support as part of the therapeutic approach. Whether this additional information helps in understanding network members’ experience as participants in Open Dialogue should be addressed in future fidelity research.

Element 5: Does a distinct Open Dialogue intervention exist?

This final element is arguably the most important element of fidelity, as it pertains to differentiation. As demonstrated by the reviewed approaches to Open Dialogue fidelity, the approach has multiple principles and components ranging from practical aspects of service delivery to more abstract concepts of dialogue and tolerating uncertainty within the therapeutic encounter. If each of these components are considered individually there is little to differentiate Open Dialogue from other psychotherapies. For instance, the principle of “tolerating uncertainty” is identified as a feature of other therapeutic approaches (Yip et al., 1993, Rober and Seltzer, 2010). The markers and their underpinning principles

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identified by Eiterå et al. (2014) are also seen in other therapeutic approaches (Rigter et al., 2010, Szapocznik et al., 2012). In particular, dialogism which was emphasised by Olson et al. (2014) and Ziedonis et al. (2018) is central to many family therapy interventions, which evaluate it using very similar instruments (Rigter et al., 2010, Szapocznik et al., 2012). It is possible that Open Dialogue consists of a unique combination of these elements, but the pressing question about what comprises the essential components of Open Dialogue and how these relate to evaluating fidelity has not been comprehensively addressed or clearly articulated across any of the reviewed approaches to fidelity. This undermines the ability to differentiate Open Dialogue from other approaches and also to determine whether the approach has been faithfully delivered.

Conclusions

The original seven principles of Open Dialogue cover a wide range of aspects of service delivery and clinical encounters. However, they are presented as general guiding principles for clinicians and are not readily operationalised in practice or measurable. None of the existing approaches to fidelity examined in this paper comprehensively address the elements of fidelity used in implementation science (Carroll et al. 2007). Most notably, none of the proposed tools sufficiently or clearly differentiate Open Dialogue from other psychotherapeutic approaches. The distinguishing features of Open Dialogue (particularly those most strongly linked to any positive outcomes) are yet to be identified.

The five approaches to considering fidelity in Open Dialogue seem to indicate that some aspects of an Open Dialogue approach, such as the organisation of network meetings, lend themselves more easily to be manualised than, for instance, inter-agency collaboration. Future attempts at developing fidelity criteria for Open Dialogue can build on existing models but, in keeping with best practice, should draw upon existing frameworks for evaluating fidelity, detach the evaluation of fidelity from efficacy, and permit evaluation of fidelity by individuals independent of the clinical team using the approach (Toomey et al., 2020). Future research should focus on more precisely identifying the essential elements of Open Dialogue that can be independently measured in a network meeting, number of sessions required before intended clinical change can occur, and specific measures of consumer and network satisfaction that are positively correlated with differentiation, dose, quality of network meeting delivery, and adherence to protocol.

Beyond Open Dialogue, these questions also need to be asked of many need-adapted mental health interventions, in order to ensure that flexible need-adapted models of mental health care can be delivered in an evidence-based, reliable fashion.

Relevance for clinical practice

Open Dialogue is firmly positioned as a need-adapted intervention for which flexibility is a defining feature, yet which has been widely disseminated, raising questions about the fidelity of these implementations. For the authors of this paper who are Open Dialogue practitioners, the questions...
raised have been deeply uncomfortable, requiring reflection on their own understandings of fidelity, evaluation, need-adaptedness, and evidence-based healthcare. Unfortunately, the lack of manualisation has made it difficult for mental health nurses to be clear about what exactly is being proposed or delivered when Open Dialogue interventions are introduced in their service. Without this clarity, it is also impossible for health services to determine whether the intervention can be delivered with fidelity. Also, there has been a philosophical stance resisting any standardisation of practices that have an ethos of being intangible, flexible and uncertain.

This discussion paper highlighted the key elements of fidelity where further implementation research on Open Dialogue is needed, to safeguard the quality of care provided to patients using this approach. The observations made apply to many other need-adapted interventions in mental health nursing, which also aim for flexibility to meet consumers’ needs; many mental health nurses using a need-adapted approach will also be discomforted by some of the questions raised in this paper. However, to ensure funding and delivery of healthcare in an evidence-based way, these uncomfortable questions must be addressed by mental health nurses working outside the biomedical model.

Table 1. Operationalizing the five elements of fidelity identified by Carroll et al. (2007) to evaluating Open Dialogue

<table>
<thead>
<tr>
<th>Element of fidelity requiring assessment</th>
<th>Question for critical appraisal</th>
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<tbody>
<tr>
<td>Delivery - adherence to protocol</td>
<td>Has Open Dialogue been delivered?</td>
</tr>
<tr>
<td>Delivery - dose or exposure</td>
<td>How much and how often should Open Dialogue be delivered?</td>
</tr>
<tr>
<td>Quality - quality of delivery</td>
<td>Has Open Dialogue been delivered well?</td>
</tr>
<tr>
<td>Quality - participant experience</td>
<td>Does Open Dialogue meet consumers’ and networks’ needs?</td>
</tr>
<tr>
<td>Delivery - program differentiation</td>
<td>Does an Open Dialogue intervention exist?</td>
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References


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