Involving Disadvantaged People in Dialogue: Arguments and Examples from Mental Health Care

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This paper examines the theoretical and practical basis for engaging in dialogue with very disadvantaged people. Using a selective literature review, conceptual analysis, and clinical examples, we explore the reasonable limits of dialogue with disadvantaged populations in order to better understand dialogue, as well as to explore ways to effectively involve disadvantaged people in dialogue. Although people with serious mental illness represent only one very disadvantaged population, we suggest that examining dialogue with this population can serve as a test case for dialogue with disadvantaged people more generally. A recovery-oriented approach can support dialogue processes with people who have mental illness, as their recovery may require, or at least benefit from, dialogue. The inclusion of two clinical scenarios serves to highlight differences in clinical and personal recovery outcomes when dialogue is and is not present in mental health care. Furthermore, although it is not required from a standard principles-based bioethical approach, involving people with mental health issues in dialogue can complement a standard bioethics approach, through *dialogical bioethics*. A dialogical approach goes beyond the standard principles of bioethics by means of a process that allows relevant bioethical principles to be prioritised, based in part on the person's informed choice. Overall, our findings suggest that involving very disadvantaged people in dialogue – in this case, people with serious mental illness – is not only possible, it is plausible and can be constructive in relation to a variety of dialogical aims that range from informing to supporting to decision-making processes.

Key words: dialogue, disadvantage/discrimination, ethics, mental health care/recovery, serious mental illness, stigma

Introduction

Dialogue is an elusive notion and a complex phenomenon. It is required for the accomplishment of a variety of outcomes, yet it is difficult to achieve. Indeed,

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human history suggests that dialogue, particularly sustained dialogue, is the exception rather than the rule in social interaction. In terms of resolving differences, it seems that people have usually, at best, engaged in compromise and, at worst, in combat, yet it neither is, nor does it include, much dialogue. So what is dialogue?

For the purposes of this paper, the characterisation of dialogue that we will illustrate aligns with this journal's definition of it as: "meaningful interaction and exchange between people (often of different social, cultural, political, religious or professional groups) who come together through various kinds of conversations or activities with a view to increased understanding" (*Journal of Dialogue Studies*, 2013). This characterisation refers to an end (increased understanding) and means (meaningful interaction and exchange, coming together, and conversations or activities), and agents or parties (people), the relationship between which illustrates the complexity of dialogue, as it involves the interaction of various agents and processes.

Dialogue is sometimes assumed to occur among equals, at least in principle. That is, even if some participants (agents, i.e., reasoning individuals, or parties, reasoning groups of individuals) are not on a par with each other at the moment – for example, with regards to the political power to influence the dialogue or the emotional ability to participate in dialogue – there is sometimes an expectation that they can, and perhaps even will, be on a par in the foreseeable future. This expectation can sometimes allow the dialogue to proceed. As, more importantly, dialogue assumes or requires collaboration or cooperation among the participants, at least in relation to the aim that the dialogue is expected to advance (Sennett 2012 p. 275). These assumptions may not hold when people who are very disadvantaged – socially and/or otherwise, to the extent that some of their basic needs such as food and shelter may not be met without considerable support – are called to participate in dialogue, as they may never be on a par with the other participants. Consequently, disadvantaged participants and/or the other participants may not be collaborative or cooperate with each other, due to significant power differentials, stigma, and/or other factors.

This paper examines the theory and practice of engaging in dialogue with very disadvantaged people, in order to explore the plausible limits of dialogue and thus to better understand dialogue generally, as well as to explore ways to more effectively involve very disadvantaged people in dialogue in order to uphold their rights as much as possible. Our inquiry – particularly in relation to dialogical bioethics (Author 2002, Author 2007) – is informed by argumentation theory/informal logic, which has addressed dialogue in detail (Walton 1998), among other relevant theories; argumentation theory/informal logic describes, analyses and suggests various communication strategies, both empirically and normatively (Ibid). We use a selective literature review with conceptual analysis, which can be

viewed as addressing the internal consistency of relevant concepts, i.e., to examine whether or not they are significantly self-contradictory, and the coherence between them, i.e., to examine whether they do not contradict each other (Yehezkel 2005). We also use clinical illustration, i.e., hypothetically relevant but reality grounded examples from mental health care, based on our knowledge of the clinical literature and our practical experiences in Canada, the United Kingdom and Israel. Such illustration cannot be confirmatory, and may even be viewed by some as being biased, considering that it serves the purpose of highlighting our arguments, but it is suggestive and provides concrete – hence useful – grounding for arguments that may be fairly abstract and therefore sometimes difficult to grasp. People with mental health challenges, particularly with serious mental illness(es), such as schizophrenia, are often very disadvantaged, sometimes due to severe and persistent impairments, such as significant cognitive (memory and other) deficits (Hoertnagl and Hofer 2014; Lin, Reniers and Wood 2013), and sometimes due to discrimination against them (Arboleda-Florez and Sartorious 2008). Dialogue with people with serious mental illness can thus serve as a test case for dialogue with disadvantaged people more generally. Furthermore, people with mental health challenges are very disadvantaged, not only as individuals but also as a group, due to the considerable stigma they collectively still suffer in most societies. Dialogue with people who have mental illness can thus address dialogue with individuals as well as with groups (or representatives of those groups).

Serious Mental Illness and Recovery

Mental health challenges, similarly to other health challenges, consist of impairments, disabilities, and disruption in participation in various environments, the latter previously being considered to be handicaps (World Health Organisation 2001). Relevant impairments include depression, psychosis and more. Relevant disabilities may include a lack of sufficient work skills, social skills and more. Relevant disruption in participation includes unemployment, social isolation and more. Impairment is necessary but is insufficient for disability, and disability is necessary but is insufficient for disrupted participation. Other factors in addition to impairment lead to disability, primarily personal factors such as personal history and coping, and other factors in addition to disability lead to disrupted participation, primarily environmental factors such as negative societal attitudes towards the disabled person and opportunities (or rather lack of them) to succeed in spite of a disability. In relation to serious mental illness, which primarily refers to schizophrenia and major mood disorders (major depressive disorder and bipolar disorder), impairments are typically moderate to severe, such as major depression, mania and psychosis; disability is considerable, for instance, poor hygiene and deficient social interaction; and disrupted participation are often the case, such as persistent or recurrent unemployment and social isolation. An additional factor

that may impede participation is a reaction to internalised stigma, as opposed to public or environmental stigma, which are referred to as the 'why try' effect (Corrigan, Larson and Rüsch 2009). Internalised stigma include an awareness of public stereotypes, agreeing with them, and subsequently applying them to oneself.

It is sometimes considered difficult, if not impossible, for people with serious mental illness, such as schizophrenia, to fully or even partially participate in dialogue, both in general and, more specifically, in relation to their mental (and other) health care. This is because they often have persistent cognitive and other mental impairments that make it difficult for them to clearly experience, process and express what is relevant to the dialogue at hand. It is also because they have sometimes had inadequate or unsuccessful experience with dialogue, due to a lack of sufficient social skills, of social isolation, discrimination, or self-stigma. Yet people with serious mental illness are provided with mental and other health care that requires their input and, often, their decisions, which presumably involve dialogue. How can such dialogue occur with them, if it can at all?

A fairly recent development in mental health care is support for the recovery of people with serious and other mental illness. Recovery means different things to different people (Author 2012a), possibly so much so that there is a risk that the notion of recovery may be deemed meaningless (Roe, Rudnick and Gill 2007). Recently, however, two general and distinct, yet arguably complementary, notions of such recovery have been discussed: recovery as a set of outcomes, which is also termed clinical recovery; and recovery as a set of processes, which is also termed personal recovery (Slade 2009). Clinical recovery relates to outcomes such as alleviated symptoms, more independent functioning and an improved quality of life. Personal recovery relates to processes such as finding personal meaning in life and getting and keeping valued social roles. Personal recovery arguably involves interaction, including communication, primarily with the social environment (Author 2008) – as well as interaction, i.e., (psychological) processing, within the recovering person (Roe, Chopra and Rudnick 2004). Recovery may thus require, or at least benefit from, dialogue between the recovering person and people who can contribute to his or her recovery. Indeed, person-centred care for people with serious mental illness assumes such dialogue across its various components (Rudnick and Roe 2011), and although there is not yet full consensus on it (O'Reilly 2011), it is emerging as best practice in mental health care (National Institute for Health and Care Excellence 2011). It is also grounded in the more general and widely accepted bioethics principle of respect for persons, which guides contemporary health care (Beauchamp and Childress 2013).

Dialogue and Bioethics

Perhaps the most widely established principles of contemporary bioethics are respect for persons, which upholds autonomy, and hence the choice(s) of the person; beneficence, which upholds the good of the person (including his/her best interests when that person is incapable of determining his/her own good), and hence the needs of the person; non-maleficence, which upholds doing the least/no harm, *primum non nocere* (although this is no longer considered more important than any of the other principles), to the person; and justice, which upholds fairness to the person and to all other relevant,involved and impacted individuals, as well as groups (Beauchamp and Childress 2013). A standard approach to bioethical decision making is the contextual consideration of these principles on balance, eventually prioritising the principle that appears to have most weight in a particular situation (Ibid). In spite of the importance of the respect for autonomy in this approach (Gillon 2003), it may still be paternalistic, if not authoritarian, as it assumes that the contextual consideration and prioritising may be done to the person rather than with and/or by him or her. Dialogue is therefore not a necessary part of this standard bioethics approach. This is even more important in regard to people with mental health challenges, who are sometimes viewed as beingt insufficiently autonomous to make important choices such as those in relation to their health care.

An alternative, although perhaps complementary approach to the principles-based approach in bioethics is found in dialogical bioethics (Author 2001; Author 2002a; Author 2007a). Dialogical bioethics uses a structured, staged, approach to facilitate relevant types of dialogue around ethical issues in health care, based in part on argumentation theory/informal logic (Walton 1998). Such dialogue proceeds with setting the conditions for dialogue (including what would count as success for the dialogue which, based on dialogue principles, cannot be pre-determined as it must be agreed by those involved in the dialogue, yet such involvement implies that success has to include the satisfaction of all involved – at least satisfaction with the process, if not always with the outcome); continues with the formal opening of the dialogue; then follows with argumentation; and ends with the closing of the dialogue (including resolution where possible) (Author 2007a). This dialogical approach addresses the above-noted principles of bioethics, as it facilitates their prioritisation, based in part on the person's informed choice. For instance, using such dialogue, a person with a terminal condition can choose whether to be informed of the diagnosis or not (Author 2002b). This would be more difficult, if not impossible, if principles were prioritised paternalistically by the health care providers. For example, if autonomy is prioritised, the person may be informed of the diagnosis in order that s/he can decide on his or her care, whether he or she wants that or not, and if beneficence or non-maleficence are prioritised, the person may not be informed of the diagnosis in order to prevent the psychological

suffering that might result from his/her knowledge of impending death. Such non-disclosure is termed "therapeutic privilege" and is less and less commonly practised, at least in Western jurisdictions. Other bioethics approaches that have recently been commonly used or reused are, respectively, feminist bioethics, which focuses on power dynamics; and virtue bioethics, which focuses on moral intent rather than on moral duty or consequence. Interestingly, care ethics, which combines both feminist-like bioethics and virtue-like bioethics, may lead to paternalism or authoritarianism in bioethics and hence may be more problematic than dialogical bioethics (Author 2001).

In the case of people with serious and other mental illness, there is concern about whether some of them are capable of making decisions, particularly regarding their health care, when they have severe mental impairments, such as major depression (Author 2002c). Admittedly, there are many variants of 'capable' decision making, some of which involve mental challenges, such as limited meta-cognition (Author 2004), which is the ability to mentally represent mental representations, or, more specifically, to think about one's own and others' thinking, yet it is not standard to abrogate personal choice due to limited meta-cognition. That being said, more severe mental challenges may pose difficulties to full dialogue, both due to the mental impairments involved and to others' negative or over-paternalistic attitudes toward people with serious and other mental illness. How can dialogue occur, if at all, with people who have severe mental health challenges?

Dialogue with People Who Have Severe Mental Health Challenges

It is important to distinguish the various aims of dialogue. If the aim of dialogue is to decide on specific treatment for mental illness, such as medication, some people with severe mental health challenges may not be capable of deciding on such treatment (Author 2004), in which case dialogue with them about that would aim only to inform and support them in relation to the decision made by others for them, rather than by or with them. This assumes that dialogue preferably, but not necessarily, allows mutual decision making, but necessitates, at the very least, reciprocal information sharing. Yet much of mental health care is about other matters, such as housing and work, and although some people with severe mental health challenges may not even be capable of deciding on these life-plan related matters, in most cases such decisions are best left to the person with mental illness to make, partly as such matters are determined by personal preferences that usually do not have much if anything to do with mental illness (Author 2002d). Indeed, paternalism regarding life plans rather than treatment is arguably coercive and ethically, if not logically, suspect (Author 2007b; Author 2013).

In order to conduct dialogue with people who have severe mental health challenges, both in relation to their mental health care and more generally, specific education may be needed, both for people with serious mental illness and for others who may be involved, such as their families and mental health care providers. Based on an adult education framework (Knowles, Holton and Swanson 2011), knowledge, skills and attitudes can be addressed in such education. For example, people with serious mental illness and the relevant service providers (as well as relevant trainees and policy makers) can be educated to better communicate with each other about service users' wants and needs (Forchuk 2011; Karnieli-Miller and Salyers 2011; Roe, Telem, Baloush-Klienman, Gelkopf and Rudnick 2010; Author 2011; Rudnick and Eastwood 2013). New – electronic, particularly mobile – technology can assist with such enhancement of dialogue between people with mental illness and others who are involved in their lives (Rudnick and Roe 2012). Additional tools for empowering decision making by people who have serious mental illness, with their families and others, can include an advance planning tool such as the Wellness Recovery Action Plan®, which was developed by a person with lived experience of serious mental illness (Cook et al. 2012).

For illustration of dialogue between people with serious mental illness and their service providers as well as others involved in their lives, we will describe here an imaginary but reality-informed clinical vignette, with two scenarios – firstly, one with little if any dialogue, and secondly, one with effective dialogue. Although the lack and existence of dialogue is not the only difference between these two scenarios, we think it is important to highlight this difference in relation to dialogue here.

Lack of or Insufficient Dialogue with a Person Who Has Serious Mental Illness

> Mr. B is a 38-year-old single man, who was diagnosed with schizophrenia when he was 23 years old, and has a history of alcohol use. He lives with his widowed, retired mother and will not help with household chores unless specifically and repeatedly asked. He has been unemployed for the past 8 years, ever since he returned to Canada from Afghanistan after a 7 year stint (most of it outside Canada) of being successful in both his professional and personal life. He was employed as a salesman at a successful business firm and was married, but both job and marriage were lost a few months before his return to Canada. He receives a disability allowance from the government, part of which his mother uses for his rent and groceries, and the rest of which he mostly spends on cigarettes and alcohol. Mr. B attends a local college to gain a new skill set in car mechanics but as he was struggling to keep up with the courses he dropped his course load part way through the school year. He has recently begun socialising with a much younger man he met at college. He has two brothers who live in a different province and do not have much

contact with him. He does not associate with other mentally ill people, as he does not feel he has a mental illness. Mr. B sees his outpatient psychiatrist every 6 weeks for follow-up, and his outpatient psychiatric nurse every two weeks for injectable medication administration. The outpatient social worker from the mental health services is available to meet Mr. B and his mother, as well as his brothers, on an as-needed basis, and the outpatient occupational therapist and psychologist are not involved in his care. When he was 30 years old, Mr. B was assessed as being incapable of making decisions about his psychiatric treatment, due to having insufficient insight into his illness. His mother is his appointed substitute decision maker (which is legally possible in various jurisdictions) with regard to psychiatric treatment, and takes him to his hospital appointments. He is administered a long-acting antipsychotic injection and has some residual symptoms despite standard-dose treatment. Mr. B was previously put on a Community Treatment Order (CTO), i.e., involuntary outpatient treatment (which is a legal option in various jurisdictions), because he has stopped taking his injections on two occasions, relapsing quickly into severe self-neglect, disorganisation and a resultant hospital admission. For the last 8 months, Mr. B has repeatedly requested a discontinuation of his medication. He has connected with bloggers on the Internet who have written about antipsychotics being toxic chemicals with many side effects, including sexual problems and Tardive Dyskinesia, a relatively rare but disruptive movement disorder that may be induced by antipsychotic medications. Mr. B feels there is no reason for him to be given such dangerous medications when, in his opinion, he does not even have a mental illness. He expressed the seriousness of his concerns to one of his college professors, who sent a letter to the psychiatrist advocating on his behalf. After failing to convince his mother (who thinks the side effects are related to his alcohol use) to withdraw consent for his treatment, he stopped attending his medication administration appointments. After two missed appointments, his mother notified his psychiatrist, who contacted him by phone and urged him to attend an urgent injection appointment with his nurse and to meet him soon after. When Mr. B refused both requests, his psychiatrist used the CTO and with the assistance of the police compelled him to come to hospital, where he was admitted as an involuntary patient to restart the medication under observation. He became severely catatonic (immobile) during the first few days of his hospitalisation, and his psychiatrist then started him on electroconvulsive therapy (ECT) to try to induce a quick remission of these symptoms. After six sessions of ECT, his catatonia subsided, and after a few more days of adjustment to the doses of his medications, Mr. B was discharged back home on the CTO with some short-term memory loss, which was probably a side effect of the ECT. Mr. B quickly resumed his regular routine in the community. His short term memory returned to baseline levels after 3 months. He continued to be distressed about the different side effects he experienced, but no longer talked about this, except indirectly by writing essays on social justice. The

psychiatrist and the psychiatric nurse periodically reminded Mr. B to reduce his alcohol and smoking consumption, which he agreed to do.

Effective Dialogue with a Person Who Has Serious Mental Illness

Ms. A is a 38-year-old single woman, who was diagnosed with schizoaffective disorder, bipolar type, when she was 25 years old, and has a history of one suicide attempt by mild overdosing with acetaminophen when she was 26 years old. She lives in subsidised housing near her widowed, retired father, and they help each other with some of the household chores, based on their preference for particular chores (e.g., he prefers vacuuming and she prefers grocery shopping). Ms. A is employed part-time as a clerk. She socialises regularly with her colleagues from work, as well as occasionally with peers whom she met in the hospital. Ms. A sees her outpatient psychiatrist every 3 months, and her outpatient psychiatric nurse monthly. The outpatient social worker from the mental health services sees her and her father at least every 6 months for support and ad-hoc counselling about their joint activities and concerns, and is available on an as-needed basis for family psycho-education for Ms. A's older brother and younger sister. The outpatient occupational therapist and psychologist each conducted weekly sessions with Ms. A six years ago for a few months both before and after she moved out of her father's home into her own housing, when they focused on the enhancement of independent living skills and on improving self-esteem, respectively. The occupational therapist also coached her in job interviewing and in the development of social skills in the workplace when she was searching for work. Both the occupational therapist and the psychologist are available to meet her for booster sessions and for other purposes on an as-needed basis. When she was 27 years old, Ms. A was assessed as being incapable of making decisions about her psychiatric treatment, due to having insufficient insight into her illness. Her father was then appointed as her substitute decision maker with regard to psychiatric treatment, and started to remind her daily to take her medications. Soon after this, her psychiatric nurse commenced psycho-education and motivational interviewing for adherence. Ms. A had been on a community treatment order because she had previously twice stopped taking her mood-stabilising and antipsychotic medications since she was concerned about the weight gain that they caused. On each of those occasions she relapsed with suicidal ideas and was hospitalised. During her second relapse, her medication was changed to medication that induces less weight gain, and she received health education about healthy diet and exercise. She also was exposed to the option of developing her own self management plan (WRAP®) and determined that she would attend the peer led group, providing her with personal tools to better address illness management and recovery and with exposure to positive role models. Two years later, and with continued psycho-education, motivational interviewing, health education by the psychiatric nurse, and community based self-help support groups, she was assessed as being capable of making decisions about her psychiatric

> treatment, and the community treatment order was discontinued. Ms. A has now once again stopped her psychiatric medications due to weight gain, and refuse to take them, despite her father's repeated requests that she should do so. Her father notified her psychiatrist, who phoned her and asked her to meet him with the psychiatric nurse at her apartment as soon as possible to address her father's concerns. She agreed, but requested that her father not attend. During the meeting, they all reviewed and reconfirmed her crisis plan, which included psychiatric hospitalisation, as required by law, if her condition worsened to the point of suicidal or aggressive plans or behaviour or severe self-neglect, such as starvation or other severe self-harm (including considerable overspending and unsafe sexual promiscuity during a manic episode). After obtaining voluntary informed consent from Ms. A, the psychiatrist initiated a medication change to further reduce the risk of weight gain, and Ms. A agreed to meet him every 2 weeks at his office for the next couple of months, to allow the psychiatric nurse to visit her at home weekly during that period, and to call them or the crisis line urgently if her condition worsens. She also agreed that her father should call the psychiatric team if he is concerned, but requested that she rather than they inform him of the new care plan. Her father was encouraged to attend a community-based support group for family members. After a couple of months, Ms. A was still in remission and the medication change was completed. She was still assessed as being capable of making decisions about her psychiatric treatment, and she continued with her regular routine in the community throughout this period. She is now planning a holiday trip with her family, and was referred back to counselling with the psychologist to address her lack of self confidence in relation to her felt need to find a partner. (Author 2012b, 311-2).

An important difference between these two scenarios is that in the first scenario neither the family nor the service providers engaged in much dialogue with the service user, but rather assumed about, and decided for, the service user. As a consequence, the service user did not engage in much dialogue with them, resulting in poorer outcomes. In contrast, in the second scenario, all the people involved engaged in more dialogue and the outcome for the service user was better, e.g., participation in peer-led groups, such as WRAP® and similar interventions, can facilitate the learning of adaptive coping from others with similar experiences (Pallaveshi, Balachandra, Subramanian and Rudnick 2014). We suggest that the outcome for all others involved was also better, e.g., for the father, who benefited from more help than he wanted and needed from Ms. A (Scenario 2). Admittedly, aiming at treatment adherence may not be considered as being fully supportive of self-determination (Corrigan, Angell, Davidson, Marcus, Salzer, Kottsieper et al 2012), which is important for dialogue; yet motivational interviewing that was conducted explores the pros and cons of adherence, with the hope, but not the presumption, that adherence will favour positive outcomes. Other factors that differ

across these two scenarios may also have influenced the outcomes; physical, mental and/or social background differences may explain the better outcome of scenario two, e.g., the relationship with the involved parent may have been better for Ms. A than for Mr. B from early on. Still, the differences in the process and outcome suggests that dialogue benefits all who are involved, particularly when the relevant people have a long term relationship that requires ongoing interaction. In addition, actions were taken towards reducing stereotypes in order to reduce internal and public stigmatisation. The questioning of whether one-time interactions benefit much from dialogue is beyond the scope of our paper, but we suggest that, even in such situations, all involved benefit from dialogue, including very disadvantaged people, such as people with serious mental illness.

Based on these scenarios and on published literature, as well as on our clinical and administrative experience, what may further facilitate dialogue with people who have mental illness, particularly between people with serious mental illness and their health care providers? A promising approach that uses dialogue to determine mental health care is shared decision making (Deegan, Rapp, Holter and Riefer 2008). Shared decision making is a structured approach that involves mutual learning between a person with serious mental illness and his or her health care providers about his or her health care goals and ways to achieve them (by means of evidence-informed interventions as well as lived experience of personal coping strategies), e.g., using a person's advance preparation of a list of goals for discussion. There are some positive outcomes for shared decision making, such as service user satisfaction, emerging and it has been shown to be safe (Duncan, Best and Hagen 2010). Another promising approach addresses future concerns by discussing and establishing contingency planning in case the service user becomes incapable of deciding on his or her mental health care. This approach uses Psychiatric Advance Directives, which facilitates communication and decision making between service users and their providers about the service users' recovery and related goals (Scheyett and Kim 2007). Other approaches, such as reduction of health care providers' and trainees' stigma towards people with serious mental illness, especially in traditionally authoritarian institutions such as hospitals (Linden and Kavanagh 2012), may also be helpful.

Other Very Disadvantaged People

How does this learning about people with serious mental illness apply, if at all, to people who are very disadvantaged in other ways? The social disadvantage of people with serious mental illness is similar to that of other people who are very disadvantaged, as discrimination is similar across populations, at least in its key characteristic of excluding people from access to a full life. The main difference may be in relation to the mental health challenges that some people with serious

mental illness have, but others do not. Still, other people, such as first generation poor immigrants, may have a language barrier, which people with serious mental illness may not have. Hence, although very disadvantaged groups (and individuals) may differ in some of their specific disadvantages, their situations may not be that different from each other, it may thus be possible to apply the learning from people with serious mental illness to other very disadvantaged people.

Conclusion

We have argued and illustrated here that dialogue between service providers, people who have serious mental illness, and other relevant participants is both possible and helpful, in relation to mental health care as well as to other matters, and that it is grounded in sound (dialogical) bioethics. We have also suggested that relevant education for people with serious mental illness, as well as for their service providers and others who are involved in their lives, can effectively facilitate dialogue by accommodating mental health challenges that may disrupt dialogue and by improving societal attitudes that may also disrupt dialogue. Although our paper is limited in that it is focuses primarily on one very disadvantaged population, i.e., on people with serious mental illness, and in that it reviews only part of the relevant literature and describes two individuals rather than a larger sample, we suggest that it supports a recommendation to facilitate dialogue with very disadvantaged people, such as some people with serious mental illness. We also suggest that dialogue with other very disadvantaged people may benefit by learning from dialogue with people who have serious mental illness. Further research is needed in relation to dialogue with such very disadvantaged people.

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