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Twin Reflections: A Consumer-Driven Schizophrenia Workshop for Psychiatry Registrars

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Abstract

This report describes an innovative approach in the education of trainee psychiatrists in Queensland, Australia. Using a multidisciplinary panel with a central role of a consumer, together with an interactive facilitative workshop approach, a training package for schizophrenia was developed and refined, concentrating on the streams of (1) evidence-based treatments (2) modern psychiatry with a consumer centred and recovery oriented approach (3) sensitising trainees to ethical issues. A unique feature of this education approach is the way it brings together 2 paradigms: the dominant professional one with its scientific background, with the less dominant one of the body of knowledge in terms of consumer lived experience. This report describes how the multidisciplinary, multi-perspective group that comprised of this educational panel planned for and managed the inevitable tensions that arise when dominant preconceived beliefs are challenged. This ethical perspective stresses a non-paternalistic approach, informed by psychosocial factors but balanced by important principles regarding professional responsibility. The result has been an involving, richly complex and flexible workshop that has engaged successive cohorts of psychiatrist trainees in reflective discussion that varies according to individual need.

Background:

We are entering an exciting era of paradigm shifts: firstly, in modern public psychiatry where the care of the mentally ill is embracing collaborative and consumer-driven treatment models, with an emphasis on supporting self directed recovery in community settings (Australian Health Ministers, 2003; Onken, Dumont, Ridgeway, Dornon & Ralph, 2002; US Department of Health and Human Services, 1999) and secondly, in educational programs where there has been a distinct shift from didactic models of teaching to interactive learning methods with a facilitative approach (Boud, 1987; Goldberg, 2001). Facilitative approaches to teaching have been found to encourage deeper learning (Kember & Gow, 1994). It is the authors' belief that such facilitative approaches are conducive to seeing and nurturing paradigm shifts, that challenges the dominant models of working with persons experiencing severe mental illness. This report describes the local experience of a multi-disciplinary group comprising of a consumer representative (an expert by experience), an ethicist and psychiatrists in Queensland, Australia who developed a training package for psychiatric trainees which embraced both of these modern approaches.

In Australia, it is now government policy to include consumer participation in all levels of mental health service provision (Commonwealth of Australia, 1996; Connor, 1999). The Australian and New Zealand College of Psychiatrists' curriculum for basic training includes mandatory experiences in consumer and carer-related activity, requiring significant input from those that have experienced mental illness (RANZCP, 2003). While these are important developments, in order for these changes not to be merely "lip-service" and tokenistic embellishments, it is well recognised that a tidal change in terms of attitudes and knowledge of a new generation of psychiatrist leaders will come only from meaningful training experiences, which resonate with real-life clinical activity and that focus on understanding and working with the lived experience of mental distress and self directed recovery.

In 2001, the Academic Subcommittee of the Queensland psychiatric training program decided to move from a traditional student-style lecture program to a series of seminar sessions which stressed adult learning concepts using case studies, interactive discussion and expert facilitation. One of the authors (PP) was given the brief to design and conduct a seminar in the most common chronic conditions encountered by public mental health services, namely schizophrenia. It was felt that the seminar should incorporate 3 streams: (1) Evidence-based treatments (2) Modern psychiatry with a consumer centred and recovery oriented approach (3) Sensitising trainees to ethical issues. To this end, a multidisciplinary "expert panel" was formed by invitation, including a consumer representative (VJ), the psychiatrist facilitator/ moderator (PP), an ethicist (PM) and a psychiatrist with a major interest in the consumer and recovery movement (VK). An important outcome of the initiative was the development of a

consumer-focused case study for interactive, reflective educational workshops. The educational session proved to be highly effective in terms of richness of discussion, reflection and student initiated participation. The case study focuses on multiple presentations to a service, across the lifespan (Harvey, 2001) of two adult identical male twins experiencing schizophrenia with varied outcomes. The lifespan perspective being important when discussing the biopsychosocial changes that occurs during illness and recovery. Furthermore, there are ethical challenges posed at each stage of the twins' lifespan and history with the mental health system. For this reason, this article has been written to provide a full description of the content and process of the workshop to assist other educators embracing the philosophy of modern public psychiatry with its focus on consumer advocacy. The focus of this three hour training was to create an opportunity for reflective discussions by the trainees about factors that promoted or hindered recovery from different perspectives. A flexible approach was planned, to allow the discussion to respond to individual needs of different cohorts of trainees. This would also allow the training package to be adaptable to different working environments.

Queensland Rotation Psychiatry Training Program

The Queensland Rotational Psychiatry Training Program is the only pathway by which psychiatric trainees in Queensland, Australia meet their training objectives before sitting examinations which qualify them for advanced training and subsequently, to become specialist psychiatrists. Requirements of training include approved training posts where the trainees garner clinical experience, supervision by specialist psychiatrists, and attendance at an academic program put together by a voluntary body of psychiatrist educators, the Academic Subcommittee of the Queensland Rotational Psychiatric Training Program.

This academic program spans 3 years: the first year dealing with basic assessment and aetiology of mental disorders, the second year dealing with clinical case examples and treatment concepts, and the third year addressing sub-specialty areas of psychiatry. The case study educational session is one of the 3-hour seminars in the second year of the academic program.

Teaching Strategy– An Interactive, Multi-disciplinary Collaborative Approach

Contribution of moderator (Dr Paul Pun):

Recognising that the trainees would have a solid grounding in clinical presentations of mental disorder as well as aetiological concepts, these workshops were designed to capture nuances of management which would be virtually impossible to do in a didactic fashion. There was a deliberate continuity with regard to the vignettes to sensitise the trainees to the subtleties of differences in management depending on the stage of the disorder. The scenarios were based on real clinical scenarios, which most of the trainees would be familiar with, to maximise the opportunities of interactive problem-based learning. The advantage of the case vignettes was the mix of evidence-based treatment, ethical conflicts and attitudinal issues regarding collaborative treatment blending together as in real life, providing a richness and level of complexity to the discussion. Another task of the moderator was to manage the tension that inevitably arises where preconceived beliefs are challenged, and provide balance to debates.

An issue that is perhaps poorly recognised where a consumer is part of a professional panel, is the negative effect of disclosure on interpersonal and academic performance (Farina, Allen, & Saul, 1968; Quinn, Kahng, & Crocker, 2004). This can be managed by:

(i) the facilitator providing adequate time prior to the workshop, so the consumer may read materials and ask questions about the intended teaching plan

(ii) the consumer meeting the facilitator prior to the workshop to discuss how trainees are normally trained and how this is approach will different

(iii) the consumer being given an explanation of medical terms to be used in the workshop

(iv) the facilitator ensuring that the consumer has time to digest complex statements

and respond during the workshop, perhaps even rephrasing comments made
(v) making sure that payment has been organised for the consumer
(vi) the consumer being made welcome to bring a "silent observer" if that would help them feel comfortable during the workshop
(vii) ensuring that debriefing is offered to the consumer as part of the plan for the workshop. This should happen immediately afterwards if possible and there should be opportunity to talk at a later stage if required.
(viii) the consumer being given copies of papers (especially this one) and references suggested in this paper. There is also a need to discuss that personal disclosure will most likely result in a temporary drop in ability (interpersonal and academic skills) and this is not due to a psychiatric illness but part of the normal response of fearing stigma by others.

Contribution of consumer perspective (Vivian Jarrett):
Consumers' lived experiences need to play a significant role in education of professionals (Corrigan & Penn, 2004). Negative stereotypes are likely to change when through working together on problem-solving activities during the workshop. The role of the consumer in the educator role is complex, as it attempts to harvest the phenomenological or holistic experience of living with a serious mental illness. The consumer perspective permits reflection on a range of similar personal experiences, which not only enriches the discussion, but promotes critical analysis of current practice and the implications of decisions on the consumer. Consumers bring not only their own experiences of the disorder, but experiences of using systems of care, medications and psychotherapy. More importantly there is opportunity to share experiences which bring out the human side of consumer's experience. Corrigan and Penn (1997) suggest that the disease and discrimination paradigms are conflicting views and interventions not embracing the knowledge of both may cause confusion and tension for consumers in treatment settings. The consumer's participation in this educator role enables discussions around interventions that could be viewed as discriminatory. This may occur when interventions are overly forceful or insensitive to the human suffering that occurs during episodes of severe mental illness (Allen et al., 2003; Carpenter, 2002). The mere presence of the consumer educator also provides a more respectful discussion that prevents over-categorising and inappropriate labelling of experiences that are not part of the disorder (ie. sadness is not always depression). Furthermore there is abundant literature showing that a reduction in negative stereotyping occurs when interpersonal contact is made with a consumer in a respected role (Kolodziej & Johnson, 1996).
In approaching the consumer educator role it is suggested that the consumer is offered adequate educational information (ie. handouts that may be given to trainees), support and adequate reimbursement for participation (NCCF, 2004). Educational support could occur through an opportunity to liaise with the workshop facilitator prior to the workshop and for debriefing after the session. Discussion of the session also contributes to improvements for future sessions, ensuring that the discussion is relevant at the local level. Consumers must also be confident and experienced in the educator role, as it is a daunting task to work freely with personal experiences at such a high academic level. The consumer needs to have an appreciation of environmental or social factors that help or hinder recovery (Onken et al., 2002) and be encouraging to trainees when they have been successful at utilising strategies that they feel would be helpful. This workshop utilises the expertise of the consumer's personal knowledge base as proposed by Trainor, Pomeroy and Pape (2004) and the impact of discrimination knowledge (Corrigan & Penn, 1997) . Working in this way creates some amount tension with the medically sourced knowledge base of professionals. One of the desired outcomes of the workshop is a mutual appreciation of both professionals and consumers knowledge, which will work to help bridge the gap in understanding the experience of a mental illness.

Contribution of multi-disciplinary panel:
The interactive, multi-disciplinary collaborative, consumer-friendly approach also informs the ethics teaching strategy for the case-study session. The pedagogical raison d'etre is to 'lead from behind' by building a non-judgemental space where participants are encouraged to articulate and explore their beliefs and assumptions about ethical responses to practice dilemmas that arise from the case material. The approach is Rogerian, rather than didactic, affirming and welcoming all analytic insights. Educational strategies include information giving, concept introduction, issue clarification and encouragement of ownership by the group of ethical reflective processes.

Putting 'Recovery' on the Agenda

It is only in recent years that the idea of the possibility of 'recovery' from mental illness has been embraced by the mental health literature (Andersen, Oades & Caputi, 2003; Bishop, 2001; Jacobson & Curtis, 2000; McGrath & Jarrett, 2004) even though there are numerous first person accounts of recovery from serious mental disorders dating back over 160 years (Beers, 1935; Percival, 1840). Prior to the collaborative work presented in this article, the trajectory of the case study used in psychiatry training in our department documented a strong bio-medical focus with an escalation of drug therapy and enmeshment of the consumer in the mental health system. One of the significant factors of the present work is that it provides openness to alternative trajectories from the one starting point (that is, identical twins with the same diagnostic condition). The rationale for such change is to affirm and extend the work initiate in recent decades that shifted the mental health paradigm from predictable deteriorative/maintenance course to a therapeutic engagement with the potential for recovery (Drake, Green, Mueser & Goldman, 2003; Harding, Brooks, Ashikaga, Strauss & Breier, 1987a; 1987b). By the very presence of a consumer advocate who is an excellent role model of recovery, the message of the possibility of recovery from serious mental illness is a fact to be observed, not simply abstract theoretical or research evidence (Ahern & Fisher, 2001). The consumer's insights and life story is a powerful medium for embracing the present metaphor of recovery as personal journal, rather than biomedical 'cure' from 'disease' where medication and institutional mental health are the treatments of choice (Deegan, 1997). This educational strategy echoes the present mental health literature that calls for the insights of the lived experience of individuals who have recovered from mental illness to be central to mental health reform (Anthony, 2001; Deegan, 2003; Kirkpatrick et al., 2001; Tooth, Kalyanasundaram, Glover & Momedsadah, 2003). The differential outcomes of the twins gives an opportunity for the educators to facilitate rich discussions about the treatment conditions that impede the recovery process and entrap a person in a life of disability managed entirely with professional dependency. This is in contrast to therapeutic relationships and conditions that recognise and support self directed recovery and promote citizenship through well thought out frameworks of support that are informed by the knowledge of lived experience and traditional knowledge (Trainor, Pomeroy & Pape, 2004).

THE CASE STUDY – Format, context and issues arising.

Figure 1 outlines a verbatim copy of the case study as it is presented to students. As the *modus operandi* for the case study is to suggest rather than prescribe, the following discussion will elaborate on background issues to provide the full context for the detail in the vignette. This discussion will be approached from the perspectives of various members of the panel, namely the psychiatrist, the consumer and the ethicist.

Psychiatrist perspective on slides:
The first scenario (slides 1 and 2) is packed with discussion points. Apart from the obvious clinical issues of confidentiality and the role of the carer, it allows discussion of

the current level of evidence of the association between cannabis and schizophrenia, as well as the burgeoning area of early intervention in this chronic disorder.

Slide 3-5 brings about a discussion of alternative models of psychiatric care (mobile teams, assertive outreach, 24-hour community availability, alternatives to hospital admission, psychosocial interventions) and the level of evidence supporting these modern interventions. Slide 4 mentions ARAFMI (2005) which refers to the local support network for carers of those experiencing mental illness.

Slide 6 brings forward the discussion about rational antipsychotic pharmacotherapy in an inpatient unit. Traditional methods of using "as required" antipsychotic medication for sedation are now being replaced by alternative anxiolytics (e.g. benzodiazepines). Intravenous injections of drugs to induce a "sleeping state" level of sedation are also being replaced by other delivery mediums (e.g. wafers, intra-muscular injections) to control agitation without necessarily inducing a non-responsive state in the patient.

Slide 7-8 triggers the clinical management of patients with schizophrenia who are treatment-refractory to conventional antipsychotic agents. The level of evidence for electroconvulsive therapy in treatment-refractory psychosis is explored, as well as the ethical issue of using clozapine, an agent proven in this condition but accompanied by dangerous side-effects.

Slide 9-10 provokes discussion about competency in chronic residual schizophrenia, by putting forward a scenario where the patient receives a substantial inheritance, and is living in sub-optimal conditions. Trainees report that it allows reflection on their "knee-jerk" paternalistic response, rather than respecting the patient's choices and maximising their decision-making ability.

Slide 11-12 deals with the controversial issue of rechallenging patients with clozapine after a previous drop in white blood cell numbers. The balance involves considering the previous positive response to medications as opposed to the problem of subjecting the patient to further harm.

Consumer Perspective on Slides:
The consumer perspective emphasises the need for personal empowerment, choice and ways to manage the effects of fear of discrimination and stigma from others (Brown & Bradley, 2002; Corrigan & Penn, 2004) .

Slides 1 and 2 bring forth a discussion on the process of becoming independent in late adolescence. Life goals are hampered by the onset of a mental disorder like schizophrenia. Often families are closely involved with their children in late adolescence, and the impact of the home environment is still very important. A family history of a serious mental illness may infer the family is stigma conscious and sensitive about labelling members in this way, there may also be fear of treatments used in the past.

Slides 3, 4 and 5 discuss the impact of the disorder over time, with the loss of education and work roles. Understanding the difficulty of regaining life roles in the face of stigma from others is valuable. It would also be important to advocate for services that are affordable and accessible in the community. Treatment in the community minimises stigma by focusing on meeting emotional needs, providing self-awareness education and a human face to the assistance. It is important to advocate that medication is only a small part of the multitude of other services that a community can offer an individual in recovery from a mental disorder. The opportunities would be different depending on the local culture.

Slides 6, 7 and 8 give an opportunity to share the personal experience of being medicated and hospitalised. The process of admission can be traumatic (Cohen, 1994) and often the system through which care is accessed, can cause harm to the consumer through excessive administrative processes and assessments. It could be discussed how the consumer is able to maintain choice and empowerment during a hospital admission.

Slides 9 and 10 demonstrate the possibility of positive outcomes when a consumer is given choice and opportunity to recover. It is helpful to discuss how an individual recovers and may take up normal life roles even in the face of some symptoms.

Slides 11 and 12 highlight the differences in possible outcomes for recovery when experiencing schizophrenia. There is a danger in institutional care for consumers to not be permitted negotiate life's natural emotional highs and lows without it being categorised into a disordered state of being. The final summary gives a chance to highlight ideas that were useful to the consumer's experience of recovery during the workshop.

Ethical Reflection:
The conceptual starting point for the discussion is that ethical reasoning is rarely situated in an unqualified 'good' but rather necessitates at its core the tension between conflicting interest of both 'goods' and 'harms'. Engaging openly with the tension within a non-paternalistic framework is posited as one of key factors operating in professional ethics. While using the language of ethical reflection informed by notions of Principlism (for example, Autonomy, Beneficence, Non-maleficence, Justice), the ethicist encourages participants to embrace a sociological perspective. Thus, the framework for discussion is at the cutting edge of ethical theory that in recent years is moving from abstract philosophical reasoning to embrace a sociological understanding of discourse and power (Frank, 2004; McGrath, 1998).

Figure 1: Schizophrenia Workshop - Case Vignette

1. Case Vignette **Mr A and Mr B are identical twins and 17 years old. Both live with their parents and Mr A is unemployed since dropping out of school the previous year. Mr A has been brought to your mental health service by his mother, a general nurse. She is concerned about his mental state, having heard her son describe a device in his head. An uncle and grandparent have also had schizophrenia. Mr A is reluctant to be at the service, stating that his brother says he does not need to see a shrink.**	**2. Mr A** **Mr A smokes 4 cones of cannabis per day. The mother has heard from colleagues about "schizophrenia being caused by drugs", "psychosis being toxic to the brain" and the "importance of early intervention". The mother wishes that Mr A could be like Mr B who is doing computer studies at university. She mentioned that Mr A had made friends with a bad group of teenagers, and it was typical of him to do the wrong thing.**
3. Several years later **Mr A is now 21 and has an established diagnosis of schizophrenia. He has moved out of home and is living with his friends. Mr B also moved into the flat after finding a job in the local area, even though he had dropped out of university**	**4. In the interim** **Mr A and Mr B are now 23 years old. Mr B has moved back to his parents' house, and they have bought him a car to get around in. While Mr B has not used illicit drugs, he also starts developing ideas about his workmates planting a bug**

several times before finishing. While Mr A has been lost to follow-up for the last year, one day he self-presents to the community health centre describing distressing voices. Mr A does not want to be admitted and asks if he can have intensive counselling rather than medication for his problem, as his brother has suggested this would help. He does not have transport and finds it difficult to get to the centre.	**in his computer, and that they are monitoring him. Mr B does not want to talk to anyone but his parents can't seem to do enough to help him out. Through their membership of ARAFMI, they put Mr B in contact with the local mental health consumer group. They, in turn, suggest he enrol in a brand new young person's program.**

5. The "at risk" clinic **This turns out to be the early psychosis program, which runs out of a shopfront in the local shopping mall. Mr B makes a good connection with one of the counsellors, who persuades him to try a "Feeling Good" CBT course. Despite initial reservations, Mr B later goes on a low-dose of risperidone. His compliance is encouraged by a good support network including counsellor, parents and members of the consumer group.**	**6. Mr A's crisis** **Mr A is now 24, and one night is admitted to hospital, having been brought in by police who state that he had punched a passer-by in the street. This was reported as a psychotically driven assault. He is put on olanzapine 20mg/day in hospital, but the nursing staff request that they have prn antipsychotics to manage his unpredictable aggression. The charge nurse also raises the query about intravenous neuroleptisation with IV haloperidol and diazepam as there are only female nurses on the night shift.**
7. Mr A's not getting better **Mr A's admission has been prolonged and complicated by the treatment-refractory nature of his illness. He has not responded to adequate trials of olanzapine, risperidone, quetiapine and depot antipsychotic medication. He refuses clozapine because of the blood tests. The nursing staff raise the possibility of ECT, reporting that they have seen other similar patients respond to this treatment. As far as you can see, there isn't an affective component to his illness, although the uncle that was diagnosed with schizophrenia did suicide.**	**8. The surprising revelation** **Mr A does not remember the assault that landed him in hospital. He feels that the medication is poisoning him, but his parents say they'll never speak to him again if he stops it. Mr B visits Mr A often and seems really worried about him. One day Mr B comes to visit and seems very upset. Mr B says that he feels so guilty because it was him, not Mr A, that hit the guy in the street. He explains that the guy in the street was drunk and confronted both of them. As Mr A had the mental health record and looked more dishevelled, Mr B thinks this is why Mr A was picked out as the one that hit the stranger. He asks you to explain Mr A's illness and what treatments are available.**

9. Six years on **After that event at age 24 Mr B chose to not see Mr A again. Mr A is now in his late 30's and is on clozapine. He lives in a hostel, where his medication is supervised. He has a predominantly deficit state illness, with poverty of thought, amotivation and anergia. He manages his own money, after the hostel deducts his board, which he spends exclusively on cigarettes. Mr A and Mr B receive an inheritance of $500,000 each. Mr A's psychiatrist thinks it should be spent on his rehabilitation.**	**10. The other half** **Mr A talks about Mr B often. Mr B is now married, has 2 children and runs a security business. Mr A complains that Mr B does not contact him any more and seems boring as he is preoccupied with security systems and talking about how to stop others from breaking into your home.**
11. ? Rechallenge **Mr A develops neutropenia on clozapine, and this drug has to be stopped precipitously. After a long period of stability on clozapine he suffers a severe relapse of psychosis with its withdrawal, which is poorly responsive to all the other antipsychotic agents. His neutrophils are currently in the normal range. He wishes to go back on clozapine, although at the same time he believes that aliens are tracking his movements via a device in his head**	**12. Grief** **Mr A seems upset and says he is depressed and asks you to treat it. He says that Mr B recently went overseas on a holiday with his mother. His father passed away last year and he is upset that he wasn't allowed to visit him before he died. The family said it would be too upsetting for the father to see Mr A, so they told him to stay away and that he should just learn to stay on his medication and stop giving everyone in the family problems. The father had phoned Mr A before he died and said that he did want him to visit.**
Summary Overview – Prognostic Factors Affecting Trajectory	
13. ? Prognostic factors **Mr A** • **Cannabinoids** • **Critical family** • **Lack of supportive friends** • **Stigma (actual and fear of discrimination)** • **Institutionalisation and poor living conditions** • **Disconnection from community** • **Absence of work role, minimal education**	**14. Prognostic factors** **Mr B** • **Non-exposure to cannabis** • **Supportive family and friends** • **Early intervention** • **Accessible treatment embedded in the community** • **Retain connections to work, family, peers** • **Further education** • **Self-directed use of services** • **Lifestyle choices**

• **Minimal resources** • **Complications from effects of medication**	

RECOMMENDATIONS

The team's experience of collaboration on the development of the case study, trialling and perfecting the content, and engaging interactively with students, affirmed the value and importance of the multi-disciplinary case study perspective. To complement the content outlined in Figure 1 and the prior discussion on process, the team would re-iterate the following recommendations:

- The case study is not prescriptive; rather it is suggestive of possibilities both in terms of openness to interpreting the consumer experience and the varied therapeutic responses. The case study needs to be used in the spirit of openness as a discussion starter. If used appropriately, educators will find that each session will lead in different directions depending on the interest and experiences of the practitioner study group.
- The case study is designed to be used with Rogerian reflective style of interaction. The modus operandi is to encourage reflexivity in students in a trusting and encouraging environment order where they feel safe to express ideas and attitudes and share exploration of alternate therapeutic possibilities.
- The provision of information is not pedantic or structured. Clinical information and evidence-based directions are introduced in response to issues arising consequentially from the discussion and are open for critique.
- The case study is to be share in small groups (under 15 participants) to allow the time and space for participation from all members of the study group.
- A multi-disciplinary, multi-perspective panel is an essential part of the case study experience. All members of the team are briefed to input into the discussion when issues arise that relate to their particular expertise. The students need to be provided with information on the background and expertise of each presenter along with a message affirming the importance of respecting difference in perspective.
- The consumer perspective is considered to be an essential and perhaps crucial aspect of the case study. Where possible, it is recommended that the team incorporates a consumer advocate with personal experience in the mental health system. The consumer's presence and response to questions conveys an authenticity and experiential learning experience for the study group that would not be captured by just theorising about consumer issues and responses.

LIMITATIONS

To date, the case study has been developed, trialled and perfected for use with psychiatry graduates. The multi-disciplinary perspective suggests it would be an effective educational medium for other groups including mental health nursing, psychology, social work, allied health and consumer groups. However, as yet the case study has not been trialled with this broad range of groups. Furthermore, there are several areas that are not covered in this case study. A further teaching session incorporating bipolar disorder, women's issues, pregnancy and parenting is being developed to complement this first workshop.

CONCLUSION

Engaging in the collaborative process of developing and trialling this educational case study has been an exciting and satisfying experience. It is gratifying to be involved in an educational experience where students engage with trust and humility in a group process and demonstrate

their capacity to be reflexive and open to attitude change. It is the experience of our team that this educational instrument goes some way to addressing the enormous challenges of attitudinal change presently required of the mental health system. It is thus our hope and expectation that in sharing our collaborative efforts, others will also find the content and process of the case study a useful medium for responding to the stimulating way forward offered by the philosophy and practice of modern public psychiatry.

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