Deakin Workshops: pioneering groups moving toward co-production—a personal reflection

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In the late-1990s, in the wake of a nationwide push to create, in public psychiatry settings, multi-disciplinary clinical teams, a project was auspiced under the National Mental Health Strategy (NMHS). Throughout Australia, services were being let down by clinicians who didn't know how to work well together and without the skills or the inclination, the newly created community teams were too often dysfunctional.

Bureaucratic Background:

Previously, the Australian Health Ministers Advisory Council (AHMAC), through the NMHS, had twice unsuccessfully attempted to drive a project around collaborative practice and clinical education. There was a high level of frustration; consumers and carers refused to accept the role of '*extras in the cast*' and clinical groups, representing constituencies with power to lose, found this new frontier unpalatable. Both these projects nosedived into political scrums and intellectual malaise.

The Organising Committee

If we learned anything at all from the two previous attempts, it was that this work was important, complex, necessary and all about power, both real and perceived. The strength of character of the organising committee for the third project was going to be vital. It would need very senior and respected clinicians and clinical educators and it would need feisty, knowledgeable, progressive consumer educators who knew each other and could work as a power base that could stand its ground.

Of great interest, both within this committee and within the larger group involved with the workshops, consumers were invited on the basis of their expertise in education and training and clinicians were expected to represent a constituency. This was the direct opposite of the usual circumstance then and still today; it was a major breakthrough. The message was that we were expert educators with pedagogical knowledge and they were representatives, bringing to the discussion the opinions and views of the organisation they were expected to represent.

As with all national projects, the capacity to meet in person was limited, which was a pity; we understood very well the fate of previous attempts at this task and the need to steer this one through to a result that was useful to the sector and to the government.

The Vision

The Organising Committee shared a vision of creating two-day workshops, meeting over a period of time; the former consulting group, 'Deakin Human Services' was contracted to run them. The idea of the project was, in part, to prefigure inter-disciplinary relationships, including relationships with consumers and carers we would expect in service settings.

The structure of the group

Prefiguring Practice: In order to realise our vision, we worked with the consultants to structure the learning group, deliberately factoring in power relationships by determining that each clinical group would be represented by academics from within their discipline and clinicians representing the major associations and colleges within the sector. These included the College of Mental Health Nursing, the Australian Psychological Association and the Royal Australian and New Zealand College of Psychiatry (RANZCP), for example. The purpose of the decision to include the clinical colleges was twofold:

1. To maintain the determination that clinical educators and clinicians should represent the power blocs within the industry and, therefore, maximise the chance of 'take up';

2. To try to inculcate new priorities in education into post-initial, college-based, training.

Critical mass: In order to keep the consumer voice (and the carer voice) loud enough to be heard, it was decided to limit numbers in each clinical category to five, resulting in five expert consumer educators, five carer educators, five psychiatric nurse educator academics and/or representatives of the College of Psychiatric Nursing; five clinical psychologist academics or representatives on the APS, five social work academics or representatives of the Australian Association of Social Workers (AASW); five academics in the field or psychiatry and/or representatives of the RANZCP and occupational therapy academics or representatives from the Occupational Therapy Council (Australia and New Zealand).

Group Guidelines: in order to skew taken-for-granted power relations, other guidelines were put in place.

- We insisted that membership of the group was closed; if 'busy clinicians', for example, failed to prioritise the workshops, they would not be replaced and the voice of their affiliate organisation would not be present.
- We deemed from the beginning that professionalism in relation to emotion would be that passion and hurt and caring would all be welcomed. This was new to many who had been taught that professionalism meant the exact opposite.
- From the beginning we observed that there was a weird sense of humour percolating through the group, resulting in clinical factions (as they saw themselves) putting each other down behind the backs of others. We deemed that when the different clinical groups assembled separately, there would be a *consumer or carer process watcher* looking out for the conduct of the group especially about '*bitching*' about other disciplines. The process watching part of the workshops also asserted the rights of consumers and carers to be important players as mediators in the mental health system, reminding others what was and what wasn't central.
- Along with encouraging emotions, there was a clear understanding that problems should be dealt with within the group and not leave the workshop unresolved. Again, we hoped we were structuring the workshops to prefigure sound collaborative practice.

Emphasis on pedagogy

Another different emphasis of this project was the intense focus on pedagogy, on the process of *how* we learn as much as on *what* we learn. An expert educator from Flinders University who had an interest in the education of clinicians was invited to all the workshops and reported back at the end of each day on the learning that was and wasn't taking place. He was a vital inclusion of the group and was, like the process watchers in the small group, a witness to good and bad collaborative and relational personal and clinical affiliate interactions. He fed back regularly about the '*hidden curriculum*' as he saw it: the covert or 'silent' learning that takes place, often outside the formal curricula intentions.

Good teachers know to listen for it, uncover it when necessary and understand it in relation to their teaching. The issue of the hidden curriculum is major, primarily given the power differences between the groups within the whole. As he was someone in a powerful position of authority in the academe realm of the most powerful group (School of Psychiatry), his position, we hoped, would be taken seriously by all.

Emphasis on collaborative practice

The task set by the NMHS was to explore ways clinical groups could adapt to working in teams that respected different clinical knowledge and strengths, worked positively towards shared goals, were mindful of power, included consumers and carers as 'equal partners' and respected the uniqueness of each professional group. The starting point was that most undergraduate education occurs in clinical silos and many practicing clinicians have very little idea what their colleagues actually do. Secondly, clinical groups have more or less power to determine how they practice and this is mitigated by managerial hierarchies. The degree of threat to status and power in the new arrangements was directly related to the power of the group under existing conditions; for example, *generic casework* was a challenging concept for clinical psychologists.

Deakin Human Services attempted to create a group environment in these workshops, where members would have to question taken-for-granted assumptions about their own clinical group and its place in relation to consumers, carers and other clinicians.

The Structure of the Workshops

The cluster of 5 weekend workshops at the Australian National University (ANU)

- The initial two weekends were designed to offer a power boost to consumers and carers for the coming weekends. One weekend was for consumers from around Australia to come together on their own to strategise; we discussed power and tactics and our own vision; learnt about each other's' strengths, weaknesses and interests; talked about our backgrounds as educators, formal and informal; found out about personal style, some of us being more '*in your face*', others more reflective and considered. We knew we needed this weekend to enable us to start the workshops from an equal place on the grid as the professional groups. Despite consumers collectively being the most qualified in teaching and learning disciplines, we knew we would carry little institutional authority without the boost of an extra weekend enabling us to claim capacity and agency.

- The next five meetings were whole-group weekends at ANU University House; the architecture of the building, a quadrangle around water, helped build rapport amongst people from all clinical groups, its age and the beautiful wood in the rooms being especially important for consumers. The slightly isolated position with a lovely restaurant and somewhat quirky special dining hall were important. Even though mobile phones couldn't be banned and technology was not evenly spread across participants, the temptation to continually dash out for impromptu coffee meetings about content supposedly more important was kept to a minimum. The green surrounds and tranquillity of nature was important although still being in central Canberra.
- The fact that we were accommodated together as a group and that we met, ate, slept and walked together in the quadrangle was significant as was the big effort made to ensure that the professional clinical representatives both had a constituency and remained constant as individual participants. Basically, we really got to know each other which cut through the power differentials and maintained a nuanced balance between an individual as, e.g. as a psychiatrist, but also as someone developing a loyalty to 'us' as a group of educators.
- The first joint activity was to play the *Lemon Looning* board game[41], a deliberate attempt to stop the clinical representatives in their track and say: "*What consumers know is knowledge. This knowledge is not just relative to individual experience. It is group experience. It has substance. It is teachable. It is a fundamentally different and important perspective which you have shown you don't understand; now please sit down and listen to us and get this straight before we start.*"

It was a deliberate attempt to start with pedagogy that was unfamiliar to many, for some very stressful and infantilising - even excruciating; a few became very embarrassed, believing we were making fools of ourselves with a game that didn't work. Thankfully, we were not drawn into this largely because the instructions of the game teach consumers how to deal with others' inevitable patronising. Without the initial consumer weekend, some consumers may also have become uncomfortable.

Amongst its many purposes, the game is *meant to* make people feel embarrassed and uncomfortable, 'aping' as closely as possible how people experience services in this sector. Real learning is often uncomfortable; the more 'scientific', powerful groups were 'stumped'; they struggled with the activity and wanted to abandon the tool, but group pressure kept them at the table. As the first activity over which they had little control, it set the scene for interactions in the group for the following weekends; not only empowered this consumer voice; we also demonstrated clearly the personal exposure, embarrassment and power-over of certain practice approaches. We knew that many clinicians would not handle this very well and they didn't and we were able to feed this back to them in the group setting.

Reflections on the five weekends

For their time, these were amazing weekends; sadly, they happened before their time. In brief, the following aspects seem worth mentioning:

1. Unfortunately the psychiatrists voted with their feet and didn't return after the first two group workshops. Those who stayed the distance were already committed to

consumer leadership and known to be 'good eggs.' In a very moving and important moment, one psychiatrist, prepared to show his vulnerability, burst into tears, saying he believed he was being picked on, that he had little power in reality, that he, too, hated the system and that in our culture, it was hard for psychiatrists too. The group surrounded him with the power of a group to heal, but consumers (gently) stood their ground and reminded him that he did have a lot of power and needed to acknowledge this. It was a fantastic learning moment for the whole group.

2. The psychologists struggled, although the same dynamic as with psychiatrists occurred, whereby the educators who were most consumer-perspective aware 'hung-in', again, those working in the public sector with a joint academic role being the ones understanding the critical consumer perspective.[42] Our request, '*education for real collaboration*,' was difficult for some psychologist-educators working from very traditional, isolated and competitive models.

3. Not surprisingly, the groups most openly, self critically and wholesomely participating were psychiatric nurse educators, consumers, occupational therapy educators, carers and social work educators. Nothing was easy in these workshops; we would have been disappointed if it had been! Educators from all disciplines were being challenged as professionals, educators and as people by groups over which they previously held enormous power. At times, even the most receptive groups struggled, those professionals looking for answers with consumers and carers rather than being defensive being rewarded. They moved to a position where 'not-knowing' was OK, a significant step forward.

4. On one occasion, the consumers staged a united walk-out; even with the structures and processes put in place to enable consumers to attend the workshops as 'equals', things went wrong. Situations where consumer knowledge was disregarded and process handled badly by Deakin Human Services still occurred; slipping into appeasing power blocks is very easy in such situations, but we needed to make a stand and collectively say, *'this is wrong'*. We did it using the only mechanism available – removing our goodwill and then our presence. The move had the intended effect; business stopped and the group dynamic for the remaining workshops changed.

The Structure of the Report and how it reflected the group

The report was written in many parts; the core group at the workshops had decided on four basic recommendations[43], strongly consumer-perspective oriented and driven by the strong carer voice. It was at that point I started to worry; the process which I thought had been good may have been flawed in ways I didn't or couldn't understand at the time. I believe the report was path-breaking; each discipline as well as carers and consumers had the autonomy to write their own chapter, Deakin Human Services writing the introduction, the description, the literature review, the analysis and the conclusion, thus reflecting process and group dynamics. The psychiatrists' chapter was fabulous, but only two psychiatrists were left standing by the end of the workshops. Nonetheless it is a permanent record of an honest attempt to make radical changes to the education of psychiatrists and the institution of psychiatry.

The chapter reflected the group struggle. A substantial issue in the group itself and the report was that the 'calamity' of status collapse was not important for consumers and carers but loomed large for clinical groups, a dissonance that persisted.

Problems:

In spite of being funded by the NMHS, the Federal and State and Territory governments through the Australian Health Ministers Advisory Council (AHMAC) would not publish the report; eventually, it was published and attributed to Deakin Human Services, after intense background lobbying.

1. None of the recommendations were ever implemented; we put this down to the project being before its time as every effort was made to build it in to medical sector unions and associations, governments at State and Territory Level and schools of Medicine, Psychology, Occupational Therapy, Mental Health Nursing and Social Work. Perhaps resentment about the process or hidden fury at the prominent role of consumers at work or a reflex from established power bases.
2. The fact that carers have considerably more power than consumers was never problematised.
3. Some clinical educators and some groups were much more experienced, confident and competent at working with consumers than others; although consumer leadership was in its infancy, it was obvious that educators in mental health nursing and occupational therapy were much more prepared to be challenged by articulate and passionate consumers. Stereotypes were challenged and some seemed able to learn from this whilst others floundered.
4. Having lobbied hard to be included, the community sector was furious at what they perceived as being 'left out'; however, from a process point of view, it was imperative for consumers that they were not there. With every added professional group, the consumer voice is one part more diluted and they fought to keep the number of players down to the five main clinical groups. Deakin Human Services understood in a way others could not that, in order for consumers to be heard, some groups had to miss out. We knew they would get their opportunity in a way consumers might never again.

The winners:

The winner from the meeting of this group was *relationships*; although no formal recommendations were implemented, powerful ties were established through people being together to achieve similar goals. For example, Brenda Happell (now Professor of Psychiatric Nursing at University of Canberra) and I came away energised and friends, scheming how to create the first dedicated Consumer Educator position in Australia, a position directly resulting from the Deakin *process* (rather than being its *product*). Other abiding friendships-across-discipline-borders grew and flourished and in many ways marked the serious entry of consumers into the clinical education landscape.

Endnotes

41. Available from the Victorian Mental Illness Awareness Council http://www.vmiac.org.au but must be sessions run by fully trained consumer educators and must be used in education sessions that are funded to employ a critical mass of grass roots consumers. This is a highly sophisticated tool, nuanced and designed with multiple learning objectives. It holds its capacity through time and is still a pedagogically sound tool given the conditions carefully notated in the instruction book. It is not a toy.

42. Critical Consumer Perspective is used similar to 'critical theory'; it simply means analytical, well informed, logical – more than simply individualistic storytelling.

43. See Wendy Weir's Summary

http://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCgQFjAA&url=http%3A%2F%2Fwww.recoveryinnovations.com.au%2Fuploads%2F9%2FDeakin_summary-pdf&ei=0cqQVM2LCtX m8AXU0oHwAg&usg=AFQjCNHnFbJVFVoia5V_CzxLhN-z3Exumg&bvm=bv.82001339,d.dGc