Nurses experiences on using open dialogue approach in a local mental health service: An interpretative phenomenological analysis

Professional Doctorate in Advanced Healthcare Practice

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2019

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ACKNOWLEDGEMENTS

Thank you to all those people who have kept me on the path during this entire course.

Thank you to Cardiff and Vale UHB for their ongoing support and backing – I could not have done it without the fantastic teams supporting me.

Thanks to Cardiff University for an excellent course – in particular to Dr Jane Harden and to my very dedicated supervisors Dr Nicola Evans and Dr Steve Whitcombe and Dr Michelle Huws-Thomas (I hope this work reflects the amount of support you have given me): along with my research review supervisors.

During this course I was fortunate to secure a travel scholarship from the Florence Nightingale Foundation. My travels took me across the world and finally to Finland that allowed me to focus and specify on my chosen topic, which I am very grateful for.

Finally, thank you to the ongoing support from my wife Georgina, my son Benjamin and my daughter Menna – I ensured we had plenty of playtime and play days; but sleepless nights for me! cariad mawr xxxx

Ac i mam, diolch am bopeth a cariad mawr xxxx

Word Count: 69000

ABSTRACT

NURSES EXPERIENCES ON USING OPEN DIALOGUE APPROACH IN A LOCAL MENTAL HEALTH SERVICE: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

Background

Open Dialogue Approach (ODA) is a collaborative intervention and framework for using with service users with complex mental health such as psychosis.

Aims

To explore nurses' experiences when using ODA and in particular how ODA culture compares to other mental health cultures within a local health board.

Method

Through the qualitative approach of Interpretative Phenomenological Analysis five members of staff were purposively sampled and participated in the research.

Findings

The participants discussed ideas and concepts that developed into the following themes: the first theme was based on learning ODA skills and concluded that experiential learning and more formalised teaching is beneficial for ODA roll out, however, having a more experienced clinician partnered with a novice is crucial. The second theme focussed on participants perception of impact: all participants/ clinicians agreed that ODA was an effective approach for the service users they worked with, due to the therapeutic relationship, service user empowerment and openness and transparency. The third theme identified 'barriers': the ODA principle of tolerance of uncertainty was a barrier that was encountered by the participants. Participants felt they must take positive risks and use minimal recording and not communicate about the service user without their presence, which is not in keeping with current legislation (UK and Wales). Also of significance is the fact that the service user is empowered within ODA to lead and direct the conversation which could be perceived as a barrier by some staff and professional groups who may feel threatened by this. This was evident in managing staff emotions within initial network meetings, managing risk and maintaining professional boundaries. In order to overcome this, the principle of tolerance of uncertainty was relaxed by participants in order to manage risk and for them to comply with current legislation. The empowered relationship in ODA is critical (through clinicians being open and truthful), as it appears to be the central and core intervention mechanism within ODA.

Conclusion

ODA is reported as being effective by the participants within this study, but it will require further research to demonstrate this effectiveness within the UK to the wider clinical body and policy developers. The study also indicates a mechanism for ODA effectiveness: control and empowerment of the service user and openness/ transparentness from clinicians. If this is employed then it appears that the principle of tolerance of uncertainty can be ameliorated to fit with UK legislation.

CONTENTS

NURSES' EXPERIENCES ON USING OPEN DIALOGUE APPROACH IN A LOCAL MENTAL HEALTH SERVICE: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

1. INTRODUCTION

This study explored nurses experiences of using open dialogue approach (ODA). ODA is an underpinning philosophy that provides the framework for psychiatric care in Western Lapland, Finland since 1990 as an intervention for those with any mental health problems (Seikkula and Arnkil 2013). The central philosophy is to position the service user within their social context and maximise this resource/ partnership for the service user's benefit, in essence putting service users in control of their own care (thereby placing the service user on an equal footing to health care practitioners – HCPs). This model of care in Western Lapland has aimed to reduce people's duration of untreated psychosis (DUP), and there have been several studies over the past 25 years that have made claims that ODA has had positive effects on the incidence of psychotic symptoms (82% decrease), reduction in use of neuroleptic medication (35% need), and increased productivity. Also, people with a diagnoses of Schizophrenia who were in education was 73% (Thomas 2011, Seikkula & Arnkil 2006) – as compared to 23% in the UK (Seikkula and Olson 2003). The studies demonstrated that 67% of those treated did not experience a relapse of psychotic symptoms over a 5-year follow up period (Thomas 2011, Seikkula & Arnkil 2006). However, it must be stated that the methods and analysis used within these studies have been the subject of criticism (Lakeman 2014). Despite this, a number of clinicians from within the UK have begun to use ODA within their practice to ascertain whether the results reported by Finnish clinicians can be replicated (Razzaque & Wood 2015). The gains achieved by ODA in Finland are impressive, e.g. lower rates of schizophrenia diagnosis, reduction in medication use and increase in maintaining employment/ studies (Seikkula and Arnkil 2013, Seikkula and Arnkil 2006). These positive results can have a profound effect on service users' quality of life and mortality due to the side effects associated with the medication available to individuals (Waterreus et al 2012, Weinmann et al 2009). Arguably these results suggests that this approach needs to be reviewed and assessed in order to ascertain whether the claims by its developers are valid and that their research has been conducted with the rigor expected within today's evidence based practice model of care. This thesis does not aim to test ODA effectiveness but rather discover clinicians' experiences of using the approach within their current practice in the UK, which is weighted towards the medical model and surrounded by a legislative framework that emphasises risk which in turn creates a more defensive practice. ODA's principles are very different to the UK's and Wales' psychiatric principles which are medically and legalistically based (McKeown et al 2015a & McKeown et al 2015b) in that the dominant profession is psychiatry and government have strict standards and targets for organisations to meet especially in relation to risk management (McKeown et al 2015a). There is also limited qualitative literature that has been found that examines ODA and none from the UK (at the time of starting this thesis), therefore in adopting the qualitative approach this study is attempting to address this gap and provide a valuable insight into this phenomenon.

The study research question was as follows:

What was the experience of mental health nurses in an inpatient and outpatient setting of using Open Dialogue Approach following its implementation in a local mental health clinical board?

The aims of the study were:

- To explore nurses' experiences when using ODA.
- To explore nurses' perceptions of ODA culture (more empowering of service users) compared to other mental health cultures (medical model led, legislative framework) within a local health board.

ODA is about partnership working through the exploration of partnerships or social networks the patient has; through network meetings, clinicians must work in partnership with the patient, carers, friends, teachers, employers etc. Welsh Government policy also advocates and recommends that clinicians work closely and in partnership with service users and their families through the principle of co-production from within their Prudent Healthcare Strategy (Welsh Government 2016a). Specifically within mental health, the Welsh Government's mental health measure (Welsh Government 2015) outlines a framework for closer partnership working through collaborative care planning, advocacy and self-re-referral mechanisms back into services. However, service user groups would argue that this legislative ambition and process has not been fully achieved (NHS Benchmarking 2018). According to the Care Quality Commission 2014, community mental health survey only over half of the respondents felt like they were involved enough in their care or that their family member was included in that plan (Devapriam et al 2015). Therefore, a more fundamental change to practice is required to address these shortfalls in current practice.

1.2 LAYOUT OF THESIS

This chapter aims to outline the context of this study by providing some of the background into mental health services. The layout of the thesis is set out along with my personal reasons for doing this study.

This thesis has the following layout; initial introductory chapters that provide the context for this work, followed by the methodological discussion and method used along with the data findings and analysis. Finally the thesis will end with chapters containing the thesis discussion, conclusions and recommendations.

This thesis follows a structure outlined by Dunleavy (2003) where an introductory information chapter is presented providing a short historical summary be offered to explain the role of the clinician in mental health and an exploration of the issues with relationship building and trust are discussed. Following this, chapter two provides further background and chapter three comprises of a literature review, discussion and exploration of open dialogue approach. Chapter four provides the theoretical position and chapter five discusses method and the rationale for choosing interpretative phenomenological analysis (IPA). Chapter six provides the methodology and outlines the structure of data analysis using IPA, and chapter seven provides the breakdown of the findings as they were interpreted within the research process. Finally, chapters eight and nine collates all of this information and provides a discussion and conclusion to the thesis. Therefore chapters three, four and five provide the core of this IPA research and thesis (Dunleavy 2003).

1.3 REFLEXIVITY

My interest in psychosis goes back to my childhood when a family member (my uncle) became unwell and required hospitalisation. I still remember (or I think I remember) my mother driving my uncle (with me in tow) to outpatient clinic appointments along with subsequent re-admissions. I suppose I remember that things were out of the ordinary, not entirely discussed in an open way and somewhat frightening to my four or five year old self. When I applied to do my nurse training it was to be a mental health nurse, but on my induction day the fear and the unknown nature of mental health persuaded me to change my vocation and I switched to general nursing. I did not think I had chosen correctly but the uncertainty of mental health held sway over me that is, until I undertook my first mental health placement. For the first time I worked with people with mental health problems and realised that they were people exactly like my uncle, they were people not monsters and there was nothing to fear, contrary to the stereotypes in the tabloids and misconceptions held in popular culture. Following this experience, I changed my professional path and studied mental health, working for the next two years in inpatient forensics and acute settings followed by eight years in the community setting. In this setting, I began to champion the cause against the stereotypical view of mental health patients. When asked about my job and I would answer community mental health nurse and the response would be why do we need community mental health nurses? I would invariably answer that the majority of sufferers with mental health problems are in the community (>95%). Following this, I moved to rehabilitation and recovery services where I realised that even my view of mental health service users was stereotyped because the clinicians working within this area were strongly motivated for service users to be more integrated within society e.g. work and living independently. Leading on from these experiences I undertook a master’s degree and then a doctorate, my interest motivated by early intervention in psychosis. My desire was for mental health services to be the best they could be for those entering them so that they would not require such services for the long term (i.e. mental health services would provide interventions that were effective and targeted resulting in a shorter duration and requirement from mental health services). I began to research for areas of excellence and my searches took me to Melbourne and to Western Lapland thanks to a Florence Nightingale scholarship. A colleague I worked with recommended I look at ODA following training he had undergone (which I had supported). Within Western Lapland I was exposed to open dialogue approach and my questions upon stigma and an effective process appeared to be answered in that the philosophy creators claim that the intervention is effective in treating psychosis and ensures people rely on medication less, are in work (or education) and living independently. Additionally they achieved this by using a social network approach, i.e. they use the community to support the individual with mental health problems and in doing so they achieve two things, the first is that they achieve their primary goal to help the individual and secondly it could be argued they achieve a community/ social educational outcome in their interventions by including the community thereby reduce the stigma of mental illness within the community. Following my return to UK my ODA trained colleague requested that he begin to use ODA within the clinical setting which I agreed to. He began to work with other staff (nurses and occupational therapists) to deliver ODA. Some staff were already aware of ODA and/ or were hearing about ODA in conferences/ workshops.

Therefore, this research was designed to explore how those staff at a local health board experienced using ODA within the UK and specifically how these mental health clinicians utilised the intervention. This study explores clinicians' views and opinions on the approach that they have been using within the Welsh urban setting with service users with severe mental illness; an approach that is embedded within the UK psychiatry setting and culture. Even though I am a mental health nurse I am not a practitioner of this approach. Rather, I am an observer and as such IPA allows me the ability to explore and study this approach from a distance from the setting up and implementation of ODA in the workplace (Delamont 1995). However, as a researcher I realise that I am now deeply involved in this work (e.g. involved in the south west region implementation group on ODA), although I was not from its establishment and implementation.

It is important to gain a greater understanding of ODA practices within a UK health culture because of ODA's apparent successes within Finland. Therefore, it is important to develop a greater understanding of how ODA principles can be transferred into the more medically led and restrictive UK psychiatric healthcare model (Razzaque & Wood 2015). ODA through reinforcing and strengthening social networks helps service users and their families understand their distress and enables them to engage with HCPs on an equitable basis, which is in contrast to the UK that is a clinically led approach where the service user and their family are led through the process and where control is held more by the HCPs (Razzaque & Wood 2015). ODA clinicians put the service user at the centre of their own care by providing them with the control to make decisions about what happens next, what is discussed and who is invited to participate in a therapeutic partnership (Seikkula and Arnkil 2013). Supporters of this shift in power who advocate the recovery philosophy that shifts power towards a more equitable stance (Perkins 1996) could favour ODA as the model to implement such a radical shift.

2. BACKGROUND

This section will explore the rationale for undertaking this study. The financial benefits along with the quality afforded to service users who receive proactive care will be explored in the context of early treatment to avoid worsening of symptoms. Along with this, it looks at historical therapies and reviews the psychiatric model of care. Proactive mental health care is considered in this work with examples such as early intervention in psychosis and open dialogue approach.

2.1 HISTORICAL UNDERPINNINGS OF MENTAL ILLNESS

Mental illness or abnormal behaviour stretches back across the records of human history (Kring et al 2017). Supernatural reasons were the earliest causes attributed to mental illness, the belief being that mental illness or deviant behaviour was caused by good and evil forces, and in some ancient cultures (Mesopotamia, India) gods were thought to be the cause of disease; mental or physical (Kring et al 2017). Whilst in the Hebrew culture mental illness was seen as a breakdown in the relationship between the individual and God (Kring et al 2017). Other reasons have been used to explain mental illness that includes physical or biological causes, i.e. physical illness or effects have an impact on the mind and can cause mental illness and can be located in the writings of Hippocrates who describes bloodletting as a treatment for mental illness.

In the 19th and 20th centuries, psychological factors have become the leading causes for mental illness and its treatment; in part due to the prevalence of a more secular society and a shift in consciousness following the age of enlightenment (Kring et al 2017). This has led to psychosocial treatment methods that have focussed on psychology, social and cultural psychopathology (Kring et al 2017). However, a more accurate position from which to explore the current approach within western cultures would be a biopsychosocial model as it attends to the way in which the majority of treatment is administered i.e. biologically through administration of psychoactive medication (Engel 1977).

2.2 DEFINITIONS AND BACKGROUND TO PSYCHOSIS AND SCHIZOPHRENIA

Psychosis originates from the Greek:

Psyche – Mind
Osis – abnormal condition.
(Kring et al 2017)

The word was first coined by Canstatt in 1841 where he used the term psychic neurosis; neurosis referring to disease of the nervous system (Burgy 2008). Introducing the term psychosis separated the understanding of a mind disease rather than a nervous system disease; and thus concentrated thinkers of the time to look at the mind to solve the problem of mental illness, and so the word "psychoses" took over from the term mad (Burgy 2008).

Further, within the 19th Century Kraeplin went on to categorise the subcomponents of this new term major psychoses. They were broken down into manic-depressive illness (bipolar disorder) and dementia praecox (Schizophrenia) (Kring et al 2017).

Today psychosis or being psychotically ill refers to someone who is impaired (in multiple ways) in being able to connect with their reality (Kring et al 2017). People may have positive symptoms such as hallucinations which ranges from hearing voices (in their mind or externally) or seeing things that are not there (Jablensky 2009). They may have strong unwavering beliefs known as delusions (e.g. people may believe they have supernatural powers, or they may believe they are being persecuted in some way; followed, controlled, penalised) (Kring et al 2017). Delusions can cause profound risks to the sufferer (mostly) and to others. Other symptoms include disorganised thinking and negative symptoms such as a flattening of emotional responses and isolation (Liddle 2009).

2.3 TRANSFORMATION – INSTITUTIONALISATION OR TRANS-INSTITUTIONALISATION, REHABILITATION AND RECOVERY

The psychiatric profession continued during the 19th century and into the 20th century to expand the mental health institutions (now called asylums) (Rogers and Pilgrim 2001). The medical profession (initially called alienists and then psychiatrist) took increasing lead of this movement as they were the creators and controllers of mental health knowledge at that time. This enabled the service to become standardised and regulated (Unsworth 1993) and psychiatry became a profession as it was legitimised through knowledge (Rogers and Pilgrim 2001, Hannigan and Allen 2006). These asylums had replaced the old workhouses and were a place of treatment (and also confinement from the rest of society) but were still as cruel and controlling as the madhouses/ work houses they meant to replace (Foucault 1967).

Psychiatry had previously adopted the moral treatment; this model/ principle was taken on by an English Quaker called William Turke when he set up a retreat in York. Within this country house, people could talk through their problems, recuperate and rest; providing people with respite from their mental illness (Charland 2007). Within the retreat, there was also a work ethic for those who stayed there to engage with and this model was viewed very positively by society at that time (Crossley 1998). Initially, outcomes were positive for the approach but as it was taken up by other institutions the efficacy rates diminished and the approach was used less, during this time the psychiatrists began using more of their own biomedical treatments (shock treatments, psychosurgery) (Hannigan and Allen 2006). By the mid to late 19th Century psychiatry was at the centre of public fear and mistrust. Society felt that the psychiatrists had too much power that could be used to confine people wrongfully and treat them with what appeared to be barbaric treatments.

Despite this even in current times according to Hannigan and Allen (2006) the mental health establishment is still rooted in the best interest model advocated by psychiatrists 150 years ago. The leading model in the UK is still a medical approach; mainly due to the fact that our most dominant current world paradigm is still positivist science and the medical profession is one of the most senior professions leading this. The medical profession relies on symptom control through use of medications that may have severe side effects; financial viability is offered as the primary reason for this (Kring et al 2017). For example, newer antipsychotic medications can cause metabolic side effects which affect people's weight leading to physical symptoms and disease such as high blood pressure, cardiac problems and diabetes (Kring et al 2017). The most efficacious antipsychotic Clozapine is monitored on a frequent basis (daily, weekly, monthly dependent upon the duration of taking the medication) due to its potential side effects on the immune system; as well as the metabolic side effects previously discussed.

The motivation behind the psychiatry movement was and is to do good but critics have argued this endeavour lost its focus of the patient which have led to practices that have restricted patients rather than empowered them (Scull 1979). However, psychiatry is rooted in the scientific modernist ideology that is positivistic and has an optimistic view of reality that through effort, work and progress then our realities will be improved (Rolfe 2000); however, this is not necessarily true if during the process people are disadvantaged in some way. The aim of psychiatry was to find a cure to mental illness (Hannigan and Allen 2006). Other treatments were sought through use of experimentation (modernist/ scientific approach) and arguments for what appears today to be quite extreme treatments were used and propagated e.g. infecting patients with Malaria, electro convulsive therapy (ECT), insulin shock therapy and neurological surgery (Kring et al 2017). ECT is still being used today mainly to treat severe depression, despite the fact that a complete understanding of how the therapy works eludes us, as does a complete understanding of how the brain works (Kring et al 2017).

The pinnacle of the experimentation movement came during the Second World War, which culminated in the eugenics movement that took place which included non-consensual human testing (torture) such as transplantation, immunology and effects of extreme conditions (dehydration, altitude and poison) etc. which society was repelled and appalled by (Sidel 1996). Within mental health, a similar movement took place that reviewed some of the historical approaches towards mental health and move towards a more inclusive form of care (Foucault 1967). Drivers for this change came from the anti-psychiatry movement by Erving Goffman, Erik Ericsson, Thomas Szasz and Karen Horney, which subscribed to a move away from the medical model towards the psychosocial (see next subchapter 2.5).

Interestingly, a biomedical solution i.e. medication (antipsychotic/ neuroleptics) provided a solution in allowing the establishment to begin to embrace the psychosocial aspect of care due to the fact people could now be treated and discharged safely back home and into society by continuously taking these medications (Kring et al 2017). This example of biological reductionism it can be argued over simplified the human anomalous experience which tended to provide medicalised pathological explanations to these unique experiences despite there being little evidence of the dopamine hypothesis or reliability of diagnostic criteria (Crossley 1998).

Thomas Main first began using therapeutic communities in the late 1940s, which encouraged patients to take control of not only themselves but also the running of the unit; by seeking the views and opinions of patients. Something that had not occurred within mental health treatment since moral treatment (Main 1989) and which is not dissimilar to the peer support workers that are being used more frequently within different areas where people with lived mental health experience are being employed by the organisation (Simpson et al 2018). Following this mental health rehabilitation was developed (learning from the therapeutic community works) alongside a developing psychosocial approach to the care provided: thus representing the beginning of the break up or move away from institutional care by integrating patients back into the community (Roberts et al 2006, Killaspy et al 2009).

In the UK in the1990s, the community care act was implemented to finalize this move away from institutional care and was driven by the social disability movement (DoH 1990). The development of evidence based community treatments began and grew so that assertive community treatment teams became established (DoH1998). New teams such as assertive outreach (reaching hard to engage patients) and crisis and home treatment teams (which have worked well to keep patients in their homes rather than admit them into inpatient environments – Paton et al 2016) relatively quickly became the new structures and pathways within the community (NICE 2014 and Andrew et al 2012).

Therefore, over the past two decades' community services have grown and more money is now being spent on community services than inpatient services. The consolidation of community services over the past three decades has been due to the initial good intention steps towards community in the early years being met with controversy. This was due to patients being discharged from hospitals with minimal care; whereas now it is expected that people are followed up robustly in the community (Kisley et al 2017). In the mid-1990s community care was seen as another form of institutionalisation where patients were discharged but not equipped to socially integrate into their communities and were left isolated and alone (Milligan 2001).

Within Wales partnerships have been forged between health, local authority partners and third sector in order to provide a holistic form of care to service users initiated through strategies such as Together for Mental Health (Welsh Government 2016b) and Prudent Healthcare (Welsh Government 2016a). Recovery initiatives have also been part of the mental health lexicon which refers to closer partnership working with service users and carers through providing hope, choice and opportunities (Perkins 2006). In addition to this peer workers (those with lived experience of mental illness) have been employed in many teams in order to facilitate the voice, perspectives and experiences of services users (Christie 2016) and such workers are thought to be beneficial in engaging with service users within a recovery agenda (e.g. recovery college) (Harper & McKeown 2017). However, this must be balanced by the fact that the government measures adverse events such as suicide as an indication of an organisation thriving or failing (Fairweather et al 2017). Therefore, as much as mental health organisations are moving towards empowering mental health service users this is ameliorated by a pull towards restrictive practices to keep service users safe.

Therefore, there needs to be a move away from the biomedical model towards non-technical paradigms that are more tailored to the uniqueness of the individual in an attempt to understand their mental distress rather than label it. Bodies such as 'Hearing Voices' and 'critical psychiatry network' call for reform in understanding and helping people with mental health problems.

2.4 BIOPSYCHOSOCIAL MODELS OF SMI - HISTORICAL AND CURRENT BIOMEDICAL TREATMENTS

As discussed earlier the biomedical model was the foundation of psychiatry from the 19th century, and a biological reason was seen as the only causal factor that needed to be resolved in order to cure the individual (Kring et al 2017). Therefore, a biological treatment could be found, prescribed, administered and would resolve the issue (Engel 1977). However, by discounting the psychosocial factors psychiatrists were failing to see how other factors could contribute to the illness and the social duties involved in care, especially social integration (rather than social isolation). Engel (1977) stated that psychiatric institutions had become impersonal, cold and desensitised to the needs of people with mental health disorders. Foucault (1967) reinforces this by stating that people (psychiatrists, the establishment) had forgotten how to speak or communicate with the 'mad' person.

Consequently, a move towards a biopsychosocial (BPS) model was seen as the basis within psychiatry, in which biology (sub personal systems e.g. cells, genes, nervous system etc.) was seen as fundamental. Also the systems around the individual (supra personal – psychosocial) were now of equal value in determining not only the cause and nature of the illness but also its treatment (Kring et al 2017): with a person developing suicidal tendencies clinicians would look at social issues such as stressors but also potential protective factors (e.g. family, friends, work, etc.). However, in addition to this, within the last decade the role of epigenetics has focussed on understanding the onset, maintaining factors and what treatment could be involved in treating schizophrenia in relation to genes, biology and environment interactions (especially the evidence of adverse life experiences and psychosis) (Read et al 2009). Therefore during the last decade there has been a growing body of evidence of how stress/ early life trauma plays a role in switching on genes that precipitate the onset of psychosis. Epigenetics is therefore grounded in the biopsychosocial approach in that it embraces not only a biomedical approach but also the wider psychological and social/ environmental impact upon mental health.

It could be argued that due to the BPS approach that service users are seen more holistically and in a multifaceted way to treat their illness; in that many aspects are now considered including financial, relational, cultural, religious/ spiritual, sociological and psychological indicators. However, critics of BPS have stated that it is a costly and time intensive process in that service users are required to have multiple assessments that are extremely comprehensive and treatments, which can consume many resources (Babalola et al 2017). However, all of the health professions would profess to support the BPS model especially in the initial teachings of each of their students (Kring et al 2017). There is a risk that once practising the real world practicalities of lack of resource and time means that those professionals take an easier route or simpler quicker course of action that follows a more biomedical approach (Babalola et al 2017).

In practice, instead of the BPS approach being a fully integrated approach many see it as a Biomedical and Psychosocial approach (or approaches). In this was the initial work to biomedically stabilize the individual and then use a psychosocial approach; if there are resources and the patient is especially complex (Kring et al 2017). Additionally, critics have stated that there is no evidence for the BPS approach (Babalola et al 2017) hence the approach has broken down into its constituent parts that are more evidenced based rather than an integrated approach. Nonetheless, the risk is that the biomedical becomes the standard and the psychosocial is added if necessary (and time and resource allows) (Andrew et al 2012). In Deacon's (2013) critical analysis of the biomedical approach recounts that in the presidential address of the American Psychiatrists Association in 2010 Dr Schatzberg (Stanford University Psychiatrist) stated that psychiatrists were still under attack (from the psychosocial model) and were required to be more medical.

Supporters of the medical model and biological modernist approach are still researching today how mental illness can be treated or cured using psychotropic medication or a genetic factor that can follow through to a treatment mode (Owen 2013). These approaches do not embrace a BPS approach but continue the historical approach of the mind body split or the biomedical/ psychosocial split (Kring et al 2017).

BPS has the potential to provide context for the person with mental illness and develop greater understanding of what is happening to that individual (Engel 1977). Nevertheless, in practice there is still a split between the two differing approaches and a potential unwillingness for the combination of approach; or at the very least a bias towards the biomedical model (Deacon 2013). However, it can be argued that this lack of adherence to the BPS model has implications for successfully or truly evaluating its effects in practice, because it is not function as it has been envisaged.

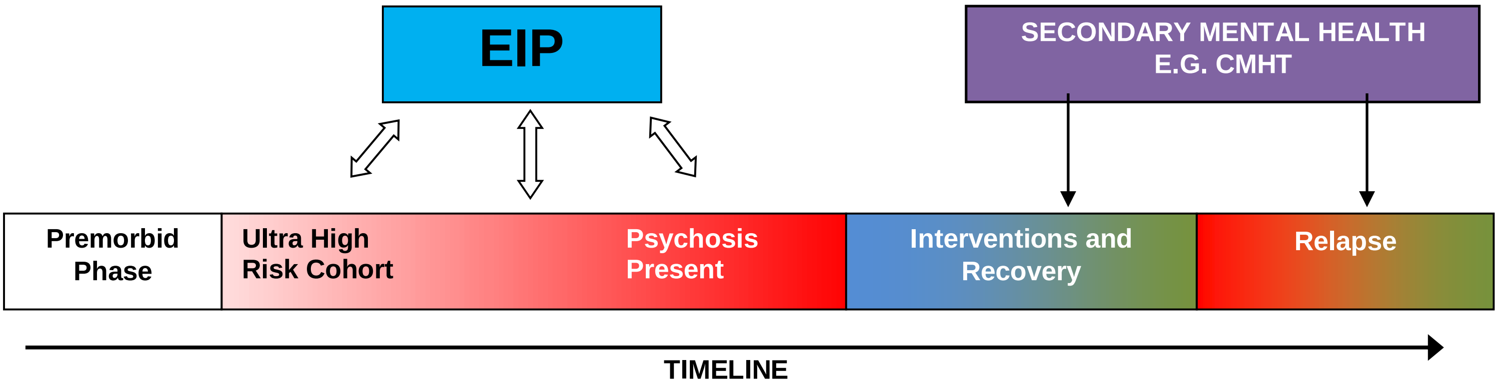
Focusing on cultural issues could provide the BPS approach with the guidance to operationalise it effectively; through having an increased understanding about the support networks around the individual and how these can be exploited/ harnessed to support them in a greater capacity (Ghaemi 2009).

Finally, BPS is an interesting model that has had various uptake. Supporters would state that it provides a holistic view of the patient and the context of their illness and thereby the avenues to treat it effectively. Critics would state that it is an expensive model in both time and resources because it encompasses a wide scope rather than focusing on the medical problem to be treated. McCann (2016) criticised the bio-psychosocial approach as stating it is still rooted in positivism and has created a diagnostic language that alienates others and has created a ‘truth’ that fails to recognise the stigma of labelling. This has now led to an emphasis on compliance i.e. the expectation that the service user will do what is expected of him or her by mental health services. McCann (2016) argues that this has led to an ethnocentric bias, ethical harms and misdiagnosis. The conclusion being that clinicians are too positivistic and need to adopt a social constructionist stance to provide a balanced view in the mental health assessment and treatment of service users in the UK. To counter this, supporters have stated that by looking at the cultural and harnessing it we are using the persons existing resources and strengths to ‘treat’ their mental illness. However, a full uptake would require the medical world and psychosocial one to work together to achieve the greatest results.

2.5 EARLY INTERVENTION SERVICES

Early intervention in psychosis (EIP) services are designed for those people who are experiencing psychotic type symptoms for the first time in their lives. These may be individuals who have recently received a diagnosis or they are at ultra-high risk of developing a psychosis (Marshall and Rathbone 2011, Williams and Carden 2010). National Service Frameworks ensured the roll out of EIP from 1999, where service users could have rapid access to treatments for up to three years (Marshall 2011). The term Ultra-high risk was coined by the PACE clinic in Melbourne and follows set diagnostic criteria for young people who are at imminent risk of developing psychosis (Yung and McGorry 2007). Ultra-high risk individuals are those who may have prodromal (precursory) symptoms of psychosis, such symptoms, for example, pseudo hallucinations – voices within own head rather than externalised, errors in thinking may facilitate wrong assumptions that over time may lead to delusions (Fig 1).

Fig. 1



(Williams and Carden 2010)

One theory on the genesis of mental illness is that delusional beliefs can develop through a layering effect of false assumptions, ‘external’ reinforcers/ confirmatory stimuli (hallucinations) and time to become established beliefs. If these beliefs remain unchallenged (through constructive exploration) then the element of time becomes a critical factor that directly reinforces beliefs and thereby negatively influencing long-term outcomes. This is because beliefs become more entrenched and a part of the person’s psyche in that the beliefs are part of their perceptual and interpretative cognitive system making it more difficult to treat (Kring et al 2017, Andrew et al 2012). The evidence for early intervention in psychosis services is strong as they were associated with superior outcomes when compared to treatment as usual (Correll et al 2018). For example, an extended duration of untreated psychosis is associated with poorer longer-term outcomes for services users (Marshall et al 2005, Farooq et al 2009). However, using psychoeducation with people who have or are developing psychosis has some benefit such as length of stay in hospital and reduced relapse rates (Xia et al 2013, Zhao et al 2015). Also, according to Pharoah et al (2010) and Marshall and Rathbone (2011) there is good evidence that EIP positive outcome rates are helped through the service’s use of family work.

Therefore, early treatment in a person becoming psychotic can prevent such long term (destructive) beliefs becoming established. A report by the Schizophrenia Commission in 2012 stated that no other disease defines itself by the potential risk it theoretically poses to others and not just those risks posed to the individual with the illness (Andrew et al 2012). Therefore, because of this fear, that is part of mental illness, discrimination and negative stigma is associated with it (Thornicroft 2006, Cattan and Tilford 2006). Not only does a diagnosis of this type come with its own internal issues as described above, in addition, a societal problem is present in that the person affected can become alienated and isolated.

The commission also states people with mental illness spend too long on inpatient wards, which costs in the region of £12 billion a year (Andrew et al 2012). Therefore, a drive to use more community resources and de-institutionalise service users has a profound cost benefit by integrating service users into their communities as successfully as possible (Killaspy and Meier 2010). Consequently, there has been strategic support in favour of EIP, for example, through the National Institute of Clinical Effectiveness (NICE 2014) published guidelines for the treatment of Schizophrenia and the Schizophrenia Commission in 2012. They advocated for health services to set up EIP services so that a more proactive and responsive treatment pathway (treatment in 2 weeks of referral – NICE 2014) would exist for those individuals developing the disease (Andrew et al 2012, Thornicroft 2006, Cattan and Tilford 2006). The commission states that if such services are not in place then service users are likely to encounter excessive delays in obtaining treatment, potentially leading to neuropsychological and cognitive health issues (Marie-Claude *et al* 2002), lack of correct diagnostic information (Cole et al 1995), lower employment rates and an increased probability that services users will become substance misuse dependent and involved with forensic services (Killackey and Yung, 2007). The commission also added that by leaving service users who require EIP services to treatment as usual on acute wards who do not have the expertise to effectively treat such individuals is inefficient and costs the NHS £12 billion per year. However, it is worth noting that due to the limitations of the biomedical model there have been calls to view the service user in a more holistic way to contextualise and individualise the distress caused by the psychotic experience on the person and their relationships and social contacts (Kring et al 2017). Therefore, not only is there an argument that EIP services can increase the quality of life of those individuals who require such services but there is also a financial incentive.

Finally, the evidence supporting early intervention services is not beyond doubt and in the last Cochrane meta-analysis of such services their summary is that efficacy of such services is as of yet inconclusive (Marshall and Rathbone 2011). However, the analysis does stipulate that there is evidence that such services through their use of family work (which helps communication in families and reducing high expressed emotion and stress), employment support initiatives maintain the individual in their homes (with family) and in their community (working/ training). Therefore part of their community acts as support in their lives (as indicated by the BPS model).

2.6 OPEN DIALOGUE APPROACH

Seikkula first wrote about Open Dialogue Approach (ODA) as an approach for people with mental health difficulties that uses individualised therapeutic approaches in a bespoke manner for service users and their families (Aaltonen et al 2011). It is described as a psychosocial network approach that promotes an integrated community principle and has developed as part of a project called Turku and Finnish National Schizophrenia project (Alanen et al 1991, Alanen 1990, 2011). The approach is also used as a crisis intervention because of one of its principles of rapid response; however, it does not have a sole diagnostic treatment function but rather a needs adapted approach to integrate people into their communities. Within Western Lapland, Finland, an additional approach has been included in their EIP treatment model called Open Dialogue Approach (ODA). This approach not only encapsulates the EIP philosophy of care but also completely revolutionises the existing psychiatric professional/ patient relationship (Seikkula and Arnkil 2013, Seikkula and Arnkil 2006). This drive to change services in Finland occurred due to poor practices that existed in the 1980s; where they had 300 beds for less than 100,000 population indicating an inpatient oriented service alone. At that time, incident levels of Schizophrenia were the highest in Europe (35 new cases per 100,000 population every year), however, within 10 years of starting the approach they had become the best in that the rates had diminished and their bed use reduced by tenfold (Korkeila et al 1998).

2.6.1 THEORY AND CONCEPTUAL UNDERPINNINGS

The open dialogue approach has philosophical origins from a number of theories and philosophies such as family therapy, social constructionism and dialogical theory (Olson et al 2012, Seikkula and

Arnkil 2013, Seikkula and Arnkil 2006). The approach is very person centred and also socially centred, which means that the interventions provided to mental health service users are not only empowering to the self through promoting understanding, choice and opportunities but also aim to maximise the social networks around individuals. This is done by not only fostering new networks but by also engaging existing social networks with a view to repairing or strengthening them initially.

Olson et al (2014) states that dialogical practice is founded on the polyphony of voices work pioneered by Bahktin. According to Seikkula (2003) the psychotic voice is one of many within the person's inner polyphony and it is important that all voices are listened to and accepted in the network meeting (which forms the outer polyphonies of the social network). Importantly, Seikkula adds that responsively listening to all utterances within the social network is vital and more important than making any interventions or interpretations; thus, developing a shared new understanding by the social network is the goal. It is vital therefore, that principle of psychological continuity (where the same clinicians remain with the service user throughout the therapeutic process) is maintained, and trust and a co-production of shared understanding can be achieved. The formulation of our self-identity is developed through intersubjective conversations with others (Bakhtin 2008). Psychotic speech is the manifestation of the person who is trying to make sense of such difficult life experiences of hallucinations and delusions that they are incapable of rational dialogue (Seikkula 2005, Anderson 2002). In this regard, the individual with psychosis has not been able to create this self-identity through dialogue through inner or outer polyphony (Lakeman 2014).

Therefore, the process of learning from each individual's thoughts and monologues allows the group to gain new understandings especially on issues where they may be a block or problem; especially concerning a psychotic issue.

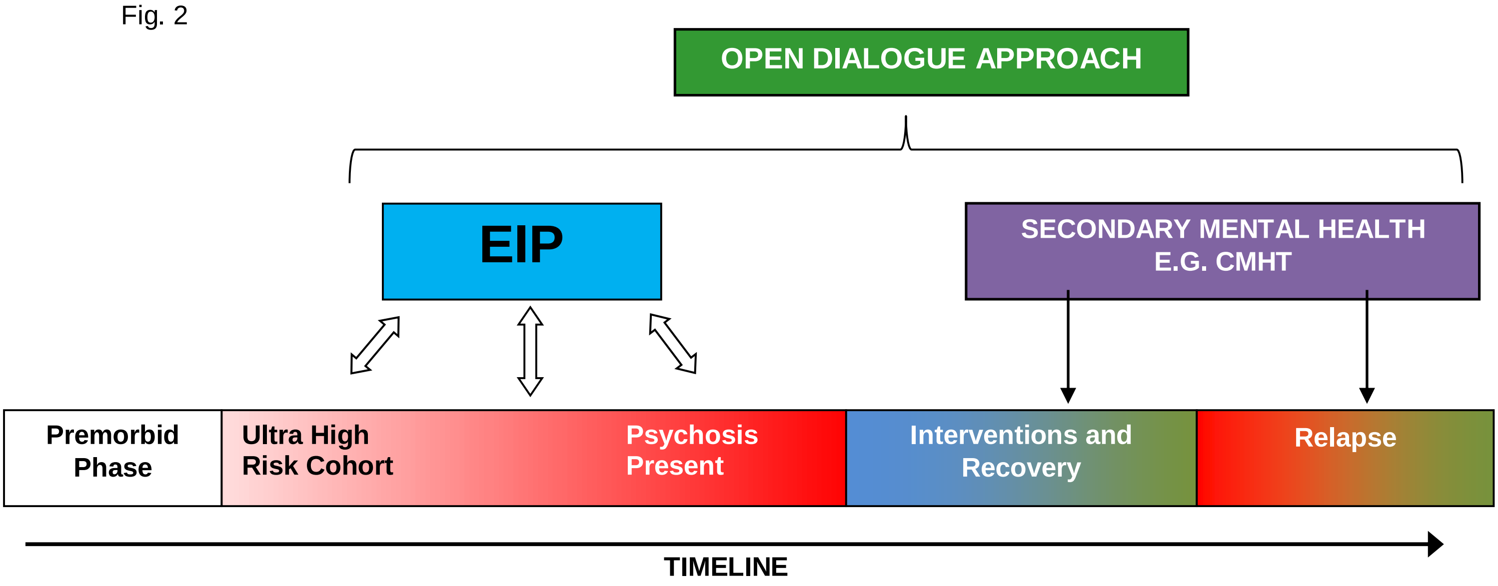
However, Buus et al (2017) asks whether ODA is about organising health care through network meetings, organising open and transparent treatment or being dialogically therapeutic as a therapeutic technique. Or is it all of the above?

2.6.2 BACKGROUND TO ODA AND RESEARCH

Open Dialogue Approach aims to engage people in dialogical practice which is a therapeutic communication within a network meeting (between service user and clinicians) (Olson et al 2014). It also aims to deliver an early intervention model of care to maximise future outcomes. The network meeting is the core and foundation of all treatment (Olson et al 2014).

In addition, outcomes for those individuals experiencing psychosis have improved in that 75% have returned to study or work and only 20% are using neuroleptic treatment within two years of the episode (Open Dialogue UK 2014). ODA is not an adjunct to psychiatric care in Finland; it is psychiatric care (Fig 2):

Fig. 2



Open dialogue approach is a needs adapted approach developed by Yrjo Alanen and integrates systemic family therapy with psychodynamic psychotherapy (Seikkula and Arnkil 2013). ODA aims to reduce isolation and promote understanding through the sharing and communication of different peoples' perspectives The approach is reported to be a radical shift for the municipality from its previous psychiatric model that was almost completely inpatient focussed. At its height the municipality had 300 psychiatric beds for its 72,000 population (Seikkula and Arnkil 2013, Seikkula and Arnkil 2006) – it now reports that the municipality has only 30 beds with a 50% occupancy rate. Developers report that the previous model was so restrictive that they wanted to completely revolutionise the system and put service users in control. They were confident, because of its systemic family therapy roots that it would be a successful way of working (Seikkula and Arnkil 2013, Seikkula and Arnkil 2006). ODA has become embedded within psychiatric care in Western Lapland and all staff (doctors, nurses, occupational therapists) participate in the principles and the interventions used within it.

Over the last 25 years, ODA has become integral to psychiatric care within Western Lapland. It is simultaneously a framework for psychiatric care as well as a specific intervention (such as social networking or network meetings). The network meeting is at the core of ODA principles and it is in this space therapy begins and its continuity maintained. The network meeting anchors the therapy and model of care provided by the approach and other therapeutic interventions can be accessed via the network meeting (Seikkula et al 2003, Seikkula 2002a, 2011).

According to Seikkula (2005) the seven main principles of ODA are as follows:

The provision of immediate help – this needs to be arranged within 24 hours of first contact being made and the individual who is having a psychotic episode needs to participate within an initial network meeting convened by the healthcare professionals. This is in order to begin to integrate this treatment mode rapidly into a person's life to avoid admission into hospital and maintain the person in the community.

A social network perspective — to enable the people who are significant to the individual affected (e.g. family, friends, neighbours, employers, helping agencies and significant others) will be invited to network meetings. The fundamental basis of ODA is the network meeting; everything starts and ends here. The network meeting is where two clinicians and service user begin the therapy. The meetings are founded on mutual respect and a principle of wanting to learn from each other. The service user is in control of who else may be invited to the meeting.

Flexibility and mobility — therapy is tailored to the individuals' specific, varied and changing needs. Network meetings can be held at the individual's home (or another venue) and can be held on a daily basis especially during crisis periods. Therefore, clinicians must ensure that their treatment plans remain flexible especially during the initial phase of treatment or during crises.

Responsibility — this lies with the professional who has first contact with the person and who must organise the first network meeting; thereafter the network team is responsible for governing the treatment of the individual.

Psychological continuity — the network team as previously stated is responsible for the treatment approach and importantly remains with the individual for the duration of need/ care; this could be within inpatient setting as well outpatient. Therapy can be tailored and individualised to suit the needs of the person receiving care. In addition, any decision to make changes to the treatment process occur within network meetings with the service user; this ensures that that the process is a shared and co-created experience for all participants (including the clinicians) as new psychological meanings that are bespoke to the service user are made.

Tolerance of uncertainty — the social network and clinicians need to feel empowered and safe to tolerate uncertainty to avoid any unnecessary decisions being made about treatment especially in the crisis phase and with particular attention antipsychotic medication; any changes to these are discussed for several meetings before hand. In order to achieve this regular daily meetings are conducted in the crisis phase for the first 10 to 12 days. The treatment chosen is discussed at each network meeting and any antipsychotic medication is discussed for at least 3 meetings before it is prescribed (although anxiolytics are used). Dialogue or dialogism is key to the enabling of tolerating uncertainty as it helps break away from the black and white thinking of the psychotic monologue and opens people up to the possibilities of other solutions and diminishes the sometimes dangerous certainties a psychotic monologue can have (Seikkula 2002b).

Dialogism — this is seen as a primary function of the network meeting in that it should facilitate dialogue between members of the network and develop understanding and a shared language; reality is socially co-constructed. It is not necessarily about changing individuals but rather about facilitating communication between those individuals (clinical and social network) for a shared narrative and a shared understanding of each other and any problems encountered; problems are encountered and reflected upon and reformulated in the conversation (Seikkula 2003, Trimble 2002). These principles' primary function is to empower the individual's control and authority over their illness. They also act as a protection in that the service user is consistently afforded dignity and respect by the clinical team and the balance of power is equitable between participating members of the network (e.g. service user, clinicians, family and friends).

The 7 principles are further broken down into 12 key elements:

1.	Two or more therapist in the network meeting	– To promote continuity, reflection and supervision in network meetings
2.	Participation of family and network	– Social/ community inclusion for support
3.	Use open ended questions	– Exploration, continue the dialogue (not close it down)
4.	Responding to client utterances	– All forms of communication used, not just words so that communication is not lost
5.	Emphasising the present moment	- Avoid being distracted and remain in the meeting
6.	Eliciting multiple viewpoints	– Create understanding between all in the network meeting
7.	Use of relational focus on dialogue	– Create understanding between all in the network meeting
8.	Responding to problem discourse or behaviour as meaningful	– All communication respected and validated by the members
9.	Emphasising the clients own words and stories, not symptoms	– Moving away from a medical approach
10.	Conversation amongst professionals (reflections) in the treatment meetings	– Important that service user hears these reflections and has an opportunity to think and reflect and learn themselves. Listening to others reflections can give the listener a break from actively speaking and allow them to listen to their inner monologue.
11.	Being transparent	- To build trust with service user

12.	Tolerating uncertainty	- See principle 6 Olson et al (2014)

There are further elements to ODA and an important one is the fact that clinicians will not speak about the service user without them being present; if a clinician requires a conversation with another clinician then permission will be sought from the service user first and the conversation will take place in their presence within the network meeting. In addition, when a therapist receives a referral of a service user from a clinician, the therapist will accept the clinician as the referred, rather than the service user (Seikkula and Arnkil 2013, Seikkula and Arnkil 2006). These shifts may seem subtle, trivial or irrelevant, however, from the service users' point of view this affords them to be shifted out of the focus of any blame or negativity associated with their illness. In addition, it avoids the service user developing any mistrust towards clinicians and protects the therapeutic relationship; and more fundamentally protects the self-esteem of the service user and their outlook on their future lives.

Open Dialogue Approach aims to engage with the individual, families and social support structures within the community (their homes) to create a dialogue that promotes understanding and empathy with all involved; this can work well for first presentation or crisis situations. Open Dialogue overlaps with psychoeducation, systemic family therapy and narrative therapy (Seikkula 2003). However, instead of trying to change participants' behaviour its aims are to create new understandings and meanings for all. Psychoeducation within ODA is concerned with ensuring that communication between the family members is maintained and information is given to the family so that they are aware of the mental illness and challenges faced by the person experiencing the illness; the main aim of psychoeducation in ODA is to maximise the networks surrounding the individual (Seikkula 2011). Systemic therapy in ODA uses techniques such as circular questioning (a specific form of questioning that looks to position the client relationally) and team reflection in order to create a shared understanding and meaning by all involved (rather to change the behaviours of family members) (Seikkula 2011). Dialogical practice is based on social constructionism similar to narrative therapy, however, in ODA the aim is to be led by the service user as to the course of the narrative and be aware of the present for the individual (Seikkula 2011); control is with the service user not the therapists.

The approach promotes that if those involved can tolerate the emotional upset and strain of the individual experiencing psychosis, then a shared understanding can be gained and thereby a resolution to the illness, however the individual and family must be heavily supported through this uncertain and at times frightening period (Seikkula and Arnkil 2013, Seikkula and Arnkil 2006).

Dialogue or dialogism (use of multiple viewpoints and tones in conversations) is fundamental within ODA; only through developing a mutual understanding within the network can progress be made, with the aim that the service user will be reintegrated into their society that will ultimately be their source of support and strength. This process begins on first presentation through using network meetings to build and or repair relationships the service user has with their family, friends and even wider community; in order for the service user to make use of societal support.

Whitaker (2010) participated in network meetings and described them in the following way:

> *Everyone sat in a circle, in a very relaxed and calm manner, and before anyone spoke, there often was a split-second moment of silence, as if whoever was going to speak next was gathering his or her thoughts. Now and then someone laughed, and I couldn't identify a time when anyone was interrupted, and yet no individual seemed to go on speaking too long, either. The conversation seemed graced by gentility and humility, and both family members and patients listened with rapt attention whenever the therapists turned and spoke to each other. (p. 344)*

This approach has the high ambition of not only achieving the latter objectives (maintaining service user support networks in their community) but also attempts to promote the de-stigmatisation of stereotypes that surround mental illness within society (Seikkula and Arnkil 2013, Seikkula and Arnkil 2006). Therefore, ODA can have a powerful effect on societal responses and uses a social constructionist perspective of society. The approach takes the stance that society has profound influences on the individual through societal dialogical interactions that happen continuously. Therefore, the ‘problem’ does not lie within the individual but rather with the collective (society), and as such this is what needs to be engaged with in order to ultimately help the individual (Seikkula and Arnkil 2013, Seikkula et al 2011).

The developers of the ODA philosophy, such as Aaltonen et al (2011), have published several papers. The authors found that implementation of ODA as a psychiatric approach decreased the rates of schizophrenia diagnosis. A follow up study by Seikkula et al (2011) reviewed ODA over a longer time period (1992-3; 1994-7 and 2003-5) and found that the gains were maintained (such as decreased symptoms and increased productivity). The positive outcomes found over the last 25 years of using ODA in Western Lapland has been lower rates of schizophrenia diagnosis (70% less), increased productivity in those diagnosed with a psychosis (75% in work or study) and only 30% experiencing psychosis for the first time are on neuroleptic medication.

Qualitative studies have also been published. Seikkula (2002b) found that the presence of three domains (dominance – service users’, symbolic meaning and dialogical dialogue) provided good outcomes for service users. Gromer (2012) conducted a review of the ODA literature (including qualitative literature) and concluded from the seven articles that met their inclusion criteria that ODA or needs adapted approaches were superior to standard care alone (reviewed in next chapter). There are other alternative approaches to bio-psychiatry model of care such as Soteria which was developed by Lauren Mosher in the 70s which again promotes an equity in the relationship between service user and clinicians. It is interesting to note that Soteria, which promotes a therapeutic community and utilises calming environments, reports a similar reduction in psychotropic medication usage which is similar to ODA. However, Soteria's fundamental philosophy is about stopping or at the very least actively reducing psychotropic medication (Mosher 1999). ODA does not take this harder line and therefore as an approach to be merged with an already established psychiatric system seems more likely, despite this there are cultural challenges to achieve this that will be discussed later in this study in chapter 8.

Open Dialogue is a multimodal approach and it is unclear as of yet which of its principles are the significant factors that have affected some of the positive outcomes associated with the approach, or in fact if it is the combination of its multimodal approach that is the root of its success. It provides an immediate therapeutic intervention by exploring and providing meaning to the psychotic event through exploring people's thoughts, dialogue and experiences. It provides a psychosocial intervention with the network meeting by including family friends and community to gain greater understanding. Finally Seikkula et al (2011) suggest that the psychoeducation provided to the community (through network meetings) has resulted in an estimated 5% to 10% increase of the population of Western Lapland gaining insight and knowledge into mental health. This has had the consequence of elevating understanding and acceptance and the decrease in stigmatisation of mental health issues.

It is interesting to highlight here that despite ODA being a humanistic, meaning making individualistic process of self-understanding and of anomalous experiences, it is still 'measured' through productivity in the research. Despite the approach embracing the individual and of people being heterogeneous research goes against this to find the homogenous traits so that they can be measured and contrasted for efficacy.

However, critics of ODA (Lakeman 2014, Jauhar et al 2019, Freeman et al 2019) have stated that the evidence supporting ODA is low quality. Steingard (2019) in an opinion piece states that there is not enough known about the successful implementation of ODA outside of Western Lapland, and Buus et al (2017) state there are issues with the way in which the founders have operationalised the seven principles ineffectively i.e. the principles too open ended and that research into this area is required to not only understand how it works with service users but how it can restructure mental health services. Additionally it can be argued that Finland and in particular Western Lapland is a very different place from a social aspect to the UK; McElroy et al (2019) in their study on deprivation and mental health problems found links between mental health and the neighbourhood environment within high deprivation areas.

Freeman et al (2019) reviewed 23 studies and concluded that there were variations in the model of ODA used by clinicians, heterogeneity in the outcomes measured and a lack of consistent implementation strategies. Therefore, randomised control trials are called for to improve the quality of the evidence that is currently available. In particular, there is a need for researchers to focus on the practical evaluation of ODA in the 'real world', not just emphasising if ODA is effective but how and why it is so. Finally, they state that the adaptations to the approach must be clearly outlined in order to better understand how this model can be implemented in the UK and specifically what particular mechanisms or aspects may be responsible for its effectiveness.

Approaches such as ODA that provide an early intervention in the person's illness and have a focus on the social networks and the person's interactions within their community and have a psycho education role with the wider community require further research (Aaltonen et al 2011); which is happening in different parts of the world (e.g. UK, Denmark, New York). Within Barnet, Enfield and Haringey Mental Health Trust there is a dedicated OD team with 12 trained practitioners; where staff have developed a form of supervision called intervision that appears to be a form of supervision and intervention (Livingstone & Kloocke 2018). This pilot is also part of the ODDESSI trial which is attempting to assess the feasibility of conducting a multicentre randomised control trial (RCT) of ODA (ODDESSI NEWS 2019).

Burbach et al (2015) in their discussion paper describe their ambition to achieve dialogical practice but state the barriers of existing team processes that 'must' be adhered to; ultimately, their barrier is convincing management to endorse this new way of working and a medical model barrier within existing UK mental health services (Ellis 2018). ODA has also been adapted into peer supported open dialogue by Razzaque & Stockman (2016) where peer support workers (staff with lived experience) are trained and use ODA with service users. Although the effectiveness of Peer support interventions is currently unknown due to the poor quality of research available (Chien et al 2019).

2.7 RECENT DEVELOPMENTS

According to a report by the schizophrenia Commission no other illness or disease (other than mental illness) highlights the risk to others rather than identifying the risk to the individual with the illness, thereby, compounding the stigma that surrounds mental illness (Andrew et al 2012). According to Thornicroft (2006) and Cattan and Tilford (2006) stigma and negative stereotypes surrounding mental illness fuelled by centuries of institutionalisation, fear of unpredictability and even the fear of contagion have been a significant barrier experienced by those with mental illness; and as a result mental health service users face enormous inequalities. According to Chang et al (2011) service users diagnosed with Schizophrenia die 14.6 years prematurely and McGrath et al (2008) states that those with Schizophrenia are two to three times more likely to die earlier when compared to the general population.

As previously discussed psychiatry has been a very reactive service (Andrew et al 2012), however, new services such as early intervention services are being more proactive and providing services that halt or impede the progress of mental illness and offer more positive long term outcomes; especially with regard to social inclusion (Thornicroft 2006, Cattan and Tilford 2006). Thornicroft (2006) states that by the general population developing an increased understanding of mental illness that fear of it and discrimination against it can be reduced (and therefore the barriers faced by mental health service users); a similar observation made by Seikkula (2011) and discussed in the last sub chapter. Additionally psychiatry within the UK relies heavily on restrictive practices that can lead to re-traumatising individuals and causing increased distress (Cusack et al 2018). Therefore, intensive community mental health services that have a focus on social integration (rather than hospitalisation) can achieve this (Thornicroft 2006, Cattan and Tilford 2006). To support this Dieterich et al (2010) conclude in their meta-analysis that intensive community mental health support for service users reduced inpatient days.

The report by the Schizophrenia Commission states that mental health inpatient services cost the UK approximately £12billion a year upon society and mental health services use 20% of their budgets on expensive out of area private beds (Andrew et al 2012). Mental illness therefore places a significant burden on society through the economic pressures from unemployment as well as health and social services costs. The demand on services is at a high due to funding cuts and bed closures (Pavolvic et al (2016). The probability of having psychotic illness when unemployed is 2.3% whilst those employed is 0.1% (McManus et al 2014). People diagnosed with severe mental illness can expect the disease to progress into a chronic condition; Larsen et al (1998) report 15% to 35% relapse rates in the first year increasing to 80% by 5 years and Wiersma et al (1998) states that the probability of full remission reduces after each relapse. During relapse phases the main treatment mode is medication and often hospitalisation. Initiatives such as rehabilitation services have been shown to reduce costs by repatriating patients from high cost out of area beds and through successful integration into the community setting by empowering service users to be in control of their lives (Killaspy and Meier 2010). By having mental health services that are proactive such as early intervention services, the NHS can make significant savings (Andrew et al 2012). Early intervention services can offset some of the long-term effects that Schizophrenia has on people’s personalities and cognitive functioning, before they may become a long-term disability (Marshall and Rathbone 2011). Therefore delays in untreated psychosis can have an impact on whether length of hospitalisation is increased (Cole et al 1995), neurophysiological and cognitive issues (Marie-Claude et al 2002), following a forensic pathway and substance misuse issues in 50% (Killackey and Yung 2007).

UK mental health services have gone through many changes in the last 20 years in its shift towards community services rather than inpatient services (Killaspy and Meier 2010, DoH 1998). Commissioners of mental health services have disinvested in services such as rehabilitation services and opted instead for evidence based services as guided by the National Institute of Clinical Excellence and National Service Frameworks (DoH 1999). The Kings Fund (2012) published that the process of deinstitutionalisation as one of shifting care and support in line with patients’ needs, some organisations saw it as their role to ensure access to other components of community living such as occupation and social networks (some of which had been inherent in the asylum system). Supporters of ODA would argue that this approach offers a solution to service users’ poor outcomes, low productivity and a way out of the burden that is put on society. However, the research to demonstrate its effectiveness is scarce. Therefore, researchers have a moral duty to search for the shifting sands of truth and present this data without bias and in a balanced way.

2.8 SUMMARY

To summarise there have been examples of mental health services engaging proactively with service users for many centuries, however, the psychiatric medical model of care has at times hindered or curtailed this way of working e.g. moral treatment and rehabilitation services. The history of mental illness perception and treatment has been a tumultuous and difficult journey. Also, it is fair to say that we are not at the end of that journey and further steps are required to be able to understand and provide the right support for those individuals with mental health problems.

In the last two decades, early intervention in psychosis has played a significant role in many services across the world to provide such proactive services. In Western Lapland, Finland ODA is their early intervention in psychosis service and provides rapid and proactive services to service users; people can self-refer and be seen the same day. Within Western Lapland in the last 30 years, they have gone from having one of the most institutionalised psychiatric services to a more liberalised through a radical approach where the service user is in control of his or her mental health care. The founders of ODA and leaders of the service were a group of family therapist psychologists therefore a family and social network approach was used a fundamental basis of the service. The outcomes for service users appear very strong from the Finnish research and supporters of the approach claim that it saves costs in the long run (through service users requiring less services) and increases the likelihood of people with severe mental illness being in employment (Aaltonen 2011). The research has been deemed not to be gold standard (randomised control trials) by critics who state that the research has only been done by the founders, and the population sizes are small. However, pioneers have begun using ODA principles within their local care settings and have reported some favourable outcomes, especially in staff, service user and carer support of the approach. It is important therefore to conduct further research into this approach and review whether these benefits found in Finland can be transferred to other areas. This transfer has already happened in pilot sites across the Scandinavian countries (Ulland et al 2013), UK (Razzaque & Stockman 2016) and USA (Gordon et al 2016). However, ODA is very different to the UK psychiatric model of care. Therefore, would the transfer of such a different model of care transfer successfully into the UK, or will it flounder, as did moral treatment when it was transferred into the fledgling asylums? Taking an apparently successful model of care out of its contextual background/ framework can undermine its effectiveness due to the layers of complex systems that support the intervention: a basic tenet of social constructionist theory on which ODA is founded. However, as previously stated there are places in the UK where ODA is being rolled out on a small scale, suggesting that ODA can, in fact, make the successful transition to the UK.

3. SYSTEMATIC REVIEW OF THE LITERATURE

A systematic review was conducted in order to expand and increase my knowledge of ODA, as it is currently being engaged with. When initially completed the area that was highlighted as needing further investigation was whether ODA was transferrable to the UK setting. Since the initial review was conducted new research has emerged indicating the transferability of ODA intro the UK setting and this has been included in the chapter.

3.1 APPROACH METHOD

The basic question for this initial scoping review was: what is the evidence underpinning ODA and is this transferrable to the UK? Therefore, the aim of this review was to find, outline and collate the rationale and evidence base for ODA; and evidence for its use outside of Finland (and the UK). The specific elements of ODA interventions and principles will be highlighted. It is essential that the inclusion exclusion criteria are outlined firstly before the search strategy of the systematic review was undertaken:

The inclusion criteria of this systematic review were studies focussing on the use of ODA within health settings. This is a broad inclusion criteria, however, due to the limited amount of writing on ODA this was felt to be necessary to obtain sufficient quantity of literature. Papers will date from 1980 onwards due to the fact ODA was developed after this time (Seikkula and Arnkil 2013, Seikkula and Arnkil 2006). Many articles will be seminal relating to ODA theory and initial research into the efficacy of the approach.

The exclusion criteria for the review will be non-English language studies and non-first presentation in psychosis clients. This is to ensure that those clients who are entering the studies have a shorter duration of untreated psychosis which is a good predictor of future outcomes; studies that incorporate individuals within the main phase of their illness risk distorting the final results. This potential distortion of the results was reported by Cassani (2011) in an opinion paper on Kerropudas Hospital, Western Lapland who stated that many of the clients who were inpatients on the wards were those who had received diagnoses before the introduction of ODA; individuals who were newly diagnosed had greater chance of being at home in the community whilst those had experienced services prior to ODA (medication and inpatient management pathways) were more likely to still require those services.

The following search strategy will be employed in order to identify appropriate studies for this review and is broken down into three stages:
Stage 1 – Initial Search
Stage 2 – Full and Detailed Search
Stage 3 – Back Chaining, Forward Chaining and manual literature search.

Stage 1 – Comprised of conducting an initial scoping exercise to search the literature to specifically look at whether a systematic review has already been conducted to answer the review question.
The databases that were used:
Cochrane Collaboration
NHS Centre for Reviews and Dissemination
Agency for Healthcare Research and Quality
Joanna Briggs Institute
Campbell Collaboration

The keywords used at this stage were:
Open, Dialogue, Approach*, Therap$

This first search was for peer-reviewed articles and was as previously stated limited to English language papers (the researcher acknowledges that due to the fact that ODA is a Finnish initiative many articles were therefore not accessed by this work).

This initial search yielded 488 hits, although, the majority of the papers found did not fulfil the search parameters and were discarded because they did not provide information to promote the understanding of ODA. Other papers whilst they did not exclusively elaborate on ODA were included because they enhanced knowledge and understanding on the development and evolution of ODA in particular the theoretical philosophies that underpin the approach.

For example, work by Alanen (1990), Räkköläinen et al (1991), Lehtinen (1993) and Lehtinen (1994) exploring need adapted approach was important to understand how ODA evolved within the 1980s and what the philosophical background and cultural perspectives that were present that influenced ODA development. Additionally, other work that was obtained about the theories of psychosis and in particular how psychosis disrupts the internal or self-dialogue within the individual which is theorised to be reaffirmed through ODA (Holma & Aaltonen 1998, Lysaker and Lysaker 2001, Lysaker and Lysaker 2010, Lysaker and Lysaker 2011, Larner 2011 and Lysaker et al 2012).

Stage 2 – A more detailed strategy search was then used to uncover the appropriate studies that may help answer the research question. The first part of this process was to decide which databases were to be used; this is in order to ensure that all the relevant articles/ data are successfully collected (Greenhalgh 2014, Boland et al 2014). In this review example the following databases will be used – see table 1.

<u>Table 1</u>

CINAHL – Cumulative Index to Nursing and Allied Health Literature – contains references to journal articles on nursing and allied health professionals

MEDLINE – contains references to journal articles related to the professions of medicine and dentistry

British Nursing Index and Archive – further journal articles on nursing

EMBASE – contains references to journal articles related to pharmaceutical, medication and drugs
PsychINFO – contains references to journal articles related to the professions of Psychology and Psychiatry
PsychARTICLES – contains references to journal articles related to the professions of Psychology and Psychiatry
ASSIA – Applied Social Sciences Index and Abstracts – Contains references to journal articles related to social sciences profession
Cochrane Collaboration – collection of high quality evidence material to inform healthcare practice
NHS Centre for Reviews and Dissemination – research based information outlining the effects of psycho-social healthcare interventions
AHRQ - Agency for Healthcare Research and Quality – collection of evidence based research with an aim to provide healthcare guidelines
Joanna Briggs Institute – repository of evidence based research that aims to provide best evidence based information
Campbell Collaboration – collection of systematic reviews of research to inform healthcare professionals

In addition, grey literature was used in this study; this is because I was aware that a pilot site had been set up in England and information from this was being disseminated in conferences. Grey literature are academic pieces of work that have as yet not been published but may be of interest to this study. To obtain this work effort was made to contact authors, experts, organisations and researchers in the subject field to identify work that they may not, as yet, have published. In addition, the below databases can be used to execute an electronic search of grey literature – see table 2.

Table 2
SIGLE – System for Information on Grey Literature in Europe
ORCA – digital repository of Cardiff University's research
British Library – containing newspapers and other sources of data that may be relevant to the subject area
Index of Theses – comprehensive collection of theses accepted by UK and Irish universities since 1716
Proquest Digital Dissertations – comprehensive collection of dissertations accepted by UK and Irish universities since 1716
Conference Proceedings – conferences associated with the topic must be explored and information contained within them extracted
Grey Literature Report – bimonthly publication that alerts healthcare professionals to the development of grey literature on different health subjects
Internet Sites of associations – these will be relevant to the topic area and include centres of excellence
Research and Clinical Trials Registers – a register of current ongoing work that may inform the systematic review (despite the work only being part complete)

The search process then used Medical Subject Headings (MeSH) terminology and keywords relating to the subject area in order to capture the relevant studies from the databases used (Cochrane Library Tutorial 2014). Databases such as MEDLINE use MeSH for indexing articles in their database and this works by sorting descriptors (keywords) into a hierarchical system that allows the researcher to search for various levels of specificity within the overall database. The preliminary keywords searched for were as follows:

Open
Dialogue
Approach*
Therap$
Psychos$
Mental Health
Need*
Adapted

The studies obtained through the above search methodology were initially screened for relevance to the study review through assessing the information within the title, descriptor/ abstract and comparing this to the MeSH terminology. Ambiguous papers were retrieved in full in order to make the correct assessment as to the relevance of the paper to the study.

Stage 3 – This last stage within the search strategy in acquiring new evidence was conducted through back and forward chaining:

Back chaining involved reviewing the references of articles already obtained and reviewing whether they were suitable for inclusion in the study.

Forward chaining reviewed articles already obtained and looked at where these papers had been subsequently cited (this is usually found online with the article). Subsequent papers were then reviewed for relevance. The initially searched papers were used to both backward and forward chain to obtain relevant papers pertaining to ODA. The final part of stage 3 involved the researcher manually searching through journals that could be relevant to the review but may have been excluded from the search process.

Following this a data extraction strategy was employed, broken into a further three stages:
Stage 4 – Screening articles and references
Stage 5 – Critical Appraisal of selected articles
Stage 6 – Data Extraction

Stage 4 – A screening tool was devised for this study (appendix A – Joanna Briggs Institute (JBI) Literature Review Screening Tool) that was used to check the suitability of the articles by the researcher. In addition, the tool was used to assess the suitability of the references and cited by lists.

Stage 5 – In order to ensure that the papers found were rigorous and displayed a high degree of validity the researcher employed a critical appraisal tool devised by the JBI (see appendix B). Critical appraisal tools allow the researcher to test the methodological quality and standard of papers and to help evaluate the research within them (Khan et al 2003, Boland et al 2014, Greenhalgh 2014). The JBI was utilised because it has tools for both quantitative and qualitative papers (preliminary searches had informed the researcher papers would cover both of these paradigms); whereas other tools such as the Critical Appraisal Skills Programme only have a quantitative tool.

Stage 6 – This final stage is crucial for ensuring that the researcher is efficient with time by capturing all the data from the papers acquired that may be required later within this study (Boland et al 2014, Greenhalgh 2014). There are tools that can be used to undertake this, however, if screening and critical appraisal has been undertaken thoroughly then extraction tools are not as important because papers have already been scrutinized and deemed valid and reliable by the researcher (Boland et al 2014); therefore, the data that is extracted from the papers within this study was completed without an extraction tool.

Following data extraction, the data was synthesized. Quantitative data was collated separately to qualitative data and presented in separate tables. If quantitative data is homogenous then a meta-analysis could be performed; the purpose of this would be to increase the power and generalisability of the data outcomes because of the increased number of participants (Boland et al 2014); however, in this study the data was not homogenous. For qualitative data due to the complexity and heterogeneity of the data a meta-narrative was formed from the themes obtained from the papers (Bryman 2012, Burns and Grove 2009, Boland et al 2014).

3.2 REVIEW FINDINGS

Papers that looked at ODA efficacy have been collated into the following tables. Other papers that were obtained in the search which were descriptive case examples that focussed on the quality of the dialogue generated within network meetings that affected the outcomes of individuals within the therapy were disregarded from the review.

Below is a table format of the collated works reviewed split into quantitative and qualitative tables.

3.2.1 QUANTITATIVE PAPERS

Quantitative (Mixed Methods)

Study/ country	Methods/ Numbers	Control group	Outcome measures and intervals	Adherence to ODA principles	Findings	Reported limitations
Aaltonen et al (2011) Western Lapland, Finland	Historical control design 111	Historical sample	New hospital admissions. Incidence of non-affective psychosis.	ODA principles outlined. Adherence not reported	Existing long stay Schizophrenia patients reduced to zero after ODA introduced and no new long stay Schizophrenia patients cases arose.	Service changed the way it diagnosed Schizophrenia. Potential issue with giving retrospective diagnosis to historical cases.
Alanen et al (1991) Western Lapland, Finland	Turku study Needs adapted approach Treatment group – 25 Historical control – 54	Historical sample	Receiving social benefits Symptoms Hospital days	Needs adapted approach/ Family therapy principles outlined.	Not on benefits – Treatment group 77% vs control 62% Symptoms reduced – Treatment group 68% vs control 41% Hospital duration – Treatment group 9 days vs control 36 days	Originators involved in the rating of symptoms. No blinding. Retrospective control and unequal sample sizes.
Bergstrom et al (2017) Western Lapland, Finland	Retrospective cohort study 65	None	Hospital days, GAF, neuroleptic medication prescribing Baseline, 1 year	ODA principles outlined and reportedly followed.	Duration of inpatient treatment was positively associated with higher rates of aggressive incidents. Authors conclude that aggression may be a factor that challenges ODA principles.	No effective controls in the variability of the diagnoses, medication use. Sample size small.
Bergstrom et al (2018) Western Lapland, Finland	Retrospective cohort study (long term) Experimental group = 108 Control group = 1763	Historical control group	Mortality, Hospital days, social benefits, Evaluated with a comparison group over a 19-year period.	ODA principles outlined and reportedly followed.	Hospital admissions over 30 days = treatment group 18.5% vs control 94.4% Neuroleptic use = treatment group 36.1% vs control 81.1% Receiving social benefits = treatment group 33% vs control 61%	Originators involved in the research. Risk of bias. No blinding. Historical data (missing data, corrupted, out of context)

Buus et al (2019) Denmark	Retrospective register-based cohort study Treatment Group = 503 Comparisons Groups: Group 1 = 19,420 Group 2 (Matched comparison group) = 1509	Comparison Groups: Group 1 = 19,420 Group 2 (Matched comparison group) = 1509	Utilisation of psychiatric services, GP services and social markers.	ODA principles outlined and reportedly followed.	At 1 year follow up the ODA Cohort had more outpatient treatment (RR=1.2, CI: 1.1-1.4) than comparison but not at subsequent follow-ups. ODA group had less emergency psychiatric treatments (1 year follow up: RR=0.2, CI: 0.1-0.5; 10 year follow up: RR=0.5, CI: 0.3-0.8) ODA group had less GP contact (1 year follow up: RR=0.9, CI: 0.82-0.99; 10 year follow up: RR=0.85, CI: 0.78-0.92)	No international fidelity criteria for ODA exists. Retrospective data archiving which the researchers admit was not wholly complete and could be interpreted subjectively. Differences in referral practices between treatment and comparison groups. Not blind or randomised.
Gordon et al (2016) USA	Mixed-methods design (case series and qualitative feasibility study) 14	None	Hospital days Work or education SDMQ, BASIS-R, BPRS, SCLFS, DSES, CSQ Baseline, 3 months, 6 months and 12 months	No adherence reported.	Improvements that were statistically significant to BASIS-R, BPRS, SCLFS, Hospital days & Work or education (9 of 14 in work or education at 12 months). DSES score approached significance.	Sample size small. Lack of control group heterogeneity of diagnosis, not blind, data missing.
Grano et al (2016) Southern Finland	Case series 130	None	Suicide/ depression assessment tool. Baseline, 1 month	They report to have used ODA and family therapy.	Suicidal ideation reduced that was found to be statistically significant.	No control in this study for against the reduction in suicide. Confounding variables
Ishaq & Jeffrey (2018) UK (Kent & Medway NHS Trust)	Cohort study	TAU	Neuroleptic medication Relapse rates Employment Bed days Over 2 years	ODA principles outlined and reportedly followed.	Bed days ODA 14 days, TAU 117 days Neuroleptic medication use ODA 33%, TAU 100% Relapse rates ODA 24%, TAU 71% Return to work rates ODA 81%, TAU 43%	Study not yet published or peer reviewed (Presentation only at conference). In addition, the numbers of service users in the study is unknown, along with

						whether there was any blinding. It is unclear what TAU meant for that cohort.
Lehtinen et al (1993) Western Lapland, Finland	Turku 5 yr. follow up Needs adapted approach Treatment group – 28 Historical control – 53	Historical sample	Receiving social benefits Symptoms Hospital days Social functioning	Needs adapted approach/ Family therapy principles outlined.	Not on benefits – Treatment group less likely to be receiving benefits (G = 9, $p<0.005$) Symptoms reduced – Treatment group more likely to have less symptoms (G= 3.9,$p<0.05$) Social functioning – more likely in treatment group (G = 3.8, $p<0.05$) Hospital duration – Treatment group 27 days vs control 56 days	Originators involved in the rating of symptoms. No blinding. Retrospective control and unequal sample sizes.
Lehtinen et al (2000) Western Lapland, Finland	Needs adapted approach API 2-year follow up N – 106 Treatment group – 67 Control – 39	Yes	Employment Symptoms Hospital days Medication	Needs adapted approach/ Family therapy principles outlined.	Improvements seen over 2 years: Employment – ODA group 32.8% vs control group 30.8% No psychotic symptoms – ODA group 58.2% vs control group 41% Hospital duration of less than 2 weeks – ODA group 50.8% vs control group 25.6%	Originators involved in the rating of symptoms. No blinding. Retrospective control and unequal sample sizes.
Seikkula et al (2001b) Western Lapland, Finland	Case series 78	None	Neuroleptic medication use, BPRS, hospital days, GAF, accepting benefits, employment. Over 2 years	ODA fidelity rated on a scale – although only reported for two cases.	Psychotic symptom severity was rated into good and poor outcomes. Poor outcomes individuals related to those with who had severe psychotic symptoms and social security support, whilst those in the good category had minimal psychotic symptoms and were working (or actively seeking work) or in education). 78% were graded as being in the good category.	Not reported

Seikkula et al (2003) Western Lapland, Finland	Cohort study API – 22 ODA – 23 Control – 14	TAU (Treatment as usual)	Neuroleptic medication use, BPRS, hospital days, GAF, relapses, employment, residual symptoms at baseline Baseline and 2 years	ODA principles outlined, but unknown if followed.	The ODAP1 and API groups found relapse rates ran at 24%-31%; whilst the control group had 71% relapse rates. However, ODAP1 group had fewer residual psychotic symptoms and 83% were in work or education (as compared to the control, which had 30%).	Originators involved in the rating symptoms and diagnosis. Sample size small, control sample chosen over 21 months.
Seikkula, et al (2006) Western Lapland, Finland	Historical comparison/ case series study 75	None	Neuroleptic medication use, BPRS, hospital days, relapses, employment, residual symptoms at baseline Baseline, 2 years and 5 years	ODA fidelity rated on a scale – although only reported for two cases.	ODAP1 – 82% residual psychotic symptoms, 76% in work or education, 24% unemployed/ on benefits, relapses 19%. API – 76% residual psychotic symptoms, 70% in work or employment, 30% unemployed/ on benefits, relapses 32%.	Originators involved in the rating symptoms and diagnosis. Sample size small.
Seikkula, et al (2011) Western Lapland, Finland	Historical comparison/ case series study 98	None	Neuroleptic medication use, BPRS, GAF, relapses, employment, residual symptoms at baseline Baseline, 2 years and 5 years	ODA principles outlined, but unknown if followed.	ODAP2 group were found to be younger than ODAP 1 and API, which the researchers conclude to be due to OD being an effective early intervention service.	Originators involved in the rating symptoms and diagnosis. Culture of small province could not be standardised.

3.2.2 QUALITATIVE PAPERS

Qualitative (Mixed Methods)

Study/ location/ setting	Design/ number/ Aims	Analysis/ Triangulation	Adherence to ODA principles	Findings
Bøe et al (2013) Dialogical collaboration; southern Norway CAMHS	Single case study Illustration of how dialogical practice facilitates change	None stated Triangulation through experienced co-researchers	Adherence not reported. References made to ODA principles.	ODA was reported as a positive experience following in-depth analysis of a single case study. Theoretical position of ODA as a change catalyst through dialogue in ethical time and space.
Bøe et al (2014) Dialogical collaboration; Norway CAMHS	Multistage qualitative interviews 22 (6 clinicians, 8 network members, 8 service users) The aim is to explore the social dynamics of lived experience of crisis from the psychosocial perspective in relation to change.	Dialogical hermeneutical analysis Triangulation through experienced co-researchers	Adherence not reported. References made to ODA principles.	Change in ethical time and space is the factor that is facilitated through dialogue that creates movement and transformation.
Bøe et al (2015) Dialogical collaboration; Norway CAMHS	Video- recorded qualitative interviews 22 (6 clinicians, 8 network members, 8 service users) To explore mental health dialogical practices within network meetings through the lived experiences of participants.	Dialogical hermeneutical analysis Triangulation not stated	Adherence not reported. References made to ODA principles.	Inquisitiveness of staff was viewed as important (along with attentive listening), which helped service users reflect on past/ future and present experiences.
Ellis (2018) London, UK	Qualitative narrative approach – using interviews 9 practitioners	Narrative approach	Not reported	Practitioners reported positive impact of ODA. Implementing ODA is complex and involves negotiating medicalised mental health systems. ODA in a good position to influence change in organisational, social and political aspects.
Gordon et al (2016)	Mixed- methods study (discussed here are qualitative interviews)	Not stated	Adherence not reported. References	Focus on community care. Clinicians found it to be positive. Reduction of medication, coercion, increased

Collaborative Pathway; USA Crisis and outpatient service	14 To explore ODA informed practice with service users and clinicians.		made to ODA principles. In addition, ODA team did not in reach into inpatient areas.	transparency and openness was reported by SU.
Holma and Aaltonen (1998) API, Western Lapland, Finland	Multi-case case study, Qualitative narrative approach 3 service users Aim to explore ODA\ Family therapy meetings	Narrative analysis to SU and families	ODA principles outlined	SU equal partner, not about content of what is said; only dialogue and understanding is important.
Holmesland et al (2010) Project joint development; Norway General mental health and substance misuse hospital	Qualitative focus interviews - 3 focus groups 12 clinicians To explore ODA in the context of professional roles and team working from staff experiences	Content analysis During interviews with participants themes were reflected back to check for accuracy and understanding	Adherence not reported. References made to ODA principles.	Issues found regarding hierarchy and power, which is related to changes in professional roles which was found to be challenging. To overcome this familiarity between health professionals and knowledge of cultural barriers need to be addressed.
Holmesland et al (2014) Project joint development; Norway General mental health and substance misuse hospital	Qualitative interviews - 2 focus groups 12 clinicians To explore ODA in the context of professional roles and team working from staff experiences	Content analysis During interviews with participants themes were reflected back to check for accuracy and understanding	Adherence not reported. References made to ODA principles.	Dialogue is seen as the factor to enable and facilitate openness and transparency, listening and attention to others. The atmosphere of the network meetings is essential, in that it is dealing appropriately with silence, difficult topics and being authentic. Finally, the outcomes may have been affected by the diversity of the sample.
Lidbom et al (2014) Dialogical collaboration; Norway CAMHS	Single case study – purposively sampled 4 (1 network member, 1 service user, and 2 clinicians) To explore the development of 'meaningful moments' through the interplay between inner and outer dialogues.	Dialogical hermeneutical analysis Triangulation not stated	Adherence not reported. References made to ODA principles.	Meaningful moments created through the interplay of inner and outer dialogues. OD approach explored and theoretical underpinnings examined.

Lidbom et al (2015) Dialogical collaboration; Norway CAMHS	Multi- perspective methodology 6 service users, clinicians, and network members To explore the interplay and dynamics between inner and outer dialogues.	Dialogical phenomenological approach Triangulation not stated	Adherence not reported. References made to ODA principles.	Inner dialogues and reflections were seen as significant in the development of insights within network meetings.
Ness et al (2014) Norway Crisis team	Multistage focus group interviews 25 (12 clinicians, 6 service users, 7 carers) Develop new knowledge on community-based practices for people in mental health crisis.	Qualitative thematic analysis Notes taken from the first stage were shared with second stage group participants.	OD used in research process and individual level, but unclear whether used at service level	Valuing uncertainty and tolerance of uncertainty became a valued principle in that it led to successful compromises. The process of learning this was through being open minded and accepting opposing points of view.
Piippo and Aaltonen (2004) Integrated network and family–oriented model; Sweden Adult mental health service	Qualitative semi- structured interviews 22 service users To discover the outline of the approach of an integrated family network model from service user experiences.	Qualitative thematic analysis Triangulation not stated	Adherence not reported. References made to ODA principles.	The themes found were as follows: Negative perception of professionals with overwhelming enthusiasm for the approach. Approach allows individuals to open up and view multiple perspectives. Unknown if this is helpful to relatives, and or wider public.
Piippo and Aaltonen (2008) Integrated network and family–oriented model; Sweden Adult mental health service	Qualitative semi- structured interviews 22 service users To explore how ODA plays a part in development of trust and previous experiences of honesty and mistrust in services/ models of care.	Qualitative thematic analysis Triangulation not stated	Adherence not reported. References made to ODA principles.	The themes found were as follows: Mistrust was attributed to when professionals dominated network meetings. Whereas trust was associated with a partnership and equitable process/ relationship.
Pylkkanen (1997)	Review of the changes to the Finnish healthcare system.	Analysis of the historical changes to the health system (method unknown)	Needs adapted approach outlined and reportedly followed.	Deinstitutionalisation was successful due to the following themes: • Staff commitment

				• Autonomy given to local providers • Quality standards provided from government
Rosen and Stoklosa (2016) McLean Hospital; USA Adult mental health inpatient service	Mixed- methods study 50 (20 clinicians and 30 service users) Staff and service users' perspectives of ODA within the inpatient setting.	Questionnaires and qualitative analysis (method unknown) Triangulation not stated	Adherence not reported. References made to ODA principles.	The themes found were as follows: Clinicians reported improvements in positive outcomes – less coercive treatments (MH act, restraints). By using tentative words. Increased compliance with treatments. Less requirement for follow-ups. Implemented at minimal costs.
Seikkula (2002b) API, ODAP1; Western Lapland, Finland Adult mental health service	2 case studies 20 service users (10 "Poor" outcome, 10 "Good" outcome) Analysis of dialogues from poor and good outcome groups in order to understand further the mechanisms of treatment	Sequence analysis Triangulation not stated	Adherence not reported. References made to ODA principles.	The study illustrates some of the mechanisms involved in ODA: Poor outcomes were associated with clinicians not responding to service user's dialogue. Good outcomes were associated with the network meetings being dominated by the service user, having increased dialogical interactions and symbolism included in the discussions.
Seikkula (2003) API; Western Lapland, Finland Adult mental health	Case studies 2 service users Demonstrate ODA key principles and ODA process.	None stated	Adherence not reported. References made to ODA principles.	Connection between individuals in network meetings is fundamental. OD is very flexible and adaptable to any situation.
Seikkula et al (2006)	Case studies 2 service users	None stated	Adherence not reported. References made to ODA principles.	ODA conducted within service users home was seen as something very valuable and effective. Emotional challenges were experienced when in depth discussions were had.

API, ODAP; Western Lapland, Finland Adult mental health service	To demonstrate poor and good outcome groups from ODAP1 and API cohorts			
Seikkula et al (2001a) API; Western Lapland, Finland Adult mental health service	Case study 1 service user Demonstrate key principles of ODA.	None stated	Adherence not reported. References made to ODA principles.	Service user reported positive outcomes. The service user interaction denotes how the principles of ODA may work.
Seikkula and Sutela (1990)	Naturalistic descriptive design	None stated	Needs adapted approach.	When a service user is admitted into hospital the family, service user and clinicians form a mutual system. This coupling forms a therapeutic mechanism.
Tribe et al (2019) UK	Qualitative inductive thematic analysis. (11 clinicians and 8 service users)	Thematic analysis.	Adherence not reported. References made to ODA principles.	ODA was effective, a preferred choice, but a challenging way of working. Service users' views were mixed, with some feeling reflective discussions were strange, but ultimately they mostly felt listened to and had developed a greater understanding between them and the clinicians. They reported that network meetings were emotionally expressive and could feel overwhelming at times. Service users should lead network meetings not the clinicians.

Vuokila-Oikkonen et al (2002) Western Lapland, Finland	Narrative approach 11 Network meetings videotaped	Method of modified dialogue analysis Triangulation between researchers	Need adapted approach – reportedly adhered.	Open ended questions used – promote dialogue Clinicians' motives explained – promoted openness and transparentness. If clinicians were too dominant in the meeting this jeopardised participation.

3.2.3 ODA INFORMATION SOURCES

Other studies described the theoretical underpinnings and provided a description of the approach. Three books were also obtained that both summarised the research and provided a description of the open dialogue process (Seikkula and Arnkil 2006, Haarakangas et al 2007, Seikkula and Alakare 2012, Sutela 2012). There are many examples of literature that provide a description of the open dialogue approach and a template of the principles and process it follows. Seikkula (2011) states that it is a network centred treatment that is similar to needs adapted approach which was developed in Finland during the 1960s by Professor Yrjö Alanen as a way to develop a psychotherapeutic treatment of schizophrenia or psychoses professionals working within the public sector (Alanen, 1997). ODA is similar to family therapy as it uses interventions such as the reflecting team used in systemic family therapy (which focuses therapy on the relationships between members of the family). However, according to Angus and McLeod (2004) it is more similar to narrative therapy (which is a branch of systemic family therapy - Monk et al 1997) on a philosophical basis due to the fact that it is rooted within a socially constructed world (rather than a psychological world alone) that is dependent upon dialogue. They represent a shift in focus from the subjective to the intrapsychic, - the internalisation of problems to the externalisation of problems as fundamentally relational and to a shift in the recognition of the co-created therapeutic space (which in itself becomes a new “system” for all involved). Although it can be argued that family therapy has moved towards a more postmodern view where reality is more socially and linguistically constructed (Rolfe 2000). However, ODA differs from narrative therapy in that the clinicians do not attempt to ameliorate the individuals’ dialogue into a positive format, they only attempt to facilitate a dialogue and develop a shared understanding of what is happening, in addition ODA is different to other interventions such as needs adapted approach because of its principles of dialogism and the tolerance of uncertainty (Seikkula and Arnkil 2006).

Dialogism in particular has an important role to play within psychosis because ODA theoretical construct is that psychosis is a socially constructed phenomena that can be resolved or lessened through the use of dialogue and dialogism (Seikkula 2002a). Mikhail Bahktin, one of the founders of dialogical theory states that all language and thought is dialogical in nature; this is because all new thinking and speech is in response to previously stated dialogue and can be a pre-emptive action to predict what may become the next response (Bahktin 1981). Therefore, all language is inextricably linked not only in time-sequenced order but also more importantly to others, in a relational way that moulds and changes the ebb and flow of what is said and understood. If a dialogue is not fostered then a monologue will be created where the individual’s narrative or story will not be listened to and any meaning ascribed to the person’s narrative will be predetermined and biased by others, therefore, true understanding cannot be created and the individual with the psychosis could miss the opportunity to develop their own dialogue to help them develop coping strategies with their psychosis.

ODA aims to reintegrate services users into their society and it begins this journey by ensuring that first service users maintain those relationships with family and friends and then wider community and societal support. This approach has the high ambition of not only achieving the latter objectives but also as a side effect it achieves a de-stigmatising effect on the stereotypes that surround mental illness (Seikkula and Arnkil 2013, Seikkula and Arnkil 2006).

Seikkula (2011) states that ODA is not only about intervening and interpreting dialogue but is also more importantly about listening to and responding to social networks and warns that monologues between participants ultimately will not lead to a developed and shared understanding between the network. If this way of working is employed by clinicians then early solutions could be developed that may not be fit for purpose, reduce the network ability to develop a shared understanding and/ or develop within individuals a dependence and overreliance on mental health services. Seikkula (2002a) argues that the clinical team should strive to develop this understanding of what the individual is attempting to say to them and even focus on any utterances the individual makes in an attempt to ascertain the communication behind this. Seikkula (2002a) also states that team reflective discussions are important within the network meeting (between clinicians) in order to promote a transparent and open understanding of what clinicians believe and currently have for the individual. It also allows the individual to have a break from the conversation so that they can hear their own internal voice during the network meeting to facilitate their own reflections and inner voice. This mode of operating ODA social network meetings are associated with positive outcomes and is viewed as a form of therapy in its own right (Seikkula et al 2001a, 2001b and Seikkula & Arnkil 2006).

Therefore, ODA developers make the bold claim that ODA has a powerful effect on societal responses (through society’s inclusion in network meetings) and uses a social constructionist perspective in its view on society, in that it believes the meaning that is created by individuals in inseparable from the social and cultural dialogical interactions which comprise our being in the world. Therefore, the ‘problem’ does not lie with the individual but rather the collective (society), and as such this is what needs to be engaged with in order to ultimately help the individual.

3.2.4 OUTCOME STUDIES

Buus et al (2017) conducted a scoping review of literature that has researched the implementation of ODA within Scandinavian countries (apart from where it originated). They found that ODA was mostly deemed as a mental health service to be favourable and promising. Gromer’s (2012) review of the literature also concluded that needs adapted approach or open dialogue were more effective than treatment as usual.

3.2.4.1 QUANTITATIVE STUDIES

3.2.4.1.1 FINLAND STUDIES

The first study reviewed here is Turku study by Alanen et al (1991) which is a needs adapted approach study looking at the effects of introducing a needs adapted approach (an early version of open dialogue) into a mental health system that was predominantly inpatient based rather than community based. It consisted of a current treatment group n. 25 and a historical control group n. 54. They looked at whether the groups were in receipt of social benefits, what symptoms they had and the amount of hospital days. They found that symptoms were reduced in the treatment group by 68%, whilst it was reduced by 41% in the control group. Hospital duration was 9 days in the treatment group whilst it was 36 days in the historical control group. There are drawbacks to this study in that the originators were involved in the rating of symptoms and also no blinding in the study.

A follow up to this study was conducted by Lehtinen (1993) called the Turku 5 year follow up. They again studied the needs adapted approach by conducting a cohort study. Within the treatment group they had n.28 and in the historical control group n.53. Again they looked at whether the groups were in receipt of social benefits, what symptoms they had and the amount of hospital days; and also social functioning scores. They found that the treatment group was less likely to be receiving benefits (G = 9, p<0.005) and also less likely to have symptoms (G= 3.9,p<0.05). The treatment group was more likely to have higher social functioning scores (G = 3.8, p<0.05) and spend less time in hospital. Very positive outcomes in favour of the needs adaptive approach, but the drawbacks were the same in that the originators were involved in the rating of symptoms and there was no blinding.

Within a need-specific Finnish study called the Acute Psychosis Integrated (API) treatment project (influenced by teamwork, service user carer participation and psychotherapeutic attitudes) by Lehtinen et al (2000) looked at need adapted approach in 1992-3; this was during the time when ODA was developing and emerging as a philosophy. One hundred and six clients were recruited into the study and they were split into experimental group (n.67) that deferred giving neuroleptics for up to three weeks following admission and a control group (n.39) that also provided a need adapted approach without the restriction of neuroleptics. Within the experimental group if improvements were found during the first three weeks then no neuroleptics were prescribed. They found that on follow up 2 years later that 42.9% of the control group were not taking any neuroleptics medication whereas in the control group only 5.9% were not taking any neuroleptics medication. Also the experimental group were more likely to have no psychotic symptoms (58.2% vs control group 41%) and spend less time in hospital (experimental group 50.8% had spent less than two weeks in hospital over 2 years compared to 25.6 % of the control group). They also reported that the experimental group were more likely to be in employment that the control group although this was not attain statistical significance (experimental group 32.8% vs control group 30.8%). Finally, Global Attainment Scores (GAS) were in favour of the experimental group (49.2%) rather than the control group (25%) and the Grip on Life scores was similarly strong for the experimental group (65.7%) than the control group (55.3%). The weakness of the study is its retrospective design, no blinding and originators of the approach and initial set up involved in the study.

In a paper by Seikkula et al (2001b) undertaking a case series study using ODA with 78 service users over two years looked at neuroleptic medication use, Brief Psychiatric Rating Scale (BPRS) score, hospital days, Global Assessment of Function (GAF) score, accepting benefits or in employment. They categorized symptom severity and employment status into good and poor outcomes i.e. good outcomes related to those in employment with residual psychotic symptoms whilst those in the poor category related to those with moderate to severe psychotic symptoms and in receipt of social income benefits. Out of the case series 78% were found to be in the good category. However, again this study was conducted by the founders of ODA and non-experimental in design (no control or blinding).

In another study by Seikkula et al (2003) which this time was a cohort study looking at ODA (baseline measurements taken and 2yrs) using a control group (treatment as usual) (n.14) and two experimental groups (API n.22 & ODAP (Open Dialogue for Acute Psychosis) n.23). The researchers chose to compare ODAP against API because they felt that the ODAP approach had developed further from the API approach; for example, ODA by this time were using dialogism and tolerance of uncertainty.

They measured baseline scores on the following measurements, neuroleptic medication use, BPRS, hospital days, GAF, relapses, employment and residual symptoms. They found that ODA groups as compared to the TAU group had fewer symptoms, relapse rates, neuroleptic use, fewer hospital days, increased family meetings and increased rates of employment. In particular, they found that the ODAP group had fewer residual psychotic symptoms and 83% of the group was in education or employment (whilst the control group had 30% in employment or education). Also they found that within the ODAP and API groups had fewer relapse rates (24%-31%) whilst the control group had 71% relapses in its cohort. Drawbacks to this study were that the originators were involved in the rating symptoms and diagnosis, they used a small sample and control sample chosen over 21 months. However, the small numbers mean that these differences were not at significance. Additionally, the small sample of the study does diminish the generalisability of the results, although the data found was encouraging and indicated some positive change on practitioners and or service users.

A further similar study by Seikkula, et al (2006) using a historical comparison/ case series study of the entire treatment system in a single catchment area (Western Lapland) over a 5yr period found positive results in favour of ODA. They studied two groups of first-episode non-affective psychotic patients, one before (API group; *n*=33) and the other during (ODA group, *n*=42) the fully developed phase of using OD approach in all cases. They found that the treatment was discontinued without a joint decision in 18% of the API and 5% of the ODAP group patients. The mean duration of untreated psychosis for the ODAP period had declined to 3.3 months compared with 4.2 months in the API period (*p*=.069). They measured neuroleptic medication use, BPRS, hospital days, relapses, employment, and residual symptoms at baseline, 2yrs and 5yrs.

There were no statistically significant differences in the use of neuroleptic medication in either group at both follow-ups (17% of the ODAP group and 24% of the API group). During the entire 5-year period 39% of API patients and 29% of ODAP patients used neuroleptic medication. The ODAP group had fewer hospital days than the API group during the first 2 years (M= 9.3, M= 25.7 *p*<.001) but no differences emerged at the five year follow up. The API group had significantly higher BPRS scores at two years that the researchers suggested were due to the API group recovering more slowly as compared to the ODA group; however, there were no differences by five years. Of the ODAP group 82% had minimal residual psychotic symptoms and of the API group only 76% had minimal residual psychotic symptoms. At least one relapse occurred in 32% of API and 19% of ODAP cases between years 2 and 5. At the 5 year follow up 70% of the API and 76% of the ODAP service users had returned to work or studies and only 30% of API patients and 24% of ODAP patients were living on disability allowance. However, the differences in-between the groups (which were found to be in favour of the ODA group) failed to reach statistical significance.

Seikkula et al (2006) concludes by suggesting OD is cost-effective for the community. The costs of the psychiatric health district in Western Lapland decreased by 33% from the end of the 1980s through to the mid-1990s and they were the lowest among the health districts in Finland. However, again the study comes under criticism from having the originators conduct the research and a small sample size.

Finally the Seikkula et al (2006) study compare its results against the Svedberg et al (2001) 5- year follow-up study looking at Stockholm mental health services using a retrospective cohort design focussing on incidence rates, treatment, and outcome of in and outpatient population of 71 patients (of 18-45 years of age) treated for a first-episode psychosis in Stockholm. They found that in Stockholm the mean length of hospitalization was 110 days compared with 17 days from the ODAP patients. Neuroleptic medication was used in 93% of cases in the Stockholm group compared with 29% of the ODAP patients and 62% of the patients treated in Stockholm were on disability allowance compared with 14% of the ODAP group. However, these results should be compared with caution because the groups were not matched and the levels of services and support structures very different from both countries.

Aaltonen et al (2011), conducted a historical control design (retrospective case study) looking at the incidence of schizophrenia following the introduction of ODA; this study was in response to a paper by Whitaker (2010) who claimed that the incidence of schizophrenia was reducing in western Lapland. The dates compared were 1985-89 and 1990-94; by which time ODA was being used. Within this period 250 service users from Western Lapland presented with non-affective psychosis; the results were quite comprehensive in that the incidence of schizophrenia dropped by 60% (from 73 to 41 patients) and saw an increase in brief psychotic reaction (from 3 to 16 patients). The results indicate that the service changed the way it diagnosed its service users. The overall number of first admissions rose from 173 to 216 suggesting that overall reduction in diagnosis was not as a result of a decrease in use of psychiatric services. However, existing long stay Schizophrenia patients reduced to zero after ODA was introduced and no new long stay Schizophrenia patients cases arose. The potential issue with this study is the historical aspect and the unknown relationship between confounding variables. That is, we do not know what the cause of the change in diagnostic habits was attributable to e.g. ODA/ need adapted approach implemented by mental health practitioners having family therapy or psychodynamic individual therapy and patients were treated in a family and network-centred manner by multidisciplinary crisis teams in the patient's own home. Therefore, during these periods when ODA was implemented, many factors may have confounded the research such as engagement, variability in symptoms, family expressed emotion, medication (and so on); we do not know what principles associated with these approaches caused the change.

Another limitation raised by the researchers was the potential variation in diagnosis at that time with the drive away from hospital treatment to community treatment. The researchers therefore retrospectively diagnosed clients from the records and to avoid bias sought an independent researcher to undertake this task blindly to reduce the risk of bias in the study. However, the major detraction to this study must be the length of time taken between undertaking the research and when the data was formed. This distance must raise questions in accuracy of some of the extraneous details surrounding the study that have been lost in the intervening time, but which may have had a significant effect on the outcomes.

In another historical comparison/ case series study by Seikkula et al (2011), this time they contrasted API (1992-3) and ODAP1 (1994-7) and ODAP2 (2003-5). The study uses a historical control design to evaluate the stability of acute psychosis outcomes using an Open Dialogue Approach by comparing it to the API outcomes. They used the following measurements; neuroleptic medication use, BPRS, GAF, relapses, employment, and residual symptoms at baseline, 2yrs and 5yrs. They found that Schizophrenia rates were lowered and productivity increased (employment or studying). The ODAP2 group were found to be younger than ODAP 1 and API, which the researchers conclude to be due to OD being an effective early intervention service. Within the three time periods a reduced mean age of schizophrenia was found by the 2003-5 (ODAP2) time period, along with a reduction in the duration of untreated psychosis (DUP) – which is a major indicator of future outcomes (Marshall and Rathbone 2011), and also another significant reduction in hospitalisation. They also found no significant differences in the data – thereby indicating that the initial positive effects of ODA in the early 1990s were maintained. However, there are other limitations to this study; the first is that the sample size of the 2003-5 group is over 50% smaller than the 1990s groups, therefore the generalisability of these outcomes must be questioned. Finally, the overall sample is arguably small due to the small scale of the Finnish municipality (Western Lapland population 78,000) and therefore again the generalisability of the findings will be weak, however, the researchers argue that this is also a strength of the study because the outcomes cannot be attributed to any other healthcare services only those who are delivering ODA. Finally the research was conducted by the originators of the approach.

A case series study by Grano et al (2016) from southern Finland looked at 130 service users who were receiving ODA and family therapy and who were measured for suicidal ideation at baseline and at 1 month and revealed positive outcomes. They used a suicide/ depression assessment tool. They found that suicidal ideation reduced and that this reduction was found to be statistically significant.

However, there was no control in this study against the reduction in suicide and the study was not blind.

In another retrospective cohort study in Western Lapland by Bergstrom et al (2017) looking at 65 service users receiving ODA took measurements of hospital days, GAF, neuroleptic medication prescribing at baseline and 1 year found positive outcomes. ODA principles were outlined by the study and they found that duration of inpatient treatment was positively associated with higher rates of aggressive incidents. The authors concluded that aggression may be a factor that challenges ODA principles. However, limitations of the study are that it had no effective control of the variability of the diagnoses or medication use and the sample size was also relatively small.

The final study reviewed in this subchapter is a follow up to the last study by Bergstrom et al (2017). Bergstrom et al (2018) conducted a larger and longer term (19yr) retrospective cohort study looking at the evolution of ODA by comparing a current treatment group (n. 108) with a historical control group (1995-1996 n.1763). They measured for mortality, hospital days and social benefits. They found that hospital admissions (for over 30 days) in the treatment group was 18.5% against the control group 94.4%. Neuroleptic medication use was 36.1% in the treatment group whilst it was 81.1% in the control group. Finally those receiving social benefits in the treatment group was 33% and 61% in the control group. This indicates that ODA has maintained and improved outcomes for service users within Western Lapland. Although the authors argue that an RCT is required. Limitations are risk of bias, no blinding and use of historical data (missing data, corrupted, out of context).

The gains achieved by ODA (lower rates of schizophrenia diagnosis, reduction in medication use and increase in maintaining employment/ studies - Seikkula and Arnkil 2013, Seikkula and Arnkil 2006) that is apparent within the work of all of these studies looked at here arguably points to the idea that this approach needs to be reviewed and assessed to ascertain whether the claims by its developers are valid and that their research has been conducted with a rigour expected within today's evidence based practice model of care. Additionally, an assessment needs to be made on the transferability of the approach into the UK psychiatric healthcare model which appears to be very different, in that, the practices can be viewed as more restrictive with the balance of power weighted towards professionals rather than service users. Supporters of this shift in power (recovery philosophy) towards an equitable stance (Perkins 1996) could favour ODA as the mode to implement such a radical shift. It is important though that evidence is found that contextualises the Finnish approach into the parameters of the individual affected, the clinical support that is available and the overall societal support networks that are available and which may be indicative to Finland and therefore be very different in the UK.

Limitations of the Finnish research is that it is non-randomised, no power calculations, it uses a convenience sample, it is mostly conducted in Finland and the originators of the approach conducted the research (which could be unintentionally biased). There is a need to conduct randomised control trials (ODDESSI NEWS 2019).

3.2.2.1.2 OTHER STUDIES

In a Danish study by Buus et al (2019) looking at ODA within their service using a retrospective register-based cohort design found positive outcomes. They used treatment group and two comparison (control groups) (treatment n.503, comparison group 1 n.19,420 and comparison group 2 (matched) n.1509). They measured the utilisation of psychiatric services, GP services and social markers. They reported that at 1 year follow up the ODA Cohort had more outpatient treatment (RR=1.2, CI: 1.1-1.4) than comparison but not at subsequent follow-ups. Also the ODA group had less emergency psychiatric treatments (1 year follow up: RR=0.2, CI: 0.1-0.5; 10 year follow up: RR=0.5, CI: 0.3-0.8). Finally the ODA group had less GP contact (1 year follow up: RR=0.9, CI: 0.82-0.99; 10 year follow up: RR=0.85, CI: 0.78-0.92). This indicates that ODA has transferrable benefits outside of Finland. The limitations of the study is that it used retrospective data which the authors reported was incomplete and required subjective interpretation. The study was not blind or randomised. Finally there were differences in the referral practices between treatment and comparison groups.

In a United States of America (USA) study by Gordon et al (2016) looking at ODA with 14-35 year olds experiencing psychosis using a mixed-methods design (case series and qualitative feasibility study) with 14 service users found positive outcomes. They looked at hospital days, work or education and symptomatology at baseline, 3 months, 6 months and 12 months. The improvements that were statistically significant to BASIS-R (Behaviour and Symptom Identification Scale), BPRS, SCLFS (Strauss Carpenter Level of Functioning Scales), Hospital days & Work or education (9 of 14 in work or education at 12 months). In addition, they report that they achieved good clinical outcomes, shared decision making and high service user satisfaction. The benefits found were similar but not necessarily the same as the ones found in Finland. However, there were weaknesses to the study in that it was a small sample, there were no controls, it was not a blinded study and there was diagnostic heterogeneity.

Within Kent and Medway NHS Trust they are conducting a pilot of ODA (Ishaq & Jeffrey 2018). It is a cohort study and currently unpublished or peer reviewed (this was presented at a conference in 2018). It uses a treatment as usual group and the preliminary results of this ‘Canterbury pilot’ was published at an ODA conference last year, it indicated that ODA had favourable results from the pilot (Ishaq & Jeffrey 2018). Within the pilot it was reported that the service manager manages everyone’s diary, referrals come from GPs and they can be crisis or routine referrals and importantly they fast track re-referrals that come back into their service.

Over a two year period the cohort study found that the ODA group had fewer bed days on average (ODA 14 days vs TAU 117 days), used less neuroleptic medication (ODA 33% vs TAU 100%), had less relapses (ODA 24% vs TAU 71%) and increased rates of people returning to work (ODA 81% vs TAU 43%). The limitations to this is that it has not yet been published or peer reviewed. Also the numbers of service users in the study is unknown, along with whether there was any blinding in the study to ascertain whether there is any bias. Also it is unclear what TAU meant for that cohort; was there similar contact time as the ODA group? If not, it could be argued that the ODA intervention was as a result of contact time rather than the actual merits of the approach.

Finally, there is an ambition within the UK to undertake a RCT of ODA. The ODDESSI trial (Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness) has recruited the Kent and Medway pilot and is looking at other sites to look at the feasibility of completing a multicentre RCT (ODDESSI NEWS 2019 – National Institute of Health Research: Award ID - RP-PG-0615-20021).

3.2.4.2 QUALITATIVE

3.2.4.2.1 FINLAND STUDIES

The qualitative effects of using the interventions were first published by Seikkula and Sutela (1990) who described how relationships change when individuals are admitted to hospitals. The study into needs adapted approach was a naturalistic descriptive design. They stipulated that staff needed to focus on the evolving relationships between family members, the affected individual and the staff, to develop new meanings to generate a new way forward. When a service user is admitted into hospital the family, service user and clinicians form a mutual system; this ‘coupling’ forms a therapeutic mechanism.

Pylkkanen (1997) provided a descriptive piece reviewing the changes to the Finnish healthcare system, analysis was provided of the historical changes to the health system and the use of the needs adapted approach was outlined and followed. The following themes were captured to inform the success of deinstitutionalising a service, staff commitment, autonomy given to local providers and quality standards provided from government. Pylkkanen (1997) concludes that the needs adapted approach reduces the reliance people have on neuroleptic medication and hospitalization.

In a multi-case study by Holma and Aaltonen (1998) using a qualitative narrative approach that involved 3 service user participants they aimed to explore ODA and family therapy meetings. They explored how network meetings operated through performing a retrospective thematic analysis of recorded network meetings. They found that service users were required to be an equal partner to ensure a positive successful outcome to therapy. They also concluded that the content and/or direction of conversation was not important, rather the focus instead was on the creation of dialogue; understanding is derived from the dialogical act, not the content of what is being said. They found and concluded that such meetings allowed people to construct coherent narratives about their lives.

Seikkula et al (2001a) reported on a case study with a service user to demonstrate the key principles of ODA. The service user reported positive outcomes of the approach and its style. Also the service user interaction denotes how the principles of ODA may work. In a follow up to this study Seikkula (2002b) presented further case studies outlining the use of ODA and the specific use of dialogue captured by the clinicians and service users were analysed. Service users who had poor outcomes (unemployed and poor symptomatology) were matched demographically (age, sex, diagnosis, DUP) with service users who had good outcomes (working or studying and good symptom control). The researcher then evaluated these service users' dialogues with clinicians further, using sequence analysis of dialogues from poor and good outcome groups in order to understand further the mechanisms of treatment. Three domains were outlined as positive for the service user – dominance – the service user has a strong voice and opinions are heard; symbolic meaning – indicating that the service user is able to use abstract concepts rather than factual descriptions alone; dialogical dialogue – indicating that dialogue builds rather than being discounted. Poor outcomes were associated with clinicians not responding to service user's dialogue. The three domains were present in the entire 'Good outcome' service user group, indicating that these may have played a factor in that the quality of the dialogue between the service user and clinician influenced the service users' positive outcomes. However, another way of looking at this is that the service users of the 'poor outcomes' group were too disabled by their illness to have an effective dialogue, nevertheless, the researcher asserts that the dialogue could have been facilitated better by the clinician. In order to reduce researcher bias the researcher held a seminar with the clinicians involved in ODA clinical staff to discuss the outcomes and conclusions of the study in order to validate findings and offer new insights into the anonymised transcripts.

In another case study by Seikkula (2003) looking at ODA processes and key principles with two service users. Seikkula found that the connection between individuals within network meetings was at the core of the treatment and fundamental to ODA. It was also found that ODA can be very flexible and adaptable to a number of situations, fulfilling its principle of flexibility and mobility.

Seikkula et al (2006) carried out another case study using again two service users, to demonstrate poor and good outcome groups from ODAP1 and API cohorts. It concluded that ODA conducted within service users homes was seen as something very valuable and effective. However, it also warns that emotional challenges were experienced when in-depth discussions were had which had to be managed carefully and skillfully.

Vuokila-Oikkonen et al (2002) in a similar qualitative study using a narrative methodological approach explored network meetings and the patterns of communication within them. Using a method of modified dialogue analysis of 11 Network meetings videotaped recordings they found that when service users raised embarrassing issues these were not responded to well by staff increasing the distress of service users. This indicates that specific training is required to prepare clinicians adequately within sessions. They also found that using open ended questions promoted dialogue and clinicians were required to be open and transparent about their motives when asking probing questions to facilitate trust. Finally if clinicians were too dominant in the meeting this could have the effect of jeopardising service user participation (see also Seikkula 2002b). They concluded that further research was required to generate new ideas to enable staff to work more collaboratively with service users. Triangulation between researchers was used to ensure trustworthiness and credibility of the data.

The limitations most apparent within the Finnish research clustered around the language/ culture barrier was mostly conducted in Finland and the fact that the developers/ creators of the approach also conducted the research (which could be unintentionally biased).

3.2.4.2.2 OTHER STUDIES

A qualitative thematic analysis study by Piippo and Aaltonen (2004) in Sweden aimed to discover the outline of the approach of an integrated family network model from service user experiences. They used qualitative semi-structured interviews with 22 service users. They found the following themes from the data they collected, 1/ there was a negative perception of professionals who had an overwhelming enthusiasm for the approach, 2/ the approach allowed individuals to open up and view multiple perspectives, new meanings and understandings, 3/ and finally it was unknown if the approach was helpful to relatives, and or wider public.

In a further qualitative thematic analysis study, Piippo and Aaltonen (2008) aimed to explore how ODA plays a part in development of trust and previous experiences of honesty and mistrust in services/ models of care. They again used qualitative semi- structured interviews with 22 service users. They found the following themes, 1/ that mistrust was attributed to when professionals dominated network meetings, 2/ and trust was attributed to working in partnership and an equitable relationship.

A study from Norway by Holmesland et al (2010) explored ODA in the context of staff experiences of team working, training and professional roles. They used three qualitative focus groups each of which comprised of twelve 12 clinicians. To improve credibility, the themes were reflected back to participants to check for accuracy during the focus groups. The themes reported were that hierarchy and power related to professional roles was viewed as challenging. Familiarity between professionals (and service users) was viewed as important in facilitating a space for knowledge to be developed and cultural barriers to be overcome. In a follow up to this study, Holmesland et al (2014) conducted further qualitative interviews using two focus groups with 12 clinicians to explore ODA in the context of professional roles and team working from staff experiences. A content analysis methodology was used to analyse the data and again themes were reflected back to the groups to ensure credibility of the data. The following themes were found, 1/ dialogue is the facilitator of openness and transparency, being attentive and listening, 2/ the atmosphere (authenticity, dealing with silence and difficult topics appropriately) of the network meetings is fundamental to creating a trusting, safe and warm environment. Finally, the outcomes may have been affected by the sample diversity.

In a single case study from Norway by Bøe et al (2013) to illustrate how dialogical practice can facilitate change, they found that ODA was reported as a positive experience. They accomplished this through in-depth analysis if a single case study using triangulation through experienced co-researchers to ensure the study was credible and trustworthy. They concluded that ODA as a theoretical position allows and catalyses change through dialogue in an ethical time and space. In a follow up study Bøe et al (2014) conducted multistage qualitative interviews with 22 participants (6 clinicians, 8 network members, 8 service users) with the aim to explore the social dynamics of the lived experience of crisis from the psychosocial perspective in relation to change. Their methodology was dialogical hermeneutical analysis and validity was maintained through triangulation with experienced co-researchers. They concluded that movement and transformation were created through change in ethical time and space and the facilitative factor was dialogue. In further study by Bøe et al (2015) they conducted video-recorded qualitative interviews with 22 participants (6 clinicians, 8 network members, 8 service users) to explore mental health dialogical practices within network meetings through the lived experiences of participants. Their methodology was again dialogical hermeneutical analysis. They found that inquisitiveness of staff was viewed as important (along with attentive listening), which helped service users reflect on past/ future and present experiences.

Within Norway Ness et al (2014) conducted multistage focus group interviews with 25 participants (12 clinicians, 6 service users, 7 carers) to develop new knowledge of community-based practices for people in mental health crisis. They used qualitative thematic analysis and they shared notes from the first stage with the second stage to improve credibility of the data. They found that valuing uncertainty and tolerating uncertainty (Principle - ‘tolerance of uncertainty’) became a valued principle in that it led to successful compromises. The process of learning this and being able to do and achieve this was through being open minded and accepting opposing points of view.

Another study from Norway by Lidbom et al (2014), aimed to explore the development of ‘meaningful moments’ through the interplay between inner and outer dialogues. They used a case study using a purposive sample of 4 people (1 network member, 1 service user, and 2 clinicians). They analysed their data using dialogical hermeneutical analysis and found that meaningful moments are created through the interplay of inner and outer dialogues. In a follow up study Lidbom et al (2015) further aimed to explore the interplay and dynamics between inner and outer dialogues. To achieve this they used a multi-perspective methodology using 6 service users, clinicians, and network members. They again used dialogical phenomenological approach to analyse their data. They found similar findings to their previous study in that inner dialogues and reflections were seen as significant in the development of insights within network meetings.

In a mixed methods study from the USA by Gordon et al (2016) (quantitative results already discussed in 3.2.2.1.2), qualitative interviews with 14 service users and clinicians were used to explore ODA informed practice. The ODA team did not in reach into inpatient areas, only community areas. They found that clinicians reported it to be a positive experience, reduced coercive practices and medication use, and observed an increase in open and transparent communication as reported by service users.

In another study from the USA looking at ODA within the inpatient setting by Rosen and Stoklosa (2016) found positive results. They used a mixed methodology using questionnaires and qualitative analysis with 50 (20 clinicians and 30 service users). The themes that they found were as follows, 1/ increased compliance with treatments, 2/ less requirement for follow-ups, 3/ implemented at minimal costs, 4/ clinicians reported improvements in positive outcomes – by using tentative words there were less coercive treatments (MH act, restraints).

A British PhD thesis by Ellis (2018) looked at ODA within a UK pilot site using a qualitative narrative approach. Interviews were used with nine practitioners and a narrative methodology was used to analyse the data. The themes reported were the following , 1/ that Implementing ODA is complex and involves negotiating medicalised mental health systems, 2/ practitioners reported positive impact of ODA, 3/ ODA in a good position to influence change in organisational, social and political aspects. However, at the time of writing this remains an unpublished thesis and not peer reviewed.

Stockman et al (2019) study that explored peer-supported open dialogue trainees used thematic analysis in peer supported open dialogue to explore perspectives on training and the approach. Following four focus groups, the study formulated four themes: personal experience, practice development, principles of the approach and pedagogical issues. They concluded that the course was positive, highly experiential and created an emotional journey/ response in the participants. Ultimately it enabled them to use this in their work.

Finally Tribe et al (2019) published a qualitative inductive thematic analysis study looking at the implementation of ODA within the UK. They interviewed 11 clinicians and 8 service users and used thematic analysis on the data. They reported that ODA was an effective approach, a preferred choice, but a challenging way of working (emotionally challenging at times). Service users' views were mixed, with some feeling that reflective discussions were strange, but ultimately they mostly felt listened to and had developed a greater understanding between them and the clinicians. However, they also reported that network meetings were emotionally expressive and could feel overwhelming at times. They concluded that service users should lead network meetings not the clinicians.

3.3 REVIEW SUMMARY

The development of ODA within Western Lapland appears to have had an impact on the duration of untreated psychosis on individuals (Lakeman 2014). Delusional beliefs usually require a layering effect of false assumptions, 'external' reinforcers/ confirmatory stimuli (hallucinations) and time to become established beliefs. If these beliefs remain unchallenged (through constructive exploration) then the element of time becomes a critical factor that directly reinforces beliefs and thereby negatively influencing long term outcomes; this is because beliefs become more entrenched and a part of the person's psyche in that the beliefs are part of their perceptual and interpretative cognitive system making it more difficult to treat (Kring et al 2017, Andrew et al 2012). As previously stated (in background chapter) early treatment in a person's journey into psychosis can prevent such long term (destructive) beliefs becoming established not only providing better quality outcomes for affected individuals but also financial savings to health and social budgets along with societal gains (increased productivity) (Andrew et al 2012).

To summarise the quantitative evidence reviewed it indicated that ODA changes diagnostic habits/ culture, it has been shown that it can reduce symptoms, hospital days, coercive practices, relapse rates, medication use (neuroleptics) and reduce need on services (emergency and GP services). It can also increase peoples' productivity, compliance (through partnership democratic approach) and social functioning. ODA appears to be an effective early intervention model of care (especially when it is used in the community in peoples' homes).

To summarise the qualitative studies within this review indicated that ODA creates a space for meaningful dialogue (between clinicians and service users), connections, understandings (through developing multiple perspectives through symbolism) which they value and view positively. Service users need to be in control of the network meetings for them to feel the benefit (mistrust is created if clinicians dominate the meetings). In addition, service users' wider networks are of paramount importance of making ODA meaningful and successful to the service user. Also, clinicians need to be open with their motives to create a trusting partnership with the service user; to achieve this clinicians need to give themselves to the session by opening up about personal experiences (which can cause boundary issues: this will be discussed further in chapter 7&8).

Qualitative research also indicated that ODA was a catalyst for change, but these papers suggested negative aspects such as hierarchical structures being a barrier to implementing ODA successfully. In addition, clinicians need to be able to value uncertainty and tolerate uncertainty, and, as such ODA can be a challenging way of working for clinicians especially within network meetings (these will be discussed further in chapter 8).

Open Dialogue Approach is the engagement of 'being with' the service user in contrast with the UK approach which is about 'doing to' the service user; this is also achieved within and through a democratic and trusting relationship. ODA demonstrates that clinicians are able to engage with the individual's social network to repair and strengthen supportive and healthy networks within the person's life (Seikkula and Arnkil 2013). However, the question still remains whether such an approach can be transferred to another country in which it can be argued there are more complexities and substantial differences: the population of Western Lapland would equate to one sector of the local UHB yet the UHB area would span 2 square miles, whereas Western Lapland covers approximately

5,000 square miles (albeit 90% of that population live within two towns). This underpins the rationale of undertaking this study at the local level in order to gain this knowledge.

However the reduction in age specific incidence of Schizophrenia (Suvisaari et al 1999) indicates that Western Lapland mental health services have achieved very positive outcomes within their community. The numbers of participants are small within these naturalistic cohort studies but the evidence is strong that something has happened although it is not possible to state that the outcomes are due to ODA interventions. This is because the numbers presenting to the clinics are so low that confounding factors may effect these outcomes (rather than ODA). Therefore to overcome this gap in knowledge there needs to be a continued roll out of ODA within the UK (to increase relevance to local mental health services).

However, there are critics (Mueser 2019, Jauhar et al 2019) who believe that utilising NHS time on a properly untested approach is wasteful and something that should not be considered. Others, such as Lakeman state that although the empirical evidence for ODA is minimal he argues about how important the ODA philosophical approach is within the current UK setting. This he states relates to the recovery oriented approach, individualized care, family work and psychologically driven treatments that ODA appears to absorb all of these examples into its framework that UK mental health services value, have adopted and promulgate (Lakeman 2014). Therefore it could be argued that adopting ODA principles within UK mental health services should be safe because we currently do many of these interventions; albeit this roll out may not be as systematic and consistent as the roll out has been within the structure and framework of ODA. Additionally, there may be unintended consequences in implementing ODA within already established ‘complex’ health systems, therefore conducting this on a small scale may provide beneficial insights into not only the effects of any unintended consequences but also any apparent benefits of ODA.

The benefits of ODA seem to be very strong and consistent for almost 30 years. The evidence demonstrating this has been criticised for not being gold standard and studies are under way to test this with suitably robust methodologies. However, studies such as this work that look at the transferability of the approach into this country are important to add to the knowledge base that is currently growing within the UK. This then became the aim of this study, to look at the experiences of ODA on nurses using the approach and to explore the effects of the approach from their experience. In this way, the study could capture data on whether ODA was transferrable to a Welsh urban setting and if so did it require any ameliorating to fit into the existing culture and health systems.

4. THEORETICAL FRAMEWORK

Within this chapter, I have discussed my theoretical framework that directed this study. Initially, the ontological and epistemological positions are explored to frame the research followed by the theoretical lens used in this study. Finally, this chapter will explore how the theoretical framework fits with both the study's methodology and the work being studied (i.e. ODA).

4.1 ONTOLOGICAL AND EPISTEMOLOGICAL POSITION

Before undertaking this research my ontological position was determinism, which has its roots in Stoics in its theory universal causal determinism (Bobzien 2001). Determinism states that all actions within this universe are as a result of previous actions that have occurred, that is, all past events are directly responsible for the present; this position is rooted in objectivism and materialistic universe. All actions that happened in the past, like the toppling of a row dominoes leads irrevocably towards the future. Although, determinism does not try to simplify the universe in this respect, it is in fact the opposite, a deterministic theoretical lens attempts to view the complexity of such actions and interactions and to embrace this.

The way humans interact with their surroundings and with each other is enormously complex; this is equally true within mental health care. To study such a thing in an empirical way would require an enormous amount of data to undertake successfully. To understand this further a complex systems theory describes and explores the complexity of the systems/ people/ organisation and offers a way of analysing them. A complex systems perspective can offer healthcare staff a theoretical lens through which to view the way in which they, their services and their overall interactions can have profound effects on the complex system that they work in. Hood (2012) uses a complex realist approach that looks at professionals within their complex social systems. Hood bases this on Bhaskar's (1978) description of real causal mechanisms that produce actual events and empirical events. In other words, cause and effect is not linear and a certain cause may produce an unpredictable effect(s); due to the complex systems they lie within. Complex systems are formed from different systems that behave autonomously but are simultaneously linked to each other; this link is described as layered and multi-dimensional, they are rapidly changing and provide feedback to other systems (positive and negative); that is, they act as buffers for the whole system in an attempt to maintain equilibrium – some of these buffering effects are visible and others hidden (Tenbensel 2013). For onlookers from the outside a complex system may appear static and unchanging due to the complex layers of the system. Within a complex system there will be a large number of complex connections that stabilise and support the overall system; destabilising or removing one of these connections or systems could have an unintended consequence on the overall system (Tenbensel 2013).

Complex systems within the NHS are equally complex and adapting to the service changes that are happening through evidence based practice and service restructuring (Holt 2004). The buffering effects by the system towards any change that is implemented can serve to counter act the effects of the change. Therefore, it is essential that all change is planned carefully (use effective networks and relationships - Agyris 1993) in order to avoid this buffering effect and to avoid potential damage to other parts of the system/ service (Tenbensel 2013). Complex systems are said to create wicked problems in that by solving one problem another appears, and in solving the new problem another appears (and so forth) (Hannigan and Coffey 2011). Due to this phenomenon it is vital that clinicians and managers do not attempt to over simplify or use a reductionist approach to tackle a problem encountered but use a whole systems approach to view the services and systems that they work in. Nonetheless, Hood (2012) goes on to state that complex systems alone cannot produce an adequate account, truth or certainty of events as they have unfolded, this is because we cannot possess all of the facts that are linked to the complex system that the event has unfolded out from – this is a combination of causal complexity and social complexity.

As initially stated, my ontological position has moved since the start of this doctorate course from an objective world position to that of a relativistic position i.e. fundamental truth is relative to the viewer and multiple truths can be held at any one time (Hood 2012). Therefore, a qualitative research approach is required to this particular study area that is holistic in that it focuses on wider the aspect of what is being researched (rather than the quantitative that is usually specific to a narrower simplified area). This fits with the research question; that asks ‘what is the experience and perception of nurses of ODA?’ (this will be varied from person to person, therefore a holistic approach is necessitated). Therefore, a more lateral view is required and I have looked at interpretivism and social constructionism as my epistemological position, which is a theory of knowledge from communication theory and sociology about how humans form jointly constructed realities of their surroundings and lives (Fairhurst and Grant 2010).

4.2 THEORETICAL LENS

Social constructionism can be applied to social contexts and proposes that human beings creatively and actively produce society. Social Constructionism is rooted in sociological discourse through Berger and Luckmann (1966). However its roots are traced back to Schultz (a phenomenological sociologist) and William Thomas and the Chicago sociologists. It is also built upon the initial ideas of Durkheim and Mead. Its basic feature is that social order can be viewed as the following:

- Man is a social product
- Society is an objective reality
- Society is a human product

Berger and Luckmann (1966)

The basis of the work for social constructionism was religion, but also deviance explored through labelling theory that was being developed at that time that concluded that deviance was also something that is socially constructed. Social constructionism also places value on communication. Social constructionism fundamentally views the role that language is also socially constructed (and thus not-neutral) and plays a fundamental role in the development of social constructs. In fact language and dialogue are seen not only as the vehicle through which social constructs are created but also as a means through which 'truth' or 'reality' are created (Fairhurst and Grant 2010).

Social constructionism can be contrasted with essentialism because social constructionism questions the social and historical roots of phenomena – in contrast to taking things for granted or the face value of things (Smith 2018). In this way, it has a naturally inquisitive position that fundamentally questions ideas and values and beliefs. Social constructionism is rooted in symbolic interactionism and phenomenology (Fairhurst and Grant 2010).

Social constructionism has been criticised for being seen to ignore the biological effects of nature i.e. it leans very heavily towards the nurture rather than nature argument (Smith 2018). Critics have postulated that due to this social constructionism could have an inherent bias within it, but counter arguments to this have been that objective conditions have been achieved when analysing data (Thibodeaux 2014). However, social constructionism does allow people to cultivate hope that their problems of living are external (socially driven) rather than internal (biological) and as such can be potentially changed and overcome. Sedgwick's (1982) seminal work Psycho Politics advocates a social approach to psychiatry. Sedgwick (1982) criticises anti-psychiatry contemporaries such as Laing, Goffman and Szaz for taking the stance that the individual is separate from society; Sedgwick counters this and purports humans are and make up society; or another way of looking at it is socialisation not medicalisation. Sedgwick (1982) goes further to state that anti-psychiatry has been the politics of nihilism and futility due to the fact that originators offered no practical solutions to their critiques; Sedgwick argued that the practical solution at the time to mental health services was to mobilise political action to make demands on the health service for better services. Today social constructivists may argue that ODA offers a practical solution to today's mental health services by moving them away from the biomedical towards the psychosocial democratic model.

Therefore, the theoretical lens that most naturally evolved and solidified as a conceptual framework for this study was social constructionism/ complex realist lens, because of their ability to balance the complexities of health service and governance along with an acceptance about multiple relativistic truths that are held simultaneously.

4.3 METHODOLOGICAL AND STUDY ALIGNMENT

In the following section, the phenomenological approach is discussed as a solution to this problem of complexity. In order to make sense of the events that unfold and of our perceptions, humans must interpret the world using their previous experiences and their internal frame of reference i.e. if we are exposed to a novel experience or thing we will contextualise it within our previous knowledge. It can be argued that because of the way in which we perceive our world (with our previous experiences) humans are prone to bring in their biases and a nomothetic truth (based on science) is naturally flawed. Therefore, an idiographic truth (based on humanities and cultural aspects) is a more realistic set of knowledge that we can feasibly obtain; especially when dealing with complex systems (Hannigan and Coffey 2011).

Interpretative phenomenology analysis (IPA) uses an idiographic approach, hermeneutics and symbolic interactionism as a philosophy that underpins it and as a distinct methodology (Smith et al 2009). Ontologically, IPA is congruent with a social constructivist view of the world in that knowledge is acquired through our social interactions with others and it attempts to focus, explore and analyse specific phenomena that occur within individuals lives and experiences (Smith et al 2009). Smith et al (2009) also state that IPA because it requires meaning making is similar to narrative analysis. Eatough and Smith (2008) state that IPA is in synchrony with social constructionism which positions historical and sociocultural factors as integral to how humans perceive and understand the world around us and our daily lives; importantly, how we create narratives about our lives and how we share these are integral to this learning process, which give us insight into the world around us (Daiute and Lightfoot 2004). Although, Eatough and Smith (2008) describe IPA lower scale of social constructionism due to the fact that IPA it could be argued takes in a broader view.

The above ontological position is congruent with ODA philosophical stance in that it too has a social constructionist ideology and through therapy attempts to create understanding through dialogue or a narrative. In this way both ODA and IPA are epistemologically similar that they explore and analyse dialogue in an interpretative and idiographic way. However, IPA is by nature phenomenological in that it explores specific phenomenon, and in turn phenomenology is part of the modernist view and the realist view because it attempts to sense make the real world (Finaly 2009, Moran 2000). Finlay (2009) argues that because phenomenology is dynamic and mercurial e.g. thoughts, beliefs and knowledge can change over time therefore coming to a fundamental truth (the modernist agenda) within phenomenology is questionable. Finlay (2009) suggests that in relation to phenomenology, reality and truth are subjective from the individual’s perspective and that of the researcher’s; that is, knowledge and truth is subject to change between the researcher and the subject

Therefore, this study has applied a complex realist lens and used an IPA methodological research approach to study the phenomena of using ODA in a UK setting. As I have described my theoretical position has moved, changed and grown during the course of undertaking this thesis thereby ensuring that my research has engaged new theories in looking for a ‘best fit’ approach to undertake this work.

4.4 SUMMARY

This work has used an idiographic IPA approach that has required the engagement of participants to explore and share their emic (inside) perspective, requiring the coalescing of multiple perspectives to form an understanding of multiple realities explore the phenomena of ODA from the participants’ viewpoint. Epistemological and ontologically this work has engaged with the contextual, qualitative, subjective and dynamic process that is involved in the creation of a shared narrative. Therefore, shared realities were collected and collated during this process which engaged my value system and that of my participants.

Therefore, my ontological position is relativism and within this research I will use a complex systems approach or more specifically a complex realist lens in that I believe we are material creatures that are being influenced by our external and internal environments in numerous and complex ways. However, to understand the complex social systems around us I require a social constructionist lens/ complex realist approach. This will allow the research to be framed within a more informed position, through enabling me to understand my biases and blind spots in the way I analysed the data that has been generated. It is vital that my personal views and research practice were without conflict and were in accord with each other.

This theoretical position and framework have provided me with the tools to explore and visualise the experiences of participants who have used ODA philosophy and has provided insights into the potential effects of this on surrounding areas or services.

5. METHODOLOGY

I have discussed the methodological choices that could have been used within this study and why I chose a qualitative approach and in particular IPA. This study will focus on the relational experiences of n.5 mental health practitioners who have used ODA in their current practice. IPA was a powerful tool to explore what ODA has meant to them and how it has been experienced by them. According to Smith et al (2009) IPA is the most suitable approach to understand how people make sense of their experiences.

The aims and objectives of the study were:

- To explore nurses' experiences when using ODA.
- To explore nurses' perceptions of ODA culture (more empowering of service users) compared to other mental health cultures (medical model led, legislative framework) within a local health board.

5.1 RESEARCH DESIGN

Within this study I realised that the questions I was asking were not necessarily about the outcomes of ODA on patients (which seemed apparently good) but how staff perceived ODA. This seemed a much more interesting perspective because all of the staff had varying length of experiences of working within the UK model of mental health care and had to face a period of adjustment in using ODA – this was congruent with a complex system lens focussing on looking at processes and not necessarily the outcomes. It is a descriptive understanding that is obtained through observation and/ or through discussions (interviews) with the research participants (Creswell 2014, Coffey and Atkinson 1996). This fitted with a qualitative approach which allows the researcher to immerse themselves in narrative data that is rich, deep and varied (but limited to a few participants) as opposed to quantitative approach that has uniform, simple data (but a large cohort of participants) (Creswell 2014, Coffey and Atkinson 1996).

Research participants are immersed in the qualitative research process, especially in IPA where the questions posed by the researcher are fluid and dependent upon the responses of the participants. There is a shared partnership in the journey taken by both participant and the researcher which complemented the research aims of exploration of the participants' thoughts, feelings and perceptions of using ODA (Seikkula and Arnkil 2013). As a researcher I had my own experiences that helped me craft my questions, but I did not have the first-hand experience of using ODA which the participants did, and in sharing their experiences it enabled me to participate with them, through the iterative cycle of IPA and using the double hermeneutic (the researcher interpreting the participants' interpretation of their experiences) (Smith et al 2009). In this way I was able to pay attention to my own feelings as I listened to their accounts and experiences that they shared, thus considering my own position self-reflexively.

5.1.1 CHOICE OF METHODOLOGY

Within the qualitative paradigm there are a number of methods that could have been used which will be discussed now along with the final choice; IPA.

The first methodology I considered was ethnography due to my experiences of being an observer of ODA meetings whilst in Finland. Ethnography originates from sociological and anthropological roots and it involves the researcher studying and immersing themselves into the culture being researched over a prolonged period of time to develop a deeper understanding of that culture and their interactions (Creswell 2014, Hammersley and Atkinson 1995). This observational method of research requires that the researcher is immersed within the culture and the participants. The observed become desensitised over time to the researcher presence as he or she becomes part of the group/ culture, at best forgetting the researcher's presence as outsider; this allows for the observed to behave "normally" and un-self-consciously (Hannigan 2013, Bryman 2012). Therefore, from a cultural perspective ethnography can provide valuable insights here that can highlight how people act within a system or service, even within a therapy. Ethnography could provide a valuable insight into how network meetings evolve and progress between all involved. However, my study aims were to explore the experiences of staff. Ethnography usually only provides the researcher's experience, perceptions and insights rather than directly from the participants through the researcher's own distanced observation. Therefore, it would have been difficult for me to ascertain from an ethnographic approach how clinicians viewed the transition of working in a UK psychiatric system and using ODA in a timely manner. Generating data through this type of study would take a long time, requiring the researcher to immerse themselves in the observed environment for long periods of time. For example, I may have to attend numerous meetings with the clinicians and service users so that all actors are comfortable with my presence there – otherwise if data is used early on my presence may have influenced and changed the dynamic of the meeting. Therefore, this could take up hours of time over many weeks or months for one research cohort, not to mention the ethical questions this may pose due to the prolonged observations of a therapeutic intervention which may be deemed intrusive.

Additionally, despite the obvious ethical constraints of the ethnographic approach I may not necessarily have the insight into how the actors in the room were feeling and what they were thinking. I observed this first hand when I was able to observe ODA clinical interactions whilst I was in Finland; the opportunity as I explained earlier was valuable although I still felt detached from what I had observed. IPA, however, allows the researcher to interact and ask questions of the participants, thereby allowing the researcher to develop a deeper understanding of what the participant has experienced and develop a greater understanding of how the phenomena has affected the person (Bryman 2012).

The phenomenological approach provides the researcher with a deeper insight into the shared phenomenon, which in this study is the ODA process. We can assume that these staff may have many shared experiences in using the ODA intervention which on paper looks very different to ‘ordinary’ psychiatric services, for example, principles of tolerance of uncertainty, social approach within network meetings. The use of IPA attempted to ascertain why certain experiences are so profound, for example, the learning and support required by staff and the differences between local psychiatric service cultures.

It became very clear that this study was about phenomena and an experience of the participants, to explore and study what was common to all participants. The use of phenomenological approach was the obvious choice to me during this process of exploration. There are many styles of the phenomenological approach (Spiegelberg 1994).

However, Dowling (2007) describes three firm areas of phenomenology:

1/ Descriptive phenomenology by Husserl – which aims to describe the phenomenon (not used in this study)
2/ Hermeneutic Phenomenology by Heidegger and Gadamer – which aims to interpret the phenomenon
3/ Dutch School by van Manen – a combination of the first two areas (not used in this study)

Phenomenology is the science of studying anything within the human world. This research aims to provide deeper understanding of these phenomena. Phenomenology is the philosophical study of consciousness and experience and provides a methodological framework for researchers to use (Smith et al 2009). It requires that the participants have experienced the phenomena e.g. in this study all of the clinicians have run and participated in ODA network meetings over a number of years, and through this it elicits from those participants meaning from their experiences. Its method is to interview participants on a one to one basis, usually through a semi structured informal interview that is transcribed and then analysed by the researcher (Smith et al 2009). Phenomenology was started as a movement by Husserl who wrote that no phenomena can be observed, apart from through another human’s consciousness or mind – the lived experience is synonymous with his work (Husserl 1998). Interestingly in a similar way to my ontological progression Husserl had become frustrated that the scientific method (or quantitative approach) could provide all the answers to the human experience (Smith et al 2009). Therefore, phenomenology aimed to derive a deeper understanding of human lived experience and attempts to search for meanings and the essence of life (Husserl 1998)

As previously stated Husserl believed that in order to successfully achieve a phenomenological study researchers had to bracket their previous experiences so as not to hinder the process of understanding the phenomena’s essence (eidos) (Smith et al 2009). A more specific interpretation of this is that the researcher should bracket their experiences of the phenomena being investigated e.g. I would have to bracket my experience and knowledge of ODA, thereby not use my teaching experiences or my first-hand experience of seeing ODA in practice in Finland. This it could be argued is achievable on a superficial level i.e. I could not write about my experiences openly and I could try to avoid thinking about my experiences when interpreting the data; however, on at least a subconscious level (if not on a conscious level too) this experience would influence me.

Phenomenology is an ever changing and developing approach in that it has been interpreted and used by researchers in different ways (Smith et al 2009). For example, the use of bracketing is controversial with researchers. Husserl would advocate bracketing, where the researcher would as much as possible remove their prejudices and biases from the research process in order to not influence the outcomes. However, Heidegger rejected this, stating that it was impossible for researchers to remove themselves from the entire process and thereby not influence it with their own experiences (Smith et al 2009, Cohen and Omery 1994).

Therefore, Heidegger moved on from Husserl's descriptive phenomenology and embraced the fact that humans cannot dissociate themselves from their research and that they must embrace it. In this regard Heidegger proposed that lived experience or phenomena required the researcher to interpret this rather just describe this as Husserl would have advocated – which some researchers would argue is superficial. This branch of phenomenology is known as hermeneutic because of its reliance on interpretation (Smith et al 2009). In addition, interpretative phenomenology in contrast to descriptive phenomenology discounts the possibility of the researcher being able to bracket their experience or past knowledge. Gadamer views Heidegger's interpretative phenomenology as comprising of the following elements:

Universality – this is where the participant and researcher share a human consciousness that ensures there is an ability for common understanding and an empathic response from both parties.
Prejudgment – Gadamer believes that prejudgement, that could imply bias and prejudice is actually a positive position to adopt in interpretative phenomenology.

Within interpretative phenomenology past knowledge is see as critical in being able to interpret new phenomenon (Smith et al 2009). Therefore, within this approach bias or prejudice cannot be removed from the study, as the study requires this level of presupposition and forethought. Gadamer's interpretation of interpretative phenomenology revolved around the use of dialogue to develop understanding between individuals (Malpas and Zabala 2010). This is similar to ODA philosophy where clinicians and service users have a dialogue where they listen and learn from each other's opinions and they develop this mutual learning in an iterative exchange between each other.

From this philosophy Smith et al (2009) created a methodological process for the researcher to follow – Interpretative Phenomenological Analysis (IPA). IPA is derived from phenomenology, hermeneutics and symbolic interactionism (Denzin and Lincoln 2011). As previously mentioned phenomenology is the exploration of experience and phenomena and hermeneutics involves the act of interpretation. Symbolic interactionism is concerned with the individual meanings created through interpretation Smith et al (2009). IPA attempts to gain a deeper understanding of the human experience, which makes it a good tool to use in the healthcare setting (Smith et al 2009).

According to Smith et al (2009) the key features of IPA are:
Interpretative – researcher and participant are making sense of what they are and have perceived – sense making.
Phenomenological – lived experience – individual perception
Analysis – Smith et al (2009) provides the researcher with an analytical framework to follow.

In this way through the double hermeneutic IPA ensures that meaning is attributed to the participants' perspective via researcher attributing meaning (the double hermeneutic) (Smith et al 2009). Therefore, phenomenology can help to understand people's meanings and adjust to new ideas as they emerge in the data, which can be seen as natural data rather than artificial. Although the drawback is that gathering the data and its analysis (which is complex) can take a significant amount of time. Also the evidence may be regarded by policy makers as low value due to the low numbers of research participants and generalisability (to use a quantitative phrase) which they value most (Giorgi 2012). However, phenomenological studies provide an indication for the direction in which further research or policies need to go.

To summarise phenomenology is not a singular entity or approach, over the decades, researchers have brought their own nuanced ways that have added to or moved the approach on. However, at the core of phenomenology is the exploration of experiences, thinking and feelings that people have perceived within their lives, and the phenomenological researcher has the role of extracting and capturing these perceptions from others. In order to do this, partnerships/ relationships are built up with those participants. In a similar way, the clinician and service user undertake a similar role within ODA meetings and therefore it seems natural and prudent for this study to undertake a phenomenological approach because of this mirroring and shared approach by both study and phenomenon. Nevertheless, perhaps most vitally, phenomenology has allowed me to become immersed in the process and engaged with the participants in order to best answer the research question.

5.1.2 RATIONALE FOR CHOOSING IPA

I chose IPA due to the fact it embraced an explorative design that was also flexible. IPA is theory bound to epistemological roots of phenomenology and provides a structured approach to analysis (Braun & Clarke 2006).

Phenomenology was used as the qualitative approach to study the questions raised, and IPA is the chosen phenomenological method (Smith et al 2009) because it was in accord with the study question and aims. According to Brocki and Wearden (2006) IPA takes descriptive analysis into the interpretative domain and they advocate it as an approach that can be used in healthcare; although they warn of the dangers in not interpreting the data deeply enough and providing a full analysis within the studies. Therefore, recent studies have attempted to engage more fully the participants' experience and vary the way in which researchers interpret, sense make and think about the data in front of them (Smith et al 2009).

IPA requires an interpretative insight into the phenomena in question. Within this study I wanted to explore how staff felt when using ODA for the first time and how this impacted upon them when compared to the historical way they had been working. This reflected issues that could be challenging for mental health nurses working in the UK as it would raise questions about professionalism, risk, authority and therapeutic intervention. It requires that the researcher is interrogative with the participants (in an enabling way) and also requires a similar application with the analysis – critical thinking must be employed to delve deeply into the data; the interviews I conducted focussed on significant professional issues for the participants and at times moved into the personal (due to their fears being exposed and an uncertainty about how much of themselves that they should share with service users). IPA approach also allowed me to identify the shared experiences and collate similar or contrasting views about these experiences (Smith et al 2009). The interview is also conducted ensuring that there is a more equitable relationship between the researcher and participant where it is expected that the participant will contribute jointly to the input of the data i.e. the participant and researcher will lead the dialogue together.

IPA is similar to qualitative content analysis where inferred and hidden information is uncovered and made explicit (Neuendorf 2017). The potential conflicts that this could raise required an approach that would be able to explore culture, beliefs, fears, hopes and personal backgrounds (Heidegger et al 2010). IPA also provided me with a structure to follow that allowed for a full exploration of the topic area and uses the iterative process to undertake this analysis (Smith et al 2009).

Due to the researcher being immersed in the data (i.e. the participant's subjective beliefs/ perceptions) it is acknowledged that the approach lacks objective reality (Smith et al 2009). The analysis, as previously described is a three-way interaction between the participants, the phenomena/ world and the researcher. The researcher is inextricably linked to the research and therefore a process of reflexivity will be discussed in the next chapter to outline this link and make it explicit within the study.

The IPA framework allows for the capture of life experiences and when these experiences are shared can be compared and contrasted to obtain new understandings such as that of using ODA within a UK setting.

6. METHOD

The aim of this doctoral study was to explore how ODA has been experienced by mental health nurses within a local health board. The experiences of these individuals is personal to them, but they have shared their thoughts and feelings about what they were exposed to whilst working in this approach from Finland. Due to the novelty of this approach in the UK clinicians' personal experience of ODA and its impact on their perceptions is under-represented in research literature. Therefore, it is arguably a valid topic to study within a doctoral research programme to develop this knowledge.

A qualitative approach using IPA method was deemed the most effective in obtaining information to address the research question and study aims. This is because IPA as detailed in the previous chapter enables the researcher and participants to make sense of their world through interpretative analysis. This was done through the generation of themes; meanings can then be established and constructed through the participants' perceptions and experiences with using ODA, the use of dialogues and the perceptions they have on the therapeutic relationships and the experiences of the service users.

6.1 THE RESEARCH QUESTION

The research question is fundamental to all research (Burns and Grove 2009). IPA research questions aim to explore in a flexible way the views and perceptions of individuals in relation to a phenomena close to them (Smith et al 2009). Therefore, this study research question was as follows:

What was the experience of mental health nurses in an inpatient and outpatient setting of using Open Dialogue Approach following its implementation in a local mental health clinical board?

6.2 OBJECTIVES

The objectives of the study were:

- To explore nurses' experiences when using ODA.
- To explore nurses' perceptions of ODA culture (more empowering of service users) compared to other mental health cultures (medical model led, legislative framework) within a local health board.
- To explore nurses' perceptions on the implementation of ODA as a values based therapeutic approach and their perception of utility gained by it for service users and their families.
- Generate ideas for service provision and implementation for future practice.

The central purpose or question of this thesis seeks to explore how participants make sense of their experiences (Denzin and Lincoln 2011). The aim is to engage and explore the meaning behind their experiences, action, interactions and unforeseen phenomena that clinicians perceived when working using open dialogue approach within a health setting. Additionally, it aims to develop an understanding through empathic exploration of their thoughts and feelings. The method used in the study required a deep understanding and insights into the participants' experiences of using ODA and its potential impact on their internal thoughts and feelings. If this was simply a descriptive account of ODA then a phenomenological approach could have been used, however a deeper more interpretative approach was required. Additionally, this study sought to deepen the clinicians' understanding of their experiences and therefore required a more interpretative/ contextual approach and as such IPA was deemed the most appropriate methodology.

As previously stated IPA aims to achieve congruence between the two positions of hermeneutics and phenomenology. Together these positions ensure that an in-depth approach is taken to explore the lived experiences of participants and their sense making of these events.

Therefore, using a complex realist lens, a qualitative research paradigm has been adopted by the researcher in order to capture and provide a depth of answers to the above research aim and objectives. Qualitative research is flexible and elastic and is capable of adjusting to what is being learned during the collection of the data (Bourgeault et al 2010).

Truthfulness of participants is trusted within qualitative research; their information is accepted as their truth – unless there is compelling evidence of the contrary. For example, in my data I had to examine if some answers were given in response to the nature of my role as a senior manager i.e. were they compelled to answer in a given way or was there a subtext to what was said as to shroud the truth (whether they were conscious of this is unknown) – this naturally generates thinking around power dynamics. However, interpretative approach states that there is no truth just perspectives of perceived truth (Creswell 2014, Coffey and Atkinson 1996). Interestingly qualitative research aims to reduce the power imbalance between researcher and the participants, emphasising the value of language and the need for reflexivity on behalf of the researcher (Creswell 2014, Coffey and Atkinson 1996) – positions which mirror the underlying philosophies of ODA.

The drawback to qualitative research argued by the quantitative researchers is that the data gleaned cannot be generalised with the degree of certainty as offered by the quantitative approach. However, qualitative research does offer up transferability meaning that theoretical insights gained may be shared to other areas. The work will develop a deeper and richer understanding of the current system or service that is being looked at.

The IPA approach may provide the researcher with a deeper insight into the scenarios that all relate to a shared phenomenon. However, there may also be contradictory experiences, for example, their interface with clinicians, family and friend support and other community resources. This approach could attempt to ascertain why certain experiences are so profound.

6.3 RESEARCH DESIGN

IPA is a method of analysis that has a flexible, theoretical and exact methodological process for the researcher to follow (Smith et al 2009). Therefore, as a doctoral student and a novice I welcomed the fact that I had a set formula to follow – which initially seemed a simple route to take. However, IPA is and was a challenging methodological approach because of the relationship the researcher has with the participants (from them being interviewed) through the double hermeneutic. Without this I could have hidden myself away from the material through bracketing myself or perhaps I could have used a quantitative route that again would have shielded me. However, by being immersed in this way I had to question myself at each step to evaluate how I was influencing and being influenced by the experience the participant and my own past. In this way I had to capture this data to ensure that it was not lost i.e. not only was I collecting information about the participants but also about myself, as the researcher is a legitimate participant within IPA. In this way IPA exposes the researcher as much as it exposes the participants being researched so that the researcher becomes an intrinsic component of the material being researched. IPA, as previously stated, embraces the researcher's own views as well as professional and personal backgrounds (Willig & Rogers 2017) – the participants' perceptions are presented through the distorted and refracted lens of the researcher within IPA (Gambling and Long 2012, Brocki and Wearden 2006).

6.3.1 REFLEXIVITY

According to Elo et al (2014) being reflective provides trustworthiness to the qualitative process and by systematically evaluating at each stage increases self-awareness when analysing the data. Reflexivity involves reflecting on the impact of the researcher and recognising that you are part of the research process (Yardley 2000). It is important to be open and transparent about personal beliefs through a process of self-reflexivity.

Within the study I have demonstrated my beliefs and how these may have led to the interpretations that were developed within the work. In particular, it is important that during my reflexivity there needed to be an exploration of the power imbalance between myself and the participants and how this may have affected the answers given. It was important, if not vital, that the way in which I imparted knowledge to the participants of the approach was to remain and be impartial and did not bias participants' answers e.g. if I expressed a view that ODA is beneficial then the participants may feel that they needed to express this view as well, in part because the researcher was also their senior manager. Similarly, they may have wanted to take the opposite view to me to show their stance against me for some reason. Therefore, it was important that my views were not part of this work.

The researcher is inextricably linked in this process and as such it became a valid tool/ approach for me to use because I have years of experience about ODA through training (conferences – through being taught and teaching others), research and benchmarking (visit to Finland). I believe these factors to be particularly important because as a mental health nurse I therefore have preconceptions and ideas about what ODA, although importantly this is not based on clinical experience: I am not trained in nor have I delivered ODA, though I have read about it and observed network meetings first-hand. Therefore, I am connected to ODA but in a different way to the participants. I could not discount this experience, but rather engage with it and use it as part of my research – in this way it could be argued that the researcher becomes part of the research and a participant in his or her own right; but importantly IPA acknowledges that the researcher does have this profound influence on the findings (Smith et al 2009). Therefore, my experiences and beliefs will need to be explored so that their influence are not lost and are recognised as having some impact, because it is as a result of me belonging to this world and engaging/ sharing my experiences (consciously and subconsciously)/ my interpretations with my participants that the data was generated, analysed and conclusions reached.

There are three things that I want to share in this part of the thesis. Firstly, my theoretical engagement with ODA, secondly my practical engagement with it and finally my role as a researcher and a service manager in the area that I have researched.

6.3.1.1 THEORETICAL ENGAGEMENT

I have been engaged with ODA for many years. I first became aware of ODA in 2012 as I completed my MSc before beginning my doctorate. A work colleague approached me to obtain authorisation to attend a course on the principles of ODA to which I agreed. Upon his return from this study leave he began holding teaching sessions on this mental health model from Finland and shared this information with me. I was struck by how different the model appeared to be in comparison with our own in the UK and I was struck by how engaging it appeared to be especially for people who were developing mental illness (early intervention in psychosis was my prime focus at that time).

I then began reading more about ODA and as I engaged with the written material I realised that this approach could be used in the UK without compromising the care of our service users. Staff within the local health board had begun using the techniques by the end of 2012 through a mixture of teaching sessions, written materials and practical experience; the anecdotal reports from these were very encouraging. The mental health directorate and clinical board fully supported the use of this approach with their service users.

Therefore in summary my knowledge of ODA has been growing since 2012 and I would have found it very difficult to put this knowledge to one side or compartmentalise it whilst undertaking this study, therefore IPA has been invaluable in this process as it has allowed me to keep engaging with the material in a reflective and critical manner; after reading the positive effects upon patients it would be difficult for anyone not to think 'I hope ODA does work' however, I had to be mindful that ODA could have been inappropriate, or not a suitable fit, for service users within the UK and therefore balanced my thoughts with the sceptical critical thinking necessary to produce a study that was valid.

6.3.1.2 PRACTICAL ENGAGEMENT

In 2013 I applied for a travel scholarship through the Florence Nightingale Foundation and was fortunate to receive this to explore early intervention in psychosis strategies from across the world. I made my plans by early 2014 and then set out to visit Melbourne's early intervention in psychosis services in August followed by Tornio, Finland in October. Both visits were very informative but the Finnish experience was very different. In Melbourne despite having different ways of working and well-resourced service there was something very familiar about it, something akin to the UK psychiatric services. However, the model in Tornio was completely different, relaxed although responsive, service user focussed but not risk averse. The service was inclusive and open (to families and wider social network), although deeply respectful of service user confidentiality. It seemed the opposite of the majority of my experience within UK mental health care. ODA appeared to me to be a refreshing way to provide a mental health service. At this point I endeavoured to focus my thesis upon ODA. I was uplifted by some of the positive research outcomes that had emerged from its use in Finland over the last 25 years or so, but I was also guarded by how easily this work could transfer to the UK setting; in that it may not fit within a UK psychiatric cultural model (staff concerns, legislative problems, professional concerns) and that the problems psychiatric patients face in the UK are fundamentally different in the UK (drug problems, alcohol issues, support issues - divided families, large uncaring communities, less social support).

My reflections on my Finland experience were as follows:

ODA service as a system –

1. Is one that is both simple and complex
2. Requires resources (2 x staff/ network meeting)
3. Requires education/ training

Simple:
Open referrals
Service user led
No planning or conversation without the service user
No bureaucracy
Minimal paperwork

Complex:
Training required

Experience required
Networks – fostering links with other people
(Difficult and emotive meetings/ mediation type meetings e.g. employers)

Resources required:
Two staff required
All qualified
Medical time protected
No routine outpatients

Education:
1-year ODA training
3-year family therapy

ODA is not the end of 1:1 care. The ODA meetings are the core of a person's journey through mental health services. They may get all the therapy they require in ODA meetings or they may require other specialised therapy that can be brokered/ requested/ referred onto from the meetings.

In February 2015 I attended a conference in London on ODA and following this I ran 3 workshops on ODA in June that year. The workshops that I taught on were information sharing sessions and they were evaluated by the attendees. Therefore, to summarise my practical engagement with ODA has been that of an observer, a student and a teacher. I have no direct knowledge using ODA as a practitioner/ clinician. Although I am trained in cognitive behavioural therapy (CBT) and family work I have not utilised the principles or key elements of ODA unlike the practitioners that were interviewed in this study. Again I have to emphasise that during my teaching sessions I was mindful to provide the attendees with a balanced view of ODA and I believe that I achieved this because the audience were at times frustrated that this approach was not being rolled out nationally. However, I brought them back to the evidence base and the need to generate evidence within this country. This was also evidenced in the evaluation forms that were returned; therefore, I believe that I was able to provide a balanced and careful description of the potential benefits of ODA despite being hopeful that the approach will work in this country.

6.3.1.3 ROLE AS A RESEARCHER AND A SERVICE MANAGER

As a manager investigating the experiences of my staff, I realised that I may have a profound influence on how the participants reacted to me and the information they may want to share with me i.e. they may want to tell me what they think that I want to hear or they may feel that they need to elaborate on their experiences in order to expedite an outcome due to the fact I may have some authority to control this, e.g. if the member of staff did not believe ODA was a positive approach they may exaggerate the negative aspects of this and under report the positive aspects. However, Smith et al (2009) states that this influence and my experiences are essential parts of the IPA process in order to make sense of the participant's perceptions; being explicit and reflective about my role and relationship with the participants along with my experiences are integral to this process and form part of the analysis affecting how I interpret their perceptions/ world view.

As previously mentioned the area that I manage is where ODA has been utilised. In mid-2016 I began to collect my data for this thesis from the research participants. This was following a consenting period where clinicians were approached in writing and if they did not contact me then no further follow up was done. All those contacted agreed to participate apart from one member of staff. I spoke to them verbally at this point and reassured them that this was not compulsory and that I was not doing this as the manager of the service but rather as a researcher. They all agreed and we proceeded to arrange dates. I had not discussed ODA with any of the staff within my service. I felt that this was important so as not to influence what they may say about it i.e. if I was a critic of ODA they may feel obliged to criticise and vice versa. When the interviews took place (discussed in subchapter 6.3.4) I ensured I wore more casual clothes so as to emphasise my different role at that time. At the beginning of the interviews I further reassured the participants that there were no right and wrong answers to my questions I just wanted to capture their thoughts, feelings and opinions on the matter. However, due to ethical limitations I was compelled as a manager to explain that if something was raised that gave cause for clinical concern then I would have to follow this up. It felt uncomfortable doing this because I was suddenly the manager again in the room but this (I felt) quickly dissipated and the interviews proceeded in a more relaxed fashion.

6.3.1.4 REFEXIVITY SUMMARY

My experience of ODA is varied and in depth. In other words, I am personally biased towards the approach especially since the team have garnered such positive individual outcomes about the approach. However, if anything this belief in ODA has only emboldened me to be more critical of the approach. I would like the approach to be successful in the UK, because it may have benefits and mean significant changes to mental health service users, but for that exact reason the approach would be useless unless it can have those effects on service users. This work explores whether clinicians indoctrinated in a UK psychiatric culture believe that ODA could work and what they perceived those barriers to be in their work establishment. Therefore, as a researcher I have strived to carefully question and critique all the thoughts (from myself and participants) and themes that have unfolded on this journey.

6.3.2 SAMPLING

IPA embraces the fact that researchers are required put themselves into the research. It acknowledges that the researcher cannot put aside their beliefs and previous experiences; if the researcher is to truly empathise with the participant and interpret the participant's experiences then the researcher requires their previous experience in order to do this successfully (Smith et al 2009). It uses small sample sizes due to the data rich element of the study, otherwise (as previously discussed in chapter 4) the complexity and variability of the data collected could not be collated and analysed in a timely or feasible way. Therefore, the compromise of smaller samples ensures that IPA studies are feasible (Smith et al 2009). IPA allowed me to undertake a study that was data rich and required a robust analysis to interrogate the data.

Within this study a small sample size was used of 5 participants so that the depth of interviews is large and rich from the individuals who have participated. Finally, the sample must be purposive and homogenous in order to have a sample that have similar (but not exact) experiences that can be compared and contrasted in order to develop themes and learning from their shared experience (Smith et al, 2009); therefore, all participants were users of ODA.

6.3.3 RECRUITMENT

Mental health practitioners working in an NHS mental health rehabilitation and recovery service who use open dialogue approach were provided by post with a summary of the research protocol (appendix C), so that they were aware of what taking part would involve. This information was sent to them by an administrator via an email rather than by myself to reduce any perceived pressure they may have had if it had come from me.

The Participant Information Sheet contained my contact details, and invited the recipient to make contact if they wanted to take part. Potential participants were given one month to decide whether they wanted to engage with the study. If I did not hear from them after this time I presumed that they did not want to engage. As participants work within the local health board and I am a senior manager within that health board, participants were not contacted directly by me in order to avoid perceptions of pressure to participate being put upon them. The participants were in control of initiating contact if interested; i.e. if they did not contact me then further contact was not made. On making contact, participants were asked if they would like any further information, or if they were happy to arrange a meeting to go through the consent form (appendix D) and be interviewed.

6.3.3.1 INCLUSION AND EXCLUSION CRITERIA

Participants had to be clinicians working in a local health board in the mental health board who had used open dialogue approach (and have been provided with ODA training or experiential learning with an experienced ODA clinician). They could be any profession and have any length of service or experience was not relevant. However, all staff/ participants had to be qualified professionals which is in line with Finnish health professionals who deliver ODA (Seikkula and Arnkil 2013). It was envisaged that these criteria provided a purposive sampling pool that contained enough individuals to make recruitment of a sufficient sample size likely.

It is interesting here to talk about fidelity to the Open Dialogue Approach. For example, what adherence did the participants have with the 7 principles:

1. *provision of immediate help* – All participants complied with this
2. *a social network perspective* – All participants complied with this
3. *flexibility and mobility* — All participants complied with this
4. *responsibility* — All participants complied with this
5. *psychological continuity* — All participants complied with this
6. *tolerance of uncertainty* — This principle was adhered to in most part but caused significant concern to participants (which will be explored later)
7. *dialogism* — All participants complied with this

At the start of the study there were 6 members of staff who fulfilled the criteria and it was hoped that they would all participate. However, not all the staff chose to participate within this study and that choice was respected and honoured; the final recruitment was 5.

6.3.3.2 PARTICIPANTS

The data obtained was about the experiences of staff who have been using Open Dialogue Approach for 18months to 2 years. The reason for this length of time was due to the fact I wanted to capture the lived experience of participant in alignment with IPA that requires the person's lived experience to be captured. In fact, it was an error to put of the participant sheet 3hrs of clinical time due to the fact the approach requires much deeper immersion in the experience; it was fortunate that ethics approval was delayed for up to one year as this meant the participants gained extra time working with ODA and developing that experience. Within the below table is an over view of the research participants' names (all changed for pseudonyms), professions, current work positions, length of experience (discussed in findings and discussion chapter re anxiety due to being professionally exposed) and the education/ training they have had:

Name	**Profession**	**Seniority**	**Experience**	**Psychosocial interventions training**	**Family Work training**
Rachel	Mental Health Nurse	Manager	>20 years' experience	Yes	Yes
Collette	Mental Health Nurse	Clinician	<10 years' experience	Yes	No
Mike	Mental Health Nurse	Manager	<10 years' experience	Yes	No
Patrick	Mental Health Nurse	Clinician	<10 years' experience	No	No
Heather	Mental Health Nurse	Clinician	>20 years' experience	Yes	Yes

All the participants who chose to be involved in this work were nurses and in senior positions within their services.

6.3.4 DATA GENERATION

This research used a qualitative approach and specifically the methodology was interpretative phenomenological approach - the shared experience of these people (interpreted and reacted to in various ways) was explored and cross-analysed (Creswell 2014, Polit and Beck 2009). Therefore, this informed the how the data was collected which in this instance was through interviews captured in transcripts (Creswell 2014, Coffey and Atkinson 1996). In total five interviews were conducted over a two-month period. The interviews were of 45minutes to an hour in duration and the data obtained was very rich and diverse – each transcript was between circa 7,000 to 10,000 word counts. The interviews conducted were semi structured in that some questions were already prepared (see appendix E). However, because of the semi-structured nature of the interviews more information was gleaned from the participants when they raised interesting points that required further exploration. This was informed by relevant literature and guidance on interview development sought through published literature (see previous) and undertaking a visit to Finland to view first-hand how the mental health teams worked using ODA. The itinerary was used flexibly, in order to allow probing of unanticipated areas that emerged. Therefore, the interview was guided by the interview schedule and not dictated by it to allow flexibility.

IPA can use a variety of data generation methods such as diaries and focus groups (Smith et al 2009). However, the most commonly used method and the one used in this study is the use of a semi-structured interview; the semi-structured interview allows the researcher to come to the interview with some questions prepared but allows the researcher to veer off script if what the participants are saying is of interest and requires further inquiry (Smith et al 2009). IPA also allows flexibility for follow up interviews to clarify responses or ask further questions that may have come to light in other interviews.

Those who chose to participate were able to choose the venue of the interview; their own clinical environment or another venue outside of their clinical environment – between us we ensured a room was booked so that we would not be disturbed for the duration of the interview. Semi-structured interviews were employed, which were audio-recorded, transcribed verbatim, and then analysed using IPA; I always checked before recording that the participants were happy with this. Interviews lasted between 45 minutes to 64 minutes.

I used an empathic (non-challenging) method when interviewing participants in order to facilitate a relaxed and comfortable exchange that encouraged dialogue (Denzin 2009). I used techniques I learned from being a mental health nurse to elicit information from my participants in a non-threatening way, but that would also challenge their perceptions and make the familiar unfamiliar, as suggested by Smith et al (2009). Following the interviews, field notes were made to start the reflective process and begin analysis as well as recording any non-verbal communication that occurred during the interviews. The interviews were then transcribed to enable a full engagement with the data, and to develop an interpretative relationship with the data. These non-verbal additional communications were captured using square brackets e.g. [pauses], to emphasise what was happening in the text. Additionally, ellipses were used to denote the removal of any irrelevant text. This allowed immersion into the participant’s stories which arguably helped capture the meanings and essence of what the participants’ were trying to communicate to me. It was important that leading questions were not used as this may have led the participants from what they were thinking and thereby lost something from the data/ research (Smith et al 2009).

Within the first interview I realised that I was nodding and smiling encouragingly during one of my first questions and this could have been a mixture of nervousness and relief that my questions were eliciting full responses. Throughout the process I had to remain mindful that this non-verbal feedback could influence the participant especially within my role as a senior manager within the service; participants may feel compelled or obliged to agree with me and provide responses that they think that I may want to hear (Smith et al 2009). Therefore, I became mindful following this initial event that during the interviews I would attempt to remain impartial in the way that I verbalised my questions along with ensuring that my non-verbal communication was similarly impartial. The first task after completing the interviews was to transcribe the audio recordings into word processing formats so that they could be analysed. The interviews were collected, transcribed and a preliminary analysis performed before the next interview was conducted, in this way subsequent interviews could be undertaken to pursue themes that may have arisen in previous interviews, to either support them or would detract from them.

6.3.5 DATA ANALYSIS

As detailed above Interpretative Phenomenological Analysis (IPA) (Smith & Osborn 2003; Smith et al 2009) was the approach used to analyse the data. I then engaged with the recorded interviews following transcription to begin to realise and develop themes, and then achieve an interpretation of the experiences (Smith et al 2009). I ensured that my transcripts were read with a critical thinking in mind, and ideographically subjective with the specific phenomena. Interpretation is based solely on the data elicited and expressed by the participants in their interview. 'To make sense of the participant trying to make sense of what is happening to them' (Smith et al, 2009:3) was then the role I employed to analyse the data. This was done through immersion into the data by coding line by line, looking for emergent themes which were then grouped together (Appendix F,G & H). Once these emergent sub-themes were identified and a discussion was had with the supervising team to explore and reflect on their relevance to the data and research aims. Those which did not meet the aims were discarded; others went on to form and support the emergent themes and superordinate theme. This was done using an idiographic approach and identifying themes mechanically using word processing packages to manually highlight and note themes.

Smith and Osborn (2003) states that IPA is very flexible in that the researcher must constantly engage iteratively and repeatedly with the data to facilitate the analysis. According to Smith et al (2009) the analysis within IPA begins during the interview process, here the researcher first hears and listens to what is communicated and begins to start understanding the meaning behind the words and tones used by the participants. However, this is only the beginning as the researcher will repeatedly re-immerse him or herself with this data after this initial event to gain greater understanding through an iterative process. Only by going back over the interviews with gained knowledge can the researcher begin to look at the data from multiple points of view and extract further meaning from it.

During this process further supervision was gained from researchers with experience of qualitative methods, and at using IPA. The analytic process was informed by guidelines for ensuring quality in qualitative research (Bourgeault et al 2010, Smith et al 2009). Supervision was vital during this process to ensure that I was being unbiased and using multiple perspectives to view that data.

6.3.5.1 INDIVIDUAL CASE ANALYSIS

To ensure that I maintained fidelity with IPA, each interview was analysed in-depth individually (Smith et al 2009, Gambling and Long 2012). Each recording was listened back to at least once, and the transcript read several times. Initial annotations were made in the margin, with comments describing initial thoughts about the content, language used and initial concepts (Smith et al 2009) (Appendix G).

Qualitative analysis requires that the researcher immerse him or herself in the data collected, therefore the approach taken to analyse the data was through a variety of different methods to gain different perspectives and attribute meaning and obtain further understanding of the interviews (Symon and Cassell 1998, Creswell 2014). The transcripts were in written format, and according to Knapp et al (2013) words make up 10-20% communication when people talk to each other (i.e. 80-90% is made through tones, utterances and non-verbal communication such as body language). It was important to be immersed in the data and in order to achieve this, the following stages of analysis were used:

Stage 1 - Reading

1 – Being immersed in the recordings through repeatedly reading and re-listening to the transcripts in order to hear the intonations and feelings behind the words.

When I began my analysis of my transcripts I found the idea daunting, i.e. trying to make sense of 10,000 words therefore I reverted back to my tried and tested method of searching for words (and counting them) to start making sense of it and begin to find or guess at potential themes, this is evidenced in ***appendix F****. This method provided me with some assurance and helped me breakdown the analytical journey that was ahead of me, but in reality it was very hit and miss in that words taken out of context were not as useful as seeing those words mixed in with their sentences and paragraphs – only by immersing myself fully with the data (with the dialogue) did I begin to find the themes that were there. Some words may have occurred many times and seemed significant but when put into context came to nothing, whilst others that occurred once or twice resonated with themes*.

2 – General reading of the transcripts without pausing to take notes, in order to remain focused on the flow of conversation and interactions between the interviewer and the participants.

Each transcript was read and a margin used to note codes/ words that were meaningful, drawing on both the transcript and the initial analyses, this is evidenced in ***appendix G.*** *Each interview was analysed in this way until all of the interviews were analysed.*

Stage 2 – Descriptive Codes

3 – The next technique I used to immerse myself in the actual contents of the transcripts was to breakdown each transcript line by line and look for certain direction of conversation, utterances or pauses used by the participants.

This allowed me to get another feel for the transcripts about where the story was going, or begin to highlight some initial ideas from the body of the text, this is evidenced in ***appendix G.***

Stage 3 - Themes

4 – Following this, a second full reading of transcripts was done to build up a picture of the codes and where they came up in the transcripts; further building on my understanding from step 3. It also allowed me to discard some codes due to ambiguity or the meaning being misinterpreted. At this point I made notes in the right hand column of the transcripts and began to develop themes from the data.

5 – The transcripts were then re-read without my (the interviewer) comments (i.e. questions and interaction).

*I did this so that I could just 'hear the voices' of the participants alone and to further attribute meaning and sense of what they were imparting within the interview. Further notes were then inserted into first column, this is evidenced in **appendix G**.*

6 – Finally I did a full transcript read through, I looked at the transcripts lists and I also read through the notes I had previously made.

*A second column was constructed to begin to create an overarching theme and I captured these concepts into a tabular form to view more easily, this is evidenced in **appendix G and H**.*

I used the following processes to achieve this:

- *Abstraction – to look at the relationship between themes*
- *Subsumption – an emergent theme takes on superordinate theme when it takes on other themes to support it e.g. power*
- *Polarisation – finding themes that are oppositional e.g. barriers vs impact, impact vs learning, learning vs barriers*

(Smith et al 2009)

By this time the interviews were very familiar to me and I was able to remember how the participants conveyed their speech and emotions to me. I also remembered how I had immersed myself into their perspectives and imagined through an empathic approach what they had experienced in the scenarios that they had imparted to me. In this way, I was able to imagine how all the people in the scenarios depicted felt and thought. It is vital that the data within the transcripts is respected and not digressed from or any gaps in the data is filled in with any assumptions, but rather provide suggestions of what may be going on, which can be researched in more depth within further studies.

6.3.5.2 EMERGENT THEMES

Emergent themes were listed chronologically and formed into clusters of related themes (Appendix G). Smith et al (2009) describe how superordinate themes can be identified through abstraction (amalgamating similar themes and developing a new name for the cluster); subsumption (where an emergent theme is described as a major theme that becomes superordinate theme that draws other related themes towards it); contextualization (identifying the contextual elements within the analysis); polarization (examining transcripts for oppositional relationships); numeration (the frequency with which a theme is supported) and function (themes are examined for their function).

6.3.5.3 CROSS CASE ANALYSIS

The next stage involved looking for patterns across the interviews that will be acquired. This was achieved by drawing up a list of themes for the group, and clustering these into master themes representing shared higher-order qualities between cases; these are outlined in table format for each participant in chapter 7 (as an example see pages 97 & 98 and appendix H).

6.3.5.4 RIGOUR - TRUSTWORTHINESS AND QUALITY

There are a number of available guidelines for doing this however Smith et al (2009) recommend the Yardley (2000) guidelines, and Smith et al (2009) describes how they apply to an IPA study, therefore this study used Yardley's four principles: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

6.3.5.4.1 SENSITIVITY TO CONTEXT

Sensitivity to context may be established through demonstrating sensitivity to the existing literature and theory, the socio-cultural setting of the study (Yardley 2000) and the material obtained from the participants (Smith et al 2009). This is similar to confirmability where the findings are based on what the participants' responses and not biased by the researcher. Therefore, there needs to be an audibility trail for others to see and evaluate (appendix G & H).

6.3.5.4.2 COMMITMENT AND RIGOUR

Yardley (2000) describes that commitment involves a deep engagement with the topic and through developing competence and skill in the method used. Smith et al (2009) suggest that this may be demonstrated through attentiveness to participants during data generation and taking care over the analysis. By rigour, Yardley refers to thorough data generation and the depth and breadth of analysis. Whilst the rigour of this study will have been affected by my status as a senior manager and as a novice qualitative researcher, and also practical constraints in terms of time and the available sample. It was important for me to demonstrate through keeping a research diary of the training and supervision I undertook to ensure that the study is done in a careful and thorough way (appendix I). Finally, this work should be dependable (whether it is repeatable by other researchers) because the methods of this work are explicit. Although it is arguable due to the complexity of the rich data available to others who may attempt to look at the research data they may find other themes and findings.

6.3.5.4.3 TRANSPARENCY AND COHERENCE

Smith et al (2009) state that transparency refers to how clearly the stages of the research process are described. There should be coherence between the research that has been carried out and the underlying theoretical assumptions of the approach being utilised. This can be demonstrated using an audit trail (through using a diary) and using reflexivity (appendix I).

IPA analysis is an inductive and iterative process; the interviews were firstly viewed as descriptive accounts i.e. phenomenological Husserlian approach. Following this further analysis can begin using the interpretative method of IPA. This is an example of credibility as well, in that the researcher gains confidence in the research findings through building up similar evidence from other participants i.e. triangulation. Similarly, the transferability of the findings is high due to the fact that the participants had been using ODA for a significant period of time (18-24 months) indicating that this form of approach was part of their practice and therefore transferrable to similar populations/ situations.

Transcripts were then converted into a table with three columns; the transcript in the centre column and then in the right column initial observation and thoughts. In the left column concepts\ themes that emerged were noted (example taken from transcript in appendix G). These concepts were later worked upon to create themes using the hermeneutic cycle i.e. the researcher, participant and the world/ phenomena; using suspicion and critical engagement with that of empathy and recollection to achieve a deeper understanding (Smith et al 2009). Importantly these themes were created and or discounted dependent upon the strength of the evidence within the data. In appendix H there is a summary table of the themes that were collated and analysed from the data. This process was carried out for each interview, although after each subsequent interview the process was iterative and cyclical because I went back to the initial interviews to explore if the themes that had become apparent in the latest interview were present in the previous, with a final review of all themes once all the data had been collected (Smith et al 2009).

6.3.5.4.4 IMPACT AND IMPORTANCE

This final principle reflects that however well or sensitively a piece of research is conducted, the most decisive way it may be evaluated is in whether or not it tells the reader something interesting and useful. This work has highlighted new knowledge from the experiences of clinicians using ODA within the UK – this is something that can be of value to other clinicians who are attempting implement ODA within their clinical environments.

6.4 ETHICAL CONSIDERATIONS

I was also aware that during the course of this study, that I may elicit information of a highly sensitive nature: such disclosures would need to have been dealt with sensitively and in a supportive capacity. All participants were provided with the opportunity to attend appropriate supportive services within the health board such as the employee wellbeing service and/ or to receive appropriate clinical supervision from an independent mental health professional; all were reassured that they could disengage with the research study at any time. Participants were reassured of their anonymity to others other than the researcher, and that all information provided would be treated as confidential and stored within a password protected computer and/ or locked filing cabinet within the healthcare premises. Serious disclosures that may affect the safety of participants or service users would have needed to be escalated through the appropriate channels through the clinical board's human resources and management structures – this was made clear to the participants before beginning the research and before they consented to undertake the study.

To provide further reassurance to the ethics committee I disclosed that I am a professional nurse and I am bound by a code of conduct enforced by the Nursing and Midwifery Council (NMC 2012). One of the edicts of the code is the preservation of confidentiality (unless there is a clinical need to know or the service user is at risk). Along with this safeguard is a local health board information governance commitment that ensures that confidentiality is maintained (although it does outline a caveat that anonymised data may be used for research purposes) (Cardiff and Vale University Health Board 2013). There was an initial application to Cardiff University School of Healthcare Sciences Research Review and Ethics Screening Committee – this process also provided valuable direction to the proposal and how the research impacts on the school's research direction and guidance on further approval pathways (Health Board Ethics Committee) (Bryman 2012, Pope and Mays 2006, Punch 2006, Fedor et al 2006). A successful school ethics approval outcome was obtained in November 2015 (see appendix J).

As a senior manager I am conscious that my role may have unduly compromised junior participants to feel obliged to take part in the research, therefore participants were written to and encouraged to contact me to participate within the research thereby avoiding any undue pressure being put on participants who did not wish to engage with the research. I was acutely aware of the power imbalance and therefore ensured I wore casual clothes and engaged in casual conversation to ease the tension and break the ice. Ethically my insider status (manager of the participants interviewed and the researcher) created some role confusion for the participants, blurring boundaries due to role ambiguity (Burns et al 2012).

All participants who participated voluntarily in the study were required to be users of ODA, to be allowed entry into the study. Invitation was initially done in writing and then subsequently by the participant responding (if they were willing to). Participants were informed that they can ask for interviews to be ended at any point, if they found discussions at all distressing. Also, participants were interviewed separately due to the fact that co-presence could affect the output from individuals especially due to the fact that they may want to share issues about how they felt uncomfortable and issues about professionalism (Denzin 2009). Similarly, as an experienced mental health professional, I would have terminated the interview if I had observed signs that participants had become distressed and unable to participate. Additionally, I reassured the participants that they could withdraw from the research at any time. To minimise the data being influenced in this way I provided reassurance to participants that there are no right or wrong ways to answer the questions, and reassure participants that they may be open and honest with their thoughts, feelings and opinions on the matters that they discussed. Reflexive conversations pre and post interview with participants was captured on the transcripts, acknowledging my presuppositions and how a balance was found in my dual role with the participants. The researcher’s transparency with participants was also captured through recording the whole conversation that was discussed, along with my complex relationship with the participant (manager and researcher) and how this was managed. This transcription was analysed later and forms part of the overall rigour of the study and ultimately to demonstrate validity of the findings.

All research participants were informed in writing that participation is entirely voluntary. Written consent was sought (appendix D) for the audio recording of meetings and interviews, and assurances provided regarding issues of storage and confidentiality. In order to preserve confidentiality, names of participants were altered at the writing up stage. A letter outlining information about the study was given to participants (appendix C). Access to participants was following formal agreement from the Local Clinical Health Board’s Research and Development Team.

In summary, everything was done to mitigate any power imbalance whilst interviewing the participants and all of the participants were happy to have further interviews in regard to the research if required.

7. DATA FINDINGS

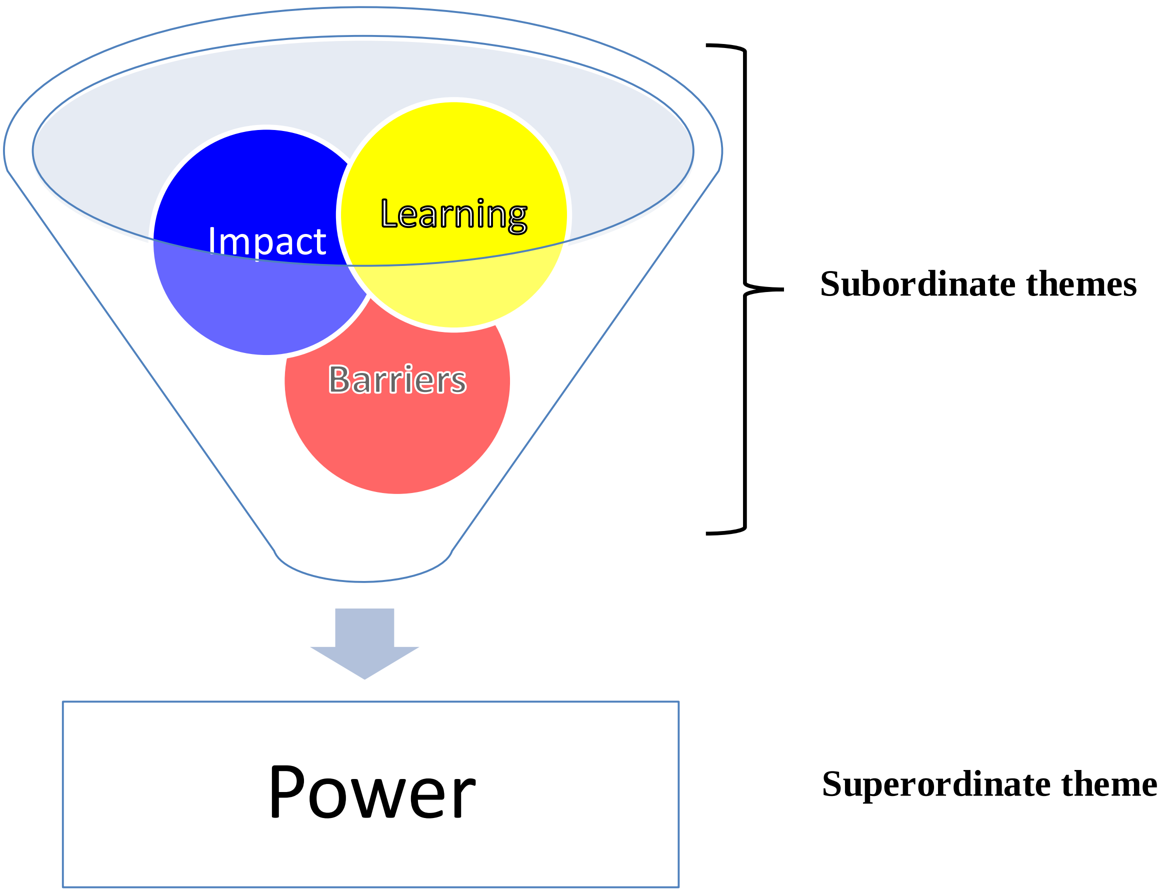
7.1 INTERPRETATION OF DATA

7.1.1 THEORY OF THEMES

The data used in this study is obtained from five interview transcripts conducted specifically for this piece of work. The interviewees were all mental health nurses working across different wards and community teams within a local health board mental health service. The participants all have lived experience of using ODA. The participants concurred that the approach was very different to anything they had previously done, not only in the mechanics of delivery but the philosophies underpinning it. This experience was reinforced when I conducted a word frequency search to highlight and begin exploring themes within the transcripts and also by reflections that I had written after visiting Finland and seeing ODA first hand.

The initial ideas that became apparent was that the work (ODA) was very powerful, different but familiar, and that there may be barriers to implementing such an intervention. These ideas existed in all five interview transcripts. The aim of re-reading the transcripts was to explore how these ideas were discussed and used by the participants within their interviews to contextualise the meaning behind them. During this process the ideas of ODA within the study was about the perception of its impact upon people and the uncertainty of implementing such an approach within a local UK setting. On subsequent re reads of the transcripts, writing of my thesis and discussions/ reflections with my supervisors, the themes evolved so that the participants' ideas, thoughts and voices came into the work.

Below is a diagrammatic representation of how the three subordinate themes are simultaneously standalone themes and are merged themes that coalesce to form the superordinate theme of power. Within the analytical process I was conscious of this cycling between the subordinate themes emerging and almost leaping out of the page as their own standalone themes, and then also sinking back into the page to form the structure and foundation of the power superordinate theme. Additionally the themes also merged and influenced each other in that examples of learning styles influenced the impact theme and barrier theme. Similarly the impact theme influenced the barriers theme and vice versa:



7.1.2 IMPACT OF THE THEMES

The themes drawn from the transcripts that will be explored in this study revolve around learning (previous experience vs training), impact of the intervention (through relationship building and social approach and choice), barriers (fear, feasibility and awkwardness), and finally power (control). These themes are interrelated but as I worked with them over time it became apparent that the overarching theme was that of power:

> Learning theme involves the acquisition of knowledge, and through this power is gained. Equally if there is minimal learning beforehand then clinicians can feel powerless/ vulnerable which could represent a barrier to using the approach. Clinicians may feel that giving up their authority (power) could make them vulnerable to criticism/ punitive actions if they do not fulfil their role. Nevertheless, the apparent impact of the approach appears to be directly related to the empowerment of service users.
>
> (Appendix I)

Power and control were related to all other themes and therefore the following four themes were explored, extrapolated and used. These themes were derived by analysing and reflecting on ideas through a cyclical iterative process of merging and discarding themes. The exploration of significant words (as previously discussed) and using a complex system approach to analyse the themes especially where themes were interrelated, was a very valuable exercise using a critical system heuristics approach (appendix K). Therefore the following themes were identified:

A – Learning/ acquisition of new skills

Learning as a theme was very important for people as they discussed how they became aware or how they were first exposed to ODA. How this process came about (some participants had more information given to them before they undertook ODA) provided the study with a research dichotomy to explore i.e. is prior knowledge of ODA an important factor or not? Is experiential learning important or not?

B – Feasibility of ODA / Barriers within the health board

The Feasibility of ODA in the health board were explored and raised by participants relating not only to loss of control but also policy and attaining standards especially in relation to risk and safety of service users. Concerns about investment and resources were also raised (in relation to room requirements and staffing).

C – Clinicians perceptions of ODA impact

A positive perception of impact of ODA upon service users was agreed upon by all participants. It focussed on the service user relationship (and how this was strengthened), and continuity of staff; ODA was seen as the antithesis of current psychiatric practice (with regard to professional barriers), reflective discussions and a socially inclusive approach.

D – Power (overarching theme)

The overarching theme that connected the above themes was the idea of power, and this was something that all participants agreed upon. They described ODA as being fundamentally different as compared to ordinary psychiatric interventions. The loss of power experienced by participants appeared to be a very tangible element but also a vital part of the therapeutic process of ODA.

Therefore the themes analysed in the next section will be as follows:

A – Learning/ acquisition of new skills
B – Feasibility of ODA / Barriers within health board
C – Clinicians perceptions of ODA impact
D – Power (overarching theme)

However, these themes will be discussed in each section given to the individual research participant so that the relationships between these themes with each person can be explored.

7.2 RESEARCH PARTICPANTS

The data below is from the experiences of 5 participants who had been using Open Dialogue Approach for at least 18months to 2 years.

7.2.1 RACHEL

Rachel was a very experienced mental health nurse and manager of a community mental health team. She was also trained in psychosocial interventions including family work and in her work position appeared very confident not only to participate in the interview but also about her professional work. The interview took place in her team base.

Subordinate Theme 1 **LEARNING/ AQUISITION OF NEW SKILLS:** ⇧	
Initial ideas	Learning beforehand positive Previous experience good Experiential learning/ role play would be positive Need good mentor
Subordinate Theme 2 **FEASIBILITY OF ODA/ BARRIERS WITHIN HEALTH BOARD:** ⇧	
Initial ideas	Feasibility of ODA (resources staffing, environment) Principle of tolerance (risk) Big culture change Raise awareness (solution?)
Subordinate Theme 3 **PERCEPTIONS OF IMPACT** ⇧	
Initial ideas	Democracy/ choice Antithesis example Deeper understanding Control/ power/ balance Social Approach

Superordinate Theme: **POWER** ⇧ ⇧ ⇧

	LEARNING/ AQUISITION OF NEW SKILLS	**FEASIBILITY OF ODA/ BARRIERS WITHIN HEALTH BOARD**	**PERCEPTIONS OF IMPACT**
Subordinate Theme	Safe in mentor's hands. (Pg8) Experience of clinicians not invited to the meeting felt wrong (as they were contradicting and challenging the client). (Pg3)	Equal power balance. (Pg5) Big change in culture. (Pg9) Tolerance of uncertainty – difficult for staff (Pg5)	Democracy/ choice. - Mark nodding furiously to 'correct' answers with Rachel (Pg1) Control (Pg2)/ Choice (Pg2)/ power balance (Pg4+5). Social Approach. (Pg1)

7.2.1.1 LEARNING/ AQUISITION OF NEW SKILLS

This first theme looks at how practitioners became involved with ODA and how they acquired the skills to become ODA practitioners. Some practitioners were provided with ODA information/ learning whilst others had been immersed into sessions without such information.

Rachel's manner during the interview was very measured in that she would usually have long pauses before answering questions during which periods she appeared to be thinking carefully about her responses. This appeared to mirror one of her responses to a question on experiential learning where Rachel felt it was important to maintain professionalism during the network meeting:

> ***… And the experiential learning, what about that?***
>
> *Well experiential learning or working with a real person, means you have to think on your feet, you can't just burst into fits of giggles and kind of start messing about because you're in a real situation and it's somebody's life, their dignity and so on. And the other thing that I think about experiential learning is that you do, it forces you to think more about what you're doing because you are with a real person. If you are in an artificial situation you can afford to make mistakes and I'm not saying in experiential learning you don't make mistakes, you do but you learn somehow more from them than you do if you make a mistake in role play because of that, because the bar is in a different place.*
>
> ***So if you say something wrong it really sticks with you because you are attuned you have to get this right as much as possible***
>
> *Yeah, if somebody suddenly starts to cry or gets angry.*
>
> ***Real emotions***
>
> *Yes, they are not somebody acting it. And it's that person's life that you are interfering with really so you've got to sort of... and if you've made a mistake you have to be upfront about it,*

> *there's a kind of honesty with it, so I think those are some of the really good things about doing the experiential stuff.*
>
> *Rachel Pg. 7*

Rachel used the requirement and expectation that she would be professional at all times with the service user as the mechanism for her to maintain control within the session. In this way Rachel was in control of her own behaviours and thereby able to maintain a sense of safety within the encounter.

Despite this Rachel felt that this experience of attending network meetings as a clinician left her quite exposed (undertaking ODA and having only some initial information about it); she states that some role play may have been beneficial:

> *I think that I would have liked to have done some kind of role play type, training.*
>
> ***Beforehand?***
>
> *Before actually going into the kind of invitro situation, but that might just be because I'm used to doing that, I'm used to that*
>
> ***Through the family work?***
>
> *And through other things like motivational interview training, you do a lot of role play before you actually you know, do it with real people.*
>
> *Rachel Pg. 7*

Although, as previously stated Rachel goes on to say that experiential learning can be a positive experience as it pushed her out of her comfort zone and enabled her to 'think on her feet'. Rachel feels it is an important learning experience to learn in real life situations, where mistakes will happen but you have to think on your feet to undo those mistakes. In a way it could be argued that this is a more honest approach and one that can be made to be successful when undertaking such an intervention with an experienced ODA clinician.

But Rachel also describes herself as being very confident that being exposed to real life ODA meetings was a positive thing:

> ***The first time it happened, what was your experience of that?***
>
> *I actually found it fine, I didn't have... aside from just that kind of awareness of you know not being over disclosing and talking about generalities, but I don't mind talking about personal things as long as I can see a point to it and as long as it doesn't kind of trespass into what I*

> *would regard as intimacy and I think that's really important, but I think I've got enough experience in a professional sense to be quite sort of careful about that, but also to be able to say I've actually experienced whatever. You could be talking about anger, you could be talking about all kinds of things that people bring up and so yeah, I think it is, it's not something, I didn't feel uncomfortable with that at all and that came quite naturally again.*
>
> *Rachel Pg.3*

However, the above shows some hesitancy ('found it fine') about the approach. I also felt that Rachel cut herself off when beginning 'I didn't have...' by veering into a professional debate about how she represented herself. The excerpt below by Rachel highlights how uncomfortable it could be for staff who are not trained in the ODA approach; this could in fact be Rachel's true initial experience of ODA itself, that is an uncomfortable experience:

> *Partnership working. I suppose the bit that is different is having that open dialogue in front of the person and everybody else about a particular aspect of what has been said. So that might be things like discussing your own life experiences, I mean not in a kind of an unboundaried and you know, kind of mawkish way, but doing so – you know at one point we were talking about what happens because there were some abuse issues for the person. What happens in the relationship sometimes between men and women and so it was useful to have a man and a woman having that dialogue I think. The perception of both can be different but equally helpful. I did feel once or twice that there were some uncomfortable moments, I think that's probably something that you have to get used to.*
>
> ***What's an uncomfortable moment? Not to break confidentiality but you tell me?***
>
> *I think it was mainly on my part to do with the presence of staff because I felt that it wasn't ODA anymore.*
>
> ***So going back to that first meeting where for want of a better word, the staff had gate crashed the network meeting and you felt that they were uninvited in a way so you found that uncomfortable***
> *Yes and also I think the person that the meeting was focussed on said a couple of things and they contradicted her and I felt that was wrong. When I say wrong, it's a difficult thing to describe but I felt that those staff had been in the meeting and been given enough information perhaps to realise it wasn't your usual meeting, if I can put it like that. And you know, I still, having done the unite family work and other work I've done with clients in the past plus this, I do get very uncomfortable when people talk about people or talk disrespectfully. I'm by no means saying that I always manage to achieve that myself, but I've become increasingly aware, sensitive to the way we talk to people.*

> ***And talk about people***
>
> *Yes*
>
> ***So going back to that first meeting then – it was uncomfortable to see that. What was the client's reaction to being contradicted?***
>
> *I think she feels quite sort of irate about it really. I think that you know, she's not here, I'm talking about her and you're not supposed to really in many ways.*
>
> ***I suppose it's your perception really***
>
> *Yes, she I think wanted to give a different image of herself and I think that's her, the image she wants to project is the one we should be going with. It's not to say you ignore what people have to say because they might have something important to say, but there are other fora in which you could do that. That wasn't really what it was intended to be. So that was uncomfortable.*
>
> *Rachel Pg. 1*

Here Rachel struggles with a meeting that has evidently not adhered to the principles that should govern it and potentially highlights her own novice failings and ability to adequately and successfully chair ODA meetings. Rachel highlights the importance of chairing the meeting effectively so that all voices are heard; ODA requires a certain level of skill to deal with invited clinicians/ staff that may not be trained in ODA and may therefore attempt to alter the tone of the meeting and take control or become too confrontational. However, another way of looking at this is that this is real life and the service user needs to start learning how to equip themselves socially with confrontations – hopefully this is done in a controlled and measured manner. It reminded me of my experience of observing ODA when I was in Finland and observed many meetings, but one stood out from the rest because one of the clinicians took on a more confrontational approach with the service user which closed the service user down and appeared to stunt the previous open flow of dialogue; apparently the nurse was new to the service and had only just started ODA training.

Rachel goes on to state how difficult it can be to talk about yourself:

> *The other thing that I found uncomfortable at first really was I suppose and still feel unsure about, is how much to disclose about yourself. It can be, I think it can be a very normalising thing for other people, people who have experienced such serious difficulties whether it's through life experience, things like being abused or through psychotic experiences. I would have thought it must be something of a relief sometimes to have that normalised. Provided of course, you know, that there are sufficient boundaries in place to protect both them and you.*

Rachel Pg. 2

The above concerns raised by Rachel about how much of a personal disclosure is revealed when service uses disclose their own personal and painful recollections/ uncomfortable moments, it is therefore important that staff are equipped and supported to deal with such revelations.

Therefore Rachel's initial experience of ODA revolved around her believing that learning beforehand through role play would be a positive thing, but simultaneously being immersed into ODA was also a positive experience. Although she felt that previous experience of psychosocial interventions helped this. However Rachel did express how staff utilising ODA for the first time could find it uncomfortable which probably represents how she felt about her initial network meeting with a service user.

7.2.1.2 FEASIBILITY OF ODA/ BARRIERS WITHIN HEALTH BOARD

Following on from the previous section Rachel describes that there are potential barriers to the implementation of ODA within the UK. She describes below that there may be barriers in where such meetings are held (which may not be the most conducive to holding the meetings):

> *I think that it's been difficult for the last person that we were doing the network meetings with in this situation because we are limited in how much choice she can have in where we do it. I mean that hopefully will change. The other thing that I found, particularly the last time we went to meet her was, she wasn't in the right place, so if I can put it like that, in that she was very distracted by some other events that were going on at the time and we weren't able to really get her involved in the meeting and I kind of went away feeling I kind of let her down in some way, that we had failed and I think that that comes down to me not having the experience, the degree of uncertainty that goes in open dialogue when you read the literature. It does emphasise that you have to have a degree of tolerance to uncertainty and I don't think I've quite got that yet, and so I feel a bit sort of a bit unsure, I don't think uncomfortable, I think uncomfortable is too big a word but I feel unsure about uncertainty, if that doesn't sound too…*

Rachel also describes here the risks that clinicians have to hold (or tolerate) which does not sit comfortably with her – 'I don't think I've quite got that yet' – indicating that she has not yet moved to a position where she is able to confidently hold that risk. This I believe indicates the culture around Rachel and the society that confers that accountability onto mental health professionals. Currently Rachel is unable to discount this reality and therefore feels 'unsure and uncertain' about it.

> *the last meeting we tried to hold, there were events going on in the environment that were concerning and so, we did attempt to hold the meeting but towards the end of it something was happening in the place where she at the time was residing and so there were safety*

> *issues and in a sense I can see that you might have to – I mean we were already winding the meeting down. That felt sort of a bit strange as well, just kind of trying to have that open atmosphere and democratic discussion with somebody whilst then immediately having to say we don't feel you should leave the building yet until we know what all this noise is about.*

This issue that Rachel recalls describes an event that is outside of her control but has a direct impact on the feeling and level of safety and trust that the service user has about the network meeting. Additionally this impacted on feelings of safety that the clinicians felt. It appears that the safe environment that all participants had presumed they were in disappeared, however, the clinicians were also left with the feeling of responsibility about leaving the service user in that potentially unsafe environment.

> *Yes that felt uncomfortable, weird. I think that the other thing I would say is that AV puts notes on (electronic record system) of the open dialogue meeting, which I am not entirely in agreement with. I'm not saying we've had any sort of violent disagreement because we haven't. I think that it's important because he's the lead clinician in this, that he does what you know, what he thinks is required. To me the discussions that we have in those meetings are not necessarily for sharing with…*
>
> ***So are all of the details of what's discussed at the meeting in those case notes?***
>
> *Yes. I mean the previous family work that I've done, I've recorded that I've gone to somebody's house or wherever it is, with whoever I've gone with and that the family work has taken place and I have noted anything that is of any real significance to the person's psychiatric treatment and that usually isn't the case because you're having a discussion about something that's not particularly relevant to whether or not they're on an antidepressant or an antipsychotic and how much. You are talking about a different thing. So I'm not sure how I feel about that, but as I say I don't think that it's for me to say that shouldn't happen, I just have you know question marks about why you need to do that.*
>
> ***Because that's not conforming perhaps to the ethos or the principle of the full open dialogue? But why do you think that is a good thing, in your mind why is it a good thing not to have those discussions afterwards or to record it, in your opinion?***
>
> *I suppose if I'm not having a discussion, debriefing discussion, I can't change the content of what happened in the meeting. When you debrief you often are adjusting and even if you are adjusting your own thinking, so if you don't have those discussions, I'm not saying you don't adjust your own thinking but it's not affected by other people as much. If I can put it like that. I don't know if that makes sense? I might sit in a meeting with somebody and they may say something or if it's a conversation that goes on between me and a colleague in the meeting*

> *and the only thing that affects that until the next meeting is what I think. It's not what anybody else thinks, it's what I think and the only thing that matters then is the connection for the next time if something comes up of relevance that I can make that connection. And as I say it's pure if you like. In terms of recording, we've got to meet our legal obligations when recording and documenting things. If we are recording a conversation that's taken place in the arena that open dialogue seems to support, why do we need to record it? What information, unless there's information in it that somebody is saying to me "I'm having suicidal thoughts", that's different, but if they are talking about, I don't know a kind of more, I don't really know how to explain it, a more kind of an emotional response that isn't necessarily of any interest to anyone about in terms of how they are treated, where they live, whether they are safe or not, you know if you are having that, surely that doesn't quite fit is all I'm saying, I'm not quite sure if there is a right answer to that but that's just how I feel about it.*
>
> *Rachel Pg.6-7*

Rachel feels uncomfortable that the recording of the meeting is more explicit than she would rather it be (as per her ODA training); the reason that her colleague is putting more information in the notes is due to the fact there is a legislative edict that states we must write up our plans of care for our service users, however, to Rachel this represents a betrayal of trust and an explicit use of professional power which undermines the service users power. This offers a tangible barrier to fully implementing ODA in this country because we cannot fully sign up to the principle of tolerance of uncertainty as the clinical governance surrounding clinical interventions stipulates the importance of safety.

7.2.1.3 IMPACT AND POWER

Rachel states that ODA appeared to resonate with her because it is a democratic approach that genuinely embraces service user choice. An example of the antithesis of this would be the ward round model where the service user is invited to attend the meeting but is powerless to control or direct the conversation. Rachel also discusses how the approach fosters a deeper understanding between the participants and thereby imparts control (power and balance) equally across the room. Additionally the social aspect of this approach resonated well with Rachel in that it attempts to utilise the service user's social networks around them to maximise their support.

The theory aims to promote and elevate service user authority, control and status in the clinical environment, and it became evident from the interviews that this aim had transferred to the local health board. Participants such as Rachel discussed it as one of their first impressions of ODA:

> ***What does open dialogue approach or ODA mean to you?***
>
> *Um, ok, I see it as a way of communicating with people who have challenges to their mental health in a manner which doesn't rob them of agency and control over what happens to them,*

> *as far as possible. I don't think that, obviously you can't ignore some issues that might be to do with their safety or the safety of other people, but I see it as a very democratic approach to finding out about the things that matter to that individual and I suppose it comes back to what I said earlier about my interest in peoples connections in the community and through different social roles I suppose.*
>
> *Rachel Pg.1*

Rachel discusses control, agency and democracy as parts of the intervention, she goes on to state how this was prevalent throughout subsequent meetings despite others (who had been invited to the meetings) not necessarily understanding that:

> ***What do those, obviously not to go into the confidentiality of those meetings, but tell me how those network meetings were run or how they might look different or were the same to other parts of your practice?***
>
> *Ok. I suppose that we started by explaining principally to her what we would be doing and we also explained to her what we saw as the purpose of the meetings, so I didn't do that bit, I kind of stood back while our colleague AV did that. So he was just explaining that they were her meetings, she could invite whoever she wanted to them, that they would be held in a venue of her choosing, that we would sometimes break off talking directly to her and talk to each other and that that might feel a bit strange at first and I think he used words like "agency" and "control"* **for her?** *Yes for her. So the first meeting was held where she lives, but where she lives is a staffed supported house and I didn't feel that the staff in the house understood that their presence in the meeting was her choice, not their choice and I don't think that we achieved that early on, I think they kind of, however they did it they kind of got into the meetings not as invited guests. So I think that is sort of an issue, although they did play along (if I can put it like that) with the way we handled the meetings and the person who was the focus of the meeting was kind of asked if it was alright for them to be there.*
>
> *Rachel Pg. 2*

The invitees to the meeting had to be managed carefully by the ODA clinicians so that they did not impose their authority over the meeting or the service user and this is something that has to be actively managed by the ODA clinicians; rather than it be a passive thing that happens, the ODA clinicians have to advocate for and empower the service user to have control and authority.

> *Um, I think the first thing that I think it is, is that I feel, I suppose it goes back to what I was saying earlier, I feel there is a power imbalance in relationships between professionals and um the people that they are providing a service to. I would say that that's true whenever I go and see my GP for example, I don't think it's unique to psychiatry. I think that there's this kind of expert advice, professional telling you what you should and shouldn't do and that's not always*

> *a nice place to be. I feel that, I think that the client that I'm talking about, seemed to feel, or certainly she seemed to tell us quite a lot in the sessions and seemed to come out with what I thought were some quite profound insights to her own situation and experiences.*
>
> *Rachel Pg. 4*

Rachel appears to understand about professional power relationships and is able to contrast the ODA relationship with other professional relationships that she has been exposed to (both personally and professionally).

> *I think it's a kind of, it's about an enhanced service, something that we can do over and above what we might call treatment as usual, that will help people to understand their own lives, situations and to have some control, or at least more control than they have, or even a feeling of control, rather than perhaps just feeling that they are at the whim of whatever their CPN or Consultant Psychiatrist says.*
>
> ***And is it a good thing that people have got more control over their lives?***
>
> *I think it is. I think that my impulses would perhaps be paternalistic towards some people so you have to be aware of that in yourself. I have this kind of urge to look after people and protect people and it's not always the best thing for them. I know that and you have to be very aware of what you're doing. We still have in this country legal responsibilities, duties of care, Mental Health Act, Mental Health Measure. Sometimes it's almost like there's a conspiracy around you to prevent people from having that degree of control over their lives and I suppose in a way I like to think that open dialogue might be a bit subversive as well, which appeals to me.*
>
> ***Subversive?***
>
> *Breaking the medical model control and establishing a more equal power balance between service users and clinicians.*
>
> *Rachel Pg. 5*

Rachel describes above an overview of current psychiatric services in how they can appear to be very paternalistic (and risk averse), whilst ODA appears to be the anti-thesis to that and because of that looks subversive (which in her view is a positive thing). Power is something that Rachel feels very important to ameliorate within the current psychiatric model of care and it appears as though her values resonate with those that she has found within ODA.

7.2.2 COLLETTE

Collette was a mental health nurse and senior clinician. She was also trained in psychosocial interventions. Collette was less experienced than Rachel and at times this came across as her being slightly under confident, however, her demeanour would change very rapidly to a confident one especially if Collette was pressed in questioning about her actions. The interview took place on the ward she worked on and again this was Collette's decision and recommendation to conduct the meeting there.

Subordinate Theme 1 **LEARNING/ AQUISITION OF NEW SKILLS:** ⇧	
Initial ideas	Learning / information session Previous experience CBT/ confident Pg6/ roleplay/ mentor
Subordinate Theme 2 **FEASIBILITY OF ODA/ BARRIERS WITHIN HEALTH BOARD:** ⇧	
Initial ideas	Barriers awkward/ strange Uncomfortable/ culture not there yet/ risks
Subordinate Theme 3 **PERCEPTIONS OF IMPACT** ⇧	
Initial ideas	Effective/ therapeutic Antithesis CTP + talking out of session Reflective discussion Invites (Power/ control)

Superordinate Theme: **POWER** ⇧ ⇧ ⇧

	LEARNING/ AQUISITION OF NEW SKILLS	FEASIBILITY OF ODA/ BARRIERS WITHIN HEALTH BOARD	PERCEPTIONS OF IMPACT
Subordinate Theme	Previous experience CBT/ confident pg6/ roleplay/ mentor Confident in myself and skills (to do ODA) (Pg6)	Barriers awkward/ strange Uncomfortable/ culture not there yet/ risks Culture not open at present - If we get better at this will lead to better understanding and respect. (pg8) Power imbalance NHS (Pg12)	Her choice of staff (pg6) Helped build trust and understanding (Pg7) Effective/ therapeutic Antithesis CTP very formal and dictate to patients (Pg9) + talking out of session Reflective discussion Invites (Power/ control) Helped build trust and understanding (Pg7) Lose the power (of ODA) by talking about it outside of the session (Pg14)

7.2.2.1 LEARNING/ AQUISITION OF NEW SKILLS

The below excerpt is taken from Collette's transcript and discusses how she was given prior knowledge of ODA:

> ***Thank you very much. And I know you've done some open dialogue network sessions***
>
> *Yes*
>
> ***What's been your understanding of that? Did you have any kind of experience or exposure of doing some of that work, and about what it is?***
>
> *I had an information session on open dialogue, but I've also had some sort of experience in training on things like motivational interviewing, CBT skills and family intervention training through the Degree course that I was doing. Obviously I was aware of the network meetings and I was kind of aware of the format of the – But previous to my information session I didn't know a huge amount about it, I wasn't aware of open dialogue and what it was based around. I suppose my understanding of it wasn't great to begin with but it was something I was interested in and curious about and to see how it worked and what it was about and this grew following my experiences in undertaking the sessions, so having information at the beginning was a big help because the meetings at first can be a bit uncomfortable.*
>
> *Collette Pg. 1*

Collette felt that having prior knowledge was a positive thing, but she also alludes to the fact that previous talking therapies training she had experienced was an important factor in her uptake and use of ODA. She also states that she had some prior knowledge about ODA and perhaps importantly ‘interest’; having this interest was probably the driver behind her participating in this way of working and helped her overcome the ‘uncomfortable’ moments that she felt at the beginning.

Collette also felt that there was some crossover between CBT and ODA:

> ***You see a lot of similarities with that CBT training and that family intervention***
>
> *Similar. It’s definitely not the same but very similar. Similar type skills and I suppose having done it that’s helped me a lot but I suppose for someone that hasn’t had that, then if they were going to provide training maybe some role playing training because it wasn’t completely straightforward! You need some theory and I think you need some practice, practical stuff like the role play and stuff.*
>
> *Collette Pg.11*

7.2.2.2 FEASIBILITY OF ODA/ BARRIERS WITHIN HEALTH BOARD

As stated in the previous section Collette’s first impressions of ODA is that it can be uncomfortable and odd:

> *... the meetings at first can be a bit uncomfortable.*
>
> *Collette Pg. 1*
>
> *... it was different, yeah, just felt a bit odd I suppose*
>
> ***What was odd about it?***
>
> *I think because they were talking about the conversation I’d been having with my patient in front of me almost like I wasn’t there and it was a totally new experience, I suppose a bit uncomfortable to begin with*
>
> ***Can I ask – did they ask your and the client’s permission to do that?***
>
> *Yes they did*
>
> ***But it was still uncomfortable as you said.***
>
> *Well no, not hugely so, just mild*
>
> ***This doesn’t usually happen as you said earlier?***

> *I suppose when you are talking to someone and you are having a conversation, I know speaking for myself, you're not always aware of like my body language, tone of voice, you know sometimes other people pick up on things that you are saying that you might not think about yourself.*
>
> ***Yeah, and they discussed that***
>
> *Yeah*
>
> ***Yeah***
>
> *Yeah and do I really sound like that*
>
> ***She said it in a certain kind of way mimicking you? Maybe she looked a bit sad or something.***
>
> *Yeah it was kind of very analytical and it was obviously a completely new experience.*
>
> ***What about, because you were there in the room, what about the client, did he or she think that was uncomfortable or that was positive? You know what was the client's reaction to that I suppose I'm asking you?***
>
> *Yeah the client's reaction was ok I mean she had experienced that before she was kind of used to it.*
>
> ***Of course, this wasn't her first time, it was your first time though!***
>
> *The client in particular was familiar with that approach and we never really had a conversation about how she felt about it initially, but from when I was in there she was quite comfortable about what was being said. She seemed to find it quite helpful because again like I said just then when you're talking you don't always notice things like your body language and the things that you're saying and the tone of voice, so I suppose it's helpful in a therapeutic way to have heard that*
>
> *Collette Pg. 2-3*

Collette first experienced ODA after the service user had already been empowered to work in that way. Collette is the guest in the first meeting she attends. Collette describes her own communication style and behaviours being reflected back to her, which on some level made her, feel awkward or uncomfortable; this is despite being asked permission for this to happen. She goes on to state:

> *The only thing I did find a bit uncomfortable I suppose was the reflective discussion where it was kind of about the conversation I'd had with the client*
>
> ***In the meeting?***
>
> *Yeah in the meeting. It wasn't anything that I didn't find useful or anything like that, I didn't feel negatively about it in any way, I just felt uncomfortable I suppose initially*
>
> ***What could have made that experience better? If there is anything?***
>
> *Maybe if I was given a bit more information about what it was about and about the approach they were using, because I didn't know about the open dialogue thing until the conference that we went to, the nursing conference so that was when they did the presentation. So if I'd known about it before that I could have looked it up. So yeah I would have done that, so I kind of knew what it was about more, I suppose because it's a different approach that not many people have heard of.*
>
> *Collette Pg. 7-8*

Collette's experience with reflective discussions again made her feel uncomfortable in that she felt the clinicians had taken away her control (talking about her as though she was not there). Although she goes on to provide a solution to this in that if she had been given information about this at the beginning this may have lessened her anxieties.

Collette's non-verbal response when describing the oddness and uncomfortableness surrounding this initial meeting was to nervously laugh at it. I felt that it was something that had affected her quite deeply and had come as a surprise to her as she was already a trained psychosocial interventionist; she therefore had probably assumed that ODA would be a similar method and mode of intervention that she would have been familiar and comfortable with. However, similar to Rachel I felt that Collette played down these initial negative experiences; potentially due to my presence as a service manager where she did not want to display any negative views about the interventions. This could be because she thought that I was a champion of it (and only wanted to hear positive things about ODA), or because she did not want me to believe that as a senior clinician she was failing in some way (again my presence as a 'judging' senior manager). I do not truly believe that either of these scenarios to be the truth here (although there may be some influence here). As previously stated I had begun recruiting into this research by being very open about capturing the experiences of those clinicians who had used ODA. I was not a champion, advocate or someone reticent about using ODA, I was a neutral person expecting to ascertain what experiences clinicians had with it over the years. Also, my management and leadership style is very democratic and empowering, I have always strived and succeeded in putting people at ease i.e. not being judgmental. Therefore I do not believe that Collette would have been in fear of being judged and criticised for highlighting her negative views about ODA.

I believe that both Rachel and Collette truly felt that these initial concerns (which I think were very significant) were overcome or played down by both participants because they saw the benefits of the approach upon their service users and upon themselves e.g. the enhanced flow of communication and understanding bestowed on all participants (see next section ‘Perceptions of Impact’).

Collette goes on to talk about other barriers in the NHS:

> *Try and keep things open and transparent as possible.*
>
> ***Yeah, keep it honest sort of thing***
>
> *Yeah*
>
> ***No hidden agendas I mean***
>
> *Yeah. I found like the culture of working in the NHS can sometimes be a bit like not quite being as open and honest and transparent as we could be but I found if you are more honest and open and transparent you get better understanding back from the people you’re working with and they respect it more rather than telling them that they can’t do something or not quite telling them the whole truth and then that kind of spikes their paranoia and things like that*
>
> ***Yeah people will get it on some kind of level – you’re not telling me everything or maybe your***
>
> *Because these are still people at the end of the day and they’ve got a pair of eyes and a pair of ears and a brain.*
>
> *Collette Pg. 6*

Collette feels that the NHS is not open and honest - whereas the principles of ODA require clinicians to be open and transparent about their thoughts and opinions with the service user. Collette here is challenging the current psychiatric model of care and she is saying this to a senior manager who has to keep control of services and ensure staff are complying with policies, therefore, this is at odds to the hypothesis that she is trying to say the ‘correct’ thing to me.

Collette in the below excerpt is questioned on another principle within ODA called tolerance of uncertainty:

> ***How do you think the service can embrace that principle of tolerance and uncertainty?***
>
> *Oh yes. By not documenting?*

> ***Documenting yes***
>
> *I think the documentation is important in………..and I suppose if you're seeing quite a few people on a weekly basis it's easy to kind of forget things. Not purposefully but because of the sheer volume of information on a weekly basis. So it's good to have the documentation to be able to look back to refresh your memory so you can recall what the structure of the session was so you don't make any errors I suppose and with the risk factor I think it goes without saying if someone is saying in an open dialogue meeting that they are suicidal then I think that needs to be addressed but if they are talking about their illness and their thoughts and it's not what we would consider an immediate threat, then I think that should be respected. The structure of the session, kept in the session should be respected. But then you've got to kind of use…*
>
> ***Your balance there***
>
> *Yeah the balance and common sense but also if something comes up in an open dialogue session that you feel needs to be brought to the wider teams attention then I think, you would need to be honest with that person about the fact that you were going to do that. You wouldn't just do it. So there wasn't that "I told you that in confidence" scenario. Then hopefully that wouldn't affect the sort of trust*
>
> *Collette Pg. 11*

Collette feels that concerning rolling out ODA that tolerance of uncertainty principle is a barrier where she attempts to compromise with the principle to satisfy the legislative duties she is bound to. This perception of defensive practice by UK NHS staff could be a significant barrier to ODA where staff feel duty/ professionally bound to act in a certain way that may be at odds to the approach.

7.2.2.3 PERCEPTIONS OF IMPACT

Collette explains that one of her sessions was positive in that the person was progressing and that she felt that she was doing a good job from the feedback from the service user:

> ***Tell me a bit of how that went, obviously not breaking confidentiality. How was that session?***
>
> *It was quite positive. I suppose the patient in particular, the client I suppose the progress was much better than anticipated so that translated into the network sessions and there may be a couple of little issues that come out but generally speaking it was more positive about*

> *reinforcing how this person was doing and looking at ways to maintain the progress and yeah it was nice it was really, you came out feeling you were doing a really good job here and this person is getting the best treatment and this intervention seems to be working well for her.*
>
> ***What gave you that feeling, what was it about it that made you come out of that meeting feeling you were doing good progress? What were the things that stick in your mind?***
>
> *I think it was the feedback from the client more so and things that person was saying to us about how they found it, you know on the ward and this is what they were getting from the staff and you know, the benefit they were getting from these meetings and yeah that was it really.*
>
> *Collette Pg. 4*

During the interview with the above exchange, Collette's body language became warmer as she recalled the experience of what happened to the service user and the positive outcomes that Collette attributed to using ODA with her. Collette was also feeling positive about how using ODA made her feel during and after the sessions (e.g. 'came out feeling you were doing a really good job') which is obviously important for staff to feel that they are getting job satisfaction.

Collette below talks about how beneficial the network meeting can be when the service user is just listening to the clinicians having reflective discussions when the service user does not feel like joining in, but despite that there still appeared to be something effective that occurred in session that they highlighted on their subsequent session:

> ***... you started doing some reflective work through network meeting, how's that, how did that go?***
>
> *It worked really well actually. On the particular client we were working with, it seemed to benefit that person as well and I think because we went through a particularly difficult week with this particular client they were refusing to talk to us, refusing to engage so when we had the planned session we kind of went for a walk with this client and they were still not really wanting to talk to us so rather than waste the session we did some reflective talking and even though he didn't join in at the time, kind of afterwards I think some of it must have sunk in because he seemed better and were engaging more talking more and I think it gave him a way out of the situation about losing face and also helping to understand where we were actually coming from. I think the misunderstanding made this situation escalate and snowball a little bit, but by hearing the 2 clinicians talking about him it was kind of ah I know where they are now what they think about me, what their motivations might be about what is happening sort of thing. It builds a bit of trust I suppose, well definitely more understanding.*
>
> *Collette Pg. 5-6*

Collette seems surprised that the reflective discussions with service users worked well (her use of the word ‘actually’ denoted surprise as her tone and pitch increased). Collette appears convinced that the reflective discussions held between the clinicians about the service user helped build trust between them all. This may have been a coincidence but Collette firmly states that due to this reflective action the service user was able to grasp the views and motivations of the clinicians and begin to communicate with them. Collette also highlights the effect of ODA on the therapeutic relationship that is strengthened through gaining trust and understanding:

> *Yeah it definitely helped with the trust and the understanding, definitely for this particular person.*
>
> *Collette Pg. 6*

> *It’s quite, it’s structured, but it’s informal and I suppose you kind of, you know you go in and you rake up on things that have been talked about in the last session. Which is good because I suppose it’s sort of validating previous discussions and showing that it’s a bit of continuity and I think it’s good in a sense that you can kind of have a more frank and honest conversation and I suppose it’s the reflective conversations that the clinicians might have, it picks up on things that maybe you wouldn’t necessarily see yourself and I think that from a client point of view, I can see that it’s really useful for getting a better understanding of us. It helps us to understand them better and also helps for a client to understand us better and kind of understand where we’re coming from and why we may be suggesting things that we suggest and why we offer what we offer. Because I think sometimes there’s a big gap between what we can offer and people’s expectations and it’s kind of trying to get them to meet in the middle more and being a bit more realistic and goal orientated with goals that are achievable.*
>
> *Collette Pg. 6-7*

The above shows that the network meetings can be quite structured but there is an informality about them (that promotes a closeness in the relationship to help the flow of dialogue), but there are also points in the meeting where discussions take place, e.g. about previous meetings that are recapped to validate the service user’s past discussions. Collette’s use of the words honest, understanding and expectations reveal some of the mechanics that she believes are at play in fostering trust and relationships with service users.

7.2.2.4 POWER

Collette appears to have been won over by ODA through the outcomes she believes she witnessed, i.e. the increased rapport, understanding, trust and relationship that was built up between the clinicians and service user. This is despite the fact that she felt uncomfortable during the initial meeting as this challenged her feeling of control especially during the reflective discussion. In effect, during this time Collette's professional role of being in control and in charge of the process was taken away from her, and control bestowed upon the service user. Ultimately the apparent fostering of ODA to empower service users is what persuaded Collette that ODA was beneficial to the service user. Collette states that she feels the ODA clinicians work hard to foster that empowerment within individuals within the network meetings:

> *And having those kind of open dialogue meetings, you can talk about that a bit more honestly in a kind of structured format which isn't too formal. Not like a CTP (Care and Treatment Plan) meeting where you go in and that can probably be quite intimidating for a person. It's bad enough for me never mind the clients.*
>
> ***How would you compare and contrast a CTP to an open dialogue or network meeting?***
>
> *CTP meeting you've got different professionals there, you could have a consultant, another doctor, at least one other doctor, social worker, nurse. There might be the Advanced Nurse Practitioner there, so there could be at least be 5 professionals or more, you know students, family members and it seems very formal. It seems very much like we are kind of dictating what we want, which isn't really the case but it can feel like that and I suppose from talking to the patients I've been involved with, it can feel very much like they don't feel they can say what they want. It's not necessarily an open sort of discussion and it can be very intimidating, anxiety provoking and for the family as well. You know families are meeting these professionals and they think that I don't know maybe they think we are looking down on them..*
>
> ***There's a power imbalance?***
>
> *Yeah. In the open dialogue meetings that kind of gets taken away a bit. I don't know if initially clients might feel a bit nervous and a bit wary I suppose – the clinicians that I've worked with have worked hard to take away those barriers and keep it kind of light and informal and you know sort of validating the clients.*
>
> ***I think you said it's kind of dictated by the clients pace so that there…***
>
> *It's what they want to bring to the meeting and yeah so it's very different.*
>
> *Collette Pg. 7*

Collette makes a good comparison between what a regular psychiatric CTP meeting would feel like compared to an ODA meeting. The CTP meeting will be filled with professionals that some of which the service user will not know and they will not have been invited there by the service user; in essence the service user would have little control in how that meeting would proceed and what was discussed.

Whereas in ODA meetings the service user has been empowered to take control and invite other people into the meeting on their terms.

> *I mean there is a power imbalance; I think people see NHS professionals up here and themselves down here like the family and the clients. There's a big power imbalance especially as it's so hard when people are detained under the Mental Health Act – they're really unwell so it's hard for them to communicate things to their family and their families don't really understand their illnesses or what the role of the NHS does or the different professionals that they come into contact with. I think an open dialogue approach that's open and transparent might help shift that power balance and finally maybe improve the working relationships we have with clients and the client's support network, which are really important to them. Yeah then I think it would be good for us to kind of have more support from the families and friends that know them really well, that know them better than we do*
>
> *Collette Pg. 9*

Collette describes the paternalistic set up of psychiatry within the UK and she believes that ODA presents a more enabling philosophy to empower others rather than control them and impose standards upon them.

In effect the initial negative part of ODA for Collette (her loss of power and how uncomfortable that is) becomes and transforms into a positive force because of the effects that it has on service users – and importantly Collette realised that her disempowering does not result in some kind of catastrophic effect upon her personally or professionally.

7.2.3 MIKE

Mike is a mature male with less than 10 years' experience working as a mental health nurse. Mike had the experience of some informal CBT training but his experience was far less than both Rachel and Collette. Mike's confidence in delivering psychosocial interventions therefore appears far less than the previous participants. Mike is a manager/ clinician who is very able and skilled in these duties, but appears out of his comfort zone whilst undertaking ODA for the first time. The interview took place on Mike's ward by his choosing.

Subordinate Theme 1

LEARNING/ AQUISITION OF NEW SKILLS:

⇧

Initial ideas	Different to what I've done before (Pg 6)
Subordinate Theme 2 **FEASIBILITY OF ODA/ BARRIERS WITHIN HEALTH BOARD:** ⇧	
Initial ideas	Awkward (viewed by other clinicians) (Pg 1) More intense (Pg 2) Planned (other meetings not ODA) (pg2) I didn't feel in control (Pg 2) but Still able to challenge (Pg 3) Unusual for me (Pg 6) Barriers would be privacy (in the current unit) (Pg 6) Different to what I've done before (Pg 6) More people on board (Pg 7)
Subordinate Theme 3 **PERCEPTIONS OF IMPACT** ⇧	
Initial ideas	Level playfield (Pg 1) Professional hats out of the room (Pg 1) Improved our relationship – Pg 2 after ODA it was resolved Insight (Pg 1) (Client) taken control (Pg 5) Being honest (Pg 4) Not controlling (Pg 4) Ownership of the process is important (Pg 7) Improve working relationships with clients (Pg 8)

Superordinate Theme: **POWER**	⇧	⇧	⇧
Subordinate Theme	**LEARNING/ AQUISITION OF NEW SKILLS**	**FEASIBILITY OF ODA/ BARRIERS WITHIN HEALTH BOARD** Awkward (viewed by other clinicians) (Pg 1) More intense (Pg 2) I didn't feel in control (Pg 2) but Still able to challenge (Pg 3) Unusual for me (Pg 6) More people on board (Pg 7)	**PERCEPTIONS OF IMPACT** Level playfield (Pg 1) Professional hats out of the room (Pg 1) Improved our relationship – Pg 2 after ODA it was resolved (Client) taken control (Pg 5) Being honest (Pg 4) Not controlling (Pg 4) Ownership of the process is important (Pg 7)

7.2.3.1 FEASIBILITY OF ODA/ BARRIERS WITHIN HEALTH BOARD

Mike appeared to be very challenged during his initial ODA meeting. The excerpt by Mike below recounts his recollections of being without control in the meetings and how this made him feel:

> *My first one open dialogue session with a clinical psychologist and ANP I found it quite interesting and awkward at the same time because I've never been in one of those situations where you have an open dialogue with your client whilst two other people are in the same room listening to what you're saying. So yes it was quite interesting. I felt we got a lot out of it. Quite a positive outcome from the client and from our point of view as well. Yes it was really interesting.*
>
> ***What does that mean, what does interesting mean to you, unpick that a bit for me?***
>
> *Interesting, to me it was interesting because the client went into the open dialogue with concerns about something that had happened between me and her in the clinical setting and so we had the opportunity to discuss that in there, we resolved it. There was a clinical incident; this client had physically assaulted me really in front of everybody else. It was resolved in the open dialogue; we came to a conclusion, the client apologised and then we worked out where we would go from here and so it was a positive outcome all round for everybody. It improved our relationship, gave me a lot of insight into how open dialogue works as well and I would be more than interested to do it again.*
>
> *Mike Pg. 1*

The word 'interesting' used by Mike to describe his first ODA meeting with a service user who had assaulted him is unusual. It appears that Mike is uncomfortable with being negative about ODA and again this could be similar to Collette where Mike was being reticent about how uncomfortable the initial ODA meeting was for him because he had seen the benefits later (as will be explored further in this section). The impression I perceived was that the encounter was viewed with mixed feelings. On the one hand Mike feels that he is taken out of his professional/ authoritative position and 'made' to have a dialogue about the incident which had happened to him in an unplanned way – this must have been outside of Mike's comfort zone (and he below goes on to say it was 'awkward'). However, the resolution at the end of the meeting must have been very positive for everyone.

> *The awkward bit for me was me sat on one side of the room with the client and the psychologist and the ANP sat in a small room, on the other side of the room, not saying a word just listening to what we had to say. Listening to our dialogue. I'd never been in a situation like that before.*
>
> ***So how did that feel?***

> *Awkward, intense*
>
> ***But why did it feel awkward and intense?***
>
> *The intensity was that I didn't feel in control. If I go into a meeting, I like to be in control, I like to know what I'm going into and have a plan of what's going to happen, but with this it was different, I didn't know what the client was going to say to me. I didn't know what her issues were, but yeah that was the intense and awkwardness of it. I think the awkwardness was sitting in a room with two people I know well, who didn't have any input at all, just sat there listening to what we were saying.*
>
> *Mike Pg. 2*

This awkwardness was generated by Mike not having control over the situation, as previously discussed the power had been removed from him by the other clinicians empowering the service user. Mike entered the meeting with very little knowledge about what was going to happen – something that as a qualified nurse and the manager of the ward would be very rare, i.e. the professionals are usually prepared for the meeting by an agenda (that they have control over and foresight) and which will direct the meeting. In this scenario Mike did not know what was going to happen and he felt awkward. If staff are not prepared for this it could lead them to think of ODA as a negative intervention, and one which they may not support and potentially create barriers to its implementation. If Mike had been prepared for this meeting in advance this could have been avoided. Not that he should have been told that the service user wants to raise these points with you but rather the nature of the meeting should have been explained to him so that he may have envisaged emotive topics being discussed, and that reflective discussions could be engaged that would have prepared him for feeling a loss of control during the meeting and potentially being challenged during it.

Mike goes on to add a more practical problem to having ODA meetings:

> *The barriers would be privacy, it's not ideal*
>
> ***You need to have that room space***
>
> *Yes you do and I think it should be completely uninterrupted, whether that be noise from outside the room. The environment we used on West 2 was sort of out of the way. The room was locked, whereas here if you are using the staff room where we have the MDT meeting, the phone outside, people may be coming back and fore to collect their property. If you had it downstairs in the lounge, that's not ideal either, so it's not the perfect environment.*

> *...Personally I think we would struggle to make it work in this environment I think it would have to be ward based. I mean there are ways around it. I suppose from my point of view as a manager if these meetings did go ahead I would make sure they were uninterrupted, you could put a notice on the door…*
>
> *Mike Pg. 5*

Mike's opinion is that ODA needs to have a dedicated clinical space for meetings to occur that are uninterrupted and protected. This is a valid point because the process needs to be protected to ensure that the dialogue and thoughts are allowed to develop and build upon prior conversations – if there is an interruption then these thoughts and valuable learning could be lost. Mike obviously understands the importance of the process of ODA i.e. the requirement to build trust through conversation and the need to protect this.

7.2.3.2 PERCEPTIONS OF IMPACT

Mike states below how ODA improved the relationship between him and the service user and how he thinks it would be good to improve the working relationship between any clinicians and any clients:

> *It improved our relationship, gave me a lot of insight into how open dialogue works as well and I would be more than interested to do it again.*
>
> *Mike Pg. 1*

> *We reached a conclusion, everybody agreed, everything was resolved and my relationship with client A, which I never ever thought we had a bad relationship, seemed to improve from there on…*
>
> *Mike Pg. 5*

> *I think it would improve working relationships with the clients, which is number one really, good work relationship with your client, good rapport and being open and honest with your client, yeah absolutely…*
>
> *Mike Pg. 6*

Therefore in Mike's experience ODA creates a space where people can have the opportunity to further develop their understanding of each other to promote trust in order for the service user to take on board suggestions and work on their future goals. I felt that this had been a difficult initial process for Mike (as previously discussed) in that it had exposed him to a difficult period of reflection and introspection about his relationship with the service user - but one that had ultimately been positive for her and for him.

7.2.3.3 POWER

Mike has experienced the movement of control and power within the therapeutic relationship. At first this is experienced as a threat to him, but then later his perceptions change due to the impact he sees it have on the service; which appears to Mike to be a positive experience:

> ***What does Open Dialogue Approach (ODA) mean to you?***
>
> *I suppose it is a way of interacting with clients on a more level playing field where the people in the room are of… have an equal status - we leave our professional hats out of the room, if that makes sense.*
>
> *Mike Pg. 1*

Mike concurs with Rachel's opinion that ODA creates an equal status professional relationship. In Mike's perspective he feels like he has to leave his professional identity outside of the room in order to sufficiently ensure that power and control is shared between the participants within the meeting. Mike goes on below to describe how when he initially participated in the meetings he felt his control was taken away:

> ***But why did it feel awkward and intense?***
>
> *The intensity was that I didn't feel in control. If I go into a meeting, I like to be in control, I like to know what I'm going into and have a plan of what's going to happen, but with this it was different, I didn't know what the client was going to say to me. I didn't know what her issues were, but yeah that was the intense and awkwardness of it. I think the awkwardness was sitting in a room with two people I know well, who didn't have any input at all, just sat there listening to what we were saying.*
>
> *Mike Pg. 2*

For Mike there was a tangible effect where he did not feel in control and this made him feel awkward. We can assume here that either the other clinicians in the room were in control or that the service user was in control. Mike's previous statement that he now leaves his professional hat out of the room is probably his mechanism for both ensuring that he complies with the ODA principles and gives control to service users, and also it may act as a way of psychologically protecting himself. In this way, before Mike goes into the meeting he can prepare himself that he will not be leading the session; it will be jointly led by everyone in the room. This is something that would be uncomfortable for Mike if he maintained his professional role where he feels he should be in charge or take the lead.

> ***What was so different about it from normal everyday psychiatric practice?***

> *I think it's about people being honest in there and I know that sounds, but it is, I think it is about people being honest. When you go into an MDT meeting, the client will talk about themselves and we will suggest things. With an open dialogue meeting, I found it was more, I'm not going to use the word controlling but it was, I think maybe not controlling, the client has, they've got more opportunity to be honest because there's less people in these meetings. I imagine in MDT meetings they can be quite overpowering for the clients because you could have 7 or 8 people in an MDT meeting or CTP meeting at one time.*
>
> ***And some of those people you might not have even met before?***
>
> *And the fact with the open dialogue as well, I've been invited into there. The client's agreeing to meet with Jayne and Andrew, so it's 3 of them they had the opportunity to invite someone else in, so they've taken control, so they are being empowered to take control of that meeting and talk about what they want to talk about, not what we want to talk about. So ……*
>
> ***That's the crux the control the client has got within those meetings?***
>
> *For us as clinicians I think to use that word control is an awful word, but I think for the client to have control, it's better. For us it's empowering the client and giving them a little bit of control.*
>
> *Mike Pg. 4*

Mike confirms that he believed the service user was in control because she had been the person responsible for inviting him to the initial meeting. He goes on below to state that by having that ownership (control) is important.

> *I suppose the most important thing is for the client for them to want to engage in it and have ownership of it as well…*
>
> ***And how can we ensure that?***
>
> *By talking to them, asking them what they want. I think ownership is really important, involvement, really important…*
>
> *Mike Pg. 5*

Mike found ODA awkward at first but following this he found the value of the approach with service users. From his perspective it is the sharing of control and choice that empowers service users not only within the meetings but also this remains with them outside of meetings too.

7.2.4 PATRICK

Patrick is the least experienced of all the participants within this study. Despite this he is a manager and a person in authority. Patrick does not have any psychosocial training either. However, Patrick seemed unphased by this and confident in his skills and actions.

Subordinate Theme 1 **LEARNING/ AQUISITION OF NEW SKILLS:** ⇧	
Initial ideas	Good to be informed before meeting… but good to go in blind too (education) (pg11) Experienced clinician required to be a guide (pg11) Easy to do ODA – just need a room then do it
Subordinate Theme 2 **FEASIBILITY OF ODA/ BARRIERS WITHIN HEALTH BOARD:** ⇧	
Initial ideas	Not professionally led (pg1) Control (pg1) Uncomfortable x 2 (pg3) What the hell is going on? (control, power, uncomfortable) (pg3) Rude to talk about someone else (barriers) (pg4) Uncomfortable (pg4) Practice could be challenged, integrity, professionalism questioned (barrier) (pg4) Professionalism (pg 5) Not in control (power) (pg6) Awkward – never experienced anything like this before (pg6) Mark comment – fishing for disciplinary (managers hat) (pg12) Professionalism/ risk (pg12) Need a good therapeutic relationship before ODA (pg12) Benefit certain patients - language can be a barrier (pg13) Continuity of staff important (pg13) Need to be honest (pg14)
Subordinate Theme 3 **PERCEPTIONS OF IMPACT** ⇧	
Initial ideas	Not professionally led (pg1) Control (pg1) Reflection (pg1) More meaningful (effectiveness) (pg2) Reflective discussion (pg3) Trust (pg5) Reflection – in-depth opportunity to do that in the session (pg7) Effectiveness of communication (pg8) Effective for every patient – network meetings? (pg8) Effectiveness – time to talk, informal things – not about risk or meds – general Experiences past and present (pg9) Reflection on relevant things(pg9) Relationship building (pg9) No repercussions (pg9) More regular meetings? … no wouldn't help (pg9) Patient listened to issue with reflective discussion (pg10)

Superordinate Theme: POWER			
	LEARNING/ AQUISITION OF NEW SKILLS	**FEASIBILITY OF ODA/ BARRIERS WITHIN HEALTH BOARD**	**PERCEPTIONS OF IMPACT**
Subordinate Theme	Experienced clinician required to be a guide (pg11)	Not professionally led (pg1) Control (pg1) Uncomfortable x 2 (pg3) What the hell is going on? (control, power, uncomfortable) (pg3) Practice could be challenged, integrity, professionalism questioned (barrier) (pg4) Professionalism (pg 5) Not in control (power) (pg6) Awkward – never experienced anything like this before (pg6)	Not professionally led (pg1) Control (pg1) Trust (pg5) No repercussions (pg9)

7.2.4.1 LEARNING/ AQUISITION OF NEW SKILLS

Patrick relates an account when he first attended a network meeting, where he recounts that he wished he had been informed what format the session would take, but in hindsight explains the merits of not knowing and going into the session blind:

> *Basically I thought it was just a session, I didn't realise it was going to be a one to one discussion conversation with the patient, no I didn't realise it was going to be like that. I probably would rather before we went in there to be told this was what was going to happen but they didn't but going in blind was just as good, I didn't have any expectations I didn't know what was going to happen, I did feel awkward at first and I didn't particularly like it but I did feel like I was being questioned on my facts but after that I was kind of fine.*
>
> *Patrick Pg. 8*

He states that both knowledge beforehand or going in blind were equally as good as each other. Although his only experience is going in blind to use his vernacular, which indicates that Patrick has reflected somewhat on his experience. He accepts the merits of not knowing about the topic and how this made it feel awkward for him, but realises that the learning experience was emotionally beneficial to him because it made the lack of control he experienced very real on an emotional level (rather than just a theoretical level that he would have been taught).

7.2.4.2 FEASIBILITY OF ODA/ BARRIERS WITHIN HEALTH BOARD

In the below excerpt Patrick explains his first impressions of ODA and how uncomfortable it made him feel:

> ***What is your experience of ODA?***
>
> *I think first of all I didn’t feel comfortable with it at all*
>
> ***You didn’t?***
>
> *No, not at all, I didn’t like it. Until the second session*
>
> ***So tell me about that first session***
>
> *I just didn’t feel comfortable because the first session obviously myself, the psychologist and the ANP were in there and the patient.*
>
> ***Yeah okay, hold that thought - but just before that how did you first become involved with ODA?***
>
> *The patient asked me to come in there with them so I did. I’ve got quite a close relationship with that person…*
>
> ***And was that to support her or was that because she needed you in the room to talk to you about something…***
>
> *I think she had a bit of an attachment to me, she just wanted me in there. Maybe she wanted to show me that “look what I’ve done” she wanted to show me “I’m not as unwell as people think”. Because prior I think she done 4 or 5 of those sessions before I went into them, so she was used to them, structure, used to people. Also talking over I wasn’t comfortable at all, I didn’t like it, it was horrible.*
>
> ***What was it about that you were thinking I don’t like that, and was it I don’t like that before you even got in the room, or was it you got in the room and I really don’t like this now?***
>
> *I got into the room and to be honest I didn’t have an expectation of it to be honest. We just began by having a general discussion and then I started going red, getting flustered, I just didn’t feel comfortable with it.*

And what was about it that made you feel uncomfortable?

I just didn’t feel comfortable talking to the psychologist and ANP about the patient who was next to me and them not being involved in the discussion. I just couldn’t... it was new to me I was just thinking what the hell is going on? Because it’s not acknowledging the patient, not even looking at them, that’s the problem I had with it, we weren’t acknowledging the patient, just looking at each other and talking about the patient, not even like bringing them into the conversation, just direct conversation without bringing the patient and the patient was just sitting there smiling and I was thinking oh I just don’t like it, I just don’t like it.

What was so bad about that then?

Because it’s rude isn’t it – I’m not directing the conversation to her, I’m talking about her and she’s smirking because of the stuff I’m saying and I know she wants to intervene but she’s being patient and letting me talk. I know she wants to come and say something – we’re talking about her.

Her joining in...

The things we were talking about were quite personal as well. Things that she’s had to deal with, things that she’s experienced and it was just difficult.

Just go back just before the start of that conversation ……clinicians – did one of the other clinicians ask the permission of the patient to have this reflective discussion?

Yeah, yeah.

That still didn’t reassure you enough?

No because there were no limits to what we could bring up and that’s the thing I suppose I struggled with because I thought you can bring up literally anything that the patient agreed to bring up and there was no kind of structure where we’re not going to talk about this, it’s free, talk about whatever comes up and that’s the thing, it was quite... unsafe…

Unsafe?

A little bit because I was questioned at the time on my working practices and how my relationship with this patient is different from other patients. How we communicate and it’s about how therapeutically, why we have, why am I so close to this patient and the way I talk to her and the way you know I talk to her it’s like as though she’s a friend. I have a little bit of

> *banter with her and we take the mickey out of each other. I didn't feel comfortable in front of them because I think oh look at Patrick he's a bad nurse, he's not, he's messing round he's talking to patients in a non-professional manner basically.*
>
> ***Right.***
>
> *But it wasn't like that, she wanted me to talk to her like that, she liked that I was down to earth with her. That was another reason why she wanted me to come in there because she had such a good relationship with me, she felt comfortable and she knows that I'm not going to be professional all the time and talk about diagnosis and all that kind of stuff – we're going to talk about life basically and how she copes with it, how I cope with it, my experiences, her experiences, what's difficult for her, what's difficult for me – things that I find easy, things that she finds easy.*
>
> ***So it sounds to me like you're already you know on that professional level sort of thing, already started having that kind of almost open dialogue type of discussions with this client before you ever came into that session sort of thing. So the start of the conversation was about why was that so then, why were you able to do that sort of thing?***
>
> *The uncomfortable thing was to get the clinicians looking at the way we talk to each other and that's I suppose the thing I was uncomfortable with because they think "oh Patrick's talking to her in such a bizarre way" that might be construed that it's though kind of like, it's difficult to put into words.*
>
> *Patrick Pg. 2-4*

It is interesting with Patrick that he discloses that the uncomfortable experience with ODA was a fear that he may be judged incorrectly by other clinicians i.e. they would judge the way in which he acted professionally with patients, and deem this to be unprofessional or inappropriate. Patrick had developed a therapeutic relationship with the patient but he had used his personal 'banter' to help him connect with her and was worried how this may be interpreted.

This fear of being judged by others may have been there for previous participants but not expressed. This could be seen as a further barrier to implementing ODA because of the appearance of scrutiny when exploring clinicians' professional relationships, although another way of looking at this is that Patrick may have had that initial fear but his therapeutic relationship with the service user was ultimately validated by all participants in the network meeting.

> *I was thinking it was so awkward, something I'm not used to, something that I've never done before*

> ***Awkward, ok. Awkward because of the rudeness to the client. Your feeling yourself getting quite anxious***
>
> *I don't know perhaps because it's so new – I just don't know what it is. You know towards the end it got a bit easier, but I think it's probably because I never even experienced it before it's just something that I've never ever done so it's going to be alien.*
>
> *Patrick Pg. 5*

Patrick thought it felt rude to talk about the service user in front of her; despite the fact that she had given her consent for this to happen. The first time this happened was very awkward for Patrick in a similar way to Collette and Mike.

Patrick's experience of ODA was unlike anything he had ever experienced in his professional career; he uses the word 'alien' denoting how dissimilar it was to anything he has done previously. However, when he described this he was smiling and relaxed because his thoughts and feelings about ODA had changed since having those initial thoughts.

> ***Do you think that bringing open dialogue in to ------- mental health teams (community and inpatients) do you think it is something that culturally it would be able to use and take on board wholeheartedly?***
>
> *I think I would struggle with some of those acutely unwell to be honest I don't know what you will get from them; although the client we are talking about today, she started her sessions whilst she was on PICU ward. I think ODA could help many people if they were able to communicate with others.*
>
> *The sessions that I was thrown into, immersed in, may have felt full on but it's only because the client was happy and they need to be comfortable. Continuity is also required within the sessions for the service, we need to have continuity of staff so that there is a progress to the dialogue and sessions and the client is not starting with a new person having to catch up to where they are.*
>
> *Patrick Pg. 10*

Patrick makes a valid point here about continuity of staff and the service user being happy for the meetings to occur; without this explicit consent ODA could not and should not be employed.

7.2.4.3 PERCEPTIONS OF IMPACT

Patrick below describes how he felt ODA helped service users:

> *She felt like she was listened to I suppose and going back to the relationship, I think it has helped the relationship along.*
>
> *Patrick Pg. 7*

Patrick reiterates that the therapeutic relationship is reinforced due to the fact that the service user felt listened to during the network meetings. Below Patrick offers an opinion that he feels many clients (so long as they are able to communicate) with different levels of acuity could benefit from ODA.

> *... although the client we are talking about today, she started her sessions whilst she was on PICU ward. I think ODA could help many people if they were able to communicate with others.*
>
> *Patrick Pg. 10*

7.2.5 HEATHER

Heather is an experienced clinician with training (both formal and informal) in both CBT and family work. Therefore she appeared to be the clinician most at ease with ODA.

Subordinate Theme 1 **LEARNING/ AQUISITION OF NEW SKILLS:** ⇧	
Initial ideas	Education – powerful but need to be aware of principles (Pg6) Previous experience family work positive (Pg7) Learning through feedback evidence – anecdotal (Pg8) Family work skills important (Pg8) Education induction (Pg12)
Subordinate Theme 2 **FEASIBILITY OF ODA/ BARRIERS WITHIN HEALTH BOARD:** ⇧	
Initial ideas	1st time scary (Pg1) Fear of reflective discussions (Pg2) Difficult to engage with initially (Pg5) Logistical barriers (Pg6) Resources barrier 2 staff (Pg7) Some staff find it bizarre (Pg9) Barrier – SU floridly psychotic (Pg9) No power, or control (SU in control) (Pg10) Barrier if you can't give yourself to the room (Pg11) Risk (Pg12)
Subordinate Theme 3 **PERCEPTIONS OF IMPACT** ⇧	

Initial ideas	Listen (Pg1) 1st time patients perplexed (Pg1) No expectations – control (Pg1) Control (Pg1) Scary but humorous (effectiveness) (Pg2) Insight (effectiveness) (Pg2) Honesty (Pg2) Trust – personal thoughts to influence (Pg3) Enjoyable (Pg3) Effective (Pg3) Safe – promotes trust (Pg4) Insight (Pg4) Effectiveness (Pg4) Medical vs person centred – power (Pg4) Person centred (power and effectiveness) (Pg4) Trust and confidence (Pg5) Conversation only with the person in the room (not outside) (Pg5) Trust (Pg5) Educating (Pg6) Effective (Pg7) Feedback from SU positive (Pg7) Reduced prn and the need for high care environment (Pg7) Therapeutic relationship (Pg9) Know the person not the illness (Pg10) Builds and builds approach (trust forming) (Pg10) No power, or control (SU in control) (Pg10) Give yourself to the room, be honest (Pg11) Small steps to build confidence (Pg11)

Superordinate Theme:

POWER

⇧ ⇧ ⇧

	LEARNING/ AQUISITION OF NEW SKILLS	FEASIBILITY OF ODA/ BARRIERS WITHIN HEALTH BOARD	PERCEPTIONS OF IMPACT
Subordinate Theme	Education – powerful but need to be aware of principles (Pg6)	1st time scary (Pg1) Some staff find it bizarre (Pg9) No power, or control (SU in control) (Pg10) Barrier if you can't give yourself to the room (Pg11) Risk (Pg12)	1st time patients perplexed (Pg1) No expectations – control (Pg1) Safe – promotes trust (Pg4) Medical vs person centred – power (Pg4) Person centred (power and effectiveness) (Pg4) Trust and confidence (Pg5) Conversation only with the person in the room (not outside) (Pg5) Trust (Pg5) Educating (Pg6) Therapeutic relationship (Pg9) Builds and builds approach (trust forming) (Pg10) No power, or control (SU in control) (Pg10) Give yourself to the room, be honest (Pg11)

7.2.5.1 LEARNING/ AQUISITION OF NEW SKILLS

Heather states in her transcript that experiential learning is an effective method of learning along with classroom training:

> ***Training for open dialogue approach – what are your thoughts on experiential learning compared to classroom training, you know things. What's your views on how...***
>
> *I think there's probably a place for both. I think it's really good to do some on the job stuff, sitting in, watching. We have had people who've joined our sessions and have never experienced it before and the feedback I remember the first time that we did it with one of the ladies and a student nurse sat in and his feedback was "oh my God that was amazing, I've never seen anything like that before" and "I want to do that" but I think you do need to have an overview of what it's about really. Otherwise you could go in there and be focussed, have a plan and – so you need to know the purpose of it. You need to be aware of what the principles are. But I think the skills, I think a lot of staff have them in their toolkit.*
>
> ***It's not too different.***

> *They don't use them. Yeah so it's tweaking what people have got and for people just not to be afraid to just sit down and listen.*
>
> *Heather Pg. 5*

For Heather a practical approach is the most accessible and most rapid way to access ODA. Although she does admit that knowledge of the principles is vital.

7.2.5.2 FEASIBILITY OF ODA/ BARRIERS WITHIN HEALTH BOARD

Heather describes below how she too was initially anxious when undertaking ODA:

> *The first time I used it, I suppose in some ways it was quite scary, I didn't quite know what to expect, but actually to say what you think and to say what you feel, listen to what the person is saying to you and to have a discussion with other people who are in the room with you reflectively about that conversation helps sometimes guide where you're going. I think when you get into it a bit further you build a relationship with the person, so you're hearing what they are saying. The very first time we did it I think the actual patient was "hang on, what's going on?" and I think she said something like "no-one's ever done this with me before".*
>
> *Heather Pg. 1*

The first time Heather did an ODA session it was the service user's first time too, and Heather recounts the service user's dismay at what was happening. In this way it could be argued that Heather did not experience ODA like the majority of the other participants, where the service user was already experienced in ODA. Therefore Heather's initial experience was probably less professionally threatening as she was in control about how and when the control was given and handed over to the patient. However, it may also be that Heather was a very experienced clinician with psychosocial training which facilitated this type of discourse.

> *I think for myself when I use the approach I give a lot of myself to that and the patients that I work with, the clinicians I work with – you get to know a lot about the other person in the room as well because I think I'm expecting the service user to be honest about how they're feeling so I'm always very honest about myself as well in that. Not giving away you know, sensitive confidential information about myself but I will share about how I might feel or experiences I might have had as a child and life experiences because they are real and I think we have to make it real. I think people will struggle about giving maybe themselves to the process.*
>
> ***It's almost about connecting with somebody on a personal level.***
>
> *Yes, so I think if some people struggle with that, then the process will not be as therapeutic.*
>
> *Heather Pg. 8*

Heather feels that only by clinicians being able to give themselves to the meetings and to disclose some of their personal experiences can ODA be effective and therefore clinicians who are unable to this could be a barrier to its implementation.

7.2.5.3 PERCEPTIONS OF IMPACT

Heather discusses below how ODA network meetings were used to reassure the service user and enable them to begin to talk and open up:

> ***But even though there was some discussion about the treatment plan or the treatment options, she was the one who was leading on it?***
>
> *Yes she was the one who was asking for that and I think as well it came out that she was really quite scared. We had quite a lot of humour in the room as well. I think humour helps with the dialogue, especially when you get to know people. But there were some jokes, I think initiated by my colleague and myself and I think that broke down some barriers, but also some self-reflecting about how we might feel if it was us that this was happening to.*
>
> *Heather Pg. 1*
>
> *My colleague and I might have a discussion about what the client was saying and if that was us, how that might make us feel and then she would have the opportunity to either agree, disagree – give some comments on how she was actually feeling. Which then enabled us to gain more insight into how the situation was affecting her really.*
>
> *Heather Pg. 2*

However, it is also about being honest and transparent about the process and about what is going on in the room so that meaningful insights can occur:

> *People who haven't done (network meetings) before they would have to listen I suppose to professionals having the conversation while they were present in that moment, but it allows you to be very honest about things with the person being present in the room and almost about making those decisions that – you're signing up to those decisions together then about where do we go with this and what is the best thing to move forward and also maybe throwing in a couple of suggestions in a conversation that you might think the person might require but they might not think of themselves or might not be aware of – so you might put them out there for them to sort of think about, but there's no expectation that they're going to take that on board.*
>
> *Heather Pg.2*

Although it should also be an enjoyable experience too:

> *No, no I think it's been enjoyable for all the people – the feedback is that they like it. Actually one lady who we've worked with for eighteen months now, and we had an open dialogue meeting with her about three weeks ago, but we'd had one the month previous and when we came away from the one the month previous, my colleague and I were having a discussion about "are we doing the right thing now, is the person getting anything out of these meetings still? You know what is the purpose of these meetings. So when we went back three weeks ago to the meeting we sort of just generally had a conversation and her key worker was also present in the room and she was present the time before and we sort of started off by saying how was it going, how were you blah, blah, blah checking it first of all and then my colleague and I had the conversation and we said first of all can we just have a conversation first and we had the conversation "were not quite sure you know is it worth us still coming anymore, have we done enough now, is it of benefit?" and the client sort of stopped us there and said "definitely, oh please, please come, I don't want you to stop yet I still want you to come monthly until possibly my discharge in October and then maybe I can go 2 monthly" and the other staff member, the key worker who was present in the room had also said that following the month's previous meeting that the client had fed back to her that she really appreciates us going and it's worthwhile because it's a positive experience.*
>
> *Heather Pg.3*

Heather above had positive feedback from the service user who found the intervention was beneficial; this was following an honest reflective discussion between clinicians about how they were unsure whether the meetings were of any use to the service user.

Heather goes on to state that ODA provides a safe place to have conversations (that can be direct and honest) that would not normally happen, but need to happen to progress the therapy.

> *It almost felt safe for them to do that in that context rather than they wouldn't have those conversations outside of an open dialogue network meeting but it sort of felt safe for them to do it within that.*
>
> *Heather Pg.3*

The below insight describes how a service user who had been accessing ODA meetings for some time was finally able to invite her family into the meetings along with professionals who were helping her, and was finally able to tell her parents deep insights into her illness:

> ***It gives the client an opportunity to get to know you and your colleagues and what you're thinking about?***

> *In another session, which was more of an MDT or bigger MDT open dialogue with one of the patients. With that it was more about, well definitely the client fed back but also the parents fed back that it was a brilliant arena for them to hear things that their daughter had never said to them and they had never heard those things before because they had never had the opportunity to be part of a sort of reflective discussion and also for the clinicians themselves. My colleagues who were having reflective conversations as to possibly what it might be like to be that person and that's really hard to do because you take on the emotional part of that, it's really hard so your holding it and feeling it a lot of the time, but then when you say something which really touches a nerve with that client that they feel "oh my God that is so powerful and they then tell their parents that they had some feelings – for her parents and her it was one of the best things that was ever said really.*
>
> ***It actually connected – communicated effectively with each other.***
>
> *Heather Pg.3*

The below account from Heather explores the benefits of breaking away from the medical model and leave the clinician to connect with the service user through dialogue and build upon trust and thereby build their confidence and rapport through dialogue:

> *I think what's good about it is the narrative part of it, you see the person. I think we work in mental health, we work with people. Often, although I work in Recovery services, some of it is still very medically driven, but this is not necessarily about the illness at all or what's going on about the illness, it's about the person and more. Yes you do definitely talk about symptoms if the patient brings those up but it's all what is distressing or good for the person at that moment in time is discussed so it should be a positive experience for the person.*
>
> ***The medical reasons are definitely not the centre of it – they might be on the periphery.***
>
> *Yeah, yeah it's about the person's goals, where they want to get to in the context of yes, some people might be in a more secure environment than others, some might be in community placement. It's not about that, it's still about them as a person, what's affecting them in their lives really.*
>
> ***Anything else?***
>
> *What else is good about it? I think, I don't know, I was talking to some nurse foundation programme nurses last week and I was talking about open dialogue and what I said was for me, using that approach allows you to get to know, it's just about getting to know the person the best way you can. Because what I might think, what I maybe used to think was important for people by being in the room with them isn't the case a lot of the time. Sometimes it's about,*

> *you might think oh they want to stop taking the medication, they want more leave. I've found it's not necessarily about that, it's about knowing that people trust them. They can build a life with an illness, that's what I think.*
>
> *Heather Pg. 3-4*

Heather below believes that those people who she has worked with using ODA have benefitted immensely from the intervention:

> *Ok, I think the people that I've worked with, the service users have found it very useful and…*
>
> ***How do you know that?***
>
> *Because of verbal feedback that they've given us, that it's helped them tremendously and I think with the one lady definitely, not just the open dialogue but the other part of the service were helping her focus on her recovery but she, her medication had dropped dramatically in a very short space of time, the use of PRN that she was using. Because she knew that she would have regular meetings with myself and my colleague once a month but also have some other sessions in between as well to help her with her symptoms. So there were all of these things going along together but the outcomes for her were tremendous in that she used very little PRN medication and she came to our service and her family also said just the general overall improvement of this lady was unbelievable.*
>
> ***So they were picking up on that?***
>
> *They picked up on that and the level of the care environment that she needed had greatly reduced as well. Where she'd been in a psychiatric intensive care unit for three years to go into a supported recovery service to now being in an open community based unit.*
>
> ***In a short space of time?***
>
> *In a short space of time and then around the carer stuff yeah the feedback. Although we worked with a client whose parents were involved with us for a while, I think we only had about five actually MDT network meetings which involved the client and the carers but we also did use the same approach just with her parents because it was quite a distressing time for them, so we used it to support them as well, which they fed back was very very useful. For them to be able to reflect on themselves and how the situation was having an effect on them. But those discussions weren't about necessarily talking about their daughter, it was about how the situation affected them.*
>
> *Heather Pg. 5-6*

This change in service user seems quite profound although we cannot say for certain whether this improvement was the direct consequence of ODA or just a coincidence. However, the fact that the ODA team were able to connect with the service user (who had been on the intensive care unit for three years previously) demonstrates some merits in their abilities and perhaps that of ODA.

Heather goes on to say that ODA could work in other parts of the service as Patrick had stated previously:

> *Yeah I think it could work across the board really and even though I said it didn't necessarily work for people who are floridly psychotic I suppose the length of the session then has to be much smaller, but it's still the opportunity to engage with that person because that person is floridly psychotic is somebody that we've worked with using the same approach for 18 months. It can work but it's about – I think you have to be consistent as well and for the person they need consistent members of whoever is going to do that open dialogue because it's about having that therapeutic relationship with them.*
>
> *Heather Pg. 7*

Heather describes that the intensity of ODA can be tailored to adapt to the changing needs of a service user who may even be floridly psychotic. However, there should always be some negotiation with regard to the goals people set for themselves so that they can be explored carefully to build on resilience and ensure that the interim goals constructed are achievable.

> *The person that you're working with it's their lives and sometimes it's their, they have to take the opportunities and whether the nurse sometimes might think it's a bit risky, you know the suggestion of what they want to do, oh it's a bit risky but then it's about exploring that a little bit more and having a discussion and finding a little bit that might not be too risky that they could just try and dip their toe in you know, maybe I would really love to – you know one of the service users said to us once "well what I'd really like to do, when I was younger I went I can't remember where it was, somewhere abroad in like an Asian country". And she took a taxi ride and visited all these different places and she'd really like to do that again. This was pre her becoming unwell. So you sort of think well ok that's a brilliant thing, but maybe you need to build some resilience but it's how, maybe the conversation about how you get there, sort of thing and how you build that, so yeah small steps.*
>
> *Heather Pg. 9*

Heather describes many examples of what she believes is the positive impact of ODA on the service users that she has worked with.

7.2.5.4 POWER

The below excerpt by Heather describes how the service user led the conversation and appears to be on her terms rather than what the clinicians may have wanted to talk about e.g. medication or treatment options:

> ***And what do you think was so different for her?***
>
> *I think it was just about her having the opportunity just to lead the conversation in whatever she wanted to talk about and it not being the conversation that was around necessarily medication or treatment options, things like that. It was just about what was happening on that day, although she had some questions about her future care, but really it was about that day. How she was feeling on that day and then what might happen following that because this lady at that time wasn't in our service she was in another service doing some sort of transition before she came to us.*
>
> *Heather Pg. 1*

Therefore control is important to Heather and giving that control to the service user is vital. The excerpt below reiterates that it is about what the service user (or person) wants to discuss, good or bad, about the things important in their lives that may be affecting them in the present:

> *Often, although I work in Recovery services, some of it is still very medically driven, but this is not necessarily about the illness at all or what's going on about the illness, it's about the person and more. Yes you do definitely talk about symptoms if the patient brings those up but it's all what is distressing or good for the person at that moment in time is discussed so it should be a positive experience for the person.*
>
> ***The medical reasons are definitely not the centre of it – they might be on the periphery?***
>
> *Yeah, yeah it's about the person's goals, where they want to get to in the context of yes, some people might be in a more secure environment than others, some might be in community placement. It's not about that, it's still about them as a person, what's affecting them in their lives really.*
>
> *Heather Pg. 3*
>
> *Yeah it definitely doesn't feel as though there is a power struggle when you're in the room, there is no eye on the nurse, none on the service user. Yeah there's no power in the room. The person has the power the service user has the control, but the clinicians don't have any power at all.*
>
> *Heather Pg. 8*

Importantly Heather states that there is no power struggle or professional struggle (as previously stated the professional hats are out of the room), it is about three or more people sitting in a room having a talk that generates greater understanding of each other through dialogue. For service users exposed to this way of working (ODA) as compared to their previous psychiatric meetings it must be a stark contrast, which they appear to appreciate from reading the above. Heather appeared to have no conflict about this whatsoever. To her it seemed the natural way of working. This probably comes down to four things: her training, her experience, her years of working in recovery services and also the positive impacts she witnessed on her service users.

7.3 THEMES ANALYSIS

7.3.1 LEARNING/ AQUISITION OF NEW SKILLS

This first theme involves looking at how practitioners became involved with ODA and how they acquired the skills to become ODA practitioners. Some practitioners were provided with ODA information/ learning whilst others had been immersed into sessions without such information.

This first theme can be seen to have generated data that alludes to the fact that participants are supportive of both types of learning and there appears to be no consensus on what should happen first; experiential learning or classroom training. The merits of both have been observed; the exposure to ODA without prior knowledge is seen as a positive experience, along with having information beforehand. This is something that may need to be explored further as it is difficult to ascertain what has greater benefits due to the subjectivity of the respondents along with the bias that they have been exposed to, i.e. the way that they were initially exposed to ODA may have influenced their responses because they cannot undo how they were first exposed to the intervention.

7.3.2 FEASIBILITY OF ODA/ BARRIERS WITHIN HEALTH BOARD

Barriers to implementing ODA were raised by all participants.

To recap on this theme, barriers to implementing ODA are as follows:

- The principle of tolerance of uncertainty – this is where no information is recorded or discussed in between meetings; participants highlight the problem of this in that legislation in this country dictates that we must record notes fully.
- The clinicians who participated in this study felt that the NHS is not open and transparent like ODA is and this dichotomy makes it difficult for ODA to be fully implemented in our services.
- Participants feel that they need appropriate clinical space in order to successfully hold ODA meetings.

- Some participants can feel judged by colleagues about their clinical practice, especially during clinical reflective discussion.
- Participants feel that you have to give some of yourself to the process – to make it real and genuine.
- Participants felt stripped of their professional mask and therefore authority in the room. Less experienced participants found this more difficult.

7.3.3 PERCEPTIONS OF IMPACT

All the participants discussed in some way about their perceptions of ODA's impact in their sessions with service users. This was experienced in a variety of ways.

To conclude this theme it is apparent that ODA clinicians feel that there is some merit in its application. They felt that they could see the impact it had on the service users that they worked with. This positive effect was observed through a reduction in clinical acuity (use of medication and hospitalisation), achievement of goals and direct feedback from service users.

7.3.4 POWER

This overarching theme explores the power relationship between clinicians and service users. ODA theory aims to promote and elevate service user authority, control and status in the clinical environment, and it became evident from the interviews that this aim had transferred to the local health board.

7.4 SUMMARY

The themes presented indicate that robust learning (experiential and classroom) is important to be able to equip staff with the skills required to undertake ODA interventions; although as mentioned by participants an experienced clinician working with an inexperienced clinician in partnership is vital. Power has a vital role in ODA in that part of ODA perception of effectiveness by the clinicians involved in this study is the empowerment of service users, although some participants can be affected by their perceived loss of power which may be seen as a barrier for some. Other barriers of ODA being successfully inculcated into the local health board is the tolerance of uncertainty principle which clinicians are expected to undertake. This may be difficult in a health board (and country) where risk is always minimised and standards assume that all safeguards are put in place. Finally, all clinicians are in agreement that ODA is effective. However to demonstrate this, further work will need to be undertaken to accurately measure whether ODA is effective or not.

8. DISCUSSION

The study research question was as follows:
What was the experience of mental health nurses in an inpatient and outpatient setting of using Open Dialogue Approach following its implementation in a local mental health clinical board?

This work has been achieved through conducting an IPA study using interviews with staff who have used ODA. In addition to this it has been informed by research from Western Lapland that purports the efficacy of ODA, and has been driven by the lack of evidence within the UK to demonstrate whether ODA is transferrable to the UK and whether it is as effective as its developers report.

During the finishing stages of this work, other research papers have been published, but in particular studies by Ellis (2018) and Tribe et al (2019). Ellis' (2018) study used a qualitative narrative approach to interview staff of their experiences of using ODA; Ellis found that ODA had a positive experience on staff practice. However there were several organisational barriers faced in implementing ODA due to the medicalised approach embedded within the organisation.

Whilst Tribe et al (2019) looked at staff and service users experience of ODA using an inductive thematic analysis approach. They found that clinicians' perceptions were that ODA was effective, a preferred choice, but a challenging way of working. Service users' views were mixed, with some feeling reflective discussions were strange, but ultimately they mostly felt listened to and had developed a greater understanding between them and the clinicians. Interestingly, service users reported that network meetings were emotionally expressive and could feel overwhelming at times (one service user stated that they felt distressed by them), which implies that the correct support is required for staff and service users. Although the description within this paper as to why service users became overwhelmed is worrying because it relates to clinicians being open about their feelings, which made the service user wary; this appears to be a miscommunication between clinicians and service users. The service users should lead network meetings not the clinicians.

Similarly to the Tribe et al (2019) study, this doctoral study would also have included the views of service users, however, at the time it was felt too time consuming within the deadlines of this programme due to delays within the early stages of developing the proposal. Therefore, any future work is recommended to include the service user voice.

This chapter explores the themes that were raised in the previous chapter data findings. The layout of the discussion is as follows:

- **ODA in a Complex System – practice and research settings**
  This section discusses the importance of a complex system perspective when employing change and implementing something as radical as ODA that challenges many of the pre-existing structures.
- **Themes discussion**

  - **Learning/ Acquisition of new skills**
    This subsection is related to how learning or experiential knowledge is preferred by the participants within this study. Dealing with professional boundary issues, increasing clinician confidence and clinician perceptions.
  - **Feasibility of ODA/ Barriers within health board**
    This subsection focussed on the potential barriers of adopting ODA from the study evidence and from other research sources. Issues found were that the NHS culture is not open and transparent, staff can feel judged/ threatened (at least initially) by ODA, staff felt reduced of their power/ control, the principle of tolerance of uncertainty was not fully implemented due to UK legislation which reinforces a power barrier or power imbalance in the relationships between clinicians and service users. Shared decision making collaborative practice barriers were explored as this could be replicated with the implementation of ODA. Staff need to be genuine/ authentic which could produce professional boundary issues.
  - **Perceptions of impact**
    This section focusses on the shift of control from the clinician to the service user, the therapeutic relationship and recovery.
  - **Superordinate theme – Power**
    The final theme is the superordinate (overarching) theme, which is interrelated to the previous themes and is discussed in each section. It looks at therapeutic relationship verses coercive practices, and the role of the clinician in empowering service users.
- **Further work, extrapolation and dissemination**
  Finally, the chapter provides an overview of further work that is required following this study and similar studies.
- **Summary**
  This section reviews the previous work and highlights strengths/limitations of this research. It concludes that whilst the tolerance of uncertainty principle was not fully adhered to the approach still appears to be effective.

8.1 ODA IN A COMPLEX SYSTEM – PRACTICE AND RESEARCH SETTINGS

Open Dialogue Approach is a multifaceted framework of care and clinical intervention that is informed by seven key principles. There is some uncertainty about which of the principles are the most significant and fundamental to the approach and there is an argument to say that all are equally important and fundamentally connected to each other. The approach aims to provide people with immediate support/ intervention by using dialogue as an exploratory tool to learn how people communicate with each other in a small consistent network. This provides the individual with a therapeutic intervention they may require. Importantly it provides an opportunity for service users to utilise their social networks as support mechanisms. Through network meetings is it estimated that 5% to 10% of the Western Lapland population have had access to psychoeducation; through the network meetings they have been invited into by the service users; this has had the effect of educating the local community in mental health issues and may have reduced the stigmatizing effect of mental illness (Seikkula 2011). This approach not only provides an early intervention service to the individual but also provides an opportunity to provide psychoeducation to the local community (Aaltonen et al 2011). This is now also happening in different parts of the world (e.g. UK, Denmark, New York).

The lens used in this work has been one immersed within complex systems theory. Therefore, when looking at my data and the themes that have arisen, they have been from a complexity theory perspective that attempts to look at a particular system in its entirety to explore all of the ways in which the parts of that system interact and effect the functioning of that system. These are invariably complex, in that they can be visible or hidden, unconscious and conscious actions of the actors involved, which can hinder and support certain actions (Holt 2004).

Complex systems theory is derived from chaos theory that describes how randomness and unpredictable events can cause magnified events, which can at times lead to ordered events spontaneously coming into effect (self-organisation or spontaneous order); complex theory would state that emergent phenomena in closed systems are caused by these random effects within the system (Holt 2004). Such systems are innumerable within health care settings which are constantly in a state of flux and change through the absorption and adoption of new practices into the overall system. This requires a robust use of change management principles to ensure that this happens effectively (due to the complexity and interconnectivity of the different layers of services, people, policies and patients) (Tenbensel 2013). A term within complex systems to describe the application of change management solutions into a complex system that appear to be ineffective is wicked problems (Hannigan and Coffey 2011). Wicked problems arise when the complex system (that is rejecting or encountering a problem with a change process) adapt against the solutions or repairs imposed upon a complex system; the system buffers itself against the change and develops ‘work arounds’ against solutions imposed. These can be from people (consciously or unconsciously) or they can be from the policies and pathways already in place. However, usually complex systems stabilise over time due to the interconnectivity that exists between the various parts of the complex system as the ‘moving parts’ within it reach a state of equilibrium; or in other words create an order or a pattern within the structure (Holt 2004).

It is here that a qualitative approach study is able to draw out this ‘pattern’, and this repetitive effect from the participants from the complex social elements that are at play within the complex systems that these individuals live and work within. It is important to state that ‘closed complex systems’ are the ideal to measure or capture an effect from an external agency. However, an argument could be made to state that there are never any truly closed complex systems as systems are continually moving in and out of each other, therefore, it is impossible to say with any certainty that the outcomes experienced are wholly due to the external agent.

Despite this, the external agency looked at here is ODA introduced into a local mental health service. It is important to state that this external agent was embedded into the system over an 18-24 month period in order for it to become part of the systems and that any effects looked at were genuine themes and issues rather than initial buffering effects of the external agent being initially introduced into the system. Complex systems predict that there will be a series of unintended consequences to any changes into a system; these can be positive or negative emergent phenomena. For example, introducing change into a system or work area can cause stress and anxiety in the workforce due to the unknown and apprehension of extra work and overload. Although in others it can be welcomed warmly and be seen as something very positive. These two extreme initial reactions to change may have happened when ODA was first used in the health board; however from this study it was important to capture the lived experience of the participants and not only their initial experiences of ODA. Whilst the participants discussed their views and experiences of beginning to work with ODA, it was from a historical point of view, where their memories of the events would be ameliorated from current working with ODA and therefore any extreme views instigated by initial anxieties or excitement of working with ODA would have been contextualised over time. Therefore, the views and experiences of the participants were viewed from a complex systems lens in order to explore the lived realities of the participants within this study. By using a complex system lens within this study a complex system tool was used to reflect and analyse the themes further. This was achieved by using a critical systems heuristics (CSH) framework (Appendix K) (Ulrich 1983). CSH looks at a whole system (that focuses on the interconnectedness of all parts) and critiques the system to understand it better through reflecting upon it. Ulrich (1983) states that using heuristics (which is to find or discover) is essential to examine the root cause of issues that are ill defined and subjective issues that are common place when dealing with people.

This framework allows the system to be explored by looking at four separate areas - the questions are split into four areas, Motivation, Power, Knowledge and Legitimation. CSH also ensures that the area examined becomes finite through imposing boundaries on what is considered. Ordinarily complex systems are connected in numerous ways and cannot be confined into a finite space, however, CSH provides a way of placing a boundary on what is looked at but acknowledges that there may be other external influences to what is explored (although the probability will be low). Mahmoud et al (2013) in their paper discuss the benefits of exploring complex models and running simulations in order to explore the ‘what ifs’; in this way CSH provides a double reflective cycle on what has happened and what could happen.

8.2 THEMES DISCUSSION

8.2.1 LEARNING/ AQUISITION OF NEW SKILLS

The first theme extracted from the analysis was about learning and being equipped with knowledge. As previously stated the clinicians involved in this study were exposed to differing knowledge and learning regarding talking therapies and ODA prior to their first ODA network meetings. It can be argued therefore that those equipped with knowledge were in a more powerful or controlling position as compared to those who were without ODA knowledge. This mostly relates as to whether participants had sufficient training, but equally it relates to service users feeling empowered by participants through the dissemination of knowledge to service users. As previously stated in chapter 1 most staff were taught through experiential learning gained through the senior clinician who had been trained and experienced in ODA via support from the local mental health service.

This theme was initially interpreted about clinicians who felt that they did not have enough knowledge of ODA in the first network meeting that they took part in. This potential exposure appeared to be quite anxiety provoking, for example, when Patrick and Mike first attended a network meeting they recounted that they would have appreciated being informed about the session. As previously stated this probably relates to a lack of control by the clinician. However, this highlighted that the theme is split into two components: the first is that of clinicians not being adequately equipped with knowledge prior to their initial meeting, and the second is concerned with the service users in those meetings already being equipped with the knowledge to function effectively within the meetings, i.e. service users were relatively empowered as compared to the clinician who was disempowered (this was especially displayed in the participants narratives of the initial meetings).

It has been claimed that both power and knowledge have become indistinguishable in modern times since the advent of science, which has been viewed as a form of control and domination over the wider population (Bracken & Thomas 2005, Laverack 2005, Thompson 2011). Although arguably, the previous paradigm of religion can equally be seen as a form of control and subjugation through the religious authorities being in possession of religious knowledge and thereby power over the masses (Rolfe 2000). Foucault outlined that knowledge and power has allowed people to develop greater self-awareness through the use of science and technical tools of knowing and exploration. However, this technical and scientific aspect of knowing has been argued against because it has impacted upon the ways power and knowledge are related; knowledge tainted by power (Foucault 1967). Although in recent times it can be argued that knowledge is abundant and accessible to the general public due to the internet (and mobility of the internet) which has empowered everyone.

Therefore, clinicians need to embrace the fact that their patients/ service users are more empowered and knowledgeable. ODA provides clinicians with a framework to facilitate this through network meetings, but to achieve this successfully they need the skills to do this. In a study by Laidsaar-Powell et al (2013) looking at triadic communication (patient, doctor and companion) in medical consultations, they concluded that such communication is helpful (to all participants) but also challenging (especially to the clinician). Health professionals need strategies to do this, i) encourage and involve companions, ii) highlight helpful companion behaviours, iii) clarify, agree and contract companion roles. To implement these strategies the clinicians need to have the appropriate communication skills through adequate training; this learning is transferrable to ODA implementation.

However, returning to Patrick's initial induction into ODA, on reflection he identifies the merits of him not being in a position of control, power or knowledge. He did not approach the session in full knowledge of what discussion topic would be raised or what plans would be concluded therefore the process was more fluid, dynamic and flexible. This was especially the case for the service user who otherwise they may have gone to a meeting where all the clinicians were certain of what would have been discussed and have outlined the plans before starting; thereby leaving the service user feeling led by them and not in control of the process. Therefore from the clinicians point of view having control taken away from them is uncomfortable, however seeing the benefits of the service user having more control was viewed as a positive. The discomfort incurred could be due to several reasons: 1/ from not knowing what he is going into and being unprepared, 2/ loss of his control/ power over the situation, 3/ feeling that he is being interrogated and the focus being on him, his practice, his actions and / or his professional integrity being questioned.

Mike also described how uncomfortable and awkward it was to hear his own words directed back to him through reflective discussions. Collette described that she felt disempowered by the other clinicians in the meeting, stating that this could have been resolved if she had been informed (had suitable training) beforehand. However, Collette's experience and opinion differs from that of both Patrick and Mike, in that she had some prior knowledge of ODA and of psychosocial approaches. Whilst Collette is still uncomfortable to some extent in the initial ODA meeting, this appears less so than Patrick and Mike (probably due to her previous training).

Similarly both Rachel and Heather initially found ODA meetings very positive and different from regular psychiatric meetings, however they appear to have embraced the new approach and be more at ease about the apparent lack of preparedness and control that they had in the meetings. They discuss the reason behind this to be because of their previous experience through long service histories, also, both had previous psychosocial training; they definitely appeared to exude confidence during their interviews. They discussed that because of this they were able to bring a relaxed approach to the meetings and that they were willing and felt confident/ comfortable to portray an authenticity about their demeanour. Similarly, a study by Tveiten & Knutsen (2011) found that patients appreciated a basis for collaboration and informed control, which is open and transparent. Rachel explicitly expressed the view that she should bring in real life examples into the therapeutic discussion; however, professionalism needs to be in place to reduce the risk of the clinician overstepping the boundary and putting themselves and their service users at risk. As previously stated a balance needs to be obtained to preserve the professional boundary and thereby not portray a sense of 'promised friendship' to the service user, but equally portray a true sense of authenticity to the process that the service user can appreciate and use as part of the therapeutic process. This will build trust, affirm service user's experience and be a potential learning point; and a valuable learning experience for the service user.

Therefore, previous training and experience is viewed as a positive that increases confidence and allows the clinician to be more relaxed and bring more of them into the ODA process. However, the danger is that less experienced clinicians without appropriate training could over step this professional boundary; although it has been seen in this study that those clinicians with less experience can feel threatened by the ODA process therefore arguably they may not be so inclined or confident to be so open about their personal experiences. Additionally ODA process is buffered by having the safeguard of a second clinician in the room therefore this could ameliorate any potential boundary problems through use of appropriate directing during the meeting and follow up supervision after the meeting. This would not be to discuss service user plans etc, but to explore why the clinician is overstepping the boundaries for example.

The merits of both prior learning and experiential learning have been explored in this first theme. However, the second theme relating to potential barriers of ODA implementation, in part, explores how the initial anxieties provoked by ODA network meetings may become a barrier for roll out of the approach if adequate training is not provided to participants. However, more research needs to look at this theme as it is such a potentially vital part of implementing the approach to ensure its success. Indications from the developers of ODA is that it requires a comprehensive training package for all clinical participants, however, this work casts doubt on whether such packages are necessary because the clinicians were able to implement ODA when they were paired with a competent clinician. Therefore, research looking specifically at this in the future may provide a definitive answer to this.

8.2.2 FEASIBILITY OF ODA/ BARRIERS WITHIN HEALTH BOARD

All of the participants within the study saw barriers to implementing ODA within the local health board. Within this sub chapter the idea of barriers will be explored. In a similar way to the previous theme, power is the underlying theme that connects the different barriers to implementing ODA.

The first potential barrier that was looked at is the movement of control towards service users and away from the clinicians: health professionals can be viewed as a powerful group of people (Thompson 2011, Paradis & Whitehead 2015) and this power differential can create a barrier between service users and the clinicians who are there to help them (Thompson 2011). However, it can also been seen as a threat to the health professional’s control and autonomy which may become a barrier to the approach being implemented. It is highlighted in the Welsh Government (2016b) document ‘Together for Mental Health’ that this power inequality is especially prevalent in mental health due to the legislation that can involve restricting a service user’s liberty due to the risks that they may pose. The Care Quality Commission stated that restrictive practices are increasing despite evidence demonstrating the lack of effectiveness of such practices (Devapriam et al 2015).

However, the philosophical tension between empowering service users and controlling them still exists especially in cultures where there is a fear of repercussions and litigation (Grant 2009, Thompson

2011). Within Wales the Welsh Government expects any serious incidents to be escalated and reported to them in a timely manner (and by implication that service users are kept safe and restricted from harming themselves).

8.2.2.1 SHARED DECISION MAKING BARRIERS/ ODA POTENTIAL IMPLICATIONS

This subchapter compares findings from the barriers to implementing shared decision meetings (SDM) to the potential barriers of implementing ODA. Legare and Thompson-Leduc (2014) literature review on SDM between service users and clinicians found twelve barriers to successfully implementing the approach. It could be argued that the twelve barriers do not relate directly to ODA, however some of the principles of SDM are shared with ODA. SDM is a process in which service users are empowered through staff sharing power with service users and therefore SDM relates in parts closely to ODA. The correlation of SDM barriers to barriers of implementing ODA will be explored further in the next sub chapters.

8.2.2.1.1 INCOMPATIBILITY WITH POLICIES/ LEGISLATION & CURRENT SYSTEMS/ CULTURES

The issue of restrictive practice or compliance is one that is seen to be in conflict with clinicians' therapeutic relationship with the service user, this is because service users must be compliant with treatment when they do not necessarily want it or feel they require it. However, safety (of the person or others) is used as the reason to take control, although this may not necessarily be open and transparent to the service user (Vuckovich 2010, Hemingway and Snowden 2012).

Collette discusses this as well, stating that she feels the NHS is not open and honest, although the principles of ODA require clinicians to be open and transparent within the therapy. Collette also states that the ODA principle of tolerance of uncertainty is a barrier where she attempts to compromise with the principle to satisfy the legislative duties she is bound to, which is precisely what the SDM study found i.e. guidelines and policies act as barriers to its implementation. Therefore participants could feel conflicted in their duty to fulfil the principles of ODA (confidentiality) whilst at the same time fulfilling their professional and legal obligations. This conflict is expressed by Rachel where she feels uncomfortable that the recording of a meeting is more explicit than she had been taught on ODA training. Her colleague was writing thorough notes because of the legislative processes he has to follow. However, Rachel interprets this as a contradiction in ODA principles that she finds difficult to reconcile; therefore UK clinicians may interpret this as a barrier to the implementation of the approach.

Interestingly to reaffirm the barrier on restrictive practices Raboch et al (2010) research study (EUNOMIA) differentiated the negative power practices across countries in Europe; the drawback to this study is that it is difficult to generalize the findings to a specific country because it is a pan Europe study. However, the study found that the only country where nurses enacted coercive practices more than physicians was in the UK. Therefore, it could be argued that the former preposition offered previously could be the case in the UK; that is, the UK may have issues in adopting ODA into its practices because nurses in particular are used to working in power imbalanced relationships where they may be reluctant to give this up and level the playing field with service users. In support of this, a study by Joseph-Williams et al (2014) into the barriers to shared clinical decision making asserted that there was a power imbalance in patient doctor relationships and that patients want to participate in SDM but cannot due to clinicians' attitudinal issues.

Rachel describes how uncomfortable it could be for staff who are not trained in ODA approach, and Mike recalls how he had mixed feelings and felt awkward about the initial meeting. This was because Mike had been made to feel like he was not in control and because of that he was no longer in his professional authoritative position. For someone uninitiated and without training, this experience could be very challenging for the individual, leading to staff (who are not prepared for it) to think of ODA as a negative intervention, and one which they may not support and potentially create barriers to its implementation. Mike added that the positive outcome of the meeting was good, however if such a positive outcome had not been forthcoming at the end of the first meeting then Mike may have felt less inclined to participate in further meetings.

Despite Collette's previous training and awareness of ODA her first impressions of ODA was uncomfortable and odd. This is similar to Mike's experiences where the service user is already familiar with the ODA process and in control of the situation, i.e. they have both been invited to the ODA network meeting at the request of the service user.

Patrick's experiences of feeling awkward or uncomfortable at the initial meeting was similar to those of Collette and Mike. However, his anxiety was that he may be professionally judged by the other clinicians due to the 'banter' he had with the service user. It appeared that he was afraid that he may be exposed publicly for his style of interaction with the service user and felt both embarrassed and ashamed of this; conversely, his style allowed the service user to feel at ease in their interactions together on the ward. However, Patrick's first experience of ODA resulted in his style of interaction being reflected back to him and exposing it which he felt very embarrassed about. Patrick also felt uncomfortable regarding talking 'about' the service user and not 'to her' during the network meeting; if he had been informed or trained about this his initial anxieties would most probably have lessened.

Some of the nurse participants within this group show varying degrees of anxiety at the loss of control within their initial ODA meetings. As stated by Raboch et al (2010) some of the nurses may have issues giving up this power especially when they first become part of an ODA meeting. In theory, at this point clinicians may stop using the approach and develop negative constructs about it and against it.

Cutcliffe and Happell (2009) in their study focused upon interpersonal relationships within the therapeutic relationship and found how power is fundamental to this. They state that nurses are particularly uneasy about this, and that there is a vacuum of such research being conducted by nurses. They state that power within psychiatry is dominated by the medical model, which nurses are drawn into by default. It can be argued that nurses are ashamed and reticent of this devolved and patronised form of power. They go further to add that the recovery principles of the last 20-30 years are an alternative to this form of power to which nurses can legitimately embrace and can break away from the medical model. It is important for health professionals to be aware of how power is related to health and how much power health professionals hold. It is also vital that they understand the drawbacks and benefits to power, especially in how they may be used to influence and propagate the therapeutic relationship.

The conundrum facing clinicians working with service users using a shared decision making approach, when they are acutely psychotic and experiencing symptoms such as hallucinations and delusions is that their thinking and behaviour may not necessarily be rationale, therefore the task of working with such individuals can become very difficult. Shared decision making processes require a collaborative approach and an ability through insight and reality orientation to empathise with each other’s positions (Vuckovich 2010 and Lysaker et al 2011).

Curtis et al (2010) offers an opinion that current UK legislation constructs socially restrictive practices that ultimately serve to disable the service user through hampering the process of them learning personal coping strategies/ resilience that can ultimately lead to true recovery and autonomous living. The rationale for socially restrictive practices appear sound in that society ‘wants’ to protect the individual and others from any harm that may come to them due to their mental illness. However the reliance on such restrictive practices takes them away from ‘living’ with their mental illness in their day to day lives and takes away the opportunity for others (family and friends) to learn, adapt and live with the mental illness as well. Therefore the service user and significant others miss the opportunity of living through an acute phase within their ordinary lives and developing a shared learning, shared coping mechanisms and shared strength through each other (Seikkula 2003).

8.2.2.1.2 SDM NOT HERE TO STAY

The next SDM barrier looked at was the belief held by individuals that it was a fleeting model that will be surpassed by something else; therefore, clinicians would be less likely to invest their time and energy in it because it will not last. This could be a valid barrier to ODA and clinicians need to be reassured if it is implemented that it is a long term commitment to the approach.

Within change management philosophies empowering others is a common theme. Transformational leaders empower their staff. Plan Do Study Act (PDSA) cycles are used by front line staff to identify issues and solve these at the source; this empowers staff and ensures that the change enacted is supported by staff. ODA similarly empowers service users to manage their own lives and make positive changes.

O’Sullivan et al (2013) within a participatory research design study found that the following attributes of flexibility, being connected, adaption to change and being collaborative helped those on the frontline deal effectively with disasters. Such attributes are found within self-organisation, which is an effective way of overcoming a controlling management model style which is focussed on risk and reduces the production of solutions into a system; especially innovation and the ability to think laterally to offer more solutions (Holt 2004, O'Sullivan 2013, Trenholm and Ferlie 2013).

Self-organisation is similar to ODA in that it is about connecting to people (through dialogue), collaborating (network meetings), ability to adapt (flexible approach) and control is with the frontline workers (or in this analogy with the service user; not with the clinicians or with management). However, according to Xiao et al (2013) self-organisation can lead to unintended consequences if left unchecked. If there is no overarching direction imposed then separate systems can evolve differently which is of course unhelpful if this involves delivering equitable services to whole populations; however, in the context of the service user's personal growth this is a positive step as they are afforded the ability to grow and develop as individuals.

8.2.2.1.3 MEDICAL PROFESSION IN CONTROL

This barrier involves the preconception held that patients cannot ask/ tell doctors what to do, or to have an equal relationship. This infers that a radical change is required to achieve a position where patients are empowered enough to feel they can be open and transparent and feel safe enough within particular the medical profession. This has been achieved in Western Lapland and within pilot sites across the world (as discussed in chapter 2 and 3), therefore in theory this could be achieved by providing clear policy on this approach that all professions must adhere to.

However imposing control and direction does not necessarily result in the outcome expected. According to Nolan's (2013) research on the 'positive effects' of protected engagement time (PET), they found no significant benefits when comparing PET to a control group; which they postulate is due to the fact that the policy was not clear and directive enough for services to follow. Therefore, change within the individual or organisations must be planned carefully and strategies used in order to achieve success (Alimo-Metacalfe et al 2008). Using a change model such as Lewin's (1951) which follows three steps describing and outlining the change process; unfreezing, moving, then refreezing, or using Kotter's (1996) model (which is expanded from Lewin's model; expanding Lewin's model into 8 steps) provides managers with a map of where they are. The issues involved relate back to complex systems where introducing change requires input or energy to keep the momentum moving and overcome buffering issues (emergent phenomena and wicked problems); otherwise an entropic effect will enter the system, reverting to previous ways of working (arguably all systems without input or energy revert to simpler states in a state of decay).

However, change must be sensitive to the needs of the system, and buffering effects must be acknowledged and taken into account, as these may be valid safety issues. Whilst looking at patient safety issues Reason (1997) reiterates that policy makers must be careful when writing such papers to not introduce system errors or latent errors that produce unintended consequences and negative outcomes. According to Thornicroft et al (2008) change management principles must be based on ethics evidence and experience (learn from past mistakes).

Lanham et al (2013) offers a balance between managerial control and self-organisation through using interdependencies (networks and relationships – common ground between staff and management), and sensemaking (how people assign meaning – to avoid miscommunication and increase clarity) that results in the organisation being able to nudge self-organising groups in the right direction through using one to one meetings and group meetings.

Therefore, choosing the correct leadership style when implementing change is crucial. Leadership styles can be either transactional (management) or transformational (leadership) (Burns 1978, Linstead et al 2009). The transactional style has been described as pure management style where authority remains with the leader who can both reward and punish (Buelens 2006). Communication is mostly one way therefore we can lose staff input and direction. The transformational style leader does not impose their will on others and has a robust communication style (Mullins 2005). They are engaging leaders, role model behaviours, inspire others, challenge existing procedures, empower others and help others believe in themselves (Kouzes and Posner 2007).

Similarly it can be seen that ODA provides this balance of control for the service user and nudges from the clinicians in order to provide the service user with many options and control of their lives. ODA clinicians it could be argued, are required to adopt a transformational and positive style of leadership within network meetings so that service users can be empowered and develop their own solutions that are bespoke to them.

Complexity theory has been used in this study to explore the balance between the individual and personal resources against the organisation / groups of people in a position of power through their number and their knowledge base, and ultimately the governmental drives that greatly influence the organisations. By using a complex system lens change in the individual and the organisation can be planned constructively in order to reduce the risk of destabilisation.

8.2.2.1.4 PROFESSIONAL BOUNDARIES

Shared Decision Making does not necessarily take into account how emotions can become heightened during the intervention; professional boundaries can be put at risk. As previously discussed overstepping the professional boundaries can cause major breakdown in the therapeutic relationship. It can lead to confusion about the relationship which may be interpreted as friendship; this can lead to serious negative and destructive relationship breakdown. However, Heather stated that she felt it was important that clinicians impart some of their own personal knowledge and experiences to the network meetings to make the process as genuine as possible and ODA to be successful; clinicians who cannot do this or do it incorrectly (i.e. stray over professional boundaries) may be a barrier to successful ODA implementation. However, training may be a solution to this.

Finally, staff need to be equipped with the correct knowledge and skills about how much personal disclosure they reveal about themselves to service users (to avoid boundary issues), and that staff are adequately equipped to deal with service user emotions.

8.2.2.1.5 PATIENTS ISOLATED

This barrier found a preconception by clinicians that patients make decisions alone. Patrick alludes to this similar point in his transcript that the service user should consent prior to the ODA meetings because they are so challenging the service user needs to be equipped and fully consented. For example when Heather first did an ODA session with a service user she stated that the service user was dismayed by the approach – this was luckily in a positive way, probably because the service user was being afforded control and choice. However, in some people this may be a frightening experience and one in which they need to be warned about and supported to achieve. Therefore, to go back to a previously discussed study by Laidsaar-Powell et al (2013) – clinicians need to be equipped with skills to educate the patient and avoid feelings of isolation and be required and able to deal with potentially emotive experiences or scenarios that may occur.

8.2.2.1.6 SDM TOO COSTLY

Shared Decision Making can be seen as too costly and time consuming. ODA has also been criticised for being resource heavy (two clinicians required for network meetings). According to Lean et al (2015) in their qualitative study using focus groups to look at barriers to sustaining interventions to maintain patient engagement they found the following barriers: resources – senior support – intervention (this requires intensive of training – which is time consuming and drains resources). For example Mike reports that he found it difficult at times to think about implementing ODA because of the requirement for a dedicated space that could hold meetings without interruption. Therefore senior support is required to ensure that ODA is implemented with the appropriate resources (time, staff, space and learning opportunities).

Formalised ODA training does represent a significant cost burden as every staff member would cost £2,500-£3,000 each.

However, developers would argue that patients who are provided with ODA present less of a burden on healthcare systems in their futures. For example, people rely less on medication and inpatient care as previously discussed.

8.2.2.1.7 STAFF UNSKILLED AT THIS WORK

Not all clinicians have the skills to do SDM. In the study by Laidsaar-Powell et al (2013) they concluded that training was required to achieve successful roll out of triadic communication. Rachel states that the role of chairing network meetings is vital to ensure that all voices are heard. In order to achieve this a certain amount of training or experiential knowledge will be required, otherwise there is a risk that the service user's voice is not encouraged or nurtured (especially within the initial meetings) and the process could fail.

Psychoses cause cognitive impairments, which can impede communication (Chan and Mak 2012). This is therefore an important issue with regard to ODA because it relies so heavily on clear and informative communication; however, this is something that the service user may not be able to do because of his or her illness. However, ODA is able to enhance dialogue and create a space for increasing awareness between participants. This is in keeping with the recovery ethos in the UK which promotes service users to be independent and importantly in control of their lives through affording them choice and opportunity. However, some criticised the professionals' role in this and a disengagement from clinicians in promoting this (Curtis et al 2010). Chan and Mak (2012) also criticise how current mental health treatments have hampered service users by not equipping them with the social skills they require to navigate their communities effectively enough. However, ODA aims to create that learning and reawakening of the service users' voice and ability to communicate effectively with others.

8.2.2.2 BARRIERS TO ODA

In addition to the previous barriers discussed, the following are ODA specific barriers that were further derived from the findings.

8.2.2.2.1 REFLECTIVE DISCUSSIONS

Reflective discussions are an important part of ODA but participants in this study have stated that they can feel intimidating and awkward, especially if they have no prior knowledge or experience of them. Tribe et al (2019) also state that service users found reflective discussions to be strange at first, one stated that they were unprepared for it and not used to it.

Additionally staff are expected to make reflective discussions and network meetings authentic by providing some of their personal experiences to make them full experiences for the service user. Within ODA, these experiences for service users are valued and regarded as therapeutic. However, barriers raised in this study revolved around maintaining professional boundaries; although again this is achievable with appropriate training. Finally, staff can feel vulnerable through being de-professionalised in the network meeting, i.e. they have less control and influence over the clinical situations they encounter in ODA network meetings. Less experienced participants found this difficult; but again with appropriate training this could be overcome.

8.2.2.2.2 TOLERANCE OF UNCERTAINTY

The principle of tolerance of uncertainty is where clinicians avoid 'solving' service user problems or issues and hold the risk with the service user; in addition to this there is no (or minimal) recording of meetings, also discussions about the service user do not take place without the service user being present. Currently legislation prohibits this (especially the recording of meetings) from being achieved. And this principle was not adhered to in the network meetings described in this paper. However, authors such as McKeown et al (2017) and McKeown (2016) discuss how important it is for nurses to champion the ability of the service to tolerate uncertainty and stand up for the rights of service users through a collective resistance to the frameworks that have previously restricted professionals.

However, from the participants' point of view, despite this perceived barrier and lack of adherence to the principle, the implementation of ODA was successful. This appears to be because participants were open and transparent with their service users. Research participants felt that ODA is open and transparent, which ensured that when risk was highlighted service users were fully aware that the clinicians would act in a certain way and would need to share information with others (partially fulfilling the principle of tolerance of uncertainty). Historically this may not have always been the case and such risk issues were dealt with in a more secretive and potentially divisive way.

This work indicates that there may be some flexibility in the way ODA is implemented in the UK. It may be that ODA can be contextualised to the cultures it is used within and the legislative frameworks that organisations must comply with. Although researchers and developers must be mindful that within Ellis' (2018) study found the medical model acted as a barrier to clinician implementing ODA. However, over time and through the generation of evidence, policy can be informed and through lobbying government, legislation can be changed.

8.2.3 PERCEPTIONS OF IMPACT

8.2.3.1 SHIFTING CONTROL TO SERVICE USERS: EQUALITY

ODA clinicians who participated in this study stated that ODA was useful and effective in their opinion. They also described the effect it had on clinical acuity (reducing use of medication and hospitalisation), service users achieving their goals and direct positive feedback from service users. They described ODA as having a very positive effect on their service users through empowerment that they received through it; the benefits for the service user was increased trust, confidence, self-belief, independence, self-reliance, increased knowledge and coping strategies. Additionally they concurred that ODA could be used in the local setting (and not just Finland). However, as previously discussed it requires an adjustment and non-compliance with all of the ODA principles to implement successfully and within the legislative parameters of this country (i.e. the responsibility put onto clinicians about maintaining risk and safety through that legislation makes it difficult for participants to take positive risks at times).

Therefore, this implies that the relationship between the service user and the psychiatric professional is imbalanced due to the knowledge and position held by the professional. For example, the service user would never tell the psychiatrist to comply with treatments or force them to stay in hospital because they require the authority and the knowledge and technical language (discourse) to do this. ODA represents a fundamental change in the relationship between mental health professionals and service users; ODA aims to break the psychiatric model of power/ knowledge relationship and instead build a discourse with the individual to create a greater understanding and knowledge that benefits the service user. Rachel felt that power was a significant factor in service users experiencing ODA as effective; her belief was that service users felt that this empowerment significantly increased the service users' confidence and trust within clinicians that promoted their recovery.

Therefore, increasing service user autonomy and equality with clinicians, i.e. working as equal partners appears to have a therapeutic function and supports the service user in their recovery and being able to lead autonomous lives; as Patrick states service users feel meaningfully listened to. The participants agreed that this shift in control was in their opinion beneficial to the service user.

8.2.3.2 THERAPEUTIC RELATIONSHIP & RECOVERY

As previously stated within mental health the recovery approach has fostered and advocated the therapeutic relationship, which is deemed as a core function for mental health professionals (Wright & McKeown 2018, Perkins 1996, Paradis & Whitehead 2015). Peplau (1988) was the champion within mental health nursing for discussing and promoting the therapeutic relationship agenda. Also highlighting the importance that such relationships have in promoting confidence and good mental health within service users; arguably through a re distribution of power from the health professional to the service user (Peplau 1988). Therefore, ODA can provide a framework for recovery through its empowering philosophy.

A therapeutic relationship is based on trust, non-judgmental approach and unconditional positive regard so that service users are able to meaningfully engage with mental health staff, which will ultimately enable mental health staff to deliver their treatments and interventions (Alanen, 1997). For mental health nurses the core of their work should be dialogue with the service user as a starting point (to create a therapeutic relationship) (McKeown et al 2015b). However, the therapeutic relationship is such a well-established and much used concept (Browne et al 2012), and within the findings, the participants relate to how ODA had some effect on their relationship with services users. For example, Mike recounts how ODA could overall improve clinicians' therapeutic relationships, whilst

Patrick offers a reason behind this, which is because service users feel meaningfully listened to. Rachel stated that for her the therapeutic relationship within ODA was one of a democratic approach, which facilitated an equity between all participants.

The participants highlighted that network meetings can be structured but that simultaneously there is an informality about them which in turn promotes a closer relationship between all in the network meeting making trust and dialogue easier. Although, the clinicians must ensure that they are empathic and sensitive to the service user's way of communicating and make this as bespoke as possible for the service user, i.e. at their pace and ability to increase their overall function (Kennedy et al 2007). Chan and Mak (2012) state that a trusting and close relationship is essential to ensuring that a therapeutic relationship can be created but add that this can only be created through managerial/ policy and legislative support. Heather stated that the network meetings through an individualised approach provided reassurance to the service user to build trust so that they felt more inclined to talk and open up. However it is also important to note that the process is open and transparent so that meaningful insights can be gained by all. The meetings should be enjoyable as well as hard work. ODA promotes working with service users as early as possible, which usually means starting work with them during the most acute phases of their illness; which according to Chan and Mak (2012) can be done and offers the moment to create a trusting relationship through which treatments can begin (bespoke to the service user).

Similarly to what the participants found i.e. democratic approach, trust, empowerment, openness and honesty, the Laugharne et al (2012) study had similar findings. The study aimed to explore the experiences relating to trust, choice and power of service users with psychosis using research interviews. The themes that emerged were that of the need for a shift in balance of power (as service user knowledge changes thus the power balance should move towards them; otherwise a coercive element that threatens the therapeutic relationship may present itself) and a trusting relationship. They describe a trusting relationship as going beyond the training and experience and express the need for participants and service users to include themselves in the process i.e. to present the self into the process; this is something that is encouraged in ODA. They also stressed the importance of touch, along with introducing hope, kindness, shared interests, friendliness and some disclosure from the health professional. Similarly a study by Shattell et al (2007) found that physical touch, providing reassurance (hope), shared personal perspectives and personal warmth, along with a stable environment and continuity of care was seen as important by service users. The study was a phenomenological approach and involved 20 service users who were based in the community. The study also found that active listening was seen as integral by service users.

8.2.3.3 RESEARCH PARTICIPANTS REFELCTIONS ON IMPACT

Collette described how much benefit she felt the service user got from listening to her and the other clinician of having a reflective discussion about the service user (with her consent obviously). The service user came back to them on the next session and had obviously been reflecting on the previous session in a positive manner. Collette also describes that she felt good about the work she was doing and it was evident to her that the work was having a positive effect.

Patrick and Heather both stated that ODA could work in other parts of the mental health service due to the fact that ODA is adaptable and can be utilised during periods when the service user is very unwell. Although they state that goal setting must be tailored to individual needs in order for them to be achievable by the service user. In this way the participants were in agreement that ODA was a positive benefit to the service user; because of its flexibility and bespoke nature to the individual. This was also observed anecdotally through increases in confidence and speech, in service user feedback and through reduction in use of as required medication (PRN – Pro Re Nata) and use of acute hospitalisation.

Heather stated that she felt ODA had a profound effect on the services users she worked with the approach, this is due to the fact it provides a safe space to communicate where participants can be open and honest and their confidence can grow. Further, she states this is because it moves away from the medical model where control rests with the clinicians, which can represent a barrier to implementing ODA as it is different to existing medical model structures in the UK (Ellis 2018). One of her service users had been on the intensive care ward for 3 years prior to the intervention however, the ODA team were able to connect with the service user and within six months of working with her she stepped down from this high intensity and also her medication use had dramatically been curtailed when the intervention began. Heather added that she found that positive feedback from the service user during a reflective discussion had not a positive effect on her continued work on ODA. In a study by Shay and Lafata (2014) on perceptions of Shared Decision Making, they found that ultimately it is what the patient said is the most important feature. By developing confidence through ODA Collette recounts how a service user felt empowered enough to invite her relatives to the network meeting to share in the knowledge and insights gained into her mental illness.

Participants felt they have something worthwhile in work, feel like they are making a difference, have control of implementing something new and do something that they value; not just the humdrum of work. In order to achieve this participants have been given the autonomy and accountability to do and achieve this. Another way of describing it is that they are implementing new ways of working where they are the early adopters. There could have been a pioneer effect or novelty effect where staff persevered through the difficult parts (especially the initial uncomfortable part where control and power was given up), in order to ensure that the approach was successfully implemented (Hawthorne effect – people respond differently when observed or interacted with in a different way to normal/ usual – Sedgwick & Greenwood 2015). In order, to test whether this was the case or not further pilots and rollouts need to be undertaken (or looked into from other sites across the UK).

8.2.3.4 IMPACT SUMMARY

Chan and Mak (2012) state that having a shared narrative should be the main goal for clinicians with their service users. ODA practices or rehearses dialogue through a number of network meetings between clinicians and service users in order for the service user to find their 'voice' but also to build trust and a therapeutic relationship; also, this develops confidence in the service user by their development of being able to communicate effectively.

Therefore, nurses need to realise that power is an important process in their therapeutic relationships with service users that cannot be ignored by them (service users cannot ignore it and do experience it). The majority of nurses do not enter into the profession for power but rather as a vocation to help others, therefore it is natural that nurses may feel alienated and uncomfortable about talking about power; however the reality is that they are in positions of great power, and importantly this is something that service users feel and experience on a daily basis. Nurses need to be reassured that some of this power is legitimate and used appropriately when used to help and treat services users; the crux of wielding power effectively is through the creation of effective relationships (therapeutic relationships). Therapeutic relationships need to be positive in that they are empowering, equitable, reciprocal and offer the clinician as a person (authentic); the opposite to coercive which fits with ODA principles and relationship building. In practical terms this takes time and effort; issues for a busy acute ward, but in reality, this is something that modern mental health services must do. These changes must be at the pace of the service user and in gradual steps that are achievable goals, and in order to achieve this ODA training must be made available to equip staff with the appropriate knowledge and skills to achieve this. In addition, it is not merely the service user who will be part of this process but (with the service users authority) their next of kin and wider social networks who will ultimately form part of the service user's coping mechanism and support in their everyday lives (Seikkula 2003).

8.2.4 POWER (OVERARCHING THEME)

Power was identified as an overarching theme that focuses on the relationship between service users and clinicians. Power is reflected in the subordinate themes as well. The barrier theme focuses on power imbalance (or more accurately power redress – in favour of the service user) that causes anxiety and feelings of being uncomfortable in the clinicians as a potential barrier to the approach being implemented. However, the learning theme addresses this issue by finding that adequate training and knowledge giving can lessen reduce these anxieties. Also the impact theme reports that through empowering the service user and giving control back to them (in a safe space) appears to be the central dynamic of the approach's success; the principles of ODA promotes and elevates the service user's status, right to choose and authority over their lives. According to Rachel her first impression of ODA was that control and power was in the service user's hands i.e. the pilot had embraced this part of open dialogue approach.

8.2.4.1 POWER HISTORY AND IMPACT

The phenomenon of power has been demonstrated to be a complicated area when dealing with humans who have evolved to have a fundamental dynamic of being egocentric and have a requirement for self-control. Within the context of the therapeutic relationship within mental health services power is especially complex and for this to be suitably examined and researched it needs to be broken down into its constituent parts (Bracken and Thomas 2005):

Legitimate Power

Health professionals working within mental health are in a position of power or at least it will perceived in that way by service users as they will be going to the professional for advice and treatment. This power imbalance is mostly viewed and used positively, in that the power is used through the therapeutic relationship as a legitimate purpose for the benefit of service users.

Power and the therapeutic relationship requires balance and reciprocity

Essentially health professionals need to give and take (balance and reciprocity) when building successful therapeutic relationships.

Force, neglect and coercion can have a powerfully negative effect

Negative power modes such as force, neglect and coercion can have an adverse effect on the therapeutic relationship; and this has been quantified through research evaluations.

Systemic effects on perceptions

The system (structural and environmental) can have a significant impact on the way in which service users perceive health professionals as acting coercively or legitimately.

(Bracken and Thomas 2005)

Foucault (1979) described that in the 19th century legal judgements were delegated to the psychiatric field; that was used to punish (withhold the liberties) and treat/ rehabilitate criminals and of those who were deemed to have mental health problems. This transfer of power from the legal system to the psychiatric establishments was as a result of the perception of knowledge held by psychiatry and a reclassification of what criminality or mental illness was i.e. something that could be treated, altered and changed through a scientific process, which now belonged or was held by psychiatry. Therefore at this time the mind became connected to the physical world where it could be measured, changed and ultimately controlled (Bracken and Thomas 2005).

Foucault's theory on power over the last 50 years is still relevant today following examination on the psychiatric model of the time and the power exerted by the medical profession (Foucault 1967, Foucault 1979). Foucault explored and concluded that power is something that exists through all levels and hierarchies within society and it is exercised by people in a constant ebb and flow, however, it is not exclusively held by certain people or groups. Power is galvanized and acquiesced through the procurement of knowledge or truth. The creation of scientific knowledge and understanding of the mind allowed the psychiatric establishment to enforce its authority and power over others. According to Bracken and Thomas (2005), power then becomes less negative, because power is knowledge and becomes a useful and productive thing. They argue that psychiatry gives society a narrative through disciplinary or controlling power. As Foucault describes during the age of reason, unreason were excluded (the 'mad' confined with the poor, unemployed, chronically sick and general criminals); psychiatry became the champions of reason and dominated madness.

Power and knowledge within mental health have had a complex and intricate influence on services (Foucault 1979). The creation of this new knowledge through the scientific discourse process allowed new facts or truths to be constructed that create a professional body (or reinforce one) and institutions. Foucault explains that at this point the power knowledge relationship becomes self-fulfilling e.g. knowledge creates power and power then creates structures and processes (institutions professions) that in turn create more knowledge (Foucault 1979). At present psychiatry which is medical model driven is the central profession within mental health due to its control of deciding who is ill and who is not through diagnostic tools that it holds at its core (Roberts et al 2006, Stevenson and Cutcliffe 2006). Therefore, people become labelled with a diagnostic criteria and a risk value that outlines what treatments they will be subjected to; this will involve a continuum of control being imposed upon them e.g. medication, regular meetings, inpatient stays, invasive treatments, subject to mental health act etc. Additionally, power does not reside in the psychiatrist alone; there are multiple professionals that work closely with psychiatrist and power is delegated to them by the psychiatrist along with the creation of power from within each professional group (due to their own knowledge). A counter argument to the new ODA approach is that this an example of other professions vying for their own knowledge and thereby power. Especially when ODA involves detracting power from other professional groups, especially the psychiatrists who historically would have chaired and led such meetings. However, these 'other professions' are giving this control to the service user and not necessarily for their own gain.

Also all professional groups have to some degree become involved in this historical control over the service user. Their professional identity becomes part of it and therefore to relinquish it may leave them feeling exposed; both professionally and personally. Bracken and Thomas (2005) state that the medical profession should not be making key decisions and that lay involvement is required (voluntary organisations, self-help groups, advance statements, advocacy). ODA offers psychiatry a potential to move away from the diagnostic medical model and allow clinicians to connect with the individual rather than medical problems that may arise out of social trauma/ issues.

8.2.4.2 POWER/ COERCION AND THERAPY

Nurses need to reflect and embrace the power dialogue to ensure that they are aware of how their own actions may affect service users and how importantly they may be perceived in using or wielding their power (for good or bad). Bad encounters or those relationships where power was used in a negative context is remembered bitterly by service users (and reported by them) and importantly may cloud their judgement and perceptions of future interactions with mental health services, which may make them resentful, suspicious and less inclined to engage with their care. Interestingly within this thesis an example of such an experience was explored with the service user who had spent many years on ICU; however, ODA clinicians were able to connect with her and overcome any previous experiences and prejudices she had with mental health services through building a meaningful and productive therapeutic relationship. According to Rachel, service users gain control, agency and democracy from the ODA approach. The case for democratising mental health services and take a move away from coercive and controlling services has been described earlier in this paper within Sedgwick's (1982) seminal work; as stated Sedgwick's solution is for political action or a more pragmatic not theoretical approach.

Dziopa and Ahern (2008) attempt to capture what concepts are at the core of the therapeutic nurse patient relationship. The use of judicious power was seen as a way of developing a positive relationship; although they note that this power differential can work positively or can be used in a negative way. Wilkinson and Miers (1998) also note this power differential, the directional use of power within the 'therapeutic' relationship e.g. used positively through leadership, empowerment and legitimately (for good) and negatively through force or threat, coercion and compulsion. Power can also be used subtly (through observation, persuasion and approval – managerial nudges) and overtly (through seclusion and restraint).

Maguire et al (2014) purposive sampling (12 nurses, 12 service users) within an Australian forensic hospital looked at a practice to set limits on service users which of course can be perceived as a form of coercive intervention. Three themes were highlighted by this study; firstly limit setting is valued by service users, secondly engagement with service users in an empathic manner ameliorate limit setting and thirdly authoritative (rather that authoritarian or autocratic) style is viewed positively as this relays that the clinician is knowledgeable as opposed to being merely pedantic or punitive in practice. The study explored clinicians' perceptions of limit setting. They found that clinicians were overall uncomfortable with limit setting due to the way in which limit setting could be perceived i.e. as a punitive coercive measure. However, the clinicians did confirm that limit setting could be perceived as positive when safety and therapeutic interventions were being maintained, although the idea of balance and fairness (reciprocity) was fundamental to this being viewed in a positive way.

Stanhope et al (2009) study looked at case mangers adoption of coercion or pressure on mental health service users whilst they were being treated in assertive community teams within the USA. They did this through service evaluation surveys through interviews with service users. They found that there was a relationship (albeit small) between mental health service providers and service users relationship. The service users did not feel coerced or felt that the health practitioner (or case manager) used coercive strategies; however, it is noted that the coercion adopted by the team was viewed as low end verbal nudging rather than wholly negative coercive strategies. Although in some cases where shorter service contacts occurred there was a small effect size of higher perceived coercion from recipients; however, it could be argued that the therapeutic relationship did not have enough time to develop and form a bond of trust; which is essential between the clinician and service user. This must be at the centre of the relationship and is formatted at the very beginning through early rapid working with the service user, providing control to the service user and continuity of care (same clinicians working with the individual). Collette highlights the effect of ODA on the therapeutic relationship in that it is strengthened through gaining trust and understanding.

Sheehan and Burns (2011) study looked at the therapeutic relationship and coercion. The study was a cross sectional cohort within a UK setting; with a 75% response rate using the admission experience survey (AES). The researcher stated that they found that the clinician (12% of whom were nurses) who admitted the service user were found to be rated as having a positive therapeutic relationship with the individual. This was evaluated as the clinician having less perception (by the service user) as being coercive (which was 6% higher in those service users who were sectioned under the mental health act), applying procedural justice or negative pressure. In another study looking at the relationship between the therapeutic relationship and perceived coercion by Theodoridou et al (2012) found that the poorer the therapeutic relationship score was then the higher the scores of perceived coercion were in service users. They also found that the AES scores were higher when service users were detained under the mental health act or had a history of Schizophrenia and being detained involuntarily.

The above articles indicate that the data demonstrates that lower perceptions of coercion indicate that therapeutic relationship is more likely. However, Wolfe et al (2013) in their study looked at the relationship with the therapeutic alliance, motivation and coercion in a drug and alcohol, centre in Australia. They found that there was no relationship between therapeutic relationship and coercion, although they did find that therapeutic relationship was associated to external motivation.

Thogersen et al (2010) study explored whether services users who accessed assertive community teams (ACT) were subject to coercive services. This qualitative approach formulated themes: Lack of active participation in treatment processes and a poor alliance with case managers; not being recognised as an autonomous person and crossing the line and intruding on privacy were related to coercive practices. Positive power themes involved collaborative processes, relationship building, commitment, perseverance and availability of social support and activities of daily living. Interestingly the researchers do not claim that the therapeutic alliance is central, however, they stipulate other factors such as time spent with service users, privacy, attitude of staff and provision of support; which can be hampered by safe staffing levels leading to more restrictive practices (McKeown et al 2019).

Finally the study highlighted that different parts of the mental health service were perceived as coercive e.g. ACT was viewed as coercive and other parts that reduced autonomy and a sense of alliance and potential to influence treatment were perceived as coercive.

However, as previously stated in the barriers chapter, control and coercive practices are a way for less confident staff to feel empowered and in control. This was something I witnessed first-hand when I visited Finland and happened during the 8th network meeting that I observed. One of the network meeting clinicians who was a new starter, had not completed ODA training and was a junior member of staff who became confrontational with the service user. The meeting became clinician led and the clinician displayed what appeared to be annoyance at the service user's lack of engagement. The example showed how by veering away from being truly service user led that the model can break down very quickly.

Critics of coercive practices within mental health services such as Foucault (1967), Goffman (1968) and Szasz (2007) have argued against the control and coercion that is prevalent in such services. Therefore, a movement against this position that has been expanding over many decades is that of empowerment that lies within the recovery movement (Perkins 1996).

However, empowering services users within a health system and a society which still endorses control and expects such responses is challenging to health staff (Thompson 2011). There is a dichotomy that staff must balance on a daily basis between empowerment and control that is simultaneously confusing and can lead to inequalities in healthcare (Thompson 2011). An example was put forward in Heather's transcript about a service user who had been in ICU for three years who was being given large doses of sedating medication, however, following ODA intervention she was transferred to a less restrictive environment using a fraction of the medication that she was previously being administered. This demonstrates very clearly the importance of what a gradual transfer of power and control to a service user can do to change a service user's life completely. This was found in a study by Gardner (2010) which outlines that the therapeutic relationship is a gradual process (this is in keeping with other research about the time taken to form the relationship and build trust). In addition, my study has already described how the principle of tolerance of uncertainty was not adhered to in order for clinicians to comply with legislative restraints, which still appeared to result in a successful use of ODA, but with the caveat that clinicians were open, honest and transparent about their duties with the service user. Perhaps this final part played a significant part in securing the trust and relationship with the service user.

In addition to the above, the therapeutic relationship must maintain professional boundaries which may be a barrier to nurses feeling that they can give themselves wholly to the therapeutic relationship. This was indeed a concern raised by a clinician doing ODA that they felt unsure about how much of themselves that they could give to the room. Even experienced participants who were comfortable with this stated that they did not give everything to the room but still maintained a feeling and a process that was authentic to the service user (Tveiten & Knutsen 2011).

Within Laugharne et al (2012) study describes that services users enjoy personal disclosure and commonalities or shared interests. Service users according to the study need a friendly process of discourse for the therapeutic relationship to begin. Interestingly the study found that previous bad mental health practice experience can be counteracted and reversed by such a friendly, warm and therapeutic interaction.

Health professionals in general are facing a patient group that is more informed, structured and cohesive through their acquisition of knowledge primarily from the internet through database providers but also perhaps more importantly from social networks (Bracken and Thomas 2005). Within mental health service user experience is valued by health professionals as this experiential knowledge can be shared not only with other users but with health professionals to help ameliorate their practice (Stevenson and Cutcliffe 2006).

Rugkasa et al (2014) found within their study that both controlling and empowering behaviours were used by clinicians to influence behaviours within their service users. The quality of the relationships that health professionals had with service users was viewed as the most significant factor for influencing behaviours within service users; this was backed up by more specific needs to support the therapeutic relationship of trust, fairness, empathy, consistency, reliability, measured curiosity and honesty. As in the Laugharne et al (2012) study that suggests service users feel that disclosure from health professionals is beneficial to build trust and the therapeutic relationship, the Rugkasa et (2014) study concludes that providing something that is outside of service users expectations such as practical help etc. could produce reciprocity that could facilitate therapeutic relationship. Rugkasa et al (2014) state that reciprocity within the therapeutic relationship is another way to positively influence the service user. Another way of influencing, or health professionals exerting their power was through authority as legislation and the mental health act; this was viewed as the least effective to protect the therapeutic relationship (although it was effective in protecting safety); however it was viewed as an underlying prevalent threat to all service users. The study found that there were difficulties changing the minds of service users who had previous bad experiences with mental health services. Which is in fact the opposite to what Laugharne et al (2012) found in their study, that a positive therapeutic relationships can be created following a previously negative experience with mental health services.

Therefore, mental health professionals operate in a society, culture and professional structure/ processes that endorse an imbalanced power relationship, but it expects clinicians to empower their service users, without the full knowledge of this power struggle (Thompson 2011).

From the evidence discussed previously (Raboch et al (2010) EUNOMIA study) it appears that in the health context (in particular mental health) that power, knowledge and therapeutic relationship exists and is experienced by staff and service users. The current research does not appear to be relevant or generalisable to the UK, therefore more research needs to be conducted into this area to provide further clarity on the UK position to whether nurses in particular have issues or problems about relinquishing their power, especially coercive power when dealing and building relationships with their service users. However, the previous papers discussed were from high income countries that in theory could be argued are similar to the UK and therefore generalisable; although idiosyncrasies are present in every country and it could be further argued that because of this the data is not relevant to the UK. However, in a study by Duxbury et al (2019a) looking at the use of restraints on fourteen adult mental health wards following the implementation of an American strategy (Six Core Strategies) found a reduction on average by 22%; indicating that coercive and restrictive practices within the UK can be reduced using approaches introduced from outside of the UK. In a further paper on the study using a thematic analysis on staff interviews, the researchers conclude that staff reported positive relationships with service users and had adapted their attitudes towards restrictive practices (Duxbury 2019b).

Therefore it is essential that health professionals understand about power and the impact it can have on their service users. However according to Cutcliffe and Happell (2009) this is not something that mental health nurses find comfortable to approach or discuss. This is further highlighted by Gardner (2010) and Maguire et al (2014) that raise the lack of research into this area. McKeown (2018) argues that nurses require an education that empowers them to engage with an ever changing political environment and more importantly to be able and equipped to challenge it. Nurses need to be empowered enough that they are confident to give up their power in relation to the clinician/ service user relationship.

Some research studies within the UK (Laugharne et al. 2012, Rugkasa et al. 2014, Sheehan and Burns 2011) do not have a nurse in the research process. However, the UK arguably may have issues in adopting ODA into its culture, especially when discussing nurses implementing ODA into their practice. Or this may not be an issue for them as they may embrace a format of working that mitigates power. Tribe et al (2019) in their study were able to implement ODA successfully in a UK culture (which is similar to other pilot areas, including the one discussed in this study). Finally according to Spandler and McKeown (2017) in their review of truth and reconciliation approaches found that dialogic communication and acknowledging past grievances (by being open and transparent) reparation and moving forward can be achieved – into a therapeutic relationship/ alliance.

8.2.4.3 EMPOWERMENT: THE CLINICIAN’S ROLE

Power and knowledge are inextricably linked, as has previously been described; knowledge legitimises power and power creates knowledge (Foucault 1979). Historically in mental health, service users have been at the will of an all-powerful psychiatric establishment that has imposed its scientific judgement, opinions and expectations upon its patients (Roberts et al 2006). According to the

Canterbury initiative (Timins and Ham 2013) an integrated health and social care system is required. The term “referrals” is not used as it provides a negative connotation as it be viewed as a clinician transferring the problem (the patient) to another healthcare clinician. This is the same as ODA where referring on is not seen in the same way as it is in the UK. Therefore, requests are made in a sharing of responsibility manner.

However, Patrick’s experience as previously discussed appeared to expose his style to the group, which, he appeared to find very uncomfortable due to the fact he thought he may be judged by his peers and something he felt embarrassed about. This fits with the above that nurses may not necessarily feel comfortable with participating in activities that may highlight deficiencies or weaknesses in their practice.

Seikkula and Arnkil (2013) state that power is legitimised through discourse, i.e. by developing an understanding of each individual a shared power is created between all participants. Through ODA and the discourse created by the approach, its developers propose that service users are empowered through this process. Within network meetings ODA clinicians are actively working hard to empower service users according to Collette, which is in contrast to the current paternalistic psychiatric model; ODA aims to enable and equip individuals with the confidence and the skills to become more independent. Heather states that the service user leads the dialogue, not the clinicians.

The ODA clinical relationship versus current psychiatric relationships was explored by Rachel; and found that the shift of power within ODA was to the service user. Mike, Collette and Patrick describe this shift in power, which is away from them in a professional sense that made them feel uncomfortable or awkward due to the fact that their control of the situation/ meeting was taken away from them. However, they all state that this shift was important for the service user.

Rachel states that current practices are risk averse and in contrast to ODA which uses tolerance of uncertainty to take positive risks in partnership with service users and their families. Collette used the Care and Treatment Planning meeting in comparison with an ODA network meeting as an example of how different current psychiatric practice is in the UK e.g. professionals making decisions before the service user is in the room, professionals in control and invite service user into the meeting; which is in stark contrast to ODA where the service user is put into the position of control and authority to invite others into the room and to choose what is discussed.

The service user movement has led to their experiential knowledge being valued and gaining power and control back from the psychiatric establishment (Stevenson and Cutcliffe 2006). In this way a new model of therapeutic engagement such as ODA may do well in filling the vacuum left by the lessened psychiatric power, in that it will truly capture the voice of the service user (avoiding the assumptions that have been made in the past) which would garner support from the wider public and avoid the mistakes of control and authority that have been made in the past.

Similarly people who are invited to the network meetings must be actively managed and controlled by the ODA clinicians in order to avoid them taking control away from the service user; in this way participants attending network meetings felt disconcerted initially (Patrick, Mike and Collette) because control is taken away from them and sits with the service user. Although Rachel reports on one network meeting where this was not facilitated effectively enough and the mood of the network meeting changed radically into an accusatory meeting which appeared as uncomfortable to Rachel as the initial network meetings had been for Patrick, Mike and Collette. Heather also states that there should be no struggle for control between the people in the network meetings, instead there should only be an emancipation effect upon the service user.

Service user compliance and control is a very emotive topic as highlighted by the participants within this study. Giving up ones autonomy is not something that we as humans relish (there have been enough conflict over the centuries to prove that). Within mental health, this discussion is complicated by the need for safety and protection, which has been demonstrated in Finland, can be achieved. ODA provides service users with the mode to compromise on compliance and be as independent as possible for as long as possible. To achieve this there needs to be an ongoing dialogue with the service user where a trusting therapeutic relationship is built upon, and to achieve this the service user has to feel in control and find their voice. In addition to this it is vital that the service user's social networks are utilised fully during this time for two reasons, to ensure that the service user is afforded the support they require and the wider network are educated to reduce the likelihood they will disengage from the service user due to the fear of the illness. Maintaining this therapeutic relationship is vital and one in which the clinicians must ensure one thing; they must continue at all times to be open and transparent with the service user in order to keep the trust that they have forged in place with them. This may be during times where the service user is required to become involved in coercive measures like detention under the mental health act; the clinicians must remain honest about what is happening and why. These principles may seem obvious and common sense but they will not be for the service users at the start of their journey or to the clinicians working in this new way for the first time in their careers. Ultimately, ODA is about clinicians repairing/ maintaining the service user connection with their social networks, with the people they are supported by i.e. their community, which they have been unable to communicate effectively with (due to the mental illness). Community derives from the Latin communis – shared in common; perhaps that is what mental health services should be there to achieve a shared common language and understandings between individuals.

8.3 FURTHER WORK AND DISSEMINATION

The future work from this study:

1/ The dissemination of this data with regard to the themes from this study – for peer review and scrutiny.

2/ This pilot site should make contacts with other UK pilot sites with regard to how ODA research in the UK is being developed; potentially looking at joint research studies. Also this could further facilitate our understanding of the 'mechanics' and complexities of what might make ODA work in the UK setting and how ODA 'impacts' upon service users and. In the future, ethnographic studies can be used locally to conduct further research into this approach. Such studies could observe network meetings first hand to explore and record what is happening and what the subtleties of the discussions are having on the service user (and the clinicians). The context of this study was only from the viewpoint and perceptions of participants (health care professionals in this case); a study looking at how power 'friendly' and equitable the meetings were conducted would be of great benefit (Gobo 2011). Additionally, this research needs to encapsulate a wider cohort of staff from different specialties along with those from different health boards to ensure we have as full a picture as possible of how views, opinions and the underlying culture pervades psychiatry in the UK. To conduct this research will pose ethical obstacles to the researcher although these are not insurmountable especially if an approach is made to the service user movement to come on board with this so that the rationale and objectives of the research is made transparent and open. It is vital that nurses rather than medical staff take the lead on such initiatives when there is some evidence that UK nurses may be opposed to such power levelling practices (Raboch et al 2010).

3/ There is a requirement for a business case prepared to bid for governmental monies to pay for staff training to a wider staffing group; and look into developing trainers to deliver training locally. This could be to expand on the pilot and conduct further research. Such data could generate a model that will demonstrate whether ODA is a sustainable model for Wales and the UK, i.e. economically feasible and effective in other parts of the mental health service. (This has already been achieved due to successfully securing Welsh Government funding £90,000 for ODA training.)

4/ In addition to the above develop a greater understanding of the power relationship with in psychiatry for clinicians and concentrate on the learning methods required for implementation in the UK. This could help develop evidence for a wider audience of the potential benefits of moving away from a diagnostic model and into a more therapeutic approach, that encapsulates a watchful waiting approach; but at the same time has a proactive stance.

5/ If ODA is demonstrated to be effective in the UK through further pilots then mental health services must lobby government for policy changes to fully implement tolerance of uncertainty; this will require the generation of 'gold standard' evidence in order to convince a wider audience of ODAs potential efficacy following the implementation of wider research within the UK setting.

8.4 SUMMARY

Experiential learning and more formalised teaching and learning is beneficial for ODA roll out, however, having a more experienced clinician partnered with a novice is crucial. At a local level it was implemented in an ad hoc way in that clinicians had varying degrees of previous ODA knowledge or psychosocial intervention knowledge and experience. The latter undoubtedly provided clinicians with a smoother transfer into ODA; however, a clinician reported that having that lack of knowledge allowed him to experience the network meetings in genuine and meaningful way.

All clinicians were in agreement that ODA appeared to be an effective approach for the service users they worked with. It is not wholly clear from this study whether a pioneer effect resulted in those clinicians overcoming initial anxieties that ultimately resulted in them seeing the benefits they found in the service users they worked with. That is, future implementation must take into account that this effect may not be there to sustain staff through early stages and adequate support and training must be available to them.

The local evidence is such that all service users who engaged in this process appeared (to the clinicians/ participants) to have benefitted from it. There is some subjective evidence in how it affected confidence in service users but also some objective reports in bed days and use of as required medication.

The power relationship is critical as it appears to be the central and core intervention mechanism within ODA. However this power transfer can be perceived as a barrier by some staff and professional groups who feel threatened by this. Tolerance of uncertainty was another barrier that was encountered by the participants and the role they felt they must follow of taking positive risks and using minimal recording and communication about the service user without their participation; which is in direct contrast to the legislative processes that currently state and assume that correct safeguards are in place for service users within the UK. This could be difficult with medical staff due to the element of risk and for medical staff who have responsible clinician status over their service users; there may be potential accountability and litigation if things go wrong. Therefore, government support would be required to change the policies surrounding mental health legislation. It could be argued that currently clinicians are not going to embark on implementing full ODA principles without senior support and direction from WG. Ironically WG are only going to make these policy changes with evidence; if ODA is effective and deemed to be implementable and safe then ODA could be promoted as core mental health services. However, clinicians within this study overcame this issue by not implementing all of the ODA principles; tolerance of uncertainty was ameliorated so that clinicians did record in case notes and had discussions with colleagues without the service user being present, however, these occurred in exceptional times of risk and probably most importantly they occurred with the service user having knowledge that these conversations would occur. This indicates a contrast to current psychiatric care where discussions happen and records kept that are not explicitly done with the service user’s knowledge. However, all participants reported the positive effect that using ODA’s other principles had on their service users. The mechanism for this may be the fact that clinicians are being open and transparent with the service user despite having to have conversations with other clinicians without the presence of the service user and documenting risks clearly for others to see. The fact that this openness is there may act to preserve the therapeutic relationship by maintaining trust between the clinicians and the service user.

The implications for practice with this work is that it indicates there may be some flexibility in the way ODA is implemented in the UK. It appears that ODA can be contextualised to the cultures it is used within and the legislative frameworks that organisations must comply with. Additionally to ensure it is implemented successfully managers must be aware of their role in delivering and managing this. Staff need to feel empowered and supported to implement ODA as the initial period may be uncomfortable for new clinicians. A transformational leadership approach is more likely to provide the correct level of support and empower staff. Additionally this style provides a role model for how ODA should be delivered to service users and embraces the complexity surrounding health care processes and successful change management principles.

Finally this study is limited due to its size (n.5) and specificity i.e. only involved nurses who worked in the same service. Therefore, the transferability of the findings are limited. However, the transferability of some of the themes found here to other similar areas are positive and something others should consider.

9. CONCLUSION & RECOMMENDATIONS

9.1 THE RESEARCH QUESTION

This is a small scale study (n. 5) however the gap in knowledge about nursing staff adopting ODA has been lessened by this study adding to a growing body of knowledge that has recently developed within the UK. This study will serve to guide future work or add to already existing work.

Complexity theory and the qualitative approach of IPA have worked well together: IPA has provided this study with a rich source of data full of complexity with which a complex systems model has been used to view analyse and offer explanations/ insights.

The study research question was as follows:

What was the experience of mental health nurses in an inpatient and outpatient setting of using Open Dialogue Approach following its implementation in a local mental health clinical board?

ODA was reported to be effective for service users by all of the participants over the 18-24 months study period. The participants were unanimous in their opinion that the intervention appeared to be effective for service users in that it empowered and created a sense of choice and control that in their previous experience had not existed. Learning methods need to be incorporated for the local area to ensure that staff wishing to use ODA can obtain safe, effective, consistent and purposeful education. Two things are required if the evidence declares that ODA is effective: Learning equipment and access to it for clinicians to undertake ODA and there needs to be support from policy drivers to ensure UK clinicians are directed to embed ODA into mental health services.

The ODA principle of tolerance of uncertainty is at odds with current UK mental health legislation and within this pilot it was not adhered to fully. Despite this ODA was reported to be effective to the service users according to the clinicians who used the approach. However, the clinicians were open and honest with the service user about when they did not adhere to it. This indicates that approach may be ameliorated and adapted to the locality it is implemented within and that the approach can be flexible in this regard.

ODA relies on clinicians devolving their power or sharing their power with service users. This may cause some anxiety within clinicians especially within the initial stages. The central element that appears to contribute to that perceived success was a change to the power dynamic or specifically a shift in control to the service user. Power was an enabler by empowering service users to take a more active role and have control over their futures. Through this it appeared give them confidence and control over their illness and lives. The clinicians involved in this study felt that this aspect of ODA was the effective part of the approach as it allowed service users to gradually develop confidence through the dialogical intercourse with clinicians, which in turn allowed them to connect with their own thoughts and develop a deeper and greater understanding of themselves and following this with others. Clinicians described how service users gradually became more confident in what they said and did. Clinicians allow service users to be afforded the basic dignity of equality and this fosters their independence and confidence, by respecting people as people and allowing them to develop and learn and move on. Psychiatry does not actively stop this development however, in the rush to treat people with medication and other treatments this may hinder growth and development, by focussing too specifically on one aspect of the service user's symptomatology.

Therefore it appears that power, learning, effectiveness and barriers play a vital role in the process of participants using ODA within this local health board. Power, and its benefits through empowering service users is in contrast to the barriers clinicians feel, as they can feel threatened by this. Initially, clinicians found this change in control and power very uncomfortable, and only through witnessing the benefits to the service user did they perceive the significance of the approach. The power shift can be/ become a barrier to the successful implementation of the approach. It potentially requires legislation changes so that positive risks can be taken with service users by increasing their control without having the potential threat of legal or disciplinary ramifications onto the professional.

Power relationship needs to be explored with staff because as well as being a source of benefit to service users it can be viewed as a potential barrier to staff uptake of ODA. If staff feel threatened by such a phenomenon then this could prevent the intervention being undertaken by them. Staff require knowledge as well as support to guide them through this process. Interestingly in this study the participants who had longer clinical experience found the power difference to be less of an issue, this may be indicative of this study alone, however, subsequent clinicians should be mindful that length of clinical experience may play a role in this phenomenon being an issue for some clinicians.

Further research has been produced since work on this study began, in particular, Tribe et al (2019) which found ODA to be overall positive although there may be some further support required for both staff and service users. In addition, Ellis (2018) study found ODA to be positive but discovered an organisation that is founded on the medical model could be a barrier to successful implementation. It is very positive that these studies overlap with this work in the qualitative approaches taken and the inquiry into staff experiences which reported the positive effect they saw on service users - although this study could have been enhanced by service user experiences.

9.2 RESEARCH LIMITATIONS

The limitations of this study is its small size (n.5) and the fact it was limited to the nursing profession alone and to one specific service within a local health board. However, the themes generated within this study are transferrable to other similar areas and something others should consider. In addition to obtaining further staff experiences from other parts of the service, it would be very beneficial to hear from service users who were exposed to ODA working. Therefore, further research into this area could concentrate on finding the service users voice (e.g. the work undertaken by Tribe et al 2019). However, further studies such as an ethnographic style could study the mechanics of the network meetings and thereby highlight the mechanisms of what makes ODA effective with service users.

A further limitation to this study is its small scale and ad hoc implementation of ODA into services, i.e. no structured consistent training for all participants. The apparent success of the implementation of ODA appears to be from the motivation and dedication of the participants involved in this pilot. Although in addition to this the pilot also had an experienced ODA clinician working alongside other clinicians.

These participants took ownership and pride in this work and were the early adopters; therefore, arguably during the early difficult phases in adopting this approach it can be argued that they persevered more through this difficult phase. The participants felt they had something worthwhile to strive for and in addition to this, they were empowered to do this work i.e. they had control over their way of working and did not have something imposed upon them. They could have been experiencing a pioneer effect (novelty effect or a Hawthorne effect – Sedgwick & Greenwood 2015); feeling empowered and enthused by the newness of the approach. Although to counter this, ODA has been used for almost 30 years in Western Lapland; albeit with a structured training programme.

Before ODA is implemented on a larger scale, evidence needs to be gathered, collated and presented so that clinicians can justify the expense of training and use of staffing resources in this way to government bodies (for financial support).

9.3 FINAL THOUGHTS

This study's contribution to new knowledge according to the participants is that ODA appears to have a role to play within services in the UK as it was effective for service users. This work also indicates that changes can be made to the principles of the Open Dialogue approach which despite this results in an apparently effective intervention/ framework. Within this study participants ameliorated the principle of tolerance of uncertainty within their implementation of ODA; they did this by recording thorough casenotes and risk assessments and having discussions about the service user without them being present which is in direct contrast to ODA. ODA has this principle in order to show respect to the person, develop trusting relationships and provide them with control (no decisions made without their presence). This study appears to demonstrate that despite clinicians recording and discussing things about the service user outside of the network meetings it is still effective. The mechanism behind this appears to be because the clinicians were open and transparent about this, thus, fostering the trust and respect that the principles of ODA promote.

In addition to the above, it would be interesting to conduct this with UK medical staff or any staff with responsible clinician status. Could such staff feel able to release this control and power especially when they are legally deemed to be responsible clinicians when the repercussions for any incidents or negative events can be so great within the UK legislative framework? However, the above principles are surely transferrable to their profession i.e. they may need to act within a legislative framework but as long as they act with openness, honesty, transparency and an ethos to empower service users then they cannot only maintain the therapeutic relationship but also propagate the ODA ethos and therapeutic mechanism.

To deliver ODA within a mental health organisation staff need to feel empowered, have access to the right support and access to training. Therefore, a transformational leadership style is advocated as it empowers staff and provides a role modelling behaviour that staff should emulate within ODA. ODA can be initially uncomfortable for staff, therefore, the supportive framework of a transformational style is advocated, especially in the initial stages; following this staff could then witness the perceived benefits to service users after the initial difficult phase has passed.

For ODA to be adopted within the UK three things need to happen: firstly more evidence needs to be gathered about whether it is effective in this country and this needs to be shared. Secondly, support from policy developers needs to be gained so that authority can be given to the approach. Finally, clinicians need to be given training to enable them to adequately perform and adhere to the UK parameters of ODA.

9.4 FURTHER WORK AND DISSEMINATION

The future work from this study:

1/ This research study needs to be disseminated for wider scrutiny and knowledge sharing.

2/ This pilot site needs to connect with other UK pilot sites to develop further shared knowledge and shared research opportunities.

3/ Create a business case for governmental monies to implement training for a wider cohort of staff. This would allow further roll out of the pilot to generate data that could demonstrate whether ODA is a sustainable model for Wales and the UK that is effective within the within mental health and economically feasible. (This has already been achieved due to successfully securing Welsh Government funding £90,000 for ODA training.)

4/ Develop a greater understanding of the power relationship within psychiatry and further develop ODA training opportunities for a wider cohort of professionals.

5/ If ODA is deemed to be effective through subsequent research then mental health services must lobby government for policy changes to legislation to allow clinicians to fully implement the principle of tolerance of uncertainty. The further implications for policy and practice is that senior support is required to help fund the further roll out of a larger pilot. Ultimately, government support is required to look at legislation in the future with regard to accepting all of the issues surrounding tolerance of uncertainty.

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11. APPENDIX

11.1 APPENDIX A

LITERATURE REVIEW SCREENING TOOL

Screening Tool

Is ODA effective as a treatment approach to psychosis and Schizophrenia in its effect on diagnostic rates, service use and in the quality of the experiences of those affected?

Author: _________ **Year:** _______ **Record Number** _________ **Reviewer** ___________

INCLUSION CRITERIA

English Language Paper? No ☐ if No - Exclude ☐
Yes ☐ if Yes – Continue.
FEP service users? No ☐ if No - Exclude ☐
Yes ☐ if Yes – Continue.
ODA No ☐ if No - Exclude ☐
Yes ☐ if Yes – Continue.

METHODS

- Qualitative ___________________
- Quantitative ___________________

TYPES OF INTERVENTION:

ODA in EIP Settings

TYPES OF OUTCOME MEASURES:

Rates of Schizophrenia Diagnosis
Social Outcome Assessments
Employment
Inpatient admission rates

CRITICAL APPRAISAL

Include ☐ Exclude ☐ Seek further info ☐

Comments:

11.2 APPENDIX B

LITERATURE REVIEW APPRAISAL TOOL

Critical Appraisal Tool

JBI Critical Appraisal Checklist for Experimental Studies

Reviewer ________________________________ Date ________________

Author ______________ Year ______________ Record number _______

Yes No Unclear

1. Was the assignment to treatment groups random?

2. Were participants blinded to treatment allocation?

3. Was allocation to treatment groups concealed from the allocator?

4. Were the outcomes of people who withdrew described and included in the analysis?

5. Were those assessing outcomes blind to the treatment allocation?

6. Were the control and treatment groups comparable at entry?

7. Were groups treated identically other than for the named interventions?

8. Were outcomes measured in the same way for all groups?

9. Were outcomes measured in a reliable way?

10. Was there adequate follow-up (>80%)

11. Was appropriate statistical analysis used?
Overall appraisal: Include _ Exclude _ Seek further info. _
Comments (Including reasons for exclusion)

____
____
____

11.3 APPENDIX C

RESEARCH PROTOCOL

Participant Information Sheet (PIS)

Study title

An exploration of staff views and perceptions of Open Dialogue Approach that is used within rehabilitation services in a local mental health clinical board.

Invitation and brief summary

I am writing to let you know about a research project I am carrying out, which is supervised by Cardiff University. The purpose of the research is to find out what perceptions and experiences staff have about using the open dialogue approach within the rehabilitation Mental Health Team. Open dialogue approach was developed as a social network model of care and approach within Western Lapland, Finland in the 1980s. It is a needs adapted approach developed by Yrjo Alanen and integrates systemic family therapy with psychodynamic psychotherapy (Seikkula and Arnkil 2013). The approach was reported to be a radical shift for the municipality from its previous psychiatric model which was almost completely inpatient focussed; at its height the municipality had 300 psychiatric beds for its 72,000 population (Seikkula and Arnkil 2013, Seikkula and Arnkil 2006) – it now reports that the municipality has only 30 beds with a 50% occupancy rate. Open dialogue approach has become embedded within psychiatric care in Western Lapland and all staff (doctors, nurses, occupational therapists) participate in the principles and the interventions used within it.

Why is this study required?

In recent years health care workers in the UK have begun using ODA principles. The results of the research will be used to help us understand what was the perceived impact of open dialogue approach within a local health board in the UK and to ascertain how training was perceived by staff. The impact of this study will be to generate qualitative data on the use of ODA within this country. No such evidence currently exists therefore this data will be a valuable source of information to clinicians within the UK who are using or thinking of using ODA within their areas.

Why have I been invited?

Only staff that have been exposed to training (by presentations and experiential learning) and have 3hours or more ODA clinical time will be asked to participate in the study.

How many will be involved in the study?

It is envisaged that between 5 to10 staff will participate in the interviews will take place.

What is involved?

In order to learn more about this, I hope to talk with members of staff on an individual basis about their experiences regarding using open dialogue approaches and undertaking network meetings. The interview will last approximately 30-60mins, will be at a venue that is convenient to the participant and will be recorded by a digital recording device; this is in order for the interview to be transcribed and later analysed by the researcher. In order to undertake this I will need you to sign a consent form to clearly state what you are taking part in and how your data will be used. Any discussions that occur will be confidential and any data that is gleaned will be anonymised.

Do I have to take part?

It is important for you to know that you are not under any obligation to agree to partake in this being interviewed for the study. You can decline to participate in this way if you do not feel comfortable with the idea.

Further information

Data collected from your interviews will be held until the study is complete – following this it will be destroyed. The digital copy of the transcript will be downloaded onto the health board's database on the researchers personal data space. The copy on the recording device will then be deleted (thereby insuring that after this point it is no longer portable and cannot be lost).

You may withdraw from the study at any point; this can be before, during or after your interview. Any data collected will be destroyed. However, if you have any queries please feel free to get in touch with me so that I may be able to answer or resolve any issues.

The study data will be used to complete a thesis and may be published. It is also hoped that this information will be publicised through local and national conferences.

This work is professionally supported and funded through the local health board. Academically the work is supported by Cardiff University. Both organisations have reviewed the study.

Thank you for your time and assistance.

With regards,

Mark Jones
Park Lodge Centre
Whitchurch Hospital
Park Road
Cardiff
CF14 7XB
02920 336410

11.4 APPENDIX D

CONSENT FORM

Participant Identification Number for this trial:

Title of Project: Open Dialogue Approach

Name of Researcher: Mark Jones

Please
initial box

1. I confirm that I have read the information sheet dated.................... (version............) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. (If appropriate) I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from [company name], from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

4. (If appropriate) I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. ☐

5. (If appropriate) I agree to my General Practitioner being informed of my participation in the study. ☐
6. (If appropriate) I understand that the information held and maintained by the Health and Social Care Information Centre (or amend as appropriate) and other central UK NHS bodies may be used to help contact me or provide information about my health status. ☐

7. I agree to take part in the above study. ☐

____________________	____________________	____________________
Name of Participant	Date	Signature
____________________	____________________	____________________
Name of Person	Date	Signature

11.5 APPENDIX E
SEMISTRUCTURED INTERVIEW QUESTIONS

What does Open Dialogue Approach (ODA) mean to you?

Tell me about your experiences of ODA?

Can you tell me what you have found to be good about ODA?
 Why did you find this/these to be good?

Can you tell me what you have found to be not so good about ODA?
 Why did you find this/these not to be so good?

Can you tell me how you found the classroom training?
 Why did you find this to be good?
 Why did you find this not to be so good?

Can you tell me how you found the experiential learning?
 Why did you find this to be good?
 Why did you find this not to be so good?

How useful or not do you think services users (and their carers) found ODA to be?

If we were going to use ODA elsewhere, how would you set this up?

Do you want to add anything on ODA?
Thank you for your time. Do you have any questions that you would like to ask of me?

CLARIFYING QUESTIONS

Can you expand a little on this?

Can you tell me anything else?

Can you give me some examples?

Why?

How did you learn about…?

Why is this considered…?

Under what circumstances does this arise?

What is the scope of …?

Which places are most affected by …?

When does it usually occur and who …?

Have you noticed any changes since…?

How do you explain …?

11.6 APPENDIX F

INTERVIEW TRANSCRIPTS WORD FREQUENCY SEARCH

Transcript breakdown

Each transcript was written into a Microsoft word document collated in the following way:

1- Text highlighted using select all in the editing tab
2- Using find and replace:
    a. Find what = space inserted
    b. Replace with = ^p inserted

The above finds each 'space' inserted into the document with ^p which is the written version of 'return' or enter and effectively creates a list of the entire document.

1- Text highlighted using select all in the editing tab
2- Sort function (Paragraph tab)
3- Use sort by headings and type by text ascending

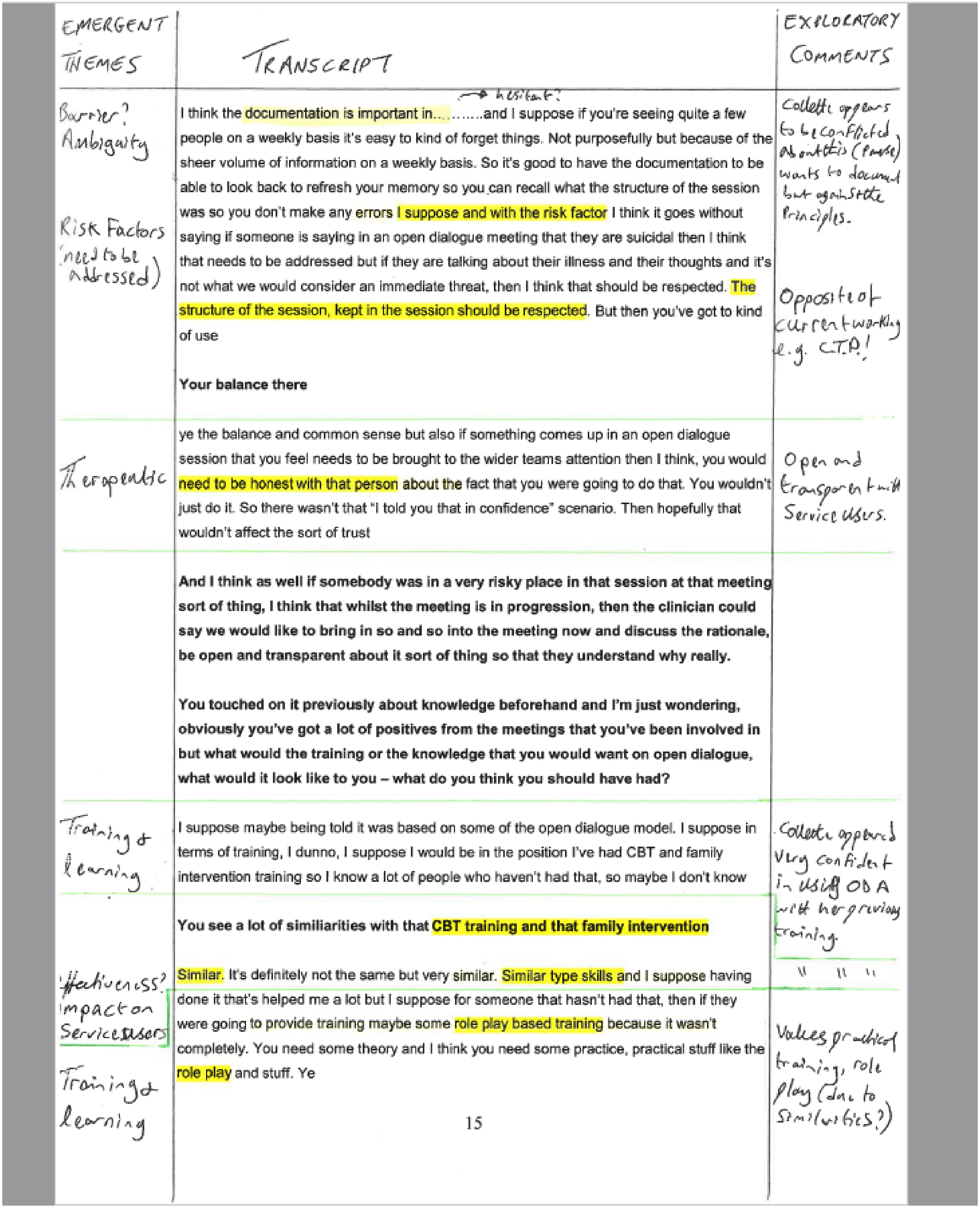
Document will then contain an alphabetical list of the entire transcript.

Words	Found in number of transcripts	Total Frequency of use
Awkward	Mike	(n.13)
Balance	Collette	(n.5)
Barriers	Heather, Rachel, Collette, Mike, Patrick	(n.10)
Being	Heather, Collette, Mike, Patrick	(n.21)
Benefits	Heather, Collette, Mike, Patrick	(n.19)
Builds	Heather	(n.14)
Comfortable	Patrick	(n.12)
Connected	Rachel	(n.7)
Control	Rachel	(n.8)
Conversation	Heather Collette, Mike, Patrick	(n.54)
Culture	Rachel, Collette, Mike, Patrick	(n.14)
Dialogue	Heather, Rachel, Collette, Mike, Patrick	(n.120)
Different	Heather, Rachel, Collette, Mike, Patrick	(n. 64)
Difficult	Heather, Rachel, Collette, Mike, Patrick	(n.25)
Discussed	Heather, Rachel, Collette, Mike, Patrick	(n.88)
Employment	Rachel	(n.3)
Engage	Collette, Mike, Patrick	(n.9)
Experience	Rachel, Collette, Mike, Patrick	(n.76)

Family	Rachel, Collette	(n.39)
Frustrated	Mike	(n.2)
Good	Rachel, Collette, Mike, Patrick	(n.56)
Honest	Collette, Mike, Patrick	(n.22)
Interest	Rachel, Mike	(n.23)
Learn	Rachel, Mike, Patrick	(n.14)
Meeting	Rachel, Collette, Mike, Patrick	(n.235)
Network	Rachel, Collette, Mike, Patrick	(n.65)
Opportunity	Heather, Rachel, Collette, Mike	(n.26)
People	Heather, Rachel, Collette, Mike, Patrick	(n.154)
Person	Heather, Rachel, Collette, Mike, Patrick	(n.77)
Positive	Collette, Mike, Patrick	(n.31)
Power	Heather	(n.25)
Progress	Collette, Mike, Patrick	(n.18)
Record	Rachel	(n.6)
Reflective	Heather, Collette, Mike, Patrick	(n.41)
Room	Heather, Mike, Patrick	(n.70)
Safe	Rachel	(n.8)
Struggle	Patrick	(n.3)
Talk	Rachel, Collette, Mike, Patrick	(n.145)
Training	Collette, Patrick	(n.18)
Uncomfortable	Rachel, Collette, Patrick	(n.24)
Understand	Collette, Patrick	(n.16)
Work	Mike, Patrick	(n.23)

11.7 APPENDIX G

INTERVIEW TRANSCRIPT CODED EXAMPLE



EMERGENT THEMES	TRANSCRIPT	EXPLORATORY COMMENTS
Barrier? Ambiguity Risk Factors (need to be addressed)	I think the documentation is important in………(→ hesitant?) and I suppose if you're seeing quite a few people on a weekly basis it's easy to kind of forget things. Not purposefully but because of the sheer volume of information on a weekly basis. So it's good to have the documentation to be able to look back to refresh your memory so you can recall what the structure of the session was so you don't make any errors I suppose and with the risk factor I think it goes without saying if someone is saying in an open dialogue meeting that they are suicidal then I think that needs to be addressed but if they are talking about their illness and their thoughts and it's not what we would consider an immediate threat, then I think that should be respected. The structure of the session, kept in the session should be respected. But then you've got to kind of use **Your balance there**	Collette appears to be conflicted about this (pause) wants to document but against the principles. Opposite of current working e.g. C.T.P.!
Therapeutic	ye the balance and common sense but also if something comes up in an open dialogue session that you feel needs to be brought to the wider teams attention then I think, you would need to be honest with that person about the fact that you were going to do that. You wouldn't just do it. So there wasn't that "I told you that in confidence" scenario. Then hopefully that wouldn't affect the sort of trust	Open and transparent with service users.
	And I think as well if somebody was in a very risky place in that session at that meeting sort of thing, I think that whilst the meeting is in progression, then the clinician could say we would like to bring in so and so into the meeting now and discuss the rationale, be open and transparent about it sort of thing so that they understand why really. **You touched on it previously about knowledge beforehand and I'm just wondering, obviously you've got a lot of positives from the meetings that you've been involved in but what would the training or the knowledge that you would want on open dialogue, what would it look like to you – what do you think you should have had?**	
Training & learning	I suppose maybe being told it was based on some of the open dialogue model. I suppose in terms of training, I dunno, I suppose I would be in the position I've had CBT and family intervention training so I know a lot of people who haven't had that, so maybe I don't know	Collette appeared very confident in using ODA with her previous training.
	You see a lot of similiarities with that CBT training and that family intervention	
	Similar. It's definitely not the same but very similar. Similar type skills and I suppose having	" " "
Effectiveness? Impact on Service users Training & learning	done it that's helped me a lot but I suppose for someone that hasn't had that, then if they were going to provide training maybe some role play based training because it wasn't completely. You need some theory and I think you need some practice, practical stuff like the role play and stuff. Ye	Values practical training, role play (due to similarities?)

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11.8 APPENDIX H

SUMMARY OF RESEACRH THEMES

Rachel

Pg 1	Democratic approach Does not rob them of agency or control - Mark nodding furiously to 'correct' answers with Rachel Social networking importance (partners? Is ODA feasible) Wider MDT
Pg 2	Agency of control Choice Natural to do ODA – previous talking therapies experience ODA reflective discussions
Pg 3	Experience of clinicians not invited to the meeting felt wrong (as they were contradicting and challenging the client). Previous experience important when doing OD
Pg 4	Powerbalance. Deeper understanding – valid knowledge of the client
Pg 5	Equal power balance Tolerance of Uncertainty – difficult for staff
Pg 6	Adjustment to thinking if you debrief
Pg 7	Experiential learning – role play?
Pg 8	Safe in mentor's hands
Pg 9	Big change in culture
Pg 10	Raise awareness, identify champions and allies (to implement ODA)

Higher themes in Rachel's

Democracy/ choice **x 3**
Antithesis example of this pg 3

Control/ power/ balance **x4**

Social Approach **x2**

Feasibility of ODA **x4**
Principle of tolerance pg5 big culture change raise awareness (solution?)

Learning? Previous experience **x3**
Experiential learning/ role play, need good mentor

Deeper understanding **x1**

Mike

Pg 1	Level playfield Professional hats out of the room Awkward (viewed by other clinicians) Improved our relationship – Pg 2 after ODA it was resolved Insight
Pg 2	More intense Planned (other meetings not ODA) I didn't feel in control

Pg 3	Still able to challenge
Pg 4	Being honest Not controlling
Pg 5	(client) taken control
Pg 6	Unusual for me Different to what I've done before Barriers would be privacy (in the current unit)
Pg 7	Ownership of the process is important More people on board
Pg 8	Improve working relationships with clients

Mike higher themes

Power Pg7 ownership of process	**x6**	
Awkward Intense unusual for me	**x3**	Negative
Barriers Privacy + different to previous experience	**x4**	
Effective	**x4**	
Honest	**x1**	
Social Approach	**x1**	

Collette

Pg 1	Information session
Pg 2	Invited – theme? Consent? Invitations to staff + clients ODA was strange to begin with At first it was uncomfortable
Pg 3	Discussed tone of voice and body language Therapeutic
Pg 4	Previous experience/ training CBT etc.
Pg 5	Felt you were doing a really good job Feedback from the client good
Pg 6	Confident in myself and skills (to do ODA) Her choice of staff
Pg 7	Reflective talking – seemed better, engaging more, helped understand us more. Helped build trust and understanding
Pg 8	Open and transparent Culture not open at present - If we get better at this will lead to better understanding and respect. ODA – different viewpoint more open
Pg 9	ODA is structured but informal Continuity Helps clinicians insight CTPs very formal and dictate to patients Intimidating anxiety provoking
Pg 10	Worked hard to takeaway those barriers validating clients Reflective discussions 'uncomfortable' initially
Pg 11	What do you think… would say exercise

	Family insight – hard to hear daughter speaking for the first time about her illness
Pg 12	Power imbalance NHS
Pg 14	Lose the power (of ODA) by talking about it outside of the session Time to reflect internally (through reflective discussions) It can create more anxieties (talking out of session) Obsessively thinking – but not positively
Pg 15	Risk needs to be addressed The structure of the session should be respected Be honest with the person (about the disclosure) Similar to CBT and family work More roleplay in training
Pg 16	Trust in your mentor

Collette higher themes

Learning / information session **x6**
Previous experience CBT/ confident pg6/ roleplay/ mentor

Power/ control **x5**
Invites

Barriers awkward/ strange **x3**
Uncomfortable/ culture not there yet/ risks

Effective/ therapeutic **x14**
Antithesis CTP + talking out of session

Reflective discussion **x3**

Patrick

Pg 1	Not professionally led Control Reflection
Pg 2	More meaningful (effectiveness)
Pg 3	Uncomfortable x 2 Reflective discussion What the hell is going on? (control, power, uncomfortable)
Pg 4	Rude to talk about someone else (barriers) Uncomfortable Practice could be challenged, integrity, professionalism questioned (barrier)
Pg 5	Professionalism Trust
Pg 6	Not in control (power) Awkward – never experienced anything like this before
Pg 7	Reflection – in-depth opportunity to do that in the session
Pg 8	Effectiveness of communication Effective for every patient – network meetings?
Pg 9	Effectiveness – time to talk, informal things – not about risk or meds – general experiences past and present Reflection on relevant things

	Relationship building No repercussions More regular meetings? … no wouldn't help
Pg 10	Patient listened to issue with reflective discussion
Pg 11	Good to be informed before meeting… but good to go in blind too (education) Experienced clinician required to be a guide Easy to do ODA – just need a room then do it
Pg 12	Mark comment – fishing for disciplinary (managers hat on) Professionalism/ risk Need a good therapeutic relationship before ODA
Pg 13	Benefit certain patients - language can be a barrier Continuity of staff important
Pg 14	Need to be honest

Patrick higher themes

Learning / information session	**x3**
Previous experience CBT/ confident pg6/ roleplay/ mentor	
Power/ control	**x5**
Invites	
Barriers awkward/ strange	**x7**
Uncomfortable/ culture not there yet/ risks	
Effective/ therapeutic	**x8**
Need a good therapeutic relationship	x1
Continuity of staff important	x1
Need to be honest	x1
Reflective discussion	**x5**

Heather

Pg 1	Listen No expectations - control 1st time scary 1st time patients perplexed Control
Pg 2	Scary but humorous (effectiveness) Insight (effectiveness) Fear of reflective discussions honesty
Pg 3	Trust – personal thoughts to influence Enjoyable Effective
Pg 4	Effective Safe – promotes trust Insight Effectiveness Medical vs person centred - power Person centred (power and effectiveness)
Pg 5	Trust and confidence Conversation only with the person in the room (not outside)

	Trust Difficult to engage with initially
Pg 6	Educating Logistical barriers Education – powerful but need to be aware of principles
Pg 7	Resources barrier 2 staff Previous experience family work positive Effective Feedback from SU positive Reduced prn and the need for high care environment
Pg 8	Learning through feedback evidence – anecdotal Family work skills important
Pg 9	Some staff find it bizarre Barrier – SU floridly psychotic Therapeutic relationship
Pg 10	Know the person not the illness Builds and builds approach (trust forming) No power, or control (SU in control)
Pg 11	Give yourself to the room, be honest Barrier if you can’t give yourself to the room Small steps to build confidence
Pg 12	Education induction Risk

Heather higher themes

Learning / information session	**x4**
Previous experience CBT/ confident pg6/ roleplay/ mentor	x2
Power/ control	**x5**
Barriers awkward/ strange	**x9**
Fear of reflective discussions	x2
Effective/ therapeutic/trust	**x18**
Listen	x1
Need a good therapeutic relationship	x2
Safe	x1
Need to be honest	x2
Reflective discussion	**x1**

Overarching themes

Learning / information session		**x13**	
	Previous experience CBT/ confident pg6/ roleplay/ mentor		
Learning?	Previous experience	**x5**	
	Experiential learning/ role play, need good mentor		
	Power/ control	**x15**	
	Invites		
Control/ power/ balance		**x4**	
	Power	**x6**	
	Pg7 ownership of process		
Democracy/ choice		**x 3**	
	Antithesis example of this pg3 Rachel		
Honest		**x4**	
	Feasibility of ODA	**x4**	
Principle of tolerance pg5 big culture change raise awareness (solution?)			
Barriers awkward/ strange		**x19**	
	Fear of reflective discussions	x2	
	Uncomfortable/ culture not there yet/ risks		
	Awkward	**x3**	Negative
	Intense unusual for me		
	Barriers	**x4**	
	Privacy + different to previous experience		
	Effective/ therapeutic	**x40**	
	Antithesis CTP + talking out of session		
	Need a good therapeutic relationship	x3	
	Continuity of staff important	x1	
	Safe	x1	
	Listen	x1	
	Effective	**x4**	
	Reflective discussion	**x9**	
Deeper understanding		**x1**	
Social Approach		**x1**	
Social Approach		**x2**	

11.9 APPENDIX I
RESEARCH LOG

11.9.1 Introduction

The research log is a summary of the developments and milestones achieved in the process of undertaking this research work over the last 7 years. The first two years were spent undertaking a taught phase of the course involved in completing eight modules and five thousand word assignments and/ or examinations. Therefore over the last 5 years I have undertaken the research part of the course that has culminated in this doctoral thesis work.

Due to the methodology employed I primarily kept a research diary as a mechanism to provide rigour and provide an audit trail. Within the reflective diary I incorporated supervision sessions, key moments (such as interviews with participants and transcript analysis).

11.9.2 Learning needs analysis

I chose a professional doctorate because of the structure the course presented in contrast to a PhD which seemed to be a daunting task. This I would say was mainly down to my personal confidence and lack of knowledge at the decision stage about taking on such a larger scale piece of research. Additionally when I started the course I was not convinced about what research I wanted to undertake. Initially I had envisaged undertaking a workplace study of evaluating mental health rehabilitation services. However, since beginning this course I have changed jobs three times; my initial ideas of the study would not have been wholly relevant to my subsequent roles.

The professional doctorate also allowed me through the taught phase to address some of my learning needs; develop a greater understanding of philosophical underpinnings and research methodologies. By gaining this confidence and having time to explore and test these different potential avenues and finally chose what research question I was passionate about allowed me to finally focus on my chosen route.

My taught phase has also allowed me to develop a very strong bond with my peers which has allowed us to provide ongoing support to each other over the years. In addition to this the taught phase allowed me to develop a very strict work ethic by completing an assignment every quarter for two years. During this time I did not miss one submission despite winning a Florence nightingale scholarship that required extensive travel and the write up of these travels with a 10k word report. Importantly the taught phase also taught me to open my mind to other philosophical perspectives, because previously I came from a very staunch deterministic view which has changed somewhat over the course of this program.

11.9.3 Key Steps

The key events of the research phase are outlined below. They highlight key activities and breakthroughs with the research.

11.9.4 Choosing my topic

The initial year of my research phase of my course involved me having robust conversations with my supervisors about my chosen pathway. Initially I was going to undertake a piece of research in early intervention in psychosis. However, within the first year of my research phase I travelled to Finland to look at their early intervention in psychosis service. I was very impressed with the model and treatment methods they had i.e. open dialogue approach. I eventually changed my research topic (after writing an options paper on all of the potential research options) and chose to evaluate open dialogue approach which had already been started in my health board.

11.9.5 Policy analysis

Following the Florence nightingale travel that I undertook it helped me understand the complexity involved of transplanting treatment processes from one culture/ system to another. Therefore, this allowed me to engage more with policy drivers and political drivers that influence legislation. The tension of introducing something locally and into a different culture has been high on my agenda because of the complexities of doing this and seeing this first-hand in different countries.

11.9.6 Research design

My supervision then revolved around methodology and my initial reluctance to move away from a quantitative approach (which I found more comfortable). We eventually moved away from a mixed methods approach before moving towards a phenomenological approach and finally settling on an interpretative phenomenological approach. After such an exploration when the topic and methodology was finally agreed upon (after 18 months!) there was a feeling of rightness about the whole thing and an excitement about beginning to collect data.

11.9.7 Ethics submission

My first submission for ethics was in July 2015. Unfortunately, this was rejected and I was expected to make amendments to the initial proposal. This took another 3 months to complete and eventually this was accepted at the end of 2015.

11.9.8 Recruitment

My recruitment process was very simple in that I purposively sampled my eventual participants. There were 6 participants that could have participated in this work (who were working with ODA) and I approached them all indirectly. 5 replied and participated. In early 2016 I began to interview these individuals and this was completed by mid-2016. I analysed the work in an iterative way between interviews and following interviews i.e. I would return to previous transcripts to look at other themes that had developed in subsequent interviews.

11.9.9 New role with public health

I moved away from being a senior nurse manager and worked as a programme manager in Public Health Wales with the portfolio of preparing the mental health safe staffing act. Preparing nationally for this act was very positive and challenging although during this time I felt I had time to work on my thesis.

11.9.10 Leaving mental health and my eventual return

My next role was in nephrology and transplant as a directorate manager. I left behind both my nurse profession and mental health working. This job was really great and very challenging, however, I found that being outside of mental health for 18 months made it difficult to keep focus on my thesis and to justify doing any thesis study within work time (as it had no relevance whatsoever to my place of work). However, towards the end of this secondment a directorate manager post came up in mental health and I was fortunate to secure this. Being back in mental health was much better as I was constantly surrounded and reminded by my thesis (in a positive way).

11.9.11 Personal loss

However, at the start of 2018 my mam was diagnosed with cancer and she passed away later that same year. Thesis work stopped during this year. I had started a new job as directorate manager in mental health and all my work efforts were focussed upon this. I spent a lot of time in north wales visiting her and the family throughout 2018 and we had some great times, creating some further great memories for me and for her grandchildren; the last memory my children have of Nain is her making the best custard for them a week before she passed.

After the Christmas festivities and New Year celebrations of 2019 I remember my thoughts turning to my thesis with a sudden excitement. I contacted my supervisors and work was back underway to complete the thesis. My first priority was to undertake the corrections that I was going to do to my work that had kindly been provided by my supervisors the year before. This was a great way to engage with the material afresh and a plan was quickly set to complete the first draft within 5 months, which I did. Over the last few months I have gone back to editing the work.

11.9.12 Supervision

My supervision from the university has been excellent. I have had two constant supervisors plus a third supervisor who provides a more displaced view on my work (to good effect). I have detailed records of 30 formal supervision (see summary 11.9.15). In addition to this there have been many email conversations between me and my supervisors that have discussed the work and strategies and outlined further goals. Finally, I also made sure that I attended the quarterly professional doctorate study days. This allowed me to liaise with my peers and attend lectures relevant to my position within the doctorate.

11.9.13 Annual reviews

I have completed three annual reviews to reflect upon my progress within the research phase of my program. They have allowed me to present different parts of my work over the years and allowed me to have support for this and/ or defend the work that I have completed. The most influential annual review I had was when I submitted my findings chapter. The feedback from the panel was that I needed to present my work in a different format so that I concentrated more on the participants rather than on the themes of the work. The panel were satisfied with the way that I had analysed the work and the depth in which I had gone into in my analysis. Each of the reviews allowed me to plan for the subsequent year which was put into effect.

11.9.14 Presentations

- Hafal workshop on ODA - February 2016.

- Doctorate research event November 2017.

11.9.15 Summary of supervision

Date	Discussion	Action points
21/11/14	**Issues discussed:** Discussed the outline of four potential proposals: 1/ Pure ODA implementation and evaluation – this may not necessarily be full implementation but could be one or more of the principles of ODA e.g. referrals 2/ EIP/ODA evaluation 3/ EIP pilot 4/ Supported accommodation evaluation	**Actions agreed (time-scaled):** Tasks to be completed 1/ Write outlines of question design, methods (with pros and cons) for each proposed outline in order to evaluate the best and feasible research proposal for the prof doc thesis. Before 10th December. 2/ Check with Jane Harden about the potential costs incurred through undertaking R&D within a local health board. 3/ Enquire through Jane Harden about PGR student resources on learning central. 4/ Following the decision about research proposal (after next supervision session) contact Dominic Roche regarding realistic evaluation.
11/12/14	**Issues discussed:** Discussed the outline of three potential proposals: 1/ Pure ODA implementation and evaluation – this may not necessarily be full implementation but could be one or more of the principles of ODA e.g. referrals 3/ EIP pilot 4/ Supported accommodation evaluation Agreed that the first proposal would be pursued due to researcher control of process indicating the likely success of completing the research.	**Actions agreed (time-scaled):** Tasks to be completed 1/ Full proposal to be completed by 22nd January 2015 – question – objectives and outline how I am going to answer the question. 2/ Link in with Norman Young (R&D steer within a local health board) 3/ Read up Rycroft and Malone – qualitative research methodologies 4/ Outline research question – what is going to answer the question – so what? 5/ Field notes – observational data / methodology 6/ Undertake research diary 7/ Benchmarking ODA – begin a dialogue 8/ Think of quantitative data – sickness, referral suitability,
23/01/15	**Issues discussed:** 1/ Research question. 2/ Review the objectives 3/ Background information – requires more sources of articles 4/ Methodology – depersonalise the section	**Actions agreed (time-scaled):** Tasks to be completed 1/ Complete changes as outlined in discussions by 2nd February.

	5/ Change the Design chapter and introduce a data generation chapter to increase specificity within the project – outline the pathways in referrals and clarify sample numbers and number of interviews required for the study. 6/ Outline the ethical considerations more clearly and denote the vulnerability of the clients and safeguards to be put in place e.g. participation when unwell, researchers mental health professional background	
05/03/15	**Issues discussed:** Discussion about the methodological validity of the research proposal, in particular we discussed whether phenomenological approach would be suitable for a prospective interventions based work. Phenomenological approach should about understanding the person's world not imposing something new upon staff and then asking them to discuss it. We explored whether this work should be a case study using a thematic content analysis. We also discussed what I was trying to capture from the research: was it the change process or the intervention effect?	**Actions agreed (time-scaled):** Tasks to be completed 1/ to change the methodological approach described in the research study. 2/ to change the question aim and objectives of the study. 3/ to elaborate more on the background of the study.
27/03/15	**Issues discussed:** Continued discussions about the methodological validity of the research proposal, in particular we discussed the conceptual framework of realism that led me to using realistic evaluation was suitable and look at whether another approach could be used. We explored whether this work should be a case study using a thematic content analysis. We also again discussed what I was trying to capture from the research: was it the change process or the intervention effect?	**Actions agreed (time-scaled):** Tasks to be completed 1/ to change the methodological approach described in the research study. 2/ to change the question aim and objectives of the study. 3/ to elaborate more on the background of the study. 4/ to look at the theoretical framework used by the researcher. 5/ to complete a 1 page draft of the research proposal
17/04/15	**Issues discussed:** Discussion about whether the proposal is ready for submission. Agreed to submit.	**Actions agreed (time-scaled):** Tasks to be completed 1/ Submit to RESC 2/ Submit proposal to a local health board 3 Look at literature review proposal and outline thesis layout.

18/05/15	**Issues discussed:** Supervisors happy with lit review proposal and requested that I should start this asap. Looking at the thesis outline the lit rev should be around 6-8k words. Nobody knew when the RESC feedback date would be therefore I will chase this up along with the local health board submission.	**Actions agreed (time-scaled):** 1/ Undertake a Hafal workshop on ODA and the proposed developments within Cardiff and Vale UHB 25th June 2015. 2/ Complete a literature review of Open Dialogue Approach by the next supervision meeting (end of June 2015). This will be broken down into the following chapters, open dialogue approach, change management, recovery philosophy and will be in the circa of 8k words. 3/ Follow up RESC submission in April to ascertain when the decision will be made. 4/ Follow up on workplace R&D submission.
16/07/15	**Issues discussed:** Unfortunately due to work commitments I was unable to achieve the second task of undertaking a literature review. This was due to a work opportunity where I acted up for 9 weeks into the adult mental health directorate manager post. However, I did complete the Hafal workshop, ascertained when the RESC outcome would be available (24th July) and I also obtained the outcome of my workplace R&D. Following a submission to the clinical board my research proposal was deemed to be a workplace evaluation.	**Actions agreed (time-scaled):** 1/ Complete a literature review of Open Dialogue Approach by the next supervision meeting (September 2015). 2/ Update on RESC submission. 3/ Enquire through Jane Harden about access to the 12th floor Eastgate House.
03/09/15	**Issues discussed:** Discussion about the rewritten proposal. Much clearer although needs more work on the objectives, methodology and ethics.	**Actions agreed (time-scaled):** 1/ Re-write and then submit RESC.
29/09/15	**Issues discussed:** Discussion about the rewritten proposal. Much clearer although needs more work on the objectives, methodology and ethics.	**Actions agreed (time-scaled):** 1/ Submit to RESC.
03/11/15	**Issues discussed:** Discussion about the next steps. Reviewed thesis layout and agreed on literature review word count (6-8k).	**Actions agreed (time-scaled):** 1/ Literature review to be completed by end of November and submitted to supervisors
15/12/15	**Issues discussed:**	**Actions agreed (time-scaled):**

	Discussion about the next steps. Reviewed thesis layout and agreed on word counts to various chapters.	1/ update changes to lit review 2/ Await ethics feedback before data generation
19/02/16	**Issues discussed:** Following successful ethics decision made to begin data generation - Discussion about the next steps – need to ensure that I have collected pen portraits of the staff involved in the research. Need to acknowledge that I manage the service ('can staff be negative?') need to explore staff relationships. Need to ask staff what they think I am doing – my motivations. Use questions that allow people to criticise the approach. Ask question – what haven't I asked that you thought I was going to ask? Look up Foucault, re. power Cost of using this approach T. Anderson reflective teams Safe uncertainty – B Mason Tolerance of uncertainty – blame towards nurses an issue? Justify themes, interpretation through iterative cycles Use thematic coding (not exact words)	**Actions agreed (time-scaled):** 1/ Begin data generation.
13/04/16	**Issues discussed:** Consider theoretical saturation. Critique more – framework good but need to find Work on reflective diary – use experience in Finland, ODA Hafal conference Anonymise the scripts Check IPA analysis -	**Actions agreed (time-scaled):** 1/ Complete data generation.
08/12/16	**Issues discussed:** Chapter on power does not quite fit at present into the analysis discussion – literature review part may need to be moved into pre-existing literature review.	**Actions agreed (time-scaled):** 1/ write more on analysis chapter and write backgrounds of those involved. 2/ IPA expand 3/ Reflexive part need more about researcher.

	Suggested that more analysis of the interviews needs to be completed. Discussion on barriers and effectiveness (change this to perspectives of participants on the success of the intervention). More information on IPA Work on reflective diary – use experience in Finland, ODA Hafal conference What are you trying to say? Is ODA applicable to UK? Has it been done? Parts of it – successful? Power as a theme discussion – what does this mean in context of the staff and the historical changes that have occurred. Learning theme involves the acquisition of knowledge and through this power is gained. Equally if there is minimal learning beforehand then clinicians can feel powerless/ vulnerable which could represent a barrier to using the approach. Clinicians may feel that giving up their authority (power) could make them vulnerable to criticism/ punitive actions if they do not fulfil their role. Nevertheless, the apparent impact of the approach appears to be directly related to the empowerment of service users. Read look up Hugh Kearns.	
20/06/17	Previous supervision sessions cancelled due to work commitments. Discussed recent annual appraisal which included discussions on findings/ analysis chapter.	Update findings/ analysis chapter.
20/12/17	Thesis work submitted to supervisors	Await corrections from supervisors.
07/02/18	Corrections obtained from all three supervisors.	Undertake corrections
10/01/19	Following an IOS met up with supervisors for the first time in a year. Agreed action plan to compete corrections by February.	Complete corrections.
13/02/19	Corrections completed.	Intro and background to be rewritten.
22/03/19	Discussed intro and background and theoretical framework. Supervisors advised cutting some of this section due to too much personal reflection.	Complete theoretical framework along with methodology and methods chapter.

26/04/19	Discussed theoretical framework and methodology chapters. Supervisors happy with findings chapter. Agreed to complete literature review with extensive changes and latest updates.	Literature review to be completed
30/05/19	Discussed competed literature review and discussed upcoming annual review next month.	Submit to annual review and await feedback from supervisors.
24/06/19	Discussion chapter explored with supervisors.	Complete first full draft by 19th July.
27/09/19	Discussion about last corrections. Agreed to leave discussion about different methodologies within the thesis.	Complete checks and submit draft on 25th October and final submission at the start of November 2019.

11.10 APPENDIX J

ETHICS APPROVAL

11.11 APPENDIX K

CRITICAL SYSTEMS HEURISTICS TOOL

CRITICAL SYSTEMS HEURISTICS

MOTIVATION

1. Who is (ought to be) the client? That is, whose interests are (should be) served?

2. What is (ought to be) the purpose? That is, what are (should be) the consequences?

3. What is (ought to be) the measure of improvement? That is, how can (should) we determine that the consequences, taken together, constitute an improvement?

POWER

4. Who is (ought to be) the decision-maker? That is, who is (should be) in a position to change the measure of improvement?

5. What resources are (ought to be) controlled by the decision-maker? That is, what conditions of success can (should) those involved control?

6. What conditions are (ought to be) part of the decision environment? That is, what conditions can (should) the decision-maker *not* control (e.g. from the viewpoint of those not involved)?

KNOWLEDGE

7. Who is (ought to be) considered a professional? That is, who is (should be) involved as an expert, e.g. as a researcher, planner or consultant?

8. What expertise is (ought to be) consulted? That is, what counts (should count) as relevant knowledge?

9.What or who is (ought to be) assumed to be the guarantor of success? That is, where do (should) those involved seek some guarantee that improvement will be achieved – for

example, consensus among experts, the involvement of stakeholders, the experience and intuition of those involved, political support?

LEGITIMATION

10. Who is (ought to be) witness to the interests of those affected but not involved? That is, who is (should be) treated as a legitimate stakeholder, and who argues (should argue) the case of those stakeholders who cannot speak for themselves, including future generations and not human nature?

11. What secures (ought to secure) the emancipation of those affected from the premises and promises of those involved? That is, where does (should) legitimacy lie?

12. What worldview is (ought to be) determining? That is, what different visions of `improvement' are (ought to be) considered, and how are they (should they be) reconciled

(Ulrich 1983)