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Service user and carer representatives' experiences of the personal effects of involvement in clinical psychology training

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Abstract

Purpose: Extant literature exploring service user (SU) involvement in clinical psychology training has been limited by its sampling from singular training programmes and its restricted application of psychological theory. This research seeks to counter limitations by exploring SUs' experiences across multiple clinical psychology training programmes in the UK and by deductively applying psychological theory relating to power, recovery, identity, and group development.

Design/methodology/approach: Semi-structured interviews were conducted with fourteen participants. A deductive thematic analysis was used to analyse qualitative data.

Findings: Five main themes were identified: Environment determines sense of safety; Meeting challenges; Sense of purpose, Worth and value; The person you see now is not the person I was; and Wanting to break the glass ceiling.

Research limitations: Carers are under-represented and the sample does not contain SUs who were no longer involved in training.

Practical implications: It is important that the environment fosters psychological safety for SUs, via positive and supportive relationships with trainees and staff, with SUs being treated as equals and financially reimbursed as such. SUs and professionals need to explore managing and sharing power to enable SUs to feel valued and to reap benefits from involvement, including developing a positive sense of identity.

Originality: The research is part of the early literature exploring SUs' experiences of involvement in clinical psychology training and is the first to explore the personal effects of involvement across multiple programmes.

Keywords: Service user, Involvement, Clinical psychology training, Experiences, Identity, Power.

Introduction

Service user involvement

Service user involvement (SUI) is ~~common-place~~commonplace in mental health services and in the training and education of healthcare professionals in the UK and abroad at the micro (own care); meso (health service); macro (health policy); and meta (education) level (Tambuyzer *et al.,* 2011). The Ladder of Involvement was proposed by Tew *et al.* (2004), suggesting five stages to involvement; ranging from level one: no involvement, to level five: partnership. However, whilst this model can be applied well when considering power, it might fail to recognise the complex, dynamic and evolving nature of involvement (Tritter and McCallum, 2006).

Involvement in professional training programmes

The level of involvement in the training of healthcare professionals varies, with some training programmes offering SUs academic positions whilst others have more limited involvement such as involvement in teaching discussions or providing feedback (Happell *et al.*, 2014). There is general agreement that involving SUs/carers in the training of healthcare professionals is beneficial for trainees. For many years much of the literature focussed on how involvement impacted on trainees' learning and future practice. For example, although not a causal relationship, McCusker *et al.* (2012) found that teaching provided by SUs/carers was associated with trainee mental health social workers having increased confidence in interacting with SUs. Additionally, Blackhall *et al.* (2012) suggest that SUI meant that trainee nurses' preconceptions were challenged, and they developed more positive attitudes and increased empathy towards those with mental health difficulties. Other found benefits for~~to~~ trainees include improved communication skills (Repper and Breeze, 2007), development of their learning (Clarke and Holttum, 2013), and the provision of a different perspective (Harper *et al.*, 2003). SU/carer involvement in education of healthcare professionals is therefore highly advocated due to the benefits it can bring to trainees in various professions. However, there is a lack of research exploring the effects that involvement can have on those involved.

Involvement in clinical psychology training

The UK Health and Care Professions Council (HCPC) includes service user (SU) and carer involvement as part of its education standards (HCPC, 2017) formalising the requirement of their inclusion in the training of the professionals they regulate, including clinical psychologists. Additionally, the British Psychological Society's (BPS) accreditation criteria for clinical psychology doctorate training programmes states "service users and carers should inform and participate in the delivery of the curriculum" via involvement in research, academic and clinical activities (BPS, 2019, p.25). A survey across UK clinical psychology doctorate training programmes showed that participating service users and carers were involved most in the selection of trainees into the programme. Across the sample, equal numbers reported being involved in attending teaching and / or contributing a little and in co-delivering teaching with course staff. There was 'a little' involvement in contributing to planning teaching sessions, delivering teaching without course staff, helping to decide the goals of training, helping to develop the syllabus, and attending training programme committees. There was a little involvement in helping to select course staff, trainee placement activity, collaborating as equal partners on projects, and evaluating trainee work (Briggs *et al*., 2017).

The accreditation criteria ~~encourages~~encourage involvement for the benefit of trainees rather than SUs involved. Although trainee clinical psychologists may of course have lived experience as service users and carers that may be shared during training activities, the accreditation criteria discuss involvement in relation to individuals who are not trainees being involved in the delivery of training for the benefit of trainees. Such individuals are the focus of the present paper, rather than trainees with lived experience.

Research predominantly focusses on trainees' experience of SUI and the implications for their learning and attitudes (Harper *et al.,* 2003; Schreur *et al.,* 2015; Tickle and Davison, 2008). Evidence is limited on the potential costs/benefits for involved SUs to support them to make an informed choice about their involvement or to inform programmes. Evidence exists suggesting involvement activity falls short of aspirations (Briggs *et al.,* 2017). Whilst providing education and training is a professional role, when this is being delivered based on personal experiences as a SU, its effects, both costs and benefits, are likely to be personal too.

Challenges include finding the educational setting daunting (Holttum *et al.,* 2011), power struggles between SUs and academics (Lea *et al.,* 2019) and feeling powerless and thus invalidated due to restricted access to students and limited decision-making capacity (Campbell and Wilson, 2017). Reported benefits include feeling valued and heard (Lea *et al.,* 2019), increased confidence and assertiveness (Holttum *et al.,* 2011); developing a powerful sense of self by positively shaping future psychologists and making a difference to mental health services and therefore other SUs (Campbell and Wilson, 2017).

Psychological theory related to SUI

Psychological theories have not been considered in detail when exploring SU experience of involvement in clinical psychology training. Considering the history of profound power inequalities between SUs and mental health professionals (Felton and Stickley, 2004) and with empowerment and recovery being highlighted as key outcomes of SU involvement (Tambuyzer *et al.,* 2011), it would seem prudent to consider theories of power and recovery and how these relate to the involvement experience.

Lukes' (1974) dimensions of power could be applied to understand the personal effects of involvement in clinical psychology training, as it is likely that SUs will be party to decisions about the amount and type of involvement and aspects of the curriculum. Relevant aspects of Luke's theory include decision-making power (ability to modify the behaviour of others) and non-decision-making power (consciously or unconsciously shaping an agenda which limits decision-making). Furthermore, French and Raven's "bases of social power'' (1959) appears relevant, in particular 'expert power' – perceiving that another person (either the SU or professional) has special knowledge or expertise. In addition, a consideration of 'informational power' (Raven, 1965); the idea that a person of power is in a position to share, withhold, distort, manipulate or conceal information.

Personal recovery is subjective and thus there is no universal definition, but commonalities include re-engagement with life, improved coping and a restoration of sense of self and purpose in life (O'Connor and Delaney, 2007), arguably factors which involvement work could facilitate. An empirically based conceptual framework of personal recovery in mental health, the CHIME framework (Leamy *et al.,* 2011),

consists of connectedness; hope and optimism about the future; identity; meaning in life, and empowerment.

It also makes sense to explore how involvement might impact on one's sense of identity. Identity has been defined as "the set of meanings that define who one is when one is an occupant of a particular role in society, a member of a particular group, or claims particular characteristics that identify him or her as a unique person." (Burke and Stets, 2009, p.3). Having a positive sense of social identity (a sense of meaning, purpose and belonging) is linked with positive psychological consequences (Haslam *et al.,* 2009).

Involvement entails "in groups" and "out groups" in terms of SUs, staff and trainees with social identity theory (Tajfel and Turner, 1979) proclaiming similarities to the in group and differences to the out group are exaggerated to enhance identity. SUI can influence identity due to changes in group identification (Tse *et al.,* 2012). However, challenges to developing a positive identity in SUI include how professionals perceive SUs' mental health, their shift in role and how SUs re-orientate themselves to their new group, which can be a stressful process (Iyer *et al.*, 2008).

SUI in clinical psychology training could elicit experiences specific to group processes that might be understood using Yalom's framework (Yalom and Leszcz, 2005), namely universality, altruism, imparting information, the development of interpersonal skills and group cohesion.

Rationale and aims

Only recently has research started to consider the effects of involvement on SUs and with some authored by SUs themselves (Lea *et al.,* 2019), this might reflect a shift in power in the involvement research sphere. Extant research has been limited by samples derived from singular training programmes and a lack of application of psychological understanding.

The present study aims to build on previous findings by specifically exploring the personal effects that involvement may have on SUs/carers, whilst deductively applying psychological theory around power, recovery, identity and group development to help explore and understand the personal effects of involvement utilising samples from multiple programmes. This will inform future involvement in clinical psychology training and help shift the focus to considering how to optimise involvement for SUs/carers as

well as trainees. It may also inform the choices of those considering involvement, based on an understanding of other people's experiences of the personal impact.

Methodology

A qualitative approach was taken, with data gathered via semi-structured interviews and analysed using thematic analysis (TA) based on the principles suggested by Braun and Clarke (2006).

Epistemological stance

The researcher took a critical realist epistemological stance.

Reflexivity

The main researcher (a trainee clinical psychologist) approached this research from the position of experiencing training and the involvement that SUs/carers provide. The researcher was mindful of their professional employment, which may have influenced how SUs/carers interacted with them compared to a peer researcher.

Quality monitoring

Quality was monitored by the researcher throughout the research process by keeping a research journal, using supervision, and by using the Critical Appraisal Skills Programme (CASP) qualitative checklist (CASP, 2018), of which all quality criteria were met.

Participants and recruitment

A sample of around 12 is deemed sufficient for a TA (Ando *et al*., 2014), thus the study aimed to recruit 10-15 SUs/carers aged 18 or over who were involved in UK clinical psychology training for at least six months, with recruitment ceasing when data saturation was reached. Study information was disseminated via email correspondence with staff who oversee SUI on their respective programmes and via the Group of Trainers in Clinical Psychology Involvement Subgroup mailing list. Purposive sampling meant they were asked to disseminate via email and in SU meetings/forums a recruitment advertisement to SU/carer representatives.

Participants were offered a £10 multi-store gift voucher for taking part. Interested prospective participants who met the inclusion criteria were asked to email or

telephone the researcher for more information. Participant information sheets were then sent and participants had the opportunity to ask questions before informed consent was sought.

Attempts were made to recruit (via snowballing) those who had left SUI. Participants were asked to pass the study information sheet to any SU/carer contacts who were previously involved in training. None were recruited.

Procedure

The study received ethical approval from University of Nottingham's The Division of Psychiatry & Applied Psychology research ethics sub-committee.

Demographic information was gathered. Four interviews were conducted face-to-face (at the researcher's University) with the remaining ten via telephone. The interview schedule contained non-directive, open-ended questions aimed at gathering detailed data grounded in participants' experiences of personal motivations for becoming involved in clinical psychology training; what involvement entails; and whether and how involvement links to SUs' self-perception, identity and sense of empowerment. See Table 1 for the interview schedule. Interviews lasted between 18 and 94 minutes (average 31 minutes) and were audio-recorded and transcribed verbatim by the researcher with the aid of transcription software. By the fourteenth interview content was relatively similar with no novel findings.

Analysis

A TA approach was used based on the principles suggested by Braun and Clarke (2006), with the six phases being followed. A deductive approach to data analysis was taken, with theoretical propositions informing the analysis, with a specific focus on theories relating to potential personal effects of SUI (power, recovery, identity, group development). All data (both confirmatory and dis-confirmatory) related to the theories was analysed.

Results

Participant characteristics

Fourteen participants from eight programmes took part, and none withdrew (see *Table 2~~1~~* for demographic information). Participants had been involved for between seven months and 10 years (mean = 3.88 years). Involvement varied across participants and

included being involved in the selection of trainees, attending meetings, sharing experiences, delivering aspects of teaching and reflective practice, feeding back to trainees on their performance, participating in research and discussing research proposals. Involvement therefore broadly reflected the types of activities identified by Briggs *et al.* (2017). Six participants were still using services. Those no longer accessing services last did so between 10 months and 10 years ago (mean = 3.75 years ago).

INSERT TABLE ~~1~~ 2 HERE

Themes

Five themes were identified, some with subthemes: Environment determines sense of safety; Meeting challenges; Sense of purpose, worth and value; The person you see now is not the person I was; and Wanting to break the glass ceiling**.**

Theme 1: Environment determines sense of safety

The environment determined how safe individuals felt in their involvement, with a particular focus on the importance of psychological safety.

Subtheme 1a: Supportive relationships

Relationships and connections built with trainees and staff were key in determining individuals' sense of safety. Having 'stimulating discussions' (*Kimberley*) with trainees was important, and it was highlighted how trainees are 'receptive and understanding' (*Megan*) and 'very respectful' (*Emma*), meaning there's a sense of enjoyment in interacting and working with trainees (*Kimberley*, *Dawn*). However, being asked to give immediate feedback to trainees can be 'awkward' (*Craig*), possibly due to not wishing to threaten the sense of safety SUs feel as a result of their positive connections with trainees.

'A very supportive ethos' (*Sheena*) created by staff was important, with a sense that even though staff 'have so much on…' (*Kimberley*), time was always made for SU support. However, there was a desire for this to not be mental health support:

> I don't think it's fair to do, is to use the tutors as psychologists to kind of work through my own problems with. I don't think that's why we're here. (*John*).

This might be because of wishing to 'feel like part of the workforce' (*Russell*).

There was however a desire for support if something was triggering:

> [if something] is a bit triggering, I can pick up the phone and talk to someone, I've got phone numbers that I can talk someone at the university. (*Dawn*)

Subtheme 1b: Group dynamics

Several participants described belonging and having mutual connection to a group of involved SUs which helped develop psychological safety; 'And we all have very similar struggles and have faced all sorts of things, and there's that feeling of group survivorship' (*Dawn*).

However, some participants described feeling overwhelmed and anxious when first joining a SU group which might be due to power dynamics within the group:

> Initially when I first started, I was a bit nervous and felt the power dynamics. Like, it felt like some people had more of a say than others… (*Abigail*).

Additionally, seeing SUs at different stages of recovery to oneself can be difficult:

> But the bad thing would be perhaps I would feel sorry for these people a little bit because they haven't been out that long…And it's kind of it, it does show that that person doesn't really want to fit into the community again. So it's a little bit depressing, but I keep quiet and think 'ah, they have to go through these things' (*Russell*).

Participants conveyed that there needs to be active awareness and management of dynamics within the group to promote both existing members and newcomers to feel safe:

> It's about handling dynamics of a group where there are, I wouldn't say really strong personalities, people with extreme needs and being able to still find a place where you can be yourself but not get involved in their problems… And I do think that it's a lot to do with the leadership…Because she's a strong leader, it doesn't get out of hand. (*Joy*)

Thus, relationships and connections with staff and trainees were key in determining individuals' sense of safety in involvement. This is important considering participants described how the environment can be triggering and have an emotional impact meaning support may be needed. However, psychological safety through shared

experiences cannot be assumed and must be promoted through active management of group dynamics and mental health difficulties arising from the work.

Theme 2: Meeting challenges

It was indicated that there are challenges to be met within involvement, some of which can result in uncertainty, anxiety, worry, feeling scared and feeling drained.

One such challenge was being involved in course selection processes, which as well as 'wearing me out a little psychologically' (*Ross*), poses a challenge due to having an increased sense of responsibility alongside those who are perceived to have more knowledge and more power (e.g. professionals):

> …there were a few instances where I realised that I had scored very differently from the other members of the panel and I felt dreadful. And I wanted to sort of rush around and change everything because I was getting it wrong. I was really getting it wrong. And it was, I got into quite a panic about it... I was thinking, oh, my gosh, what if what I've said is, you know, means someone doesn't get on the course and so on. (*Kimberley*)

However, over time increased confidence arose as a result of realising that those with a higher educational level do not necessarily have more knowledge, thus feeling empowered:

> And I think my confidence in actually what I know, what I experienced, what I've experienced from other people is valid and is, I think initially, I was a little bit like, oh, am I am I allowed to say this? Like, you know, when people are like sat there with degrees and done research projects and this, that and the other, like oh they've got loads more knowledge than me. But actually over the years I've realised that actually that's not necessarily the case. (*Claire*)

Despite the emotional impact of challenges to involvement, involvement generally had a positive emotional impact, for example David described 'I've enjoyed every minute of it [involvement] that I've done there.'

Whilst involvement can result in challenges that lead to an array of emotions including initial self-doubt, meeting these challenges can lead to a sense of empowerment and increased confidence, impacting identity.

Theme 3: Sense of purpose, worth and value

All participants referred to feeling a sense of purpose, worth and value as a result of involvement.

Subtheme 3a - Feeling listened to and valued

A sense of worth and value was contingent on feeling listened to by course staff and trainees: 'And the teaching staff listen. They don't go 'hold on a minute, I'm the professional'' (*Jamie*).

Although rare, tokenistic involvement where decisions could not be influenced led to feeling less valued:

> …when things are tokenistic it does feel like you're not able to contribute and you're not valued there. Because if all the outcomes have already been decided, it's like you're just there for the sake of it… (*Abigail*)

Being paid equally equated with value, suggesting this goes someway to addressing power imbalances. Whilst on some programmes those involved were paid the same rate as psychologists, others described the voluntary nature of involvement or not being paid equally at selection:

> you don't get paid for it… But I know that there's some people that are working for the NHS that…still get their working hours included whilst they're doing the interviewing… so I kind of felt it wasn't fair that some people were getting paid for it and some people weren't. (*Ross*)

Subtheme 3b - A positive way to feed back into the system

An increased sense of purpose was related to being able to put their difficulties to good use:

> I think by really feeling that this was sort of a positive way to feed back into the system something that had been such a negative for the bulk of my life, to find a positive way of framing that was really useful. And so yes it has been very, it has very much affected how I feel about myself. (*Sheena*)

A sense of purpose was particularly important when other aspects of life were difficult:

> …when I feel like I'm failing at everything else I'm like, actually look at me, I've got several paid roles and I'm doing this, people are asking my opinion on this and that feels really good. It's a really big boost. (*Claire*)

The sense of purpose was also important in confronting ageist views whereby society might perceive that older people do not have much to contribute:

> …because people say, what do you do? And I tell them what I do. Well, I'm with the course at the university and it's, it feels that I'm not just some old guy who's finished, you know. (*John*)

Involvement leads to feelings of worth and value, particularly when ideas are listened to and implemented, suggesting being treated as experts and having decision-making power leads to empowerment. SUs feel less worth and value when not fully listened to or ideas are not implemented, or when their contribution is not financially rewarded. Involvement also leads to a sense of purpose by being able to put difficulties to good use in an altruistic way, thereby helping build a more positive identity.

Theme 4: The person you see now is not the person I was

The overarching commonality amongst participants was that their mental health and social functioning had improved as a result of involvement; 'I didn't realise this would be a kind of by-product of my involvement, but it's helped my mental health enormously' (*John*).

Subtheme 4a: A game changer for personal growth and development

Aspects of personal growth were identified as a result of involvement amongst several participants including improved social skills and social functioning, decreased isolation, increased confidence, and further development opportunities. These factors seem to have led to an improvement in quality of life and the development of a positive sense of identity, e.g.:

> …the person you'll see now is not the person who I was… I'm developing as a person mentally, physically and socially and everything, all because of [involvement]. It's, it's been a massive game changer. (*Jamie*)

Increased confidence as a result of involvement has also led to pursuing other opportunities, such as Dawn volunteering at a local foodbank, or John engaging in

further involvement activities; ‘So it sort of gave me the confidence to sort of do those things [other involvement]’ (*John*).

Other benefits outside involvement include confidence to continue recovery:

> It's given me a little bit of confidence to do other stuff and, pursue my recovery outside of [involvement] that I wouldn't have been able to do without [involvement]. Without [involvement] I wouldn't be in the fantastic place of recovery that I am at the moment. (*Jamie*)

Subtheme 4b: Relating to difficulties in a different way

Relating to difficulties in a different way was an important consequence of involvement which helped participants redefine their sense of self and identity by feeling less stigmatised and having more self-compassion.

Several participants indicated that being involved in clinical psychology training meant they had access to theoretical knowledge which enabled them to understand their own difficulties. There was a sense that this information was not readily shared with SUs across a range of mental health services:

> …when you're accessing services... things are not explained to you. Whereas when you're taking part with the teaching programme, things are explained… And therefore, I think I've understood quite a lot more about the way, the way I function. (*Kimberley*)

Additionally, accessing new explanations led to ‘being kinder to myself’ (*Megan*), with some of the stigma around participants’ difficulties lessened:

> I could see clearly why things had happened as they happened and why I was as I was. And that was wonderful. I mean, it took it took a lot of the stigma away for me. It took a lot of the blame away for me as well. (*John*)

Subtheme 4c: Reengaging with skills that I thought had gone

Involvement provided opportunities for participants to reengage with skills they thought they had lost, thus helping them restore their sense of self and rebuild their sense of identity:

> I am a trained teacher... So here I was using something difficult that had happened to me, the positive using some skills that I had that I had forgotten about because they'd become that lost in my illness. (*Claire*)

Evidently, involvement offered opportunities that gave rise to a shift in identity through personal growth, understanding and relating to difficulties in a different way and reengaging with aspects of their identity they thought they had lost.

Theme 5: Wanting to break the glass ceiling

Frustration was indicated due to a desire to be fully involved, but there being a limit to involvement, summed up by Kimberley: 'I think there is a glass ceiling. I think there is one', and Joy who stated she has 'tried to push it [involvement] to the ceiling'. Although 'glass ceiling' is a term often used in relation to gender equality in the workplace, in this case it was interpreted to refer instead to equality (or lack) of opportunity for service users as compared to professional course staff. Frustration was evident by repeated attempts to become more involved:

> I've expressed an interest more than a couple of times at doing this type of work, but I've not been able to do it yet, which has been a bit of a bugbear of mine. (*Ross*).

It was implied that the decision-making power ultimately lies with professional course staff:

> …what I would say is that we're very welcome and we are involved and we do all kinds of things, but we're kind of almost…under supervision. (*Kimberley*)

This indicates that SUs might not always be treated primarily as colleagues, a factor which was previously identified as important in determining a sense of psychological safety.

Discussion

The research is part of the early literature exploring SUs'/carers' experiences of the personal effects of involvement in clinical psychology training and is the first to do so across multiple programmes.

Building a safe foundation for involvement

Underpinning participants' experiences of involvement was their sense of safety which centred around the quality of their relationships with staff and fellow SUs. Aspects of high-quality relationships which facilitate psychological safety in organisations include carrying capacity, tensility, connectivity, mutuality, and positive regard (see Carmeli *et al.,* 2009). How to optimise these aspects of high-quality relationships between SUs, staff and trainees warrants further research, particularly considering each group holds distinct roles and the potential tensions within these relationships.

The felt supportive group dynamics might be understood as related to ideas of universality and group cohesion promoting group development (Yalom and Leszcz, 2005), meaning SUs feel part of an 'in group' (Tajfel and Turner, 1979) likely to be important in fostering safety amongst SUs who may have been marginalised and treated as part of the 'out group' in society. However, transitioning to the 'in group' in involvement might not be as easy as social identity theory proclaims due to SUs being at different stages of recovery and multiple individuals and identities being present. Additionally, power imbalances between new and existing group members were highlighted as barriers to re-orientating to the new group, adding to what is already a stressful process (Iyer *et al.,* 2008). However, overcoming these difficulties can give opportunity to develop socialising techniques (Yalom and Leszcz, 2005), building connections which is an important part of the personal recovery journey (Leamy *et al.,* 2011). Therefore, management of group dynamics might lead to longer-term benefits for SUs. However, management by programme staff has the potential to invoke a power imbalance.

Power, empowerment, and identity

As with previous research (Campbell and Wilson, 2017), further challenges centred around power were identified by SUs. Participants initially perceived professional staff to have more 'expert power' (French and Raven, 1959), particularly at selection where there is increased responsibility. This appears to subside over time when SUs described taking over the 'expert' role, empowering them and contributing towards building a positive identity. SUs and professionals should therefore explore in depth the intricacies and nuances of managing and sharing power.

Feeling valued seemed to be contingent on feeling listened to and staff not exerting expert power (French and Raven, 1959) by overruling SUs, but rather ~~and allowing~~ SUs ~~to hold~~taking decision-making power (Lukes, 1974). Less value was felt when decisions were already made by professionals, implying that there can be times where professionals exert non-decision-making power by controlling agendas (Bachrach and Baratz, 1962). This reported power dynamic within clinical psychology training adds to previous findings that almost all involvement can lead to empowerment (Masters *et al.,* 2002) or disempowerment (Felton and Stickley, 2004), but goes further by considering the types of power at play. Findings also suggest that whilst empowerment is a desired outcome of involvement in clinical psychology training (Tambuyzer *et al.,* 2011), SUs do not feel fully empowered. This may be due to the emphasis on clinical psychologists providing the majority of learning opportunities rather than SUs (BPS, 2019). Additionally, there may be different perspectives on what being fully empowered means. Regardless, SUs not perceiving that they are fully empowered could have implications for SUs who are still in recovery from their difficulties considering empowerment is one of the typical characteristics of personal recovery in mental health (Leamy *et al.,* 2011).

A valued identity has been linked to personal recovery (Slade, 2009; Walsh and Tickle, 2017), thus the provision of equal pay in involvement has the potential to impact a SU's personal recovery as well as building a positive identity. Ensuring equal pay also goes some way to addressing power struggles that can arise between SUs and academics in an educational setting (Lea *et al.,* 2019) by aiming to solidify SUs' 'expert power' (French and Raven, 1959) as equals alongside professionals on the programme. Furthermore, paying SUs is recommended by the HCPC (HCPC, 2017). Therefore, a more standardised system whereby those involved are paid equally across clinical psychology training courses is recommended in earnest.

The benefits of access to theoretical knowledge via involvement suggests that within some services professionals exert informational power (Raven, 1965) by withholding information. Professionals working in services should be mindful of this finding and consider sharing information which might help SUs to better understand their difficulties. This might also go some way to addressing the historical profound inequalities of power between SUs and mental health professionals (Felton and Stickley, 2004).

Participants indicated frustration when they could not be involved as much as they desired. Wanting to break the glass ceiling is in line with previous involvement research which suggests that involvement activity falls short of aspirations (Briggs *et al.,* 2017). Requests for involvement were sometimes rejected and there was a sense that professionals ultimately decided how much SUs could be involved, supporting findings of Campbell and Wilson (2017). This implies that professionals hold non-decision-making power as they involve SUs but limit their decision-making capacity by preventing involvement in certain areas. Although likely to vary between programmes and ~~'full' involvement not being defined~~it not being clear what 'full' involvement would entail, in relation to the framework by Tew *et al.* (2006), participants' ~~described~~descriptions of involvement in clinical psychology training seemed to equate to limited or growing involvement, with some ~~in clinical psychology training despite~~ aspects of collaboration and partnership ~~(Tew *et al.,* 2004)~~.

The glass ceiling could be raised by ensuring that SU representatives are involved in designing programme modules. This should follow recommendations by Tew *et al.* (2004) which suggest that SU perspectives should be treated as equally valid and part of the core agenda. It was not clear from the present study how much SUs are currently involved in module development.

Recovery

Many participants described benefits of involvement in line with the CHIME framework (Leamy *et al.,* 2011). In addition to the discussed experiences around power and empowerment, there was a sense of connection with their SU/carer group. Additionally, participants identified personal growth that arose from involvement leading to an improvement in meaning and quality of life, hope and optimism about the future. Many of these experiences led participants to indicate they had developed a positive sense of identity including overcoming felt stigmas. Therefore, whilst not its explicit aim, involvement can offer an opportunity to further develop recovery, sometimes beyond what has been achievable within services.

Limitations and future research

There were no participants no longer involved in clinical psychology training and only two carers (who were also SUs). Future research should aim to address this as their experiences might differ.

As the research did not recruit every SU representative or recruit from every programme, other perspectives might be held by SUs who did not participate. This limits the findings as not being representative of every SU/carer involved in clinical psychology training. It does, however, provide useful guidance to developing involvement so that it is meaningful for SUs.

To further understand the nuances of involvement, future research may wish to investigate whether different types and levels of involvement relate to different (positive or negative) effects for those involved. In addition, the issue of payment for involvement and how this affects self-worth also warrants further investigation. Whilst payment was highlighted as important by some participants in the present study (e.g. desiring equal pay), many participants highlighted that they gain other benefits from involvement that arguably might be more important to them than money. However, if involved service users are not demanding particular rates of pay, this in itself might indicate issues of power and sense of worth. Whilst beyond the scope of the present study, future research may wish to explicitly explore this in more detail.

Conclusion

Exploring the personal effects of SUI in clinical psychology training has revealed that SUs derive benefits from involvement relating to a greater understanding of themselves and their difficulties; an improvement in mental health and social functioning; feelings of worth, purpose and value; building and enhancing a positive identity and some feelings of empowerment. However, these benefits are contingent on the environment fostering psychological safety, via positive and supportive relationships with trainees and staff and SUs being treated as equal colleagues and financially reimbursed as such. The environment also has the potential to be triggering for SUs and as such support should be available at these times.

It is suggested that the building of a positive identity is partly contingent on whether participants felt a sense of value, worth and purpose in their involvement, which was determined by how empowered they felt. Thus, SUs and professionals should explicitly discuss the intricacies and nuances of managing and sharing power to increase the opportunity for SUs to feel valued and therefore increase the chances of them reaping the benefits of developing a positive sense of identity. If this can be achieved, involvement in clinical psychology training will likely be beneficial for SUs and may

even help in their continuing personal recovery, alongside the original aim of enhancing the trainees' experience and training.

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Table 1. Interview schedule

	Question and prompts to expand
1	What led you to become involved in clinical psychology training?
2	In what ways are you involved in clinical psychology training?
3	Has your involvement in training led to any changes in the way you see yourself? a. [if yes] What has led to this? b. [if yes] How does this differ to the way you seen yourself when you began involvement?
4	Do you feel like you have a sense of control and influence over the involvement activity that you are doing? To what extent? a. Can you give me some examples?
5	Has your experience of involvement influenced your sense of control in other areas of your life?
6	Can you give a specific example of a positive experience of involvement, when something went really well? a. How did that experience impact you personally that day? Weeks later? b. Does it still have an impact on you now, and if so how?
7	Can you give a specific example of a negative experience of involvement, when something did not go so well? a. How did that experience impact you personally that day? Weeks later? b. Does it still have an impact on you now, and if so how?
8	Can you think of a specific experience of involvement that has had an impact on your mental health? a. Did this impact on your involvement moving forward and if so, how?
9	How well supported do you feel in relation to your involvement? a. Is there anything missing from your support network?
10	Can you tell me about how you've experienced being part of a group of involved service users and carers? a. Are there any dynamics within the group that have impacted on you personally or your ability to undertake involvement work?

Table 2. Sample characteristics

Characteristics	*Category*	*Participants (n)*
Gender	Male	6
	Female	8
Age bracket	25-29	1
	30-34	1
	35-39	1
	40-44	2
	45-49	1
	50-54	1
	60-64	4
	65-69	2
	75-79	1
Ethnicity	White British	7
	British	2
	Asian British	1
	British Indian	1
	Mixed	1
	Italian	1
	German Syrian	1
Service user or carer	Service user	12
	Carer	0
	Both	2
Affiliated programme (anonymised)	A	4
	B	2
	C	2
	D	2
	E	1
	F	1
	G	1
	H	1
Mental health services used[1]	Psychotherapy	7
	Counselling	1
	Psychiatry	5
	Perinatal	1
	Inpatient	3

[1] Some participants used multiple services and are subsequently represented more than once

Table 2. (Continued)

	Community learning disability services	1
	Community mental health teams	3
	Early intervention	2
	Eating disorder services	1
	Personality disorder services	1
	Pain services	1
	Crisis teams	2