Leading change in public mental health services through collaboration, participative action, co-operative learning and open dialogue

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Abstract
Mental health services in Ireland, as elsewhere, have a mandate to improve their services in line with national policy. Key to policy is the partnership of service users, service providers and family/carer involvement in the development and evaluation of these services. Traditional approaches to service improvement are more likely to follow bureaucratic and/or professional models of change that are not necessarily commensurable with a partnership approach, nor do they accommodate multiple perspectives on what constitutes service improvements. This paper reports on how a new model of leadership and change management has responded to the policy mandate and brought about significant service improvements through collaborative leadership of service users, carers and service provider professionals. Utilising an educational service improvement programme underpinned by the parallel processes of co-operative learning, participatory action and open dialogue, leadership teams develop and implement service improvements in their local mental health services. Through ongoing involvement by specific services in the programme a snowball effect is occurring where the underpinning processes are beginning to have a systemic impact on the wider organisational developments and the new model of leadership and change is replacing the less flexible traditional models.

Key words
Service improvement; collaborative leadership; participatory action; open dialogue; trialogue.

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Introduction

'Problems cannot be solved at the level of thinking that produced them.' (Albert Einstein)

The majority of statutory mental health services in Ireland are provided as part of an overall public health service. Until 2006, the principal policy document influencing how services developed was published in 1984 – *Psychiatric Services Planning for the Future* (Department of Health, 1984). Since this time, one would imagine that policy and practice has changed radically, both in Ireland and elsewhere. The traditional hierarchical leadership models and professionally or bureaucratically-driven service developments have certainly been questioned and replaced in international healthcare policy (Mental Health Commission (NZ), 1997; NSW Health Department (AUS), 1998; Department of Health (UK), 1999; New Freedom Commission on Mental Health (USA), 2003); as well as contemporary wisdom on organisational leadership (Buchanan & Badham, 1999; Kernick, 2004; Spencer, 2004; Chinn, 2004; Rubin, 2009). A new mental health policy direction in Ireland with the publication of *A Vision for Change* (Government of Ireland, 2006) provided a much-needed stimulus and roadmap to change the approach to how services are led, developed and provided.

This paper presents an account of how a new model of leadership and change in mental health services has evolved, spurred on by the policy vision, hopes of a better public service and a belief that the majority of people associated with mental health services would like to see them change for the better.

A brief contextual overview of the status quo with a discussion on the impetus or drivers for changing this will foreground the remainder of the discussion. The search for and development of a conceptual and later practical model of collaborative leadership with its underpinning processes will be discussed, followed by illustrative practical examples of how the model has impacted on service improvement initiatives around the country. Finally, the paper will examine the wider snowball effect of service changes in relation to process outcomes and widening the impact of change from within services to the community at large.

A manifesto for an alternative framework to lead service improvements in Irish mental health services

'When you change the way you look at things the things you look at change.' (Dr Wayne Dyer)

Mental health services in Ireland have, until recently, been primarily driven by professional governance. The same can be said for most western mental health services. It is only in the last 15 years that health policy is beginning to recognise the importance and necessity of involving service users and carers in the design and implementation of effective mental health services (Mental Health Commission (NZ), 1997; NSW Health Department (AUS), 1998; Department of Health (UK), 1999; New Freedom Commission on Mental Health (USA), 2003). There are many factors influencing the momentum driving this new agenda, including; service users' self-determination and empowerment (Beresford, 2005); political (Hanley *et al*, 2004); and the acceptance that different perspectives and knowledge bases need to be considered (Nolan *et al*, 2007). Ireland's most recent policy document, *A Vision for Change* (Government of Ireland, 2006), embraces this partnership approach as a cornerstone in developing a national mental health service, where service users and carers are expected to work with service providers in determining the planning and delivery of mental health services for the future. The demand for service users and family members/carers to be involved in the development of improved mental health services (World Health Organization (WHO), 2004; Government of Ireland, 2006) is not necessary matched by any discernable impact of this partnership approach (Irish Advocacy Network 2004; Mental Health Commission (IRE), 2005).

As has been the case with policy aspirations elsewhere, there is a major challenge in trying to foster a genuine partnership approach at service development level. While there is no shortage of service user and carer representation and partnership at national level, this has not filtered down to, or grown up from, the grass roots local service delivery

level. However, the challenge is set down and services have to respond.

Translating policy and rhetoric into a reality on the ground can be fraught with real world challenges not necessarily apparent within the environs of policy and speech making. There can be cultural resistance, local policy restriction, professional agendas, perspectives on best practice and difficulties transforming infrastructure to accommodate new ways of thinking and seeing how services can be transformed. Traditional hierarchical leadership in healthcare organisations are not conducive to meeting the needs of all those associated with the service provision. They are fed by and more conducive to meeting the needs of bureaucracy, professional interest groups, political ideology and privileged knowledge (Kernick, 2004).

Modern perspectives on leading organisational change recognise the complexities of large organisations and are far more conducive to participation, multiple perspectives, alliances, shared governance and collaborative approaches to changing the organisation (Buchanan & Badham, 1999; Kernick, 2004; Spencer, 2004; Rubin, 2009). Although these leadership styles are slow to replace traditional approaches, there appear to be sufficient like-minded people in leadership roles within Irish mental health care to address the challenges and utilise new approaches to help transform the policy vision into tangible service improvement outcomes.

Embracing uncertainty, discovering a better way

> *'Be the change you want to see in the world.'* (Mahatma Gandhi)

In 2007, a group of individuals came together who shared some common ground. They were all members of the International Initiative for Leadership in Mental Health (IIMHL); subscribed to the view – in line with the ethos of IIMHL – that a radical new approach to mental health service improvement was necessary; and were all connected in some way with how statutory mental health services in Ireland were being provided. The group represented service user and carer organisations; Irish Advocacy Network and national Service User Executive; the National Office for Mental Health, HSE; and mental health leaders providing local mental health services around the country. They identified the need for service users, carers and mental health professionals to learn about each others' perspectives if they were to successfully work together to improve services, and the idea of an educational service improvement leadership programme was born. Individuals in the School of Nursing, Dublin City University who had previously worked with the HSE on ground-breaking programmes, and were also members of IIMHL, were approached to join the steering group that would develop and deliver the programme that has changed the status quo in mental health services.

Through combined expertise, continuous dialogue, reflection and harnessing some of the ongoing participative work, an alternative framework for leading change in mental health services emerged from this initial collaborative steering group. Fundamental to the framework was to ensure that family carers, service users and professional providers were involved as equal partners from conceptual stages of thinking about change to implementation and evaluation. Considering some of the traditional power imbalances between professionals, carers and service users and the centrality of privileged professional knowledge (Faulkner & Thomas, 2002; Kartalova-O'Doherty *et al*, 2006; MacGabhann & Stevenson, 2007; McGowan *et al*, 2009) it was necessary to include processes that would prevent the continuity of these traditions.

Developing the framework

The framework for improvement centred on an educational practice development programme that culminated in teams of three (service user, carer, service provider) participating on the programme with other teams, leading the implementation of a service improvement project in their sponsoring mental health service.

Each service interested in improving their services through this framework recruited a team of three from their local community and services. Each team was linked in with a senior manager in the service who would be the team mentor and, where necessary, trouble-shooter on behalf of the team. The mentor role ensured buy-in at executive level in each sponsoring organisation.

Each service user and carer was paid an agreed weekly remuneration for college fees, accommodation and expenses for the duration of the programme and rollout of service improvement programme. Democratically and symbolically it was important to have similar conditions for all members of each team in an attempt to level out power imbalances. Each team then joined other teams as an action learning group on the practice development programme at Dublin City University co-ordinated by a team equally representative of service user, carer and service provider, plus academia.

The programme: co-operative learning: service improvement leadership for mental health service users, carers and service providers

The programme carried 10 ECT credits at degree level 8 and participants entered the programme with either a previous minimum educational requirement at diploma level, or through accreditation of prior experiential learning (APEL). It was delivered over nine months across two academic semesters in Dublin City University. Attendance was mandatory because of the required group processes undertaken during classroom time. The first semester comprised two study blocks of three days each, where participants resided in local hotel accommodation and the second semester comprised three two-day residential study blocks using a combination of master classes and action learning sets.

In addition to a service mentor for each participating team, individuals worked with a designated tutor from the programme team, on individual learning objectives and used them as both an academic and personal support during the formal programme participation, and following this as the projects were being implemented.

A critical link was established between the steering group, mentors, programme team and participants. This was partially because of the logistical challenges in service, eg. establishing a payment mechanism for service users and also to keep the wider participating group in the loop. We were trying to integrate learning from an educational institution with real-world experience and practice in mental health services as praxis. Historically, this equivalent 'theory–practice' gap has been difficult to bridge (Rolfe, 1996; Badger, 2000). We took the position from the outset that it was specifically within this gap where the tension, creativity and, crucially, change would happen (Whall, 1989; Murphy, 2000; Coghlan & Casey, 2001). Our processes enabled this, alongside the communication loop among the wider participating group that remained in constant parallel to the programme delivery itself.

Programme aims

There were two aims for participants on this programme:

1. to have an informed understanding of the nature and practice of a collaborative and open dialogue approach to leading change in healthcare organisations
2. to have developed the requisite knowledge and skills to lead service improvements in partnership as service users, carers and service providers.

Sample syllabus and learning methods

This programme is about leadership, partnership and service improvements through a defined process of participation, co-operative learning and open dialogue. ***Table 1*** (opposite) offers an example of some of the key areas covered on the programme. Apart from the underpinning processes discussed in the next section, a range of learning methods were employed to ensure participation, equity and creativity in the learning process. The main group itself was the principle learning forum, with ground rules, etiquette and group goals identified at the outset. ***Table 2***, opposite, lists particular learning methods used within and outside the main group.

Assessment

Assessment for the course was based on each team developing a project proposal and demonstrating that engagement with relevant stakeholders had commenced. There are three summative elements. The first was a personal cyclical reflection by each participant on the challenges they perceive the service improvement project might present for them. The second element was a peer-assessed team presentation on work in progress

Table 1: Key topic areas covered on the programme

Semester 1	• Exploration of obstacles to service improvement – health systems and social context • Citizenship and social inclusion • Open dialogue approaches to co-operative learning and working with different perspectives • Values based practice • Leadership through co-operative action • Adult learning and critical reflection • Social, political and cultural influences that impact on service improvement projects • Action research, organisational development and change processes • Co-operative relationships with service users, carers, professionals and other groups in the healthcare community • Completing simulated mini projects
Semester 2	• Trialogue symposium (with invited and interested stakeholders) • Leadership in the HSE (Health Service Executive) • Project definition • Participatory action • Change and organisational development • Project planning • Process mapping • Project outcomes • Academic writing and proposal writing • Team appraisal and leadership roles • Project execution

Table 2: Programme learning methods

- Presentations
- Open dialogue discussion
- Simulation
- Assessment
- Problem posing and simulated resolution
- Team group work
- Role play
- Group and individual critical reflection
- Creative expression (eg. collage and music)
- Action learning

towards developing the project proposal and engagement with relevant stakeholders.The third element comprised a proposal write up developed by all three team members. In addition, each team member added a personal critical reflection on the service area they were seeking to improve and the factors they perceived would impact on the outcome of the project. Creativity was encouraged with a view to harnessing different learning styles and expertise in articulating knowledge and experience. For example, presentations included music, poetry and art.

Crucially, the programme team, mentor and steering group continued to support and keep up to date with the service improvement projects as they were implemented.

Underpinning processes supporting the service improvement framework through collaborative leadership

There are three key dynamic processes that underpin the learning and interaction on the practice development programme. Furthermore, as participants become adept at engaging in these processes they carry them through into

the service and with relevant stakeholders involved in the service improvement projects. These processes are *participation (or participatory action), co-operative learning, and open dialogue.*

Participation

As indicated above, there is ample rhetoric and documented aspirations around the idea of partnership. One of the fundamental aspects of a transparent partnership is participation, and any programme that attempted to collectively represent all participant perspectives toward mutually agreed action would need to ensure participation. We identified a few educational courses that sought to harness partnership approaches to service improvement, yet the process of participation was flawed in that all of the potential partners learned about each other in isolation.

In broad terms, 'participation' can be understood as a process where individuals take part in the decision-making of institutions, programmes and environments that affect them (Wandersman, 1984). Arguably, the rhetoric contends that this participation is evident and certainly any public documents contain textual accounts of participation that would loosely fall under this definition. However, the historical and political context and power relations evident between the constituencies participants may represent, warranted a much more transparent and specific process of participation, not only for those on the programme; for other stakeholders in the prospective change process too. It is important that the right approach is employed for given circumstances. For example, examining or seeking to empower people through power-sharing and self-determination would employ a humanistic approach to participation, such as 'communicative action' (Webler & Tuler, 2002), rather than a 'bureaucratic' approach often founded on consumerism with an emphasis on economy, efficiency and cost-effectiveness (Meyer, 2001).

Webler and Tuler (2002) have developed their theoretical contributions to 'participation' based on critical theorists' perspectives, in particular Jurgen Habermas (1987), which corresponds well with the aspirations of our programme. They describe the 'communicative approach' with two main components, fairness and competence.

Fairness relates to what people are permitted to do in the participatory process with a minimal of four necessary opportunities:

- to attend (be present)
- initiate discourse (make statements)
- participate in the discussion (ask for clarification, challenge, answer and argue)
- participate in the decision-making (resolve disagreements and bring about closure).

Competence refers to reaching the best possible understandings and agreements on the basis of what can be reasonably knowable to participants, at the time that discourses take place. Competence entails two basic necessities:

- access to information and its interpretations
- use of the best available procedures for knowledge selection.

Additionally, it is necessary for a consensus on how decisions will be made, though not necessarily in the decision-making itself. Furthermore, the process must pursue mutual understandings before agreement is reached on actions. Webler and colleagues (2001) identified a number of emerging perspectives on what constitutes a good participative process.

A good process acquires and maintains popular legitimacy through a consensual democratic process.

1. One that facilitates an ideological discussion among a core of stakeholders.
2. One that focuses on the fairness of the process, concentrating on high-quality democratic deliberation and achieving participation by all segments of society.
3. One that pays attention to mitigating the relative power balances among participants.
4. One that highlights the need for leadership and compromise, in combination with collecting insights and fostering deliberation among a wide range of the public.

The conjoint processes of co-operative learning and open dialogue offers an opportunity for

this depth of participation that we believe is required for successful partnership learning and subsequent service improvements.

Co-operative learning

If we were to develop a programme that demonstrated a genuine participatory process, our educational model would have to also encompass similar principles. Co-operative learning provides such a model and was adopted as one of the underpinning processes for the leadership programme. Co-operative learning has roots in several theoretical frameworks, including; behavioural learning, cognitive development theory and social interdependence theory (Johnson *et al*, 1998). Though, it is the critical social theory perspective and the pedagogy of Paulo Freire (1996) that underpins the co-operative learning approach on this programme. Freire's (1996) approach to education and transforming the social system of participants through the educative process of critical conscientisation mimics the aspirations of this programme.

Freire rejected the 'banking' system of education where there are expert purveyors of knowledge who pass this on graciously to their students, in favour of critical reflective learning informed by the collective experience of particpants and transcending the individual contribution and traditional power relationships of teacher and student. Crucial to his approach is that learning is gleaned from the lived experience and understanding of participants relating to subject matter that is important to them. Freire's problem-posing methods (as opposed to problem-solving), where the teacher/facilitator/animator encourages participants to critically reflect individually and collectively on the relevant issue, enables people to understand what it is they do, can do and through critical dialogue and praxis (*reflective action*) they can transform their world (Freire, 1996; Hope & Timmel, 2007). Co-operative learning enables the harnessing of the individual and collective experiences and perceptions, together bringing about a transformation of their community or system under which they are oppressed (Hope & Timmell, 2007).

Participants on our programme had different lived experiences of a problematic mental health system that warranted transformation, and our aspiration was to engage in a critical reflective process that would enable us to transcend the existing oppressive unchanging structures that influence us and maintain the oppressive status quo, towards a mutual emancipatory change, which is indicative of a new and better future. Freire (1996: 65) puts it more poetically:

> *'Problem-posing education is educative futurity. Hence it is prophetic (and as such hopeful)... Hence, it affirms women and men as beings who transcend themselves, who move forward and look ahead, from whom immobility represents a fatal threat, for whom looking at the past must only be a means of understanding more clearly what and who they are so that they can more wisely build the future.'*

The strength of co-operative learning lies in the student centeredness, although this is not unique to co-operative learning and is a familiar feature of many educational models. In response to some of the criticisms of the approach, for example that weaker students are carried by their stronger peers, there is a concentration on extending the co-operative approach into the assessment of learning outcomes (Divaharan & Atputhasamy, 2002). Examples include peer appraisal and peer assessment of each others' work. Proponents of co-operative learning who argue on the basis that co-operative learning is superior to traditional approaches, have pushed for a displacement of traditional approaches, rather than supplementing them with aspects of co-operative learning (Slavin, 1980; 1987). There is a wealth of literature supporting Slavin's research and the contention that co-operative learning demonstrates: an increase in student learning, attention, achievement, makes course content more meaningful and enables students to make their own tacit knowledge explicit (Ventimiglia, 1993); that it enables an awareness of how we learn, of valuing understanding of concepts and offers an opportunity to discuss and modify prior beliefs (Mills *et al*, 1999); that students are more motivated, feel more accountable for their contribution to work and raises the awareness of group dynamics (Lourdusamy & Divaharan, 2000).

The nature of co-operative learning itself has come under criticism and what proponents view as strengths, critics view as a weakness

of the approach. Randall (1999) argues that it is unfair and unrealistic to place the responsibility of student learning on students themselves. Furthermore, she contested the advantage of students being graded on the basis of what other students learn. The idea that under-achievers may free-ride the group and/or still under-achieve while high achievers will do so anyway has also been discussed by Divaharan and Atputhasamy (2002), who argued that this possibility is lessened if structures for peer assessment are put in place. That people are working in groups and subject to the dynamics of any group processes, runs the risk of negative outcomes. For example, the formation of dysfunctional groups; an inability for people to work together; to deliver the desired outcomes; and a lack of democracy within the group to reach consensus on roles (Beckman, 1990). On the other hand, within groups there are often differentials of power that influence the dynamics, where for example, 'groupthink' takes over the process. This might be where there are a few loud voices with perhaps charismatic or overbearing people who set an agenda and others conform rather than challenge (Janis, 1982). Janis explained this phenomenon as the desire for groups to maintain concurrence on important topics and to develop cohesiveness at the expense of ignoring realistic challenges to this consensus. Where power relations is an issue, the conforming or censoring aspects of groupthink can have a detrimental effect (Carey & Smith, 1994). Within our cohorts of participants there are clearly predetermined power relations as an artefact of the mental health system and their place within that system. Therefore some of the potential pitfalls of co-operative learning needed to be overcome. The second underpinning process of the programmes, 'open dialogue' addresses these potential pitfalls.

Open dialogue

The critical dialogue associated with co-operative learning frequently involves some sort of pre-existing homogeneity among participants, as an oppressed community of people with similar cultural norms (Freire, 1996), people sharing similar chronic health conditions (Koch & Kralik, 2006), or people from one industry completing an educational programme (Mills *et al*, 1999). The participants on this programme were very purposely not a homogenous group, although 'mental health service delivery' was an assumed common interest by virtue of participating on the programme. Differentials in power relations were overtly present and ingrained into any participant's value systems and social norms. Our experience and the wealth of literature testified to the diversity of opinion, values, cultural and social perceptions, and experiences of participants, whether they were service users, carers, or professional care providers accordingly.

Open dialogue can accommodate this diversity towards mutual understandings and commonly-agreed purpose. In particular, it is the social constructionist process of open dialogue that is useful here. Bakhtin perceived 'dialogue' 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 (Bakhtin, 1981). This 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 & Goolishian, 1992). It is a process or performance, an action that creates, sustains or alters worlds of social relationships (Gergen & Kaye 1992). Open dialogue is applicable at the individual communication level (Anderson & Goolishian, 1992), group level (Gergen & Kaye, 1992), and at organisation or large systems level (Gustavsen, 2001). For Seikkula and Aaltonen (1995) with other colleagues it provided a process by which they changed the entire approach to how mental health services were delivered to 'people experiencing psychosis' in Western Finland. Whenever a person is referred by any means to the service, first a meeting is set up with any persons who are or may be affected by the individual's experience. Each person's views, perceptions and understanding of the situation are shared before a consensus is reached on how

the person might progress from their present difficulties. Our open dialogue approach adapted that of Seikkula and Aaltonen (1995), where we incorporated the three main constituencies affected by a person experiencing mental health problems. For a number of years since the 1980s there has been a grass-roots movement, principally in Germanic countries, that utilises open dialogue to foster better understandings of mental health issues and the responses of people/services to them. Known as 'trialogue meetings' (Amering *et al*, 2002), these are regular meetings arranged at neutral venues in towns and cities, where mental health professionals, carers and service users/survivors come together in a new form of communication, not perceived possible in mainstream psychiatric services, where each have their given social roles. On the leadership programme we have taken the trialogue approach, applied it first in the classroom and then as a requirement of the programme it is embedded into a service improvement project for each participating team. Open dialogue is not necessarily a natural form of communication and a significant amount of group learning was given to developing open dialogue communication. Open dialogue brought the teams together as working groups in a way that co-operative learning alone could not have achieved. For many teams and for several projects it was the practice of open dialogue that brought about the most fundamental changes and project outcomes.

Service improvement outcomes and process outcomes

The notion of group leadership and shared decision-making took some time to become an accepted reality and was more pronounced in some teams over others. As individuals developed open dialogue skills within their teams, they also developed joint leadership approaches.

Eighteen projects have been or are presently being implemented in Cork, Dublin, Mayo, Galway, Tipperary and Donegal. They range from changing the physical infrastructure of services; establishing community support groups; improving information systems; setting up community advocacy programmes; to completing a needs analysis of all constituent stakeholders in mental health service provision.

The projects themselves are at times small in the scheme of overall organisational development. However, for the more successful endeavours, the underpinning processes are becoming embedded in the sponsoring organisations and systemic changes are occurring. For example, several services have adopted the 'trialogue' approach to decision-making in their organisation, with meaningful representation of carers, service users and 'coalface' service professionals on senior management and other decision-making groups. In addition, open dialogue groups are being convened within services as a means to foster participation and shared governance in many of the services.

Implications for future directions, adopting the underpinning processes for ongoing change

This service improvement framework for collaborative leadership is already beginning to demonstrate a snowball effect with systemic changes occurring in participating organisations. Not all projects have yet been implemented and there are still expected challenges to overcome for some. Nonetheless, each of the services has been impacted upon by the changes, beyond the parameters of the initial service improvement projects and continues to be. As each service sponsors new teams and new services join the collaborative, a critical mass of collaborative leaders are emerging and the framework is gaining a foothold as a successful change management initiative.

The underpinning processes are filtering out into other services and organisations, with frequent requests for the programme team to engage in discussions about possibilities for adopting the framework in other organisations and to facilitate open dialogue 'trialogue' meetings. In parallel to the next group of leadership teams undertaking the programme, a research team at Dublin City University have been funded to establish a network of trialogue meetings in each community being served by mental health services participating in the service improvement programme. In this way it is hoped that the underpinning processes conducive to democratic participative change will not only influence the development of public services, they will also influence community forums interested in mental health and mental health care. Thus fostering a sense

of community inclusion of and by people with mental health problems and mental health services, as opposed to the more traditional segregation and exclusion more often a feature of these social relations. The prospects are promising and the momentum is building. Of course there are many factors affecting the ongoing improvement of mental health services in Ireland. Those involved to date in this collaborative initiative would like to stake some claim to those improvements, and for now remain in flux on this transformational journey.

Implications for leadership in practice

- This paper describes a model of leadership and change that is commensurable with mental health policy and identifies a process that can integrate policy with actual change on the ground.
- The leadership programme demonstrates the capacity to improve services based on mutuality and conjoint agreement among stakeholders on what constitutes improvement.
- Providing that an equitable process of co-operative learning, democratic participation and a space for open dialogue can be embedded into mental health services, this initiative has shown that service improvements addressing the needs of all stakeholders is possible and traditional challenges can be overcome.

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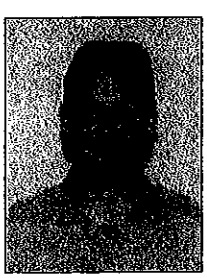
Líam MacGabhann qualified as a mental health nurse in 1988 and headed off from Ireland with his new-found insights to change the world. Spending most of his early career in England, with some brief sojourns in Australia and the Middle East, he has pretty consistently worked with people whom some would classify as having a serious psychotic illness, and more specifically concentrating on acute mental health care. He now practices on an acute psychiatric admission ward and co-ordinates the Graduate Diploma/MSc in Health Care Practice/Nursing Practice plus some interesting professional development courses at Dublin City University.

Paddy McGowan from Omagh in County Tyrone recovered from schizophrenia with the support of other survivors and professionals. Paddy speaks authoritatively and humanely from the inside out, relying not on the presuppositions of dubious and largely unproven scientific theories, but from reflecting sensitively, honestly and often painfully on the experience of 'hearing voices' synonymous with a diagnosis of schizophrenia. He is currently at Dublin City University, School of Nursing.



Jim Walsh used mental health services for approximately 14 years. During that time he returned to education completing a degree in Psychology at Queen's University, Belfast and became actively involved in various mental health initiatives set up with the specific aim to improve the status of people experiencing psychological and emotional distress within mental health care systems. Later he became employed by a health trust in Northern Ireland; first as a day care worker and later co-ordinating a partnership initiative – the Mental Health Alliance. He is involved in several local, national and international user and carer initiatives – the Irish Advocacy Network (www.irishadvocacynetwork.com), the Institute for Mental Health Recovery, Mental Health Ireland (www.mentalhealthireland.ie) and the International Network of Treatment Alternatives for Recovery (www.intar.org). He is presently a PhD candidate at the School of Nursing, Dublin City University.

Orla O'Reilly's career in nursing commenced with the Daughters of Charity Dublin services where she trained as a Registered Nurse Intellectual Disability (RNID). Following that, she trained in Jervis Street hospital as a Registered General Nurse (RGN). Orla has worked in both in residential and community services for individuals with intellectual disability for a number of years. Following her return to nursing education in the Daughters of Charity services in 1986, she completed a Bachelor of Nursing Studies at UCD in 1996 and Masters in Adult and Community Education at NUI Maynooth in 1997. She is an elected member of An Bord Altranias representing Intellectual Disability Nursing Education and has served on the Education and Training and Fitness to Practice Committees.