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Development and policy

Mental health service user involvement: teaching doctors successfully

George Ikkos
Associate Medical Director (Medical Education), Barnet Enfield and Haringey, Mental Health NHS Trust; Chair, Charing Cross General Professional Training Scheme in Psychiatry, London; Consultant Psychiatrist in Liaison Psychiatry, Royal National Orthopaedic Hospital, London; Chair, London Division, Royal College of Psychiatrists, UK

ABSTRACT

to come

Keywords:

Introduction

The Bristol Royal Infirmary Inquiry exposed the grave risks of medical paternalism and failure of healthcare professionals to reflect on our practice. It led to the specific recommendation that the NHS should become more explicitly an organisation whose practice is patient centred.[1] A patient-centred NHS should be equally centred on those with psychiatric disorder as well as without.

At the same time that the government accepted the Bristol Royal Infirmary Inquiry recommendations, it supported the establishment and development of the Expert Patients Programme for the management of chronic diseases.[2] Curiously the programme has excluded psychiatric disorders, despite the fact that these, not infrequently, persist long term, whether intermittently or continuously. Perhaps this reflects unspoken assumptions and stigma against those with a psychiatric disorder, and the persistence of medical paternalism in relation to this vulnerable group. In the light of this there is concern that patients with a history of moderate or severe psychiatric disorder may be excluded from patient-centred service developments and staff training in both primary and general hospital medical care.

Possible stigma notwithstanding, the Department of Health had previously mandated active user involvement in mental health service planning and delivery as well as the planning, delivery and evaluation of mental health training.[3,4] Such requirements, however, have not eliminated the fear that user involvement may be more spin than substance and that service users may remain undervalued and underused.[5,6]

Holsgrove has highlighted that the newly established Postgraduate Medical Education and Training Board (PMETB) will make service user involvement a mandatory requirement.[7] A review of the literature on developing the role of patients as teachers,

however, identified only one study related to mental health.[8] Since then Walters and coworkers have demonstrated the possibility and desirability of engaging patients with common mental disorders in undergraduate teaching in general practice.[9]

The current report adds to that of Walters *et al*, and a previous report by the present author, to demonstrate that it is also possible, as well as desirable, to engage patients with moderate to severe, recurrent or enduring mental disorder, as well as those presently recovered from such disorder, in postgraduate teaching.[9,10] It also demonstrates that such a project can persist and develop successfully long term. The findings suggest a need to consider the use of service users with a history of moderate or severe psychiatric disorder in primary care service development and staff training.

Royal College of Psychiatrists' psychotherapy training

The Royal College of Psychiatrists (RCPsych) first published *Guidelines for Psychotherapy Training as Part of General Professional Psychiatric Training* 12 years ago.[11] First year objectives of training included the ability to interview the patient in a manner which elicits the required information, to be aware of and describe the importance of non-verbal communication from the point of view of the patient, to understand the various ways in which the patients may view their illness, to understand and practise the principles of supportive counselling and to be aware of the complexities of the doctor–patient relationship.

Subsequently the RCPsych published new extended requirements for psychotherapy training.[12] These requirements set out specific aims, knowledge objectives and skills objectives.

In the first six months of training the *aims* are:

- to develop knowledge of and expertise in psychological skills involved in interviewing individuals and families
- to recognise the relevance of past and present psychological and social stresses in predisposition to and the development and maintenance of psychiatric disorder
- to be able to use knowledge and skill to agree a formulation
- to form a treatment plan with the patient, and to gauge prognosis.

In the first six months *knowledge objectives* are to explain the importance of both verbal and non-verbal communication from the point of view of the patient and the psychiatrist, to discuss the importance of the therapeutic alliance in the doctor/patient relationship, to explain the significance of the psychiatrist's own feelings in any clinical situation and to explain the importance of motivating patients and their families. Objectives also include being able to allay anxiety, to encourage co-operation with treatment plans and to explain the necessity of ensuring an interview setting in which neither patient nor doctor is at risk.

Skills expected to be acquired as a result of fulfilment of the above aims and objectives, are to recognise the stress of the interview to the patient, establish rapport, gain and clarify information, use open and closed questioning, use non-directive, non-judgemental style to allow affective expression, accept negative feelings, emphasise positive strengths and develop a supportive approach; also to interview and assess silent, paranoid, hostile, violent or suicidal patients, to monitor and modify own communication style and emotional reactions to patients, to recognise situations that need supervision and support and, finally, to conduct a brief family interview for the purpose of information giving and information gathering.

The workshop

The cycle of workshops reported here first started in 1993, in response to the original RCPsych guidelines. The cycle recurs every 6 months. The duration of each session is 1.5 h.

The content of the workshops has evolved over the years to reflect changing requirements and practice. Sessions have persistently included an introduction, training on individual interviews, multidisciplinary interviews, family interviews, interviewing across cultures and didactic seminars on basic psychodynamic concepts such as the 'transference', 'counter-transference', the 'unconscious' and the 'mechanisms of defence'.

The present report refers only to the introduction and training on individual interviews. For introduction and training on the individual interview, the total number of sessions per cycle has usually varied from seven to nine sessions. Over the years, mental health services users have contributed to as little as 10% and as much as 100% of the sessions on introduction and the individual interview.

All mental health service users have experience of being interviewed by clinicians, including psychiatrists. Casement has previously highlighted the benefits of learning from the patient.[13] The

Postgraduate Psychiatric Education Board, in Edgware, North London, agreed therefore, in 1999, to the proposal by the psychiatric tutor and workshop leader, to invite the local mental health services users' group 'Barnet Voice' (BV) to contribute to the workshop. Participation of BV members in the workshops commenced in August 1999, and has been limited to the introduction and training on individual interview. We report on the period 1999–2004.

Underpinning the workshop are the RCPsych requirements and the 'Three function model of the medical interview'.[14] The three-function model identifies eliciting information, showing empathy and educating the patient as to the three functions of the medical interview. This model complements nicely the RCPsych requirements. It also concurs well with the three fundamental values BV members have decided they wish to convey to the doctors participating in the workshops, namely *equality*, *engagement* and *empathy*.

BV representatives have agreed to work together with the tutor to help attendees meet RCPsych requirements. They have attended in pairs. They have contributed to the introduction and sessions on assumptions prior to the interview, expectations and feelings prior to the interview, getting the interview started, moving on, and terminating the interview. They participate in seminar-type sessions and complementary sessions where opportunities for role-play are offered. Over the years, two or more of the sessions have consistently been used for role-play.

BV representatives have taken the leading role in the second session. In this session trainees are invited to consider what expectations their patients might have of them in the view of their professional status. This is achieved through inviting the trainees to imagine/reflect on what they might expect themselves from a visit to another professional (e.g. bank manager). In this session, also, the Barnet Voice representatives invite the trainees to imagine the feelings of patients as they approach a psychiatric interview. They also encourage them to reflect on their own feelings as they approach an interview, and how these emotions might affect their conduct of the interview.

The second session is usually concluded with the reading of an evocative poem, which brings to full view the strength of feeling involved in a psychiatric interview. It particularly highlights the fact that the behaviour of the interviewer will have a major impact on whether relevant, sensitive, personal material will be disclosed by the service user or not.

BV representatives make an active contribution to the other sessions they attend, through observations and comments, though they do not lead these sessions. Though BV members are present in the role-play sessions they do not take part in role-play themselves. BV participants review together with the tutor/workshop leader all feedback from participating doctors and plan together the next cycle of workshops on the basis of such feedback.

Evaluation and response

Fifty of 57 participating doctors, between August 1999 and August 2004, have responded to the opportunity to feedback through questionnaire. The total length of the questionnaire is one side of an A4 sheet of paper. For reasons of confidentiality, it is not possible to distinguish between different groups of doctors (e.g. psychiatrists in training versus general practitioners in training).

The responders have been asked to rate their *overall experience* of being taught/trained by BV on a scale of 1 to 10, where 1 is 'terrible' and 10 is 'excellent'. They have also been asked to respond to the following questions:

1 what have you found helpful about the patient/user involvement in clinical interview skills training?'
2 what have you found unhelpful about patient/user involvement in clinical interview skills training?
3 how can patient/user involvement in clinical interview skills be improved?

Figure 1 presents results from overall rating, year by year. Initial results were encouraging. The modal response for the years 1999–2000 and 2000–2001 was 8/10, with averages being approximately 7.5/10 and 7/10 respectively. It will be noted that the range of scores is wide, with one candidate giving a score of 3 and two scores of 5. Furthermore during the years 2001–2002 and 2002–2003 there is some evidence of declining satisfaction, with more doctors allocating low scores and the respective averages dropping to

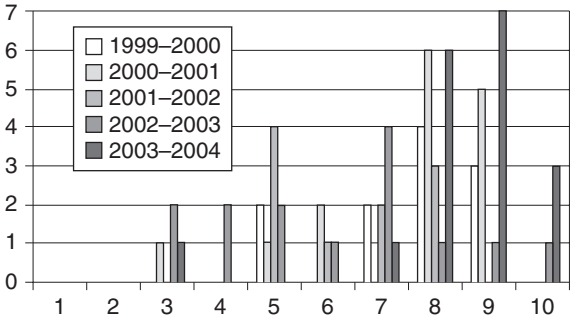

Figure 1 Annual results 1999–2004.

approximately 6.5/10 and 6/10. Particularly during the year 2002–2003 there was a significant number of low scores, with two scores of 4, and two scores of 5.

In the year 2003–2004 there is a reversal of this trend, with a modal score of 9, an average of approximately 8.5 and three scores of 10. The reversal in fortunes has been achieved through attending to the doctors' responses to the three more detailed questions.

In responding to the question 'What have you found helpful about the patient/user involvement in clinical interview skills training?' all responders said they found something useful, and a number commented on the value of hearing the views of users explicitly articulated. They emphasised the importance of becoming aware of the difference in perspective between doctors and service users, and the value of understanding this difference in helping them foster empathy and to change their own attitudes, behaviour and practice.

In response to the question 'What have you found unhelpful about patient/user involvement in clinical interview skills training?' during the years 1999–2003, some criticisms were expressed, which suggested that the doctors had not understood the rationale for user engagement as teachers. For example some doctors criticised users for speaking from personal experience, others criticised the service users as having the wrong views and one trainee objected to 'overtly democratic values'!

Other, better-founded, criticisms included the presence of BV at the introductory session, the limited number of users (i.e. two) involved in each cycle, the limited nature of role-play and some lack of structure in the sessions. Not surprisingly, a significant number of doctors have also commented that the presence of service users inhibited dialogue.

In response to the question 'How can patient/user involvement in clinical interview skills be improved?' suggestions have included the use of a greater number of service users, strengthening the role play, the need for balanced expression of opinion and for everyone viewing the situation as a mutual learning experience for doctors and service users. Encouragingly, there was also a wish expressed for more specific feedback from users on doctors' behaviour.

In response to the above criticisms and suggestions the following changes were introduced:

1 after the absence of a number of years, a weekly Balint-type group was set up for the doctors to reflect on their own emotional experience with their patients, unencumbered by the presence of service users
2 the introductory session is conducted by the tutor, without BV, and is devoted entirely to explaining the rationale and process for user involvement in training. The complementary value of this process to the benefit of the Balint group is highlighted
3 members of BV meet in advance to prepare sessions they contribute to and, also, after the sessions, to reflect and support each other. Issues from the sessions have also been discussed by BV members in six weekly supervision sessions by a trained psychotherapist
4 an extra session has been added on, as the second session in the cycle. During this session the tutor interviews a service user, for an hour, about his/her experience of mental health services. This provides additional depth as well as increasing the total number of users the doctors are exposed to
5 BV members continue attending in pairs. However, whereas one member of the pair is constant in each cycle of workshops, their partner changes every two sessions so as to give doctors the opportunity to hear views from a greater variety of users. In total, doctors are exposed to a minimum of five different service users during each cycle, as opposed to two service users previously. This number includes the service user interviewed at length in the second session
6 BV members explain to doctors that the importance of their views arises not only from their own personal experience, fundamental though this is, but also from experience of visiting patients on the wards, engagement in the local patient council, co-operation with the local advocacy and patient advice and liaison services (PALS) etc.
7 BV members have provided role-play scenarios, and an actress has been engaged to help act these out with the doctors, giving the doctors an opportunity to practise newly learnt skills and benefit from direct feedback from service users, as well as from fellow trainees and the highly perceptive actress herself
8 at the end of the cycle, a further additional session has been added. A group discussion is held, in which the doctors, all five participating users in the cycle and tutor contribute. Focused initially on reflecting on the importance and relevance of exposure to user's experience, this session often broadens into a more general discussion, and allows the doctors to integrate their experience of previous sessions into a broader framework, which is immediately relevant to their clinical work.

As indicated above, the introduction of these measures has led participants to express increased levels of satisfaction. Furthermore, during the year 2003–2004 a more detailed questionnaire has been introduced to evaluate how effective user involvement is in meeting the specific aims, knowledge and skills

objectives of the RCPsych psychotherapy training requirements.[12] Specifically the doctors have indicated that user involvement in training has been particularly helpful in the following:

- *aims*: develop knowledge of and expertise in psychological skills involved in interviewing
- *knowledge objectives*: to explain the importance of both verbal and non-verbal communication from the point of view of the patient and the psychiatrist, and to discuss the importance of the therapeutic alliance in the doctor/patient relationship. Also, to explain the importance of motivating patients and their families, of allaying anxiety, and to encourage co-operation with treatment plans
- *skills objectives*: to recognise the stress of the interview to the patient, establish rapport, gain and clarify information, use open and closed questioning, use non-directive, non-judgemental style to allow affective expression, accept negative feelings, emphasise positive strengths, develop a supportive approach, and to monitor and modify own communication style and emotional reactions to patients.

Discussion

Walters et al have demonstrated that many patients with common mental disorders find it therapeutic to engage in teaching medical students in primary care.[9] Our experience suggests the service users with moderate to severe or recurrent or enduring mental disorders, whether fully recovered or not, also view positively the experience of contributing to postgraduate training of doctors in psychiatry. BV representatives have persistently expressed positive views about the initiative presented here, and the project is seen as a flagship in the meaningful development of user involvement in local mental health service development and training.

There is an increasing emphasis on engaging patients in medical decision making,[15] and it is hoped that engaging patients in teaching psychiatrists and other doctors will ensure that mental health services users have similar opportunities for such engagement to those of users of other medical and surgical services. There may be scope for extending training in a similar way to that presented here, to multidisciplinary groups of professionals in primary care to ensure equitable engagement of those with moderate or severe mental illness in medical decision making about their care, and avoid stigma and discrimination compared with other clinical groups attending primary care.

It will be noted that over the years a number of doctors have scored the contribution of mental health service users very low. We cannot be certain as to why this may be so, especially in the face of positive scores by most other doctors. It may be that some young doctors find it difficult to handle feedback that is not immediately flattering. Primary care trainees and staff may be particularly sensitive to such a risk, not due to any personal peculiarity, but due to reduced levels of familiarity with this group of service users, compared to those training or working full-time in mental health services. The following point, therefore, is particularly important to consider in extending this project to primary care.

In the face of the low scores referred to above, special emphasis is given to ensuring that trainees understand that the presence of BV in training is not intended to highlight criticism of the medical profession, in general, or the workshop participants in particular. Rather, their experience as witnesses and potential contribution as expert patients is emphasised. Indeed BV take pains to emphasise the positive role that professionals can play in their care and that it is because of this positive potential that they see it as a priority to engage in training young doctors. It is encouraging therefore that in the most recent cycle of workshops (August 2004–February 2005, the results of which are not included in Figure 1) the lowest score given by the nine doctors who completed questionnaires was 7/10, with four doctors out of nine giving an overall score of 10/10!

Wykurz and Kelly have highlighted that 'the experience of being taught by a trained patient can increase confidence, reduce anxiety, and generate new insights'.[8] A number of trainees have specifically reported to the tutor that it has been particularly in difficult/anxiety provoking interviews, in the inpatient or outpatient setting, that the value of having been exposed early to the views of service users has stood them in good stead and helped them manage both their own and their patient's anxiety. Extension of training such as that presented here, therefore, may be particularly helpful in supporting general practitioners and other primary care workers in dealing confidently not only with those with common mental health problems but also with those who present with more acute and agitated or other anxiety-provoking behaviour.

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CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Dr George Ikkos, Consultant Psychiatrist and Associate Medical Director (Medical Education), Education and Training Centre, Edgware Community Hospital, Burnt Oak Broadway, Edgware, Middlesex HA7 4LP, UK. Tel: ?????????; fax: ???????; email: george.ikkos@barnet-pct.nhs.uk

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