I : R V : Q S H O D A : I :

Ana Ca lina Fl ence[1] · Ge ald J dan[1] · Sil i Ya i[2] · La Da id n[1]

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Abstract
The Open Dialogue approach was developed in Finland in the 1980s as a form of

Introduction

The Open Dialogue (OD) approach was developed in the 1980s in Finland as a form of psychotherapy inspired by systemic family therapy and a way to organize mental health systems [1]. OD emphasizes a social network perspective and conceives of mental health problems as relational. With a focus on creating meaning through language, psychosis and other mental health crises are understood as extreme experiences not-yet-spoken about, and the goal of the treatment is to generate therapeutic dialogue by bringing all the voices to a shared forum where meaning can be created jointly [2]. Accordingly, treatment is structured around network meetings with the person at the center of concern and others who are part of their support network. During network

results and has prompted several adaptations and implementation efforts of OD throughout the world in UK, Austria, Italy, Germany, Poland, Norway, Denmark, Japan and in the United States, however, descriptions of the implementation process are lacking.

Open Dialogue was introduced and adapted in Scandinavian countries in the early 2000s and a scoping review of the evidence showed great variation in how the OD was adapted outside of Finland [7

A purposeful sampling method was used to recruit people who were information rich about the topic under investigation.

Data Collection

Data were collected using four focus groups – two at each site with five to six participants each - and three unstructured interviews. One focus group was composed of supervisors and directors, while the other three were composed of staff providing direct services. Focus groups were conducted to uncover a shared understanding of how the CNA was implemented; gather a broad range of information about the subject; and capture interactions and contrasting perspectives between participants. A focus group guide was not used; instead, broad questions were asked to elicit stories about the development and implementation of the CNA. Example questions included: how did you become involved with OD? how has OD affected your work? and what are the difficult parts about this work? Participants' answers prompted new questions that were discussed within the group. Focus groups were conducted by the first author and lasted approximately 60 min.

offering a diagnosis and medication may not be that helpful “in terms of a person’s ability to develop meaning for who they are and finding purpose in life”. Another participant, who was a psychiatrist, stated: “I didn’t have any skills for working with people in acute psychosis other than offering them medications and support”. In the original Finnish model, avoiding the introduction of a neuroleptic medication early in the treatment was important; however, it is not clear how adaptations of OD outside Finland have approached the issue.

Staff reported a shift towards a more collaborative way of working with colleagues after training in the CNA and the majority of participants referred feeling less burnout. As expressed

many ways I think you have to step back and verbally say that I’m not controlling this and we don’t know the plan, but we’ll see where we go. For some people that’

This study addressed several important knowledge gaps about the development and implementation of OD in the United States. First, it addressed the lack of systematized accounts of implementation efforts throughout the country. Second, it did so using a qualitative approach to provide a rich description of the Vermont case. And, finally, we hope to have contributed to the field in a way that will support further efforts to develop and implement OD-informed approaches by pointing to potential successes and challenges future OD program developers may face.

The study findings are consistent with a previous study evaluating the implementation of OD in Massachusetts [9]. Both studies found that challenges to implementing OD were related to the length and cost of providing training and inadequate billing structures. Our findings are also consistent with the process of adaptation and implementation of the OD approach in Scandinavia. A scoping review [7] showed that the lack of standardized measures to determine

A a Ca , a F e ce PhD is a clinical psychologist and a Postdoctoral Associate at the Yale Program for Recovery and Community Health, Department of Psychiatry, School of Medicine.

Ge a d J da PhD is a Postdoctoral Fellow at the Yale Program for Recovery and Community Health, Department of Psychiatry, School of Medicine.

S , Ya , PhD is a clinical psychologist and an Associate Professor at the State University of São Paulo (UNESP) in Brazil.

La Da , d PhD is a professor of psychiatry and Director of the Yale Program for Recovery and Community Health, Department of Psychiatry, School of Medicine. He is Senior Policy Advisor of the Connecticut Department of Mental Health and Addiction Services and the Director of the New England Mental