The Deep Dialogue Project Evaluation.

Consumer-Staff Collaborative Groups:
A Strategy for Enhancing Workplace Culture in Pursuit of Quality Outcomes

Thanks goes to all the participants in the Deep Dialogue Pilot for being prepared to 'give it a go' and for their ongoing contribution to this project.

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●Executive Summary

The Deep Dialogue Project was a pilot Consumer-Staff Collaborative Group trialed in the North Western Health Care Network (N.W.H.C.N)., Secure and Extended Care and Continuing Care Unit (C.C.U.). Services [Royal Park Campus]. The Pilot provided an opportunity for a small group of consumers, [not current in-patients], and staff to meet regularly, in a formal setting, over ten weeks, to discuss and reflect on consumer experience of service provision in mental health. It was anticipated that staff who participated would act as culture carriers introducing the issues and concerns raised in discussion into their workplace.

Significant outcomes.

Evaluation of the Pilot demonstrates significant outcomes

- Interview reports from staff themselves and feedback from the facilitators and Unit Managers indicate changes in attitudes and practice.

- Staff have responded positively to the process and continue to meet on a regular basis.

- Staff reported that this experience has enabled them to reflect on workplace practice and has reinforced the importance of a consumer sensitive approach

- Staff have reported back to the Unit staff meetings, have initiated and involved other staff in discussion, and have taken steps to address issues of concern. (eg. the lack of de-briefing opportunities for staff).

These outcomes confirm that involving a small number of staff in groups of this kind can act as a catalyst for changes in workplace culture and practice leading to improvements in service quality.

Critical Factors

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

- The program was developed in collaboration between service and consumer organisations.
- The project was managed by an organically formed[1] Steering Group made up of staff, consumers and interested others.
- Implementation of the project in workplaces where there was pre-existing awareness of consumer issues, structures for consumer consultation, and support from management.
- Joint facilitation by two experienced practitioners.
- A planned program of sessions held weekly for at least ten weeks.
- Staff who were not forced to be involved.
- Involvement in the group of a number of staff from the same workplace.
- Employing consumer participants familiar with consumer systemic advocacy and issues in mental health services, but who were not current or recent expatients of the area service
- Payment of all consumer participants for their work and for their travel.
- A location was chosen for the pilot away from the workplace and comfortable for participants, but still needing to be accessible to staff who might be on duty.

Recommendations

1. That the N.W.H.C.N., in collaboration with the Melbourne Consumer Consultants' Group, implement a Program of Consumer-Staff Collaborative groups.

[1] Ie. people attracted by their interest in the process and commitment to the exercise rather than by the position they might hold in any organisation.

2. That this Program be managed by a Steering Group of staff, Staff Consumer Consultants and consumer members.

3. That this Program is introduced in collaboration with the Staff-Consumer Consultants.

4. That the equivalent of a 12 month, full time, position of Program Convenor be established for the N.W.M.H.C.N as well as a .2 position of Evaluator. A budget will be forthcoming. It is recommended that these positions be filled by (at least) two people working part-time. The Program Convenors would report to the Program Steering Group and would be responsible for:

    - Co-ordinating the establishment of a Program of Consumer-Staff Collaborative groups.
    - Presenting information sessions on Consumer-Staff Collaborative groups for staff, consumers and Staff-Consumer Consultants.
    - Resourcing regular staff forums.
    - Promoting Staff-Consumer Collaborative Groups within and outside the N.W.H.C.N. as an innovative educative tool for staff development and as a mechanism for quality improvement activity.
    - Evaluating and documenting the process and outcomes of the Program
    - Liaising with the Steering Group and other groups within the N.W.H.C.N
    - Co-ordinating the writing of a joint paper/workshop for the 1998 The Mental Health Services (THEMHS) Conference in Hobart.

●Terms of Reference

●*Rationale*

Recent State and Federal initiatives in mental health stress the importance of consumer involvement. The participation of consumers in the planning, development and delivery of services is seen as essential for service accountability and to ensure best practice. To facilitate communication between consumers and staff it is necessary to establish appropriate structures and processes. These must be able to overcome barriers to communication, particularly the stigma and powerlessness often associated with mental illness. The development of successful strategies for staff/consumer communication is the key to effective and efficient consultation and service delivery. Communication needs to occur at a systemic level as well as at the level of interpersonal interaction.

In early 1997 a pilot series of consumer-staff discussions, now known as Deep Dialogue, was trialed in the North Western Health Care Network (N.W.H.C.N.) Secure and Extended Care and C.C.U. Services [Royal Park Campus]. The methodology employed provided a unique opportunity over ten weeks within an unstructured format. for staff and consumers to come together to identify and discuss workplace issues and concerns (see methodology). The trial of Deep Dialogue was a joint project of two organisations, the N.W.H.C.N. and the Lemon Tree Learning Project(V.M.I.A.C.) .

Subsequent to this trial the N.W.H.C.N. has funded the V.M.I.A.C. to auspice an evaluation of the Project.

The Aims

The aims of the evaluation were to:

- Assess and document the effectiveness of the pilot consumer/staff collaborative group.

- Determine the appropriateness of this process as a method of improving consumer-staff communication and developing a greater awareness of consumer perspective amongst staff.

●• If suitable, develop a recommendations for a Deep Dialogue consumer/staff program for the N.W.H.C.N.Methodology

This evaluation utilised a qualitative and collaborative methodology. This approach was adopted because of its capacity to elicit the experience of different interest groups and link these to structural factors and processes. It was essential to identify and incorporate an understanding of the different values of the various interest groups in the evaluation in order to ensure an accurate and incisive analysis of the issues.

To facilitate this, a the Deep Dialogue Streering group was formed which undertook a dual function of steering group and reference group. The focus for this group was collation of material and to develop and effect the evaluation and report. Membership of this group came from different interest groups and included two N.W.H.C.N. staff, two consumers, a N.W.H.C.N staff consumer consultant, a psychologist , and the Lemon Tree Project Co-ordinator. Four members of this group were participants in the Deep Dialogue pilot. The steeringgroup met monthly throughout the evaluation to provide feedback and clarification.

Data Collection

The major tool for data collection was the semi-structured interview. Project workers held individual and group interviews with members of the different interest groups: staff and consumers.

●Area managers

Each Area Manager was interviewed once over ninety minutes to discuss the Pilot and possible issues, benefits or difficulties involved in implementation.

●Unit Managers from the Units where the Pilot was trialed

Unit Managers were interviewed once over ninety minutes in order to determine the impact of staff participation in the Pilot and issues associated with its implementation.

- **Staff consumer consultants**

Two focus groups, and one individual interview, were conducted with the Staff-Consumer Consultants employed by the N.W.H.C.N. The focus groups were for two hours whereas the individual contact was of only one hour duration.

Issues associated with the implementation of the Pilot and its impact in the workplace were discussed.

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- **Participants in the Pilot: consumers, staff and facilitators.**

One hour, taped, open ended interviews were conducted with each participant. Participants were asked to describe and assess the impact and effectiveness of the Pilot. A tTranscript of their interview was returned to each person for approval before being used in this report.

 Documentation

A draft of the evaluation document was distributed to all Pilot participants and members of the Reference Group for feedback .

●Deep Dialogue: An Outline of the Process

The concept of Deep Dialogue has been developed through various projects associated with the N.W.H.C.N.. The methodology offers an opportunity for staff and consumers to engage in open-ended discussion about mental health issues without the responsibility and constraints attached to decision-making. This provides an opportunity for staff and consumers to engage and share in reflection and communication.

During the Lemon Tree Learning Project the opportunity arose for a trial of this methodology. N.W.H.C.N. staff member, Tim Robinson, with Merinda Epstein and Julie Shaw from the Lemon Tree Learning Project, arranged a joint project between the N.W.H.C.N. and the Lemon tree Learning Project to pilot Deep Dialogue as an education package. The Project was jointly funded and developed.

The goal of the Pilot was to facilitate reflection and exchange of experiences between staff and consumers in order to develop new understandings and to be able to make innovative contributions to the development of consumer sensitive work practices. The focus was on introducing and reinforcing attitudinal change in workplace culture. Deep Dialogue is not a substitute for the establishment of ongoing mechanisms for feedback and communication with service users. It is an approach that can sensitise staff to consumer viewpoints and concerns as a foundation for changes to professional practice and organisational culture.

The emphasis of discussions was consumer experience in mental health services. It was a reciprocal exchange, not in terms of a straightforward exchange of views, but in the mutual exploration of what it means to be a consumer of mental health services.

The essential aspects of the project were:

- **Joint planning and development:** A central aspect of the project was development of the project by the N.W.H.C.N. and a consumer organisation. Staff from both organisations were closely involved in project management and implementation.
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- **Facilitatio**n: Two facilitators were employed in the Pilot. Their role was to provide a framework; to ensure continuity in the sessions; to mediate in the event of conflict; and to minimise the risk that the sessions could

be damaging for participants. Factors that were considered in selecting the facilitators were: gender mix; experience in working as a team; and psychotherapeutic training. The facilitators had previous experience of working together.

- **Participants**: Four staff and four consumers volunteered[2] to participate in the Pilot. At this stage it was considered important to have equal numbers of staff and consumers, with gender balance [equal numbers of men and women in both groups].

- **Recruitment for the Pilot** A number of strategies were used to recruit staff. Memos were sent to all staff canvassing interest. This elicited minimal response. Staff groups were then visited and the proposed staff development program was discussed. This was also unsuccessful. Staff holidays and roster changes were a barrier to participation. Recommendation by senior staff and personal contact proved to be successful recruiting strategies.

It was easier to recruit consumers. They also were identified by personal recommendation and contact. All were participants in consumer organisations. They were not recent users of the N.W.H.C.N. services. This was a deliberate tactic intended to minimise the likelihood of a pre-existing 'therapeutic' relationship between staff and consumers.

- **Program:** The exercise was conducted over ten weeks. The facilitators met with each group separately for two consecutive weekly sessions,. This was followed by six weeks together. In the first two sessions for each group participants met with the facilitators to establish goals and a degree of group cohesion. The two groups then came together once a week for six weeks for one hour and fifteen minutes of discussion.

- **Payment**: The intention was that all participants be paid for their participation.

[2] Volunteering in this context implies willingness to participate not being unpaid.

- **Questionnaire:** Participants, excepting the facilitators, completed questionnaires designed to assess attitudes and beliefs around staff-consumer relationships. These questionnaires were filled in on three separate occasions: before the discussions took place; at the conclusion of the series of discussions; and six months after the event.
- **Diaries:** Staff and consumers were asked to complete diaries of their experiences. Although the organisers stated that they would appreciate the opportunity to see participants' diaries it was stressed that this was voluntary. The expectation was that examination of the diaries would provide one method of evaluating the Project.
- **Location:** The group met in the boardroom of the Mental Health Research Institute, Parkville. This choice intended to accommodateconsumers who it was felt might be uncomfortable with any facility associated with the hospital campus, and also met the needs of staff who, because of the pressure of shift work, had a strong preference for a site close to their workplace.

●Evaluation of the Pilot:

Outcomes

Data from the interviews with participants conducted after the Pilot suggests that the process had a significant impact on staff. One staff member commented that:

"*Although it was difficult to find a meeting time, we met to prepare a brief paper on issues raised within the dialogue which we would like to see changed on the ward. We want to review issues around seclusion, debriefing, relationships and power.*"

Comments from managers and feedback from the facilitators indicate that staff attitudes and practice have changed subsequent to the Pilot.

Staff involved in the pilot have:

- Continued to meet for further discussion among themselves, in their own time. These discussions are continuing, at the time of writing.

- Prepared a report for the Unit staff meeting.

- Initiated a working party, involving other staff members, to take up issues raised in the discussions with consumers.

- Reported that this experience enabled them to reflect on workplace practice and reinforced the importance of a consumer sensitive approach.

Facilitation

Facilitation is essential for the effective management of the group. Feedback from participants confirms the need for facilitators. Two would be optimal because of the formal nature of the group and the potential for misunderstandings and conflict. The presence of the facilitators increases the 'safety' of the process for participants and increases the chance that individuals will not feel obliged to facilitate the process rather than actively join in as a participant.

The following factors need to be considered in selecting facilitators:

- **Gender balance**

- **Established working relationship**

- **Significant experience** in group facilitation is needed, particularly experience in situations where conflict may arise.

- Facilitators should **not be members of the N.W.M.H.C.N. staff**. They need to be seen by both staff and consumers as independent from the service provider.

Other issues that need to be considered are:

●Professional identity of facilitators

Care needs to be taken in introducing the facilitators and defining their role. The facilitators in the Pilot were introduced to participants as "psychotherapists". Some consumers and staff expressed ambivalence about having 'therapists' involved in the project. One person commented that one of the facilitators got: "*...so far up my nose I thought* [they] *were dancing on my brain.*" They added: "*The psychotherapeutic gobbledy-gook just annoys me so much.*"

The group process is not, and should not be presented as, therapeutic. Use of a psychotherapeutic approach and language will be counterproductive if there is not sufficient sensitivity to the impact on consumers and staff of this professional position. This requires further investigation.

●Role of the facilitators

There has been extensive discussion about the role of the facilitator. Concern was expressed by some consumers that the facilitation focused on the group rather than the issues. The facilitators: "*would frame the issues that were coming out ...as conflicts between people or differing ideas or something in each session. Then that step extra of contextualising that in a consumer framework didn't happen.*"
This concern led to the suggestion from a number of consumer participants that, in the future, one of the two facilitators should be a consumer.

●Impact of the Project on other staff

It should be noted that the impact of the project was not confined to the staff participants. The facilitators, and other staff involved in organising the sessions, reported that the experience was challenging and that they learnt from it.

** *Dialogue***

There were different expectations among participants about the reciprocal nature of the dialogue. Consumers stated that they thought 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."* Staff focused more on each group developing a better understanding of the others' experiences and position.

The focus of the group was on discussing consumer experience in mental health services. It is reciprocal, not in a straightforward exchange of views, but in the mutual exploration of what it means to be a consumer of mental health services.

Consumers reported that they tried hard to present their information in a way staff would find acceptable. "*They* [staff] *could see what bothered me and what didn't ...but everything filtered down, as much as I could, hopefully to a comfortable level where they could, at least meet you.*" The consumers presented personal experiences and made connections between these and wider systemic issues in service provision.

Another aspect of the dialogue process was an expectation of personal connection by some staff and consumers. Some pilot participants suggested that more time for informal contact would have facilitated communication between consumers and staff by establishing personal connections. When participants described the sessions they focused on issues and most, on interview, could not remember the names of other group members. It is not clear whether establishing some sense of personal connection between group members is a necessary part of the process. This was certainly deemed to be important by some consumer and staff members involved with the pilot.

As could be expected, the emotional impact for participants was significant. Both staff and consumers reported that the experience was intense, with feelings of hostility, frustration, fear and anger. What was not anticipated was the level of care consumers expressed for staff participants. One of the facilitators commented that "*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 the staff.

This was not necessarily the experience of staff who, often, found the process confronting. "*It was difficult to feel responsible for the bad experiences the consumers recounted. Many of them seemed to be related to acute ward experiences. Having not worked on an acute ward, feeling a loyalty to unknown colleagues involved, wondering about the incidences from their viewpoint, feeling a horror at the treatment of the consumers, were all very difficult to deal with at once- especially as there were doubtless other feelings not expressed/recognised.*" They all reported that although the experience of participating in the Pilot was not always comfortable yet it was a valuable experience.

Pilot Project Timeframe

The model used in the pilot of one hour fifteen minute sessions, weekly, over ten weeks appears to work well. Feedback from participants in the Pilot would suggest that a slightly longer session, one and a half hours would perhaps be more effective. Several participants reported that it seemed that the sessions had only just got going when it was time to stop although others mused that perhaps this would have happened regardless of the length of the session.

The two separate initial sessions for staff and consumers respectively, do not seem to be necessary. All participants, staff, consumers and facilitators, stated that this was not needed. One initial planning and orientation session for consumers and staff outlining the process, and exploring expectations of participants, should be sufficient. It requires further investigation to determine whether the introductory session should be held with all participants or with the staff and the consumers separately.

Participants expressed the need to document the main issues and important points raised in the sessions. Group members commented that the process did not feel

finished and that they wanted input into written records and descriptions of the process. Maybe this lack of resolution was an important factor in prompting further outcomes with staff. It was suggested that in future groups the final session is devoted to evaluating and documenting the main points and major issues raised in the sessions. All participants should be involved in deciding what happens to written material and who has access to it. If group members permit, this material may be useful for wider circulation.

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 sessions 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. This conclusion is supported by the findings of the Lemon Tree Learning Project, which reported that there is no evidence of one-day sessions leading to ongoing change in staff practice or culture.

Consumer Participants

The consumers involved needed to be familiar with the issues associated with the provision of mental health services and have had a background in working with service providers and/or professional organisations. They also needed to be experienced at working in groups. The consumers brought a consumer perspective to the sessions. They presented a description and an analysis of the impact of service provision from a consumer's point of view. It was not intended that they represent consumers overall, nor were they present simply as individualstelling their own stories. The role of consumers in the process was complex and requires further clarification.

Consumers need to be employed for an initial, consumer only, planning session and for debriefing time as well as for the sessions with staff. Provision needs to be made for transport and childcare costs.

Staff Participants

Self-selection was an effective method of identifying participants. Staff suggested that word of mouth contact with others who had been involved, and personal invitation, would be the most effective ways of encouraging staff participation. Staff involved in the Pilot were interested in continuing their involvement by speaking to other staff about their experience.

Staff participation in these sessions should be voluntary. Participation requires a willingness to engage in discussion and reflection. It is unlikely that this process would be productive for participants who are reluctant to become actively involved. The effectiveness of this process does not require the involvement of all staff in the network nor indeed all staff on a particular unit or in a particular program. The aim is to inform and support a small group of staff who then act as 'culture carriers', introducing ideas and issues into the workplace.

The impact of the Deep Dialogue process on the workplace was greatest where a number of staff from the same unit participated. Having other staff in the work environment that have had the same experience allowed staff to support each other, to continue reflecting, and to act on issues raised in the Pilot.

To ensure optimal outcomes it is desirable that staff are able to commit themselves to attending all sessions. Deep Dialogue is not a series of discrete sessions but an ongoing process of connection and communication. It is necessary to find ways to minimise the difficulties posed by staff shiftwork and holidays

Appropriate staffing arrangements would need to be made to ensure that staff who have been through the Deep Dialogue process and are keen to promote it to other staff within the network are able to do so with confidence that their position will be adequately backfilled and without resorting to doing so in unpaid time.

Matching Staff and Consumer Backgrounds

Staff often request that they speak with consumers who have used either the service where they work or one similar. Consumers, however, consistently state that the issues important to them are universal, not service specific.

There are significant difficulties for consumers participating in dialogue with workers with whom they may previously have had a client/service provider therapeutic relationship. There are concerns about stigma, vulnerability and the impact on continuing access to services.

The goal of the Pilot, and of consumer/staff collaborative groups generally, was not to provide specific feedback to staff about the service in which they work. The pilot was an opportunity for reflection and communication. This provided a foundation for establishing improved communication and feedback from current service users and supported staff in providing consumer sensitive services.

Payment and Conditions

It is fundamental to the success of the process that all participants are paid. These sessions attempted to bring staff and consumers together, promoting a situation which made them as equal as possible. The recognition, by payment, of the value of consumer contributions is essential.

There are a number of difficulties:

- Differential pay rates for facilitators, staff and consumers;

- Staff did not always receive direct payment but were sometimes able to attendin work time. This was straightforward for staff working regular hours but more difficult for shiftworkers. If the sessions fell during a shift they had study leave, so no loss of pay, however there was no payment for sessions that fell outside shifts;

- There have been difficulties arranging prompt payment for consumers. The Network's payment arrangements for sessional work are unsatisfactory. On one

occasion a consumer was in the unfortunate position of waiting almost twelve months for payment. It is imperative that these problems are resolved.

The difficulties faced by consumers, such as travelling long distances by public transport, need to be acknowledged and addressed. One participant commented on the problem posed by the location of the sessions saying, *"I think that we all had to make huge efforts to get to that location."*

- ***Venue***

Most of the sessions were held in a boardroom in the Mental Health Research Institute. It was a formal environment, with a large immoveable table. There were mixed responses from participants about the appropriateness of this environment. These ranged from a staff member who thought it was inappropriate because of its formality, to a consumer who appreciated the beautiful furniture and the lovely view. At this stage it is not possible to be certain about the effect of the venue on the process. The important factors appear to be:

- To facilitate access for staff, especially for staff working shifts, it needs to be on, or very close to the working environment;

- Held in a neutral space, not in the staff's working environment.

- ***Diaries***

Four participants (one staff member and three consumers) reported that keeping a diary was a useful adjunct to the sessions. They stated that it assisted them in reflecting on the content of sessions. Most of the participants expressed concerns about sharing their diaries, particularly comments about other participants. These concerns limited the use of the diaries. One consumer noted his disappointment that, "*all members of the pilot project did not maintain diaries and hand them in because I found it a valuable experience to record the intricacies and dynamics of the meetings. Otherwise this information will get lost."*

Only two participants (one staff member and one consumer) handed a diary in at the end of the Pilot. Three consumers handed in a diary or in one case other

material to be seen only by staff of the Lemon Tree Learning Project, [consumer organisation].

It appears there was some confusion about whether keeping a diary was necessary. Some people heard the stress on the voluntary nature of submitting diaries as meaning that the diaries were basically for individual use. One of the staff members who did complete a diary commented that it would have been less useful if it had to be handed in. S/he would have censored what s/he wrote in it.

Recommendations

On the basis of evaluation of the Pilot it is recommended that:

1. The N.W.H.C.N., in collaboration with the Melbourne Consumer Consultants' Group inc., implement a Program of Consumer-Staff Collaborative groups (Deep Dialogue).
2.
3. This Program be managed by a Steering Group with staff, Staff-Consumer Consultants and consumer members.
4.
5. This Program is introduced in secondary collaboration with the Staff-Consumer Consultants.
6.
7. That the equivalent of a 12 month, full time, position of Program Convenor and a part time .2 position of Evaluator be established. It is recommended that this position be filled by at least two people working part-time. (A 1998 budget structure is currently being drafted.)
8.
9. The Program Convenors and evaluator would report to the Program Steering Group and would be responsible for:
10.

- Co-ordinating the establishment of a Program of consumer/staff collaborative groups.

- Consultation with Staff -Consumer Consultants

- Presenting information sessions on Consumer-Staff Collaborative groups for staff, consumers and Staff-Consumer Consultants.

- Resourcing regular staff forums.

- Documenting the process and outcomes of the Program

Recommended Process and Structure for Deep Dialogue groups

1. Joint facilitation by two experienced practitioners.
2.
3. A planned program of sessions held weekly for at least ten weeks. The initial session to be an introduction and information session.
4.
5. Staff selection to be by attracting volunteers.
6.
7. Consumer participants to be familiar with working in groups and experienced in working with service providers from mental health services and/or policy planners and professional organisations.
8.
9. Payment of consumer participants with recognition of the skills required for this work.
10.
11. Accessible and neutral location for sessions.
12.
13. The final session of the Group's program should include evaluation and documentation by group members of important issues and experiences.