Service user involvement in the assessment of a practice competency in mental health nursing — Stakeholders’ views and recommendations

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Summary Competence in building therapeutic relationships is essential for student mental health nurses and therefore requires robust assessment. However, the assessment of such complex skills is problematic. Following policy directives exhorting increased service user involvement in general, there have been recent suggestions that service users could contribute to the assessment of practice. This paper outlines a research project which investigated the views of 24 stakeholders (service users, lecturers, mentors, ex-students and student nurses) about the potential involvement of service users in the assessment of student mental health nurses’ competence in forming therapeutic relationships. The findings revealed that service users interviewed had a largely positive attitude towards this potential development. Nurse participants were more ambivalent. Despite citing several key advantages, nurses also expressed some important reservations about how such a proposal could be implemented in practice. Nevertheless, on balance, they were in favour in principle. Key recommendations for the implementation of this potential development included strategies to enable anonymity and freedom of choice for service users. A range of options for obtaining service user feedback were put forward, along with some ideas about how the fairness of the assessment might be protected.

KEYWORDS Consumer participation; Clinical competence; Education; Nursing; Mental health services

Introduction

In the UK, the Nursing and Midwifery Council (NMC) have recently begun consulting with nurses about the principle of involving service users in the assessment of pre-registration students’ practice competence (NMC, 2005). This paper reflects the findings of a research study, undertaken in 2005, which investigated the views of a range of stakeholders on this topical issue. Stakeholders were interviewed about the possibility of asking current mental health service users to provide feedback...
about student mental health nurses’ ability to form therapeutic relationships. Information is provided about stakeholders’ attitudes and some possible strategies for involving service users in the assessment of practice are put forward.

Background literature

The importance of the therapeutic relationship

The literature from both professional (Moyle, 2003) and service user (Adam et al., 2003) sources suggests that the therapeutic relationship is multidimensional, encompassing affective, cognitive, moral and behavioural components. In terms of its function, research indicates that in the field of mental health the formation of a therapeutic relationship is a necessary precursor to any other formal therapeutic approach (McAllister et al., 2004; Sainsbury Centre for Mental Health, 2001). Moreover, the quality of the therapeutic relationship is considered a clear predictor of outcome (McCabe and Priebe, 2004). Widespread consensus has been reached that the ability to form such a relationship is essential for any competent mental health practitioner (Sainsbury Centre for Mental Health, 2001; Roberts, 2004). Therefore the central importance of the therapeutic relationship is beyond doubt. What is not beyond doubt, however, is the robustness of current strategies for the assessment of competence in this vital and complex phenomenon.

The assessment of practice competence — the challenges

There is broad agreement about the tortured history and problematic nature of the assessment of clinical competence (English National Board (ENB), 2000; Redfern et al., 2002). This is especially so when applied to complex, subjective and multifaceted skills such as those required in the formation of the therapeutic relationship (Anderson and Stickley, 2002). Whilst Mercer and Reynolds (2002) contend that empathy is technically observable, Chapman (1999) is a particularly fierce critic of existing assessment methods in mental health, arguing that

‘to render (interpersonal) interactions observable, much less measurable, could be intrusive, unethical, inappropriate, impracticable, inhibiting or a combination of any of these’ (p.133).

Inter-rater reliability and subjectivity are perennial problems and, with the realities of the workplace, the validity and reliability of assessments are often compromised due to a conflict between care delivery and assessment (While, 1991; ENB, 2000). There is a myriad of factors influencing assessment in practice and the opacity of this complicated phenomenon is compounded by the fact that few students fail on clinical grounds (Duffy, 2004), thus casting aspersions on the current assessment tools’ ability to discriminate (Girot, 2000). What is more, there is plenty of evidence to suggest that nurses’ assessments of service users’ views, perceptions and needs often lack accuracy (Twinn, 1995; Löfmark et al., 1999). This, coupled with the evidence that there is a strong relationship between the service user perception of the therapeutic relationship and its effectiveness (Cape, 2000), lends legitimacy to the question of whether mentors can assess this particular competency confidently without feedback from service users.

There is consensus that whilst every method of clinical skills assessment has its strengths and weaknesses, the validity and reliability of assessment are improved through the adoption of a multi-method approach (Norman et al., 2000). Furthermore, Redfern et al. (2002) recommend the better triangulation of witnesses as well as method, with assessment hinging on a range of informed views. More specifically, Norman et al. (2000) highlight the need for studies exploring the feasibility of better triangulation of the assessment process through the use of contributions by service users, citing research showing service users to be acute observers of clinical care (Redfern and Norman, 1999a, b).

Service user involvement in the assessment of practice competence

There is little provision for current service users to offer feedback in the assessment of student nurses’ practice competence. However, contemporary mental health services place emphasis on service users having a voice (Department of Health, 1994; UKCC, 1999). This development has occurred against a backdrop of increased consumerism (and its underlying doctrine that recipients of services have a better grasp of their needs than professionals) and an increasingly vociferous user movement expressing dissatisfaction with services (Bertram, 2002). In part, the purpose of this thrust is to redress power imbalances, particularly prevalent in mental health services (Breeze et al., 2005).
There are many examples of research in which the opinion of current mental health service users, both in community and inpatient settings, is solicited (Lofmark et al., 1999; Adam et al., 2003; Edwards, 1995, 2000; Morgan and Sanggaran, 1997; McCabe and Priebe, 2003, 2004). In nurse education, although there is some evidence that service users are being included in mental health curriculum development (Khoo et al., 2005) and classroom learning (Wood and Wilson-Barnett, 1999), a search of the literature reveals that there have been few initiatives involving mental health service users in the assessment of professionals’ interpersonal competence.

There is much evidence to suggest the benefits of mental health service user involvement in terms of empowerment (Wood and Wilson-Barnett, 1999; Norman et al., 2000), even if the process of empowerment is not without complication (Edwards, 2000). However, resistance to service user involvement arises from fears of tokenism, the defence of ‘superiority’ adopted by many professionals, along with scepticism and fear amongst users arising from negative historical experiences (Rudman, 1996; Frisby, 2001). Indeed, Davies (2005) reports the prejudicial view that service users are incapable of expressing a rational opinion. However, two studies that have attempted to involve service users in the assessment of competence (Twinn, 1995; Morgan and Sanggaran, 1997) showed that a combination of benefits and obstacles emerged, although, on balance, the benefits appear to have outweighed the difficulties.

The rationale for the research study

Pulling together the literature, legitimacy is added to the idea that the involvement of service users in the assessment process could be desirable from educational, professional and clinical perspectives. However, there is a dearth of literature on the subject of whether this is achievable. As the literature also suggests that the issues are complex, this research study aims to take the first step and investigate stakeholders’ views. The findings will inform any next step regarding the advisability and practicality of the implementation of the idea.

Methodology

Located in the interpretive paradigm, this study investigated the views of 24 people (or stakeholders) involved in differing ways with the formation and assessment of the therapeutic relationship (five service users, seven students, four ex-students, six mentors and two lecturers). Semi-structured interviews were used, providing the opportunity to probe and clarify participants’ views about the importance of the therapeutic relationship, along with the advantages and disadvantages of service user involvement in the assessment of this particular practice competence. A mixture of focus groups and individual interviews were held. Nurses were interviewed in peer groups to reduce the danger of power differentials affecting group dynamics, whilst service users were interviewed individually to preserve their confidentiality. The ethical principles most likely to be compromised were autonomy and non-maleficence (avoiding harm), particularly as teacher–student and nurse–patient relationships are fraught with power imbalances, providing the potential for the researcher to coerce respondents (but, equally, providing the opportunity for an emancipatory component). Therefore, all participants were required to ‘opt in’, having been provided with sufficient detail about the project to inform decision-making. Service users were approached only if they had the capacity to provide valid consent and permission to undertake the project was given by the local Ethical Committee. The interviews were audio taped, responses transcribed verbatim and a simple thematic analysis was applied to emergent themes. The small sample size limits the generalisability of the project, requiring caution and realism when discussing the findings. This said, what is lost in scope is gained in the rich and detailed resultant data, reflecting the small community on which the study is based.

Findings and discussion

In this section, some participants’ verbatim comments have been included in order to give an authentic flavour. These are italicised in the text.

The findings indicated some differences of opinion both between and within different stakeholder groups (the literature available describes just such tensions). There was unanimity among all participants about the importance of the therapeutic relationship. However, nurses placed more emphasis on the functional aspects of the therapeutic relationship – ‘‘If you don’t have it then you can’t do the work’’ whilst service users highlighted how interactions with nurses made them feel and focused on the ‘ingredients’ – ‘‘unless I can trust someone I don’t have anything to say’’. For service users, trust and the ability to listen were crucial.

All the service users interviewed were of the opinion that they themselves are best placed to
make a judgement about the quality of the therapeutic relationship because no one except themselves could confidently know their real views. Of the six groups of nurses, only two agreed with this perspective. During all eleven interviews (except the interview with mentors), mention was made of the value of involving service users in assessment, although a continuum of views existed about the emphasis that should be placed on the service users’ contribution, with service users being most enthusiastic and mentors being least vociferous about the potential benefits of this.

**Service user involvement in practice assessment — potential advantages**

During all the interviews except one, the advantage to the student of learning from service user feedback was highlighted. All bar two service users identified the advantage of unmediated, “first-hand” feedback. The third most mentioned advantage was that the act of seeking service user views would reflect the therapeutic approach students are encouraged to take — “it’s more collaborative and this reflects the philosophy I want in my practice”.

All the interviews involving nurses, and one service user, highlighted the potential increase in the validity of the assessment created by soliciting evidence from additional and “more truthful” sources. In terms of reliability, the lecturers spoke of the value of subjective opinion, provided that the subjectivity is not disguised or overlooked. Advantages for service users mentioned during most interviews with nurses were firstly the potential for empowerment, and secondly, congruence with espoused philosophy of increasing service user involvement – “it’s respectful”. Two out of five service users also mentioned these advantages but, for them, the most mentioned theme was the idea that nursing care could improve as a result of students learning from feedback and individualising their care better – “better qualified staff for the future!”

**Service user involvement in practice assessment — potential disadvantages**

Mentioned during most interviews was the concern that students could become demoralised and their confidence depleted. Ex-students spoke powerfully about the vulnerability of the student whilst current students appeared keen to consider their need to develop resilience. The issue of the threat to student confidence was developed in two main ways. Firstly, it was argued that service user feedback might not be fair. Amongst the reasons given for this were the idea that service user’s mental health problems might colour their attribution, that angry service users could scapegoat students – “your anger could be aimed at the student because you are getting a voice, for once” or that students could be affected by transference (the experience of thoughts, feelings and roles in one relationship that actually, unconsciously belong in another relationship). Secondly, in terms of the interpretation of feedback, lecturers wondered whether students would have sufficient experience to put feedback in the context of service users’ wider situations and, on the whole, qualified nurses were most mindful of the fact that service users are not trained in the art of constructive feedback in the way that mentors are and would not know what to expect from students at different stages in their training.

Minority themes included the potentially iniquitous position for students whereby, from time to time, they are expected to take legitimate actions likely to make them unpopular with their clients (yet may be dependent on those clients for feedback). The argument was put forward that many external variables affect the ease with which a therapeutic relationship can be made (such as staffing levels and a tense inpatient atmosphere). Also mentioned was the danger that practice could become “more assessment driven”.

Most interviews made mention of the capacity for the assessment to be unreliable, unfair and/or lacking in credibility if it was reliant on feedback that could be inhibited or influenced by unrelated factors. All the groups of nurses expressed concern about students “picking and choosing” the feedback they share with mentors or the service users they approach for feedback.

Most participants spoke about potential service user fearfulness about the repercussions of giving negative feedback. Although service users were much less likely than nurse participants to bring up negative issues around their involvement with assessment, two out of five service user interviewees expressed concerns related to the involvement of service users when acutely unwell and the impact of responsibility for some. In contrast, there was virtually unanimous mention by nurse groups of the danger that service users could feel obliged to participate against their will and that the assessment process could harm service users. Examples of how this might happen included the stress of giving negative feedback directly, the emotional impact of being excluded from giving feedback and the possibility that service users
might "feel used". Generally speaking, the more experienced the nurse, the more they both envisaged and dwelt upon potential problems for service users (see Fig. 1).

Safeguards and options for operationalisation

The question of how best to involve service users and what safeguards might be necessary prompted the greatest amount of debate and produced numerous and diverse ideas. One theme that was brought up at every interview was the option of allowing participating service users to remain anonymous if they wished. Although there was emphasis on anonymity, four out of five service users mentioned the possibility of giving direct feedback and three of the four added that this would be their preference. This said, the most frequently mentioned strategy for soliciting service user feedback was that of a questionnaire, with a tick box element and room for optional comments.

The qualified nurse interviewees spent much time focusing on the question of which service users should be involved. This issue appeared to trouble them much more than it troubled the service user participants. A view frequently aired was that service users should not be approached if they were too unwell. However, at most of these interviews the opposing view was also put forward (that mental state should not necessarily exclude service users from participating). Despite some understandable protectiveness, there was also widespread acknowledgement of nurses’ general indebtedness to service users – "they are why we are here!" Thus there was ambivalence over this issue. All the groups containing qualified nurses mentioned the idea that the views of a number of service users should be sought and the mentors expanded on this theme, suggesting that service users should be randomly selected to provide feedback.

Most groups of nurses mentioned the need for careful management of the feedback process, suggesting that feedback given via an intermediary (mentor or advocacy worker) might provide a safeguard in that feedback could be "filtered", ensuring it was imparted in a balanced and constructive way. Furthermore, the possibility that mentors could assist the students in supportive retrospective reflection on the feedback they had been given was discussed, thereby assisting feedback to be put in context whilst also hearing valuable information to assist them in the assessment of competence.

However, the lecturers warned against making "paternalistic" judgements in this way, citing the danger of "rationalising away" valid but unwelcome feedback.

Other suggestions put forward included confining this assessment strategy to final year students;
the rationale being that they would be more resil-
ient and better able to make constructive use of
feedback. Lecturers also mentioned the possible
construction of a deliberately strengths-focused
assessment tool. Most groups brought up the need
to ensure service users are genuinely free to opt
in or out of the assessment and feedback process.
Three service users specifically mentioned the
need for feedback given to remain confidential to
those directly involved. Lecturers and mentors
wondered whether it might be an option for stu-
dents to regularly solicit feedback informally,
eventually assimilating this as a way of working
collaboratively.

No group settled on a preferred feedback strat-

ey and, overall, the message that emerged was
that service users should be offered a choice of
methods and safeguards (see Fig. 2).

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<th>Key finding arising from interviews</th>
<th>Implications for implementation</th>
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| 1. There should be a choice of ways in which service users could be involved in the process of assessment. | A continuum of involvement could be offered, including:  
  - Students asking service users informally for feedback and then using this to inform self-assessment. Feedback will provide material for reflection (with support and guidance if required).  
  - Completion of a simple, tick box questionnaire (which could be deliberately strengths-focused, be structured around the ingredients of the therapeutic relationship and contain space for optional additional comments). The feedback contained in the questionnaire could be explored by the mentor and student together.  
  - A three-way interview between service user, student and mentor.  
  - An interview between service user and mentor, with the mentor acting as a filter and conduit for feedback. Thereafter the mentor might offer support for the student, facilitating reflection.  
  - The use of an advocacy worker to relay feedback from service user to mentor and / or student. |
| 2. There are reservations about whether service user involvement in assessment will work in practice |  
  - The implementation of service user involvement in assessment should be piloted for a limited period (probably for the duration of one student placement) and then evaluated.  
  - Initially, service user involvement in the assessment process should be confined to giving feedback about competence in making therapeutic relationships, pending evaluation.  
  - Students and mentors may need additional training from lecturers to prepare them, along with access to ongoing support and guidance from lecturers.  
  - Lecturers would need to liaise widely with staff in the mental health service, to enlist support and answer queries prior to implementation. |
| 3. Service users should be able to give anonymous feedback if this is their preference |  
  - Questionnaires could be completed anonymously and deposited in a designated box in the clinical area, or posted in a stamped addressed envelope if the service user is in the community.  
  - Where service users have opted for the option to give feedback directly, there should be an agreement that the feedback will remain confidential to those involved. |
Conclusions

There was widespread commitment amongst stakeholders, *in principle*, to the involvement of service users in the assessment of student nurses’ competence in forming therapeutic relationships. However, *in practice*, some important reservations emerged, with stakeholders expressing varying degrees of ambivalence about the risk/benefit balance of such a move. Service users interviewed saw their involvement as largely positive, with the potential to improve the validity of assessment, student learning and the quality of care. However, some did acknowledge the fear that future care could be jeopardised if negative feedback was warranted. Nurses interviewed were more ambivalent. On balance, most nurses decided that the potential advantages of such a project outweighed the disadvantages. However, they qualified their commitment to the principle by adding that certain provisos would be needed to quell their reservations about implementation. For them, advantages of service user involvement centred on service user empowerment, improved student confidence and learning and the better triangulation of evidence in support of competence. Disadvantages included possible harm done to service users through coercion and overly onerous responsibility. In addition, concerns for students revolved around the damage done by ‘unfair’ feedback (either positive or negative) potentially provided by service users, either due to their troubled mental state or because of lack of training in assessment.

Primarily, these findings provide a warning that, were such an initiative to be undertaken, some opposition would probably be experienced and some logistical problems encountered. On the other hand, they also point to sufficient goodwill and enthusiasm, at least from those who volunteered to be part of this study, to support a ‘next step’. What participants’ deliberations tell us about any ‘next step’ is that it must be very carefully considered, involving a choice of methods and safeguards. On balance there was broad agreement that the final responsibility for making pass/fail decisions should be retained by the mentor, although service user feedback could assist both the decision about competence and students’ learning.

In summary, some useful concrete suggestions about the implementation of this concept (service user involvement in the assessment of practice competence) in practice have been put forward (see Fig. 2). These suggestions are sufficiently detailed to inform a future pilot. Thus lessons learned
from this research study may assist the implementation and evaluation of this concept.

References


Nursing and Midwifery Council (NMC), 2005. Consultation on Proposals Arising from a Review of Fitness for Practice at the Point of Registration. NMC, London.


