



# *Rapid Review Report: the evidence for system reform impacts of the Open Dialogue approach*

Report prepared for the Open Dialogue Centre

by the Centre for Mental Health Nursing,  
University of Melbourne

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We acknowledge the First People on whose lands we work and pay respect to their elders and to all aboriginal and islander people among us and across their lands.

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# Abstract

**Background:** There is growing momentum in Australia and internationally for change in models of care delivered in acute and community mental health services. Recent inquiries and policy documents highlight the demand to better meet the needs of people and their families. The Open Dialogue approach has emerged as a promising practice, and interest is growing in and beyond the mental health sector. Open Dialogue operates from an established set of principles and elements, providing a unifying frame for its application.

This Rapid Review of literature is a structured search, analysis and presentation of existing evidence, to answer a primary research question: *How do systemic impacts of the Open Dialogue approach contribute to recommended transformation of mental health systems?*

**Methods:** We addressed the research question in three steps. These were: 1. Identifying the main features of mental health system transformation recommended by three prominent reports, the Productivity Commission Mental Health Inquiry Report (2020), the Royal Commission into Victoria's Mental Health Services (2021), and the World Mental Health Report (2022); 2. Systematically searching peer review literature for evidence of systemic impacts of Open Dialogue approach; and 3. Analysing and mapping the Open Dialogue evidence of impacts against the recommended system transformation.

**Results:** Analysis of the policy documents identified key areas of reform, encompassing service provision and service organisation. We found seven key areas of reform to service provision, including: enhancing the MH workforce, enabling equity, focusing on consumer priority, promoting psychosocial wellbeing, upholding human rights, combating discrimination, and supporting families and carers. We identified five areas of reform to service organisation, including: being led by lived experience (consumer and carer) encompassing service co-design; care in community; ensuring access and ongoing support; integrating broad social services; and achieving treatment and recovery outcomes.

Fifty-three papers using diverse methodologies and published from 2003 to 2025 met the inclusion criteria. The papers were grouped into five clusters for analysis: practitioner experiences of training, participants' experiences of network meetings, peer supported open dialogue (POD); implementation reports, and outcome studies.

**Discussion:** In principle, Open Dialogue is very well aligned to Australian and international reform intentions. The strongest evidence of system reform impact to date highlights how Open Dialogue focuses service provision on consumer priorities, promotes psychosocial wellbeing, supports families and carers and enhances workforce experience. There is growing evidence that Open Dialogue is an effective treatment, reduces stigma and supports human rights. However, research also shows integration challenges for mental health practitioners, and considerable implementation challenges for organisations. Further research is required to better understand population outcomes and impacts. Implementation research is also needed to better understand challenges and to test strategies for establishing high fidelity practice.

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# Findings Summary

## Introduction

Governments are increasingly focused on service reform to more effectively and equitably meet mental health needs. Demand for mental health care is high, accompanied by community demand for a better fit between the needs of people and families and the structures and experiences of care. Prominent inquiries and policy documents add momentum to the reform of existing models of acute and community mental health service delivery.

The Open Dialogue approach has emerged as a promising practice in recent years, and interest is growing in and beyond the mental health sector. Open Dialogue practices and the system of provision evolved in Finland over 40 years and have spread across countries and languages for more than 20 years. Despite its implementation in very diverse settings, Open Dialogue operates from an established set of principles and elements providing a unifying frame for its application.

This report presents a **rapid literature review**, commissioned by and tailored to the focus of the Open Dialogue Centre. The Centre aspires to develop an evidence-informed approach to Open Dialogue (OpenD)<sup>1</sup> tailored to meet the needs of diverse communities in various settings.

## Purpose of the work

This rapid review comprises a structured search, analysis and presentation of the existing peer reviewed literature, to answer a primary research question:

***How do systemic impacts of the Open Dialogue approach contribute to recommended transformation of mental health systems?***

## Review questions and methods

We addressed the research question in three steps:

**Step 1:** Identify the **main features of mental health system transformation** recommended by three prominent reports: Productivity Commission Mental Health Inquiry Report (2020), the Royal Commission into Victoria's Mental Health Services (2021), and the World Mental Health Report (2022).

**Step 2:** Systematically search peer review literature for **evidence of systemic impacts of Open Dialogue approach**

**Step 3:** Analyse and map the **Open Dialogue evidence of impacts** against the recommended **system transformation**.

Details of the method used in each step are provided in Appendix 1.

<sup>1</sup>Use of 'OpenD' as an abbreviation through the report is intended to refer to Open Dialogue distinctly from the lay use of 'OD' for 'overdose'; this has been pointed out by readers with lived expertise as a mis-reference to avoid.

## Findings

Analysis of the three policy sources generated 12 fields of recommended system-wide reform:

### Seven fields related to provision of service

**1) enhance MH workforce, 2) enable equity, 3) focus on consumer priority, 4) promote wellbeing, 5) uphold human rights, 6) combat discrimination, 7) support families and carers.**

### Five fields related to organisation of service

**8) lead by lived experience (consumer and carer) AND design with consumers and carers  
9) base in community, 10) ensure access & ongoing support, 11) integrate (broad) social services and 12) treatment and recovery outcomes.**

For two decades literature has cited seven principles of Open Dialogue: Provision of immediate help, A social network perspective, Flexibility and mobility, Responsibility, Psychological continuity, Tolerance of uncertainty and Dialogism.

It is notable that Open Dialogue approach aligns *in principle* with the reforms to mental health care provision; including central ‘dialogical practices’ used with people and their networks. Several principles related to structural elements of Open Dialogue approach also equate *in principle* to the five reform fields regarding organisation of services. Overall, there is alignment between Open Dialogue principles and the 12 fields for system reform.

## Empirical evidence about Open Dialogue overall

**The central purpose of this report is to identify empirical evidence of OpenD contributing in the direction of recommended mental health system reforms.**

A systematic search of Open Dialogue studies identified 53 papers since 2003, with findings impacting system reform. These papers were grouped in 5 categories related to their primary focus: **practitioner experiences of training, experiences of network meetings, peer open dialogue, implementation evaluation, and OpenD outcomes.**

Research findings across the 53 papers show:

- **OpenD research is accelerating:** 31 of these 53 papers are recent, ie. since 2020.
- OpenD trained staff experience **transformation within their identities, practices and team relationships.**
- **Consumers and families valued network meetings,** felt supported by **trust, flexibility and collaboration**
- **Network meetings** can be provided **alongside other care and support activities**
- **Network meetings are feasible** and valued across the globe
- In network meetings **benefits included improved relationships and communication**

- Successful OpenD implementation **requires a substantial investment in training** and ongoing organisational **support** (to contribute significantly to desired reforms)
- Practitioners were characteristically uplifted by being able to attend well to consumers and families and were **hopeful about outcomes** of therapeutic work.
- Tensions between and within teams were common in OpenD implementation processes. Longterm embedding requires an **ideological shift for workforce** in services, **supported by leadership**
- Significant **ongoing implementation costs** were related to training and co-therapy.
- In Finland specifically, reported outcomes of OpenD were: changes in population diagnostic patterns, reduced use of neuroleptic medications, improved consumer physical health and changed patterns of service use: shorter admissions and less recurrent admissions
- In other sites, reported outcomes mainly from cohort studies and service case studies were: **improved functioning, family relationships, social networks and employment, and less long-term dependence** on psychiatric treatment systems.

Trends over the recent decade, suggest a trajectory of OpenD evidence building in volume and with a broader focus.

### Specific evidence for system reform impacts

Evidence for OpenD **enhancing workforce** was frequently examined across many sites and countries and **was very strong**, included:

- OpenD training had **positive effects on wellbeing and job satisfaction** for workers across mental health disciplines
- Skill building and practice of OpenD **was both welcomed and emotionally demanding for staff** and challenged some practitioners' formative disciplinary training
- OpenD training and practice was readily embraced for **lived experience/ peer roles** and for workers with **family therapy, social care and welfare** backgrounds
- OpenD training and practice (in facilitating network meetings) presents a powerful opportunity for **developing our mental health workforce** in skills and care provision that is **valued by consumers and families**
- **Transformational benefits** for workers were sustained where accompanied by organisational support for system changes.

Evidence for OpenD enabling **focus on consumer priority** was also strong in many qualitative studies and across countries.

- **Consumers reported feeling heard**, they could express needs openly and their perspectives were taken seriously.

- Both consumers and families appreciated the attentiveness of team members, their interest in life issues as a part of crises, the use of non-medical language and non-judgemental stance
- Taking time with people to make sense of the situation was valued across OpenD sites
- When decision making in inpatient settings, practitioners did not always maintain focus on consumer priorities
- Peer workers contributed significantly to team focus on the persons needs and choices

Evidence of OpenD **approach providing support for families and carers** was strong.

- Families appreciated the OpenD team’s attentiveness, openness and transparency
- In the UK (where all community care is routinely rated by consumers and families) peer supported OpenD was rated significantly more highly than both usual care in the same region and than the national average.
- Families and carers across studies conveyed that network meetings were challenging and even odd, but considered that the process mediated and enhanced family communication, in some cases benefitting them beyond the network meetings
- Using an OpenD approach with families was unproblematic for the many services that grew out of family therapy and support services.

Evidence of OpenD **promoting psychosocial wellbeing** was moderate.

- Qualitative studies display OpenD supporting a holistic and relational view of people, and supporting a treatment goal of wellbeing, broader than clinical recovery
- A range of life issues well beyond symptoms were ‘in scope’ for attention in OpenD approach, from the crisis point to more ongoing work.
- Consumers reported OpenD had benefits for their relationships with family and others, for building their sense of purpose and for activating psychosocial growth

Evidence of OpenD **enabling equity** was moderate.

- Equity, i.e. direct inclusion of socially marginalised groups in services was not reported
- Findings across qualitative studies indirectly reflected equity, in intentional invitations to diverse views and carefully attending to every voice
- Practitioners experienced a shift in power relations in OpenD: medical hierarchy was flattened, staff were more open with each other

Evidence of OpenD **combating discrimination** was moderate.

- Consumers in several countries identified that openness of communication in OpenD was itself de-stigmatising
- Across four papers, destigmatising was strongly linked to peer roles.

Evidence of OpenD **achieving treatment and recovery outcomes** was moderate.

- The earlier section about overall OpenD outcomes shows modest evidence for OpenD achieving recovery and psychosocial outcomes at least comparable with other approaches

- One study reports significant gains in functioning and a longitudinal population study of OpenD for child and youth identified positive employment and education outcomes and less need for emergency mental health services.
- Higher fidelity OpenD service was associated with teams having research capacity.

Evidence of OpenD ***caring in the community*** was lacking, beyond one survey of care location.

- A cross-sectional survey of more than 100 teams showed most OpenD services were being provided in the community (i.e. not in hospital).
- The practice of outreach and homebased services was evident in only one study (Parachute) beyond Finland
- No qualitative or quantitative services reported the actual location of network meetings, community embeddedness or outreach.

Evidence of OpenD ***upholding human rights*** was lacking.

- No studies reported frank data about the legal status of people receiving OpenD services, as the key indicator of over-riding human rights.
- One study reported positive data for consumer perception of shared decision making
- Many qualitative studies identified valuing of consumer voice, choice and advocacy and illustrated resistance by practitioners to making substituted decisions (about treatment).

Evidence for both ***lived experience leadership*** and ***codesign*** in OpenD services was lacking.

- Lived expert roles in leadership were not explicit in any study; however, the equal and valued role of LE peer workers, fully integrated in teams was strongly affirmed
- None of the 53 papers described or provided data about family or consumer roles specifically in codesign of OpenD services or research
- Though not claiming leadership, peer roles added value by enhancing hope for both consumers and carers, foregrounding human rights, consumer choices & decisions

Evidence of OpenD ***ensuring access and ongoing support*** was lacking.

- Implementation studies show variable performance in timely initial care and no studies beyond Finland reported durations of episodes of care or their approach to ongoing support
- One individual US-based service reported outreach as standard
- Several studies show how organisational context factors, such as insurance arrangements, mitigate against this reform field, by for example, dictating service duration or limiting the number of network meetings.

Evidence of OpenD ***integrating broad social services*** was lacking.

- The cross-sectional survey study of OpenD teams referred to integration as connection across community and hospital services.

- Only one study provided data about engagement with diverse social supports and other psychosocial services.
- Several studies reported structural and attitudinal barriers to engaging across social care

Overall, the evidence was strongest for OpenD impacting reform fields associated with direct provision of service (especially consumer-centredness, psychosocial focus, and family support), and weakest for fields related to organisation of service (immediate access, ongoing support, integration with social services, codesign and lived experience leadership).

## Discussion

### Reform impact evidence to date

- Strongest evidence shows the contribution of OpenD to reform towards **high quality of direct service provision** processes for people and their networks: **supporting consumer priorities** and **psychosocial recovery**, including **supporting families**.
- Strong evidence of OpenD training and practice **enhancing workforce skills and wellbeing** underpins these positive service provision impacts
- The workforce benefits reflect a strong and welcomed alignment between practitioners' values and OpenD practices, and also with values of families and consumers
- These impacts are powerful, because these four practice fields are fundamental to the MH reform agenda and are evidently difficult to effect and to sustain, challenging embedded ways of thinking and interacting in healthcare
- To date there is a **significant gap between the reform potential** of OpenD approach, based in its principles, and the depth and breadth of **research evidence** for those impacts.
- Some evidence shows OpenD also impacting **equity of service, treatment effectiveness and outcomes, upholding of human rights** and **reducing MH stigma**.
- These fields should be subject of/embedded in OpenD research programs

### Research directions and methods

- Our report of evidence is generated by synthesis of many pilot- and case-studies and small comparative studies, that are generally not benefitting from common measures and methods. Stronger research is emerging through international collaborations.
- To be more robustly evidenced, OpenD impact on these reform fields needs coordinated research investment
- For effective evaluation of OpenD as a core model of care provision at the service level, agencies require research commitment
- The reform fields of **service accessibility, ongoing support, and social care integration** require system commitments and investments, more than research efforts
- The reform fields of **lived experience leadership** and of **co-design** hold as yet unrealised potential to both drive and to advocate for an OpenD approach

# Background

## Introduction

Mental health is understood as a vital component of wellbeing, and worldwide demand for mental health support is rising. Governments are increasingly focussed on reforming services, to more effectively and equitably meet mental health needs. Recent reviews and policy documents have highlighted dissatisfaction with existing models of acute and community mental health service delivery.

Recommendations for system wide change, arising from both the Royal Commission into Victoria's Mental Health Services (2021) and the Productivity Commission's Inquiry into Mental Health (2020) in Australia, point to the need for increased focus on service approaches that are acceptable and effective for people accessing services, including individuals and their families and supporters. In addition, the report commissioned by WHO entitled *World mental health report: Transforming mental health for all (2022)* identifies broad reforms needed for mental health services internationally.

The Open Dialogue (OpenD\*) approach, developed in Finland from in the 1980s (Seikkula et al., 2003), is gaining attention globally for its innovative team practices and structure, geared to addressing the needs of people experiencing mental crises and ongoing distress, through work with their families and social networks. Promising applications of OpenD have emerged in recent years, and interest in the approach is growing. To date, many thousands of practitioners have undertaken training in dialogical practices and more than 100 services across 24 countries (Pocobello et al., 2023) have reported on efforts to adapt and implement OpenD in a wide range of settings.

The team at the Open Dialogue Centre (ODC) considers this to be a potentially transformative approach for mental health and social care systems. The ODC seeks to contribute to the development of OpenD approach for mental health across the health, community services and education sectors in Australia.

This Rapid Review of literature is a structured search, analysis and presentation of existing evidence, to answer a primary research question: ***How do systemic impacts of the Open Dialogue approach contribute to recommended transformation of mental health systems?***

The report is commissioned by and tailored to the needs of the Open Dialogue Centre, that aspires to create an evidence-informed approach to OpenD, adapted to meet the needs of different communities.

## Open Dialogue in mental health systems

Open Dialogue developed as an innovative clinical and service organisation approach within the mental health services of Western Lapland in Finland during the 1980s and was consolidated there in the 1990s. The involvement of social care networks has led to broad

engagement of health and social care in that community, however the OpenD teams in Finland are themselves based in the specialist mental health system. In other countries, while OpenD has been initiated in mental health services for both adults and children and their families, many teams continue to target mental health care for young people including those with experiences of psychosis.

Seven OpenD principles evolved in early research programs and training: (1) immediate help, (2) a social network perspective, (3) flexibility and mobility, (4) responsibility, (5) psychological continuity, (6) tolerance of uncertainty, and (7) dialogism (Seikkula et al., 2001). The first five principles underpin organizational structures for mental health services provision, while the last two refer to the interpersonal/therapeutic practice of OpenD practitioners during network meetings with clients, commonly referred to as dialogism (Seikkula et al., 2003).

Interest in OpenD is growing with regard to providing mental health support in the neighbouring sectors of social care, homelessness and education. A scoping review by Buus et al. (2017) of OpenD adaptations across Scandinavia reported that OpenD had “evolved into a social movement” with a diverse range of service types adapting the approach, whereby people and families are offered “alternatives to conventional psychiatric treatment” (p392). We have not limited the literature search, in regard to the settings included for this review.

## Open Dialogue studies reviewed

The body of this report is a systematic search and synthesis of research studies of Open Dialogue to 2025, summarised and then analysed through the lens of mental health reform. So, this section provides a brief introduction to studies – the kind of evidence and where in the world it is generated.

In peer reviewed literature, OpenD has been the subject of considerable discussion and some empirical research for more than 30 years. The early literature was generated in Finland; international literature has flourished in the past 10 years. We note the wealth of theoretical and discussion papers, in addition to streams of empirical work diversely focussed on process, outcomes and adaptations. In 2023 Pocobello et al. (2023) noted that OpenD has been implemented in more than 20 countries, yet its transferability and effectiveness have been demonstrated in very few contexts.

**The heart of this report is empirical research.** Many other longstanding models of care have not been the subject of research, recognising the many challenges associated with conducting high quality psychosocial research. Reflecting its origins in family therapy, numerous OpenD studies illustrate or describe close up the therapeutic practices themselves, while fewer focus on evaluations of outcomes for people and communities. Two published literature reviews (in 2017 and 2019) to date have focussed respectively on implementation and outcomes of an OpenD approach.

*Research of OpenD outcomes:* In the first systematic review of outcomes for OpenD, Freeman et al. (2019) identified that the majority of studies then were generated from the single service where OpenD developed. Researchers had explored symptom reduction, use of antipsychotic

medication, hospitalization, implementation of OpenD principles, principles in network meetings, and consumer and family acceptability. Freeman identified the best supported finding for participants in OpenD approach across evaluated services were two valued features of authenticity and trust.

*Research of the spread of OpenD approach:* The earlier scoping review by Buus et al. (2017) detailed some long established adaptations of OpenD such as for community based crisis support of children and youth in Denmark, and modes of integrating the approach in specific sites in Norway and Sweden, such as introducing network meetings in some inpatient mental health units or in adult or youth-focused social care services. Many of the included studies were fine grained explorations of the therapeutic process. The next scoping review specifically of OpenD implementation focused on organisational challenges to implementation, drawn from the experience of trainees, practitioners and families (Buus et al., 2021).

All these reviews highlighted the modest scale of empirical studies, mainly featuring small samples within one specific organisation. This situation, plus the use of varied measures and naturalistic research design to examine diverse adaptations, all serve to constrain the generalisability of findings. These reviews also pre-date implementation studies in English speaking countries including Australia, and the first cross-national study (Pocobello et al., 2024). A protocol for a randomized controlled trial, comparing peer supported OpenD with standard community care in NHS services in the UK, was published in 2022 (Pilling et al.). The trial itself commenced in 2017; it includes rigorous evaluation of the clinical and cost-effectiveness of the approach. The findings will be a significant addition to the OpenD research evidence.

## Transformative potential of Open Dialogue

The focus on seven principles of Open Dialogue in all literature provides strong markers of potential systemic impact. For example, the principle of ‘immediate help’ when applied should give rise to evidence regarding service accessibility. Similarly, evidence of inclusion of family and wider social supports is to be expected using the principle of ‘social network perspective’. Reviews of literature up to now have not been looking for empirical evidence relevant to this topic of systemic impact. The reality of partial implementation and adaptations, and the lack of reporting against overt fidelity criteria may be an obstacle to our examination of systemic effects. Whereas literature consistently identifies the transformative principles and intentions of OpenD, **this rapid review focuses squarely on the evidence for those impacts, as found in empirical studies.**

# Questions and Methods

## ***How do systemic impacts of the Open Dialogue approach contribute to recommended transformation of mental health systems?***

The review addressed a set of three sub-questions that guided the policy and literature searches and analysis.

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

**Question 2:** *What are the systemic impacts of the Open Dialogue approach?*

**Question 3:** *How do identified system impacts of Open Dialogue approaches accord with recommended features of mental health system transformation?*

A document review addressed question 1.

A systematic search and rapid evidence appraisal addressed questions 2 and 3:

The Rapid Review steps included: systematic literature searching, screening, data review, extraction and thematic synthesis. Two reviewers conducted the full text screening stage. Five reviewers undertook data extraction and the whole team met to confer on clustering, development of themes and cross analysis with the 12 reform fields. The software Covidence was used through the processes of searching, screening, extraction and bibliography generation.

The four steps taken to answer these questions are also summarised visually below:

Step 1. Search for recommended system transformations features within 3 policy documents;

integrate across 3 policy documents into ‘system transformation fields’

Step 2. Systematically search peer reviewed, empirical studies of Open Dialogue for evidence for Open Dialogue impacts overall

Step 3. Map Open Dialogue impacts against the transformation fields

Step 4. Synthesis evidence and identify gaps

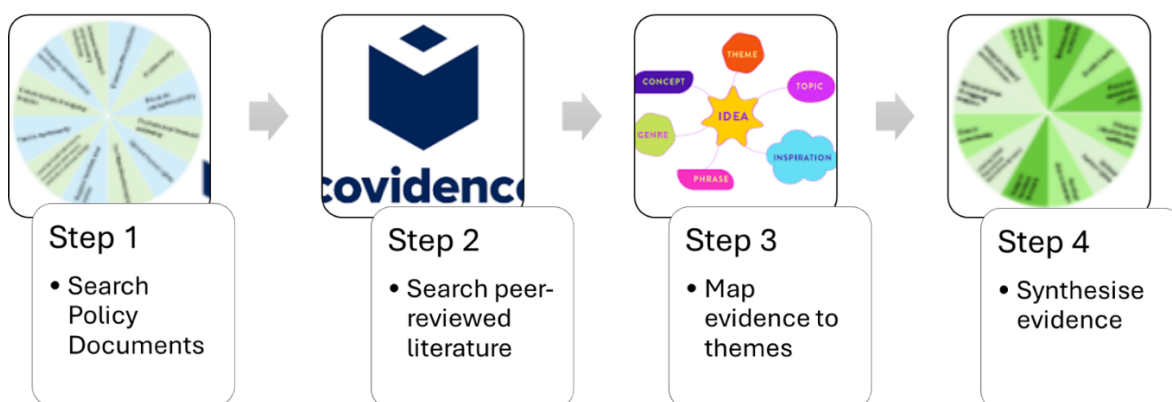


Figure 1: Steps for rapid review project method

Further methods details are provided in the supplementary file.

The report concludes with a discussion of areas of evidence strength, gaps, and research recommendations.

## Findings

### Finding 1: Identify the main **features of mental health system transformation** recommended by key reports

Analysis of these three policy documents - Productivity Commission Mental Health inquiry Report (Productivity Commission, 2020), the Royal Commission into Victoria's MH Services (State of Victoria, 2021), and the World MH Report (World Health Organization, 2022) - generated 12 fields of system wide reform (see Figure 2). Half of the fields relate to the reform of direct provision of services to people, shaping the way people experience and deliver services at close range. Half of the fields guide the organisation of services: the system structures, such as accessibility in terms of time, location and cost. All the reform fields are titled here to emphasise the active reform intent (i.e. verb then noun):

#### Reform of service provision

1) enhance MH workforce, 2) enable equity, 3) focus on consumer priority, 4) promote psychosocial wellbeing, 5) uphold human rights, 6) combat discrimination, 7) support families and carers

#### Reform of service organisation

8) lead by lived experience, include consumers and families in design, 9) base in community, 10) ensure access & ongoing support, 11) integrate (broad) social services, 12) achieve treatment and recovery outcomes.

Each field is briefly defined, based on its use in reference reports (See supplementary file of Reform fields with examples).

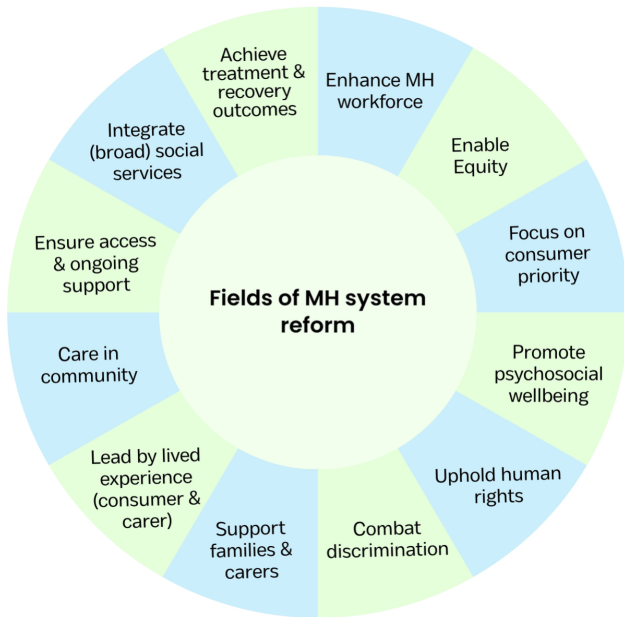


Figure 2. Fields of Mental Health System Reform

## Reform of service provision

### 1) Enhance MH workforce

The specialist workforce is both underdeveloped and undersized to meet the demand for quality mental health support. Recruitment, training and support structures are required to optimise the skilful treatment and support to be offered by mental health services to our community. The workforce mix is to include peer workers and integrate other knowledge and expertise: physical health and social wellbeing, advocacy, culturally fitting support for people and families.

### 2) Enable equity

Equity and inclusion of diverse communities, meeting the needs of individuals and families for mental health care and support. Many marginalised communities are over-represented and currently underserved regarding mental distress and crises, diagnosed mental ill health and complex ongoing mental health needs, due to layers of disadvantage (social determinants of health), significant life trauma and discrimination. This reform field is focused on mental health care that is culturally acceptable, timely and sufficient to the needs of disadvantaged groups.

### 3) Focus on consumer priority

This field is prominent in the Royal Commission report, in recognition of the many submissions decrying a focus of service provision driven by system considerations other than consumer-expressed needs. Commonly, the reported focus is a person's behaviour, which is viewed by others as risky. A broader focus of care, on psychological and social needs of people, was a prominent theme in advocacy by families also. This reform field is framed by the Productivity Commission and in the WHO Mental Health Report as shifting to a 'patient-centred' focus.

#### 4) Promote psychosocial wellbeing

This field refers to the public provision of mental health care, which is required to be more comprehensive than clinical treatment. It encompasses contemporary recovery-oriented approaches and community expectations of promoting mental wellbeing, fostering contributing lives for people who access services and for their networks of family and supporters.

#### 5) Uphold human rights

This field of upholding rights included recognising the impingement of human rights via mental health laws, upholding autonomy in decision making, ending use of restrictive practices. The purpose and reach of this field of reform is most fully illustrated in the **WHO Quality Rights initiative**, which included training and documentary resources for supported decision making, recovery planning and strategies to end use of seclusion and restraint.

#### 6) Combat discrimination

This field featured in all sources; the focus was on initiatives for mental health promotion and redressing stigma, including examples of a need to redress stigma experienced within healthcare settings/from healthcare providers.

#### 7) Support families and carers

This field related to recognising that any person engaged in mental healthcare has important relationships and actively engaging with the people that matter; it encompassed recognising and addressing the specific support needs of people including family members, supporters and carers.

#### Organisation of service

#### 8) Lead by lived experience (consumer and carer), include in service design

The role of lived experience features at three levels in the policy documents: the embedded roles 1) of peer workers in face-to-face service delivery and 2) of lived expertise in managing and leading within services, and 3) the (intermittent) role of current service users (consumers and families) in service co-design processes.

#### 9) Care in community

This reform field encompasses more than the issue of local access; its purpose is to ensure mental health care is embedded *within* local communities, continuing relationships and ordinary lives and routines. This field emphasised the lay and social aspects of mental health and wellbeing, in contrast to the separation from community, in technical biomedical environments of tertiary care systems, organised around inpatient hospital care.

#### 10) Ensure access & ongoing support

This field refers to access in terms of timeliness, geographic setting, referral pathways and costs. Emphasis was placed on both ends of the time scale: immediate responsiveness during

times of crisis and the long-term, continuing availability of support as needed. The aspect of reform speaks to the need for removing existing structural and logistic barriers to access.

### 11) Integrate (broad) social services

This field requires service systems to join up the wide range of supports that address the social determinants of mental health: social networks, finances, education and employment as well as services for housing, justice and addiction issues. It also includes resolving conventional challenges of integrating services across crisis (acute) and rehabilitative supports, including residential/inpatient and community-based services, where these may be disconnected.

### 12) Achieve treatment and recovery outcomes

This field encompasses the requirement to both examine and achieve outcomes for all people and communities served by mental health providers. The requirement to report on effective treatment and support outcomes, including psychosocial goals, personal experience of recovery and wellbeing, mirroring the broad psychosocial remit. \*

See Appendix 2 for fields mapped across the three sources

\*The topic of suicide prevention was also promoted across the three source documents; we ensured such content was encompassed by outcomes, as were diverse recommendations for specific diagnostic groupings

## Finding 2: Systematically search peer review literature for evidence of systemic impacts

This section is central to the report, identifying the current research evidence for OpenD, upon which the conclusions are based. The analysis of papers occurs in three steps:

- Brief description of the identified papers: originating country, method, research sites.
- Presentation of systemic findings in Open Dialogue literature **overall** in 5 clusters,
- Specific mapping of findings back to the 12 system transforming features.

The process of searching and screening is summarised in the Prisma chart, overpage.

Systematic search identified these 53 papers with findings related to system reform:

- Published across 22 years from 2003-2025
- Originating in 14 countries: Finland (11), Norway (5), United Kingdom (9), United States (10), Australia (8), Italy (2), Germany (2), Netherlands, Switzerland, Denmark, Israel, Ireland, Portugal, Spain
- Methods: more than half were qualitative interview studies (28), single service client cohort studies (14), team case studies (6), mixed methods service evaluations (3) and surveys (2)
- Of note, 10 included papers were recently published in an edited series in the journal: *Frontiers in Psychology* (2023-2025)
- The total of 53 papers related to 42 OpenD sites or services, in that some services were the site/data source for multiple papers. In addition to the Finnish original service (11), there were three papers related to the HOpenDialogue survey of implementation, two studies were based in a Norwegian service, two papers from Australia related to overlapping services, and 3 UK papers were site-based studies of implementation and experiences, nested within the ODDESSI trial, which is across 6 sites within the NHS.

Details of each of the included studies are tabled in the Appendix to this report. We did not appraise the quality of studies, as this would add complexity for rapid review. Also, the diverse methods used in the studies make quality comparisons less meaningful.

While these studies emerge from many countries, it is notable that some common research questions and aims have been explored, using similar methods.

### Themed findings

Through the process of screening and analysis, the 53 papers were first gathered inductively into these five clusters: **practitioner experiences of training, participants' experiences of network meetings, peer supported open dialogue (POD); implementation reports, and outcome studies.**

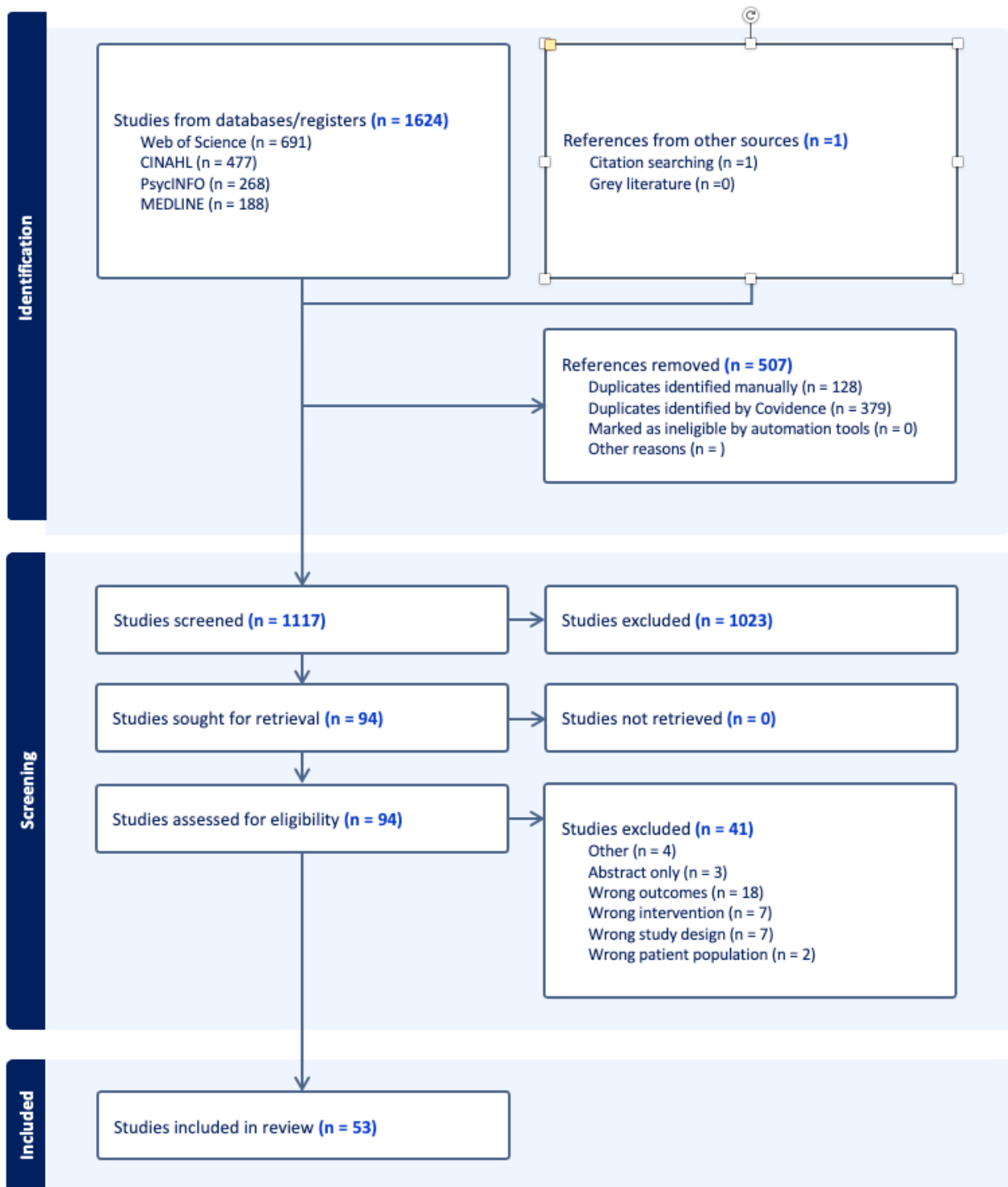


Figure 3. Prisma Chart

### *Practitioner experience of Open Dialogue training*

This set of nine papers (Anestis et al., 2024; Buus et al., 2023; Holmesland et al., 2010; Jacobsen et al., 2021; Olson, 2015; Schubert et al., 2021; Stockmann et al., 2019; Taylor et al., 2023; Wates et al., 2022) addressed questions about practitioner experiences of OD training and associated identity formation, as a result of engaging in training and in some studies also

linked to early experiences of facilitating network meetings. Studies were reported from 2007 to 2024, originating in UK (3), Australia (2), Norway (2), US (2) and most methods were qualitative, focus group interviews and ethnographic fieldwork; one longitudinal cohort study used qualitative data, one used mixed methods.

Participants described significant transformations within themselves, in their worker identities and their personal and collegial relationships. Training had a marked positive effect on their own wellbeing. Learning about polyphony helped some participants see their own voices as more valuable. They felt encouraged and more able to speak up/advocate, in situations where they may not have previously, i.e., advocating for or against the use of medication or restrictive interventions. They experienced this as a democratic way of working, based on sharing power. Participants across studies valued a more relational understanding of distress and increased their motivation and involvement of social networks. They found dialogical practice to be a more authentic and compassionate way of working, aligned with their personal values, and also with the values of clients/families. Dialogical practice was seen by some as a 'way of life', and a more ethical and equitable way of working than the current biomedical model.

Challenges which practitioners experienced with OpenD practice included:

- Trying to sustain dialogical approach in small teams alongside colleagues and processes that would override dialogical practice
- Carrying tension or burden of upholding humanistic principles of dialogical practice, within an organisation where culture was at odds with these values.
- Fear associated with responsibility and accountability for risk (i.e. about death by suicide), when attempting to redistribute power and respect clients' voices.
- Their own willingness to be vulnerable, as a necessary condition for dialogical practice.

### *Experiences of Network meetings*

This set of 11 papers (Bergstrom et al., 2022b; Buus & McCloughen, 2022; Dawson et al., 2021a; Florence et al., 2021; Gerken et al., 2025; Gidugu et al., 2021; Hendy & Pearson, 2020; Omvik et al., 2025; Tribe et al., 2019; Twamley et al., 2021; Wusinich et al., 2020) addressed questions regarding the experiences of network meetings. Studies were reported from 2019 to 2025 across six countries: United States (4), United Kingdom (2), Australia (2) and one each from Finland, Norway, and Ireland. Most methods were qualitative (7), as well as two case studies, a cohort- and a conceptual study.

Common findings regarding network meetings highlighted that consumers felt they were in a non-hierarchical safe space, which was well supported by trusted relationships, collaboration, flexibility, and negotiation. Consumers appreciated less emphasis on treatment and medication and improved understanding and choice in their care, as well as a decrease in feeling stigmatised. Home visits, availability of staff in times of distress, and multidisciplinary teams, including lived experience leaders, were also valued by consumers. Improved

relationships and communication between network members were a frequently mentioned benefit of participation in network meetings.

Findings related to organisations included open dialogue aligning with the recovery orientation and mission of the agency, whilst highlighting tension with the prevailing culture of safety and related staff concerns regarding liability (Gidugu et al., 2021).

### *Peer Open Dialogue*

This set of five papers (Elran & Hefer, 2022; Friesen et al., 2024; Hendy et al., 2023; Kinane et al., 2022; Sunthararajah et al., 2022) addressed the involvement of peer workers/ peer support specialists within multi-disciplinary OpenD teams. The studies aimed to explore experiences and a range of perspectives from clients, their families and the staff members themselves, about the impact of ‘Peer-supported’ OpenD, (in some services entitled POD). Studies were undertaken recently, in years ranging from 2022 to 2024 across countries outside of Finland: UK (3), USA and Israel. Methods were qualitative, except one study in which a mixed methods approach was adopted for consumer self-assessment of wellbeing and also clinician reported questionnaires.

Common findings affirmed Peer-supported OpenD (POD) delivery. Benefits for consumers and for families of peer support workers or peer specialists in teams were reported. The OpenD approach could be enhanced and positively influenced through the principles of Intentional Peer Support that peer specialists work with (such as inspiring hope, empathy etc). In the UK, where consumers and families routinely rate all community care, POD was rated significantly more highly than both usual care in the same region and the national average. Peer advocacy for rights foregrounded consumer understanding and choice, so participants felt they had a greater voice in treatment or decisions related to their care, ultimately enhancing their experience of accessing the services. Studies recommended ongoing exploration of POD delivery within services. Services and organisations that involve peer support staff within their Open i teams identified several challenges that may be posed, such as emotional discomfort experienced by Lived Experience staff. Studies recommend that the Lived Experiences roles are embedded within multi-disciplinary teams and are well supported.

### *Implementation reports and evaluations*

This largest subgroup of 15 papers (Dawson et al., 2021b; Einboden et al., 2024; Florence et al., 2020; Gordon et al., 2016; Heumann et al., 2022; Jacobsen et al., 2023; Klatt et al., 2025; Lennon et al., 2023; Lorenz-Artz et al., 2023; Pocobello et al., 2023; Razaque & Wood, 2015; Sidis et al., 2020; Uehling et al., 2024; Ulland et al., 2014; von Peter et al., 2022) primarily addressed implementation questions. Mainly these studies were centred in one or two community sites, with three notable exceptions: Pocobello et al. (2023) in Italy, Heumann et al. (2022) in Germany, Norwegian comparison of 3 teams Ulland et al. (2014). The papers spanned the dates from 2014 to 2025. These implementation-focussed studies were based in

Australia (4), Germany (3), USA (3), Norway (2), UK (2), and Italy (1) and settings were mostly specialist adult mental health / psychiatric settings, with the exception of two child/adolescent settings (Dawson et al., 2021b; Sidis et al., 2020), and a womens' social health unit (Einboden et al., 2024). Methods were case study (4), case series/cohort (3), qualitative evaluation (6) survey (1) and mixed methods evaluation (1). Aims were: to explore experiences of implementation including enablers and barriers, challenges, adaptations and service user experience, often through initial implementation. Qualitative and mixed studies explored staff and service user experiences and views.

Prominent findings included the high enthusiasm expressed by individual practitioners and participants at network meetings. Practitioners were characteristically uplifted by the experience of attending well to consumers and families. Further, they were hopeful for the benefits they perceived in the experience of network meetings and their resultant relationships with service users and co-working colleagues. However, tensions were also commonly reported at the organisational level. Implementation barriers of cost were identified – both for training and for co-therapy. Central tensions were associated with the ideological shift required – this was expressed as an issue when interacting with other MH services and also (Sidis et al., 2020) within some OpenD implementing teams and services. Three papers (from Germany, Norway and Australia) explicitly described this tension as a problem of power relations, both across organisations and within the OpenD teams. The role of leaders was identified as vital to holding tensions between parties within the organisation and to deal with practical obstacles. On that basis, some teams persisted and were satisfied with OpenD overall, whereas other teams struggled to maintain dialogical practice.

In contrast with the single site focus and bespoke methods of most implementation studies, the study by Pocobello and colleagues (2023) reported a cross-sectional survey of 118 services. It describes many features of the current implementation and clusters services, according to self-assessed quality criteria. Details from the evaluation findings are included in the later section of this report, as they relate directly to several fields of service transformation. Another paper reported both interviews and details of the related survey findings for 38 teams in Germany, illustrating the difficulty of re-orienting existing organisations to the structural elements of OpenD. Notably, the larger implementation studies are not reporting on preliminary experiences of OpenD; in the German study (Heumann et al., 2022), teams had been undertaking training and delivering Open D for an average of six years. Overall, implementation research in the form of organisational case studies and qualitative methods echoed the findings in the two previously reported clusters of studies, affirming the value of practitioner learning and positive experiences of network meetings.

The Italian outcomes study by Pocobello et al (2024) features in the next sub-section, regarding reported outcomes. However, these authors identified relevant implementation challenges associated with the necessary training and system reorganisation, when aiming for implementation of OpenD with fidelity: "*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.*" (Pocobello et al., 2024, p. 13)

### *Open Dialogue outcome studies*

This set of 14 papers (Aaltonen et al., 2011; Bergström et al., 2017; Bergstrom et al., 2023a; Bergstrom et al., 2022a; Bergstrom et al., 2018; Bergstrom et al., 2023b; Bergstrom et al., 2022b; Bergström et al., 2019; Bergström et al., 2023; Buus et al., 2019; Pocobello et al., 2024; Seikkula et al., 2003; Seikkula et al., 2011; Tavares et al., 2023) directly addressed questions of outcomes for individual consumers and populations, following implementation of OpenD (within Finland and outside Finland) and including personal meaning-making about psychosis. Studies were reported from 2003 to 2023 across four countries: Finland (11), and one each from Italy, Portugal, and Denmark. Most methods were cohort studies with long-term follow-up; also, one was a qualitative study and another a mixed methods case study. We note that studies based in Finland were all from the region of western Lapland and they included overlapping study populations. All but one study focused on adult populations in mental health services; the study by Buus et al. focused on child and family support services in Denmark. The evaluated services had integrated network meetings into a model of brief community-based children and family crisis intervention.

Being in the treatment group receiving OpenD in western Lapland (where service included rigorous staff training and whole of system reform) compared to matched comparisons was associated with a different diagnostic pattern - reduced reported chronicity, decreased diagnosis/incidence of schizophrenia and an increase in diagnosis 'brief psychotic reactions'. Characteristic earlier initiation of treatment and a decrease in use of neuroleptic medications were both reported as favourable for physical health.

Additional findings were changing patterns of consumers' service use, for example;

- Statistically significant decrease in the number of days in hospital compared to the comparison group
- Statistically significant reduction in the use of hospital services
- Less use of psychiatric services and out-of-home care for adolescents
- Elimination of long patient stays, among people with a schizophrenia diagnosis, without a corresponding increase in frequency of short hospitalisations.

Findings related to reduced cost burden included: less use of disability allowance for mental health disorders in the adolescent cohort and significantly lower cost of psychiatric treatment and disability allowance, compared to comparison groups.

These studies demonstrated the benefits of continued engagement in social networks, with significantly higher occurrences and more positive experiences of family meetings compared to the control groups.

In research with participants other than the Western Lapland cohorts, OpenD was found to be well received by patients and social networks/families and yielded clinical improvements. The study in Portugal reported improvements in functioning, clinical outcomes, expansion of social networks, and improved experience of well-being. Of note was the higher number of network meetings for people with less or no social network (Tavares et al., 2023). The large scale study of Danish young people with follow-up at 10-years found that recipients of OpenD had less emergency psychiatric treatment and less use of general practitioner services, and experienced 26% less unemployment. In the one-year follow-up within this study, people receiving OpenD had utilised outpatient psychiatric services more than the comparison group, but not at subsequent follow-up (Buus et al., 2019).

The recent Italian longitudinal study across six services reported significant strengthening of social networks, and psychological (CORE-OM) and functional (GAF) improvements over 12 months for study participants. There was no matched controls or alternative services with which to compare these outcomes (Pocobello et al., 2024). This study reported constraints impacting fidelity of implementation. No fidelity limitations were reported in the many studies in Finland, or in Portugal or in the application of OpenD in the Danish study, within a children and family community service.

### *Findings overall*

Read together, these five themed summaries present a picture of the research foci and system-related findings, at this stage in the development of research into the OpenD approach internationally. The next section of analysis sharpens the focus on the primary question of the Rapid Review, examining what the current research has to say about OpenD in regard to recommended system wide transformation impacts.

### Finding 3: Analyse the **Open Dialogue evidence of impacts against recommended system transformations.**

This section of the findings is the culmination of the earlier steps. It contains our analysis and supporting data for the relationship between OpenD approach and each of the 12 reform fields.

As noted earlier in the findings, seven of the fields relate to the reforms needed for direct provision of improved services to people. We begin with the transformational potential that is evident in the way staff are prepared to deliver OpenD approach.

#### Field 1. Enhance MH workforce

The largest volume of our research findings relates to the **workforce** focussed field of reform. Many studies directly examined the experiences of workers, as learners in training programs and/or their early experiences of practice using OpenD (as summarised on p 13). The term ‘transformation’ was used directly by research participants themselves and by those undertaking data analysis across countries (Lennon et al., 2023; Wates et al., 2022). One study described “The one-year Open Dialogue foundation training was a transformative experience for participants” (Anestis et al., 2024, p. 1) and another (Lennon et al., 2023) exploring individual’s learning experiences, explicitly identified depth of change as reported in theme “transformational nature of training”:

*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”. (Lennon et al., 2023, p. 999)*

Both training and practice were experienced by staff early in the OpenD work as emotionally demanding: *Clinicians expressed an authentic self in their interactions with service users and both service users and clinicians described network meetings as emotionally expressive, although this was described as overwhelming at times (Tribe et al., 2019, p. 1). Through the experiences of practice and training, many workers reported a welcome shift in their understanding of their role: "Letting go of the ‘expert’ position: The experiences of polyphony described by clinicians also related to a sense of relief in not needing to have all the answers or solutions to problems in the meetings.” (Sidis et al., 2020, p. 13). “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” (Stockmann et al., 2019, p. 315). The impact on themselves and their practice: “The personal insight. Integration of personal insights in training “had a notable flow on effect into the quality of their practice, and their own wellbeing.” (Wates et al., 2022, p. 793).*

Equally, the depth of learning investment for staff and the extent of changes in personal and professional identity, thinking, practising and living could also give rise to substantial challenges for people. One study in a German setting presented this conclusion: *“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.* (Lorenz-Artz et al., 2023, p. 5). These conclusions point to the disruptive impact of OpenD, it's not always welcomed.

This challenge requires attention, as it arose across several studies. In the USA (Florence et al., 2020), staff across two teams experienced a split between those who embraced OpenD and those who did not; in a team in Australia (Dawson et al., 2021b) a vacuum or absence of leadership occurred when new OpenD ways of working were taken up, and along with it assumptions of democratic team process that was poorly articulated. In Germany one team experienced “intolerable conflict between staff”, especially those who have versus have not trained in OpenD....“The interviewees made clear that the OD training polarized teams that had previously 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.’” (von Peter et al., 2022, p. 2). Uehling et al (2024) expressed the tension with this finding: “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.” (Uehling et al., 2024, p. 7).

Stepping back from that caution, many participants reported that the practice of OpenD enhanced their wellbeing in various ways: energising, increasing hopefulness, strengthening and deepening collegial relationships (Schubert et al., 2021) and decreasing sense of burnout (Florence et al., 2020, p. 687). Studies identified that staff embraced OpenD for reconnecting them with their purpose in mental health work and for building on their previous foundation of family therapy (Lennon et al., 2023; Seikkula et al., 2011).

Practically speaking, enhancing workforce skill for practicing high fidelity OpenD reportedly requires a significant investment in training. *“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 [adjunct model]”* (Uehling et al., 2024, p. 7). The longest-standing Finnish service has supported all staff to undertake a three-year training program, and internationally, implementers affirm a one year Foundation program, of approximately 20 days (Pocobello et al., 2023).

This section highlights that the significantly transformational workforce benefits of OpenD depend on the quality of accompanying organisational support. That is: high individual worker commitment to Open D may be undermined, and transformational skill building may be demoralising for the workforce, without strong and sustained organisational commitment.

## Field 2. Enable equity

Evidence for an experience of equity, the language of equity and inclusion for diverse families and clients was sparse across studies.

Features of marginal group inclusion were not routinely identified or analysed in service evaluations. One specific finding: [We have] ‘*Difficulty in translating the equity and polyphony principles beyond network meetings to the whole of service model.*’ (Einboden et al., 2024) gives attention to equity within the network meeting and in modes of intrasystem relating, not to equity of access in the broader societal sense.

There were more adjacent references, such as that network meetings created opportunities for appreciation among people who may have been devalued, oppressed, marginalised and traumatised. For example, positive experiences of more inclusive and equitable teamwork were identified in 5 studies. This could be considered a pre-condition for inclusive practice with communities and network participants. Research participants explicitly reported and valued feeling their contribution in network meeting was **as equals**:

“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” (Hendy & Pearson, 2020, p. 97).

Practitioners also reported a shift in power relations, whereby the traditional professional and medical hierarchy was disrupted and de-emphasised, and staff were able to be more vulnerable and open with each other. However, contra-findings identified that team equity was harder to sustain for whole teams. A services was aiming for “*change in power structure, but split between those who did and did not 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 agency; and second, as a power dynamic that was described as being unspoken within the agency.*” (Florence et al., 2020, p. 689).

This is a reform field for which there is conceptual alignment with the OpenD principle of **polyphony**, the active invitation for diverse voices. However, there was little to no evidence demonstrating OpenD impact of on enabling equity in social terms of diverse communities having ready access to service provision.

### Field 3: Focus on consumer priority

This field of reform was linked to a significant range of research findings. As evident in the reference reports of the WHO and the Productivity Commission, the focus on consumer priority showed up in the language of being ‘person-centred’, a value of OpenD observed by service users and workforce in an OpenD survey study: “*Agreed values included: Person-centered, Transparency and openness, Empathy, Warmth, Active listening Recovery focused:*” (Razzaque & Wood, 2015).

Evidence of network members determining the focus of care was provided across many qualitative studies. In the study by Omvik et al (2025), participants considered they could express needs openly, that important and difficult matters were carefully attended to, and this was reflected for network members in the “*three themes: “Empowered through participation,” Being welcomed and taken seriously,” and “Provide more clarity to enhance our ability to*

contribute.”(Omvik et al., 2025, p. 337). In the study by Gidugu et al. (2021) people reported this experience in network meetings: *“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”* (Gidugu et al., 2021, p. 157). And in the interview study by Sidis et al, *“Family members described appreciating transparency, openness, and a sense of collaboration that appeared to be associated with being able to direct content in sessions.”* (Gidugu et al., 2021, p. 23).

In a long term follow up interview study of recollections of OpenD experiences, participants reported they appreciated the workers showing interest, being open-minded and non-judgemental (Bergstrom et al., 2022a). A more recent group of OpenD participants reported they were able to define their own issues, feel heard and validated (Dawson et al 2021a). In a US study of OpenD-influenced model of Patient Centred Communication, the treatment cohort scored higher on the survey item: *“were you involved as much as you wanted in treatment decisions”*(Gerken et al., 2025, p. 7).

Outside of network meetings and in moments of decision making, it was not always easy to keep the focus on consumer priorities: *Principles were not simple to implement: including “network perspectives” and “having the person included in planning dialogues”* (Heumann et al., 2022, p. 6) especially in inpatient settings. A limitation to the privileging of consumer priorities in care may be seen in the findings where family members rate their influence more positively than do consumers. Pocobello et al. (2024) reported that *“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.”* (Pocobello et al., 2024, p. 8). This paper further identified that while families/networks immediately rated OD sessions highly, patients' ratings improved over time to almost match network/families' high ratings. Gidugu noted: *“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.”*(Gidugu et al., 2021, p. 159).

A subset of findings related to the value of peer workers in focusing on the person's needs and priorities: *“...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”* (Hendy et al., 2023, p. 5). That peer attunement might be of particular value, in situations where the consumer feels their priorities to be at odds with the priorities of other family members.

#### Field 4: Promote psychosocial wellbeing

A rich range of findings across more than 15 studies related to this field of reform, the relational core of OpenD supports a contextual and holistic view of people, so practice was intrinsically amenable to a promoting personal recovery and wellbeing:

*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: “Of course some people might benefit from treatment, I mean medication and stuff like 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.” (Bergström et al., 2019, p. 110).*

Similarly, Wusinich et al. (2020) reported: “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)” (Wusinich et al., 2020, p. 1037). In the study by Schubert et al. (2021), practitioners, especially psychologists, appreciated scope to relate authentically and humanely with people in distress.

The OpenD approach included more than medical issues in its ‘comprehensive care’, a common starting point in literature about the psychosocial breadth of care. Diverse life issues were evidently ‘in scope’ for OpenD work, from the initial crisis point through to more ongoing support. A prominent theme from OpenD was sense making: “*participants receiving open dialogue noted the collaborative experience of sense-making and feeling validated when medical professionals reflected using the participant’s own words.*” (Sunthararajah et al., 2022, p. 4). A narrative by Olsen (2015), deeply engaged in the life of a particular person within a network meeting, showed how the attentiveness between people opened up “a whole contextual structure” of the person’s difficulties, and an opportunity for them to take a different direction. The issue of violence within a key relationship came to light in a network meeting and space was held for the person to speak, listen, decide and act. Olsen related the story to illustrate the profound impact this had on her, regarding her practice and identity.

Individual consumers and families reported valuing new ways of speaking listening and relating, with ongoing benefits for family members together and individually, activating different types of psychosocial support. Several studies highlighted the breadth of disciplines in the OpenD team, re-balancing expertise away from medical dominance and with prominent allied health and peer roles, as one indicator of psychosocial focus. Diversity of team and disciplines was reported as a favourable feature supporting psychosocial remit, in the large survey of services by (Pocobello et al., 2023).

In addition to privileging wellbeing in the language and moment of the relational work by teams within the network meetings, many findings related to the larger ideological reform: a shift towards lay and non-medical language and understandings, recovery and identities as a philosophical foundation for OpenD services:

*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. (Schubert et al., 2021, p. 154).*

Such associated shifts were identified as having benefits for clinicians engaged in OpenD. However, this topic of promoting psychosocial wellbeing is associated with the same tensions that were raised in the section about the reform field Enhancing MH Workforce. Originating in family therapy and philosophy about human systems, the OpenD theoretical underpinnings contrast with common models. Jaakko Seikkula describes this contrast:

*“The two approaches differ in their theoretical assumptions about psychosis. OD emphasizes the most intense crisis phase and the process quality of building treatment plans. From the perspective of the stress-vulnerability model (posed by Zubin & Spring, 1977), ...families are involved in psychoeducation to improve communication to prevent relapses and to enhance remission either in individual session or multiple-family groups...many programs see psychosis as symptoms of an illness, whereas in OD psychotic behavior is seen as one possible answer in the present dialogue... (Seikkula et al., 2003, p. 7).*

These differences cannot be brushed aside, because the theoretical base of OpenD, placing mental distress, symptoms and wellbeing in their wider social context, is fundamental to the OpenD investment in working with these systems.

Finally, the evidence for psychosocial and wellbeing outcomes, for consumers and network members, were not routinely part of outcome studies and not often reported with common indicators. It appears that the crisis focus of the Open Dialogue approach, with an emphasis on aspects of early engagement especially in treating people experiencing psychosis, may mean the work done in support of wider wellbeing over the longer term is less attended to as yet in OpenD research. Even the foundation service in Finland has generated more research evidence for post crisis impacts than for psychosocial outcomes.

In addition to meaning-making, outcomes for psychosocial recovery could include: changes in relationships, housing, education, employment, income, physical health, breadth of social inclusion and citizenship. A small number of outcome studies in Finland (Bergstrom et al., 2022a), Italy (Pocobello et al., 2023) and USA (Florence et al., 2021) evidence a psychosocial focus of OpenD most strongly on the quality and extent of people’s connections or relationships with family members, friends and others. Longterm cohort studies in Finland and one in Denmark also identified improved employment outcome. So again, in principle OpenD sets the scene for psychosocial wellbeing and personal recovery; but to date the research does not routinely track these experiences or outcomes, so the evidence is preliminary.

## **Field 5. Uphold human rights**

While no studies reported frank data - regarding use of involuntary detention and treatment in OpenD services - more than 10 studies’ findings were at least partly relevant to this field of upholding Human Rights. The process of facilitating dialogue works at odds with substituted

decisions that are the basis of overriding human rights in mental health settings. Valuing of consumer voice, meaning and decision making within the OpenD approach appears to support advocacy for rights, in practice. Wates et al. (2022) reported:

*“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). (Wates et al., 2022, p. 795).*

Organisational expectations posed a continuing tension for participants working in public settings, wherever they perceived that policies and legislation required a decision or action without equitable dialogue, for the stated purpose averting risk or ‘safeguarding’: *“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) On such occasions, the principle of tolerating uncertainty and other elements of OD such as transparency and shared decision-making were undermined. (Anestis et al., 2024, p. 7).*

Other findings were less overtly about rights, but the evidence was geared for recognising consumers exercising choice: *“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) (Florence et al., 2021, p. 1776).* Consumers’ experience of choice was featured in an OpenD feasibility study: *“perceptions of shared decision making (SDMQ) were high throughout (CSQ53.236.36 on a 4-point scale and SDMQ55.296.501 on a 6-point scale; higher scores on both indicate better outcomes (Gordon et al., 2016, p. 1166).* In the UK study of peer supported OpenD, the high level of choice exercised by service users was contrasted with experiences in other NHS settings (Kinane et al., 2022).

Again, this topic connected through the lens of worker identities: *“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.” (Schubert et al., 2021, p. 160).* We read the term ‘acting upon service users’ as a reference to controlling practices and this finding as expressing practitioners desire to distance themselves from that practice. The practitioners were attempting to “adopt dialogical approaches”, which meant to resist “being action oriented” and to instead to listen.

Recent international implementation evaluation studies present OpenD as a promising approach for providing a more person-centred, recovery-oriented and rights-based mental health care system (Heumann et al., 2022; Pocobello et al., 2024; World Health Organization, 2022), however these studies do not report actual outcome data *per se* about recovery or human rights and legal status.

## Field 6. Combat discrimination

Some seven papers directly attended to stigma. The voices that spoke on this topic were the consumer and the peer workers, and destigmatising was strongly aligned to peer roles. From their survey about experiences of POD, Elran and Hefer (2022) found peer workers were proud of their destigmatising impact:

*“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 there and living your life’. The practitioner presents an affirmative model of disability and potential for post-traumatic growth.”* (Elran & Hefer, 2022, p. 10).

Likewise, Friesen et al. (2024) reported that the presence of a peer specialist “*makes you feel less alienated*”. Consumer participants reflected that the openness in OpenD itself was destigmatising:

*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”*(Twamley et al., 2021).

In one finding, a clinician shifted in their own stigmatising stance, as a result of training and working beside peer work colleagues (Stockmann et al., 2019). A peer worker identified that the OpenD training strengthened her self-perception, valuing more her own voice and contribution (Wates et al., 2022). These destigmatising impacts operated on a personal and local level; no studies directly reported impacts to show OpenD combating discrimination at a community or political level.

## Field 7. Support families and carers

Support for families was intrinsic to every OpenD service and so this field is evident in the literature, at least in common references to families and social networks. Family inclusion was somewhat taken for granted, in so far as *data* about practices and experience *for family members* was not prominent, within data about network meetings or episodes of treatment. Family experience did feature in this evaluation of a USA outpatient and crisis program:

*“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* (Gordon et al., 2016, p. 1167).

Similarly, in an Australian child and family service, family members appreciated transparency, openness and collaboration within their experience of directing content in sessions (Sidis et al., 2020) (Sidis et al 2020). More findings in youth services also indicated that both clients and families appreciated the Open approach, for its transparency and its ability to interrupt and

mediate difficult family communication (Buus & McCloughen, 2022). In this study, families sometimes found network meetings challenging, hard work; this was not necessarily a criticism:

*“While network members generally appreciated the dialogical approach, it was also occasionally described as uncomfortable and anxiety provoking (discussion p.314). ... 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. (Buus & McCloughen, 2022, p. 313)*

It appeared that the most longstanding OpenD services developed out of specific family therapy services. Several studies of workers’ skill development reported that the family-focus did not represent fundamental change, as family therapy or support was noted to be a foundation skill of the team members from the outset, in Finland and in other early expression of Open D: *“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 ((Lennon et al., 2023, p. 98).* This could account for the way that the service provided to families was taken for granted, not described in detail.

More recently established teams sought feedback from family members: “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.” (Kinane et al., 2022, p. 9). Many services reported the raw numbers of network meetings conducted by their team as it became established, or reported the numbers of meetings per consumer as a process measure. As OpenD reach has widened, (Pocobello et al., 2023) reported that services targeted to younger clients operated more closely in line with attending to the needs of the person within their context of family network. Indeed these child and adolescent focussed teams more strongly supported all the 7 principles.

So far we have reported on evidence for OpenD impact in seven of the 12 reform fields; those related to engagement with people and their networks in **direct service provision**. The following five reform fields centre on the **organisation of services**. Across the 53 studies we found less datapoints to analyse, related to four of these organisational fields. There was a range of findings for the final reform field of achieving treatment and recovery outcomes.

### **Field 8. Lead by lived experience** (with consumer & family roles in service design)

In this set of studies the involvement of people with lived experience of service use as colleagues was entirely cast as peer work; no papers included evidence of lived experience leadership, or of service co-design.

Embedding of peer roles in service provision is a reform recommendation in its own right. Examining peer work in OpenD approaches was the central aim of 5 papers reported in the earlier findings section of this report. In this section, mapping findings to fields of reform, peer

role have notably contributed to and in some cases lead reform in fields of enhancing workforce, upholding Human Rights, combating stigma and matching consumer priorities. Pocobello et al. (2023) reported that peer roles are embedded in 56% of the 118 services surveyed. However, there are a range of roles and frames around peers roles, some of which are partially excluding of peer workers.

The third element of lived experience featuring in reform is that of co-design, expected to encompass consumers and families. One study referred to use of participatory methods of research/evaluation that included service users, but provided no further detail. There may be illustrations to come of family/carer input into the *design* of services in the reports of the ODDESSI trial in the UK, since (Kinane et al., 2022) refer to co-production as fundamental to peer supported OpenD (POD). However, none of the 53 papers described or provided data about family or consumer engagement specifically in the design of OpenD services, or in the design of OpenD research.

## Field 9. Care in community

Studies of OpenD services align strongly in principle with the reform intent, that care be provided in the communities, to be available with ‘flexibility and mobility’ where people live and gain support. However, evidence that OpenD contributes in this direction is sparse.

Most services in the organisational survey implementation reported the OpenD being provided in community settings. Also, according to Pocobello et al. (2023), there was generally ‘integration’ of community-based MH services: *“Majority of the 72 [public sector] 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).

These existing descriptions are thin representations of the intent of community based care being delivered within communities, as opposed to in hospitals. A small proportion of OpenD services described as ‘not integrated’ were based in hospital only, clearly out of line with this field of reform. One included study, by Jacobsen et al. (2021) and based in Norway, examined the experience of OpenD, which was implemented entirely in inpatient settings. The extent to which community care was provided in outpatient clinics within larger health service settings was not clear.

Several of the papers reporting OpenD in Finland described early changes to service models, as context of the study. Aaltonen et al. (2011) reflected on the changed role of the hospital and the move of staff from hospital to out reaching crisis intervention (p8). Friesen et al. (2024) described the Parachute model in the USA as including outreach, with peer support enhancing community connections. The practices of outreach or home based service, which feature in the Finnish materials as part of Open Dialogue, were rarely or barely detailed in the majority of studies of service experiences or outcomes.

Considering the breadth of qualitative studies detailing OpenD practices for a specific service, it was striking that the issue of location of the team and of network meetings, the extent of outreach to people in their chosen settings, was not described or systematically reported.

### Field 10. Ensure responsive access and ongoing support

This reform field ties closely to OpenD principles of immediate help, flexibility and being needs adapted. However, there is little evidence from the 53 studies of OpenD services (beyond Finland) being accessible in the immediate sense and staying engaged, if needed for the longer term.

Many of the published studies centred on responsiveness in dialogical practices within network meetings; very few reported *actual data* specifically on the timeliness of service response. An emerging source of evidence is the service provider survey HOpenDialogue (instrument available in Pocobello et al. (2023)), which has operationalised principles including immediate help and collects data about structural details such as sources of referral and service hours. Using this survey, sub-study of 38 teams in Germany detailed their performance.

The German study (Heumann et al., 2022) reported challenges to providing easy access: “...several OpenD principles were not simple to implement, especially “immediate help in case of crisis” (Heumann et al., 2022, p. 10). Due to service system and team constraints, timely access was reported as “a weak element of implementation: access is slow. Minority of German services (25%) sometimes/often offer help within 24 hours.” (Heumann et al., 2022, p. 8). Further:

*“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).*

An Italian cohort study reported outcomes for newly referred clients to 8 specially established OpenD teams across 6 cities (Pocobello et al., 2024). In this study all participants were seen within 24 hours at a venue of their choice, clearly demonstrating the responsive access intended in this reform field. However, the recruitment ceased when team capacity was reached, suggesting that such responsiveness is not an ongoing feature of these services.

In line with OpenD principles, practice in Finland and with reform recommendations, Gidugu et al. (2021) identified that, in the Collaborative Pathway service in USA, families/carers could in a crisis recontact known team members, rather than (re)attending an emergency or triage service.

In terms of the reform priority that support should also be provided as long as needed, the research over two decades in Tornio reports a long period of engagement as commonplace, typically a three-year period or more, for people with a presentation of early psychosis. But current OpenD services appear to vary greatly in their capacity or intent to stay engaged for more than a limited number of sessions. In one service models reported here, the data mining study of Danish youth mental health service consisted of a single session up to a few network meetings (Buus et al., 2019). The Italian cohort study of OpenD services reported an average of eight network meetings per study year, but did not provide data on the duration of care episodes (Pocobello et al., 2024).

The idea that families themselves determine commencement and closure of an episode of support also posed a challenge for conventional provider-determined services. One study reported: “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” (Kinane et al., 2022, p. 10).

No study reported specifically on the OpenD principle of ‘psychological continuity’, which would be operationally relevant to this reform recommendation. To date, the OpenD research evidence attends mainly to the *content* of OpenD interventions, and not to the system and structure in which network meetings are provided: referral allocations, team arrangements, scale of resourcing, location and policies enabling access, responsiveness and continuing support.

## Field 11. Integrate social services

This reform field speaks to the range of practical supports that are associated with personal and social recovery. In principle, integration of a wide range of social services, as part of a person’s rich network, is expected in studies based in Turku, Finland. As illustrations of potential benefits of integration, Bergström et al. (2019) identified the value of partnering with schools, as young people in crisis often reported bullying. Friesen et al. (2024) suggest that peer workers are valuable for connecting people and families into community supports.

The reform field of integrating social services is not featured in service descriptions or explicitly evaluated with any data. We did not find elaborations on how social support teams were effectively included in network meetings, or any reports of social outcomes directly linked to integration. The survey study by Pocobello et al. (2023) referred to integration as joining up of community and inpatient care and to psychosocial integration by reporting the disciplinary diversity (and heterogenous skillset) of the team, and valuing the most diverse “multiprofessional teams” which were reported in 17/96 services.

On the contrary, studies reported staff perspectives on obstacles to multi-agency engagement. The study by Holmesland et al. (2010) provided a set of findings about the workers’ experiences and challenges of integrated transdisciplinary work within the Open Dialogue approach and network meetings, in a service for adolescents and young people in

Norway. OpenD team members experienced colleagues from other agencies as wanting the OpenD team to take action, more than to talk and collaborate. They identified a need for significant relationship building, and a change of OpenD team member roles, for interdisciplinary work to be facilitated and effective. This finding aligned with concerns raised by Hendy and Pearson (2020) about relating with colleagues from other parts of the health system. OpenD team participants experienced conflicting expectations and pressure to just fix problems, where providers held more traditional views of expert roles as intervening, rather than wanting to join in the dialogue.

Details were lacking about any specific *process* of including social supports, beyond family and team members. Though mentioned in the background of many papers, there are as yet few empirical accounts of this integrated service model, such as the inclusion of wider community specialists (education, employment, housing) in OpenD network meetings or other collaborations for psychosocial benefit.

## Field 12. Achieve treatment and recovery outcomes

This reform field highlights that reporting of outcomes for people and communities is fundamental to an effective and accountable mental health service system. As noted in earlier findings in this report (page 14), several quantitative outcomes studies, samples are small, lack controls, and rely on service use indicators, such as inpatient days as (proxy) measure of effectiveness, arguably reflecting social recovery.

The background section of this report included the early studies for 3 cohorts of service users in Tornio, Finland. Reported outcomes included lower long term medication use, reduced dependence on acute services as hospitals and community outcomes of lower rates of serious mental illness diagnoses and reduced dependence on disability allowances. These studies have been widely reported and critiqued, noting the overlapping samples across studies, the lack of controls or comparison data and querying if medication prescription and acute service use is an outcome or an input of the model of care itself. For patient populations in the 2000s the service reported shorter duration of untreated psychosis as an important feature of service delivery and population outcomes of high levels of return to studies and employment, low levels of enduring symptoms (Seikkula et al., 2011).

A small subset of OpenD studies report service users' outcomes beyond Finland. The outcome evaluation study in Portugal reported statistically significant changes in functioning (via the GAF). Clinical outcomes (BSI), distress (CORE-OM) expansion of social networks (LSNS-6), and experience of well-being were promising, but non-significant (Tavares et al., 2023). The study of Danish young people found at 10-year follow-up that recipients of OpenD demonstrated lower requirement for emergency psychiatric treatment and primary care/general practitioner services, and experienced 26% less unemployment (Buus et al., 2019). Employment or education outcomes were also reported for the small sample in the UK:

*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. (Kinane et al., 2022, p. 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. (Kinane et al., 2022, p. 8)*

Effective outcome reporting relies on a commitment all of its own, in addition to the demands of practice. Pocobello et al. (2023) identified that having research capacity to support the OpenD teams was one significant quality indicator.

**Summary of evidence in support of Open Dialogue having impact across service reform fields.**

The included studies show that an OpenD approach contributes to mental health and social support systems, in the direction of recommended reform. The acceleration and international span of OpenD research publications in recent years points to the likelihood that this body of evidence is growing.

This core findings section of the report highlights and explains several areas of evidence strength for OpenD at this moment, and recognises other areas with some supporting evidence. However, limited evidence, silences and gaps are clearly evident in research so far. This diagram provides a summary ‘heat map’ of the reform fields of evidence strength and the fields where there is as yet little evidence of OpenD impact.

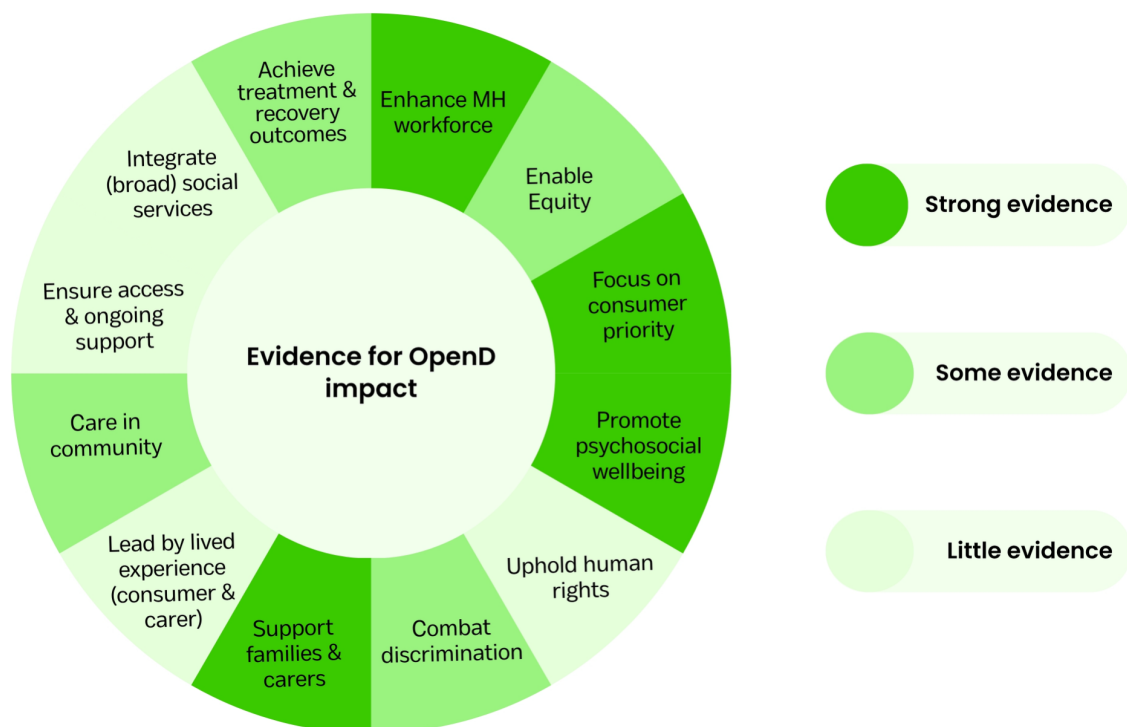


Figure 4: Evidence for Open Dialogue impact in system transformation

The following discussion section brings forward current strengths and opportunities for OpenD research to provide the greatest value add to the process of reforming mental health systems internationally.

## Discussion

This final section of the report is organised to answer these questions:

What is the compelling evidence for transforming impacts of OpenD? And what are gaps in evidence/questions that are worthy of attention in future research?

It begins with a section examining evidence of reform impacts, including the strongest and modest evidence, and evidence of implementation challenges. This is followed by discussion of evidence gaps and research recommendations.

### Evidence of reform impact to date

#### 1. Strongest evidence for valued experience of service provision

The strongest evidence across the 53 reviewed studies shows the contribution of OpenD to high quality service provision, directly for people and their networks, by: **enhancing workforce, supporting consumer priorities, promoting psychosocial recovery, and supporting families.**

The philosophical underpinnings of OpenD give first priority to interaction and meaning making (Olson et al., 2014) for understanding and addressing the wide range of mental distress and crises. This can be contrasted with a biologically dominated research agenda in mental illness and treatment, especially for psychosis (For example Nelson et al., 2011). It follows that consumer and family priorities are elevated in OpenD service delivery regardless of resource limitations, and also that the interactional focus is supported by skill-development in workforce. These field are closely aligned with the international drive for mental health care to be recovery oriented, that is attending to personal recovery and the experience of living well and not only supporting clinical recovery, which is often defined by clinical expertise (Slade et al 2014).

Building on the OpenD theoretical foundation, current research shows most elaborate evidence of reform through **enhancing workforce** skills and wellbeing through training and practice, which leads to positive service provision impacts. Almost all qualitative studies in the reviewed findings related to experiences of growth and valuing of learning by practitioners/trainees, including lived experience peer workforces. Evidence suggests that peer supported development of OpenD strengthened these impacts, as peer work is typically invested in advocating for consumer priorities and emphasising support for recovery (Mead, 2014). OpenD training requirement is a significant commitment for organisations and practitioners; evidence shows most OpenD services investing in year-long training for staff. Both training and early OpenD practice enhanced practitioners' knowledge, skills and

experience of their work; this impact is highly valued by almost all who opt in for this learning and change.

These OpenD impacts are powerful for MH systems, because these particular, practice-centred fields are evidently difficult to effect and to sustain, challenging embedded ways of thinking and interacting in healthcare (Davidson et al., 2021). Recovery expert Larry Davidson and colleagues reflect on the experience of reforming US mental healthcare since 2000, where the overarching aim is for services to give greater attention to social and personal recovery. They identify a tendency for MH systems to emphasise expert treatment first, individualise responsibility for recovery and move away from addressing social determinants of health and collective roles. We discuss this further in regard to evident challenges associated with OpenD.

A feature of OpenD evidence is positive experience of service, as reported by consumers and family members across a range of qualitative studies and reflected in a report of comparatively higher service ratings. For the purpose of reform fields, consumer and family experiences of OpenD were mapped also to fields of equitable communications, greater control, and support. But the simpler overarching message was that for families OpenD was a preferred approach, associated with higher satisfaction. The review of OpenD by Freeman et al. (2019) showed that *“families appreciated the openness and transparency of network meetings and felt that reflections promoted a collaborative atmosphere”* (Freeman et al., 2019, p. 62). No study reported specifically on the OpenD principle of ‘psychological continuity’, although ongoing relationships and trust are common features of consumer and family satisfaction. One exception in the private sector may be the Collaborative Pathway service in US that enables families to recontact team members (Gidugu et al., 2021).

A significant driver of reform is consumer, family and community dissatisfaction with services, a dominant subject in the *Royal Commission into Victoria’s MH services* reports, being one of the three key references for the 12 reform fields. As a significant driver for continued reform, service users and communities are likely to value and advocate for services that achieve change across all reform fields.

This set of strongest evidence results from integrating findings from multiple qualitative studies. Though each included study is modest in scale, the combined analysis is compelling, especially given the geographic, linguistic and cultural reach.

## 2. Evidence of impact on treatment effectiveness, reduced stigma and support of rights

Some evidence shows OpenD impacting a further four, widely recommended reform fields of: **enabling equity** of service, **achieving treatment effectiveness and outcomes**, **upholding human rights** and **combating MH stigma**.

Evidence of clinical and recovery effectiveness of OpenD is modest at this point. Valuable evidence regarding OpenD outcomes is reported across a few sites and papers, but the case for its effects is not yet robust (Freeman et al., 2019). It is an indicator of mature systems and

models of care to report how well people are doing, after an episode of care. A strong experimental approach to trialling peer supported Open Dialogue (POD) via a cRCT study in UK will be important for strengthening the evidence base (Pilling et al., 2022). International collaborations for real world evaluations are also critically important developments for standardising reporting of routine outcomes (Pocobello et al., 2023). Some standard tools and approaches are emerging for measuring social networks, personal recovery, citizenship participation, as well as routine measures of consumer and family experiences of service (for example see the Clinical Outcomes in Routine Evaluation–Outcome Measure (CORE-OM) and the Lubben Social Network Scale (LSNS), in Pocobello et al. (2024).

In the fields of reform of enabling equity, upholding human rights and combating MH stigma, OpenD shows promise of impacts. The character of the supporting evidence here is implicit, seen in descriptive findings for several qualitative studies, for each of these reform fields. Across sites, countries and cultures, findings refer to shifts in the attention given to diverse perspectives, processes of decision-making and power relations in practice. The evidence for these positive shifts is principally identified within the practice setting of OpenD network meetings, and mainly from the perspectives of practitioners.

### 3. Open dialogue growth as one systemic impact

In light of this evidence of OpenD impact in the specific fields, there is value in noting the trajectory of growth in interest and uptake of OpenD, across countries. According to analysis by Pocobello et al. (2023), implementation in mental health services accelerated in 2006, growing by 24% each year, from 5 services in 2006 based in Finland and Norway, to more than 100 centres in 24 countries by 2020 (Pocobello et al., 2023, pp. 5, supplement). As many qualitative studies attest, growth has so far been driven by grassroots innovators within services and researchers. Accordingly, the global proliferation of OpenD is characterised by diverse approaches and efforts to integrate the principles and practices into existing (and mainly) community-based models of specialist MH care.

Given the significant impact of OpenD training for workers' identity and mindsets, this growth is itself having an influence on the mental health sector. As a counterpoint, we note also that, while implementation was underway in many sites across Europe and English-speaking countries by 2022 (Pocobello et al., 2023), there is currently no endorsement of OpenD at a policy level across any national system, including in Finland.

### 4. Evidence of challenges for OpenD impact

#### **Challenges for MH practitioners**

Originating in family therapy and philosophy about human systems, the theoretical underpinnings and the assumptions about psychosis and family/network engagement are different for OpenD systemic approaches than dominant biopsychosocial approaches. As identified in the findings sections (p. 10, p. 16), the strongly positive findings of OpenD impact for the workforce are offset by a set of findings about conflict experienced by practitioners, at the levels of internal turmoil, interpersonal and intra-team conflict. In some instance this is

reported as intolerable, leading to rejection of OpenD. This challenge must be further examined in implementation research, to see if positive impacts of OpenD can be realised and sustained.

### **Implementation challenges for organisations**

Several features of implementation were noted to impede reform impacts.

Training costs, staff turnover and logistics pose substantial initial barriers to implementation of OpenD (Gordon et al., 2016; Hopper et al., 2020). Florence et al. (2020) concluded that lengthy and expensive training and resistance to changing organisational culture were the main challenges to implementation, operating at the two levels of structural changes and practices of OpenD. Further, there are particular and pressing funding issues for services based in the US, where the insurance-reliant funding structure presents a challenge to implementation in any public (i.e. widely accessible) service system.

This research reinforces the conclusion of Jacobsen et al. (2023) that initiating and sustaining dialogic practices requires comprehensive organisational buy-in: shared understanding of OpenD and collaboration between professional networks, among leaders and across service elements, such that whole services need to take responsibility to facilitate change and make room for an OpenD approach (Razzaque & Wood, 2015). Freeman et al. (2019) suggested that the differences in individual service-level implementation of the OpenD approach in clinical systems “may depend on the ‘double challenge’ of introducing a transformation at the individual and the service level” (Pocobello et al., 2023, p. 2). The review of OpenD implementation by Buus et al. (2021) linked the distinctive challenge to the high degree of indeterminacy that is a feature of dialogical practice, as a ‘needs adapted’ therapy, more than a technical process. This helps to explain the work of continual negotiation amid teams and across organisations, and the effortful unlearning, for many staff familiar with more structured practices.

So, beyond the (usual) cost of training, the broadly reported requirement in this review is the depth of leadership commitment, openness to philosophical change and substantive investment in operational restructuring and communication. Investment at these three levels is required to match the depth of individual practitioner commitment to learning and practicing, to achieve high fidelity implementation.

A protocol for a randomized controlled trial comparing OpenD with standard community care in NHS services in the UK was published in 2022. The trial itself commenced in 2017; it is evaluating the approach’s clinical and cost-effectiveness.

Two published reviews highlighted the modest scale of research studies, mainly featuring one specific organisation, and the naturalistic research design of varying adaptations, all of which temper the strength of outcome findings. While the evidence for OpenD impact is formative and diverse, there are clear gaps. These are the focus of the next section.

## Evidence gaps

The diagram (p 29) summarises the areas of strength and weakness in OpenD evidence. At a glance we can see that there is not currently strong research evidence that OpenD impacts several important aspects of reform.

The first findings section of this report detailed 12 fields of reform that are widely affirmed for mental health systems. In the background section, we summarised key features of the OpenD approach, including the seven principles that are widely cited (Olson et al., 2014). Alignment is obvious between OpenD in principle and all 12 fields. Yet research evidence for outworking of many principles and related reform fields is lacking.

So to date, there is a **significant gap between the reform potential** of the OpenD approach, based in its principles and evidence, to show that impact on reform. Further, the depth and breadth of **research evidence** for impact on all fields could be of higher quality, more consistent in design and with a broader reach across countries, populations age-groups and sites/settings. It stands to reason that those areas with modest or weak evidence are also gaps. Valuable evidence regarding OpenD effectiveness is reported across a few sites and papers, but the case for its effects is not yet robust.

Practices and data about immediate access and ongoing support deserve attention. Although the enabling of access, immediately and ongoing, can be a resourcing issue OpenD can be useful in foregrounding reform to access in ways that consumers, families and communities' favour. OpenD is progressive in its objective to continue working with people until they choose to end contact, rather than the clinician and service process determining those decisions, as is traditional in the medical world. OpenD research might show its impact in the area if services reported against the OpenD principle of psychological continuity, to what extent does the service enable ongoing consumer/family/worker relationships in crisis and longer term support.

These fields of **enabling equity, integrating social services, achieving treatment effectiveness and outcomes, upholding of human rights** and **reducing MH stigma** should be the subject of and embedded in OpenD research programs.

OpenD research is silent on the reform fields of **lived experience leadership and codesign**. In addition to endorsing peer workers as a feature of enhancing workforce, Australian and international policy sources promote a critical role for people with lived experience of mental distress and of service use in driving and inspiring reform. The Victorian commissioners were explicit in recommending lived experience leadership exercising strategic and management roles, to bring vital perspectives and to maintain reform momentum (State of Victoria, 2021). Both the national Productivity Commissioners and the WHO authors identified the critical need for contributions from grassroots service users' (consumer and family) to be prominent in processes of co-design. While lived experience voices continue to advocate for OpenD (Seikkula, 2025), OpenD researchers are yet to partner with this community of experts.

Even where evidence of certain impact was compelling across qualitative studies, this was usually not backed up by quantitative data. There is scope for positive impacts to be more strongly evidenced through large scale, rigorous and cooperative research efforts.

## Research recommendations

Surveying the reviewed OpenD research overall, the areas of evidence reported here are generated by synthesis of many pilot- and case-studies and small comparative studies, often not benefitting from common measures and methods. Stronger research is recently emerging, through international collaborations. This review provides stimulus for researchers of the OpenD approach to strengthen the evidence; indeed this is needed to underpin the current and next wave of implementation and to inform systemwide investment.

### Need for further research of population outcomes and impacts

In addition to endorsing peer workers as a feature of enhancing workforce, these policy sources promote a critical role for people with lived experience of mental distress and of service use in driving and inspiring reform. The Victorian commissioners were explicit in recommending lived experience leadership exercising strategic and management roles, to bring vital perspectives and to maintain reform momentum. Both the national Productivity Commissioners and the WHO authors identified the critical need for contributions from grassroots service users' (consumer and family) to be prominent in processes of co-design.

The existing outcome research raises the question: OpenD is ...for whom? It is notable that the Finnish literature supports a proposition that the Open D approach is designed to target psychosis, whereas the calls for reform and the current MH service innovation are not mainly addressing the population with these experiences or diagnoses. Because the **calls for reform are for entire communities, the emphasis on responding to crises with network and therapeutic response that lose that specificity, making only side reference to sub-group of people characterised as experiencing severe mental illness and their supporters.** Reform-driven innovations may indeed sidestep this important group of people. Are we planning in terms of treatment outcomes or something else? As referenced in (Jacobsen et al., 2023): "In the United Kingdom, service users reported significant improvements in wellbeing and functioning with OpenD" (Kinane et al., 2022, p. 199).

### Need to target, structure and coordinate further evidence for organisational implementation

Since the review by Freeman et al. (2019), the body of evaluative research has grown, reporting on OpenD as a way of organizing services, including fidelity i.e. whether the intended service-level and structural changes of the OpenD approach are actually in place and effective. This work is important to underpin all evidence of OpenD and it links to many fields of reform that are the focus of this review.

In earlier pages we reported also on the topic of implementation challenges and barriers, because pursuit of transformational reform is contingent on *feasibility*, i.e. the potential to implement with adequate fidelity. So, the growing evidence for barriers to implementation warrant investigation.

In summary, we recommended these ways forward:

- In existing and new OpenD research collaborations, priority should be given to consolidating the most fitting tools and methods for evidencing OpenD service outcomes
- To evidence OpenD impact in fields of psychosocial wellbeing and recovery, equity and human rights, OpenD research could be strengthened by connecting with recovery researchers and programs.
- To mature the evidence base about the impact of OpenD on internationally affirmed system reform, coordinated research investment is required
- To consolidate evidence about the effectiveness of OpenD, as a core model of care provision at the service level, agencies also require research commitment.

The OpenD approach is unlikely to show evidence of several aspects of reform without system investment. There are no obstacles in principle to OpenD showing impact across reform fields of **social care integration** and **service accessibility and ongoing support**; indeed, since the earliest research studies specifically in Finland, these are asserted as features of the Open Dialogue service on which international implementation is based. **Enabling equity** as a reform feature is also aligned in principle with OpenD as a respectful and inclusive approach, but equitable access may be limited by resourcing. Finally, **lived experience leadership, and codesign** are not as yet codified features of an Open Dialogue approach, but these power-sharing initiatives sit well with the increased implementation of peer supported Open Dialogue (POD) in the recent decade. So these four reform fields first require system commitments and investments (Harvey et al., 2023) within OpenD implementation projects and systems, more than research efforts.

# Appendix

Table of papers

## Supplementary files

Supplement 1: Review Methods

Supplement 2: Reform fields with examples from policy sources

Supplement 3: Tables of data extracts mapped to fields

.

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