

Rapid Review Combined supplementary files

Rapid Review Supplement 1 Rapid Review Methods

Review questions

This Rapid Review answered the following 4 questions.

Question 1

*What are the main features of mental health system transformation recommended by **three reports**: Productivity Commission (2020), the Royal Commission (2021), and the **World MH Report 2022**)?*

Question 2

What approaches, within and beyond the Australian context in the three sources, are associated with one or more reform feature/s?

Question 3

What are the systemic impacts of the Open Dialogue approach?

Question 4

How do identified system impacts of Open Dialogue approaches accord with recommended features of mental health system transformation?

Here we detail the approach used to address each question.

Steps 1 & 2

A document review addressed questions 1 and 2.

Question 1: What are the main features of mental health system transformation recommended by the Productivity Commission (2020), the Royal Commission (2021), and the WHO MH Report &2022)?

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Question 2: What approaches, within and beyond the Australian context in the three sources, are associated with one or more reform feature/s?

This material was uploaded to a secure University of Melbourne AI platform (SparkAI) searched with these queries:

The output was summarised and themed, identifying key transformation-related fields for use in structured review for Question 4

The reports uploaded on Spark AI platform were then searched to identify in these documents examples of models of care, interventions or approaches that are (also) recommended or used to illustrate transformative potential.

Step 3: A systematic search and rapid evidence appraisal was conducted to address question 3.

Question 3: What are the systemic impacts of the Open Dialogue approach?

This question was answered through systematic literature searches, review and synthesis. The scope of this search and review is related to the definitions of fields identified in section above.

The most relevant research was identified to be:

- Health services research and implementation science studies of OpenD approach
- Intervention studies of OpenD model of care/service including (for example) in MH services, youth and educational settings
- Evaluations of OpenD services/programs
- OpenD Case studies that document services that have been reformed
- OpenD cost-effectiveness evidence.
- The quality of the evidence in the studies was not classified according to any agreed classification system as much the evidence was found to be not amenable to standard appraisal (as per Freeman 2019 and Buus 2017.)
- We produced summary tables of the papers/reviews, grouped by aim OpenD model of care.

Columns for the tables include:

- Publication/Link

- Year
- Population/s
- Flag if these models of care were delivered over large geographic regions
- Study design
- Details of the OD model of care or practice
- Setting
- Outcomes
- Methods
- Results
- Barriers & enablers regarding successful OD implementation (can be drawn from author insights in the discussion also)

The final table headings were agreed in discussion with the commissioning ODC in discussions of progress

The reviewers provide comments on:

- why or why not effects were observed in the studies
- any specific findings for features of OpenD models delivered across wide geographic regions
- gaps in the OD evidence base.

Step 4: An integrative analysis is proposed to answer question 4.

Question 4: How do identified system impacts of Open Dialogue approaches accord with recommended features of mental health system transformation?

This question is answered by appraising the evidence identified in answer to Question 3 against the transformational priorities and recommended approaches identified in answer to Questions 1 and 2.

Reviewers will produce tables of the Open Dialogue approach evidence, mapped against transformational priorities.

Columns for the tables include:

- Publication /Year
- Author/title
- Systemic change outcomes

- Implementation feature highlighted: barriers and weaknesses
- Details that may be noted/ of particular interest are features of successfully adapted OD model of care implemented across a health or service system:
- Resources noted identified to implement the model
- Culture of the service
- The environment in which the model is delivered
- care delivered across large geographical regions

Reviewers do not specifically highlight per study transformative OD models potentially best suited to Australian contexts.

Notes regarding evidence quality

- As anticipated, there were very few high-quality studies focused on question 3.
- The research team focused on evaluations of services and case studies of ‘service turn arounds’ as relevant.
- The review reports on these limitations, noting the evidence gaps
- The review notes equivocal/conflicting evidence in relation to the review questions.

Types of evidence included

The review will include evidence sourced from:

- The peer reviewed literature of systematic reviews or primary studies (e.g. searches of relevant electronic databases: Cochrane, Medline, PsycInfo, CINAHL)
- Final Report of the Royal Commission into Victorians Mental Health Services
- Productivity Commission Report (measures/ management)

Limits

- The review includes full studies and abstracts available in English only
- Countries and jurisdictions within scope are: other jurisdictions in Australia, UK, NZ, Canada, western Europe, Scandinavia & USA.
- The review will focus on the last 10 years (Reviewers may highlight seminal work prior to 2010).

Report format and language

The review is organised by review questions

The scale is well beyond the proposed range of 10-20 pages, not including tables and references.

The review includes the following elements:

- A table of contents
- An Executive Summary of no more than 2-3 pages
- Background and introduction
- Description of the method used for searching and selecting research papers
- A flow chart of the article selected process (e.g. a PRISMA diagram)
- Search results (i.e. number of papers)
- Analysis of the evidence in terms of the specified review questions including tabulation of relevant research as outlined under each question above.
- Synthesis of the findings and discussion
- Implications of the findings related to Open Dialogue approaches for mental health care sector and for wider community
- Reference list in Endnote
- Appendices, as required.

The reviewers provided the Endnote Library with the final report.

The language of the review is appropriate for senior policymakers, leaders in the field.

Rapid Review Supplement 2: 12 Reform Fields and related examples from policy sources

| Reform Field | RCVMHS | PC | WHO |
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| Reform of service provision | | | |
| 1) Enhance Mental Health Workforce | <p>Ch 33</p> <p>ORIMA Research workforce survey, page 18</p> <p>Multidisciplinary – integrated teams (successful in NZ)</p> <p>Mental Health and Wellbeing Workforce Capability Framework, titled <i>Our workforce, our future</i></p> <p>Enhance workforce wellbeing</p> | <p>National MH workforce strategy to address gaps</p> <p>Expanded LE roles</p> <p>Enhance training and PD</p> <p>Incentives for rural areas</p> <p>Support innovation such as digital</p> | <p>Financial incentives</p> <p>Hiring rural</p> <p>Career Development and improved working conditions</p> |

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| | <p>The South Australian Department for Health and Wellbeing's Mental Health Services Plan 2020–2025</p> <p>Professional Development: HETI is the GP Mental Health Assessment and Management Skills workshop</p> | | |
| <p>2) Enable equity</p> | <p>Co designing the following:</p> <p>Locals/ MHW connect centers</p> <p>LE Leadership</p> <p>Shifting power - drawing on Arnstein's Ladder of Citizen Participation</p> <p>CRPD</p> <p>Closing the Gap initiative.</p> | <p>Person centred care</p> <p>Cultural Safety and Indigenous Leadership</p> <p>The report underscores the need for mental health services to be culturally safe and led by Aboriginal and Torres Strait Islander people. This leadership ensures that services are respectful and responsive to the cultural needs of Indigenous communities, fostering trust and improving outcomes</p> <p>Social determinants</p> | <p>Task-Shifting Approaches: Training non-specialist health workers to deliver mental health care, thereby expanding the reach of services in underserved areas.</p> <p>Peer Support Programs</p> <p>Policy Reforms: Advocating for changes in laws and policies to ensure mental health services are inclusive and equitable.</p> |

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| <p>3) Focus on consumer priority</p> | <p>The Victorian Mental Illness Awareness Council proposed that ‘consumer leadership and participation must be core to all regulatory and oversight processes’ because consumers can bring further insight to the issues being regulated compared with people who have not experienced compulsory mental health treatment. These processes include accreditation, complaints management, service efforts to improve quality, investigations into incidents and inspections of services.</p> | <p>(accessible in time, place and cost) ?Virtual MH support</p> | <p>involve people with lived experience in the design, implementation, and evaluation of mental health services.</p> <p>Actively engaging consumers</p> <p>Including advancing public health, promoting and protecting human rights, and enabling social and economic development. These benefits underscore the significance of placing consumer priorities at the forefront of mental health care transformation</p> |
| <p>4) Promote psychosocial wellbeing</p> | | <p>Integration of Mental Health into Schools</p> <p>Workplace Mental Health Initiatives</p> | <p>Community-Based Mental Health Services, School and Workplace Mental Health Programs, Early Childhood Interventions, Social Support and Community Engagement and Empowerment and Anti-Discrimination Programs</p> |

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| <p>5) Uphold human rights</p> | <p>Human rights approach (<i>Charter of human rights and responsibilities Act 2006 (VIC)</i>)</p> <p>Protection against torture and interference with a person’s privacy and autonomy.</p> | <p>Legal Representation and Advocacy</p> | <p>Aligning Mental Health Laws with Human Rights Standards</p> <p>Replacing Psychiatric Institutions with Community-Based Care</p> <p>Empowering Individuals and Families</p> <p>Ensuring Access to Quality Mental Health Care</p> |
| <p>6) Combat discrimination</p> | <p>Equal Opportunity Act 2010</p> <p>All people should enjoy human rights equally. Under the Charter of Human Rights and Responsibilities Act 2006 (Vic), every person has ‘the right to enjoy his or her human rights without discrimination’, and the right to ‘effective protection against discrimination’</p> <p>Mental Health First Aid training</p> | <p>National long-term stigma reduction strategy</p> | <p>Public Awareness Campaigns – Promoting positive narratives around mental health to reduce stigma and challenge negative stereotypes.</p> <p>Peer Support Programs – Involving people with lived experience of mental health conditions in service delivery and advocacy.</p> <p>Legislative Reforms – Encouraging legal protections against discrimination in healthcare,</p> |

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| | <p>Mind Matters programs in high school</p> <p>RUOK Day</p> <p>Rotary community forums on mental illness</p> <p>Mindframe</p> | | <p>employment, and education.</p> <p>Workplace and School Interventions – Promoting inclusion and anti-discrimination policies.</p> |
| 7) Support families and carers | <p>Increased accountability re supporting families.</p> <p>Tandem’s role in the commission – funding for 5 years</p> <p>In New Zealand, the ‘Whānau Ora approach focuses on the family, not the individual ... Whānau Ora workers provide a lot of navigational support — they help to coordinate the various services or resources that a family needs to be a healthy family’.</p> <p>In some southern African communities, ubuntu is a philosophy that embraces caring for each other’s</p> | <p>Recognition and Inclusion of Families and Carers</p> <p>Provision of Information, Education, and Support</p> <p>Respite and Practical Support</p> <p>Carer-Inclusive Practice</p> <p>Supporting Indigenous Families and Kinship Networks</p> | <p>Training</p> <p>Inclusion</p> <p>Policy and structural supports</p> |

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| | wellbeing and fostering mutual support; it ‘means that people are people through other people’. | | |
| Reform of service organisation | | | |
| 8) Lead by lived experience, include consumers and families in design | <p>Leadership capability development for LE</p> <p>For example a 2005 edition of Australasian Psychiatry states, ‘[i]t is contended that the paradigm shift from consumer ‘participation’ to consumer ‘leadership’ may be more fruitful in realizing the considerable benefits that result from effective consumer involvement in mental health services</p> <p>Arnstein’s Ladder</p> | Co-design and co-delivery in mental health services | <p>Training and Capacity Building</p> <p>Inclusion in policy and Service Design</p> <p>LE Leadership</p> |
| 9) Base in community | <p>SEWB</p> <p>biopsychosocial approach</p> | Integrated and expanded community based services | <p>Integrate MH services into Primary Health Care</p> <p>Community Mental Health Centres</p> |

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| <p>10) Ensure access & ongoing support</p> | <p>WHO Mental Health Action Plan 2013-2020.</p> <p>World Health Organization describes as a ‘state of well-being’ in which ‘an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community</p> | <p>Leveraging technology, such as online treatments and telehealth, to overcome geographical barriers and ensure that underserved populations receive adequate care</p> <p>This Way Up (TWU) program (digital)</p> | <p>Digital Mental Health Solutions: Utilizing technology to provide mental health support, especially in remote regions where traditional services are limited.</p> |
| <p>11) Integrate (broad) social services</p> | <p>Victoria Legal Aid’s Your Story, Your Say project</p> | | <p>1. Chile’s “Construyendo Salud Mental” Strategy</p> <p>Chile's national mental health strategy, Construyendo Salud Mental (Building Mental Health), exemplifies the integration of mental health services with social services. This initiative strengthens leadership in mental health across all sectors, improves service delivery, enhances support in emergencies, and bolsters data,</p> |

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| | | | <p>evidence, and research.</p> <p>2. WHO’s Special Initiative for Mental Health</p> <p>The WHO's Special Initiative for Mental Health (2019–2023) aims to ensure access to quality and affordable mental health care for 100 million more people in 12 priority countries. This initiative emphasizes integrating mental health services into primary health care and strengthening the delivery of mental health care services to meet the full spectrum of mental health needs. It also advocates for a whole-of-government and whole-of-society approach to mental health promotion, protection, and care.</p> |
| 12) Treatment and recovery outcomes. | Committee on Quality of Health Care in America, Institute of Medicine, Crossing the Quality Chasm: A New Health System for the 21st Century (National Academy | Emphasizing early intervention, the report recommends integrating mental health support into schools, workplaces, and tertiary education. By | |

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| | <p>Press, Washington, 2001), pp. 5–6. 25</p> <p>The National Health Information and Performance Principal Committee, The Australian Health Performance Framework, 2017, p. 6. 26 Lord Darzi, The Lord Darzi Review of Health and Care Interim Report, 2018</p> <p>Outcome measurement needs to be reformed to capture a comprehensive view of people and their circumstances.</p> <p>Social Determinants</p> | <p>addressing mental health issues early, the system can mitigate long-term disparities and promote equitable access to care.</p> | |
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Rapid Review Supplement 3: Table of evidence mapped to fields

| | Uphold Human Rights |
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| Anestis et al., 2024 | <p>IMPACT OF ORGANISATIONAL CULTURE ON PRACTICE - WHERE TREATMENT AS USUAL (TAU) & OD ARE BOTH PROVIDED.</p> <p>Besides the cultural influences of TAU and restrictions related to resources, participants reported that they also have to adhere to professional and organisational standards, policies and procedures which were often not aligned with the OD values. “We still have to adhere to policies and procedures of the organisation that we are working for. We still have to work along the guidelines of our own professional bodies. So, there are certain standards, there are certain things that we have to</p> |

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| | <p>adhere to as well to keep things safe, to keep you know. So, when it comes to risk, or safeguarding, or something like that we may have to make decisions that are not maybe discussed with the service user, or it doesn't have full participation with them, if that, if you understand. So, there might be times when we do have to step out of a dialogical role and pursue a more treatment as usual' sort of process." (P9)</p> <p>On such occasions, the principle of tolerating uncertainty and other elements of OD such as transparency and shared decision-making were undermined. P7</p> |
| <p>Buus et al., 2023</p> | <p>In both pre- and post-training focus groups, participants described Open Dialogue as a critical and more just alternative to the dominating medical model in mental health and social care, which was seen as limited by an individualist treatment philosophy. p998</p> |
| <p>Dawson et al., 2021a</p> | <p>In the context of various ideas being offered, and feelings being expressed, service users made their own decisions about how they responded to the dialogue, which they described as very empowering.(results p. 142)</p> <p>The inclusion of multiple voices was experienced as minimizing relations of power that exist between “professionals” and “patients”, with a sense of having a “conversation” instead of being in an interview (results p. 142)</p> <p>The dialogical process was also seen as a way of flattening an established hierarchy, challenging traditional notions of professional as ‘expert’, and creating more space for voices of the service users (results p.142)</p> |
| <p>Florence et al., 2020</p> | <p>"CNA has changed how clinicians and psychiatrists approach this issue" [of use of medications].</p> <p>For example: "offering a diagnosis and medication may not be that helpful “in terms of a person’s ability to develop meaning for who they are and finding purpose in life” p687</p> <p>“I think a lot of the reason why I would get burned out was just being involved in things that didn’t feel good, that were inhumane, or that were taking people’s freedom away, or autonomy away and just watching the system be so cruel to the people that I am getting paid to help, year after year, it’s just horrible. And this work is probably the most humane way of work that I’ve ever done.” p687</p> |
| <p>Florence et al., 2021</p> | <p>[participants] "also reported a shift in the power dynamics in favor of the person at the center of concern" (results, p.1774)</p> <p>"Generally, participants felt like they were in charge of decisions about their treatment and their lives, pointing to experiences of “empowerment” and “agency”. For one participant: “I think that Open Dialogue fosters that kind of recovery where you are kind of leading; you’re in the driving seat.” (results, Decision-making, p. 1776)</p> <p>Most interviewees agreed that their relationship with their doctors had significantly improved compared to past experiences and that changes in medications could be</p> |

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| | negotiated jointly, often resulting in reducing doses or stopping completely (results, medication, p. 1778) |
| Gerken et al., 2025 | (p. 399) Implementing these person-centered changes, including practices that might be considered radical in an acutely ill patient population—such as reading nursing notes aloud during rounds and sharing clinician assessments openly with patients—showed no evidence of worsening outcomes. p.398). Congruent with the goal of providing more person-centered care, the outcomes reported here are based on patient experiences of their care, including perceptions of respect and dignity. While none of the improvements in PoC items reached statistical significance for multiple comparisons, there were trends toward improvement suggestive of an effect in several domains, including patients’ perception that their care was adequately explained to them and that they felt involved in their care. |
| Gidugu et al., 2021 | Safety culture: Clinicians noted that tolerating uncertainty while balancing safety issues has an added layer of complexity in the U.S., which is that of liability (not a significant concern in Finland), making the practice more challenging. (results p. 160) |
| Gordon et al., 2016 | Scores for client satisfaction (CSQ) and perceptions of shared decision making (SDMQ) were high throughout (CSQ53.236.36) on a 4-point scale and SDM (Q55.296.501 on a 6-point scale) p1167 |
| Hendy et al., 2020 | The participants spoke of a dialogical way of problem solving and exploring difficulties within the meetings, which was felt to promote autonomy. Moreover, participants commented on having the agency to decide when a topic would not be discussed ..p99 |
| Olson et al., 2015 | In Open Dialogue (J. Seikkula, personal communication, 2013), the medication has always been prescribed in a way consistent with the new evidence. It is used pragmatically to reduce suffering without stripping the crisis of personal meaning by reducing it to a “chemical imbalance.” Antipsychotics are avoided if possible. If not, they are used in as low dosages and for the shortest period as possible, with the person as an active partner in making decisions. P724 |
| Pocobello et al., 2023 | no report of rates of involuntariness |
| Schubert et al., 2021 | Current pressure/barriers: Participants positioned themselves as needing to differentiate their identities from a mental health system that others clients by pathologising distress and requires participants to act upon service users. Rober et al. (2008) noted how therapeutic contexts which avow expectations that therapists are helpful gives rise to prominent concerns for therapists about what they do. Our participants similarly experienced a pressure to be action-oriented. Psychiatrists felt compelled to medicate and eradicate risk whilst psychologists felt compelled to ‘do’ something to eradicate distress. Rober and Seltzer (2010) describe how action-orientation approaches can result in well- |

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| | <p>intentioned therapists becoming overly responsible and pushing for change whilst adopting subtle colonising positions (Rober and Seltzer, 2010). This implicit loss of agency through institutional pressures and medicalised psychiatric discourse aligns closely with the experience of psychiatrists found by Borchers (2014). Perceived pressure to be action-oriented was felt to diminish the capacity to adopt dialogical approaches. Paradoxically, whilst wanting to push against the risk-averse system, participants appeared to find temporary relief in the system as a refuge from the anxiety of tolerating uncertainty. P160</p> |
| <p>Sunthararajah et al., 2022</p> | <p>‘having a choice and a voice’ and ‘confusion and making sense of experiences’ are more represented in the open dialogue group compared to the treatment as usual group.</p> <p>Participants valued experiences of autonomy and having a choice and a voice in their treatment encounters (for example, in being able to discuss their mental health needs and be involved in their treatment plan). Open dialogue participants valued their choice, for example, in having autonomy within sessions, which allowed for breaks when they felt they were needed. Pg 4</p> |
| <p>Taylor et al., 2023</p> | <p>I have begun to learn what humility is, realizing that much of my career in emergency psychiatry did do harm, now, in offering and teaching others the history and practices of Open Dialogue, there might be, maybe, some reconciliation, for myself, and others, at the same time.</p> <p>I recall many times where I participated in care within a hospital setting where procedures and decisions made privileged the ease of systems and policy instead of the motto seen on posters about the hallways “PATIENTS FIRST.” ...</p> <p>I walked a narrow line at times, dare I say I buried this moral injury, some kind of bystander effect, being a part of a system where human rights were not always honored, I tried to serve patients and their families, while feeling I had my hands tied behind on my back. It took a toll. Enter “open dialogue.” p4 (Perhaps link here to wellbeing also)</p> |
| <p>Wates et al., 2022</p> | <p>Some participants felt that they had grown in confidence and in ability to assert themselves as a result of training. For some this meant feeling more motivated and better able to question poor practice within a hierarchy. p795</p> <p>Both a nurse and a peer-worker gave examples of times, since undertaking the training, when they had challenged particular practices and felt that in so doing they had averted significant harm to their clients: Now I am able to (.) challenge certain things really, especially in the area of medication (...) I went back to the doctor and I said to her, there’s no way am I going to stick this needle into this patient. (Aburi, FG1). 795</p> |

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| | <p>Both psychiatrists who participated in the study noted that the more collaborative approach they came to adopt, as a result of training, led to increased agency on the part of service users. p796</p> <p>Participants' practice changed to embrace more democratic ways of working based on sharing of power. p 797</p> |
| <p>Wusinich et al., 2020</p> | <p>The strongest themes associated with relationships to the Parachute team involved advocacy on behalf of the enrollee, non-stigmatizing attitudes towards diagnostic labels, peer support, and the presence of multiple providers on the Parachute team (results, relationships with the Parachute Team, p. 1038)</p> |

Enhance MH workforce

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| <p>Anestis et al., 2024</p> | <p>WELLBEING.</p> <p>Although reflecting on their own networks and personal experiences was generally perceived as emotionally challenging, it enabled trainees to “dig deep” (P5), “find their true voice” (P6) and become “more in tune” (P7) with themselves.</p> <p>This process was considered empowering on a personal level and allowed some Participants to make significant life changes (e.g., becoming vegan, re-evaluating relationships with significant others).</p> <p>At the same time, this enhanced self-understanding as a result of the training was perceived as a prerequisite for becoming an OD practitioner: “The whole, you know Open Dialogue training is, a lot of it is being in tune with yourself, so you can support other people. You can’t support other people if you are not in tune with yourself, how can you be in tune with them?” (P7) p.5</p> <p>Having to openly share reflections about their own personal experiences and influences of their networks highlighted the shared ‘humanness’ and vulnerabilities amongst trainees. Participants mentioned how they started seeing their colleagues as humans beyond their roles and professional titles and were thus able to better connect and relate to them. This was contrasted to the “isolated way of working” (P9) in TAU. Participants used the words ‘closeness’, ‘collectiveness’ and ‘togetherness’ to describe the team bonding that came as a result of having been through this intense learning experience together and having been able to support each other emotionally. p5</p> <p>However, this was not felt by all - those who attended training online missed out on this connection and support. The two 'peer practitioners' experienced feelings of loneliness and othering.</p> |
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| | <p>"I think because everybody had their own, you know they were in their own working groups, you know they'd come in teams from different NHS Trusts, um, yeah I did feel quite separate from everybody and again there was that sort of re-experiencing sort of a separateness and outsiderish feeling. I couldn't understand why nobody wanted to, like I was sharing quite a lot you know in these essays and I thought, I don't know I thought maybe that would create more connection. It was quite painful." (P6) p5-6</p> |
| <p>Buus et al., 2023</p> | <p>Participants in the post-training groups reported intense experiential learning spaces during the training course, most notably during supervision and Family of Origin work, which resulted in personal transformation. These learning spaces included small group reflective processes exploring both clinical work practices and personal biographies, which allowed the participants to share personal vulnerabilities and to relate differently to other people (clients and colleagues) in a variety of contexts. p999</p> |
| <p>Dawson et al., 2021b</p> | <p>Monthly Open Dialogue clinical supervision in dialogical practice was introduced. Supervision sessions assisted staff to reconnect with the principles of working dialogically. p384</p> |
| <p>Dawson et al., 2021a</p> | <p>Practitioners appreciated the opportunity to be vulnerable and share their own personal and professional stories, insights and reactions (results p. 143)</p> |
| <p>Einboden et al., 2024</p> | <p>Initially "participants described how Open Dialogue offered a sense of alignment between personal and professional values. Most described how practicing dialogically felt good and how Open Dialogue carried a sense of 'interpersonal magic' (P4) that extended beyond the work, into personal relationships. Amidst their shared values, relations among the practitioners deepened professionally and personally." p264 However, the change in practice contributed to a lack of role clarity: Repositioning of practitioners to create greater professional equity was not a smooth process. An internal practitioner recounted jostling between some of the practitioners in what she called, 'office politics'... Some participants expressed uncertainty regarding how to step up and take a lead in facilitating network meetings and questioned who had the legitimacy to step into such roles. p265 Renegotiating team roles whilst learning practice was problematic: Some practitioners described feeling that their practice of Open Dialogue during network meetings was criticised by other practitioners. Aiming for equity amongst themselves, practitioners were self-regulating with no one assigned to give overt feedback about dialogical practice to others with less training or experience. Some practitioners gave feedback that was experienced by others as criticism.p266 Over time, practitioners developed clarity around how they wanted the services to be delivered, but the implementation, staff development process and team relations were not so clear cut. The emphasis on dialogue did not translate beyond the network meetings. The group has difficulty determining how much training and supervision was needed/enough, for whom and by whom.</p> |

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| <p>Elran et al., 2022</p> | <p>The use of lived experience is a body of knowledge brought into the team, just as other mental health professionals bring their knowledge and experience. Broadly speaking, multi-professional teams hold a wider perspective and promote diversity. More specifically, the voice of lived experience holds a unique and precious embodied knowledge and allows for: 'an interaction with a body of knowledge that speaks the experience from within, versus a person that views the experience from outside'. Pg 9</p> <p>However, even though the approach promotes equality, even teams that manage to flatten hierarchy may still experience power imbalances within the organisation in which they work. Even beyond the organisation level, there is also a battle between paradigms, and lived experience is still not accepted as an equal and legitimate body of knowledge and practice: "I am finding that even with dialogic work, professionals and institutions still hold the power and define the narrative". Pg 8</p> |
| <p>Florence et al., 2020</p> | <p>"Staff reported a shift towards a more collaborative way of working with colleagues after training in the CNA and the majority of participants referred feeling less burnout." p687</p> <p>A quote for example: 'I think that that is a big shift for me, thinking that the answer lies within the client and the network, so not feeling that burden I think that that has led to me to feel less burned out'"p687</p> <p>OpenD (CNA) training of all workforce was needed and valued, not just training those in client facing roles p687</p> |
| <p>Friesen et al., 2024</p> | <p>Second theme of concern from family/carers (network members): "might be still going though it"</p> <p>So it's a proper balance of "well, I have mastered this, and I'm a professional," versus "me and you are in the same boat" 'cause "me and you in the same boat," that feels more again, like "we could be friends, but neither of us ha[s] any answers," and a lotof the times, that's kinda how it felt. Pg 3</p> <p>Theme: Lack of shared experiences/ too different</p> <p>"However it was a male, not a female. It was someone much older" Pg 3</p> <p>But consumers valued peer work more than family/carers - echoing other research in which service users valued peer contributions more than did family member. Pg 3</p> <p>Most teams use one or two peer specialists, so differing degrees of shared experience are likely, and enrollees may not be able to choose the peers with whom they interact. "the flexibility of the Open Dialogue model allows team members to be responsive to different connections that form between program staff and enrollees" Pg 3</p> <p>The finding (related to varying credibility that participants reported) indicates that different forms of credibility or expertise may be recognized. Pg 3</p> <p>Another concern from one participant was about lack of cohesion among the multi disciplinary team. Lack of cohesion may be experienced by participants in network meetings as unsettling, especially given how much this approach differs from mainstream biopsychiatric approaches. This concern regarding team unity raises questions about the role of peerspecialists on Open Dialogue teams. Pg 3</p> |

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| | Critical reflection on the role that peers should play within the Open Dialogue model is warranted. Pg4 |
| Gidugu et al., 2021 | Nearly all of the clinicians talked about how they were drawn to the idea of the primary focus being on the person and their preferences rather than the symptoms, safety, or diagnosis, which were the foci of their usual work (results, p. 158) Clinicians were drawn to this approach because it allowed for working in a person-centered way that emphasizes finding treatment options that are aligned with the individual's preferences. (results p.158) |
| Gordon et al., 2016 | Staff satisfaction was high. The team was well trained by completing two years of training. Staff expressed satisfaction with their ability to better engage patients and families. They enjoyed working with families and in teams. Clinicians reported that this structure promoted nonhospital options by affording additional support and safety. |
| Jacobsen et al., 2023 | Theme: "Liberating & supportive Clinicians enjoyed co-facilitation: 'I get energized. I think it's because there are two of us ... working together'. ...and enjoyed focus: 'You don't need to perform. You don't need to be so damn clever. You can really just be present'. Many of the clinicians found the approach liberating - ...feeling part of a more equal and transparent collaboration with patients and their social network. These experiences changed them professionally and were described as promoting development of ODNM. One clinician said, 'It makes a big difference ... we dare to be transparent as professionals. We dare to show feelings. We dare to be touched, like the network meeting yesterday, when the psychiatrist sat and ... shed tears ... It's so damn different to all the other meetings around here. It's impressive!' p202 Theme: Versus feeling alone with responsibility: Several clinicians felt left alone with responsibility for the development of ODNM in their units. One stated, 'We feel that this has become our project, not the unit's project'....'Some of our colleagues are positive, but others are indifferent or not interested'. Lack of support from their leaders was highlighted. In units where ODNM had been practised before the project, leadership was perceived as more present. p202 Supervision experience and success was mixed. Supervision encouraged cooperation across units. One said, 'Without the supervision I'd never have joined a network meeting with X'. In another unit, the supervision failed. They chose to terminate the supervision sessions because they were dissatisfied with the supervisor's facilitation p203 |
| Kinane et al., 2022 | Open Dialogue requires a reflective space for clinicians to have time to consider their practice and relational way of being with each other and the service users and social network. Pg 1 |

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| <p>Klatt et al., 2025</p> | <p>"The specific form of implementation of OD in Leipzig could serve as an example for similar processes in other environments in Germany and possibly internationally."Page 10</p> |
| <p>Lennon et al., 2023</p> | <p>The establishment of Open Dialogue at Site A was largely based on a bottom-up implementation, supported by a stable and relatively large group of committed and family therapy (systemically) trained clinicians. Implementation at Site B was predominantly a top-down approach by a tightly knit senior management group with a keen interest in working collaboratively with clients and carers, an awareness of shortcomings of conventional medical models. p98</p> |
| <p>Lorenz-Artz et al., 2023</p> | <p>Changes in thinking and practice (for all people in the service) were severely underestimated: 1. Difficulty for OD professionals and OD trainees to understand OD, resulting in an underestimation of the profound and far-reaching impact of applying OD on themselves and the organization of care. Pg 5 2. Gap in meaning and implication (training vs practice). 3. Insufficient insight at the start - what it entails. 6. Lack of blueprint - learning by doing/ experimenting. Pressure of continuous reflections and learning from mistakes. ...Lack of clarity among teams. Demanded creativity and flexibility. 7. Staff: In addition to the struggle to understand the concepts of OD, they have experienced the OD team as closed, not transparent, and inward-looking during the whole pilot. Pg 5 8. Challenges related to personal change process among professionals. Transformation is required on a human level to embed OD as a way of life. Intensity and its impact on self is noted. 9. Emotional discomfort: the sense of discomfort was common, in the liminal space between the old and new situation. But could also be attributed to the resistance against the manner in which OD was introduced, its confrontation with deeply ingrained paradigms, and the multitude of changes inherent in the transitional process Pg 7 12. Letting go of the tendency of fixing/ provide solution when perceived 'crisis' situation occurs. "Tolerance for uncertainty, not knowing, not diagnosing, but allowing meaning to arise. Yes, well, I think that's the most beautiful thing about the whole OD. It's about the moment. And that's the pitfall. There are people who sit on the couch with a family and think it's all fine. And where will they end in 5-years? And can you tolerate that as a society? Is it okay for people to sit on the couch for 30-years?... As a society, can we tolerate that? Why do we all have to do what someone has come up with?" (OD trainee). Pg 9 13. Organisational aspirations related to OD need to be explicit and consistent. Whole of organisation approach is required. - "the necessary changes among the professionals and team could only be fully achieved if others also move along with this change" pg 9</p> |

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| | 14. Challenging how knowledge is understood. E.g. Novel concepts such as person centred care and OD within a dominant bio medical model organisations. Traditional models that lack practical knowledge about the person. |
| Olson et al., 2015 | Workforce can reconsider mental illness as dilemmas and crises of expression, be encouraged and learn to take dialogue seriously. "The live multivoiced interaction, that is, dialogue – allowing voices to be present – can animate a space for becoming, even in the severest psychiatric crises" p727 |
| Pocobello et al., 2023 | OpenD teams were on av 20 people; Across all teams surveyed largest discipline group was nurses (27%), social workers (17%), psychologists (16%), peer support (9%), psychiatrist (9%), OTs (5%); configuration differed across public/private.(p8) Training engagement across services ranged from 100-10% of team; Median of 14 OpenD trained staff in specific OpenD teams; (but median number of all service staff trained in OpenD was 5? i dont understand p7); v high rate of current training provision at time of survey. Most common training (80%) was 1 year foundation training. p9 Just 66% teams had OpenD supervision. p9. |
| Schubert et al., 2021 | Workforce wellbeing: All clinicians identified opportunities in working dialogically, including enhancing self-reflection, workplace relationships and clinical work. Participants unanimously spoke about how their own personal and embodied experience of encountering Open Dialogue facilitated a deeper self-reflection and deepening of relationships with colleagues, which left many clinicians Contemplating what a dialogical approach could offer clients. They described reconnecting with their initial motivations for becoming therapists. P153 Dialogical communication with colleagues emerged as improving relationships and fostering a supportive team culture. Some clinicians reflected on incorporating elements of dialogical listening exercises into team meetings. One senior consultant psychiatrist spoke of the devastation experienced by clinicians when a client completed suicide and how staff wellbeing had not been adequately addressed. The psychiatrist facilitated an Open Dialogue meeting with staff described as being profoundly healing. p154 |
| Seikkula et al., 2011 | The comprehensive training in both family therapy and individual therapy for all staff members has made the treatment system itself more willing to consider psychotic phenomena from a psychological and systemic viewpoint: the entire treatment system is more oriented towards the changing needs of patients, families, and their relational system. p10 |
| Sidis et al., 2020 | (NB. paper could also be in 'experience of training' cluster). Clinician experiences: "Letting go of the 'expert' position: The experiences of polyphony described by |

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| | <p>clinicians also related to a sense of relief in not needing to have all the answers or solutions to problems in the meetings.</p> <p>... that you didn't have to be an expert, you could be "well alright, we're all learning about this together" and I think that was really freeing. And I think also for the families that was quite freeing" "</p> <p>p 13.</p> <p>Staff satisfaction:</p> <p>Satisfaction of being yourself - A number of clinicians reflected on the experience of flexibility to be oneself in meetings with families.</p> <p>'It's certainly improved job satisfaction, because in some ways the role has been really dumbing down what one has to offer, so this has enabled not just myself, but also other staff, nurses, who I thought were really good and need that satisfaction from their job.'(Participant 7)." p16.</p> <p>Different paradigm:</p> <p>"The (family oriented practices and) systemic perspective of viewing psychotic problems as existing between people (Seikkula & Olson, 2003), rather than within them, represents a significant shift from the individualist paradigm" p20</p> |
| <p>Stockmann et al., 2019</p> | <p>Greater job satisfaction and personal wellbeing following the training was also mentioned, "I was very close to being burnt out...I'm in a very different place now. I've got a passion back" (12) p315</p> <p>Mindfulness was linked to the development of self-compassion, "It's taught me to be kinder to myself actually, in a lot of ways. And actually listen to myself and the internal sometimes the battles that go on in my head you know when I've had a difficult time, I've actually been able to sit with that a little bit more and listen instead of trying to block it out" (03) p316</p> |
| <p>Taylor et al., 2023</p> | <p>Early in my career, I was shocked when one client told me they could share with me because I had crossed boundaries and shared my struggles. I then realized that careful sharing of my real self was actually more effective in helping to support behavioral changes than "treatment as usual."</p> <p>I began to notice more "aha!" moments in my clients when I shared, as opposed to when I did not.</p> <p>In network meetings, I experienced a sense of "opening" and interest when I spoke of my own experiences. One client in a network meeting spoke of his auditory hallucinations and then of feeling lonely. I asked if he wanted to meet people who also heard voices, and he agreed. His face lit up when I shared that I heard voices and offered to share my experiences with him. p2</p> <p>WELLBEING</p> <p>I feel honored to be in network meetings to witness and support participants in being</p> |

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| | <p>their own genuine selves. By witnessing and accepting others in the context of network meetings, I have found I'm more likely to provide myself the same care and compassion that I give to clients.</p> |
| <p>Tribe et al., 2019</p> | <p>Clinicians "suggested that leadership take a more transparent and inclusive approach to changes in service delivery, which would adhere more closely to the open dialogue approach. When implementing complex clinical interventions, it is important for those delivering the service to collectively define the procedures and actions needed to maintain changes, in order to encourage continued involvement and commitment". (organisational challenges, p5).</p> <p>Clinicians reported that discussions and decisions needed to be more open and transparent, and that the concerns of team members needed to be voiced and heard (organisational challenges, p5).</p> <p>Clinicians referenced the fixed hierarchy and power dynamics in NHS mental health services as an integral part of the way teams are structured and a function of how services monitor work and divide responsibilities. It is therefore important to further explore how to adopt a radically different approach to service delivery in the NHS and other international healthcare providers. (organisational issues p. 5)</p> <p>Lack of resources and processes (from Table 2, p. 6)</p> |
| <p>Uehling et al., 2024</p> | <p>Experience of change: A medical resident said: the intervention 'breaks down part of the medical model' by giving clinicians "a little bit more space to be themselves and have interactions that are a bit more genuine and human, rather than focused on safety or biology" p5</p> <p>Learning OpenD takes time: The learning curve for OD is steep and long. In our work, the learning curve for OD was longer than the learning curve for CSC [adjunct model]. Some of the reasons for this, we think, are that 1) OD is not manualized, and 2) facility with the model is less testable. The teaching and learning of OD are like an apprenticeship" p7</p> <p>Challenge: the OD/CSC model put the individuals and the team at odds with their professional training, the broader social organization of the hospital, and the existing system of psychiatric care.</p> |
| <p>Ulland et al., 2014</p> | <p>2 year training program, training oversight included service users (p410?)</p> |
| <p>vonPeter et al., 2022</p> | <p>Themes of (intolerable) conflict between staff, especially those who have Vs havenot trained in OpenD p02</p> <p>"The interviewees made clear that the OD training polarized teams that had previously</p> |

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| | <p>been working well together: 'Unfortunately, our teams have been divided since the OD training. People first felt energized by the training -[...] but that only went so far, as power games came into play.' Interviewee"p 02</p> <p>Three issues posed a threat to existing power relations: Intrinsic challenge in OpenD stance of not knowing and ambiguity, OpenD people presenting themselves as 'know it all'/superior, mistrust about OpenD people's motives. Main contribution : "How can we reduce the power-related implementation obstacles?" 04</p> <p>"Even if psychiatry may have its own dogma, this does not entitle us to (ab)use OD to create a counter-ideology. Thus, we should be careful with disseminating unifying or unified messages." p04</p> |
| <p>Wates et al., 2022</p> | <p>The training had a significant impact on participants who described it as life changing and transformational.</p> <p>Participants describe gaining personal insights around themselves and their family relationships, being able to integrate and become more authentic, and being more present in the moment as a result of training. This had a notable flow on effect into the quality of their practice, and their own wellbeing.</p> <p>"Over half of participants (eight) shared that the training had helped them resolve either personal or family difficulties... For some this had shifted long-standing family dynamics through facilitating communication, and had allowed the opportunity to hear alternative narratives" p793</p> <p>"Importantly, this new insight and knowledge was viewed as critical to informing practice. Participants felt that their clinical work had benefited from their improved ability to understand and reflect on their own emotional responses towards clients and colleagues." P793</p> <p>Over half (seven) of participants discussed how training and practising OD allowed them to integrate parts of themselves they had previously felt required to separate or suppress in the workplace. This led them to feel more "congruent" (Helen, FG1) with themselves and had a positive impact on wellbeing. p793</p> |

Lead by lived experience (and include consumers and families in service design)

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| <p>Elran et al., 2022</p> | <p>The presence of a lived experience practitioner as an integral part of the team is another way to flatten hierarchy within the team, and also reflects upon the network. Making space for the voice of lived experience reduces the 'otherness' of the person in</p> |
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| | <p>crisis, and helps all the participants talk ‘with’ the person, not ‘about’ the problem. Pg 8</p> <p>Regarding the hierarchy between the different voices in the network, the presence of a lived experience practitioner in the team empowers the voice of the person in crisis and helps balance the social power relations. Pg 8</p> <p>An interesting issue that came up is the risk of creating a new hierarchy, in which experiential knowledge replaces professional authority. Pg 8</p> <p>These benefits include the ability to form a bond with the person in crisis based on a feeling of shared destiny and deep empathy extending beyond words. The person in crisis can feel ‘the power of having someone that understands what you are going through, what it is like to feel helpless, different, dependent, that everyone is here because there is something wrong with you’. Pg 9</p> <p>Another benefit similar to that brought by traditional peer support is the unique ability to listen to the voice of the person in crisis and validate this voice. The practitioner can empower and act as advocate for the struggling person, while helping to create a bridge of understanding between the person and the network. The presence of the practitioner can help the network talk about the crisis in an everyday language that does not pathologize or exclude the person. Pg 9</p> |
| Hendy et al., 2020 | <p>There was also reference by participants to the manner in which having a peer worker within the meetings enhanced the dialogue using self-disclosure: [...] to my mind that person was very subtly feeding into the process that she understood the fears and concerns and behaviours because she had done similar things herself at a point in time [...] for someone to be able to say well I used to do exactly the same thing and this is how I got past it was worth it's weight in gold quite honestly. (Network member) p100</p> |
| Hendy et al., 2023 | <p>The ODDDESSI trial in UK "– has included an explicit commitment to peer practitioner involvement in multidisciplinary teams" (Introduction, p. 2)</p> |
| Pocobello et al., 2023 | <p>No reference to LE leadership</p> |
| Ulland et al., 2014 | <p>Members of service user organisations worked with staff to plan the service (p408?)</p> |
| Hendy et al., 2023 | <p>?Codesign used in "The first national multi-site trial evaluating Open Dialogue in English NHS mental health services – Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness"p2</p> |
| Heumann et al., 2022 | <p>The addition of peer support providers in the open dialogue team:(Results, peer support, p. 1038). Experiences with peer specialists were overall very positive, with many interviewees</p> |

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| | <p>commenting on the importance of having someone there who was relatable.</p> <p>Others spoke about how the role of the peer specialist was unique and could not be provided by someone else: “It’s much better hearing it from somebody who actually knows that you can get over it. You know, you can like achieve what you wanna achieve and actually recuperate”</p> |
| Kinane et al., 2022 | <p>Co-production/ citizen control is fundamental to POD which is democratic, collaborative and sees each person in the network meeting as an equal or potential partner in recovery. In a service user led report it was identified that most service users who took part in the project which gathered their views felt that social approaches to mental health, which take account of the whole person and wider societal issues affecting them, are the most helpful. pg 8</p> |
| Sunthararaj h et al., 2022 | <p>Having a voice in treatment planning and acknowledged the benefits of a transparent and collaborative process.</p> <p>Some participants acknowledged the importance of having a choice; that is, a choice in being able to decide the frequency and location of meetings and a choice in how their supportive network wereinvolved in sessions. P 4</p> |
| Ulland et al., 2014 | <p>Developing a collaboration area that includes service users in all stages of the projects was an essential implementation factor p 410</p> |
| Wusinich et al., 2020 | <p>The addition of peer support providers in the open dialogue team:(Results, peer support, p. 1038).</p> <p>Experiences with peer specialists were overall very positive, with many interviewees commenting on the importance of having someone there who was relatable. 1038</p> <p>Others spoke about how the role of the peer specialist was unique and could not be provided by someone else: “It’s much better hearing it from somebody who actually knows that you can get over it. You know, you can like achieve what you wanna achieve and actually recuperate”1038</p> |

| Focus on consumer priority | |
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| Bergström & Seikkula., 2022b | <p>After a period of years from their initial crisis, most participants indicated that the important element in their mental healthcare for first-episode psychosis was the possibility to discuss difficult experiences openly, together with the fact that someone was showing an interest in an open-minded and non-judgemental manner. However, some participants were remembering that there had sometimes been too many people</p> |

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| | participating in the treatment meetings, and that the immediate home visits and inclusion of family members had not worked well in their situation.(p. 892, discussion) |
| Buus et al., 2022 | The non-pathologising approach could be regarded as a way of not offering the authoritative clinical certainty and closure of a diagnosis and treatment. This allowed families to be themselves and follow their own ideas about their trajectories through life. In particular, the young people described it as very helpful not to be “labelled” with a diagnosis. However, this responsive/open-ended communication style could also be regarded as generating challenging interpretative work for the families about the significance of the young person’s experiences and behaviour (Findings, theme 3 p. 313) |
| Buus et al., 2023 | The universal principle of participants to “hold ideas lightly” referred to clinical approaches, practices, and assessments, which could be premature and incorrect and inadvertently add to clients' problems. p998 |
| Dawson et al., 2021b | Identified that Open dialogue requires a paradigmatic shift from medical treatment orientation to a recovery orientation; not readily achieved in the study setting |
| Dawson et al., 2021a | <p>All the service user participants emphasized that the key difference for them with the dialogical approach was a heightened sense of safety, compared with their usual communication experiences with care providers. This notion of safety was rooted in the space of the shelter itself, but extended into the dialogical process and interpersonal relations within the network meetings. (analysis, p. 141)</p> <p>Through exploring the experiences of Open Dialogue network meetings from the perspective of service users and practitioners, we have found that the dialogical process added to the safety created by an Australian women’s shelter. Open Dialogue resisted hierarchies and resulted in a non-pathologizing experience where service users defined their own issues and felt heard and validated. These findings suggest that dialogical practices align with a nonviolent approach that holds the opportunity to attend to dominant relations of power within which women live, and within which healthcare and social services are provided. (discussion, p. 144).</p> |
| Florence et al., 2020 | “I think sometimes some of our colleagues, myself even, come in and think you’re going to fix things, control things, and in many ways I think you have to step back and verbally say that I’m not controlling this and we don’t know the plan, but we’ll see where we go. For some people that’s comfortable and for some people it’s not”. p689 |
| Florence et al., 2021 | While all participants agreed that the presence of family was crucial to treatment, the role played by family varied: some participants understood the network as a support system, to feel less alone: “So, that seems to have some effect to helping if someone is experiencing shame, humiliation, things like that, to understand that it’s not something you have to do alone”; other participants felt that the importance of having |

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| | <p>the network present was related to being able to have certain conversations that didn't feel possible at home (Results, Network focus, 1775)</p> |
| <p>Friesen et al., 2024</p> | <p>Findings categorised through IPS principles being key part of peer work. Following quotes relate to each of the principles mentioned.</p> <p>Mutuality: relatability of peers citing the value of shared experience Pg2</p> <p>Hope: Enrollees also commented on how inspiring it was to work with someone who had been through a similar experience and who could help them “to say ‘Yes, I can do it, too’” or to believe that “you can, like, achieve what you wanna achieve and actually recuperate”</p> <p>Moving towards: “I thought, ‘Wow there’s a light at the end of the tunnel here . . it’s possible for a person to come back together and bring himself or herself together’” Pg2</p> <p>Connection: “good connections” with peers mattered more than shared experiences' Pg3</p> |
| <p>Gerken et al., 2025</p> | <p>Implementation of practices inspired by Open Dialogue on an acute inpatient unit are feasible and may improve patient experiences of inclusion and respect.</p> |
| <p>Gerken et al., 2025</p> | <p>“This intervention was associated with statistically higher scores for these questions: Did staff explain things in a way you could understand? (OR 2.08; p0.08) Were you involved as much as you wanted in decisions about your treatment (OR 2.13; p0.07) Did the staff give you reassurance and support (OR 2.41; 0.04)”</p> |
| <p>Gidugu et al., 2021</p> | <p>"Evidence represents the aspects of the model that clients and family members identified as contributing to their experience including the benefits and limitations related to these aspects." (Results p. 156-7)</p> <p>Participants described interactions that conveyed a sense of genuine caring and acceptance to them such as the following interaction described by a client: “He was very, very flexible . . . met us on campus a couple of times...I really felt like they genuinely cared and were invested and they wanted, you know, to . . .to do whatever it took.” (results, p.157)</p> <p>[Other elements that participants valued]: Non-hierarchical environment, client and family setting the agenda, sharing of ideas, transparency and openness (no secrecy or hidden notes) clinicians sharing their thoughts about the situation (p. 157)</p> |

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| | <p>Dialogue: Talking about the experience, Reflections: Demonstrating understanding: "I liked how they would have conversations with each other, and it would really let me . . . show that they understand what's going on. " (results p. 158).</p> <p>Exploring multiple perspectives "Also, some of the time, "Clinician 1" would agree, or identify with my mom; while "Clinician 2" was hearing what I was saying... rather than my mom and I having a disagreement, they were able to just talk among themselves about representing our viewpoints... Yeah I felt that it removed me from the situation so that I could get perspective on it" (results, p. 158)</p> <p>Family involvement: It promoted more open communication within the family, and strengthened the individual's support system.</p> <p>While they valued the family aspect of the model, some clients still felt the need for separate individual therapy in addition to the Collaborative Pathway services.</p> |
| <p>Hendy et al., 2023</p> | <p>...peers may have an enhanced ability, based on surviving their own experiences of mental distress, to tune in to experiences that may be particularly hard to voice. As one peer put it, "Your antennae are more sensitive" (p. 5)</p> <p>Within the wider polyphony of voices in the network meeting, it was felt that "if you have had similar experiences you'll pick up on all sorts of things that others might not notice" – and the importance of self-awareness was recognized in mitigating against the imposition of the peer practitioner's own "agenda" or experience. (Attunement, p.6)</p> <p>Peer-supported Open Dialogue can create "a space for them to be in the world as a valid person" – something that may be seen as a cornerstone for recovery (validation, p. 6)</p> <p>While peer practitioners are often aware of the tensions with their own position as paid workers, they are not bound by the same statutory responsibilities as their clinical practitioner counterparts. This may allow for greater openness to connection and developing relationships based on a greater similarity in their experiences of the operation of power: "I do not think any peer workers have any statutory responsibility around incarceration or sectioning or anything like that I think affects the ability to be with...that allows me a certain level of proximity to somebody that they cannot do." (connections & mutuality, p.7)</p> <p>It involves feeling able to bring one's whole personhood (and not just some construction of a professional self) into the interaction. Although practitioners from professional backgrounds also report how they have been moved in dialogic</p> |

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| | <p>encounters, such an ability to “step together” into a space of shared learning may come a little more easily when entering the interaction from the orientation of peer rather than professional. (connection & mutuality, p. 8)</p> <p>The title of peer practitioner already constitutes a level of self-disclosure, indicating that a person has their own experience of mental health difficulties alongside wider life experience. In network meetings, peer practitioners should use their discernment and intuition to assess whether self-disclosure would or would not be helpful in supporting or bringing out other voices in the room – and should only do this when they feel it is safe and helpful in doing so. (From Table 2: Self Disclosure, p. 9)</p> |
| Heumann et al., 2022 | Principles were not simple to implement:including "network perspectives" and "having the person in include in planning dialogues.p06)" |
| Holmesland et al., 2010 | Since taking part in the first meeting, professionals in the Health Care Group had gained conflicting understandings with respect to the possibility of adjusting their professional role according to holistic approaches. One claimed: “We talk a lot more about what the families are concerned with. Then it becomes a more humane meeting where everyone participates with their experiences, but without compartmentalization based on role knowledge” (HCG/2m/2). P9 |
| Jacobsen et al., 2021 | “For each training day I become more and more convinced that OD is a useful approach for the patients and their social network.” p42 |
| Kinane et al., 2022 | <p>Service users rated the POD service more highly than other local and national data and suggests this approach may address some outstanding issues with mental health services around service user satisfaction. Pg8</p> <p>This service was demonstrated to be beneficial to service users in terms of clinical outcomes and overall satisfaction. It incorporates shared decision making and the option to mobilise social support networks with a high level of choice offered to the service user and this may address national quality issues of service user satisfaction identified by the Care Quality Commission. Pg 8 pg 9</p> |
| Olson et al., 2015 | When I resumed my practice in Massachusetts, I found that a dialogic approach produced startlingly positive shifts with families with teenage and young-adult daughters experiencing severe depression, early psychosis, and eating disorders, although not with every family. The basic change that I embraced was “being with,” rather than “doing to,” thus dropping the time-honored “clinical gaze.” In this way, I discovered listening as a primary mode of communication with a more lightly held professional knowledge integrated into my responses. p722 |
| Omvik et al., 2025 | For patients, there were two themes: “Enhanced trust within our relationships” and “Providing us a safe space to talk openly,” and for network members there were three: “Empowered through participation,” Being welcomed and taken seriously,” and |

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| | <p>“Provide more clarity to enhance our ability to contribute.” (abstract, p. 337)</p> <p>Participating in one or two dialogical network meetings at a mental health outpatient clinic was considered highly valuable by both patients and network members. By comparing their experiences, similarities were found in their emphasis on getting the opportunity to express themselves freely and on the meeting leaders’ role in facilitating discussions on important and difficult matters. Differences included the network members’ need for more predictability and the patients’ emphasis on the importance of feeling understood and enhancing trust within the relationships. (p. 348)</p> |
| Pocobello et al., 2023 | No report of network meeting foci |
| Pocobello et al., 2024 | <p>OD was well received by patients & families:</p> <p>Patients rated the outcome of OD-network meetings lower compared to social network members, and the outcome of OD-session was rated higher over the course of the OD-therapy. p8</p> <p>(Families/networks immediately rated OD sessions highly, patients' ratings improved over time to almost match network/families high ratings)</p> |
| Razzaque et al., 2015 | <p>Staff and service users agreed on the value of Open dialogue principles, especially flexibility and mobility (93/94%) and non-medical dialogue/listening (91/95%) and lack in NHS (35/33%)</p> <p>‘Open Dialogue is client focused and likely to provide a much better and much more helpful experience for the client’ (Staff participant) p934</p> <p>Agreed values included: Person-centered, Transparency and openness, Empathy, Warmth, Active listening Recovery focused</p> |
| Schubert et al., 2021 | <p>Participants, particularly the psychologists, identified dialogical approaches as a means through which they could prioritise being with clients and relating more authentically. Dialogical approaches offered opportunities to embrace a shared sameness with clients. The approach was seen to offer a way of working with clients that deconstructed the pretence of separateness; rather than seeing clients as pathologically unwell and in need of acting upon, they were seen as fellow humans in distress. p154</p> |
| Sidis et al., 2020 | <p>"Feeling good to let things unfold - This subtheme was associated with clinicians’ experience of allowing families to direct content of sessions and appreciating the resulting conversations.</p> <p>"I think it was exciting to actually have something you can hang your hat on and say “no seriously, we value you, and your input.”(Participant 3)</p> <p>Some clinicians expressed some surprise at the results of network-led conversations in Open Dialogue meetings: That idea of, whatever needs to be talked about, whatever is important, does come up with the family, like I really found that to be true... Participant 9 "p12</p> |

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| | <p>"Family members described appreciating transparency, openness, and a sense of collaboration that appeared to be associated with being able to direct content in sessions. Families were also encouraged to continue with meetings as a result of a developing sense of closeness, or ability to talk through problems both within the therapy meetings and at home." p23</p> |
| <p>Stockmann et al., 2019</p> | <p>As well as a sense of returning to original ideals, there was unexpected insight into limitations of individual practice, "I like to think that I am not just somebody who just prescribes medication, but that listens and tries to understand people's experiences ...It's been quite humbling actually finding out that there is a whole new, a whole another level to that that I don't do" (06). p315</p> <p>Participants described significant changes in their approaches to clinical work, identified in the practice development and POD principles themes. A widely-expressed view was that POD allows for a more intuitive, humanistic practice than currently, comparable to "post-technological psychiatry" outlined by Bracken et al. (2012), with increased emphasis on meanings, values and relationships p317</p> |
| <p>Tribe et al., 2019</p> | <p>A crucial element of open dialogue was the felt and perceived authenticity of interactions within network meetings. It will be important for further studies to look at how authenticity has an impact on the therapeutic relationship and whether this fosters trust. Previous studies of open dialogue have shown that the increased trust between service users and therapists may be an essential mechanism of change within open dialogue. (p. 5)</p> <p>Tolerating uncertainty and dialogism were experienced as positive aspects of the approach by clinicians (Impact of open dialogue principles, p.5)</p> <p>Participants experienced network meetings as different from TAU. Clinicians, in particular, were extremely positive about the approach and used powerful language to denote their preference of open dialogue in comparison with TAU. Service users frequently referenced their previous negative experiences within mental healthcare and reflected on the increase in positive communicative experiences in network meetings. (delivery and monitoring open dialogue, p. 5)</p> <p>(from table 2 p. 6) Service users: Feeling listened to and understood, previous experiences of treatment unhelpful, "reflections" as strange, Uncertainty as unsettling"; authenticity of self and perceived authenticity of clinician; heightened emotional expression. Clinicians: Open D as a preferred way of working reflections as therapeutic; uncertainty as challengingeliciting multiple perspectives; authenticity of self; heightened self-disclosure. (Table 2 p6)</p> |

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| <p>Twamley et al., 2021</p> | <p>All participants commented on the transparent practice of reflections in meetings where the team discuss openly and record collaboratively: Ann-Marie: "they weren't hiding anything. Normally when you go to see a doctor you've got your file, but you don't know what they are writing". results p. 496)</p> <p>Participants reported "lost faith" in the service pre-adapted OD implementation. Network meetings offered participants a new relationship with mental health services characterised by transparency, approachability and trust. (Discussion, p.497).</p> |
| <p>Uehling et al., 2024</p> | <p>"...dialogic work can be a catalyst for systemic change", for "doing things differently" p6</p> <p>"Ultimately modelling treatment for psychosis on a dialogic approach" ... "made space for members of the OD/CSC team to experience a sense of personal and professional transformation" p6</p> |
| <p>Wusinich et al., 2020</p> | <p>Features that are central to the Open Dialogue approach arose in interviews, including the lack of hierarchy present in network meetings (results, p. 1036)</p> <p>Several themes arose in interviews related to the Parachute team, which was described as "easy going" (E13, NM14, NM12), "down-to-earth" (NM9), and "open-minded" NM10). (results, relationships with the Parachute Team, p. 1038)</p> <p>Several enrollees noted that Parachute provided a place to grow and to consider new ways of understanding themselves and their experiences. (results,Selfunderstanding, p. 1039)</p> |

| <p>Enable equity</p> | |
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| <p>Dawson et al., 2021a</p> | <p>Our findings indicate that Open Dialogue network meetings create opportunities for healing potential that are especially useful for people who have experienced trauma and violence. (discussion p.146)</p> |
| <p>Einboden et al., 2024</p> | <p>Difficulty in translating the equity and polyphony principles beyond network meetings to the whole of service model.</p> |
| <p>Florence et al., 2020</p> | <p>"Aiming for change in power structure, but split between those who did and didnot use OpenD impacted org culture in two ways: first, as a not quite permeable group of people who were trained and worked together setting themselves apart from the rest of the</p> |

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| | agency; and second, as a power dynamic that was described as being unspoken within the agency." p689 |
| Friesen et al., 2024 | Ideal codesign - An ideal design would have included Parachute enrollees in a more substantive way, including through member checking and study design. Pg 4 |
| Hendy et al., 2020 | Participants identified the importance and value of feeling that they were viewed as equal within the network meetings: "It was like an equal feeling, of respect and listening to each other. (Client)' and 'It felt like everyone was given equal value in those meetings there was a lot of turn taking, I felt there was some sort of system in place which made sure it created that sort of feeling of inclusivity' p97 |
| Kinane et al., 2022 | Move to recovery outcomes: Employment or Education: At baseline 22% were in full-time employment (n=11) and 12% were in full-time education (n=6). At the six month point 30% were in full-time employment (n=15) and 18% were in full-time education (n=9), indicating a 14% increase in take up of employment or education. Pg 7 The WASAS scores record ongoing improvement in self-reported functioning in work and social activities at each time point with the scores between baseline and 3 months being significantly different. Pg 8 |
| Pocobello et al., 2023 | No report of service user ethnicity |
| Uehling et al., 2024 | Experienced changes to power relations. Analysis identified "patterns in participants' descriptions of the ways a willingness to be vulnerable with another individual disrupted structural hierarchies." p4 "Calling out power differentials among clinical roles, and then also calling out power differentials between clinicians and clients, was unusual, and might even be contrary to the training a clinician had received" |
| vonPeter et al., 2022 | Equity and ideological struggles between staff; culture shift for trainees away from medical hierarchy resulted in inside and outside groups. 02 Discussion question: "are we, who practice or train people in it [Open Dialogue approach], as power reflexive as it/we claim(s) to be?" p 03 |

| Combat discrimination | |
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| Elran et al., 2022 | Another benefit is the reduction of stigma and an embodied presence of hope and potential recovery: 'you physically make present what can be achieved just by being |

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| | there and living your life'. The practitioner presents an affirmative model of disability and potential for post-traumatic growth. Pg 10 |
| Florence et al., 2021 | [participants] "described how having family and others (therapists, case managers) in the meetings reduced stigma and helped them feel less singled out than in a one-on-one situation with a clinician". (p.1774) |
| Friesen et al., 2024 | Presence of a peer specialist "makes you feel less alienated" "it's much better hearing it from somebody who actually knows that you can get over it" Pg2 "It does help to know that there are people [who] have been througha little bit of what you might have been through. Pg2 how the peer specialist would say "we consumers" when talking to her son and that this phrasing may have helped him to "not feel like everybody is ganging up [on him]" and to "be acknowledged for who he was and how he felt" Pg2 |
| Stockmann et al., 2019 | Participants described positive changes in their relationships following the training... Changes included listening skills and compassionate understanding of others' perspectives, "I've been to conferences where service users are present and I've felt very attacked on a personal level. And, by the end of that week I saw them as a wonderfully charismatic group of a very kind, loving people who had a very strong voice, but important voice that hadn't been there before" (06). p315 |
| Twamley et al., 2021 | As Sarah noted "OD kind of brought us all together and put everything on the table". This awareness helped with mental health stigma: Alice: "I think [OD] kinda took that stigma away, that mental health isn't a bad thing, ... for (people) who had never dealt with it and had no experience of it". |
| Wates et al., 2022 | Learning about the concept of polyphony enabled participants to see their own voices as valuable. Ellen, a peer worker, felt the training had impacted on her role in the organisation, enabling her to influence change at a broader level. This appeared to represent an internal shift in the way she viewed her own value and contributions: "I suppose the... training then for me has helped to provide a framework to do that (...) I feel as though...my sphere of influence is much broader now than before" (Ellen, FG1). p795 |
| Wusinich et al., 2020 | Several enrollees commented that they felt like more than merely their diagnosis when they were with the Parachute team (Results, stigma & diagnosis, p. 1038), |

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| <p>Aaltonen et al., 2011</p> | <p>The role of the hospital changed rapidly after the out-patient unit in the hospital started working. During the first full year (1988) of this new activity, out of the total number of patients referred to the hospital by GPs or psychiatric out-patient centers, 40% were not hospitalized (Keränen, 1992); thus the out-patient crisis intervention organized by the unit appeared to be a successful alternative to in-patient care. p8</p> <p>The number of new long-stay schizophrenic hospital patients in the District fell to zero in 1992. p8</p> <p>It did not, however, mean that patients were treated in other in-patient institutions outside psychiatric treatment. p8</p> |
| <p>Bergström et al., 2017</p> | <p>Reliance on hospital services declined over time</p> |
| <p>Buus et al., 2019</p> | <p>Recipients of the intervention had fewer emergency psychiatric treatments (1 year follow-up: RR = 0.2, CI: 0.1-0.5; 10 years follow-up: RR = 0.5, CI: 0.3-0.8) and less use of general practitioner services (1 year follow-up: RR = 0.90, CI: 0.82-0.99; 10 years follow-up: RR = 0.85, CI: 0.78-0.92)</p> |
| <p>Elran et al., 2022</p> | <p>The OD approach aims to reduce hierarchy in various ways, especially by awareness of social differences and by promoting dialogue and polyphony of voices within the network and within the team. Pg 8</p> <p>The emerging Israeli model that acknowledges lived experience as an equal body of knowledge and practice can help break the glass ceiling constricting the professional development of peers within the mental health system. Pg 10</p> |
| <p>Friesen et al., 2024</p> | <p>Multi disciplinary teams/ third theme of team based peer support:- a variety of positive and mixed responses were collected about shared goals and different perspectives.</p> <p>"Other participants appreciated the team members' different contributions, with one commenting on the "good combination" of the peer who "gives a personal experience" and "the person [who] is a professional, you know, a social worker or clinician [to] interpret that" Pg3</p> <p>Strength of peer support - community connections: "A review of research on assertive community treatment teams (which offer "intensive, wraparound" care to individuals diagnosed as having serious mental illness) showed that peer specialists enhanced outreach, service engagement, and service users' social relationship" Pg 3</p> |
| <p>Gidugu et al., 2021</p> | <p>Clinicians described many ways in which flexibility was executed and proved beneficial. Often it meant families could contact a known clinician in a crisis instead of going to the hospital emergency department like in this case: "We went out a number</p> |

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| | of times and she said ‘If we didn’t have you guys, I would have called the ambulance and had him brought to the ER.’” (results p. 159) |
| Gordon et al., 2016 | OD network meetings were successfully integrated into the clinical program, with good client engagement. OD network meetings were held a mean of 12.53 times per client (range five to 28), and 66 of the meetings (36%) involved a psychiatrist. p1167 |
| Kinane et al., 2022 | reduced hospitalisation: 5 times lower The mean number of bed days for the service users receiving the POD service was 0.44 in hospital during their complete period of continuous care starting from their first referral to date of their final discharge. This seems a low figure and, as a reference point, traditional services reported a mean number of 2.24 bed days for service users accessing the locality CRHT/CMHT services over the same period; over five times higher. pg 9 |
| Pocobello et al., 2023 | Majority of the 72 OpenD services were working across outpatient/ inpatient modes, integrated at that level. Exceptions was outpatient services in private/third sector, which were mostly not integrated with inpatient services. p7 A small proportion (?) of OpenD services described as not integrated were based in hospital only p7 |
| Razzaque et al., 2015 | Staff(88%) and consumers(89.5%) agreed about the high value of immediate help and this lack of it in NHS (41/36%) (p934) |
| Seikkula et al., 2003 | "It has meant moving hospital personnel to crisis intervention work in the outpatient setting" p15 ODAP group patients had significantly fewer hospital days than API group patients. p12 |
| Seikkula et al., 2011 | Statistically significant reduction in number of days in hospital. |
| Sidis et al., 2020 | Prioritised community based family meetings/sessions |

| Ensure access and ongoing support | |
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| Florence et al., 2021 | The frequency of meetings was described as being jointly decided, with the treatment team being flexible (results, structure of care, (p.1776) “I think that also when they talk to each other and reiterate what we’re talking about and what they believe is going on, it makes us realize that we have been heard.” (results, reflections, p. 1777) |

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| | <p>The findings suggest that elements of Open Dialogue are highly consistent with the vision for recovery-oriented care, in that they are flexible, person-centered, encourage processes of negotiation, and highlight the importance of family and social supports in care. (abstract, p. 1771).</p> |
| <p>Gidugu et al., 2021</p> | <p>Organizational support was also critical to implementing the Collaborative Pathway in a practice environment where choices such as providing outpatient support rather than opting for hospitalization increased risk of liability. Given the organizational support afforded by Advocates Inc., clinicians felt comfortable pursuing treatment options that were not as drastic, stigmatizing, or traumatic as a hospitalization can be (Robins, Sauvageot, Cusack, Suffoletta-Maierle, & Frueh, 2005).</p> |
| <p>Heumann et al., 2022</p> | <p>...several OpenD principles were not simple to implement, especially “immediate help in case of crisis” (p10) Timely access was reported as “weak element of implementation: access is slow. Minority of German services (25%) sometimes/often offer help within 24 hours. (p8)</p> <p>“As the German health care system provides resources only for the treatment of individuals, involving his or her social network is not covered by insurance. This also applies to the additional time needed to organize network meetings and other administrative tasks related to implementation of the OD approach: “We do not meet regularly in the patient’s home environment. We don’t have the time for that. We meet too many people during the day for that.” (participant 5, psychologist) p08</p> |
| <p>Jacobsen et al., 2023</p> | <p>Because most network meetings were in the daytime, shift workers found it difficult to attend regularly, suggested holding meetings in afternoons and evenings. They thought this could ease the daytime workload, and access many members of the patients' social network after working hours. However, since the psychiatrists and psychologists only worked regular office hours, evening meetings were impossible, which was emphasised as negatively affecting ODNM p205</p> <p>Lack of sufficiently large rooms for network meetings also hindered ODNM. p206</p> <p>COVID-19 was a major obstacle to developing ODNM. During the lockdown restrictions, all network meetings and supervision sessions were cancelled. Digital meetings were tried out to replace face-to-face network meetings in some units. However, most clinicians were unfamiliar with digital meetings. Some reported that their units lacked the necessary equipment. p206</p> |
| <p>Kinane et al., 2022</p> | <p>Need based/ service user driven:</p> <p>POD model (which) is responsive to need as perceived and expressed by the service user rather than on the basis of appointment slots or capacity of clinicians in clinics</p> |

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| | <p>unless a service user declares their issue urgent in traditional services when they then receive duty worker support. Pg 9</p> |
| <p>Pocobello et al., 2023</p> | <p>46% of services were accessed by self-referral 87% services reported referrals by GPs Teams were available for OpenD practice median of 14 hour per week</p> |
| <p>Seikkula et al., 2011</p> | <p>Statistically significant reduction in Duration of untreated psychosis</p> <p>Duration of untreated psychosis (DUP) was 3.3 months during the first ODAP period compared to 4.2 months in the API period ($p = .069$), as shown in Table 4. It declined to half a month in the ODAP 2003-2005 group, the longest time being three months" p8</p> <p>All this [system changes & staff training] has led a shortened duration of untreated psychosis, and to first contact tending to be made at a younger age. The overall result is that psychotic symptoms are less entrenched than is the case where psychotic patients may have been psychotic for a year before first contact. P 10</p> <p>Some suggestions can be drawn that the long-term development of the system has changed the overall culture of the basic population in a more positive direction in relation to all psychiatric treatment. This is reflected in earlier initiation of treatment processes, often within prodromal phases, and in an increased openness in participating psychiatric treatment. p11</p> |
| <p>Sidis et al., 2020</p> | <p>Limited access times: "The public mental health system in this region operates between the hours of 9am and 5pm, in line with others in New South Wales. As service users improve in functioning and attain employment many find they can no longer continue in treatment. A number of [clinician] participants reflected on the cultural and technical challenges of introducing this model in their current workplace.p15</p> |
| <p>Sunthararajah et al., 2022</p> | <p>Contrasting experiences between groups in the OpenD program and the Treatment as usual program: OD - Described feeling supported in the knowledge that help was available if needed. P 3</p> <p>TAU - described difficulty in accessing services and feeling particularly invalidated when attempts to obtain support from services were denied regardless of a voiced need. As a result, participants acknowledged disappointment and feeling abandoned. P 3</p> |
| <p>Twamley et al., 2021</p> | <p>Results highlight organisational components of flexibility and availability as key elements of this new relationship, thereby underlining the importance of these challenging shifts in practice. (Discussion p. 497)</p> |

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| Wusinich et al., 2020 | <p>Four aspects of Parachute that came up frequently within interviews were the nature of network meetings, the accessibility of care, the speed and structure of the process, and the approach to psychiatric medication (reflections on the parachute approach, p. 1036)</p> <p>On accessibility: “The beauty of it is, they came to my home, and I really needed that at the time...I was not able to get washed, dressed and come to the office so, the visits to my home were paramount, really helpful” (Results, accessibility, p.1037)</p> <p>The availability of the teams was also mentioned frequently, with enrollees and network members emphasizing how important it was to be able to call or text Parachute team members when they were distressed. (Results, accessibility, p.1037)</p> <p>Enrollees’ experiences of having multiple providers on the Parachute team were generally positive (results, multiple providers, p. 1038)</p> |
| Aaltonen et al., 2011 | Extensive ongoing support was implicit in this study (and across the Finnish cohort studies); in many instances lengthy episodes of engagement, several years, and high numbers of network meetings. |
| Bergström et al., 2017 | For example: length of engagement? |
| Heumann et al., 2022 | Limited ongoing care options in (german) service funding model. |
| Kinane et al., 2022 | challenge(s) in continuing to work with people until they felt they had achieved recovery and were ready for discharge rather than the clinician and service design making those decisions as is traditional in the medical. Pg 10 |
| Seikkula et al., 2003 | All cohorts had ongoing (>3 years) support |
| Tavares et al., 2023 | A very strong negative correlation between the number of sessions and the LSNS6 score was found ($r = -0,896$; $p = < 0.01$) |

| Promote Psychosocial Wellbeing | |
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| Bergström et al., 2019 | <p>Many participants also emphasized their own actions in the gradual process of surviving. Other factors that brought relief were also often found outside the actual mental health treatment, especially in relationships with significant others:</p> <p>"Of course some people might benefit from treatment, I mean medication and stuff like</p> |

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| | <p>that, but for me the most important thing was my friends and my family. It's just that someone listens to you, is interested in you, and is present." p110</p> <p>The experiences interpreted as a psychosis were associated directly with the adversities that occurred in the current social environment. p110</p> <p>ROLE FOR PSYCHOSOCIAL INTERVENTIONS:</p> <p>Many participants also indicated that during the acute phase of psychosis they had significant difficulties in interacting with others since they were so deep in their own reality.</p> <p>Maybe without it (the psychosis) I wouldn't have those friends that are so important for me, but on the other hand, there are those negative things; I don't have a job, no education and, well, the coin always has two sides, right? p111</p> <p>SEE ALSO MULTI-AGENCY.</p> <p>People often seemed to make sense of such phenomena by linking them to a life-crisis, which formed an expected and inseparable reaction to actual life-events. Also, the factors that brought relief were narrated as deriving from real life, outside the actual treatment. p111</p> <p>The relative lack of the treatment-related narratives was somewhat unexpected, as the wish to get feedback on network-oriented treatment approach was expressed in the invitation. This might be partly due to the treatment approach itself, as it might have shift the whole initial treatment process closer to "real-life". Moreover, dialogical response to crisis might itself be beneficial (Seikkula, in press), enabling the creation of shared understanding and helping people to maintain their sense of agency. p112</p> |
| <p>Bergström & Seikkula., 2022b</p> | <p>in the majority of participants' life stories treatment-related narratives were de-emphasized as compared to other themes; rather than focusing on mental health treatment, participants underlined the support from their close networks as well as their own actions in the gradual process of surviving from psychosis.(892 discussion)</p> |
| <p>Bergström & Seikkula, 2023a</p> | <p>It is therefore possible that the risk–benefit ratio of neuroleptic medication treatment is different when applied to treatment naïve patients who, at onset, receive immediate intensive psychosocial support and need-adapted drug treatment. Consequently, there may be a substantial sub-group of people with diagnosed psychosis who would benefit from an alternative form of treatment (Bola et al., 2009),</p> |

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| | and/or a systematic dose reduction of neuroleptics (Wunderink et al., 2013). This is also supported by recent controlled studies, indicating that neuroleptics may not always be needed in the treatment of FEP, so long as intensive psychosocial support is guaranteed (Francey et al., 2020; Morrison et al., 2020). |
| Buus et al., 2022 | The current study suggested that the Open Dialogue approach may be helpful by activating different types of psychosocial support and transformative change for the young person. This included the relatively immediate support of network members turning up and participating in network meetings, and the more sustained support stemming from transformed interpersonal relationships in the family. (discussion, p.315) |
| Gidugu et al., 2021 | Organisational culture: Many clinicians mentioned that an important contributor to the adoption of the Open Dialogue model at Advocates Inc. was its compatibility with the recovery-oriented services and mission of the agency. (RESULTS, P. 160) |
| Gordon et al., 2016 | Two of families cited a need for supplementary social services. |
| Heumann et al., 2022 | "Overall, the survey demonstrated that a large number of facilities within various care contexts have implemented certain elements of OD. At the same time, several OpenD principles were not simple to implement", including "network perspective," p10; also limits to Tolerate Uncertainty and Dialogue p10 (ie having the person in include in planning dialogues.p06) |
| Jacobsen et al., 2021 | Participants described their new understanding of how OD can be a useful tool in the treatment process. p42 |
| Klatt et al., 2025 | Experiences of the traditional mental health care system motivate professionals and peers to seek alternatives p. 10 |
| Lorenz-Artz et al., 2023 | OD is not anti psychiatry but rather promotes its' transformation (towards person centred approaches). Pre conceived notions may be a barrier through those that consider OD to be anti other disciplines. |
| Olson et al., 2015 | Theme: Dialogical practice creating new opportunities: We all sat together in a circle. Closest to the door was a pale, blonde, and ethereal-looking woman, Hanna, age 20. She was still wearing her coat, a zipped-up, puffy, white parka with an imprinted snowflake pattern. The color in her face was drained. And, she seemed inert and her body, limp, as if her spirit was also gone. Next to her sat her somewhat older fiance, Jukka, a social worker, who by contrast, was dark-haired, wiry, alert, and watchful. His body was turned slightly toward Hanna. Jukka immediately sensed my need for a translator and was fluent in English. I had the counter impression that he was a caretaker of the first-order of magnitude. Birgitta started by asking about the history of the idea for the meeting. Hanna's |

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| | <p>therapist who had requested the meeting answered. She said that Hanna had told her that she wanted to kill herself. She explained further that Hanna had recently arrived from another part of Finland where she had been living with her family, which was very abusive. Hanna had fallen in love with Jukka, who had returned to his home in Tornio for work. She had left her town to come with him. He was the only person whom she knew in the area. Birgitta listened attentively to the therapist and then shifted her attention to Jukka. She asked whether he had any comments about the therapist's remarks. He hesitated. There was a silence. The atmosphere was still. I was struck by Birgitta's expression, which was open and intent without any suggestion that she was assessing or scrutinizing the couple. Instead, she was waiting for Jukka to answer. Then, he looked at Birgitta and said suddenly: "I get drunk and beat her."</p> <p>Upon hearing his confession, color rushed to Hanna's face, and she appeared immediately more alert. Although stunned at first, I, too, felt movement. A question came, which, a few minutes later, I asked of Hanna: "Which is more dangerous to you; your thoughts about suicide, or the beatings?" Hanna answered instantly: "the beatings."</p> <p>It suddenly became easy to see what Mary Catherine Bateson would say "[a] whole contextual structure." The man she loved and relied on to rescue her from her family was also violent and abusive at times, and yet she was isolated and wholly dependent on him. In a subtle way, the professionals created the conditions where Jukka's revelation could occur because of the way they embodied what Bakhtin calls "dialogicality," or Shotter (2004) translates as "withness." From the stammering, imperfect words, there was now a common language forming in which Hanna gained a voice. The intangible bind dissolved. She was no longer alone, but part of a conversation in which both she and Jukka were defined as each equally in need of help. At this crucial turning point, Jukka had thrown a lifeline.</p> <p>My understanding was that she was still kept overnight at the hospital for safety reasons. New possibilities for action opened up, with the option of a treatment program for men who are violent toward their partners. The same team was available to meet with the couple (and monitor the situation) for as long as needed. In contrast to leading with a psychiatric evaluation of Hanna as an individual, there was quite a different approach to the crisis that led to building a safety net—more than that, a sustaining net—that made the whole situation less dangerous. p721-721</p> |
| <p>Pocobello et al., 2023</p> | <p>Team diversity reflected breadth of psychosocial focus: teams were clustered as 'clinical' (33 teams, w 33% psychologists), 'nurse and OT' (30 teams w 24% nurse, 14% OT), 'multiprofessional', including more than 6 disciplines (17 no single discipline more than 15%), 'social work & support work' (16 teams, social work 47%, no psychiatrists, usually in non-clinical third sector).p8</p> <p>All clusters included peer support workers (8-11%). p7</p> |
| <p>Schubert et al., 2021</p> | <p>Clinically, participants reflected on instances where working dialogically resulted in valuable but unexpected clinical information emerging. This was attributed to increased awareness about how participants can unintentionally steer therapeutic</p> |

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| | <p>conversations and a subsequent resolve to be less directive. One psychiatrist recalled working with a suicidal adolescent and his parents, and the therapeutically counter-productive pressure he perceived to get the boy to report no risk.</p> <p>Shifting the therapeutic goals to focus on strengthening the family relationships to ensure the adolescent could approach his parents during times of high suicidality produced better therapeutic outcomes.</p> <p>Psychiatrists identified dialogical approaches as offering an alternative to medication and reducing their own anxieties about being identified as medication prescribers. Psychiatrists uniformly expressed frustration around navigating expectations to ‘fix’ human distress. Their identities shifted from one of resisting the perceptions of others as medication prescribers to one of embracing the role of facilitating dialogue as part of their professional identities. P154</p> |
| Seikkula et al., 2011 | SS reduction in residual psychotic Sx at 2 year follow up. |
| Sidis et al., 2020 | "Valuing ‘opening up’ and learning how to talk to each other - Family members expressed an appreciation for being able to speak to and hear from one another about things that felt important to them. A mother described her experience of opening up of dialogue following the first meeting with her daughter. As much as she [daughter] didn’t say much at the actual Open Dialogue, but I did make a note that, like, we just talked and talked in the carpark afterwards. (Participant 13)", p18 |
| Sunthararajah et al., 2022 | The confusion and need to make sense of experiences was more frequently endorsed by open dialogue participants than TAU participants. Several participants receiving open dialogue noted the collaborative experience of sense-making and feeling validated when medical professionals reflected using the participant’s own words. Pg 4 |
| Ulland et al., 2014 | The [service] premise was that the client should no longer be understood purely as a single individual who is isolated from her/his surroundings, but rather as a person within a context;...aiming to increase involvement of the social network and offer sufficient help and assistance in the client’s natural surroundings p413 |
| Wusinich et al., 2020 | Enrollees often spoke about how they appreciated that network meetings were not “overly clinical and strict on medication,” especially compared to other outpatient and psychiatric services they had received (Results, medication, p. 1037). |

| Integrate social services | |
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| Bergström et al., 2019 | <p>Role for health care & schools partnering. (Also belongs in psychosocial interventions)</p> <p>Another frequent theme was difficulties with peers, which included bullying and other negative phenomena within close relationship.</p> <p>"In elementary school I was bullied constantly. So much that I wanted to kill myself. I think my psychosis started then, though nobody realized it..."</p> <p>"I was bullied quite severely, and I think my mind somehow got stuck in the school premises..."</p> |
| Florence et al., 2020 | Inclusive of children and families, not just adult MHSs |
| Friesen et al., 2024 | <p>Integrated services:</p> <p>"Findings complement existing literature indicating that integrating peer specialists into mental health care teams helps generate hope for service users and family members by offering tangible proof that recovery is possible" Pg 3</p> <p>Strength of an integrated system - community connections</p> <p>"Peers' unique ability to engage with service users and connect them to a community may have a positive impact on dialogic or team-based care" Pg 3</p> |
| Hendy et al., 2020 | <p>Identified a problem with lack of integration, with potential for :</p> <p>...splitting between the open dialogue service and wider mental health services. It appears that the potential for this splitting is rooted within the lack of integration, owing to the significantly difference paradigms underpinning open dialogue approaches and more traditional mental health services. p99</p> |
| Heumann et al., 2022 | Fragmented acute Vs community support p8 |
| Holmesland et al., 2010 | <p>Theme: Identity and pressure on/changes to roles within multi-agency network meetings:</p> <p>Professionals in the Health Care Group claimed that practical issues were often brought up by these same professionals: "They can be prescriptive and much focused on implementing solutions" (HCG/1m/5). The Social and Educational Group confirmed this by referring to the pressure they felt when either the individual seeking help or their family called for immediate help: "Now it was a question of what we had to offer. They really demanded that I come through on this" (SEG/1m/1).</p> |

Professionals in the Health Care Group search for role release by reducing the impact of therapeutic skills and altering terms denoting their position. Also for those without any previous experience in social network interventions this was possible. On the contrary, members of the Social and Educational Group emphasized communication guided by the help seeker and role expansion. The stereotypes that become apparent represent difficulties transforming their professional roles according to transdisciplinarity. p9

Theme: Challenges in understanding roles in Multiagency approaches. "Fighting against stereotypes".

Others claimed that numerous problems arose when several agencies were involved but in which vague role and responsibility structures occurred.

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Stereotypical positions and workplaces were still associated with obstacles, e.g., when teachers were met with traditional expectations: "When I'm together with teachers it's completely different. Then there's usually a lot of talk about school" (HCG/2m/1). The other group confirmed these observations: "If the meeting is with Child Mental Health Services or the Family Center, they talk about feelings, about being in a process. If they come to Child Welfare Services, schools, or drug addiction services, they expect us to do something. Not just talk, talk, talk" (SEG/2m/1). p9

Theme: Role identity as barriers to teamwork in initial meetings

Professionals in the Health Care Group demonstrate an increased sense of insecurity linked to mistrust in others. They place professionals in the other group in a marginalized position, pointing to their unfamiliarity with medical terms in which a decrease in effectiveness emerges. However, the Social and Educational Group place themselves in the periphery, pointing to the health care sector as representing the principal paradigm.

"It's the traditions we're a part of that determine how things happen. I don't feel like there's been very much change" (SEG/1m/3)P10

Theme: Progress over time:

The Health Care Group's example regarding mutual confidence and trust illustrates the importance of becoming familiar with partners in order to achieve transdisciplinary engagement. Nevertheless, some professionals are still being marginalized through questioning their competence. Professionals in the Social and Educational Group demonstrate practical implications because of diverse understandings and thus, the need of respect for eclecticism in order to achieve collaborative processes which will lead towards transdisciplinarity. p11

Theme: What is needed for positive interagency collaboration?

The processes generated in teamwork find the importance of the professionals'

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| | personalities when taking part in close collaboration to be a critical factor. Moreover, working in a transdisciplinary way increases the professionals' knowledge about each other, both professionally (how they understand collaboration in terms of their position) and individually (their personal values and beliefs). Consequently, transdisciplinary collaboration may potentially contribute to a stronger culture of transformation, compared to interdisciplinary collaboration. p12? |
| Olson et al., 2015 | OpenD as a humane system with therapeutic engagement and social supports foregrounded and pragmatic use of medications. Olsen ref? |
| Razzaque et al., 2015 | important factors included: Multi-professional involvement Interventions across the system; Shared ownership |
| Seikkula et al., 2011 | The second major aspect involves the importance of the social network functioning collaboratively. In each new contact those professionals who are seen as relevant are invited to joint meetings. As one element in this, the employment authorities are invited to joint therapy meetings, in order to plan rehabilitation support for clients if this should be necessary. The young patient is regarded as competent to remain in active social life, even if he/she experiences crises and possible symptoms... In the open dialogue treatment system of western Lapland, young patients are encouraged to stay within the social context, and this seems to encourage a return to active employment and studies. p 10-11 |
| Stockmann et al., 2019 | Some spoke of making valuable interpersonal connections during training. A sense of community was seen to aid learning through increasing perspectives making the training and practice less daunting. Learning about other trainees appeared to help empathetic understanding of others' circumstances and generated trust, which in turn allowed for some trainees to disclose more difficult aspects of themselves. |
| Ulland et al., 2014 | Three programs sought to integrate sectors in dialogical team: one integrated CMH with service user organisations and two integrated Mental health with Education for children and families, all with links to university and local municipalities p?408 |

| Ensure ongoing support (join this to 'ensure access') | |
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| Aaltonen et al., 2011 | Extensive ongoing support was implicit in this study (and across the Finnish cohort studies); in many instances lengthy episodes of engagement, several years, and high numbers of network meetings. |

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| Bergström et al., 2017 | For example: length of engagement? |
| Heumann et al., 2022 | Limited ongoing care options in (german) service funding model. |
| Kinane et al., 2022 | challenge(s) in continuing to work with people until they felt they had achieved recovery and were ready for discharge rather than the clinician and service design making those decisions as is traditional in the medical. Pg 10 |
| Seikkula et al., 2003 | All cohorts had ongoing (>3 years) support |
| Tavares et al., 2023 | A very strong negative correlation between the number of sessions and the LSNS6 score was found ($r = -0,896$; $p = < 0.01$) |

| Include consumers & families in design (join this to ‘Lead by Lived experience’) | |
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| Hendy et al., 2023 | ?Codesign used in "The first national multi-site trial evaluating Open Dialogue in English NHS mental health services – Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness"p2 |
| Heumann et al., 2022 | <p>The addition of peer support providers in the open dialogue team:(Results, peer support, p. 1038).</p> <p>Experiences with peer specialists were overall very positive, with many interviewees commenting on the importance of having someone there who was relatable.</p> <p>Others spoke about how the role of the peer specialist was unique and could not be provided by someone else: “It’s much better hearing it from somebody who actually knows that you can get over it. You know, you can like achieve what you wanna achieve and actually recuperate”</p> |
| Kinane et al., 2022 | Co-production/ citizen control is fundamental to POD which is democratic, collaborative and sees each person in the network meeting as an equal or potential partner in recovery. In a service user led report it was identified that most service users who took part in the project which gathered their views felt that social approaches to mental health, which take account of the whole person and wider societal issues affecting them, are the most helpful. pg 8 |
| Sunthararajah et al., 2022 | <p>Having a voice in treatment planning and acknowledged the benefits of a transparent and collaborative process.</p> <p>Some participants acknowledged the importance of having a choice; that is, a</p> |

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| | choice in being able to decide the frequency and location of meetings and a choice in how their supportive network were involved in sessions. P 4 |
| Ulland et al., 2014 | Developing a collaboration area that includes service users in all stages of the projects was an essential implementation factor p 410 |
| Wusinich et al., 2020 | <p>The addition of peer support providers in the open dialogue team:(Results, peer support, p. 1038).</p> <p>Experiences with peer specialists were overall very positive, with many interviewees commenting on the importance of having someone there who was relatable. 1038</p> <p>Others spoke about how the role of the peer specialist was unique and could not be provided by someone else: "It's much better hearing it from somebody who actually knows that you can get over it. You know, you can like achieve what you wanna achieve and actually recuperate"1038</p> |

| Support families & carers | |
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| Buus et al., 2022 | <p>The findings indicated that clients and families appreciated the Open Dialogue approach for its transparency and its ability to interrupt and mediate difficult family communication.(discussion p. 314)</p> <p>While network members generally appreciated the dialogical approach, it was also occasionally described as uncomfortable and anxiety provoking(discussion p.314). The current study focussed on how the Open Dialogue approach added to the families' psychosocial workload. They reported increased interpretative, psychosocial, and practical work before, during and in between meetings. However, the intensified work significantly strengthened the support of the young person, and, in some situations, led to sustained changes in family communication and interpersonal relationships. (theme 3, p.313)</p> |
| Dawson et al., 2021b | More support was provided to families: "At the end of the data collection period, the team had completed approximately 49 network meetings." p384 |
| Florence et al., 2020 | <p>implementing OpenD on a background of family inclusion: "One of the agencies had worked with systemic family therapy for many years" p686</p> <p>"Participants reported improvement in the relationship with clients and families, and among colleagues" p687</p> |
| Friesen et al., 2024 | The presence of a peer specialist facilitated empathy for a family/carer or peer specialists' ability to engender empathy among family members: |

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| | <p>"There was a time when I wanted to talk about medication, and the peer specialist, he understood why [the enrollee] wouldn't want to talk about that with her family . . . 'cause he went through something similar . . . and I felt a little bit . . . excluded at that point. But I also tried to understand, to put myself in her shoe"Pg 3</p> <p>Because peers are not often integrated into family therapy, the combination of Open Dialogue and peer support may support this underacknowledged and important benefit. Pg 3</p> |
| <p>Gordon et al., 2016</p> | <p>In qualitative interviews, participants and family members appreciated the openness and transparency of the approach and felt part of decision making. They felt cared for rather than being "on the clock" and appreciated that treatment was not just medication focused. Families cited meeting in their homes and observing the clinicians' "reflections" as promoting a collaborative atmosphere. (p1167)</p> |
| <p>Hendy et al., 2020</p> | <p>Both clients and network members reported they felt listened to and their experiences validated...</p> <p>However, for others, such open and unrestricted dialogical approach was experienced as challenging, especially when exploring past difficulties and traumas in such an open way, within the network. One family member reported that, due to the dynamics within their network, the meetings would often leave her feeling very emotional:</p> <p>Well we just spoke about the past [...] I usually end in tears every week I'd go home in floods of tears and dread the next meeting. And that was the same every time. (Network member) p100</p> |
| <p>Heumann et al., 2022</p> | <p>Network is included sometimes/often >75% of OpenD services, at least 3 network meetings sometimes/often for >50% services; continuity of team for 85% services p8</p> |
| <p>Jacobsen et al., 2023</p> | <p>including families:</p> <p>'What really touches me is when new narratives enter the room ... it can make me cry ... because you can see the changes that happens'.</p> <p>This was confirmed by the supervisors. One supervisor said, 'The success stories clearly engage'. These stories inspired the clinicians themselves as network leaders but also their colleagues who were unfamiliar with ODNM who saw the positive response and development in the families.</p> <p>Patients were also seemed inspired when joining network meetings with their families. One clinician said, 'Patients find that network meetings are important to their families. They see that their families need this'. Another said, 'The patients' relatives are excited to be involved. They've often felt uninvolved. Being involved is a big win, which can affect family relations a lot'. However, a constraining factor was challenging network meetings where emotions and disagreements were strongly expressed. p205</p> |

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| | Timing challenge in inpatient context: "The logistics of planning and arranging network meetings were underlined as a constraining factor for ODNM. Contacting the patients' social network and treatment team to find a time suitable for everyone was time consuming. If time passed between patients' approval of a network meeting and actually holding the meeting, some patients and their families lost interest." p205 |
| Kinane et al., 2022 | The 6 month score of 48.0 in our study shows a marked increase in the how carers perceived they were being supported by the POD team. It is also striking to note that at baseline the POD participants record a score of 41.67 suggesting that carers acknowledged the initial support provided by the POD service even at this early stage of the intervention. Pg 9 |
| Lennon et al., 2023 | the promise of Open Dialogue was well aligned with other family-oriented initiatives in the service and thus became part of larger local service initiatives.p98 |
| Olson et al., 2015 | In US need to re-invest in engaging families, family therapy and relational/systemic understandings in MH care. "The engagement of the social network and continuity of the team is designed to generate a safe, healing, relational matrix" p725 |
| Pocobello et al., 2023 | Family caseload per OpenD worker - median was 15.5 (p ref?) |
| Pocobello et al., 2024 | One possible hypothesis for the initially higher scores given by family members is that network meetings provide immediate relief by offering support and a sense of being heard, which alleviates their sense of isolation. In contrast, the impact on the well-being of the patient in crisis may take longer to manifest, as the therapeutic process needs time to unfold and address deeper issues. p11 |
| Razzaque et al., 2015 | Staff (92%)and consumers (92%) agreed re priority of family/social network perspective, and lack in NHS (42/37%) Theme included: Collaborative relationships Non-medical dialogue Meaningful involvement of the family system |
| Seikkula et al., 2003 | Significant difference occurred in the number of family meetings in that the Comparison group had fewer meetings than API group (p <.001). The number of meetings varied from 6 through 55 in the API group, from 0 through 99 in the ODAP group and from 0 through 23 in the Comparison group |
| Sidis et al., 2020 | Staff were told by families that they 'felt heard' in the sessions : "clinicians noted the shift in focus from collecting information and formulating, to generating dialogue. Some described how their engagement in this different way of practicing was supported by reports from families on their experience of being heard." p12 However; "Another participant described how carers could also struggle with |

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| | <p>tolerating uncertainty: 'Some of these families just want direction, and answers, and for us to be really clear' (Participant 8). Tensions between Open Dialogue concepts of tolerating uncertainty and collaborating with families, and the pressure to take an expert stance and direct the situation, was challenging for clinicians..." p 14 .</p> <p>And young people and family members were hesitant for family therapy:"Hesitations about doing family therapy - Families described some trepidation about entering into therapy together. Two sub-themes here were anxiety about meeting together and expressing emotion, and dealing with conflict. Anxiety about meeting together and expressing emotion. Both of the young people interviewed expressed nervousness about the family meetings. Participant 15, a 21-year-old male user of the service describes his concerns: I was really anxious, I um, was very fidgety and I didn't, I was like, completely uncomfortable because I didn't want to open up and I knew that it would, it could like, get very nasty between us... (participant 15). p 17</p> |
| Wates et al., 2022 | <p>Participants also described having developed a relational understanding of distress, and a greater appreciation of the importance of involving social networks. p794</p> |
| Wusinich et al., 2020 | <p>Importantly, several enrollees reported that the process of engaging in network meetings improved lines of communication within the network, and improved relationships between those enrolled and those in their network. This suggests that the model may produce a sort of ripple effect, in which the program's benefits extend to both enrollees and network members. This intuitive and yet infrequently discussed benefit aligns with research by Bøe et al. (2015), which also found that experiences with the dialogical model can have a significant impact on relationships between individuals in distress and their network members, leading to new forms of understanding (Discussion, p.1039)</p> |

| Achieve treatment and recovery outcomes (includes clinical, recovery and population outcomes) | |
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| Aaltonen et al., 2011 | <p>CHANGE IN HOSPITALIZATIONS</p> <p>By 1995 almost all the psychiatric staff were trained psychotherapists... To establish the best possible working conditions for the trained staff, so that they could put their training into practice, the system of treatment was arranged so that mobile, multi-disciplinary case-specific teams (consisting of both out-patient and in-patient staff) were established in the psychiatric hospital, and in all the out-patient centers. p9</p> <p>In parallel with this process, the number of new long-stay schizophrenic inpatients fell to zero – the only psychiatric catchment area in Finland in which this occurred (Tuori, 1994)p9</p> |

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| | <p>This was not replaced by more frequent shorter hospitalisations.</p> <p>CHANGE IN DIAGNOSTIC PATTERNS</p> <p>The incidence of all schizophrenic disorders (schizophrenia and schizophreniform psychoses) significantly DECREASED. p8</p> <p>However, the decrease in this Psychosis group occurred only in Schizophrenia. The incidences of the other non-affective psychoses and prodromal state did not change significantly. The Incidence of brief psychotic reactions increased. p8 (shorter more transient episodes vs chronic?)</p> <p>The mean annual incidence of schizophrenia decreased highly significantly during the period in which the new system of treatment became well-established, in comparison to the previous situation, Fewer psychiatric crises developed into schizophrenia. p9</p> <p>"It can thus be argued that the ODA has been helpful – if not in actually preventing schizophrenia, at least in moving the commencement of treatment in a less chronic direction" p9</p> |
| <p>Bergström et al., 2019</p> | <p>There are indications that needs-adapted and network-oriented treatment approaches – in which it is possible to collaboratively create and maintain the personal meanings of experiences – are associated with promising long-term outcomes in the treatment of psychosis. p113</p> |
| <p>Bergström & Seikkula, 2023a</p> | <p>OD had a smaller proportion of people with dispensed benzodiazepines, antidepressants, and neuroleptics over the entire 10-year follow-up. p5</p> <p>In OD, there were more people with no medication dispenses p5</p> <p>Via OD it may be possible to detect a subgroup of people with acute psychosis who do not need long-term neuroleptic treatment. It is possible that this improves the functional outcome for some patients, given that high cumulative exposure to neuroleptic medication has been associated with many adverse effects. p7</p> <p>Those people who had received more neuroleptics were more likely receiving treatment for metabolism and cardiovascular disorders at the end of the follow-up, and they had also spent longer periods in hospital and on disability allowances. (However, this could have been due to confounding by indication, since persons with more severe symptomatology – and thus poorer outcomes – could be expected to have a higher cumulative exposure to psychiatric medicines over the long follow-up.)p7</p> |

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| Buus et al., 2019 | OpenD group 26% less unemployment than comparison group |
| Friesen et al., 2024 | <p>Recovery through hope/ inspiration: described how their peer specialist provided a model for recovery: "There's one, when you see him, he's healthy . . . and he's strong. He organizes the whole program and stuff. That's how I wanna live. That's how I wanna be". Pg 2</p> <p>Vocation/ growth: This enrollee had also signed up for a peer training program and was receiving a reference from their peer specialist. A network member spoke about how their son was inspired by a Parachute peer specialist to visit a community center. Pg 2</p> |
| Gordon et al., 2016 | <p>Clinical outcomes were generally positive. Linear mixed-model analyses showed a significant positive change in symptoms, functioning, and need for care, as measured by the BPRS (p,.001), BASIS-R (p5.002), and SCLFS (p,.001), respectively; average work or school hours per month (p,.001); and hospital days (p5.023). The change in DSES score approached significance (p5.07). Nine of 14 participants were working or in school at one year. Of note, four individuals had six short-term psychiatric hospitalizations (two involuntary)(p1167)</p> |
| Kinane et al., 2022 | <p>Clinical symptoms, experience of service, wellbeing, impact on daily routine and carer support: improvements from the baselines score at the 3 and 6 month time point. Pg 6</p> <p>Clinical Outcomes POD clinical outcomes are encouraging with all clinical measures of service user outcomes showing benefits in terms of recovery and function from three self-report measures and one clinician-rated measure. All four measures show improvements from the baselines score at the 3 and 6 month time point with statistically significant improvements recorded in all the outcomes. Pg8</p> |
| Pocobello et al., 2024 | <p>Over a 12-month period, the application of OD principles in network meetings correlated with significant positive changes in the Global Assessment of Functioning (GAF), Clinical Outcomes in Routine Evaluation (CORE-OM), and the Lubben Social Network Scale (LSNS). These findings are particularly noteworthy given the diverse and comprehensive measures employed to assess therapeutic progress.</p> <p>The use of a linear mixed-effects model provided robust insights into the longitudinal data, revealing a substantial effect of time on all assessed outcomes. Notably, GAF scores showed a significant increase, suggesting improved psychological, social, and occupational functioning among participants. Similarly, CORE-OM scores indicated a decrease in psychological distress and an enhancement in well-being, which aligns with the core objectives of OD in promoting recovery through dialogue and network involvement. Additionally, LSNS scores demonstrated an increase, reflecting</p> |

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| | strengthened social networks and support systems, which are vital for sustainable mental health recovery. |
| Seikkula et al., 2003 | Comparison of the Western Lapland API and ODAP groups to the Comparison group showed that in the first two groups hospitalization was shorter and neuroleptics were used in fewer cases |
| Seikkula et al., 2011 | <p>The group of psychotic patients in the 2000s seemed to be different, in the sense that the patients were younger and included fewer schizophrenia patients (Table 2). The duration of untreated psychosis had declined to half a month, compared to 3.5 months during the 1990s. Second, differences occurred in the remaining psychotic symptoms, with fewer symptoms in the 2000s than in the 1990s. In other ways the outcomes – including the employment status – remained the same, so that more than 84% of the patients were capable of returning to active social life, or were in full employment, or studies. However, in the third period the relative proportion of brief psychotic episodes was higher than in the first two groups. Even taking account of this bias, the social outcome for non-affective psychoses seems to remain positive. p10</p> <p>Under the new system, the families are immediately invited to joint meetings in all cases of crisis. This has led to a positive change in the whole culture of using mental health services. This is reflected in a general trend towards earlier initiation of treatment. p10</p> <p>Over the 20-year period in question, the number of psychotic patients and the incidence of schizophrenia cases seem to have declined p11</p> <p>It appears that the open dialogue, with its early engagement with mental health problems, and retention of family involvement and the social network, plays an important role in the prevention of further deterioration into schizophrenia. p11</p> |
| Tavares et al., 2023 | <p>The GAF showed participants' scores of global functioning increased from baseline (M = 57.71; SD = 10.468) to the last (M = 65.71; SD = 11.398); [t(6) = -2.506; p = 0.023; g = -0.887], with statistical significance and Hedges' g large effect.</p> <p>The BSI showed pathological symptom scores decreased from baseline (M = 1.585; SD = 0.744) to the last period (M = 1.078; SD = 0.350); [t(6) = 1.921; p = 0.052; g = 0.631], marginally non-significant statistically.</p> <p>The CORE-OM test results showed participants' psychological distress symptom scores decreased from baseline (M = 1.899; SD = 0.883) to the last period (M = 1.252; SD = 0.343); [t(6) = 1.712; p = 0.069; g = 0.562], which was non-significant statistically.</p> <p>The LSNS-6 test results showed that the participants' social network size/support increased from baseline (M = 12.429; SD = 5.533) to the last period (M = 13.429; SD = 4.315); [t(6) = -0.548; p = 0.302; g = -0.194], even so, non-significant statistically.</p> |

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| Uehling et al., 2024 | aligns with the contemporary trend towards recovery-oriented and community-based approaches |
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| OTHER notable system impacts | |
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| Anestis et al., 2024 | <p>TRAINING AS A MECHANISM FOR CULTURE CHANGE.</p> <p>OD training seemed to reflect these values and was thus not perceived as a didactic process but more of an experiential introduction to a new culture, a new way of understanding mental health and as a prerequisite for the ‘cultural shift’ needed for OD practice: “...it did prepare us with the basic tools and skills and whatever. But more so for me, the other thing it did was to try to make it a way of life. For me I see the Open Dialogue more as a culture, it’s a way of being that is just very different from how services are organised. So yeah from that point of view, you know it prepared me for a new culture, a new approach and a new understanding, a new way of relating to others and to the people who have used our services.” (P1) p.4</p> <p>Training was sometimes experienced as a process of “unlearning.” “I think training is the wrong word in a way, because it’s actually we’re not trained, it’s just, it’s stripping away if anything, stripping away how we were trained.” (P2) p.4</p> <p>Because of OD’s focus on ‘being with’ people in crisis, tolerating uncertainty, developing relationships and generating dialogue, participants discussed how they had to revisit their previous professional training as well as their own values and beliefs about mental healthcare. P.4</p> <p>TRAINING AS TRANSFORMATIONAL - AND CHANGING THEIR WORLD VIEW</p> <p>For this participant, the introduction to OD was an interesting challenge that contested their previous ideas about learning and led to personal transformation. This sense of a personal transformation as an outcome of OD training was a recurring theme amongst participants which was perhaps needed for participants to embrace the ethos of the approach. p5</p> <p>When asked about their experiences of the OD training, the responses predominantly revolved around the impact of the training on a personal level and less on the acquisition of skills. Participants described their overall training experience as ‘transformative’, as a process that “cannot not change you” (P5), leading to radical changes in their worldview and the way they perceive themselves and relate to others. The transformative impact of the training was largely associated with its strong emphasis on self-work activities and reflective processes: “I’ve changed, I’m massively changed as a person. And just acknowledging how important those people are and we did like the genograms and ... just acknowledging how your family and your network and people around you have created who you are and I’ve always thought about that, but it’s never been really brought to the forefront of my mind.” (P2)</p> <p>WHERE OD IS DELIVERED ALONGSIDE TAU, OD PRACTICE IS MORE LIKELY TO BE IMPACTED.</p> <p>“Staffing is shared across both teams and inevitably if there’s something going on in one team whether it’s resources or something else, it impacts on the OD team and</p> |

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| | <p>more importantly the culture of the team, the two teams seep, you know there is a little bit of seepage across that interface in terms of the culture. More so from TAU over into OD, because that's the, that's what we're surrounded with in the organisation, it's a harder force to resist in terms of becoming less dialogical in our work." (P17). P7</p> <p>LIMITATIONS OF TRAINING FOR SUSTAINING CULTURE CHANGE</p> <p>Although OD training was effective in initiating the process of culture change (at least within the OD teams that were formed), this process may not have been adequately supported on an organisational level. Lennon et al. (2023) argue that the implementation of humanistic approaches, such as OD, in conventional mental health services requires complex systemic change and adaptive leadership that is committed to change and managing the consequent organisational tensions. p8</p> <p>Organisations who aspire to introduce OD to their services should be cognizant of the need to support practitioners by being committed and ready for change. This could include appropriately managing resources in a way that reflects the demands of dialogic practice (e.g., having two practitioners in every network meeting) and reviewing current policies and protocols which might contradict dialogic practice (e.g., emphasising the need for diagnosis and standardized risk-assessments). p9</p> |
| Bergström et al., 2017 | Long term service use was analysed for 65/135 people treated in the study period. 40 were excluded as not resident in the area and 11 had died. |
| Bergstrom et al., 2018 | Over the entire follow-up, the figures for durations of hospital treatment, disability allowances, and the need for neuroleptics remained significantly lower with OD group. No difference between groups in mortality rates, over the entire sample 55% of deaths occurred within 10-years of onset and 31% of those died by suicide. |
| Bergström & Seikkula., 2022a | At the end of the follow-up, more people from CG than from OD were still receiving psychiatric treatment and disability allowances due to mental health disorders. No difference was found in mortality and suicide rates (Table 2). The administration of treatment outside OD predicted ongoing treatment and disability allowances at the end of the follow-up (Table 3). E-values indicated that it would require moderate- to-substantial confounding to render the findings non-significant. In CG, the average costs of psychiatric treatment and mental health disability allowances were significantly higher than in OD. In OD, the total and average basic social assistance expenses and other disability expenses were higher, but not at a statistically significant level (Table 2). The cumulative 10-year cost of all new adolescent patients who came to the treatment during one calendar year was 439 euros per capita in OD and 539 euros per capita in CG (Table 4). When all the outpatient visits under OD were calculated at a higher price the figure was 485 euros per capita (see sensitivity analysis in Section 2.4) |
| Bergström & Seikkula, 2023b | The association between service type (OD vs. standard care) and 5-year suicide hazard ratio (HR: 0.8, 95% CI 0.4–1.8, p: .6 > Bonferroni corrected p-value .025) was not statistically significant. After adding potential confounders (age, substance abuse, psychosis, mood disorder) into the model, the effect of service type remained statistically non-significant |
| Bergström & Kurtti, 2023 | treatment commenced under OD was a statistically significant predictor (p < 0.001) of increased time to an out-of-home intervention (adjusted hazard ratio [aHR]: 0.61, |

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| | <p>95%CI: 0.52–0.72) as compared to CG. Out of those adolescents who were discharged from their first out-of-home intervention, 57 (36 %) in OD and 7607 (48 %) in CG were re-admitted or re-placed outside the home at some point during the follow-up. OD was associated at a statistically significant level with an increased time to a second out-of-home intervention after discharge from the first out-of-home intervention (aHR: 0.75, 95% CI: 0.58 –0.96, p < 0.05). Over the entire follow-up, the proportion of adolescents who had out-of-home interventions was significantly lower in OD as compared to CG.</p> |
| <p>Bergström & Seikkula, 2023a</p> | <p>PHYSICAL HEALTH EQUITY The OD-based treatment for FEP is associated with a stable reduction in treatment via psychiatric medications. This may minimize the risk of iatrogenic medication effects, and thus partially explain the favourable outcomes reported in earlier studies. p8 Limitation/challenges: It should be noted that OD did not include systematic deprescribing practice and it may be challenging to discontinue already-commenced neuroleptic medication (Horowitz et al., 2021), especially if neuroleptic maintenance treatment has been going on for many years. p7</p> |
| <p>Buus et al., 2019</p> | <p>Patients receiving Open Dialogue intervention had more psychiatric outpatient treatments at one year of follow-up (RR = 1.2, CI: 1.1–1.4) than the comparison group, but not at subsequent follow-ups</p> |
| <p>Buus et al., 2023</p> | <p>Theme: Flexibility of OpenD practice as a way of navigating systemic barriers. In the following data extract from focus group #4, Libby reflects on initially having aspirations for making organizational changes in line with the seven principles that were impossible to implement, as they were outside her sphere of influence. Libby: I feel the way we've embraced Open Dialogue within our service is like family therapy, but with a bit more of a dialogical approach. Because it's been difficult to implement the systemic changes, because of all the silos within our service and all the barriers in terms of instantaneous care and continuity, psychological continuity, and all of those things. So I feel like we've embraced family therapy, and then we've put a dialogical slant on it, in terms of "let's kind of keep the agenda open" and "let's kind of make sure that it's not hierarchical" and "let's kind of maybe not be so much in control in terms of our stance." But it feels to me, more at the end of the training, like "oh, this is family therapy." P998</p> <p>The theme of "extending possibilities by holding ideas lightly" referred to a position where participants prioritize flexibility in their treatment approach to their work with families sometimes at the expense of fidelity to Open Dialogue. In addition, "holding ideas lightly" functioned to legitimize participants' own personal understandings of Open Dialogue texts and practices and allowed them to integrate and disregard particular aspects of Open Dialogue in line with the participants' existing treatment philosophies and local clinical practices. P999</p> <p>Participants negotiated how to describe the learning processes. One position was to see the Open Dialogue training as "unlearning," as it entailed a major shift away</p> |

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| | <p>from a conventional treatment modality to working systemically/dialogically. Another position was to think of Open Dialogue as complimenting existing practices that had proved to work well rather than replacing them. Proponents of this latter position ultimately introduced the “holding ideas lightly” metaphor, which allowed them to make use of the most appropriate ideas in a concrete situation.</p> |
| Dawson et al., 2021b | <p>Somewhat successfully introduced network meetings, but none of the system changes also needed to support/ integrate Open Dialogue, beyond those isolated meetings.</p> <p>And inpatient settings are challenging environments in which to implement recovery oriented practices.</p> |
| Elran et al., 2022 | <p>Polyphony within the network is represented through different voices and viewpoints of the participants. The OD team aims to promote dialogism within the network by inviting different voices to be heard. Pg 8</p> <p>The dialogue invites participants to openly explore different possibilities within themselves, thus allowing new meeting points with each other. Pg 9</p> |
| Florence et al., 2020 | <p>Faced many systemic (funding and structural) implementation challenges and barriers</p> |
| Gordon et al., 2016 | <p>Conclusion: Results of this feasibility study suggest that the OD model can be successfully integrated into an established U.S. out-patient and crisis program, with satisfaction for participants, families, and staff, and that the model appears to be reasonably safe and clinically effective when implemented with appropriate risk assessment and crisis team availability. However, serious barriers to implementation remain. Training costs and time were substantial. We had training from an expert who worked relatively nearby, and we had grant support. Shorter training models are being created, implemented, and tested nationally and internationally. p1168</p> |
| Heumann et al., 2022 | <p>Lack of whole of service OpenD models. High level of interest from grassroots, 500+ people completed foundation training, but the lack of integration within an institution was related to a lack of support from the management level.</p> <p>"Some interviewees found that rolling out OpenD in too short of a timeframe or with an overly radical desire for change represented additional obstacles promoting reservations from the outside "If you didn't call it Open Dialogue all the time, if you didn't sell it as the miracle concept from Finland, so to say, it would not scare people off so much [...]” (participant 16, psychologist)" p10.</p> |
| Jacobsen et al., 2021 | <p>Theme:Challenges with leadership buy-in & support for training and implementation. The project group suggested supervision groups for leaders similar to professionals’ supervision groups to commit leaders and provide them a better understanding of the OD approach. This idea was overruled by leaders, who argued that leaders had no time to participate in the implementation process. As a result, the commitment from management might have been lacking throughout the training program. p45</p> <p>Implementation of new approaches has advantages when anchored to leadership as well as staff. With lack of support from their leaders, implementation depends on an individual, which might be a difficult and lonely journey. p45</p> <p>We experienced, during the training program, that obstacles in committing</p> |

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| | <p>professionals to participate are multifactorial; leaders have to clarify professionals' interest in participating in a training program, and they have to make it possible to participate; working shifts have to be taken into account, and someone must take over professionals' urgent tasks. Without a strong commitment to implementing OD, the implementation will be difficult to manage. Generating dialogical practice requires shared understanding of OD and collaboration between professionals and among leaders. p45</p> <p>Theme: Need for multidisciplinary training. As most participants in this study had a nursing education, it seems reasonable that nurses may benefit from OD training. However, in mental health practice, several professionals work together, so it might also be an advantage for other staff to join OD training as part of their collaboration. p45</p> |
| <p>Jacobsen et al., 2023</p> | <p>Implementation challenges: This project implemented network meetings into program in acute inpatient units - unclear to me which people were included in the Networks.</p> <p>"Three of the six units had major ongoing reorganisation of their services. This was highlighted as a constraining factor for ODNM. One unit changed both leaders and project members several times during the eighteen months. Many clinicians considered themselves as crucial in developing the ODNM. They called themselves 'passionate enthusiasts' to explain their commitment. Several clinicians stated that, without the enthusiasts, the development of ODNM would die. One explained, 'I'm worried about the ODNM. We've seen a lot of approaches come and go. We need passionate enthusiasts to keep it going, who want it to be part of the treatment programme'. New ideas evolved during the development process thanks to the clinicians. One unit started weekly group teaching and dialogue with patients using ODNM as part of the unit's regular treatment programme.</p> <p>Theme: "Passionate enthusiasts... Patients learned about the approach, and those who had attended network meetings shared their experiences and inspired other patients to invite their families to meetings. One clinician said, 'When a patient talks positively about his experience it's more important to other patients than if we talk about it'. Another unit changed the admission procedure by conducting network meetings instead of traditional entry interviews and found this to be a good start for collaboration between patients, their families and the clinicians. A third unit started using reflective talks as part of information meetings for relatives and families." p204</p> |
| <p>Kinane et al., 2022</p> | <p>Reduced symptoms, better functioning with service satisfaction are highly desirable goals of any mental health service and even small improvements can have a clinically valuable benefit for those in receipt of and providing services in terms day to day life and work fulfilment. Pg 9</p> <p>Implementation: A review of the evidence for Open Dialogue found that there has been considerable variation in how the Finnish OD approach has been implemented in different locations making comparisons unreliable. Pg 10</p> |

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| | Organisational investment is also needed to allow the implementation of service user choices including training clinicians in shared decision making as within the POD model. Pg 10 |
| Klatt et al., 2025 | On sustainability of the Open Dialogue programs: "This study demonstrates several strengths: the participatory approach was pursued sustainably from the outset and maintained over an extended period, fostering a thorough and inclusive process. Despite limited financial support, the research team sustained a long and continuous investigative process, marked by openness to reflection and methodological creativity. The diversity and interdisciplinarity of the research team contributed to methodological and theoretical innovations that enriched the study." P 15 |
| Lennon et al., 2023 | Two most notable leadership features impacting staff experience and sustainment were: leaders facilitated the gradual development of clinical and organizational legitimacy for the non-standardized Open Dialogue approach, by 1)holding the anxiety and frustration of practitioners and parts of the administration and by 2)continually removing organizational obstacles. p100 |
| Pocobello et al., 2024 | The project also highlighted several systemic challenges, including the need for consistent funding, administrative support, and alignment with national health policies. Addressing these challenges could be crucial for the broader implementation of OD. Policymakers and health administrators might need to recognize the value of OD and allocate resources to support its integration into mental health services. |
| Razzaque et al., 2015 | Implementation challenges included: Taking risks Applying Open Dialogue within the NHS legal frameworks Re-educating a large workforce Resource intensive intervention Working with difficult systems Working with unsupportive family systems required cultural shift: Challenging the medical model understanding of mental health Staff attitude change Integrating Open Dialogue meaningfully Sharing power and expertise Overcoming fear of change Organisational change Commitment from staff and leaders |
| Schubert et al., 2021 | Pre-existing barriers: Tensions between consumer/family priorities and clinician fear of risk and accountability: Some psychiatrists spoke of the power imbalance between doctor and patient. They referred to their deep commitment to promote client dignity rather than pathologise distress, but described challenges. Attempts to redistribute power and respect clients' voices could be surpassed where psychiatrists risked being held accountable for completed suicides by the |

Coroner's Court. The necessity for psychiatrists to have control and responsibility if they are held accountable in the instance of a client death emerged as a dilemma for prioritising service user voice and autonomy. P150

One senior psychiatrist deemed that responsibility must be accompanied by authority; how can a psychiatrist be held responsible for a death without the authority to take control over the situation when they judge it to be life-threatening? The tension between balancing this responsibility with a commitment to prioritising the voice, autonomy and choice of clients produced a dilemma. An Incongruence between professional values when working within a system described as needing 'scapegoats' was upsetting. The realities of managing these risks was interspersed with vulnerable reflections of personal heartbreak after losing clients to suicide. P155

Challenges: Willingness to become vulnerable

Participants detailed how a dialogical approach necessitates a willingness to be vulnerable which was felt to be professionally discouraged. Limitations in how much participants feel able to display vulnerability in their work emerged as a key barrier, particularly for psychologists. Most participants recognised and valued their vulnerability as humans – with fears, pains, wishes and desires – and embracing this emerged as a desired opportunity but also as a key barrier to working dialogically. p155

Participant 4 went on to identify that a key reason for therapists steering away from positions of vulnerability was a discomfort in humility and admitting they are not always in positions of knowing. Concluding the interview, this participant spoke of an emerging and deep sadness that their training, models and expectations had taken them further away from an approach of openness and curiosity. p157

The discomfort with privileging technical expertise and undermining families' own expertise was matched by a discomfort with admitting to a 'not knowing' position (Anderson and Goolishian, 1992). Willingness to admit to 'not knowing' was difficult in a risk-averse mental health system and risked exposing participants' own vulnerability. Whilst vulnerability was described as a necessary requirement for deep and authentic connection, the admission of vulnerability on this basis was perceived as unacceptable. Yet adopting a 'not knowing' position appeared the only truthful option. The 'not knowing' position was both annihilating and necessary P159

Feasability concerns:

Whilst all participants articulated Opportunities in working using a dialogical approach, there were initial reservations and almost all participants expressed concerns about the feasibility of dialogical approaches within the current system. P154

OF NOTE:

Participants often referred to the integration of dialogical approaches into their

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| | existing clinical work, rather than the implementation of Open Dialogue as a model of care. P157 |
| Seikkula et al., 2011 | <p>Medication: Neuroleptic medication was used in the first two groups in only a quarter of cases, but showed an increasing trend in the third group, in which 50% had taken and 28% were continuing to take medication. However, this aspect may have been affected by the larger number of dropouts in ODAP2003-2005, since treatment had been terminated among those patients who were not reached at the follow-up, and according to preliminary information they were not using antipsychotic medication. In the two first groups, first generation neuroleptics were used as the antipsychotic medication, while in the third group, second generation antipsychotics were used.</p> |
| Stockmann et al., 2019 | <p>Systemic barriers to system change through OpenD:</p> <p>The approach was described as natural to clinicians, but discouraged by a system prioritising a technical approach, “This is the way I wanted to work with people, but because of the restrictions in the system...we become very sort of clinical and sort of ‘chchchch’ [completing a checklist]” (05). Some participants spoke of the emotional burden of reconciling humanistic intentions with an opposing system, “The disillusion which has always been there for me, is stronger because I have been here and because I so want it to be different, that it feels more painful in some ways having to be working in the ways I am having to work” (06)</p> <p>The challenges of overcoming limited financial resources and achieving a necessary shift in the existing system were deemed fundamental. It was emphasised that barriers were systemic, rather than individual, and a split between POD and non-POD staff should to be avoided. There was a degree of pessimism about achieving meaningful system change, although others expressed optimism. P315</p> |
| Taylor et al., 2023 | <p>ENGAGING IN OPEN DIALOGUE INFLUENCING RELATIONSHIPS & COMMUNICATION ACCROSS DIFFERENT WORLDVIEWS.</p> <p>(from the perspective of a psychiatrist) Thanks to Tom’s family and others like them, I have found within me a greater capacity to tolerate the viewpoint of someone whose stated realities and motives are not completely known to me. It is possible to set boundaries, respectful ones, while keeping open lines of communication with the understanding that we may never in this lifetime agree on some of the most basic things. If this kind of relationship is possible with a family member, it is possible with anyone. My relationships with everyone have shifted in the direction of my possessing a more open mindset when others speak of their realities. I can listen to somebody’s opposing point of view and still hold firm to my most basic core value system. Somehow, as a result, I believe I have also become a bit less prideful.</p> <p>TRANSFORMATION /MINDSET & BEHAVIOUR CHANGE</p> <p>In the context of Open Dialogue network meetings all three of us practitioners attributed our personal transformations, at least in part, to what happened during network meetings. We agreed that our internal changes were profound enough</p> |

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| | to change our mindset and our behaviors, though our transformations themselves varied. p4 |
| Uehling et al., 2024 | compares with Soteria, 'alternatives p6 "reveal[s] how frameworks that subvert the existing psychiatric system, such as the practice of Open Dialogue in the context of CSC, may be a path forward to larger systemic change." p8 |
| Ulland et al., 2014 | Critique about the lack of inclusion and dialogism in the change processes, and lack of power sharing, leading to limited success. (p410?) |
| Wates et al., 2022 | Connections/relationships: Participants experienced deeper connections/richer relationships with clients, colleagues, and their families.p792? Change in world view. Some participants felt that the training had led to a fundamental shift in the way they understood the world; some expressed an increased belief in the social construction of reality and identity. p794 Aburi (FG1) also described how the training had profoundly altered his understanding of the very nature of "truth" as he had come to appreciate how much of our reality is subjective. p794 |