The ALIVE National Centre
IMPLEMENTATION BRIEF

IMPLEMENTATION & TRANSLATION

IMPLEMENTATION BRIEF 2025 SERIES

Implementing Open Dialogue in an Australian Context

What is Open Dialogue?

Open Dialogue is an approach to supporting people experiencing psychological distress and their social networks, and a way of organising mental health supports. Central to the organisation of support is rapid access to help in the form of a network meeting – a forum for understanding what is going on, hearing multiple perspectives, and making plans through dialogue, with all voices considered equal [1]. There is a focus on creating dialogue between everyone involved in the network meeting, with the network seen as a resource for working through issues or crisis, finding a way to go on, and living well [2]. The nature of dialogical practice means there has been no standardisation or manualisation of the practice or training of practitioners [2].

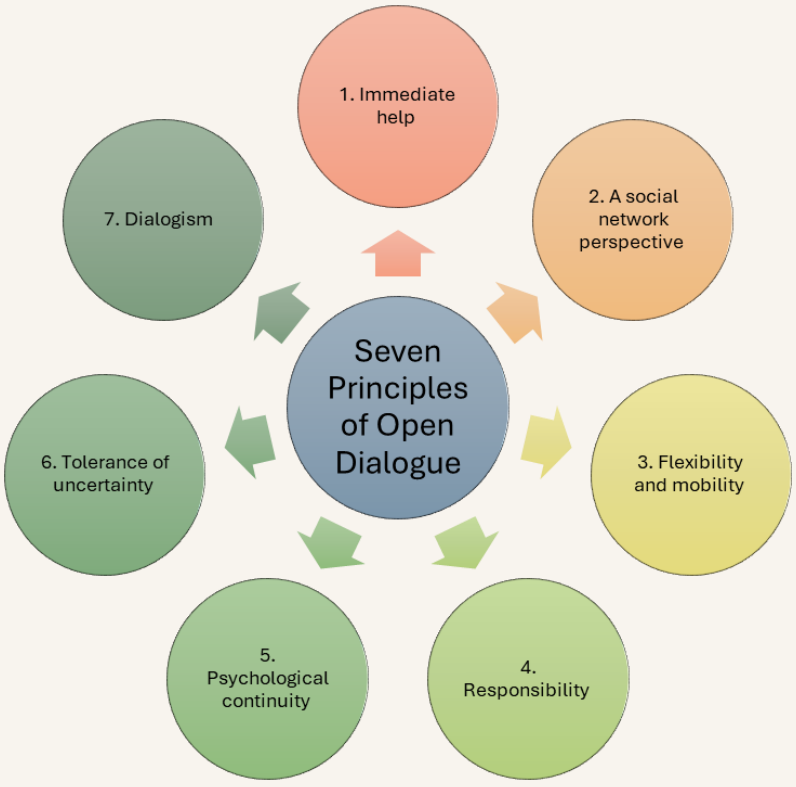

Figure 1: Seven Key Principles of Open Dialogue

A network meeting involves a person, their family, friends, supporters or other professionals along with a minimum of two Open Dialogue practitioners [1]. This meeting is flexibly organised to meet the network's needs, and support continues through a series of network meetings. The Open Dialogue practitioner who makes the first contact with the network takes responsibility for organising care and psychological continuity is fostered by having the same staff involved from the first meeting [1]. Staff voices are not privileged above others and staff work to foster dialogue among everyone present. Being in this dialogical space involves staff taking a stance of 'not knowing' or uncertainty, engaging with curiosity and transparency, not offering ready-made solutions, and being 'part of' the network [1]. The dialogue may include how to utilise different therapeutic approaches or expertise that can be offered outside of the network meetings. Further explanation of the seven key principles and 12 elements of fidelity to dialogic practice is listed in Figures 1 and 2 [1, 3].

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IMPLEMENTATION GUIDELINES/STRATEGIES

A range of actions, with different targets, would increase traction of dialogical practices and availability of Open Dialogue in Australia.

1. Systems level e.g. policy makers, government structures	• Embedded research that seeks to construct and understand contextual factors required to implement and sustain Open Dialogue in Australia, and to allow adaptation of the practices to suit an Australian system context. • Continuing support for small-scale Open Dialogue trials, with funding and governance that enables fidelity to the approach and adds to the evidence. • Advocacy to implement Open Dialogue routinely in mainstream services • Support (time and funding) for staff to undertake experiential training in variable levels of intensity - long (160 hours over 1 year), short (5 days). Shorter training (5 days) has been described as effective in building skills in dialogical practices [16] and may be a realistic way to commence skill development. • Provide enabling environments for further consolidation of skills and learning • Adapted practice and funding models that allow for two practitioners in network meetings and access to rapid, responsive and intensive support when people experience crisis.
2. Community level	• Strategies to build family, network and community awareness and understanding of the principles and practices of Open Dialogue. • Succinct explanations of the approach and what will be asked of potential network members to overcome the identified challenge of rapidly engaging families and others in network meetings. • Cultural adaptation of the Finnish model for successful implementation internationally and in Australia.

3. Service level	• Organisation level buy-in and leadership to create the conditions for staff and teams to initiate and sustain the practice changes required of Open Dialogue [17, 18]
	• Introducing high fidelity Open Dialogue in services will require shifts in routine practices including:
	  • Rapidly responding to people in crisis with same/next day network meetings,
	  • Pairs of practitioners working in a needs-adapted way with each network,
	  • Avoiding talk about the network outside of network meetings,
	  • Allowing the network to set the direction rather than an initial focus on assessment undertaken by professionals,
	  • A shift from clinical expertise and diagnostically driven interventions to ones where multiple perspectives are honoured.
	• Provision of opportunities for staff to reflect on their own practice to develop dialogical skills because shifts in practice have been described as both transformative and draining [19].
	• Consider a staged approach to implementation, such as the introduction of dialogical practices, due to the lower threshold of implementation change [19].
	• Consider provision via telehealth to address geographical distances and increase access to Open Dialogue [20].

4. Individual level (open dialogue practitioners)	• Raise awareness of the extensive self-reflection and family of origin work required in training, noting both the potentially transformative and disruptive outcomes for trainees [19, 21]. Some trainees may leave the training as a result. • Support individual practitioners pioneering implementation of Open Dialogue in services as they may encounter resistance. • support advocates and champions?

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Open Dialogue was developed in Western Lapland in Finland during the 1980s and 1990s, drawing from family therapy, and was first named Open Dialogue in 1995 [4]. Originally developed to support people experiencing psychosis, further developments in Finland and internationally over the past 30 years have expanded the focus to mental health challenges, emotional distress and crisis more broadly.

Twelve key elements of fidelity to dialogical practice in Open Dialogue	1. Two (or more) therapists in a team meeting
	2. Participation of family and network
	3. Using open-ended questions
	4. Responding to clients' utterances
	5. Emphasizing the present moment
	6. Eliciting multiple viewpoints
	7. Use of relational focus in the dialogue
	8. Responding to problem discourse or behaviour in a matter-of-fact style and attentive to meanings
	9. Emphasising the clients' own words and stories, not symptoms
	10. Conversation amongst professionals (reflections) in the team meetings
	11. Being transparent
	12. Tolerating uncertainty

Figure 2: 12 Fidelity Elements of Open Dialogue

Early research from Finland that reported positive outcomes for people with first-episode psychosis indicated relatively low use of neuroleptic medication (33%) [5] and high rates of reengagement (84%) with full-time employment and education at 2 years [6]. A review of 23 more recently conducted studies in diverse settings synthesised by Freeman and colleagues in 2019 [7] reported promising but low-quality evidence, noting the challenges of conducting this type of research due to variations in implementation approach and outcome measures used. Some authors have argued that irrespective of outcomes, that can be hard to measure, adoption of Open Dialogue is warranted because it offers "respectful and ethical ways to practice" [2], in a needs-adapted, client centred, and family-inclusive way, aligned with human-rights [8]. They believe conventional research methods such as RCTs will be challenging to undertake due to the individualised nature of the practice. A large program of research is accompanying implementation of Open Dialogue in the National Health Service in the UK (ODESSI trial) [9, 10], with results due to be reported over the next few years.

OPEN DIALOGUE INTERNATIONALLY

Open Dialogue has been introduced to more than 24 countries including almost all countries in northern and western Europe , Australia, India, Israel, Italy, Japan, Latin America and United States. Open Dialogue was referenced as a rights-based and recovery oriented "good practice" for providing mental health crisis support in World Health Organisation's Guidance on community mental health services [11].

LIVED EXPERIENCE INVOLVEMENT IN OPEN DIALOGUE

Increasingly, there is a focus on the inclusion of people with lived experience as peer practitioners in the practice of Open Dialogue [12], including Peer-supported Open Dialogue (POD) [13] developed in the Netherlands from the mid-2010s and being implemented elsewhere, including in the ODESSI trial. In Peer-supported Open Dialogue (POD) peer workers playing a core role, facilitating network meetings, supporting fragmented networks and fostering agency within these networks [14]. Empirical evidence for the effectiveness of POD is in development through the ODESSI trial.

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IMPLEMENTING OPEN DIALOGUE IN AUSTRALIA

For more than a decade, individual Australian practitioners have been inspired by the practice of Open Dialogue and have engaged in training in Finland, UK and Europe. They have brought these ideas back to dispersed services in Australia and have gained some traction in implementation. In 2017 a three-year foundation course was offered in Australia, further consolidating a group of people advocating for implementation, and considering the adaptations needed to support effective implementation in Australian service settings. The Open Dialogue Centre is now offering one-year foundation training and shorter training offerings in Australia, supporting an increase in practitioners able to practice. The Open Dialogue Centre also provides access to range of international resources including videos and podcasts.

Open Dialogue was recognised in the Victorian Royal Commission into Mental Health [14] as a promising practice worthy of further implementation because of its alignment with the stated intentions of reform – strengthening non-institutional, non-medicalising, human-rights-based approaches to support. Similarly, it is aligned with Australia's National Mental Health and Suicide Prevention Plan.

Alfred Youth Early Psychosis Team "Alfred Health currently uses the Open Dialogue methodology in its Youth Early Psychosis Program. In its submission to the Royal Commission into Victoria's Mental Health System, they said that Open Dialogue:

> *"provides a set of values and techniques that seek multiple perspectives and client strengths … Staff across the program received extensive training in the dialogic approach. After the technique was implemented, further training and supervision were provided … The technique has now evolved, in response to differences experienced … The approach to care continues to emphasise a collaborative adaptive network approach, which is shaped by family engagement and support." [15, p.105]*

Lived experience quote sourced from a family member's reflection on the ODC website

> *The Open Dialogue forum has allowed our family to speak freely and without fear of judgment about events and emotions running 5+ years. It has been a catalyst for our collective healing process and has brought us together in a very short period of time after years of fragmentation*

SCALING CHALLENGES

Despite the enthusiasm for Open Dialogue across Australia achieving implementation at any substantial scale has been met with difficulties. Scalability refers to the challenge of how to transfer what may have worked in a research context, into practice or policy settings. Shifting the status quo of the current functioning and foundations of mental health services is a significant implementation challenge related to Open Dialogue, therefore there should be a multi dimensional focus on scalability that accounts for policy change (scale up), culture change of the mental health system and related services (scaling deep) as well as spreading open dialogue (scaling out) (link to additional scalability information). Potential pathways supporting scalability are outlined on the following page.

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