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Service User and Carer Involvement in Mental Health Education: A Grounded Theory Investigation into its Impact on (Trainee) Clinical Psychologists' Learning

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Summary of the portfolio

Section A provides a critical review of the literature pertinent to students' learning from service user and carer involvement in the context of mental health education. Definitions, conceptualistions and rationales for service user and carer involvement are discussed and situated within socio-historical and political contexts. Attention is drawn to the lack of theory underpinning service user and carer involvement, followed by a discussion of theories that could helpfully illuminate learning processes, in particular theories relating to power, stigma and learning. A brief overview regarding the current empirical evidence base for service user and carer involvement in general is provided, followed by a more in-depth critique of the few studies that have examined the impact of service user and carer involvement in the education of mental health students. The review concludes by highlighting gaps in the extant evidence base and how a future research agenda could address these.

Section B represents a qualitative investigation into what and how (trainee) clinical psychologists learn from service user and carer involvement during clinical psychology training. Semi-structured interviews with 12 (trainee) clinical psychologists were conducted and grounded theory methodology was used to analyse the resultant data. A preliminary model of (trainee) clinical psychologists' learning from service user and carer involvement in their training is presented and discussed with reference to existing empirical evidence and theory. Study limitations, clinical implications and future research directions are presented.

Section C constitutes a critical appraisal of the research project and is structured according to four stipulated questions. The authors' key learning points are discussed and reflected upon. Further, the study's limitations, clinical implication and future directions as discussed in section B are elaborated upon.

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Section A: Literature Review

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1. Abstract

In the United Kingdom, service user and carer involvement has become a priority in the education of health and social care professionals. Yet there is no clear conceptualisation of what service user and carer involvement encompasses and why it is done. One rationale for involving service users and carers derives from the idea that it will lead to improvements in health care. However, the mechanisms of how this may occur as a result of service user and carer involvement are poorly theorised and there is a contentious gap in the service user and carer involvement literature when it comes to evaluating impact.

Two (mostly implicit) ideas about how students could benefit from service user and carer involvement in mental health education are evident in the literature. One relates to content and positions service users and carers as experts of their own experiences who impart this knowledge into their students through direct teaching. The other relates to process and hypothesises reduced stigma and more empathetic, person-centred attitudes as a result of learning *with* rather than *about* service users and carers.

Evaluating service user and carer involvement initiatives is hampered by different conceptualisations and rationales for service user and carer involvement across studies, although preliminary evidence suggests that it can lead to better outcomes in the fields of health care services, research and medical education. A literature review on the impact of service user and carer involvement in mental health education identified only nine studies, which yielded encouraging although preliminary support for the assumption that service user and carer involvement can contribute to students' learning but contained multiple methodological flaws. These will need to be addressed by more rigorously designed quantitative and qualitative

studies if a robust evidence base is to be established. In particular, research is needed that advances theoretical modelling of students' learning in the context of service user and carer involvement, and the literature review also revealed a gap of studies investigating service user and carer involvement in educating psychologists, which needs to be filled.

2. Introduction

In the United Kingdom, service user and carer involvement in planning and developing public services and educating health and social care professionals has become mandated by government, and is also encouraged in research (Department of Health [DoH], 2005, 2007, 2009, 2010; Involve, 2004, 2007). The Health Care Professionals Council (HCPC, 2013) just published their decision in July this year to amend the standards of education and training to require service user and carer involvement in approved programmes. Yet service user and carer involvement is often used as an umbrella term and clear operationalisations as to what it encompasses and why it is done are lacking. The first section of this review aims to give an overview of the different, and often fluid, conceptualisations of service user and carer involvement along with explicit and implicit rationales, situated in socio-historical contexts. This is followed by theoretical considerations regarding service user and carer involvement, particularly in relation to stigma and learning. Subsequent sections cover questions relating to what is known about evaluating service user and carer involvement, focusing on the field of mental health education. This includes the close scrutiny of relevant qualitative, quantitative and mixed-methods studies, thereby highlighting gaps in the service user and carer involvement literature, leading to recommendations for a future research agenda.

2.1. Definitions and conceptualisations of service user and carer involvement

The terminology referring to service user and carer involvement is contentious and generally depends on socio-cultural context. Services users are often synonymously referred to as 'patients', 'clients', 'experts by experience', 'customers',

'consumers' or 'survivors' and no single term is universally accepted (for reviews see McLaughlin, 2009; Wallcraft & Nettle, 2009). Compounding this issue further is the question as to what delineates service users and carers from other professionals or lay people who have at one point used services or cared for someone. For the purpose of this review service users and carers are defined as "people who receive or who are eligible to receive health and social care services and their carers who may be family or close friends" (Barnes & Cotterell, 2012, p. xxiii); the terms are used to refer to particular standpoints while acknowledging that those identities are not fixed.

There is no clear definition of what exactly service user and carer involvement encompasses and levels of participation range from tokenistic one-off engagements to continuous involvement in equal partnership (Hubbard, Wilkinson & Petch, 2004; Rhodes, 2012). Service user and carer involvement has both been defined in hierarchical as well as in continual terms. Arnstein's (1969) ladder of citizen-participation has commonly been used to illustrate the levels of control service users and carers have in their involvement. More recently, however, attempts have been made to move away from hierarchically driven conceptualisations, reframing involvement on a continuum (Hickey & Kipping, 1998). Two decades ago, Beresford (1992) called for greater clarity as to what is meant by service user and carer involvement, yet the term is still used to describe a whole array of different initiatives (Rhodes, 2012), perhaps reflecting the complexity in this area.

2.2. History and rationales

Broadly, rationales tend to derive from two different viewpoints, one ethical-based and one evidence-based (Thornicroft & Tansella, 2005). The ethical argument

centres on ideas of citizen participation, democratic principles and consumer rights (Cowden & Singh, 2007). The evidence based argument bears the assumption that service user and carer involvement will lead to meaningful changes to the way health care is provided, improving standards of care. While those positions signify distinct rationales for service user and carer involvement, these are often not made explicit (Purtell, Rickard & Wyatt, 2012).

Historically, professionals have exerted power over service users and carers, particularly in the arena of mental health where service uers were routinely placed in asylums and socially marginalised (Felton & Stickley, 2004). While critical psychiatry movements originating in the1960s highlighted abusive practices, power imbalances remained (Barker, 2004) and the coercion over service users under legal frameworks such as the Mental Health Act (HM Government, 2007) continued. Over the last 30 years, service user and carer voices have become more prominent in seeking social justice, and their calls for tackling structures that promote inequality and exclusion have informed government agendas (Barnes & Cotterell, 2012). These days, service user and carer involvement has become firmly embedded in NHS policies; as Bradshaw (2008) states, "the extent of (the NHS') acknowledgement (of the importance of service user and carer involvement) is in rhetorical terms at least, knowing no bounds" (p. 674). Yet concerns have been raised whether this rhetoric translates into meaningful service user and carer involvement (Stickley, 2006). Ironically, what started out as a bottom-up process has gradually become a top-down process, with some service user and carer involvement initiatives being set up (at least partly) to meet legal requirements handed down by government, increasing the potential for tokenistic tick-box service user and carer involvement exercises.

Further, reservations have been aired as to whether service users and carers who become involved in health or social care activities are representative of the wider

service user and carer base. Concerns have been expressed with regard to the 'professionalisation' of service user and carer involvement (Boote, Telford & Cooper, 2002). However, others have asked why service users and carers should be representative, highlighting that this issue could be misused to exclude and devalue service user and carer voices (Barnes, 1997).

3. Theoretical considerations

This section aims to summarise theories relevant to service user and carer involvement and learning in educational contexts.

3.1. Theorising service user and carer involvement

There is agreement in the service user and carer involvement literature that service user and carer involvement has been poorly theorised, largely linked to its politically driven ad-hoc implementation (Spencer, Godolphin, Karpenko & Towle, 2011). Two central ideas about how service user and carer involvement could lead to change seem to emerge from the literature although they are rarely explicitly named; one is content-based, the other process-based. The former assumes that service users and carers have first-hand, experiential knowledge of their private mental lives and the services they receive, which offers a more comprehensive level of understanding (Cotterell & Morris, 2012). This understanding is then accessed through involving service users and carers in developing models of psychological distress and services, which are assumed to be more valid through their grounding in relevant experiences. In this scenario, change would be facilitated through imparting

this knowledge to students via direct teaching (relevant learning theories will be covered later).

The process-based approach, on the other hand, hypothesises that change occurs through learning *with* rather than *about* service users and carers (Tew, Gell & Foster, 2004). It is assumed that this process in itself challenges stigma, existing orthodoxies and power-dynamics, thereby eroding traditional 'us' and 'them' barriers. This idea can be related to theories relating to stigma and power and theories of implicit learning, which are reviewed in the following two sections.

3.2. Theories relating to stigma and power

Mental health related prejudices and associated power dynamics have predominantly been theorised in the fields of social psychology and sociology. Since Goffman (1963) introduced the concept of stigma, its definition has evolved to encompass human differences that get labelled in derogatory ways to create a cognitive separation of 'us' from 'them', resulting in loss of status and social exclusion of stigmatised individuals through the exertion of power by dominant social groups (Link & Phelan, 2001). A plethora of theoretical models pertaining to stigma exist, yet few have been empirically validated within a mental health context (Link, Yang, Phelan & Collins, 2004).

A common theoretical assumption is that 'stigmatised' identities are socially constructed through cognitive, affective and behavioural processes (Yang, 2007). Scheff's (1966, 1974) labelling theory and its modified version (Link, Cullen, Struening, Shrout & Dohrenwend, 1989) presume that negative stereotypes are learned and reinforced through social interactions (e.g. by constructing people experiencing mental distress as different whilst legitimising this discrimination based

on this 'otherness'). In line with Tajfel's (1978) theory of social identity, it is hypothesised that human beings have a desire to maintain a positive self-image and social identity, which influences how in-group and out-group members are perceived and treated. Research has demonstrated that individuals without (disclosed) mental health needs (in-group) often hold stigmatising beliefs about service users (out-group), biasing the way information is processed. This, in turn, leads to the adoption of unequal socially mediated role-identities, which are behaviourally reinforced (e.g. through avoiding contact with stigmatised individuals). Through this process, a psychological, defensive split occurs, which in its extremest form can result in the dehumanisation of out-group members who need to be controlled through oppression (Barton, 1976; Goffman, 1968), "a class of inferior persons" (Hopton, 1994, p.49)

With this in mind, one long-held hypothesised view on redressing power imbalances and stigma reduction focuses on interactions between in- and out-group members, assuming that increased contact and familiarity will reduce negative attribution-biases (Allport, 1954). More recently, however it has been noted that contact in itself might not suffice to improve attitudes towards people with mental health problems, highlighting the importance of the contextualised nature and quality of that interaction (Thornicroft, 2006). For example, mental health professionals holding negative views about psychiatric in-patients might find those views reinforced if their contact is limited to encounters with acutely distressed service users. Hence, contact must be based on "equal status between majority and minority groups in pursuit of common goals" (Allport, 1954, p. 281) in order to challenge assumptions. Thus, it follows that in order for service user and carer involvement to 'work', it should happen in the context of equal partnerships.

3.3. Learning theories

Learning theories have mainly been developed in the fields of psychology and adult education. Early psychological models of learning focused on processes occurring within individuals in isolation (e.g. Piaget, 1990; Skinner, 1974). Within educational contexts, learning was and to some extent remains seen as a one-directional process, whereby knowledge is imparted into passive learners ('banking education'; Freire, 1996).

In contrast, more recent models have endeavoured to understand learning as socially situated (see Bandura, 1977; Cole, Engeström & Vasquez, 1997; Lave & Wenger, 1991; Vygotsky, 1978). Particularly where adult learning is concerned, importance has been increasingly placed upon the particularities and contexts in, which the learners engage, whilst emphasising that adults have their own motivations for learning, which will depend on their previous life experiences and the practices and roles they engage in outside the classroom (Candy, 1991).

Esland (1971) has framed those ideas as two opposing educational paradigms that either define knowledge as objective and finite, to be handed down to students by expert-teachers, or as something infinite and constantly co- and re-constructed in the space between identified 'learner' and 'teacher'. Both paradigms are alive in mental health education and often closely linked up with 'art' versus 'science' debates, particularly in nursing and psychology (Hui & Stickley, 2007). In Western societies, scientific method tends to function as a key ideological apparatus to distinguish 'good' knowledge from other forms of knowledge by enacting a hierarchical science/nonscience binary (Ziman, 1996).

This has meant that the knowledge and expertise of service users and carers has long been ignored, devalued and marginalised (Felton & Stickley, 2004). Freire

(1996) draws attention to the power of pedagogy and the self-serving interest of the 'established' teachers to maintain this power by defining as to what passes as 'knowledge'. Involving service users and carers therefore represents a radical move away from traditional educational orthodoxy and represents a challenge to existing power-structures.

Freire argues that the line between the subject and object of educational processes is blurred. Therefore, neither the identified students nor service users and carers come to a teaching episode 'tabula rasa'; their biographies and expectations will impinge on the educational process.

The acknowledgement that knowledge does not exist independent of social activity points to learning not being a linear process that can simply be planned in advance; what is learned – if anything – might often not be immediately obvious. Many learning theories see reflection as key to learning from experiences (Kolb, 1984; Mezirow, 1991), which can occur both in-action (during an experience) or on-action (post-experience) (Schon, 1983). Mezirow (2000) theorises that the critical reflection on an experience, which is perceived to be incongruent to pre-existing beliefs or assumptions can give rise to tranformative learning. However, transformative learning has been criticised for its over-reliance on rational cognitive processes to the neglect of unconscious ways of learning, in particular through feelings (Dirkx, 2001, 2006). Research has suggested that emotional reactions to experiences may lead to the forming of implicit memories, which, in turn, may contribute to the development of new attitudes and habits (Phelps, 2004). In particular the empathy literature has highlighted that viewing somebody else's emotional state may lead to the unconscious activation of personally relevant associations ('state matching'), which is thought to be integral to developing deeper levels of empathy (de Waal, 2008). Applied to the present context, this may indicate

that service user and carer involvement could bring students in touch with own experiences of emotional distress, increasing their capacity to empathise. This unconscious process may lead students to develop more inclusive beliefs, which in turn may influence their practice and promote partnership working.

In summary, learning is an intrinsically contextualised process and students' and teachers' class-room activities do not take place in a vacuum but are embedded within broader cultural discourses regarding service users/carers, knowledge and mental distress; each come to the classroom with their own personal experiences, which will impinge on the learning process.

4. Evaluating service user and carer involvement initiatives

4.1. Conceptual problems

There is agreement in the service user and carer involvement literature that evaluating service user and carer involvement is complicated (Purtell, Rickard & Wyatt, 2012). Given the variety of reasons for service user and carer involvement, there is little consensus as to what identifies 'successful' involvement, i.e. is service user and carer involvement intrinsically worthwhile and its implementation in partnership-working an end in itself worth celebrating or should there be clear measurable changes as a result (see Doel, 2007)?

These kinds of conundrums have led to two different types of evaluation, namely those relating to processes of service user and carer involvement and those relating to outcomes (Spencer, Godolphin, Karpenko & Towle, 2011). The former refers to assessing *how well* an organisation involves service users and carers, often making reference to whether involvement happens in 'meaningful' ways ('Asking the

experts', 2001). The latter, in contrast, relates to assessing the *impact* in terms of identifiable changes as a result of service user and carer involvement (User Involvement Shared Learning Group, 2008), for example its impact on the recipients' learning, service structures, care provision or research processes.

4.2. General findings

4.2.1. A brief overview

A common finding regarding service user and carer involvement across the domains of service planning and development, education and research is that the majority of studies is purely process-focussed (Minogue et al., 2009). The seeming reluctance to investigate outcomes has been linked to underlying fears in the scientific and service user/carer communities regarding potential research outcomes, acknowledging that a (mandated) commitment to service user and carer involvement may make it difficult to be objective in research. Potentially negative or iatrogenic effects are rarely mentioned (Staniszewska, 2009).

Nonetheless, process studies offer valuable qualitative descriptions of attempts at partnership-working and indicate a general openness and willingness of organisations to engage with service users and carers meaningfully in ways that go beyond the rhetoric of policy objectives (see Repper & Breeze, 2007). Potential barriers to involvement are often highlighted in this type of research and typically include funding and budgeting constraints, (staff)-resistance to change, power dynamics and lack of motivation (for a more detailed analysis see Bassett, Campbell & Anderson, 2006).

Few studies have attempted to assess the impact of service user and carer involvement on services, research or education. It is beyond the scope of this review to critically evaluate research efforts in those three domains; however, given the paucity of available evidence regarding assumed benefits of service user and carer involvement, a brief description of the current evidence base in those areas seems warranted to enable a critical review of studies examining service user and carer involvement in mental health education that is not divorced from the wider context.

4.2.2. Health care services

A recent systematic review evaluating service user and carer involvement in NHS healthcare settings identified its influence on health services at various levels, from designing information packages to participating in service planning, restructuring and commissioning (see Mockford, Staniszewka, Griffiths & Herron-Marx, 2009). However, while there was clear evidence of impact, the quality of this impact was generally left unevaluated. Mockford, Staniszewska, Griffiths and Herron-Marx (2009) concluded that service user and carer involvement is such a politically-laden and sensitive topic that researchers are too apprehensive to rigorously investigate its impact on services.

Findings regarding service user and carer involvement impact on staff are mixed. While some studies reported changes in staff attitudes, beliefs and values towards a more user-centric perspective, others described staff discontented with the primacy given to user-perspectives over 'established' professional orthodoxy, tensions regarding role-occupancy and lack of service users and carers' representativeness (see Peck, Gulliver & Towel, 2002). Standardised ways of

measuring outcomes across the studies were lacking. Methods were often not described in sufficient detail to adequately assess quality (Mockford et al., 2009).

4.2.3. Research

There has also been an increase in service user and carer involvement in research processes in recent years, with service users and carers taking part in developing research designs, implementing and disseminating results (Smith et al., 2008). Findings were encouraging, pointing to higher recruitment rates, improved identification of topics and findings relevant to the public and more wide-spread disseminations of findings (see Staley, 2009). When service users acted as interviewers, findings indicated that participants gave more in-depth responses and responded more critically, which was interpreted as enhanced ecological validity (Simpson & House, 2003). However, again the quality of the studies was questionable, being dominated by anecdotal narrative descriptions of researcher teams (Barber, Boote, Parry, Cooper & Yeeles, 2012).

4.2.4. Medical education

There is a long history of integrating service users and carers into medical education with a shifting emphasis from using 'patients' as passive exemplars to more active participation in teaching and assessing examination-skills (Livingston & Cooper, 2004). A recent systematic review of 'patient involvement' in the education of intimate examination skills (Jha, Setna, Al-Hity, Quiton & Roberts, 2010) concluded that service user and carer involvement could be beneficial in enhancing students' technical skills, which appeared to be linked to service user feedback in the context

of a non-threatening environment. However, a major weakness of the review was that it did not differentiate between 'simulated' and 'real patients'.

In line with this, a recent review of the few UK-based studies (Morgan & Jones, 2009), found that the most studies did not detect significant differences between conditions where medical students were either taught by service users, simulated service users or consultants and the dependent variable was student-performance on a particular skill (e.g. history-taking or physical examination). However, the nature of the studies in both reviews was suggestive of a rather passive involvement of service users in role plays with subsequent feedback.

Rees, Knight and Wilkinson (2007) examined more active service user and carer involvement at one British medical school where service users were engaged in teaching, assessment and curriculum development. Drawing on socio-cultural learning theories (Lave & Wenger, 1991), they found learning to be socially situated, occurring through interpersonal communication using humour, dramatic devices such as metaphors, question-asking and negotiation of agenda. Most of the medical students' learning emerged to be in the arena of what they termed 'people skills' (e.g. developing empathy, listening skills, respect).

4.3. Summary

Conceptual problems hamper evaluating service user and carer involvement initiatives. Different rationales exist for involving service users and carers, yet these have not been linked with different outcomes and agreements as to what signifies 'successful' involvement are lacking. Overall, the evidence base regarding impact of service user and carer involvement is limited. This stems partly from the majority of evaluations concerning service user and carer involvement being process- rather

than outcome-based. However, studies that include outcomes have often lacked rigorous research designs and offered poor descriptions of methodological details, making an accurate assessment regarding their quality difficult. Hence, evidence for the assumption that service user and carer involvement will lead to improved standards of care is equivocal (Bradshaw, 2008). Findings concerning service user and carer involvement in research are encouraging but similarly flawed by methodological weaknesses (Smith et al., 2008). Against this backdrop, the following section will provide a more detailed account of the current evidence base regarding service user and carer involvement in the education of mental health professionals.

5. Evaluation research in the education and training of mental health professionals

5.1. Process Studies

With regards to service user and carer involvement in education and training of health professionals, process-research has highlighted that service users and carers have participated in a number of ways, ranging from one-off consultations or 'testimony' engagements to continuous joint or user-led teaching, curriculum development, generation of training materials, assessment and interviewing (see Minogue et al., 2009; Repper & Breeze, 2007, Towle et al., 2012). Most of these initiatives come from nursing and social work; a recent review by Townend, Tew, Grant and Repper (2008) of service user and carer involvement in educating psychologists failed to identify any papers.

In addition to some more general barriers discussed above, specific barriers to service user and carer involvement in mental health education have been identified

as notions of exclusivity as to what passes as (scientific) knowledge and academic jargon (Bassett, Campbell & Anderson, 2006).

5.2. Outcome studies

The majority of outcome studies have focussed on students' perceptions of service user and carer involvement in their education. Overall, findings illustrate that students appeared to rate service user and carer involvement highly and thought it impacted on their learning positively (e.g. Ikkos, 2005; Rush & Barker, 2006). Students often expressed an enhanced sense of sensitivity to service user and carer perspectives (McAndrew & Samociuk, 2003) and their roles in decision- making processes relating to their care (Frisby, 2001). Largely, perception studies to date have relied on small sample sizes, informal or anecdotal feedback and lacked in detail regarding their specific methodology (see Morgan & Jones, 2009).

Crucially, whether or not those subjective perceptions were mirrored by students' actual learning of knowledge or skills, changes in attitudes, behaviour or practice has rarely been examined. Given the theorised roles cognitive, affective and behavioural processes play in both learning and the acquisition and maintenance of stigmatising beliefs and assumptions, it would seem important to ascertain whether service user and carer involvement in education facilitates any changes in those areas. Hence, studies that have investigated the impact of service user and carer involvement on mental health professionals' learning and/or practice warrant further scrutiny and will be reviewed in the following section.

6. Literature review of the impact of service user and carer involvement on students' learning in mental health education

Studies were reviewed if they assessed outcomes of service user and carer involvement in the education of either qualified or student mental health professionals that went beyond capturing the learners' perceptions, i.e. where changes in learners' knowledge, skills, attitudes or behaviour were explored as a result of service user and carer involvement. Due to the paucity of rigorous studies, local evaluation initiatives were included if they were published in English. A detailed search strategy to identify those papers is displayed in Appendix A and a summary of the studies is displayed in table format in Appendix B.

Overall, nine studies were identified, of, which five were qualitative, one was quantitative and three employed a mixed measures design.

6.1. Quantitative and mixed methods studies

The quantitative study (Cook & Jonikas, 1995) employed a between-groups design in, which 57 mental health professional trainees were randomly assigned to teaching by either a service user or a non-service user trainer for one day during a two-day workshop on assertive community treatment in the US. Before the start and at the end of the workshop, trainees' attitudes were measured using a 30-item questionnaire. While pre-test measures revealed no differences between the groups, post-test measures showed that the trainees taught by a service user held significantly more positive attitudes towards service users with mental health problems, were more positive about service users acting as service providers and held fewer stigmatising views of mental illness. However, no difference was found

between the groups regarding attitudes towards the potential for recovery from severe mental illness.

Drawing on Ellis, Ladany, Krengel and Schult's (1996) evaluation-criteria regarding methodological threats to validity, several limitations were identified. Firstly, the evaluation questionnaire was designed by the researcher-team and therefore psychometric properties could not be established. A relatively small sample size meant that power was poor (as acknowledged by the authors). The use of only one service user and one non-service user trainer in each of the conditions meant that trainees' ratings could have been influenced by any personality characteristics. An isolated finding from two days of teaching with two groups has limited generalisability and ecological validity. Additionally, the study relied on self-report measures and the lack of follow-up meant it was unclear whether differences in attitudes found immediately after the teaching could be sustained.

The three mixed-measures studies were all local evaluations of service user and carer involvement. One evaluated a specific instance of service user and carer involvement in teaching (Wood & Wilson-Barnett, 1999), the other two evaluated service user and carer involvement at their respective institutions more broadly (Barnes, Carpenter & Dickinson, 2006; Khoo, McVicar & Brandon, 2004).

In their comparative study, Wood and Wilson-Barnett (1999) assigned 29 mental health nursing students to two different groups during term six. For group 1 (n=15), all seven sessions of the 'client-review' module were facilitated jointly by service users and a lecturer whereas group 2 (n=14) was facilitated by a lecturer-only. The impact of service user and carer involvement was evaluated post-teaching using an open-ended questionnaire eliciting students' views on a video clip, which showed a simulated mental health assessment. Their answers were screened

against a researcher-developed measurement tool for detecting 'user-centredness', drawing on three different criteria relating to 'terminology and jargon', 'empathetic understanding' and 'an individualised approach'. It was found that students in group 1 were more likely to employ a user-centred approach to the mental health assessment. This was indicated by higher number of instances where students made reference to concepts that fitted the three user-centred criteria, e.g. they were more likely to try and avoid professional jargon, to try and understand the problem from the service user's perspective and shying away from one-size-fits-all approaches. Significance levels were not reported but the students' answers were backed up by one researcher's field notes taken during observations of sessions in both groups.

The study employed a novel design and demonstrated creativity in using simulated assessment videos. However, similar limitations to the previous study apply as in that non-validated audit-tools and questionnaires were used, sample size was small, no follow-up occurred and the one-off evaluation of one isolated local initiative hampered generalising findings. Additionally, no pre-measures were used to control for any pre-existing differences in user-centredness between the groups. Also, the role of the service users was not well described and the classroom-observations were only carried out by one (potentially biased) researcher.

The remaining two studies evaluated ongoing efforts of service user and carer involvement in two educational institutions. Barnes, Carpenter and Dickinson (2006) provided a summary of the partly formative evaluation of service user and carer involvement in the commissioning, management, delivery and participation in a post-graduate programme in community mental health. Forty-nine students from two cohorts completed pre- and post-measures in the form of questionnaires of, which three items concerned partnership-working with service users. It was found that students rated their competencies as significantly higher at the end of the programme

in terms of both knowledge and skills in 'facilitating therapeutic co-operation' and being able to use 'a user and carer oriented perspective' in their mental health assessments. Design limitations meant it was impossible to disentangle whether this perceived change in competencies resulted from service user input or whether other variables were decisive. Additionally, 23 individual and 18 group interviews were carried out, in, which students identified changes in attitudes and practice in relation to being more more user-centric. Again, reference was made to 'the programme' as a whole, making an accurate evaluation as to what was influenced by service user and carer involvement difficult. For example, it is possible that students were particularly drawn to a programme, which worked in partnership with service users because they had pre-existing positive beliefs about the importance and value of service user and carer involvement.

Khoo, McVicar and Brandon (2004) investigated effects of service user and carer involvement in curriculum design, review and delivery (predominantly in the form of SU-led seminars and discussion groups) in a post-graduate interprofessional mental health course. Both researcher-developed attitude questionnaires (n= 26) and individual interviews were used (n=10). Responses from questionnaires indicated that the vast majority of students thought they had benefited either personally or professionally from service user and carer involvement and that it had helped improve their working relationship with SUs. Those findings were reported alongside isolated quotes from the interviews (e.g. participants voiced a desire to change existing services or set up more user-centric groups).

Similar to the study by Barnes et al (2006), findings of this study might not be transferable due to bias in recruiting students who opted for a programme known for its emphasis on service user and carer involvement. The quality of audit-trail provided in the paper was poor; interviews were not audio-taped so analysis relied on notes

taken by the interviewers. All three researchers were associated with the identified institution and considerations how this could have impacted on both student-responses and the data-analysis were omitted. Generally, limitations of this study were not discussed by the authors.

6.2. Qualitative studies

Five studies explored the learning experiences of students in the context of service user and carer involvement in mental health education qualitatively, including student nurses (Happell & Roper, 2003; Rush, 2008) postgraduate interprofessional mental health professionals (Benbow, Taylor, Mustafa & Morgan, 2011), pharmacy students (O'Reilly, Bell & Chen, 2012) and social work students (Tew, Holley & Caplen, 2012). All studies were local evaluations and the nature of service user and carer involvement ranged from one-off educational sessions provided by service users and carers to ongoing learning initiatives jointly developed and implemented by service users and carers groups and lecturers (for details refer to Appendix B).

Four studies used thematic analysis, either on free-text questionnaire responses (Happell & Roper, 2003) or transcripts of focus-group interviews (Benbow, Taylor, Mustafa & Morgan, 2011; O'Reilly, Bell & Chen, 2012) or individual interviews (Rush, 2008), while one study did not identify a method of analysis for free-text responses gained from questionnaires (Tew et al., 2012). With regards to changes in attitudes, students credited service user and carer involvement with making them see the person instead of the problem (O'Reilly et al., 2012), breaking down 'them' and 'us' barriers' (Benbow et al., 2011; Tew et al., 2012), understanding service users and carers perspectives and user-centred care (all studies). In terms of service user and carer involvement's impact on practice, students identified being more reflective

(Benbow et al., 2011; Happell & Roper, 2003), being more competent in relationship-building (Benbow et al., 2011), using less jargon (Happell & Roper, 2003), being more patient (O'Reilly et al., 2012) and being more person-centred (all studies). Some studies found that a minority of students reported no impact of service user and carer involvement (Happell & Roper, 2003; O'Reilly et al., 2012; Tew et al., 2012). In contrast, two studies found that a significant proportion of students experienced service user and carer involvement in their education as 'life-changing' (Tew et al., 2012) or that it had fundamentally changed their view of themselves and the world (described as 'transformative learning'; Rush, 2008).

Only one study attempted to explore *how* learning occurred. Rush (2008) identified five mechanisms that appeared to facilitate students' learning: hearing the lived experience of service users, the emotional impact, role reversal in the classroom, reflection and training/preparation for service users. The context that allowed this learning to happen was identified as 'the classroom', which students constructed as a place 'to relax' (in the absence of persistent evaluative scrutiny) rather than 'work'.

Drawing on the quality criteria for qualitative studies as described by Mays and Pope (2000), several limitations of the five studies were identified. All studies were conducted by researchers associated with the institutions where service user and carer involvement was being evaluated but none included accounts of researcher reflexivity. Sampling strategies were either not described or constituted opportunity sampling, making it likely that the full range of cases was not included in the studies (e.g. some students' experiences may not have been captured due to participant self-selection bias). Also, all papers described local evaluations only, indicating that findings might not necessarily be transferable to other contexts so that conceptual (rather than statistical) generalisations cannot be made. Descriptions of methodology

and data-collection lacked detail and were particularly poor in two studies; Benbow et al. (2011) omitted details relating to sample size and none of the identified themes were backed up by interview quotes; Tew et al. (2012) gave no description of how data was analysed and only provided a superficial description of students' learning without evidencing their claims with quotes. Of all the studies, only one (Rush, 2008) mentioned attempts at obtaining inter-rater reliability.

7. Summary of the review and research recommendations

The review offers encouraging although preliminary support for the assumption that students can learn from service user and carer involvement in mental health education. However, overall the quality of the studies is questionable and the methodological limitations discussed need to be addressed by future research if a robust evidence base is to be established.

All studies under review took place at single educational sites and most represent local programme evaluations, highlighting the need for more rigorously designed research studies in this field (both quantitative and qualitative). Different, mostly non-validated outcome-measures were used in the quantitative and mixed-methods studies, calling for further empirical research into standardising service user and carer involvement outcome tools. The studies also covered many different ways of involving service users and carers in the various education programmes, making conceptual generalisations of what was being evaluated difficult. However, based on both stigma and learning theories, *how* service user and carer involvement is implemented (i.e. context) will impact on students' learning. Surprisingly, only one study tried to explore the mechanisms through, which learning is mediated in a particular context. Therefore it would be useful for future studies to consider how

different contexts and different ways of implementing service user and carer involvement impact on learning. Similarly, no studies to date have paid attention to the theorised transactional nature of learning, so future studies should include some exploration of how the learners' own backgrounds might impact on their learning in the classroom.

Further, given the gaps in theorising service user and carer involvement, it is noteworthy that eight out of the nine studies made no reference to theoretical modelling or development. As Stanszewka (2009) points out "a conceptual model or theory (of service user and carer involvement) might provide an opportunity for clarity of concepts and consideration of the influence of contextual and process factors" (p. 296). Hence, in the field of qualitative research it would be useful to conduct studies that go beyond thematically analysing accounts of learners; a grounded-theory approach might prove particularly fruitful in the endeavour to advance theoretical modelling of service user and carer involvement in mental health educational settings.

Finally, there is a noticeable absence of research into service user and carer involvement in psychology training programmes; it would be important for future research to address this gap, particularly given recent HCPC (2013) publications indicating service user and carer involvement will be required in this context.

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Section B: Empirical Paper

Service User and Carer Involvement in Clinical Training and its Impact

on (Trainee) Clinical Psychologists' Learning: A Grounded Theory

Investigation

Word Count: 7998

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ

Church University for the degree of Doctor of Clinical Psychology

SALOMONS

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1. Abstract

Service user and carer involvement has become a priority in the education of mental health professionals. While preliminary evidence suggests that service user and carer involvement is perceived positively by mental health students, there is a paucity of research investigating impacts relating to changes in learners' knowledge, skills, attitudes or behaviour.

The present qualitative study sought to investigate what, and how, (trainee) clinical psychologists learn as a result of service user and carer involvement in their training. Overall, 12 (trainee) clinical psychologists were interviewed and grounded theory methodology was used to analyse the data.

Findings indicated that (trainee) clinical psychologists learned from service user and carer involvement in a variety of ways and a preliminary model was proposed, encompassing four main categories: 'mechanisms of learning', 'relational and contextual factors facilitating learning', 'relational and contextual factors hindering learning' and 'impact'.

The findings are discussed in relation to extant empirical research, taking into account theoretical considerations. Recommendations for educators in clinical psychology training programmes are provided alongside suggestions for a future research agenda. A methodological critique of the study is offered.

2. Introduction

2.1. Definition and historical context

In the United Kingdom, service user and carer involvement has become a priority in the education of mental health professionals (Department of Health [DoH], 2005, 2007, 2009, 2010; Involve, 2004, 2007) and will soon be made a requirement for training programmes approved by the Health Care Professional Council (HCPC, 2013). For the purpose of this paper service users and carers will be defined as "people who receive or who are eligible to receive health and social care services and their carers who may be family or close friends" (Barnes & Cotterell, 2012, p. xxiii).

Service user and carer involvement in mental health education has been linked with both ethics-based and evidence-based rationales. The former is linked to democratic principles and moral standpoints and has its roots in the historical oppression and marginalisation of service users and carer perspectives by professional mental health 'experts' (Felton & Stickley, 2004). Service user and carer movements have long challenged structures promoting inequality and exclusion, campaigning for their voices to be heard and included in decisions affecting service users and carers (on individual, service or national levels) (Coles, 2010).

The evidence-based argument, on the other hand, assumes that service user and carer involvement will lead to improved standards of care and outcomes (Cowden & Singh, 2007).

2.2. Theoretical considerations

There is agreement in the literature that service user and carer involvement has been poorly theorised, largely linked to its politically driven ad-hoc implementation (Minogue et al., 2009; Spencer, Godolphin, Karpenko & Towle, 2011). Two distinct ideas seem to exist in the literature how students might learn from service user and carer involvement, one relating to content, the other to process. The former indicates that learning happens through the acquisition of knowledge on a conscious level. The latter assumes that change occurs through students learning *with* rather than *about* service users and carers, thus conceptualises learning to primarily result from implicit processes.

Given the lack of theoretical underpinning in relation to service user and carer involvement, psychological theories relating to stigma, power and learning might help elucidate potential learning mechanisms.

Stigma has been defined as socially constructed human differences, which get labelled in derogatory ways through cognitive, affective and behavioural processes by dominant social groups (Link & Phelan, 2001). While few stigma theories have been validated within a mental health context (Link, Yang, Phelan & Collins, 2004), prejudice and social exclusion are common experiences for individuals with mental health difficulties (Mason, Carlisle, Watkins & Whitehead, 2001). Allport's (1954) contact hypothesis would indicate that increased contact in the context of equal status may reduce cognitive separations of 'us' (mental health professionals) from 'them' (service users and carers), promoting more inclusive practices in mental health students.

Recent learning theories, on the other hand have emphasised that the lines between object and subject of learning are more blurred, indicating that mental health

professionals and service users and carers come to the process with their own motivations and life experiences, which will impinge on their learning. Generally, learning has been increasingly conceptualised as socially situated (e.g. Bandura, 1977; Lave & Wenger, 1991).

Many learning theories see reflection as key to learning from experiences (Kolb, 1984; Mezirow, 1991, 2000), which can occur both in-action (during an experience) or on-action (post-experience) (Schon, 1983, 1987). Mezirow (2000) theorises that the critical reflection on an experience, which is perceived to be incongruent to pre-existing beliefs can give rise to transformative learning, e.g. students who come to a learning process with particular assumptions regarding service users and carers may need to revise those based on reflections on different experiences. Further, the emotional reactions to experiences may lead to the forming of implicit memories, which, in turn, may contribute to the development of new attitudes and habits (Dirkx, 2001, 2006). The empathy literature has highlighted that viewing somebody else's emotional state may lead to the unconscious activation of personally relevant associations ('state matching'), which is thought to be integral to developing deeper levels of empathy (de Waal, 2008), a process that could be central to learning from service user and carer involvement.

2.3. Empirical support

Research on service user and carer involvement in mental health education can be broadly defined as either process- or outcome-focussed.

2.3.1. Process Research

Research has highlighted that while service users and carers are increasingly involved in mental health education, initiatives vary from tokenistic one-off engagements to continuous user-led partnership-working (Minogue et al., 2009; Repper & Breeze, 2007, Towle et al., 2010). Studies have been predominantly disseminated from nursing and social work research; a recent review by Townend, Tew, Grant and Repper (2008) of service user and carer involvement in educating psychologists failed to identify any published papers.

2.3.2. Outcome research

Studies investigating mental health students' perceptions of service user and carer involvement have found that they rated it highly (e.g. Ikkos, 2005; Rush & Barker, 2006). Students expressed an enhanced sense of sensitivity to service user and carer perspectives (McAndrew & Samociuk, 2003) and their roles in decisions relating to their care (Frisby, 2001).

Studies that have gone beyond researching students' perception, examining the impact of service user and carer involvement on their knowledge, skills or practice are rare.

One quantitative study (Cook, Jonikas & Razzano, 1995) found that mental health trainees taught by a service user for a two-day workshop held significantly fewer stigmatising views of 'mental illness' post-intervention, but their attitudes towards the potential for recovery from 'severe mental illness' mirrored those in a control group.

Three mixed-measures local evaluations of service user and carer involvement have been conducted; Wood and Wilson-Barnett (1999) evaluated the impact of service user and carer involvement on mental health student nurses' 'user-centredness'. They found that students taught by service users were more likely to employ a user-centred approach and less likely to use jargon.

The other two mixed-measures studies evaluated ongoing efforts of service user and carer involvement in two educational institutions. Barnes, Carpenter and Dickinson (2006) found that students rated their competencies as significantly higher at the end of the programme in terms of both knowledge and skills in 'facilitating therapeutic co-operation' and being able to use 'service user and carer oriented perspectives' although it was unclear whether this necessarily related to the service user and carer involvement element in teaching.

Khoo, McVicar and Brandon (2004) investigated effects of service user and carer involvement in curriculum design, review and delivery in a post-graduate inter-professional mental health course. Responses from questionnaires and interviews indicated that the vast majority of students thought they had benefited either personally or professionally from service user and carer involvement.

Overall, studies were generally small in sample size, representing local evaluations, using non-standardised outcome tools and lacking follow-up.

Five studies explored the learning experiences of students in the context of service user and carer involvement in mental health education qualitatively (Benbow, Taylor, Mustafa & Morgan, 2011; Happell & Roper, 2003; O'Reilly, Bell & Chen, 2012; Rush, 2008; Tew, Holley & Caplen); the nature of service user and carer involvement ranged from one-off educational sessions provided by service users and carers to ongoing partnership-working initiatives.

With regard to changes in attitudes and practice, students reported that service user and carer involvement made them see the person instead of the problem, broke down 'them-and-us' barriers, and helped them understand service users and carer perspectives. Some studies found that a minority of students reported no impact of service user and carer involvement (Happell & Roper, 2003; O'Reilly et al., 2012; Tew et al., 2012). In contrast, two studies found that some students experienced the impact of service user and carer involvement in their education as transformative (Tew et al., 2012; Rush, 2008).

Only one study attempted to explore *how* learning occurred. Rush (2008) identified five mechanisms that appeared to facilitate students' learning: hearing the lived experience of service users, the emotional impact, role reversal in the classroom, reflection and training for service users.

Again, the quality of the papers was questionable, they all represented local evaluations with poor description of audit trails and lacked discussions regarding researcher reflexivity.

3. Rationale

While some studies seemed to suggest that service user and carer involvement could have beneficial effects on mental health students' learning, the extant literature highlighted a paucity of research in this area, in particular with regard to investigating learning mechanisms. Given that service user and carer involvement has become a priority in the education of mental health professionals and will be required in HCPC-approved training programmes, this gap in the evidence base seems both surprising and contentious. Hence, research into the processes of how - and if - students learn from service user and carer involvement seems warranted,

particularly in the context of clinical psychology training where research seems especially scant.

Related to the lack of theoretical modelling of learning from service user and carer involvement, the use of a qualitative research methodology to advance theoretical developments appeared particularly appropriate. Hence, the present study sought to examine the mechanisms and outcomes of learning from service user and carer involvement in clinical psychology training, through conducting interviews with (trainee) clinical psychologists. The primary research questions were:

1. How do (trainee) clinical psychologists learn from service user and carer involvement in their training?
2. What do (trainee) clinical psychologists learn from service user and carer involvement in their training?

4. Method

4.1. Participants

Individuals were eligible for this study if they had experienced service user and carer involvement during training, and were either third-year trainees or clinical psychologists who had qualified within the last three years. Overall, 12 (trainee) clinical psychologists (qualifieds: n=5, trainees: n=7) from six different courses were recruited for the study (Appendix C). While all had experienced service user involvement to various extents, only five had experienced carer involvement. Theoretical sampling was employed to allow for the developing model to be refined, challenged or elaborated upon. Participant demographic data are appended to situate the sample (Appendix D).

4.2. Ethical considerations

The study was approved by the Canterbury Christ Church (CCCU) Ethics Committee (Appendix E) and all procedures adhered to the British Psychological Society (BPS) and HCPC code of ethics and conduct (BPS, 2006; HPC, 2004). For ethical reasons, it was agreed that the researcher would not interview trainees from her own cohort although they could be used for interview piloting.

4.3. Design

The study adopted a grounded theory design within a critical realist framework (Willig, 2001). A semi-structured interview schedule was used to elicit the rich data required for grounded theory analysis (Appendix F). This methodology is regarded as particularly helpful in advancing conceptual and theoretical development in under-researched areas (Pidgeon & Henwood, 1997)

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4.4. Data collection

Interviews were carried out over the duration of 11 months and were either conducted face-to-face (n= 9) or via video-link (n=3). Participants were provided with detailed information about the study (Appendix G); their right to withdraw from the study was highlighted. Prior to obtaining participant consent (Appendix H), they were made aware that they could omit any interview questions and that steps would be taken to disguise identifiable data.

One pilot interview was conducted with a fellow trainee and the interview schedule was slightly altered as a result (Appendix I). In line with grounded theory, questions were adapted throughout the research process although no further significant changes were made. Participants were given the opportunity to ask questions post-interview.

Interviews lasted between 25 – 65 minutes, were audio-recorded and transcribed verbatim.

4.5. Data analysis

Data analysis drew on methods outlined by Charmaz (2006), Glaser (1992) and Strauss and Corbin (1994, 1998)[1]. Transcripts were coded line-by-line to develop codes that described the main activities in the texts (see Appendix J for example transcript); often in-vivo codes were used to preserve participant meaning. This stage was followed by focussed coding whereby initial codes were repeatedly compared so they could be subsumed into broader codes. From this, theoretical codes (categories) were developed and their relationships to each other were explored. Memo-writing was used throughout this process to inform theory development (Appendix K).

4.6. Quality assurance

Good practice guidelines (Henwood & Pidgeon, 2003) were followed; the maintenance of researcher reflexivity seemed particularly pertinent given that the researcher belonged to the researched population, thus might share assumptions with participants. Therefore, a reflective interview was conducted (Appendix L) and a reflective diary was kept (Appendix M).

Further, participant quotations were used in the write-up of the research to evidence emergent theory (Williams & Morrow, 2009). An extensive audit trail is appended (Appendix N). Research supervisors were consulted regularly to cross-check transcripts and theory development. One transcript was coded independently by one of the author's colleagues; no significant discrepancies were found. The resultant grounded theory model was presented to three fellow trainees for reasons

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[1] Despite the authors' different epistemological approaches, their procedures for conducting GT analysis are similar.

of data triangulation and appeared to be a good fit in describing their learning from service user and carer involvement (Appendix O). Further, Laura Lea (co-ordinator of service user and carer involvement, CCCU, and one of the author's supervisors) commented on the model from a service user perspective, reporting that "your results very much tally with how I see service user and carer involvement, both in terms of what and how people learn, and also how sometimes involvement is a turn-off to peoples' learning" (personal correspondence).

5. Findings

Figure 1 summarises the model of learning from service user and carer involvement during clinical training derived from the grounded theory analysis of participants' responses. The model aims to elucidate the relationship between service user and carer involvement in clinical psychology training and the impact this has on (trainee) clinical psychologists' learning, taking into account mediating factors that either facilitate or hinder learning. The model and examples of each category are presented below.

A summary of the findings has been made available to the CCCU ethics panel and participants (Appendix P).

Figure 1. Theoretical model of (T)CPs' learning from SUCI
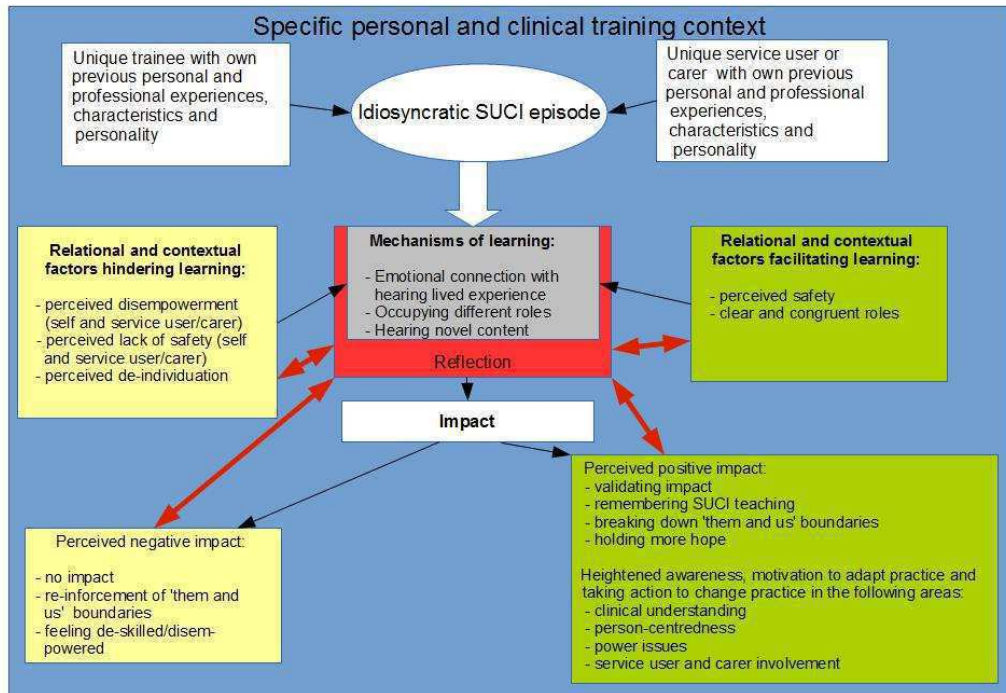
5.1. Mechanisms of learning

This category relates to the mechanisms through which participants appeared to learn from service user and carer involvement.

<u>5.1.1. Emotional connection with hearing lived experience</u>

Participants reported that hearing the lived experience of 'real' people in an academic setting enriched the learning, eliciting emotional reactions in participants. Participants described their experiences of academic and clinical learning as usually split and felt service user and carer involvement could help move academic learning into a real-life domain:

...there's something about being able to bring these experiences to life and actually it helps to bridge the gap between...theoretical teaching and the application of that in practice. (ResearchParticipant[RP]_3)

Participants heard how problems 'felt' and developed in context, resulting from a plethora of particular individual and systemic circumstances:

It was really helpful to hear...how it felt. Just hearing their life stories, hearing how it developed rather than seeing them as a borderline person. (RP_8)

Further, most participants reported that their learning was enhanced if service users and carers were able to reflect on their emotional struggles (often coupled with the ability to link their understanding with academic concepts). It emerged that this

aspect seemed to be an important difference to presentations of service users and carers on placements/work, where the distress was typically current:

When the teaching went particularly well was when people had themselves wanted to understand why it had gone wrong for them or...understand their own condition more. (RP_5)

Many participants described experiencing powerful emotions elicited through hearing service users and carers lived experiences, which seemed to put (trainee) clinical psychologists in touch with their own humanity and, sometimes, memories of own distress:

It was very emotional because people were sharing incredibly personal stories that were often very sad, very touching. I've had people in my family experience dementia and partly it puts you in touch with that. (RP_10)

Being able to empathise, relate, or identify with service users and carers appeared to be of particular importance for participants without reported own experiences of severe distress who came to the process with more of a cognitive 'them-and-us' binary:

My default position is to think it couldn't be me. So I think that anything that made me feel like I could identify with them was always helpful. (RP_5)

5.1.2. Occupying different roles

This sub-category relates to learning as a result of (trainee) clinical psychologists and service users and carers occupying different roles as compared to most clinical settings. Many participants felt that clinical training and mental health services emphasised 'them-and-us' boundaries by positioning professionals as 'experts' who treat 'ill' individuals. Working jointly with and learning *from* service users and carers rather than *about* them helped re-conceptualise roles and identities as more fluid. Often, participants described experiencing a reversal or balancing out of power dynamics:

(In services) there feels a greater gap in some ways, in teaching you're working alongside, but you're looking at them as people that you can learn something from. In an equal way. (RP_11)

Seeing service users and carers outside their sick role as capable, resilient trainers was a powerful experience for some:

He was a service user in a...really well-respected professional role. And I think that was more powerful...in breaking down the them-and-us boundary, more than the content...Seeing him being very, very capable...reminded us that it could be any of us... (RP_5)

Some participants relayed that it was an important learning experience for them to see service users and carers model the successful integration of 'professional' and 'service users and carer' identities. This seemed to be particularly

salient for (trainee) clinical psychologists with own experiences of mental health difficulties as courses appeared to give them mixed messages, both reportedly welcoming their lived experience but only if it was "closed off in a box" (RP_6). Hence, seeing presenters as embodied representations of 'professional' *and* 'service user' provided a powerful learning experience for some:

It introduces a discourse where people don't have to feel, '...what does it say about me as a professional'. Because you think, oh there's someone else who can...be a professional and have mental health problems... (RP_1)

5.1.3. Hearing novel content

Participants identified that service users and carers often introduced them to innovative concepts. In a placement context, this seemed linked to service users' and carers' ideas of how to use the therapeutic space:

They'd come up with things that were related to their interests. …music projects, film projects… (RP_10)

Radical ideas also related to service provision:

One woman was saying why can't services rather than sending out a letter that can feel a bit cold...send a dvd that introduces the team. And I thought why not? (RP_1)

Further, participants highlighted that some service users and carers were presenting with and on mental health problems they had not encountered previously:

There's the opportunity to hear service users from different areas that I've not worked in. (RP_12)

5.1.4. Reflection

This mechanism was not always explicitly identified by participants. However, the crucial role of reflection was evident in the way they spoke about their experiences. Reflection in the classroom was sometimes demonstrated through participants describing their thought processes in service user and carer involvement episodes:

I was just observing this...someone laughing when they were nervous and thinking about how other people would respond to them (service users with learning disabilities). (RP_7)

Some (trainee) clinical psychologists also explicitly highlighted the importance of room being given to process in a teaching session:

It's important...(to dedicate) quite a lot of space not only to the presentation but also what's going on with people within the room. (RP_3)

Participants continued to reflect on service user and carer involvement experiences outside the classroom, often drawing on psychological understandings.

Importantly, reflection seemingly allowed participants to learn from service user and carer involvement they had experienced as negative:

It was uncomfortable but…I learnt from it.(RP_7)

The role of reflection seemed particularly pertinent to (trainee) clinical psychologists' learning when they were open to critically examining their own as well as service users' and carers' emotions, roles, values, positions and defences that might have contributed to, or exacerbated, unhelpful experiences:

...there's something a little bit threatening about service users coming in saying: "no, what you're doing isn't right…" so it can be a bit scary too... (RP_9)

...we have to take responsibility for that ourselves, why are we feeling so superior? I think we're so anxious as trainees. (RP_5)

...maybe they say (only really negative things) because they feel really helpless... (RP_6)

Reflection about service user and carer involvement appeared to mostly happen in isolation. A few participants reported valuing the discursive exercise of the research interview in furthering the learning process:

It's actually been a...really useful process for me to do this interview coz it's helped me to think about it a little bit more clearly. (RP_3)

5.2. Relational and contextual factors facilitating learning

This category reflects the mediating factors that were identified by participants as facilitating learning.

5.2.1. Perceived safety

An important aspect that appeared to mediate learning from service user and carer involvement was how safe participants perceived learning episodes to be both for themselves and service users and carers. Several participants highlighted an emphasis on assessment throughout clinical training. The non-assessed nature of their contact with service users and carers during teaching seemed to facilitate discourses that were different from those in other settings:

It was really good...to have an opportunity to have a more relaxed, non-assessed conversation with her. (RP_2)

Further being taught by service users and carers who had processed their own emotional difficulties appeared to make sessions feel safer, enabling (trainee) clinical psychologists to ask questions without worrying about causing distress:

(It felt safe because)…the people had obviously come through their experiences even though it was obviously still quite difficult. (RP_3)

Participants further appeared to think the different power dynamics enabled service users and carers to feel safer in being honest and questioning of particular

therapeutic approaches and services. Similarly, participants reported that feeling freed up from their clinical roles made it safe to engage with service users and carers in however way suited their respective learning styles:

> *You can forget all kind of social norms and just stare at the person and listen…it frees you up to really process and digest what the person is saying without thinking about how to respond in the here-and-now. (RP_7)*

Participants explained that having clearly communicated boundaries around service user and carer involvement sessions enabled greater discussion, engagement and hence learning; this related to making clear expectations of trainees and service users and carers, e.g. what questions could be asked or how service users, carers or trainees could respond if difficult feelings arose:

> *I know with some service users...you felt safer to (ask questions)…probably cause they invited us to ask questions. (RP_12)*

> *(It would be helpful to…)say this might press somebody's buttons, just to be aware that at any point you want to discuss something or you want to meet afterwards or whatever. (RP_3)*

The presence of boundaries was often associated with participants' sense that service users, carers and/or co-presenters had prepared for the learning episodes beforehand.

<u>5.2.2. Clear congruent goals</u>

This sub-category referred to some participants' accounts that the communication of clear learning aims helped learning from service user and carer involvement. A certain level of goal congruency was identified as important to ensure trainees, service users and carers were working jointly towards shared objectives:

I feel awful saying this, but service users that have at least a sort of sense of what we're there for and doing in terms of training can be really helpful (RP_5)

...at interview, I could have been rated on things that I would want to be rated on...so things like personal warmth, friendliness, approachability (RP_6).

Most participants identified that they wanted to understand what had helped and hindered service users' recovery, so that they could learn from this in terms of their own practice; they hypothesised this was also a motivation for service users and carers to get involved:

For me as a trainee, it's useful to hear what worked, what didn't work and for me to take that on board in terms of my own clinical work. (RP_4)

If you're telling health professionals about what was good and what was bad, you're hoping they'll take that forward. (RP_7)

5.3. Relational and contextual factors hindering learning

This category related to the factors identified as hindering learning from service user and carer involvement. To a great extent reported barriers represented either the flip-side of facilitating factors or acted to neutralise some of the mechanisms of learning.

<u>5.3.1. Perceived disempowerment</u>

This sub-category reflected participant accounts that learning was curtailed when either (trainee) clinical psychologists themselves felt disempowered in service user and carer involvement episodes or they experienced service users and carers as disempowered.

Many participants reported having experienced 'tick-box' service user and carer involvement, which unhelpfully perpetuated traditional power dynamics:

Service users...weren't being listened to at all, they were just ticking a box...and I felt really strongly against that. (RP_6)

It was further perceived as negative when service users and carers were either not fully integrated as equals or were perceived to lack informed consent in participating.:

They kept talking about her experience and her therapy and the psychologist was correcting her on some things. Saying: "No-no-no. We didn't do that, we did this…". (RP_7)

Additionally, it seemed unhelpful to (trainee) clinical psychologist's learning if they themselves felt disempowered. Clinical training was often described as a time characterised by anxiety, self-doubt and unequal power relations anyway. Hence, any experiences that enhanced those feelings were perceived as unhelpful.

Feeling disempowered appeared to partly relate to experiences where service users and carers got involved for reasons that were perceived to be unclear or incongruent with the participants' own learning aims but where they could not opt out. For example, two participants spoke of a teaching session with a service user coming along for reasons that seemed to be connected to his exposure style therapy (rather than for the benefit of trainees), without this being agreed beforehand:

The service user involvement wasn't for our sort of sake...It was part of their therapy and we were never told or asked...I would have much preferred to have been explained about this and given my consent. (RP_12)

It was further said that personal experiences of distress could be used as a tool of power by telling trainees that they could never understand 'what it's like'. Feelings of disempowerment were amplified when service user and carer involvement was perceived to be driven by personal vendettas, resulting in defensive reactions:

It became very attacking...an opportunity for service users to essentially tear apart trainees because they were in a position where they could…(it felt) humiliating. (RP_5)

Similarly, some participants felt critical discussions of service user and carer involvement were closed down, invalidating unhelpful experiences:

It felt we were only allowed to reflect on how wonderful and positive it (service user and carer involvement) was. (RP_2)

Further, it was experienced as disempowering if service users and carers spoke only about negative experiences of care, giving a message that (trainee) clinical psychologists could not help people. While participants generally wanted to learn from unhelpful experiences, they had a desire to understand what they could do better:

As a trainee...you want to be motivated…if there are negatives to balance it up with some positives so we feel like there is something we can do, not completely helpless. (RP_6)

5.3.2. Perceived lack of safety

Participants repeatedly reported that they could not fully engage with a service user and carer involvement episode if it did not feel safe.

A perceived lack of safety seemed related to anxieties in the context of unclear boundaries, e.g. if the management of questions, discussions or high-running emotions had not been negotiated beforehand:

For me it came from not knowing whether something I'm saying...presses buttons within them. It made me in some ways say less because I thought I'm not sure how safe this is. (RP_3)

Many participants raised a sense of unease when they felt that mental distress was still too raw for service users and carers. Some participants experienced feelings of helplessness, guilt or even anger as a result of those situations.

It felt uncontained, her boundaries were…cut down and it felt retraumatising. And then you feel...guilty...watching this happen and not really knowing what to do…but also angry that you've been put in that position. (RP_5)

Some participants responded by reverting back into more clinical roles in these instances, feeling a need to look after service users and carers, which seemed to undermine learning. Participants were also sometimes left with anxieties how service users and carers coped with the exposure post-session:

She (co-lecturer) didn't spend any time with him when he left…to check out he was okay, it felt potentially harmful to him. (RP_11)

5.3.3. Perceived de-individuation

Some (trainee) clinical psychologists recounted experiences of feeling 'othered', labelled as harmful professionals, which led them to disengage from service users and carer -presentations:

It makes you feel like, Oh you just think I'm gonna be another one of those, horrible, unsympathetic doctors that you've met before...you're not giving me a chance, you're just assuming that we're all the same. (RP_6).

Similarly, a few participants talked about own experiences of mental distress or caring for others. Not having those acknowledged was often experienced as counter-productive and de-individuating:

It was just like, hang on, some of us would admit have also used services so, I think sometimes that needs to be appreciated. (RP_3)

5.4. Impact

Service user and carer involvement impacted on (trainee) clinical psychologists in a number of ways and appeared to be linked to their qualitative experiences of service user and carer involvement.

When service user and carer involvement episodes were experienced as negative, participants reported it impacted on them in the following ways:

5.4.1. No Impact

Several participants said they did not learn from some service user and carer involvement episodes, primarily when service users and carers were not given any real power ('tick-box'-service user and carer involvement):

I think there was an opportunity there that was just lost. (RP_1)

5.4.2. Reinforcement of them-and-us boundaries

A few participants reported that they had experienced service user and carer involvement episodes that left them feeling more different from service users and carers than previously, reinforcing 'them-and-us' boundaries. This seemed to be particularly linked to teaching where (trainee) clinical psychologists had felt othered, disempowered and/or persecuted by service users and carers:

Why I was so angry with those experiences was that I felt they set me apart from them. I ended up coming away feeling very different from those service users (RP_5)

5.4.3. Feeling de-skilled

Feeling de-skilled seemingly related to experiences where service users and carers had given negative messages without providing constructive pointers how these problems could be addressed:

No one could do anything. 'It's pointless what you're doing'. It really grates and you think so there's nothing we can do? (RP_6).

When service user and carer involvement was experienced as helpful, participants reported the following impacts:

5.4.4. Validating impact

Many participants reported service user and carer involvement re-affirmed humanistic values, mostly in relation to being able to connect and empathise with service users and carers:

Feeling heard and being warm and empathic, the kind of fundamental things I maybe already knew deep down. (RP_4)

Further, the lived experience of service users and carers seemed to validate academic ideas, approaches or psychological understandings:

I'm sure his (clinical psychologist-lecturer) approach would be the same. But there was something about feeling more important with someone in there who has had that experience. (RP_1)

5.4.5. Memory

Further, teaching that had involved service users and carers seemed to be remembered particularly vividly, apparently linked to participants connecting with its emotional content:

I think it sticks with you more. These are all things that are learned academically, but to hear it from the SU…it gives it an emotional power. (RP_12)

Some (trainee) clinical psychologists seemed to even have internalised service users and carer voices:

I carry it when I am talking with people. I carry her voice in my head. (RP_1)

5.4.6. Breaking down 'them-and-us' boundaries

For some participants, service user and carer involvement appeared to be very effective in normalising and humanising experiences of mental distress:

It (teaching delivered by service users with BPD) shifted my thinking. I can say: 'I've met some people with this'. Sort of, they're very much people… (RP_8)

While this impact seemed of more fundamental importance for (trainee) clinical psychologists who did not have own experiences of severe distress, it was also experienced as de-stigmatising and de-shaming for those who did:

There's something about the way that she's (service user & professional) so open about her experiences of mental health, it's almost the shame of having a mental health problem yourself is lost. (RP_1)

However, there were limits to this. Many participants thought that it remained culturally unacceptable for mental health professionals to show vulnerability:

She (trainee) had depression and she wanted to start a group for..trainees as service users...but it would never happen ... cause we're still maintaining this idea that we're like superhuman...immune from difficulty. (RP_6)

5.4.7. Hope

Seeing service users and carers who recovered or were able to manage their difficulties gave (trainee) clinical psychologists hope with regard to therapy outcomes and validated their career choice.

I suppose I've learned about the importance of hope. (RP_1)

One participant reported that the message of hope and the potential for recovery was so crucial that it made her reconsider offering therapy to a client group often branded as "untreatable":

It…gave me hope...I would actively offer to take on clients with a diagnosis of borderline, rather than shying away like I would have previously. (RP_8)

Further, service user and carer involvement appeared to impact (trainee) clinical psychologists' awareness, motivation and practice in four key areas.

5.4.8. Clinical understanding

Some participants described that service user and carer involvement had furthered their clinical knowledge, particularly where service users and carers had

presented with mental health difficulties that they had not encountered in their clinical practice settings.

Depending on participants' points in their professional developments it either seemed to

- Enhance (trainee) clinical psychologists' perceived competency in recognising and supporting individuals with those problems:

So I don't have experience of working with someone with psychosis but (through service user and carer involvement) I feel I've got a bit more breadth of knowledge. (RP_1)

- Motivate people to work with particular client groups:

I never thought I wanna do neuropsychology and actually that's my chosen route now…(the service user and carer involvement lecture) was just so inspiring. (RP_6)

- Impact on (trainee) clinical psychologists' practice by being able to recognise and work with service users and carers with particular problems, drawing on clinical approaches/tools service users and carers had identified as helpful:

Her (service user's) descriptions of her experiences helped me identify it (Dissociative Identity Disorder), that this was what the person in front of me

was struggling with. It also helped me think about how I could work with this person. (RP_11)

5.4.9. Person-centredness

Having been taught by service users and carers with their own individual experiences of mental distress and strengths had seemingly helped (trainee) clinical psychologists see service users and carers as 'whole' people. This seemed to have:

- made participants more aware of the reductionist, problem-focused nature of research approaches, which subsume groups of individuals under one umbrella of a specific disorder. It also appeared to have enhanced (trainee) clinical psychologists capacity to recognise that mental health problems were only *one* aspect of any service user's life :

They were also able to speak about some of the positives. It helped me not see everything as just being about it being very sad. (RP_10)

It also helped participants learn about the importance of factors other than therapy in recovery, such as social changes or the importance of peer and carer support:

I think it had put in my mind much more thinking about communication with carers. (RP_6)

- reminded and motivated participants to not lose sight of some of the more human qualities in their work:

It encouraged me to think more about the person as a whole rather than just their symptoms. (RP_4)

- impacted on participants practice in thinking about and working with their clients in more holistic terms:

That is something I have taken away with me and with new clients, will always take time to ask about them. (RP_8)

5.4.10. Power issues

Service user and carer involvement appeared to impact most participants' understanding of power dynamics. This seemed to be linked to service users' and carers' accounts of both positive and negative experiences of mental health services, and (trainee) clinical psychologists' reflections on their own feelings of disempowerment in the context of service user and carer involvement.

Participants reported being more mindful of power dynamics, for example in relation to:

- the unequal distribution of power within services
- the inherent power imbalances involved in 'doing therapy'
- their own potential to help but also to harm service users and carers

- the potential for service users and carers to feel disempowered at a time of mental distress and by the act of help-seeking

- the power of the medical discourse and labelling

- the power and exclusion involved in using medical/psychological jargon

- the importance of being collaborative with service users and carers, giving them control in choices affecting their care

- systemic failures enabling the abuse of power over service users and carers

- practices to address and reduce power imbalances

It made me really aware of the kind of power differentials. (RP_9)

I learned to open my eyes more, or realise even more limitations to NHS mental health services. (RP_2)

You could really understand what the impact of what we can do as psychologists can have on a person, both in a positive way and in a negative way. (RP_11)

This motivated participants to:

- be more collaborative when working with service users and carers

- involve service users and carers in decision-making regarding their care

- consulting with service users and carers regarding service developments

- wanting to change the way mental health services are run

- learn from and avoid practices that service users and carers identified as abusive

- redress power differentials

I always want to take myself down a level to make it feel more equal for the client. (RP_8)

It (service user and carer involvement) has been quite useful in a lot of ways about how it might be good for services to be set up. (RP_10)

Participants reported numerous ways how their critical engagement with power issues had impacted their practice. Examples included:

- listening to service users and carers and not giving primacy to own understandings of their problems

- dressing down (e.g. not wearing high heels)

- sharing of therapy agendas

- consulting with service users and carers how they would like to use their therapeutic space

- using non-jargon language

- asking clients, which terms they prefer to describe their experiences

I ask them those questions when I meet them. Well... "Is this word okay?" (RP_12)

I'm more collaborative, I suppose. (RP_9)

<u>5.4.11. Service user and carer involvement</u>

Finally, service user and carer involvement appeared to also impact participants' understanding of service user and carer involvement itself. Again, this appeared to be an area where participants were also able to draw on both positive and negative experiences.

Facilitated for some through the process of participating in the research interview, participants appeared to be more aware regarding:

- the existence of service user and carer involvement and its differential implementation

- the importance to think about rationales and objectives for involving service users and carers to avoid it becoming a tick-box exercise

- what service user and carer involvement has to offer

It seemed almost like an example to us of what not to do. (RP_11)

I think for me it's made me think a lot more about how service users and carers can be involved and it's made me think a lot more about the usefulness of it (RP_3)

This motivated a few participants to:

- wanting to involve service users and carers themselves in their service settings (post-qualification)

- seek out service user and carer involvement opportunities on placement

- support service user and carer involvement initiatives

I have an interest in involving service users and carers. I think it's something that - increasingly, as my training has progressed - I've become more interested in. (RP_10)

One participant felt her previous experience of service user and carer involvement influenced the way she negotiated service user and carer involvement at work:

We just had one planning group at the moment where I've already raised a few questions about how this could be managed, what's the point of it. (RP_5)

6. Discussion

The present study investigated what and how (trainee) clinical psychologists learn from service user and carer involvement in their training. This section discusses its findings in relation to existing research and theory.

(Trainee) clinical psychologists appeared to learn from service user and carer involvement in a number of ways. In line with previous research, hearing the lived experience of service users and carers was identified as a crucial learning process (Rush, 2008). In particular, the potential of service user and carer involvement to elicit emotional responses in learners seemed of relevance here. It could be hypothesised that hearing from service users and carers about experiences of distress resonated with (trainee) clinical psychologists on a personal level, creating

an experience of 'state matching' as suggested in the empathy literature (de Waal, 2008), which may have led to participants' enhanced empathetic understanding of service user and carer experiences as supported by previous research (Tew et al., 2012; Wood & Wilson-Barnett, 1999). Consistent with extant research, service user and carer involvement appeared to help (trainee) clinical psychologists adopt person-centred approaches, both in their thinking and practice, taking into account the whole person, not just their problems (O'Reilly et al., 2012; Happell & Roper, 2003; Wood & Wilson-Barnett, 1999). The emotional resonance further seemed to create lasting memories of experiences of service user and carer involvement, a finding compatible with implicit learning theories (Dirkx, 2001, 2006).

Stigmatising discourses surrounding mental health problems seemed to be reflected in some participants pre-teaching assumptions regarding service users and carers' ability to be capable, professional and robust, exposing 'them-and-us' thinking (see Mason et al, 2001). Hence, encounters, which challenged those beliefs appeared particularly effective in eroding those cognitive boundaries, as theories relating to transformative learning would suggest (Mezirow, 2000). Consistent with previous research (Benbow et al., 2011; Tew et al., 2012), being able to empathise and identify seemed to normalise human distress. Service users and carers modelling the successful integration of the dual identities of 'service user/carer' and 'professional' was further found to be an important learning mechanisms for (trainee) clinical psychologists with own experiences of caring or mental distress, exemplifying the social nature of learning through observation (Bandura, 1977).

The finding that participants found it helpful to hear about experiences of distress from service users and carers who were able to offer their own reflections on them, resonates with the importance being placed on the role of reflection in learning (Kolb, 1984; Mezirow, 2000). Reflective perspectives may have added to the

meaning-making process in understanding experiences of distress and developing competencies to help others with similar difficulties. Other studies have similarly found that service user and carer involvement can help students feel more equipped and knowledgeable (Barnes et al., 2006; Happell & Roper, 2004).

It further seemed that the absence of 'live' distress along with clear boundaries and service users and carers being prepared for teaching made participants feel safer. Visibly distressing disclosures seemed to be conceptualised as dangerous, creating anxiety in participants. Drawing on psychodynamic understandings, this anxiety appeared to result in (trainee) clinical psychologists engaging in defensive processes, which hindered learning, e.g. by disengaging (denial) or conceptualising service users and carers as fundamentally different (splitting) (see Freud 1936). Yet (trainee) clinical psychologists are typically frequently exposed to experiences of severe distress, which may suggest that regressions to those more primitive psychological defences was activated by the specific setting. (Trainee) clinical psychologists often seemed to construe the teaching context as their non-assessed 'secure base' (Bowlby, 1958), which may help explain why anxiety-provoking situations were experienced as uncontaining, limiting (trainee) clinical psychologists' capacity to think and 'go out and explore'. Alternatively, (trainee) clinical psychologists' assertions that - while valuable - service user and carer experiences of distress should be contained may relate to processes of mirroring (see Searles, 1955), given (trainee) clinical psychologists reportedly received similar messages from training courses.

Negotiations of power appeared dominant in participants' experiences of service user and carer involvement. Working with service users and carers as equals or superiors may have given rise to experiences that caused enhanced attunement with service users and carers regarding their traditionally disempowered roles, as

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well as empathy, a finding consistent with extant research (Barnes et al., 2006; Rush, 2008). Importantly, this experiential understanding appeared to help motivate (trainee) clinical psychologists to address power imbalances in services and their own practice. Collaboration with service users and carers was seen as important, a belief, which seemed embedded in wider socio-cultural values regarding democratic principles (see Kymlincka, 2001).

In line with Allport's (1954) contact hypothesis, it seemed of importance that service user and carer involvement episodes were grounded in the pursuit of common aims. Participants appeared keen to learn from service users and carers in relation to what can help and hinder recovery, and the roles services can play in this. This required that service users and carers were given real power in conveying their views.

Hence, the disempowerment of service users and carers in educational episodes appeared to negate learning and served to reinforce dominant socially mediated power dynamics. Particularly if service user and carer involvement was perceived as a 'tick-box' exercise, (trainee) clinical psychologists seemed less able to learn from it. Khoo et al. (2004) and Happel and Roper (2003) have similarly found that some students did not learn from some service user and carer involvement experiences.

Further, (trainee) clinical psychologists feeling disempowered appeared to hinder learning. Experiences of service users and carers attacking trainees or positioning them as harmful professionals left some participants feeling labelled, helpless, guilty and angry. Interestingly, these feelings seem to mirror how service users and carers have historically felt in the context of abusive mental health systems (Thornicroft, 2006). This may suggest a re-enactment of difficult emotions, projected onto trainees. The seeming introjection (Freud, 1936) of those feelings by (trainee)

clinical psychologists may also be linked to their particular training stage; it appeared that participants often felt disempowered in the face of constant clinical and academic assessment, which may make trainees particularly vulnerable in relation to their perceived status and competencies. As a result, some (trainee) clinical psychologists seemed to resort to defensive splitting (Freud, 1936), which may explain why those experiences appeared to reinforce 'them-and-us' boundaries. This indicates that a lack of acknowledgement regarding the lines of subject and object of educational processes being blurred (Freire, 1996) may do a disservice to service users and carers and (trainee) clinical psychologists alike, both potentially leaving the process with assumptions and prejudices re-confirmed. Iatrogenic effects of service user and carer involvement such as this one have not been reported in previous research in this area.

However, reflection on those experiences appeared to enable (trainee) clinical psychologists to learn about power and service user and carer involvement. In accordance with many learning models, the critical reflection of their experiences seemed key to learning and sense-making (Kolb, 1984; Mezirow, 1991, 2000). Learning from service user and carer involvement about service user and carer involvement appeared to be an on-going developmental process whereby most participants had reached a depressive position at research interview stage (Klein, 1935), neither conceptualising service user and carer involvement as all-good nor all-bad, facilitated by having experienced service user and carer involvement in different contexts. No previous research has indicated this type of learning to date.

Some participants specifically valued the interview experience in their endeavour of sense-making. It is noteworthy that participants generally did not seem to draw on discursive 'others' to make sense of their service user and carer involvement experiences (e.g. in supervision), a surprising finding given the

hypothesised socially mediated nature of learning (Lave & Wenger, 1991). This lack of discourse may reflect some participants' accounts that more critical reflections about service user and carer involvement seemed 'taboo'.

6.1. Implications for practice

Based on the present findings, there are several aspects educators[2] in clinical psychology training programmes may wish to consider in the planning of service user and carer involvement episodes to optimise learning, although given the exploratory nature of this study, the following recommendations are tentative.

Firstly, (trainee) clinical psychologists appear to learn from service user and carer involvement in a number of ways, indicating a need for it to be an integral part of training programmes. Educators should gain some clarity regarding their rationales for service user and carer involvement, in particular whether service user and carer involvement is primarily implemented for ethical or evidence-based reasons. Their position may be particularly important and/or contentious where the selection of service users and carers as trainers is concerned. The present findings suggest learning may be enhanced when service user and carer-trainers have recovered and are able to take a meta-reflective position. However, the issue as to whether service users and carers lacking those criteria should therefore not be able to participate in educating trainee clinical psychologists is debatable given the implication that some service users and carer voices would be privileged at the expense of others. This may seem counter-indicated from an ethics-based perspective, perpetuating notions of exclusion.

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[2]   Educators in this context refers to any individuals involved in planning, implementing, delivering and evaluating learning episodes for (trainee) clinical psychologists, including service users and carers and non-service users and carers.

Whatever rationales educators develop, findings of this study indicate that learning goals should be clearly formulated and, ideally, negotiated with trainees as working jointly towards agreed goals appeared to facilitate learning. While (trainee) clinical psychologists appeared open to learning from service users and carers' helpful and unhelpful experiences of services, it may be important for educators to ensure constructive input is given if trainees feeling de-skilled is to be avoided.

It would further seem beneficial for educators to prepare for and run service user and carer involvement episodes in equal partnerships. Educators should be clear regarding boundaries, i.e. communicating session outlines, what is acceptable for trainees to ask or what service users and carers and trainees could do to keep themselves safe. Generally, it may be beneficial for educators to acknowledge that trainees may have their own experiences of distress or caring, and encourage an exploration of how this impacts their relationship with and learning from service user and carer involvement. This may also help avoid the polarised positioning of service users and carers and (trainee) clinical psychologists, which could reinforce 'them-and-us' boundaries. Further, given that service user and carer involvement appeared to often trigger strong emotions in both service users, carers and (trainee) clinical psychologists, educators may want to consider protecting space for process and reflection in their sessions. In this context, it would further seem important that trainees are allowed to reflect on the full range of their experiences of service user and carer involvement.

6.2. Future research directions

As this study represents the first of its kind, replication may be helpful.

Further, while it is encouraging that service user and carer involvement seemed to impact on (trainee) clinical psychologists' attitudes, beliefs and practice, it

is unclear how lasting these effects may be. Hence, research involving psychologists who have been qualified for some time may be helpful.

Also, some (trainee) clinical psychologists' responses indicated that clinical training may be a particularly anxiety-filled time. Some research into how qualified clinical psychologists learn from service user and carer involvement at their work place may be fruitful in shedding light onto whether there is developmental component to learning in this context. Similarly, it may be of interest whether students and/or qualified professionals from other disciplines learn from service user and carer involvement in similar or different ways to (trainee) clinical psychologists. Further, participants had limited experiences of carer involvement, and more research in this area specifically would be useful.

Additionally, this study indicated that participants appeared to draw on particular discourses in relation to service user and carer involvement, for instance when positioning service users and carers as different to professionals, an area that would warrant further research, e.g. discourse analysis.

Lastly, participants came to service user and carer involvement episodes with different experiences, some reporting own experiences of using services/caring, others not. Some more in-depth research into how (trainee) clinical psychologists draw on their own experiences and make sense of them in relation to service user and carer involvement may be helpful; interpretive phenomenological analysis may be an appropriate methodology in this endeavour.

6.3. Methodological limitations

The study is limited by its reliance on (trainee) clinical psychologists' retrospective accounts regarding their learning from service user and carer involvement; given the theorised multi-faceted nature of learning, it could be

hypothesised that some learning occurred outside (trainee) clinical psychologists' consciousness, which they were unable to report. Hence, relevant learning mechanisms may not be reflected in the model. Also, although steps were taken to ensure (trainee) clinical psychologists with different beliefs and experiences of service user and carer involvement were included in the study, it is possible that those who came forward and participated may not be representative of the wider (trainee) clinical psychologist base, hence limiting the finding's conceptual generalisability. Due to the paucity of carer involvement experienced by participants it is also unclear to what extent the findings apply in this context.

Lastly, while quality assurance methods were used, the researcher's own beliefs and assumptions may have influenced the research.

7. Conclusion

This study aimed to explore (trainee) clinical psychologists' learning from service user and carer involvement in their training. The findings indicated that (trainee) clinical psychologists learned from service user and carer involvement in a number of ways; service user and carer involvement created lasting memories, normalised experience of distress, gave hope and educated participants in relation to power dynamics, clinical understandings, personalised approaches and service user and carer involvement itself. Some factors seemed to facilitate service user and carer involvement while others seemed to hinder it. The use of critical reflection emerged as a key component for the (trainee) clinical psychologists' learning, and they appeared to draw on their own prior life experiences in their integration of knowledge and understandings gleaned from service user and carer involvement, highlighting the importance of situating learning from service user and carer involvement in

context. While some methodological shortcomings were identified, the preliminary grounded theory model of learning from service user and carer involvement in the context of mental health education represents a first, and as such valuable step, in advancing the theoretical understandings in this field.

NB: In accordance with MRP assessment guidelines, Section B was prepared as a stand-alone paper following the style guide for the journal intended for its publication (Appendix Q).

8. References

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Section C: Critical Appraisal

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A thesis submitted in partial fulfilment of the requirements of Canterbury Christ

Church University for the degree of Doctor of Clinical Psychology

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

Reflecting back on negotiating the various tasks involved in undertaking this research project, I feel I have learned about and developed numerous research skills, particularly in relation to selecting feasible and appropriate research topics, conducting thorough and systematic literature reviews, developing relevant research questions and interview schedules, writing research proposals, obtaining ethical approval, recruiting participants, utilising grounded theory methodology, writing up research, using research supervision, and managing time constraints. Particular learning points in relation to developing some of those abilities are discussed below along with reflections which skills I may need to develop further.

While the application to the Salomons ethics panel was rigorous, I understand that many fellow trainees applied to the NHS ethics panel which seemed to be quite a different process and one I would like to learn more about given that I will be working as a scientist-practitioner in the NHS.

In terms of developing interview questions, I found the experience of conducting a pilot interview invaluable. Initially, I was worried this step might delay my recruitment of participants; I just wanted to 'get on' with my project in the context of experiencing anxiety given the tight time frame. However, feedback from the pilot interview proved crucial, particularly in relation to how my questions would be perceived by potential participants, giving pointers for a revised interview schedule that would elicit even richer data. Hence, I learned that this is not a step to be missed when conducting qualitative research.

Further, this project taught me about the need for researcher reflexivity. This seemed particularly pertinent given that I was conducting research on the population I belonged to, and that both of my supervisors were involved with and advocates for service user and carer involvement in the education of trainee clinical psychologists, one being a service user representative herself.

It therefore appeared important to consult good practice guidelines (Henwood & Pidgeon, 2003) how to best negotiate the impact researcher (and supervisor) beliefs, assumptions and attitudes may have on the study. In interviews, it felt important to stay alert to tacit taken-for-granted knowledge (*reflection in-action*, Schon, 1983), a skill I gained competency in throughout the project. Following my first interview, I specifically set out to identify areas where I may have colluded with my participant. These particularly appeared to relate to shared beliefs regarding the intrinsic value of service user and carer involvement and trainees often being motivated to enter the clinical psychology profession due to own experiences of service use or mental health difficulties. Reflecting on those in conversations verbally (with supervisors and fellow trainees) and in writing (in my research diary) helped me adopt a more critical stance with participants, a learning experience that will stand me in good stead in my future clinical research activity, e.g. when undertaking service evaluations.

If you were able to do this project again, what would you do differently, and why?

Given the externally stipulated requirements and time limitations it would have been difficult to carry out the research in significantly different ways. However, I may consider the following aspects in relation to this question:

Having carried out the literature review, I needed to decide which research methodology might be most appropriate to further our understanding of service user and carer involvement in mental health education. Given the lack of theoretical underpinning, grounded theory methodology sprang to mind. However, neither I nor my supervisors were particularly knowledgeable about this approach. My subsequent familiarisation with grounded theory indicated that it would indeed be a useful methodology to advance theoretical modelling. However, in hindsight I feel my limited knowledge of qualitative research methodology may have unhelpfully biased the selection process. For example, I discounted interpretive phenomenological analysis (IPA) (Smith, Flowers & Larkin, 2009) on the basis that I would not be able to generate theory from it. Having broadened my learning about qualitative research methodology since, I now understand that both IPA and grounded theory can be used for theoretical modelling, and that the main difference lies in the methods' epistemologies. While my alignment with a realist ontology and relativist epistemology is consistent with a grounded theory rather than IPA approach, with the benefit of hindsight I feel that I chose the right methodology for the wrong reasons. Hence, I would spend more time on familiarising myself with the various research methodologies to make a more informed decision.

Further, without the pressures of time constraints, I would consider interviewing more participants. While theoretical sampling was used, advice as to when true theoretical saturation is reached is unclear in the grounded theory literature. Concrete guidelines as to how many times a code needs to occur to be deemed significant for emergent category development are lacking as are definitions how many focussed codes or concepts need to minimally emerge for the constitution of theoretical categories. Allan (2002), for instance, advises that one important concept can be sufficient to form a category in its own right. While theoretical

saturation seemed indicated by the lack of new relevant emergent data, it is debatable whether further sampling may have challenged this view. I was particularly concerned that participants seemed to share my general assumption that service user and carer involvement, in principle, was valuable and important, even participants with really difficult and challenging experiences of service user and carer involvement. As Willig (2001) points out, theoretical saturation should be seen more as "a goal than a reality" (p. 35), and I am left unclear as to whether assumptions regarding the intrinsic value of service user and carer involvement are reflective of the wider trainees base or related to self-selection bias. While I explicitly stated that I wanted to hear from participants whatever their experiences of opinions were regarding service user and carer involvement, I equally cannot discount the possibility that some participants may have felt unable to share their honest opinions about service user and carer involvement with me. As some participants pointed out, it felt culturally 'taboo' to question service user and carer involvement which may have constrained participants. However, many shared difficult and personal experiences relating to service user and carer involvement with me and my 'gut feeling' was that participants felt safe and able to be up-front in their interviews.

Further, given a longer time-frame, I feel it would have been valuable to include service user and carer perspectives of learning in the context of clinical psychology training for reasons of triangulation. Specifically, an investigation into their perceptions regarding trainees' learning, but also how – and if – service users and carers themselves learn as a result of involvement episodes, and how that sits with the research results and learning theories.

Clinically, as a consequence of doing this study, would you do anything differently and why?

The research indicated that (trainee) clinical psychologists learn from service user and carer involvement about clinically important areas, the two that stand out for me and personally resonate relate to power and reflection.

I feel conducting this research has helped me develop my thinking regarding power imbalances, and I think this learning stems from multiple sources, including – but not limited to – my research interviews with participants, discussions with supervisors and shared experiences with service users and carers in my own teaching. In particular, having been supervised by a service user representative and an academic lecturer has highlighted power differentials in academia, with the former stressing she was concerned that the latter should be my final 'arbiter' with regard to the final write-up, due to being more familiar with the academic course requirements. This made me aware of the imagined audience for this project which – in the first instance – will be two academics (who may or may not also have service user and/or carer identities).

Clinically, this has made me think much more of the continued marginalisation of service user and carer voices, despite lip service being paid to 'empowerment'. For example, on my health placement, medical jargon often dominated referral letters to psychology (with the intended audience seemingly predominantly representing 'professionals' rather than service users and carers) and it was always important to me to clarify what clients actually understood and thought about the referral. I further endeavoured to gather their views on the doctors' letters – what was helpful, what was unhelpful – and fed that back to doctors' in one of our monthly team meetings, to

give voice to service user and carer experiences and encourage reflection within the team.

Similar to some participant views, doing this project has underlined the value of service user and carer involvement to me and motivated me to think about ways of involving service user and carers in my own future and current practice. While I was on my learning disabilities placement, I noticed a real service drive to involve service user and carers which, at least partly, appeared to represent a response to trust objectives. During a one-day work shop, I chose to join a group designated to think about service user and carer involvement in the service and felt I was able to make valuable contributions in raising questions relating to aims, desired outcomes and partnership working with service user and carers, e.g. why had no service user and carer been asked to join us at this planning stage? My research has affirmed the importance of equal partnership working to me.

Drawing on my acquired knowledge of learning theories through this project, I think that much of my learning was situated in the social interactions (Merriam, Caffarella & Baumgartner, 2007) I had with my supervisors; the discursive exchange of ideas and my reflections on them (Kolb, 1984) remained central to advancing my understanding of the phenomena under investigation throughout the project. Hence, in my future work I will strive to protect reflective space both for me as an individual but also within teams so that we can optimise learning from, with, and about each other.

Section C: Critical appraisal

If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?

The findings of this project indicated that previous life experiences impacted trainees' learning, in particular in relation to own experiences of distress or service use. It may be important for me to own that I have a particular interest in exploring the interface of 'them' and 'us' and would like to conduct further research in this area. This may stem from my own experiences of seeing close family members and friends struggling with mental health difficulties, some of whom also happen to work in helping professions. This may have influenced my perception that the lines of service user and carers and mental health professionals are more blurred and less dichotomous than they might seem.

Perhaps partly driven by my idiosyncratic interests and life experiences, I feel further research on this topic specifically would be valuable to explore and elucidate how trainees with own experience of service use make sense of service user and carer involvement in mental health education and how they position themselves in relation to 'them-and-us' debates. I found it interesting how some participants seemed to identify with service user and carer labels while others did not. I am intrigued what influences those decisions and how it impacts on trainees' (personal and professional) identity development.

Specifically, I would like to address the following research questions: What meaning do trainees with own experiences of service use give to service user and carer involvement in their training? How does their past (or potentially current) experience of mental distress influence their learning from service user and carer involvement? How does their positioning along the identities 'service user' and

'mental health professional' impact service user and carer involvement learning episodes?

Given its phenomological and idiographic focus in understanding lived experience, I think that IPA would be a suitable methodology with regard to addressing those research questions, interviewing a homogenous sample of (trainee) clinical psychologists with experiences of mental health service utilisation.

Additionally, this research highlighted that participants seemed to draw on cultural discourses in talking about their experiences of service user and carer involvement; for example in relation to positioning 'service user' as dichotomous to 'professional'. Equally assertions by some participants that they would strive to reduce power imbalance by 'bringing themselves down a level' seem to reveal assumed and real power differentials. While these were considered in the findings, I feel that further research in this area may be warranted, paying particular attention to the way linguistic and discursive practices contribute to and maintain power. Research using discourse analysis (Wodak & Meyer, 2009) might prove particularly fruitful in this endeavour.

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Fides Katharina Schreur BSc Hons

Section D: Appendix of Supporting Material

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ

Church University for the degree of Doctor of Clinical Psychology

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix A: Search strategy and outcomes

Relevant studies were identified conducting a systematic search of four electronic databases up until the last week of April 2012: PsycINFO, Medline, Web of Knowledge and Cochrane Library. Four to five search terms were used in combination (1-4, 1-3 in combination with 5, or 1-5).

1. Service user and/or carer; search terms used for service user: service user, consumer, survivor, patient, client, customer, expert by experience.

2. Involvement; search terms used for involvement: involvement, participation.

3. Education; search terms used for education: education, training.

4. Mental health

5. Mental health professionals; search terms used for mental health professionals: mental health professionals, mental health trainees, (student) nurses, psychiatrists, psychologists, therapists, counsel(l)ors, social workers.

In total, this search strategy identified the following number of studies per database once duplicates were removed:

1. PsycINFO: 18

2. Medline: 14

3. Web of Knowledge: 22

4. Cochrane Library: 2

Studies were included if they were published in English and assessed outcomes of service user and carer involvement in the education of either qualified or student/trainee mental health professionals that went beyond capturing the learners' perceptions, i.e. where changes in learners' knowledge, skills, attitudes or behaviour were explored as a result of SUI. Due to the paucity of rigorous research studies, local evaluation initiatives were included if they were published in English Abstracts were screened against inclusion - exclusion criteria and the reference sections of relevant papers were scanned for additional studies.

Outcomes are described in Appendix B in three tables under 'Quantitative studies', 'Mixed studies' and 'Qualitative studies'. The terminology relating to service users was adopted from the papers and not altered.

Appendix B: Outcome studies

Mixed studies

Study	Design	Sample size	Target population	Intervention	Quantitative outcome measures	Nature of qualitative data	Methods of analysis	Results
Barnes, Carpenter & Dickinson (2006)[•]	Formative and summative evaluation over five years	Questionnaires: n = 49 ; individual interviews : n = 23 ; group interviews , n = 18	Students on an interprofessional, post-qualifying programme in community mental health at Birmingham University	Service-users are involved in the commissioning, management, delivery, participation and evaluation of the programme	Three items concerning SUI from a self-report questionnaire on core competency measures for mental health practitioners (Sainsbury Centre for Mental Health, 2001)	Researchers' notes of participant observations of teaching; researchers' notes from individual and group interviews	Qualitative data: thematic analysis using Nvivo of which outcomes were assessed using Kirkpatrick (1967) outcome model in interprofessional education. Quantitative data: paired-sample t-tests	Perceptions of service-users as teachers were mixed. Questionnaire findings indicated that students rated their own competencies at the end of the programme in 'facilitating therapeutic cooperation' using a 'user and carer oriented perspective based on partnership in the provision of assessment, treatment and continuing care' significantly higher (p < 0.001), with a much smaller range of responses. In their interviews, student identified changes in attitudes as well as behaviour (e.g. being more transparent with service-users, setting up service-user groups, higher SUI in

[•] NB: Where student learning formed only one part of a study or evaluation (e.g. alongside service-user or provider perceptions), only that part is described.

								care planning)
Khoo, McVicar & Brandon (2004)	Local mixed-measures evaluation	Questionn aires : n = 26 ; Individual interviews : n = 10	Past or current post-graduate students on an interprofessio nal mental health course at Anglia Polytechnic University	Service-users are involved in curriculum design, review and delivery, leading seminars and discussion groups	Researcher-designed attitude questionnaire	Researcher notes taken during semi-structured interviews	Quantitative data: descriptive statistics Qualitative data: content and thematic analysis	Of the questionnaire respondents, 79% rated SUI as good or excellent, 87% said they had benefited personally or professionally from SUI, 64% said SUI had enhanced their working relationship with Service-users. Findings were backed up by isolated quotes from interviews relating to desire to change services that involve service-users more centrally.
Wood & Wilson-Barnett (1999)	Comparati ve, mixed measures	N = 29 (15 in group 1, 14 in group 2)	Mental health students undertaking the Diploma in Higher Education and Nursing programme at King's College London	Term six (7 sessions): Group 1: 'client review' module facilitated by service-users and lecturer Group 2: 'client review' module facilitated by lecturer-only; Term seven (5 sessions): Group 2: 'client review' module facilitated by lecturer-only	None used but qualitative responses were categorised, counted and tabulated.	Researcher notes on participant observations for group 1 and 2 – term six; transcripts of audio-taped group discussions in group 1 – term six; questionnaire on students' views on a video-clip showing a	Qualitative: modified grounded-theory approach which incorporated aspects of thematic analysis; answers were screened against a researcher developed measurement tool for	Findings were only reported for student questionnaires and observed classroom sessions, focusing on results after term six. It was found that students from group 1 were more likely to employ a user centred approach to assessment following SUI in their teaching. This was indicated through higher numbers of instances where group-1 students made references to concepts that fitted the three criteria of user-centredness

					client review' module facilitated by service-users and lecturer		simulated mental health assessment; transcripts from an audio-taped focus group with two students from each group at the end of the course.	detecting 'user-centredness'; answers from different groups that were identified as user-centred in terms of 'terminology and jargon', 'empathetic understanding' and 'individualised approach' were counted up and tabulated for the two groups.	('terminology and jargon', 'empathetic understanding' and 'individualised approach'). This finding was triangulated with researcher observation from class-room settings with similar findings.

Qualitative studies

Study	Design	Sample size	Target population	Intervention	Nature of qualitative data	Method of analysis	Results
Benbow, Taylor, Mustafa & Morgan (2011)	Focus groups	Not described	Postgraduate, interprofessional students	A 13-week module on older people' mental health designed and delivered by service-users, carers and representatives of independent and voluntary sector organisations	Verbatim transcripts of an unspecified number of focus group interviews	Thematic analysis	In relation to the students' learning experiences from the service-user and carer-led sessions, key themes included that the sessions allowed reflections, changed the way students thought, made them think about their own practice, broke down barriers between different groups of people, changed attitudes, facilitated seeing user and carer points of view and helped building relationships. These themes were presented broadly without specific examples or breakdown of how many students commented on the specific points.
Happell & Roper (2003)	Open-ended questionnaires	N = 21	Psychiatric nursing students in their first semester at the University of Melbourne	In semester one, half of the weekly 2-hour long lectures on 'psychopathology in context' were provided by a consumer academic (the other half focused on the medical model	Students' free-text responses to seven open-ended questions relating to students' perceptions of the consumer-led teaching, contributions (positive or negative) to their learning and	Thematic analysis	Findings showed that most students felt the teaching had enabled them to see things from a consumer perspective and which had changed their attitudes towards their nursing practice. Roughly half of the students thought they were more reflective about their practice, more aware of consumer points of views and therefore better clinicians as a result of the teaching (example included rethinking use of jargon and talking to patients within the earshot of others). A

				on mental illness)	changes in their nursing practice		small minority reported no changes as a result of the teaching.
O'Reilly, Bell & Chen (2012)	Focus group design	Intervention: n = 258 Focus groups: n = 11	Third year undergraduate pharmacy students at the University of Sidney	One consumer-led educational session followed by students interviewing service-users about their medication history and medication counselling	Verbatim transcripts of three focus group interviews	Thematic analysis using a constant comparative approach; content analysis using NVivo	Participants reported a decrease in stigmatising attitudes (seeing the person not the problem). Some thought it had impacted on their behaviour (e.g. being more person-centred, patient, asking open-ended questions).
Rush (2008)	Realistic evaluation (Pawson & Tilley, 1997)	Individual interviews: n = 26; group interview: n = 7	Mental health student nurses in their second or third year of a Diploma Nursing course at the University Nottingham School of Nursing	Students received teaching sessions from service-users	Verbatim transcripts of audio-taped individual and group interviews.	Thematic coding using Nvivo software related to researcher's theories of 'outcomes', 'mechanisms' and 'context'	All participants identified changes in their behaviour or acquisition of knowledge which they attributed to SUI in teaching. Twelve students were identified as having undergone 'transformative learning' whereby SUI fundamentally changed their view of themselves and the world. As learning mechanisms were identified: a) lived experience, b) emotions, c) role reversal, d) reflection, e) training, preparation and support for SUs; The context that was found to facilitate

							learning was the classroom environment where students could 'relax'.
Tew, Holley & Caplen (2012)	Open-ended questionnaires	N = 69	Social work and nursing students specialising in mental health at the University of Birmingham	A learning initiative jointly developed by a group consisting of six service-users and carers, two lecturers and an e-learning specialist, consisting of: E-learning using videos featuring different perspectives on mental distress; group discussion, service-user or carer facilitated learning groups, student presentations	Students' free-text responses to open-ended questionnaires exploring the students' expectations, hopes and anxieties before the learning initiative and what and how they had learned from the initiative afterwards.	No method of analysis identified	Feedback from 'the majority' of students suggested the impact of the initiative had been 'life-changing' (e.g. broken down barriers, enabled deeper levels of understanding, more person-centred approaches to care, importance of role of carers).

Quantitative studies

Study	Design	Sample size	Target population	Intervention	Outcome measures	Results
Cook, Jonikas & Razzano (1995)	Randomised between-groups design	N = 57	Mental health professional trainees	Two-day course on assertive community treatment: group 1 received teaching on the second day from a consumer trainer; group 2 received training on the second day from a non-consumer trainer	30-item instrument designed to measure attitudes towards individuals with mental illness on a Likert scale; open-ended training satisfaction questionnaire	Trainees in group 1 showed significantly higher levels of positive attitudes towards consumers overall (p < 0.001); they were more positive towards consumers acting as service provider, were less stigmatising of mental illness although there was no difference regarding attitudes towards recovery potential of people with severe mental illness between the groups

Appendix C: Recruiment message distributed to trainees/recently qualified clinical psychologists

Dear third year trainees/recently qualified psychologists,

My name is Fides Schreur and I am a Trainee Clinical Psychologist on the Salomons Doctoral Course in Clinical Psychology at Canterbury Christ Church University (CCCU). For my research project ('Service user and carer involvement in clinical training and its impact on (trainee) clinical psychologists' learning: A grounded theory investigation'), I am looking for third year trainees and recently qualified clinical psychologists (up to three-years post-qualification) who have experienced service user and carer involvement (SUCI) in their training.

Overall, I am hoping to individually interview ten to fourteen trainees or qualified clinical psychologists about their learning experiences in the context of SUCI during their training. Ideally, I would like to include participants with varying levels of experience, interest in and attitudes towards SUCI. So whether you had a lot, some or very little experience of SUCI in your training and regardless of what you think and how you feel about SUCI, I would like to hear from you!

If you think you might be able to help and participate in this project, I have attached a detailed participant information sheet and consent form for further information.

The project has full ethical approval from the Salomons Ethics Committee, CCCU.

If you are interested in participating or have any queries, please do not hesitate to contact me (email: fks1@canterbury.ac.uk).

Thank you for your time and I look forward to hearing from anyone curious to find out more.

Best wishes,

Fides

Appendix D: Demographics

Participant	Reported experiences of service user involvement (SUI) during training	Reported experiences of carer involvement during training	Reported own experiences of using mental health services	Reported own experiences of severe distress	Reported family experiences of distress/experiences of having been in a carer role	Beliefs and assumptions about SUCI prior to interview
RP_1, third-year trainee. Stated reason for participating: question not asked in pilot interview.	• SUI was described as part of the course's identity • SUCI co-ordinator employed by the university • Regular SUI groups with trainees • SUI consultancy group available for trainees • SUI in designing the course and teaching	• Carers were involved alongside SUs in the regular groups with trainees • Carer involvement in some lectures	Yes. Did not identify with service user (SU) label.	Yes.	Yes.	SUCI is important, helpful and should be extended.

	• SUI at interview stage • Various lectures (co-)facilitated by SUs • Trainees asked to seek out SUI opportunities on placement					
RP_2, third-year trainee. Stated reason for participating: wanted to develop own thinking about SUCI, and had often been frustrated by SUCI, hence she thought the piece of research sounded valuable	• SU strand throughout the three years which focused on SUI as a topic • SUI in lectures • SUCI co-ordinator employed by the university • Placement scheme of trainees being paired with SU to meet for monthly	• Carer involvement in some lectures • Placement scheme of trainees being paired with carers to meet for monthly conversations	No.	Yes.	Yes. Did not identify with carer label.	• Identified as pro SUCI • However, thought the way SUCI was implemented often put up barriers and labelled experiences in a rigid way • Thought SUCI needed to be carefully thought out • Assumed that trainees often go into the

	conversations					clinical psychology profession related to ownown personal relevant experiences
RP_3, third-year trainee. Stated reason for participating: wanted to talk to somebody about SUCI experiences to develop thinking and wanted to use this thinking to develop SUCI initiatives in her own future practice	• SU advisory group • SUs involved in teaching • SUCI co-ordinator employed by the university • SUs available as consultants	• Carers involved in teaching	Yes.	Yes.	Not reported.	• Believer in SUCI • mixed experiences of SUCI
RP_4, third-year trainee. Stated reason for participating: had just completed her	• Three lectures that involved SUs • Helping a SU sign up to a SU register on	• None	No.	No.	Yes.	• No particular interest in SUCI. • Described herself as 'somewhere in the middle'

own thesis and had never participated in anybody else's research so wanted to give back.	placement.					when in relation to SUCI
RP_5, qualified CP. Stated reason for participating: wanted to think about SUCI in more depth and talk it through with somebody else, particularly about the more negative experiences because she never got the chance to talk about them with the course.	• SUs were involved in lectures • SU advisory group • SUCI co-ordinator employed by the unversity	• None mentioned	No.	No.	No.	• Thought that there was a huge political investment in SUCI and thought that while it could be helpful, there was also a lot of scope to get it wrong
RP_6, qualified CP.	• SUs (co-) facilitating lectures	• Carers were part of the advisory	No.	Yes.	Yes.	• Thought that SUCI was very valuable

Stated reason for participating: wanted to communicate how valuable SUCI has been for her and to encourage more SUCI in clinical training	• SUs involved at interview stage • Placement scheme where trainees were paired with SU to meet monthly and have conversations • Optional lunch time seminars with SUs • SUCI co-ordinator • SU advisory committee	group • Some lectures were (co-facilitated by carers)				and should be happening more
RP_7, qualified CP. Stated reason for participating: Wanted to give back as had never participated in any research.	• SUs involved in delivering lectures	• None reported.	No.	No.	None reported.	• Had not thought about SUCI much before the interview and was unsure whether she would be able to contribute to the research.

RP_8, third-year trainee. Stated reason for participating: wanted to help another trainee with her research and thiking it sounded like a valuable piece of research	• SUs involved in delivering 4-5 lectures across the three years • A recent change had been that trainees were required to attend two SU forums on placement though this did not apply for the participant's intake	• None reported.	No.	No.	No.	• Liked the idea of SUCI but had had bad experiences of it prior to starting clinical training when she started having more positive experiences of SUCI and saw its value.
RP_9, third-year trainee. Stated reason for participating: A combination of having just finished a piece of course-work herself and having the time to take part in this research but also thinking	• SU feedback day on trauma placement • SUs involved in meeting regularly with service providers over informal dinner on CAMHS placement • SUs involved	• Carer fed back how they experienced an end-of-life service on placement	No.	None mentioned.	None mentioned.	• Felt strongly about SUCI and described it as powerful; thought there should be more SUCI in clinical training but also thought if SUCI was not done 'well', it could

that SUCI was important, making this a valuable piece of research	in doing research • SUs involved in delivering three lectures across the three years					act to re-inforce 'us and them' positions.
RP_10, third-year trainee. Stated reason for participating: Interest in SUCI which had developed over clinical training.	• SUs involved in delivering few lectures • SU involved in community project on CAMHS placement	• None mentioned.	No.	No.	Yes.	• Thought that SUCI was important and helpful in training.
RP_11, qualified CP. Stated reason for participating: Wanted to help out a friend of a friend, but also thinking that SUCI was important and there should be research to back up its evidence base	• SUs involved in interviewing and selecting trainees • SUs involved in university committees • SUs involved in delivering lectures (about 10% of the lectures) • SUs involved on some	• None mentioned	Yes. Had also been involved in SUCI as a SU in developing guidelines.	Yes.	None mentioned.	• Related to own experience of being involved in SUCI as a SU, the participant said that she was probably biased and thought SUCI was important and valuable.

	placement project but none the participant was on					
RP_12, qualified CP. Stated reason for participating: Wanted to help a friend of a friend, but also appreciating how difficult it could be to find research participants related to her own experience of this.	• SUs involved in interviewing and selecting trainees • SUs involved in delivering lectures	• None mentioned.	None mentioned.	None mentioned.	None mentioned.	• Felt that SUCI was important although unsure what she took away from it.

NB. All participants were female, between 25 and 46 years old and from varied ethnic backgrounds.
In order to guarantee confidentiality, participant data has not been linked to particular courses, age groups or ethnicity.

Appendix E: Ethical approval (this has been removed from the electronic copy)

Appendix F: Initial interview schedule

Questions

- What is the first thing that comes to mind when you think about service user and carer involvement in your training?
- Can you tell me about what SUI looked like at the university you trained at? What forms of service user and carer involvement have you come across generally?
- Can you tell me a little bit about your own background or any aspects that you feel might be relevant to your own experience of SUI in training (e.g. own experiences of using services/caring, previous experiences of SUI. Make clear participants only have to share however much they feel comfortable with). Follow up with questions of how participants feel this might have shaped or influenced their experience of SUI in training
- Can you tell me about an experience with service users that was important to you (either positive or negative)? What made it important? Do you think you learned something from that experience, if so, what? What was helpful/not helpful to your learning from that experience?
- Can you think of any unhelpful or negative experiences of SUI? What made it unhelpful? What would have made a difference to this experience, if anything? (potentially: Do you feel this experience has influenced the way you feel about SUCI in general?)
- Can you think of a time when you talked to someone about your experience of service user involvement in training? What did you talk about?
- Did learning from service users as tutors, consultants or mentors differ from learning on placements where you see service users every day as your clients? If yes, in what ways?
- Do you think SUI in training has made a difference to the way you relate to clients?
- Can you think of a situation where you feel you might have acted differently because of your experiences of SUI in training? Can you describe that situation for me? In what way was your reaction different? What was it that prompted you to act the way you did?
- Do you think your experiences of service user and carer involvement have been similar or different to other trainees?
- What is the most important thing that you take away from service users and carer involvement, either positive or negative?

Canterbury
Christ Church
University
Salomons Campus at Tunbridge Wells

Information Sheet

**<u>Service user and carer involvement in clinical training and its impact on
(trainee) clinical psychologists' learning: A grounded theory investigation</u>**

My name is Fides Schreur and I am a Trainee Clinical Psychologist at Canterbury Christ Church University (CCCU) investigating (trainee) clinical psychologists' learning processes in relation to service user and carer involvement in the training of clinical psychologists. This research is conducted as partial fulfilment of the requirements of the university for the degree of Doctor of Clinical Psychology and is supervised by Dr Louise Goodbody, Clinical Psychologist and Year 2 director, and Laura Lea, Co-ordinator of Service User and Carer Involvement (both affiliated to CCCU). This study has been reviewed and approved by CCCU's Department of Applied Psychology Ethics Panel and is sponsored by CCCU.

Although service user and carer involvement (SUCI) in educating health professionals is increasingly recognised as important and mandated by government, little is known about its effects on learners, in particular in the field of psychology. The aim of this study is to develop a preliminary theoretical model of what and how trainee clinical psychologists learn in the context of service user and carer involvement in clinical training.

Who is this study for?
This study is for third-year trainee clinical psychologists or qualified clinical psychologists up to three years post-qualification. The level of service user and carer involvement during training is not an inclusion criterion.

If you decide to take part in this project, here is what will happen:
You will be interviewed about your experience of service user and carer involvement (SUCI) during training. The interview should last no longer than 60 minutes and will be arranged at a place that is convenient for you. It will be audio recorded and I will ask you about what you have learnt from experiences of SUCI, particularly during training, whether it has affected your clinical practice and also what facilitated and what got in the way of learning from SUCI. You can omit any questions you do not wish to answer.

What will happen to my information?
Your part in this study is confidential. The audio-file will be password-protected and transcribed into an anonymous written form, either by myself or an external transcriber. If an external transcriber is used, s/he will sign a confidentiality agreement and any identifying information will be removed by myself beforehand. Once the interview has been transcribed, the audiofile will be destroyed.

Transcriptions will be stored on an encrypted memory stick. Confidential paper-based data such as signed consent forms will be stored in a locked cabinet. Some extracts from the transcribed interviews will be made available to my supervisors and

fellow trainee clinical psychologists in a peer-learning research group for quality control purposes. However, none of the information will identify you by name and other potentially identifiable personal information will be disguised.

The study will be written up and all practical steps will be taken to disguise your identity. Anonymised quotes from the interviews may be used. The final report will be made accessible to some university staff and external examiners. It will also be publicly available through the library at the university and British Library. A version of this report may be submitted for publication. All participants will be offered the opportunity to receive a summary of the findings.

Once the study is completed, transcribed and anonymised data will be kept on a password protected CD in the Clinical Psychology programme office in a locked cabinet and in my possession for 10 years before it will be destroyed.

Do I have to take part?
Participation in research is voluntary. You have the right to refuse to take part in this study. If you decide to be in the study and change your mind, you have the right to drop out any point in time before the data is anonymised.

Before you decide to take part, you will be given the opportunity to ask questions. Should you want to find out more or have any questions now or once the interview is completed, please
contact me at

Fides Schreur
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Email: fks1@canterbury.ac.uk .

Complaints Procedures

If you have a concern regarding any aspect of this study, you can contact me on the above email-adress and I will do my best to answer your questions. Should you wish to complain formally you can do this by contacting Professor Paul Camic, Head of Research at Canterbury Christ Church University via his email p.camic@canterbury.ac.uk.

A copy of the information sheet and signed consent form will be given to you for your reference.

**Canterbury
Christ Church
University**

Salomons Campus at Tunbridge Wells

Consent Statement

By signing this document you consent to participating in the research project *'Service user and carer involvement in clinical training and its impact on (trainee) clinical psychologists' learning: A grounded theory investigation'*.

Researcher: Fides Schreur, Trainee Clinical Psychologist, Canterbury Christ Church University

Supervisors: Louise Goodbody, Clinical Psychologist and Year 2 Director; Laura Lea, Co-ordinator of Service User and Carer Involvement, Canterbury Christ Church University

By signing this statement you

[ ]   Confirm you have received and read the information sheet.

[ ]   Confirm the nature of this research has been explained to you and you have been given the opportunity to ask questions.

[ ]   Understand that your participation is voluntary and you are free to withdraw at any time before the data has been anonymised.

[ ]   Agree that the interview can be audio recorded for the purpose of analysis.

[ ]   Agree that anonymised quotations drawn from the interview may be included in the report.

[ ]   Understand that anonymised audio data will be destroyed after transcripton. Transcripts will be treated confidentially and will be stored on a password protected CD in the Salomons Clinical Psychology programme office in a locked cabinet and in the possession of Fides Schreur for 10 years whereupon data will be destroyed.

A copy of the informed consent will be given to you.

_____   _____   _____

Signature of participant   Printed Name   Date

_____   _____   _____

Signature of researcher   Printed name   Date

Appendix I: Revised semi-structured interview schedule

- Can you define service user and carer involvement (SUCI) in a clinical training context for me?
- What forms of SUCI have you come across during training (description)?
- How would you position yourself in relation to SUCI?
- What do you want to get out of SUCI in your training? Learning objectives (also more general)? What about service users and carers?
- Can you tell me about an experience with service users or carers that was important to you (either positive or negative)? What made it important? Do you think you learned something from that experience, if so, what? What was helpful/not helpful to your learning from that experience?
- Can you think of an experience of SUCI that was the opposite (i.e. depending on previous answer: unhelpful/helpful)? What made it unhelpful/helpful? If unhelpful: What would have made a difference to this experience, if anything?
- Did learning from service users as tutors, consultants or mentors differ from learning on placements where you see service users every day as your clients? If yes, in what ways?
- Do you think SUCI in training has made a difference to the way you relate to clients? Can you think of a situation where you feel you might have acted differently because of your experiences of SUCI in training? Can you describe that situation for me? In what way was your reaction different? What was it that prompted you to act the way you did?
- Can you think of a time when you talked to someone about your experience of service user involvement in training? What did you talk about?
- Can you tell me a little bit about your own background or any aspects that you feel might be relevant to your own experience of SUCI in training (e.g. own experiences of using services/caring, previous experiences of SUCI. Make clear participants only have to share however much they feel comfortable with). Follow up with questions of how participants feel this might have shaped or influenced their experience of SUCI in training.
- What is the most important thing that you take away from service users and carer involvement, either positive or negative?
- How do you feel have you learned about SUC perspectives (i.e. own experiences, placement, teaching, SUCI)?
- Following feedback from RP_1, the following question was also added: What made you participate in this research?

Appendix J: Example of a coded transcript (this has been removed from the electronic copy)

Appendix K: Examples of analytical memos and theory development

<u>Initial stages</u>

The following memos have been typed out from my memo notebook and were selected to demonstrate my developing thinking in the initial coding stages. RP* was used to protect participants' anonymity.

11 October 2012

RP*, RP* and RP* talked about feeling very moved by SUC accounts. Is this related to memory? RP* said how she was normally crap with names but the name of the SU who came to lecture that day is still really clear in her mind. Similarly, RP* said that she still carries the voice of a particular SU with her and that certain stories and snippets of conversations have stayed with her. This would link in with memory research. How does this link in with what type of emotions were elicited in the sessions? For example, RP* also seems to have a very strong memory of when she felt SUs were behaving in persecutory ways to her and fellow trainees, but this does not seem to be a good memory. She felt it led to the reinforcement of them and us boundaries. So maybe feeling moved and touched by stories creates some kind of connection with SUCs and therefore stresses human commonalities while more difficult feelings seem to create or underline differences. Does this link in with defences as described in the psychodynamic literature? For example, splitting or projection?

21 November 2013

What I'm really struggling with in this project is the fluidity of identities and how this seems to impact on learning. For example RP* talked about having been a SUC herself but she did not identify with the label. She feels it almost serves to enhance differences as it requires the labelling of experiences in a certain way. At the same time she can see that this might be necessary in the wider cultural and NHS context. However, her sense was that most trainees will come to training because they have had experiences of distress or something of that nature. Hence, the labelling of 'trainees' on one side, 'SUCs' on the other can be unhelpful. RP* said something similar in her interview. What strikes me is that while some participants feel it's important to acknowledge that distress is experienced on a continuum, nobody would question the labelling of certain parts of identities as 'professional', i.e. we also put a label on our professional identities such as 'psychologist' and nobody would question this saying that 'psychologist-dom' exists on a continuum and that we all have experiences of trying to make sense of understanding our thoughts, feelings and behaviours, including SUCs. Why is the labelling of some experiences perceived as unhelpful in some contexts but not in others?
 It really interests me what discourses trainees seem to draw on when discussing professional and SUC identities. In some ways, professional identities are seen as 'good', and RP* said how it was helpful that a SUC was able to be 'professional' about relaying her experiences, making reference to the SUC being able to step back and be objective about her experiences to some degree. Is the professionalisation of SUCI desriable? And what does this professionalisation mean? What is so dangerous about SUCs not being able to distance themselves from their feelings and talk about them in a way that might be distressing? I guess being emotional, or visibly

distressed, is culturally quite taboo (thinking of the 'stiff upper lip' English stereotype here) and it seems trainees don't know what to do when a SUC gets upset in teaching sessions. Which is interesting as this is our bread and butter. There must be something about that particular context which makes it so unacceptable.

29 November 2013

I've been thinking some more about the aspect of trainees learning through feelings. So on some level emotional connections seem important, so SUC sessions need to have emotional resonance for some learning to occur. On the other hand, trainees feel SUCs need to slightly removed from their experiences so they can offer some reflective insights on them, which seems a bit of a contradiction but when I've asked specifically about this, it does not seem that this slight detachment takes away from trainees feeling very touched to hear about SUCs experiences.

I wonder about learning from more difficult feelings. Some trainees have said how some SUC sessions left them feeling guilty, angry or anxious and how some then disengaged from the teaching. However, they still appeared to be able to learn from those sessions but this appeared to be post-sessions. Both RP* and RP* said how they reflected on SUCs behaviours and their own emotional responses. They seemed to draw on their experiential and psychological understandings. For example, RP* said how she could feel herself getting defensive, maybe because she 'was not in a position to hear it'. RP* similarly said how she felt really anxious at this stage in her life generally and did not want to listen to SUCs saying trainees could not help others. It made them question their own assumptions about why they felt they did not want to hear certain things SUCs were saying and felt it was related to the way they were saying it (angry) and how they themselves felt in the session. They also appeared to try and make sense of these experiencesby understanding what may have caused SUCs to feel so angry and reflected on wider power dynamics. RP* also said that maybe the fact the SUCs were still so angry might mean that their message was not being heard, so there was still a need to meet those needs. I feel that actually really important learning happened, although it was a difficult and also painful process (seemingly for SUCs and trainees). What I find difficult is, if some experiences are relayed by trainees as unhelpful and left them feeling disempowered, but important learning seemed to occur as a result, what does that say about these type of experiences? Should they still be happening in education or should we aim to minimise them? Can the same things be learned through a process that is experienced as less persecutory or defensive? I guess the learning here seemed to occur through reflection, so it may be important to leave room for process?

Later stages

The following memos were selected to demonstrate my progress in thinking about theoretical modelling in relation to learning from SUCI.

The ideas about learning from emotions were explored further:

29 January 2013
I'm not sure whether learning through feelings should be a category in its own right. It's certainly very prevalent in the data, both in terms of feeling moved, touched,

empathic but also in terms of feeling anxious in particular. I feel I've been sticking too much to thematic analysis which I'm familiar with. I've kind of just grouped those feelings together but this might not be so helpful when I want to actually understand how those feelings interlink with other aspects on the interface of learning. Just because they're all feelings does not mean that the learning mechanism is the same I guess? For example, both feeling disempowered as a trainee and feeling moved seem to have the same impact, in the sense that trainees seem to be able to relate more to SUC positions and can have empathy for their positions. But from the data it seems that mechanisms are actually mediated differently, because trainees who feel disempowered don't actually feel empathic in the session whereas trainees who feel moved do. In the former instance, what seems important is role or reflection, it is more in hindsight that trainees are then able to make sense of their experiences and I guess their empathy is arrived at through cognitive processes, in the reflection of experiential feelings. I suppose if my model should be of value to SUCs and training programmes, it needs to be more refined rather than saying trainees learn through feelings. I think I need pay more attention to the particular contexts and maybe also what trainees bring to the sessions. This stuff is so complicated! Back to the transcripts.

Initially two different learning routes were considered for (T)CPs with own experiences of distress/caring and those without:

3 February 2013
I feel that trainees with own SUC experiences come to the process differently to those without and that this impacts on their learning in significant ways. For example, RP* said that seeing SUCs presenting with BPD radically altered her view of individuals with those tpye of experiences, so her learning seemed to be of transformative nature (similarly to RP* who said the process of being able to identify meant she could think 'this could be me' which she had not thought previously). In contrast, trainees with own SUC experiences seemed to have less of a cognitive them and us separation to start with, so their learning seemed to be different, maybe more of validating nature?

This idea was revised shortly afterwards:

15 February 2013

Having re-read the transcripts and talked my idea through with (fellow trainee), I don't think that the routes to learning are distinctly different. I think I let myself be a bit organised by the only other study which had examined MH students learning mechanisms (Rush, 2008) because they had grouped students in polarised ways, those undergoing transformative learning vs those who didn't. I don't actually feel that is such a helpful theoretical conceptualistion. After all the learning mechanisms as such seem to be of similar nature for all trainees. They all seem to learn through SUCs sharing their lived experiences with them and their emotional reactions to the content, although their reactions might be different and partly depend on in how far SUCs stories resonate with their own (e.g. RP* was saying that it reminded her of personally similar experiences, but similarly RP* was saying that she could identify with some SUC experiences despite not having experienced severe distress; I suppose experiences of distress will always happen on a continuum and as such, whether trainees have used MH services themselves or not, there will always be

something trainees can relate to personally. Also, trainees obviously differ in relation to their own experiences of distress, it's not like they're all the same, I feel maybe I'd actually bought into some labelling of experiences myself here. Interesting.).

Also, while past experiences might mean that trainees come to the process with different beliefs and assumptions about mental distress and SUCs, I no longer feel coming to training without 'them and us' thinking curbs the potential for transformative learning although it might happen in other areas. For example, RP* said how she felt seeing a SUC present in a professional capacity changed the way she thought of her own experiences and that the disclosure of MH difficulties can be useful professionally and does not mean you cannot also be a MH professional. So I now think that learning happens through similar processes for all, even though learning will necessarily always be idiosyncratic and context-dependent. However, creating binaries that distinguish trainees with and without own SUC experiences seems overly simplistic and unhelpful in understanding the more nuanced experiences of negotiating sameness and difference.

Appendix L: Abridged Research Diary

July 2011

Ok, so I've just met with (lead supervisor) and it looks like I might have found myself my MRP project, hurrah. Really disliked the whole process of having to compete for the internal and external supervisors, it all felt so competitive! But I guess that's what you get when you apply to one of the most competitive courses in the country, i.e. clinical training. Feels good to have my friends to support me through this time (and the next 2 years I shall imagine!!). Plus all this other course work. So much to do. Anyway, the project's on service user and carer involvement (SUCI) in training and will be supervised by (lead supervisor) and (second supervisor). I'm quite excited. But it also feels daunting. Wonder how they will differ in terms of supervision.

August 2011

I've just met with both of my supervisors and it all seems to come together now as a project. The way we discussed it all made sense to me, seems (lead supervisor) will be more of a supervisor re academic requirements and methodology, while (second supervisor) will be supporting me in thinking through user and carer perspectives. I wonder how having her as my supervisor might influence my thinking. I have to admit I've not been very active in any of the user involvement stuff myself, e.g. we have this advisory group and I've not put myself forward to attend those. Not because I'm not interested or because I don't think it's a good thing but have just had so many other things to contend with that I've not had head space for it.

Makes me think about my reasons for choosing this project. I think it's a mixture of interest and pragmatism. When it was presented at the research fair it sounded interesting and made me think about my experiences of user involvement. Hadn't actually thought about them that much before. Some I really liked, others less so. So there was something drawing me to this project and making me reflect. But then there was also the aspect of interviewing fellow trainees, so there was also this thought 'Oooh, it might be easier to recruit this population'.

October 2011

Just had my panel with (names removed). I have to admit that I felt a bit nervous when I read both of their names as they have a bit of a reputation for being quite tough, in particular when it comes to research. They were actually really interested in the project but pointed out that I was perhaps not very clear in my own mind what I was going to be investigating. (Name removed) said rather than asking 'how' trainees learn from user involvement, it should be asking 'what'. (S/he) pointed out my assumption that user involvement is a good thing and that trainees learn something from it. Hence, I've been asked to revise and write a new proposal. Also, need to up my numbers to 12-14 participants so all MRPs can be equally as effortful. My current placement sup only qualified from Sals 2 years ago and she had 7 participants for a similar project. Very unfair. Should have gone to Sals a few years ago as everything seemed better then (free food, accommodation, less course work)… Ok, back to being serious, will need to look at how to address the issues raised.

Feb 2012

Phew, have not written anything for a looong time. It's that frustrating thing of having so many things at once on the go. Anyway, I've just submitted my ethics form to the Sals panel and I feel it's actually ok. I've done a lot of thinking since I wrote in here last time and also looked at the research more. Really interesting how there's such a huge gap in the evidence base for SUCI but not many people seem to realise.

March 2012

Got my ethical approval so I can officially now interview people!! Now the daunting prospect of actually recruiting… But will first do the pilot!

So done my pilot interview today, a friend of mine on the same course who said she had no particular interest in SUCI and was unsure if she would find anything to say. The interview took over an hour!! So I guess my questions do elicit reflections on SUCI experiences and give rich data. The feedback was good too, although my friend said to maybe ask about personal experiences of mental health problems more towards the end once a rapport has been established. It's so interesting how we're so touchy about talking about vulnerability in ourselves. I wonder why, seeing we're meant to have very non-stigmatising attitudes already. Food for thought!
She also noticed that I had not specifically asked what she understood by SUCI which is just major oversight. Just shows how easy it is to go into an interview with assumptions. She also said some question seemed slightly repetitive. Will revise my interview questions to reflect those ideas.

April 2012

I had an interesting experience on placement today. Sussex is bringing in SUCI more and more and my sup was saying how it needs to be implemented, bringing it to the team's discussion how it could be best achieved. It made me think about my project and the unclear rationales for SUCI so I raised it in the meeting, like 'to what end, what's the point of it?'. Really interesting as nobody had really considered this. The how seems more important than the why. Probably to do with its top-down implementation. Kind of validated the point of my project, I feel.

Interview 1

I felt nervous making my way to my first interviewee. Even though I had piloted the interview on a fellow trainee in my cohort, I felt uncertain about how the questions would be received by someone who did not know me. Would it all work? How long would it take? Would it be enough to elicit rich data?
The interview took place in the trainee's home and although I thought I had allowed myself plenty of time to get there, I ended up running late due to wrong information from google about which bus number to take. Luckily, I ended up being only about 10 minutes late and was also able to let the trainee know as she had provided me with her mobile number. She instantly made me feel very welcome and started by apologising as she did not think she would have much to say about SUCI. She said she had responded to my recruitment request only after she had read the info sheet and was reassured that it did not matter how interested you were in SUCI and how much experience of SUCI you had had in your training.

During the interview, the trainee actually provided very rich and detailed answers to the questions and surprised herself, saying later on how she did not think the interview would take very long at all (in fact it took almost an hour). I felt the interview went really well although maybe I stuck too much to my interview schedule. Towards the end, there were several points where I thought 'Ooh, you could ask some more about that' but didn't as I did not want to run over the hour which I had given as the maximum amount of time the interview would take. Maybe I should have just checked out with her whether she would mind. Interestingly, when I shared this with the trainee after the interview, she said there were some points where she had felt she could have elobarated or said more but was conscious of the time and did not want to run over, thinking of how much I would have to transcribe. We reflected how as trainees we are sometimes trying to second guess and empathise with the other person perhaps too much and also how her own experience of doing a qualitative research project head meant she could see things from the researcher's side.

I also asked the trainee if there were any questions that weren't asked that she felt would have been helpful to. She said that maybe a question about what had driven participants to take part in the study could help illuminate their motivations which could help with interpreting the data. I thought this was an interesting suggestion which I will bring to the meeting I've got with my MRP supervisors next week.

Interview 2

I think this was a really rich interview. The participant seemed to have thought about SUCI a lot, even though she initially said she had not. Maybe there is something about the process of being asked and questioned on something particular that somehow taps into reflections and knowledge the participants don't even know they have.

The participant talked a lot of about SUCI somehow perpetuating the othering of people and putting people into boxes. That was interesting. She said she had experiences that could be classified as being a 'carer' although that is not how she would choose to identify herself. There's something about the notion of exclusivity of identities or maybe teaching often not acknowledging the other identities. E.g. I think she said it would help to acknowledge that being an SU or carer might be an experience on a continuum. Why is this so important for SUCI. Just thinking that when someone comes to speak to us in a 'professional' capacity, no one would complain that we're all 'professional' on a contiuum. So what is this resitance about? Somehow feeling this is a stupid thought. Maybe there is something about the universality (is that a word?) of mental distress and if that's not put on the table it angers people and hinders learning? There was also something about being made to take up certain SUCI initiatives and that she felt she might have benefitted more if it hadn't been compulsory. 'Taboo' of questioning usefulness of SUCI somehow seemed to actually render it less useful.

23 September 2012

Right, finished transcribing the first interview. What a lengthy process that is. I do hope I'll get quicker as have no idea how I'm meant to accomplish all these things while starting new placement, going to uni, getting all the other coursework in… I've kind of coded loads and wondering if being too literal. But understand that's how the first stage works. Wish I'd done some GT before so I could feel at least certain about something. Though I know safe uncertainty is *the* position to be in, but not sure how

'safe' my current uncertainty feels. I've got so many memos flying around now, I wish I was that kind of person to whom a sense of order would come naturally.

But there's some really interesting ideas in there, finding it fascinating that having a SUCI-co-ordinator seemed to facilitate a culture where people could be open about their own mentalh health problems. So different from my year, I feel our cohort it not great with vulnerability and talking about it (including myself). How can that be fostered?

30 September 2012

Finding it hard to reconnect with this project after all the other coursework. This process of dipping in and out of my research feels frustrating. Have just looked at other MRPs to get an idea of what is expected of us and feeling soooo overwhelmed. Ahhhh. I know if I do everything step-by-step I'll be fine but I've just started coding and my memos are flying around everywhere and they're not numbered chronologically etc. Will do so from now as just seen they need to be included. Have a feeling I might have to make out I was a lot more organised and systematic than I was. But then that's not great either, really. Well, at least I know what's expected of us now and I can hopefully try and and do things bit by bit and be fine!

January 2013

So I've done six interviews now. I really wanted to keep on reflecting on each interview as I thought this would be really helpful but have just made bullet point observations on a note pad and have not written them up on the computer afterwards. Just don't have the time at the moment. Slightly pre-occupied with own stuff. Can I put this in here for something the examiners might read? Weird, I'm just thinking that I'm going through such a horrible time personally and am now wondering whether it would be 'professional' for me to put that in here: one of the prevalent codes about how personal distress still seems such a taboo and somehow juxtaposed to 'professional'. Exactly my dilamma now, and somehow feel writing about personal stuff might not go down well in MRP, even if just in the appendix. Could be wrong, but won't include for now. What an intersting personal reaction though, will need to think about it more.

Anyway, I feel the people who are coming forward are either strongly aligned to SUCI or have had really difficult experiences of it. I think I need to make an effort to recruit people who have no particular interest in SUCI or, I guess, a particular agenda in taking part as I suspect those people would represent the majority of trainees. I think I'll try word of mouth and see what happens. Friends of friends are much less likely to have particular attitudes towards SUCI and I hope their agenda will be more just wanting to help out.

March 2013

I've done ten interviews now, the theory is really coming together and I think I've pretty much reached saturation in the sample. It seems to be an even mix of people and experiences of SUCI. I've got two more interviews lined up and we'll see what they bring. I've not really had a negative case, somebody who's not learned anything from SUCI (even those with negative experiences have actually learned, seemingly through reflection, but maybe that IS key, as my assumption would be that as trainees we're very trained to reflect so might be hard pressed to find somebody

who's learned nothing). Also, people seem to share the underlying assumption that SUCI is important. Is that representative? I know in my year there's people who find SUCI difficult but I actually haven't heard anyone say that SUCI is not important or should not take place. Is that because that's what people think or because they feel it's taboo to say that? Maybe people who think that would also not want to take part in a project on SUCI, but then again maybe they would because it would help them get their point across safely, being anonymous and all. I shall see what the next interviews bing.

May 2013

Met with (fellow trainee) and we went over his codings of one of my anonymised transcripts. Luckily no major discrepancies. Actually not sure how I would have coped. I also showed him my preliminary model of learning from SUCI and he said it made sense and seemed convincing. Good! Relief! Will now share it with a few more trainees so I can get it validated that way. Just glad what I'm saying makes sense as I'm so immersed in the data now I'm worried whether people who are unfamiliar with my project will still understand my conclusions.

June 2013

In the stages of finalising the model. Part of the problem is that I'm no good with computers and drawing but will need to send it to (my supervisors) electronically. Could just post my hand crafted drawing… Maybe not! Will need to tackle paint programmes. I hope it will make sense to them as I know I'm up against time now… What if they think it's completely useless. I hope not!

July 2013

This is so hard work. I feel a real responsbility for my participants and not sure which quotes to include on the expense of others. I suppose most of it is in the audit trail but who will actually bother to read through that (apart from the examiners, obviously). But then who else will read my work anyway. Will need to look into publication if this piece of work is to actually make a difference! After the deadlines though…

Appendix M: Reflective interview - excerpts

Interviewer (fellow trainee): Ok, so I guess my first question is what interested you in this project.

Fides: Hm, ehm, I think it was a combination of things. So I think there were two things really, or reasons, so I think it was partly related to finding having an interest in service user and carer involvement (SUCI) and I'll say some more about that in a minute but also, ehm, I think related to advice from friends, trainees, or rather previous trainees to go for a project that's feasible and where I wouldn't anticipate too many problems with recruitment. One of my friends' project was a quantitative project where she had to rely on other people doing a lot of things for her, gathering data and stuff, and, ehm, she really, really struggled and had to defer in the end actually. So, you know, I suppose there was a pragmatic component to my choice because I thought that this isn't a project where I'll have to rely on others…

I: Uh-huh.

Fides: …and where I would hope that I could get participants just because other trainees will know how difficult it can be to recruit, so an emotional black mailing component (laughs), ok, not really, but I hoped people would take part.

I: Mmh.

Fides: And then there's my interest in the area and I suppose that comes from, ehm, many things. So I suppose, ehm, I guess related to stuff in my own background and experiences I've had of user involvement, ehm, both at Salomons and before. So I guess, my view is that service user involvement is important and before reading up on the area I'd never questioned its usefulness.

I: Really?

Fides: Yes, it was interesting for me, ehm, doing the, ehm, going to the MRP proposal panel-y thing, or what is it called? Well, anyway, where I was sort of presenting my research proposal and making a case for how we should understand how trainees learn from SUI and then there was (name removed) saying, well have you actually thought about if they learn? And I was like, wow, I hadn't even realised I'd made a massive assumption.

I: Mmh.

Fides: So that started a really different thinking process and I had to be quite honest why I'd thought that. So I think that relates to my own beliefs, and ehm, I've not used mental health services myself but some close friends and family have and I'm thinking of one time in particular where I've been more in a caring role and I think I've been at the receiving end of feeling pretty powerless in the wider system, that, ehm, was when I first moved to England with my boyfriend at the time and he became really, ehm, quite unwell. And I didn't really know the system and neither did he and then we were told there was a waiting list of about 10 months to a year.

I: So this was related to mental health services?

Fides: Ehm, yes, yes, it was. So anyway, I think I'm of the opinion that service user voices need to be heard and that I have an experience where I'd felt quite socially isolated myself and stuff..

I: Ok.

Fides: Well, anyway, so I think there's that side, that I'm a believer in it but then I've also had experiences of user involvement myself, and some of them have been good others less so and I think I wanted to understand a bit more why that was, or what makes service user involvement good or bad and what do I bring to sessions. So some personal motivation in there for me too.

I: Ok, so you have some assumptions that service user involvement is good and valuable. How do you think might that impact your research?

Fides: Pff, I'm not sure. Ehm, I don't really know. I think it's just something I might need to stay alert to and, ehm, I guess, I, I should, ehm be prepared for other people not sharing those assumptions and being open to that, so exploring those thoughts and, actually, that just makes me think, equally, ehm, equally it would be important to explore those thoughts with people who do, so participants who do share those assumptions because it would be easy for me not to and assume reasons for believing in service user involvement, and carer involvement, ehm, would be the same as mine when actually people might hold same assumptions for different reasons and vice versa. So, yes paying attention to those things when I'm interviewing people and also when it comes to analysing and interpreting data.

I: What else might be important, do you think?

Fides: Like, in terms of biasing me?

I: Uh-huh, yeah.

Fides: Ehm, I think, maybe, I think I need to be aware of assumptions my participants might make, so like I wouldn't want anybody to feel like they can't be honest with me, and I guess there will be assumptions about my own investment in the project which will be partly correct, so that I probably would want my data to show that we do learn from SUCI in important ways, but I also need to be open to the possibility that we don't and… Ehm, I think potentially it could be quite difficult for participants to volunteer if they feel their views are not wanted, or, maybe that's the wrong word, maybe that I wouldn't want to hear their views because, I suppose, I really do so I can also undertstand the conditions when we don't learn from service users, so service users and carers. Yeah.

I: Ok, so how do you feel your personal experiences map onto that?

Fides: So, I think I feel that… Sorry, personal experiences of SUCI, you mean?

I: Yes, or generally, but I was thinking of your own experiences of SUCI in your training?

Fides: Ehm, they've been really helpful, I think. Although, actually, a bit mixed, I've just remembered that… There were some lectures that were quite difficult and I remember that there was one SUCI lecture (extracts removed) ehm, which I think people wanted to follow up on, because, ehm, I think it had been a tricky lecture, both for (the lecturer/s) and us and I think there was a plan to follow up on the lecture but it never happened (extracts removed). Which was, ehm, was really quite disppointing because we then never got the chance to address it again, ehm, as a year group.

I: I'm also aware that you have a staff member representing service user and carer voice as your supervisor, how do feel about that and how that might influence you, the data?

Fides: Ehm, I think it's really important because, well it's obvious really, but I think it's important to have a service user perspective and voice in a project that is looking at service user involvement. It's interesting, if I'm honest I hadn't thought or really considered how that might shape the project. I suppose she has, well, actually both (lead and second supervisor) have an investment in the project and a view that trainees learn from SUCI and that it is important. So, in a way, it might be unhelpful that we all share this assumption and who is there to challenge and bring in the other side. I'm probably more detached than (my supervisors) are, actually, yet still have similar assumptions. So again we need to be attentive to this and I feel…

I: Yes?

Fides: Ehm, I was just thinking any more challenging findings would resonate with (second supervisor) on a different, more personal level, maybe. So, I think it's important for me to talk about this with her and how she would feel about hearing negative findings as it would be easy for me to jump to conclusions. I mean, she's representing service user and carer involvement, she's holding a lot of that at the university I feel but she is also a paid member of staff and I don't want to collude with ideas about service users not being able to hear certain things or be challenged and stuff. So yes, it might be important for us just to have reflective conversation on how me being a trainee and her being a service user rep might shape things as we're representing both the objects and subjects of the study.

Appendix N: Audit trail

Supporting Quotes	Initial and Focused Codes	Sub-category	Category
I think there's something about being able to almost bring these experiences to life. *It became much more alive and made it just so much more real, actually.* *(SUCI) made the topic come to life in a way that you just didn't get when it was removed from any kind of context. It made more sense, it had more meaning.*	Bringing academic teaching alive	Emotional connection with hearing lived experience	**Mechanisms of learning**
Just really hearing their life stories, hearing how it developed rather than seeing them as a borderline person. *You can sit and look through a book and look at lecture slides…. But the patient, you know.* *To, you know, to hear it from the person rather than just, there's been six or X number of RCTs conducted, you know, on this population that doesn't really exist out in the clinical world.*	Hearing from the person behind the label		
I think that it has worked very well that the service users and carers we've had have been able to reflect	SUCs being able to step back from own experiences and reflect on them		

and that they have processed it and gone through it a lot *She was mostly in a pretty good place when we were meeting and therefore a bit more able to reflect from a bit more of emotional distance, from a bit of a meta-position* *(On placement) you're not hearing the voice of somebody who's recovered or who has that perspective yet, it's still really about the problem that they're dealing with.*			
Whenever you talk about anything academic or looking at a model or something you have someone there that can say 'Oh, I actually found that difficult to grasp' when it was, you know, spoken about, or 'that was very helpful' *It was really helpful to hear from these people how the treatment had really helped them, how they'd improved their lives.* *I think, you just say: "oh, that one's really avoiding…" and actually hearing from them, okay, what does avoidance actually mean? Why is it difficult to come. I think, it's just really helpful.*	Receiving feedback grounded in experience		

So it was very moving to hear them talk about the experience of psychosis and you could tell it was very moving for them. They got quite emotional but it was, you know, that was touching. *It puts you back in touch with what you're doing it for - why you're learning.* *But, yeah, just hearing their life story, hearing the struggles, hearing the emotional content… I was just really touched and I didn't… I didn't feel scared of them.*	Emotional responses		
My default position is to think it couldn't be me. So I think that anything that made me feel like I could identify with them was always helpful to me. *I… this is going to sound really weird, but, in some ways, I found I connected with some of them, I can identify with them and, maybe, it was just that…* *I found that I was really able to identify with her struggles.*	Identifying		
They can be seen as an equal cause, like in the academic environment, they're talking about their experience in such a way that they're linking into the lecture	Change in power dynamics	Occupying different roles	

They're almost given the power that we're consulting them. They are bringing their thoughts so they teach us on training. *When they're teaching you they're in the more powerful position I feel and that's, and you're then experiencing the different power dynamics and I guess that makes you think that you're a lot more mindful about what it is like to hear what I'm saying.*			
Having, you know, a client come in and talk about their clinical care in your academic setting, I think, is quite helpful because then you can talk about it academically together, so the theory/practise links. *Just working alongside them, again, I keep saying it, it just normalised a lot of what was going on for them.* *It was a good experience for me because I didn't really see them as, you know, service users in that I felt, I saw them as colleagues and we were working on this together.*	Learning with service users rather than about them		
The service users were able to be objective as well as kind of being able to kind of think about it and drawing on their own personal	Modelling dual identities		

experience. So they really were able to be professionals, I suppose. *It introduces a discourse where people don't have to feel, 'oh what does it mean if I say that, what does it say about me as a professional'. Because you think, oh there's someone else who can do that, be a professional and have mental health problems, or be a clinical psychologist and have bipolar.* *Seeing service users as trainers is quite powerful. Cos you know, I think my kind of ex-service user identity is really quite important to me and... and so is my professional identity now, and it's how I amalgamate those in a, in a, in a profession that still doesn't really allow for it that much.*			
There's something about bearing witness to someone's resilience and strength. *They were teaching us how to do, use Makaton signs. It was just nice being taught by the people you were gonna meet, you gonna be working with. Ehm, and something that they can do.* *He's a really famous service user*	Seeing SU/Cs as capable		

psychologist who's in psychosis. I think what people were looking for in a way was experiences of seeing service users as really capable people.			
Being able to talk to the person afterwards and say thank you for sharing that, really appreciate it and kind of, yeah, talk. *Having that SU or carer present talking to you when you're having a cup of coffee when you're in the department, ehm, and having a laugh over something, it introduces different conversations, discourses. I find it not so shaming to talk about all of us experiencing mental health problems.* *The whole way it was set around a meal rather than being a, kind of, hospital environment. That kind of thing was really nice and opened up conversations.*	Sharing informal moments		
(They introduced) radical ideas. Radical in that they're, ehm, very different from what goes on currently in our services but you know, is not necessarily good. *Where service users or carers, you know, have been involved (in services), they have come up with ideas that are really, are useful.*	Systemic ideas	Hearing novel contect	

One woman was talking about, you could like have a little stall that you set up in a big shopping centre and people drop in and you're like ok. There are some ideas that are a bit but you know, she was just floating ideas around and saying you can run things in very different ways if you want to.			
I had a great meal with (service users with psychosis), it was really nice and I wouldn't have had that contact with them and heard about their experiences because I haven't in my professional career. *We had someone that came in and spoke about their experience of dissociative identity disorder. And I think I really valued that because it's not something that you come across, it's not something that you come across in any… I'd read about it a bit, but it's not something I'd come across clinically, and it's not, you know, in training it's unlikely that you're gonna come across it.* *I think in training there's the opportunity to hear service users from different areas, different... different areas that I've not worked*	Clinical knowledge/presentations		

in yet.			
And just observing this, sort of, someone laughing when they were nervous and thinking about how other people would respond to them (service user with learning disabilities). I guess I just… just a bit of reflection really. *Whereas, in an academic setting they say: "right, take 15 minutes. Talk to the person next to you….", that space is protected for you to reflect on what you've just seen.* *Yeah, and leaving us space to kind of process a lot of the information, and some of that happened afterwards I think, individually but, yeah, I think it was just about having the time and space to kind of process what is going on in the room.*	In the classroom	Reflection	
But I guess we have to take responsibility for that ourselves, why are we feeling so superior when service users come in and just tell us their stories? I think there is something about training that, ehm, I think we're so anxious as trainees that we want to learn as much as possible, we have that real sense of just give us models, just give us tools, give us anything	Outside the classroom On self		

you can to help us feel more equipped. *And I think as third years, we'd probably come up with more interesting questions whereas in the first year it's a bit overwhelmig.* *It could be a bit of a defence, yeah, everyone who is, you know, not 30 yet and is doing a phD, they've all had perfect childhoods and they're all, you know, yeah it could be defence or way of coping, 'They don't know anything, I know a lot cause I've been through so much and they don't know anything, they can never treat me because I know more than them'. So yeah, it could be all sorts of defences going on there.* *The easiest way to deal with that is to, kind of, you know… kind of, dismiss it a bit and think: "oh, they're just angry…". But I think, at the same time, it's really important. You know, that they felt so strongly and the fact that they're, kind of, repeating what they're saying at every opportunity, suggests that maybe it's not really being addressed either. That it's, kind of, something that's not resolved for them.*	On service users		

But I also wonder if there's something about the need for that separation because, erm… maybe mental health can feel quite threatening, even to mental health professionals. And by creating a kind of 'them and us' divide it protects us from getting too close to the difficulties.	On SU – professional relationships		
I think it was partly also about wanting to have this experience and talk and reflect about it (SUCI) I didn't really get a chance to voice it to the course I suppose. *Ehm, it's actually been a really, really useful process for me to do this interview cause it's helped me to think about it a little bit more clearly.* *Before this (interview), at the beginning, I thought: 'I don't really know what I'm going to say because I can't even remember who's come in and what's happened, because I just haven't thought about it…'* *Having, sort of, talked about it, I do think it's really important and… [pause] and also I… it's made me think - doing this - it's made me think I'm really keen to find out from some of the people I've seen,*	In the research interview		

what they would… what they think about psychology.			

Relational and contextual factors facilitating learning

Supporting Quotes	Initial and Focused Codes	Sub-category	Category
It was really good to hear those things first-hand from her and to have an opportunity to have a more relaxed, non-assessed conversation with her. *(On placement) you feel you're kind of there to help that person and stuff I just think you're more caught up then in what your role is, you know. (With SUCI), that's kind of dedicated time for you to listen to their experiences, there's no expectations of you.* *It frees you up to really process and digest what the person is saying without thinking about how to respond in the here and now.*	Being freed up from clinical roles in a non-assessed space	Perceived safety	**Relational and contextual factors facilitating learning**
(…) they had been able to kind of feel slightly removed, you know, when standing in front many people and being able to talk about their experiences without feeling like, without it being retraumatising in some way. *(it felt safe because) I think, ehm, lot*	SUCs having processed own difficulties		

of the people had obviously come through their experiences even though it was obviously still quite difficult. *She was in a good place. I didn't need to look after her at all which it sounded like other trainees felt like they were having to be really very careful with how this person was managing and didn't feel that safe or open to have more challenging conversations or potentially challenging*			
I think because, the way it was set up was that one of the tutors from the course was actually kind of almost interviewing the service user and ehm, which they'd obviously been prepared for beforehand and I suppose that we were to some extent, it was quite good to say, this is what's going to happen today and to make it clear just so that we were all kind of ready for it. I think it was done in quite a containing way so that it felt safe to then kind of spontaneously speak directly to the person who had discussed their history. *I think it was very much that the service user had control over what it was that they were saying rather than, yeah, cause I think it had been*	Clear boundaries Preparation Clear agreements Preparation		

prepared beforehand.			
They were also able to manage the exposure in a way which was containing so they had their own personal boundaries and they were able to protect themselves. Ehm, so they would go so far but maybe not, so also hold back	Clear internal boundaries		
I think because it was kind of a very discreet piece of work and we had the same goals… it felt very collaborative.	Learning with SUCs towards shared objectives On distinct pieces of work	Clear congruent goals	
So it felt like even though it felt quite hard to hear some of it, it felt like they were able to share some of the things that would be helpful for us to hear.	SUCs having thought about trainees learning goals		
I think what helped was just people, people talking about their experience and what was helpful for them, I guess. So what for them, what qualities, what did they find helpful in therapy. I think that was really, really helped.	Trainees learning aims		
It's just so good to get input on the practice from someone who's gone through the system, I think. And what hasn't been so good.			

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Relational and contextual factors hindering learning

Supporting Quotes	Initial and Focused Codes	Sub-category	Category
They would aks trainees questions. Ehm, and it became very attacking, it became an opportunity for service users to essentially tear apart trainees because they were in a position where they could. (…) it was a total car crash.	Self Feeling abused	Perceived disempowerment	**Relational and contextual factors hindering learning**
It felt like any time anybody ever tried to raise in her sessions these points about 'well, what are the disadvantages' it got really shut down (so) people have either really given up or disengaged from it.	Feeling shut down Disengaging		
She was not someone that would respond to being challenged because she was there to teach us and we weren't there to, you know, to be there and contribute in... in any... in any way, if that makes sense.	Feeling shut down		
I found the scheme really bizarre and I didn't have any choice in it. (…) Not that I would have chosen not to but it annoyed me there was no option.	No choice in participating		

And we were never told or asked our, you know, permission whether or not we wanted to be involved in this person's therapy.			
Ehm, what wasn't helpful was when we had someone come and talk to us about their MS. And, ehm, it wasn't her fault really. It was more, she wasn't integrated into the teaching.	SUCs Lack of integration/equality		
So the psychologist and the client were presenting about it and I felt there was something that I felt a bit uncomfortable with about that. And I wondered if it was something to do with their therapeutic relationship that she... that this service user felt obliged in some way. *But it felt like she (psychologist-lecturer) was bringing her… a piece of her work to show off to us.*	SUCs potentially being co-erced into teaching Objectification		
I felt uncomfortable for the service user because I felt they weren't really understanding… [pause] what was going on. It didn't feel meaningful in that sense…a bit abusive.	Lack of informed consent 'Abusive'		
It wasn't an equal kind of... it was a slot in a teaching session that	lack of equality		

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she had, sort of about, you know, only about sort of 20 minutes or so.			
Ehm, I suppose for me it came from, ehm, within, particularly within an interview setting not knowing the person's history and therefore not knowing whether something I'm saying is something that presses buttons within them, ehm, so yeah, having to really, really think about what I was saying and how I was saying it which isn't a bad thing. But I think it made me in some ways say less because I thought, there's some-, I'm not sure how safe this is.	Unclear boundaries Not knowing what it safe to say Silencing	Perceived lack of safety	
I guess we weren't sure what we could ask and probably people felt like they didn't want to be rude, ehm, you know, to challenge.	Not knowing what is safe to ask Silencing		
So we'd see a service user sort of, you know, go over their own experiences and feel like they were disclosing even more stuff that they haven't necessarily processed in front of (x number of) people. And then you feel in a guilty sort of position sort of watching this happen and not really knowing what to do.	Uncontained raw distress Unsafe disclosures Not knowing how to respond		

It felt uncontained, her boundaries were kind of cut down and it felt retraumatising cause we were all there and watching and something felt very unhealthy about us watching this woman go into something that was very unprocessed and quite , sort of, it felt quite dangerous	Unsafe disclosures 'retraumatising' feeling voyeuristic 'dangerous'		
That sounds awful, you know but everyone would be like, well you'd have six therapists in the room and this one service user who's telling you their distressing story and you immediately fall back into that position	falling back into therapy mode as a result of distress perceived as unsafe		
And the first person who came to my group… [pause] just didn't want to talk and was upset and it just… [pause] they seemed distressed by the situation and by all the attention being on them. So, it was hard to know what to do in that teaching setting.	Unsafe distress Not knowing how to respond		
There was an element (of a SUCI experience) being patronising and positioning me as a trainee as somebody that was quite naïve and unaware of these issues. *I always felt positioned in a certain way and really trapped in it.*	Feeling othered Feeling positioned as naïve	Perceived de-individuation	

it was almost like sometimes we'd be positioned as the people who were the mental health professionals and in some ways representative of maybe their bad experiences	Feeling positioned as 'bad'		
(It really grates) when they point out how much more privileged you are. Because they don't know, they don't know what your background's like, they don't know how much some people may have struggled to get on the course or, you don't know. They just make an assumption.	Feeling positioned as privileged SUCs making unjust assumptions		
there's this sort of language around whether you do or don't have a service user of carer experience and therefore whether or not you can really understand what this is like *she was kind of saying if you haven't come from an ethnic minority background then you couldn't possibly understand* *And if people were to give off the impression that if you haven't directly experienced it then you can't possibly know.*	Not understanding 'what it's like'		
In this particular session it was just like, hang on, some of us would admit have also used	Not having own experiences of distress acknowledged		

Supporting Quotes	Initial and Focused Codes	Sub-category	Category
services so, I think sometimes that needs to be appreciated that there are people who have and are gonna use services.	Having own experiences of using services		
I think sometimes even just a caveat (that trainees might have SU identities themselves) can help to think, right ok, I can be a little bit more open to what's being dicussed today.	Feeling caveats could help to open up discussions		
But I think it's something that certainly if service users are gonna be involved in the teaching that they need to be aware of the different people that are in the room, they might see us as a group of psychologists but actually we all have very different experiences, we are all at very different places within the room at the same time so, yeah.	Identifying need for SUCs to acknowledge difference in the room		

Impact

Supporting Quotes	Initial and Focused Codes	Sub-category	Category
I didn't think it added that much. _There was a learning opportunity that was just lost._ _I don't think I took anything from it._	Not learning	No impact	**Impact**
I think it is a weird irony that in an	Putting up barriers	Re-inforcing us & them boundaries	

attempt to break down these barriers, it actually sometimes puts so many of them up."			
Handled badly, it can be a very adverse experience and, I think, can do the service users harm, both as a reputation - as in how others view them - and for themselves, and I've experienced that first-hand.	SUCI as harming service user reputation		
I think if it's done well it breaks them down. I think if it's done poorly it reinforces them.	Re-inforcing boundaries		
I think it's almost undermined my confidence.	Losing confidence in own abilities	Feeling de-skilled/disempowered	
Well, no one could do anything. I don't think any of you can help the lot of us anyway. It's pointless what you're doing.it really grates and it just feels like, uuuhh, you know, just makes me feel really frustrated.	Not being able to help Feeling frustrated		
Yeah, you wanna be enthusiastic and hopeful, you know, and think that you can at least help most people, that if you haven't helped somebody, that there was something positive that came out of it and, that somebody wouldn't be that resentful.	Wanting to feel able to help service users Feeling threatened by own potential to do harm		

It's not like those sessions (with SUs) have ever made me go (…) 'I hadn't really thought of the human impact of these things' or 'I couldn't have imagined that by myself. Actually, I probably could have done but it still enriched the learning.	Validating human core values	Validating impact	
All the stuff that I know they teach you anyway - but hearing the service user talk about it, I was so aware of the importance of it.	Validating importance of what is learned		
A part of the course philosophy was all about recognising power differences in the therapeutic relationship and reducing them and... So that was inherent in... in the way I work anyway. But I think the service user involvement in the course, you know, in some of the course teaching, I think strengthened that perspective for me, so it kind of added weight to that, to why that's important, I think.	Validating importance of thinking about power dynamics		
I remember sort of, you know, sort of, I remember her name and I've got an awful memory so that's pretty good going.	SUCI sticks Remembering SUCs	Remembering SUCI teaching	

In the sessions where they've been kind of made more real by people talking about their experience first-hand has made teaching richer and sort of stick in my mind much better.	Teaching richer and 'sticks'		
But it kind of, ehm, it was so engaging that I remember if you asked me about other modules that we studied or been taught on, I'd struggle to tell you of what I remember. But there was something very powerful that it sticks.	SUCI engaging and 'sticks'		
Yeah. So it's, kind of, little things that then really stick.	SUCI anecdotes 'stick'		
It was very important for her to hear that people could get better and, and fulfill a dream. It's things like that, you think, ehm, it's with me, I carry it when I am, am talking with people.	Internalising voices Carrying voice inside		
I suppose what I learned is that I carry her voice in my head, well not just hers but other people I've spoken to, ehm, or I listened to, ehm, who've come and spoken to us so, yeah.	Carrying voices inside		
I assessed someone with dissociative identity disorder, erm, the other month, and erm, you	Holding SUC in mind during interaction with clients		

know, it was very much in my mind, erm, the person that came to our teaching was very much in mind.			
And also, it made me feel that, ehm, her presence, there's something about the way that she's so open about her experiences of mental health that it's almost the shame of having a mental health problem yourself, ehm, is lost. And, that's very powerful. There's a culture I think within my year where we can be very open about experiences that you might have had of distress.	SUCI presence as de-shaming mental health problems Introducing culture where mental health problems can be talked about	Breaking down them and us boundaries	
So, ehm, all those cliches are really breaking down of, ehm, othering people, in, ehm, in a meaningful way. I suppose that's my experience.	Breaking down 'othering' discourses		
It sort of brought the humanity of, ehm, mental illness back into the room and the immediacy of that distress which was, ehm, again makes it more engaging (…) and that helps to make it more human somehow rather than something a bit scary that only weirdos get.	SUCI as humanising and normalising experiences of distress		
It just normalised having a learning disability. Just someone, you know, just like you or me, and they	SUCI as normalising learning disabilties		

were talking about their things that they liked and disliked, and challenges that they'd faced.	'like you and me'		
These are just normal people, just like you or me, that psychosis is definitely on a continuum, you know.	normalising psychosis 'like you or me'		
It (SUCI) just made it feel more tangible, it made it feel… it, sort of, gave me hope and it made me think that, actually, I would actively offer to take on the same client with a diagnosis of borderline, rather than shying away like I would have previously	Feeling more hopeful working with particular client groups	Holding more hope	
It made me feel, um, excited about what I could achieve, erm, through changing small things because I thought I can do something… every Tuesday that's really tiny, um, like smile at someone and ask them how they are in the corridor and it might make a difference to them and it might be a good thing.	Feeling more hopeful about making a difference through small changes		
I suppose I've learned about the importance of hope, a lot of it is just really simple stuff, it's not technical.	Being more aware of the importance to embody hope for SUCs		
Ehm, but it (SUCI) has in other respects made me much more mindful of,you know, ehm giving hope.			

(I've learned about the importance of) having a positive view of them, kind of acknowledging their achievements and having, being hopeful about what they might achieve in the future.			
Just kind of being human and seeing them as a whole person so it's not just about their illness but they have other strengths, you know, they are a whole person, they're not just, you know, for example, they're not a schizophrenic but it's a person with schizophrenia.	Awareness Recognising the importance of 'seeing the whole person'	Person-centredness	
You don't lose sight of the client, you know, you're not kind of just reading a text book and following the instructions or whatever.	Seeing the client, not just the problems		
(I learned about) the importance of not just objectifying someone and… and I think it, also, has uh… influenced the way I might read research as well and think about, kind of… *You know, when statistics are quoted at you, they can sound very impressive. But if you try and, sort of, actually boil it down to like the individual and… I think it just keeps… keeps things a bit more human, somehow, for me*	Recognisins the objectification of SUCs in research Reading research more critically bearing in mind it is about humans, not disorders		

it made me really aware of how you, in a way, you're, kind of, really objectifying an individual.			
I think (SUCI) encouraged me to think more about the person as a whole rather than just their symptoms. *I felt that it just reinstated some of the kind of, or reminded me of some of the core values, you know like, eh, I guess like human qualities that are important, ehm, in services.* *I guess, the thing I took away from it was, you can just show kindness to anyone. And, yeah, I definitely took that away, because I think, in psychology, we can be, so much of the time, be thinking about the outcome measures.*	Motivation to action Wanting to think about the whole person Re-instating on human qualitites Wanting to treat SUCs with humanity		
(The SU) said: "I just want someone who'll just take an interest in me and not just my mental health problems…' and, actually, that is something I have taken away with me and I always, with new clients, will always take time to ask about them. And in sessions just try and bring in something I know about them unrelated to the issues.	Action Learning about the whole person, not just their problems		

Kind of reminds you to focus on the other areas of someone's life. Ehm, not just on their illness, but enquire about other things, things that are maybe going well, things that they used to do but they're perhaps not doing anymore *You celebrate the individual, you learn all you can about a person, and the dementia or memory loss is just one small aspect.*			
And I think probably, before the training I have been an assistant and you become arrogant…you try to fit them into boxes or, ehm, you can get influenced by a culture. It (SUCI) has made me much more mindful of (…) thinking about their situation where they might feel pretty powerless. *To remember that it can be quite a scary thing to go and see a mental health professional you're in a vulnerable position because you're not coping with certain aspects of our life or things are not good for you in terms of mental health* *Ehm, but it (SUCI) has in other*	Awareness of disempowerment of distress and disempowering practices Recognising potential for SUCs to feel powerless Recognising potential for SUCs to feel vulnerable when seeking help	Power dynamics	

respects made me much more mindful of my language. *I guess just the importance of erm… [pause] that equality…* *it was like holding the mirror up thinking: 'okay, what are you saying and how are you rating these people…'*	Recognising potential for jargon to be excluding Recognising disempowering practices		
So I think that kind of more organisational, more systemic sort of thinking about how systems can be abusive and how to avoid getting into those sorts of situations, I think that is where service users were really helpful in training. *I learned to open my eyes more to, or realise even more limitations to NHS mental health services.* *It made me question about the way that services are structured and, ehm, that sort of gives you another perspective on the way mental health services are structured and I remember thinking that was quite moving.* *It has been quite useful in a lot of ways about, erm, how it might be good for services to be set up, given their specific experiences.*	Awareness of systemically ingrained power imbalances		

	Awareness of being in a position of power as a psychologist		
you could really understand what the impact of, you know, of... of what we can do as psychologists, can have on a person, both, both in a positive way and, and in a negative way.	Recognising potential do to good and harm		
certainly in terms of kind of the potential to do harm, I don't think that's something that... that we're taught enough about on the course. You know, the research and the evidence-based focus is on what we can do with people, it doesn't really focus on... on actually what doesn't, what isn't helpful for people and what's actually harm- harmful.	Learning about the potential to do harm		
Some things that have been quite powerful for service users who have talked about it. That makes me think: 'wow'. You can't really predict what mechanism of change is going to be, or what you're going to mean to that person.	Being aware of the power of the therapeutic relationship		
	Motivation to action		
Yes, I always want to take myself down a level to make it feel more equal for the client. So…	Wanting to redress power imbalances		

(SUCI reminds you to) and giving people as much choice and control as possible.	Wanting to give choice and control to clients		
It will make me try and foster the same kind of feeling in a, say, a carers group or something. So, to do that, for example, I might give them the agenda, give them the… the role of facilitating. But I might try and do that. Try and spread out the power rather than it being me at the front giving out all these tips and ideas and problem solving, you know.	Spreading the power Taking a non-expert position		
I'm trying to be really, really holding back without, erm, going in assuming that I've just interpreted what they've said and I've got it right.	Action Not making assumptions Not giving primacy to own interpretations		
someone with psychosis was interviewed and he said: "there's nothing worse than people that wear high-heeled shoes and when you're really anxious in the waiting room you hear like this clip-clop, clip-clop of high heeled shoes…' and for him it triggered off so much paranoia. And I always used to wear heels and now I don't wear heels. Because I'm so conscious of the noise and the authority and	Hearing from a service user that the wearing of heels symbolises a power differential No longer wearing heels		

the… divide.			
I certainly look to try and make our sessions and equal and collaborative as they can be.	Working as collaboratively with clients as possible		
I try and keep their views and their wishes as central to the process as much as possible as I can, within the limitations of the system I work with.	Listening and acting on client perspectives within a limited system		
I learned how they like to be treated, and I learned what language they prefer me to use, That makes me more conscientious when I'm seeing people.	Being more conscientious about what language is used		
	Critical awareness	SUCI	
Yeah, I'm sure it is something I think of more. So in way I think that my experiences of SUCI have made me think about these issues more even though some of my experiences were negative. Ehm, I think it's that kind of fear that you could jump on a band wagon with something because it's sounds like that is what everyone should be doing but it's not being thought out very much.	Thinking about SUCI more Being aware of the dange of SUCI 'tick-box' exercises		
"(SUCI teaching) was the beginning of my realisation that	Becoming aware of SUCI and SUCI discourses		

there is this whole world and dialogue about user involvement which I'd been kind of oblivious to before (…) in a fairly naïve way."			
I think, it's, I think for me it's, it's made me think a lot more about how service users can be involved. Ehm, and it's made me think a lot more about the usefulness of it	Thinking more about SUCI and the usefulness of it		
And my current placement has made me think… [pause] service user involvement isn't just a tokenistic thing - which I did previously think.	SUCI during training changing perception and view of SUCI		
	Motivation to action		
In terms of what I might hopefully do in the future I would still like to really involve service users, do joint projects and kind of in terms of evaluating services, I think, ehm, yeah, I think that's something I would still like to do. Ehm, or even if it's like empowering service users to start up something for themselves, then I think that's great.	Wanting to involve SUCs in joint projects Empowering SUCs to start up own intitiative		
I guess it helped me, anyway, think about how - in my future practice - I might involve service users beyond just getting them to tell me their story or getting them to tell a group	Wanting to involve service users meaningfully at all levels		

of people a story, but, being engaged in different levels of management and thinking about setting up services…			
Service user involvement isn't isn't really thought about in any way (in the service I work in). It's something I want to try and sort of broaden where I work in due course. But it still feels quite early days for me in my career to go kind of trying to change the world and all that.	Wanting to develop the SUCI aspect at work		
So, you know we just had one planning group at the moment where I've already raised a few questions about how this could be managed, what's the point of it.	Action Raising questions about implementation and rationaly of SUCI in a planning meeting at work		
(SUCI) gives you more knowledge in your own mind of the different ways people experience certain things. You know, it's like an extra layer of clinical experience so I suppose it maybe moves you on a bit more quickly.	Awareness SUCI as 'extra layer of clinical experience'	Clinical knowledge	
I feel I've got a bit more breadth of knowledge.	Broader clinical knowldege		
There's a lot about meeting people	SUCI as preparing for working with		

who you might meet on a placement or in a clinical setting that is really useful in terms of knowing a bit about what to expect from your work and preparing you for placements. so I think, generally, where I haven't experienced it in my placements or pre training, whatever... then it's particularly useful	particular client groups		
One was, ehm, a neuro-psychology lecture, and I never thought I wanna do neuropsychology and actually that's my ehm, chose route now. *I thought, I really want to work with that client group.*	Motivation Wanting to work with particular client groups following SUCI		
I copied (the SU's) idea to use later in a dementia placement that was I on. *Her descriptions of her experiences helped me identify it that this (DID) was, you know, what the person in front of me was struggling with but it also helped me kind of think about how I could work with this person.* *The psychosis teaching we've had,*	Action Copying clinical approaches introduced by SUCs in lectures Clinical presentations of SUCs in lectures helping to identify particular mental health problems Changing clinical approach as		

I think that's influenced very strongly my, the direction I take with that. I've now kind of considered the importance of thinking about trauma, erm, I think about kind of dealing with, you know, I look towards dealing with the distress about kind of voices rather than necessarily work to change the voices themselves, you know	result of SUCI		

Appendix O: Example quotes from trainees in reflecting on the model

"I think this makes a lot of sense to me. I can very much relate to service user and carer involvement (SUCI) creating stronger memories, I was just thinking back to my experiences of SUCI, and there are some that really stand out and which I remember very vividly. Three were really, really good and one – I am just thinking, well – anway, that one was just so difficult and I remember going away feeling really quite de-skilled, sad and angry actually, so very similar to what you're saying with the model. That one was related how we were given really negative messages, or maybe some really negative messages, yet at the end we all had to go round and say one positive thing each we took away from the session. It just felt so, well, false.
But then the other three I'm thinking of were really, really good, and I like your link with emotions because I do remember that I felt very touched by some of what the service users were saying. And what was really powerful, too, was that they seemed to, ehm, well they were giving a message of hope and they used some humour when they talked about how bad things had been for them. Really inspiring like I said. And I definitely learned lots of stuff from it, generally thinking about power dynamics, so I can understand why that's such a prominent theme. So, ehm, yes, makes a lot of sense, the model does."

"I'm not really very involved with SUCI as you know, but the model, yes it seems really convincing and I think I can relate to it. Particularly the role of reflection and, obviously, ehm, we're on a very reflective course and I think that's so useful sometimes to make sense of experiences that have been difficult. Sometimes I've not been sure what I took away from SUCI but it's a gradual process in a way, ehm, and now looking back, I do think I learned a lot of things, for example what it might be like to be stuck in a mental health system like ours. I think I mainly learned this from placement, long waiting lists etc., but I think SUCI helped."

"I really like the model. It made me think that often you learn about things you didn't realise you learned. For example, I'd not thought about SUCI that much before and wouldn't have been able to tell you what I learned from it, but seeing some of your categories makes me think, yes, I did learn things. Particularly in relation to SUCI actually, so I'm glad that's a theme in itself because I don't think I had a, how shall I put it, ehm, critical awareness of it. I was just pro it but now I think about the how and when etc much more, and that's from SUCI where I got it from."

Appendix P: Research summary for participants and Salomons ethics panel

Research Summary - July 2013

Service user and carer involvement in clinical training and its impact on (trainee) clinical psychologists' learning: A grounded theory investigation

Context

Service user and carer involvement (SUCI) has become a priority in the education of mental health (MH) professionals and will soon be made a requirement for training programmes approved by the Health Professional Council. While emergent evidence suggests that SUCI can impact positively on MH students' learning, learning mechanisms are poorly understood and research is limited, particularly in relation to the education of psychologists.

The present grounded theory study sought to investigate what and how (trainee) clinical psychologists ([T]CPs) learn from SUCI in their training.

Methodology

Overall, 12 (T)CPs (qualifieds: n=5, trainees: n=7) from six different courses participated. Sampling aimed to recruit (T)CPs with a range of SUCI experiences; all had experienced service user (SU) involvement, five had experienced carer (C) involvement. Data were gathered using semi-structured interviews

Findings

A preliminary model of learning was generated, grounded in participants' account of their learning from SUCI (see Figure 1 below).

Figure 1. Theoretical model of (T)CPs' learning from SUCI
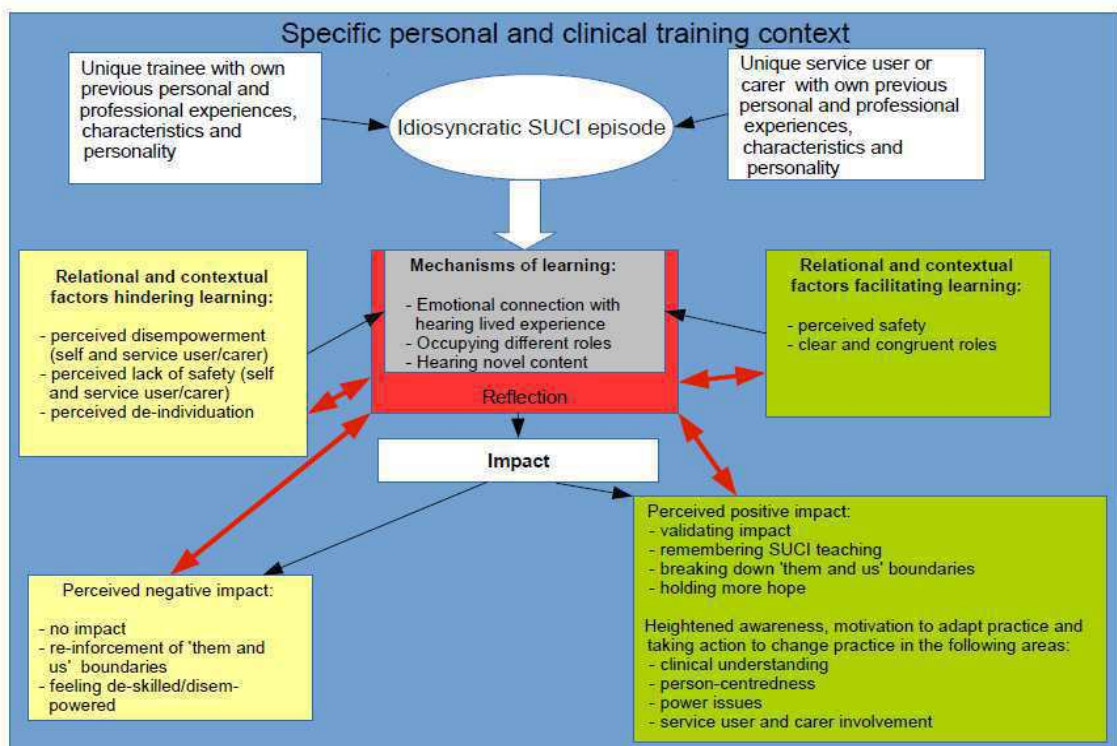
The following categories and sub-categories emerged:

1. Mechanisms of learning

a) Emotional connection with hearing lived experience

Hearing the lived experience of SU&Cs could bring the academic teaching 'alive', eliciting emotional reactions in participants. Learning was enhanced when SU&Cs were able to reflect on their experiences, linking it to academic concepts.

b) Occupying different roles

Participants reported experiencing power dynamics with SU&Cs that were different to traditional clinical settings, with SU&Cs being either in equal or more powerful positions. Learning further seemed to occur through seeing SU&Cs outside their 'sick role' as capable trainers and modelling the successful integration of the dual identities of 'professional' and 'SU&C'.

c) Hearing novel content

Participants reported that SU&Cs often came up with novel ideas relating to service provision and use of therapy space. SUCI further provided an opportunity to learn about MH difficulties (T)CPs had not encountered through their work.

d) Reflection

Participants appeared to make use of reflection both in SUCI episodes (reflection in-action) and post-SUCI episodes (reflection on-action). Some explicitly valued the research interview as a discursive site of reflection. (T)CPs often drew on psychological understandings to make sense of their own and SU&Cs behaviours, thoughts and feelings, and could learn from SUCI episodes experienced as negative.

2. Relational and contextual factors facilitating learning

a) Perceived safety

Feeling safe enhanced learning. This appeared to relate to (T)CPs being freed up from clinical roles, not being assessed in SUCI episodes, an absence of 'live' distress in SU&Cs, SU&Cs being prepared and the presence of clear boundaries.

b) Clear, congruent goals

Learning was enhanced when (T)CPs and SU&Cs were working towards shared objectives, which seemed linked to SU&Cs sharing with (T)CPs what had helped and/or hindered their recovery.

3. Relational and contextual factors hindering learning

a) Perceived disempowerment

(T)CPs learning from SUCI appeared hindered if they either perceived SU&Cs to be disempowered (e.g. tick-box SUCI) or if (T)CPs felt disempowered themselves (e.g. not being given a choice regarding their participation in particular SUCI episodes).

b) Perceived lack of safety

Learning seemed curtailed when (T)CPs felt unsafe (e.g, unsure which questions they could ask) or worried about the safety of SU&Cs (e.g. SU&Cs being visibly distressed).

c) Perceived de-individuation

Some (T)CPs appeared to disengage from SUCI episodes where they felt labelled and positioned as 'harmful professionals'. A lack of acknowledgment that some (T)CPs might have own experiences of service use/caring/distress was equally regarded as unhelpful.

4. Impact

The impact of SUCI was dependent on the particular SUCI experiences participants had experienced.

SUCI that was experienced as negative could:

a) have no impact (particularly when SUCI was experienced as tokenistic)
b) Reinforce them-and-us boundaries (particularly when (T)CPs felt de-individuated or disempowered)
c) leave (T)CPS feeling de-skilled (particularly when(T)CPs received messages they could not understand or help SU&Cs)

SUCI that was experienced as positive could:
a) validate (T)CPs' humanistic beliefs or psychological approaches
b) create lasting memories linked to the emotional connections to content
c) Break down 'them-and-us' boundaries by normalising MH difficulties
d) Provide (T)CPs with hope regarding recovery potential

Further, SUCI appeared to impact (T)CPs' awareness, motivation and practice in four key areas.

Area	Awareness	Motivation	Practice
Clinical understanding	Enhanced competency in recognising and supporting individuals with particular MH problems	Desire to work with particular client groups	Using clinical tools/approaches presented by SU&Cs; recognising specific MH problems
Person-centredness	Seeing the whole person and support network	Desire to ask about the whole person; involve carers; make use of peer support	Asking about the whole person; involving carers; encouraging peer support
Power issues	Heightened awareness of power imbalances in services and therapy	Desire to work more collaboratively	Working more collaboratively
SUCI	Heightened awareness of SUCI and potential pitfalls	Desire to involve SU&Cs in services in helpful and meaningful ways	Involving SU&Cs

Clinical implications
It was recommended that educators (including SU&Cs and non-SU&Cs) in clinical psychology training programmes should:
- continue involving SU&Cs
- gain clarity regarding rationales and objectives for SUCI
- negotiate learning aims jointly with SU&Cs and (T)CPs
- prepare for and run sessions in equal partnership or led by SU&Cs
- provide clear boundaries
- acknowledge that both SU&Cs and (T)CPs may have professional and SU&C identities and encourage exploration of how this may impact learning episodes
- protect space for honest reflections on how SUCI episodes are experienced
- provide constructive input when negative experiences of professionals/services are discussed

Appendix Q: Publication guidelines of journal chosen for publication
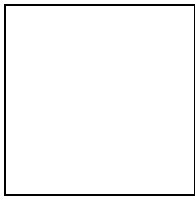
Psychology Learning & Teaching

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