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Exploring service users, families, and professionals' experiences with Open Dialogue in a Portuguese Psychosocial Rehabilitation Unit

Ana Raquel da Rocha Ferreira

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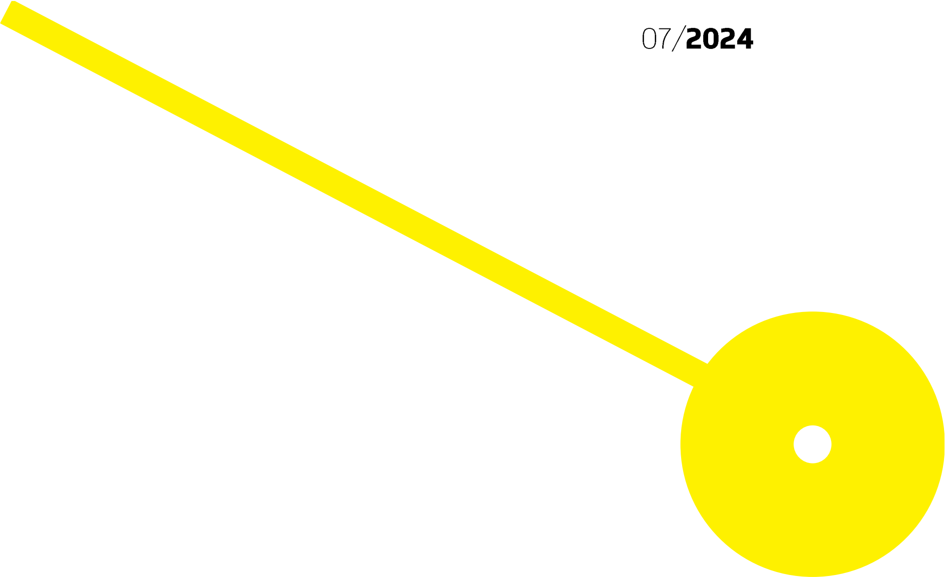

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Exploring service users, families, and professionals' experiences with Open Dialogue in a Portuguese Psychosocial Rehabilitation Unit

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Resumo

Introdução: O Diálogo Aberto é uma abordagem colaborativa e contínua, no domínio da saúde mental, que surgiu na Lapónia Ocidental, Finlândia, na década de 1980. Desde então, difundiu-se a nível mundial, apresentando resultados excecionais, nomeadamente no tratamento de psicoses agudas. Esta abordagem envolve a pessoa no centro das preocupações, a sua família e os profissionais, em reuniões de rede, com o objetivo de promover a compreensão mútua e a tomada de decisões conjuntas. Apesar do seu sucesso, a implementação da abordagem pode enfrentar desafios, nomeadamente na adaptação a diferentes contextos organizacionais e na superação de resistências profissionais.

Este estudo procurou explorar as experiências da pessoa no centro das preocupações, das famílias e dos profissionais durante a implementação do Diálogo Aberto, numa Unidade de Reabilitação Psicossocial portuguesa, denominada Mentemovimento.

Métodos: Foi conduzido um estudo qualitativo descritivo, tendo sido realizadas treze entrevistas com quatro pessoas no centro das preocupações, quatro familiares e cinco profissionais. Os participantes foram selecionados por amostragem não probabilística intencional. Os dados foram recolhidos através de entrevistas semiestruturadas e analisados através da análise temática, com recurso ao software WebQDA.

Resultados: Emergiram três temas dominantes: desafios na implementação, impacto dos princípios e impacto nas pessoas no centro da preocupação, famílias e profissionais. Os desafios incluíram a resistência à mudança, as limitações de tempo e a necessidade de adaptação cultural. Foram valorizados princípios-chave como a flexibilidade, a ajuda imediata e a aceitação da incerteza. As sessões promoveram uma melhor comunicação e um ambiente terapêutico mais humanizado. Também facilitou um melhor envolvimento da família e a colaboração profissional.

Conclusão: Os resultados indicam que o Diálogo Aberto promove um ambiente terapêutico mais humanizado e eficaz, enfatizando a importância do envolvimento da família e do cuidado colaborativo. No entanto, os desafios na implementação evidenciam a necessidade de formação contínua e de apoio organizacional para que os benefícios desta abordagem sejam plenamente alcançados.

Palavras-chave: Diálogo aberto; abordagem colaborativa; reabilitação psicossocial; estudo qualitativo.

Abstract

Background: Open Dialogue is a collaborative and ongoing mental health intervention that emerged in Western Lapland, Finland, in the 1980s. Since then, it has spread globally, showing exceptional results, especially in the treatment of acute psychoses. This approach involves the person at the center of concern, their family and professionals in network meetings, with the aim of promoting mutual understanding and joint decision-making. Despite its success, the implementation can face challenges, particularly in adapting to different organizational contexts and overcoming professional resistance.

This study sought to explore the experiences of the person at the center of concerns, families and professionals during the implementation of Open Dialogue in a Portuguese Psychosocial Rehabilitation Unit called Mentemovimento.

Methods: A descriptive qualitative study was conducted with thirteen interviews with four persons at the center of the concern, four family members and five professionals. The participants were selected by purposive non-probabilistic sampling. Data was collected through semi-structured interviews and analyzed through thematic analysis, using WebQDA software.

Results: Three dominant themes emerged: challenges in implementation, impact of the principles and impact on the person at the center of the concern, families and professionals. Challenges included resistance to change, time constraints and the need for cultural adaptation. Key principles such as flexibility, immediate help and acceptance of uncertainty were valued. The sessions promoted better communication and a more humanized therapeutic environment. It also facilitated better family involvement and professional collaboration.

Conclusion: The results indicate that Open Dialogue promotes a more humanized and effective therapeutic environment, emphasizing the importance of family involvement and collaborative care. However, the challenges in implementation highlight the need for ongoing training and organizational support if the benefits of this approach are to be fully achieved.

Keywords: Open dialogue; collaborative approach; psychosocial rehabilitation; qualitative research.

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1. Introduction

Open Dialogue (OD) is a collaborative, continuous, and outpatient-oriented intervention approach in mental health, that originated in Western Lapland, Finland, in the 1980s and has since spread to more than 30 countries (von Peter et al., 2021), including Europe, Australia, Japan, India, Latin America, and the United States (Pocobello, 2021).

This approach, deeply rooted in family therapy and dialogical philosophy, has garnered international attention for its exceptional results, particularly in treating acute psychoses (Seikkula et al., 2006). Later, it became a well-defined system of care offered to anyone asking for mental health support, in the public or private sector (HOPEnDialogue, 2023).

In this approach, the Person at the Center of Concern (PCC), his/her family, and the professionals are involved in treatment planning from the beginning and throughout the whole therapeutic process, using network meetings as a central therapeutic element. These meetings, with a non-pre-defined agenda, intend to open space to a mutual and deeper understanding of the current needs, brought by the PCC, the family, or his/her social network, as well as to explore the resources of the network and empower transparent and joint decisions for further actions and desired changes, through dialogue (Freeman et al., 2019; Seikkula et al., 2006; von Peter et al., 2021).

OD prioritizes community-based treatment over hospitalization (Freeman et al., 2019), and in such instances, the same team continues to work with the individual and their network as a whole. Additional interventions, such as individual psychotherapy, medication, nursing, social work, and others, are provided and integrated as necessary (von Peter et al., 2021).

Seven principles and guidelines were originally established by the Finnish team for the training, research, and implementation (Olson et al., 2014). These principles not only describe a way of engaging with others, reflecting the dialogical therapeutic style but also provide a framework for organizing mental health services to facilitate dialogue and ensure continuity of care (Bergström et al., 2018):

1. Immediate help: A meeting with the PCC and their network should be established within 24 hours of first contact with the mental health service, preventing hospitalization, if possible, and promoting outpatient treatment.
2. A social network perspective: The PCC, the family, and significant others are invited to the network meetings. All the persons concerned about the current situation, involved in it, or able to help should be included, and depending on the situation they may change over time.

3. Flexibility and mobility: The therapeutic process is adapted to the specific needs of the PCC and the frequency, schedule, duration, and location of the sessions will be discussed between the PCC, his/her family, and the professionals.

4. Responsibility: The treatment team immediately takes responsibility for establishing and continuing network meetings and integration with other treatment processes.

5. Psychological continuity: The team will be responsible for treatment as long as necessary, regarding both outpatient and inpatient settings.

6. Tolerance of uncertainty: Treatment options are discussed at length to avoid premature decisions.

7. Dialogue: The aim is to create a safe space for dialogue and collaboration with the PCC, the family, their network, and professionals. Dialogue does not seek behavioral change or consensus, but increased meaning and understanding about the present needs (Olson et al., 2014; Seikkula et al., 2006).

In Finland, where OD was developed, the application of this approach is embedded in a specific reorganization of the entire mental health care system (Seikkula et al., 2011). However, as the OD model has been implemented in many countries, it has been adapted to fit into different mental health services and contexts (Freeman et al., 2019; Heumann et al., 2023; Kinane et al., 2022).

The evidence associated with the OD approach in the treatment of first-episode psychotic disorders is supported by several studies and includes: reduced inpatient stays, lower relapse rates over time (Bergström et al., 2018; Seikkula et al., 2006), minimal use of neuroleptic medication, initially and during treatment (Bergström et al., 2018; Seikkula et al., 2006), shorter and less severe psychotic episodes (Bergström et al., 2017; Seikkula et al., 2006), decreased use of psychiatric services (Bergström et al., 2017; Seikkula et al., 2006), fewer disability allowances (Bergström et al., 2018; Seikkula et al., 2006) and stability or improvement in treatment outcomes remained fairly stable or even increased over time (Bergström et al., 2018).

Also, OD has shown success in facilitating the reintegration into work and education for a substantial percentage of participants (Bergström et al., 2018; Seikkula et al., 2006).

The network meetings can have a profound effect on all participants, including the PCC families, and professionals (Bergström et al., 2018; Buus et al., 2021). The data indicated that most participants felt network meetings were different from previous experiences where they did not feel listened to or understood, were coerced, or experienced an unpleasant focus on medication (Tribe et al., 2019; Twamley et al., 2021). In turn, the families discovered increased capacity to support their loved ones (Gidugu et al., 2021). They valued the transparency in the process and perceived the network's involvement as a way to diminish stigma, validate concerns, gain diverse perspectives, make joint decisions, understand others, articulate conflicts and interpersonal dynamics, and observe fellow family members collaboratively working toward a shared understanding of the situation (Florence et al., 2021).

On the other hand, professionals appreciated the opportunity to talk with the PCC without so much time pressure and to work in a way that they can express themselves equally and transparently, strengthening mutual respect, autonomy, and self-determination (Tribe et al., 2019), assuming a more democratic stance about the PCC and their families (Jacobsen et al., 2023). Moreover, their own professional identity has changed to greater openness and growth, personally and as a team (Skourteli et al., 2023).

OD sessions were reported to yield positive experiences by most of the family and network members, as indicated in the scoping review conducted by Buus et al. (2021). However, implementing OD can pose some challenges at the organizational and/or individual level.

Existing organizational or cultural norms may resist the principles of OD, making it challenging to introduce and implement effectively (Tribe et al., 2019). The original approach is associated with the implications for the organization of services to offer flexible and immediate help. This requires a structured organizational framework with an ample number of professionals, appropriate shifts, extended service hours, ongoing care, training, and supervision (Seikkula et al., 2011). While the initial implementation may raise financial and human resource costs, these can be gradually reduced throughout the intervention. OD proves to be cost-effective by preventing hospitalization and enabling community-based care, leading to overall savings (Seikkula & Olson, 2003).

Other concerns are related to increased workload and time constraints contribute to professional reluctance, while logistical challenges exacerbate difficulties in maintaining consistent interactions (Jacobsen et al., 2023).

At an individual level, the OD frequently generates resistance from professionals, who feel their position and identity are challenged in various ways that can lead to a lack of genuine engagement and understanding of dialogism (Buus et al., 2017). Also, embracing uncertainty and co-creating solutions with the PCC may be particularly challenging for professionals accustomed to more structured and directive approaches (Skourteli et al., 2023). This challenge is also felt by some families and the PCC valuing authority and expecting guidance may find the OD format confusing (Buus et al., 2017).

Connecting theory to practice is a broader challenge, as translating OD principles into actionable strategies proves complex (Skourteli et al., 2023). Despite challenges, OD has demonstrated positive outcomes, although, there is limited understanding of PCC, families, and professionals' experiences of implementing the approach, namely with the network meetings.

OD is a non-manualized approach and is firmly positioned as a need-adapted intervention in which flexibility is a defining feature (Waters et al., 2021). It follows a set of principles, identified for training, research, and implementation, that are put into use or recombined in various ways depending on the needs of the context (Olson et al., 2014). In this way, it is imperative to evaluate the OD approach in different contexts where it is implemented.

The present study sought to explore the PCC, families, and professionals' experiences during the implementation of OD in a Portuguese Psychosocial Rehabilitation Unit named Mentemovimento.

2. Methodology

2.1. Service context

The data for this study was collected in a Psychosocial Rehabilitation Unit, located in S. João da Madeira, Portugal, which is aimed at people who have experienced significant mental distress, currently stable, but with relational, occupational and social difficulties still remaining. The unit operates during the daytime on weekdays and is not a crisis intervention unit.

The researcher who collected the data is also a member of the team of mental health professionals. At the time of data collection, professionals were at different levels of training (1st, 2nd or 3rd year).

Of the universe of families, on the date of data collection, one family was no longer participating in the sessions and the others were still.

All professionals had access to training and several moments of supervision facilitated by an external OD professional. The need to implement the approach was recognized by the institution's management. The costs associated with training have so far been covered by funding.

2.2. Design

A qualitative descriptive design was used to cultivate a rich understanding of how the PCC, families, and professionals experienced OD (Bradshaw et al., 2017).

An inductive analysis guided by the principles of thematic analysis was undertaken (Braun & Clarke, 2006). To create transparency, the authors followed the consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007).

2.3. Participants

Sampling (non-probabilistic) was guided by a purposive approach, once the research team deliberately chose participants based on specific criteria relevant to the research question. The local was selected by convenience based on their easy accessibility and proximity (Andrade, 2020; Renjith et al., 2021).

The inclusion criteria outlined for this study were: being the PCC and a family member participating in OD meetings and being a professional with training or in training in OD. In turn, participants who experience language barriers or previous experienced with OD were excluded from the study.

A total of thirteen participants were recruited. All the professionals in the Unit were interviewed, as well as all the families and PCC involved in OD sessions.

Each PCC chose the family members they would like to include in the sessions, with an average of one to two family members participating.

The professionals interviewed were at different levels of training in OD, with two psychologists having a master's degree in Clinical Health Psychology and another in Psychology of Justice and Deviant Behavior. The others had completed short training courses in specific areas.

The main researcher was a master's student in Occupational Therapy in Mental Health, with three years' training in OD.

The sample characterization is depicted in Table 1.

Table 1

Sample Characterization of Participants

PCC				
Participant	Gender	Age	Time in OD service (years)	Diagnosis given (years)
1	Male	32	1	13
2	Male	37	1,5	17
3	Male	28	1	8
4	Female	24	1	6
Families				
Participant	Gender	Age	Time in OD service (years)	Degree of kinship
5	Female	64	1,5	Mother
6	Male	67	1,5	Father
7	Female	52	1	Mother
8	Female	66	1	Mother
Professionals				
Participant	Gender	Age	Area of work	Training in OD (years)
9	Female	42	Social Worker	1
10	Female	40	Psychologist	1
11	Female	33	Social Worker	1
12	Female	30	Psychologist	2
13	Female	28	Psychologist	1

Note: OD – Open Dialogue; PCC – Person at the Center of Concern.

2.4. Procedures

A review of the literature on the subject was the initial procedure carried out to understand the current state of knowledge, identify gaps, and build a basis for the study.

Once the literature review was completed, the next step involved creating a semi-structured interview guide, which included a set of open-ended questions. Before using the interview guide, it was reviewed and approved by a panel of experts in this field and after, the main researcher conducted a pilot test to ensure clarity and completeness.

Next, all participants were identified and subsequently contacted by telephone by the main researcher, explaining the characteristics of the study and inviting them to participate. Everyone agreed to voluntarily participate in the study and signed the free and informed consent form.

By email, participants received information about the purpose of the study, specific details about their involvement, and contact information for the research team. Along with this communication, a consent form was attached and was carefully reviewed with the participants at the beginning of the interviews.

After the initial communication, participants were invited for face-to-face interviews, at a mutually convenient time suitable for the interviewee. The environment was carefully organized to ensure a calm and confidential environment, conducive to audio recording and allowing for uninterrupted conversation.

2.5. Data collection

The main researcher obtained data through individual in-depth interviews, with open-ended questions, with the PCC, family members, and professionals. A semi-structured format was adopted in which follow-up prompts were often used to encourage participants to expand on their answers.

Data collection was conducted by the main researcher, face-to-face, in the institution during May 2024. An interview guide (see Appendix 1) was created with the following questions: Background and Engagement (2 questions), Experiences and Impact (3 questions), Communication and Collaboration (2 questions), Adherence to Principles (7 questions), Effectiveness and Outcomes (2 questions).

Once it was a semi-structured interview guide, other questions arose from the profiles, such as "How do you feel about the way meetings are organized (*e.g.* timing, location, persons involved)?" or "What challenges have you encountered during the implementation of OD?"

In addition, the following sociodemographic data were also collected: age, gender (for all the participants), number of years with diagnosis (PCC), time in OD service (PCC and family), degree of kinship (for families), and area of work, number of years of training in OD (for professionals).

The main researcher informed all interviewees (PCC, family members, professionals) that participation was voluntary and obtained written informed consent before study participation. Each interview lasted approximately 60 minutes. All interviews were audio recorded and transcribed verbatim and field notes were also taken.

2.6. Ethics statement

This study was performed in accordance with the Declaration of Helsinki ensuring ethical standards for all participants. The nature and aims of the study were explained to the PCC, families, and professionals and written consent was obtained, whilst participants maintained their right to withdraw from the research process. Collected data were coded to promote the anonymity and confidentiality of all participants and were stored electronically in password-protected files only accessible by the researchers; following completion of the research, all data will be permanently destroyed. Finally, participants of the interviews were debriefed about the research process to promote transparency and inclusion in the research process. Ethical approval was sought from the ESS, Polytechnic University of Porto Ethics Committee (n. CE0044E).

2.7. Data analysis

Thematic analysis was employed to analyze data from interviews with the PCC, families, and professionals, following the six-step process by Braun and Clarke (2006): becoming familiar with the data, generating initial codes, identifying themes, reviewing potential themes, and defining and naming the finalized themes. Audio recordings were transcribed verbatim, and transcripts were analyzed inductively to capture participants' experiences. The main researcher read and re-read transcripts, generating initial codes, which were then organized into recurrent themes. Afterward, the main researcher temporarily maintained a distance from the data collected, to gain a broader perspective before revisiting and analyzing the data again. This step was further supported and validated by discussing the themes with the research team.

These themes were refined to ensure coherence and meaningful representation of distinct entities aligning with participant narratives. The thematic analysis was conducted using the WebQDA software.

The research team consisted of four members, namely the main researcher (an occupational therapist, the person who collected the data, and a master's student), a supervisor (an occupational therapist and the main supervisor of the master's thesis), and two co-supervisors, an occupational therapist and a psychologist, who contributed with their technical guidance, discussion, and revision of this manuscript, both with a background in OD.

3. Results

The results are displayed below and are organized into themes and sub-themes: Motivations for change; Implementation challenges; Adherence to principles; Challenging professional identity; Impact on PCC and families.

3.1. Motivations for change

3.1.1. Focusing care on personal development and autonomy

All the PCCs felt that, throughout their time in previous mental health services, the focus of care was essentially on medication *"I think that sometimes we should focus more on... on personal development, sometimes we don't focus so much on that, we focus more on medication" (P2, PCC); "I was expecting more, since it should be more usual to pay more attention to the patient, rather than the medication itself" (P4, PCC)*, stating that they believe care should focus on personal development and acquiring skills, to integrate into the job market and/or study, thus promoting their autonomy *"Care is focused on medication, it's also focused on abstracting negative thoughts. I think that part of personal development is lost. Trying to do, perhaps, some activities that help people to acquire skills that they may not have, to prepare themselves for an autonomous life, for an independent, self-sufficient life and for people to have skills, to have...know-how to be able to find work, to be able to keep a job or study (...)" (P2, PCC).*

Some PCCs also reported that taking medication can be an obstacle to achieving autonomy and independence, mentioning that the side effects can hinder a person's ability to look after themselves, find work, or study *"(...) I think that medications are sometimes also an obstacle to a person being able to lead an autonomous life, to lead an independent life. (...) most medications also affect rest...they make people need more rest. Then, often... they take so many medications that they can't be... awake as they should be and be able to work, study or look after themselves" (P3, PCC).*

3.1.2. Share the same language

One of the main motivations identified for training in OD was the perceived need to expand care to include greater involvement and collaboration with families and the support network *"At the time when I started hearing about open dialogue, it was because I was working at the Mentemovimento Association, and...since it was...a way...of working in which it was perceived* *that there was a great need here to work with families in addition to working with users" (P12, professional).*

This need was identified within the Association's work context, where the team had already been applying the approach for around two years. Therefore, the decision to take part in the OD training was influenced by an understanding of the importance of aligning with the existing language and practices *"This approach has already been used by my colleagues for around two years. And for me to enter into this same language, I needed to start the training" (P10, professional).*

3.2. Implementation challenges

The results show that there are several challenges associated with implementing OD, both on a personal and/or organizational level.

3.2.1. Traditional healthcare

The change from a traditional approach to OD can be challenging, especially when professionals are conditioned to follow certain protocols and established practices *"We are formatted to do things in a certain way (...) as a social worker I'm also very attached to all the bureaucracies that I can't escape, but maybe try to take them and break them down in another way or present them in another way to the beneficiary" (P11, professional).*

They recognize that a paradigm shift is not easy, especially when it comes to changing established practices within an institution or health system, and it is common to encounter resistance from colleagues and the organizational structure itself *"(...) I remember this last training session, realizing, having other colleagues who said: we don't own the services, so we can't just take the approach and say from now on we're all going to do things this way" (P11, professional).*

However, the professionals emphasize that commitment to change can begin with individual change *"(...) we don't need to force anyone to do things the same way we do. But if we can manage, individually, to put a little bit of this approach into what we do, sometimes in the simple dynamics and routine that we have as professionals, that changes everything" (P11, professional)*, incorporating elements of the approach into their daily practice, into the way they interact with people, from the way they listen to people's stories to the way they position themselves about their needs *"The way I position myself about people's stories, how I receive what people are telling me, why people have come to the service or why they haven't, why they don't want to come* *to the service. So, the way I position myself towards things, of course, I can't always do that, I'm not going to lie, right? the way I worked, and the way I work, is very deep-rooted" (P11, professional).*

3.2.2. Lack of time and pressure for quick results

Lack of time is pointed out as a significant factor contributing to the automation and standardization of care *"Everything is very typified. I think we're still working too much in a very automated way, don't you? (...) Because we don't have time to look at people calmly, to be able to provide care calmly, to be able to listen carefully" (P11, professional).*

Professionals feel under pressure to complete many tasks in a limited period *"Sometimes we're forced to have this script, sometimes we can't even complete that script, because in one day we have a lot of situations to deal with and so, ok, let's prioritize, I just want to know this, this and this. Let's focus on this and we don't have time to look at things... in general, right? And I think that's a lot of it, our professional practice is falling very much into this logic of, ok, I've done these tasks, my work is done" (P11, professional).*

3.2.3. Resistance to change and lack of preparation

Many professionals are used to traditional working methods and may find it difficult to adapt to less standardized approaches *"(...) I think this is also a question of changing mentalities. And we know that there is still a lot of resistance (...), especially to medical-centered models" (P9, professional).* One professional mentioned that *"being willing not to apply any structure of techniques" (P10, professional)* is a challenge for her.

Change can generate constraints and resistance, mainly due to a lack of knowledge and/or training *"I think it can also be very challenging because they can look at our way of trying to implement a little outside the box. I don't think we're all prepared to see things in this way. As we are all very typified and things have to be done in this way, someone who challenges this can appear to put up some constraints, and resistance, a lot of it due to unfamiliarity too, because we have spent many years doing things in a very typified way and we don't have time to go out and see things differently" (P11, professional).*

The lack of knowledge about the approach on the part of professionals from other organizations can be a significant obstacle to networking *"I think it would be very important for open dialogue to be worked on more widely in the network. It's much more difficult to work on open dialogue* *when the professionals from the other entities that involve us don't know about the approach" (P9, professional).*

3.2.4. Family involvement

The introduction of a differentiated approach that involves actively inviting families can be met with initial awkwardness or discomfort.

The professionals mentioned that not all families are available or willing to actively participate in the therapeutic process *"I feel that one of the challenges we anticipated as a team had to do here with accepting an approach that is differentiated. Our users are, in a way, used to going to the services and having consultations that are quicker and one-to-one, where the family isn't always involved or is left on the sidelines, and here the invitation is very different. As well as working with the patient, we also end up finding out who the people of reference are and inviting them to our meetings... this gives us another dynamic that can often be received with some strangeness" (P12, professional),* which can hinder adherence and participation in the therapeutic process.

In addition to this challenge, coordinating the schedules of families can make it difficult to coordinate compatible times for meetings *"Families aren't always available at the times when our people are attending the association and this can be seen as a more central challenge here" (P12, professional).*

3.2.5. Non-hierarchical approach

The difficulty professionals have in abandoning the position of authority is associated with the fact that *"(...) we were taught this way" (P9, professional).* Although the intention is to adopt a horizontal relationship, professionals still tend to take control *"There's a problem there that requires resolution. And so, we take on a role. So, I have the problem there that I have to solve" (P9, professional),* which creates a complex dichotomy between solving problems and sharing decisions equally.

One participant illustrates the complexity of this dichotomy by recognizing that professionals, because of their training, tend to believe that they are more right in certain aspects *"You have been taught that this way is the right way and that the other ways are not so right. Maybe, because of that, you think that maybe you're more right about this or that or you know more about this or that" (P2, PCC).*

The idea is to value the PCC's narrative, recognizing the person as the expert in their own story *"(...) health professionals do not place themselves as decision-makers. I don't have the right to decide for the other person, even if I believe that a certain decision or option would be beneficial. It's this idea that the person who brings the story is somehow the 'professional', the one who knows the most about it, the one who has to dictate the rules of the game in some way and not the other way around (...) The person who brings the narrative is an expert, in their narrative, they know the most" (P12, professional).*

However, one participant mentioned the need for a more assertive and occasionally *"manipulative" approach to "(...) coerce people more. You have to be more manipulative, in the sense of getting people, sometimes, along a not so docile path, to do what they're supposed to do" (P3, PCC)* contrasting with other experiences of care *"(...) For example, sometimes when I go to a psychiatrist, the psychiatrist is cold to me. (...) And he has to be. The profession demands it. Sometimes, when I go to a doctor, he says: "You have this and you have to do this' and he doesn't nurture much sympathy" (P3, PCC).*

3.3. Adherence to principles

3.3.1. Immediate help

The meetings were scheduled based on the requests received, prioritizing a quick and flexible response to the participants' needs *"The meetings are scheduled according to the requests that come to us and are scheduled as quickly as possible, depending on our availability" (P11, professional).*

One family member mentioned that, for her, mental health care could ideally take on a more dialogical approach and be less focused on drug interventions *"And as my son, in particular, calms down, restructures himself with conversation, ideally in my opinion and instead of calling the doctor to say that we are here with a crisis (...). For me, ideally, the contact wouldn't be with the doctor, but it could be with...a psychologist, a therapist, it could be more along these lines, not medication, more along these lines" (P7, family).* Suggesting that this type of care should be more widely available *"I think that here the reflection on the reflection... could only go in the direction of expansion. I leave the challenge. Because, being on the front line, being accessible at a time of crisis would be ideal" (P7, family).*

This perspective highlights the importance of adapting mental health services to meet people's specific needs, offering flexible and accessible support that is aligned with their preferences.

3.3.2. Flexibility and mobility

The frequency, time, duration, and location of the sessions are discussed between the PCC, their family, and the professionals *"It's not exactly dictated by us, but it's something that's asked and in the logic of what makes the most sense for you, when you feel you should come back here or that it would be beneficial for you to come here again, within what our availability is and the hours we have to provide care and to be at the service" (P12, professional)*, based on individual awareness of their own needs *"We are also the ones who have to be aware of when we need to seek help" (P2, PCC).*

On the other hand, one family member expresses her preference for receiving guidance, emphasizing that the personal decision makes no significant difference to her *"It's up to us to choose? It makes no difference. I like being told, look, on this day..." (P5, family).*

Finally, one participant reflects on the freedom and comfort provided by the possibility of deciding when to seek help, in contrast to a more imposing approach *"It seems to me to be an attempt to give people a certain amount of freedom, so that people feel more at ease (...) it seems to me that... if this were something, perhaps, imposing, that could lead people to think differently: I have to go, they're there to boss me around" (P3, PCC).*

The possibility of holding meetings in a home context is mentioned as important since it is recognized that offers valuable insights into the life of the person and the family *"And often we are talking to someone without understanding where that person comes from. So the home context also allows us to observe other things beyond that dialogue" (P9, professional).*

3.3.3. Embracing uncertainty

The OD recognizes that uncertainty is part of the human and therapeutic experience, and that sufficient time is needed for everyone to be heard and for a dialogue to emerge in which the most important issues/experiences for the PCC/network can be addressed, avoiding premature decisions *"Having to deal with that with the unpredictable is also something very difficult to do. But I think that if it's done together, it has a different impact. As professionals, we also have a lot of... ambition that what we're working on will have an immediate result and that will have an immediate effect. There's that tolerance of uncertainty, that something that might not happen exactly like that is something that has to be built up" (P11, professional).*

Tolerance of uncertainty is reinforced by creating a space in which everyone involved can feel sufficiently secure in a joint process *"We are effectively building a path together, it makes all the* *difference for everyone to feel an integral and collaborative part of the process" (P9, professional).*

Tolerating uncertainty also implies that professionals don't bring an agenda to meetings *"There's no need for external planning" (P12, professional)*, but rather a willingness and openness to listen and respond to the needs and concerns that arise at that moment. By starting the sessions with questions such as *"What do you want to talk about today?" or "What brings you here today?" (P12, professional)*, the professionals create a space where the participants set their agenda and topics of conversation, which increases the feeling of security, but also reinforces the perception that their questions are important and valid *"It gives the other person security, capacity and the feeling that they are being seen, that their questions are being considered" (P12, professional).*

3.3.4. Impact of reflections

Reflections should be based on what has been said or expressed during the conversation. It is important that the reflections shared are not declarations, opinions or statements of meaning, but are formulated as ideas or suggestions (van Dieren & Clavero, 2022) *"(...) we can disagree here or there. There's nothing wrong with that. (...) This openness is fantastic because it's like this... we talk and then in the end no one is judging anyone but they're reflecting on what we've been talking about" (P6, family).*

In addition, there is a perception that this moment of sharing promotes trust and transparency among the participants, creating a safe environment *"This sharing I think also promotes some trust here and shows that it is a safe place" (P9, professional).*

The participants express appreciation for the opportunity for reflection provided by the interaction with the professionals. They see it as an opportunity to look at and broaden their perspectives *"(...) it draws my attention to aspects that I might also have to look at a second time. (...). And it also shows us our mirror, our image in the mirror. When we're interacting, we don't see it. And you give us that reflection" (P7, family)* and to consider different points of view *"Maybe it also helps us to reflect on our own opinion, that by listening to the opinion of others, maybe we can even change our opinion, maybe we can see a point of view that we hadn't seen before you shared it, maybe we can have a more comprehensive view of things, more differentiated" (P2, PCC).*

According to the literature, the reflection teams don't give much concrete guidance, but one family member says *"The fact that they give feedback on the paths, the choices that are being made,* *what is happening, is also positive because I feel that my son needs constant external confirmation. It's not always easy for that to happen, or rather, I try to do it, but I feel that he needs other people to do it too. This is the moment when that happens" (P7, family).*

The sharing of reflections by professionals is an important contribution to promoting a polyphonic environment, and it is also important to engage in dialogue with the body and sensations. When this happens, professionals can also be transparent about the fact that they feel touched by the feelings of the *participants "We are very motivated in training, throughout these years of training, to bring what our anxieties are, our sensations, and sometimes even our sensations that are physical, that are bodily, and I feel that this is a surprise, or is received as a surprise for those who listen to us and makes us all closer to what the human experience is. It's almost as if some walls have been broken down between therapists and people who are being helped or asking for help" (P12, professional).*

The professionals recognize that this sharing *"(...) is important because we are also human and we bring this humanity to the dialogues" (P9, professional).*

3.3.5. Multiplicity of voices

OD recognizes the need for a network approach, considering the person as *"(...) a multifactorial, multidimensional system (...)" (P12, professional).* From this principle, *"(...) it makes perfect sense that the premise is to involve the people who are somehow involved in the therapeutic process of the person asking for help" (P12, professional),* believing that *"the dynamic influences the patient and vice versa"* (P11, professional) and that *"despite being a unique and original person, they have different areas of their life, which only when combined form what they truly are" (P13, professional).*

All participants had at least one family member present, and whenever possible, other network professionals such as psychologists, psychiatrists, nurses, and social workers were included.

The PCC valued the participation of family and the network in the meetings: *"It helps to seek new goals" (P1, PCC); "It felt good to have the opportunity to connect with my mother" (P3, PCC).* However, two PCCs mentioned that they felt the involvement of family was seen as a form of intrusion: *"She ends up knowing everything about my life and I don't want that" (P4, PCC).*

Professionals believe that the network's participation offers the PCC *"a greater sense of trust in the services, (...) seeing that everyone is coordinated and almost nothing is hidden (...). This greatly increases the user's security, seeing that several reference people are united for the same cause"*

(P13, professional), besides demonstrating *"(...) transparency about the situation" (P7, family) and being considered "highly essential, (...) enriching any work with the user and the family, since each situation is unique and requires a different approach" (P11, professional).*

They also felt that *"The family is very grateful to be able to participate in the intervention, to contribute, and also to be heard. Because many times the family's difficulties do not have a space to be re-signified" (P10, professional)*. Without their presence, it might not be possible to access certain information *"They bring things that I might never remember or never know if they were not in that dialogue. I'm only hearing one person's perspective" (P9, professional).*

Family members recognize the importance of their participation *"No, I can't stay out of it. The problem is mine too" (P6, family)* and that despite different roles between professionals, family, and PCC, there is mutual recognition of them *"(...) I know what your place is. And you also know what mine is" (P6, family).*

Furthermore, having several therapists (co-therapy) is seen by professionals as supporting the development of polyphony, promoting alternatives, and giving space to different voices. Professionals feel that *"this has an impact on the user and the family as well, and it is very beneficial to have another voice and the conversation between two professionals, in my case, from different areas, I feel that this is very enriching for the therapeutic process" (P12, professional)* and that the possibility of co-therapy expands the possibilities *"because if it is at an individual level, it's me, my thoughts, my emotions, and the patients. Together it is much richer" (P10, professional).*

3.4. Impact on PCC, families and professionals

3.4.1. Challenging professional identity

OD promotes a collaborative approach to change, recognizing that both professionals and PCC are active agents in this process *"Sharing the responsibility for the process of change with people means recognizing that change is a co-construction process and that professionals are not the only agents of change" (P12, professional).* This perspective promotes a sense of lightness in the profession, as it removes the pressure from professionals to produce results *"I feel that it is something that is more shared, even in terms of responsibility per se in the process. It is something that is shared and co-constructed together, and that also brings some lightness to the* *profession itself (...) the view of an 'I' as a tool, as a facilitator, and not an 'I' as responsible for the change in the other" (P12, professional).*

Furthermore, it is emphasized that instead of professionals focusing on providing answers and quick solutions, the importance of active listening and reflecting on narratives is highlighted *"There is another issue that has to do with the need, which is often felt by health professionals, to provide answers, to create strategies, and the approach moves away from this vision. It is more related to active listening, reflecting on the narrative that is brought to us, and these different roles and how this resonates with us, rather than producing results and objectives, strategies that come here to alleviate suffering in a faster and more urgent way" (P12, professional),* which can allow a deeper understanding of people's needs and experiences.

The ability to slow down and truly connect with people can strengthen the therapeutic relationship. When professionals take the time to listen attentively and respond empathetically to people's concerns, it can increase trust and engagement in the therapeutic process *"I will introduce a concept that may be strange but that comes to mind, which is slow living, which is about slowing down, stepping back a little, stopping, putting your feet on the ground, and actually thinking about things and being able to listen to each other. This, by the way the system is organized, is not allowed. It's not because professionals are bad and don't want to, but they are not allowed to act in another way. And we have had some references from users we follow who complain about this being very fast, professionals almost not being able to look them in the eyes, writing on the computer, just looking for a list of symptoms and never the stories, never the narratives" (P12, professional).*

Professionals also shared how the adoption of OD not only influenced their professional practice but also impacted their personal lives and interpersonal relationships *"This approach also helps us a lot in the relationships we create daily because we end up deconstructing many ideas and even the way we manage certain conflicts, how we position ourselves in some family dynamics, or how we are building certain professional relationships, all of this, this approach fits into our lives" (P11, professional); "In the end, it is a change in the way of being. I think that as professionals and as people too" (P9, professional); "Open dialogue influenced my way of being with others, I think it even influences our personal life, the relationships we maintain in our daily lives" (P13, professional),* mentioning improvements in active listening, empathy, and valuing others' concerns as results of this approach *"(...) we are much more able to implement active listening,* *empathy, all those concepts that seem obvious, that should always be included, with open dialogue it seems that everything makes more sense" (P13, professional).*

3.4.2. Interactions and communication

The meetings provided a safe and mediated space where families felt comfortable addressing sensitive topics *"At home, I don't talk about this. I avoid it. I don't even talk to my husband because we always end up disagreeing" (P5, family)* and potentially conflictual ones *"They serve as a moment where there is mediation and my son feels at ease to talk about issues that he sometimes doesn't touch on in conversations just with me, or that he touches on and gets very inflamed, and here there is attenuation because we are in a space that is not his because we are with people who help in the mediation and control of the level" (P7, family).*

Furthermore, the meetings were perceived as a valuable opportunity to know perspectives *"Sometimes my parents say things here in Open Dialogue that they wouldn't say at home... (...) and here, I get to know that, which maybe if I didn't come here, if I didn't have this meeting, I would remain unaware of (...)" (P2, PCC)*, concerns, and needs of each other "*By making some issues conscious, it takes them out from here. What is done here we then take to the family and we are all more attentive and we all have that issue more present. And with... the care that we feel that issue deserves" (P7, family)*, which otherwise might remain unknown.

The improvement in intrafamily communication is perceived by professionals as an opportunity for greater openness, mutual understanding, and problem-solving. They observe a positive change in family dynamics, where everyone feels free to be authentic and genuine *"People feel they can be themselves and genuine because they think, consider, and ultimately, that's what it is, that it should be an approach without value judgments, without judgments, they feel that therapists come free of prejudices and stereotypes (...). And the fact that it ends up being a topic brought by them, but still guided by the professionals, can help them feel more and more at ease to have assertive communication, where it is free from hurting or wounding the other's feelings" (P13, professional).*

In turn, the family reports feeling supported, valued, and closer to each other due to the opportunity to share and be heard *"I think my son values very much the fact that we make time to be here, and he feels more accompanied and more loved and more valued, and that also goes outside, it affects him and all of us in the family" (P7, family).*

3.4.3. Wellbeing and recovery

The OD approach has been recognized for its positive impact on people's well-being and recovery.

By participating in the meetings, people are encouraged to make decisions about their own lives and identify their own goals *"(...) people feel more empowered to make a change, to be able to make their way in a much better way autonomous (...) is the person with experience of mental illness the one who knows best about themselves" (P9, professional).*

This empowerment promoted by OD can also contribute to reducing dependence on health services *"(...) that these are practices that can be implemented at home, when we are not there so as not to create that perspective of dependence" (P13, professional)* strengthening the people's ability to deal with their challenges independently.

Furthermore, OD was also recognized by professionals and PCC as a factor in reducing stigma, since when people feel heard, they understand *"here people understand me well" (P1, PCC)* and respected in their experiences, this not only strengthens self-esteem, but also challenges stigmatized perceptions that can hinder the recovery process *"I think that open dialogue also comes a lot in this sense of reducing stigma, reducing prejudice, not listening to expressions like: people who have an experience of mental illness, they don't know what they want, they will never know what is best for them, they should hardly have an opinion, because they are not in a position to think about it" (P13, professional).*

The promotion of hope also appears as a fundamental element of the recovery process "*I don't see a light at the end of the tunnel, but when I leave here, I leave with the hope of seeing it one day" (P5, family),* as it incorporates the ability to believe in one's own ability to recover, as well as the ability and flexibility to act and overcome future obstacles (McCarthy et al., 2023).

OD, by promoting empowerment, autonomy, hope and reducing stigma, can contribute to a greater sense of individual well-being *"I feel better, whenever I come here, in everything (P8, family)* and in the family *"Because he feels good, because I feel good too... Because well-being is also contagious" (P7, family).* These meetings create a symbiosis between the PCC and their families, where the well-being of one directly influences the well-being of the other *"Because if a person is as healthy as possible, the family context will be as healthy as possible. And if the context is healthier, it will also contribute to the person's improvement (...)" (P13, professional).*

Finally, after participating in the OD meetings, a PCC reported feeling improvements in terms of participation in domestic tasks and personal organization, which may indicate an increase in functionality, important aspects in the recovery process *"It contributed in a more positive way, the level of recovery, on a cognitive level, on a mental level, on a developmental level, more on a health level, because I recovered a little better (...). I improved in terms of domestic tasks (...)" (P4, PCC).*

4. Discussion

This study aimed to explore the experiences of PCC, families, and professionals regarding network meetings during the implementation of the approach in a Psychosocial Rehabilitation Unit.

The study identified three dominant themes that illustrate the professionals' experience with the approach and how PCC and families received it. These themes were: implementation challenges; impact of principles; impact on PCC, families, and professionals.

The implementation of OD in this context was not about restructuring all pre-existing care but facilitating better therapeutic collaboration among professionals, PCC, and the support network. It was developed alongside other existing therapeutic approaches to expand the care offered.

Overall, the majority of participants reported that their involvement in network meetings was positive, aligning with the findings of Freeman et al. (2019) who concluded that the approach was generally well-received by participants and the network. Additionally, in the study by Wusinich et al. (2020), participants in a community-based mental health program valued the time spent in dialogue and the decreased focus on medication.

The experiences reported by PCC indicate a clear need for reformulation of mental health services, which should go beyond medication and include strategies for personal development and skills acquisition. These findings are consistent with most results published in the literature on previous experiences with mental health care, where participants felt an undesirable focus on medication (Gidugu et al., 2021; Tribe et al., 2019).

However, adopting a dialogue-centered approach requires significant changes in the attitudes and practices of professionals as well as organizational restructuring.

4.1. Implementation challenges

For professionals, implementing OD represents significant challenges related to changing established practices, lack of time, resistance to change, difficulties in engaging families, and adopting a non-hierarchical approach. Although professionals identified these challenges, resistance to change and non-hierarchical positioning were not significant difficulties for them, unlike what has been described in other studies where the approach often generated resistance from professionals who saw their positions being challenged (Buus et al., 2017; Buus et al., 2021; Kinane et al., 2022).

Additionally, as described in the literature, professionals with less formal therapeutic training were more capable of integrating the approach's principles into their practices, which may have minimized difficulties in adopting the model by professionals (Skourteli et al., 2023).

As described by Buus et al. (2021) an adjusted organizational preparation is necessary, including institutional willingness and readiness for change, which can be seen in the present study. Furthermore, cultural and contextual adaptations of the approach must be considered, which involves actively incorporating local perspectives and adjusting practices to respect cultural differences (Mosse et al., 2022).

Professionals also emphasized that overcoming challenges requires coordinated commitment, including continuous training, awareness-raising, and gradual adaptation of daily practices to facilitate their involvement and that of other professionals. Furthermore, professionals mentioned that inviting families is sometimes met with strangeness. The exclusion of families from care was also confirmed in the study by Gidugu et al. (2021), where in their previous experiences, they were intentionally or passively excluded from the care provided to their family members. Eassom et al. (2014) highlight various reasons for the absence or scarcity of family involvement in care, including marginalization and distancing from care planning, lack of recognized roles, and/or not being heard.

4.2. Impact of principles

The adherence to the principles in OD was reflected in prioritizing immediate assistance, flexibility and mobility, tolerance for uncertainty, impact of reflections, and multiplicity of voices. However, the implementation of these principles posed some challenges, especially regarding the principles of immediate assistance and the network perspective. Meetings were quickly organized in response to received requests, prioritizing flexibility and the needs of participants. However, as observed in the study by Gidugu et al. (2021), professionals are not solely dedicated to conducting meetings, which can be difficulty in organizing them. Other contextual contingencies relate to the lack of a dedicated means of transportation for conducting meetings outside the institution. Tolerance for uncertainty and dialogism were considered positive aspects of the approach by professionals, with all service users and families mentioning that during meetings, they felt that all their needs were heard, respected, and validated equally. This fact may have resulted from the space created by professionals that allowed for the sharing of multiple perspectives and understandings, as described by Tribe et al. (2019), aligning with the goals of dialogism.

Professionals acknowledged that tolerance for uncertainty is strengthened by creating a safe environment where everyone feels like an integral and collaborative part of the process, where there is no predefined agenda for meetings, but rather availability and openness to listen to and respond to narratives. Reflections, based on what was said during the conversation, formulated as ideas or suggestions, promoted confidence and transparency. Professionals felt that sharing their own experiences and feelings humanizes the therapeutic process, which, according to Olson et al. (2014), fosters a greater therapeutic connection and prevents being too distant from people. Some participants in the present study expected to receive direct advice and solutions from professionals. Considering the traditional care culture, this result is aligned with the observations of Skourteli et al. (2023), who report that families with a strong belief in authority and an expectation of being guided by professionals may find the approach format confusing.

4.3. Impact PCC and families

Consistently to the study by Jacobsen et al. (2018), the meetings provided a safe and mediated space, characterized by transparency, where PCC and families could address sensitive and potentially conflicting issues more easily, get to know each other's perspectives, concerns, and needs better, contrasting with their previous experiences of care where they found it difficult to talk about their problems and concerns.

Although two participants felt that the presence of the network was seen as an invasion of their privacy, the remaining results showed the opposite, the presence of the network was experienced by families and service users as an improvement in intrafamily communication, accessing multiple perspectives, avoiding premature decisions, understanding others, and slowing down (Florence et al., 2021).

Furthermore, the presence of support network members was felt as a way to promote empowerment, hope, autonomy and stigma reduction (Bergström et al., 2018; Florence et al., 2021; Gidugu et al., 2021).

Finally, one participant mentioned that her participation in the meetings had an impact on her participation in day-to-day activities. Occupational therapy plays a crucial role in the care of people with an experience of mental illness, as it promotes the process of recovery through participation in meaningful activities. In addition, Occupational Therapy shares principles of providing holistic and person-centered care. Furthermore, the OD approach is not manualized and can be generated with other forms of psychotherapy, especially individual therapy, but also family therapy, art therapy, occupational therapy, among others (Seikkula & Olson, 2003).

Villares (2019) suggests that occupational therapy can incorporate strategies that focus on the person's social and temporal context, relationships and shared construction of reality, in line with the principles of dialogism.

These results indicate that the principles of OD are aligned with the essential elements that contribute to the recovery process of people with lived mental illness, concurrently with flexibility, a focus on the person, working with the support network, and co-construction of decisions (Jaiswal et al., 2020).

4.4. Impact on professionals

The professionals recognized that both they and the PCC are active agents in the therapeutic process, not placing themselves in the role of "solving problems". The shift to a more collaborative way of working in mental health has also been indicated in other studies (Florence et al., 2021; Schubert et al., 2021). However, as professionals tried to adjust to a new way of working, they found it difficult to abandon their more conventional expert and decision-making positions (Einboden et al., 2024).

Additionally, in the study by Schubert et al. (2021), the impact of OD on professional identity was, in some cases, perceived as an exposure and placement of professionals in a vulnerable position, which in the present study was not mentioned by any of the professionals.

Professionals reported that sharing responsibility for change (co-construction) alleviates the pressure on professionals to produce results and that the possibility of slowing down and truly connecting with people strengthened the therapeutic relationship, increasing people's trust and engagement in the process. In general, professionals felt that the approach aligned with their professional and personal values and improved the quality of care, results that were also reported in the study by Tribe et al. (2019).

The literature has essentially focused on the need to make positions horizontal between professionals and the people they serve (Seikkula et al., 2006), devoting little or no attention to what occurs between professionals themselves in this process (Buus et al., 2021).

5. Limitations and future research

The study aimed to explore the experiences of the PCC, families, and professionals regarding the network meetings during the implementation of the approach in a Psychosocial Rehabilitation Unit. The research was conducted during the professional training process, therefore, caution is needed before generalizing the results to other services where the OD practice is already well established. It would be important to explore the internal dynamics among professionals during the implementation of OD.

Furthermore, this study included a small sample of participants at different stages stages of participation in meetings, with one family having already stopped attending, which on the one hand can create guidelines at a local level, but can make it somewhat difficult to generalize to other contexts. The sample was also not diverse in terms of gender, as most of the participants were predominantly women, although this reflects the demographics of service users and mental health professionals in general.

The sample also lacked gender diversity, as most participants were predominantly women, although this reflects the demographics of the service users and mental health professionals in general.

The fact that one of the researchers was an integral part of the team (practitioner-researcher) and that the researchers identified the participants may have introduced biases in the sample.

Voluntary participation may have been influenced by the fact that participants knew the researcher. On the other hand, a distortion of data towards social desirability would be expected, in our view, especially in the levels of implementation of fidelity criteria.

Additionally, we consider it relevant to evaluate the long-term impact in order to deepen the understanding of the OD impact in this context.

Since one participant said that taking part in the meetings had an impact on her participation in day-to-day activities, it would be pertinent to assess the impact of OD on occupational participation.

In addition, it was important to ensure that the research did not prejudice the therapy and vice versa, which was safeguarded through continuous monitoring, flexibility to adjust the methods as necessary, conducting the interviews in a different environment to the one used for the sessions, asking open-ended questions, being available to clarify doubts and ensuring easy access to the main researcher.

Lastly, this study made it possible to evaluate the local implementation of the approach, something that had not been done to date, in order to become aware of possible changes and adaptations.

6. Conclusion

The experiences of the PCC, family members, and professionals indicate that the approach was valuable from each of their perspectives. Some elements, including transparency, respect, collaborative involvement, as well as the promotion of hope and new ways of seeing and hearing others, were fundamental to the satisfaction expressed by the participants. Among the reported strengths, the involvement of the family and the support network stood out as a vital component.

In summary, the implementation of OD in a Psychosocial Rehabilitation Unit proved to be a valuable approach, despite the challenges, promoting closer collaboration and a more humanized therapeutic environment. The results suggest that adopting a dialogue-centered approach can significantly improve the quality of mental health care, as long as it is accompanied by adequate organizational preparation, as well as ongoing training and supervision of professionals.

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Supplementary material

Appendix 1 – Interview guide

1. Background and Engagement

- Can you provide some insight into your involvement with the Open Dialogue approach and what led you to be involved in this method of support?
- What motivated you to participate in the Open Dialogue approach training or sessions?

2. Experiences and Impact

- How have your experiences within the Open Dialogue approach influenced your understanding of your health journey or the concerns being addressed?
- What changes have you noticed in yourself or your family member/professional role as a result of participating in the Open Dialogue sessions?
- Can you highlight any specific positive aspects of the approach that have been particularly helpful for you? Conversely, are there any negative aspects you've encountered?

3. Communication and Collaboration

- How do you perceive the involvement of PCC, family members, and professionals in these Open Dialogue meetings?
- How has Open Dialogue impacted family dynamics and relationships, or professional interactions, in your experience?

4. Adherence to Principles

- Do you feel that the Open Dialogue approach respects everyone's decisions and needs equally?
- How does Open Dialogue create a safe space for dialogue and collaboration among participants?
- In what ways does Open Dialogue contribute to community connections or access to other services?
- Do you feel OD allows for everyone's voice to be heard and respected equally?
- Do you feel the care plan options are discussed in detail to avoid premature decisions?
- Do you feel you receive help quickly when you need it?
- Do you think that OD sessions empower you to actively participate in decisions regarding the care plan?

5. Effectiveness and Outcomes

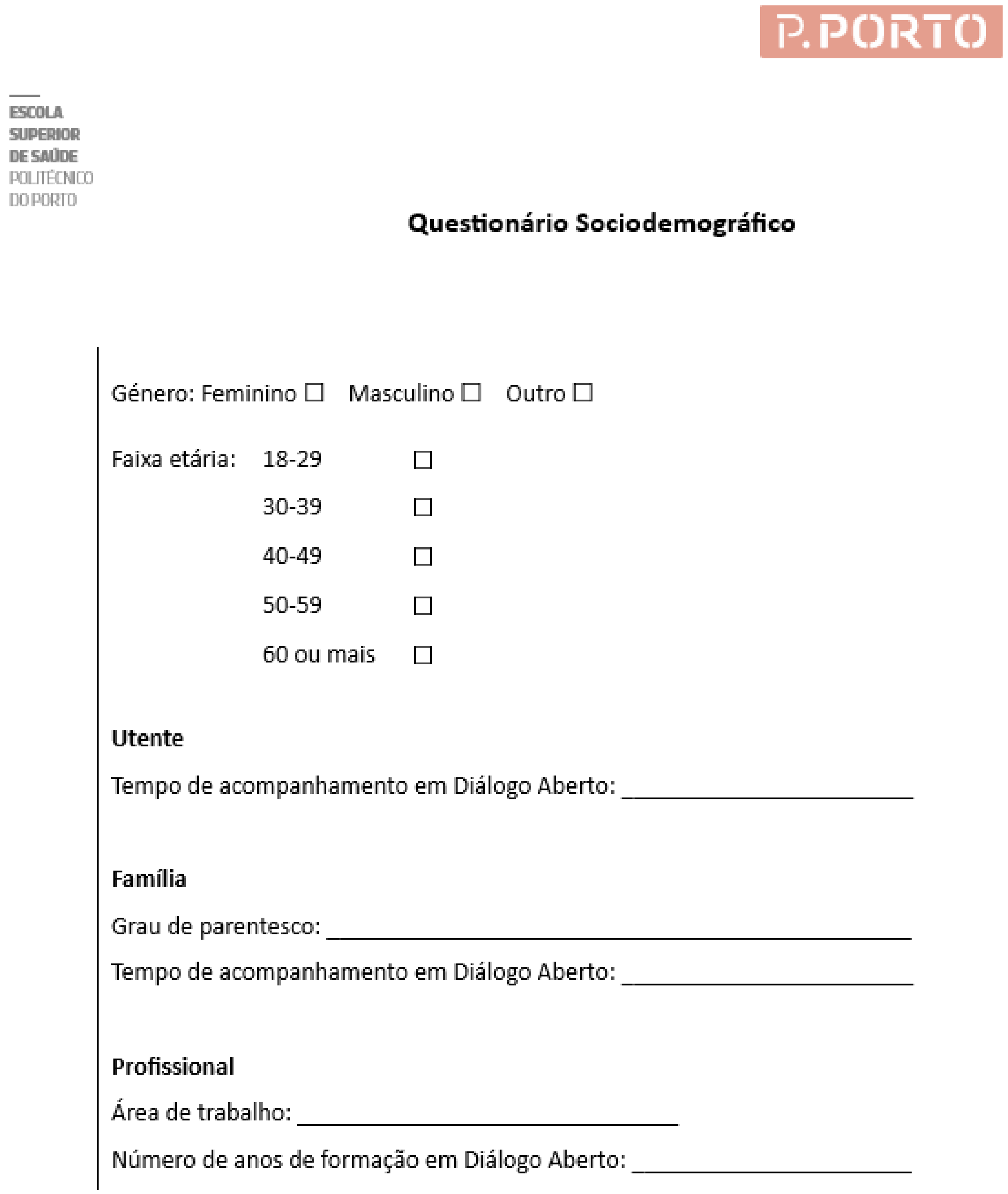
- How do you believe participating in Open Dialogue meetings has contributed to your well-being or recovery, or that of your family member/PCC?
- From your perspective, how has Open Dialogue influenced your participation in occupational or daily life activities?

6. Final Thoughts

- Is there anything else you would like to share or any aspects of your experience that we haven't covered?

Thank you very much for your contribution.

Appendix 2 – Sociodemographic questionnaire



P.PORTO

ESCOLA
SUPERIOR
DE SAÚDE
POLITÉCNICO
DO PORTO

Questionário Sociodemográfico

Género: Feminino ☐ Masculino ☐ Outro ☐

Faixa etária: 18-29 ☐
30-39 ☐
40-49 ☐
50-59 ☐
60 ou mais ☐

Utente

Tempo de acompanhamento em Diálogo Aberto: ______________________

Família

Grau de parentesco: ____

Tempo de acompanhamento em Diálogo Aberto: ______________________

Profissional

Área de trabalho: ____________________________

Número de anos de formação em Diálogo Aberto: _____________________

Appendix 3 – Theme tree

MOTIVATIONS FOR CHANGE	IMPLEMENTATION CHALLENGES	ADHERENCE TO PRINCIPLES	IMPACT ON PCC, FAMILIES AND PROFESSIONALS
FOCUSING CARE ON PERSONAL DEVELOPMENT AND AUTONOMY	TRADITIONAL HEALTHCARE	IMMEDIATE HELP	CHALLENGING PROFESSIONAL IDENTITY
SHARE THE SAME LANGUAGE	LACK OF TIME AND PRESSURE FOR QUICK RESULTS	FLEXIBILITY AND MOBILITY	INTERACTIONS AND COMMUNICATION
	RESISTANCE TO CHANGE AND LACK OF PREPARATION	EMBRACING UNCERTAINTY	WELLBEING AND RECOVERY
	FAMILY INVOLVEMENT	IMPACT OF REFLECTIONS	
	NON-HIERARCHICAL APPROACH	MULTIPLICITY OF VOICES	