start a portfolio that you begin to appreciate its potential
benefits (Rees & Sheard, 2004), with the opportunity for
reflective learning being developed (Roberts et al., 2002).

Preliminary evidence shows that educational portfo-
lios may benefit the educational process but additional
studies are needed to confirm this. Whatever their effi-
cacy, they are here to stay. This survey reinforces the
need to make portfolios a compulsory feature of
continued learning beyond the foundation years, with
clear explanations regarding their content and rationale,
otherwise their use may remain low.

Declaration of interest
None.

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Service user involvement in psychiatric training:
a practical perspective

The systematic involvement of service users (patients or
clients; McGuire-Snieckus et al., 2003) and carers in
an active educational role in psychiatric training is a relatively
recent development. The National Service Framework for
Mental Health states that ‘Service users and carers should
be involved in planning, providing and evaluating training
for all health care professionals’ (Department of Health,
1999). The Royal College of Psychiatrists declared that
from June 2005 all psychiatric trainees must have training
from service users or carers. This is a sizeable shift away
from traditional medical teaching, where patients have
been involved only in a passive way, as the possessor of
symptoms and signs, with teaching delivered by experi-
enced clinicians and academics. The reasons behind these
changes have been discussed frequently in recent medical
literature (Livingston & Cooper, 2004). The primary argu-
ants for this initiative are that service users have a
unique understanding of their illness and are best placed
to judge trainees on their empathy and communication
skills. Increasingly, service users’ views are being taken
into account in training and examination of medical
students and doctors (Vijayakrishnan et al., 2006).

Although the need for these changes has been well
documented, less has been said about how they should
be implemented. For those involved in the organisation
and delivery of training to junior psychiatrists, these
proposals may seem daunting. The helpful article by
Fadden et al. (2005) suggests ways in which the process
may be taken forwards, giving suggestions and pitfalls
regarding recruitment, preparation and process. But how
easy is it to translate these ideas into practice?

Our perspective
Three of the authors (O.H., R.M., N.T.) are honorary clinical
lecturers at the University of Birmingham. In conjunc-
tion with consultant supervisors they are responsible for the
delivery of courses for senior house officers (SHOs) in
preparation for parts I and II of the Membership of the
Royal College of Psychiatrists (MRCPsych) examination.
These courses are attended by SHOs from three local
training schemes.

Traditionally these mandatory courses have
consisted of three hour-long lectures, run on a weekly
basis, supplemented by practical sessions. However, involvement of service users and carers has rarely been a feature. In light of the recent impetus, we were given a mandate to begin introducing service users into the established course. This gave us the opportunity to reflect on and update our practice. We considered recruitment of suitable users and candidates, learning outcomes, feedback, support and remuneration. These issues were discussed at the MRCPsych course board meeting, attended by consultants (including the Director of Medical Education), postgraduate medical education administrators, honorary clinical lecturers and trainee representatives.

Initial changes
The initial changes introduced pilot sessions, using service users carefully selected by experienced lecturers. Choosing suitable candidates involved consideration of those who would have reasonable experience of, and perspective on mental healthcare, be reliable, not be intimidated by addressing up to 50 doctors and have an ability to take an objective overview of their experience.

Service users were chosen from general adult and forensic backgrounds, along with a carer of an older adult patient. Sessions were moderated by an experienced clinician. The clinician acted as mentor, explaining the aims of the course and the learning outcomes. The initial sessions consisted of an introduction and explanation by the moderator, a talk on a specific aspect of their experience of mental health services from the user and then an opportunity for questions and discussion. The moderator aimed, in as non-intrusive fashion as possible, to support the user, address inappropriate or difficult questions and assist in directing discussions. These pilot sessions were used for mainstream topics such as schizophrenia and bipolar disorder.

Each trainee was asked to compete an anonymous Likert scale feedback form, rating relevance, content and delivery, with room for additional comments. The initial feedback from trainees was extremely positive; for combined service user lectures, mean scores for the respective categories above were 4.6, 4.5 and 4.6, each out of a possible 5. This compares favourably with the same standard disbursement through the Department of Postgraduate Medical Education. This has been accepted by all involved, without difficulties. Those receiving benefits were directed towards appropriate agencies to advise them about the possible effects that earning money might have on their benefits.

Learning objectives
It was agreed that learning objectives needed to be formulated by the moderator in conjunction with the service user. For initial sessions, these tended to be generalised, such as

- improve understanding of subjective experience of the disorder
- understand the impact of admission under the Mental Health Act 1983.

However, it is envisaged that with the progression of service user participation, these discussions, and in turn the learning outcomes, will become more refined.

Recruitment and remuneration
It was considered vital that those carers and service users who contributed to the course were on an equal footing with the moderators and professionals who comprised the other speakers. To this end, each person was paid the same standard disbursement through the Department of Postgraduate Medical Education. This has been accepted by all involved, without difficulties. Those receiving benefits were directed towards appropriate agencies to advise them about the possible effects that earning money might have on their benefits.

To date, recruitment of some speakers has been through people the course organisers have known directly; many have been longstanding patients with valuable perspectives, who are currently well, with the resilience to tackle inquisitive SHOs. Others came from specific services, such as the Early Intervention Service for Bipolar Disorders. They needed to be reasonably articulate and able to some degree to be objective about their own experiences (Fadden et al, 2005). Others have been recruited through their prominence among voluntary agencies and support groups. Occasionally a colleague or similar professional who has personal experience of being a carer has agreed to assist. Voluntary organisations such as Mind, Rethink, Care Services Improvement Partnership and the Alzheimer’s Association are valuable resources.

We intend to make future recruitment more structured, with advertisement throughout local trusts and voluntary organisations. Prospective participants will be interviewed as per standard recruitment procedures, offered relevant training and support and evaluated to ensure standards are met. The longer-term aim will be to establish a pool of motivated, experienced speakers with a range of skills. This will help avoid burnout of a small number of overused speakers.

Feedback
As with all other sessions on the course, each trainee is asked to fill in a feedback form, as described above. This
allows SHOs to offer constructive comments in an attempt to improve the course. All speakers are provided with a summary of their feedback.

Future plans
Recently, we formed a 'service user and carer group'; all those who have spoken on the courses to date were invited. A representative of the consultant body and the specialist registrars also attended, together with administrative support. The meeting brought together all parties involved with expanding service user involvement.

The aim was to facilitate the further introduction of similar sessions and to plan for the future. To improve service users' understanding, there were presentations on the training of psychiatrists, the courses and the MRCPsych examinations. The College impetus was explained, as was the future direction of psychiatric training.

After discussing the changes introduced so far, service users gave feedback from their sessions. Overall they reported enjoying the experience and had encountered few problems. One person had found the experience difficult because of the personal nature of some questions, and the importance of the role of facilitator was emphasised. Several suggestions were made for changes, such as to room arrangements, group size or more time for questions. The meeting allowed open dialogue in an informal environment, in order to stimulate new ideas and methods.

This group will continue to meet and is seen as the next stage for us in expanding the role of service users and carers in psychiatric training. It will be important to develop service user involvement with the course board, which oversees development and structure of the course. However, to do this in a meaningful fashion will require careful planning. Too often in such circumstances, service users are included as a token gesture, without real support, and are often inhibited and unable to participate in any manner of consequence. Therefore currently service user/carcer feedback remains via the doctors who attend both the ‘service user and carer group’ and MRCPsych course board meetings.

Conclusions
Introducing involvement of service users and carers into psychiatric training is valuable, however, it is not without its difficulties. As a relatively recent innovation, those charged with the organisation of courses for trainees face several challenges in implementing these changes.

Introduction of these changes needs to handled sensitively for the benefit of users, carers, existing teachers and those being taught. Reservations have been expressed by some trainees regarding the relevance of service user training to MRCPsych examinations. Junior doctors may, at times, become overly focused on passing examinations as the ultimate goal of their training, rather than seeing examinations as one of several methods of ensuring an adequate standard has been attained. In fact, the true goal of training must be preparation to become a competent and caring doctor, and when seen in this light the need for involvement of those receiving the service becomes clear.

It is hoped that this article will be beneficial for those with responsibility for implementing the changes. There are undoubtedly many other successful methods to mimic and modify, and pitfalls to avoid. Clearly, further research and audit will be important in informing future developments.

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