Mental Health Trialogue Network Ireland
Transforming Dialogue in Mental Health Communities
Mental Health Trialogue Network Ireland: 
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Acknowledgements

When you are trying to write a story about an on going conversation between so many people it is impossible to acknowledge everyone by name or even according to their role in the story. To all of the Mental Health Trialogue Network Ireland (MHTNI) Trialogue participants past and present this is your Trialogue story, thank you so much for sharing it, and we hope in the telling that others have the opportunity to share similar experiences to those we shared together. We have tried to be true to the conversation and hope we got it right.

To the 34 mental health leadership teams around the country who got so much out of Trialogue as they completed the DCU Mental Health Leadership programme that they put on the pressure to bring Trialogue out into their communities. Thanks for pushing it; we hope you have found it was worth it.

To the project advisory group, in particular: Catherine, Martin, Jenny, Colette, Clem, Adrian, Gerry, Kevin, Maeve, Anne, Damien, Lorraine and Michael. Thanks for trusting in and supporting the Trialogue process.

To the local community facilitators in Galway, Mayo, Donegal, South Tipperary, West Cork, Dublin South Central and Tallaght who helped to bring about and lead the establishment of Trialogue Meetings in your communities, thanks. Among others thanks to – Libby, Paul, Gerry, Evelyn, Vinnie, Sue, Joan, Josephine, Eoin, Kathleen, Alan, Susan, Cathy, Andrea, John, Steven, Bernie, Johanna, Gavin, Angela, Theresa, Joe, Ann Marie & Iseult

This national project was a huge and very uncertain initiative to undertake and we needed to believe it could happen so that it would happen. Our core project team had that belief. Thanks to Lorna for co-ordinating the setting up of the network, ensuring we had a streamlined process, an on going profile around the country and for her consistent optimism. Thanks also for collating the wealth of information that has enabled a thorough evaluation of Trialogue and the MHTNI. Thanks to Michaela for her support, wisdom and perpetual enthusiasm & charisma. Thanks to Anne for helping us understand technology and providing an online platform to provide information, knowledge and interaction in support of the overall aims of the MHTNI.

This project was made possible by the funding and support provided through GENIO Trust. Thanks for seeing the potential of this project to make a difference in communities.

Liam Mac Gabhann         Paddy McGowan
Project Lead             Project Lead
Key Outcomes from the Mental Health Trialogue Network Ireland

There were a number of aims for the Mental Health Trialogue Network Ireland:

1. To facilitate the establishment of community leaders in the area of mental health
2. To develop a community forum using the ‘Trialogue’ processes
3. To strengthen the voice of people with mental health problems & families/carers regarding needs & supports in their communities
4. To provide a focus for developing awareness and action around mental health within communities.

The story of Trialogue in participating communities and indeed other communities interested in establishing Trialogue Meetings has demonstrated that these aims have been achieved through several means. It is difficult to extrapolate specific indicators of this from what has been an evolving testimony, though there are several key outcomes that summarise how as a concept, as a process, and as a means to address significant issues relating to mental health in communities Trialogue provides an adequate forum:

- Trialogue Meetings were established as self sustaining community groups
- Trialogue Meetings provided a safe and empowering space where people could discover diverse meanings, develop mutual understandings and experience a collective expertise about mental health not available as individual learning or elsewhere
- Forty two percent of people continued to participate in Trialogue Meetings
- Developing an online presence provided a frequently used window for other national and international viewers, knowledge seekers and potential Trialogue enthusiasts
- Regardless of constituency, people are committed to trying to improve how mental health issues are understood and responded to
- Once people have engaged in Trialogue it has a positive effect on the dynamics of relationships they might have with each other in their interactions outside of Trialogue
- Regardless of geographical location, size of meeting or threads of conversation there is a common positive experience in Trialogue common to all meetings
- There is a levelling of power imbalances not experienced in normal professional relationships with service user or carers
- Of note is the 6% ‘interested community members’ who have had a major learning experience. If we consider the difficulties in promoting mental health in the community; the relationship of stigma, discrimination and fear to ignorance in the general public; then Trialogue offers a wonderful and creative mechanism for mental health promotion in the community to the community with the community
Trialogue meetings are very different from other representative meetings, offering a new, enlivening, accepting, comfortable experience with a sense of openness and freedom.

You gain not only knowledge and awareness of new expansive knowledge; you become aware of the capacity of community to respond to the challenges brought about by mental health problems for people.

There is a renewed energy, motivation and stimulation bringing about a sense of being more alive, empowered; and with an increase in awareness, acceptance and tolerance of diversity.

It is a rich learning experience, an education of each other that enhances how they comprehend others and their own experiences.

Where you develop communication skills that improve sense of self and a confidence and allow you to share your own experiences and enhance how you connect with others.

It can change the way you think about mental health and mental distress; increasing your understanding, being more informed of how people cope and manage mental health problems, more aware of what is positive and lacking in mental health service provision, increasing awareness of the experience of stigma and discrimination in communities, and the responsibility for promoting mental health and managing mental health problems in communities.
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What is good and not so good about the mental health services in communities?
If/how people with mental health difficulties experience stigma and discrimination?
Who has responsibility for mental health and mental illness in communities?
How can mental health be promoted in communities?

The initial Trialogue Experience

Table 4 – General reasons why people came to Trialogue Meetings

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What people learned?
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Is it to be recommended?

On becoming a local Trialogue Meeting facilitator

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Recognising and utilising the processes for community and organisational development
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Summary of Pertinent Findings
Chapter 1 – Introducing a Community Development Initiative

The backdrop to the development of this community development initiative is provided by the current state of affairs with mental health care provision in Ireland. Like many other western countries Ireland has been examining national policy in relation to mental health services delivery, and how we understand and respond to the challenges in society that arise when people, families and communities are adversely affected by mental health problems. For some time now ‘Community Mental Health Care’ has provided a mantra that underpins how people think about and talk about mental health care provision. Here ‘A Vision for Change’ (Government of Ireland, 2006) provides radical and innovative policy position for the future of mental health services in Ireland. One of the long standing issues in service delivery seems to be the prevailing location of understanding and addressing mental health problems within the bubble of mental health services. Whilst there is no doubt that services have changed and improved over the years, people still in the main rely on mental health services to provide understanding and care. Care has indeed moved into the community, the big hospitals have often been replaced by institutions without walls as part of community mental health services. The impetus for this project arose from a concern that no matter how much we can improve mental health services; so long as we perpetuate a mental health bubble where people with mental health problems, perceived expertise and solutions rest in a segregated place disconnected from family, community and society generally; then a fundamental flaw in societal response will remain.

The purpose of this project was to move outside of the mental health bubble into communities that were eager to reconsider the nature of mental health problems and how society responds to them. Through a participatory community action process the Mental Health Trialogue Network Ireland (MHTNI) emerged. Participating communities established monthly Trialogue Meetings in local towns and cities around the country.

What is Trialogue

Trialogue is a conversation between three or more people or groups using a form of open communication known as Open Dialogue. The Trialogue uses open dialogue as a means to allow everyone participate in the conversation. Open Dialogue enables the creation of a common language and a mutual understanding around the given topic. There is no exclusivity of expert knowledge or power, with the diverse experiences and expressions carrying equal weight. The combined expertise is taken on board by all in the Trialogue and together they create a shared reality that is mutually acceptable and accessible to all.

What is a Trialogue Meeting?

A Mental Health Trialogue Meeting is a community forum where everyone with an interest in mental health participates in an open dialogue. Trialogue meetings are welcoming and inclusive of all community members, including mental health service users, carers, families friends, professionals and anyone with an interest in mental health in the community. They can help communities to change the perception that only those who work in the field of mental health are the experts in mental health. Mental health is everyone’s business, regardless of their background and experience. A Trialogue Meeting takes place in a neutral location where communities can gather to develop their understanding of mental health issues, the challenges of maintaining mental health and to transform thinking on developing better services and healthy communities.
This report will outline how the Trialogue Network evolved within three action cycles over nine months in different communities and a snapshot of where the project is at this time. The report will illustrate to what extent the MHTNI has impacted on people, families and communities capacity to engage with the challenges for them posed by mental health problems. The report comprises a background context to the community development initiative and how people and communities engaged with the MHTNI in chapters 2, 3 and 4. Chapters 5, 6 and 7 provide an account of the three development cycles and at each stage how people and communities were affected by the process. Finally, chapter 8 will provide a reflection on this somewhat radical process in an Irish setting; implications for people and the mental health agenda; and a tentative suggestion as to where Trialogue is relevant to mental health in Ireland.

This is an evaluation report because it is important to know that Trialogue makes a difference and what that difference is. Though, more than a report this is an attempt to unfold the story of MHTNI and people’s experiences of Trialogue. So that other interested people, organisations and communities can build on successes and avoid some of the pitfalls. It is not a short story, unfolding as it did over more than a year and still being told. Throughout the report the voices of participants will be heard through direct quotes illustrating the lived experience that has brought about this textual account and to provide contextual meaning to the author’s interpretations. We too were part of this story and will speak in the first person adding our own voice to what transpired. Although there will be technical detail in some of the findings and some out of the ordinary words, our intention is to write the story in plain English to the best of our abilities.
Chapter 2 – Background to the Mental Health Trialogue Network Ireland

A Community Development Initiative

Community development initiatives will always have some common ground in how people engage with them, yet there are a diversity of approaches and applicable models, depending on context and the purpose of any development. At one level the very basic ability of community to rise above systemic oppression or empower disenfranchised groups requires particular emancipatory approaches (Freire, 1996; Hope & Timmel, 2007) whilst other groups and communities maybe involved with democratising how their communities evolve (Webler and Tuler, 2002); or try to create participatory collaborative processes by which communities can develop (Heath, 2007; Reason & Bradbury, 2008). When embarking on this initiative there were a number of particular factors that influenced the development approach. The first was perhaps the common interest or common ground ‘mental health’ and the many issues that arise in relation to vested interest in mental health. There are such diverse perspectives from all walks of life on anything to do with mental health and mental ill health or mental health problems and how they are responded to. Of note are vastly different conceptual understandings on what constitutes mental illness, what effective care constitutes; who is responsible for health care; and significant power dynamics between professionals, service users and family/community members (Barker and Stevenson, 2000; Faulkner and Thomas, 2002; McGowan et al. 2009). It was essential that a space could be developed where this diversity could be recognised and harnessed for the good of the community. Not all people in a community might be interested in a single topic or issue for development, so the initiative needed to be cogniscent of this. The initiative was a first in Ireland and the process needed to be flexible enough for easy participation and context specific ownership of each community group. The project leads were already familiar in working with a variety of approaches that would be adaptable to the required context. A Participatory Action Research (Reason and Bradbury, 2008) approach underpinned by a form of open communication known as Open Dialogue (Bakhtin,1981) was adopted for the project.

Open Dialogue

Open Dialogue has been described and applied in many ways. The evolving from of Open Dialogue for this project was that described by Bakhtin (1981)

“... as a joint action that joins people together in a temporary mutual world experience ... Participants have to be willing to engage in this dialogue or a situation needs to be created where it can ensue”

Dialogue brings about mutual understanding through the formation of a communicative space, where people bring their social baggage and narrative histories to share, and the formulation of a joint language and meaning (Bakhtin, 1981). This is created through individual utterances spoken and listened to, each response bringing new understanding with the construction of new words that lie somewhere between the speaker and the listener (Volosvinov, 1973). The emergent change in individual stories within that communicative space is a consequence of dialogue (Anderson and Goolishian, 1992). As a process of communication, open dialogue is viewed as more than just a conversation. It is an open conversation that in itself is a transformation or an action that is and can bring about change. For Freire (1996) this Dialogue constructed through the critical discussion of oppressed people was the act that in itself can overcome oppression. The emerging dialogue enables the sharing or unveiling of participants’ worlds, as opposed to the domination of one by the other. Through this unveiling and critical reflection, participants engage in an authentic practice or dialogical action, co-creating and naming their new world.
Open Dialogue is now a recognised applied theoretical approach to communication between individuals, groups and organisations. In Psychotherapy open dialogue provides a process that enables relationships between individuals or networks of people to evolve that can bring about effective change within the existing relationships and for individuals involved. Within the dialogue; imbalances in power can be redressed, diverse perspectives listened to in a safe place and a shared understanding of any given situation can evolve (Anderson and Goolishian, 1992; McNamee and Gergen, 1999). As a therapeutic process it can underpin approaches to mental health services delivery (Seikkula and Aaltonen, 1995; Seikkula et al. 2006). As a process for bringing people together in participatory and collaborative decision making conversation within and across organisations open dialogue accommodates a diverse range of perspectives and opinion that enables organisational development (Gustavsen, 2001; Mac Gabhann et al. 2010).

**History of Trialogue Meetings**

Trialogue Meetings are underpinned by open dialogue and are more like a community forum than a formal service or organisation development or therapeutic process. They emerged in the early 1990’s in Germanic speaking countries alongside a similar community group process development Psychosis Seminars (Bock & Priebe, 2005) with over 5000 people in over 100 locations in Germany, Austria and Switzerland now participating regularly in Trialogue Meetings (Amering et al. 2002, 2010a). Trialogue approaches and Trialogue Meetings have begun to emerge in several other countries over the past decade, including United Kingdom, China, USA and Ireland (Amering, 2010b; Mac Gabhann et al. 2010).

Trialogue meetings are usually held once or twice a month at a neutral venue. Participant make up consists as a basic requirement of representation from mental health/psychiatric professional providers, service users and carer/family members. However, anyone from a given community with an interest in mental health can participate. Anywhere from 10 to 100 people participate in these discussions. The combination of knowledge and expertise provides a unique wealth of collective knowledge that individuals or people from different perspectives would not otherwise be exposed to. This empowers people in how they relate to challenges and circumstances of their involvement with mental health issues. The Trialogue discussions help people to develop skills that allow them to contribute to and tap into this knowledge pool and experience. It can transform your own experience, and provide back up for utilising new knowledge in everyday life towards recovery, caring for a family member or friend, interacting with neighbours or providing professional care to people with mental health problems. Bock & Priebe (2007) described characteristics and possible effects of Psychosis-seminars and Trialogue Meetings:

- Where many participants are characterised by a lot of experience, often over many years
- Where the main benefits for carers stem from gaining knowledge, sharing experience and being able to discuss concrete issues they struggle with within their family with persons, who know similar situations from their own experience, but with whom they are not intimately entangled through emotional and biographical bonds
- Where consumers benefit from respect for their individual experiences and a chance to make sense of psychotic and other experiences in their personal social and biographical context
- Where professionals value not only the opportunity to gain new insights into the experience of psychiatric problems, but also review their role and their practices in new and comprehensive perspectives
- Where many participants share the wish to improve current psychiatric practices and advance the concepts of mental illness and health
Service Improvement Leadership Programme

In 2007 a partnership of Dublin City University (McGowan & Mac Gabhann), Irish Advocacy Network, National Office for Mental Health HSE, National Service User Executive (NSUE) and six local Mental Health Services around Ireland was formed. Stimulated by mutual membership and activity within the International Initiative for Mental Health Leadership (IIMHL, http://www.iimhl.com/) and a desire to implement a Vision for Change (Government of Ireland, 2006) this group developed an innovative service improvement leadership course and programme of service improvement projects that has been running successfully now for over five years – Cooperative Learning: Service Improvement Leadership for Mental Health Service Users, Carers & Service Providers

The Vision For Change document was clear in determining that health care providers, service users and family members were to be actively involved as partners in the planning, development and evaluation of mental health services into the future. Service users, carers and mental health providers had been working on a partnership basis within HSE structures for a number of years. However, it was not clear what impact if any, a meaningful partnership had on service improvements (Irish Advocacy Network, 2004; Mental Health Commission (IRE), 2005).

The purpose of the Leadership programme was threefold – to bring service users, carers/family members and service providers together in a joint learning environment; for participants to understand the nature and practice of a cooperative approach to leading change in healthcare organisations; and for teams (service user, service provider and carer) to instigate and lead a service improvement in their local mental health service. The emerging service improvement model is underpinned by two principal processes; Participatory Action; and Open Dialogue. Participants had to engage in Trialogue approaches within their service improvement projects and frequently members of the programme team familiar with Open Dialogue practice and Trialogue were asked to facilitate Trialogue Meetings (Mac Gabhann et al. 2010). Over time the participating communities have identified the strengths of Trialogue and expressed a need to develop them in their communities.

To a large extent the MHTNI as an idea for a project emerged as a process outcome or inevitable next step from the ongoing evaluation of the leadership programme. Mac Gabhann and McGowan subsequently applied for and were successful in getting funding support from GENIO to establish the Mental Health Trialogue Network Ireland.

The aims of the Mental Health Trialogue Network were:
- To facilitate the establishment of community leaders in the area of mental health;
- To develop a community forum using the ‘Trialogue’ processes;
- To strengthen the voice of people with mental health problems & families/carers regarding needs & supports in their communities;
- To provide a focus for developing awareness and action around mental health within communities.

The aims would be met through:
- Establishing monthly Trialogue Meetings in 7 communities in Ireland during 2011;
- Creating an online Mental Health Trialogue collaborative community accessible to the public;
- Providing a learning forum for leadership teams to develop community development & trialogue facilitation skills,
The key benefits of establishing the MHTNI would be the:

- Emergence of community leaders in relating to mental health problems and community response;
- Increased understanding of mental health problems among community members;
- Increased capacity among people with mental health and their families & carers, and mental health care providers to advocate for and determine supports needed in communities;
- Provision of a community focus for actions aimed at developing mental health awareness and action;
- Creation of an online resource and Mental Health Collaborative Network.
Chapter 3 – Engaging Communities in a Trialogue Experience

In any community development initiative where external facilitation is involved there are potential pitfalls. Issues with ownership, responsibility, control, agendas etc. are common place. The methodology for developing the Mental Health Trialogue Network was Participatory Action Research (PAR). By its very nature PAR is inclusive from the outset, flexible with a purposeful intent to transform the system through engagement with and by the people in that system. Open Dialogue as the medium for communication fits well with PAR and the overall aims of MHTNI, as illustrated in Figure 1 with the converged characteristics adapted from (Gustavsen, 2001). Moreover, Trialogue Meetings themselves are owned and developed by the participants. We were optimistic that this approach would be effective in developing a sustainable community initiative by the communities for the communities.

Each of the seven communities who had volunteered to participate in the project had a number of service users, family members and service providers that had participated in the Leadership programme over the previous four years, which meant there was a core group in each community who already had developed Participatory and Open Dialogue skills, and were familiar with Trialogue Meetings. These core groups offered to be the initial local co-ordinators and for the project and potential facilitators of the Trialogue Meetings.

Figure 1 – Characteristics of Open Dialogue and Participative Action

<table>
<thead>
<tr>
<th>Characteristics of Open Dialogue and Participative Action</th>
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<tbody>
<tr>
<td>■ The dialogue is based on give and take as opposed to one way communication</td>
<td>■ An argument can be rejected only after an investigation (and not for instance, on the grounds that it arises from a source with limited legitimacy)</td>
</tr>
<tr>
<td>■ All people concerned by the issue under investigation should have the opportunity to participate</td>
<td>■ All arguments to enter the dialogue must be represented by the actors (participants) present</td>
</tr>
<tr>
<td>■ Participants are obliged to help other participants be active in the dialogue</td>
<td>■ All participants are obliged to accept that other participants may have better arguments than their own</td>
</tr>
<tr>
<td>■ All participants have the same status within the dialogue arena</td>
<td>■ Among discussion issues can be the roles occupied by participants with no one exempt from such a discussion</td>
</tr>
<tr>
<td>■ Experience is the point of departure for participation</td>
<td>■ The dialogue should be able to integrate a growing degree of disagreement</td>
</tr>
<tr>
<td>■ At least some of the experience the participant has when entering the dialogue is seen as relevant</td>
<td>■ The dialogue should continuously generate decisions that provide a platform for joint action</td>
</tr>
<tr>
<td>■ It must be possible for all participants to have an understanding for the topics under discussion</td>
<td>(Gustavsen, 2001)</td>
</tr>
</tbody>
</table>
The Project Team

The overall project team is not possible to calculate as it includes several layers and Trialogue Meeting participants all over Ireland. However, there was a structured process in place that enabled ongoing auditing, monitoring, evaluation and insurance that a quality process as aspired to was in place. Joint Project leads Liam Mac Gabhann and Paddy McGowan were the instigators of the project following an approach by the participating leadership teams and their steering group with aspirations for such a community development initiative. Once they had applied for and were successful in receiving funding support from GENIO Trust the core DCU project team and support was then formed. In addition to Liam and Paddy Lorna Ni Cheirin, became the National Project Co-ordinator with researcher input. Michaela Amering provided consultancy, facilitated development workshops for local Trialogue co-ordinators and inputted to the final evaluation of MHTNI. Anne Spencer developed the initial Web Site, provided ongoing ICT support and advice, and maintained the online presence for the duration of the initial funded project.

Figure 2 – DCU Central Project Team

Anne Spencer, Liam Mac Gabhann, Michaela Amering, Lorna Ni Cheirin and Paddy McGowan.

Advisory Group

There had been an evolving steering group for the Leadership programme that were linked into each of the participating communities. In addition this group had representation of carers, service users and HSE at a national level. The National Office for Mental health, Irish Advocacy Network, and National Service User Executive. We agreed that this same group would become the advisory group to the MHTNI and had bi-monthly discussion meetings on the progress and direction of the project.

Local Community Trialogue Facilitators

From the outset one or two people in each community had offered to be part of the local co-ordination of the project, creating the necessary link to central team and each community. This group were the cornerstone and key to the success of Trialogue Meetings in communities. Although, initially nominated people took on the co-ordination roles, the people changed regularly as other natural leaders and interested community members came forward. Mostly there was usually one of the original local facilitators that remained core to each group, though not always so. Figure 3 offers a snapshot of a group of local facilitators during one of the community development workshop days at DCU. By the next workshop several of the faces had changed, an indication of ever evolving community involvement.
Designing the Process

The key focus of this project was to establish sustainable monthly Trialogue Meetings in each of the participating communities and whilst doing so achieving the overall aims of the MHTNI. A roll out programme was developed by the central team in conjunction with local co-ordinators at each site with an initial objective of having six monthly meetings at each site. The idea was that initially the national project coordinator and at least one of the project leads would participate in each Trialogue Meeting, to offer support, answers to questions and moderation of meetings where requested. So a coordinated schedule of meetings were organised over a seven month period. This set up took time and the team wanted to engage as many people as possible from the outset whilst offering information on the upcoming project. This was achieved through the early development of our interactive project web site and entry into the world of social networking through Facebook.

Interactive Project Website (www.trialogue.co)

From the outset the project set out to provide a broad base for the evolving MHTNI and developing an interactive website was part of this. It meant that to interested browsers; a cohesive evolving network was evident; information on upcoming Trialogue Meetings was available; other interconnected projects and relevant events were identified; a blog spot provided an on going narrative as to how the project and individual Trialogue Meetings were going; and information on Open Dialogue and Trialogue was available to peruse. For people already part of the MHTNI the website enabled information to be available to all, regardless of the diverse geographical locations of each community, and to keep up with how each group was going. The site also provided a window to the outside world on how the Irish were engaging in Trialogue and latterly in the absence of an international site for Trialogue activities our website started to develop an international page.

Initially the central project team came up with www.mhtni.com as the working website title. Following a focus group analysis with site users and local community facilitators we agreed that the name did not mean anything to the uninitiated. The word ‘Trialogue’ was difficult to understand so warranted branding, yet it was exactly what we were trying to achieve, so our new site name went about just that task and has stuck to date. Moreover, it lends itself well to any evolution of the site usage, for example, the international dimension.
Although the facilitation of MHTNI on the ground now lies entirely with local communities, the Central Project team committed to maintaining the same web presence for the foreseeable future. The Web statistics in Figure 4 represents the time period when the DCU central team were still actively involved with implementing the overall project.

**Figure 4 – Website Usage Over Seven Months of Project**

The graph illustrates a consistency in visitations to the Website with surges in use around the time when monthly Trialogue Meetings were taking place. Almost 2000 pages were uploaded; there were 1,324 unique visits to the site; 1,096 first time visits; and 228 returning visitors. People from 26 countries accessed the Website over the timeframe with the majority from Ireland, UK, USA, Canada and Australia respectively. In Ireland there was an even spread of people accessing the site around the country north of Kerry, Cork and Waterford, including Northern Ireland. No visits were recorded from Kerry, Cork or Waterford during this time. As part of an overall engagement process we believe that these figures and breadth of dissemination is indicative of the Web site being a useful tool for enhancing success with the project and bodes well for enhancing sustainability.

**Social Networking**

In addition to establishing Trialogue Meetings in participating communities the project sought to engage other communities that might have also been interested in participating. Social Networking is not a medium for communication that everyone uses, though it is frequently utilised by community groups, disenfranchised communities and people from diverse communities. A process was in place to reach out to those that may rely on traditional mechanisms for communication. We decided on Facebook to form our online community group and believed that in addition to our Webpage this would provide an opportunity to engage in a wider conversation with potentially interested people. The most active period for the Facebook community was during the first seven months of the project implementation and this time period usage is reflected in Figure 5. The Trialogue Facebook group is still live and active today.
There was a consistency in how/who Facebook was accessed over the time period with 9,300 visits in total. Usage predominantly stemmed from Ireland, USA, UK, Canada and Australia, with 58% female and 33% male. The highest age range was 35-44 at 30% and then 45-54 at 29%, though usage occurred across all age ranges.

**Participating Communities**

The seven community sites that initially engaged with the project are identified in Figure 6. This provided a good cross section of urban and rural settings distributed across the four provinces of Ireland. Once the core local group were ready to commence and the Website was up and running, the project was ready to go live on the ground. As indicated previously the central DCU team were to be initially part of each Trialogue Meeting and would provide experiential learning for all participants on how meetings are set up; are conducted; are moderated; and can be adjusted to any number of participants.
Community Development Support

In designing and implementing what can be considered quite a radical community development project in the area of mental health, the central team were aware of the need to provide sufficient support to local facilitators and community participants, balanced against a need for communities to take ownership of the process as soon as possible. Support came from four main directions, apart from the existing supports people already had in their daily activities. The National Project Coordinator managed the ongoing daily process and initial establishment of venues, advertisement routes, production of flyers, etc. She was also a daily contact for local coordinators or people seeking information should they need immediate support or advice.

The project leads were experienced Trialoguers and provided roving support and one to one support where necessary. In each of these communities, both had already some established relationships through their ongoing work with Leadership programme and other initiatives and were familiar with some of the challenges, dynamics and environmental circumstances that might impact on type of support required.

After the second Trialogue Meeting in each community the first of two planned Community Development Workshop days were held at DCU, in April where local coordinators from each site came together to a facilitated learning, development and support day together with the DCU central team. This provided the opportunity to form a collective identity; gain strength from each other’s successes, learn from arising challenges; and develop further knowledge about the project and further skills in facilitating Trialogue Meetings in their communities. This day also enabled us as a whole project team to take stock of how people felt their part in the overall project was progressing. This process was repeated again in July with the second workshop day.

Crucially it was expected that the Trialogue Meetings themselves would provide the most support for both local coordinators and participants themselves, which turned out to be the case.

Evaluating the Process and Impact

The impact or effect of Trialogue Meetings has been traditionally difficult to evaluate. Partially this is because of the fluid and creative nature of meetings, processes and the diversity of how they are set up. To some extent there has been a reluctance to interfere in a process that seems to be working so well, lest the interference might spoil the benefits. There have been some small qualitative studies completed, alluded to already that offer some insights into the experience of Trialogue Meetings. However, most participants would say that to understand how Trialogue works and what impact it has, one has to experience it. We were in a position from the outset to establish a process with sufficient collective similarities at each site to design an effective evaluation as part of the overall Participatory Action Research project. This was a new concept at least in Ireland, though elsewhere the evaluation would be an important new development in demonstrating how Trialogue Meetings could impact on individuals, groups and communities.

There were a range of initial criteria by which the effectiveness or usefulness of Trialogue Meetings and the wider MHTNI were to be evaluated by. These altered somewhat as the process evolved, as would be expected from a PAR project. Initial criteria included:

- Establishing a profile of who (constituency groups) participates in Trialogue Meetings and how often; and to what extent meetings continue to be held
- Identifying initial perceptions and understandings by a select sample of Trialogue Meeting participants in relation to common important topics discussed in similar meetings elsewhere
- Gathering information of first impressions of Trialogue participation
- Developing a storyline of different representative groups experience of Trialogue
- Charting the evolution of the community process itself, apart from any outcomes at the other end
- Charting the developmental phases of the people involved and the direction the MHTNI evolved in relation to its aims and objectives. For example, ownership by local communities and evolving community leaders
- Creating data collection opportunities at each cycle of the project, determined by the MHTNI activity at the given timeframe where data is being collected. For example, in cycle 1 a brief structured interview with a participant sample; in cycle 2 there were focus groups and in cycle 3 there was a final Trialogue discussion group at each site and a questionnaire.

These will be discussed and illustrated in more detail in relevant chapters throughout this report. As each cycle evolves it becomes clearer how the MHTNI and participation in Trialogue Meetings affects people’s understanding and response to mental health issues; how their thinking and experience has changed; and the overall impact on people, groups and communities.
Chapter 4 – A Profile of Who & When People Participated in Trialogue Meetings

By agreement with participants a confidential record of their names and the perspective they represent (service user; carer; professional provider; other interested community member) was kept and analysed for the first seven Trialogue Meetings in each area. Some people chose not to sign in, so the following figures under report the actual numbers of participants. This information is particularly useful as knowledge of the make up and continuing involvement of people in Trialogue Meetings over time has been scarce, often anecdotal and not generally published. In published material and expressed opinion from experience, there tends to be more service users followed by carers and with least participation coming from service providers, though this is not always the pattern.

Six participating communities followed what is considered the standard approach to establishing and conducting Trialogue Meetings and participated in an agreed evaluative process. West Cork took a different approach to the introduction of Trialogue Meetings and when and where they took place. Meetings took place in the mornings as opposed to the usual evenings; a separate Trialogue Meeting took place over time in a series of towns rather than as a process of consecutive meetings taking place in the same area; and slightly different ground rules were adopted during meetings. Although West Cork report an overall positive experience, the difference in approach; (a) means the experience cannot be evaluated in tandem with other sites; and (b) meant that they did not engage in all of the evaluative process. Where applicable the experience of West Cork will be incorporated into the evaluation and where relevant and available findings will be reported separately.

Participant numbers

Across the six sites 318 individual people participated between March 2011 and September 2011 in 42 Trialogue Meetings. Including people returning to consecutive meetings 609 people participated over the course of six months. Figure 7 illustrates the breakdown of individual participation across sites over the six month duration, with the overall participation in each month shown in Table 1. Female participation accounted for 59% and male 38% of overall participation. Participation ranged across the adult life span with the majority 50% in the 15-25 age group.

Figure 7 – Number of participants at Trialogue meetings in participating communities in Ireland
Table 1 – Overall Participation in Trialogue Meetings from March-September 2011

<table>
<thead>
<tr>
<th>Trialogue</th>
<th>Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (March)</td>
<td>175</td>
</tr>
<tr>
<td>2 (April)</td>
<td>106</td>
</tr>
<tr>
<td>3 (May)</td>
<td>103</td>
</tr>
<tr>
<td>4 (June)</td>
<td>120</td>
</tr>
<tr>
<td>5 (July)</td>
<td>80</td>
</tr>
<tr>
<td>6 (August)</td>
<td>54</td>
</tr>
<tr>
<td>7 (Sept)</td>
<td>86</td>
</tr>
</tbody>
</table>

As singular events Trialogue Meetings provide a curiosity that is likely to ensure initial participation if well advertised. Therefore, if sustainability is to be likely the trends in participation provide some scope for estimating the potential for sustainability. Generally the trend for sites with larger participation were similar. i.e. Galway, Castlebar, West Cork and Clonmel, as indicated in Figure 8. Letterkenny had a more erratic participation with Dublin South Central showing a steady decline and Tallaght remaining relatively constant. Some explanation for these trends will be offered in the ensuing chapters.

Figure 8 – Participation Trends in Trialogue Attendance in 7 Communities over Time
Returning participants and representative make up of meetings

Over 42% of people participated in 2 or more Trialogue Meetings with the breakdown of this over time illustrated in Figure 9.

Figure 9 – Percentage of returning participants in 2 or more Meetings

Participants were asked to identify with a particular lived perspective of mental health they most identified with on the sign in sheets. Some participants identified with more than one, so the percentage representation in Figure 10. Illustrates the percentage of all perspectives recorded. Interested community members constituted those who did not identify with the other perspectives yet had an interest in mental health. Examples included; police, pharmacists, students, and local politicians.

Figure 10 – Participants’ mental health perspective: All Locations

In all areas there were some people who in particular saw themselves as both service users and service providers. A lot of people were from the voluntary and NGO sector and were involved in providing services outside of statutory mental health provision, which may account for some of the cross over. The average representiveness for service users and carers is similar to Trialogue Meeting participation elsewhere. Of note is the high percentage of service provider participation, whereas elsewhere and to some extent expected of the MHTNI there is often much less participation from
this constituency. MHTNI was set up in part to enhance community capacity for understanding and responding to mental health problems. That 8% of participants came from the community with no direct experience of mental health problems or care is encouraging and in chapter 7 some of the benefits of this participation will become apparent.

When participation is broken down across sites in Table 2, representiveness is not so balanced at all sites. For example, in Letterkenny and Clonmel there was a high percentage of carer participation with a lower ratio of service user than other sites. Tallaght had a higher proportion of service users whilst West Cork a higher proportion of service providers. There are number of possible reasons for this: Donegal had a strong core group of local facilitators who were carers; Tallaght had the same only they were service users; Carer participants in Clonmel frequently came only once or twice seeing the Trialogue Meeting as a valuable information and service signposting source; and in West Cork the high proportion of service providers might be influenced by the timing of Trialogues being during the day. Perhaps the most important aspect of these figures is that each group had a wide representation that lent to the Open Dialogue communication process that is necessary to enable the positive experience of Trialogue.

Table 2 – Percentage breakdown of participants’ perspectives over the course of Trialogue Meetings on each site

<table>
<thead>
<tr>
<th>Percentage participant perspective all areas</th>
<th>Tallaght</th>
<th>Letterkenny</th>
<th>West Cork</th>
<th>Castlebar</th>
<th>Galway</th>
<th>Dublin South Central</th>
<th>Clonmel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Users</td>
<td>38%</td>
<td>19%</td>
<td>27%</td>
<td>25%</td>
<td>25%</td>
<td>27%</td>
<td>14%</td>
</tr>
<tr>
<td>Carers</td>
<td>21%</td>
<td>38%</td>
<td>13%</td>
<td>22%</td>
<td>22%</td>
<td>27%</td>
<td>39%</td>
</tr>
<tr>
<td>Service provider</td>
<td>24%</td>
<td>24%</td>
<td>54%</td>
<td>26%</td>
<td>26%</td>
<td>31%</td>
<td>31%</td>
</tr>
<tr>
<td>Service user and provider</td>
<td>3%</td>
<td>8%</td>
<td>0</td>
<td>16%</td>
<td>16%</td>
<td>0</td>
<td>3%</td>
</tr>
<tr>
<td>Interested community member</td>
<td>14%</td>
<td>11%</td>
<td>6%</td>
<td>6%</td>
<td>6%</td>
<td>15%</td>
<td>8%</td>
</tr>
</tbody>
</table>

* Shortfall from 100% relates to undisclosed perspectives

Summary of Pertinent Observations

West Cork had a different approach to developing Trialogue Meetings, which means that generally this site has to be viewed in parallel with the other six sites. None the less it is interesting to see the differences and similarities between both sites being played out.

People across the lifespan participated in Trialogue with the majority being between 15-25 and the ratio of female to male 6:4. After initial participation of 318 people across six sites 42% continued to participate in Trialogue.

Although there is a downward trend in participation figures across the late summer months, consistently Trialogue Meetings continued to occur and the numbers began to increase across all sites again in September.

There is generally a balanced representation from the 3 main stakeholders in Trialogue and a consistent input from other interested community members.

The West coast had the largest groups of participants and the two Dublin sites had the smallest groups. However, size is not indicative of success and most Trialogue Meetings had a consistent core group of participants.
Chapter 5 – Cycle 1: The Initial Experience of Establishing Community Trialogue Meetings

The initial Trialogue Meetings around the country were preceded by a comprehensive public relations campaign instigated by the core team and snowballing throughout each community who utilised local knowledge and network relationships to get the message out that Trialogue Meetings were coming to a neutral venue. Methods included flyers, radio interviews, articles in papers, e-lists, and organisational networks. All initial Trialogue Meetings created sufficient curiosity that large representative groups participated in each one. Much of these first meetings involved clarification about what they are for, how they work and what Trialogue actually means and entails.

Creating a Picture of Participants’ Ideas around Topics and Trialogue Meetings

There are always common topics that time and time again arise in Trialogue Meetings and six of these were agreed in advance to be introduced over six meetings in each community. The reason for this slightly more prescriptive approach to topic choice was to enable an evaluation of the Trialogue experience across six of the sites. The six topics were:

- People’s understanding of mental health and distress?
- How people respond to, manage and cope with mental health problems?
- What is good and not so good about the mental health services in communities?
- If/how people with mental health difficulties experience stigma and discrimination
- Who has responsibility for mental health and mental illness in communities?
- How can mental health be promoted in communities?

As with all Trialogue Meetings the scope was always open for the conversation to take its own direction.

A brief structured questionnaire was developed (Appendix 1) to begin the process of evaluating people’s experience of either first or second time participating in Trialogue. 42 people across 7 Trialogue sites were interviewed following either the first or second meeting they participated in. The age range of people was 25-65+ with most being in the 45-55 age group. 27 females and 15 males were interviewed. Because some people identified with more than one constituency (e.g., service user & interested community member), of these 42 people the breakdown of what groups they identified with in total was 64 as illustrated in Table 3.

All of people’s responses were recorded, transcribed and underwent content analysis to identify emerging themes across sites.

Table 3 – Breakdown of grouping that 42 interviewees related to

<table>
<thead>
<tr>
<th>Service User</th>
<th>21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carer/Family member</td>
<td>9</td>
</tr>
<tr>
<td>Service Provider</td>
<td>18</td>
</tr>
<tr>
<td>Interested Community</td>
<td>16</td>
</tr>
</tbody>
</table>
The overall experience of Trialogue was positive with an expressed sense that it was much different to any other similar type of meeting people have been to or participated in. This cycle will focus on the findings that relate directly to the 6 main topic areas and on the impact of Trialogue for them. The initial questions on people's knowledge and experience are in part to get a sense of people's perceptions as they begin to engage with Trialogue. Later in cycle 3 people report on how they have changed their understanding and perception around these areas as a result of participating in Trialogue. Quotes will be used as illustration and to give voice to the participants in Trialogue Meetings. At the end of quotations $R =$ the respondent and the number represents which respondent it was.

**People’s understanding of mental health and mental distress?**

Generally when people spoke about mental health it was about having a life balance, peace of mind and being able to cope with their difficulties. There is a clear indication that it is a very individual experience as is mental distress. People reported their experience of mental distress as: failure to cope day to day, inability to function, social isolation and experiencing stigma.

The following words of participants offer some idea of how they view mental health and mental distress.

“Well for me, mental health is complete peace of mind where nothing that you perceive has any effect on your state of mind. You know then, what goes on around you has no power over your peace of mind or your mental health unless you give it power to affect your mental health.” $R.2$

“Positive mental health is a balanced approach and understanding of life. Mental distress is the reverse.” $R.24$

“Mental health is how you feel in your body as well as your mind; it’s just how you feel, your body affects your mind so it’s all interrelated, it’s quite complex, it’s got to do with your everyday life and how you run it.” $R.34$

“Mental health is the ability to stay well and cope with everyday life and issues that it throws at you. Mental distress would be the inability to cope with your life, the issues, the problems that you face.” $R.7$

“If you are mentally healthy I’d say you’re in control of your daily functioning in life and you can keep a job and fend for yourself etc., where if you’re mentally distressed you’re incapacitated as regards those daily living functions that is required, but then that varies in degrees as well, I mean we are not diagnosed, (my partner) and I, with any mental illness but we are often distressed because of the mental illness of our loved ones.” $R.13$

“I will give you an example [of what mental distress is] – once upon a time I was diagnosed with something called schizo affective disorder with bipolar tendencies and I had a girlfriend, a fiancée, and we were getting on great and I wanted to marry her and I told her that I was diagnosed with this stigma, this issue, this diagnosis, and she left me. So I basically would like to point that out that that is an example of how the psychiatric system diagnosis and the stigma attached to all of that actually worsened my mental health.” $R.38$

**How people respond to, manage and cope with mental health problems?**

People's overwhelming response to either having or responding to mental health problems is one of stigma, secrecy and holding back from divulging problems. People have a hard time accepting a diagnosis and problems, which delays help seeking. When people do look for help they find little information about what is available.
On the other hand people have found individual people and some services very helpful, particularly in the community.

“Very badly, in my experience. I suppose the most important characteristic is that they tend to internalise social problems and dismiss your circumstances, dismiss your history. Generally with low levels of mental distress with your friends and family and your society, people will accept it; but if it gets beyond a certain point, and that point is different for each individual and in each community, you know there is a switch gets turned off and people no longer accept that your feelings are a valid response to your experience.” R.18

“I think it could be a lot better. Everyone has a different way of coping with this. I think there is not a lot of discussion about it in society. Each one finds their own way through it.” R.25

“I think the first response is secrecy. People try to manage and cope by themselves and to keep it in house but support is the key to managing and I think people don’t realize that as yet.” R. 33

“People are fearful of them and I don’t think they cope very well or manage very well in society, maybe ‘cos they are fearful of them.” R.22

“I would say generally well this is just my own opinion, that people in general are kinda afraid of the whole issue and even if they suspect that they themselves might have an issue they will do their best to try brush it under the carpet almost and not acknowledge it.” R.5

“Most people can’t deal with them alone. It’s very difficult to recover without the help of services or other people in the similar situation who have managed that situation and overcame it. And I believe there are so many fantastic fellowships nowadays to help people overcome daily issues on a daily basis outside of the mental institutions and the hospitals even. These are in the community ... self-help groups basically.” R.3

“It absolutely depends on their attitude, the attitude of the health care providers, the attitude of society and the town. Some towns have really good proactive mental health initiatives where stigma has been lifted – maybe able to go into local GP, chemist, community project and be treated with respect.” R.23

“I think a lot of the time they toss it around in their own head to see, you know, well is this anxiety? Is this depression? Or is this normal what I am going through? Possibly by educating themselves and talking to other people who have similar experiences, then ... they realise that – well you know, I think this is anxiety or this is depression that I have. And some people are able to deal with it on their own while others then might go to mental health professionals and have a diagnosis or whatever.” R.4

**What is good and not so good about the mental health services in communities?**

People were initially more inclined to talk about the not so good aspects of local mental health services, though were able to recognise good as well. Generally at an individual level healthcare professionals were viewed as helpful and pockets of service delivery equally so.

Overall the perception of service delivery was negative across all sites, apart from individual pockets. People reported that they sometimes find services underfunded. They were also concerned that services themselves were stigmatizing, which to some extent contradicted the purpose of care. There is a trend in responses that the services and personnel have difficulty accepting or understanding people’s emotional experiences and subsequent problems, often resorting to unhelpful labelling instead of helping. Although, there was a general recognition of the difficulty in getting a balance and being able to respond to all needs. There were subtle differences between sites, though non that would really have one stand out more than another.
"Well … for me like, I think there is very good support networks in my experience but I do think they need to broaden the services and they need to do a lot more work in the community itself.” R.6

“Community help is very helpful once my daughter needs the psychology and the psychotherapies then her life change slowly but sometimes when something happens she gets down and cannot cope again … but once she joined her therapy she feel some relief.” R.39

“But I do community work myself with people that I meet on the street and I can understand why the people in the institutions get frustrated, because it is a very hard task; both for the person who is suffering and for anybody that thinks they can heal somebody that is suffering.” R.2

“It’s good that the acutely and severely … people with severe mental issues, can find a place there, that they can go and relax there and take time out, away from the rigors of everyday existence they are living in. until they are able to return to live in the community and face reality and face living on a daily basis.” R.3

“I think what’s good about them is that they are community based. They are accessible; a lot of them are walk-in. You know that I can go up to my local mental health facility and knock on the door and say, you know, can I talk to somebody and that will be facilitated. I think that is good.” R.4

“Well I think as I said to a group of people yesterday that, not wanting to generalise or not wanting to be facetious or whatever, but this is a good time to have a mental health problem, in that compared to 30 or 40 or 50 years ago, you know, even though there is still a stigma or a taboo today to it today, there are still are a lot more options, there are a lot more opportunities. It’s still not perfect and it might never be perfect, but … R.20

“The services there and there are people manning it, some of them are very good but others lack the understanding that they should have dealing with people with mental health.” R.37

“I think where there are placed, in my opinion, where they’re placed is how I would see, the services themselves are probably very good but they are still very much placed in buildings that are old and isolated and which carry a certain stigma. For me I suppose mental health services should be on a main street and they should possibly be in conjunction with other services …” R.24

“What’s not so good about it really, its kinda about the whole … I feel the whole thing about labelling somebody, you are inclined to categorize them, and sorta of pigeonhole them, its kinda like taking away from their humanity in a sense … that’s why, as I mentioned earlier when there was a discussion about labelling, that it can be quite damaging, it can almost be a self fulfilling prophecy in one sense … if you happen to get caught up in that label, you know, you can literally be caught there for life.” R.5

“There is a definite lack of choice and a lack of communication with the service user; what they want, and to support them and to look at the strengths and rather than what they sometimes see as weakness, which can be actually be strengths as well. Because I know for myself, I was always seen as – oh, your nerves, your nerves … you are so … so … so sensitive, so sensitive …” R.1

“There needs to be a trust that people know themselves better and don’t need a diagnosis and that the gatekeeper shouldn’t always be the service providers. It should be more of a community initiative. It’s about prevention, by the time someone reaches the psychiatric services, they’re often gone too far.” R.23

“I found the psychiatrists very bad, they never see me as a person – I was always an illness and I got no support whatsoever outside a psychiatric hospital.” R.16
“It’s an aspiration in one way because there are so many vested interests. You can’t deliver any service with vested interests, or you can’t deliver a social need or a human need when there are vested interests and like, there is a lot of damage done between the attitudes of drug companies and all that type of thing.” R.20

“I don’t think people are aware of mental health services in the community at all – unless you’ve gone to see a GP they might direct you to a mental health service but if you don’t want to go through that route and if you just want to see someone about your mental health, then people don’t know.” R.25

“Well I think the whole thing is rather underfunded, extremely underfunded and for the psychiatrist, plural the psychiatrists, to diagnose me on the basis of observations which I report to them on a bimonthly basis, it would really help if the same guy was doing the observations because I don’t know how the methodology can actually be valid if 20 different people are observing me. The only record they have is the file which they don’t read because I know that because they read it while they are interviewing me!” R.38

“I think it’s too easy like for people to say that’s your illness talking in the various ways they do that, you know. And if there is an issue, if there’s a difficulty, if there’s a disagreement, it’s like: you’re mad and I’m not; I’m right and you’re wrong. There’s no mediation or anything.” R.18

**If/how people with mental health difficulties experience stigma and discrimination?**

Although this was separate question in itself Stigma was voiced as a concern in responses across all questions. Every response reported the existence of stigma and discrimination in one form or other. The stigma people feel internally and experience from others is huge and on going and is a wider societal thing. The very experience of seeking help and being diagnosed is seen as the cause and continuation of stigma, more so than having the mental health problem. People were despairing of the extent of stigma and not knowing how to overcome it.

“Absolutely, I do. I think this stigma for a lot of people probably starts with themselves and has got to do with self stigma and there’s a certain shame attached to the illness, I suppose we can blame other people but a lot of it starts with yourself; there is this self stigma.” R.36

“I think it’s like anger, when you get angry, angry inside, I think stigma is internal. I think if you perceive a problem then you’re going to find that problem.” R.35

“Yes absolutely yes. When they see you they avoid eye contact, they might cross the road or they think you are … they feel sorry for you, as they think you are a weak person and that you’re not as worthy a person as you would be if you didn’t have a mental health problem, which makes you feel absolutely worthless, and lowers your self esteem.” R.16

“Yes, people don’t believe there are such things as mental illness, people mock people for having mental illness, it’s an Irish thing. It was always swept under the carpet. It’s still a very big problem, the stigma around it.” R.21

“Yeah. That they don’t want to talk about it. I had an experience there recently ... I was working and I mentioned just a tiny little thing about my own situation and it was very very little what I said and I just felt afterwards that, that person was reacting to me in a totally different way. You know, that they had it in their own mind, pigeonholed me in a certain way.” R.5

“Definitely, through the media people with mental health issues would be portrayed would be like lunatics or crazy or psychos and that, they’d see the white coats and the detention centres and so I think they think things like that still happen today.” R.31
“Absolutely, yes. People are isolated from mainstream society, trust is taken away from people and decision making is taken away from people and they’re treated that they can’t make up their own mind, they can’t make their own decisions or they can’t really look after themselves. And people don’t believe that people can recover and it has to be this massive catastrophic thing whereas it need not be.” R.33

“Yeah … because … way I put it … I think some people … when they hear you have mental illness … its like … they are afraid to be around you because they are afraid it’s contagious you know … and they would catch it or there are afraid … ” R.6

“Unfortunately I would love to be able to say that society allows for difference and celebrates individuality but I think we’re a lot more closed, I hope my view changes a hell of a lot but I think we’re a lot more comfortable keeping things quiet and not asking questions.” R.25

“I think in the workplace – I’ve experienced it myself in the workplace. I’m presently working for a good employer but I’ve seen the other side of it. I’ve seen people left out of things in the community ‘cos of the stigma attached to mental illness.” R.22

“If you look at housing, if you look at education, if you look at employment, the stigma is right across the board. And we collude with that.” R.9

“Absolutely. Absolutely. God, I think there is the unknown that was mentioned inside, I think there’s the fear of that unknown, there’s the fear of behavioural issues, if I use that word. “They’re not stable, and they’re going to …”. It’s not always violence as was used inside, but I didn’t want to keep harping in, its behavioural, it’s … not stable, and I think it’s the unknown that is the biggest, society doesn’t know how to … is fearful so they don’t know how to cope with it.” R.12

**Who has responsibility for mental health and mental illness in communities?**

This question was geared towards people thinking about community as a resource other than statutory services. People reflected on previous questions in relation to the difficulties in communities with stigma, fear and lack of understanding. They spoke of the need for communities themselves to become healthy in order to be able to connect with people. Through acceptance, tolerance and education it was felt that stigma could be broken down in conjunction with services addressing the stigma associated with usage and diagnosis.

In some responses there was a sense of duty expressed, where communal or neighbourly concern and responsibility should be encouraged along with state responsibility.

Education was a consistent theme and people talked about education about positive mental health, mental illness and how to stay well, being brought into the class room from primary school and upwards into all institutional walks of life.

Information for and within the community about services and voluntary support is lacking and generally people felt that more information available in all community areas is needed.

There was a general theme of bringing people from different walks of life and perspectives on mental health into forums where they could collaborate and participate in creating a better overall understanding in the community, which would generate acceptance and a celebration of diversity or at least not treating people different because of mental health difficulties.
“Well if there was a healthy community then people would be healthy within that – because community would be the people. And so if I keep that definition going I think there is a lack of community so I’m not surprised there is a huge lack of mental health. If there was a vibrant sense of community, the sense that we are all in this together, then there would be a visceral sense of community, nearly be like a shared family – I’m going overboard now with Utopia! But a sense of having not just one door open, but connected and belonging already – accepted and belonging, that would be fantastic.” R.25

“I think that the community can fund self help groups and make places available for self help groups to operate and community must include all members within the community in establishing them … otherwise it leads to a stigmatization of different groups because of their attitudes or the beliefs or behaviors. They must all be included.” R.3

“Community can help by being aware. You don’t want them to … if they wish to bring sympathy or it’s one thing to bring support and sensitivity, that’s fine but communities need to be aware. They need to be aware, they need to have an understanding and an education. Communities need to be educated. But like, don’t we educate them about keeping their houses warm, we educate them about water, we educate them about road traffic, we educate people. But we don’t educate them on health. We educate them on physical health, but we don’t educate them on mental health.” R.20

“By allowing people to participate in the community. To identify the level of participation they can engage in and to be accepting … to be understanding and know that if people are engaged in difficult behaviour, it’s because of circumstances in their history, and it’s not very easy to help them make wiser choices but as much as people can take to have them participate, and include them and tolerate things and have a certain understanding that the issues they have are real life issues, they’re not just … madness is like … okay [suggesting caution/keep it away from me] … I don’t understand that because it can’t be understood, you know, but that idea has to sort of filter through.” R.18

“I don’t think community can help people until the services themselves address stigma and discrimination themselves.” R.32

“I think, in my personal view, everyone has a responsibility for their own mental health and for their neighbours’ mental health. So there is a personal responsibility and there is a communal responsibility and then there is a state responsibility …” R.9

“I definitely think there needs to be an educational programme put in place from national school up and you know, it’s all about looking after yourself in terms of exercise, in terms of recognising what stress is, what’s good stress, what’s bad stress, how do I cope with it. So I think it should be a part of the curriculum you know, in schools and built on … so you are dealing with suicides and lots of those things and maybe having support groups and stuff like that.” R.4

“I think it’s not discussed enough in the community. I think a lot of people are fearful and don’t know if they’re doing right or wrong by talking about it or by not talking about it. Maybe if there was more educational on positive mental health – even in the schools – ‘cos we have education about every other forms of illness – diabetes and cancer for example.” R.22

“The community can help by not treating people any different … eh … I mean, by kinda not smothering them either, like you know, because there are two ways; by being afraid of people or … and ignoring them, punishing them or the other thing would be smothering them and kinda taking their dignity away and treating them like kids, which I think very often happens at the moment. A friend of mine who was diagnosed with depression said ‘ok, got the diagnosis of depression and the next thing they try and teach me how to tie my shoe laces properly’. By not smothering and by interpreting (?) people and not making a difference between any other illness or disease.” R.1
“The community can help people with mental health difficulties by providing – there already is I know – even more support groups and where it's not just people with mental health difficulties, but again – like the Trialogue thing, where you have people from different parts of the service, that engage in the service, coming together and talking about it – that's a great idea” R.15

“Well ... I think actually, that something like this, were people can come along and talk and publicity, and I think as well as regards community, if there are people that are out there that are in the community that are prepared, like I know there are some public figures, I know the likes of [named celebrity] … and you know people like that, that actually talk about their own experiences and stuff like that. Because it kinda breaks down the whole stigma … which I think stigma is a huge thing.” R.5

“I suppose meetings like we are having now can help because it can break down barriers because as you described it yourself there is three groups of people, there is no professional here as such, there is a shared understanding. I think this is a great way to do it because it brings out the whole level of acceptance.” R.36

**How can mental health be promoted in communities?**

Much of the the points made from the last question were reiterated or drawn out further in response to this question. Every Trialogue group had substantive conversations about education in the community, starting with schools and into other community groups. It was not always clear what the education would entail, though it was generally with the aim of increasing awareness and reducing stigma.

People spoke about taking responsibility for promoting and maintaining their own health through self awareness and proactive measures to that end.

Again there was a view that more support groups and interactive groups like Trialogue should be set up in the community. Positive mental health and mental health awareness campaigns through advertising and the media were seen as a useful way of promoting mental health.

“I think it needs a general sort of education ... Asking people to come to talks, asking people to get involved in this, that, and the other doesn't always work. It needs to be in the media, messages, advertising. I go into schools sometimes and I say to the kids, 'have you seen the ad about letsomeoneknow.ie? And they'd say 'what ad?' And i'd say 'what about the fellow with the hoodie and the other student is talking about him withdrawing into himself’ – 'oh yeah I remember that'. It's advertising.” R.20

“Through promoting positive mental health in schools so that at an early age that you've more understanding and awareness that you have mental health and that you have to look after your mental health and that you have to use techniques if it’s exercising, if it’s going to the gym or talking to someone that you trust.” R.31

“I think through educational programs and self-help groups being propping up all over the place really, community, in each community really, making it a community ... it is a community problem so therefore the community have two have the solution.” R.13

“I think each one of us, speaking for myself as a user, has to take some kind of responsibility for it because a lot of stigma starts with self stigmatization and that’s where, every individual could start with themselves. And then meetings like we had today, the Trialogue meeting.” R.1

“I think events like this. (Trialogue) I think giving people the opportunity to be aware of mental health and not threatened by it. I mean one of the biggest things people are threatened by is change and is fear of the unknown. I mean, I think the future has to be that people say I have a mental health illness- big deal, big whoopee, i still get on with my life.” R.9
“Get away from these labels e.g. ‘mad pride’. Building community initiatives, e.g. walking, sailing. Make mental health part of your life, your everyday.” R.41

“By people being aware that people have issues and they can get over them, and doing things to promote their own mental health … I do a blog to remind me of the good things in my life, I take photos every day, and exercise, and good diet they’re all conducive to mental health under the tag ‘being kind to yourself and being good to your mental health.’” R.33

“By this type of thing, trialoguing, getting discussion going, actively promoting this. By being a little more vocal about promoting it and I suppose getting the language around this, to keep it nice and simple, but still keeping its significance and importance.” R.25

“I know that the ad campaigns were very useful that have been run lately. I think maybe just to advertise evenings like this evening for people to come along that may not always necessarily have an idea about mental health but then can learn – like there were one or two people here tonight that were just here by chance really and they learnt a lot from this evening.” R.14

“The media is a useful tool. It’s all very fine to see the ad for example about road safety or about drink driving but where are the ads about mental health? We’re immersed in consumer society, there should be a serious concerted media campaign dealing with this whole notion of mental health. Cancer used to be ‘the big c’, now it’s widely accepted.” R24

The initial Trialogue Experience

A series of questions were included on the interview questionnaire to help explore how people heard about, came to and experienced their first Trialogue Meetings. We were interested in how the advertisement of meetings had been picked up so asked people how they heard about them and why they came. The main ways people heard about upcoming meetings were: through friends and family, regional papers, a network e-list, from a local voluntary group, from educational course, on notice boards, at a presentation from core project team or people connected to the DCU leadership programme, and from professional service providers.

People gave a variety reasons for deciding to come to Trialogue Meetings with a lot of similarity. Table 4 illustrates the combined answers into general themes.

<table>
<thead>
<tr>
<th>Table 4 – General reasons why people came to Trialogue Meetings</th>
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<tbody>
<tr>
<td>Why People Came to Trialogue Meetings</td>
</tr>
<tr>
<td>Curiosity though it would be interesting</td>
</tr>
<tr>
<td>Have free time</td>
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<tr>
<td>To get and receive help</td>
</tr>
<tr>
<td>To see what the format of the meeting was</td>
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<tr>
<td>It’s a social meeting</td>
</tr>
<tr>
<td>Carers wanting to get involved in any aspect of mental health</td>
</tr>
<tr>
<td>Talking about it is good for my mental health/Communication</td>
</tr>
<tr>
<td>To voice my opinion/contribute</td>
</tr>
<tr>
<td>To help somebody else experiencing the same thing</td>
</tr>
<tr>
<td>To hear about Trialogue</td>
</tr>
<tr>
<td>To educate myself and increase my knowledge</td>
</tr>
<tr>
<td>Interested in mental health</td>
</tr>
<tr>
<td>It is outside of the hospital setting</td>
</tr>
<tr>
<td>To help somebody else experiencing the same thing</td>
</tr>
<tr>
<td>To see what was happening to experience them</td>
</tr>
<tr>
<td>Work in the area of mental health</td>
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</tbody>
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Examples of what people had to say that contributed to the overall themes are offered below.

“I suppose because I was interested in the idea of talking about it, and being able to talk about it ... it’s a difficult topic to talk about in a public... yeah...” R.8

“I thought it would help me with my illness and to find out other ways of coping with things.” R.22

“Primarily because I work in the area. I would like to say I would come anyway but honestly I don’t know that I would have.” R.23

“I felt it would benefit me in my coursework (student nurse). The best way to learn is from lived experiences.” R.32

When people spoke about their experience in Trialogue Meetings there was a marked difference between when they spoke earlier in the interview about mental health. Although these questions evoked emotion they were generally matter of fact. When people described how they felt in Trialogue it was in an emotional excited way.

Although, an array of emotions and feelings were experienced, for example, initial fear, discomfort and anxiety; these were always followed with an inevitable openness, comfortableness with a sense of safety and empowerment.

The discussion evoked painful and forgotten memories, yet the Trialogue provided a safe space to experience these and people did not feel re traumatised by the experience. The voiced experiences added to the collective understanding of issues discussed.

For others they were heartened, felt alive, that they were discovering something new and challenging and were touched by the experience, with a sense of hope.

Because of the honesty and extent of experience in the meetings some people felt somewhat overwhelmed by what they were hearing, which caused them to question their own ideas and the way that care has been provided over the years.

Some of the responses below speak for themselves.

“Yeah, a lot of fear was surfacing straightaway, it was the confrontation of the subject and even the discussion because it was so open and I didn’t know where it was going to go next and that allowed a lot of fear to surface.” R.25

“I felt very comfortable actually, and I felt intrigued and I like the vying, you could see people leaning forward and watching the dynamics of the interaction.” R.33

“Very comfortable. I felt there was a lot of trust in the room and that was very open.” R.14

“In the beginning I felt really anxious but then I was okay ... so” R.6

“I don’t want to cry here, it touches a nerve, it’s emotional.” R.28

“Very empowered. Very confident. I just feel worthwhile and that I’ve ... I do have something to say that might help others or somebody could relate to.” R.16

“I felt very welcome and very accepted and I felt very positive attitude here to everyone and most people here had an input and they had a voice.” R.3

“I felt heartened that was people to speak and to feel safe that they can speak and that really at community level something was beginning to happen.” R.13
“Myself, I felt very good, it’s a good system of doing things, I went to other meetings and got railroaded so I didn’t like that. With during the Trialogue, I like the way it’s done.” R.35

“I felt ok, fine like. I felt that a lot of people, that you could really sense it in the room that for a lot of people it was very new to talk about it. Like you know, so reluctant and very, very careful … but that it got much livelier towards the end.” R.1

“I was very conscious that people who suffer mental distress need to talk more and so do the people who care for them. Often times professionals have circles where we can talk so I was happy to sit and listen. I think we need to. (sit and listen).” R.23

“I thought it was very humbling to hear a lot of people’s experiences and you know, they were very honest and open.” R.4

“I was excited. My hope was restored in humanity. These people found the courage to come and to tell people what’s going on for them, and there’s more holistic understanding than I thought.” R.29

“I was disheartened and fed up by the things I was learning. A lot of people are giving their power away to the medical model and to doctors – God, we are such a long way from an authentic service user movement.” R.30

“I felt there are people who can make a difference, I feel there’s hope for the mental health system, a lot of people spoke well and they’d been through the system.” R.21

“Okay. There was a lot of stuff that came up … I mean I’m a bit passionate about the word mental, I feel if we avoid using it we’re contributing to stigma but I mean listening to the viewpoints of other people is very helpful because I can see different points of view to it now, do you know what I mean? It all going to a greater understanding of what it means to different people really.” R.11

“I don’t know, it brought me back. I hadn’t considered – emotionally I was fine, I didn’t get agitated, I didn’t get excited, by gorrah I can, I had a golf club meeting last night and there was times I was in. I didn’t do that emotional stuff that I can do in a meeting … there was no stress regarding contributing. You could speak, so from a facilitation point of view – excellent, that’s what you need. I didn’t feel that I couldn’t get in. But there was stuff I was being brought back to think about, there were things people were saying, that some of it was kicking something else off, and I said things that I probably haven’t even thought about for years. Like that thing that I said about St Luke’s, that’s something I’ve often put in my head, but it’s not something I talk about much. So some stuff came out. So emotionally there wasn’t any stress.” R.12

What did people say they learned from others, how would they describe a Trialogue Meeting and would they recommend it?

What people learned?
Respondents felt that the meeting provided a place where people could really learn from each other, learn how to connect with different understandings and people, and that generally everyone wants to be supportive of people. There was a sense that no one constituency is any more committed to this than another.

People discovered that there are so many realities, understandings and different perceptions about mental health, mental health problems and how they are dealt with. Yet also that there are so many similarities between people from different perspectives

You learn about what people were like before illness and how they came out of it and that people with problems are not alone and that others have had similar experiences.
More educational than reading books or writing essays and there is a huge opportunity to learn new knowledge

That there is a need and a willingness to talk about the issues and that just maybe collectively we can do something about them, and to listen to all points of view as being important

“Plenty. That I can help a lot of people with my experience, and they can help me and together we can help other people.” R.17

“That we are all very different people and there is lots of different ways to come at the idea and the concept of mental health. There was lots of different experiences within much but I did see that there was a lot of common experiences in that as well.” R.25

“That everybody has a huge different understanding of mental health and mental illness and what’s needed, and the instinct of carers to control or to care for, and they believe they’re looking at from their view and they believe that they know and people who have self experience are looking at it from their viewpoint and it’s the interchange of the ideas. I learnt a lot.” R.33

“I think I learnt that people are generally very concerned and very willing to do good, to be supportive of others and I really think that there is no constituency in the Trialogue that isn’t as committed to the process as any other. I think we are are all equally committed as each other to making improvements. I really like hearing other people’s point of view, the ones that I haven’t known before, so I can develop my point of view on the issue and I can psychologically comprehend what the meaning of this mental health thing is.” R.38

“Just the people have similar experiences to me that I’m not alone in my views of the service are opinions of other service opinions – and not in my own.” R.14

“I learned a lot more from that than maybe reading books or whatever, or reading books about psychotherapy.” R.15

“I learn from other’s experiences and get to know how they were before and how they come out from this, it’s possible.” R.39

“That there is a willingness to talk about it and a need to talk about it. And that there is fear as well to talk about it.” R.1

“I’ve learned that maybe we can do something about the issues regarding mental health. When you don’t have somewhere to discuss it, you feel powerless.” R.22

“Again I suppose that everyone has their own interpretation of what’s happening and where they are at, you know, their reality, my reality and it’s everybody’s reality. It’s, you know, that everybody is an individual.” R.9

“I suppose again, listening, everybody has their story no matter where they’re from, no matter what viewpoint they’re coming from, there’s something to be learned from everybody and I suppose the importance of listening from all points of view really.” R.36

How would participants describe a Trialogue Meeting

It’s an egalitarian meeting where people voice their views in whatever capacity they are there, with no hierarchy around the circle, where service users, carers and service providers can listen to each other in neutral space.
A very safe open comfortable space to learn a little and add your piece around mental health. A space to go in with an open mind and partake in a non-threatening conversation. The format is good in that it allows for anonymity and the choice in whether you speak or not, which adds to the safety aspect.

It's a group that provides a wider perspective than say a service user or carer group, more than a niche group, a place where sense can be made out of confusion.

It is a great way of involving and empowering communities to understand and deal with mental health issues.

“So the Trialogue meeting brings these groups together in a more egalitarian fashion, it’s more balanced, and families and professionals ... I suppose there’s a bias with the professionals who’ve chosen to come as well as who families and service users who can start more openly discussing the reality of the situation.” R.18

“Interesting, comfortable to talk about the issues of mental health, I found it very comfortable, very safe, a place to learn a little, to maybe add your piece.” R.20

“I would have to explain the word Trialogue because it’s a new word and a different word for me and for anyone that I’ve tried to explain it to. So if I was to describe it, it’s an open meeting in which we discuss some aspect of mental health in a safe environment. And it’s a good opportunity to learn more about mental health because we don’t get many of those opportunities day-to-day” R.25.

“It’s a very comfortable group environment where you can express your feeling towards mental health and learn new ideas in combating stigma and hopefully creating new policies maybe towards the mental health sector” R.31

“A whole load of people with different viewpoints in the same room being civil! Very enjoyable, definitely would come back for more, I just think it’s a very balanced and open way of people getting to talk, it’s grassroots conversational community based, it’s great actually.” R.33

“I do think the Trialogue is the great great thing to be involved in and I really hope it develops and grows and builds a bit of momentum and I would like to see it as a snowball rolling down a hill and hopefully the snowball will get very big and it will envelop the mental health service and then people who need to wake up, in a good way, I don’t mean that in a bad way. I would like to see it going from strength to strength.” R.38

“I think the Trialogue is a really good idea, I think it empowers the community, and I suppose I could use the phrase ‘empower the community’ as a principle and write an essay about but here I actually felt it in practice and that’s the difference, it was experiential” R.40

“Just that they become a regular monthly thing would be really good because a lot can grow and develop from that for all people concerned really and for the community in general, not just people who have mental health issues.” R.13

“I would say it’s an open, honest, frank, non-hierarchical discussion about mental wellbeingness and if you’re going to go, go with an open mind and an open mind and leave your prejudices outside. It’s very worthwhile but you have to invest in it” R.40

“I would say that it’s a way for, it’s a wider perspective than just a service user group or a carer group, it’s more than just a niche group or one of the three strands groups, I think of the wider group and we can learn something from it in that regard.” R.34
“It’s kinda a support group and what I liked about it particularly was that it wasn’t aimed at just one section, it was open to everybody – service users, people who experienced mental health difficulties etc. etc. I thought that was actually great because it meant then that you weren’t been labelled … I also like the fact that you didn’t have to say who you are, where you are coming from, a little bit about yourself; you know, this usual thing you have to go on with it because then you would definitely feel … marked” R.7

“It’s a chance, a space for people, service users, carers and staff to sit down and to listen to each other.” R.30

“It’s like a meeting without barriers, an open forum for everyone to come see, experience, enjoy and learn.” R.24.

**Is it to be recommended?**

Not necessarily as it is not for everyone, particularly those that are only interested in their own perspective

Yes as it provides a great place for generating a shared understanding, particularly for those who do not suffer with mental health problems, it might help them treat you differently.

“No. It’s not for everyone. If it’s for you, you’d be gone there. But you could inform them but you wouldn’t advise them. No, not to everyone, no way [wouldn’t recommend it]. They would probably fuck it up. They might just come just to have a look and then they’d just … here for nothing else is it. They’d be wasting time, and seats, and tea, and biscuits” R.17.

“Absolutely, it definitely it helps with a shared understanding of an issue and there’s no hats in the room – I do like the way that people aren’t introduced at the start … some of the most intimate conversations I’ve had have been on midnight trains with people I don’t know.” R.33

“I would, yes. Especially to people who are not sufferers of mental health problems, because after going through 30 years of family not understanding, and thinking I’m sick and just seeking attention, if people like this … sit in and listen to people who do suffer and who do have problems it might just help them treat you differently.” R.16

“Yeah I’ve been trying to recommend to my mum, mum is a very good person, I don’t know if she would really benefit from it but she’s suffered a lot over it with me so maybe she should get the opportunity to get it off her chest.” R.34

**On becoming a local Trialogue Meeting facilitator**

The first two Trialogue Meetings at each of six sites were moderated by the core project team, usually a project lead and the project co-ordinator. Meetings took place before and afterwards with local facilitators regarding how they were conducted, the suitability of the venue and participant make up etc. Initially the venue booking for most sites were organised by the project coordinator under advice from local facilitators. For some sites the local community facilitators organised the venue, refreshments and signage for each meeting. This was a period of observation and getting immersed in the experience of Trialogue. Prior to the third meeting the first local community facilitator’s development workshop was held in DCU on 20th April.
The purpose of this day was seven fold: to provide support and information sharing; to enhance the leadership capacity of local facilitators; to learn more about the Trialogue Meeting model; to explore the role of facilitation moderation of Trialogue Meetings; exploration of engagement with community stakeholders; usage of the online resource www.trialogue.co, for example, writing and posting blogs following Trialogue Meetings; and Sustainability. All of these areas were not covered, as the Trialogue format adopted for the workshop addressed what was most pressing for the participants. Part of the day was given over to a conversation about the emerging story of Trialogue at each site from the perspective of local facilitators. This was recorded, transcribed and pertinent themes emerged that offer an insight into how Trialogue Meetings were progressing and challenges for the future.

**Challenges for facilitators**

All facilitators remained excited about Trialogue, yet had some trepidation about how they would maintain momentum and develop their own capacity to lead Trialogue Meetings in their communities.

For some there was confusion about their role, i.e. what they actually do as facilitators. Some felt it was organising the meetings, others thought it was more about facilitating the meetings. One point of confusion was the double edged use of ‘facilitator’. As a group we decided to use the more commonly used term ‘moderator’ when it relates to moderation of meetings and ‘facilitator’ when it is about at a local level enabling and leading a core group of people who would be the nucleus of the Trialogue Meetings. This offered some relief to people, particularly those who would prefer not to moderate the meetings. We established that the facilitators are the core nuclear group and that the make up may change as other leaders emerge from the community. This group would ensure that meetings happen and whatever logistics needs to accompany this, e.g. refreshments, emptying bins, advertising meetings, etc.

It may also be the case that facilitators take on the role of moderator, though not necessarily so. We agreed that over the duration of the project that the core team would still play a big role in organisation of meetings, as the facilitators began to take over. We also agreed that for the same duration that one core team member plus one other Trialogue Participant would moderate meetings from the third meeting onwards.

There was much talk about the size of each group, for example at one site 69 people turned up for the first meeting and at another 15. Some people were concerned that the group need to be big to be successful. People were reassured that as long as there is ‘Trialogue’ representation from at least the three main perspectives that it does not matter how big the group is. We have already seen in the last chapter that consistency and Trialogue is key and this occurred across sites throughout the project.

People reported that the word ‘Trialogue’ is alien to some people unless they have been part of the MHTNI or DCU Leadership Programme already and they felt that this posed some difficulty in marketing the meetings. The agreement reached was that we would need to be aware that and clear explanations of what Trialogue and Trialogue Meetings are need always to accompany advertisement, discussions and presentations about it. This would ensure that the idea of and brand ‘Trialogue’ becomes synonymous with the simpler message. This issue is revisited again in Cycle 3.

“It took a while … I had to spend some time with them and that was across the board, anybody I spoke to who heard the word Trialogue who heard the word for the first time … they could understand the word Dialogue and monologue but they had difficulties with Trialogue” R.6

People felt that because of the excitement, diversity and emotion in Trialogue Meetings that they would find it difficult to moderate and were concerned that they did not have sufficient skills or training to be confident they could do it. Partial to these concerns was the worry that ‘things might
get out of hand,' e.g. outbursts, self harm, someone taking over the meeting, etc. Michaela Amering who has been part of the Trialogue movement since the beginning was able to chronicle what has at least happened to date in relation to these two issues. In relation to moderation it is important that the people are not seen to be some specially trained professional moderator, as they are supposed to be part of the Trialogue, with no special status. Moreover, moderation comes from the group itself as a self sustaining conversation with the moderator only there to ensure the agreed ground rules are maintained. Yes some people are naturals and others may need to remember that they are not the ‘chairperson’ and simply the person that keeps the conversation going around. To some extent people’s concerns were alleviated, though they were not all convinced. People commented that the Trialogue Meetings are such a safe space that they are therapeutic in nature and wondered at the likelihood that they might be seen as such. Although people often undergo beneficial transformation in Trialogue it was reiterated that to enter into a purposeful therapeutic dynamic in the group, would compromise the intent and the benefits of the process.

“So it has so many therapeutic effects … so it can be very easy to mistake it for therapy and also you have therapist other group members that might think that they need to understand therapy mechanisms or whatever … but that is what it is exactly not and that’s the richness of it and maybe the shared ownership is an important concept to keep us from this misunderstanding.” R.2

Michaela pointed out that it is very rare that things get out of hand and suggested that if it was to happen anywhere then Trialogue Meetings were a safe place for it to happen. Considering mental health expertise, there is nowhere else that has so much collective expertise on mental health than a Trialogue Meeting. People accepted this and spoke then more about moderation skills to get over dynamics that arise. We talked through the ground rules again and added in another one at the bequest of the group – ‘that everyone should ensure to the best of their ability that they feel personally safe in the meetings’. We also agreed that an interim working set of ground rules and tips for aiding moderator skills would be written up and published on the MHTNI website (Appendix 2).

“As it went on it started to steam roll and when you have 40 people in a room … when it kicks off first maybe 20 minutes nobody wants to say anything … no one wants to kick it for touch to get the ball rolling and then all of sudden by the end of it then you are trying to harness the whole thing, it was going out of control, you know … it’s quite exciting to be honest …” R.8

Several facilitators and the national project co-ordinator expressed some frustration at the amount and diversity of advertising that went into setting up the meetings and wondered at what they perceived as the minimal return. A general agreement was reached that each approach has had some return and does profile the Meetings regardless. People felt that ultimately the best approach was word of mouth and individual invitation, in the hope that once experienced then people would return and pass on the good news. People also felt that the national and regional radio interviews had stimulated participation and we agreed to focus on regional radio interviewing, particularly with local community facilitators.

“Yeah … just the … ideally you want posters the sides of rooms displayed to get people’s attention … that’s what I found now … I was kinda disappointed that there wasn’t a bigger crowd … I felt that myself and [relative] spent the whole week, driving around, three or four hours a day putting these things … got my husband involved … he got his friends in work involved … going around … cause they are delivering to all these health centres and everything and putting in leaflets … photocopying them and I was kinda disappointed really … on the night that the turnout was so small.” R.1

Some of the issues above form part of the thematic analysis of the recorded discussions and although they won’t be repeated below, pertinent quotes from participants have been included.
Emerging themes on the experience of Trialogue Meetings so far

During a recorded discussion using focus group format facilitators were asked to describe their experience of Trialogue meetings so far. There were 17 people in the group including the moderator. Although, sites differed in the extent of separate experiences, an interesting aspect of the discussions was that there was little difference in the experience of people across sites. This mirrors the experience of the previous interviews with participants at the beginning of the process. Although, still early in the process, the similarities across sites offered an argument that if the conditions for Trialogue can be established anywhere then the nature of the experience itself is something that is mutual to all these meetings. In the authors experience of many years this is indeed the case.

Much of the emerging themes are similar to those arising out of the earlier individual interviews. For example, people felt that they were getting a better idea of where people are coming from and that we are not alone. Finding out what is going on for people, what service changes are happening, and developing shared understandings of mental issues was seen as an important outcome of Trialogue. As well as developing joint understandings the Trialogue was seen as an excellent place to explore how it is to see things from another perspective and to be able to own up to not knowing.

“Attaching meaning to the stories very everybody … as Liam said, the whole healing process by telling your story in a safe environment and knowing that you can pass if you want to pass … the fact that you get that opportunity in a place that is safe and non-judgemental is huge.” R.10

“Yeah, my friend really enjoyed it … that night and the following night then, I went down to [hospital] … I brought a service user that is already that’s in the services. She’s never involved before in … well, obviously its only new and she found she was able to express, you know … what she felt that she couldn’t say, in a certain (?) way and at home as well. Listening to other carers as well I found different ways and means of going about things as well … at home … you know where there would be frustrations in communications and that and all … so eh ...” R.4

Again people felt that Trialogue was a safe place where you are happy to talk, which helps overcome stigma, especially for young people. There is a sense that you can say things in Trialogue that you can’t in other circumstances, partly because it is such a comfortable relaxed open environment.

“Yeah, and as well for young people … ‘cos with young people as well I think there is that little bit more of a stigma as well … you would be afraid to kinda say … oh … I am bit depressed or low or whatever … at least with the Trialogue there you can …” R.4

“I suppose my experience of it … We only had two meetings and I found it great … you know, it was very comfortable kinda relaxing environment to it … it was really open … I felt there was a lot of respect between each of the members of the group and it was really interesting to hear different people’s perspectives … like just their opinions of mental health and how we respond to mental health and people’s idea of what mental health is.” R.5

“People seem to be, from my perspective, more honest about their feelings. They engage with each other very well … Its a very calm and safe space … I always leave with a lovely feeling … a happy feeling I suppose even though sometimes what you hear isn’t … how would I say … wouldn’t be happy or nice maybe, but honest.” R.6

An interesting thing for some people was that once they had engaged in conversations with people in Trialogue, from different perspectives and constituencies that then outside of Trialogue pre-existing relationships and conversations seem to improve. As if people have now seen each other in a different light.
“And one thing I noticed as well, there are a few people I would have known, maybe not that well and friendships have really strengthened between us and we feel we can be more honest with each other because we actually spent time in the space and outside of the Trialogue there’s contact.” R.6

Some discussion arose about how the group can take ownership away from facilitators, as it has its own energy that promotes shared ownership.

“But I think there is also a really interesting dynamic around ownership of the Trialogues because when you organise the Trialogues and you book the venue and actually you are just facilitating the Trialogue owning itself and it can choose ... it can go a different way from your stated topic, for example ... and you can bring it back but the Trialogue has its own energy that decides where it wants to go ...” R.7

Although, alluded to above there was still a general anxiety about potential sabotage and emotional crisis arising within Trialogue. People worried about some participants having their own agendas and sabotaging the Trialogue itself. This conversation came back to the role of the group and the collective energy and ownership that should be able to absorb and manage these potential circumstances. In relation to someone possibly getting upset and leaving the meeting the facilitator explained that this was one of the reasons why the MHTNI encouraged two moderators. It provides an opportunity for one to follow a person out and provide reassurance if necessary. Relating to this possibility some professionals voiced concern at the tension between their normal duty of care, e.g. if they were dealing with someone in crisis outside of Trialogue and if the same person went into crisis in Trialogue. No definitive resolution to that tension emerged and it became more about the ability to discuss it in Trialogue and consider solutions for it and indeed other questions.

“I think it’s not solution orientated as it has been said but if you look for a solution it would be just the right place because ...” R.2 [continue next]

“It does ... I have seen it ... as there is so much wisdom and experience in this group ...” R.7

“I don’t want to go too far into that but I think if you are in that room, you have to be in that room for the very reasons that the Trialogue is about. you can’t just be there. you know ... in terms of showing your face ... and be there one week and be gone the next ... it really has to have meaning ... because there is such a lot at stake and for everybody who makes the effort to go there, that genuinely wants to be there.” R.11

“The main reason for having a second facilitator [moderator] watches the safety of the space in that room so if somebody does leave... Just get up quietly and walk out after them ... you don’t have to make contact ... it’s just a matter of being around the area the person is in ... they will come to you or if you think you need to go to them. But it’s the importance of having a second person there.” R.9

One issue that arose was that sometimes it was difficult to get a balanced mix of service users, carers and service providers, particularly for two sites who felt that there was insufficient involvement of service providers. One stream of conversation focused on the possibility that the providers might be feeling got at by some of the topics discussed and subsequently were unwilling to engage. On the other hand people spoke about how it was particularly good to have the providers there, as they were in a position to let people know what developments were happening in services. There was recognition that it was difficult for professional to ‘clock off’ and then come to face the other Trialogue participants, because ultimately they are still seen as providers who should have the answers.

“I think there was a lot of people not understanding that you could just go, not talk and just be there give yourself pass (?) and I think as service providers, people feel a lot of the time, that they are supposed to come up with the answers.” R.10
“There was a service provider who came, a lady who I had never meet before and in actual fact, she doesn’t work in St James hospital, but she is a service provider in her area were we have the Trialogue meeting and she said to me afterwards – this is fantastic – you know, I am working in this area and there is a lot of stuff here tonight that wouldn’t have occurred to me in my professional role, I’m really seeing things differently she said … I’ve really learned a lot tonight.” R.16

This evolved into a general discussion about one of the aspirations of Trialogue where everyone can ‘leave their hats’ at the door. There was some consensus that this may be an aspiration but that in reality it is difficult to do because people’s constituency role, e.g. professional carer is often a part of the whole person. At best people felt that the ‘hat at the door’ was more about the normal interrelations, associated roles, perceived power and expertise that occur in normal daily interactions.

There was some discussion about the reluctance of carers at times to speak out in Trialogue and that they were still testing the space to see if they felt safe speaking out. This ties in with some points made that several people expressed themselves angrily in meetings and perhaps this may initially put carers off. We agreed that conflict was necessary and inevitable and Trialogue was a safe place to resolve some of this conflict.

“There’s richness in that but I think there is a risk as well I think. I think everybody is taking a chance … putting themselves out a limb in a way, to leave their hats at the door, maybe they are hard hats and they protect us, sometimes … it’s a challenge isn’t, with facilitation, to make it safe to relate to …” R.7

Summary of Pertinent Findings

The ideas and knowledge around mental health and the experience of Trialogue from initial individual interviews was similar across all sites. After two months when local facilitators relayed their experiences of Trialogue again it was similar across all sites, offering some suggestion that regardless of local infrastructure around mental health that the experience in Trialogue itself is something that is mirrored everywhere. Equally, even where there were contentious issues at some sites the overwhelming experience in all Trialogue meetings was positive.

It’s is interesting that even though individual interviewees and later facilitators generally took a negative attitude to a singular medical view of mental health problems, the language that pervaded conversations was surprisingly absent of medical jargon, despite being centred around issues that might in other arenas be dominated by medical jargon. It is not clear why this is the case, perhaps partially because topics were introduced in a neutral language, or that when people from different perspectives communicate they have to forge a common language?

A clear message evolves from interviewees that the mental health system fails to respond to the needs of carers and service users. One of the reasons identified was because the mental health system does not relate to people’s emotional, social and psychological needs and only sees people through one narrow lens. One of the voiced benefits of Trialogue was the opening of several lenses to view, understand and respond to people’s mental health issues.

Stigma and discrimination is pervasive in society and mental health services according to respondents and they see this as a major hurdle in overcoming prejudice and for people to be perceived as normal alongside others in society. The Trialogue was seen as a useful process to try and reduce and overcome stigma.

Education around mental health, healthy lifestyles and emotional wellbeing in schools, sports clubs and other community groups was seen as important for communities to be able to respond to mental health issues and promote good mental health in communities.
Trialogue participation is an exciting and emotional experience where people find trust, hope, acceptance and a safe space to generate more understanding and offer their own perceptions in a respectful presence, where there is the possibility to speak openly as an equal without fear or repercussions.

Trialogue is a place of learning; beyond books or training that brings experience to life and provides enhanced knowledge and understanding for all participants.

Trialogue can be transformatory in that it offers alternative futures, is empowering and people beginning to think differently than they did before about mental health and their own experience.

Although in principle setting up and holding Trialogue Meetings are simple, there is trepidation, anxiety and remaining perceived challenges associated with establishing them and ensuring they are safe, positive and sustainable.

Trialogue has the potential to change how people engage with each other outside of meetings, which would be different than if they had not experienced Trialogue.
Chapter 6 – Cycle 2: Communities Embracing Trialogue Meetings

The Mental Health Trialogue Network Ireland began to move from a series of established facilitated Trialogue Meeting sites around Ireland to a self-sustaining national community development project after about five months. There was no cut off period and each site took ownership at its own pace. Parallel to the existing Trialogue Meetings other snowball effects were taking place directly and indirectly connected to the MHTNI. This was a period of growth and consolidation of the Network and community groups. Over time the local facilitator groups chopped and changed a bit, though usually at least two original members remained part of the core team. These teams began to take on responsibility for e-lists, advertising, organising venues and moderating meetings. The national coordinator was still available as were project leads, and they still participated in all Trialogue Meetings sometimes moderating and other times just participating.

From a Facilitated Process to Community Ownership

A second local facilitator development day was held on 20th July 2011 with some original and some new local community Trialogue facilitators, eleven in total. West Cork did not participate in this day. Since the initial development of the MHTNI West Cork had continued to hold once off Trialogue Meetings in towns around the area, though over time some towns were revisited. They still continued to collect demographic information, though did not engage with the wider evaluative process, which would have been difficult because of the different approach to Trialogue taken.

The main purpose of this day was to establish from participants’ experience where each site was in relation to ownership, sustainability and required on going support from the core team. In addition it was to provide another support day and exploration of any challenges and solutions that collectively the group could accomplish. As with the previous development day an initial discussion about the experience of Trialogue to date and challenges along the way was recorded, transcribed and emerging themes are reported below. The discussion itself set the agenda for the rest of the day, as the experiences themselves identified what needed to be addressed. As before there were many similarities between sites, though now there were also some differences and where these arise they are discussed under relevant themes.

Ownership by local Trialogue groups

Participants eagerly spoke about how local facilitators are taking over from core team, though a few sites were still reluctant to take over full ownership yet. Some felt that once this transition took place that the the meetings would loosen up even more. For example, for the duration of the project period there was a requirement to follow a sequence of topics and some felt that having more choice would enhance local buy in and be more context specific. As part of this thread of conversation people spoke about commitment of a core group of people at each site being necessary.

"From the point of view of facilitating groups, I feel it’s important that the facilitator has some experience of facilitation, of watching the flow of the group. People aren’t offering very easily and I can see why people are sticking to the topic." R.10
“There’s trust, intimacy and we’re building up relationships. Identity is only a level of human being, a superficial level of ‘Hi, you are this’. We’re actually community with awareness in the Trialogue group, so I find myself stepping beyond that and finding a mutuality, a universality. The need to take ownership of the Trialogue group really came home to me so I’m going to take some personal responsibility now. I’m excited by the Trialogue, it’s a hopeful space.” R.8

“I feel like the ownership of the Trialogue came from outside, from DCU, so I’m not exactly sure about my role at the moment. We seem to be in a state of forming, it seems very formal and like the trust isn’t there yet, like we’re not moving on.” R.10

“Listening to Mayo and Galway (the experiences of Trialogue meetings there) made me feel like we weren’t making an effort if truth be told. I thought participants from the last (DCU Leadership) course might do it but it made me realise that more of an effort could be put into it, maybe I could meet up with the others. I’m glad the next Trialogue has to be facilitated by local people, not by DCU facilitators. Even though it’s a small group, it’s the quality that counts.” R.12

**Trialogue Meeting venues**

Generally participants were happy with the venues and felt that they were neutral and suitably placed for ease of access. However there were a few concerns over one or two venues. In Dublin South Central the venue was very cosy and inviting. However, it was difficult to find and off the beaten track in an area that people were uncomfortable walking through. This group decided to change venue once the project time was up, to a more accessible and public venue. There were some concerns that the venue in Donegal was not sufficiently neutral because it was owned by an NGO service provider and access was not always guaranteed. Although as a venue it was very accessible and suitable for meetings.

Another issue raised was in relation to payment for venues. During the project lifespan all except one venue had a charge for the facility and this was covered by the project funding. An agreement was reached that people would examine ways of paying for a venue, for example, charge £2 each, negotiation of flexible rates with venues and seeking a free venue. It was felt that once the ‘project name’ was lifted from each local Trialogue Meeting that it would be easier to negotiate cheaper or free venues because it would be seen as purely a local community project.

“I have to say first, this has been a very positive experience and we have been fortunate with the location, in the sense that we don’t have to pay for it and hopefully we might get that for another while” R.5

“Yeah, but it just has a lovely energy in it, its calm, its nurturing and its welcoming ... It’s spacious but it’s also intimate and it’s in a part of Dublin that maybe you wouldn’t want to walk around late at night when it’s dark. When I walk out of that building, just the location gives me a sense of community.” R.8

**Trialogue is established**

As far as participants were concerned Trialogue is established in their communities, even in two that have been struggling somewhat with keeping the energy going. Previously people may have spoken about ‘coming along to the meeting’ or being able to ‘tell their story’. Whereas now people are more likely to say ‘I was at the Trialogue’ or ‘what we do in Trialogue’. The idea, the experience seems to be part of the fabric of what people talk about when they refer to the meetings.
“My participation has evolved, I remember one night I had started off, I spoke and then I stopped and I just waited and I was amazed then ... nobody came in, there was that space and I just stopped and I experienced that ... I didn’t have to keep talking and I could stop and I didn’t know what I was going to say next and that was brilliant. That was probably one of the most striking things that I could stop and the space would still be there for me and I could NOT know what I was going to say. I think if I could drop more into that space of not knowing, it would be more interesting and maybe more transformative as well.” R.7

“I felt as well that there were professionals there and whatever and from my point of view to see people like that there ... I find that good as well and hearing different perspectives. It is actually changing my views, although I never really had any problems with nurses, it was doctors I had problems with ... (laughter ...) but it is, it is a learning thing for me as well.” R.6

“I’ve left the Trialogue feeling more energised and connected. It was the first space that was a kind of coming out for me, a very good space for me. I was surprised that I spoke that much about it (my experience of the mental health services). Also I’d have feelings of compassion when I’d hear others’ stories, I’d feel touched and appreciative of them in someone, a feeling of compassion. I would love to see this in great depth, to understand what makes this so nourishing.” R.7

“It’s the freedom, the not knowing, the democracy of it, the potential of it. We don’t know what’s going to be said or what’s going to happen. When we meet in the Trialogue group, I’ve forgotten that we’ve hats – it’s like really good, positive, human contact.” R.8

**Conversation and activity around the Trialogue Meetings**

Part of the Trialogue Meeting format is to have some time before and after the meetings for mingling and refreshments. There was an agreement that for people who don’t speak out in Trialogue that they often do approach people afterwards to discuss topics or their own experience.

On one site participants felt that the Trialogue has impacted on conversations and interactions outside of the meetings, in other forums and in the work space generally.

“So some of the relatives say they have got to take responsibility but they also don’t want to take responsibility as well ... it’s a complicated role and I suppose that’s what they are saying ... at the ends of the meetings they are more or less saying ... more outside of the meeting rather than during the meetings.” R.2

“One of the spin offs has been that some people have joined other groups, such as groups for relatives or for service users. Other spin offs include a series of workshops that we did between service users, carers and relatives. Another spin off I’ve witnessed has been the conversations of people who’ve attended, I’ve seen quite intense conversations lead onto it- even happened during work time.” R.2

**The buy in of service providers**

The participation of service providers is still a contentious issue, as much for themselves as for other participants. There is expressed concern at the buy in from service providers, particularly at two sites, though it is a general issue.

On the other hand for the professionals who have been participating there has been some shifting of what they may have previously called a defensive position to one of trying to listen and learn from what they are hearing in Trialogue.
“I’m disappointed with the lack of professional people in the group and it’s not for the want of trying, getting the professional people into the group. There’s no medics, they’re all signing up for vision for change, pathways and projects but where are they?” R.5

“I suppose a lot the staff providers have been on this … on the DCU project or involved in it in some way and they stopped defending the services, I suppose that is what has happened as well, so they are no longer defending what’s there. That has been a change, so people are listening more, I suppose that’s a good thing.” R.2

“All I can say, is that my thinking is challenged at every meeting and I do think it’s probably a harder space for the service providers to speak than anyone else in the room because you do have a natural tendency to defend your service or defend what you do. But on the other hand, you have to try and let the real experience in the room, which is the people who have experienced the service, try and take on board what they are saying and that’s the challenge for me personally” R.5

**Professional development and education**

Several conversations have alluded to both the benefits of Trialogue for professional development, particularly of service providers. The Trialogue Meetings were also frequently been referred to as a place of learning and education.

“Oh I have saying to the Doctor each time, the psychiatrist and all the disciplines, look you could use this as our CPD and some student nurses have come to it alright … .Sorry, continuous professional development and saying to them, look this is a great opportunity for you to get the service user perspective and staff perspective and relative perspective and your training … it’s just a real life experience.” R.2

“Yes it has … [an educational component]. We have had parents coming to the Trialogue who think there their children may have mental health difficulties but don’t know where to start and actually come to the Trialogue just to try and learn about mental health and I think that has been quite beneficial and people sort of … you will see people calling people aside at the end of the night that has spoken and sorta asking them … I think the self-help is something I see going on a certain amount and people with enquiring minds coming, finding out and maybe parking the whole situation for the moment but at least they are getting a forum to explore what is going on, either in their own head or a members head within the family and its sorta of an education forum.” R.5

“The DCU (Leadership) course keeps you very grounded and I think health professionals need to be kept group. I think service professionals, every one of them, have fantastic defence mechanisms and putting people into the room together, I think that’s where it’s at. It would be great to see the royal college of psychiatrists require the students to come to a Trialogue, to better understand the people they work with”. R.5

**New faces & continued participation**

Some people expressed concern about the people who came to a Trialogue Meeting and did not come back and wondered why. Others were concerned that sometimes it is the same faces all the time. Generally though, on most sites they always had a few new faces and relished the newcomers excitement and input.

“I’d recognise a lot of the faces through the different services and what not but I think it’s great to get people in that are just, completely new, faces that I wouldn’t recognise. Obviously just to keep the group ticking over, it’s good to get new ideas and new impetus you know and that sort of thing.” R.3
"I feel that we are probably losing some of the carers but I’m not sure why. I am delighted and sort of enriched every time I see new faces and I am sort of saying, why did they pull out, they were very good sort of people, that would be going through my head, I would be saying, especially we would have people that was vocal and seemed really connected with the whole process and you are sorta saying, why did we lose them, that keeps going through my head. And yet, you are sorta refreshed by the fact that there is a couple of new people there that brings a whole new impetus to the meeting.” R.5

Sustainability concerns
Not all groups were confident about sustainability once the core project team stood back. Although, tentatively most people were looking forward to the DCU core team withdrawing there were still some concerns about this. Of particular concern was how to keep up the momentum, get the community engaged and improve how the message gets out to people. Despite these concerns people still felt Trialogue Meetings would continue in their communities.

“We are getting some in, but we are not getting … you know … we have good crowds from … we have average of between 35 and 40, no more than Mayo. And the worst night would have been 25ish and we have had a great representation of service users and service providers and carers.” R.5

“Our response is not great; there is no sense of community, that’s what I put it down to. We haven’t got a good response and I don’t know why; posters everywhere, you name it and we put them. It’s very disheartening to go round and find that they are not there even … used to be back involved in the services and to find that there is not even a poster up in the unit in [named area] I found very disheartening and very annoying and I just feel that … our mental health services aren’t engaged in this and they are paying lip service to it.” R.9

“Good work you know [named person] who organises a group people to come together every month before the Trialogue happens. I think we have been publicising it as much as we possibly could, just to get people … to let people know it’s out there first of all and to allow everybody from all spheres across the community to come in.” R.3

Roles and responsibilities
There was a lot of discussion around how meetings would be organised and the process continued once the core team withdrew from this role. The group agreed that there needs to be a small core group representative of Trialogue who would take on and distribute this role between them. For example, one person would take responsibility for updating contact lists and getting advertisement out; another for ensuring venue was ready and refreshments organised; and another for keeping track of topics from one meeting to the next. This group would not necessarily moderate meetings, though would ask for volunteers to write a blog about each meeting to be shared on the MHTNI website. Rather than having to meet regularly people felt that this group could meet up each month a half hour before the Trialogue Meeting to touch base.

Eureka moments: what Trialogue is about – the experience continued
Since the facilitator development day in April people have shifted quite a lot in their understanding and level of engagement with Trialogue. At that time they were trying to get the meetings going and had anxieties, concerns, along with curiosity about how meetings would be. Where before they wondered at what seemed to be a very positive experience in a safe environment, the conversation on this day was more about knowing what happens in Trialogue, celebrating it and wanting to hold onto it.
There is more of an understanding from the last development day when people felt Trialogue affected relationships outside and that the experience was empowering. They argue that Trialogue has an extra enabling effect on people who feel a sense of release and freedom because it is okay to give voice to their emotions and stories. There was more of a belief in the learning and transformation that occurs in Trialogue.

“And then I was aware in my own sharing and I knew there was nurses there and stuff like that but I felt the fact that there were nurses there that it was good really that ... I found it good that there were professionals there, that it added something to it rather than just a group of people talking among ourselves in a sense. That there were people and they were interested enough to listen to people’s experiences.” R.6

“I found it very nourishing. Generally, at the end I would feel more connected and more expanded, that I had connected in some way with people and I like that because I often take a withdrawn position. And I suppose, it was the first forum I’ve found to vent you might say, even rant against the medical profession and what might be called abuse. And I’ve never spoken about it in a group before.” R.7

“And for me the Trialogue is kinda, it’s like a conversation that I have been looking to have for years, didn’t know I was waiting to have this conversation and suddenly I found it. So I get really excited about going to the Trialogue and I get very excited within the Trialogue and sometimes I might get over-excited and I crash into people and interrupt them and perhaps I shouldn’t.” R.8

“I don’t look at myself so much as a professional therapist, I’m more and more seeing myself as another human being with other human beings ... what can I do to communicate with them. And I learned so much from other people ... just be open to that ... that’s something I think Male you were saying that really resonates with me, entering the uncertainty and seeing what happens.” R.8

“Personally I spoke a few times and I got a bit wound up – I agree with Male about he found it democratic, open, liberating and I find that at the Trialogue a number of things get discussed, I get energises and I’ve about 4 things I want to say and then I lose the run of myself and I wonder have I said too much. I don’t think there’s anything negative about Trialogue, I think it needs to dispel myths about mental health and to get people out of their shell.” R.8

“What I’ve learnt from the Trialogue is that I used to feel that I had to have the answers and the solutions but the whole idea of the Trialogue is about sharing, not having the answers, about telling it as it is.” R.5

Mental Health Trialogue Network Process Related Activities

Interrelationship DCU mental health leadership programme

The MHTNI was in part a process outcome of the leadership programme and the intention was to integrate the strengths of both processes to build community capacity whilst improving services and integrating a participative change model into services. What became clear during cycle 1 and 2 of this process was the constant close symbiotic relationship between the two. The programme has been frequently referred to as providing a grounding for open dialogue, participatory action and being able to engage safely with open discussion about differing perceptions. Although, it is not possible within this evaluation to assess to what extent the learning and preparation for open dialogue on the leadership programme has affected the success of Trialogue, it has been clearly relevant. It was anticipated that once people engage in the process of Trialogue that they will become comfortable with diversity and develop open dialogue skills, which has been demonstrated so far in the process. It would seem however, that we cannot underestimate the possible impact that having a core group
of leadership graduates at each site has had on the speed by which Trialogue has become established at most of the participating sites. The team may have to consider this where Trialogue Meetings are being established on sites not involved with the leadership programme and be careful not to assume immediate success.

**Profiling the process at external events**

As Trialogue Meetings are new in the Irish context the core team felt it was crucial to profile activities outside of participating sites. At local level facilitators frequently gave presentations to service providers and other organisations on the merits of Trialogue. From the outset of the project the core team were also involved in presenting the MHTNI process:

This included research events where the process itself as a participatory methodology was presented and discussed and events where the relevance of Trialogue Meetings were explored. Examples include:

1. **Action Research Colloquium, June 9th & 10th 2011. Waterford Institute of Technology, Ireland**
3. **GENIO Trust Knowledge Exchange event, 2011, Mullingar**

In addition the on going Website and Facebook usage reported in chapter 4 is indicative of a wider profile outside of participating sites and Ireland itself.

**Recognising and utilising the processes for community and organisational development**

This project was successfully funded in part because of the potential to build community capacity in understanding and responding to the challenges associated with mental health problems. For the project team two crucial underpinning processes were ‘participatory action’ and ‘open dialogue communication’. These are transferable processes to any form of change and improvement. Two particular milestones for the MHTNI provided excellent examples of how this is the case.

1. **In September 2011 the MHTNI was received the DCU Presidents award for Civic Engagement and Community Impact.**
2. **In June 2011 the MHNTI were invited to co-host the ‘Open Dialogue Mental Health Conference’ with Bamford [Northern Ireland Mental Health Policy Document] Monitoring Group in Northern Ireland. Trialogue was introduced and utilised as part of the days proceedings in order to provide a tripartite perspective on how mental health policy would continue to be monitored in Northern Ireland.**

**Trialogue Meetings outside of participating sites**

During cycle 1 and 2 there was a lot of interest expressed by other communities in establishing Trialogue Meetings. Time was an issue for the core team and local facilitators and only a few approaches translated into actual Trialogue Meetings. These include North Kerry, and Balinasloe, Galway.

**Decisions Emerging for Mental Health Trialogue Network Ireland**

Although there has been an on going dialogue between local facilitators and the core project team, at Trialogue Meetings, by phone and email, the facilitator development day enabled some specific decisions to be made in relation to the continued process.
People agreed to establish a core team in each community to ensure Trialogue Meetings continue.

After some discussion, people decided that they would hold an August Meeting in the absence of any DCU input, to use it as a test case for how things will go after the project ends. Then the September meeting was planned to be a shared one with the core team to reflect on how far each site has come and plans to continue.

For two sites that felt they were struggling with maintaining momentum the facilitators agreed that they would try and increase momentum and get more buy in from other stakeholders.

All sites agreed that the final cut off point for community ownership need to be now. So for example, no more meetings would be arranged or moderated by core team.

Each local core team would look into cheaper or free venues for meetings after September that still fitted the neutral criteria.

Apart from the existing Trialogue Meeting sites there were other activities that had been occurring or talked about. The core team had the opportunity to focus more on these as their local site roles were diminishing. So a decision was made to profile the MHTNI more in Ireland and also elsewhere.

**Summary of Pertinent Findings**

Towards the end of this cycle facilitators were eager to take community ownership of Trialogue Meetings and have begun to form a core facilitation group at each site.

The project had provided a budget to facilitate Trialogue Meetings, e.g. venue fees and refreshments and a challenge arose for groups about how to fund future Meetings.

There has been a major shift in how participants view and engage with Trialogue. As people become accustomed to Trialogue they are developing their open communication skills, which subsequently have enabled a deeper level of experiential engagement with the Trialogue process. The transformatory nature of Trialogue Meetings is more obvious than in cycle 1.

The symbiotic relationship between MHTNI and the Leadership programme seems to be important, particularly to those local facilitators who completed it.

There is an evolving national and international profile of MHTNI and the work this network is involved with.
Chapter 7 – Cycle 3: How has participation in the Mental Health Trialogue Network Influenced People and Communities

The last Trialogue Meetings that were formally part of the MHTNI project took place at each site in September 2011 and at this juncture in cycle 3 an evaluation of the project to date was undertaken. By prior agreement with local facilitators and Trialogue participants the Trialogue Meetings would be a reflective discussion about how Trialogue Meetings have emerged in communities and how they might continue. By agreement notes were taken of the conversation streams within the discussions and later underwent thematic analysis to draw out themes from each discussion.

Establishment and Sustainability of Trialogue Meetings

As of the middle of September 2011 the following account is a summary of where each of the six Trialogue sites see Trialogue being established and sustained in their communities, as reflected upon by Trialogue Meeting participants. Participants were asked to reflect on five aspects of the Trialogue experience:

- Why they came to Trialogue?
- Why they returned to Trialogue?
- If they found the Trialogue useful?
- How they think Trialogue can be sustained in their community?
- What specific action needed to be taken to keep Trialogue going in their community?

Because quotations were recorded with a notepad and no identifying number was allocated at the time it is not possible to know who each quote is attributed to and consequently how much of a spread across conversations they represent.

The Tallaght experience

People came to the Trialogue Meetings for a number of reasons. Some for support; to represent agency; on recommendation; because they had time on their hands; curiosity; to hear relatives better; to have a cup of tea and dispel myths about mental health. Some had experienced Trialogue on the DCU leadership programme and others heard that there was no hierarchy and no one had power over anyone else.

“I have a lot of time on my hands. I learnt a lot from others. Initially it was curiosity. It’s a good forum here to gain perspective.”

“I came after experiencing the Trialogue in DCU, I can hear my [relative] better here. It’s given me hope for the future because I don’t have hope for the mental health services here.”

“I come because we get a cup of tea and it’s a grand room, there’s giving and taking and we get to dispel myths about mental health and to nail the truth.”

“Normally hierarchies make it difficult to be heard. There is no hierarchy here, nobody is the boss here, or got any power over anyone else.”
People keep coming back because they enjoy the experience; become motivated; feel there is hope; and because it helps to dispel fear. The make up of the group is great and although you hear so many perspectives and people’s experiences, no one is trying to impose their views on anyone else. People are sharing; learning new things; increasing their knowledge and the group coming together is powerful. It is a therapeutic experience.

“*So many of the ways that people explained mental health and mental ill-health in that first Trialogue really helped me. You get gems. The motivation if I am to be honest is because it is running here*”

“*Knowledge is power. I was always quite fearful before, I am not quite so fearful as I was before. I am going to dump the word recovery and start using the word discovery.*”

“The make up of the group is great – people who have experienced mental health difficulties, people who work in mental health, and people who care for or who are in relationship with people who experience mental health difficulties. It’s a discussion, we’re just sharing, and no-one’s trying to impose their view on anyone else. it’s educational.”

“I found it very therapeutic, it’s very difficult to make sense of it, the existing mental health services don’t help you make sense of it all. Pills do the job of the old asylum building, they keep you locked up. The fact that I could offer my opinion here without fear of being threatened was very important to me. And in my experience I will always lose with the psychiatrist, because they have the power. I come here and between us we can make sense of it, you can’t put a price on that kind of therapy, it’s really invaluable.”

When asked how useful the Trialogue was people started off with reiterating some of what was said about the experience and quickly progressed to a conversation about how it needs to continue.

“There is a major outcome for the three constituencies – service users, service providers and family members. This is not a group just for service users. This is a group for creating understanding between these three constituencies, so they can bounce ideas off each other, I can bounce an idea of my opposite. Service users are preaching to the converted, saying something however to a service provider is very different. We can only ever have a partial understanding otherwise. The three perspectives give us a fullness of understanding”

People were motivated by the fact that the August Trialogue in the absence of any DCU representation went very well. They discussed way of setting topics in advance and that people could be targeted particularly because they may have an interest in certain topics. People felt that once people are in the door it is not difficult to keep them because of the positive experience. They still have some concerns at getting new members. One suggestion was that the Trialogue could be marketed as a professional development experience for service providers. And if carers could experience Trialogue as part of their regular carer meetings it might encourage them to come to the Trialogue Meetings. It was expressed as a concern that carers had difficulty coming to Trialogue because of lack of time and not wanting to discuss private matters in public. Yet, it was also noted that once they do come along they have a positive experience.

“The August trial strangely enough did work. Eight people came. It felt like people took more part, and it was chaired very well by [named person]”

On a discussion of marketing materials, it was pointed out that the DCU generic flyers were good and the template would be adopted by the Tallaght Trialogue in the future. Other explanatory and promotional material developed as part of MHTNI and on the Website was also found to be insightful and planned to be used again.
It was agreed that the Trialogue Meetings would continue in the same venue for three months and then progress would be reviewed. Each month one person would offer to write the blog for the meeting and send it into the core team to post on the Trialogue website.

**The Dublin South Central experience**

The neutrality of the venue out in the community was an attraction to Trialogue, as was curiosity about what it might turn into. Without prompting the group started talking about why they keep coming and the benefits it brings. People described the space as a very creative place where it is easy to share, to be open, direct and be part of a group.

The democracy and freedom of Trialogue was applauded the point being made that no matter how we speak to ‘person centredness’ in therapy or services there is always a power imbalance, except in Trialogue. Also how when people from different perspectives are speaking it gives depth and life to those experiences and conversations occur here that do not between the same colleagues in other spaces.

“I very much liked the idea of a meeting in a neutral venue talking about something that impacts on all of our lives, mental health. I see it as an opportunity in itself, it is up to us to take it or not. I don’t know what the outcome will be – change, support, education, to make friends”.

“I have really enjoyed sharing, I love sharing, I really enjoyed listening as well and being on service providers. I’m a mom, a carer, a family member. I’ve always learned some little thing to ponder on, I have never wasted my time, time passes quickly and I am always surprised when it is time to finish. I would love to see it grow. I would love to get the word out there because it is for the ordinary Joe soap, so many people would enjoy it, we are all touched by mental health. And there is no pressure to participate if you don’t want to, if you just want to listen.”

“For me I feel this is something that will grow so I’m happy to keep coming back because I’m prepared to give it the time to flourish.”

“It’s a brilliant thing, it takes the fear out of it the fact that you don’t have to say anything if you don’t want to.”

“I like to come and I love the freedom and the democracy of it and when clients or service users are carers are talking about their experience of it it gives it depth and colour and brings it to life and now I get it. I could read about it in a book but it would be nowhere near the same.”

“Here I can play the role of Democrat, libertarian, revolutionary, and open and honest endeavour. This is a place where a mask can come off.”

“Even to listen to colleagues, that we don’t normally have the opportunity or the time to have these conversations with, is so valuable, to meet these people in a different environment.”

There was a clear message that the Trialogue had to and would continue because it was felt that their impact was too important to let go.

“I want to belong to a community. We co-create as vibrant beings, like notes on a piano.”

“It is just a matter of time. The fact that they are regular and that people know they are here is useful. The boundaries of confidentiality keep it safe and handing it back to the community as you are doing now is very important”.

54
People agreed that there needs to be a stronger service user presence behind the Trialogue and that it does not just come from one or two constituency bases. They agreed to form a core co-ordination team representing Trialogue constituencies. People reiterated the pleasure of Trialogue in existing venue, though agreed that it was too far off the beaten track and difficult to find. One person is to explore the possibility of another venue in a more accessible central area that is already used frequently by community groups.

The Trialogue is to continue in a new venue, flyers will be updated and a monthly blog posted on the Website.

The Mayo experience
People came to Trialogue meetings to meet new and different people, as they were more comfortable speaking here than in other meetings. It’s a place where people come to share ideas and perhaps turn talk to change. People welcome hearing all sides and different angles to get away from secrecy associated with mental health. There was a sense that Trialogues would keep change in motion. People felt that the conversation was a way of increasing learning, help to overcome stigma and bring about common understandings. It is a way of slowly trying to change cultures and bring about positive change. The Meetings are seen as a place that might generate action outside as a result of Trialogue conversations.

“The more you have this kind of conversation, the less stigma, the more understanding of all the different people’s stigma. What was a fear of mental health reduced fear) Trialogue creates a collective awareness that takes down stigma and provides a joined up understanding”

“The Trialogue is a bit like below the iceberg, below the surface, the system will continue to be there, addresses ways of attitudes, thinking, of culture”

“These meetings are productive in terms of generating ideas that might lead to action and change”

The core team is already well established in Mayo and they have decided to continue with meetings, in another venue as the present one is too costly.

The Galway experience
People came to hear about what is going on, for information, to hear about people’s experience of mental health, and out of curiosity having seen it advertised. People continued to participate because they found it interesting, liberating, because there is no requirement to come up with answers.

Others spoke about the wealth of experience and learning in the room, where people feel safe to speak their mind, where service providers come because they are interested and they feel that they can share the learning in Trialogue with other colleagues. It helps people feel confident and comfortable talking about their experiences both in and outside of Trialogue. It helps to overcome fear and get back power. There was also a sense expressed that in Trialogue people can be humble, which results in an empowering experience.

“I facilitated the last meeting, I never had done anything like that before, I surprised myself really. I got quite a lot out of facilitating, to allow others to express themselves”

“I like it because there’s no action or answers needed in the Trialogue. In other forums, you always have do things, to take action, but here there’s nothing to do except to share and engage in reflective listening.”
“As a nurse, there is only so much expertise you can get from lectures and textbooks – you can’t get a textbook with this collective expertise – one of the benefits is that I’ve learnt more about how to be a good nurse. This is a place where there’s a good mix of knowledge.”

“As a professional, there’s a certain amount of information going out there now to other colleagues as a result of the Trialogue sharing. You are impacting on other colleagues, even if they’re not here.”

“Maybe I’m not unusual in this but with hindsight I realize that I was a bit apprehensive of what could happen in Trialogue as I had never any contact with the adult mental health services. I realize now that this fear was really because of my ignorance, and hearing so many stories from so many people about their experience of mental health has taken the fear out of it for me and so a result of going to Trialogues I feel very comfortable now talking about mental health and I’ve a much better idea of what the issues are with regards to mental health services in Ireland.”

“I was a bit fearful coming too but I really enjoyed it. For me it’s some kind of community. Generally I feel better after the Trialogue. Here’s a place where we all have our own power, whereas in (the documentary) Behind the Walls, there was power being imposed and abused.”

“Illness is not just an individual thing, that’s a limited understanding of it. Trialogue does something bigger than that…”

“It’s how humble people can be that empowers others. When John Hume was asked what was his greatest achievement he said it was introducing the credit unions into the North. Maybe that’s what you get at the Trialogue, to be humble and to listen to and to empower others.”

When considering sustainability there was a lot of discussion about the pleasure of always seeing new people and on the other hand dismay that certain groups of professionals do not engage with Trialogue. People also wondered, as was the case elsewhere why some people come once seem to enjoy it and then do not return.

“I’ve been fascinated by how we pick up new people along the way but my question is why are we losing people? They seem enthusiastic and they’re making a great contribution and speaking to them afterwards they’d be eager to contribute but then they don’t come back – why is that?”

“It suits a lot of professionals not be here to listen to the real experiences of people. What takes away my power – if I speak and someone is trying to diagnose or interpret me that diminishes me in some way. The journey goes on.”

The Trialogue Meetings will continue in Galway in the same venue and a small core facilitation group will divide roles, e.g. writing the monthly blog and getting the information out each month.

**The South Tipperary experience**

Some people initially came because they heard about it at a conference and others because they care for someone with a mental health problem. Others out of curiosity and/or because they liked the concept. Some felt that collectively people might be able to change things in Clonmel. Coming back was because of the sharing with the people you meet or because people had committed to it.

“I came back because people were sharing, and the Trialogue meetings were making people aware and taking the stigma way. You meet the most wonderful people, who care and who want things to change. We’re desperate for help. If I could have afforded it I would have flown home each month for the Trialogue Meetings.”
“The reason I came is that we would be able to talk as a collective and the psyche might begin to change.”

The reflection quickly turned to what were perceived as serious issues with the Trialogue setup in Clonmel. There were only a few people involved in this conversation and one of them seemed to have a different experience of Trialogue than what had been heard from participants collectively. This person felt that sitting in Trialogue listening to people’s stories was just despairing.

Concern was expressed that service users did not come to Trialogue Meetings and very few service providers. This does not match the demographic information that has a high percentage of both of these groups. From the core teams perspective there were times when both of these groups were ominous by their absence, and other times when there was a good balance, similar to other sites. However, at this last meeting there were few people and only three voices to speak for the future of Trialogue. These people saw no future for Trialogue in Clonmel and felt that the dwindling numbers indicated the lack of interest. They thought there may be an opportunity for Trialogue to emerge in another town where community activism is more prevalent. One participant felt that a recent leadership programme project may be in a position as part of their remit to bring back some momentum for Trialogue.

It appeared that there was not sufficient support for the Trialogue meetings to continue in Clonmel and there were no further plans made to hold meetings.

The Donegal experience

People generally came to hear about how others see things, to compare their views with yours, and have shared voices in the room. It seemed to be a place where you are not on your own dealing with issues and the group interactions means people care. It is a place that you can come to get back the power you might have lost, e.g. by being in hospital and it can provide a bridge back into the community, and prevents further isolation. People felt that actually having such a forum is a change in itself, where conversations amongst equals can occur. People also felt that there was a learning in the Trialogue because of the diversity of perspectives.

“I came because you can have an equal discussion as possible about mental health issues ...”

“You realise you are not on your own dealing with issues and there is support, interaction and a sharing of ideas in conversations that make it seem as though people care.”

“People need to get together to have different voices heard and shared with others. There is a lot of stigma out there and within yourself – maybe this can help people become normal again ...”

“One of the good things about it is it provides a space that helps people get back the power if they have been in hospital, once they get back into the community. Trialogue can help as a bridge back ...”

A frustration was expressed that service users cannot get together with the one voice and make their needs and independence count and it was suggested that these meetings could be a useful start in getting the voices heard and plant a seed to grow.

There was a sense that Trialogue Meetings could continue and take off if more people got involved. For example, people felt that psychiatrists should attend. Service providers do not seem to have taken up with Trialogue meetings, though there has been a small group generally associated with the leadership course that participates.
People thought that the word ‘Trialogue’ was still not understood by those people not involved, though felt that over all the name should stay as it cannot be mistaken once people know about it. People came up with a few ideas of how to better advertise meetings, e.g. accessing community group contact lists, using key workers, and getting another interview on Highland radio.

People agreed who the core facilitation group would be and what roles they would play. The consensus was that Trialogue Meetings would continue.

How Enhancement of People’s knowledge, Awareness & Understanding of Mental Health Themes Evolved?

A LIKERT questionnaire was developed to assess whether regular participants in Trialogue had increased their awareness, knowledge or thinking around key topics discussed in Trialogue over the previous six months (Appendix 3). The questionnaire also asked for additional personal comments respondents chose to add. Prior to the Trialogue Meeting commencing the questionnaire was explained and a request for volunteers to complete it after the meeting was made. The inclusion criterion was that respondents had to have participated in two or more meetings. 42 people completed the questionnaire, which comprised over 56% of the total number of people recorded as participating in more than one Trialogue Meeting. Respondents were from all age brackets with the majority 47% in the 45-55 age bracket; 57% were female and 43% male. Figure 11. Offers a breakdown of respondents stated mental health perspectives.

The findings suggest that participation in a Trialogue process over time enhanced people’s understanding, knowledge and awareness of selected mental health themes. Figure 12. provides a summary of results. Percentage figures are the combined answers of those who responded ‘a lot’ or ‘quite a bit’ when asked about the themes “as a result of participating in 2 or more Trialogue Meetings’.
Figure 12 – Summary results for impact of Trialogue process on awareness, knowledge and understanding

<table>
<thead>
<tr>
<th>Mental health themes</th>
<th>Service users</th>
<th>Carer/family members</th>
<th>Service providers</th>
<th>Interested community members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding of mental health and distress increased</td>
<td>64%</td>
<td>56%</td>
<td>84%</td>
<td>67%</td>
</tr>
<tr>
<td>More informed about how people respond to, manage and cope with mental health problems</td>
<td>72%</td>
<td>89%</td>
<td>63%</td>
<td>100%</td>
</tr>
<tr>
<td>More aware of what is good and not so good about the mental health services in their community</td>
<td>64%</td>
<td>55%</td>
<td>73%</td>
<td>100%</td>
</tr>
<tr>
<td>Have increased awareness of where and in what way people with mental health difficulties experience stigma and discrimination in their community</td>
<td>71%</td>
<td>67%</td>
<td>68%</td>
<td>100%</td>
</tr>
<tr>
<td>Are more aware of who has a responsibility for promoting mental health and dealing with mental illness in their community</td>
<td>43%</td>
<td>44%</td>
<td>69%</td>
<td>66%</td>
</tr>
</tbody>
</table>

Throughout the process in developing the MHNTI it has been clear that people have a positive transformatory experience that becomes enriched and more significant as people engage more often in Trialogue. People have developed relationships and ways of communicating that contribute to a more meaningful engagement with services, community and each other. One of the challenges for the project was to see if by engaging in Trialogue that people in the community would be in a better position to understand and respond to mental health issues in their community. The findings in Figure 12. suggest that Trialogue participation does rise to and overcome some of these challenges and people across constituencies report significant learning, increased awareness and understanding in relation to mental health issues. Of note is the 6% ‘interested community members’ who have had a major learning experience. If we consider the difficulties in promoting mental health in the community; the relationship of stigma, discrimination and fear to ignorance in the general public; then Trialogue offers a wonderful and creative mechanism for mental health promotion in the community to the community with the community.

The last words ...

The final questionnaire offered a space for people to offer a final comment relating to their participation in Trialogue Meetings. Their parting words provide food for thought.

“Does ‘Trialogue’ have any overall goals beyond the value of the discussion, or does it seek to provide answers? I believe it to be very useful that the purpose is so very open-ended, but an ultimate response to the issues of mental health remains an answer that answer to which I would like to find.”

(service user)
“It is good to get different perspectives and to talk freely.”
(carer)

“Triologue is an open space for commenting without fear of the repercussions. It is also a space where people using the services will divulge information without fear of judgement which can be both hard to hear and invigorating.”
(service provider)

“I find that Triologue is a unique experience of discourse with the ‘mental health’ field. It is an open and equalitarian exchange of views and experiences of the participant’s. One is more normally exposed to a monologue which may (if the person hold’s power) be imposed without discourse. Thanks!”
(service user)

“Excellent way of hearing people’s experiences of mental health. Hope it continues. Great learning experience!”
(community member)

“Because of my involvement as a carer in the services for many years, I am well aware of the difficulties experiences and responsibilities with promoting mental health.”
(carer)

“I usually come out of Triologue meetings feeling invigorated and connected. Often I feel a sense of compassion for myself and others. Also I often have a sense of freedom. Great initiative”
(service user)

“Many thanks for the great commitment and the wonderful concept of the Triologue.”
(service provider)
Chapter 8 – Implications for People, Communities and Mental Health

Trialogue Meetings provide a unique experience for individuals, constituency groups and the community that is grounded in an empowering grass roots community development model and underpinned by Open Dialogue. This provides a process of open communication that has otherwise over time become a rarity, maybe in society generally, though certainly between people who do or might engage with issues around mental health and mental distress. The story of MHTNI to date suggests that Trialogue can be used as a mechanism for people to communicate better with each other, for communities to understand mental health issues and by association help to remove stigma and discriminative behaviour in the public, by people with mental health problems and as an outcome of service provision. It is a place of learning where the collective expertise is greater than any one person or group of people; where the shared experience is so profound that it is only through the experience that one can understand it. A number of pertinent insights and outcomes have emerged though out this story:

- That the Trialogue meetings are very different from other representative meetings, offering a new, enlivening, accepting, comfortable experience with a sense of openness and freedom
- You gain not only knowledge and awareness of new expansive knowledge; you become aware of the capacity of community to respond to the challenges brought about by mental health problems for people
- There is a renewed energy, motivation and stimulation bringing about a sense of being more alive, empowered; and with an increase in awareness, acceptance and tolerance of diversity
- It is a rich learning experience, an education of each other that enhances how they comprehend others and their own experiences
- Where you develop communication skills that improve sense of self and a confidence and allow you to share your own experiences and enhance how you connect with others
- It can change the way you think about mental health and mental distress; increasing your understanding, being more informed of how people cope and manage mental health problems, more aware of what is positive and lacking in mental health service provision, increasing awareness of the experience of stigma and discrimination in communities, and the responsibility for promoting mental health and managing mental health problems in communities

The Mental Health Trialogue Network Ireland Now

Over the course of this project when people who had not yet experienced participation in Trialogue Meetings asked about it, they had difficulty in understanding what Trialogue meant and what a Trialogue Meeting comprised. In an attempt to simplify understanding and provide a tool for people interested in Trialogue to be able to establish Trialogue Meetings themselves a simple leaflet was designed for widespread dissemination (on homepage of www.trialogue.co). So far the feedback on this leaflet in terms of explanation and a practical tool has been positive.

Five of the original seven participating sites have established self sustaining monthly community Trialogue Meetings, regardless of what the MHTNI is or becomes. As a Network the MHTNI continues to have an online presence through Facebook and through information sharing, event advertising and monthly blogs on the Website. It will continue to provide this online presence as long as there is an identified desire for it. It has become a useful point for people that have heard about Trialogue or open Dialogue to begin their onward explorations.
There is no central point of contact or information sharing for the international Trialogue community. The international Trialogue community are exploring the possibility of MHTNI www.trialogue.co being the host for international updates and to that end have already began to engage with the international literature, events and evolving Trialogue groups, e.g. Toronto, Canada.

The MHTNI team continue to engage with other interested organisations and communities who wish to explore Trialogue and see this as an important ongoing progression of the Network.

The core team are committed to Trialogue as a very effective community development process and will continue to develop possibilities as part of their wider research & development interests and programmes through conferencing, papers (e.g. Mac Gabhann et al. (2012)), and other possible project initiatives within mental health and across other sectors of community, health and social care.

**Epilogue**

One year on from the Cycle 3 evaluation, the project is self sustaining. Five original sites continue to have monthly Trialogue Meetings. One other original site is trying to restimulate Trialogue Meetings in the same geographical area, though another town as part of a Leadership project. Several new Trialogue Meetings have been established around the country with others planned for the near future. It would seem that the Trialogue conversation in Ireland is well and truly established.
Bibliography


**APPENDIX 1 – Evaluation Questionnaire for Mental Health Trialogue Network Ireland**

**Researcher:** Thanks so much for agreeing to do a questionnaire with me. I want to reassure you that this is a confidential questionnaire and your name will only be known to the DCU researcher. To protect your identity, your questionnaire will be kept in a locked filing cabinet in the researcher’s office and will be destroyed once the data has been analysed. Is that ok with you?

If you like, we can send you a copy of the final research report. Would you like to receive this?
Yes/No

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
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<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Researcher</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respondant’s Name (first name only &amp; initial of surname)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Researcher: I’m just going to ask you a few short questions first and then I’ll ask you opinion in some longer questions. Okay, let’s begin:

**Q.1 How would you currently describe your engagement with mental health?**

<table>
<thead>
<tr>
<th>Mental Health Service User</th>
<th>Mental Health Service Provider</th>
<th>Family/Partner/ Friend of someone with a mental health difficulty</th>
<th>Interested Community member</th>
<th>Other – please specify</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Q.2 How would you describe your current employment status?**

<table>
<thead>
<tr>
<th>Unemployed</th>
<th>Self-employed</th>
<th>Employed – PAYE worker</th>
<th>Retired</th>
<th>Homemaker</th>
<th>Student</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q.3 What age group are you in?

<table>
<thead>
<tr>
<th>16-24</th>
<th>25-35</th>
<th>35-45</th>
<th>45-55</th>
<th>55-65</th>
<th>65+</th>
</tr>
</thead>
</table>

Researcher: Listen to the statements below and decide which best describes you

Q.4 I often talk about my experience and understanding of mental health issues

<table>
<thead>
<tr>
<th>Yes, absolutely</th>
<th>Yes, sometimes</th>
<th>Don’t know</th>
<th>No, not really</th>
<th>No, definitely not</th>
</tr>
</thead>
</table>

Q.5 I know who to talk to and where to go if I need support for myself, or for someone I know who is having mental health difficulties

<table>
<thead>
<tr>
<th>Yes, absolutely</th>
<th>Yes, sometimes</th>
<th>Don’t know</th>
<th>No, not really</th>
<th>No, definitely not</th>
</tr>
</thead>
</table>

Q.6 I think I am well informed about mental health and mental illness

<table>
<thead>
<tr>
<th>Yes, absolutely</th>
<th>Yes, sometimes</th>
<th>Don’t know</th>
<th>No, not really</th>
<th>No, definitely not</th>
</tr>
</thead>
</table>

Q.7 I feel I could help change attitudes around here about mental health

<table>
<thead>
<tr>
<th>Yes, absolutely</th>
<th>Yes, sometimes</th>
<th>Don’t know</th>
<th>No, not really</th>
<th>No, definitely not</th>
</tr>
</thead>
</table>

Researcher: Okay, here come the longer questions, say as much or as little as you want. Let’s begin:

Q.8 What’s your understanding of mental health and mental distress?

Q.9 How do you think people respond to, manage and cope with mental health problems?

Q.10 What is good and not so good about the mental health services in your community?

Q.11 Do you think that people with mental health difficulties experience stigma and discrimination in your community – if yes, in what way do they experience stigma and discrimination?

Q.12 Who has responsibility for mental health and mental illness in your community?

Q.13 How can mental health be promoted in your community?
Researcher: Finally, I just want to ask you some questions about the Trialogue meeting. Here we go:

Q.14 How did you hear about the Trialogue meeting?
Q.15 Why did you come to the Trialogue meeting?
Q.16 How did you feel during the Trialogue meeting?
Q.17 What did you learn from other people at the Trialogue meeting?
Q.18 If you were to describe the Trialogue meeting to someone who has never been, what would you say?
Q.19 Would you recommend the Trialogue meeting to colleagues/friends/family? If yes/no, why?
Q.20 What would you like to see done differently or improved at the Trialogue.
Q.21 Are there any final comments that you would like to make about mental health or about the Trialogue meetings?

Researcher: That’s it, thanks so much for your time.

If it's ok with you I would like to come back to you in 6 months time at the end of the Trialogue meeting in September and ask you more or less the same questions so we can see if attending the Trialogue changes anything for people. Would you be ok with that?

Could I take your name, email address and phone number so I can contact you to remind you? This information will remain confidential.
APPENDIX 2 – Guidelines for Participants engaged in Trialogue Meetings

These guidelines are not intended as hard and fast rules developed and dictated by people who assume some sort of expertise in this area. They have been developed by request from people interested in Trialogue; based on over two decades of people engaged in Trialogue Meetings and for now adopted as work in progress guidelines for the Mental Health Trialogue Network Ireland. They may be helpful for others interested in developing their own Trialogue Meetings.

All groups have different formats depending on their purpose and Trialogue Meetings are no different. As a way of promoting an empowering space, providing opportunity for people to develop Open Dialogue communication skills and for some to experience a personally nourishing and transforming conversation the following guidelines seem to work:

Some useful Ground rules

- Topics would normally be decided by the participants on the evening of meeting or possibly in the previous meeting so that prospective participants know in advance.
- Generally Trialogue Meetings take place in a circular gathering with no barriers in between participants. This provides a neutral open space for conversation.
- Where possible ‘leave your hat at the door’. One of the frequently voiced empowering things for people in Trialogue Meetings is to be able to speak their mind without feeling restrained by their day to day responsibilities. For example, a carer normally focussed on the needs of their family member may speak out on behalf of themselves; a service user normally intent on trying to get through the day may want to seriously question the choice of care available to them; and the mental health professional may wish to voice their frustration with daily organisational and/or legal restraint on their ability to provide the care they know is good.
- Everyone in the meeting is understood to be bringing their own expertise to the conversation so that all can gain from each other.
- People leave their mobile phones off or on silent.
- The right to anonymity is important. People are not asked to say who they are or where they come from, which is quite different from many other groups.
- Everyone has the right to speak or not to speak.
- One person speaks at a time with no one speaking over another.
- Every one’s opinion and comments are both respectful and respected.
- Participants should ensure that they feel personally safe and comfortable in the group.
- Although there is no onus on people not to talk about the Trialogue experience and things that comes up at meetings, it is expected that outside of meetings people respect what people said and do not personalise comments.
- Usually Meetings last between an hour and a half to two hours with some informal chat before and after the meeting. Some people have a refreshment break halfway through or at the end.

Facilitating or Moderating Trialogue Meetings (words sometimes used interchangeably)

Just like ground rules, the role of facilitation or moderation in meetings or groups depends on the purpose of them. For Trialogue Meetings the role is kept very simple on the basis that any participant can moderate a meeting, and in Trialogue the intent is not to manage or guide the conversation according to any agenda other than the open conversation about an agreed topic. It is useful to have someone who is happy to co-facilitate, particularly if the group is large.
The group will usually agree a facilitator at the beginning of each meeting or in some cases they agree that one or two will take on this role for a designated period of time. Alternatively the group may just agree to have a rotating facilitator from meeting to meeting.

The principal role of the facilitator or moderator is to ensure that the ground rules are respected and that the meeting starts and finishes on time. The group themselves will usually ensure that this will happen and may only need a gentle reminder at times.

Ensuring that the ground rules are respected may entail a number of actions by the facilitator during a meeting. For example, she/he:

- Will observe for indications (sometimes a nod or a hand raised) that someone wants to speak and bring them in and encourage turn taking
- May encourage responses to comments made
- May seek clarification or try to summarise (in their view) what has been said so far
- May signify that one person or conversation piece is monopolising the overall conversation
- Will ensure that everyone has the opportunity to speak by asking at various times (particularly towards the end of meeting) if anyone who has not spoken yet would like to do so

Trialogue Meetings can be very energetic and enthusiastic conversations and at times it is different to stick to the agreed topic. The facilitator will also remind the group of the topic if this occurs and ask if they wish to refocus on it.

**Some Common challenges with facilitation**

As with any meeting or conversations amongst people, there will be challenges. Usually the group themselves will manage to overcome them, and a humorous comment or further question from the facilitator will usually help. Some of the common ones occurring in Trialogue Meetings are outlined below.

*One person or small group monopolising the conversation*

This is a common occurrence in conversations and the facilitator may need to remind people to be more inclusive of all of the participant’s voices.

*Personal arguments*

Sometimes debate becomes more of a personal argument between two or more people and it may be useful to remind people that this is an open conversation for all participants.

*Silence*

Silence can be awkward for some, though it is often a time for reflection and not a bad thing. Usually it happens at the beginning of a meeting and will eventually be broken by someone beginning to speak. If necessary, the facilitator could reintroduce the topic for conversation or relay it again in a slightly different way if it appears that the silence is lasting too long.

*Personalising the issues raised*

The topics of conversation in Trialogue Meetings are very important to participants and some may find themselves personalising comments in a non respectful way to other individuals. A reminder of respectful ground rules will usually address this.

*Going off the topic*

Going off the topic tends to be the norm and is not necessarily an issue, as it is the conversation amongst participants that sets the direction. However, the facilitator may remind the group of the agreed topic and ask are people happy to continue with the present theme or refocus on the topic.
Keeping the conversation going

Sometimes the conversation just runs out and people stop talking or appear to have noting more to say. Some simple questions from the facilitator like – ‘have we anything more to say about this’, ‘is there another way of looking at this’ or ‘is there another burning issue relating to the topic that someone wants to discuss’ may stimulate the conversation again.

Distress

People may get distressed when talking about very personal issues in Trialogue Meetings and this would be accepted as normal. Because these meetings are normally very safe spaces with respectful ground rules and a group of understanding experienced people, those experiencing and voicing distress tend to find it comforting to be in the safe space of the Trialogue Meeting. At times the facilitator or co-facilitator (friend or co-participant) may approach a person who voiced distress, after the Trialogue Meeting to offer reassurance and establish if they are okay.

Acting out

Some participants have at times expressed concern (outside of the Trialogue Meeting) that individuals may act out in anger, distress or as a result of emotional turmoil during a Trialogue Meeting beyond ‘acceptable/safe behaviour’. In the experience of several decades of Trialogue Meetings ‘acting out’ in this manner would be very rare. In these instances the normal human response would be to manage that situation with all of the available expertise in the room, rather than ignore it and try to continue the meeting.

Avoiding facilitator pitfalls

Being the meeting facilitator particularly if new to the role or where people in the group might perceive you to have more of an important role in the conversation than is the case, may sometimes cause pitfalls that can be avoided.

One of the normal disadvantages for the facilitator is that it is likely they will not engage in the conversation with their own opinion as much as others, because they are focussed on facilitating the whole conversation. However, it is possible that the facilitator in trying to generate discussion will end up using their ‘speaking rights’ to monopolise the conversation with their agenda or their opinions and this is to be avoided.

The facilitator may sometimes find themselves aligned with one stream of conversation or alternatively at odds with a stream of conversation. It is important to realise this and ensure that they do not inadvertently try to direct the conversation because of their own views. At the same time they do not need to censor their own views.

Sometimes the facilitator may find themselves defending a view or expressed opinion over another, or offering a defence in response to what some participants are saying about others. This may have the consequence of interfering in the ‘open dialogue’ where everyone’s opinion no matter how diverse is respected. This pitfall is difficult to avoid at times, where the facilitator may not be used to strongly diverse opinion being key to a good Trialogue Meeting.

Everyone brings their own characteristics and experience to facilitation, which is something to celebrate and with rotating facilitators particularly, the diversity can help to enrich the flow of conversation in meetings. Two common pitfalls that people may inadvertently fall into depending on their back ground experience is to either; (a) manage the meeting a bit like a an educational, action or committee meeting; or (b) facilitate the meeting as if it were a therapeutic group. Both approaches have the potential to distract the conversation from its intended purpose. There are other forums where this type of facilitation is crucial and beneficial, though not within Trialogue Meetings as they have so far evolved.
APPENDIX 3 – Evaluating the impact if any on people who have participated in two or more Trialogue Meetings

Thank you for agreeing to complete this questionnaire. I want to reassure you that this is a confidential questionnaire and your name will only be known to the DCU researcher. To protect your identify, your questionnaire will be kept in a locked filing cabinet in the researcher’s office and will be destroyed once the data has been analysed.

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
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<table>
<thead>
<tr>
<th>Respondant’s Name (first name only &amp; initial of surname)</th>
<th>Gender</th>
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To begin we would ask you to tick the relevant box(s) that applies closest to you in the relation to the following 3 questions:

Q.1 How would you currently describe your engagement with mental health?

<table>
<thead>
<tr>
<th>Mental Health Service User</th>
<th>Mental Health Service Provider</th>
<th>Family/Partner/ Friend of someone with a mental health difficulty</th>
<th>Interested Community member</th>
<th>Other – please specify</th>
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Q.2 How would you describe your current employment status?

<table>
<thead>
<tr>
<th>Unemployed</th>
<th>Self-employed</th>
<th>Employed – PAYE worker</th>
<th>Retired</th>
<th>Homemaker</th>
<th>Student</th>
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Q.3 What age group are you in?

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<tr>
<th>16-24</th>
<th>25-35</th>
<th>35-45</th>
<th>45-55</th>
<th>55-65</th>
<th>65+</th>
</tr>
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Please read the statements about Trialogue Meeting discussion topics below and tick ✔ the box that more best describes your experiences of participating in Trialogue discussions.

<table>
<thead>
<tr>
<th>As a result of participating in Trialogue Meetings;</th>
<th>Not at all</th>
<th>A little</th>
<th>Don’t know</th>
<th>A lot</th>
<th>Quite a bit</th>
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<tbody>
<tr>
<td>Q.4 – to what extent has your understanding of mental health and distress increased</td>
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<td>Q.5 – are you more informed about how people respond to, manage and cope with mental health problems?</td>
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<td>Q.6 – are you more aware of what is good and not so good about the mental health services in your community?</td>
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<tr>
<td>Q.7 – have you developed an increased awareness of where and in what way people with mental health difficulties experience stigma and discrimination in their community?</td>
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<tr>
<td>Q.8 – are you more aware of who has a responsibility for promoting mental health and dealing with mental illness in your community?</td>
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If you would like to add any further personal comments about your experience of participating in Trialogue meetings please do so here:

Thank you for helping to evaluate the Mental Health Trialogue Network
Mental Health Trialogue Network Ireland
Transforming Dialogue in Mental Health Communities