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GRÁINNE FADDEN, MIKE SHOOTER AND GARETH HOLSGROVE

Involving carers and service users in the training of psychiatrists

In June 2005 it became mandatory for psychiatric trainees to receive training directly from people who experience mental health problems and their carers. This will be checked on approval visits to all training schemes, and accreditation may be withheld until this aspect of training is in place. For many of those who are responsible for training, this may be a new undertaking. We outline some of the issues that trainers need to consider when involving service users and carers in their training programmes, including background issues, how to prepare both those delivering and those receiving training, and logistical considerations. It is hoped that this paper will alert trainers to issues that need to be considered if such training is to be successful.

In 2004 the Royal College of Psychiatrists made clear its commitment to increasing the involvement of service users and carers throughout psychiatric education. This became mandatory in June 2005. It is now one of the compulsory aspects of training that will be checked on approval visits to all training schemes, and accreditation may be withheld until such time as schemes can demonstrate that service users and carers are involved in a meaningful way in the training that psychiatrists receive. The Royal College of Psychiatrists is the first of the professional bodies in the UK to make this decision, and the aim is that this practice should become the norm in psychiatric training. It is a decision that has been welcomed universally by carer and service user organisations, who see this as an opportunity for the recipients and providers of care to develop a fuller and richer understanding of each other's perspectives. It is also consistent with all of the guidance that has been published recently by the Department of Health in relation to workforce issues (Department of Health, 2004*a*,*b*,*c*), and is likely to be required by the Postgraduate Medical Education and Training Board (PMETB), a new body that will have responsibility for standards and quality assurance of all postgraduate education, training and assessment in medicine and dentistry (Holsgrove, 2004).

The involvement of carers and service users in training can confer benefits on all involved. Tew *et al* (2004) anticipate that service user and carer involvement in training will produce practitioners capable of delivering improved and more relevant outcomes for carers and service users, in the same way that the involvement of service users in service planning has resulted in improved service outcomes (Carpenter & Sbaraini, 1997). There can be substantial benefits for teaching staff in terms of professional development and the challenge of developing the curriculum in an innovative way. It also keeps tutors in touch with current issues relating to mental health service delivery, which is very relevant given the findings of the report by Owen *et al* (2005) in relation to the clinical activity of lecturers. For the service users and carers who take on these training roles, benefits that have been described include the development of a more balanced doctor–patient relationship, a better appreciation of professional perspectives (Walters *et al*, 2003) and the enhancement of recovery linked with improved self-esteem because of having a training role that is valued (Masters *et al*, 2002).

There are already areas of good practice where service users and carers are involved in psychiatric training, and there is a growing literature on this topic (Crawford & Davies, 1998; Butterworth & Livingston, 1999; Turner, 2000; Ikkos, 2003; Livingston & Cooper, 2004). It must be recognised, however, that ensuring that this happens routinely is likely to present challenges, particularly where those providing education lack experience in this area. The involvement of those with lived experience of mental health problems, either directly or indirectly, is less developed in mental health than in other areas of medicine. In their review of publications between 1970 and 2001 looking at the involvement in training of those who were receiving services, Wykurz & Kelly (2002) reported that only one of 23 articles reviewed related to mental health.

Another issue is that service users and carers are often grouped together, but there may be different issues in the involvement of both groups. It may be that it will be more challenging for those charged with training psychiatrists to involve family members in training. In mental health, professionals must have a relationship with the service user. The relationship with the family has sometimes been ignored, and in many instances has been less than positive. This backdrop is likely to affect how readily those providing and receiving training can accept

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the involvement of carers in curriculum development, training and assessment.

The purpose of this paper is to highlight the issues that need to be considered by those involved in psychiatric training who will be implementing this new guidance. We outline the background issues; preparation of carers, service users and trainee psychiatrists; some logistical considerations; getting started; and training and preparation for accreditation teams.

Background and context factors

The shift towards the greater involvement of carers and service users in training is to a large extent value-driven, and represents a change from some of the stated and implicit values that have been in place in training environments. Key among these is the challenging of the traditional role of professionals as 'experts'. The new value base involves a three-way partnership between professionals, service users and carers, where the contribution of each is recognised, valued and respected by the others. This may conflict with the values and practice of some tutors and clinicians, and its introduction needs to be handled sensitively. There may also be a divergence between what trainees learn in training sessions, and the views held by their supervisors on clinical placements. People responsible for training may find it useful to develop a values statement around the area of service user and carer involvement so that everyone is aware of the issues involved.

Training providers need to reflect on what the current culture of the training context or environment is, as this will have an impact on the experience of carers and service users involved in training. Despite the reform of the undergraduate medical curriculum in the 1990s, recent publications have continued to draw attention to the concept of the 'hidden curriculum' in medical education, and the fact that students still describe a hierarchical and competitive atmosphere, where students can experience humiliation in the learning environment (Marinker, 2001; Seabrook, 2003; Lempp & Seale, 2004). In considering the curriculum and the learning environment at both undergraduate and postgraduate levels, those charged with training need to reflect on a range of issues before embracing this new development of involving carers and service users in training. It is important to consider whether the ethos of the training environment is hierarchical or open. One way of doing this is to ask how easy it is for junior staff and trainees to state their views freely and to challenge the orthodoxy, provided this is done in an appropriate manner. If they are not able to do so, it is unlikely that invited service users or carers will find it easy to present challenging ideas. Another question is who the experts are considered to be, and whether different types of expertise are properly recognised and valued. Linked with this is the concept of a 'learning together' approach – providers and recipients of services learning from each other.

There are other factors, such as the style of questioning and when colleagues make presentations at seminars or case conferences, and whether this is supportive, confrontational, challenging or analytical. Particular styles can become accepted over time in different contexts, but these may not be appropriate when carers and service users are presenting their experiences and personal stories. The typical interaction patterns, both verbal and non-verbal, of trainees and those supporting their training are important. This covers issues such as whether they reflect together, give feedback, share experiences and express interest and opinions. A key consideration is how easy is it for trainees to be open about their own experiences of mental health difficulties or of having a family member with difficulties. Do they worry that it will affect their career progression if they are open? Many junior staff can feel that this is only 'safe' if they have achieved a senior position.

The ethos to aim for is one of mutual respect, with thoughtful questions that reflect a recognition that service users and carers are sharing their experiences, and that this can be painful. Trainees need to remember that this is not an academic exercise, and that there is a need for sensitivity in relation to how they respond to presentations. The format of presentations may be different from approaches that the learners might be more familiar with: for example, service users or carers will not put their life story on a Powerpoint presentation, but are likely to prefer a conversational or question-and-answer style.

The involvement of service users and family members in training is not just about their providing presentations to psychiatrists. It is much more than a one-way process, requiring a shift of focus from the exclusive learning needs of students to a consideration of the experiences of service users and carers. It also influences all areas of training of junior staff, and may require a review of other practice relating to training. For example, a rationale frequently given for ward rounds is that they are important for training junior staff, even if service users and carers gain little benefit and sometimes find them traumatic experiences. The concept of openness to service users and carers must be an integral characteristic through the whole of training, otherwise it is ineffective. There are a number of ways in which both user and carer groups can become involved in training, including:

- planning of training
- sharing experiences and perspectives
- more detailed training, e.g. interview skills training
- helping junior staff to learn about the experience of mental health or caring issues by being willing to be interviewed about their experiences
- commenting on assignments
- supervision and consultancy with service users and carers while on placement
- feedback from those who receive services from a trainee about capability, attitudes and skills (although it must be acknowledged that this can be tricky to manage if the person is still receiving services from the doctor in training)
- involvement in the selection of trainees for training schemes

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- involvement in selection of tutors and others responsible for training.

Getting started, and developing carer and service user involvement

If the whole concept of involving those with lived experience of mental health problems is new to those responsible for psychiatric training, it can be difficult to know where to start. A useful first step is to make connections and establish relationships with different local service user and carer organisations. This can help to ensure there is proper consideration of the implications of involvement, and not just the token involvement of a few individuals. Another helpful strategy is for tutors to meet or invite in people who already have experience of carer and service user involvement, to facilitate a discussion on the issues to be considered and to share their experiences.

In the longer term, it is useful to have contact with different people who can contribute to training in different ways, or speak on different topics such as in-patient experiences, having a relative admitted under section, and crisis care. A common mistake is to have the same couple of people who present all the time or who are on several committees and groups, because they might become exhausted and weary. It can be a good idea to have carers and service users presenting together on some topics (confidentiality, for example, is a good one) as this can provide different perspectives in the same session, and can encourage trainees to see different facets of complex situations.

Crossover arrangements with neighbouring schemes can also be useful. This ensures that people are not presenting in the area where they receive services. On the other hand, exclusively using people from elsewhere means that you will not obtain feedback on your own service. Other situations that need careful consideration include, for example, involving people on committees of which the person responsible for their clinical care is also a member. These issues can lead to complications and result in painful experiences for all those involved, so careful thought needs to be given to how different roles might be reconciled – for example, how it could be managed if the service user relapses or a relative becomes stressed.

Preparation

The successful involvement of service users and carers requires careful preparation on both sides. For those new to doing this, and those who will be delivering training over time, pre-training workshops can be very useful. It is better to take time with this in advance than to have to undo bad experiences when something has gone wrong. The following two sections suggest some of the issues that can be covered in preparatory sessions.

Carers and service users

In the same way as it would be difficult for someone who is recently bereaved to offer training on grief, it is recognised by carers and service users who are experienced trainers that it is difficult for those whose experiences in services are still very 'raw' to become involved in training at that stage. Many service user and carer groups offer workshops for those who wish to become involved in training. These cover both the emotional and practical elements of training. It is important that carers and service users feel able to express their feelings and experiences openly, including elements of service provision and their contact with professionals that were difficult for them. However, training sessions should not be used as an opportunity to go through every unpleasant issue that has occurred with a psychiatrist in the past. If sessions are totally critical of services and professionals, they are likely to be counterproductive. This has been the experience of courses where there has been no preparation in advance of training, or where briefing has been inadequate. It also makes it difficult for forward-thinking psychiatrists who may be battling on behalf of those receiving services within their own profession to bring about change. It is also the case that the people who attend training sessions are often those that are most open to listening to service users and carers.

It is important for those experiencing mental health problems and their family members to avoid talking about particular individuals by name, or making comments that are insensitive, inaccurate or that overgeneralise, such as talking about the 'poor communication skills' of psychiatrists. It is always productive and worthwhile to focus on what would be helpful as well as on what has gone wrong, and to come up with some suggestions about how things could be improved. Those invited to deliver sessions in this way should be encouraged to see it as an opportunity to influence services and professionals favourably. It is always wise to check in advance who will be chairing the session, what previous training the group members have had about service user and carer issues, and what preparation they have had about the involvement of those who have expertise by virtue of their experience in their training.

Trainee psychiatrists

This type of preparation is important for psychiatrists at any stage of career progression who are attempting to involve service users and carers in services. However, in this article we focus on psychiatrists in training.

An important aspect of preparation is an exploration of any anxieties trainees are experiencing in relation to receiving training from service users and carers. How do trainees think this might differ from other aspects of training? What kind of behaviour is appropriate or inappropriate? The issue of unacceptable behaviour and types of questioning should be addressed prior to training sessions. For example, trainees should be clear that personal questions such as 'Do you feel that if you were more understanding, your wife might not become

depressed as often as she does?' are not appropriate. They should be encouraged to reflect on what they think the experience will be like for the carers and service users, and to think about how presenters might feel facing a group that they may perceive as frightening or intimidating.

Even with good planning, it is usually not possible to predict the entire content of training sessions, so trainees need to think about how they will feel or react if carers or service users are critical of colleagues or services. This can be particularly difficult for those who feel they are providing a good service, and who are trying to make a difference. They need to think about how they can be open and reflective rather than defensive. How can they ensure that they truly hear what is being said? Those responsible for training need to help trainees to see the benefits and pay-off for them of being provided with the most valuable perspective on services they can get – the views of those who receive services.

Logistics

Advance preparation is essential, including clarity about what is expected, who will be involved, and how it fits in with the rest of the training. Service users and carers who are becoming involved in an unfamiliar system for the first time will need ongoing support through the whole process. It is easy to forget the practical factors that can make the difference between somebody feeling comfortable in the learning environment and finding it stressful. For example, there are obvious issues such as the use of language and jargon which need to be considered. Other practical issues that are sometimes overlooked include information about the venue, maps, parking, smoking policy and the availability of toilets or drinks. One person needs to be responsible for the well-being of the person who is presenting, which includes greeting them on arrival, showing them where cloakrooms and toilets are, familiarising them with the place where the session will be held, the programme and timings, and checking that they know the arrangements for claiming fees and expenses.

Another practical issue is the establishment of a budget for payments to carers and service users. The question of payment for work done (including preparation and travel time) has to be addressed, as well as the method of payment. Many of those who become involved in training are unwaged, and most are not part of a system that provides administrative support. Everything that they do therefore costs them personally, including telephone calls, photocopying and paper for printing out lengthy documents. This is often forgotten by those who are used to working in systems where all of this support is provided. Delays in payment are also difficult for those who are on low incomes, and this again needs to be planned for in systems where a delay in payment of expenses is all too often the norm. A number of useful guidance documents have been produced on this area (Scott & Seebohm, 2002; NIMHE West Midlands, 2003; Scott, 2003), and people involving

service users and carers in training will find these helpful. Local services are also likely to have their own guidance documents.

Process

It is essential that sessions are competently chaired by someone who will check if the person is willing to take questions, answer particular questions and shield them from insensitive or inappropriate questions (e.g. 'Don't you think you are being a bit overprotective towards your son?'). This links back to issues of culture, context and hierarchy that were raised earlier. A useful question to ask is whether the person chairing the session is able and willing to confront senior staff who are acting in an inappropriate manner, or are they more concerned about hierarchy than about protecting the carer or service user? Those organising training, recipients of training and those chairing meetings often become anxious about particularly difficult situations that can arise such as angry outbursts, people getting upset or conflicts about complex issues such as confidentiality. It is possible to prepare for how these can be handled, adhering to principles such as setting ground rules at the beginning, avoidance of becoming defensive, and trying to find areas of common ground.

It is important that there is a system of debriefing for those who have contributed to training, and 'thank you' letters for the efforts people have made are always important (and often neglected). Follow-up support is also helpful, and this should always be provided if sessions or meetings have been tense, stressful or contentious, or if difficult issues have been raised.

In general, the involvement of carers and service users is most effective if an ongoing relationship is established in which those involved learn to trust each other and work through initial discomforts and uncertainties. Involvement is more meaningful if service user and carer trainers understand the system and process of training and what the tutors are hoping to achieve. In this way, all involved can 'grow' together and can help to develop the curriculum. Involving both service users and carers will provide a richer and fuller set of experiences for trainees. Each provides a different perspective. Trainees who are working in traditional mental health services may have little exposure to family members in their clinical work, so this input from carers may be particularly enlightening. Both groups can be involved separately, and it can be fruitful to have service users and carers present together about different aspects of the same experience, for example compulsory admission to hospital. However, once again, this needs careful planning. Some service users have had difficult experiences in their own families, resulting in a difficulty sharing a forum with family members. Hostile interactions between both groups in sessions can inhibit the learning of trainees, and can distract from issues. This again highlights the importance of tutors getting to know the people whom they will be asking to deliver training sessions.

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It will be important for those on accreditation teams to assess the involvement of carers and service users in training in a variety of ways. Observing training sessions directly will be useful, and service users and carers who are involved in training should have an opportunity to talk on their own to the team without tutors present. The PMETB endorses the involvement of lay people as assessors and examiners, and will have a mandatory requirement for lay membership of approval visit teams; it is therefore likely that carers and service users will be members of the accreditation teams in future.

Auditing by training schemes of the impact of greater involvement of service users and carers will be crucial to evaluate the impact on attitudes, values, skills and knowledge, as well as on the individual service users who contribute to them and on those who care for them. Training scheme leads may wish to use existing tools such as the Continuous Quality Improvement Tool (Northern Centre for Mental Health, 2003) to help them with this process.

Conclusions

This is an exciting development in training that it is hoped will lead to a richer learning experience for trainees and ultimately more responsive services for both service users and those who care for them. It is a new area that is at present under-researched and is not as yet routine on the training courses of professionals. As this new approach is introduced, it will be important to audit carefully the extent to which it is happening, and also to evaluate the experiences of tutors, trainees, service users and carers in the whole experience. Learning about the most effective ways of doing this will need to be disseminated, so that those new to this process gain from the experiences of others in terms of what works well and what should be avoided. Some training schemes are already beginning to audit what is happening (Vijayakrishnan et al, personal communication), and it is hoped that this will become more widespread.

A number of guides on this topic will be helpful to those embarking on service user and carer involvement for the first time (Simpson et al, 2002; Tew et al, 2004). The College is keen to be supportive of training schemes and staff who are trying to bring about change. A number of training days have been arranged to help those involved in training to get started, and to provide them with materials that may be helpful. Heads of training schemes are encouraged to develop a realistic plan for developing involvement, and ongoing support will be available to help to monitor how this is progressing. As part of the process, baseline data are being collected on the current extent of involvement of carers and service users in training. Tutors who partake in the training will be followed up over time to evaluate how they are implementing the guidance.

So far, there has been no report of harm linked with this initiative, and with careful preparation this should remain the case. Early audits indicate that trainees already see the benefits, as well as describing some anxieties (Vijayakrishnan et al, personal communication). It is important that this type of evaluation continues, as is the case with any new initiatives.

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*****Gráinne Fadden** Consultant Clinical Psychologist, Birmingham and Solihull Mental Health Trust, 71 Fentham Road, Erdington, Birmingham B23 6AL, **Mike Shooter** President, **Gareth Holsgrove** Medical Education Advisor, Royal College of Psychiatrists, London