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CONTENTS

EDITORIAL 351
Robert L. Flood

PAPERS

Building in Dialogue Between Consumers and Staff in Acute Mental Health Services 353
Yoland Wadsworth and Merinda Epstein

Value Systems—A Way to Greater Understanding 381
Misha Hebel

Analyzing Collaboration as Drama 403
Jim Bryant

Soft Systems Methodology and Systems Maintenance 419
M. J. Taylor, E. P Moynihan, and A. T. Wood-Harper

A Comparison of Interactive Planning and Soft Systems Methodology: Enhancing the Complementarist Position 435
Jeffrey S. Sinn

A Model for Design of Human Activity Systems 455
Nils O. Larsson and Anders Malmsjö

Systemic Practice and Action Research Vol. 11, No. 4, pp. 351–480 August 1998 P

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outlining the analytical theory of drama and shows how it can be applied to practical situations.

M. J. Taylor, E. P. Moynihan, and **A. T. Wood-Harper,** in the next paper, discuss "Soft Systems Methodology and Systems Maintenance." They argue that business systems maintenance is a large proportion of the work undertaken by IT staff. Of concern, then, is that much greater methodological attention is paid to systems development rather than systems maintenance. The authors begin to redress this situation through soft systems methodology focusing on payroll administration for illustrative purposes. Soft systems methodology features in the next paper, by **Jeffrey Sinn,** called "A Comparison of Interactive Planning and Soft Systems Methodology: Enhancing the Complementarist Position." The two approaches are compared through their underlying theory, techniques employed, and expected outcome. This helps to point to possible different ways in which the two approaches might be employed. Soft systems methodology is again in the cast of the last paper in this issue by **Nils Larsson** and **Anders Malmsjö,** which presents "A Model for Design of Human Activity Systems." They apply the concept to failures in management information systems.

Robert L. Flood, *Editor*
Centre for Systems Research
University of Lincoln and Humberside, UK
e-mail:robertflood@compuserve.com

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Building in Dialogue Between Consumers and Staff in Acute Mental Health Services[1]

Yoland Wadsworth[2,4] and Merinda Epstein[3]

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This paper describes some aspects of the methodology, material, and findings from a lengthy participatory action research engagement by a consumer organization in Australia, which was undertaken in collaboration with staff at a major public psychiatric hospital and then went on to involve "players" throughout the local and national mental health services system. A small first phase established a dialogic methodology for the exchange of experiences and thinking between staff and consumers. The purpose of the second phase of the research was to explore how consumers' voices might be heard, and how staff–consumer communication about that feedback, might be "built in" to ongoing organizational structure and culture. Systems thinking about defensive routines, silences, and voice-as-discourse is reported as offering a possible way of cracking the puzzle of the closed-loop cycle of claim/blame-defense-and-counter-claim/blame-defense that has been characteristic to date.

KEY WORDS: dialogue; participatory action research; consumer feedback; systems change; defensive routines.

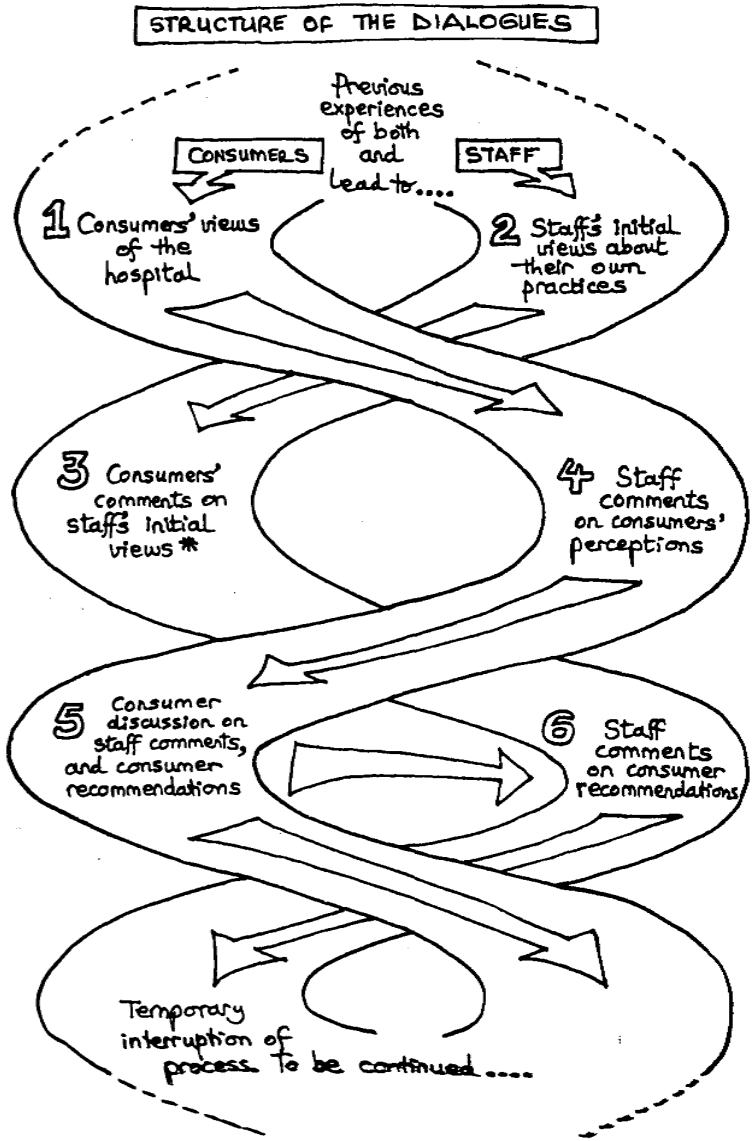
1. BACKGROUND CONTEXT

Between 1989 and 1996 an Australian Statewide representative consumer[5] organization, the Victorian Mental Illness Awareness Council (the VMIAC) engaged

[1] An earlier version of this paper was presented to the "Reclaiming Voice" Ethnographic and Qualitative Research Methods conference, Los Angeles, June 1997. Original research data and Fig. 1 first appeared in research reports (McGuiness and Wadsworth, 1991; Wadsworth and Epstein, 1996a,b) from the consumer auspicing body, the Victorian Mental Illness Awareness Council, to the two funding bodies, the Sidney Myer Fund (1991) and the Victorian Health Promotion Foundation (1997).

[2] Department of Psychology, Victoria University of Technology (Werribee), Melbourne, Victoria, Australia 8001, and the Melbourne Action Research Issues Centre.
[3] c/o The Action Research Issues Centre, Melbourne, Victoria, Austalia.
[4] To whom correspondence should be addressed. Fax: 61 (0)3 9216 8226. e-mail: YolandWadsworth@vut.edu.au.

[5] This paper employs the term "consumers." In Australia the mental health consumer movement has adopted the same use of this term as the national health consumers' movement on the understanding that consumer is presumed to have *choice*. This has been judged strategically useful at



* Time did not permit this material (at 3) to go to staff (at 6). Instead consumer discussion and recommendations (at 5) went to staff (at 6).

Fig. 1. The design and process of the initial study.

rial (which many were very interested to read, the book still selling well 7 years later), this small first study raised the question at the VMIAC of how this kind of exchange might, instead of always ending just when it seemed to be beginning, become "built in" as a routine and ordinary element of practice and as a comprehensive and permanent "package" of feedback, communication, and evaluative inquiry methods.

2. THE MAIN STUDY—"BUILDING IN" DIALOGUE THROUGHOUT ACUTE MENTAL HEALTH SERVICES

The second and largest iteration commenced with Merinda and two other consumer members of the research work team Moira Somerville and Ross Findlay (both committee members at the VMIAC) with Yoland as design consultant, attempting to engage staff and consumers in small, voluntary, participative and action-oriented inquiry efforts at the ward level. We were able to find a small but adequate "space" for this in systems terms in the hospital's QA (Quality Assurance) discourse. In responding to the difficulties of achieving this, the project's inquiry group[6] drew on a wide range of methods in a prefigurative way to try naturalistically to test for various methods' capacities for both hearing from consumers and assisting communication and deeper dialogue between staff and consumers. Over the course of the 4 years of the project these methods included story-telling, dialogue, strategic questionnaires, and special-purpose or "spot" surveys (for example, to ask staff what questions they might like to ask of consumers or to ask consumers what they'd like staff to do in a particular service element), participant-observation, group discussions, conversational-analysis, suggestion boxes, consumers' case stories, and the use of an extensive inquiry network of more than 120 consumers, staff, and policy-makers. We also documented staff's use of managerially authorized methods and their effectiveness and ineffectiveness (such as representatives on committees, satisfaction surveys, complaints procedures, advocacy, etc.).

2.1. Methodology

The project was based around negotiated agreement with ward staff and with management (primarily nursing) to use "new paradigm" participative,

[6]The project inquiry group (the "we") comprised a core research work team of three consumer researchers and a research consultant; an "inner inquiry group" or Collaborative Committee of around a dozen (half staff and half consumers), which later became a Collaborative QA Seminar of around 30; a broader inquiry network, which included the 60 staff and consumers who took part in the interviews, discussions, and small subprojects and later expanded to around 200 people strategically located throughout the state and also national mental health system; plus a self-run group of around 12 to 15 consumers who were acquiring experience as paid consultants in a range of different capac[illegible] (as interviewers, librarians, committee members, policy commentators, speakers, and so o[illegible]oth within the project and then increasingly called on by other services, at area, regional, and state government levels).

in two cycles of systems research with staff and consumers in a large public acute psychiatric service system. We were employed as research consultant (Yoland Wadsworth—both cycles) and research officer (Merinda Epstein—second cycle) by the group. The larger purpose of the work was to "build in" routine methods for staff to seek and receive consumers' evaluative feedback and collaborate with consumers to make valued changes to services as a result of this feedback. We want to report on a small portion of this extensive project, particularly on those elements that involved (and confronted) consumers naturalistically experimenting with various methods to "reclaim voice" and take part in dialogue with staff. Then we explore the critical contradictions of staff's difficulty in "hearing" consumers' voices in terms of their own suppressed, self-suppressed, and repressing voices—within their own discourse, and one which is experienced by consumers as dominant. There may be important implications for how people can speak to each other from one discourse to another (particularly when one is dominant and the subordinate discourse is striving to replace or transform a dominant and damaging discourse). There may also be yet-to-be-explored implications for what it might mean for those of us trying to facilitate such dialogue (including as participants to the dialogue ourselves) when needing to occupy each discourse (in order to understand and be trusted to have understood the "other" discourse). Yet, when speaking in one discourse, we are by definition no longer speaking in the other.

But first, we will introduce the story of this large-scale, emergent-design, and whole-systems project in terms of its methodological journey. Yoland tells this part of the story.

1.1. Introduction—Initial Cycle of Dialogue

From "automatically" starting with the idea of a conventional questionnaire to people as they were being discharged from hospital (to collect evidence of poor quality practices), a small group of consumers at the VMIAC moved to wanting something which would do more justice to their own experience. The group settled eventually on more of a systematic story-telling approach.

The consumers wanted change in ward practices and felt that yet more one-way speaking to staff was not going to be as effective as two-way dialogue with staff, and thus it was determined that the project should involve staff speaking

this point in time to enable a political expectation of change toward such an assumption. The U&I project documentation details service-users' thinking on this. As well, in the Australian context, "user" was a term already associated with drug and alcohol service consumers. The term "customer" has been explicitly rejected by the consumer movement as a far more passive and market-subjected position. The term "staff" has been used to avoid the specialist implications of the term "professionals" and to try and match the service-user/provider systems connotation.

as well. In this way the first iteration of the research involved an elaborated exchange of views (see Fig. 1).

A series of informal interviews by the consumer-selected project worker with a total population of all inpatients of one acute adult ward during a 1-week period was matched with a series of consumer-perspective questions she put to staff. The purpose of the consumer discussions was to hear people's experiences of coming to, being in, and then leaving the ward, and a small number of very open questions were used in order to honor each person's own voice and self-told story. The staff were asked consumer-perspective questions (about what they were trying to achieve for consumers, what they were up against, how they knew if they achieved useful things for consumers), and then each of these two initial sets of views was swapped between the two groups for further comment. One further exchange followed this.

1.2. Reflections on the Initial Dialogue

At the end of this series of exchanges, looking back over them, a simple characterization of the dialogue might be as follows.

- Firstly, consumers told realistic tales of their admissions—sometimes uneventful, but still also notably painful.
- And staff told idealistic tales of their objectives, as well as stories of frustration.
- Then consumers were chuffed to hear staff were trying hard for them, but still felt indignant about damaging treatment, and made positive suggestions for change.
- Staff were divided over consumers' negative descriptions, with some urging attention and change while others felt defensive or complacent or skeptical or all three.
- Then consumers went through a further phase of sympathy but again became impatient for improvement and continued to press for change.
- Then staff continued to be pessimistic, saying either that things had already been tried, that consumers' suggestions wouldn't or couldn't work or were too hard, or that consumers should do more things themselves rather than look to staff.

Some readers of this unfinished, contradictory, and contingent set of voices longed for us to be traditional evaluators—and simply tell staff the conclusions they should draw. On the other hand, many other staff readers responded with more or less appalled or offended feelings, even without our doing this.

Besides addressing the issue of dialogue between the two parties (consumers and staff) and also generating some richly interesting experiential mate-

staff's own repressed, self-repressed, and repressing emotional responses block their hearing and because the carefully constructed objectifying professional mental health discourse has as little place for active, sensible, valuable input from patients as it has for staff who can admit to not knowing all the answers all the time for all consumers, without the need to inquire of consumers how things are going for them with their experiences of the services.

This is powerful "closed-loop" thinking (Argyris, 1993), which, while distancing and protecting staff from much of their anxiety (Menzies, 1970) and safeguarding the conditions for objectification and coercion at a possible future timepoint, also "protects" staff and consumers from being able to make resonant connection with each other that can be experienced as illuminative, mutually affirming, healing, and strengthening.

Three issues which will be presented here for discussion are regarding reclaiming the voice of consumers, reclaiming the voice of staff, and reclaiming the voice of the researcher(s)/facilitator(s).

2.5. Consumers' Voices

We made considerable headway in constructing a consumer-driven project which developed both consumer-run and consumer-only groups which more powerfully assisted the reclaiming—or claiming—of consumers' voices.[7] The project was consumer-driven in a number of ways. It was initiated by a consumer organization and its topic and popular titles were selected by consumers; the project was run by the consumer organization, which selected and employed a research team comprising a consumer research officer, two part-time consumer researchers and a research consultant; and the project then employed a further 23 part-time consumers as casual researchers and consultants over the 4 years. It operated out of its own project office (in a sympathetic nursing research and training center) in which consumers felt safe and confident enough (even though it was on hospital grounds); and consumers shaped all phases of the project, including selection and asking of questions, analyzing and synthesizing results, and deciding on the findings. These methods for nurturing consumer voices were all trialed as prefigurative for future "building in" to the acute psychiatric services system. There was excellent evidence that consumers considered the project a great success throughout its active life, and their voice was "reclaimed" (or found) by them to a reported gratifying extent. Unlike the frequent claim

[7] In particular, in the form of a group of around 15 articulate users of acute psychiatric services who came together to give advice to the project hospital and then State systemwide, proactively "giving voice" on their own terms (see their book—The Melbourne Consumer Consultants' Group, *Do You Mind? . . . The Ultimate Exit Survey . . .* , Melbourne, 1997). The group is now ongoing and a legally-incorporated organization in its own right. This book, as well as the U&I monographs and manual, is available from ARIC, 4/247 Flinders Lane, Melbourne, Australia 3000.

that it was hard to get consumers involved, the project was successful in attracting around 30 committed consumers to work on it over several years, as well as keep the enthusiastic support of the consumer organization throughout its active life, and a wider circle of consumer support throughout Australia and eventually extending internationally via the internet.

Despite the inclusiveness and safety the project offered, consumers found the process of "coming to the table" with staff enormously difficult. In attempting to reclaim their own discounted voices, consumers were in practice constructing together a new discourse in the face of a dominant existing mental health services professional one. The relations comprising the system were powerfully structured indeed.

This is the kind of thing they said in answer to the question, Why is it so hard to be involved in giving evaluative feedback to acute psychiatric services?

> It's too stressful, too confrontational.
> I want to make a good impression—otherwise who knows when I'll get out.[8]
> They're too busy—I don't want to be a bother.
> They know what they're doing—they're the professionals.
> Who am I to think I know better.
> I don't want to upset them—it's hard enough for them as it is.
> They could take it personally and I don't want to hurt their feelings.
> I might have to come back here and I don't want them to see me as a troublemaker.
> I don't want to upset them—some of them are my friends.
> I don't want to upset them—some of them I am afraid of.
> I don't want to upset them—they're really doing a good job under the circumstances.
> I don't want to feel worse.
> They're the ones who need looking after.
> Maybe I'm wrong.
> Maybe I only saw it as negative because I was depressed/in a bad mood/paranoid/anxious.
> If I say what really happened, they'll say it's my illness.
> If I get really upset, they'll put me back in the lockup.
> I'm not sure that I have the right.
> I must have done something to deserve it.
> Things are not that bad/it's OK.
> They have all the power—I can't buck it.
> Personally, I'm not political.
> They can't hear it anyway—they are so stressed out themselves/they're more stressed out than I am.
> It's not really them, they're just doing their job under a whole lot of stresses—it's "Their" fault . . . government, politicians, the hospital, the drug companies, psychiatrists/nurses, the managers, the carers, the lawyers, the medical establishment.
> . . .
> They're doing the best they can.

[8] And specifically for outpatients: "They'll think I'm still sick/getting sick again if I speak up;" "I just want to stay anonymous—you won't post me anything at home in a hospital envelope will you?"

action-oriented, "practice research." This developmental and emergent approach was only twice contested on the grounds of not being objective science (initially at the ethics and research committee stage for phase one and, secondly, when we were trying to engage one of the hospital acute units, contestation coming from psychology and psychiatry professionals). This contestation was relatively subdued and did not irreparably damage the project (primarily because its small-scale inquiry approach had found its structural niche in QA as a form of applied qualitative research—although we never used those particular terms ourselves—and the project and key personnel had gained the respect of the most senior staff). Although many of the new "structures" for consumer feedback and staff—consumer communication have remained in place both in the study hospital and elsewhere following the achievement of Government policy and a statewide funding program, they too are simultaneously both welcomed and contested and weakened by a new wave of managers and policy-makers for paradoxical reasons that were well theorized by consumers and staff involved in the project (see Wadsworth and Epstein 1996b).

2.2. Some Findings

The project articulated key "sites" that were needed in order for staff successfully to hear the voices of consumers and for consumers and staff to be supported to speak to and hear from each other. The sites were those considered essential to assist staff enter into a consumer discourse and for consumers to work with staff on critically reflecting on their own discourse. These sites were as follows.

(i) Firstly, all *organizational decision-making forums* (such as routine program and hospital management committees, Board meetings, Ethics committees, staff meetings, handovers, policy committees, staff selection committees, as well as via feedback methods, etc.).
(ii) Secondly, staff–consumer (non-decision-making) *dialogue forums* in which deeper presumptions, beliefs, undiscussables, and other thinking could be shared, surfaced, and reexamined.
(iii) Thirdly, if consumers (and staff) were going to have the strength and emotional support to engage in such dialogue, then *consumer-only forums* (and *staff-support forums*) were identified as needed too.

We called the staff-support methods, forums, and other structures the "*missing fourth site*," as the project was late in coming to theorize staffs' needs, for reasons explored in the following discussion. The research in effect ended at the beginning of this next phase of inquiry.

Without all of these sites, we concluded, feedback and communication

methods suffered decay and distortion given the constellation of factors driving acute psychiatric hospital services from their "health, healing and recovery" discourse toward a "control and coercion" one.

2.3. Theory

The project contributed some new thinking by the consumer movement as to why it is so hard for staff to hear from consumers. It moved beyond the "mere" making of demands on staff both to hearing what staff say in response to these demands and, secondly, to probing deeper into the contradictions in staff's practice between desire (to hear from and respond to consumers—to work *with*) and "role" (to decide for and do *to* consumers—even against their will). This deep paradox of assisting consumers' own recovery to health, versus forcing return to "health" (particularly by resort to administering compulsory medical drugs), appeared central to the issue at hand. The project speculated also on how and why humans respond with fear, dislike, and control to those seen and experienced as different (in this case, in the ways the mind works)—rather than always with compassion, responsive, and enabling strategies, and it contemplated how these emotional defenses become incorporated in organizations, roles, and routines.

2.4. Issues

Profound issues were theorized as arising from the relationships between emotions, organizational and cultural change, and the mutual construction of power relations, especially arising from the intentional use of an iterative, emergent, situation-responsive, consumer-driven, and noncoercive dialogic methodology. To give a single example, we found that staff were dismayed by their own disempowerment within the services structure and appeared unable to hear consumers until they first themselves were heard. However, the things of which staff *most* wanted to speak (emotional responses of fear, anxiety, rage, frustration, and feelings of being badly treated) appeared to be simultaneously the things they felt most forbidden to say (and most forbade themselves saying) for fear of dismantling the carefully constructed "difference" and "othering" on which are based their authority and legalized powers as mental health professionals, as well as their own professional understanding of what they should do to "provide care." That is, a line is drawn (reflecting the "othering" constructed elsewhere in society) between a "them" (sick, emotional, dependent, nonrational, out of control, noncompetent) and an "us" (the healthy ones, responsible, rational, calm, in control, and competent). Within each of these two poles were varying degrees of respect for consumers and self-respect for staff. Consumers, therefore, in some ways continued not to be heard both because

I couldn't do their job.
Some consumers don't deserve to be listened to.
I didn't deserve it—but I'll just keep quiet.
I don't want more blood taken/ECT given/time in seclusion.
It can't have happened—it's a hospital, how could they have done that in a hospital?.
It was alright last time—maybe it was just my bad luck.
Nothing ever changes.
Nothing happened last time I wrote a complaint.
I prefer to "shut up and ship out."
It was just that one person, the others have been really good to me.
I don't want to be here/I want to leave/I don't want to come back.
Why should I have to try and improve the service? I'm meant to be the patient.
I'll be out of here soon.
Last time I tried, they explained why it's all so impossible.
Last time I tried, they wrote it in my file.
It's all too hard and too big to change.
Even if they wanted to do something, they'd have to contend with their peers.
I just need to concentrate on getting better.
I want to get on with my life.

Consumers themselves required huge courage to "come out" and speak up and cocreate their voices. They faced constraint also in the form of the difficulty staff experienced in meeting consumers on territory in which it was safe and enabling for consumers, and in engaging in discourse which was not (even if unwittingly) hurtful or offensive for consumers.

2.6. Staff's Voices

All staff in the hospital who wanted to be were also involved in shaping the project—indeed in important ways the project focused more intently on working with staff than on working with consumers. However, far fewer staff were actively involved and most found engaging with consumers tremendously difficult—despite sometimes strong convictions and commitments to so doing. These are the kind of things they said, or could say (or were more or less "allowed" to say) about why it is so hard.

"*We'd like to but we don't really need it*":
We already know what to do.
We already know what to do but are prevented from doing it by . . .
lack of time, "Them"—funders, politicians, government, cutbacks, the hospital, the network, managers, carers, the influx of agency nurses, the pharmaceutical companies, the threat of litigation, . . . etc.
We don't really need to be told how to do our jobs.
Managers and the department tell us what to do quite enough as it is—we don't need the patients doing it too.
Reforms are already in place/we have already worked out what to do and are getting it under way.
We read "*Understanding, Anytime*" when it came out.

If we are meant to be the professionals, then we should already know what to do—what did we go to university for?
We already observe, monitor, and guess pretty accurately what consumers think and need.
Things seem to work fine without it.
We did all that in the 70s.
Nothing really matters except for waiting for the drugs to work.
Consumer participation is just another management fad imposed on us.
We're not actually hearing about any problems, our patients don't seem to complain.
We're already looking into it.
We did ask but no one had a problem.
There can't be any real problems, they'd tell us if there were.
They tell us the problems all the time, we don't need to hear more.
I'm sure we'd hear if there was something really big, like a rape or assault.
To be honest, things work more efficiently without it.
There doesn't seem any point because there really aren't any solutions.
It'll just be a Catch 22—and it will raise patients' expectations.
We already know what the problems are . . . .
(Repeat cycle of reasoning)
We already know what to do.
We already know what to do but are prevented from doing it by . . . lack of time, by "Them"—funders, government, the hospital, the network, nurses/psychiatrists, managers, carers, pharmaceutical companies, threat of litigation, . . . etc.

"*We'd like to but we can't*":
We just haven't got the time.
This is not a very good time at present—perhaps in another year or two.
We've had a lot of changes and need to let them settle a bit first.
We haven't got anywhere near enough staff.
There are a lot of competing demands.
All we've got time for is processing people in and out.
Eight hour shifts don't give you enough time to speak to patients as well as everything else we have to do—paperwork, review meetings, admissions, discharges, transfers, reports, arranging for patients to see everyone—doctors, consultants, the social worker, procedures, tests, it just goes on and on . . . .
Other things always seem to be more important, urgent, pressing.
There's no time for talking here—they'll get that in the community.
We have to go really slowly with introducing this idea.
Patients are too ill/too confused/too paranoid to give accurate/sensible feedback.
I'd like to ask consumers but the other staff would talk about me behind my back/think I was breaking ranks.
This is new, staff don't really understand it yet.
They might find it a bit threatening.
We can't force consumers to give their feedback if they don't want to.
We have to maintain a secure environment.
We haven't found consumers who are representative enough.

"*It'd be alright if it was constructive, but criticism really is unwarranted*":
We are already doing the best we can.
We have to do "certain things" to people.

There are no other choices that anyone has been able to identify.
It's what is expected by the job—by the managers, the institution, by my profession, by my job description, society at large—they don't know what else to do either.
We do a good job already.
We've tried everything else.
This is the way it has to be—and when consumers get insight they usually accept it too.
There have to be rules and procedures.
Of course they'll be critical—it's an acute ward.
They magnify things because of their illness.
If we made it any nicer they wouldn't want to leave.
Who made that criticism?
They'll be gone soon—we turn them round as fast as we can now.
I'm just doing my job.
We have to keep control, you can't be too soft—especially in a crisis.
This is an acute ward, there are always crises.

"*We'd like it but we just don't want criticism*":
Morale is low enough here as it is.
You think I like all aspects of my job? Get off my back per-leeze.
You think I think this is good nursing?
Staff aren't ready to hear it.
It would only stir things up.
I'm worried it could turn bad if there is criticism.
They're only going to want the impossible anyway.
We can't give them what they want.
I don't like it either but I can't challenge it on my own.
It'll only make staff defensive.
I like to focus on the positive.
It might clash with things we already believe/are committed to/from which we gain respect in team meetings/from which we gain status as a professional/have to believe and say and do if we're to be listened to.
I already feel bad enough as it is—I don't want to feel even worse.
I don't deserve it, I've always stuck my neck out for consumers.
I have a hard time too.
I suspect consumers wouldn't want us if they had the choice.
Consumers give us a hard time—I'm not allowed to talk about that.
I get abused but I don't complain—it's part of being a professional, it's up to me to hold together/get it right/not wimp.
Actually I'd prefer thanks.
We never get much appreciation.
No one else wants to do this.
We're the ones who've stayed in the public sector—the private send us their "too hards."[9]
I couldn't bear to think they never forgot some of the things that get said and done to them.

[9]For the private practice people, "We left public so we wouldn't keep harming consumers, so criticism is now unwarranted."

I'm getting out of acute as soon as I can.
You should criticize "Them" . . . funders, government, politicians, the hospital, the network, managers, carers, lawyers, . . . etc.
It's too hard and too big to change.
I just need to survive.

3. THE SYSTEM

It took us a long time to make these lists. They appeared overwhelming—and in a way they were. Because when all these individual trains of thought are put together, you get something bigger than the sum of the individuals. You get a system. And in a system everyone can go on feeling more or less locked in and dissatisfied (and despite many obvious symmetries—such as both staff and consumers just wanting to survive or get out, or seeing the system as too big and hard to change).

Peter Senge (1990, p. 7) in *The Fifth Discipline*, describes the system as ways of thinking which result in "invisible fabrics of interrelated actions":

> We just find ourselves feeling compelled to act in certain ways. (*ibid.*, p. 44)

Chris Argyris calls them "routines" because they "occur continually and independent of individual actors' personalities" and they are "immediate," "automatic," "unconscious," and "highly skilled" (1993, p. 20). They include also what he calls circular, "closed loop," "self-sealing," and "self-fulfilling" thinking. None of this might prove problematic unless it means that a system is thus prevented from making needed change—or if the "how things are" is so taken-for-granted that the system remains impervious to realizing there even is a need for change and that things could indeed be better. It is when the system in a sense goes into "denial" or "overdrive" that the effects of it being caught in its own compulsive routines become tragic if the end result is the displacement of its own most valued goals, purposes, visions, and mission. In some ways the system thus immunizes itself against needed change. Or rather it displays something more like an autoimmune response whereby it acts against itself to prevent its own healing when it experiences excess anxiety.

Thus if a system's code remains uncracked, staff can go on feeling trapped, defensive, hurt, misunderstood, or not heard, at the same time as sure that they are already doing the best they can. And consumers can go on bottling up their experiences and feeling frustrated, cynical, or angry and criticize "chronic avoidance and self-justification" and, as Mary O'Hagan has put it, be defeated by the view of mental health services that "the customer is always wrong."

Up until now, the common response to this paradox in acute psychiatric services all round the world has been one largely of stalemate around a closed loop of claim or blame and defense (and sometimes counter-claim or blame and defense). But why are these patterns so powerful? Why have they proved so

To this we added the following:

> If you want to known how we are repressed,
> listen carefully to what we are not allowed to say.
>
> *(Source unknown)*

In a sense, the lists of what staff and consumers say about "why it is so hard" seemed to us to be what *can* be said. What could not be said (or was muffled or buried in these statements), however, became an increasing topic for our attention as we continued our detective work into the paradox of why it seemed to be so hard to hear directly from consumers about their experiences of the services and work together on positive change. When we traced the threads behind these statements of "why so hard" back to their underlying factors, we began to unearth a deeper analysis of what seemed to be going on in an acute public hospital psychiatric ward.

Eventually we named as "cork-in-the-mouth" all those instances, across a range of different circumstances, where staff felt constrained to speak. These included the following.

- *Regarding their own stress, fears, and emotions.* Ironically in a mental health services system there appeared to be a taboo operating against appearing or speaking emotionally—particularly, for our purposes, in relation to the system not hearing from or responding to consumers, or treating consumers in less than ideal ways. Even outside a therapeutic environment, staff seemed to feel constrained from expressing the range of emotions that they experienced (e.g., in working with inpatients) to ex-consumers involved in discussions around achieving structural change. There appeared also to be a taboo that staff exercised against each other talking about these matters—even to the point of mutual shaming (e.g., with comments about not being capable, or "up to it," if emotions were shown).
- *Regarding ordinary interpersonal contact.* Many staff seemed to have developed elaborate ways to avoid conversation with people—staff and consumers. There was the head-down/walk-fast strategy, the speak while standing side on and stepping away approach, the failure-to-get-eye contact method, the I-must-answer-my-phone-beeper emergency, and the no-time-to-answer-letters-or-return-phone-calls gold standard. "Consumer Resistant Disorder" was initially a cheeky but empowering way for us to understand this when directed at us.[11] But when we realized

[11] While simultaneously offering a comment on how the DSM (*Diagnostic & Statistical Manual* of the American Psychiatric Association) was using objectifying terminology experienced by many consumers as insulting or hurtful.

that staff also treated each other and inpatients in these ways of avoidance, we realized that it was a more general phenomenon.

- *Regarding asking questions per se.* Staff seemed to be required to have answers rather than questions, to already know what was best for the patient and be required to operate from a general sense of certainty and control rather than there being space for uncertainty, new ideas and creativity, or alternative ways of seeing things. Staff professional culture and scientific discourse appeared to hold in place norms of "knowing what to do" (without reference to consumers' self-knowledge) and defined this as "care."
- *Regarding bad practice, poor quality care, and patient "incidents."* Staff seemed so pained by direct reference to these we learned generally to speak in euphemisms, approximations, and abstractions. At times the split between consumers' steady stream of stories of these, and staff's denial of these was unbearable.[12] Staff's medical discourse allowed for "case management" according to prescribed, preestablished criteria for all situations and incidents.

The following is an exchange at a staff-consumer Collaborative Committee meeting of the U&I project which goes to the heart of some of the silences, repressed voice, and euphemism:

> *First consumer.* I think it's difficult for staff because they come to—you know, it's not working in a rose garden and they have to face a lot of things and follow a lot of procedures that perhaps naturally they wouldn't choose. And so they go home at the end of the day and are not happy with it but cope and then they come to a consumer meeting and realize the hopelessness of it.
>
> *Consumer research facilitator.* Yes, and hear more of how it's awful.
>
> *First consumer.* Yes.
>
> *Consumer research facilitator.* And also don't have a chance to talk about what they did and things that have worked or whatever.
>
> *Community person.* Well, but most—didn't take the chances that were there. . . .
>
> *Staff.* . . . _____ (*speaking to an inpatient consumer*) you said what goes on here is about lies and deceit. And that's then how people start to feel it. Yes, isn't it? Can you elaborate on that . . . ?
>
> *First consumer.* . . . Yesterday I had a nurse. . . . I got my medication from her and (another nurse) grabbed it from me. She says, "Patients aren't allowed." And I thought, what the heck—can't we pour our own medication? She said, "When you get home, you can do it without us because we won't be there."

[12] Even the writing of the U&I research monographs was itself a microcosm of the paradox. When Yoland Wadsworth went to the files of material she found numerous stories which had never been able to be told, examples, observations and discussions we'd never been able to raise or put in the bulletins, and consumers' anecdotes that seemed so often to be in the negative, with so few in the positive. It was an exhausting process trying to write up under these conditions—yet it supplied a further insight into the "undiscussables," and the "undiscussability of the undisscussables" (Argyris, , p. 97).

hard to overcome? And what lies under them to make them so "self-sealing" and circular?

In the first place, they operate as important self-protective defenses[10]—maintained with great tenacity. We experienced the power of the system to self-protect in our own project. When we examined our own silences or self-editing, we got a clue to the power of the system to protect itself from disturbance. At times, for example, we were stopped in our tracks by the sense that the more staff only wanted to hear about the "all good," the more consumers only wanted to tell about the "all bad." Even the paradox of staff's 'good intentions but no effective actions' was itself unable to be stated without numerous qualifications. We found ourselves endlessly allowing for all the difficulties and taking care not to imply that there were actually "no actions" being taken by staff to hear from consumers, but just that these were at the moment unavoidably delayed or that we understood they were in the pipeline, and so on. We found ourselves becoming at times so contorted with the simplest descriptions of our project as to feel that even the smallest "ask" was an imposition or alternatively that what we were asking *per se* implied a terrible insult to staff.

We were aware that we were often joining consumers and staff in their own self-muffling. We became experts in unspeak—referring to "difficult times for consumers" or "incidents," and at times not even referring to "improvements" to services for fear of implying anything less than best practice was already in place. Alternatively, if there was some concession by staff to the real situation, it would soon be followed by their making an effort to draw the conversation to a close. If we continued to press by asking, "Is there anything that could be done?" "Could we just try asking a single consumer a single question just before discharge?" we would feel more and more uncomfortable for obviously not understanding, or for asking the impossible or otherwise harassing well-meaning staff. And of course we felt for them—caught between their intentions and their situation. We edited carefully: both staff (so consumers could hear) and consumers (so staff could hear). We could not describe consumers' anger or descriptions of some of what had happened to them for fear of triggering anxieties or incredulity, for example, we could not use words like "condescending," "punitive" or "savage" in relation to staff. These were "unbearables" and seemed terribly unfair to staff. Sometimes we even edited staff so other staff would not be offended, for example, taking out a reference to staff having to "carry" other staff who needlessly upset consumers, making hard work for everyone trying to calm the consumer down again. At times, and looking back

[10]The nature of what is being defended by staff is the subject of a new piece of dialogic research (by Yoland Wadsworth) following on the heels of this one. Entitled "Understanding the Conditions for Staff to Hear Consumers" (short title, "Understanding Staff" or "US"), this project is seeking to answer the question, "What would it take for staff to *want* to seek and respond to consumer feedback?" It is being conducted in a different hospital setting.

from a distance, some of our self-editing (of both staff and consumers' words) reached ludicrously sensitized extents.

But when we faced the possibility of bringing some of it into the light of day we frequently could see no way to broach things, or, if we did, we'd suffer feelings of guilt and shame about hurting staff. We'd say to each other (in the research team), "We'll raise it later" or "Put it in the file." Some staff would *commence* discussions with us (before we had even spoken) with assertions of how we saw them in a negative light leading to our strenuous affirmations to the contrary (after all, these were staff who at least were wanting to meet with us) but also to our then feeling unable to raise any questions. Several times we found we only needed to use the word "consumer" instead of "patient" and there would be a defensive reaction. Yet even to have used the term "defensive" was enough to incur further hurt, offence, and defense.

And these were in addition to staff's self-editing. At times we felt that staff in meetings, or when speaking to each other, were literally swallowing the words they wanted to say. We found they often either could not or did not want to speak about certain topics—even ones that seemed on the surface relatively unproblematic or obvious to us. They might gloss over something, move on quickly to something else, cut the conversation short, or otherwise indicate we'd strayed into uncertain, unpleasant, or difficult waters. We learned that many staff dealt with stress and their emotional responses in private, at their own cost, and in tightly knit and closed circles of trusted colleagues or friends. There are many instances recorded throughout the U&I monographs. The silence that fell in the nurses' meeting when the young nurse suggested that staff and consumers really had a lot in common. The silences in staff meeting rooms when we asked who would like to trial asking consumers some questions about their experiences of their inpatient stays—questions which many staff themselves had nominated as ones they wanted to ask.

What were all these patterns of thought and action protecting people from?

3.1. Silences

At some time in the life of the project, someone had pinned the following quote to the U&I project office noticeboard:

> What are the silences
> that you swallow day
> by day?
> If we wait until we
> are not afraid to speak,
> we shall be sending back
> messages from the grave.
>
> *(Audre Lorde)*

Consumer research facilitator. Now, say you tell that story here . . .

First consumer. Yes.

Consumer research facilitator. And other staff hear that.

First consumer. Yes, I know. They'd be upset.

Consumer research facilitator. . . . Yes, but . . . how can we get conditions under which the staff can say, "Oh, goodness, that's awful _____ (*inpatient's name*). Now why do we do that? How can we think about why we do that? Now what would it need to not do that?" _____, what would you prefer to have heard?

First consumer. "You can look after your own medication. You're very good. We know you can do it. You've got . . ."—they build up your confidence.

Second consumer. And also the reason we [staff] can't say that is because if people get their own medication because of different states of mind, we can't keep a tab on everyone and people will OD.

Consumer research facilitator. And we've got to have a procedure. . . .

Second consumer. And so controlled medication has happened in hospitals historically all along, and that kind of history's very hard to . . .

Third consumer. There are ways around it. I mean, they could perhaps . . . have just poured it and just put it down and you still have taken it. You still have power. You picked it up . . .

Consumer research facilitator. Now . . . staff want to say, "We don't have power either," but they feel they can't say it. How do we arrange a forum where consumers can say that [what you just said] and then staff feel they can say, "You know, we haven't got power either. . . . And then together you go, "Well, what would have to change? How could we do it differently?"

Second consumer. Or give the itsy bit of power I do have which is handing you the medication and why I want [not to even give that] to you.

3.2. Reclaiming and Failing to Reclaim Voice

From these areas of difficulty, the project concluded that there was a need to "build in" the ability for homogeneous groups to meet, away from the dialogue, in order to self-empower people to be able to speak and "surface the undiscussables" (Argyris, 1993; Senge, 1990, Chap. 12). We had some considerable success in identifying and trialing the conditions for consumers feeling free to speak their minds, and we had some, but significantly less success in achieving the same with staff. Table I describes the results of one joint consumer–staff meeting where staff went a long way down the track to hearing—and affirming—consumers' realities, and unpacking the dominant discourse embedded in language.

However, at the point when consumers needed staff to "come back" to analyze how they, with consumers, might break through to take the next step beyond the following kinds of expressions, we experienced some staff feeling unable to speak of their discomfort. The second column in Table I was the result of consumers' interpretations of staff's intentions based on their observations (and supported in the first place by some staff's perceptions too). On reflection, one key member of staff withdrew and the dialogue failed. We were left to

Table I. Consumers' Perceptions of Some Professional Mental Health Language

Word/term used re. consumers	What it really means to staff	What consumers would prefer
High dependency (HD)	Boring/fearful/drag	Intensive Care Unit
Personality disorder	Pull yourself together	Psyche Distress
Treatment plan	We fix you up	Recovery Plan
Attention-seeking	You're still bothering me	Seeking attention or assistance
Case manager	You're a case, and we'll manage you	Manager of services to individual (We are not cases, and we don't want to be managed)
A schizophrenic	That's all we see you as	A whole person who happens to be medically diagnosed as having schizophrenia
Disturbed	Disturbing me/us	Frustrated; signaling 'I need help'
Disruptive	Disrupting my group/my ward/etc.	Seeking attention
Hostile/aggressive	Having a go at me	Angry/angry and asserting (whatever form of physical) strength in reaction to something that has happened
Absconded	Left against staff's wishes	Left with the continuing support of community-based staff
Treatment-resistant	The doctors don't know what to do/to do yet	The doctors don't know what to do/to do yet
For no apparent reason	We couldn't work it out	Ask *us*
Was observed to . . .	We thought he/she was . . .	Ask *us*
Confidentiality	Secret from no-one but the consumer	Secret from all except at the discretion of the consumer
Compliant	Takes the drugs	Choosing, collaborating
Challenging behavior	We haven't worked out what to do yet	They haven't yet understood us
Coping	Not a problem	Holding it together, often at a great cost
I'll talk to you later	I hope I might get time to talk to you later (or I hope you might not need to)	Let's talk now
Lacks insight	Does not yet see it our way	Our own hard-won insights

Table I. Continued

Word/term used re. consumers	What it really means to staff	What consumers would prefer
Argumentative	Does not agree with me/us	Has their own opinion which does not correspond to ours
Difficult	Asks too many questions	Answer our questions
Psychiatric art	Amazingly good or obvious further evidence of diagnosis/disorder	Art
Seclusion	Alone in a room, locked in by others	A safe personal space, able to be locked by self
Settled	Taking the tablets, the injection is taking effect	Many of us would like to feel naturally settled
Specialled	Keeping an eye on them, having to stay with them all the time	Rather than someone knitting or reading nearby, we prefer: being treated as special; sympathetic company of staff
Unco-operative	Won't do as we say	Needs to be listened to more and responded to better
Ventilating	Harmless expression of minimized emotion	Expressing what we really feel and having it heard and acted on
You'll be fine	Keep taking the tablets	Ask us, What do you need to be OK?
Back into the community	Out of the hospital	We wish that there *was* a community

speculate as to whether, if staff then had feelings (of anguish, indignation, etc.) at these attributions, and could have found ways to express them, then consumers might have responded by correcting their own speaking to "this is what it *looks* like to us to really mean to staff/or to some staff"; and then staff might have been able to say, "Well we are much more caring than that," to which consumers could say, "Well, could you use the alternative language that would express that to us"; and staff could say, "Well, we don't like the language either" or "We did not realize how it made you feel," and then stop and reflect and ask, "Well, why *do* we use that language?" then perhaps speculate, "Well, perhaps we use that language because . . . ," and then—with consumers waiting more or less expectantly—staff might say, "Well, we'll have to change that. What could we do. What would consumers prefer/or Why don't we . . . ," and consumers could say whether whatever strategi[illegible]oposed would be good,

and so on until the changes are made to practice, and consumers felt more healed and staff achieve a sense of well-being.

But this dialogue did not take place. Instead, staff may not have been able to go past feeling wrongfully attacked, and either complained (or felt unable to complain), and then withdrawn. But we were unable adequately to test these thoughts. On reflection, it seemed we needed to find ways so each "side" could hold their perspective and express their feelings in tension with the reaction of "the other," in order to move forward, comprehend the situation and its underlying factors, and eventually make consumer-responsive changes.

To have supported staff staying with such an interchange we realized that staff needed self-strengthening staff-only sites. Yet these did not form. While a successful Consumer Consultants' Group was catalyzed, not only was there no impetus from staff to form a group to deal with their "end" of the process, the consumer project was reluctant to facilitate this for two reasons. Firstly, when we tried to engage with staff, we found that they needed to talk at length about their own troubles. It was beyond the part-time resources of the team to service this need—and in any case, it seemed rather cruel to consumers who had been through sometimes quite nightmarish bad treatment to have to sit and listen in a theapeutic way to staff's troubles. Nor was it even a simple matter of trying to find other staff to provide this resource, because—quite apart from the things dividing staff from being able to do this with each other—consumers' fear (similar to many women's at the thought of men's groups forming for mutual support about how hard it was to live with feminist women) was that staff would then feel free to use the same damaging terminology and linguistic forms (unconsciously "othering" consumers) that consumers experienced in mixed groups where they were present.

Thus an unresolved issue was how to form symmetrical homogeneous mutual support groups (to assist the heterogenous dialogue group) without the "problem of incommensurable discourses." While there was a tradition and neophyte culture of consumer self-help groups, only a demoralized industrial union culture existed for staff which, at the time, positioned consumers as a danger to occupational health and safety.

There were many other issues to consider about staff's culture in order to understand this, and we achieved only limited insight into how to address it. Our preliminary thinking drew on the analogue of racism support groups and some of the thinking in the men's movement. Here also had been encountered the "problem of discourse," that is, of where repressed or self-repressing voices needed "freeing up," but the only language available was a damaging one for "the other." To work with this, the men's movement, for example, incorporated one or two women acting as trusted witnesses/critical friends to men-only groups or, by analo[illegible] one or two consumers in staff-only groups. While we initially thought of h[illegible]ogeneous groups both being a prelude to heterogeneous groups

and being superseded by the latter (a la Guba and Lincoln, 1989), we finally concluded that it might be more useful to conceptualize *permanently operating* homogeneous and heterogeneous opportunities—but with each retaining, somewhat self-consciously, elements of "the other" within the homogeneous groups. Ironically in our project, staff and consumers had to first learn about and hold consciously their real differences before they could join to find the commonalities. Dissolving or denying these differences generally resulted in the predominance of the existing power relations (or disempowering relations).

3.4. Going Deeper

In exploring these matters of speaking and hearing more deeply, a senior nurse commented on how nurses who are compelled to nurse in poor quality ways may not want to hear ex-consumers tell their excruciating stories of how they felt. In the following painful exchange, which marked a deep point in the achievement of trust between a small group of staff and consumers in our project, another senior nurse and a consumer responded thus.

Second nurse: They don't want to, . . . they don't want to hear . . . I think that one of the sad things that we do as nurses, and I think from years of observing nurses they do it because they think that they're doing it in the patient's best interests. . . .
First nurse: That's right. That's right.
Second nurse: . . . [We say] "We're carers." And they disempower people, they strip them of their responsibility and [say] "You will tow the line" . . . we beat people into submission basically: "You will do and say what we want, and it's the only way you'll get out. . . ."
Consumer: That's right. And when you lock that door on them, then the fear and all the negative—and you can't. . . .
Second nurse: That's right.
Consumer: You can't fight it. . . .

Here then is illumination of the sometimes more and sometimes less gap between consumers' ways of seeing and staff's ways of seeing. Language and practice form the power relations. Thus what may have been experienced by some consumers as "abuse, humiliation or neglect, emotional blackmail and atrocity" may instead for some staff have been "limit-setting, standard treatment, individual service-planning and an incident." What might be for some staff "safe seclusion, necessary medication, a successful treatment option in $x\%$ of cases, unavoidable duty of care and behavioural modification" can be for many consumers "being locked up, forcibly injected, electrically shocked till you lost your memory, being assaulted, and treated like an animal." What can be for some consumers "frightening powerlessness and terror" can be for some staff "therapeutic restraint and temporary ideation."

From 18 months' reflection on this matter of paradox, silence, and difficulty, and on the basis of some illuminating exchanges between a small number of staff and consumers who worked on "cracking" this deeper puzzle, plus a unit manager and a consumer research facilitator gaining access to a small literature on systems' dynamics and change,[13] we developed a theory which tries to take into account the paradoxical, even contradictory tendencies of the system that we were observing.

We came to see the basic operating dynamic as being one which builds a services system both reactively and proactively in relation to two sets of human responses and desires—*reactions of fear and efforts to ensure control* and, at the same time, *responses of concern and desires to ensure healing and recovery*. The latter tendency is a more or less "admissible" one, while the former one is the area in which there is more systems' silence (compelling consumers repeatedly to try to raise it to attention).

We have concluded that, while understandable, the system's tendency to "fear and control" must be "surfaced" as a regular act of self-awareness if those in the system are to strengthen the desired tendency towards being for health, healing and recovery. Alternatively, if fear and dislike are routinely responded to with control, a system can come into being which routinely will carry out goal-displacing routines, and incorporate systemic resort to overcontrol and coercion. Everything we saw around us—from the neo-rationalist funding cutbacks to mental health services and their effects on depleted service access, through to the reliance on "scientific" diagnostic distinctions, the use of the medical/health metaphor, the resort to police, special powers to override civil rights under mental health legislation, the locating of services in "the community," and the burgeoning involvement of the pharmaceuticals industry, could be read as manifestations of one or other element of these dual system's tendencies.

3.5. Surfacing "the Undiscussables"

In moving to dialogue, two responses of the past appeared to us to need to be left behind. One was to not understand—and blame. And the other was to understand—and excuse. The future seemed to lie with understanding—and neither blaming nor excusing—but instead staff and consumers setting to work to surface and address the fears, seek to apply the least possible control and under conditions only where fear and loathing are absent, and strengthen with renewed vigor the positive practices of health, healing, and recovery. Our "model" for getting consumer feedback and engaging in communication and

[13] Notably Isabel Menzies' 1970 classic, which one of us went to Tavistock in London to obtain, while the other of us found an abridged version at Swinburne University and had it waiting on the desk of the London traveler, for her return!

dialogue about it—including the employment of consumers as consultants on acute wards, and reflective practice dialogue groups, etc.—was our contribution to this (Wadsworth and Epstein, 1996b,c).

Risking "surfacing of the undiscussables" therefore, we concluded, precedes doing something about ensuring that fear-and-control responses are contained and do not get out of hand, that they get wound down to a minimum, and their effects are healed properly. In the first place this requires courage, confidence, and pride, and then a system which continuously is aware of its own fears and the level and kind of control exerted as a result—rather than denying them or projecting them—is more likely to be a safe system for consumers and staff. If it carefully organizes the resources it needs to enable it to recover from its own anxieties and impetus to control, and to nurture its own levels of warm "fellow-feeling," it will also be in a better position to provide a therapeutic and healing experience instead of a shaming and stigmatising one.

There were two "sites" we identified as necessary for this. Deep dialogue forums were one critical element in such a range of resources to address the silences and stand-offs between consumers and staff, and contribute to defusing fear and control reactions. As one of the consumer research team put it, after having worked in a number of different hospital areas as a consultant, "Deep dialogue forums effectively break these standoffs when staff and consumers realize that when we talk, we are all winners, and a non-decision-making forum is a nonthreatening one, thus encouraging dialogue."

Some guidelines we drew out for iterative dialogue that might break through the barriers to voice were as follows.

> Listen intently to each other, with respect, even with reverence.
> Hear the person out, even when you want to jump on something they said.
> Sit with conflict. When there is disagreement, take off the pressure to decide. Go away, and come back later. Let there be more talk away, where people feel more safe. We had a "permanent draft" idea—things were always provisional and open to change.
> Listen carefully—especially to silences. Ask why people can't speak rather than force too-painful speaking about the "undiscussables."
> Come into them sideways. Repetition is not bad—it's a sign something is not yet properly resolved. People can come back to an issue later in the conversation. This is not only tolerated but encouraged. We don't say, "We've already discussed that." Agreements will only stick in practice if real.
> People agree to keep going—until glass walls of undiscussables are cracked and broken through. Keep remembering why we like and respect each other—and verbalizing it.
> Sit with silences. When all is black and there is no light apparent from the bottom of the deep hole—sit and let your eyes acclimatize to the new reality. Suddenly someone sees a rope ladder in the gloom. Ask questions. What are our worst fears? How else can we see this? Why do we think like this? How else could we think? What else could we do? Who else could we ask?

The other site—only sketched in point form in this consumer research project—and mirroring the consumer supports site, we named "the missing fourth site." We listed numerous nascent ideas and efforts in this area including the following.

- Peer mentoring/"peer vision," peer support, professional codevelopment
- Co-counseling, re-evaluation counseling
- Check-ins, check-outs
- Professional supervision
- Professional practice reviews
- Critical incident debriefing
- Critical incident analysis
- On-site support of a (Rogerian-style) psychologist
- Contact with consumers when they are not needing immediate assistance
- Time-out from the acute/crisis frontline
- Working part-time in different settings
- Staff self-help groups
- Training in decision-free, nondiscussion, nonargumentative dialogue
- Supportive and consultative leadership/managers who model user-responsiveness, encourage consumer projects, etc.
- Rewards built in to the system for staff who listen to and respond to consumer feedback
- Support and rewards for staff who arrend and present papers about practice with consumers and/or attend consumer-led workshops and conferences
- Keeping all services open to the free flow of outsiders, visitors, academics, friends and families, advocates, and so on, hold open days, etc., to diminish secrecy and hold practice open to accountability
- Consumers involved in training and education of professionals from the outset to avoid impoverished or fear-based perceptions of patients as "other" being learned

But we were aware that, in the absence of larger numbers of staff who could articulate this for themselves (in concert with some consumers so that consumers are happy that support structures do not reinforce existing stigmatising attitudes), we were uncomfortably close to representing staff's voice for them—which was just what we hoped they might not do for consumers!

If the Tavistock tradition was to see the organization or society as "sick" and needing diagnosis and treatment, the new metaphor in the light of our research may be to see the organization or society—and all who make it up—as "losing the story" and needing to be able to speak and to hear each other's

stories until together people find the new preferred stories. As a survivor said recently, "There will be no healing until *all* the stories are told."

4. THE VOICE OF THE RESEARCHER(S)/FACILITATOR(S)

Traditionally—and even in much new paradigm research—the voice of "the researcher" has not been heard or has been suppressed: sent underground by beliefs about bias, contamination and objectivity. Yet if groups of people are co-constructing realities, the nominal researcher (or research facilitator or convenor) cannot be "outside" this joint discourse (or indeed the separate ones which are "coming to the table"). Indeed, in order to understand, the researcher or facilitator enters each of the differing discourses to grasp their structure, content, and consequences. Even a "going back and forth" between them may more be a witnessing of the engagement in a speaking back and forth *from* them—or an enabling of the "native language speakers" to speak directly to one another. Yet in doing this, any facilitator will need to occupy (and be trusted to enter) the world of either or both consumers or staff. Thus the facilitator (and depending on their own prior positioning) needs to engage in exactly the same processes of dialogue as are being proposed between the groups. At the moment of occupying (or entering) the domain of the "other" group, they will (and will be observed by the first group to) have left the first group's world and become both knowledgeable and possibly seen as untrustworthy to the exact extent as exists for the broader context of dialogue.

The search for the unitary "neutral" facilitator appears, in this light, to be fruitless. Eventually it may be more useful to see the "facilitator role" as one occupied more or less by a number of people, with each different person moving to close gaps and facilitate or construct overlaps of understanding between those operating within the relevant discourses. To this end we found ourselves frequently asking the question, "How would you say that?" or "What words would be good to describe (whatever phenomenon)?"

As well as pointing up the inappropriateness of the concept of "neutral" facilitation, this may also implicate a far more active role—entering one or the other, holding up questioning mirrors between the two, assisting dialogue that illuminates the different forms of speaking, and being comfortable with sitting with silences that may lead to moments of deeper communication and the "aha" insights. Indeed the "neutral" facilitator may be doomed to fail to enter and grasp any of the relevant discourses and, instead, be only mildly trusted or mildly mistrusted from all sides. The outcome may be only shallow depth of understanding and weak change.

This paper ends at the point of each of the authors beginning a new phase of inquiry into the ways that researcher/facilitators need to work when two (or more) parties are equal neither in status nor power, in order for one group to

be able to contemplate the others' ways of seeing and to inquire into their own ways of seeing and the grounds for this. In human services, if an effort is directed toward enhancing user-responsiveness, then the "direction of the gaze" of the inquiry group is toward narrowing the gap between the two ways of seeing in order to strengthen the impact on staff practice of consumers' perceptions and experiences. This implies a new kind of symmetry if the concept of collaborative inquiry is to remain meaningful—a symmetry which may fundamentally call into question the exact "othering" on which the current situation rests.

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