The
British
Psychological
Society

Division of Clinical Psychology

Good Practice Guidelines:
Service User and Carer Involvement within
Clinical Psychology Training

Contents

Foreword

Service users in training: from absence to presence

The emergence of service users as a creative force in the mental health system has been a remarkable feature of the last 25 years. In 1985, the House of Commons Social Services Select Committee Report on Community Care spoke of the difficulty of 'hearing the authentic voice of the ultimate consumers of community care'. Such a complaint would not stand up today.

The experience, insight and expertise of service users are out in the open to an extent that would have seemed impossible in the early 1980s. We can question the degree to which our increasing involvement in developing services or challenging social attitudes has led to positive change. That many people are now speaking out and acting for change is undeniable.

One sign is the growing number of service user-controlled action groups which has risen in England from less than a dozen in the early 1980s to more than 600 today. Another is the existence of service user networks within large voluntary organisations like Mind and Rethink (formerly National Schizophrenia Fellowship). At the same time, service user involvement has become a necessity enshrined in legislation, Government policy and guidance and the training programmes of mental health workers. There are few areas of mental health services where we are not taking action. There are hardly any significant initiatives, nationally or locally, where our involvement is not sought. In mental health debates, service users are a legitimate presence where before we were a notable absence.

Service user involvement in training and education has been an important aspect of these developments. Many service user activists have always placed a high value on this work. The networking group Survivors Speak Out had a Training and Education Officer (unpaid) on its first co-ordinating group. And the first project that three national groups – Survivors Speak Out, Mindlink and the United Kingdom Advocacy Network – worked on together was to organise the first training event for mental health service users as trainers in 1991. Today, many service user groups and individuals are involved in training mental health workers.

The contribution of service users is rooted in our personal experience of mental distress, receiving mental health services and living in a society that discriminates against us. This direct experience, alongside that of relatives and loved ones involved in our day-to day support, is an essential element in the proper training of mental health workers. Although there is not yet enough

evidence of whether and how it contributes to better practice, it is undoubtedly valued by many students and trainees.

But it is not just about personal experience. Service users have developed analysis and practical proposals based on their experience. Some of the most interesting developments in recent years have either come directly from service users or have gained attention because of their enthusiasm: for instance, advocacy, advance directives, crisis cards, crisis houses, self-management. It is important that mental health workers hear from service users about such new ideas.

The full potential of service users as trainers has still to be realised. We need to have greater input into curriculum development and within teaching. This may not be easy to achieve but it is clear that an increasing number of people, from service users to trainees, feel it is worth working for. This publication should be a valuable step towards achieving these goals in the training of clinical psychologists.

Peter Campbell
Freelance Trainer and Mental Health System Survivor.

Purpose and status of this document

> 'Brings a different dimension. Brings direct experience that professionals can't bring and don't hear.' (Service user, Exeter)

> 'Being involved has done a lot for me. It's given me hope and positivity, knowing that I can make changes for the better and help the trainees in their learning.' (Service user, Surrey)

The involvement of service users and carers within the training of health care professionals is now required by the Department of Health through the Quality Assurance Agency. More specifically, a commitment to the involvement of service users, carers and community representatives forms part of the revised Criteria for the Accreditation of Postgraduate Training Programmes in Clinical Psychology.

We have prepared this document in consultation with programme staff, service users and carers who are committed to the integration of multiple perspectives into the training of clinical psychologists. Its key purpose is to guide members of the profession and training providers in ensuring that clinical psychologists, upon qualification, have a broad sense of the needs, perspectives and aspirations of the recipients of services, and the skills to work alongside service users and carers in a variety of roles and contexts.

The guidance offered in this document is intended to aid the planning and evaluation of training programmes and reflects the experience of programmes that have sought to integrate the views of service users and carers into their learning environments. This document also aims to stimulate creativity and pragmatism as the challenges associated with the meaningful involvement of service users and carers are embraced.

Since work on this guidance commenced, the DCP has established a Service User and Carer Liaison Committee to assist in its policy, strategy and advisory roles. The Committee wholeheartedly supports the principles and suggestions set out in this guidance and the areas of debate that are highlighted. Arrangements for accrediting training courses and for registration of clinical psychologists are under review. At the same time, the range of needs that clinical psychologists will meet in their careers is becoming ever more diverse,

as is the overall profile of service users and carers who might valuably contribute to training. For these reasons, the Service User and Carer Liaison Committee plans to extend this guidance. Areas such as special considerations when involving children and young people, older people, and people with learning disabilities in training, and widening the scope beyond mental health, will be addressed.

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Defining the terms

We are all sensitive to descriptions of ourselves, and service users are no exception. But what is a 'service user'? There is a range of alternative terms: 'client', someone 'suffering from mental illness' (or 'mental distress') or a 'learning disability', 'consumer of services' and so on. At the opposite end of the spectrum many people who have experienced mental distress and/or disability have re-claimed the language and proudly call themselves 'nutters' or 'loonies'; in much the same way as lesbians and gay men have re-claimed the word 'queer', which historically has been used as a derogatory term. Rachel Perkins (2006) argues that using 'client' or 'consumer' (of health services), while avoiding the medical model associated with 'mental distress or disability', implies choice although choice is not always available to people referred to NHS services.

Perkins further argues that describing oneself as a 'service user' binds one's identity with the use of health services. She also points out that the description 'survivor', which many choose to use (including Peter Campbell who introduced this Guide), begs the question 'survived what?' and wonders about those who haven't survived the health system. Her own preference is to talk about 'madness'. However, for the purposes of this document we are going to refer to:

● **service users:** people who at some time in their lives (past or present) have accessed mental health/psychological/disability services;
● **carers:** those people who both care for and about people who have accessed mental health/psychological/disability services (usually partners and family, but also friends, neighbours, colleagues);
● **mental health services:** we are aware that users of NHS psychological services include people with a range of difficulties and disabilities, including those related to physical health. This document focuses primarily upon those people who access services due to distress and/or disability associated with mental health and/or cognitive impairment. In this context, the term 'mental health services' is used as short hand for a variety of NHS services that are offered across the lifespan.

These terms are chosen as they are widely recognised among people who access and work within health services that are commonly provided by clinical psychologists. However, we would urge everyone to 'watch their language' and be mindful of how we refer to ourselves and others.

Finally, although this *Good Practice Guide* is aimed primarily at clinical psychologists we see it as 'aspirational' in its aims. We would like to think that anyone working professionally with service users and carers will be aiming at the sort of goals and values outlined here.

1. Context and drivers

Department of Health policy emphasises the importance of involving service users and carers in all aspects of health care planning and delivery (National Service Frameworks – DoH, 1999; NHS Plan – DoH, 2000). Moreover, Section 11 of the Health & Social Care Act places a statutory duty on NHS Trusts, Primary Care Trusts and Strategic Health Authorities to consult service users in service planning and operation. These policy and legislative initiatives are premised on the right of service users and carers to be consulted about the services they receive, and the potential value of engaging with the experience of those who have used health care services.

If the traditional division between 'us' (the professionals) and 'them' (the service users and carers) is to be challenged, practitioners require opportunities to learn in a variety of ways from the experience of those who have personally lived with mental distress and disability. Such opportunities are enshrined within *The Ten Essential Shared Capabilities* (DoH, 2004), a framework of values and practices that all mental health workers should develop as part of their pre-qualifying training, e.g. working in partnership, challenging inequality and providing client centred care. The Quality Assurance Agency also requires the providers of healthcare education to make a commitment to promoting diversity, inclusion and opportunity for all through the involvement of service users (Skills for Health, 2006).

This emphasis upon service user and carer involvement within the education of health care professionals has stimulated a number of initiatives that are developing an evidence base for the effectiveness of service user involvement in training across a range of disciplines: Nursing (e.g. Masters et al., 2002), Social Work (e.g. SCIE, 2004), and more generically (e.g. Khoo et al., 2004; Hayward et al., 2005; Tew et al., 2004). Benefits have been reported by both the service users involved in the educational process and the students. Service users spoke of learning new skills, increased self-confidence and a genuine feeling of empowerment (Forrest et al., 2000; Master et al., 2002). Students demonstrated a greater use of a collaborative language, empathic understanding and a more personal approach (Wood & Wilson-Barnett, 1999), and spoke of a focus on partnership, existing approaches being challenged and confidence being enhanced (Khoo et al., 2004).

The clinical psychology training community is well placed to add to the evolving evidence base for the effectiveness of service user and carer involvement. We have already debated the benefits of and barriers to the involvement of service users and carers (Goodbody, 2003; Harper et al., 2003; Hayward &

Harding, 2006) and begun to develop initiatives to involve service users and carers in an advisory capacity and within teaching and the selection of trainees (Curle & Mitchell, 2004; Vandrevala et al., 2007). A recent initiative also offered an opportunity for a trainee to be on placement with a service user organisation (Hayward et al., 2006). Further initiatives are required and we need to ensure that the lessons learnt are disseminated throughout the health care training community.

2. Accreditation criteria

The 2002 accreditation criteria made limited reference to the need to involve service users and carers within clinical psychology training. References to involvement were restricted to one learning outcome:

B 1.1.3   The skills, knowledge and values to work effectively with systems relevant to clients, including, for example, statutory and voluntary services, self-help and advocacy groups, user-led systems and other elements of the wider community.

And two domains of competence:

B 1.3.7   Personal and professional skills – working collaboratively and constructively with fellow psychologists and other colleagues and users of services, respecting diverse viewpoints.

B 1.3.9   Working with users and carers to facilitate their involvement in service planning and delivery.

The DCP Service User and Carer Liaison Committee made a formal response to the consultation on the 2007 revisions to the accreditation criteria. The Committee's comments were taken into account, with others, resulting in the following criterion being adopted under 'Organisation & Governance':

6.4   *Programmes must work collaboratively with service users, carers and community representatives to identify and implement strategies for the active participation of these stakeholders within the programme. These strategies, and the practical support available to implement them, must be acceptable to the different groups in the programme and have wide support.*

3. How to involve

The involvement of service users and carers typically takes place within one or more of the four 'strands' of training: selection, teaching, research and placement activity. These strands of involvement can be pivoted by some form of service user and carer advisory group/committee.

Service user and carer advisory groups/committees
A number of programmes have established an advisory group in the early stages of the development of their involvement initiatives. Membership typically includes services users, carers, programme team members and other community representatives.

> '**Members were clear what they wanted:**
> **– informal meeting with facilitators rather than a chair;**
> **– notes rather than minutes;**
> **– equal contributions to the agenda;**
> **– flexible attendance without a feeling of obligation;**
> **– travel and carer expenses, but not a fee;**
> **– a lunch and social time together;**
> **– feedback about the impact of their input.'**
> **(Exeter – Curle & Mitchell, 2004, p.13)**

Advisory groups can offer an initial opportunity for stakeholders to collaboratively develop the initiative and scope possibilities for meaningful involvement. Such groups can subsequently evolve to become embedded within the committee structure of the programme and develop terms of reference that facilitate communication and influence through that structure.

> '**I have been so impressed over the years how all of us on the advisory group coming from so many different disciplines and walks of life have worked together as colleagues – to one end, namely, enhancing the involvement of service users and carers in all aspects of the training of clinical psychologists.' (Carer, Surrey)**

Teaching

To varying degrees, most programmes have involved service users and carers within teaching sessions/lectures for a number of years. For some programmes these opportunities arose due to the existing ethos and relationships with service users, carers and their organisations, for others it may have represented the opportunism and passions of individual lecturers.

Involvement in teaching can occur at a number of different levels. Service users and carers can be invited to 'tell their story' as part of a broader learning experience. Whilst such contributions have been labelled as tokenistic by some service users, the impact upon trainees can be striking:

> **'Can't say enough about how useful and powerful it was to hear people talk about their experience of distress and using services. I won't forget it. Gave me a lot to think about and brought back into focus why I wanted to be a clinical psychologist in the first place. Brilliant.' (First-year trainee, Surrey)**

More extensive involvement within a teaching session may involve service users and/or carers jointly facilitating with a clinical psychologist or taking sole responsibility for facilitation.

> **'A good recent example was a user group from learning disability services who presented a drama workshop explaining the care planning process. It was well received: a good moment was when one of the service users asked the trainees what their goals would be for the next year … and after much discussion a conclusion was that trainees, trainers and service users alike share similar hopes for creativity, companionship and meaningful occupation.' (Plymouth)**

A more strategic approach to involvement within teaching can enable service users and carers to consult on the development and review of the curriculum. These 'behind the scenes' forms of involvement may be better suited to service users and carers who find it difficult (for whatever reason) to contribute to teaching.

Selection

Selection is another way that programmes have made progress in involving service users and carers. This may be attributable to the discrete and periodic nature of this task and in addition to the establishment of an advisory group, may constitute a good way of getting started.

> **'… trainees also say that user involvement in selection is positive and marks the importance of humanity in training (who you are rather than what you know).' (Plymouth)**

Involvement in selection can take place at a number of levels. Indirectly, service users and carers may consult on a review of the selection process from the perspective of accessibility for applicants who experience distress/disability. The complexity of the issues associated with an inclusive approach to applicants with a disability has recently been explored through the publication of *DCP Good Practice Guidelines* (DCP, 2006). Indirect involvement may also take the form of service users and carers offering questions to be asked at interview panels.

More direct opportunities for involvement in the selection process include service users and carers joining existing interview panels, or creating an interview task solely assessed by service user and carer interviewers. These opportunities need to be established with equity in mind; existing panels may need to be redeveloped in order to maximise the contributions of service users and carers.

One way of combining the indirect and direct approaches is to consult with service users and carers on a review of the selection process, with a view to redeveloping the process, so that service users and carers can offer meaningful input.

> **'Our commitment was to involvement from the beginning; programme staff and service user and carer colleagues forming a working party and collaboratively developing an innovative discussion task that had meaning and value to all stakeholders, and genuinely added something novel to the selection process.' (Surrey)**

Involvement within the selection process enables prospective trainees to be aware of the programme's commitment to the integration of service user and carer perspectives from the outset.

> **'And a number of trainees said that having service users on the selection panels was a factor in helping them to choose Exeter as a place to train.' (Exeter)**

Research

The involvement of service users and carers within trainee research activity seems to be one of the less well-developed strands of involvement. This is ironic given the requirement by the National Research Ethics Service (NRES) and most Trust Research and Development departments that involvement in research is essential. However, some programmes have made significant progress.

> 'Service user and carer involvement in research has really lifted off. Advisory group members presented the research ideas they thought psychologists should be working on to the first years, and also went to second year proposals and offered feedback. Since then, trainees, service users and carers have just wanted to talk to one another and a range of consultations have taken place. It's got its own momentum now.' (Salomons)

The notion of involvement at different levels is again relevant to research. Some programmes have established reference groups who trainees consult about issues of design, recruitment, understandability of information sheets, etc. Given the many layers of approval that trainees have to gain before recruiting participants, thought needs to be given to the voluntary or mandatory nature of such groups. Alternative forms of involvement within research activity can include service users, carers and their organisations proposing research questions and topics that have meaning to them.

> 'One supervisee did an excellent project where she worked with a learning disability advocacy organisation, convened a small group of people with learning disabilities and allies and consulted them about what topic would be most useful. She chose to focus on how people with learning difficulties who were activists in the disabled movement experienced discrimination and how they campaigned for anti-discrimination using Grounded Theory. After developing an analysis of the data she presented it to the group, incorporating their feedback.' (University of East London)

Service users and carers can also act co-researchers and field supervisors to projects.

> '**The lived experiences of my supervisor gave me a strong rationale for the importance of researching this area and she has encouraged me to think about the implications of my research not only in terms of service delivery, but also in terms of its personal and social implications for people who experience this form of distress. She has also invested in my personal and professional development which has helped me to be aware of the political context that I work in and how I can use research to contribute to improving service and social responses to people experiencing distress.'**
> **(Final-year trainee – Surrey)**

Placement activity

Service user and carer involvement in placement activity seems to be the least well developed of the four strands. Reasons for this may include the placement being the domain where the roles of clinical psychologist and service user/carer are most distinct and where the power differential is more explicit, making equal collaboration problematic.

From the outset it is important for placement documentation to reflect the expectation that trainees will have opportunities to learn from and alongside service users and carers in a variety of ways. Consequently, contracts, mid and end-of-placement review forms and logbooks can all prompt trainees and their supervisors to discuss possibilities. It is important that programmes provide opportunities for supervisors to reflect upon the issues and challenges related to service user and carer involvement. This can be achieved through the involvement of service users and carers within the training and CPD events that programmes regularly provide for new and experienced supervisors.

From the trainee's perspective, opportunities to learn from service users and carers may reside both inside and outside of the therapeutic relationship. A number of programmes have asked service users and carers (as clients) to evaluate a trainee's performance as part of the broader process of evaluating clinical activity. However, concerns have been raised about the possibility of these responses being skewed by social desirability factors. Outside of the therapeutic relationship, opportunities to learn from service users and carers may involve trainees spending time with service user and carer organisations, to learn more about their values, aims and activity. A more integrated approach could involve a trainee spending part of their placement working within a service user or carer organisation, getting fully involved with all its activities in pursuit of the trainee's placement objectives. The complexity of such arrangements shouldn't be underestimated, although the benefits can be many:

> '… I was a bit apprehensive about how I would be received [on placement with a service user organisation]. I wondered if I would be seen as encroaching upon and undermining user empowerment and if this might be resented … my experiences on this placement have suggested to me that human qualities such as commitment, genuineness and humour can be valued more by some service users than a specific professional training or theoretical model.' (Final-year trainee, Surrey – Hayward et al., 2006, p.11)

A further opportunity for involvement within placement activity can occur around mentoring and supervision. Mentoring by a service user or carer as an adjunct to supervision can provide trainees with further opportunities to reflect upon issues that may be significant to local service users and carers.

4. Facilitating involvement

Leadership

It should be added that the involvement of service users and carers in training is not seen by everyone as beneficial. This may not necessarily stem from antagonism, but perhaps from apprehension:

> **'… in our experience there is fear both from programme staff and service users about service user engagement in clinical psychology training. This relates to differences in power, acknowledging vulnerability, using exclusive language (jargon), demanding too much of the 'other'. Programme staff addressed this early on by being open about our own vulnerability, acknowledging that one could and had been both a professional and a service user, setting ground rules for safety in the group … trying to use plain language … and be prepared to place the meeting in a way that all could contribute.' (Exeter)**

A gradual process of development and regular consultation with all stakeholders is essential to ensure that concerns are allowed to be expressed and discussed openly.

> **'We've worked hard to roll this out over a number of years and to consult with all stakeholders at key stages of the project, drawing upon a 'stages of change' model, and this seems to have helped in bringing with us those individuals who may have had initial doubts about the value of involving service users and carers in the Programme.' (Manchester)**

Many programmes have commented on the value of a 'champion' – someone who can lead the initiative forward with passion and enthusiasm. For some programmes the champion has been one of the Directors, for others a regional psychologist: and for others a service user organisation. Ultimately, programmes should work towards the establishment of posts filled by service users or carers that are dedicated to the co-ordination of involvement.

> **'I would employ someone to work on this as their job as I am part-time and have several other commitment so it feels as though this work gets left behind sometimes.' (Coventry & Warwick)**

Differing needs and aspirations of service users and carers
While living with mental distress or disability can be a lonely and isolating experience for service users, carers too can be isolated. The role of carer can be thrust onto any one at any time, and suddenly finding oneself categorised as a 'carer' can bring up a range of feelings. Developing an interface with mental health services that may have limited resources available to meet the needs of carers may also generate strong feelings.

Within this document and within involvement initiatives generally there has been only a limited attempt to differentiate the needs and aspirations of service users and carers who wish to influence the development and delivery of services. Where differentiation does exist it is often to focus upon service users to the exclusion of carers. The reasons for this are unclear and require further exploration.

Payment
Payments to service users and carers for their contributions to programmes will be dependent on a number of factors: levels and types of skills, experience and expertise that service users and carers bring to the role, time commitment expected, comparative levels of pay elsewhere in the establishment, level of responsibility, etc. Some programmes have worked hard to develop mechanisms by which service user and carer colleagues can be paid in an equitable manner.

> **'We were determined that CLG members [Community Liaison Group, the course's Advisory Group] should be paid fees and expenses, commensurate with those paid to clinicians who teach on our Programme … it took a lot of phone calls and e-mails to various finance people before we could find a way forward.' (Manchester)**

Yet the sticking point for many programmes is that for service users and carers who are on social security benefits, any extra income received may reduce their benefits payments, with the added irritation of dealing with more paperwork (or expensive phone calls to benefits agencies). And there still remains the problem of paying income tax on any additional earnings. Consequently, many service users and carers simply don't claim payment for their contributions to programmes, even when payment is available. Unfortunately there is no recognised national standard of paying service users and carers, although the Department of Health's *Reward & Recognition* (2006) sets out good practice guidelines for such involvement.

Paying service users' and carers' expenses can be more straightforward as these may not necessarily count as income. A pre-requisite for any programme wishing to involve service users and carers will be the ability to pay for expenses in cash on the day of the meeting or event to prevent any contributor from being out-of-pocket.

Funding

The sources of funding secured to instigate and maintain involvement initiatives vary across programmes. Sources include the Higher Education Academy, Strategic Health Authorities and University Widening Participation Schemes. Some programmes have utilised monies from within existing programme budgets, while some have struggled to attract funding from any source.

The use of funds also varies. At the inception of an initiative, funding is typically used to scope, instigate and fund the expenses of an Advisory Group. As the value and contribution of the initiative grows, some programmes have been able to attract additional funding, possibly related to a specific project, e.g. appointing a Co-ordinator of Service User and Carer Involvement. However, if this funding is obtained from an external grant awarding body it will be time limited and may not be sustainable in the long term. Funds provided by Strategic Health Authorities that are additional to existing funding can lead to the perception of service user and carer involvement as an 'add on', rather than a core task, which again may have implications for sustainability. An alternative may be the prioritisation of involvement as a core task, leaving it to compete with other priorities for a share of existing budgets.

Training

Service user and carer colleagues will have existing skills and experiences, for instance: interviewing from a service user or carer perspective, experience of user research, employment specialist, teacher/lecturer, etc. It is essential that these skills are utilised, built upon and factored into training requirements.

Training may be resource intensive initially and should be budgeted for. Wherever possible, this training should involve all the people who will be participating in projects. So for a project around placement activity this would include service user and carer colleagues, clinical tutors, supervisors and trainees. As projects involving service users and carers become embedded within training programmes, the need for formal training will diminish as experience and skills develop within the team responsible for delivering the activity. In this respect, retention of the services of service user and carer colleagues will be crucial.

Representativeness

How representative is one service user or carer of the whole of that particular population? It's worth remembering that not all clinical psychologists, mental health nurses, psychiatrists, social workers and so on are representative of their whole field either!

If we wait until we have a perfectly representative group of service users and carers incorporating every aspect of age, ethnicity, race, gender, class, disability, sexuality and – for want of a better word – diagnosis, we'd never get going. No service user or carer group, whatever their remit, will be wholly representative of its members either.

> **'Our initial Terms of Reference … stated that the eight members of the Advisory Group should 'aim to reflect the diversity of the populations with whom clinical psychologists work' – e.g. adults, children, older adults, people with learning disabilities, people with physical health problems, carers. Since then, we've come to realise it would be impossible to expect true representativeness; each member has their own unique contribution to make …' (Manchester)**

Representativeness should be an aspiration, but not an obstacle. It's important to be welcoming of service users and carers who wish to contribute to our programmes, and utilise those resources to recruit others who can offer views from an under-represented perspective.

Evaluation

Programmes were asked: 'How is your involvement initiative viewed by service users, carers, trainees, regional psychologists, programme staff?' The response was an overwhelming 'Very positively.'

> **'… trainees consistently report teaching by users as amongst the most moving and influential teaching they receive; makes a big impact on their personal values and motivation in relation to becoming a practitioner …' (Plymouth)**

> **'The UAG [User Advisory Group] is highly regarded by trainees …' (Exeter)**

Anecdotal support of this nature is useful but adds little to the evidence base for the effectiveness of involvement. In order to influence the attitudes and behaviour of prospective funders and the broader health care community it is important for projects to be rigorously evaluated. This can be done on a project by project basis, capturing the impact and experience of all of those involved, quantitatively and qualitatively, or more comprehensively using a questionnaire to measure any changing of views over time (see Appendix A for a measure of views on involvement, developed by Sue Holttum at Salomons).

5. Review Process

These Guidelines should be reviewed in 2011. At that time, if not earlier, CPD requirements will be considered, including the type of competencies and experiences which should be consolidated in the first 18 months post-qualification.

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Appendix A: Service User and Carer Involvment Questionnaire

Note: Most questions are about Service Users, some are about Carers, and one or two are about both Service Users and Carers.

First for all, we realise you may have previous experience of Service User involvement, either in training or services, which could influence your responses to this questionnaire.

1a. What is the extent of your previous experience of involving Service Users in clinical psychology training? Please indicate your response by circling an answer.

| None | A little | Some | Quite a lot | A great deal |

1b. What is your previous experience of Service User involvement in health services?

| None | A little | Some | Quite a lot | A great deal |

2. As far as you know, to what extent are Service Users involved in each of the following aspects of the clinical psychology training programme? Please rate each aspect as follows:

1 = Not at all; 2 = A little; 3 = To some extent; 4 = Quite a lot; 5 = Very much so; x = Don't know.

Service Users	*Not at all*					*Don't know*
a. Contribute to planning teaching sessions.						
	1	2	3	4	5	x
b. Help select trainees.						
	1	2	3	4	5	x
c. Help select course staff.						
	1	2	3	4	5	x
d. Participate in teaching on the course.						
	1	2	3	4	5	x
e. Help decide the goals of training.						
	1	2	3	4	5	x
f. Are involved in placement activity.						
	1	2	3	4	5	x
g. Attend course committees/decision-making meetings.						
	1	2	3	4	5	x
h. Suggest research projects or ideas.						
	1	2	3	4	5	x
i. Collaborate as equal partners on research projects.						
	1	2	3	4	5	x
j. Help in developing the training syllabus.						
	1	2	3	4	5	x
k. Evaluate trainees' work.						
	1	2	3	4	5	x

3(i). The following questions are about the degree to which the clinical psychology training programme is Service User-friendly. Please indicate your level of agreement with each statement below, using the following scale:

1 = Strongly disagree, 2 = Disagree, 3 = Neither agree or disagree, 4 = Agree,
5 = Strongly agree, x = Don't know

On the Training Programme

	Strongly disagree				*Strongly agree*	*Don't know*

a. Service User experience is valued as much as mental health practitioner knowledge.

1	2	3	4	5	x

b. If staff want to talk openly about mental health service user experiences they may have, there are opportunities to do so.

1	2	3	4	5	x

c. The involvement of service users seems tokenistic.

1	2	3	4	5	x

d. If trainees want to talk openly about mental health service user experiences they may have, there are opportunities to do so.

1	2	3	4	5	x

Please comment on the issues in Question 3(i) in the space below, if you wish:

3(ii). The following questions are about the degree to which the clinical psychology training programme is Carer User-friendly. Please indicate your level of agreement with each statement below, using the following scale:

1 = Strongly disagree, 2 = Disagree, 3 = Neither agree or disagree, 4 = Agree,
5 = Strongly agree, x = Don't know

On the Training Programme

	Strongly disagree				*Strongly agree*	*Don't know*

a. Experience as an informal carer for someone is valued as much as mental health practitioner knowledge.

1	2	3	4	5	x

b. If staff want to talk openly about informal carer experiences they may have, there are opportunities to do so.

1	2	3	4	5	x

c. Informal carers are rarely involved at all in the programme.

1	2	3	4	5	x

d. If trainees want to talk openly about experiences they may have as informal carers there are opportunities to do so.

1	2	3	4	5	x

Please comment on the issues in Question 3(ii) in the space below, if you wish:

4. If Service Users were more involved than at the present time, how much do you think it would change the training programme? Please circle your answer.

None	A little	To some extent	Quite a lot	A great deal

Please say how you think the Training Programme might change, if you wish.

5. The following questions are about the degree to which the clinical psychology training programme is Carer User-friendly. Please indicate your level of agreement with each statement below, using the following scale:

1 = Strongly disagree, 2 = Disagree, 3 = Neither agree or disagree, 4 = Agree,
5 = Strongly agree, x = Don't know

	Strongly disagree				*Strongly agree*	*Don't know*

a. It is easy for service users and carers to find support to enable them to be involved in clinical psychology training.

| 1 | 2 | 3 | 4 | 5 | x |

b. Bias is a problem when involving service users because only certain people come forward (for example the most vocal).

| 1 | 2 | 3 | 4 | 5 | x |

c. It is easy for staff to find support for involving service users and carers in the clinical psychology training programme if they wish to do so.

| 1 | 2 | 3 | 4 | 5 | x |

d. Most service users are too vulnerable to get involved.

| 1 | 2 | 3 | 4 | 5 | x |

e. It takes more time than is actually available to involve service users and carers in clinical psychology training.

| 1 | 2 | 3 | 4 | 5 | x |

f. Most service users are keen to be involved with training mental health staff once they are better.

| 1 | 2 | 3 | 4 | 5 | x |

g. There are too many obstacles in the way to realistically involve service users as equal partners in clinical psychology training.

| 1 | 2 | 3 | 4 | 5 | x |

h. A great many service users are certainly well or able enough to contribute to clinical psychology training in some way.

| 1 | 2 | 3 | 4 | 5 | x |

6. In general, have we done as much as we can to involve Service Users and Carers in the clinical psychology training programme? Please circle your answer.

| Definitely not | Probably not | Maybe or maybe not | Yes probably | Yes definitely |

Please comment on your answer to Question 6 using the space below, if you wish.

7. In general, to what extent do you feel that the training programme has given you skills and confidence to empower Service Users? Please circle your answer.

Not   A little   To some   Quite   A great deal
at all   extent   a lot

8(i). Overall, how would you rate the training programme on Service User involvement? Please base this on your experience of working with the programme so far. Please circle your answer.

Very poor   Poor   So so   Good   Very good

8(ii). Overall, how would you rate the training programme on Carer involvement? Please base this on your experience so far. Please circle your answer.

Very poor   Poor   So so   Good   Very good

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The Society has more than 46,000 members and:

- has offices in England, Northern Ireland, Scotland and Wales;
- accredits undergraduate programmes at 117 university departments;
- accredits 143 postgraduate programmes at 84 university departments;
- confers Fellowships for distinguished achievements;
- confers Chartered Status on professionally qualified psychologists;
- awards grants to support research and scholarship;
- publishes 11 scientific journals, and also jointly publishes *Evidence Based Mental Health* with the British Medical Association and the Royal College of Psychiatrists;
- publishes books in partnership with Blackwells;
- publishes *The Psychologist* each month;
- supports the recruitment of psychologists through the Psychologist Appointments section of *The Psychologist,* and www.psychapp.co.uk;
- provides a free 'Research Digest' by e-mail and at www.bps-research-digest.blogspot.com, primarily aimed at school and university students;
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- recruitment – the target is 50,000 members;
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- public understanding of psychology – addressed by regular media activity and outreach events;
- influence on public policy – through the work of its Policy Support Unit, Boards and Parliamentary Officer;
- membership activities – to fully utilise the strengths and diversity of the Society membership;
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