DEEP DIALOGUE: PROJECT ONE

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Introduction:

Two projects known as 'Deep Dialogue' grew out of the Understanding & Involvement (U&I) Project and the following Lemon Tree Lemon Project. The two projects were quite different but the underlying principle was shared. It is an underlying thread that was first described in the U&I through the development of the Collaborative Committee. Next the same thread appeared, again in the U&I with the 'Three Sites for good practice in consumer/staff dialogue for change':

- the site we all probably know the best –decision making sites that usually look like familiar meetings and behave bureaucratically and predictably. These are the sites Flick Grey has come to call, 'Other People's Committees';
- consumer-only sites where we have the opportunity to unite, plan, strategise, organise, gain critical mass and prepare for times when we will be relatively powerless; and
- non-decision making site where 'real' discourse can occur and where time does not have to be wasted making decisions often handed down by others. This is the site out of which Deep Dialogue emerged following the real success of the Collaborative Committee.

The thread re-emerged in the concept of root learning so central to the Lemon Learning Project.

Deep Dialogue Forums

We wanted to test the idea that we could develop a structure that would allow for the deep conversations to continue taking place between consumers and service providers. Importantly, we developed a set of rules around how deep dialogue forums would be conducted. This was not to structure it into rigidity, rather it was to test what we had learnt in the U&I about what would best enhance meaningful dialogue between consumers and clinicians.

The Deep Dialogue Forum Rules:

50% consumers and 50% staff	More consumers (to even up the power imbalance) if this was deemed to be necessary in the early stages
Consumer initiated and consumer perspective facilitated	This also may mean consumer-chaired or/and consumer organisation facilitated
Organically grown	Like the town planner who designs a town square in a place where no one ever gathers and then is dismayed about its lack of use by the community, forums that are artificially constructed won't work. Many of us have seen what happens when organisational 'planners' start contriving a group. The group does not cohere or share a purpose and runs out of steam quickly. Here, people **choose** to come because they are **wanting to** (both consumers and staff) – often because of the way they or those around them have been treated by mental health services or the way they have seen 'patients/clients' treated. **This is not bias**. The expression the U&I project used was 'divining for where the energy is' which is good practice for many things including longevity.

Agenda Free/single topic	Meetings commence with a single issue such as medicalisation (for example) or prejudice or fear. There is no pressure to get through several items on the agenda. Indeed, there is no agenda. These meetings are driven by passion for change, not agendas.
Decision-free environment	What a relief this was for most of us. In Deep Dialogue no decisions need to be made. Those discussions that had traditionally been cut short by an anxious chair were now welcome and honoured.
Prefiguring good Practice	People are carefully and actively listened to and people speak until they feel heard. There can be silence, discomfort, repetition of stories and the putting of different points of view. People can change their positions and ideas. Everyone, clinicians and consumers, get practice truly listening with an open willingness to postpone 'observing', 'listening for pathology', 'diagnosing' or explaining or 'tolerating' using the tools of psychiatry. We all had to learn to live with our embarrassment if someone needed time to tell the group than was comfortable for some. It's like we were all practising what we want to see more often in clinical practice.
Chocolate cake factor	Meeting over lunch or tea and cake. Sharing food. Declinicalise the encounter. Any prop that can be used to bring people together and moving us all away from our roles as 'clinicians' and 'patients'. For some reason homemade food did this task better.
Location	Accessible place for staff and an emotionally and historically safe place for consumers. This can be hard to find but those involved in the original U&I Project found it in and around the U&I offices in the hospital.
Continuity of membership where possible	Trust-enhancing. There was an endeavour to keep the group as cohesive as possible and this meant trying to get the same people there each session. It was hard because, predictably, every other conceivable competing priority seemed to get in the way.
Internal Privacy	What wisdom is generated or lessons learned are the business of those attending, and each takes away from the meeting what they learn themselves.

In Practice

We worked hard to maintain the momentum of the deep dialogue initiatives but this was difficult for a number of reasons:

- It was difficult to persuade clinicians and managers that these decision-free discussions were important.
- And even when we could attract the numbers the discussions were sometimes hard:
  - Consumers, needed to tell and sometimes retell stories of bad practice. For many grass roots' consumers, storytelling is a fundamental communication tool. People won't stop till they feel heard. For some until some sort of remedy action is in process.
  - Clinicians on the hand sometimes felt less comfortable with their own stories as they struggled with what we couldn't help thinking were archaic definitions of professionalism. There were a number who couldn't help trying to 'help us' (that was their job!) and found it impossible to listen in the very different sorts of ways the process required;
  - Clinicians had problems allowing themselves to 'just be' as human beings with feelings like the rest of us. This was scary for them because it could potentially rob them of the clinical identity that protected them;
  - It seemed to us that the more consumers needed to tell stories of bad practice the more clinicians needed to hear stories of good practice.
  - We were mindful of the fact that these self-chosen clinicians (good eggs) who found themselves in the position of hearing and re-hearing stories of bad practice by their colleagues. There were times during the deep dialogue where practitioners felt a need to defend their professional group or where they felt unfairly treated because it was not 'their' personal practice that had caused the offence.

The challenges for the whole group within a deep dialogue context were to;

- maintain a capacity to keep asking each other questions and to dig deeper below superficial explanations or existing understandings;
- maintain the ability to continue to not criticise each other **and also** to not avoid raising the difficult topics;
- sit with silences and give people time to get the courage to speak up;
- maintain a systems perspective – that is, an ability to see how social expectations operated to 'structure' patterns of action and practices in ways that could either be experienced as determining or, if aware of them, could be used as levers and pulleys to bring about change;
- maintain a reflective space where energy doesn't have to be immediately converted into political strategy.

The Good News

- The good news was that the seminars survived for over a year after the end of the U & I project.
- In the end we wrote: "The provision of a 'space' and the sustenance of a culture of non-judgemental, non-decision making dialogue – where the spirit of deeper collaboration and respect is maintained whilst traversing the revelation of pain – remains fragile, tentative but continuing." [1]

[1] Wadsworth Y and Epstein M. *Understanding and Involvement (U&I) Consumer Evaluation of Acute Psychiatric Hospital Practice* "A Project Concludes…", Victorian Mental Illness Awareness Council, Melbourne 1996 p 15