ORIGINAL ARTICLE

Generating Dialogical Practices in Mental Health: Experiences from Southern Norway, 1998–2008

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Abstract In Norway and many other countries, political guidelines prescribe the development of mental health strategies with both a service user's perspective and a treatment system established by the local authority. The development of new strategies frequently involves challenges regarding procedures and treatment as well as a view of knowledge and humanity. Dialogical practices might provide a solution for these challenges not only because of its procedures but also due to its attitudes toward service users. The aim is to explore the implementation of three dialogical practice programs in Southern Norway from 1998 to 2008 and to critically analyze and discuss the authors' experiences during the implementation process. Three different programs of dialogical practices were initiated, established, and evaluated within the framework of participatory action research. Sustainable changes succeed individually and organizationally when all participants engage as partners during the implementation of new mental health practices. Generating dialogic practice requires shared understanding of the Open Dialogue Approach (ODA) and collaboration between professional networks and among the leaders. Developing a collaboration area that includes service users in all stages of the projects was one of the essential implementation factors. Other factors involved a common vision of ODA by the leaders and the actors, similar experiences, and a culture of collaboration. However, ODA challenged traditional medical therapy and encountered obstacles to collaboration. Perhaps the best way of surmounting those obstacles is to practice ODA itself during the implementation process.

Keywords Dialogical practices · Mental health · Participant action research

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Introduction

Ten years ago and earlier the treatment of Norwegians with mental disabilities was flawed at all levels (St. meld. 25 1996–1997). The National Program for Mental Health, which operated between 1997 and 2008, reported that many people lacked proper and timely treatment (St. prp. nr. 63 1997–1998). This program indicated a paradigmatic shift in understanding, describing, and meeting people with mental health problems, achieved through deinstitutionalization and client-oriented treatment centered within primary health care. Some criticized the medical understanding of mental health problems, which focused on pathology, deficits, and symptoms. At the same time, the program declared the need for greater specialization to increase timely diagnoses and aid proper treatment. This ambiguity, which criticizes the medical perspective and emphasizes the advantage of diagnosis, is open to different interpretations and new perspectives. One possible change in perspective could be to underline the humanistic mental health services and activate the client's network. This change represents an alternative to medical understanding and is well suited to

the Open Dialogue Approach (ODA) (Seikkula and Arnkil 2006), which was developed by Finnish professor and psychologist Jaakko Seikkula and colleagues in 1980. We assumed that this approach would increase client orientation and include the client's network, thus fulfilling important goals of the National Program for Mental Health and tried to implement elements of ODA in mental health services in Southern Norway from 1998 to 2008. In this article we reflect upon the process of implementation during this period. We believe that this approach will increase client orientation and include the client's network, thus fulfilling important goals of the National Program for Mental Health.

After introducing the theory of dialogical practices, we give a historical picture of ODA in the mental health field, higher education, and research. Further, we discuss the challenges by changing from one perspective to another, highlighting the obstacles presented by some parts of the treatment system. We also argue why dialogical practices have already been established in other parts of the mental health system. This article addresses two research questions: What are the essential implementation factors of an Open Dialogue Approach? How can obstacles in the implementation process be surmounted?

Dialogical Practices

One motivation for becoming interested on Open Dialogues was the information received from many studies in Finnish Western Lapland that have reported the outcomes and processes in ODA treatment of psychosis and other severe problems. For instance, in the first episode of psychosis 85 % of clients returned to an active social life within 5 years, and 80 % no longer showed psychotic symptoms (Haarakangas 1997; Seikkula 2011; Seikkula et al. 2006, 2011, 2003).

Dialogical practice understands individuals with mental problems in relational terms, as a part of a social network. The social network generally includes (1) family relations living in the same economy; (2) family relations in different economies and extended family relations; (3) relations in daily activity (e.g., school, workplace, or day-treatment contacts); and (4) other relations (e.g., friends, hobbies, neighbors) (Pattisson and Pattisson 1981). In psychosocial services, relations between clients, their families, and different authorities emerge as an important network. An important aspect of social network intervention involves the client's active involvement in all occasions rather than professionals making plans and decisions for the clients without their participation. Thus, social network interventions focus simultaneously on all or some aspects of the social network.

In his therapeutic approach, Seikkula (2002) acknowledges the influence of the theorist Bakhtin. In Bakhtinian theory, dialogue is a process where human beings living beings assert their presence from the very beginning of life. Dialogue is not an exchange of utterances, which can be analyzed individually, but rather is communication in which each speaker already takes account of the expected response of the other (Bakhtin 1993; Shotter 2010). More than simple communication, dialogue is a much more profound life factor through which we construct ourselves as human beings in responsive relations to each other. Open Dialogue as a form of dialogical practice is a social network intervention that focuses on immediate help for clients in crises; it includes the relevant social network from the very beginning and integrates different treatment methods into the same process. This approach does not follow specific manuals; to the contrary, it emphasizes the generation of dialogue in therapeutic meetings within the social network and adapts to the client's unique and changing needs. In places that apply Open Dialogue, the entire system usually is organized to work in the same direction. In developing dialogical practice outside Western Lapland, the aim has not been to move Open Dialogue from Northern Finland to Southern Norway (or some other place), but rather to adapt elements of dialogical practice used in Western Lapland to the local cultural and historical context. The specific aspects of the original ODA is it's idea to change the comprehensive service system to support possibilities for working together with all relevant parts around the client in crises. It is not only a method for conducting dialogical meetings with families, social networks or single clients. Implementing ODA in Lapland started with traditional psychiatric treatment. In the context of Agder, the implementation of ODA in two of the projects presented started in mental health care for children and adolescents in the clinic and in the municipalities. In Agder, a program for education emerged in the implementation process itself. The actors in Agder came from different contexts: service users, the university, the municipalities, and the clinic. The collaboration between the university and the clinic was unique. Both in Finland and in Norway, Lapland and in Agder, the common models were to practice the seven principles for ODA: (1) immediate support, (2) the social networks' perspective, (3) flexibility and mobility, (4) responsibility, (5) psychological continuity, (6) tolerance of uncertainty, and (7) dialogism (Seikkula and Arnkil 2006).

Method

To implement dialogical practices in Southern Norway, we chose a participant action research (PAR) method. Because changes in the mental health field involve education,

practices, and research, PAR is well known for supporting organizational change. Thus, the method becomes a social process. Kemmis and McTaggart (2005) illustrate PAR as consisting of repeating self-reflective cycles that (1) plan a change, (2) act and observe the process and consequences of change, (3) reflect on the processes and consequences, (4) plan again, (5) act and observe again, and (6) reflect again, and so on (p. 563). Therefore, PAR requires the personal involvement of both researcher and research (Kemmis and McTaggart 2005; Whitehead et al. 2003).

In Southern Norway, different implementations of dialogical practices have been meant to improve the mental health service by generating a new way of understanding, describing, and treating people with mental problems. Three different projects aimed to solve problems identified by the National Program for Mental Health. The three projects were selected because they all were designed and implemented in the same region. Additionally, they represented collaboration between the university, the hospital, and the municipalities in the region; they also had the same promoters. All projects were such characterized by collaboration between service users, clinicians, researchers, students, and educators as well as two different regional service user organizations (i.e., Mental Health Norway and The Norwegian Family Alliance for Mental Health). The University of Agder and Sørlandet Hospital also participated in the collaboration.[1] Cooperation cannot be taken for granted because service users' involvement could lead to some dilemmas. When service users' and relatives' voices are heard, you might run the risk that they express loyalty to the existing, medically oriented system. In the local context, however, there has been a collaboration tradition between service users' organizations related to mental health and the other participants in the projects. Because of this local cooperation culture, the service users' and relatives' voices and the voices from the municipalities have not expressed much criticism of ODA. All participants both designed and created practical solutions to their own problems. Through planning and evaluation, the overall aim was to work together to implement dialogical practices. Thus, the validity of PAR involves interpersonal and personal constructions (Whitehead et al. 2003).

Methodological and Ethical Considerations

Participant action research might also involve epistemological and ethical challenges. Knowledge attained through

research is the product of close collaboration between different groups. However, in our projects researchers at the university originated some initiatives. In Project 1, researchers introduced the idea of ODA to clinicians and service user organizations. When academics initiate ideas, we might question whose side are they on and whether service users would have taken the same approach. Was the dialogical approach really an improvement? David (2002) reports that "academics might be more bold and suggests 'we are on our own side'" (p. 11). Moreover, because the authors of this article are all academics, we run the risk of ignoring other viewpoints. As initiators and authors, we are in a strong position to demand results that confirm our expectations. On the other hand, we had discussed ODA for a long time with different service user organizations and clinicians who strongly supported these first steps toward a change in the mental health field. A possible bias is that the results are only built upon the experiences of the authors. Thus, we have to be aware of the lack of information from the families and professionals who have participated in the projects.

Dialogical Practice Programs in Southern Norway

Dialogical practice programs in Southern Norway aimed to mobilize the social network of clients and professionals toward better collaboration before severe crises occur. Such networks include adults, children, and youth-oriented mental health services and social care, including child protection services. Worldwide, very few cases integrate mental health and social care services with other public services to introduce a social network-based practice in all types of crises. The dialogical practices in Norway provide a template for sensible collaboration for every professional need and accept responsibility for treatment of all clients, regardless of their specific problem or diagnosis.

Efforts to implement ODA in Southern Norway between 1998 and 2008 comprised several projects. However, this article includes only projects that were initiated and conducted in close collaboration between the agents mention above. The following section highlights and summarizes three chronological examples of this mutual effort to enhance dialogical practices (i.e., working practices, education, and research).

Project 1: Dialogue in Context (1999–2001)

Inspired by Seikkula and his work on Open Dialogues, the first small step toward changing the understanding, description, and treatment of mental health problems in

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[1] Further on we will alternate between "the local hospital" and "the hospital" when writing about Sørlandet Hospital; when writing about the University of Agder, we will use "the local university" or "the university". Before 2007, the University of Agder was a university college.

Southern Norway began in 1997. A managing group (the leader and the psychologist of a newly established Mental Health Centre, two professors from the regional university, and one general practitioner from the local municipality) initiated and conducted a project called dialogue in context. Formally, the project started in August 1999 and ended in December 2001.

Clinical Practice

Dialogue in Context aimed to enhance treatment for adults suffering from mental health problems and also provide support for their friends and relatives. The premise was that the client should no longer be understood purely as a single individual who is isolated from her/his surroundings, but rather as a person within a context. The project aimed to gradually reduce inpatient treatment and simultaneously increase outpatient rehabilitation through Open Dialogue. Thus, the overall goal was to increase involvement of the social network and offer sufficient help and assistance in the client's natural surroundings (i.e., in their homes). An easily achieved treatment threshold would give the client and her/his network access to a group of professionals who specialized in dialogical practices. Primary responsibility for the new clinical changes fell to the leader of the district psychiatric center, and the psychologist was responsible for organizing teams suitable for outpatient service.

Interdisciplinary Educational Program

Inspired by Seikkula's experiences in Finland, all staff members were invited to join a training program. The management group discussed different solutions, and Seikkula met with the group and the staff to discuss both the possibilities for developing a dialogical approach and the need for an educational program. The group also invited representatives from service user organizations and employees of the local mental health service and hospital unit to discuss the new idea and its possible consequences for the entire mental health service. After thorough discussion, the group agreed to collaborate with the National Centre for Psychotherapy and Psychosocial Rehabilitation for Psychoses, and to implement a predesigned multidisciplinary educational program for the staff. Begun in January 2000, the education program lasted 2 years. It aimed to increase employees' general knowledge about severe mental health problems while developing their competence in dialogical practices. A university professor directed the program and clinicians from the regional hospital were engaged as supervisors. A reference group, which comprised representatives from all collaborating partners and included service users and students, guided the program.

Research

The research project sought to describe how the staff implemented dialogical practices. Through participant observation in the outpatient teams, knowledge should tell how to implement the treatment methods and, at the same time, evaluate the project. However, the study's results were disappointing because the researcher found almost no dialogical practices in the Mental Health Centre: the deeply entrenched medical perspective of psychiatry prevented new ways of understanding, describing, and treating mentally ill patients (Larsen 2001). Project 1 attempted to create a new narrative for mental health problems and provide a template for dealing these problems. Two powerful individuals from the institution worked together with two outsiders (one from the university and one from the local municipality) to design the narrative, creating the story in a meeting room where neither the clients nor the families were present. The researcher suggested that this approach was illogical because one of the main ideas of the project was that changes happen when everyone involved participate in Open Dialogue. In its eagerness to change the process, the managing group forgot to include the most important people (Larsen 2001, p. 121).

Project Summary

Although promising and interesting, the research project failed to achieve the overall goal, and the desired change in ideology and clinical practice did not succeed. On the one hand, this is readily understandable. Although the Mental Health Centre had recently transformed itself from a psychiatric nursing home for the elderly and should have met the expectations of the National Program for Mental Health, the overall goal was far too ambitious. On the other hand, the project revealed that participants' understanding of the basic assumptions for dialogical practices were different. Moreover, these differences were not discussed thoroughly before the project began. Furthermore, anticipation that supervisors in the educational program somehow shared the dialogical perspective proved incorrect. The project visualized a gap in perspectives between the different collaborative participants. Kemmis and McTaggart (2005) report a similar experience: "it was a mistake not to emphasize sufficiently that power comes from collective commitment and methodology that invites the democratization of the objectification of experience and the disciplining of subjectivity" (p. 569).

Project 2: Joint Development (2003–2005)

In cooperation with the University of Agder and the cities of Mandal and Flekkefjord, Sørlandet Hospital's Department of Child and Adolescent Mental Health initiated the

Joint Development project to establish dialogical practices in both cities. The collaboration group recruited around 40 secondary school teachers, social workers, and mental health workers to participate in a joint education and guidance program. The participants (i.e., teachers, guidance counselors, and supervisors) met monthly for a 1-day seminar. Two clinicians and two professors oversaw the sessions. The project was established in August 2003 and lasted until June 2005.

Clinical Practice

Joint Development aimed to help young people, age 14–25 years, with early-stage mental illness, and offered youths with more severe problems an opportunity to take an active role in their own treatment (Holmesland et al. 2010). The idea was that increased competence in network dialogues among professionals would improve the mental health of young people. This approach was based on social network intervention in the form of ODA (Seikkula and Arnkil 2006). Dialogue and interaction are key elements in this approach—meaning that service users and helpers develop a joint language when they come together in network meetings. The different institutions maintained responsibility for all activity regulated by national law but also established a collaboration group including participants from all of the institutions as well as representatives from service user organizations. In practice, the collaboration provided help as soon as possible within a 24-h time frame, established an emergency phone, distributed a brochure at local schools and offices, and provided information to the local media. Two or three participants conducted multiagency network meetings at the school, in the families' homes, or in the health worker's office.

Interdisciplinary Educational Program

Joint Development also established a two-year training program for 40 mental health professionals and teachers, led by professionals from the university and the clinic. The program, focused on dialogue, networking, mutual understanding, processes, and ethics. Eighteen participants completed the program with an exam at the university, earning 30 points from the European Credit Transfer System within community mental health networks. This program was among the first in Norway to systematically train mental health professionals and teachers together in a collaborative effort to help local youth in crisis.

Research

Joint Development has completed two research studies. The first study explored whether ODA allows professionals sufficient latitude in providing assistance and determined that teachers play a crucial role with adolescents in crisis—not as therapists, but rather as confidants. Although the results were not generalized, the researcher concluded that proper dialogue is helpful and improves life. However, even with positive change, some young clients hoped for more. Thus, collaborative efforts are important for young people with complex problems (Hauan 2010).

The second study examined professionals' understanding of ODA, their roles within it, and teamwork, including knowledge and communication. It determined that

> [t]hrough synergetic effects, it follows that transdisciplinary social network intervention may also improve results in other cases involving the same professionals. This may occur through the generation of more flexible solutions for the help seekers based on increased levels of reciprocal confidence among the professionals. Moreover, the focus on person centredness followed by a change in the helper′s position may in turn affect the stereotypes associated with professionals. Bearing this in mind, the increased familiarity between the professionals developed in transdisciplinary multi-agency teamwork may improve the health care system in general (Holmesland et al. 2010).

Project Summary

This clinical project aimed to improve adolescents' mental health by strengthening the competence of school professionals, social workers, and healthcare workers. The project succeeded when professionals practiced dialogue among themselves and also between themselves and the families. However, facilitating this dialogic approach required effort and competence, and the project encountered several challenges related to professional cooperation. How can professionals safeguard their own roles and professional identity while simultaneously pursuing common understanding and providing common treatment? Moreover, involving both the needy and private treatment networks proved challenging. One remarkable outcome was the establishment of a new, tailored education program at the university. Initially conducted as part of the development project, the program eventually became part of the curriculum at the local university.

Project 3: Education Clinic (2006–2008)

The Education Clinic was a collaboration between the Faculty of Health and Sport and Sciences at the University of Agder; the Clinic for Mental Health/Department of Child and Adolescent Mental Health at Sørlandet Hospital;

the regional service user-led center (i.e., Advice and Opportunities); and the Regional Centre for Child and Adolescent Mental Health of Eastern and Southern Norway. A planning group comprising participating partners worked for 2 years before the project began in October 2006; most participants later became team managers. The students who participated in the project were mental health work—and family therapy students.

Project Education Clinic

The Education Clinic, which aimed to develop a practical and relevant training and guidance program for students, was mandated to engage in teaching, guidance, and research within the fields of mental health work and family therapy. The project focused on collaboration between academia, the clinic, and service users. Ethical reflections focused on service users' experiences. Therefore, service users helped plan the project and implemented the teaching and supervision. Thus, the project used the competence of service users, teachers, students, and therapists.

This project resulted in the establishment of the University Clinic (UNIQUE) in 2008. UNIQUE aimed to continue cooperation between education, guidance, and research in the field of mental health. Today, students pursuing master's degrees in community mental health gain practice-related experience in the hospital's Clinic for Mental Health, which integrates clinical and service user experience with teaching, guidance, and research. This collaboration between the university and UNIQUE generated several research projects both during and after the project period.

Interdisciplinary Education Program

The Education Clinic reflected the project's study areas (i.e., family therapy and mental health work), but much of the teaching took place in the clinic and involved service users, therapists, and academics. All participants mingled during the process of developing knowledge. While education programs in the first two projects were designed for the projects, the education program in the third project was not new—it was already part of the regular program at the university. The project merged this program together as part of academia and practice.

Research

The collaboration between the university and the clinic generated several research studies on dialogical practices. A pilot project that focused on inner and outer dialogues in therapy with youths (Grosås 2010; Ropstad 2010) determined that both the youths and their parents judged dialogue and polyphony more helpful than monologue in articulating their experiences. Another study, which explored collaboration between public health nurses and nurses in the clinic (Palucha 2010), determined that the clinic should practice more locally based networks even as it continues to provide reports. A third study explored if classroom dialogue promotes health (Bøe 2010). The results showed that a working model of classroom dialogue encouraged students to talk about their feelings and thoughts. The dialogues increased reflection and strengthened solidarity between the students.

After the project period ended and the University Clinic was established, two Ph.D. studies followed up on the pilot project on inner and outer dialogues in therapy (Bøe 2011; Lidbom 2011).

Project Summary

The Education Clinic, which aimed to strengthen relations between different areas, successfully established an education program in the clinic, using service users, therapists, and university professors. During its second year, the project established a new resource by forming groups of supervisors and researchers; the groups continued after the project ended. On the other hand, the project failed to establish a model for education, supervision, and research within all desired contexts. Collaboration with service user organizations also requires further integration between service users in the education and in the research program.

Conclusions

Between 1998 and 2008, the University of Agder and Sørlandet Hospital collaborated to deliver three programs promoting ODA in Southern Norway. Jaakko Seikkula participated in all three projects by (1) teaching the basis of Open Dialogues; (2) clinically supervising local therapists and mental health service users and (3) designing research projects. However, the lack of documentation and too little emphasis on reflection invites criticism. This article attempts to provide that criticism.

The three projects might be understood both in isolation and in relation to each other, signaling some progression and including experiences from earlier projects. All projects aimed to strengthen the interaction and dialogue between clinical practices (Fig. 1).

The collaboration model emphasizes the importance and necessity of Open Dialogue, not only as an approach toward clients and service users but also as an overall scientific discourse about the contribution of practical knowledge (i.e., evidence-based practice). Importantly, evidence-based practice developed through open, mandatory, and appreciative dialogue between service user
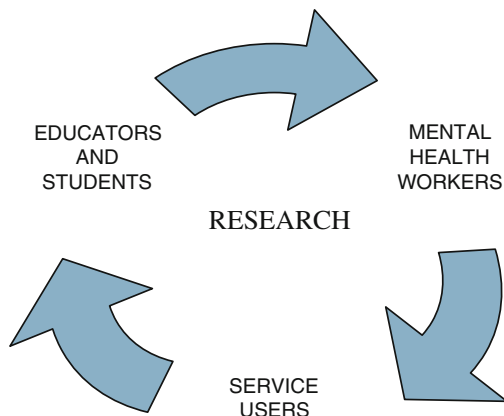
Fig. 1 Collaboration model (ODA) in Southern Norway

representatives, who promoted experience-based, service user knowledge; professionals and leaders working within the services, who promoted experience-based professional knowledge; and university scientists, who promoted recent research. This approach is compatible with the model of evidence-based decision making presented by Haynes et al. (1996), who emphasize the importance of clinical experience, patient preferences, and research evidence in clinical decisions.

Positive results emerged from Southern Norway's 10-year experience with ODA seen in the perspective of successful implementation. But the positive results reported consist only of indicators of successful implementation. Although the benefits of ODA are interesting and promising, we need more studies to show if a successful implementation of ODA will positively impact outcomes compared with usual care. The cities of Mandal and Flekkefjord are now running dialogical practices in many contexts, through daily work, seminars, student practice, and collaboration between the clinic and primary and secondary schools. The University has increased staff from 2 to 12 and added new study programs and research programs (e.g., an ODA-based program for community mental health services that includes master's and Ph.D. degree programs). The University Clinic, which accepts 30 students each year, serves many teachers, therapists, and service users who cooperate in education and in practice. Service user organizations and many regional municipalities have accepted dialogical practices as an important approach that recognizes service users' concerns.

In addition to the projects presented here, a parallel process generated dialogical practices in the region. This process emerged as dialogues between the various actors and institutions that relate to the generation of dialogical practices in Southern Norway. These discussions are reflected in correspondence between actors and institutions, in local newspapers and national scientific journals.

Discussions about ODA in Southern Norway actually combined a national debate, which was published in Tidsskrift for den norske lægeforening the (Friis et al. 2003), with a debate in the regional media and publications. The national debate focused on methodology, research, epistemology, the power of definition, and the authority to decide the proper paradigm for practice, education, and research.

Discussion

The process of initiating dialogical practices activates challenges concerning various attitudes, actions, and processes between the actors and the collaborating institutions. What are the most essential implementation factors and how can obstacles in the implementation process be surmounted?

Life and Doctrine: Were Dialogical Practices Generated Dialogically?

Generating new practices requires *collaboration*, particularly regarding who should participate in the cooperation necessary to conduct a successful dialogical practice, and the kinds of obstacles faced during implementation of a new approach to mental health problems. Let Us Examine the *Differences* in the Programs.

The setting for Project 1 had previously been a *psychiatric home for the elderly*. Most of its employees (e.g., nurses and nursing assistants) continued working in the new psychiatric center, which was designed for short-term treatment of adults suffering from severe mental problems. The staff's experience in working for an institution with a solid, medically based perspective made them bearers of a medical tradition that cares for patients as diagnosed individuals (i.e., professionals know what is best for patients) (Larsen 2001). In addition, the patients were accustomed to being treated as incapable of caring for themselves. In contrast, ODA views an individual's personal network as an important part of the recovery process.

In Projects 2 and 3, the clients were young people. In this respect, *age* might be an important factor because young people with mental problems have no preformed expectations of professionals, and it seems more natural to include a young client's network (i.e., parents and teachers). The successful implementation achieved by Projects 2 and 3 might also be explained by looking at the professionals. Family therapists traditionally collaborate with colleagues from different educational backgrounds. Moreover, the flexibility and creativity exercised by therapists as they guide clients toward recovery encourages dialogue about various ways of understanding mental health problems. Finally, the *leaders* in this part of the hospital

welcomed dialogical practices. Despite disagreement about the seriousness and quality of ODA, the Education Clinic resulted in a permanent collaboration between clinic administrators and university faculty members.

Indeed, the leaders' attitudes toward collaboration were important in all three projects, representing a particular criterion of success in Projects 2 and 3 and possibly explaining the lack of implementation success in Project 1. The medical perspective seemed more strongly embedded in Project 1 compared to Project 2 (collaboration between two cities) and Project 3 (a family clinic located outside the hospitals). The idea that knowledge constructs ways of acting meant that different *educational programs* were a turning point for putting ODA into practice. Project 1 did not succeed, possibly due to its local setting and its tutors' incomplete embodiment of ODA. In contrast, Projects 2 and 3 started their programs from scratch, constructing them in local settings that included service users, teachers, and professionals as well as students at different educational levels. Education and research intertwined within the practices.

ODA: A Way of Working and a Way of Thinking?

This question spotlights how ODA was perceived and received in the psychiatric field. On the other hand, one might argue that ODA requires taking a stand on an epistemological level and acknowledging the insight that follows the social construction of reality (Berger and Luckmann 1967). This interpretation will lead to highly different views on the meaning of dialogue, as illustrated by the local debate between the hospital and the university: "[T]he dialogue can never be more than a frame condition—a requirement for the quality of interaction. The dialogue is not the goal or the content of the treatment" (Dokka 2006, p. 44, authors' translation). This quotation might increase the understanding of a perspective that relates dialogue to words (i.e., a working alliance that values the process of connecting with clients). In other words, dialogue makes "real things" (e.g., cognitive behavior therapy [CBT], milieu therapy, and medicine) work. "[T]he students learn that dialogue and cooperation both is a goal itself and a professional way of working" (Andersen 2006, p. 51, authors' translation). This second quotation regards dialogue as the thing that works.

Some in hospital psychiatry does not fully acknowledge Seikkula's research on dialogical practices in Finland. Furthermore, it does not value naturalistic studies of the outcome of ODA in Finnish Western Lapland at the same level as randomized clinical trials. Importantly, the discussion presented here is rooted in different views about knowledge and research methods. Although the Finnish research projects were quantitative designs, they were not

accepted by the clinic. The Norwegian research projects were qualitative designs, but this probably did not strengthen the position of research done in the university.

This national debate was transformed into the local clinic. Even when ODA was shown to be an evidence-based practice, it was not approved, and perhaps because ODA challenges clinical practice in a basic way by asking what should be in focus: crisis and polyphony, or pathology and diagnosis. ODA focuses on the crisis and traditional psychiatry focuses pathology. In other words, ODA disturbs the well-known therapeutic way of acting. Thus, the discussion is about what threatens the basic ideas, not necessarily what helps people.

Who Should Have the Power and Authority to Decide a Proper Education and Practice? Trust and Mistrust to Education and Practice

In spite of the positive effects resulting from dialogical practices in Southern Norway, another central question has emerged: *Who should have the power and authority to define and decide a proper education and practice?* When education systems followed the national framework, it was easy to understand that conflicts arose. This happened despite strong contacts between the actors, many of whom had attended seminars and meetings to discuss and identify agreements. The focal problem was one of trust. Were the academics too eager to teach and implement this new dialogical practice? Were some of the therapists too afraid of a new practice model that might decrease their responsibility toward their patients or threaten their positions and power? However, it is possible to introduce dialogical practice in a way that emphasizes the alternative more than the supplement. In this way, ODA is marginalized and may become invisible in the context of traditional psychiatry (Søndergaard 2009).

Until now, our discussion may have appeared easy to understand: education will slowly bring ODA into practice. Unfortunately, it is not that simple. One aspect of the difficulties is that the process clearly involves questions of power. Although collaborators agree that changes are necessary, conflicts always arise due to different ways of understanding, describing, and acting. We should not forget that when ODA was introduced, the focus was shifting from a specialization for nurses within psychiatry to a specialization within mental health work. Traces of this shift were found in the national plans for mental health care, which began to emphasize dialogue, networks, relationships, and service users' experiences. The debate showed that the actors could agree about the necessity for different kinds of knowledge, but suspicion and misunderstanding arose when one type of knowledge was dominant (e.g., ODA or the medical model).

The clinic viewed education at the university as focusing on theoretical issues, which are discussed from an "outside perspective" in relation to practice. Some therapists expressed concern that this focus "undermines students' identification with the mental health care and leads to role confusion and uncertainty in relation to the tasks and disciplines that students will be qualified for" (Dokka 2006, p. 44, authors' translation). They also suggested that education focuses on dialogical practice and service users′ experiences at the expense of more "knowledge-based academic content". Therapists said, "in various contexts, it is a strong expression of the principal objections against the thinking of disease, the use of diagnoses and medications" (Dokka 2006, p. 45, authors′ translation). Students have not acquired enough knowledge to deal with patients in the acute phase of mental illness, creating an academic gap between education at the local university and mental health care in the clinic and leading to a mutual lack of confidence.

A point-by-point response by the university began with a statement of focus and then said that the statement creates confusion and uncertainty among students. Representatives of Mental Health Norway, the largest service user organization in Norway, and representatives from the municipalities supported the university. Importantly, although the therapists' critique emerged from a small group, the clinic's management promoted it on behalf of the entire clinic. Thus, the therapists' reviews will be even more severe, according to Andersen (2006, p. 50). In a newspaper interview, a consultant from Norway's public health system in the county said that she was astonished by the clinic's reaction, describing it as "foul", "unfriendly," and "crass" (Fædrelandsvennen 2006, authors' translation).

Later, these discussions took another direction. After the initial project period for the Education Clinic (2006–2008), collaboration between the university and the clinic continued a successful collaboration. The university staff and some clinic leaders have initiated and promoted the implementation of dialogical practices, supported by service users, students, and mental health workers in the clinic and the municipalities.

Conclusion

Ten years of dialogical practice in southern Norway have produced positive results, regarding implementation, education, an increased teaching staff, and several research projects. What are the most essential implementation factors, and how can obstacles in the process be surmounted?

The projects' implementation processes showed that developing a collaboration area during project preparation was an essential implementation factor. In this way ODA is practiced among the networks of the professionals and the service users in the implementation process. This collaboration is strengthened when the process includes service users from the very beginning of the implementation. Doing this, the focus is on what helps in therapy. The next step ought to be to involve the families in evaluations of the different kind of therapies build on ODA.

Another essential implementation factor is that leadership and staff members at the university, the municipalities, and the clinic shared the same vision of ODA and were willing to use time and resources in education, supervision, and research to conduct the projects.

However, since generating dialogical practices requires a shared understanding of ODA and collaboration among professional networks, the obstacles occur if the gap in perspective is too large. Choosing a treatment method is the core function of therapy for people in crisis. Although ODA may be understood as opposing the medical model, it is better understood as one of many therapeutic languages. Understanding dialog as more than an exchange of information in therapy (i.e., an approach and attitude that helps clients create changing language for the client′s crisis) is a fruitful way of surmounting obstacles. However, dialogical practice challenges and disrupts therapeutic safety that often focuses on pathology and diagnosis, leading to a struggle for power over the determination of appropriate practice, education, and research. It may be that coping with fundamental attitudes (e.g., trust and mistrust) in therapy and collaboration is the most difficult task in the implementation process. In this regard, we argue that it is important to create an atmosphere of respect and acknowledgement among the actors and, in this way, practice ODA.

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