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Structured Abstract:

Purpose: This study sought to build a theoretical model of how and what clinical psychologists learn from service user and carer involvement in their training.

Design/methodology/approach: A qualitative research design was adopted, and verbatim transcripts of semi-structured interviews conducted with 12 clinical psychologists were analysed using grounded theory methodology.

Findings: Findings indicated that 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'.

Research limitations/implications: Further research is required to establish to what extent the current findings may be transferrable to learning from service user and carer involvement in the context of educating professionals from other disciplines. Additionally, participants had limited experiences of carer involvement, and more research in this area specifically would be useful.

Practical implications: This study advocates for service user and carer involvement in clinical psychology training, and specific recommendations are discussed, including service user perspectives.

Originality/value: Service user and carer involvement has become mandatory in HCPC-approved training programmes for mental health professionals, yet if and how learning occurs is poorly understood in this context. This study makes an important contribution in evaluating outcomes of service user and carer involvement in clinical psychology training by advancing theoretical understanding of the learning processes involved. The authors are unaware of similar work.

Keywords: service user involvement, carer involvement, patient involvement, education, training, mental health, clinical psychology.

Article Classification: Research Paper

For internal production use only

Running Heads:

Learning from Service User and Carer Involvement in Clinical Psychology

Training

Introduction

The current context

In the United Kingdom (UK), service user and carer involvement (henceforth referred to as *involvement* for brevity) has become a priority in the education of mental health professionals (Department of Health [DoH], 2005, 2007, 2009, 2010; Involve, 2004, 2007) and has been made a requirement for training programmes approved by the Health Care Professional Council (HCPC, 2013). As a result, *involvement* has been developed and expanded across mental health training programmes in the UK, including at the university where the first author trained, and where the second author and third author are employed as lecturers. As both organisers and recipients of *involvement* in teaching, the authors were interested in how *involvement* could be implemented in meaningful and successful ways. A central consideration in this context is whether *involvement* is intrinsically worthwhile or if there should be clear measurable changes as a result (see Doel, 2007). There is no clear-cut answer to this question, and *involvement* in mental health education has been both linked with ethics-based and evidence-based rationales which in turn have produced two different types of research, namely that focused on process and that focused on outcomes (Cowden & Singh, 2007).

Empirical support

The vast majority of research on *involvement* in mental health education has been process- rather than outcome-focussed (Minogue *et al.*, 2009). While process studies suggest that service users and carers are increasingly involved in mental health education, the nature and impact of this involvement is often not evaluated, although emerging evidence indicates that students rate *involvement* highly and feel they benefit from it (e.g. Ikkos, 2005; Rush & Barker, 2006; Tickle & Davison, 2008).

Interestingly, studies that have gone beyond researching students' perception, examining the impact of *involvement* on knowledge, skills or practice are scant. While it is possible that this may point to researchers largely adopting ethics- rather than evidence-based rationales for *involvement*, it is intriguing that these rationales are hardly discussed explicitly. Rather, benefits of *involvement* tend to be assumed, and the authors were only able to identify ten papers that examined impact of *involvement* in mental health education on students' learning:

One quantitative study (Cook *et al.,* 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.

Four mixed-measures local evaluations of *involvement* have been conducted. They found that students taught by service users and/or carers were more likely to employ a user-centred approach, less likely to use jargon, felt more competent in therapeutic skills, and had perceived increased confidence in engaging with service users and carers (see Barnes et al., 2006; Khoo et al., 2004; McCusker et al., 2012; Wood and Wilson-Barnett, 1999).

Five studies explored the learning experiences of students in the context of *involvement* in mental health education qualitatively (Benbow *et al.,* 2011; Happell and Roper, 2003; O'Reilly *et al.,* 2012; Rush, 2008; Tew *et al.,* 2012). With regard to

changes in attitudes and practice, students reported that *involvement* made them see the person instead of the problem, broke down 'them-and-us' barriers, and helped understand service users and carer perspectives. Some studies found that a minority of students reported no impact of *involvement* (Happell and Roper, 2003; O'Reilly *et al.,* 2012; Tew *et al.,* 2012).

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

All studies reviewed here constituted local evaluations at one educational site only.

Theoretical considerations

The dearth of research into the processes of how students may learn from *involvement* speaks to the poor theorisation of *involvement* in mental health training, which some academics see linked to its politically driven ad-hoc implementation (Minogue *et al.,* 2009; Spencer *et al.,* 2011). However, two distinct ideas about how students may learn from *involvement* seem to exist in the literature, one relating to content, the other to process. The former implies that students learn through the acquisition of knowledge on a conscious level. The latter assumes that the process of learning *with* and *from* rather than *about* service users and carers is central to the formation of new ways of thinking and being, thus conceptualising learning to primarily result from implicit processes.

Theories pertaining to stigma (Allport, 1954; Link and Phelan, 2001) may be of relevance here which similarly argue that increased contact in the context of equal status may reduce cognitive separations of 'us' (in this case: mental health

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professionals) from 'them' (in this case: service users and carers), promoting more inclusive practices in mental health students. It should be noted, however, that few stigma theories have been validated within a mental health context (Link *et al.,* 2004).

In contrast, recent learning theories have emphasised that the lines between the subject ('us') and object ('them') of learning are blurred anyway, indicating that mental health students, service users and carers come to the process with their own motivations and life experiences, which will impinge on their learning. Generally speaking, learning has been increasingly conceptualised as socially situated (e.g. Bandura, 1977; Lave and Wenger, 1991), with reflection being key to learning from experiences (Kolb, 1984), including emotional ones (Mezirow, 2000). The empathy literature has further highlighted that viewing somebody else's emotional state may lead to the unconscious activation of personally relevant associations ('state matching'; de Waal, 2008), which may in turn lead to the forming of implicit memories, contributing to the development of new attitudes and habits (Dirkx, 2006).

Rationale

While some studies suggest that *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 *involvement* has become a priority in the education of mental health professionals and is now 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 *involvement* seems warranted, particularly in the context of clinical psychology training where research seems

particularly sparse (see Townend *et al.,* 2008; Vandrevala *et al.,* 2007), and where *involvement* has developed considerably in recent years.

A grounded theory approach was used to try and build a model of the mechanisms and outcomes of learning from *involvement* in clinical psychology training, through conducting either face-to-face or video link facilitated interviews with clinical psychologists (henceforth psychologists for brevity) who were either in their last year of training, or recently qualified (< 3 years). The primary research questions were:

1. How do psychologists learn from *involvement* in their training?
2. What do psychologists learn from *involvement* in their training?

Method

Data collection

The study adopted a grounded theory design within a critical realist framework (Willig, 2001). Theoretical sampling was employed and overall, 12 psychologists (qualified within last three years: n=5, third-year trainees: n=7) from six different courses were recruited for the study. While all had experienced service user involvement to various extents, only five had experienced carer involvement.

A semi-structured interview schedule was used in the interviews which were carried out over 11 months, and lasted between 25 – 65 minutes.

Data analysis

Data analysis drew on methods outlined by Charmaz (2006), Glaser (1992) and Strauss and Corbin (1998). Verbatim transcripts were coded line-by-line to

develop codes that described the main activities in the texts. 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 were developed and their relationships to each other were explored. Memo-writing was used throughout this process to inform theory development.

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, and thus might share assumptions with participants. Therefore, a reflective interview was conducted and a reflective diary was kept.

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 trainee psychologists for reasons of data triangulation and appeared to be a good fit in describing their learning from *involvement*.

Findings

Figure 1 summarises the model of learning from *involvement* during clinical training derived from the grounded theory analysis of participants' responses. The model aims to elucidate the relationship between *involvement* in clinical psychology training and the impact this has on psychologists' learning, taking into account

mediating factors that either facilitate or hinder learning. The model and examples of each category are presented below.

(Insert figure 1 here)

Mechanisms of learning

This category relates to the mechanisms through which participants appeared to learn from *involvement*.

Emotional connection with hearing lived experience

Participants commonly described their experiences of academic and clinical learning as split and that *involvement* could help move academic learning into a real-life domain. Hearing the lived experience of 'real' people in an academic setting elicited emotional reactions in participants through which they learned by being able to empathise, relate, or identify with service users and carers:

> *...there's something about being able to bring these experiences to life and actually it helps to bridge the gap. (Research Participant [RP] _3)*

Occupying different roles

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, power dynamics and identities as more fluid.

Seeing him (service user) being very, very capable...reminded us that it could be any of us... (RP_5)

Hearing novel content

Participants identified that service users and carers often introduced them to innovative concepts, e.g. relating to service provision or models of distress:

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)

Reflection

This mechanism was not always explicitly labelled by participants although some explicitly highlighted the importance of room being given to reflective process during teaching.

Participants continued to reflect on *involvement* experiences outside the classroom and learned through critically examining their own as well as service users' and carers' emotions, roles, values, positions and defences in the learning process:

...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)

Relational and contextual factors facilitating learning

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

Perceived safety

An important aspect that appeared to mediate learning from *involvement* was how safe participants perceived learning episodes to be both for themselves and service users and carers. Being taught by service users and carers who had largely processed their own emotional difficulties, the presence of clearly communicated boundaries and the non-assessed nature of contact emerged as important in this respect:

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

Clear congruent goals

A certain level of goal congruency was identified as important to ensure psychologists, service users and carers were working jointly towards shared objectives. Most participants identified that they wanted to understand what had helped and hindered service users' recovery, so that this could inform their own practice, an objective they felt was shared with service users and carers:

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

Relational and contextual factors hindering learning

This category related to the factors identified as hindering learning from *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.

Perceived disempowerment

This sub-category reflected participant accounts that learning was curtailed when either they themselves felt disempowered by *involvement* or they experienced service users and carers as disempowered.

Many participants reported having experienced 'tick-box' *involvement*, which unhelpfully perpetuated traditional power dynamics. Further, clinical training was often described as a time characterised by anxiety, self-doubt and unequal power relations, thus *involvement* experiences that enhanced those feelings were perceived as unhelpful:

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

Perceived lack of safety

Participants repeatedly reported that they could not fully engage with *involvement* episodes that felt unsafe which was often perceived to be the case when mental distress was current and raw:

> *For me it came from not knowing whether something I'm saying...presses buttons within them. (RP_3)*

<u>Perceived de-individuation</u>

Some participants recounted experiences of feeling 'othered', labelled as harmful professionals, which led them to disengage from *involvement* episodes. Furthermore, a few participants talked about own experiences of mental distress or caring for others, and how it was experienced as counter-productive and de-individuating when these were not acknowledged:

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)

Impact

Involvement impacted on participants in a number of ways and appeared to be linked to their qualitative experiences of *involvement*.

When *involvement* was experienced as negative, participants reported it impacted on them in the following ways:

<u>No Impact</u>

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

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

<u>Reinforcement of them-and-us boundaries</u>

A few participants reported that *involvement* where they had felt othered or disempowered had inadvertently reinforced 'them-and-us' boundaries:

Why I was so angry with those experiences was that I felt they set me apart from them. (RP_5)

<u>Feeling de-skilled</u>

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 *involvement* was experienced as helpful, participants reported the following impacts:

<u>Validating impact</u>

Many participants reported *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)

<u>Memory</u>

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

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

<u>Breaking down 'them-and-us' boundaries</u>

For some participants, particularly those without own experiences of mental health difficulties, *involvement* appeared to be very effective in normalising and humanising experiences of mental distress across the range:

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)

<u>Hope</u>

Seeing service users and carers who recovered or were able to manage their difficulties gave some participants hope with regard to therapy outcomes and validated their career choice.

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

<u>Direct impact on applied practice</u>

Further, *involvement* appeared to impact trainees' awareness, motivation and practice in four key areas; clinical understanding; person-centredness; power dynamics; and *involvement*.

Table 1. Impact of *involvement* on applied practice as identified by participants in four domains

Domain	Awareness	Motivation	Practice
Clinical Understanding: Some participants described that *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.	*Involvement* enhanced participants' perceived competency in recognising and supporting individuals with those problems.	*Involvement* motivated participants to work with particular client groups	*Involvement* impacted on participants' 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.
Person-centredness Having been taught by service users and carers with their own individual experiences of mental distress and strengths had helped some participants to see service users and carers as 'whole' people.	*Involvement* helped raise awareness of the reductionist, problem-focused nature of research and some clinical approaches, which subsume groups of individuals under one umbrella of a specific disorder. It also appeared to have enhanced participants' capacity to recognise that mental health problems were only *one* aspect of any service user's life.	*Involvement* reminded and motivated participants to not lose sight of some of the more human qualities in their work:	*Involvement* impacted on participants' practice in thinking about and working with their clients in more holistic terms:
Power dynamics: *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	Participants reported being more mindful of power dynamics, for example in relation to: • the unequal distribution of power within services	*Involvement* motivated participants to: • be more collaborative when working with service users and carers • involve service users	Participants reported numerous ways how their critical engagement with power issues had impacted their practice. Examples included: • listening to service users and carers and

services, and participants' reflections on their own feelings of disempowerment in the context *involvement*.	• the inherent power imbalances involved in 'doing therapy' • the power of the medical discourse and labelling • the power and exclusion involved in using medical/psychological jargon • the importance of being collaborative in therapy	and carers in decision-making • 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	not giving primacy to own understandings • 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
Involvement: *Involvement* appeared to also impact participants' understanding of *involvement* itself. Again, this appeared to be an area where participants were also able to draw on both positive and negative experiences.	*Involvement* appeared to raise awareness regarding: • the existence *involvement* and its differential implementation • the importance to think about rationales and objectives for *involvement* • what *involvement* has to offer	*Involvement* motivated a few participants to: • wanting to involve service users and carers themselves in their service settings (post-qualification) • seek out *involvement* opportunities on placement • support *involvement* initiatives	One participant felt her previous experience of *involvement* influenced the way she negotiated *involvement* at work.

Discussion

The present study investigated what and how psychologists learn from *involvement* in their training, and found that they appeared to learn in a number of ways. In line with previous research, hearing the lived experience of service users and carers emerged as crucial (Rush, 2008), often creating powerful emotions in learners. It could be hypothesised that hearing from service users and carers about experiences of distress resonated with 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 enhanced empathetic understandings of service user and carer experiences as supported by previous research (Tew *et al.,* 2012; Wood and Wilson-Barnett, 1999). Consistent with extant research, *involvement* appeared to help learners adopt person-centred approaches, taking into account the whole person, not just their problems (O'Reilly *et al.,* 2012; Happell and Roper, 2003; Wood and Wilson-Barnett, 1999). The emotional resonance further seemed to create lasting memories of *involvement* experiences, a finding compatible with implicit learning theories (Dirkx, 2006).

Stigmatising discourses surrounding mental health problems were reflected in some participants' pre-teaching assumptions regarding service users' 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 some learning theories 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. 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, psychologists' own reactions to this, and developing competencies to help others in distress. Other studies have similarly found that *involvement* can help students feel more equipped and knowledgeable (Barnes *et al.,* 2006; Happell and Roper, 2004).

It further seemed that the absence of 'live' distress along with clear boundaries and service user trainers being prepared for teaching made participants feel safer. Visibly distressing disclosures seemed to be conceptualised as dangerous, creating anxiety which hindered learning.

Negotiations of power appeared dominant in participants' experiences of *involvement*. Working with service users and carers as equals or superiors may have given rise to experiences that caused enhanced attunement with them regarding their traditionally disempowered roles (see Barnes *et al.,* 2006; Rush, 2008). Importantly, this experiential understanding appeared to motivate psychologists to address power imbalances in services and their own practice.

In line with Allport's (1954) contact hypothesis, it seemed of importance that *involvement* was grounded in the pursuit of common aims. Participants appeared keen to learn from service users and carers about 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, disempowerment of service users and carers in educational episodes appeared to negate learning, instead reinforcing dominant socially mediated power dynamics. Particularly if *involvement* was perceived as a 'tick-box' exercise, psychologists seemed less able to learn from it. Khoo *et al.* (2004) and Happell and

Roper (2003) have similarly found that some students did not learn from some *involvement* experiences.

Further, feeling disempowered appeared to hinder learning. Experiences of service users or carers attacking psychologists or positioning them as harmful professionals left some participants feeling labelled, persecuted, 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 and the seeming introjection (Freud, 1936) of those feelings by psychologists may also be linked to their particular training stage; participants often felt disempowered in the face of constant clinical and academic assessment, which may make practitioners in training particularly vulnerable in relation to their perceived status and competencies. As a result, some participants seemed to resort to defensive splitting (Freud, 1936) which led to reinforcement of 'them-and-us' boundaries. Iatrogenic effects of *involvement* such as this one have not been reported in previous research.

However, reflection on those experiences appeared to enable psychologists to learn about power and *involvement*. In accordance with many learning models, the critical reflection of their experiences seemed key to learning and sense-making (Kolb, 1984; Mezirow, 2000). Learning from *involvement* about *involvement* appeared to be an on-going developmental process whereby most participants had reached a depressive position (Klein, 1940) at research interview stage, neither conceptualising *involvement* as all-good nor all-bad, facilitated by having experienced *involvement* in different contexts. No previous research has indicated this type of learning to date.

Implications for practice

Recommendations for training providers

Based on the present findings, there are several aspects educators[1] in clinical psychology training programmes, and similar programmes, may wish to consider in the planning of *involvement* to optimise learning, although given the exploratory nature of this study, the following recommendations are tentative.

Firstly, participants appeared to learn from *involvement* in a number of ways, indicating a need for it to be an integral part of mental health training programmes. Educators should gain some clarity regarding their rationales for *involvement*, in particular whether *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 mental health education 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.

Whatever rationales educators develop, findings of this study indicate that learning goals should be clearly formulated and, ideally, negotiated with learners, as working jointly towards agreed goals appeared to facilitate learning. While participants seemed open to learning from service users and carers' helpful and

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[1]   Educators in this context refers to any individuals involved in planning, implementing, delivering and evaluating learning episodes for student practitioners, including service users and carers.

unhelpful experiences of services, it may be important for educators to ensure constructive input is given if practitioners feeling de-skilled is to be avoided.

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

Comment by Laura Lea – Service User Educator

Both the literature and research demonstrate that there is richness in the learning that comes from *involvement* in the education of mental health professionals. The learning is different to the learning from other professionals, and brings with it complexity if not the possibility of discord. As is demonstrated in the findings, learning from *involvement* can sometimes be experienced as disempowering and deskilling. This leaves those of us involved in facilitating *involvement* in education with some challenges. The new HCPC standard has served to concentrate minds, and as a training community we need to address some as yet

unanswered questions, particularly in relation to what we are expecting *involvement* to achieve. Perhaps the complexity and dissatisfaction that sometimes occurs is inevitable given the complex power issues that are played out as service users, often without academic qualifications, come into historic institutions. How can we best enable the genuine service user voice to be heard, when there is a shift towards professionalisation of *involvement*? How can courses adjust tight academic timetables to enable transformational learning from *involvement* of the sort which increases compassionate care?

Clear and congruent goals in relation to training are necessary. However it has been our experience that while the need for students to learn is an identified shared goal, service user trainers and professional trainers are often offering very different perspectives. This can lead to a confusing and emotional learning experience for the student. This can be further exacerbated when the service user experience being brought is negative, sometimes leaving the student to feel that they are on the wrong side of an us-and-them divide. Making these differences explicit and inviting students to reflect on them enables resolution of this challenge. Indeed by identifying difference, complexity and even possibly hostility, the genuine voices of the service user or carer, the professional and the student may be enabled. Reflective space is necessary so students do not get stuck in simplistic understandings of the power relationships which exist in relation to professionals and service users and their families.

Much work will no doubt take place in relation to the guidance for the new HCPC standard. Service users say 'nothing about us without us'. Yet so much of mental health professional training takes place in the absence of the service user voice. Herein lies perhaps a final challenge for *involvement*: what place might the experiences of students with a service user or carer background have in relation to

the training cohort and in what way may they be brought into the learning experience? This is rarely considered a problem or opportunity, perhaps because it gets to the heart of an old dynamic about expert professionals. However, in the face of a recognition of the expertise won through life experience, students and professionals are beginning to raise the need for recognition of their own service user experience. In the coming years we can look forward to more research which will guide and enhance the effectiveness of *involvement* in the training and education of mental health professionals.

Future research directions

As this study represents the first of its kind, replication may be helpful. It may further be of interest whether professionals from other disciplines learn from *involvement* in similar or different ways.

While it is encouraging that *involvement* seemed to impact on practitioners' attitudes, beliefs and practice, it is unclear how lasting these effects may be or how they may prime continuing professional development. Hence, research involving practitioners who have been qualified for some time may be helpful.

Also, some participants' responses indicated that being in professional training may be a particularly anxiety-filled time. Some research into how qualified practitioners learn from *involvement* at their work place may be fruitful in shedding light onto whether there is developmental component to learning in this context. Further, participants had limited experiences of carer *involvement*, and more research in this area specifically would be useful.

Methodological limitations

Although steps were taken to ensure psychologists with different beliefs and experiences of *involvement* were included in the study, it is possible that those who participated may not be representative of the wider psychology 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.

Conclusion

This study aimed to explore psychologists' learning from *involvement* in their training. The findings indicated that *involvement* created lasting memories, normalised experience of distress, gave hope and educated participants in relation to power dynamics, clinical understandings, personalised approaches and *involvement* itself. Some factors seemed to facilitate *involvement* while others seemed to hinder it. The use of critical reflection on emotional experience and power relations emerged as a key component for learning, and psychologists appeared to draw on their own prior life experiences in their integration of knowledge and understandings gleaned from *involvement*, highlighting the importance of situating learning from *involvement* in context. While some methodological shortcomings were identified, the preliminary grounded theory model of learning from *involvement* in the context of mental health education represents a first, and as such valuable step, in advancing the theoretical understandings in this field.

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