Implementing Open Dialogue approaches: A scoping review

Professor Niels Buus (Corresponding Author), PhD, MScN, RN
Relationships Australia NSW, Sydney, Australia; University of Southern Denmark, Institute of Regional Health Research, Odense, Denmark; University of Sydney, Faculty of Medicine and Health, Sydney, Australia.
Address: Relationships Australia NSW, Sekisui House, Level 1, 68 Waterloo Road, Macquarie Park, NSW 2113, Australia.
ORCID: 0000-0003-4980-4096.
niels.buus@sydney.edu.au
Tel: +61 (0) 401 498 108

Mr Ben Ong
The University of Sydney. Susan Wakil School of Nursing and Midwifery, Faculty of Medicine and Health, Australia; Nepean Blue Mountains Local Health District, Child and Youth Mental Health Service, Penrith, NSW, Australia.
ORCID: 0000-0001-5281-9980
Address: Susan Wakil Health Building, Western Avenue, The University of Sydney, NSW 2006, Australia.
bong2050@uni.sydney.edu.au
(Tel) +61 2 47259800

Dr. Rochelle Einboden, PhD, RN
The University of Sydney Susan Wakil School of Nursing and Midwifery. Faculty of Medicine and Health, Australia.
Address: Susan Wakil Health Building, Western Avenue, The University of Sydney, NSW 2006, Australia.
ORCID: 0000-0002-9541-899X
rochelle.einboden@sydney.edu.au
(Tel) +61 2 9351 0574

Dr. Elizabeth Lennon
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The Leader Factor Pty Ltd
8 Bay Street Birchgrove NSW 2041, Australia.
ORCHID: N/A.
elizabeth@leaderfactor.com.au
+ 61 412319330

Dr. Kristof Mikes-Liu
University of Sydney, Nepean Clinical School, Faculty of Medicine and Health, Australia;
Nepean Blue Mountains Local Health District, Mental Health Service, Nepean Hospital,
Derby St, Kingswood, NSW 2747, Australia
0000-0003-2413-9050
kristofmikesliu@sydney.edu.au
+61-2-47344347

Dr. Steven Mayers
The Centre for Family-Based Mental Health Care, St. Vincent’s Private Hospital Sydney,
Australia.
ORCHID: 0000-0003-2194-8696
Email: steven.thomas.mayers@gmail.com
Telephone no. +61 421503940

Dr. Andrea McCloughen
The University of Sydney Susan Wakil School of Nursing and Midwifery. Faculty of
Medicine and Health
Address: Susan Wakil Health Building, Western Avenue, The University of Sydney, NSW 2006, Australia.
ORCID: 0000-0002-5045-0558
andrea.mccloughen@sydney.edu.au
(Tel) +61 2 91144085

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¹Relationships Australia NSW, Sydney, Australia
²University of Southern Denmark, Institute of Regional Health Research, Odense, Denmark
³Susan Wakil School of Nursing and Midwifery, Faculty of Medicine and Health, University of Sydney, Australia
⁴Nepean Blue Mountains Local Health District, Penrith, NSW, Australia
⁵The Leader Factor Pty Ltd, Birchgrove, NSW, Australia
⁶University of Sydney, Nepean Clinical School, Faculty of Medicine and Health, Australia
⁷The Centre for Family-Based Mental Health Care, St. Vincent’s Private Hospital Sydney, Australia

Author Note

We are grateful from valuable assistance from: Ms. Rachel Barbara-May, Ms. Carolyn Durrant, Mr. Ross Jamieson, Mr. Bradley King, Ms. Mie Leer, Ms. Dorthe Vedel Nordahl, Mr. Matthew Russell and Dr. Campbell Thorpe.

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Correspondence for this article should be addressed to Prof Niels Buus
Relationships Australia NSW, Sekisui House, Level 1, 68 Waterloo Road, Macquarie Park, NSW 2113, Australia. Email: niels.buus@sydney.edu.au

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Abstract

Open Dialogue approaches fall broadly into the area of systemic psychotherapeutic practices. They encourage active participation of families and social networks, and emphasize genuine collaboration within highly integrated systems of health care service delivery. These approaches are currently being implemented in a growing number of services across the globe, and in this review, we summarize and discuss insights from papers concerned with implementation of Open Dialogue. We used a scoping review method, which included systematic literature searches and summarizing data extraction as well as consultation with eight Open Dialogue implementation stakeholders who were invited to comment on preliminary review findings and a draft paper. We included 18 studies in the review and present their content under four thematic headings: 1. Training, 2. Family and network experiences, 3. Staff members’ experiences, and 4. Structural and organizational barriers and resistance to implementation. In general, the studies did not include rich descriptions of the implementation contexts, which made it difficult to draw conclusions across studies about effective implementation practices. The discussion draws on Jamous and Peloille’s (1970) concepts of “indeterminacy” and “technicality”, and we argue that the indeterminacy that dominates Open Dialogue is a challenge to implementation efforts that favor specific and standardized practices. We conclude by encouraging the development of implementation initiatives that theorize Open Dialogue practices with higher levels of technicality without corrupting the fundamental spirit of the approach.

Keywords: Family Therapy, Implementation Science, Open Dialogue, Scoping Review

Implementing Open Dialogue Approaches: A Scoping Review

Open Dialogue approaches can be characterized by dialogical and collaborative psychotherapeutic practices that encourage active participation of families and social networks with an additional emphasis on well-integrated health care service delivery (Freeman et al., 2019; Gromer, 2012; Lakeman, 2014). Open Dialogue approaches are mostly modeled on local interpretations and adaptions of seven Open Dialogue principles that were derived from practice at a small mental health service in Western Lapland in Finland in the 1980s and 1990s: immediate help, a social network perspective, flexibility and mobility,
responsibility, psychological continuity, tolerance of uncertainty, and dialogism (Seikkula et al., 2001a, 2001b). However, it remains unclear exactly how these principles were established, and how they should inform implementation and service delivery in other contexts, particularly considering that they emerged in the context of extensive deinstitutionalization and mainstreaming of services. Open Dialogue implementation is further challenged by an absence of widely accepted manuals or fidelity criteria for Open Dialogue practices (Waters et al., 2021). Open Dialogue approaches can be described as complex interventions as they involve several interacting, non-standardized practices at several organizational levels. Open Dialogue approaches continue to be employed in a growing number of services around the world, such as is described in a promising Danish register-linkage study (Buus et al., 2019). Therefore, we aimed to review studies concerned with Open Dialogue implementation to gather insights that might assist future implementations.

There is a strong narrative around the origins of Open Dialogue in Western Lapland (Seikkula & Arnikil, 2006). In the early 1980s, the Finnish “National Schizophrenia Project” introduced the systemic and family-oriented “Need-Adapted Approach” emphasizing individually tailored treatment planning and therapy with a minimum use of neuroleptic medication (Alanen et al., 1991), which in time was transformed into Open Dialogue. Open Dialogue was characterized by collaborative psychotherapy with clients and members of their families and social networks, and was organized around interventions by mobile crisis teams. Innovative collaborative network meetings were ultimately theorized from a “dialogical” point of view and, most notably, the potential multiplicity of voices in a network meeting was conceptualized as a “polyphony” of voices. By the mid-1990s this approach was available for all patients across mental health services in Western Lapland (Haarakangas et al., 2007), and substantive family therapy or other psychotherapy training programs for all staff was established. Considering this strong change narrative there is a notable paucity of research from Western Lapland concerning how the evolving practices of Open Dialogue were gradually embedded as the key local practice, and how this was supported amid organizational changes over time. Most publications from the Finnish context have focused on identifying outcomes or theorizing the approach.

Haarakangas et al.’s (2007) chapter on collaborative therapy is a rare exception as it describes some of the difficulties mental health nursing staff encountered when they were invited to partake in more inclusive democratic decision-making processes. They were accustomed to having a custodial role and a limited voice in the traditional medically...
dominated hierarchy. The nursing staff struggled to recognize the value of their own voices in network meetings. Haarakangas et al. (2007) only hint at organizational problems regarding the professionals’ shifting roles and identities, which highlights important questions around both anticipated and unanticipated organizational responses following implementation of an Open Dialogue approach.

Søndergaard’s (2009) case study from Southern Zealand in Denmark also raised questions regarding the potential challenges related to implementing an Open Dialogue approach. Søndergaard (2009) described a challenging implementation process where an outreach team made several compromises in their provisions of care that conflicted with Open Dialogue principles and procedures. Unexpectedly, the team abandoned their Open Dialogue approach at the end of the fieldwork, and Søndergaard (2009) did not offer any post hoc explanations as to why this happened.

In a scoping review, Buus et al. (2017) analyzed peer-reviewed research and grey literature (33 publications in total) on the adaption of Open Dialogue approaches implemented in the Scandinavian countries (Denmark, Norway and Sweden). They concluded that Open Dialogue was mainly described as a promising and favorable approach to mental health care. Further, the authors observed that there was considerable variation in the ways that Open Dialogue had been adapted and that most publications were based on relatively small qualitative studies.

Open Dialogue approaches are often presented as more collaborative and less pathologizing than traditional medicalized models (Bellingham et al., 2018; Dawson et al., 2021; Ong et al., 2019). However, it remains uncertain where and how implementation of these alternative approaches challenge conventional mental health services, and how organizations should prepare for such implementations. In order to support future implementation of Open Dialogue approaches, the aim of the current review is to identify the range and scope of empirical, peer reviewed research on implementing Open Dialogue approaches globally. The review offers a summary of this research in dialogue with stakeholders who are engaged in implementing Open Dialogue approaches.

**Methods**

Given that studies on the implementation of Open Dialogue approaches belong to an emerging area of research, we decided to perform a scoping review (Arksey & O’Malley, 2005; Levac et al., 2010), where we followed Arksey and O’Malley’s (2005) description of six distinct steps.
1. Identifying the research question. The research questions were: “What has been reported regarding the implementation of Open Dialogue approaches?” and “What is the clinical and organizational scope of these reports?”

2. Identifying relevant studies. The key inclusion criteria were: Peer-reviewed, English-language studies concerned with the implementation of Open Dialogue approaches or approaches heavily inspired by Open Dialogue. Some studies were explicitly focused on the implementation of Open Dialogue, while others were more indirectly focused on implementation by studying, for instance, the experiences of clients, families, and staff members in the first two years of implementing a new Open Dialogue service. NB conducted systematic searches in the PubMed and PsycINFO databases. As Open Dialogue was not a controlled heading in either database, NB searched for “Open Dialogue” as free text and identified texts related to the Finnish mental health approach. NB also systematically searched for similar references to the relevant references. NB identified 23 relevant references in the SCOPUS citation index and searched for their ancestry (reference lists) references and descendancy (referring to) references using the SCOPUS citation index and included the additional relevant references. See the flow chart in Figure 1.

3. Study selection. We excluded theoretical papers and papers about dialogical practices outside health care service delivery because of the markedly different implementation contexts. Decisions about 11 borderline papers were based on consensus decisions by the full author team using the questions: “Is this study sufficiently concerned with the clinical implementation of Open Dialogue?” In total, 18 studies were included in the review.

Arksey and O’Malley’s (2005) original framework did not include a quality assessment of studies because a quality “cut-off” would lead to a reduction in the number of studies and corrupt the purpose of scoping a field. However, in line with reflections by Pham et al. (2014), we believe that a quality assessment without excluding papers can provide valuable information about gaps in the research outputs of an emerging field of study. Therefore, we systematically assessed 14 qualitative studies using the criteria for the evaluation of qualitative research papers (Blaxter, 2013). This tool includes 20 items covering the areas of aims, connection to past literature, data collection, analytic methods, presentation of results, and ethics. The descriptions of methods in the remaining five studies...
were so anecdotal that a formal evaluation was not possible (see Table 1). There were no quantitative studies found using our search and selection strategy. We suspect this was because many services begin with a smaller scale implementation using “pilot” studies, and there has not yet been a study designed to assess implementation with the number of clients sufficient for meaningful quantitative analyses.

[Insert Table 1 here]

Each paper was independently read and evaluated by two reviewers (from the author group) followed by a discussion of similarities and differences. Members of the author group had contributed to four of the papers. However, no reviewer participated in reviewing a paper they had contributed to. The aim of the discussions was not to reach consensus, but to develop a nuanced and contextualized understanding of each study. While these understandings informed the overall analysis, details of these evaluations are not reported due to word-count limitations.

4. Charting the data. The included publications were charted in a table according to: 1) Author(s) and the year of publication, 2) Study location, 3) Methods, and 4) Key findings. See the chart in Table 1.

5. Collating, summarizing and reporting the results. NB imported all the papers into NVivo 12 and coded results sections and discussion sections. Initially, the coding process was open. Later, the codes were gradually collated into four themes through a process of comparison of similarities and differences, which was supported by the search-and-retrieve functions in NVivo. The four themes are reported in the results section of this paper.

6. Consultation exercise. Arksey and O’Malley (2005) proposed the consultation exercise as an optional sixth stage that could “inform and validate findings from the main scoping review” (p. 23). Therefore, a preliminary draft of the paper, including the original sample of reviewed papers, was distributed to a purposively selected group of stakeholders (n=9) from four organizations in Australia and Denmark that were currently engaged in implementing Open Dialogue approaches. The purpose was to consult them about our review, and to identify if they thought important insights were missing from the draft findings. We received written responses from eight stakeholders and used these responses to refine all parts of the document, and in particular to inform the discussion. While the stakeholders generally recognized the face validity and value of the findings, we also noticed that they asked for more description of the organizational contexts, which was rarely provided in the reviewed
texts. The lack of contextual information in the original studies represents a shortcoming that limits the practical usefulness of our review.

Findings

The 18 included papers originated from Australia (n = 4), Ireland (n = 1), Norway (n = 2), Sweden (n = 2), the United Kingdom (n = 3) and the United States (n = 6). In four instances, two papers reported from the same study. Out of the 13 papers that were systematically evaluated, seven drew on interview data, three drew on focus group data, one drew on a combination of interview and focus group data, and two drew on ethnographic data. Most of the papers were informed by data from both service users and social network members and staff members (n = 9), others drew on data exclusively derived from service users and social network members (n = 4) or exclusively from staff members (n = 5).

Implementation of Open Dialogue approaches was not standardized, and the scope of implementation activities varied significantly between study sites. Some teams could be positioned at one end of a continuum, making a single clinical practice more dialogical, and others could be positioned at the other end of the continuum, introducing a series of new clinical practices and organizational changes. The research on newly implemented Open Dialogue approaches was thus primarily focused on micro levels and secondarily on broader organizational structures, culture, leadership, or systemic issues.

Through the coding process, we identified four themes across the papers: 1) Training, 2) Family and network experiences, 3) Staff members’ experiences, and 4) Structural and organizational barriers and resistance to implementation.

Training

Most papers did not include any descriptions of the Open Dialogue staff training that had been used as part of the implementation. The papers that included descriptions indicated that several different approaches had been used, often in combination with other training, for example Intentional Peer-Support (Hopper et al., 2020), a peer-support model with specific tasks for the peer-worker including developing mutual and transformative relationships (Bellingham et al., 2018). Training was described as difficult to organize and costly, because most programs relied on pairs of Open Dialogue trainers travelling from Europe (Florence et al., 2020; Gordon et al., 2016).

Training programs were described as being based on experiential learning through various exercises and role-plays. Pope et al. (2016) described the Open Dialogue training as “needs-adapted” (p. 516) and modeled in line with a clinical Open Dialogue approach and treatment philosophy. This modeling meant that trainers were reluctant to present a clear
curriculum, and adjusted content and process during training sessions. Without a clear structure, the trainees became frustrated. In response, ethnographic fieldworkers described how they stepped out of their researcher-roles to offer their re-written versions of course materials to trainees, who perceived the original course materials as dense and inaccessible (Pope et al., 2016). While training was reported to inspire hope through a promise of changing services (Dawson et al., 2019; Florence et al., 2020), it was also perceived as “intense” (Florence et al., 2020, p. 690), “disorganized” (Pope et al., 2016, p. 516) and offered trainees “little clarity” (Dawson et al., 2019, p. 9) about practices. Schubert et al. (2020) described how staff members’ personal and embodied experience of Open Dialogue during training facilitated a deeper self-reflection and deepening of relationships with colleagues. Both Florence (2020) and Hopper (2020) emphasized that a substantial aspect of participants difficulties with learning Open Dialogue was linked to unsettling processes of “unlearning” previous conventional practices and establishing a new type of expertise.

Family and Network Experiences

The vast majority of family and network members reported positive experiences of participating in Open Dialogue sessions.Aligned with core Open Dialogue tenets, papers reported on the establishment of safe, open, non-paternalistic and non-hierarchical treatment environments, with staff members being able to take the position of the family and tolerate uncertainty within a collaborative and non-directive approach. However, a few studies also reported a small number of instances where clients and families/social network members expressed a preference for more conventional services including expert advice or less involvement of family members.

Network meetings were generally perceived as validating and acknowledging, and participants appreciated the reflection practices between staff members. In the study by Clement and McKenna (2019), parents of children undergoing social assessment unequivocally described feeling supported during network meetings, and that the Open Dialogue approach made it easier to access help compared to previous experiences with services. In Dawson et al.’s (2019) description of a network meeting, a young person at the center of concern had some trepidation before and during the meeting, but she and her family found it meaningful to share their concerns about each other. In the study by Sidis et al. (2020), young clients expressed being nervous before and after meetings but being able to say what they wanted to say. Staff members’ reflections were appreciated as they shared their thinking about the situation (Sidis et al., 2020).
Tribe et al. (2019) reported a number of challenges experienced by clients who struggled with unusual practices of reflection and non-directive meetings. Network meetings were described as emotionally tense. While some clients felt that staff members were really engaged in the clients’ situation, others were uncomfortable with staff members’ expressions of authenticity and emotion during reflections. Participants in Piippo and Aaltonen’s (2004, 2008) study stated that the network meetings allowed them to genuinely collaborate and to say what they needed and wanted to say. However, there were also expressions of concern about the fruitfulness of relatives hearing about clients’ problems, and that the meetings could become too “abstract” and rigid in staff members’ application of the dialogical practices where, for instance, no-one seemed willing to make any decisions during meetings (Piippo & Aaltonen, 2004, 2008).

**Staff Members’ Experiences**

The studies of staff members’ experiences noted that Open Dialogue approaches had given staff members more opportunity for responding authentically, and for assisting clients and families/social networks. Sidis et al. (2020) found that working with Open Dialogue was very much aligned with staff members’ personal values. They valued being more authentic in their approach and the privileging of the families’ perspectives. Schubert et al. (2020) interviewed psychiatrists and psychologists following Open Dialogue introductory training and found that they identified their recognition and display of their own vulnerability as both the greatest strength and challenge of working in this way. Psychiatrists identified Open Dialogue approaches as offering opportunities to identify oneself beyond the role of “fixer” of mental illness. For psychologists, Open Dialogue approaches offered a framework for embracing their sameness with clients and relating with deeper, more authentic capacity (Schubert et al., 2020).

A reported tension was linked to a gap between Open Dialogue (and its promise of a less hierarchical and medicalized service delivery structure) and the perceived realities of conventional mental health services. Both Dawson et al. (2019) and Tribe et al. (2019) reported polarized responses to the implementation of Open Dialogue with some participants embracing the possibility of creating a less oppressive medicalized service and others dismissing the idea of challenging existing hierarchies in siloed services.

Florence et al. (2020) described a “cult-like culture” (p. 689) following Open Dialogue training, where non-Open Dialogue trained staff members felt left out as the new Open Dialogue practices positioned them as separate from the rest of the service. Further, different levels of participation in Open Dialogue training introduced new “unspoken”
hierarchies in the service, which a participant noted was surprising considering the underlying philosophy of not privileging specific voices (Florence et al., 2020).

Pope et al. (2016) described “ideological rifts” (p. 517) between team members comprising both conventionally trained clinicians and peer-support workers. Conflict was fueled in the context of the Open Dialogue approach being implemented in tandem with “Intentional Peer-Support”, which took an explicit radical stance against conventional, biomedical treatment. This tension made some clinicians feel alienated, and this needed attention from the training team early in the project. Without being part of the seven Open Dialogue principles, the developers of needs-adapted (Alanen et al., 1991) and Open Dialogue approaches (Seikkula & Arnikil, 2006) recommended a minimum use of neuroleptic medication. Both Florence et al. (2020) and Gidugu et al. (2020) reported examples of how newly implemented Open Dialogue practices led to a reduced reliance on medication as team and family collaboration supported medical staff members so that they would not feel overwhelmed by risk and responsibility, which would previously have made them resort to prescribing more medication.

### Structural and Organizational Barriers and Resistance to Implementation

Several studies described that Open Dialogue approaches were difficult to implement in health care organizations that were not designed to accommodate this way of working. Reportedly inadequate billing structures, such as fee-for-service, made it impossible to fully implement sustainable Open Dialogue approaches, often provided at a slow pace in people’s homes by two staff members at the same time, see for instance (Florence et al., 2020; Hopper et al., 2020).

Hopper et al. (2020) and Pope et al. (2016) described a top-down implementation of a combined Open Dialogue and Intentional Peer Support approach, that was hastily organized because of a funding opportunity. The hastiness added to a non-receptive context, where important organizational partners were not prepared or supportive of the approach. This made the approach vulnerable and undermined the sustainability of the model. Further, these authors argued that implementation in the US context was very different to the original Finnish welfare state context, and staff had to address a wider range of unmet client needs such as adequate housing, job training, etc.

Other studies described implementation via bottom-up strategies, where Open Dialogue practices were very gradually merged into the existing structures, practices and workloads, which raised questions of adoption and fidelity to a full Open Dialogue approach. Dawson et al. (2019, 2020) reported how the implementation of Open Dialogue practices was
not prioritized above the organizational imperatives in an Australian private hospital. According to staff, these included inflexible and “silied” practices with staff fulfilling duties in the least resource-intensive ways. In this context, while management and many staff members reported to be motivated to change practices, they saw little opportunity for actual change within the organization. Florence et al. (2020) described an opportunistic stance towards the implementation of Open Dialogue where staff adapted their clinical practices “when possible” (p. 690). In this context, standardization and fidelity to the “full” Open Dialogue approach were seen as barriers to the organic implementation process. Gidugu et al. (2020) stated that it was not possible to implement the same team working across outpatient and inpatient settings, which was believed to be more in line with the original Finnish approach.

**Discussion**

Effective implementation strategies most often depend on well-defined activities designed to develop specific practices (Toomey et al., 2020), and Open Dialogue practices can be regarded as complex activities that are introduced into complex contexts. However, with very few exceptions the reviewed studies did not account in detail for organizational contexts of implementation of an Open Dialogue approach (for instance culture, resourcing and management/leadership factors) or the organizational strategies for the implementation. The studies mostly reported consequences of organizational under-preparedness and struggle to develop sustained change. Due to variations in approaches, and limitations in reporting it remains unclear what types of implementation would be more effective than others and under what circumstances.

Drawing on the work of French sociologists Jamous and Peloille (1970), Traynor (2009) described occupational work as a ratio between “indeterminacy” and “technicality”. Indeterminacy emphasizes the elements of practice that require personal and professional judgment, and “technicality” emphasizes elements of practice that rely on standardization and the use of manualized knowledge (Traynor et al., 2010). High levels of indeterminacy support the need for individuals who bring personal and disciplinary knowledge and judgment into decision making, legitimizing the need for expertise. Conversely, high levels of technicality support the use of decision-making tools such as protocols, policies or expert systems, which could be used by those without expertise, aiming instead for consistency and standardization. Jamous and Peloille (1970) developed the ideas of indeterminacy and technicality as a part of a sociology of the professions, but we have found these concepts useful to think through issues identified from this review of Open Dialogue implementation.
The many references to “a needs-adapted approach” positions Open Dialogue as an indeterminate, humanistic, common factors practice, where clinicians’ personal knowledge and qualities are continually utilized in training, teamwork and clinical sessions. Indeterminate practices permeate all aspects of Open Dialogue: training, cross- and inter-organizational collaboration, teamwork, clinical work, and individual professional identity. These practices can have destabilizing and anxiety provoking effects that have previously been under-estimated in planning and executing Open Dialogue implementations. The high levels of indeterminate practices complicate organizational implementation processes that traditionally rely on high levels of technicality, such as fidelity measures and manualized protocols for practice (Waters et al., 2021).

The leaning towards indeterminacy is evident in Open Dialogue training. The studies included very limited descriptions of the learning outcomes, structure and content of Open Dialogue training, which was deliberately kept flexible and open-ended by trainers. The common stance towards formalized curriculum development and teaching makes it very difficult to evaluate the quality of education programs preparing trainees for Open Dialogue practice, and the links between Open Dialogue and the systemic family therapies and other psychotherapies it grew out of. The notion of “unlearning” previous skill sets could indicate that different groups of staff members go through markedly different learning processes and might need different learning opportunities and post-training support. In a descriptive focus group study on Peer Supported Open Dialogue training, Stockmann et al. (2017) described trainees being uncertain about the training course, which was linked to insufficient explanation and feedback from the trainers. While some participants regarded the experiential “tolerating uncertainty” (one of the seven principles) to be a helpful part of their learning, this was apparently not a formal or intentional aspect of the training program. More research and evaluation is needed to better determine how to tailor the character, type and size of training programs required for service-wide implementation of an Open Dialogue approach across diverse contexts, and for trainees with potentially different needs.

According to the reviewed studies, the vast majority of staff members, clients and social network members expressed a stronger affinity for Open Dialogue approaches than to conventional service delivery, but exceptions were also reported. While these findings are in line with a previous review (Buus et al., 2017), they must be considered carefully in regard to the implementation contexts identified in the papers, where there are no measures to indicate if the newly implemented Open Dialogue approach was delivered in accordance with defined fidelity standards. The reviewed papers often reported from research contexts where
conclusions could be interpreted as anecdotal because they were often drawn from
descriptive analysis of limited data from modest numbers of participants (Freeman et al.,
2019). Future research must compensate for these limitations and systematically explore the
organizational and biographical contexts of expressed affinity as well as dislike or resentment
towards Open Dialogue practices.

Limitations

This review has a number of limitations that readers should consider. First, while we
noticed high levels of recall in our literature searches, they only included English language
journal articles, which means that monographs and grey literature were not systematically
taken into account, such as the dissertations by Gidugu (2017), and Søndergaard (2009), and
the white paper from Parachute NYC (2015). Second, while we tried to make most parts of
the review process collaborative and include a consultation exercise, we are aware that as
mental health professionals who practice and research Open Dialogue approaches, our
interpretations are positioned, and this will have influenced our interpretations of the included
studies. Third, while Arksey and O’Malley’s (2005) original method did not include an
assessment of the quality of reporting, we chose to include one, but without introducing a cut-
off that would exclude low-quality or descriptive studies. We decided to do so because a cut-
off would be controversial (Buus & Perron, 2020), and because it could reduce the number of
studies significantly, placing us in a poorer position to scope and describe the heterogeneity
of the emerging field of implementation research. Finally, choosing to discuss the findings
with Jamous and Peloille’s (1970) concepts allowed us to address some core issues in the
review findings. Other concepts could potentially have brought out other fruitful points, but
we believe a key strength in using “indeterminacy” and “technicality” was that they were so
abstract that they could cut across the heterogeneous and minimally contextualized findings.

Conclusion

While the review findings strongly indicated that participating staff members, clients
and social network members largely embraced the implemented Open Dialogue approaches,
there were also particular ideological and organizational challenges linked to implementation.
The findings highlight different levels of implementation, from the philosophy of practice of
individual practitioners, to the way teams structure and facilitate clinical meetings, to the
possibility of whole-of-service adaptations that reflect engagement with dialogic or Open
Dialogue principles. We believe that extensive organizational preparation including
institutional willingness and readiness, is needed before any medium to large-scale
implementation and that organizational change processes could be integrated into Open

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Dialogue training programs to ensure a good fit between a locally adapted Open Dialogue approach and the wider organization’s willingness and readiness for change. Furthermore, because of the anxiety that can be caused by Open Dialogue training, we suggest that Open Dialogue implementations include extensive systemic safety plans and ongoing support for possible organizational and individual responses.

Initiatives that theorize Open Dialogue practices with higher levels of technicality without corrupting the fundamental indeterminate spirit of the approach, might mitigate possible conflicts with existing approaches. We hope that future implementation research will focus more exclusively on the actual processes of adaption and implementation of Open Dialogue approaches in contexts outside the medically dominated mental health services, e.g. social services (Dawson et al., 2021), where we believe there is great potential for implementing Open Dialogue approaches.

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Table 1
The Included Articles

<table>
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<tr>
<th>Publication/location</th>
<th>Study context/type of Open Dialogue</th>
<th>Methods</th>
<th>Key findings regarding Open Dialogue implementation</th>
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<td>Piippo and Aaltonen (2004), Västerås, Sweden</td>
<td>A family-centered need-adapted approach (Integrated Network and Family Model (INFM)) implemented in a setting where the client needed assistance from both mental health services and municipal social services.</td>
<td>Qualitative interviews with 22 patients, 6 months after they had started having contact with the INFM team. A Grounded Theory inspired thematic analysis.</td>
<td>Patients had positive, ambivalent and negative experiences. The latter included that the professionals seemed to have more trust in the model than in the patients’ own resources and the meetings became too abstract and removed from their daily lives.</td>
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<td>Description</td>
<td>Methodology</td>
<td>Findings</td>
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<td>There were experiences of both trust and mistrust in the INFM context. The latter included that personnel were too eager to control the situation by implementing the principles of the INFM and occasionally the patients experienced confusion and exclusion.</td>
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<tr>
<td>Holmesland et al. (2010), Southern Norway</td>
<td>“Project Joint Development”. Interagency meetings as part of Open Dialogue involving professionals from the health care services and the social and educational services.</td>
<td>Content analysis of two multistage (three meetings over 3 years) focus groups, one group from health care services (4-6 participants) and one group from social and education services (2-5 participants).</td>
<td>There were some signs of increased transdisciplinarity but also a maintained interdisciplinarity in both groups. Lack of trust and acceptance hampered a reconciliation of professional roles.</td>
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<td>Holmesland et al. (2014), Southern Norway</td>
<td>“Project Joint Development”. Interagency meetings as part of Open Dialogue involving</td>
<td>Content analysis of two focus groups (the first of multiple) and illustrative anecdotal observations.</td>
<td>The atmosphere during meetings was important for collaboration. It was challenging for participants to</td>
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<tr>
<td>Authors</td>
<td>Country/Region</td>
<td>Study Design and Intervention</td>
<td>Data Collection Methods</td>
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<td>Gordon et al. (2016)*, USA</td>
<td>USA</td>
<td>“Collaborative pathway” Pilot study with eight Open Dialogue trained clinicians working in a mobile crisis team and outpatient services.</td>
<td>Feasibility study. Qualitative analysis of interviews with 6 clients and their families and 7 clinicians. Quantitative analysis of 14 clients’ service use and service costs (before and after design).</td>
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<tr>
<td>Pope et al. (2016)*, New York, USA</td>
<td>USA</td>
<td>“Parachute NYC” combined needs-adapted treatment model (NATM) and intentional peer support (IPS).</td>
<td>Applied anthropological analysis. The research team followed the four mobile crisis teams.</td>
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<tr>
<td>Rosen and Stoklosa (2016)*, Massachusetts, USA</td>
<td>Implementation of four mobile crisis teams, four community crisis respite centers, and a “warm line” offering counselling and referral services. Peer specialists were involved in all parts of these elements.</td>
<td>and four crisis respites, attended staff meetings and clinical supervision, conducted key informant interviews, shadowing mobile crisis teams, and attending all staff trainings.</td>
<td>alienated by IPS ideology and in doubt about the effect of the approach. High staff turnover and inflexible mobile teams made network meetings difficult to organize and rigid “uninformed” organizational partners challenged reconnecting to the community.</td>
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<td>An inpatient teaching unit. Four teams implemented an Open Dialogue inspired change to current practices, in particular the structure of rounds.</td>
<td>Feasibility study. Qualitative and quantitative analysis of data from more than 20 staff and qualitative analysis of exit interviews with circa 30 clients.</td>
<td>Patients stated that seeing the team discuss their care in front of them has fostered trust in their treatment team. The unit implemented collaboratively developed patient-centered cultural changes through brief training sessions without additional cost and without adding time to</td>
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<td>Clement and McKenny (2019)*, London, UK</td>
<td>Assessment in child and family social care. Implementation of a 12-week pilot with 12 Open Dialogue inspired network meetings concerning 40 children.</td>
<td>Study of a focus group at beginning and end of the pilot, written feedback before and after meetings, a standard quality audit and interviews with four parents. Re-referral rates were probably reduced. Both professionals and parents found the structure of the meeting helpful. Professionals struggled with meetings with no time limit and “translating” minutes into standardized records.</td>
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<tr>
<td>Dawson et al. (2019), Sydney, Australia</td>
<td>“The Open Dialogue Initiative”. One-week introduction to Open Dialogue and follow-up supervision at four sites.</td>
<td>Analysis of data from a long-term ethnographic field study (observations and interviews) at a private inpatient young-adult mental health unit. The unit’s neoliberal ideology and medically dominated custodial organizational practices conflicted with the integration of the alternative, recovery-oriented approach.</td>
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<tr>
<td>Tribe et al. (2019), London, UK</td>
<td>Implementation of Open Dialogue, including peer-support and mindfulness) in specialist care psychosis teams in</td>
<td>Thematic analysis of 19 interviews with 11 clinicians, 5 service users and three network members. Clinicians considered Open Dialogue as a preferred, but challenging way of working. Compared to previous</td>
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a NHS trust community mental health service. experiences service users experienced network meetings as positive. Organizational change was needed to support the delivery of network meetings. There was resistance from non-Open Dialogue clinicians.

<p>| Dawson et al. (2020), Sydney, Australia | “The Open Dialogue Initiative”. A one-week introduction to Open Dialogue and follow-up supervision at four sites. | Thematic analysis of qualitative interviews (n=16) and a focus group (n=8) with staff at a private inpatient young-adult mental health unit. | The unit’s individualist ethos and business model and biomedically dominated, siloed and inflexible organization conflicted with efforts to integrate an Open Dialogue approach. |
| Florence et al. (2020), Vermont, USA | “Collaborative Network Approach”. Adaption and implementation of Open Dialogue in two community mental health centers. | Thematic analysis of 4 focus groups with staff, supervisors and directors (5-6 participants in each focus group) and 3 unstructured 1:1 interviews with the developers of the approach. | The versatility of the approach allowed a gradual integration into clinical work, while training costs and billing structures were barriers to wider implementation. |</p>
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<td>Gidugu et al. (2020), Massachusetts, USA</td>
<td>“Collaborative pathway”. Open Dialogue pilot where clients were assigned two clinicians who met with the client and support network in the client’s preferred setting, typically the family home.</td>
<td>An evaluation using the Promoting Action on Research in Health Services (PARiHS) framework. Two thematic analyses of interviews with 6 clients/10 family members, and 9 clinicians respectively.</td>
<td>Clients, families and clinicians identified several beneficial features of the approach. Clinicians reported resistance from the more traditional psychiatric practitioners and reported liability issues, resource limitations and fee-for-service billing structures as key implementation barriers.</td>
</tr>
<tr>
<td>Hendy and Pearson (2020), UK</td>
<td>Peer supported Open Dialogue in a NHS service.</td>
<td>Thematic analysis of “focus groups” with four clients and three of their network members.</td>
<td>Clients and network members referred to Open Dialogue as significantly different from traditional services. They felt a sense of mutuality and equality in the meeting space and in the interactions</td>
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<td>Hopper et al. (2020)*</td>
<td>New York, USA</td>
<td>“Parachute NYC” combined Open Dialogue and intentional peer support (IPS).</td>
<td>Ethnographically informed implementation analysis of the project’s peer support, network engagement and crisis respite.</td>
</tr>
<tr>
<td>Schubert et al. (2020), Wollongong, Australia</td>
<td>“The Open Dialogue Initiative”. A one-week introduction to Open Dialogue and follow-up supervision.</td>
<td>Discourse analysis of 1:1 interviews with 5 psychologists and 4 psychiatrists implementing Open Dialogue.</td>
<td>Participants identified Open Dialogue as offering opportunities to construct alternative professional identities, and they understood the implementation of Open Dialogue as the integration of dialogical ways of working into existing clinical practice.</td>
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<tr>
<td>Sidis et al. (2020), Wollongong, Australia</td>
<td>“The Open Dialogue Initiative”. A one-week introduction to Open Dialogue and follow-up supervision within a child and adolescent mental health service.</td>
<td>Thematic (Interpretative Phenomenological Analysis) analysis of interviews with 11 clinicians and 5 service users and family members.</td>
<td>Clinicians expressed concerns regarding perceived lack of skill and struggles switching from an individual to a systemic perspective. Service users and family members expressed hesitations about family therapy, but valued experiences of collaboration and openness.</td>
</tr>
<tr>
<td>Twamley et al. (2020), Cork, Ireland</td>
<td>Implementation of Open Dialogue in a rural community mental health team.</td>
<td>Thematic analysis of semi-structured interviews with 12 services users and 10 network members.</td>
<td>Network meetings offered participants the opportunity to review well-established communication patterns and, for the majority, advance communication skills, which enabled them to feel connected, heard and understood.</td>
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* Papers that were not quality assessed because of anecdotal descriptions of methods.

**Figure 1**
Flowchart of Literature Search
Records identified through database searching

- PubMed: 384, 34, 35
- PsycINFO: 410, 59, 62

Additional records identified in SCOPUS (n = 13)
* = total number of references free text searching for “Open Dialogue”
§ = total number of English language references relevant to Open Dialogue as a dialogical practice
# = total number of English language references after adding references from “similar references” searches.