STRENGTHS AND WEAKNESSES OF THE METHOD

The method is in continuous development and adaptation. Its original use (Feather and Labonte 1995) involved creation of insight cards, but did not include creation of categories and theory notes. These stages were added to deepen the analysis and increase the usefulness of practice knowledge. Much of its present use is directed towards establishing benchmarks, indicators and explanatory notes. Proposals for its use in case study evaluations are pending. Although documented experience with the method consists primarily of "one-offs" with practitioners facilitated by the first author, it is known that many participants have adapted the method to their work, including its use to assess retrospectively the effects of a number of community-based health promotion projects.

The strength of the method lies in the appeal of stories, grounding the stories in first-person experiences, affirming that practitioners and community members have important knowledge and the intuitive logic of the structured dialogue. Evaluations of the method almost universally agree that it is "a good way to learn from one's own and others' experiences," "a great way to stimulate creative thinking and problem solving," "a legitimate form of qualitative research," "a starting point for work with communities" and "a useful means for team building" (Feather and Labonte 1995). Weaknesses in the method do exist, and pertain primarily to differences in the ease with which practitioners are able to prepare "good and revealing stories" (Feather and Labonte 1995), to move from the concreteness of description to the abstraction of explanation, to "discover" or articulate insights and to search for patterns when creating categories. When practitioners encounter difficulties in these areas, there is a tendency to retreat into the personal stories and problem-solve the particular, rather than to move into assessing and analysing the generalised knowledge the stories help to create. Also, there is a tendency for practitioners to accept the story-teller's explanation for the story at face-value without questioning the validity of the account. This can be overcome by more probing questions from the story group on the documentation that might support the story-teller's claims. It is also important to distinguish use of the method for evaluating a particular case, where triangulating many different stories on the same case would increase validity, from using the method to generate more useful and generalisable practice-based theory.

The ability to document revealing experiences, to analyse and explain these experiences, to synthesise the analysis and to search for patterns and abstract from the particular to the general are all skills that can be acquired with practice. Practitioners recognised the importance of these skills in improving their work. The method has evolved to assist them in acquiring them, notably through briefing and support of story-tellers prior to their crafting of the case story, use of briefed facilitators in each story group, creation of a detailed handbook on the method and development of additional stages, such as "benchmarking," that return the abstract theory notes to the particulars of practice.

CONCLUSION:
THE METHOD'S RELEVANCE TO HEALTH PROMOTION KNOWLEDGE
DEVELOPMENT AND EVALUATION

The story/dialogue method is one of many approaches to knowledge development, program planning and evaluation. It is not intended to replace other methods, nor does the group approach to story analysis, synthesis and generalisation preclude the more traditional qualitative analysis of such "texts" undertaken by individual researchers. The logic of the method—the structure of the dialogue, generation of practice-based theory and application of theory to the creation of evaluation indicators—represents a "robust" technique for postpositivist research that can be, and is being, adapted to a range of program evaluation questions. It is particularly suited to analysis of health promotion strategies and activities, whether from the vantage of practitioners, their agencies or community members.[5]

Expert knowledge in theorising and evaluating health promotion practice is important, but often has overshadowed the knowledge of practitioners and community members. The story/dialogue method, by basing itself on the day to day experiences of these groups, moving from their particulars to a somewhat rigorous statement of more generalised or abstract knowledge, and applying that knowledge to specific program evaluations, can create a better balance between the knowledge and power of institutions and professionals, and the knowledge and power of communities.

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[1] The authors of this Chapter owe a debt to many people in the development of this method: The hundreds of health promotion practitioners who have participated in the various iterations of the method; Marcia Hills (University of Victoria, Canada) and Nina Wallerstein (University of New Mexico, United States) who worked with Ronald Labonte in several applications of the method; the project team which piloted the method (Nicole Dedobbeleer, Marcia Hills, Nancy Kotani, Heather Maclean, Karen Parent and Irving Rootman); Health Canada for funding various stages in the development of the method; Nancy Hamilton of Health Canada for her support and insights; Patricia Williams, Edmee Korsberg and Carmelle Thibodeau, who reviewed drafts of the handbook on the use of the method (Labonte and Feather 1996); Bonnie Sproat, who designed and produced many of the documents and graphics used in applications of the method; the Centre for Health Promotion, University of Toronto, which funded a review of the method's use after the first 18 months; and the European Office of the World Health Organization, which funded an earlier draft of this Chapter. A different version of this Chapter is presently under review by the Journal, Health Education Research.

[2] Quotations from Labonte and Feather (1996) are from participants at various workshops that employed the story/dialogue method.

[3] For a slightly different "structured dialogue" approach used in health education, see Wallerstein and Sanchez-Merki 1994.

[4] Indicator in this instance does not mean simply quantitative measures! A variety of methods can be used to "indicate" that the benchmark has been achieved, such as participant/observer field notes, interviews (ranging from structured to unstructured), surveys and reviews of project notes and records.

[5] One useful distinction to consider when using the method in health promotion evaluation is between evaluation and research. Evaluation should document that we have accomplished what we said we would. Research should help us to determine if what we accomplish is important relative to our goal. For example, surgeons performing a bypass operation do not have to "prove" that such operations make a difference in overall CVD mortality. They simply have to document that they have accomplished the surgery according to established procedural norms and that, at a minimum, the patient did not needlessly die or suffer. Research determines the broader and longer-term effectiveness and efficacy of such operations. The same should apply to health promotion work. This distinction would not preclude health promotion from including research questions in its evaluation design. But it usually takes more rigour and expense to answer research questions than to document evaluation accomplishments; and a program should not be judged by the answers to a single set of research findings anymore than a cardiovascular surgery should be judged by the outcomes of a single operation.
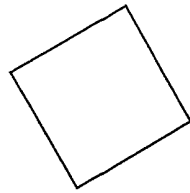
CHAPTER 6:

Theorising Health-Promoting Partnerships

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INTRODUCTION

The three themes of this book-power, participation and partnerships-build logically upon each other. The story/dialogue method is used in the following example to analyse and synthesise participants' experiences with partnerships, both partnerships for health promotion and partnerships that are health promoting.

THEME: CREATING PARTNERSHIPS

> Everyone talks about the need to develop new partnerships or intersectoral collaboration. The health sector has even been charged with becoming the leaders in this process. Our work should lead us beyond ourselves, to partnerships with like-minded (or potentially like-minded) groups, organisations, sectors. But territoriality, competition over resources, different language and concepts, different accounting structures and priorities all seem to get in the way. Also, power differences/inequalities between partners are often large and are rarely talked about so that they might be resolved. This is particularly true in partnerships involving community people and groups, whose participation is often token, largely because the terms of participation (and thus of partnerships) still remain largely with institutions. Despite recognition that supports for citizen participation are essential they are often meagre or lacking. There's also a general participation exhaustion with everyone running from one consultation meeting to another in the hopes of not missing something that just might be important, but often is not.

Sharing one's practice experience for purposes of analysis and synthesis requires risk-taking, since personal details about oneself and others is needed to ground the story in actual experiences. Story-tellers always have the option to request confidentiality for their stories. However, by the time the particular stories have been analysed and synthesised, the insights and theory notes generated are at a level of generality that they can be shared with little risk to story-tellers or those named in their stories. Theory notes are collected from the stories.

This Chapter includes a number of examples, the categories of insight cards created by the story group participants, their theory notes on the categories and the benchmarks they established from the theory notes. This is done to make the process transparent and understandable to readers who have not experienced the process.

The links between the categories of insight cards and the actual story may not always be apparent though, since the insight cards are based less on the story as told, and more on the structured dialogue that happened around the story.

The Chapter continues with theory notes and benchmarks for three different story groups, identified by the title the story-teller selected for her or his story. Some editing of the theory notes and benchmarks was undertaken for purposes of clarity and readability. Occassionally, additional comments on the theory notes and benchmarks have been prepared by the author (Ronald Labonte). A meta-synthesis of the theory notes from all of the stories is undertaken by the author (Ronald Labonte) in the next, and final, Chapter.

AN ILLUSTRATIVE STORY:
USING PARTNERSHIPS TO DEVELOP AN ADOLESCENT HEALTH PROGRAM

Story-teller: Professor Glenn Bowes
Director VicHealth Centre for Adolescent Health, University of Melbourne

I am a medical graduate, specialist physician and PhD physiologist who has had a lifelong interest and involvement in community based youth activities. I was recruited 5 years ago to establish an adolescent health program—The Centre for Adolescent Health—which was the first clinical academic program in adolescent health to be established in Australia. Those who came together to stimulate this initiative were 3 hospitals, a university and VicHealth. What quickly became apparent was that these multiple agencies did not share one single vision, had many differing agendas and had chosen me for different reasons. The agencies had clearly come together in good faith but were not in reality partners. The agenda of the hospitals was largely focussed on improving service delivery to young people in problem areas. The academic agenda was more to do with the usual academic areas of interest being research excellence and education/training. VicHealth clearly had an agenda that was informed by an imperative that had developed during the late 1980s following the release of the Burdekin Report on youth homelessness. There was a clear need for action to improve the lot of young people, particularly those disadvantaged by social circumstance.

In a similar fashion the agencies saw in me different values. The hospitals valued my physician status and my knowledge of the health service delivery. The University valued my academic achievements and VicHealth looked towards my non-professional commitment to young people as an indication of my understanding of the importance of a social view of health and the promotion of well being as integral components of an adolescent health program.

My initial attempts were to try and please the multiple constituencies by attending management meetings, faculty meetings, staff meetings and key committee meetings at all of these agencies. It quickly became apparent that this was not a good strategy. I was not keeping anyone happy and not achieving core objectives. I came to realise that the true constituency for the Centre for Adolescent Health was young people in the community and that addressing their needs was the key to the desired outcome. Moreover, as I worked towards these goals, the "partners" started to develop a common vision that was aligned with the Centre's work and hence satisfaction started to develop across most agencies.

I took a pragmatic decision to focus attention on two of the agencies, Royal Children's Hospital and VicHealth. By building strengths in these areas the Centre was able to then take on board other partnerships with a greater potential for success.

The things I learnt during this process of developing an adolescent program were firstly the need to keep a focus on the big picture and the true constituency for the work of the program. Secondly, that there was a need to create a vision around which to rally the partners, rather than to necessarily try and create a hybrid vision from all the different agencies involved. Thirdly, I learnt to build on strengths and not to try and pursue too many concurrent relationships.

CATEGORIES OF INSIGHT CARDS:

Goal Definition

The leader must ensure the partners have a common goal to share a true partnership.

The leader must work to establish the value & the role of the organisation and define the future role.

The leader needs to focus on the goal and not try to please all the partners.

Choice of Partners

Partners develop ownership through exposure to the constituents and the setting ("coalface").

The leader needs to identify key partnerships for sustainability.

The leader must recognise changing power bases to ensure relevance of current partners.

Skills

Participants and stakeholders need to actively acquire skills, through the organisation, to build on the partnership.

The constituency/participants need to actively acquire skills to empower them to play an active role.

Generic skills are important to successful partnerships. These skills include being analytical, and being able to build a vision.

Strategic Management of Partnerships

The leader needs to be able to unpack the agendas of the partners.

The leader provides opportunities for partnerships to occur at all levels of an organisation.

The leader must recognise changing environments and partnerships and be able to move on.

The leader should allow time for the partners to develop ownership and commitment through their own understanding of partnerships objectives.

The leader needs to feed current partnerships, to look ahead to potential partnerships and to train future leaders in their roles.

THEORY NOTE:

Effective partnerships require the establishment of a clear vision of the role of the organisation and a definition of what future role the organisation will play. Having agreed on the vision, effective leadership requires working to ensure that the partners have a common goal and a commitment to share in a true partnership. Effective leadership must focus on the common goal for success, and not try to please all the partners.

Partners may be pre-determined, self-selected or chosen. As development and management of multiple partnerships is difficult, it is essential to identify key partners to ensure any long-term sustainability for the partnership. Key partners may be those who have certain forms of "power-over" in relation to the issue, often through their control over funding relationships. Changes with partnerships and the external environment require monitoring of power bases—who has power, who has not, and how this changes over time. Introduction of new partners, or termination/repositioning of existing partners, may be needed to ensure their ongoing relevance to the issue around which the partnership formed, and their effective contribution to achieving partnership goals.

Good partnerships take time to develop. It takes time to develop a shared common goal, a sense of ownership of the project and an intellectual and emotional commitment to successful outcomes for the project. To accomplish this, the leader needs to be able to unpack the agendas of different partners (which are often hidden) and to understand fully their individual motivations, interests, goals and expectations. The leader may also need to expose the partners to the constituents (those benefiting through the partnership's activities) and the setting at the coalface (where the activities take place). The leader needs to develop and nurture current partnerships while recognising the need to identify potential new partnerships and train future partnership leaders. The leader also needs to be aware of his or her own personal limitations and be prepared to draw on others' skills to supplement his or her own.

Finally, partners from the constituency (those benefiting from the partnership's activities) need to be provided with opportunities to develop and use skills that empower them to play an active role in the project/organisation.

Benchmarks:

- The agendas of each partner are clearly stated and a common agenda reached, through agreement on one or more superordinate goals.
- The partners agree to a process that exposes managers of the partnership to "coalface" experiences.
- Partnerships establish a process to actively skill the service users (the constituency) so that they are empowered to participate actively in the partnership itself.
- Partners agree on mechanisms to enable skilled service users to participate in the partnership, and methods to monitor that participation.
- Partnerships are strategically managed through establishment of a clear, common vision formally documented and agreed to by all of the partners.

STORY NO. 2: PARTNERING A POWERFUL PARADOX:
               CONSUMER EVALUATION OF PSYCHIATRIC HOSPITAL PRACTICE.

Story-teller: Yoland Wadsworth, Chief Investigator, A collaborative project between consumers,
*   staff and others to establish in-built evaluative feedback and communication mechanisms*
*   for acute Psychiatric Hospital Practice.*
*   Funded by VicHealth using the tobacco levy.*

I started work as an evaluation consultant to the peak Victorian psychiatric service users'
organisation in 1989. At this time, the idea of patients of public psychiatric hospitals evaluating
such services was greeted frequently with widened eyes and audible gasps. As Mary O'Hagan of
the New Zealand survivors' movement has wryly observed, the mental health services area may
be the last remaining bastion within the entire services sector where it is presumed that 'the
customer is always wrong.'

Yet the idea of customer-focus as part of quality assurance was gaining ground in the managerial
world—largely in the form of customer satisfaction surveys or the involvement of customers in
focus groups and occasionally in a representative capacity on program committees. By 1993,
when our three year study began, there was therefore some presumption that the involvement of
service-users was an appropriate and viable thing to do, and even somewhat inevitable. Lying
behind the power of this logical rationale lurked as well the knowledge that acute inpatient
experience had also often been a painful and disempowering experience for consumers and a
more or less heart-wrenching paradoxical one for staff whose healing, nurturing role is
combined with reserve statutory powers to forcibly subjugate patients against their will.

The VMIAC then attracted VicHealth support to research the:

> ... establishing and refining processes by which staff and consumers in psychiatric hospital
> wards could routinely collaborate to research and evaluate the experiences of consumers and
> make the consequent relevant and appropriate changes to hospital practices.

Now here indeed was a chicken and an egg. Consumer evaluation of acute psychiatric services
was a radical enough proposal for most people. The idea of staff actively wanting to seek it out
seemed even more unbelievable. But consumers wanted staff to want to hear from them—and
to listen, and respond accurately. And many staff wanted consumers to appreciate their efforts,
and to see them as favoured partners in the processes of healing and recovery.

So we began[1].

The fundamentals of our methodology were to establish and sustain a sequential dialogue designing a process which firstly, enabled consumers to tell their stories of their admissions—sometimes uneventful, but mostly painful. Secondly to enable staff to tell the stories of their objectives and their consumer feedback activities, as well as stories of frustration. This material would be swapped between the two groups.

Generally we found then that consumers were chuffed to hear staff were trying hard for them, but still felt indignant about damaging treatment, and wanted to make positive suggestions for change. Staff are then routinely divided over consumers' negative descriptions, with some urging attention and change while others feel defensive or complacent or sceptical or all three.

Then consumers go through further phases of sympathy but became more impatient for improvement and continue to press for change. They may experience their stories of poor practice as unheard—and retell them. In the 'final' typical response, a small number of staff voices still urge change, but the stronger messages are those of pessimism, reiterating that either things have already been tried, that consumers' suggestions wouldn't or couldn't work or are too hard or 'too radical' 'under current circumstances'. This is the basic 'dance of power and powerlessness' with which our project has engaged for nearly four years.

In a sense what emerged was 'the project we did while we were busy making other plans', or rather, the project we did instead of the one we had expected! It was the project we had planned—we did indeed carry out each of the five major objectives of the original design. Yet within that framework—everything continuously changed. We found ourselves responding iteratively to wave after wave of new events and unexpected outcomes—all in a response to this fundamental 'dance'.

The effects of going down the track of commencing with a longer period than planned of more in-depth discussions with a wider range of players involved in the psychiatric services system, were multiple. Firstly, from the first discussions we were able to begin to sketch a model of a surprisingly comprehensive range of consumer feedback methods. These included more applied use of community ward meetings; a range of complaints procedures; the entire area of interpersonal communication including body language, verbal language, and between staff and inpatients, and between staff themselves; spot surveys, exit surveys, customer satisfaction surveys

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The range of people interviewed at the outset prefigured the range of 'partners' with whom we were to collaborate over the three years - that is, all those who might contribute to shaping the experience of the inpatient. We spoke with roughly equal numbers of consumers, nurses, hospital administration, research and education people and State government departmental officers, non government mental health services, and hospital medical, psychology and social work, and community mental health staff.

By the second and third years we were adding interested out-of-area and interstate people who were also giving us feedback about the relevance of the model to their work. This meant that the dialogue circles, the participation and 'partnerships' and thus the necessary 'culture shift' and naturalistic testing of the model spread even wider

This model includes infrastructure to sustain the partnering relationship. They became the new loci for the 'dance of power and powerlessness'. (They include a standing Implementation Committee - half staff, half consumers; a consumer office in each of the two trial area mental health services; consumer representation on a variety of service planning and development committees; a consumer-only sub group to provide support and assistance to all consumers participating in the program; monthly staff/consumer QA seminars for dialogue about the deeper issues; a consumer participation program Network of supportive staff and consumers; a panel of people able to provide additional consumer consultancy and other consumer program staff development and support assistance; and a fund dedicated to support these latter functions.

and other quality assurance activities; special dialogue opportunities between staff and consumers; feedback from ex-consumers and their involvement in staff training and other management meetings; ward program feedback (non therapy) discussion groups; involvement in treatment plans and assessment meetings, the use of independent advocates, suggestion boxes, and so on.

Secondly and perhaps most importantly we learned a lot from and about staff and how not to proceed if we wanted their participation. We got our first glimpse of the strong emotions some staff were carrying—anger, hurt, fear, cynicism, powerlessness, shame and demoralisation. We called all this material the 'cultural context for consumer evaluation'. This also began a discussion around the critical barriers and enablers of communication—diagnoses, language, labelling, the medical model, stigma and the emotional experiences of staff and consumers, coercion, violence, and so on—which ended up being central to understanding why it was so difficult for partnerships between consumers and staff to achieve change, rather than peripheral.

We abandoned some ideas, and began to present ourselves more as working with and for staff in a supportive way, that is, to support their efforts, rather than expecting them to do what we thought they would want to, or should do, to assist consumers.

Thirdly, this initial survey yielded some concrete material with which we could return to the wards for a further attempt at engaging staff in discussion and activity.

Fourthly, we networked to get the original group of participants—then went on networking for three and a half years. Even in the process of developing a technique for the 60 participants to comment on and edit or approve the write-up of the initial round of the new larger dialogue, we developed a mail list network. Here was another apparently peripheral matter which proved to be both an important process issue as well as a central finding! This came to comprise an unexpected element of an even larger dialogue, as we found that—while staff and consumers might come and go from active participation in the central 'sites' of the acute units on the hospital campus or the VMIAC organisation—they frequently turned up again at a later date. Meanwhile they had continued to receive information about the unfolding of the project's thinking (in the form of monthly bulletins throughout the second year), and would come back 'on line', still in some sense a participant (although generally at arm's length). This happened so

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The idea of consumer consultancy was perhaps one of our project's most important findings, as well as the idea of a mutual support group for consumers providing this consultancy advice to the system on how to seek consumers' evaluative feedback. We developed and successfully trialed both these concepts.

An important area of our thinking resulted in the development of the monthly staff-consumer Collaborative Seminars. These are somewhat analogous to the Medical QA meetings at which doctors get access to the latest information about drugs and other research, but in this case are to provide access tor staff to a consumer perspective and to information about consumer and staff initiatives to get feedback from consumers. They are also most importantly, efforts in which to explore consumers' and staffs' views about the really deep issues of fear and stigma and how 'the system' holds these in place, and what to do instead.

April Lawrie Smith (1996), Restraint of Love Vol 1, 'Silence, Conversation and Voice', Young People and Family Violence Action Group, South Australia, page 91.

In recent weeks, after having consumers employed as consultants on two acute units at the hospital, things looked difficult. Staff seemed to be at a peak of dissatisfaction. Then yesterday came some tremendous news that there had been a shift. Suddenly some staff were planning an exit survey, some others were engaging in working on a dialogue about better communication, and at last an administrative support method planned a year ago - had been put in place.

often that by the third year, we had not only built it into our understandings about the operation of the psychiatric services system but also into our expectations, as we realised the value of it as a structure in its own right for any future model for staff-consumer collaboration.

We described our approach as working 'prefiguratively', that is, we constantly examined what we were doing in terms of whether and how it might survive our absence, and instead become—and stay—'built in'. To do this, we had to identify what practices or discourses had power or a place in the organisational culture for us to harness our purposes to. To this end we found ourselves increasingly utilising the discourse of 'quality assurance'.

Every iteration of the project saw us learning in this same way from each new phase which unfolded. For example, after returning to the wards to try and work with staff on small QA studies of consumers' views, we found staff still not able to engage with the project. So we used a hospital-wide questionnaire to ask staff to identify questions they might like to ask consumers. This yielded over 1,400 different questions and gave us material to try to re-engage with staff, which appeared to suggest staff did indeed want to seek consumer feedback, yet curiously, staff continued to find it difficult to take up small studies of their own. Finally we trialed the use of ourselves and ex-patients as consultants, working on the wards, and at last found things began to happen. In quite short periods of time a series of small-scale inquiries and improvements took place, and we completed the second year with a proposal for a 'package' of paid consultants and some support infrastructure.

In the third year we tracked this proposal until it was funded, and then were able to trial the steps needed to implement an area-based consumer participation program, necessary to achieve our project's ends.

Along the way we worked not only with local ward, hospital and area office staff and consumers, but also with the VMIAC and the State Department of Human Services as well as the Royal Melbourne Hospital (which acquired Royal Park in the middle of our project!) firstly at regional level, then centrally—to achieve both funding of the pilot, as well as a new State policy on Consumer Participation in Mental Health Services, plus a pilot State-wide funding program for consumer consultants. We also won two national awards, one for our pioneering evaluation reports, and the other for a successful 'partnerships project'.

But did we ever really get to dance with our partners? At the end of three and a half years, we still cannot yet document the building in of new consumer feedback mechanisms. Staff can still feel demoralised and under siege. Consumers still have not yet seen many changes as a result of telling their stories. Most staff still do not welcome consumer feedback or seek it out, and those few who have, often repeatedly describe the same small exercises which took place at an earlier time. The consumer participation program and staff-consumer consultants—despite being a source of pride to many staff—go on having to work hard to hold to their basic purposes and outcomes. There remains a persistent tendency to either shoot (or muffle) the messenger or for the messenger to be tempted to keep quiet and wait.