Staff Perspectives of Service User Involvement on Two Clinical Psychology Training

Courses

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Abstract

This study investigated both negative and positive staff perspectives of service user involvement on two clinical psychology training courses as part of an ongoing process of service evaluation. Ten clinical psychology staff from two training courses were interviewed over the telephone by a current trainee clinical psychologist using a semi-structured interview method. Data were coded into textual units of meaning and then analysed using content analysis. The categories most cited by participants regarding the positives of service user involvement were that it 'develops trainees' learning' and 'challenges power differences'. For opportunities of service user involvement to provide benefits to the training courses, most participants cited 'meaningful versus tokenistic involvement', followed by 'strategic involvement'. Regarding negatives and barriers, those most cited were 'differences of opinion or agendas' and 'lack of resources'. Whilst the findings suggested that the service user involvement initiatives on both courses have been well received, research is needed into how service users also experience the process. Interventions that facilitate staff reflection and processing of multiple perspectives was also recommended, particularly with regards to negative experiences of service user involvement.

Keywords: Clinical psychology training; service user and carer involvement; content analysis; staff perspectives; opportunities and barriers

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In recent years there has been a growing recognition of the importance of involving service users in the organisation, planning and delivery of services (Department of Health [DoH], 2001; National Social Inclusion Programme, 2004). This shift in policy has extended to the requirement for higher education institutions to involve service users in health professionals' training (DoH, 1999) and is part of the British Psychological Society's (BPS) accreditation of post-graduate clinical psychology training (BPS, 2007; 2010). However, the implementation of service user involvement programmes in higher education remains inconsistent (Bassett, 1999; Curle & Mitchell, 2004). This highlights a need for further research on the positives and potential barriers that can facilitate, or prevent, effective partnership working between education providers and those who use services (Felton & Stickly, 2004).

Service User Involvement in Context

Service user involvement has a large role within Government policy initiatives in health and education. However, this is a relatively recent policy development (Beresford & Croft, 2001). Service user groups have been campaigning for a number of years in order to have an influence in the running of mental health services (Beresford & Campbell, 2004). Many argue that the iatrogenic effects of some medical treatments, combined with professional models of expertise that marginalise service user voices by labelling their experiences as the product of diseased biochemical processes (Bentall,

1994), have contributed to service users' experiences of stigma and exclusion (Beresford, 2002; Perkins & Slade, 2012).

However, the growth of a large and politically active service user movement coincided with major structural changes in the health service (Beresford & Campbell, 2004). Service user roles became more active, perhaps reflecting more democratic models of service provision (Beresford, 2002). Within higher education, service users began to be employed as trainers (Bassett, 1999), with the opportunity of taking on more socially valued roles with a potential income (Hanson & Mitchell, 2001). Despite this, there is evidence that attitudes in higher education can still be hostile to service user involvement (Bassett, 1999) and professional models of expertise still remain dominant over 'expertise by experience' (Felton & Stickley, 2004).

Reasons for Involving Service Users in Higher Education

Involving service users in higher education is an important aspect of social inclusion that also is likely to have a positive benefit on people's recovery (Anaya, Eggleton, Grant & Shaw, 2000). It has a clear mandate in Government policy (DoH, 2001). It actively challenges inaccurate stereotypes of service users that they are incompetent, unreliable or even dangerous (Bassett, Campbell & Anderson, 2006). Finally, increasing involvement on higher education professional training courses is likely to socialise new professionals in partnership ways of working (Curle & Mitchell, 2004). This can enable the development of more recovery-orientated mental health services that are based on mutuality and a shared understanding or focus. It is likely that mental health services will be less empathic and more stigmatising or repressive without

such mutuality in the relationships between staff and service users (Davidson et al., 2008), Taken together, these represent powerful arguments for increasing involvement on clinical psychology training courses (BPS, 2008).

Previous Research

There is still a lack of good evidence regarding the impact of service user involvement within higher education and it is a key area that requires further investigation. Despite this, there are studies that have looked at the effectiveness of service user involvement in mental health professional training (see Repper & Breeze, 2007). What follows is a review of both the benefits and the potential barriers to service user involvement in higher education.

Benefits and opportunities of service user involvement.

According to Harper, Goodbody and Steen (2003), the benefits of involving service users in higher education included challenging professionals' assumptions and breaking down the 'us and them' thinking that sees service users as different. One study reported that a group of nurses trained by service users had more positive and less stigmatising attitudes compared to a group of participants trained by professionals (Cook, Jonikas & Razzano, 1995), whilst Rees, Knight and Wilkinson (2006) observed similar benefits of user involvement in medical training, if the process was managed carefully. Finally, Repper and Breeze (2007) in their literature review of user and carer involvement in health care education, observed that service user programmes showed promise in

enhancing workers' professional skills, but recommended such initiatives should be developed in collaboration with local service providers.

Regarding clinical psychology training, Hayward and Harding (2006) found that participants on a service user/carer involvement workshop reported positive effects of service user involvement, such as offering different perspectives and adding to trainees' learning. Eke (2008) found that the majority of trainee participants in her survey made reference to the benefits of involvement, some of which included: gaining knowledge/understanding, facilitating learning and professional/service benefits, gaining service user perspectives and challenging 'us and them' beliefs.

Negatives and barriers of service user involvement.

Although the research on service user involvement in higher education has highlighted its positive impact on trainees in higher education, some of the research has also found negative perceptions or experiences. Hayward and Harding (2006) identified inadequate representation, negative perceptions of the consequences of involvement and difficulties with the 'service user' label as relevant factors. Interestingly, the responses were unanimously positive until the researcher deliberately invited participants to express negative attitudes. Stallard, Hudson and Davis (1992) pointed out that service satisfaction questionnaires tended to receive overly positive responses and recommended inclusion of questions about negative aspects of services. In service user involvement, the climate of 'political correctness' may in fact limit the expression of 'true' attitudes amongst professionals (Soffe, 2004).

Another issue is the identification of organisational and personal barriers that make involvement difficult. For example, Harper et al. (2003) identified several barriers to increasing involvement amongst participants on a service user involvement workshop, such as a reliance on medical/expert knowledge models, organisational issues and personal fears, e.g. being politically incorrect. According to Harper et al. (2003), some of the barriers are related to professionals themselves and perhaps insufficient attention is paid to their views, understandings and needs in developing service user and carer involvement.

In one of the few studies that have specifically investigated staff attitudes towards service user involvement, Felton and Stickley (2004) interviewed 10 staff members about service user involvement on a mental health nursing training course, and found that one of the most significant barriers to involvement was staff perspectives of service users. For example, service user trainers were viewed by many as being unpredictable and unable to cope with the demands of higher education. Such attitudes highlight how the structure of higher education can serve to undermine service users and reinforce the dominant discourse of medical/professional expertise (Barrett et al., 2006).

Need for Project

This study took place on two neighbouring clinical psychology doctoral training programmes. Both courses had a history of facilitating service user involvement and had service user liaison groups that met regularly. This study was part of an ongoing service evaluation of the impact of the service user involvement initiatives on staff and trainees on both training courses.

As highlighted by Harper et al. (2003), staff attitudes towards the process of increasing service user/carer involvement are a potentially crucial determinant in the success or failure of such initiatives. Whilst evaluations carried out on both programmes had generally indicated favourable responses from trainees and some staff (e.g. Eke, 2008; Holttum & Hayward, 2010), there was a lack of detailed understanding of how staff (beyond the core development teams) had evaluated the strengths and weaknesses of these developments, and a need to begin dialogue with the wider staff groups in a way that would not feel exposing. Such understanding was essential to help the course teams identify current barriers or opportunities to further developing and expanding the involvement programmes. The aim of this study was thus to provide a way of engaging the staff teams in non-threatening discussions about their perspectives on both negative and positive aspects of the service user involvement initiatives on the two training courses. It was anticipated that these discussions would provide the basis to improve involvement initiatives by identifying areas of strength and any barriers that may be perceived by the staff team.

Study Questions

In a sample of staff across both courses:

1. What are participants' opinions of the positive consequences of service user/carer involvement on their clinical psychology training programme?

2. What are participants' views of the negative consequences of involvement?

3. What do participants see as the potential opportunities for expanding involvement across the programme?

4. What do participants see as the potential barriers for more service user/carer involvement?

Method

Participants

Ten clinical psychology staff members from the two training courses were selected (five per course) to participate in the study. They were selected using purposive sampling (Krippendorff, 2004) in order to include people from different specialties and employment grades and with different levels of involvement in the service user/carer programme on their respective courses. The aim was diversity rather than representativeness and would enable the gathering of a range of perspectives. A detailed breakdown of the specialities of each participant is not included in order to protect anonymity. Contributions to service user involvement ranged from substantial to none at all. No one who was approached refused to participate.

Design

Data were collected via semi-structured interviews over the phone with staff members by a current trainee clinical psychologist on one of the courses. Five questions were devised by the researcher, in collaboration with one staff member from each course. These questions were:

1. What is your experience of service user/carer involvement on a clinical psychology training course? What is your definition of 'service user'?

2. What do you think are the positives of having more service user/carer involvement on your institution's clinical psychology training course?

3. What do you think might be the negatives or potential problems the programme might encounter – or that perhaps the programme already does – as a result of having more service user/carer involvement on your institution's clinical psychology training course?

4. What are the potential opportunities to your training course for having more service user involvement – ways in which they might become more involved?

5. What do you think are the potential barriers for more service user involvement on your institution's clinical psychology training course?

Responses were recorded by the researcher as closely to verbatim as possible, and then analysed using content analysis in order to generate categories that captured the essence and frequency of participants' responses (Oppenheim, 1992). Content analysis has long been used to code transcribed speech and to collate the number of participants in whose contribution one finds reference to particular categories of content (Krippendorff, 2004). Whilst in small samples this number is unlikely to be representative of the wider population, it probably represents the relative salience of concerns within the sample at a given time, and this is particularly informative when care has been taken not to restrict the diversity of possible perspectives in the sample (as might happen if one only selected participants known to be actively working to increase service user involvement).

Procedure

Recruitment was conducted in collaboration with a staff member contact from each course. The staff contacts initially presented the project at a staff meeting. Staff members were then selected by the staff member contacts in order to ensure there was diversity in experiences of service user involvement and across specialities. The collaborating staff member then approached the potential participants and, once they had agreed, the researcher was given the contact details of the participant. Interviews were conducted over the telephone. Once agreeing the conditions of the interview, the researcher proceeded to ask the participant each question. At the end of the interview, the researcher then read back to the participant their responses for each question to check recording accuracy. Changes were then made if necessary on request of the participants.

Data Analysis

The results describe the responses from ten participants. Responses were divided into a total of 195 units of meaning overall. From this, 5-6 codes were identified for each question. The categories for the questions on 'Negatives for service user involvement' and 'Barriers to service user involvement' were collapsed due to the high level of overlap between responses. Inter-rater reliability was calculated using Cohen's Kappa coefficient of agreement (Seigal & Castellan, 1988) on approximately 50% of the data, which was randomly selected. The ratings suggested reasonably good inter-rater reliability (Kappa = 0.75; $p<0.001$). The categories are presented below according to the relevant question, along with examples from participants in order to illustrate the category.

Results

Positives of Service User Involvement

Categories for the positives of having service user/carer involvement on a clinical psychology training course are presented below (Table 1). Most of the responses for 'Develops learning' were about the impact of this on trainees, although two participants also included the development of service user skills as well. Responses for 'Challenges power differences' were mainly around relationships between professionals (both trainees and staff) and service users, while responses for 'Breaks down barriers' were mostly about the relationships between trainee and service user. Reponses for 'Humanises training' were mainly about the general impact service user involvement has had on the professional culture, whilst responses for 'Feedback on services' was concerned with the benefits to trainees' learning of first-hand accounts from service users about their experiences of treatment. 'General statements' reflected individual opinions about the process of service user involvement.

[Table 1 goes here]

Opportunities for Service User Involvement

The categories for the opportunities for service user involvement on the training course are presented below (Table 2). 'Meaningful involvement' was concerned with real rather than tokenistic involvement, 'Strategic involvement' concerned service user involvement at a management level (e.g. Strategic Health Authority), while 'Local context' concerned involvement on trainees' placements or within local NHS Trusts.

Responses for 'Social inclusion' were mostly about making the course more accessible to non-psychology personnel, including service users, whilst 'On the course' concerned service user involvement in the main aspects of the day-to-day running of the course including selection, assessment, teaching or research.

[Table 2 goes here]

Negatives and Barriers of Service User Involvement

The categories for negatives and barriers of service user involvement on the training course are presented below (Table 3). These were collated together due to the degree of overlap between categories for both questions. Responses for 'Differences of opinion or agendas' were about disagreements or different views between staff on the course, and also between service users and professionals (trainees and staff). It also included how these differences were communicated or managed. 'Lack of resources' concerned personal, as well as financial, limitations, whilst 'Tokenistic involvement' included such things as inadequate representation. Responses for 'Organisational barriers' concerned the bureaucracy of university systems (e.g. payment of service users for their time), whilst 'Negative experiences' concerned both bad experiences in the past for both service users and professionals and reinforcement of prior experiences for service users. Responses for 'Personal defences' were mostly around staff defensiveness to personal weaknesses, frailties or vulnerabilities that may be provoked by service user accounts of their experiences, whilst 'Inflexibility' concerned over-investment in particular positions, roles or identities for both professionals and service users.

'Unfulfilled expectations' concerned disillusion experienced by both professionals and service users, whilst 'Insufficient skills/training' were mostly around service user skills/training not being equivalent to staff. Finally, 'Low interest' mostly concerned opposition or lack of enthusiasm to service user involvement for staff and trainees.

[Table 3 goes here]

Discussion

This service evaluation described the responses of 10 clinical psychology training staff from two training courses on their positive and negative experiences of service user involvement on their training courses. The sample reflected a fairly diverse spectrum of perspectives from which to view service user/carer involvement. A discussion of the findings according to benefits, opportunities and negatives/barriers is presented below.

Positives

The most frequently cited positive benefit of having service user involvement on a clinical psychology training course was that it 'Develops learning'. This follows similar results reported by Hayward and Harper (2006) and Eke (2008). However, only two participants mentioned that it also developed service user skills. Whilst this may be understandable given that clinical psychology courses are for the purposes of developing new professionals, it may highlight the need for clinical psychology programmes to be more socially inclusive and have a wider focus than just the development of specific training competencies (Curle & Mitchell, 2004).

The second and third highest cited category for positives of service user involvement was that it 'Challenges power differences' and 'Breaks down barriers'. Harper et al. (2003) and Cook et al. (1995) also reported these factors as significant potential benefits of service user involvement. However, as Hayward and Harding (2006) have observed, participants may report what is deemed politically correct, rather than their 'actual' opinions, which may be different. Social desirability can be a difficult thing to overcome in interview and questionnaire research (Crowne & Marlowe, 1960), but needs to be taken into account in interpreting findings for service user involvement research (Stallard et al., 1992). Finally, although it is encouraging that participants evaluated service user involvement as having a strong impact on social exclusion (e.g. by breaking down barriers and challenging power differences), this may not be the experience of service users who are involved on the course. Future service evaluations may need to investigate service user perspectives of such initiatives to evaluate the degree to which they are genuinely inclusive.

Opportunities

The highest number of responses for opportunities concerned the need for 'Meaningful involvement'. This may reflect concerns that service user involvement remains genuinely democratic and participatory and does not become a 'tick-box' exercise (Beresford, 2002). It may also echo the observation that genuine involvement must be managed with care (Rees et al., 2007). In Eke's (2008) study with a cohort of trainees, the majority of participants stated that they did not find the service user involvement tokenistic or unrepresentative. However, future service evaluations may

want to find out how service users on the course view their participation and whether issues of tokenism are reflected in their experiences.

The second and third highest reported categories were for 'Strategic involvement' and involvement in the 'Local context'. It is not surprising that the former category figured highly as many of the participants were involved in service user focussed projects at a strategic, managerial level. Such initiatives are important, as the creation of a 'justifying rhetoric' at policy level (Brunner, 2006) can facilitate a wide sense of ownership of service user involvement by the course as a whole, and not just be the business of a few interested individuals (Curle & Mitchell, 2004).

However, the 'Local context' category reflects Repper and Breeze's (2007) findings that service user involvement is more successful when done in partnership with local service providers. As much of the contact between training institutions and service providers takes place in the context of placements, this would seem to be the obvious place to develop service user/carer initiatives (BPS, 2008; see Hayward, Hughes, Southwood, Pearce, & Holmes, 2006). However, attention will need to be given to the conditions that would bring about learning, since the power dynamics established in the clinical setting may work against it (Rush, 2008).

Rush (2008) drew on Mezirow's (2000) concept of transformative learning to suggest that service user involvement in training may produce learning by reaching the student on an emotional level and promoting reflection. Rush (2008) reported evidence suggesting that some nurses had undergone this kind of learning in the context of service users talking in the classroom about their experiences. The service users had received preparation and training that enabled them to put student nurses at ease so that the latter

would neither feel uncomfortable about how other professionals including nurses had treated the service users, nor that they had to perform the professional role. Reports by participating students suggested they felt able to relax and just be learners, and so ask questions they would not ask of a patient while on placement. This highlights that the content of what is learned may be difficult to separate from the mode of learning. Students in this study reported behaving differently in practice because of the identifications they had made with service user trainers, which they reported not always making to patients in hospital or clinic. Without the context facilitative of learning, similar content may not have had such a profound effect.

Negatives and Barriers

Two of the most frequently cited negatives/barriers were 'Differences of opinion or agendas' and 'Tokenistic involvement'. Tokenism in service user involvement can be a disempowering experience for service users (Barrett et al., 2006) and can result in the reinforcement of negative professional stereotypes and attitudes (Fenton & Stickley, 2004). Representation for previously 'hard to reach' groups like learning disabled clients, older adults and child and adolescent service users should also be encouraged (e.g. Parkes, Samuels, Hassiotis, Lynggaard & Hall, 2007; Dening & Lawton, 1998; Harrington, Kerfoot & Verduyn, 1999). However, at the same time, such things as 'inadequate representation' and 'lack of resources' should not be used as an excuse to stop developing service user initiatives (Curle & Mitchell, 2004).

Rees et al. (2007) observed that the process of service user involvement should be managed with care, as differences of opinion can provoke some unhelpful conflict.

Service users who have had negative experiences from mental health services may feel mistrustful of professionals (Barrett et al., 2006), whilst professionals may feel like they are being unjustly blamed or judged (Hayward & Harding, 2006; Rush, 2008). Thus, service user involvement initiatives on clinical psychology training courses should aim for genuine democratic, partnership working whenever possible (Beresford, 2002), alongside the recognition that different perspectives will always exist (BPS, 2008), and should adequately prepare service users and carers for their training role.

'Lack of resources' and 'Organisational barriers' were also two of the most frequently cited negative experience/barriers. As Tew, Gell and Foster (2004) have observed, service user involvement requires a significant investment in terms of time, money, resources and capacity. This is impossible without institutions enabling initiatives to happen through funding, allocation of staff resources etc. (Crossley, 2004). It is also a question of organisational priorities and how the agenda for collaboration can be integrated within already packed training schedules (BPS, 2008). If future research were to demonstrate more fully how service user involvement is linked to an improvement in training outcomes (Repper & Breeze, 2007), this might help to build organizational support for spending time and resources on it.

However, in the realm of services (as opposed to training), some initiatives have already begun around the UK, with the REFOCUS project (Refocus on Recovery, Slade et al., 2011) and the high uptake of the ImROC project (Implementing Recovery through Oganizational Change, Shepherd, Boardman & Burns, 2010). Arguably it is time to replicate these initiatives in mental health training courses, perhaps beginning by carrying out workshops with a range of courses and service users and carers who have experience

of working with courses, to identify the key challenges for organizational change. In the ImROC project twenty-six services opted to begin tackling a list of 10 key challenges that had been generated in this way (with services rather than training courses), which include creating a different culture, leadership initiatives and actively valuing staff's own service user and carer experience and supporting staff in drawing upon these appropriately. Slade (2009) highlights the importance of leadership in bringing about change through positive processes such as empowering and inspiring people, communication of a shared vision and appropriate staff training.

Methodological Considerations

Telephone interviewing is considered a valid means of collecting data for short, structured interviews (Fontana & Frey, 1994) of the type reported in this particular study. Whilst there are differing accounts of the quality of data for interviews conducting over the telephone compared to face-to face interviews (see Sturges & Hanrahan, 2004), some research suggests that participants are more likely to be honest, particularly if discussing sensitive topics as the telephone contributes to the participants' feelings of anonymity (Greenfeld, Midanik & Rogers 2000). However, it also likely that the author's position as a trainee would have important ramifications for how open and honest participants felt able to be. For example, participants may have felt obliged to give more 'politically correct' responses, or to demonstrate the expected attitudes to a trainee and to those staff members and service users who were involved at the universities.

The sample size was relatively small compared to other studies in higher education (see Repper & Breeze, 2007). Thus, the study cannot be viewed as

representative of either the courses being evaluated or the profession as a whole, and nor was this the aim. However , the study findings have provided a greater insight into some important issues on these two courses.

Finally, responses were recorded with hand-written notes and whilst measures were taken to ensure that accuracy was checked (e.g. reading back responses to participants), this method cannot be considered as accurate as tape-recording (Oppenheim, 1992). However, tape-recording and transcribing interviews were beyond the time resources available to the project. Hand-written notes were deemed to be sufficient for the scope of this project.

Implications for Clinical Psychology Courses

As Hayward and Harding (2006) have observed, there appears to be a pressure for people to report only the positive aspects of service user involvement, perhaps through fear of judgement or appearing politically incorrect. Thus, in order to gain the full spectrum of opinion concerning service user involvement amongst staff and, from this, find a way of bringing more staff members on board, it is necessary to provide the appropriate forum for multiple perspectives to be heard and learning to take place.

For most participants, resource issues were the single most important factor providing a barrier against the development of new initiatives. Within the climate of evidence-based practice in Higher Education and the NHS, there is an increasing need to justify how initiatives are linked to specific learning outcomes (Klein, 2006). Thus, it may be necessary for the courses to develop outcome data to evaluate the effectiveness of service user involvement programmes on trainees' professional development (BPS,

2008). However, whilst this could help provide the 'justifying rhetoric' (Brunner, 2006) necessary to secure more financial backing for new and existing programmes (Crossley, 2004), arguably it should not hold up the implementation of service user and carer involvement. Firstly to wait until further research has been carried out may mean nothing happens, because we have entered 'catch-22'. Secondly, none of the other ways of training clinical psychologists have had to demonstrate evidence of efficacy other than by unvalidated assessments.

Conclusion

This service evaluation reported the findings of interviews with 10 clinical psychology training staff from two courses concerning their experiences and perceptions of the positives, opportunities, negatives and potential barriers of service user involvement on their training courses. It is clear that there are significant challenges ahead in ensuring service user involvement in clinical psychology training remains a meaningful and helpful experience for trainees. It is important that honest discussion concerning the potentially negative effects of involvement is balanced along with recognition of the progress that has been achieved. Like the apparently successful facilitation of student nurse learning (Rush, 2008), clinical psychology training staff need a forum where they can be safely "not-knowing" and ask questions that may be politically incorrect or demonstrate their not knowing. It is likely that future evaluations and research in this area will contribute more fully to this ongoing debate. We suggest these should be collaborative exercises with service users and carers in an atmosphere of mutual learning and reflection.

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Table 1.
Categories for the positives of having service user/carer involvement on a clinical psychology training course

Category	Example	Number of responses N = 55	Number of individuals N = 10
Develops learning	"Having service users on the course provide a learning opportunity beyond the therapeutic space"	13	7
Challenges power differences	"Poses professionals with interesting and difficult questions which we all need to think about"	12	7
Breaks down barriers	"It helps develop a different mind-set for the trainee – experiencing the other in a different way but not 'othering'"	10	7
Humanises training	"Allows for discussion and debate which is no longer hypothetical because it is based on real-life situations and stories"	9	6
General statements	"More positives if more representation…"	6	4
Feedback on services	"Can make trainees aware of iatrogenic effects of services"	5	3

Table 2.
Categories for the opportunities for service user/carer involvement on the training course

Category	Example	Number of responses N = 38	Number of individuals N = 10
Meaningful involvement	"Making service users integral to the process of change – not just a 'bolt on'"	9	7
Strategic involvement	"For example, developing guidelines to create a context and giving permission to give things a go"	8	7
Local context	"There could be more opportunity on placement for learning about service user perspectives and working with self-help/community groups"	9	6
Social inclusion	"Making the course more accessible for people outside of clinical psychology"	6	4
On the course	"Selection – could be integrated with others aspects of selection, but may be a bit more difficult"	6	4

Table 3.

Categories for negatives and barriers to service user/carer involvement on the training course

Category	Example	Number of responses N = 102	Number of individuals N = 10
Differences of opinion or agendas	"Differences in opinions can become heated – both staff getting defensive and service users perceiving staff as 'the system' and representing negative views"	22	8
Lack of resources	"Time and resources are always stretched for already busy people"	19	7
Tokenistic involvement	"We feel better for having involvement but must be prepared to share power"	10	7
Organisational barriers	"Finances – payment rewards for contributing are not great and this has an impact on who can and cannot contribute"	8	6
Negative experiences	"If not done with care can be a very disempowering experience for service users and confirm prior experience of services"	8	6
Personal defences	"Defending against one's own vulnerabilities, e.g. life becoming overwhelming – difficult for people to accept own weaknesses"	6	6
Inflexibility	"Some SUs who are involved have a particular experience that is very powerful and has led them to invest their time presenting a particular view"	10	5
Unfulfilled expectations	"Wasted time or effort and heightened expectations or unachievable goals, e.g. total representation, can lead to disillusionment all sides"	5	5
Insufficient skills/training	"Service user criteria cannot be seen as equivalent to staff – e.g. quality of training"	8	4
Low interest	"Individual attitude – some trainees not being interested or keen on agenda"	6	4