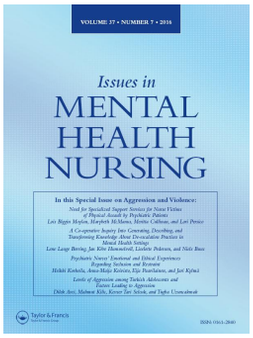

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ABSTRACT

Open Dialogue is a resource-oriented mental health approach, which mobilises a crisis-struck person's psychosocial network resources. This scoping review 1) identifies the range and nature of literature on the adoption of Open Dialogue in Scandinavia in places other than the original sites in Finland, and 2) summarises this literature. We included 33 publications. Most studies in this scoping review were published as "grey" literature and most grappled with how to implement Open Dialogue faithfully. In the Scandinavian research context, Open Dialogue was mainly described as a promising and favourable approach to mental health care.

Introduction

Open Dialogue is a resource-oriented approach to mental health (Priebe, Omer, Giacco, & Slade, 2014), which aims at mobilising psychosocial resources in a crisis-struck person's social network (Seikkula, 2000). It includes a particular *dialogical* approach to psychotherapy and an emphasis on organising responsive and seamless healthcare pathways. The approach is recognised for its capacity to promote personal autonomy, social inclusion, service user, family, and social network involvement (Gordon, Gidugu, Rogers, DeRonck, & Ziedonis, 2016).

Open Dialogue was originally developed in Western Lapland in Finland, but has now been implemented in several places outside Finland, where it has been modified to fit the particular local healthcare organisational structures. The other Scandinavian countries were the first ones outside Finland to adopt Open Dialogue and some sites have accumulated several decades of experience with the approach. In this paper, we focus on how Open Dialogue was adapted and implemented in these countries and summarise both scientific and grey literature. Summarising the literature in English may be helpful in the continuing work of adapting Open Dialogue into healthcare services and social services in countries inside and outside Scandinavia.

Open Dialogue was developed gradually in Western Lapland in Finland from the early 1980s to the mid-1990s where it grew out of a therapeutic approach for treating and rehabilitating people with schizophrenia called *the need-adapted treatment* (Alanen, Lehtinen, Räkköläinen, & Aaltonen, 1991). The need-adapted approach emphasised a flexible and individualised approach to each person and their families, including family-oriented therapy meetings (Lehtinen, 1993; Räkköläinen, Lehtinen, & Alanen, 1991). Open Dialogue extended need-adapted treatment by implementing mobile crisis intervention teams and by having a particular dialogical focus on the communication in the index person's social support system.

The development of Open Dialogue included a gradual, but substantial reorganisation of the psychiatric services where individually tailored crisis teams comprising relevant inpatient and/or outpatient staff became responsible for the treatment. Furthermore, all staff members of the mental health services went through a three-year psychotherapy training course (Seikkula, Alakare, & Aaltonen, 2001a). In the mid-1990s, experiences from developing the model and several local action research studies led to the articulation of seven principles that have been articulated in numerous publications: 1) Immediate help: The first meeting takes place within 24 hours of the first contact. 2) A social network perspective: Treatment meetings engage the index person's social network as integral participants. 3) Flexibility and mobility: Therapy is designed to meet the specific needs of each individual, flexible to changing needs, and often takes place at the person's home. 4) Responsibility: The first professional in contact with the family takes responsibility for the first network meeting, hereafter the team takes over the responsibility. 5) Psychological continuity: The same team continues to be responsible throughout the whole treatment. 6)

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Tolerance of uncertainty: Decisions about treatment are preferably discussed over several meetings before being implemented. A subsequent treatment meeting is always planned at the end of each meeting. 7) Dialogism: During the treatment meetings, the focus is on building up new understanding among the different participants (Seikkula, 2000).

The gradual development and implementation of Open Dialogue in Western Lapland has meant that the approach did not lend itself to being rigorously tested in a randomised controlled trial. However, Seikkula and colleagues have published a number of descriptive *post hoc* studies drawing on clinical register data from the cohort of people that received Open Dialogue throughout the implementation period.

In Seikkula, Alakare, and Aaltonen (2001b), the aim of the study was to identify factors associated with good and poor responses to Open Dialogue treatment. The research team classified people with first-episode schizophrenia-type psychosis ($n = 78$) during a five-year period (1992–1997) according to the severity of psychotic symptoms and their type of income (Seikkula et al., 2001b). In a two-year follow-up study (Seikkula et al., 2003), the sample included people with first-episode schizophrenia-type psychosis who ended receiving a schizophrenia diagnosis. Three samples were compared: a group ($n = 22$) receiving an early version of Open Dialogue (1992–1993); a group ($n = 23$) receiving full scale Open Dialogue (1994–1997); and a group ($n = 14$) of people with schizophrenia at another treatment centre (1992–1993). In a subsequent two-year and five-year follow-up study (Seikkula et al., 2006), the sample included people with first-episode schizophrenia-type psychosis who were divided into a group ($n = 33$) receiving an early version of Open Dialogue (1992–1993) and a group ($n = 42$) receiving full-scale Open Dialogue (1994–1997). Aaltonen, Seikkula, and Lehtinen (2011) studied the incidence of functional non-affective psychosis or prodromal symptoms of schizophrenia by comparing a group ($n = 139$) treated before the implementation of Open Dialogue (1985–1989) to a group ($n = 111$) treated with Open Dialogue (1990–1994). Finally, Seikkula, Alakare, & Aaltonen (2011) used two-year follow-up data to compare three samples: a group of people ($n = 18$, 16–50 years old) with non-affective psychosis receiving Open Dialogue (2003–2005); a group ($n = 33$) receiving an early version of Open Dialogue (1992–1993); and a group ($n = 43$) receiving full scale Open Dialogue (1994–1997).

The abovementioned studies promisingly suggested that Open Dialogue was associated with positive effects on social function, better work and education retention, and a reduction of days of hospitalisation for people with first-episode psychosis/schizophrenia (cf. Gromer, 2012). However, because of the basic before-and after-designs, the reliability of data, and the use of basic statistical methods, including the omission of adjusting for important confounding variables, it is not possible to draw any strong conclusions about the effects of Open Dialogue, (cf. Lakeman, 2014).

Open Dialogue in Western Lapland has also been examined using qualitative methodologies. The thesis by Haarakangas (1997) examined linguistic interaction during 10 video-recorded network meetings by means of a dialogical analysis. The analysis drew primarily on Bakhtin's and Voloshinov's theories of dialogism and on Maturana's concept of structural coupling. In Seikkula (2002), good and poor outcomes, in terms of source of living and psychotic symptoms, were explored by means of a qualitative sequence analysis of the 2–3 first therapy meetings of a matched sub-sample of 10 people with good outcomes and 10 people with poor outcomes. The treatment meetings were video recorded and analysed according to: 1) Interactional dominance, 2) Indicative vs. symbolic meaning, and 3) Monological vs. dialogical dialogue. Open Dialogue has also been presented and discussed by means of case stories and lengthy extracts from Open Dialogue network meetings, see for instance (Seikkula, 1994, 2003, 2008, 2011; Seikkula et al., 2001a, b; Seikkula & Olson, 2003; Seikkula et al., 2006). In different ways, this group of papers illustrate and theorise how the seven main principles of Open Dialogue have been operationalized as well as some of the benefits and challenges of working with social networks and dialogism.

AIMS

Despite a lack of robust evidence about the effects of Open Dialogue, Open Dialogue and dialogism have evolved into a social movement seeking and providing alternatives to conventional psychiatric treatment and the approach has been adopted in several places other than the original sites in Finland. At some sites Open Dialogue practices have been in place for several decades. In the current review, we focus on the Scandinavian countries as they have the longest history of adopting Open Dialogue. The aims of this paper are 1) to identify the range and nature of the existing literature on the adoption of Open Dialogue in Scandinavia, in places other than the original sites in Finland, and 2) to summarise this literature. The findings may be of interest to policy makers, social and healthcare practitioners, and mental health service users.

Methods

We chose to perform a scoping review (Arksey & O'Malley, 2005; Levac, Colquhoun, & O'Brien, 2010), which is appropriate for mapping an emerging field of research, such as Open Dialogue. Further, it is an appropriate approach for answering broad research questions in an area where the literature is based on a variety of study designs and published both with and without peer review. We adapted the methodological framework described by Arksey and O'Malley (2005), which consists of six steps:

1. *Identifying the research question*. The research questions were: "What has been reported regarding the adoption and implementation of the Open Dialogue approach in places other than the original sites in Finland?" and "What is the scope of these reports?"
2. *Identifying relevant studies*. The key inclusion criterion was: Publications concerned about the adoption/implementation of Open Dialogue in the Scandinavian countries outside Finland. As Open Dialogue had been appropriated to places other than the original sites in Finland, it was a continual challenge to differentiate between reports of projects with high levels of fidelity to the original Open Dialogue principles and projects with mere tokenistic references to Open Dialogue. There are several similar approaches to network intervention and we chose to include

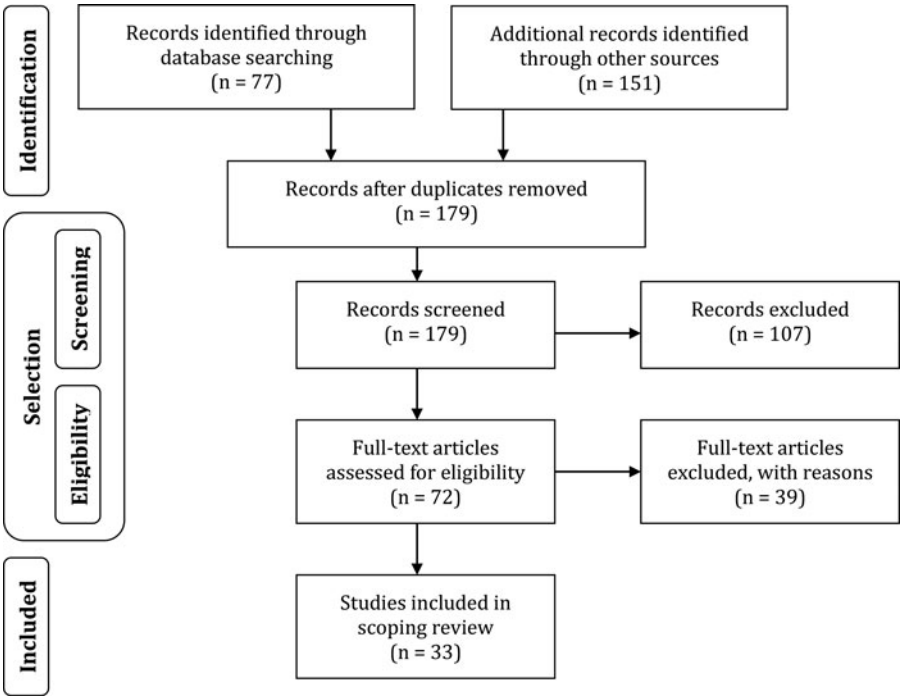

Figure 1. Flow chart of literature search.

publications where the authors acknowledged a strong influence of the Open Dialogue principles. Finally, we included studies in Danish, English, Norwegian, and Swedish, and did not impose any limitations on the year of publication. Systematic searches were conducted in the following databases: PubMed, CINAHL, Embase, and PsycINFO. We searched for grey literature using the Google search engine. We systematically searched for further publications through Open Dialogue websites and the authors/project managers associated with the identified Open Dialogue projects. The reference lists of all identified publications were reviewed and relevant references are included in the search.

3. *Study selection*. We applied an exclusion criterion that was developed *post hoc* to focus on relevant studies: 1) Publications with a very limited use of empirical data from adopting/appropriating Open Dialogue. These studies were excluded because they did not contribute to answering the research questions. We included 33 publications. For more detail on the selection process, please see search flow chart in Figure 1.
4. *Charting the data*. We have charted the included publications according to: 1) Author(s) and the year of publication, 2) Study context, 3) Methods, and 4) Key findings. See the chart in Table 1.
5. *Collating, summarising and reporting the results*. "Results" section includes a narrative summary of the publications thematically organised around the sites of implementation.
6. *Consultation exercise*. Aiming at increasing the review's relevance to Open Dialogue practitioners and stakeholders, we asked members of the Australian and Danish Open Dialogue networks to comment on a very early draft of manuscript. We asked them to consider to which extent the review reflected their perspectives on Open Dialogue adoption and implementation and whether they had ideas about additional or new issues that would make the review more valuable to them as key stakeholders. Five out of the six invited members responded and we used their feedback to reorganise and alter the manuscript. Most changes were made to "Discussion" section, where the comments increased our understanding of the tensions between those stakeholders defending the original open-ended and needs-adapted approach from Finland and the more pragmatic stakeholders emphasising the need for manualising and operationalizing the approach.

Results

As the majority of publications were linked to particular Open Dialogue projects, we present the findings related to each of the selected Scandinavian countries and, where appropriate, specific projects. In the sections below, we have also chosen to refer to publications that were not included in the final sample. This was done with the aim of providing readers with a stronger sense of the context of the included publications that reflects the gradual growth in the implementation of Open Dialogue. These background references are marked with an asterisk "∗."

Denmark

Open Dialogue was first adopted into the Danish social services and mental health services in the early 2000s. In 2000–2002, Open Dialogue was evaluated in a child and adolescent outreach crisis intervention team at Augustenborg Sygehus in Southern Denmark. A qualitative and a quantitative evaluation (Jensen & Jensen, 2001) indicated that the intervention had been effective

Table 1. Chart of included studies.

Country/ publication(s)/place	Study context/type of open dialogue	Methods	Key findings
Denmark			
Jensen and Jensen (2001) Augustenborg, Southern Denmark	Interdisciplinary child and adolescent crisis outreach team offering Open Dialogue network meetings	Qualitative interviews with patients, families, and professionals; and quantitative survey of collaborative partners	The responsive outreach intervention relieved the families and was perceived as a less intrusive alternative to hospital admission
Thylstrup (2009) Odsherred, Zealand	Interdisciplinary and cross-sectorial teams offering Open Dialogue network meetings. A focus on dual diagnosis patients	Repeat qualitative interviews with patients, significant others, and professionals; and psychometric measurements of patients	The intervention strengthened the size and quality of family relationships and supported positive interactions among collaborating participants
Balleby and Søbjerg (2012), Søbjerg and Balleby (2012)[⌘] Odsherred, Zealand	Interdisciplinary and cross-sectorial teams offering Open Dialogue network meetings. A focus on marginalised patients	Participant-observation of network meetings/staff meetings and collecting documents. Qualitative interviews with patients, relatives, and professionals	The approach seemed to increase the professionals' perspectives, which strengthened coordination of care focused on the patients' own wishes
Johansen and Bille (2005) Central Zealand	Psychiatric outpatient treatment organised round network meetings inspired by Open Dialogue	Qualitative interviews with two families	Network meetings were respectful and involving, but the professionals' level and type of engagement was not always clear to the families
Johansen and Weber (2007) Central Zealand	Five wards; inpatient mental health treatment organised round network meetings drawing on central elements of Open Dialogue	A pragmatic evaluation drawing on observation, qualitative interviews, focus groups, and survey data on all professional groups	It was possible to implement network meetings, to focus more on networks, and use reflection. Medical staff became increasingly sceptical towards the concept.
Søndergaard (2009) Southern Zealand	A group of staff at an outreach team pragmatically integrating some core Open Dialogue principles into their work	Case study approach based on ethnographic field work	The implementation process was very challenging and ultimately failed. Several compromises were made that were in conflict with Open Dialogue principles and procedures
CFK - Folkesundhed og Kvalitetsudvikling (2016) Four municipalities across Denmark: Ballerup, Frederiksberg, Faaborg-Midtfyn, Herning, and Aarhus	Open Dialogue network meetings used to organise social and healthcare	Survey, before-and-after design, evaluating 41 network meetings, including perspectives of patients, and private and professional network members	The majority of patients and private network members found network meetings helpful in addressing their problems. The majority of professional network members described increased understanding and new opportunities
Norway			
Lie et al. (2001) Valdres, two municipalities, North Aurdal and South Aurdal	Open Dialogue inspired network meetings used to organise outpatient social and healthcare	Field notes/summaries from network meetings of 10 patients and the patients' reflections	The network meetings were experienced as good, but presupposed a reorganisation of all levels of the mental health services
Brottveit (2002) Valdres, two municipalities, North Aurdal and South Aurdal	Open Dialogue inspired network meetings used to organise outpatient social and healthcare	Qualitative interviews with patients, private network members, and professional staff. Limited survey of patients	The large majority of interviewees appreciated the network meetings. The meetings initiated learning processes in patients' private networks and professional networks
Lian (2006) Valdres, Gjøvik and Øystre Slidre	Open Dialogue inspired network meetings used to organise outpatient social and healthcare	Participant-observation at different project-groups and focus groups and interviews with professionals	Network meetings were appreciated, but the organisation of the meetings did not facilitate optimal outcomes
Holloway (2009) Valdres region	Open Dialogue inspired network meetings used to organise outpatient social and healthcare	Survey of patients, private network members, and professional staff	Network meetings were generally appreciated by respondents, but the response rates were low
Larsen (2001) Solhøgda	A treatment philosophy inspired by dialogism	Prolonged ethnographic fieldwork	The psychiatric institution's buildings and spaces resisted the implementation of Open Dialogue
Hauan (2010) Vest-Agder	Network meetings inspired by Open Dialogue	Qualitative interviews with young people who had received Open Dialogue	Open Dialogue was only achieved in 1/3 of the cases and needed personal conviction, expertise, and planning.
Nielsen (2011) Vest-Agder	Network meetings inspired by Open Dialogue	Qualitative interviews with health care professionals who had provided Open Dialogue	Knowledge, trust, and experience were important in leading network groups that made the professionals work more person-centred
Bjørnstad (2012) Vest-Agder	Network meetings inspired by Open Dialogue	Multistage focus groups with health care professionals who had provided Open Dialogue and an interview with a parent	Three main themes: i) mutual uncertainty as strengthening; ii) coping through powerlessness and power; and iii) Open Dialogue creates opportunities in everyday life.
Holmesland (2015), Holmesland et al. (2014), Holmesland et al. (2010)[⌘] Vest-Agder	Network meetings inspired by Open Dialogue	Multistage focus groups, observations/audio recording of network meetings, and qualitative interviews with help-seekers	It was difficult for the professionals to change their roles in the treatment teams. Authentic listening under network meetings was challenging
Sættem (2008) Nordmøre and Romsdal	Open Dialogue inspired network meetings during an admission to an acute ward	Qualitative interviews with patients that had participated in the network meetings	Most of the informants appreciated the network meetings and found that their network could be a resource and not part of the problem

(*Continued on next page*)

Table 1. Continued

Country/ publication(s)/place	Study context/type of open dialogue	Methods	Key findings
Sjømæling (2012) Nordmøre and Romsdal	Open Dialogue inspired network meetings during an admission to an acute ward	Qualitative interviews with staff that had participated in the network meetings	Network meetings were seen as good for patients, but meant disclosure of staff members' personal insecurity
Brottveit (2013) Nordmøre and Romsdal	Open Dialogue inspired network meetings	Prolonged fieldwork, including observing patients in network meetings, and interviewing patients, network members, and professional facilitators of the network meetings	Network meetings opened social space that had the potential to increase the participants' collective scope of opportunity and action
Grosås (2010), Ropstad (2010)[⌘] Sørlandet	Network meetings inspired by dialogism at a youth outreach team	Video recordings of network meetings and follow-up interviews with participating young people and with their parents	Inner dialogues seemed to be more frequent in (outer) dialogical dialogues and less frequent in monological dialogues
Lidbom et al. (2015), Lidbom et al. (2014)[⌘] Sørlandet	Network meetings inspired by dialogism at a youth team	Video recordings of network meetings and follow-up interviews with all participants	Network meetings give participants the opportunity to see utterances from different perspectives. Movement between reflection and presence is essential in the emergence of significant meaningful moments
Bøe et al. (2013), Bøe et al. (2014), Bøe et al. (2015)[⌘] Sørlandet	Network meetings inspired by dialogism at a youth team	Multistage qualitative interviews with young patients, their private network, and professionals embedded in a participatory design	Dialogue can create change – becoming by movement through ethical time and ethical space – into life and forward in life
Sweden			
Guregård (2009), Guregård and Seikkula (2014) Göteborg and Borås, Western Sweden	Systemic family therapy meetings with refugee families, both an inpatient and an outpatient setting	Transcriptions of meetings, therapists' written comments, transcriptions of discussions among therapists, and interviews with families	When the meetings were examined from an Open Dialogue perspective, they often had dialogical qualities, but without creating genuine polyphony
Piippo and Aaltonen (2008), Piippo and Aaltonen (2004) Västerås, Central Sweden	Open Dialogue inspired mental health services and social services	Qualitative interviews with patients	Trust and honesty between staff and patients were important features for patients, but were established differently in different services

[⌘] Some publications originate from the same study and are so similar that we have decided to describe them as a single publication.

in eliminating waiting lists for outpatient psychiatric evaluation and that all groups of stakeholders found the intervention to be a relevant alternative to inpatient treatment. After this evaluation, the Open Dialogue outreach crisis intervention team was made permanent (Vange et al., 2009)*.

In 2004, Open Dialogue was introduced in municipalities in Odsherred, Denmark and Thylstrup's (2009) doctoral work examined relationships between dual diagnosis patients and therapists in the Open Dialogue context in 2005–2006. This work included qualitative interviews of patients and staff as well as structured ratings. The results showed that the Open Dialogue approach had a positive impact on the number and quality of family relationships. Patients ascribed much value to relationships with friends for transcending social isolation. Staff found it challenging to collaborate with professionals from other disciplines, and occasionally felt inadequate providing Open Dialogue (Thylstrup, 2009). The Open Dialogue approach in Odsherred was also evaluated in a project in 2009–2012 using a flexible case study design (Balleby & Søbjerg, 2012; Søbjerg & Balleby, 2012). The intervention targeted marginalised citizens with or without contact to the mental health services. Open Dialogue was used in two ways, first as an approach towards citizens and second as a new approach for collaboration among the social and healthcare workers. The evaluators noted that it was very challenging to evaluate the outcomes of the highly flexible and non-standardised approach. Data were collected through participant observation of network meetings and staff meetings, collecting documents; and by means of interviews with citizens, their relatives, and social and healthcare professionals. The inquiry concluded that Open Dialogue made the citizens feel seen, heard, and respected. Finally, it was challenging to recruit sufficiently trained Open Dialogue therapists and coordinate the network meetings, but the tentative conclusion was that network meetings were potentially valuable because of better coordination between social and healthcare services (Balleby & Søbjerg, 2012; Søbjerg & Balleby, 2012).

Johansen and Bille's case study (2005) explored users' and their relatives' experiences of community-based Open Dialogue network meetings in Zealand, Denmark and whether the approach effectively resulted in more user participation than conventional psychiatric treatment. Two families, the study's cases, found the Open Dialogue network meetings to be respectful and involving, but that the purpose of the meeting and the conclusion/closure of the meeting were not always clear. The professionals' level and type of engagement was not always clear to the families because of the more cautious approach of the professionals. Johansen and Bille (2005) concluded that the network meetings were genuinely more involving albeit the approach should probably be used in families whose thinking was somewhat aligned with the unconventional approach to mental health.

Johansen and Weber (2007) examined a multidisciplinary team of professionals' views on Open Dialogue and evaluated their appropriation of the approach in Zealand, Denmark. The evaluation identified resistance towards the implementation at several levels: Individual, organisational, and professional. Individual professionals found it challenging to adapt the expert role and establish a new type of expertise, the particular financial management structures made it difficult to implement network meetings, and the approach challenged the traditional

professional hierarchy. Johansen and Weber (2007) found that the team never seriously discussed and challenged the already implemented conventional stress-vulnerability model and that medical staff generally embraced the new Open Dialogue methods, such as implementing network meetings, but not the alternative Open Dialogue treatment philosophy.

Søndergaard's (2009) doctoral work was concerned with exploring the innovation process of implementing an Open Dialogue approach in a small outreach team in Southern Zealand, Denmark from a Science and Technology Studies/Actor–Network Theory perspective. Data were collected by means of observation and video observation as well as informal and formal interviews. The findings described some of the problems in the innovation processes that the team faced when they adapted the "alternative" Open Dialogue approach to their "conventional" psychiatric healthcare setting. Surprisingly, the team abandoned the Open Dialogue approach during and after the fieldwork (2009), however Søndergaard does not offer any *post hoc* explanations about what might have influenced this event.

Open Dialogue is currently being evaluated in five Danish municipalities, Ballerup, Frederiksberg, Faaborg-Midtfyn, Herning, and Aarhus by means of a non-controlled design using a contribution analysis (Lægsgaard, 2014)*. In this study, there is a manual for the provision of Open Dialogue, including fidelity criteria (Rambøll, 2014a, b)*. Preliminary findings (½-way evaluation, before-and-after design) included 41 persons, out of which 11 had completed treatment with network meetings. The findings indicated that clients and members of their networks experienced Open Dialogue as having positive outcomes. Recovery and well-being had improved slightly, while quality of life had not changed (CFK—Folkesundhed og Kvalitetsudvikling, 2016).

Norway

In Norway, the early implementation of Open Dialogue was very gradual and difficult to track because it merged with other network-oriented initiatives and approaches to reflective practice. In particular, there was a cross-fertilising relationship between the Finnish Open Dialogue clinicians and Tom Andersen and his ideas of reflective processes and reflecting teams. In 1999–2001, the *Valdres Project I* included patients into a mental healthcare system that was organised around Open Dialogue network meetings (Andreassen, 2004*; Lie, Andreassen, & Nysveen, 2001). Lie et al. (2001) used an action research approach to develop an Open Dialogue network intervention. They described four patients' psychosocial process through a series of network meetings and concluded that the treatment was good, but presupposed a major reorganisation of the mental health services to create this strong treatment chain. Brottveit (2002) evaluated the implementation by means of qualitative interviews and questionnaires, and found that patients and their network had been satisfied with the new model, which mobilised their social network, gave them better insight, and strengthened their ability to cope with their mental health problems. Staff members, who had invested a substantial part of their spare time in the project, also evaluated the model positively, but had struggled with abandoning their usual expert role (Brottveit, 2002). The subsequent *Valdres Project II* (2001–2002) was a competency development project for network meeting leaders. This project subsequently led to the establishment of a formal training course at the Gjøvik University College (Vigrestand & Hellandshølen, 2012)*.

The *Valdres-Gjøvik Project*, 2005–2006, included an implementation of Open Dialogue inspired network meetings that were meant to strengthen collaboration between the outpatient and inpatient mental health services (Ødegård, Svendsen, Rødberg, & Andreassen, 2006)*. On the basis of participant observation and interviews, Lian (2006) evaluated organisational and professional parts of the implementation. The number of network meetings was less than anticipated and collaboration among the professionals was less than optimal. Finally, poor management of staff and financial resources had hampered the implementation process (Lian, 2006).

Holloway (2009) surveyed perceptions of stakeholders from the *Valdres Project*: Clients ($n = 48$), network members ($n = 23$), and healthcare professionals ($n = 41$). In general, respondents perceived Open Dialogue as positive, although network members were less enthusiastic than clients. Both clients and networks members were divided regarding their ability to talk freely about their feelings at the meetings, and 30% of the network members felt somewhat coerced to participate (Holloway, 2009). As mentioned above, the *Valdres Project* also included educational initiatives and Øygard published a handbook for network leaders in 2011 (Øygard, 2011)*.

The *Dialogue in Context* project took place in 1999–2001 and entailed an implementation of a network/Open Dialogue approach, including a two-year long educational program. Based on five months of fieldwork, Larsen (2001) described the character of the de-institutionalising and re-organising of a psychiatric centre. Certain institutional spaces, in particular the locked backstage areas, added to clinical staff members' monologues over the patients. Larsen found it outrageous that patients and networks were not invited to participate in the negotiations of the implementation of Open Dialogue, especially because the approach is based on engagement (Larsen, 2001). Ulland, Andersen, Larsen, and Seikkula (2014)* described *Dialogue in Context* as a failure because it did not facilitate the anticipated changes of ideology and practice. In particular, it was viewed as problematic that different perspectives on what "dialogism" entailed were not sufficiently discussed before the implementation.

The project, *Joint Development*, was piloted in 2003–2005. Hauan (2010) interviewed six young women, who had participated in at least two or more Open Dialogue inspired network meetings several years before. Hauan found that Open Dialogue was helpful when dialogue was established in the session, which—according to Hauan—had happened for two participants, only partially for another two, and not at all for the last two participants (Hauan, 2010). Nielsen (2011) interviewed six health care professionals who had participated in training courses on Open Dialogue network meetings. The participants believed that Open Dialogue had improved their professional attitude (Nielsen, 2011). Bjørnstad (2012) based her study on multistage focus groups with six health care professionals and a single interview with a parent who had participated in a dialogical network meeting. Bjørnstad's (2012) findings emphasised that the approach presupposes the challenging position of not knowing the outcome of dialogical position.

In her doctoral work, Holmesland (2015) also explored the experiences of the healthcare professionals working in Joint Development, 2003–2005. Data for three analyses were based on multistage focus groups, observations/audio recording of network meetings, and interviews with help-seekers (Holmesland, Seikkula, & Hopfenbeck, 2014; Holmesland, Seikkula, Nilsen, Hopfenbeck, & Erik Arnkil, 2010). Through content analyses, Holmesland found that: 1) The healthcare professionals were able to develop a transprofessional identity and role; 2) It was challenging to foster the professionals' ability to genuinely listen; 3) Professionals without formal therapeutic training were able to integrate Open Dialogue skills into their practices; and 4) healthcare professionals adapt to each other during network meetings (Holmesland, 2015).

Healthcare services in *Nordmøre* and *Romsdal* collaborated with Molde University College to develop a training course in facilitating network meetings (Berg & Oppigård, 2009; Sjømæling & Vatne, 2009)*. Two studies had been made in an acute ward context: 1) Settem (2008) explored the experiences of five patients who had participated in one or several network meetings based on Open Dialogue at the acute ward. The patients' experiences were wide-ranging, but a common theme was that network meetings could initiate the development of new roles in their families (Sættem, 2008). 2) Sjømelding (2012) interviewed four healthcare workers about their experiences of participating in network meetings and the thematic analysis indicated that the professionals felt that network meetings were personally challenging because of high levels of uncertainty and disclosure, but that at the same time it constituted an important event for patients' learning and psychosocial maturing.

Brottveit's doctoral thesis (2013) explored the psychotherapeutic/healing effects of network meetings at two sites in *Nordmøre* and *Romsdal* and used Turner's ritual theory to conceptualise the network meeting as the *liminal* part of a ritual. The thesis was based on ethnographic fieldwork. This included following patients for 6–18 months, observing 11 patients participating in 30 network meetings, and interviewing patients, network participants, and facilitators of network meetings. Brottveit (2013) concluded that the network meetings opened a particular social space that had the potential to increase the participants' collective scope of opportunity and that key significant moments were particularly related to self-disclosure and conflict in the network meetings.

The project *Education Clinic* was established during 2006–2008 as a partnership between the University of Agder, Sørlandet Hospital, the regional centre for user-led services, and the Regional Centre for Child and Adolescent Mental Health of Eastern and Southern Norway. In the wake of this, *Dialogical Collaboration in Southern Norway* was established in Agder in 2010. Ropstad (2010) explored patients' inner dialogues during three network meetings and Grosås (2010) explored parents' inner dialogues during the same meetings. Data were collected following videotaped network meetings, where both the groups of participants were interviewed regarding their thoughts, feelings, and experiences during researcher-selected sequences. The results indicated that patients' and parents' inner dialogue was probably more strongly linked to the conversational theme of dialogical dialogues than that of monological dialogues (Grosås, 2010; Ropstad, 2010).

In a similar vein, Lidbom, Bøe, Kristoffersen, Ulland, and Seikkula (2014) explored the interplay between outer and inner dialogue at dialogical network meetings with a young person, his mother, and two therapists. The network meeting was video recorded and shown twice to the four participants within four days. The second time the video was shown, the participants were continually asked to explicate: "What went through your mind right there?" In the analysis, two sequences of inner and outer dialogues were juxtaposed to illustrate the polyphony of voices in the network meeting. Lidbom, Bøe, Kristoffersen, Ulland, and Seikkula (2015) scaled up the approach and worked with participants at six video-recorded network meetings. The results indicated that there were 26 sequences that each of the meetings' participants found significant. But in seven of these, at least one participant experienced the sequence as negative. A multiplicity of movements in perspective and time in the inner dialogues seemed to be linked with the emergence of significant moments.

Bøe et al. (2013) used Bakhtin's and Levinas' concepts to theorise a case description of a young man's experiences during an Open Dialogue inspired practice. The man and his brother were interviewed three times during a nine-month period. The theoretical reflections highlight how the therapy tries to re-establish his faith in relationships with others. Working with a participatory design, Bøe et al. (2014) interviewed eight young persons who had received an Open Dialogue inspired intervention, including members of their network and healthcare professionals. In six cases, follow-up interviews were performed and the total number of conducted interviews was 28. A 2 × 2 grid was presented along the metaphorical dimensions of *ethical time* and *ethical space*. By drawing on concepts of Bakhtin, Dastur, and Shotter, change was conceptualised as *becoming* through movement through these metaphorical dimensions (2014). Bøe et al. (2015) further interpreted the findings of their analysis by means of concepts of Bakhtin and Levinas. The results described dialogues as facilitating movement into life and forward in life.

Several of the projects mentioned above have evolved into an everyday clinical operation and there are several new Open Dialogue initiatives, such as *Valdres Viser Veg* (http://www.valdresviserveg.no), *Åpne Dialoger i Nettverksmøter* (ODIN) (Hopfenbeck et al., 2014)*, and *Romeriksprosjektet* (Heskestad & Rosengren, 2012)*.

Sweden

Guregård's doctoral thesis in systemic psychotherapy was called "Open dialogue across cultures". It was concerned with exploring the first meetings between 6 refugee families and 5 Swedish systemic family psychotherapists from an Open Dialogue viewpoint (Guregård, 2009; Guregård & Seikkula, 2014). Data collection took place at two settings in Göteborg and Borås in Western Sweden. The dataset was complex and consisted of transcriptions of 15 meetings, the written comments of therapists about the meetings, seven transcriptions of selected discussions among therapists about the meeting, and transcriptions of interviews with five of the refugee families. The transcriptions of the meetings were labeled in a structured Dialogue Sequence Analysis focusing on dominance, dialogue/monologue, symbolic/indicative meaning, reflective utterances, and new

understanding plus an additional analysis of voices (Guregård, 2009, chapter 3). Guregård concluded that the meetings between refugee families and two of the therapists had the qualities of Open Dialogue, but without any signs of polyphony.

Two of the papers included in Piippo's doctoral thesis (2008) were based on data from Västerås in Sweden (Piippo & Aaltonen, 2004, 2008). Piippo and Aaltonen (2004) interviewed 22 mental health patients about the help they received in an Open Dialogue inspired approach to coordinating family-oriented care that included both the mental healthcare services and the social services. Interviews took place six months after first contact with a coordinating healthcare team and the analysis was inspired by Strauss and Corbin's approach to Grounded Theory. The analysis identified four positive, two ambivalent, and two negative aspects of treatment. Two core categories, "trust-mistrust" and "honesty", were connected to all eight aspects and indicated that the healthcare professionals' trust in the patient facilitated a sense of mutual honesty. In another Grounded Theory analysis of the same dataset, Piippo and Aaltonen (2008) compared the participants' experiences with the family-oriented approach to their previous experiences of social and healthcare delivery. Again, trust was identified as a central concept. Notably, the participants described mistrust in situations where the team was experienced as over involving and in situations where the team seemed to avoid taking decisions.

Discussion

The scope of publications on Open Dialogue was substantial and indicative of how the approach has been taken up over time across Scandinavia. The publications indicate that there is a considerable variation in the ways in which the approach has been appropriated, which is most probably related to the original developers' efforts to avoid describing a prescriptive and standardised method. This reluctance, combined with brief and relatively superficial descriptions of actual Open Dialogue practices in the included publications, often made it challenging to decide to what extent—a service provided Open Dialogue and how it was actually organised. In the same vein, it remained unclear, which of the Open Dialogue principles were deemed as most important by clinicians and researchers and how prioritisation between principles influenced the implementation of new practices. In this respect, it would be more correct to argue that the review is indicative of the spread of a set of principles rather than a method.

Eiterå et al. (2014) argued that Open Dialogue—from a research perspective—needed to be more clearly defined and they developed a series of key markers of the seven Open Dialogue principles mentioned above. However, they were reluctant in setting up too rigid criteria and cautioned researchers to always consider the particular context in the use of the markers. In a similar vein, Olson, Seikkula, and Ziedonis (2014) developed 12 key elements, that could be used as fidelity criteria for dialogical practice taking place in Open Dialogue. However, the majority of these criteria were not designed in a way that could be used as part of a standardised measurement. Once more, this reflects the reluctance towards defining the specific core elements of the approach that are perceived as personal experiences of being touched during the dialogue with people in a group. The tensions between the dialogical stance towards the human condition and the scientific need for simplification and quantification will probably continue to challenge most types of empirical research in this area.

Although there are notable exceptions, the majority of publications are based on relatively small-scale studies, and designs are primarily qualitative and cross-sectional. No randomised or controlled trials have been published in this field yet. It is also notable, that the Norwegian implementations of Open Dialogue and Open Dialogue inspired network meetings have been developed in a close collaboration with universities and university colleges. The Danish and Swedish initiatives have not to the same extent been successful in developing such relationships. The relationships to universities and university colleges have most probably enhanced the strengthening and institutionalising the Open Dialogue approach and expanding collaboration to include the development of larger research programs and establishing research capacity could strengthen the field of research to include larger and more complex studies. Finally, the vast majority of the included studies have been designed with only a very limited user involvement in developing research and/or delivering Open Dialogue. This may be contingent on the Scandinavian welfare states' healthcare services that do not have a strong tradition of user activism and user involvement in policymaking and research. This observation serves as a reminder that the adoption of any healthcare delivery model, such as Open Dialogue, always needs careful consideration about the socio-cultural fit to local conditions.

In general, the included studies depicted Open Dialogue as a good and welcomed alternative to conventional mental health practices by professionals, service users, and members of their network. However, the studies also contained evidence of problems related to implementing Open Dialogue and participating in Open Dialogue. Studies focusing on the implementation emphasised that the approach often generated resistance from practitioners, whose positions were challenged in different ways. In particular, the full comprehension of the Open Dialogue approach seemed to be vulnerable by the disarming externalisation, "there is nothing new about it" (Søndergaard, 2009, p. 150), which often implied a lack of genuine engagement and understanding of dialogism. Despite the reported problems of implementing Open Dialogue it remains unknown whether the generated resistance is in fact more pervasive compared to any other large-scale reorganisation of mental health services that include re-positioning users and professional groups in the treatment setting. Finally, the publications also highlighted that not everyone experienced Open Dialogue as a good thing. Some service users and their families found the group format uncomfortably challenging and felt partly coerced into participating. Additionally, families with a strong belief in authority and an expectation of being informed about what to do to recover can find the open format confusing and frustrating. However, the level of reported criticism appears relatively mild and is most likely not more prevalent than in any other psychotherapeutic intervention.

Limitations

Our search strategies were systematic and comprehensive and we aimed at producing an exhaustive review within our sampling frame. Exhaustion in literature reviews, a high level of

recall, is usually experienced as a sense of continually identifying the same group of studies. While we experienced some degree of recall, we did not experience finding a bounded corpus of studies referring to each other, which probably had several causes: 1) A substantial part of the literature was grey literature, which was often characterised by unorthodox ways of reporting and a limited use of references. Further, these publications were challenging to sum up consistently because the content was very heterogeneous; 2) The area of research is young and characterised by drawing on a very different types of literature and on several very different theoretical perspectives; and 3) The corpus of included studies was contingent on judgements about the amount/level of Open Dialogue at a site, which was not always very easy to determine. Our inclusive approach could mean that we have a larger corpus of eligible studies than purists in the Open Dialogue milieu would recognise.

Scoping reviews do not typically include a quality appraisal of the included studies (Arksey & O'Malley, 2005), which, as discussed by Levac et al. (2010), makes it challenging to interpret findings presented in scoping reviews. It would have been very difficult to identify checklist(s) that would be useful in evaluating, in particular, the large proportion of grey literature in a valid and meaningful way. This is because many of these studies were not reported in line with traditional scientific conventions. Therefore, the results of the review can rightfully be criticized for being based on the mere existence of the included studies rather than their intrinsic validity, (cf. Grant & Booth, 2009).

Conclusion

In the Scandinavian research context, Open Dialogue was mainly described as a promising and favourable approach to mental health care. Most of the studies in this scoping review were published as "grey" literature and while some of the studies were qualitative evaluations of the effects of Open Dialogue, most of the studies grappled with how to faithfully implement Open Dialogue. The review emphasised that some of the issues arising were intrinsically linked to the fact that the original developers of the approach never operationalized the seven Open Dialogue principles. It is possible that these open-ended principles continue to add tension to the discussions of what constitutes real/pure Open Dialogue at sites across Scandinavia: Is Open Dialogue defined by organising health care intervention by means of network meetings, by organising transparent and person-oriented treatment systems, and/or by adopting a dialogical psychotherapeutic position and technique? This remains unclear and these basic questions need to be addressed and further explored in future research.

The review clearly indicated that it is very challenging to adopt and implement Open Dialogue, which suggested that Open Dialogue teaching, training, and supervision needs to be carefully planned. Training, teaching, and continuous supervision most probably need to be protected as intrinsic to the approach. Finally, there probably needs to be spaces where Open Dialogue principles are adhered to and modelled and where robust, open discussion among health care staff members, service users, and other key stakeholders is welcomed and respected.

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