Community Ment Health J (2015) 51:931–938
DOI 10.1007/s10597-015-9849-5

ORIGINAL PAPER

Open Dialogue and its Relevance to the NHS: Opinions of NHS Staff and Service Users

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Received: 23 September 2014 / Accepted: 12 February 2015 / Published online: 17 February 2015

Abstract Open Dialogue is a model of mental health services that originated in Finland and has since, been taken up in trial teams worldwide. As this is a relatively unknown approach in the UK, it is important to tentatively explore perspectives of NHS staff and service-users. Sixty-one Open Dialogue conference attendees, both staff and service-users, were recruited for this study. A feedback questionnaire was administered to determine the extent to which they believed the key tenets of Open Dialogue were important to service user care, and the extent to which they existed within current NHS services. Analysis of data demonstrated a strong consensus on the importance of the key principles of Open Dialogue for mental health care and also moderate disagreement that these principles exist within current NHS service provision. The Open Dialogue principles may offer a useful framework in order to develop services in a clinically meaningful way.

Keywords NHS · Open Dialogue · Opinions survey · NHS staff · Service users

Background

Open Dialogue is a needs-adapted treatment approach developed in the 1980s in Western Lapland with the aim of improving the psychiatric care in severe mental illness. Since its development, Open Dialogue's popularity has been continuing to increase and services have been piloted in a number of countries around the world, including much of the rest of Scandinavia, Germany and some US states (Scandinavian Network 2011).

Open Dialogue's involves a psychologically consistent family and social network approach to mental health care—especially in crisis—where all psychotherapeutic treatment is done in the presence of the patient's support system (Seikkula et al. 2003). The aim is to develop a dialogical communication between the patient and their support system as a therapeutic intervention. The primary focus of service provision is around regular "network meetings" between the patient and his/her immediate network of friends, carers and family, and several consistently attending members of the clinical team. The aim is to empower the family and social network via a process of dialogical communication, which involves the equal hearing of all voices and perspectives as both a means and an objective of treatment in itself (Seikkula et al. 2001a).

The Open Dialogue approach is based on seven key principles developed by Seikkula et al. (2006). Firstly, it is extremely important that there is a provision of immediate help to service users. An initial meeting must occur within the first 24 hours with the aim of preventing hospitalisation. Secondly, a social network perspective of the service user's presenting difficulties is sought through a meeting involving family and any other key members of the service user's network. Flexibility and mobility in the care provided from the professional team is essential. Meetings, psychological and pharmacological treatment are agreed in partnership with the service user. It is also extremely important for staff to take responsibility. The clinician who meets the service user initially takes responsibility of organising the first meeting. Following this, the team collaboratively take responsibility for organising the care with the service user. Psychological continuity is also extremely important within Open Dialogue care. The team who meet

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with the client initially sees the client throughout both inpatient and outpatient admissions with the service user's network staying as involved as possible. Treatments are integrated as consistently as possible. Tolerance of uncertainty underpins Open Dialogue care. This is involves positive risk taking and not making premature decisions about service users care e.g. not introducing pharmacological treatments straight away. Finally, diologism, which is the idea of promoting an open dialogue throughout the service user's care. The open dialogue is ultimately key to treatment and produces positive change.

Open Dialogue has a encouraging emerging evidence base, particularly for people with experiences of psychosis (Seikkula 2002; Seikkula et al. 2001a, b). A number of small-scale pilot studies conducted by Seikkula and colleagues have shown that Open Dialogue is a promising treatment approach for those who experience psychosis, although it is utilised trans-diagnostically in several areas now. People with first episode psychosis who received care via an Open Dialogue approach—around whom the published data has focused exclusively to date—have shown encouraging results. At 2 year follow up, the Open Dialogue group had significantly less days in hospital, significantly lower Brief Psychiatric Rating Scale (Overall and Gorham 1962) total scores than the treatment as usual group (Seikkula et al. 2003). At 5 year follow up the Open Dialogue group has significantly reduced duration of untreated psychosis (declined to 3.3 months), fewer days in hospital and a reduction in medication use compared to those who had treatment as usual. Furthermore, at 2 year follow-up in the Open Dialogue group, 82 % did not have any residual psychotic symptoms and 86 % has returned to full-time employment/education (Seikkula et al. 2006). Although results are promising, they do need to be interpreted with caution as there a number of potential research biases. For example, all studies have been conducted by the same research group, there was a lack of control and blinding in research designs, and potential bias in sampling.

In the UK, no Open Dialogue services are currently established but interest is continuously growing with conferences and small scale services being developed (Jackson 2012). Open Dialogue offers an approach arguably in contrast to current National Health Services (NHS) mental health services. Our current NHS mental health services have been developed in the context of medical based Victorian institutions which used extensive medical interventions to treat mental health patients in isolation from their social networks (Campbell 2005). Mental health services have developed extensively since this time but arguably treat the individual without extensive input of their network. Moreover, our current NHS mental health services are still based upon the foundations of the medical model and our NHS National Institute of Clinical Excellence (NICE 2014) guidelines outline the importance of diagnosis and prescribing psychiatric medication as the primary treatment method for mental health difficulties with psychological and social therapies as an addition.

The dominant medical approach has brought increasing concerns from service users and staff alike for not meeting the recovery needs of service users (Andreasen et al. 2003; Chadwick 1997; Pitt et al. 2007). More recent research into the recovery needs outline the recovery is not just about the alleviation of symptoms but an array of psychosocial factors such as rebuilding self and rebuilding life (Pitt et al. 2007). As Open Dialogue is a needs based systems approach, it may offer an alternative which may be more acceptable to service user's recovery needs. It is collaborative, embedded in social relationships and instils hope which are all key factors outlined important to service user's recovery (Allot et al. 2002).

In order to see if Open Dialogue may be relevant to current NHS services, initial examinations of opinions of NHS staff and service users are important to consider. Eliciting their opinions will examine the potential acceptability of the Open Dialogue approach and the impetus for further pilot studies to examine its feasibility and acceptability in the NHS. Therefore, this study aimed to:

1. Examine the views of NHS staff and service users on the key principles of the Open Dialogue approach for their importance and availability in current NHS services.
2. Examine the view of NHS staff and services users about the possible challenges to applying Open Dialogue to the NHS.

Method

Participants

Participants were recruited from an opportunistic sample of an Open Dialogue conference audience. An Open Dialogue conference, hosted by North East London Foundation Trust (NELFT) titled "Developing Open Dialogue in the NHS", was held inviting clinicians, managers and service users from across the UK to learn more about the model and discuss the pros, cons and possible logistics of its implementation in UK services. Conference attendees were a combination of psychiatrists, psychologists, service users, carers and a handful of other mental health professionals. A total of 119 people attended the conference.

Materials

Participants were given a questionnaire booklet which included a demographics sheet eliciting their gender, ethnicity and role at the conference.

An Open Dialogue opinions questionnaire was developed to evaluate participants' views about Open Dialogue. The questionnaire was divided into two sections including a qualitative and quantitative element; one with a series of Likert questions and a second with open ended questions. The Likert questions asked participants to rate the seven core principals of Open Dialogue as defined below (Seikkula et al. 2003):

- The provision of immediate help: Access to services in the first 24 hours with the aim of integrating treatment as soon as possible within the patient's everyday life.
- A social network perspective: Central involvement of patient's key networks in care e.g. family, friends, employers, other care agencies, neighbors, who are all seen as partners or potential partners in the process.
- Flexibility and mobility: Adapting the therapeutic response to change in needs using the therapeutic models which best suit each case.
- Responsibility: The first staff contacted are to take charge of arranging first meetings and the initial team coordinates the entire treatment process.
- Psychological continuity: The same team in engaged with the social network throughout, and for as long as necessary.
- Tolerance of uncertainty: An active attitude among the therapists to stand together with the network, and allow for tolerance of uncertainty around the presentation and treatment that is provided
- Dialogism: The focus in primarily on promoting dialogue, and secondarily on promoting change in the patient or in the family, thus fostering a sense of agency in service users and their family.

Participants were asked two Likert questions per key principle, 'to what extent do you agree that this is important to service user care?' and 'to what extent do you agree this is available in current NHS mental health services?'. Participants had to rate their answers on a 10-point Likert scale questionnaire from 0 (total disagreement) to 9 (total agreement).

Three open questions were asked to gain qualitative feedback from participants about Open Dialogue. These questions were, 'what important points have you learnt about Open Dialogue?', 'what are your opinions/thoughts on Open Dialogue?', and 'what challenges do you envisage implementing Open Dialogue approach?'.

Procedure

Participants were given this questionnaire in their conference packs which also included information about the conference and speakers. Questionnaires were completed before the conference began to minimise bias. Participants were asked to fill out the questionnaire booklet anonymously and leave it at their tables once completed. Questionnaires were collected after the conference had finished.

Statistical Analysis

Questionnaire data was inspected for normality using visual inspection and analysis of skewness and kurtosis. Percentages of endorsements were calculated by using average Likert scores across staff and service user groups. As all data was normally distributed, independent t-tests were used to analyse the Likert scale data.

Qualitative data taken from the feedback questionnaires was subjected to a thematic analysis in order to identify key themes. Thematic analysis is qualitative analytic methods that searches for themes or patterns, and in relation to different epistemological and ontological positions (Braun and Clarke 2006). A realist, inductive approach was taken identifying codes at a semantic level with the aim of developing a rich description of the data (Braun and Clarke 2006). The thematic analysis was conducted in three phases. LW read through each questionnaire line-by-line in order to identify codes. Once codes were identified they were collapsed together to form overarching themes. In stage three, final themes were generated with and uncertainties were discussed with RR.

Results

Demographics

Sixty-one (n = 61) participants took part in the study, a response rate of 51 % of total conference attendees. Demographics of the sample can be seen in Table 1.

Open Dialogue Likert scales

The Likert scales (Table 2) illustrated consensus between service user and staff perceptions on the importance of the seven principles to the NHS mental health services. All key principles were endorsed at least 78 %, with the majority of the principles being rated highly in the 90 % range. All items were non-significant between staff and service users except for responsibility (t (59) = 4.251, $p < 0.01$), where staff thought responsibility was less important than service users.

Regarding the availability in the current mental health services, the majority of items scored below 50 % illustrating moderate disagreement with their presence in the NHS. NHS staff generally rated items higher than service users for their current availability. None of these differences differed significantly.

Thematic Analysis

A thematic analysis was conducted on the qualitative element of the Open Dialogue opinions questionnaire. Two superordinate themes were identified, *important Open Dialogue factors* and *challenges of applying Open Dialogue*, containing two subordinate themes respectively (Table 3).

Important Open Dialogue factors

The superordinate theme of *important Open Dialogue factors* encompassed the key benefits to an Open Dialogue approach and what should be prioritised if an Open Dialogue service were to be developed. It involved both person-centred and systemic practice.

Person-Centred

Person-centred outlined the key characteristics of Open Dialogue which puts the service user's needs first. In the first instance, person-centeredness was about being human.

> 'It has that essence of being basically human, simple and positive in a way that many movements, which struggle to become mainstream and accepted, are' (Staff participant).

It incorporates key clinical skills which ensure that Open Dialogue is a person-centred approach. The majority of respondents outlined the benefits of being person-centred when implementing the Open Dialogue approach.

> 'Open Dialogue is client focused and likely to provide a much better and much more helpful experience for the client' (Staff participant)

Respondents emphasised of importance of clinician microskills, particularly transparency, as an important part of the Open Dialogue approach.

> 'The practise of supervision in the presence of the patient has vast implications as being an improvement upon not just traditional psychiatry but also traditional psychotherapy' (staff participant)

Systemic Practice

Systemic practice outlines the predicted benefits of including the service user's system in the intervention and treatment approaches. Respondents spoke about how dealing with the system is more effective than respective medical approaches.

> 'I like the idea of dealing with the space around the individual. i.e. if an individual is mentally disturbed by abuse. To treat them long-term is harmful. To treat the issue and circumstances and to train them in life

Table 1 Sample demographics

Demographic	N (%)
Gender	
Male	22 (36)
Female	37 (60)
Did not disclose	2 (3)
Ethnicity	
White	50 (82)
Black	2 (3)
Asian	5 (8)
Did not disclose	4 (7)
Role	
Psychologist	29 (47)
Psychiatrist	8 (13)
Service user	12 (19)
Carer	4 (6)
Other MH professional	6 (8)
Did not disclose	2 (3)
Experience of Open Dialogue	
None	16 (26)
Some limited knowledge	34 (58)
Well read	9 (14)
Practising Open Dialogue Therapist	1 (1.5)
Did not disclose	1 (1.5)

Table 2 Staff and service users percentage endorsement of the Open Dialogue seven core principles in the NHS

	(a) Importance		(b) Availability in MHS	
	SU (%)	Staff (%)	SU (%)	Staff (%)
Provision of immediate help	89.5	88.0	36.2	41.4
A social network perspective	92.3	91.7	36.2	41.8
Flexibility and mobility	93.7	92.8	35.5	47.6
Responsibility	95.8	78.2	30.3	24.0
Psychological continuity	97.2	91.4	31.8	27.9
Tolerance of uncertainty	93.7	89.5	36.3	37.1
Dialogism	95.1	91.4	32.6	34.5

Table 3 Superordinate and subordinate themes extracted from the thematic analysis

Important Open Dialogue factors	Challenges of applying Open Dialogue
Person-centered	*Professional challenges*
Transparency and openness	Taking risks
Empathy	Applying Open Dialogue within the current NHS legal frameworks
Warmth	Re-educating a large workforce
Active listening	Resource intensive intervention
Recovery focused	Working with difficult systems
Empowerment	Fidelity to the Open Dialogue model
	Working with unsupportive family systems
Systemic practice	*A cultural shift*
Collaborative relationships	Challenging the medical model understanding of mental health
Non-medical dialogue	Staff attitude change
Meaningful involvement of the system	Integrating Open Dialogue meaningfully
Multi-professional involvement	Sharing power and expertise
Interventions across the system	Overcoming fear of change
Shared ownership	Organisational change
	Commitment from staff and leaders for change

skills is a more useful approach and prevents a revolving door situation' (service user participant)

Respondents identified the importance of having a collaborative relationship with the service user and their system and how it can be beneficial in outcomes for service users. It was highlighted that the Open Dialogue approach facilitates such collaborative relationships.

'Open Dialogue offers the benefit of developing therapeutic alliance whilst being able to give power and self-knowledge to the client with the support and kindness of mental health worker rather than imbalance of power' (staff participant)

Challenges of Applying Open Dialogue

The superordinate theme of challenges of applying Open Dialogue approach highlights the practical and logistical difficulties of implementing an approach so vastly different from current NHS services. Two subordinate themes were identified *professional change* and *a cultural shift.*

Professional Change

This theme identified the need for individual and services to take responsibility in order to facilitate change in services and make room for an Open Dialogue approach. All respondents highlighted the need for resources to be made available.

'Ensuring that there are enough resources to train staff and then to provide the level of input needed for Open Dialogue, service will need extra funding to achieve this' (service user participant)

Respondents also outlined the difficulties of incorporating an Open Dialogue service to existing services and ensuring that Open Dialogue is not seen as a replacement but a service which compliments existing ones.

'It is important that we connect an Open Dialogue service to what we are already doing and or perceived skills and what we are proud of so it's not positioned/ either or but is seen as enhancing and strengthening us' (staff participant)

Participants also spoke about how Open Dialogue may operationalise key factors which they apply already in their clinical practice.

'It feels both innovative yet "old" at the same time. For me, it fits with my value base and is a 'system' that I would always aspire to be a part of'. (Staff participant)

Participants also spoke about concerns and apprehensions about an Open Dialogue being applied to current NHS clinical practice.

'If I am honest, I am worried and skeptical about whether the implementation of Open Dialogue can be fully realised, but the "journey" may set the ball rolling the most important shift in attitude seen in mental health services for years' (Staff participant).

A Cultural Shift

The theme *a cultural shift* shows the need to make a paradigm shift in the way we perceive and treat mental health difficulties. One main theme identified by respondents was changing the way we understand and construct mental health difficulties.

> 'The National Health Service (NHS) is built on the foundations of the medical model and needs a radical shift to make room for Open Dialogue' (service user participant)'

Developing an Open Dialogue service requires change in currently entrenched practice such as taking risks and sharing of power. Because of this, respondents were wondering whether the government will consider Open Dialogue as an important practice and back the development of these services.

> 'Convincing the government that Open Dialogue is a useful important practice which can potentially improve the quality of life of most individuals with mental health problems, get them back to work, saving the NHS money in pharmaceutical and sick days' (staff participant).

Participants also commented on the difficulties of applying an Open Dialogue service within the constraints of our current clinical policies and guidelines.

> 'Not having very clear National Institute of Clinical Excellence (NICE) guidelines on this approach. Being prepared to take risks and deal with them appropriately (staff participant).

Discussion

This study aimed to examine the opinions of NHS staff and service users about the Open Dialogue approach and its relevance to NHS mental health services. It examined qualitatively and quantitatively participant's opinions of the seven principles of Open Dialogue, their importance, their relevance to the NHS and potential challenges of applying Open Dialogue. This novel study highlights some important findings which may support the need for further Open Dialogue research to be conducted. It has highlighted that there is broad agreement that the core principles of Open Dialogue, could potentially serve as an important framework for the delivery of mental health services, yet, at the same time, there is also broad agreement that these facets are largely lacking from the current model of mental health service provision. This consensus is consistent in both staff and service users.

The theme 'important Open Dialogue factors' outlined the key tenets of the approach. Person-centred care is an essential part of engaging participants in Open Dialogue, which was recognised by the participants. This approach facilitates the development of helpful relationships, a meaningful dialogue and understanding all the perspectives of the social network (Seikkula et al. 2006). Borg et al. (2009) outline Open Dialogue as a person-centred approach as it prioritises the person's needs and preferences. Participants also recognised the systemic nature of the Open Dialogue approach in the theme 'systemic practice'. The collaborative relationship and meaningful involvement were highlighted as essential. Trusting relationships are required to ensure that all parties feel safe to tolerate uncertainty and develop a dialogue (Seikkula and Olsen 2003). Importantly, the participants outlined the appropriate use of language used within Open Dialogue. Open Dialogue stresses the importance of the service user and their network developing their own language and narrative in order to describe and explain their mental health difficulties (Seikkula and Olsen 2003).

The thematic analysis outlined two themes relating to the potential challenges faced when implementing an Open Dialogue approach; professional change and a cultural shift. Professional change acknowledges that individual clinicians would be faced with a number of obstacles if they are willing to develop a new way of working when implementing an Open Dialogue approach. It is clear that the implementation of an Open Dialogue framework will involve clinicians taking a significant personal responsibility which they may not feel able. A first step in implementing an Open Dialogue approach would be to update current clinical guidelines to ensure the clinician felt safe and protected to work differently. Some existing clinical guidance would support the approach, for example positive risk taking (Morgan 2000), but further guidance would need to be developed for an Open Dialogue approach.

Open Dialogue requires its practitioners to surrender their professional power and work on an equal standing with the service user and their network (Holma and Aaltonen 1998). As noted in the thematic analysis, this may be threatening and uncomfortable for clinicians in the NHS who have been taught and practising as experts for many years. The inherent power that lies within the psychiatry profession has long been acknowledged and, for many, an attractive part of the role (Szasz 2010). Giving up this position of power may be incredibly difficult, even for those who are willing. Practitioners will require training and support to relinquish their position of power and transition to a 'not-knowing' (Anderson 1990) and inquisitive stance.

A significant concern from NHS stakeholders is likely to be the financial and human resources needed to implement

an Open Dialogue approach, which was highlighted in the thematic analysis. Initially, Open Dialogue is a resource intensive intervention and requires multiple professionals to be involved with the family; however this reduces throughout the intervention process. Seikkula et al. (2003) outline that Open Dialogue is a cost-effective approach due to its prevention of hospitalisation and facilitating the care of people in the community. However there is yet to be a formal examination of its cost effectiveness. It is likely that Open Dialogue will reduce costs if it is able to prevent hospital admissions in the UK. Inpatient care is the most expensive division of health provision, with the average inpatient stay costing £6,080 (Lloyd-Evans et al. 2010). Examination of sustainability and cost-effectiveness of Open Dialogue is imperative in order to promote Open Dialogue to NHS stakeholders.

A cultural shift highlighted the need to move away from the current NHS medical based approach and towards a holistic psychosocial package of care. Currently, NICE guidelines for psychosis offer anti-psychotics as first-line treatment with individualized Cognitive Behavioural Therapy (CBT) being offered secondary to this (NICE 2014), which is clearly at odds to the Open Dialogue approach. Moreover, the traditional medical approach which underpins our current services views mental health recovery as an individualised approach dependent on symptom change which is quite contradictory to the Open Dialogue approach (Silverstein and Bellack 2008). Open Dialogue will require a whole-systems collaborative approach to ensure that it is integrated meaningfully which will involve taking a step back from medical treatment. To enable this, extensive development of the evidence base of Open Dialogue would be essential.

A very significant movement in the UK of both clinicians and service users has started to evolve to actively strive to move services in the direction of Open Dialogue. Certain cities, like Leeds and Nottingham, have active Open Dialogue service user groups, who are established to teach and lobby people about Open Dialogue (Jackson, 2012). In addition, up to 7 NHS Trusts around England are now looking into establishing pilot Open Dialogue teams in each of their territories in order to jointly participate in a multi-centre randomised controlled trial to deepen the evidence base and further determine the efficacy and applicability of such services within an NHS setting—both for psychosis services, as well as trans-diagnostically (Razzaque. 2014). Such further study will therefore assist the possible translation of this evident consensus among NHS staff and service users into the actual components of future service provision, along Open Dialogue lines.

A strength of this study is that it is the first to examine NHS staff and service user's opinions of Open Dialogue and its relevance to the NHS. Currently Open Dialogue has not been evidenced in the UK and there is uncertainty about its acceptability. This study allowed for tentative exploration of opinions in order to provide a rationale for further research. A limitation was the sample, as they were recruited opportunistically from an Open Dialogue conference and potentially not reflective of NHS staff as a whole (e.g. the majority of the sample were female psychologists). All conference attendees had at least an interest in the Open Dialogue approach which is likely to have impacted the results. Unsurprisingly the findings, particularly the survey results, are favouring the Open Dialogue approach. However, it was not possible to gather opinions from NHS staff in any other way as Open Dialogue is not widely known in the UK. Another limitation was that only 51 % of attendee's completed the questionnaire as a low response rate can risk sampling bias and impact on the accuracy of results.

Conclusion

In conclusion, Open Dialogue and its key principles were endorsed highly by both NHS staff and service users indicating that it may be an acceptable approach to consider for NHS mental health services. However, what was clear was that there are likely to be many challenges in implementing an Open Dialogue approach in current NHS services. Further research is into the feasibility and acceptability of the Open Dialogue approach is needed to develop its evidence base in the UK.

Conflict of interest None.

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