Deep Dialogue Groups

Merinda Epstein

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During the 1990s, the Victorian Mental Illness Awareness Council (VMIAC) trialled the idea to co-create with mental health institutions conversation groups emulating and learning from the power dynamics of institutional practice. We wanted to better understand and explore solutions to the tensions, contradictions, communication mismatches, language limitations and discursive fault lines in communication between services and the people who use them, particularly those forced to use them.

The idea of *Deep Dialogue Groups*[44] was developed through two consecutive projects over seven years: the Understanding and Involvement (U&I) and the Lemon Tree Learning Projects. The groups were experimental and we all learnt a great deal from them, also from things which went wrong and from our mistakes. Dynamic groups can be set up with great care for detail and co-production, but sometimes the design itself is adversely affected by the power differentials the groups were set up to explore. This was particularly apparent in the second comprehensively evaluated Deep Dialogue Group trial. They might not have worked as we wanted, but even with all the mistakes and parts we would do differently next time, it remains an interesting idea.

Deep Dialogue Groups bring mental health clinicians/workers/service providers together in a room with consumers/patients to meet regularly to enable '*deep dialogue*', 'beyond the ordinary', 'beyond the cursory', 'beyond the formulaic', 'beyond the established power relationships', 'beyond the prism of social and professional roles', indeed, beyond the prosaic, instrumental and politic. We got to this place incrementally; in the first stage, researchers in the U&I project (Understanding, Anytime[45]) the project team acted as conduits to bring information and knowledge from consumers to staff and then back from staff to consumers, the two groups not being in the same room.

From such position of lack of trust we hoped to create groups in which it was safe to be raw and to *not know*; where questioning was more important than answers; where staff felt safe from bosses, administrators and consultants; where attendance wasn't worth marks and everyone came because they wanted to; where every person was there because they saw a misfit between the practice they experienced and the one they wanted to experience, *between what is and what ought to be* (Do it yourself social Research[47]). We wanted to see if it was possible for groups of staff and consumers to be genuine, explorative, withholding judgement, labels and medical paraphernalia, to notice truths and sit with them, to notice power and sit with that too. We hoped that the groups would be structured in such a way that different and in many ways

antagonistic discourses could be in the room together, the group dynamic allowing the minority discourse to be heard.

History

The idea of Deep Dialogue Groups grew out of a major project undertaken by the Victorian Mental Illness Council in the 1990s, the *Understanding & Involvement* (U&I) project, an attempt to build-in dialogue between service providers and users in an acute hospital setting. Deep dialogue groups were part of a collection of different 'mechanisms' trialled by the project, the fundamental idea being that, in order to achieve the necessary balance of power, these groups needed to be *consumer-driven but staff collaborative* and that we would trial and evaluate them. The concept was revisited a few years later as part of the *Lemon Tree Lemon Project*. The two efforts were similar in name but quite different in realisation; it is interesting to place them side by side and see what they achieved and where they struggled. They were to inform later attempts to create non-decision making groups that still survive within a sector often under funding stress and suffering from competing ideologies.

In the beginning… the Steering Committee

In the beginning there was a committee; like many projects before and after, the collaborative committee started off as a steering committee, but with a difference. An effort was made to fill it not with one each of various categories of staff, administrators and consumers, but rather to invite people from areas of service participation who already were supporters or allies. A '*liquorice allsorts*' committee, allowing us to tick-off all the boxes and pretend that '*all important minorities were included*,' did not appeal to us.

The justification for this process was two-fold; *first*, we used the '*divining rod principle*': we believed that those bending the rod with their enthusiasm and demanding inclusion were likely to see the distance out and that those co-opted, often reluctantly, would end up finding excuses not to come, wouldn't understand our process and would be liabilities rather than assets, no matter who they were and how much power they wielded. The *second* principle was about not playing institutional games. We had already done the hard yards guiding a consumer project through research and ethics committees. After that we enlisted our known clinical and administrative allies to steer this project with us from that point.

Next… the Collaborative Group

The meeting format let us down; regular meeting structures with a chair person, agenda, minutes and strict order didn't work. With the degree of enthusiasm in the room, the urgency to get on with the task of relating to each other through our differences in position and discourse tugged. We found we were just getting to the meeting's substantive best, when the chair felt impelled to stop the dialogue and bring us back to order and the agenda. After a few meetings, everyone was unhappy, so we changed it. As a research project, we wanted to collect our wisdom and turned the Steering Committee into a Collaborative Group, recording and taping the meetings which we extended from one to two hours. It proved

the making of the project; by turning the role of participants from committee to group members, the project was blessed with invaluable insight from administrators, consumers, clinicians, a non-government organisation, a community visitor and two nurse educators – all of whom attended because they wanted to see the way the institution operated change. As we had been careful to maintain a majority of consumers, the power of their voice was enabled; indeed, several consumers were surprised how much they had actually said and how attentive the group had been to their suggestions when reading the transcription of the discussion.

The Collaborative Group becomes a Deep Dialogue Group

Because of the success of the collaborative group, a decision was made to widen it to include more people and remove the layer of research; as interesting as it probably would have been to tape and record the jostling of discourses in a many-faced, larger deep dialogue group, it was logistically impossible and may well have stopped some people from talking – probably affecting staff more than the consumers who were, on the whole, thrilled to be heard at last and wanted to share insights garnered over many years.

The *deep dialogue* group emerged as part of the development of a need for *three sites* which would together maximise the opportunity for services to improve as a result of feedback loops between patients and staff; the following '*sites of intense activity*' were identified:

- **Decision-making sites:** the sites we all probably know the best – they usually look like 'familiar' meetings and behave bureaucratically and predictably; Flick Grey has come to call them '*Other People's Committees*';
- **Consumer-only sites**: 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 sites (deep dialogue groups):** where 'real' discourse can occur and time does not have to be wasted making decisions often handed down by others.

Deep Dialogue Groups Rules

We wanted to test the idea that we could develop a structure that would allow for the deep conversations taking place between consumers and service providers to continue. Importantly, we developed a set of rules how deep dialogue forums would be conducted; they were not to structure the process into rigidity, rather to test what we had learnt in the U&I project and would enhance meaningful dialogue between consumers and clinicians.[48]

50% consumers and staff	More consumers (to even up the power imbalance), if deemed necessary in the early stages.
Consumer-initiated & 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.
Agenda Free/ single topic	Meetings commence with a single issue, such as medicalisation, prejudice or fear. There is no pressure to get through several items on the agenda, there being no agenda and meetings they are then rather driven by passion for change.
Decision-free environment	What a relief this was for most of us; in Deep Dialogue, no decisions needing 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 different points of view. People can change their positions and ideas mid-meeting and that's fine. Everyone, clinicians and consumers, get practice in truly listening, with an open willingness to postpone 'observing', 'listening for pathology', 'diagnosing' or explaining, or 'tolerating' using the tools of psychiatry. Sometimes people needed more time to tell the group something and we all had to live with our feelings about this, while understanding that this was less than 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; de-clinicalising the encounter. Props can be used to bring people together, moving us all away from our roles as 'clinicians' and 'patients'. For some reason, homemade food was better for this task.
Location	Use accessible places 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.

In Practice

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

- It was difficult to persuade clinicians and managers that decision-free discussions were important; too many people have it in their heads that important groups, in service settings, are there only to make decisions.
- 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 grassroots consumers, storytelling is a fundamental communication tool; people won't stop till they feel heard, for some until some sort of remedial action occurs.
    - Clinicians sometimes felt less comfortable with their own stories, struggling with - what we couldn't help thinking - were archaic definitions of professionalism. Several couldn't help trying to 'help us' (that was their job!), finding it impossible to listen in the way the process required.
    - Clinicians had problems allowing themselves to 'just be' as human beings, with feelings like the rest of us; it was scary, 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-selected clinicians found themselves in the position, of having to hear and re-hear stories of their colleagues' bad practice. Sometimes during the deep dialogue, practitioners felt a need to defend their professional group, or felt unfairly treated because it was not 'their' *personal* practice that 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 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."[49]

The Second Deep Dialogue Project: The Lemon Tree

Unlike the first Deep Dialogue Groups associated with the Understanding & Involvement Project, the second project started when a psychologist approached the *Lemon Tree Learning Project,* with ideas he was interested to explore. This led to a partnership between the VMIAC and the North West Mental Health Service. It achieved a lot, was educational for everyone and cast light on interesting mistakes made by the two organisers – me being one.[50]

It was unusual that a psychotherapist was at the origin of the idea, because we had largely failed to engage either psychologists or psychiatrists (including registrars) in the U&I project. We should have seen from the start that this enthusiastic clinician was well-meaning but didn't actually '*get it*'; but I was blinded by my enthusiasm that 'psychology' was keen to be involved with us – at last.

The process

The idea focussed on a small group of consumers and staff, who would meet regularly, for a limited number of structured group meetings; staff would derive from the same unit (clinical setting) so they could support each other; consumers would be experienced educators and staff would be supported, by a consumer organisation (VMIAC), to act as culture carriers, taking their learning back and applying it in their workplace.
The hypothesis was that relational, shared-ownership group processes would enable cultural change, in a way one-off exchanges may not. The process would be evaluated by the consumer organisation.

We were working at the acute end of service provision; consumers had indicated that this was the 'deep-end,' where relationships with staff were most scarred and where most effort needed to be exercised. They also talked about the '*acute unit syndrome*,' where staff saw consumers at their most vulnerable and then extrapolated, from that experience, what it is to be '*someone with a mental illness*'. We hoped we might learn something about this phenomenon and be able to test it.

This was an effort to bring together staff from acute units and consumers, who were very far from being 'most vulnerable.' Consumers were also asked to understand their role as *educators*. This was intended to enable them to take up their power; and we needn't have worried: they had no problem with power!

The Deep Dialogue Group Structure

Two facilitators	One staff member (psychologist) and one consumer (employee of the VMIAC).
Group members	4 experienced and politicised consumers and 4 staff members from the same acute unit (3 nurses and a social worker).
2 moderators-psychotherapists	Psychotherapists: purposely chosen as one female and one male.
Venue	Close to staff but safe for consumers. Eventually the board room at the Mental Health Research Institute was chosen.
No agenda but determination to focus on consumer experiences	Consumers understood their role as educators; so not a simple exchange of views, but rather a mutual exploration of what it means to be a consumer of mental health services.
Conducted over t en weeks	1 1/4 hours, the first weeks consumers with moderators and then staff with moderators.
Questionnaires	All group members were invited to fill in pre-and-post-questionnaires.
Diaries	People were also invited to keep diaries.
Confidentiality	All that was said in the group and in diaries was confidential to the group, excluding the facilitators.
Culture Carriers	The staff members of the group were supported, by consumers, to go back to their unit, with some weight of knowing that there were 4 of them to bring the new learning to their workplace.
Evaluation	VMIAC received a second grant to do a comprehensive evaluation of the group process.

What went well?

- What went wrong also went right; we learned from both, about how to do relational groups in this setting.
- A cursory look at the evaluation shows that all four staff involved did return to their unit with a very strong desire to influence their colleagues. They reported that all being in the same unit was imperative for encouragement and they organised a special staff meeting to raise the issues and a survey to garner what support they had. Considering that they were not senior staff, this is an extraordinary achievement.
- One staff member commented that: "*We want to review issues around seclusion, debriefing, relationships and power.*"
- The culture carrier component slowed down without support from VMIAC, but we expect that the four people involved were personally changed forever.
- "*Evidence, from the interviews, strongly suggests that this process cannot be presented in a one-day workshop format. The key attributes of the process, communication and reflection take time. Staff reported that the time between [the group meetings] gave them an invaluable opportunity to think about issues raised and to make connections between these and workplace practice. To ensure optimal outcomes, in quality improvement, this format is essential.*"
- The consumers very much held their own and, by so doing, challenged preconceptions, not only of the four clinical staff but, also of the two psychotherapists.
- The venue worked for consumers; they loved the massive table and the beautiful wood; the staff were a bit intimidated by the group convening in a boardroom.

The following factors were seen as critical to the success of the project by those consulted during the evaluation.

- The program was collaboratively developed between service and consumer organisations.
- The project was managed by an organically formed Steering Group, consisting of staff, consumers and interested others.
- Implementation of the project in workplaces, where pre-existing awareness of consumer issues, structures for consumer consultation and support from management existed.
- A planned program of sessions held weekly for at least ten weeks.
- Staff who were not forced to be involved.
- Involvement by a number of staff from the same workplace.
- Employing consumer participants familiar with systemic consumer advocacy and issues in mental health services, but not 'representatives' or current/ recent ex-patients of the area service.
- Payment of all consumer participants, for their work and for travel.

What went wrong?

- The psychologist co-convenor, with the best intentions in the world, but also blinded by his own training, insisted that the group be moderated by two psychotherapists.

He probably was thinking of 'duty of care' but, it was totally inappropriate for our purposes. With hindsight, this should not have happened.

- The moderators were psychotherapists; understandably, consumers argued that they were not neutral as they were clinicians and, therefore, there were six clinicians in the room and only four consumers. The therapists were shocked by this candour.
- The psychologist co-convenor met with the two moderators on his own; they had private practices and were difficult to catch and I think we overly regarded their status. We had no idea how he was instructing them and I had suspicions, about his limited grasp of the politics or practice of this endeavour.
- I was not introduced to the two moderators (and never asked to be, to be fair). This was a mistake, as I told consumers one thing and the psychotherapists were being instructed quite differently.
- The convenors, lacking briefing from me, insisted that they meet for two weeks separately with staff and then with consumers, before the start of the group. Consumers, particularly, thought this was a waste of time. This meant that all participants only met 8 times and consumers felt patronised, before the process even started.
- The group started to resemble a rather clumsy, power-down, therapeutic group which was not what was intended.
- Payments for consumers were stuffed-up and they were cross.
- Oh no! The flowers and the cake! At the end of the 8 weeks, the psychologist and I wanted to acknowledge the group. Unfortunately, I am a hopeless cook, having no idea about making a chocolate cake and the one I bought felt inappropriate as soon as I entered the room. It felt like some sort of 'betrayal to capitalism' or, at least, to values we were trying to critique. The psychologist brought flowers for the two moderators who had given time from their respective practices to do this 'work'. The consumers were furious and I knew they would be; they had also given their time. Again, we were giving opposite messages from those we intended; I should have stopped him, or at least demanded we give flowers to everyone. Why didn't I? I was probably intimidated by his position and gobsmacked by his political innocence and betrayal of the very meaning of deep dialogue. I am embarrassed by my failure to assert my convictions.
- Staff did learn a lot and they took it back to their workplace. However, as the money dried up, the consumer organisation support, of the four culture carrier staff and the groups of staff they had developed in the unit, slowed down and ceased after the four month evaluation was complete.

Important learning

- Much to their surprise, those that probably ended up learning most were the two psychotherapists! One of them was sufficiently intrigued to write a paper on the process and present it at a psychotherapy conference. The draft I saw was reflective, questioning and attempted to be true to the process; it was critical of the two facilitators

and of aspects of the process, while striving to understand this strange 'consumer stuff,' with respect but also with cynicism. S-he was referencing internally to therapeutic groups, which was the stumbling block; nonetheless, s-he was committed enough to spend time writing an academic paper, which, unfortunately, was not published.

- Consumers trumped the staff intellectually and conceptually, intimidating a few staff members. One moderator commented: "I thought the consumers were very gentle, though they were sharp with their tongues it is true ... given what they could have gone to town about, they were really restrained." Several consumers reported that they attenuated what they said, to make it easier for staff.
- Consumers stated that they were there to inform staff about consumer experience and did not see how this could usefully be reciprocated. One stated: "For us to learn how to be better patients isn't going to help the system."
- It wasn't an even-playing field; staff and consumers said power was an issue, but it was mainly a power differential between the two moderators and members of the group. The moderators were introduced to participants as "psychotherapists" and some consumers and staff expressed ambivalence about having 'therapists' involved in the project. One person commented that one of the moderators got "...so far up my nose I thought [they] were dancing on my brain." S-he added: "The psychotherapeutic gobbledygook just annoys me so much."

Conclusion

Deep Dialogue Groups are an important addition to the group repertoire of consumers; they are places where consumer education meets advocacy, research and evaluation. They challenge the pervasive belief that peak consumer leadership occurs in the decision-making of Boards and the myriad of decision-making committees. They challenge organisations to think again about how to utilise consumer consultants and how to prefigure the way such consultants 'ought to' demonstrate leadership. Deep Dialogue Groups demonstrate the importance of *relationships* as the centre of all practice and all communication in services – a reality that has been endorsed at a national level, but often forgotten at a local level, by clinicians and participating consumers alike. Deep Dialogue Groups have the potential to rewrite policy, putting the emphasis on *learning together,* rather than the usual meeting structure which, too often uses consumers as pawns in a power game not of their making.[51]

Endnotes

44. Deep dialogue groups should not be confused with the 'open dialogue' approach, a Finnish alternative to the traditional mental health system for people diagnosed with "psychoses" such as "schizophrenia". This approach aims to support the individual's network of family and friends, as well as respect the decision-making of the individual. See: http://www.mindfreedom.org/kb/mental-health-alternatives/finland-open-dialogue/jaako_seikkula_paper.rtf/view

45. McGuiness, M & Wadsworth, Y,, Understanding, anytime: a consumer evaluation of an acute psychiatric hospital VMIAC 1991 p.10

46. Note the 'snakes' diagram from' Understanding, Anytime'

47. Wadsworth Y, Do It Yourself Social Research, Allen & Unwin 2011

48. For other uses of 'dialogue' groups, see Westoby and Dowling (2013) for uses in community development and adult education processes; see also David Bohm (2014); Martin Buber and Emmanuel Levinas as well as Paulo Freire are often considered 'parental' to the dialogue approach.

49. Wadsworth, Y. & Epstein, M. Understanding and Involvement (U&I) Consumer Evaluation of Acute Psychiatric Hospital Practice "A Project Concludes...", VMIAC, Melbourne 1996:15

50. Merinda Epstein

51. Mad Meetings, Our Consumer Place; http://www.ourcommunity.com.au/files/OCP/MadMeetings.pdf