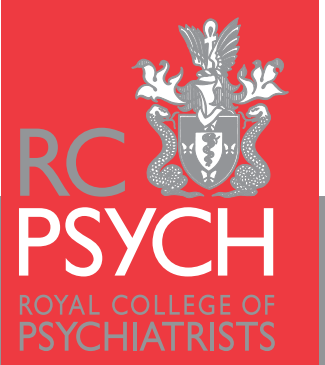


OP66



Mentoring and coaching

November 2008

OCCASIONAL PAPER

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November 2008

Royal College of Psychiatrists
London

'[Mentoring means] helping people to become better at helping themselves, helping them develop their opportunities and manage their problems, helping them become more effective, more functional, more empowered members of the workforce.'

Nancy Redfern, Specialty Dean, Northern Deanery

'I do listen to many people [who have used a mentor] say "[thanks to my mentor] the way I deal with cross patients is different, the way I manage complaints is different, the way I manage conflict in the department, the way I manage uncertainty, my ability to go and ask when I don't know what the answer is, my confidence".'

Jolyon Oxley, Mentoring for Doctors

'I have had different mentors at different stages of my career – not always another doctor.'

Professor Sheila Hollins, Past President, Royal College of Psychiatrists

Contents

| | |
|--|----|
| Authors | 4 |
| Mentoring: statement of intent | 5 |
| Introduction | 6 |
| What is mentoring? | 8 |
| Mentoring issues specific for psychiatrists | 11 |
| Mentoring in practice – how to do it | 15 |
| Training and support in developing mentoring skills | 20 |
| Mentoring: current issues for psychiatrists | 22 |
| Appendices | |
| 1. Summary of the mentoring survey | 26 |
| 2. An exemplary template for developing a 'pen portrait' of mentors on a scheme | 29 |
| 3. Mentoring contacts | 30 |
| 4. Frequently asked questions | 33 |
| 5. An example of a mentee/mentor matching pathway | 35 |
| References | 36 |
| Further reading | 37 |

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Mentoring: statement of intent

The Royal College of Psychiatrists supports mentoring as a means of enabling members to work to their full potential in carrying out their clinical and other responsibilities at work.

The College views mentoring as being useful to psychiatrists from different specialties and at different stages of their careers.

In order to support the development of appropriate training for mentors and promote the uptake of mentoring by members the College has developed an action plan:

- link in with Images of Psychiatry campaign 2006–2008 on retention of members
- promote local mentoring champions nominated by College divisional chairs and continuing professional development (CPD) coordinators, with support from the medical directors' group and the College director of CPD
- nominated mentoring champions from each division to form a virtual network
- consider further meetings to support and promote mentoring with other Colleges through the Academy of Medical Royal Colleges and with other mental health professionals through the National Institute for Mental Health in England (NIMHE)
- provide information on mentoring on the College website and direct members to it through the e-newsletter
- nominated College officer for mentoring to discuss potential training courses on mentoring with the College training unit director
- propose a series of articles on mentoring in the *Psychiatric Bulletin* to cover such issues as what mentoring is, report on medical directors' survey, personal accounts of psychiatrists with different responsibilities who have had experience with mentoring at different stages of their careers (e.g. clinicians, psychotherapists, medical directors, etc.); the series could also cover other forms of development/support, for example action learning sets, coaching, peer support, etc.

Introduction

This guide on mentoring and coaching is a practical resource and reference guide. It is aimed at prospective mentees and mentors, with suggestions on training and preparation for these roles. Those involved in setting up mentoring schemes will find suggested approaches and templates for useful documents. The main body of the text includes 'capsules' of additional detailed information on specific topics and the appendices provide examples of useful publications and where to find further information.

The guide covers both mentoring and coaching. These terms can be used interchangeably to describe a similar activity, which can lead to confusion. Often the setting will determine which one is used – for example, in the private sector coaching is the most commonly used term. However, most models of mentoring and coaching share the same basic premise, namely that the mentee is resourceful and that the key role of the mentor/coach is to help the mentee use this untapped resourcefulness. **For the purpose of easy reading, compound words such as mentoring/coaching are avoided and the terms 'mentoring', 'mentor' and 'mentee' are used preferentially to cover both mentoring and coaching; coaching may be referred to in specific instances.** Table 1 may help clarify some of the differences between these terms.

Table 1 Mentoring and coaching

| Mentoring | Coaching |
|---|--|
| • ongoing relationship that can last for a long time | • relationship generally has a set duration |
| • can be more informal and meetings can take place as and when the mentee needs some advice, guidance or support | • generally more structured in nature and meetings are scheduled on a regular basis |
| • more long-term and takes a broader view of the person | • short-term (sometimes time-bounded) and focused on specific development areas/issues |
| • mentor is usually more experienced and qualified than mentee – it is often a senior person in the organisation who can pass on knowledge, experience and open doors to the otherwise out-of-reach opportunities | • the coach does not need to have direct experience of their client's formal occupational role, unless coaching is specific and skills-focused |
| • the focus is on career and personal development | • the focus is generally on development/issues at work |
| • the agenda is set by the mentee, with the mentor providing support and guidance | • the agenda is focused on achieving specific, immediate goals |
| • mentoring revolves more around developing the mentee professionally | • coaching revolves more around specific development areas/issues |

From Jarvis, 2004, with permission.

The National Health Service (NHS) is currently undergoing a major cultural shift with the emergence of foundation trusts, performance management and a plurality of service providers. Trusts need to ensure good recruitment and retention of medical staff and reduce locum costs. Psychiatry too is changing – the advent of New Ways of Working (Department of Health, 2005), payment by results and the fact that psychiatrists nowadays may have less leverage within trusts, create new challenges for the specialty. Shorter specialist training periods place new pressures on trainees and consultants. This is taking place alongside high expectations from the government and the public. Consultants need to be adaptable and to have sound methods to facilitate their professional and personal development. Achieving an optimal work–life balance is increasingly important.

There is a growing evidence base on the usefulness of mentoring to both individuals and organisations (Oxley, 2004). Since 2002 the College has recommended that all newly appointed consultants be offered a mentor, but a recent survey of mental health trusts conducted by the College (Appendix 1) shows patchy implementation of this recommendation.

A key aim of this guide is to highlight the usefulness of mentoring to all grades of psychiatrists at different stages in their careers. We hope mentoring will become a 'normal' widespread activity accessible to all psychiatrists.

What is mentoring?

The term 'mentor' derives from the Greek mythology – before setting off on his epic journey, Ulysses entrusted his young son Telemachus to the care and direction of his trusted friend Mentor. Since then the name has been given to approved individuals who are willing to share their knowledge and networks with a less experienced person in a relationship of mutual trust.

Mentoring describes a relationship, not an activity. A mentor is an objective and empathic 'sounding board'. Mentors bring a broad experience of work to the mentoring relationship and perform a number of other tasks:

- challenging the mentee to look at opportunities as well as problems
- sharing know-how at a strategic level
- assisting the mentee in identifying realistic career goals and planning how to achieve them.

The mentoring relationship lasts for varying lengths of time, but for newly appointed consultants a typical period may be up to 2 years, with meetings at least once a month. There is some agreed structure to the meetings, which may include an agenda and brief notes, with possible interim contact if needed. The mentoring relationship progresses from an 'initial phase' to the 'working phase' and on to the 'dissolving phase'. Mentor and mentee may eventually establish a more equal lasting friendship.

MENTORING

There are a number of definitions of mentoring. Here are some examples from a range of perspectives.

CAPSULE 1. DEFINITIONS

'[Mentoring is] the process whereby an experienced, highly regarded, empathic person (the mentor), guides another individual (the mentee) in the development and re-examination of their own ideas, learning and personal and professional development. The mentor who often, but not necessarily, works in the same organisation or field as the mentee, achieves this by listening and talking in confidence to the mentee.' (Standing Committee on Postgraduate Medical and Dental Education, 1998)

The tendency to use the term mentoring rather loosely has been challenged by Freeman:

'[Concerns were expressed over] the growing tendency to use the title "mentor" to cover a wide variety of activities, thus creating confusion and threatening the ability of doctors to make accurate choices about the type of support they might need in facing the professional challenges of the next decade.' (Freeman, 2000)

'There are some core characteristics in mentoring and these are:

- It is a learning relationship between two people
- Mentoring involves key skills, for example: active listening, using a range of challenging questions, challenge and support
- There are certain key human qualities involved. They include: trust, commitment, authenticity, honesty, integrity.' (Garrett-Harris & Garvey, 2005)

'The central concepts [of mentoring] are ... to help people to help themselves, to find their own solutions to indeterminate problems – a developmental rather than remedial principle.' (Oxley, 2003)

'[Mentoring is] helping another person become what that person aspires to.' (NHS Leadership Programme for Chief Executives, 2000)

'The mentor represents knowledge, reflection, insight, understanding, good advice, determination and planning, qualities that cannot be mastered alone.' (East, 1995)

COACHING

Jenny Rogers (2004) provides a simple definition of coaching 'that conceals [its] complexity':

'The coach works with clients to achieve speedy, increased and sustained effectiveness in their lives and careers through focused learning. The coach's sole aim is to work with the client to achieve all of the client's potential – as defined by the client.'

The International Coach Federation (www.coachfederation.org) describes coaching as follows:

'Coaching is partnering with clients in a thought-provoking and creative process that inspires them to maximise their personal and professional potential. Professional coaches provide an ongoing partnership designed to help clients produce fulfilling results in their personal and professional lives. Coaches help people improve their performances and enhance the quality of their lives. [They] are trained to listen, to observe and to customise their approach to individual client needs. They seek to elicit solutions and strategies from the client; they believe the client is naturally creative and resourceful. The coach's job is to provide support to enhance the skills, resources, and creativity that the client already has.'

David Clutterbuck's definition points out that the coach 'guides and actively encourages the protégé in the development of relevant skills and attitudes for the future. The focus ... is on the ability to see beyond what is, to identify what can be, and then to work with the protégé to achieve that potential.'

CPD PEER GROUPS

'The purpose of the peer group is to review the objectives of each individual in turn and to identify practical ways in which these may be achieved. Each peer group would have three core sets of functions:

- 1 objectively referencing the work done by individuals to construct a personal development plan and using it as a framework for learning

- 2 supporting members in achieving their goals and objectives
- 3 in some circumstances, providing CPD that is oriented towards helping the group members achieve their personal development plans' (Royal College of Psychiatrists, 2001).

In relation to point 3 in particular, the Royal College of Psychiatrists' policy (2001) states that

'the peer group must provide a supportive, rather than a critical environment for all the members. The group should provide ideas and be imaginative in helping each individual to overcome barriers to achieving objectives. Peers must strive to make each other feel secure enough to discuss openly [their] abilities, progress and achievements as well as any problems, gaps and mistakes, and learn from them. The techniques ... likely to prove appropriate [here] include: focused discussion, reflection, positive critiquing, [and] appraisal.'

Mentoring issues specific for psychiatrists

Psychiatrists may have reservations about mentoring arising from misconceptions about the whole process. They are expected to have highly specialist communication skills, including listening. Some psychiatrists may therefore assume that they have no need for either training or indeed any involvement in mentoring issues. Optimising communication skills has been a high priority in all areas of medicine. This has led to the development of sophisticated training in communication skills in undergraduate and post-graduate training programmes.

In broad principles, mentoring involves assisting the mentee to find solutions to their own problems; however, it is not about telling the mentee what they should do. This approach can be considered quite developed in psychiatry, with examples of shared agenda-setting in cognitive behavioural therapy. We therefore suggest that training in mentoring skills for psychiatrists should focus on emphasising the difference between a therapeutic and mentoring approach. It should also facilitate the adoption of the mentoring approach, rather than stressing the validity of communication skills with which psychiatrists are generally familiar.

Some psychiatrists might be overly critical of the mentoring process as they may regard it as a form of psychotherapy. This may strengthen the case for trusts to consider appointing non-medical or external mentors for their psychiatrists.

Mentees have a responsibility to bring reasonable and valid issues to discuss in mentoring sessions, which will inevitably make the process time-consuming. A sensible, practical allocation of time for the meetings coupled with a positive attitude on the parts of both mentor and mentee are crucial if the process is to be constructive.

Psychiatrists' work is by its very nature emotionally charged but these are particularly stressful times. There has been radical management restructuring in the NHS and doctors are being subject to New Ways of Working, which involve adapting to rapid and often significant changes in their traditional roles in multidisciplinary teams. During this state of flux, with lack of clarity regarding roles, changing responsibilities and finding one's position in the team, the need for formal mentoring is stronger than ever before.

WHO CAN BENEFIT FROM MENTORING?

Psychiatrists at any stage in their careers may benefit. There are likely to be different needs for support at different career stages, such as tackling new

roles and taking control of personal and professional development, as well as addressing immediate problems. However, it is worth bearing in mind that mentoring relies very heavily on one-to-one interactions and not everyone may find this a comfortable experience.

SPECIAL GROUPS OF PSYCHIATRISTS THAT MAY BENEFIT FROM MENTORING

Targeting specific groups of doctors can help in organising and setting up mentoring schemes as it allows for specific planning and allocation of resources. Nevertheless, there are possible disadvantages in focusing on specific groups of doctors. For example, it may lead to stigmatisation of the targeted group(s), who may be perceived as 'weak'. It could also make it harder for established doctors or those who do not belong to the targeted groups to recognise their need for mentoring and may deter them from seeking this sort of support. Still, targeting specific groups of doctors is probably the most effective way of establishing mentoring schemes and having them accepted as an appropriate activity. A selection of groups that might be targeted follows.

- **Doctors at a time of transition**, for example new consultants. This is the most recognised group who might be considered for mentoring given the enormous shift in role that occurs in the 'graduation' from trainee to consultant. Mentoring sessions could be used as a very effective, private and safe forum to discuss issues of concern and doubt. Apart from the obvious benefits of providing support, advice and information on coping with the changes in responsibilities and management skills, a mentoring scheme for this group could help with wider issues such as poor morale, recruitment and retention of staff, burnout, stress, etc.
- **Doctors taking on new management roles** (e.g. medical directors). This group would be a uniquely small one to target locally and the relative lack of local role models might well necessitate the appointment of an external mentor. There may be more reference to coaching here, for example because of the increasing use of 'executive coaching' for executive members of trust boards and the influence of the private sector. Given the intensity and frequency of management changes occurring in the NHS, the need for coaching/mentoring in this group has probably never been greater.
- **Those returning to work after a break** (e.g. maternity leave or following lengthy sick leave). With the current rush of clinical and management reorganisations occurring in trusts, doctors who return to work following a period of time away would probably embrace the opportunity to discuss issues and seek advice in an appropriate, formal mentoring relationship.
- **Consultants at the mid-point of their career**. Mentoring this group could be useful in providing a platform to review alternative career choices and changes in role. It could ultimately aid retention of senior staff who might otherwise not feel supported if they experience a period of stress, burnout or boredom doing the same job for years on end.
- **Consultants with work-based difficulties**. For example, people experiencing bullying, difficulties with colleagues, and a range of

other issues that might include being subject to reviews and inquiries. The Psychiatrists' Support Service at the College will help to link psychiatrists experiencing such difficulties with a local mentor.

- **Those approaching retirement.** This is another point of transition and mentoring could help psychiatrists to optimise the range of choices available to them at this stage in their career and make full use of their experience, with some potential to review their work commitments.
- **Those working flexibly.** Flexible working has become more popular and acceptable and is usually taken on because of other personal commitments. Doctors who work part-time hours will inevitably experience different kinds of stress compared with those who work a full working week, and they may find a mentoring relationship helpful.
- **Refugee doctors.** These doctors face a great number of hurdles to resume their medical careers in the UK. Contact with fellow health professionals and a strong support network are vital to ensure they remain motivated, and good mentoring arrangements could help enormously in achieving this.
- **Those with performance problems.** Unfortunately, targeting this group will invariably be seen as stigmatising but this perception could be reduced as mentoring schemes become more widely established and accepted as a normal way of developing and learning.
- **Training-grade doctors and non-training posts.** With Modernising Medical Careers (MMC) fundamental changes in medical training are under way. Newly qualified doctors have to make crucial decisions about their career direction at an earlier stage, therefore careers advice for students and doctors is regarded as essential. The MMC scheme should enable switching in career direction and facilitate mentoring. It should include specific advice and mentoring for those interested in careers outside the mainstream and careers currently facing a critical shortage, for example in clinical academia.
- **Locum consultants.** Locum consultants may be in post for significant lengths of time. They may initially take up a locum position prior to having a substantive post within the trust. They should have access to mentoring in the same way that locum consultants are encouraged to take part in annual appraisal cycles.

CAPSULE 2. WHAT OTHER HEALTHCARE ORGANISATIONS DO ABOUT MENTORING.

Several of the medical Royal Colleges have declared their recommendations and suggestions regarding mentoring:

- Royal College of Ophthalmologists (Oxley *et al*, 2003)
 - 'It is important that all newly appointed consultants are offered a mentor so that there can be no inference that seeking a mentor means professional weakness.'
- Royal College of Psychiatrists (Dean, 2002)
 - The Court of Electors recommended that all newly appointed consultants should have access to a designated senior colleague – a mentor (or mentors) – to whom they could turn (in person, by telephone or via email) for advice, support or information in these crucial early days.

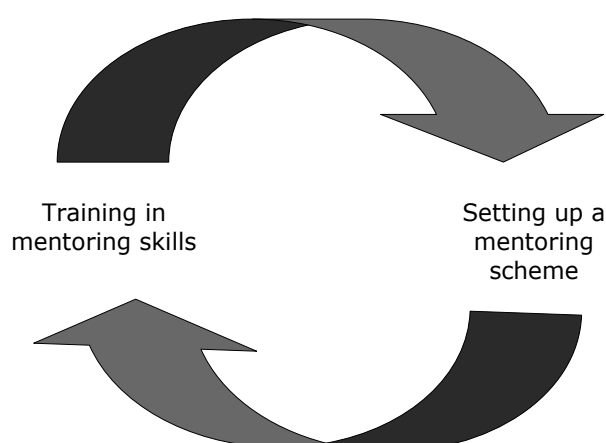
- Royal College of Obstetricians and Gynaecologists
There is a mentoring scheme for obstetrics and gynaecology doctors who have voluntarily contacted the College to seek a mentor because they have been experiencing difficulties in relation to their work.
 - British International Doctors Association
Formerly known as the Overseas Doctors Association, it set up mentors in all specialties and UK regions in 1998.
 - Academy of Medical Sciences
Doctors wanting to achieve a Certificate of Completion of Specialist Training as well as continue their research training (clinician scientists) should be provided with a mentor drawn from the Academy's fellowship, which has been operating since 2000 and is supported by the Department of Health and various charities.
-

Mentoring in practice – how to do it

There are both practical considerations and training issues to be addressed (Fig. 1). We consider each separately but they are interdependent and need to be addressed in parallel:

- practical considerations in setting up a scheme
- training and support in mentoring skills.

Fig. 1 Mentoring in practice



CAPSULE 3. PRACTICAL CONSIDERATIONS IN SETTING UP A MENTORING SCHEME.

- establish a pool of mentors trained in mentoring skills
- identify a psychiatrist with lead responsibility for the scheme
- establish the role of a central coordinator for the scheme
- obtain the support of key stakeholders
- provide written material on the scheme to human resources to be included in 'job packs' sent out to applicants for new consultant posts
- decide the target population of the scheme
- develop a clear pathway for the matching of mentee and mentor
- ensure that all potential mentees are aware of the scheme and the process of getting a mentor
- identify the resource implications of the scheme and establish budget lines.

This section will take a 'menu' approach to the key steps in setting up a mentoring scheme.

STEP 1

ESTABLISH A POOL OF MENTORS TRAINED IN MENTORING SKILLS

A suggested approach is to contact all consultant psychiatrists in your area and invite them to a half-day 'taster' session. This will cover the basic outline of what mentoring is and what it isn't, present the benefits of mentoring, describe a useful model (e.g. Egan's skilled helper model) and present a short 'live example' with two people trained in mentoring skills taking on the roles of mentee and mentor dealing with a real issue for the mentee using the framework of the outlined model. The last part can be very powerful in influencing the audience to become involved in mentoring.

It may be worth having a number of taster sessions at different venues and times. The taster day can be followed up by a more comprehensive course on developing mentoring skills.

It is very important that a mentee has a choice of mentor from a pool of mentors. Having a prescribed mentor tends not to work well.

STEP 2

IDENTIFY A PSYCHIATRIST WITH LEAD RESPONSIBILITY FOR THE SCHEME

This individual should have an advanced level of mentoring skills. They could lead a small subgroup of more advanced mentors whose task is to ensure that there is a support and developmental structure in place for the mentors themselves.

STEP 3

ESTABLISH A CENTRAL COORDINATOR FOR THE SCHEME

The central coordinator's main role is to be the link person between the mentee and the mentor. Mentoring schemes can take a pragmatic approach to this and seek a local solution depending on circumstances and available resources. This role may be taken up by, for example, an interested medical or clinical director. Some schemes have identified a member of medical staff in their trust's human resources department as a central coordinator, and other organisations have involved outside agencies such as the National Institute for Mental Health in England (NIMHE) to provide one. Should the coordinator be a non-medically qualified individual, it may be helpful to support this role with a consultant who has a lead responsibility for the scheme.

The coordinator has the following responsibilities:

- to hold a central database of the mentors in the scheme
- to match mentees with potential mentors from the 'pool'
- to collate a 'pen portrait' of each mentor to aid the matching of mentee and mentor (see Appendix 2 for an example of a proforma)
- to help the mentee navigate through the pathway (Appendix 5) of establishing the mentoring relationship
- to provide clear communication to all the stakeholders (see below)
- to hold regular meetings with the consultant with lead responsibility.

STEP 4

OBTAIN THE SUPPORT OF KEY STAKEHOLDERS

The coordinator makes initial phone contact followed up by written contact, outlining the scheme and their role within the system.

These will include:

- medical directors of the relevant trusts in the area – obtain their commitment to have time for mentoring factored into the job plans of both mentors and mentees
- College regional adviser
- trust medical staffing officers
- local trainee forums (for mentoring schemes targeting newly appointed consultants)
- the College (the Associate Registrar has specific responsibility).

STEP 5

PROVIDE WRITTEN MATERIAL ON THE SCHEME

This should be provided to human resources to be included in all 'job packs' sent out to applicants for new consultant posts.

This written material could include an outline of the scheme, the contact details of the coordinator, and a frequently asked questions document (an example is in Appendix 4).

STEP 6

AGREE THE TARGET POPULATION OF THE SCHEME

It can be helpful in the early stages of a scheme to focus the mentoring resource on a specific population where mentoring could have the biggest impact (newly appointed consultants are generally regarded the appropriate initial target population). The following lead questions can help with the business planning of the scheme:

- What is the turnover rate of consultant posts in the area?
- How many new consultant posts are there per year?
- How many trained mentors do you need?

CAPSULE 4. EXAMPLE

A large mental health trust in the north-east with 160 consultants had an annual 7.5% turnover of consultant appointments, with 12 new appointments in a 12-month period; 50% of these accepted the offer of a mentor. It is too early to say accurately how long the mentoring relationships continued – the scheme was going to be formally evaluated in late 2007 – but 2 years seems a reasonable estimate. There have been additional demands on the scheme as specialist registrars and more established consultants were seeking a mentor. To date, a mentoring scheme with 15 consultants trained in mentoring skills has covered this demand, with most mentors having one mentee.

STEP 7

DEVELOP A CLEAR PATHWAY FOR THE MATCHING OF MENTEE AND MENTOR

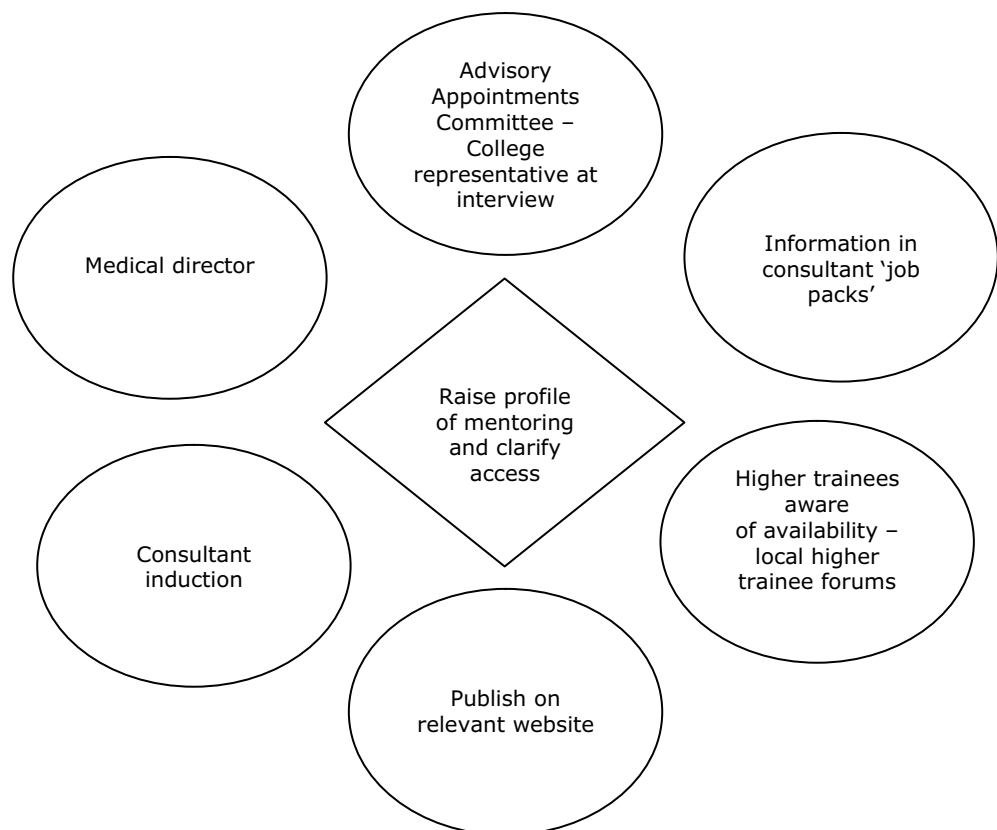
Apart from securing the best matching of mentee and mentor, it is also very desirable from the outset to ensure that it is possible to change the mentor in a non-judgemental way if the initial matching did not lead to a good fit. A suggested approach is that both parties should regard the first 6 months as a two-way probationary period that would not automatically run on but need a mutual positive decision in order to continue (Appendix 5 gives an example of a pathway).

STEP 8

ENSURE THAT ALL POTENTIAL MENTEES ARE AWARE OF THE SCHEME AND KNOW HOW TO GET A MENTOR

Maximise all potential ways of highlighting the profile and the availability of the scheme. Make sure that contact details of the scheme coordinator are highlighted on all relevant written and electronic documents. For newly appointed consultants this would include the following (Fig. 2):

Fig.2 Ways of highlighting the mentoring scheme



STEP 9

IDENTIFY THE RESOURCE IMPLICATIONS OF THE SCHEME AND ESTABLISH BUDGET LINES

This will include the cost of training and supporting mentors, the cost of the coordinator's time, the consultant's time and any evaluation of the scheme. Many of the costs could be met from the medical training budget. In any business plan, the costs of not having a mentoring scheme in terms of ineffective and inefficient consultants, stress-related sickness and high locum costs can be a powerful motivator for organisations in allocating the necessary resources.

Training and support in developing mentoring skills

SOME ASSUMPTIONS ABOUT MENTORING

Training schemes often advise that the term 'trained mentor' should be used with caution – 'trained in mentoring skills' is preferable, as it does not imply a formal qualification. Many training schemes are introductions to practice and often do not have a built-in quality assurance. Another assumption, particularly from psychiatry, is that postgraduate training in psychiatry and in psychological therapies in particular is sufficient training for mentoring. This has been discussed earlier.

DEVELOPING A DIFFERENT MINDSET

Many of the key skills in mentoring require a different mindset from that of medicine. In medicine we learn from day one in the clinic how to elicit information from the service user (symptoms and signs), use these to formulate a differential diagnosis and from this a treatment/management plan. By contrast, the mentor helps the mentee to clarify what is the real issue for them and helps them to decide on the best course of action that suits their personality, context and preferred way of working.

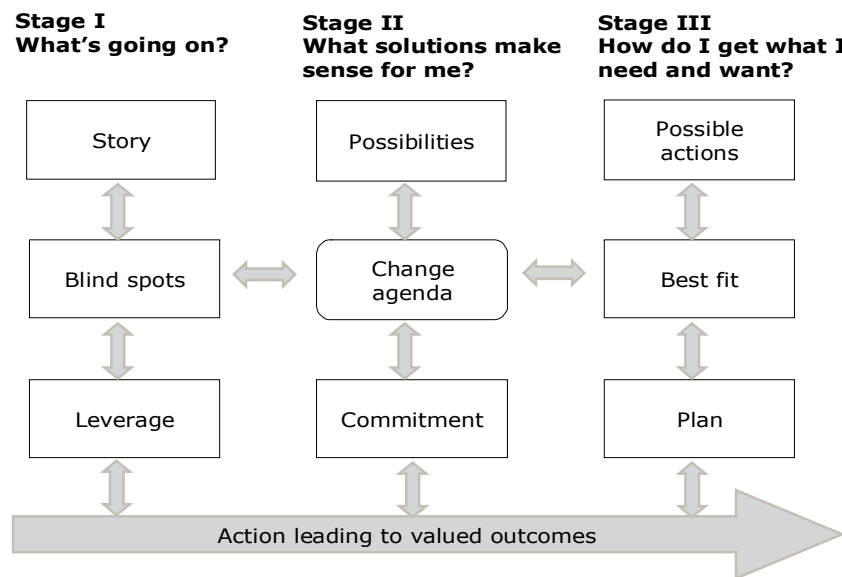
For this reason, courses in mentoring skills should emphasise skills training, which can be time-consuming. A question of how much extra training a psychiatrist may require given their sound foundations in interview skills practice is still being debated. Some psychiatrists have asked for an abridged training package to take into account this previous training. These previously acquired skills are doubtless of value for a prospective mentor; however, many psychiatrists still welcome the opportunity to develop their mentoring skills further on a specific course.

AN EXAMPLE OF A MODEL – THE SKILLED HELPER MODEL

The skilled helper model (Egan, 1998) has been in continuous development since 1975. Its essence is a three-stage framework for helping: 'It focuses on how the mentee is now and how the mentee would like to be. Mentees become empowered through the shared use of a model and skills, within a helping relationship' (Connor, 2001). A recent version of the skilled helper model is outlined in Fig. 3.

Although the model is presented in a rational and linear way, it is intended to be used flexibly, according to the mentee's particular needs. It is underpinned throughout with 'consciously developed listening, responding and challenging skills' (Connor, 2001).

Fig. 3 The skilled helper model (Egan, 1998)



CAPSULE 5. ELEMENTS OF A MENTORING SKILLS COURSE (BASED ON THE NORTHERN DEANERY MENTORING AND DEVELOPMENT PROGRAMME)

- a 5-day training programme spread over 3 months
- theoretical overview of the stages of the skilled helper model
- techniques to use in practice
- skills training in all the stages with trained facilitators
- enhancing the trainee mentor's self awareness with the Myers-Briggs Type Indicator (Kroeger & Thuesen, 1992) and Learning Styles Questionnaire (Honey & Mumford, 1982)
- introduction to some tools to facilitate change, for instance Force Field Analysis (Pedlar *et al*, 1994)
- ethical and professional implications
- on completion of the course, participants are encouraged to join a supportive mentoring network; annual 'refresher' days are organised, with speakers and opportunities for networking and practising skills.

Mentoring: current issues for psychiatrists

ENGAGING WITH A MENTOR: MENTORING SCHEME OR BY INDIVIDUAL REQUEST?

Mentoring arrangements may be set up through different routes. Some trusts run a mentoring scheme through which new consultants can link up with a named mentor. Other psychiatrists can independently approach a colleague to be their mentor. An advantage of meeting a mentor through a scheme is that the scheme organiser has a chance to match the mentor and the mentee in terms of specialty and location, while the independent request to an individual psychiatrist allows a mentee to choose the individual they would value as their mentor.

SHARED INTERESTS AND LOCATION?

There is a question about how close the mentor and the mentee should be in terms of their clinical work (the same trust or the same directorate?) and geographically. We suggest that with large mental health trusts it is generally feasible to have a mentoring arrangement with a colleague in the same trust but in a different directorate. If mentor and mentee work in the same service or in the same directorate, there is a chance of the mentor knowing too much about the mentee's situation, which could complicate the mentoring relationship. On the other hand, it is also worth being as geographically close as possible to keep travelling time to a minimum. Very senior psychiatrists, such as a medical director, may need to have a mentor from outside the organisation.

MENTORING SCHEME

Having a scheme running in a trust allows some monitoring in terms of the number of mentors and mentees offered the service. It can promote training either in-house or through another organisation as well as offering follow-up training and support for mentors. The mentoring scheme facilitator is likely to be a senior psychiatrist who can be the first port of call for either the mentor or the mentee should any tricky situations or specific difficulties

arise that either of them wants to discuss. The scheme facilitator also acts as a broker organising new mentoring arrangements and can support the development of a positive mentoring culture within the trust itself and with other disciplines.

ESTABLISHING GROUND RULES: MENTORING CONTRACT

There should be some basic ground rules for mentoring available for trust staff and discussed at the start of mentoring. For a newly appointed consultant these might include discussion about the time framework, for example an arrangement to meet every 6–8 weeks on a particular day for a period of 18–24 months. If either mentor or mentee needs to change an appointment, they need to let the other person know with as much notice as possible. The contract may also include discussion about the mentee 'preparing' for sessions and thinking ahead about things they would like to discuss ('put on the agenda') and to consider how to handle giving feedback. It may be helpful for the mentor and mentee to spend a little time after the first two sessions in 'taking stock' about the mentoring process up to that point.

POSITIVE MENTORING EXPERIENCE

Mentoring sessions may be tough and challenging with the mentor encouraging the mentee to think about an issue, but they should also be positive and seen as useful and helpful by the mentee, not an ordeal to endure.

WRONG CHEMISTRY – CHANGING THE MENTOR

Occasionally the mentee and/or the mentor may find it hard to work together and they may feel the sessions are not helpful. A third party – perhaps the mentoring scheme organiser – should be approached as a first step towards considering changing the mentor.

HOW LONG WILL THE MENTORING RELATIONSHIP LAST?

Some mentoring relationships last a short period of time while others continue for longer. Often mentoring for a newly appointed consultant lasts about 2 years. It is usually good practice to set an expected end date for the mentoring relationship at the start to give a sense of pace. However, new goals may emerge and the mentor and mentee may wish to review the planned end date.

MENTORING AT A DISTANCE: USING TELE- AND VIDEOCONFERENCING

Particularly in remote areas it may be helpful after the initial face-to-face meeting to discuss whether some of the work can be done at a distance, either by phone or video-link at pre-arranged times.

CONTACT BETWEEN SESSIONS

It may be helpful for the mentor and mentee to exchange contact details. It is also worth discussing (as part of the 'contract') a phone or email contact between planned sessions to discuss particular matters that have arisen.

CONFIDENTIALITY

One of the ground rules in mentoring is confidentiality. Mentees need to feel that they are able to talk about the issues they are dealing with knowing that the information will not go outside the meeting. However, it should also be clear that in exceptional circumstances the mentor might need to consider raising concerns about professional practice outside the mentoring setting. As a first step it may be sensible to discuss those concerns with the mentoring scheme organiser before taking further action.

MENTORING TECHNIQUES

One of the issues for psychiatrists involved in mentoring is that they are already aware of and use some of the techniques taught in mentoring, for example open questions or motivational interviewing skills. Mentors need to be clear about their role. They are not offering any form of psychotherapy to a client but supporting the mentee in a mentoring relationship.

MENTORING AND THE JOB PLAN

A time for mentoring should be included in the mentee's and mentor's job plan so that it is seen as a core part of work, not an extra job squeezed in at the end of the day. This also promotes mentoring as a core part of the individual's work.

MENTORING ACROSS PROFESSIONAL BOUNDARIES

Some mentoring relationships go across professional boundaries and this may be a useful experience for both mentor and mentee, for example a psychiatrist having a mental health manager as a mentor or vice versa.

TRAINING FOR MENTORS

Although more experienced consultants are likely to have well-developed mentoring type skills, we recommend attending some specific training in mentoring, for example to review the ground rules and to consider some of the specific issues that can arise in mentoring as opposed to supervision or in other sorts of interaction with colleagues. Training courses may also describe particular scenarios and allow discussion about how to act in these circumstances (see Appendix 3 for a list of training course providers).

SUPPORT FOR THE MENTOR

Some mentors will have their own mentor or support system developed but in general it is important to consider how trained mentors can learn from their mentoring role and share experiences with other mentors. The issue to consider here is that of confidentiality and how within a support network of mentors they can discuss any issues that have arisen during the confidential mentoring session.

Appendix 1. Summary of the mentoring survey

A questionnaire on provision of local mentoring services was sent to 115 trusts in England and Wales. The trusts were asked to submit a copy of their mentoring policy or answer eight questions if they did not have such policy. The questions asked:

- whether mentoring was restricted to new consultants
- whether it included existing and senior consultants and staff and associate specialist grades
- what percentage of those to whom the scheme had been offered had taken it up
- whether the scheme had specific 'rules'
- whether there were any plans to develop the scheme
- whether mentors were from within or outside the trust
- what training arrangements were in place, and
- whether there were any other arrangements which it would be interesting to know about.

Sixteen trusts responded and not all answered the questions. Twelve trusts reported that they had local mentoring schemes (or were part of shared schemes), five trusts admitted to having mentoring restricted to new consultants only, three had schemes open to other doctors and four gave unclear answers regarding this. Four trusts stated outright that they had no policy on mentoring. One large London trust stated that 'coaching' was offered to more experienced consultants, consisting of sessions with a 'non-doctor'. A trust in Wales reported an 80% uptake of mentoring, another trust stated the uptake was 'limited' and the other trusts either offered no data or did not answer this question. Some trusts described a few specific 'rules' but the majority (11) had no rules or no schemes. At one London trust, if a mentor does not suit the mentee, another person will be offered. Both mentor and mentee can decide to terminate the mentoring process at any time without explanation and the mentoring process is confidential unless there is a professional cause for concern about patient care or serious misconduct (which had not occurred to date).

WHO ACTS AS A MENTOR?

At one regional trust, doctors involved in management roles such as medical or clinical directors are generally not mentors. A trust in Wales recommends

that mentoring arrangements should be flexible and largely informal, mentors should be consultants working within the trust and should preferably have been consultants for at least 5 years. The relationship should be confidential, regular training sessions should be provided and there should be no financial remuneration. Initial meetings are recommended to be held monthly for the first 2 years and should have some structure but the agenda should be devised by the mentee. The mentor should not have management responsibility for the consultant and mentors should be approachable and have good personal management skills.

A London trust stipulated that candidates eligible to act as mentors must be volunteers who are prepared to allocate the requisite amount of time and who have been consultants for at least 5 years. They recommend that no mentor should support more than two mentees at the same time and that mentors should take responsibility for informing the trust and the College when they have no vacancies for mentees.

MENTORING SCHEMES

A few trusts expressed an interest in developing mentoring schemes. A large London trust has already got 24 mentors and decided not to recruit more. Instead, the trust plans to enhance their training with a full day of more practical and advanced coaching skills. One regional trust stated that they expected to have a more formal approach to mentoring in the near future as a result of trust mergers. Of the four trusts that declared they did not have any mentoring policies, one mentioned that it would consider offering mentoring to other staff members if more personnel were employed and another planned to ask consultants to volunteer to become mentors to start a scheme.

Five trusts indicated that they had mentors available from both within and outside and one trust stated that they only provided external consultants to mentor their newly appointed consultant psychiatrists; they were unaware of any mentors within their trust.

TRAINING AND OTHER ARRANGEMENTS

Not all of the trusts that provide mentoring also have training arrangements for mentors (the medical director of one trust stated that he had been 'deterred from attending or encouraging others to attend the commercial conferences on this subject'), but some do provide internal training either within the trust or relying on the local deanery for this.

With regard to any 'other interesting arrangements' that the trusts were asked to describe, three provided some information. A London trust advises its more experienced consultants to access the trust's coaching service which comprises sessions with a non-doctor. The trust also provides coaching training so there is access to coaching from supervised non-doctors. There is a mentoring scheme for senior house officers, run by a specialist registrar. All new senior house officers are provided with more experienced mentors who are supervised as a group by one of these specialist registrars. The oversight of the mentoring scheme is undertaken via the continuing professional development (CPD) group which meets on a 2-monthly basis. All consultants are members of peer CPD groups providing documentation to the College. These groups provide support and if necessary more informal mentoring.

Another London trust stated that it actively participates in providing a list of suitable mentors in each sub-specialty in liaison with the London Division of Psychiatry. The trust requests that the College representative on each advisory appointments committee brings with them a list of College-approved mentors for newly appointed consultants. The trust guarantees that time will be allocated in job plans for mentor/mentee contact as required. Access to a training programme for all those interested in the mentoring scheme is offered. In addition, the trust sends out anonymous annual evaluation questionnaires to participants of the scheme and makes results available to the consultant body, the trust itself and the College.

Each senior locum doctor employed by one of the regional trusts is allocated a mentor/supervisor for the duration of their employment.

Appendix 2. An exemplary template for developing a 'pen portrait' of mentors on a scheme

Please complete sections I–V in the template to facilitate the mentorship matching process. Section VI is optional and can be used should there be any requests on issues related to managing a work-life balance.

I Personal information and contact details

Name Telephone/Email

Gender NHS trust

II Employment

Area of clinical practice

Contractual status/hours

Geographical work base

Specialist interest

III Experience

Previous areas of psychiatric clinical experience

Qualifications/interests outside psychiatry

IV Personal statement

V Additional information

VI Personal circumstances (optional information)

Please email the completed form to: Ineedamentor@st.elsewhere.nhs.uk
Thank you for supporting the mentoring scheme.

Appendix 3. Mentoring contacts

ORGANISATIONS AND NETWORKS

- The Royal College of Psychiatrists Education and Training Centre
6th Floor, Standon House
21 Mansell Street
London
E1 8AA
Programme administrator, tel: 020 7977 6652/57
Currently runs a 1-day course on coaching skills with Prof. John Wattis.
- Coaching and Mentoring Network, www.coachingnetwork.org.uk
- Chartered Institute of Personnel and Development, www.cipd.co.uk
- European Mentoring and Coaching Council, www.emccouncil.org
- Employment National Training Organisation, www.ento.co.uk
- International Coach Federation
Email: icfheadquarters@coachfederation.org

SOME COURSE PROVIDERS

- Executive and team coaching courses
Management Futures
37 Gray's Inn Road
London WC1X 8PQ
Tel: 020 7242 4030
- Jan Laver
International Centre for Coaching and Leadership Development
Oxford Brookes University Business School
Wheatley Campus
Oxford OX33 1HX
Tel: 01865 484534, Email: jlaver@brookes.ac.uk
- Eric Parsloe
Oxford School of Coaching and Mentoring
Centrepont
Chapel Square
Deddington
Oxford OX15 OSG

- Professor David Megginson
Coaching and Mentoring Research Unit
Sheffield Hallam University
City Campus
Howard Street
Sheffield S1 1
- Course Director
Advanced Professional Diploma in Mentoring
Carnegie Faculty of Sport and Education
Leeds Metropolitan University
Civic Quarter
Leeds LS1 3HE
- Course Director
Certificate in Coaching and Mentoring
East Riding College
Gallows Lane
Beverley
East RIDING HU17 7DT
- Chartered Institute of Personnel and Development
151 The Broadway
London SW19 1JQ
www.cipd.co.uk/training/coaching
- Clutterbuck Associates
Grenville Court, Britwell Road
Burnham
Bucks SL1 8DF
www.clutterbuckassociates.com
- Cygnus Mentoring and Professional Development
79A High Street
East Grinstead
West Sussex
RH19 3DD
www.cygnusmentoring.com

The following Deaneries have well-established mentoring training programmes. Please contact the relevant person:

- Dr Nancy Redfern
Specialty Dean Director
Northern Deanery
Postgraduate Institute for Medicine and Dentistry
10–12 Framlington Place
Newcastle upon Tyne
NE2 4AB
Tel: 0191 222 8913
- Dr Chris Franklin
Postgraduate Dental Dean & Consultant Histopathologist
Postgraduate Dental Office
Don Valley House, Savile St East
Sheffield S4 7UQ
Email: c.franklin@sheffield.ac.uk

- Dr Rebecca Virey
Associate Director
London Deanery
Stewart House
32 Russell Square
London WC1B 5DN
Tel: 020 7866 3100

The following individuals have a lead on mentoring skills courses within their organisations:

- Dr Gordon French
Consultant Anaesthetist and Mentoring Lead
Northampton General Hospital
Course organiser: Lyn Holmes, Education Coordinator
Cripps PGMC
Northampton General Hospital
Cliftonville, Northampton, NN1 5BD
Tel: 01604 545160, Email: Lyn.Holmes@ngh.nhs.uk
- Dr Kenny McCormick
Consultant Neonatologist
John Radcliffe Hospital
Headley Way
Headington
Oxford OX3 9DU
Email: Kenny.mccormick@orh.nhs.uk
- Vicky Osgood
Portsmouth Programme
Director of Postgraduate Medical and Dental Education
St Mary's Hospital
Milton Road
Portsmouth PO3 6AD
Tel: 02392 286000 ext 5837, Fax: 02392 286024
Email: Vicky.Osgood@porthosp.nhs.uk

Appendix 4. Frequently asked questions

WHAT IS MENTORING?

There are many definitions and it is useful to be clear what you mean when using the term. At its core, mentoring is a two-way learning relationship. A skilled mentor can help the mentee refine and clarify the main issues they need to address, and help them to find their own workable solutions.

A mentoring scheme organiser has defined mentoring as follows:

'Helping people to become better at helping themselves, help them develop their opportunities ... manage their problems ... become more effective, more functional, more empowered members of the workforce.'

A mentor is not an adviser, a patron, a counsellor or a substitute for a good induction process.

WHY IS MENTORING NEEDED?

Mentoring helps address various issues concerning psychiatric practice.

- In the NHS:
 - rapidly changing work environment
 - high public and Department of Health expectations directed at psychiatrists
- In the College:
 - shorter training
 - maintaining professional standards
 - changing roles of consultant psychiatrists
- In the trust:
 - recruitment and retention of consultants
 - cost of locums
- For the individual:
 - personal and professional development
 - work–life balance

WHAT PREPARATION SHOULD THE MENTOR UNDERTAKE?

- training in mentoring skills, for example listening skills, how to encourage the mentee to reflect upon their issues
- understanding and acquiring skills in using a mentoring framework, such as Egan's skilled helper model

- ensuring protected time with the ability to be flexible
- identifying and using a network of other mentors for support

WHAT PREPARATIONS SHOULD THE MENTEE UNDERTAKE?

- to make the mentoring relationship a priority, mentees should make sure they devote some time to prepare beforehand, attend the session and reflect afterwards
- the mentee should try to be an active participant and not a passive recipient
- they should try to develop the following personal qualities:
 - willingness to open up
 - ability/willingness to look at things with 'fresh eyes'.

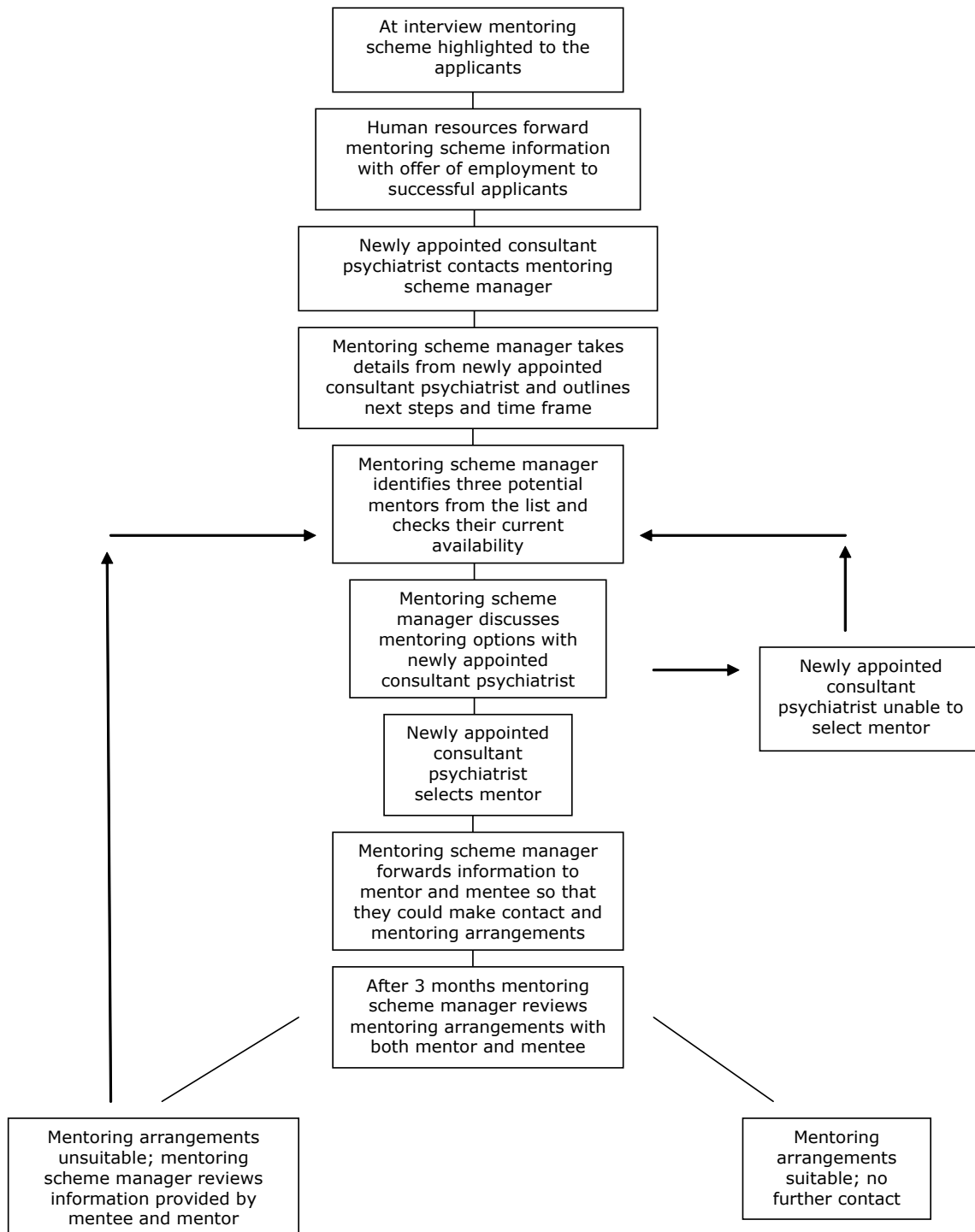
HOW SHOULD A MENTOR/MENTEE PAIRING GET STARTED?

All mentor/mentee pairs should have a preliminary meeting to clarify meeting arrangements (e.g. regularity, suitable time and place) and agree an initial few mentoring sessions. They should agree on a date to review the process and assess whether their mentoring relationship is working. Both should feel able to share their views on the mentoring in an open and honest way. If for whatever reason their mentoring partnership is not working, the pair should agree to end it and the mentee should contact the mentoring scheme organiser to arrange to meet a different mentor.

Ideally, newly appointed consultants should have a mentor for at least the first year in their new role.

Appendix 5. An example of a mentee/mentor matching pathway

Fig. 4. Matching pathway – example



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There have been a number of relevant articles on mentoring and coaching published in BMJ Careers. These can be accessed from the online archive (<http://careerfocus.bmjournals.com/contents-by-date.0.shtml>). Some recent examples are:

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