Using written information in clinical work with patients and carers

Philip Timms, Rosalind Ramsay & Roslyn Byfield

Abstract   In all areas of medicine there is increasing awareness that patients need information that is clear, relevant and appropriately timed. This is obviously connected with ethical concerns of patient dignity and autonomy, but it also underpins the principle of informed choice. It is not possible to make an informed choice about how you want a problem to be managed, if you do not have the relevant information. Doctors have, historically, been poor communicators of such information. Although, on the face of it, this seems a straightforward issue to rectify, there are a surprising number of practical problems to be addressed before such communication can become a reality in daily practice.

There are pitifully few examples of good communication of information to patients in psychiatry. Pollock *et al* (2004) used focus groups to look at the situation on an in-patient ward. Patients and carers felt that information about their medication was helpful, reassuring – and generally absent. Written information was particularly valued because it could be read and absorbed over a period of time. However, this information was not there – not even the manufacturers' leaflets that would usually be included with medication dispensed from a chemist in the community. Staff were often busy and patients tended to feel that their concerns and questions were not important enough for staff to spend time on them. So, even in a restricted and highly controlled environment, information is lacking, jeopardising an opportunity for patients to be constructively involved in their care and recovery. These findings would be recognisable in most mental health wards in the UK. We suspect that the same is true of most community services, but are not aware of similar studies in such settings. One, carried out among mental health workers in primary care, found that although staff were aware of good-quality information for patients, it was not readily available to them (Blackburn, 2001).

Some psychiatrists might feel that their skills in communication render leaflets redundant. There is surprisingly little published evidence on psychiatrists' communication skills, but one study suggested that even motivated general practitioners (GPs) manage to generate multiple misunderstandings in consultations, often not realising that a patient needs or wants information (Britten *et al*, 2004). Low levels of literacy have been shown to impair understanding of warning labels on medications (Davis *et al*, 2006). Given the communication difficulties generated by the cognitive distortions and impairments that many psychiatric patients will experience, it is unlikely that psychiatrists will be performing any better. It therefore makes sense to seriously consider ways of improving information transfer between mental health professionals and service users. Some of the benefits of informing patients about their illness and treatment are listed in Box 1.

> **Box 1 Key issues**
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> - Informed decision-making
> - Increased patient autonomy and self-determination
> - Better doctor–patient communication
> - Reduction of the power differential between doctor and patient
> - Strengthening of the doctor–patient relationship

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Some recent policy drivers

In recent years, patient information has become a prominent issue because of a number of public, political and professional forces.

Public forces

The development of the service user movement has emphasised the acknowledged, but neglected, issues of patient dignity and autonomy. This has been reflected in the increasing use of patients' views in service monitoring across all specialties in medicine. The UK National Patient Survey is an example of this – anyone can log on and check how their local psychiatric service is doing (http://2007ratings.healthcarecommission.org.uk/healthcareproviders.cfm). Such surveys are increasingly including questions on patient information (Box 2).

Political/professional forces

In the UK there is a bewildering variety of government – and government-funded – bodies concerned with health service improvement. They all have something to say about patient information.

The Modernisation Agenda

The Improvement and Development Agency defines the Modernisation Agenda as 'The Government's strategy to reform and update local government', continuing: 'local government should be "in touch with the people, provide high quality services and give vision and leadership for local communities"' (www.idea.gov.uk/idk/core/page.do?pageId=1118437). In medicine, including psychiatry, the application of this emphasises patient choice and empowerment. It is obviously necessary to have the relevant information if you are to make a reasonably informed decision, so healthcare professionals must develop information provision if they are to improve patient choice.

This view is echoed by the UK National Director for Mental Health, Professor Louis Appleby, who stated: 'choice has begun to redefine the relationship between providers and users of services, giving people a voice and driving up the quality of care and information' (Care Services Improvement Partnership, 2006).

Essence of Care

Essence of Care is a UK government initiative designed to support quality improvement measures and clinical governance in healthcare, as set out in

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> **Box 2 Questions from the 2004 survey of users of in-patient services**
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> - When you had questions to ask a doctor, did you get answers you could understand?
> - Were you involved as much as you wanted to be in decisions about your care?
> - How much information about your condition or treatment was given to you?
> - Did a member of staff explain the purpose of the medicines in a way you could understand?
> - Did a member of staff tell you about medication side-effects to watch for?
> - Did a member of staff tell you about any danger signals you should watch for?
> - Did hospital staff give your family or someone close to you all the information they needed?
> - Did hospital staff tell you who to contact if you were worried about your condition?
>
> (Healthcare Commission, 2004)

A First Class Service (Department of Health, 1998). Its benchmarking process helps clinical staff to share and compare practice in a structured way, to identify best practice and to develop practical ways of correcting poor practice. The newest benchmark (Department of Health, 2006*a*) shifts the focus from treating ill health to promoting healthier life choices in patient care, grouping its benchmarks into seven factors. Two of these are particularly relevant here:

- factor 1, 'Empowerment and informed choice', cites as an indicator of good practice that 'sign-posting people to information and/or services can be demonstrated'
- factor 7, 'Access and accessibility', defines two benchmarks in information terms:
  - information should be available in a way that meets individual needs
  - there should be evidence that people are aware of available information and support.

These support fundamental principles of *Essence of Care* such as empowerment, informed choice and fair access to health-promoting information.

Care Services Improvement Partnership

This consists of eight regional centres in England and Wales established to support the development of health and social care services. For England, the White Paper *Our Health, Our Care, Our Say* (Department of Health, 2006*b*: 5.24, 5.25) states:

we propose that services give all people with long-term health and social care needs and their carers an 'information prescription'… The information prescription will be given to people using services and their carers by health and social care professionals … to signpost people to further information and advice to help them take care of their own condition.

By 2008, we would expect everyone with a long-term condition and/or long-term need for support – and their carers – to routinely receive information about their condition and, where they can, to receive peer and other self care support through networks.

Professional standards

General Medical Council

One of the duties of a doctor described by the GMC (General Medical Council, 2006) is that of working in partnership with patients to:

- listen to patients and respond to their concerns and preferences
- give patients the information they want or need in a way they can understand
- respect patients' right to reach decisions with the doctor about their treatment and care
- support patients in caring for themselves to improve and maintain their health.

Royal College of Psychiatrists

Good Psychiatric Practice (Royal College of Psychiatrists, 2004) states that the psychiatrist will ensure that patients understand their treatment plans and have access to information or advice that will help them develop that understanding. A specific example of unacceptable practice that is mentioned is 'persistently refusing to provide information when appropriate or necessary' (p. 27).

Professional competencies

The ability to share knowledge and information in a way that the patient understands has been suggested as an essential competency for achieving concordance between patient and practitioner in the area of medication (Clyne *et al*, 2007).

Ethics

The ethical principle of respecting the patient as an autonomous person (Downie & Calman, 1995) is common in discussions of medical ethics. To be an autonomous person is to have the ability to choose for yourself and to carry out plans for yourself. To deny someone the information they need to take such decisions and to make such plans is therefore to reduce their autonomy.

NHS managerial/governance

Clinical Negligence Scheme for Trusts (CNST)

The NHS Litigation Authority's (2006) clinical risk management standards for mental health and learning disability state that service users have the right to information about their condition and the treatment options available to them. Before they start any treatment, professionals must establish:

- what the service user wants to know
- what the service user ought to know
- that the service user understands the information that has been given
- that the service user consents to the treatment.

The CNST continues:

issues which might need to be discussed with the service user will include: the nature of their diagnosis, the recommended treatment, what the treatment will involve, the risks, the benefits, available alternatives (and their risks and benefits) and the consequences of not accepting the proposed treatment. Proposals for treatment should be supported by written information in a form that the particular service user can understand [NHS Litigation Authority, 2006: p. 70].

Healthcare Commission

This is styled as 'the health watchdog for England' (Healthcare Commission, 2005) and carries out an annual 'health check' in which it requires trust boards in England to make public declarations on the extent to which they meet standards set by the government. There are 24 core standards, which are grouped into seven domains, the fourth of which is 'patient focus'. This includes core standard C16: 'Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care' (Healthcare Commission, 2006*a*). In the 2005–2006 health check, most mental health trusts declared themselves compliant with core standards (Healthcare Commission, 2006*b*).

Evidence

What do patients themselves want?

Traditionally, doctors have included their patients in decision-making to a limited extent. They might hold back information that they feel might distress the patient or cause the patient to reject treatment that the doctor believes to be in their best interest.

In one study, psychiatrists reported that they discussed a wide range of medication side-effects with patients (Smith & Henderson, 2000). However, although the more common, reversible side-effects of parkinsonism were discussed, troubling or potentially fatal problems seemed to be avoided. These included sexual side-effects, weight gain and cardiac toxicity.

Research (Hill & Laugharne, 2006) indicates that psychiatric patients want more information about their illness and its treatment than they have been receiving. In particular, those who are young and employed want more involvement in decision-making. Moreover, giving patients information about their medication seems, on the whole, to slightly improve rather than reduce adherence (Desplenter *et al*, 2006). Although this effect may be attenuated by more severe illness (Tilley & Chambers, 2000), it does not seem to tip over into the negative. A review (Trevena *et al*, 2006) found that, in some settings, providing detailed written risk information increased patient knowledge and satisfaction without increasing anxiety.

Other studies (Powell & Clarke, 2006) suggest that patients:

- see a general lack of information as implying a lack of respect
- want an explanation of mental health problems in physical terms
- want to hear about others' experiences of the same disorder
- think that health professionals feel challenged when patients find out information for themselves
- are inhibited from seeking information by stigma about mental illness.

Reassuringly, there is evidence that many patients still see doctors as their preferred first source of information about their condition and treatment (Simon *et al*, 2006), ranking doctors twice as high as the internet (Coulter *et al*, 2006). However, even before someone gets to speak to a doctor, they may face an uphill battle in finding information about the health and social services that they need (Swain *et al*, 2007). This seems to be owing not to a lack of information but to the poor or absent signposting of information by official agencies and a lack of coordination across sector and organisational boundaries. Swain *et al* comment that health professionals are particularly important because they are often a person's first port of call for information. However, they also assert that health professionals 'do not systematically or proactively provide their patients with information about the variety of local information services' (Picker Institute, 2007: p. 1).

Does it make patients feel better?

There is evidence that giving information to patients with chronic medical conditions can in itself have a significant therapeutic effect (Maly *et al*, 1999). This work has not yet, to our knowledge, been replicated in a mental health setting. There is certainly evidence (Gigantesco *et al*, 2002) that not giving information to patients and relatives is a source of considerable dissatisfaction with psychiatric services.

Opportunities

It is likely that increased service user involvement in decision-making leads to better engagement with services and increased adherence. Indeed, clinical outcomes can be predicted by patients' perceptions that services have met their needs (Noble & Douglas, 2004).

Possible pitfalls

'Health literacy' – or 'the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions' – cannot be assumed (Institute of Medicine, 2004). Nearly half of US adults have difficulty understanding healthcare instructions. Poor general literacy is one of several elements contributing to the problem. Others include language, cultural understandings and problems with understanding basic mathematics or scientific concepts.

A study commissioned to support the Department of Health's (2006*a*) promises on information provision (Coulter *et al*, 2006) reported that a vast amount of information is available but many patient information leaflets and websites do not provide sufficiently accurate and detailed information to assist patients in making decisions. The study looked at the quality of current health information and assessed the potential value of accrediting or 'kitemarking' information providers. It suggested guidelines to ensure that information is comprehensive, evidence based and user friendly. Such high-quality information can be obtained from national sources such as mental health charities or the Royal College of Psychiatrists (www.rcpsych.ac.uk). Other information may be available locally, usually through primary care trusts or voluntary organisations.

Paper v. electronic information

Information for patients can be ordered in print format or downloaded from the internet (Table 1).

Table 1 Reliable web sources

Information sources	Web address	Who are they?	Focus	What's there?
Depression Alliance	www.depressionalliance.org	Service user and carer charity	Depression	Self-help CBT programme, personal accounts, book recommendations
Rethink	www.rethink.org	Service user and carer charity	Psychotic disorders	Personal experiences, general information about mental illness and about how services work
MIND	www.mind.org.uk	Service user and carer charity	User perspective	Factsheets and booklets on many areas of mental illness/distress and an alphabetical list of drugs used in psychiatry. Some very detailed information
Royal College of Psychiatrists	www.rcpsych.ac.uk/ mentalhealthinformation. aspx	Professional body and educational charity	Mental health	Readable leaflets on a range of conditions and treatments, plus aides-memoires of questions for patients and carers to ask professionals
NICE	www.nice.org.uk	Governmental department	Evidence-based treatment	Existing treatment guidance, but also treatment areas on which consultation is being sought. It has some very good summaries for patients and carers
NHS Direct	www.nhsdirect.nhs.uk	Governmental department	Physical and mental health	Information about staying well. Interactive tools on healthy eating, exercise, drinking safely, giving up smoking
NHS National Library for Health – Mental Health Specialist Library	www.library.nhs.uk/ mentalhealth	Governmental department	Mental health	Designed for professionals but may be useful for some patients. Detailed, in-depth information on a range of treatments, with links to a broad range of documents and references
Clinical Knowledge Summaries (National Library for Health)	www.cks.library.nhs.uk	Governmental department	Physical and mental health	Answers to common questions – but nearly all about physical health. Some pages on mental health, but a bit like a medical student's revision guide
Patient UK	www.patient.co.uk	Commercial supplier of GP IT systems	Physical and mental health	Patient information designed for primary care and approved by the Centre for Health Information Quality
BBC	www.bbc.co.uk/health/ conditions/mental_health	Broadcaster	Mental health	Sections on emotional health, disorders and conditions, supporting and caring, therapy and therapists, coping techniques and understanding drugs

BBC, British Broadcasting Corporation; CBT, cognitive–behavioural therapy; GP, general practitioner; IT, information technology; NHS, National Health Service; NICE, National Institute for Health and Clinical Excellence.

Some organisations provide the same information in several formats. One study has suggested that those who use the internet to access information tend to be younger, employed and with internet access at home (Gray & Whittington, 2002). So, although the internet may provide the richest source of information, it is still not used by many clients of mental health services.

Well-published paper leaflets may look more professional but they raise the questions regarding cost and availability, and different services have different protocols for making such information available to staff, patients and carers. Services must decide on the number and range of leaflets to supply and ensure that supplies are maintained. Clinicians have access to a vast amount of material but it can be difficult to identify exactly what a particular patient (or carer) needs. Moreover, to download material from the internet, they need access to both a computer and a printer, ideally during the consultation. For the moment, it appears that clinicians will need access to both paper and electronic information to get the best 'information fit' for individual patients.

Individual needs and equity

Different services will be meeting patients from different backgrounds and with different language needs. To ensure equal access, it is necessary to provide information in as many languages as possible. Attention should be given to material written for particular groups such as young people, older adults and those with intellectual difficulties.

Local information

Information on local services and resources may be lacking or not collated, so it may be necessary to develop this in collaboration with individual services and local partners. For example, we know of one trust that, in implementing the National Institute for Health and Clinical Excellence's clinical guidelines on schizophrenia (National Collaborating Centre for Mental Health, 2002), decided to provide information about the recommended psychological interventions for the disorder: cognitive–behavioural therapy for psychosis and family intervention work. Information leaflets were produced that described each treatment, how it would be delivered and the evidence supporting it. These were 'localised' by the inclusion of a blank box at the end of each leaflet in which teams could enter locally specific information such as contact details for members of staff. Other teams provide written information for clients that describes what the team can offer and how to contact staff, both during the day and out of hours.

Developing materials

This is more difficult, resource-hungry and time-consuming than many people imagine. Clinicians are used to writing for professional colleagues. The language they use may not be easy for lay readers to understand. However, there are several pieces of well-organised guidance available (Department of Health, 2003; Duman, 2003). This section will focus on written material that might appear either on a web page or in a leaflet.

Planning

First, has this already been done? There is a lot of good information out there – and nobody wants to waste time re-inventing the wheel. Then answer the following questions.

- Whose primary responsibility is it?
- What is the need? Patients and doctors generally worry about different things, so make sure you are addressing issues of real interest to patients.
  - Who are your intended readers?
  - What do they want to know?
  - What do they need to know?
- Who are the key stakeholders who can contribute to the process? This should include patients and carers as early on in the process as possible.
- How will the leaflet (or other media) be made available to patients?
- Where is the money? The time of enthusiastic staff and patients may not cost extra, but the design, printing and distribution of material certainly will.
- What system will be established for future review, revision and re-supply?
- When can it be ready? Timing may be crucial if a leaflet or web page is to support a specific project or initiative.

Process

Keep it simple and try to deal with one issue at a time.

Writing

'Plain English' is essential if you are going to communicate effectively to a wide audience. To use straightforward English is a socially inclusive act, ensuring that as few people as possible are denied this information by reason of poor education, cognitive impairments or other deficits. Although grammar checks in word-processing programs make writing

Box 3 Saying it in plain English

The Department of Health (2003) on writing patient information:

- Use familiar words in simple well-planned sentences
- Try to keep sentences short (usually no more than 15–20 words)
- Use the present tense and active voice where possible. For example, 'Your appointment is on…', not 'Your appointment has been made for…'
- A question and answer format helps to divide up text
- Bulleted or numbered points divide up complicated information
- Use short paragraphs with headings

George Orwell (1946) on the use of English in politics:

- Never use a metaphor, simile, or other figure of speech which you are used to seeing in print
- Never use a long word where a short one will do
- If it is possible to cut a word out, always cut it out
- Never use the passive where you can use the active
- Never use a foreign phrase, a scientific word, or a jargon word if you can think of an everyday English equivalent
- Break any of these rules sooner than say anything outright barbarous

Box 4 Advice on presentation of materials

- Lower-case letters are easier to read
- White space makes the information easier to read
- Use a large, bold font to emphasise text
- Avoid upper-case letters, italics and underlining, as they make the text more difficult to read
- Write numbers from one to nine in words, and numbers from 10 as numbers
- A font size of at least 12 point
- Use diagrams and pictures to illustrate the text, remember to label them and do not print over them
- Don't use clip art – it looks cheap

to tolerate the inevitable delays and false starts, but also to polish your rough diamond to a shine.

Once you have your new patient information in your hand – or on your screen – how do you get the material to the people for whom it was created?

Delivering information: the Lambeth Information Project

In our introduction to this article we mentioned the lack of information made available to service users in spite of the large amount of information

easier, there is no substitute for checking the text yourself. There is a significant overlap between the recent Department of Health guidance on writing patient information and George Orwell's advice on the use of English (Box 3).

Presentation

Getting the text right is the first step – but it will be to no avail if your readers cannot read it. The font (typeface) may be too small, or there may be insufficient contrast between the background and text, or an attractive graphical design may obscure the text (Department of Health, 2003; Norah Fry Research Centre & RNIB, 2004) (Box 4).

Some practical points

Most good patient information is a collaborative effort that takes time, discussion and many revisions. Box 5 lists some practical points that can help you

Box 5 How to polish a diamond

- Make use of your word processor to check for spelling mistakes and long sentences
- Be prepared to write a number of drafts
- Print a paper version to read – several times
- Read what you have written out loud. Does the writing flow?
- Does each idea follow logically from the previous one?
- Have your efforts at style slipped into pretentiousness?
- Do the words sound right?
- Ask a number of people – colleagues, patients and carers – to read the draft
- Don't be offended by criticism – it may be hard when you have put a lot of effort into a project, but you will end up with a better end result
- Re-read the draft after a week
- Check and re-check references to other sources, especially websites

that there is. The Lambeth Information Project was set up to address this specific problem – how to get the right information to patients and carers (Byfield, 2007). We were involved in setting up the project, and outline here how it proceeded.

The local trust (South London and Maudsley NHS Foundation Trust) had no budget stream for patient information, so charitable funding was found to fund an information facilitator for 3 days a week for 12 months. It was decided to focus on paper information because of the fragile and patchy nature of the IT facilities available at clinical sites. The tasks for the information facilitator were to:

- define an appropriate core list of information leaflets
- establish a mechanism for the distribution of leaflets and factsheets
- estimate the staff and funding needs to sustain a robust and responsive framework for patient information in the trust.

A preliminary survey of clinicians and service users suggested that there was broad agreement that information was important and that service users were not getting what they needed, but less clarity about how the situation might be improved. Service users were dissatisfied and felt that information should automatically be provided without them having to ask for it. Some said they had not received any written information during their contact with mental health services, but that they would have valued it, had it been offered.

Implementation

A core list of information was established, which included:

- purchased leaflets from MIND, the Royal College of Psychiatrists and Health Scotland
- free self-care leaflets from the Northumberland, Tyne and Wear NHS Trust
- free items related to physical health from the Mental Health Foundation, British Heart Foundation, Food Standards Agency and the Department of Health's smoking cessation service
- UK Psychiatric Pharmacy Group (UKPPG) medication leaflets downloaded from the trust intranet
- obligatory trust items relating to the complaints procedure, use of personal information and the Patient Advice and Liaison Services
- a template of local organisations that services could adapt for their locality.

A number of services were identified and meetings held with the staff to introduce the project.

On each site a local 'champion' was identified who would act as a facilitator for local implementation. For each site, appropriate storage and display was organised. Flyers and posters were distributed in clinical areas to remind patients to ask for information.

Findings
Practical issues

In setting up the information intervention some practical obstacles emerged. One was the delay caused by having to use the trust's purchasing department to buy leaflets and display equipment from external providers. Another was the question of where to put the information on each site. For example, one site's initial location for information in an interview room meant that the material was often inaccessible, and on another site keeping it in the team leader's office deterred staff from using it. There was often very limited access to computers and printers for the downloading and printing of information.

Staff attitudes

At the start, we asked sites to nominate a member of staff to take responsibility for the resources, to spend a little time each week to encourage use, check stocks and liaise with the information facilitator about supplies, and so on. Initially, only one site appointed an information monitor, suggesting a general lack of interest in the issue. This probably led to reduced use of information, with items running out and untidy displays.

The highest level of interest came from occupational therapists, who made good use of a range of resources, especially self-care material on anger management and physical health, which could be useful in group work. Clinicians recognised that they needed to make time to familiarise themselves with the materials. They seemed more comfortable with sources they already knew, such as information from MIND or the Royal College of Psychiatrists. Differences in preference of format – paper *v.* electronic – emerged but it was recognised that both are valid and necessary depending on the context.

Some staff asked for information covering more topics, such as local leisure and volunteering opportunities, benefits advice and the effects of street drugs on mental health. However, other staff reported there were too many leaflets available and that this could be confusing. On balance, the steering group agreed to reduce the number of leaflets when rolling out provision to other sites in the borough.

Patient attitudes

Service users particularly liked the self-help leaflets such as those dealing with sleep problems, anxiety and anger. However, they wanted more information on medication side-effects and stopping medication.

Outcomes

The work encouraged clinicians to reflect on their practice and working methods. Although we did not investigate staff behaviour directly, there is evidence that this needs attention. One study identified eight domains for learning in this area (Jones *et al*, 2001) that included placing a high priority on patient information and education, understanding the patient's information needs and environment, knowing about information sources and learning from the patient. To be successful, the provision of information needs to be a central part of the consultation process between clinician and patient. It seems that clinicians have yet to convert into practice the evidence that providing patients with information, and making sure that it is understood, forms a vital part of their patients' care and treatment.

In Lambeth, staff expressed concern at the lack of a ring-fenced budget for information, and the trust-wide information group is therefore considering asking all teams to allocate a proportion of their budget for patient information. Meanwhile, the information facilitator has produced a resource list, supplemented with providers' contact details, so that teams can buy items using their own budgets and source the free items.

Conclusions

It should not take government policy to convince doctors of the wisdom of sharing information with their patients. However, the emphasis on informed decision-making as a central element of service provision has helpfully lent impetus to this aspect of good practice. In the USA it has been reconceptualised as a discrete intervention – 'information therapy' – albeit mainly so far in physical healthcare (Kemper & Mettler, 2002). Part of this concept is the notion of the 'information prescription', which is currently being piloted at 20 NHS demonstration sites (www.information prescription.info).

Of course, information transfer in mental health is complicated by the fact that patients often hold rather different health models from those used by healthcare professionals and services. It may
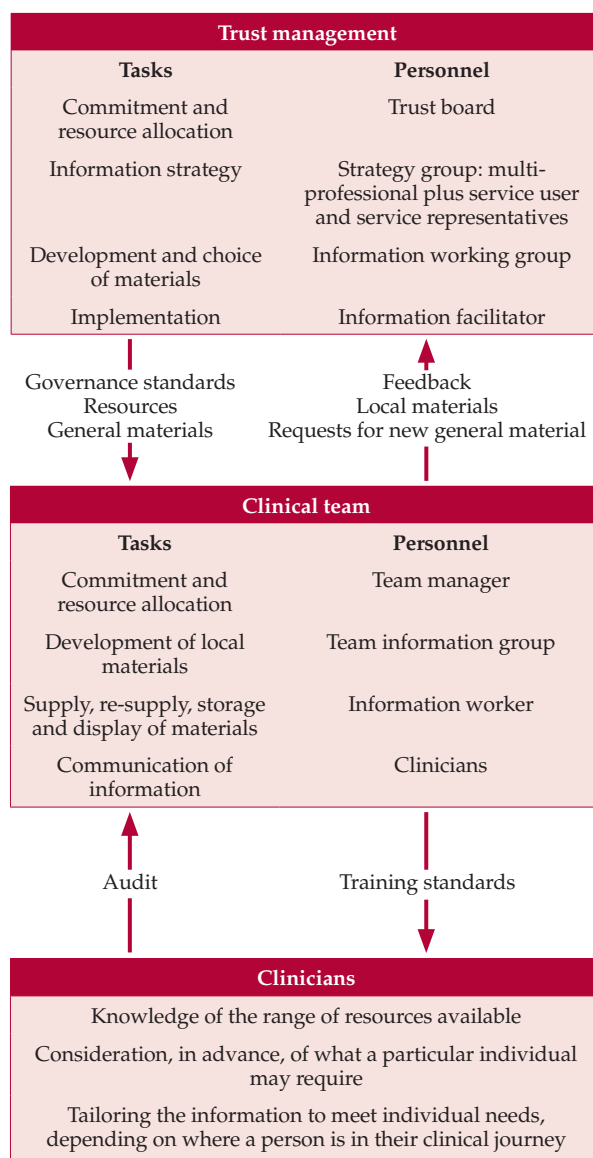

Fig. 1 Model for providing patient information in clinical services.

therefore require more work than in other areas of medicine to establish a therapeutic relationship. Information alone will not solve this problem but it can help clinicians address it in a more systematic way.

Our local experience has given us some evidence on which to build realistic information-sharing strategies. It has also highlighted the need to substantially increase clinicians' appreciation of information and the need to make information-sharing a routine, integral part of the clinical consultation. The difficulties encountered illustrate the depth of change needed in clinical, managerial and administrative practice. Changing an established culture requires active support from senior managers and

clinicians as well as continuing work with team members, and may take some time. We would suggest that, to provide information effectively for service users, clinicians need to:

- become familiar with the range of resources available
- consider in advance what a particular individual may require
- tailor the information to meet individual needs, depending on where the person is in their clinical journey.

Given the pressures of service delivery, they are unlikely to do this unless there is a supportive structure for this activity (Fig. 1), including:

- a clear strategy
- a supportive managerial and administrative structure
- budget
- dedicated staff time
- training for clinical staff.

Declaration of interest

The authors were involved in the Lambeth Information Project. P.T. and R.R. edit public information leaflets for the Royal College of Psychiatrists.

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MCQs

1 Research suggests that patients:
a do not want to know about their disorder if it will upset them
b are less likely to take their medication if they are informed of the possible side-effects
c feel that if they ask a doctor questions they will be perceived as challenging or difficult
d feel respected if they are not given information
e tend to want explanations of their problems in psychological terms.

2 'Informed decision-making' means that:
a a doctor needs access to the relevant information to make an appropriate treatment decision
b the doctor is the best person to inform the patient of the relevant information
c the patient needs access to the relevant information to make treatment choices
d the patient plays less of a part in decision-making
e the doctor is selective in the information given to the patient.

3 Patients tend to:
a look first to sources other than their doctor for health information
b rate doctors below the internet as a source of information
c find that health professionals 'systematically and proactively' provide information about the variety of local services
d engage better with services when given information
e have a high level of health literacy.

4 The internet:
a provides consistently reliable health information
b is used by most patients with long-term mental illness
c provides enough information for patients to make decisions
d tends to be used by those who are younger, employed and with internet access at home
e has now rendered paper-based information redundant.

5 Information materials for the public should:
a be available in a range of formats and languages
b use upper case letters, italics and underlining for emphasis
c use clip art to make them look 'friendlier'
d use scientific language so that they appear authoritative
e use the passive voice.

MCQ answers				
1	2	3	4	5
a F	a F	a F	a F	a T
b F	b F	b F	b F	b F
c T	c T	c F	c F	c F
d F	d F	d T	d T	d F
e F	e F	e F	e F	e F