# MAJOR RESEARCH DISSERTATION

# Clinical psychology and mental health service user involvement

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# DEDICATION

For Julia, for your selfless patience and support

For Maisy Emilie and Alice Lily, you are my world

For Dad, you were right as always, I did know the difference

For Mum, Grandma and Michael, for ‘being here’

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Also, to dissident voices, you helped me too, because the clarity of my thinking is much stronger when challenged.

Thank you

“In each society there are favoured ways in which two individuals can approach and have dealings with each another, for example, as kindred to kindred, or high caste to low” (Goffman, 1961, p. 283).

# NOTE ON TERMINOLOGY

The author is aware of the contentious nature of many of the terms used in this report. It is important to highlight that inconsistent usage throughout this thesis is a reflection of the different bodies of literature reviewed. In general, the author's preferred term of "service user" has been broadly adopted to refer to people with current and/or historical experiences of "psychological distress" or "mental health difficulties", who are recipients of mental health service provision. However, it is fully acknowledged that there are other preferred terms such as "survivor", "consumer", "patient", "person with lived experience", or "expert-by-experience". "Service user" has been adopted here as it is reported to be the least ideologically charged term (Barnes & Cotterell, 2012). That said, the terms "mental illness" and "people with mental illness" have also been used at times, purely for the purposes of brevity and should be interpreted as "people carrying mental illness diagnoses". The term "client" has also been used when discussing the therapeutic relationship and the author is fully aware of its consumerist connotations. It is stressed, however, that people are, first and foremost, "people". "Service provider" has been used to refer to those delivering a mental health service.

Additionally, the terms "service user involvement", "user involvement", and "involvement" are used interchangeably throughout the report but should be interpreted as one. Readers may note a distinct absence of discussion on "carer" involvement. This is not to say that the author believes carer involvement is less important; it is not the focus of this current work, due to its connections with the provision of psychological therapy. It is acknowledged that, for some, the roles of "service user" and "carer" may not be mutually exclusive.

# THESIS OVERVIEW

This thesis comprises three interconnected chapters: a systematic literature review (chapter one); empirical paper (chapter two); and an extended discussion (chapter three) which incorporates an accessible version of the research findings, and a future research proposal.

The systematic review[1] aims to find, describe and critique the empirical evidence for the impact of mental health service user involvement on the design, delivery, commissioning or evaluation of mental health services. Secondary objectives are to ascertain whether any attempts have been made to apply psychological theory and whether clinical psychologists are involved in the research. The review implements a comprehensive, replicable search strategy and identifies 11 studies published between 1997 and 2014. The included studies highlight both positive and negative impacts at individual (e.g., for service users and service providers) and strategic (e.g., for services and organisations) levels. Process issues, barriers and resistance to the implementation of involvement were also found. No studies applied psychological theory. Clinical psychologists were involved in a small portion of the studies.

The review does not support previous reports that user involvement lacks an evidence base. A small empirical evidence base for involvement was found.  However, the majority of studies were poorly reported and had significant methodological flaws. None of the 11 studies included in the review had applied psychological theory to its findings. Therefore, this review applied psychological theories of power and empowerment, attitudes, stigma and intergroup contact to the impact and barriers reported in the included studies. The methodological limitations of the included studies and the review process were discussed. The review concludes with a discussion of the clinical implications, implications for clinical psychologists and areas for future research. It is important that the findings of the systematic review are considered in light of the numerous implications and limitations and, therefore, interpreted tentatively.

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[1] The systematic review has been written and prepared for submission to the journal “Clinical Psychology Review”. Tables 5 and 6 would locate in the appendix of the journal. Here they remain in the main body of the thesis to aid the reader.

The empirical paper[2] provides empirical research designed and conducted to investigate the attitudinal and organisational barriers to involvement. In utilising the psychological therapist-client dyad, the research aims to ascertain whether there are relationships between psychological therapists' explicit attitudes to mental illness, implicit attitudes to service user involvement, and perceptions of organisational culture. It establishes whether there are relationships between these and the quality of the client-rated therapeutic alliance. The research employs a cross-sectional design comprising 28 psychological therapist-client dyads within two North West NHS Trusts in the UK. The study found that therapists' explicit attitudes to mental illness and implicit attitudes to service user involvement were, on the whole, positive. Most therapists perceived the organisational culture of the NHS as market-driven and results-orientated. Counter to expectation, no significant relationships were found between therapists' explicit attitudes to mental illness, implicit attitudes to service user involvement, and client-rated alliance, and the hypotheses were unsupported. The empirical paper concludes with a discussion of the possible reasons for the lack of significant findings, with reference to methodological, theoretical, and ethical considerations, and clinical implications.

The extended discussion initially provides a brief overview of the preceding chapters. It then discusses methodological and ethical considerations, research paradigms and the nature of evidence, clinical psychology, leadership and user involvement and policy. It suggests that clinical psychologists' skills as scientist-practitioners make them well placed to research, formulate, theorise and provide psychological understandings of user involvement and its impacts and barriers. It concludes with the suggestion that the input of clinical psychologists into service user involvement strategy at individual, organisational and strategic levels could be synonymous with a recently proposed paradigm-shift for the profession of clinical psychology.

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[2] The empirical paper has been written and prepared for submission to the "British Journal of Clinical Psychology".

# CHAPTER 1: SYSTEMATIC REVIEW

## What is the Evidence for the Impact of Service User Involvement in Mental Health Services?

# Abstract

Mental health service user involvement is a political and legislative imperative for all healthcare professionals including clinical psychologists. Profession specific guidance and ethical codes provide further drivers for clinical psychologists to involve mental health service users in all aspects of the design, delivery, commissioning or evaluation of mental health services. However, involvement is reported to lack an evidence base. This is problematic for clinical psychologists as scientist-practitioners who apply theory and research evidence to practice.  This systematic review examined 11 empirical studies that reported and evaluated the impact of mental health service user involvement initiatives.  A small empirical evidence base for the impact of user involvement was found. However, the research was poorly reported and methodologically flawed. Studies highlighted a wide range of negative and positive impacts at individual and strategic levels, together with process issues and barriers and resistance to involvement. The impacts reported in the studies reviewed lacked application of psychological theory with only a few having input from clinical psychologists. Psychological theories of power, empowerment, attitudes and intergroup contact were, therefore applied. The review discussed the methodological limitations of the included studies and review process, implications for clinical psychologists and areas for future research.  The review concluded that user involvement impact research requires significant enhancement in the quality of its reporting. Establishing what works for whom, and in what circumstances using empirical research is essential, especially in times of fiscal constraint where support for user involvement based on values and experiential knowledge is harder to defend.

***Keywords: Service user involvement, mental health services, impact, systematic review, psychological theory***

# What is the Evidence for the Impact of Service User Involvement in Mental Health Services?

For more than four decades, the need to involve service users in mental health services in the United Kingdom (UK) National Health Service (NHS) has been emphasised incrementally. It has pervaded the policies (see Department of Health, 1999, 2000, 2008a, 2008b, 2008c, 2009) and legislation (see the NHS and Community Care Act 1990; the NHS Act 2006; the Health and Social Care Acts 2001, 2008, 2012; Department of Health, 2010, 2013) of each subsequent governmental administration. Health and Social Care Acts (2008, 2012) have progressively widened the remit for involvement of mental health service users to include commissioning (Health and Social Care Act, 2012, part 5) and regulation (Care Quality Commission, 2009; Health and Social Care Act, 2012; Duty 14Z2). Therefore, there are strong legal obligations to plan, design, implement, commission, consult and evaluate with mental health service users.

This paper systematically reviews 11 empirical studies that have explored the impact of service user involvement. The main aim is to identify, describe and critique the evidence for the impact of the involvement of mental health service users in the design, delivery, commissioning or evaluation of mental health services in the UK. First, the importance of user involvement and the evidence base for clinical psychology as a profession is considered. This is followed by a discussion of psychological theories of power and empowerment, psychological attitudes, stigma and intergroup contact.

The British Psychological Society’s Division of Clinical Psychology (DCP) provides profession-specific guidance on the need to involve service users and carers in clinical psychology services (see DCP, 2010a) and on clinical psychology training courses (see DCP, 2008). The “Core Purpose and Philosophy of the Profession” (see DCP, 2010b) expects clinical psychologists to work collaboratively with service users as equal partners. The UK statutory regulator of health and care professionals has profession-specific Standards of Proficiency for clinical psychologists that incorporate the need to use interpersonal skills to encourage the active participation of service users (see Health and Care Professions Council, 2012). There is an expectation that clinical psychologists will, in addition to policy and legislation, adhere to professional practice guidance, ethical codes and standards of proficiency.

Clinical psychologists are scientist-practitioners and apply theory to practice. Drawing from and contributing to the evidence base via research is integral to the profession and fundamental to the identity of a clinical psychologist (DCP, 2010b; Kinderman, 2013). There is a reported lack of evidence for a link between service user involvement and positive outcomes (Campbell, 2008; Crawford et al., 2003; Haigh, 2008; Rose, Fleischmann, Tonkiss, Campbell & Wykes, 2002; Rose, Fleischmann & Schofield, 2010), uncertainty as to whether involvement improves service quality and a lack of evidence as to the proportional contribution service users themselves make to project outcomes (The National Involvement Partnership; NIP, 2013). It is important for clinical psychologists, and others, to know what involvement works for whom and in what contexts.

There are also debates surrounding whether research into service user involvement is within the remit of clinical psychologists. Some clinical psychologists suggest close collaboration with service users should be “our business” (Soffe, 2004, p. 15) and “goes to the heart of our professional and personal identities and power relations” (Hayward, Cooke, Goodbody & Good, 2010, p. 8). Authors have highlighted involvement as a potential area for clinical psychologists to apply their research skills and theoretical knowledge stating that the lack of theory should give more impetus to theorise it and not less (see Diamond, 2010; Diamond, Parkin, Morris, Bettinis & Bettesworth, 2003; Harding, 2010; Harper, 2003; Hayward et al., 2010; Mitchell & Purtell, 2009; Soffe, 2004).

Despite the reported lack of a theoretical basis for involvement, there is existing psychological research which is applicable. Whilst involvement may be un-theorised, it is not un-related to psychological theory. Psychological theories related to power, empowerment, attitudes, stigma and intergroup contact all have the potential to inform an understanding of the particular issues faced when providers and users of services work in close proximity. These may illuminate understandings of the process of involvement from a psychological perspective.

## Power and Empowerment

Unequal power distributions are undoubtedly a complicating factor in any encounter between service users and providers (Diamond, 2010; Harding, 2010; Pilgrim & McCranie, 2013; Rogers & Pilgrim, 1991; Rose et al., 2002). Psychological theories of power and empowerment are applicable especially in light of the multifaceted disempowerment of mental health service users. These consist of: abuses of power (see Chamberlin, 1988; Campbell, 2013; Kemp, 2010; Rogers & Pilgrim, 1991) and stigmatised attitudes from within (Friedrich et al., 2013; Lammie, Harrison, MacMahon & Knifton, 2010; Link & Phelan, 2001; Nordt, Rossler, & Lauber, 2006; Smith, 2013) and outside of the mental health system (Chambers et al., 2010; Corker et al., 2013; Corrigan & Shapiro, 2010; Evans-Lacko, Henderson & Thornicroft, 2013; Lammie et al., 2010). These are compounded with oppression and social exclusion (World Health Organisation; WHO, 2010) which are in addition to the psychological effects of mental distress.

Power and empowerment are mutually influencing with any discussion of one reported to be superficial without the other (Gilbert, 1995). Empowerment lacks a single unified definition and is thought to be dependent on different socio-cultural and political contexts (Oladipo, 2009). Various attempts to operationally define empowerment include: gaining mastery over issues of concern (Rappaport, 1987), expansion of freedom of choice and action, fighting for rights, having decision making power (Oladipo, 2009) and having choice, influence and control (WHO, 2010). Psychological empowerment is said to be "an individual's cognitive state characterised by perceived control, competence and goal internalisation" (Oladipo, 2009, p. 121) which should lead to psychological benefits (WHO, 2010).

There is a multitude of conflicting theories of power and empowerment (Masterson & Owen, 2006). These concepts are cross-disciplinary and span psychology, sociology, politics and education (Barnes & Bowl, 2001). Weber's constant sum conceptualization of power sees it as finite and something that someone exercises over another. Where one group is dominant and another disempowered, the powerful would need to transfer their power to those with less power in order for them to be empowered. In contrast, Carl Rogers' psychological model, which operates at the level of the individual, sees power as a personal attribute that can be cultivated through relationships, and nurtured by empathy and unconditional positive regard (Gilbert, 1995). Psychological empowerment is generated within individuals and is, therefore, said to be infinite. Empowerment is said to arise when people's knowledge, skills, self-confidence and self-esteem are increased (Falk-Rafael, 2001) and they are enabled to take control of their own lives (Rodwell, 1996). The psychological approaches to empowerment at the individual level have been criticised on the grounds that they do not involve the shift of power from one place to another and thus may serve to maintain power imbalances (Ryles, 1999).

Foucault theorised notions of power following observations of the psychiatric system (Foucault, 1971). Three dominant forces: "knowledge", "truth" and "power" combine to control people in society. Disciplines (e.g., psychology and medicine) are ascribed roles through knowledge, and the discourse is the medium in which the language is relayed to others and the power exerted. Service user involvement can be understood through Foucault's theories of power. The language and educational attainment of service providers at the pinnacle of the institutional hierarchy excludes those who have not been exposed to this language through education (Masterson & Owen, 2006). Involvement is said to encompass the relatively powerless offering, or being invited to learn the language of the dominant discourse (Masterson & Owen, 2006; Stickley, 2006). Yet they can be seen as competing unequally (Barnes & Bowl, 2001) where the excluded people remain relatively powerless and lack the ability to influence those in power. Dominant discourses then remain powerful by relegating competing discourses to a subordinate position. Power is therefore self-serving.

Barnes and Bowl (2001) suggest the empowerment of mental health service users should encompass power-to, power-with and power-from-within as opposed to power-over. Power from the dominant discourses in mental health services means providers of services sharing power with those generally thought to be lacking it, the users of services. Diluting "us" and "them" boundaries and sharing power may require a cultivation of non-stigmatising psychological attitudes.

## Psychological Attitudes, Stigma and Intergroup Contact

Theories of psychological attitudes, stigma and intergroup contact have applicability in understanding service user involvement. Attitude theory, proposed by Gordon Allport, defined attitudes as mental states, organised through experiences, which induce a predisposition to respond in the same way to a given object (Allport, 1935). A further definition suggests that attitudes are triggered by certain stimuli (e.g., individuals, social issues, situations) and result in various classes of response. These include: affective responses (e.g., what a person feels about the stimuli, and how favourably or unfavourably something is evaluated); cognitive responses (e.g., beliefs about the attitude object or situation); and behavioural responses (e.g., how a person responds or intends to respond; Kiecolt, 1988). A more recent, simplified definition defines attitudes as "a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour" (Eagly & Chaiken, 1993, p. 1).

Stigma, originally defined by Goffman (1963), is described as a mark or attribute that reduces a person “from a whole and usual person to a tainted, discounted one” (p. 3) and broadly denotes negative attitudes. Stigmatised attitudes towards people with mental illness have culminated in perceptions of “dangerousness”, “incompetence”, “unpredictability”, “recklessness”, “helplessness”, “weakness”, “irrationality”, and “incoherence” (NHS Information Centre for Health and Social Care, 2011; Nordt et al., 2006; Rose et al., 2002). The collective identity is, arguably, one that is more often than not, socially devalued. There is evidence that some health care providers share the public’s stigmatising views towards people with mental illness (Chambers et al., 2010; Friedrich et al., 2013; Lammie et al., 2010; Link & Phelan, 2001; Nordt, et al., 2006). Expecting service providers to work closely with service users could potentially give rise to a negative response set as it has been proposed that humans identify with groups they perceive they are similar to, and respond negatively to groups they perceive themselves to be dissimilar to, known as “out-groups” (Hinshaw & Steir, 2008). Providers and users may occupy different groups.

One of the most important and promising strategies for reducing stigmatised attitudes and discrimination against people with mental illness is said to be increased personal contact with a stigmatised group (Allport, 1954; Corrigan & Shapiro, 2010; Evans-Lacko et al., 2012; Pettigrew & Tropp, 2006). This is referred to as intergroup contact theory (Allport, 1954). Allport (1954) suggested four primary conditions that were required for reducing prejudice against out-groups: equal status between members of the “in-group” and out-group; an orientation towards common goals; intergroup co-operation, and support from “authorities”.

A meta-analytic test of intergroup contact theory, comprising 713 independent samples from 515 studies, concluded intergroup contact typically reduced intergroup prejudice (Pettigrew & Tropp, 2006). Pettigrew and Tropp (2006) further concluded that if Allport’s optimal contact conditions are in place, even greater reduction in prejudice is possible. Evans-Lacko et al. (2012) provided additional support for intergroup contact theory and investigated social contact as part of the National Time-to-Change anti-stigma programme. The study consisted of people with and without mental health problems at baseline ($N$= 403) and follow-up ($n$ =83). The authors concluded that the Time-to-Change events facilitated intergroup social contact which was sustained six weeks after the social contact itself. Furthermore, the presence of Allport’s (1954) conditions predicted improved stigma-related behavioural intentions.

The study of attitudes, stigma and the theoretical position of intergroup contact theory can be applied to the study of user involvement. The involvement of mental health service users in mental health services increases the contact between members of a stigmatised out-group (mental health service users) and a non-stigmatised in-group (mental health service providers). Potentially increasing the social contact (e.g., the involvement of mental health service users in the design and delivery of mental health services) could be a promising strategy to reduce prejudice and stigmatised negative attitudes towards people with mental illness by health service providers. Furthermore, if the four primary conditions are met via the implementation of the specific service user involvement strategy, further positive relational gains could result.

In conclusion, for clinical psychologists, service user involvement is a political and legislative imperative and permeates profession-specific guidance, regulations and ethical codes. Its purported lack of both a research evidence base and a lack of theoretical underpinning make the implementation of involvement practices difficult for clinical psychologists whose identity is one of scientistpractitioner. The apparent lack of an empirical evidence base for the impact of involvement requires attention as it is important to establish whether involvement is, at the very least, doing no harm. It may also be useful to explore whether psychological theory has been applied in this field of research as this may enable an understanding of the impact of involvement from a psychological perspective.

Four previous reviews could be located that focused on evaluating the impact of involvement. One systematic review contained international papers, the majority of which were non-UK based and not in mental health services (see Crawford et al., 2002). Another systematic review contained UK papers which would not meet the inclusion criteria for this review (see Simpson & House, 2003). Two reviews examined outcomes generated from non-empirical non-peer reviewed research (see Mental Health Foundation, 2011; Rose et al., 2002). Three of these were conducted over a decade ago in different political and legislative arenas. This systematic review aimed to establish the empirical research evidence for the impact, outcomes, or effects of mental health service user involvement, evidence of application of psychological theory to the impacts and involvement of clinical psychologists in the research.

### Operational Definition of Involvement

For the purposes of the review, it was necessary to operationally define involvement in the event that the included papers did not. Involvement is described as an activity “being carried out with or by [members of the public], not to, about, or for them” (INVOLVE and the National Institute for Health Research, 2012, p. 6).

## Objectives

The objective of this systematic review was to identify, describe and critique the empirical evidence for the impact of the involvement of mental health service users in the design, delivery, commissioning or evaluation of mental health services in the UK. A further objective was to ascertain whether any attempts had been made to apply psychological theory to the impacts and whether there was any involvement of clinical psychologists in this work. Literature for the review was retrieved using systematic searches of electronic databases and supplemented by hand searches. The aim was to identify empirical research reporting the impact or outcomes of an involvement strategy.

## Review Question

The following review question was addressed:

What is the empirical evidence for the impact, or outcomes of mental health service user involvement in the design, delivery, commissioning or evaluation of mental health services in the UK?

In addition, the following review questions were explored:

- Has psychological theory been applied to the impact of involvement, within the research found?
- Are clinical psychologists involved in the research found?

## Method

A scoping literature search was conducted on the 8th of December 2014 to ascertain: the size of the body of literature, trial and refine the search terms, pilot inclusion and exclusion criteria and define the parameters of the review question. Literature was retrieved via five electronic databases spanning; multi-disciplinary (Web of Science), health (MEDLINE with full text, and CINAHL Plus), and social sciences (PsychINFO) disciplines and dissertations and e-theses. Database searching was supplemented by hand-searching. Criteria for inclusion into the review are provided in Table 1.

Table 1

*Inclusion Criteria*

| | |
|---|---|
| Study design | Empirical research. All study designs considered |
| Date limiters | Published 1st January 1980 to 10th December 2014 |
| Population | Mental health service users and providers |
| Setting | UK NHS mental health services |
| Intervention | Provides details of a service user involvement strategy whereby mental health service users and providers have worked together on some aspect of the design, delivery, commissioning or evaluation of mental health services (including policy, strategy and guideline development) |
| Outcomes | Reports on the impact or outcomes of the involvement strategy |

Criteria for excluding papers are provided in Table 2.

Table 2

*Exclusion Criteria*

| | |
|---|---|
| Study design | Non-empirical research<br>(e.g., discussion pieces, editorials and essays) |
| Population | Service users from children's and learning disabilities and learning disability services |
| Setting | Non-UK |
| | Involvement in drug action teams |
| | Involvement in forensic, learning disabilities, children's services and prison settings |
| | Non-NHS (e.g., focus on involvement in the education and training of healthcare professionals in educational settings outside mental health services) |
| | Physical/general health services |
| | Focus on service user involvement in research |
| Intervention | Provides details of a user involvement strategy but does not evaluate it or report the impact |
| Outcomes | Focus solely on involvement in aspects of own clinical care |

The searching process aimed to be sensitive enough to capture as many studies on service user involvement in mental health services as possible. The screening and selection process aimed to be specific enough to capture only studies reporting the impact and outcomes of those strategies from empirical research. A lower bound date limiter of 1980 was applied to the searches. This date was chosen due to increased opportunities for involvement being created at this time[3].

The review excluded studies from outside the UK where there are different policies governing involvement and any studies not reporting involvement in mental health services. It excluded service

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[3] This was triggered by deinstitutionalisation (see the NHS and Community Care Act 1990) and the resultant shift towards increased citizenship and rights together with questions surrounding the legitimacy of bio-medical theory and aetiology of mental illness. Also, consumerism placed emphasis and value on consumer feedback on services (Pilgrim & Waldron, 1998), and "abuses of power" within the mental health system which triggered protest against individual treatment (see Chamberlin, 1988). This also created more opportunities for involvement.

users from children's, learning disabilities, forensic, drug action and prison services. It was thought that various factors, such as ability to give informed consent to be involved and the complex nature of secure provision (e.g., court mandated treatment) may result in a different relationship between users' and providers. Involvement in research and in aspects of own clinical care pose particular challenges and was also exclusion.

## Search Strategy

### Electronic database search.

A comprehensive electronic search of five databases was conducted on the 10th December 2014. Databases were chosen in order to capture a wide array of literature to address the review question. Databases spanned multi-disciplinary, health, and social science disciplines and were: PsychINFO, CINAHL Plus, MEDLINE with full text, and Web of Science. Databases were searched using the following free text search terms: ("service user involvement", OR "user involvement" OR "patient public involvement") AND ("mental health services") AND ("evidence", or "effect*" or "impact*" or "outcome*"). The search strategy used site specific "Boolean operators", word "Truncation" and searched in the full text in order to maximise the chances of capturing all empirical research papers (see Appendix A). A further search of ProQuest Dissertations and Theses was conducted ("Full text" and "UK & Ireland") using the same search terms (no date limiters).

### Hand-search.

A hand search was conducted within "The British Journal of Clinical Psychology", "Clinical Psychology Review", "The Journal of Mental Health", and "Health Expectations". The former three journals were chosen to maximise the chances of capturing research on psychological theory and user involvement and the latter two journals chosen as they are particularly inclusive to involvement research. Hand searches of electronic journals were supplemented with a general internet search using Google Scholar and by combing the reference lists of the final articles included in the review.

## Screening and Selection

Electronic databases yielded a total of 115 articles. Following removal of duplicates, 84 articles remained. Full text versions of the 84 articles were obtained. Hand searches found a further two articles. Inclusion and exclusion criteria were applied (see Tables 1 and 2) to all articles yielded from electronic and hand searches. A total of 11 studies met the criteria for inclusion in this review.

Figure 1 depicts a flow chart of the article extraction and source method.

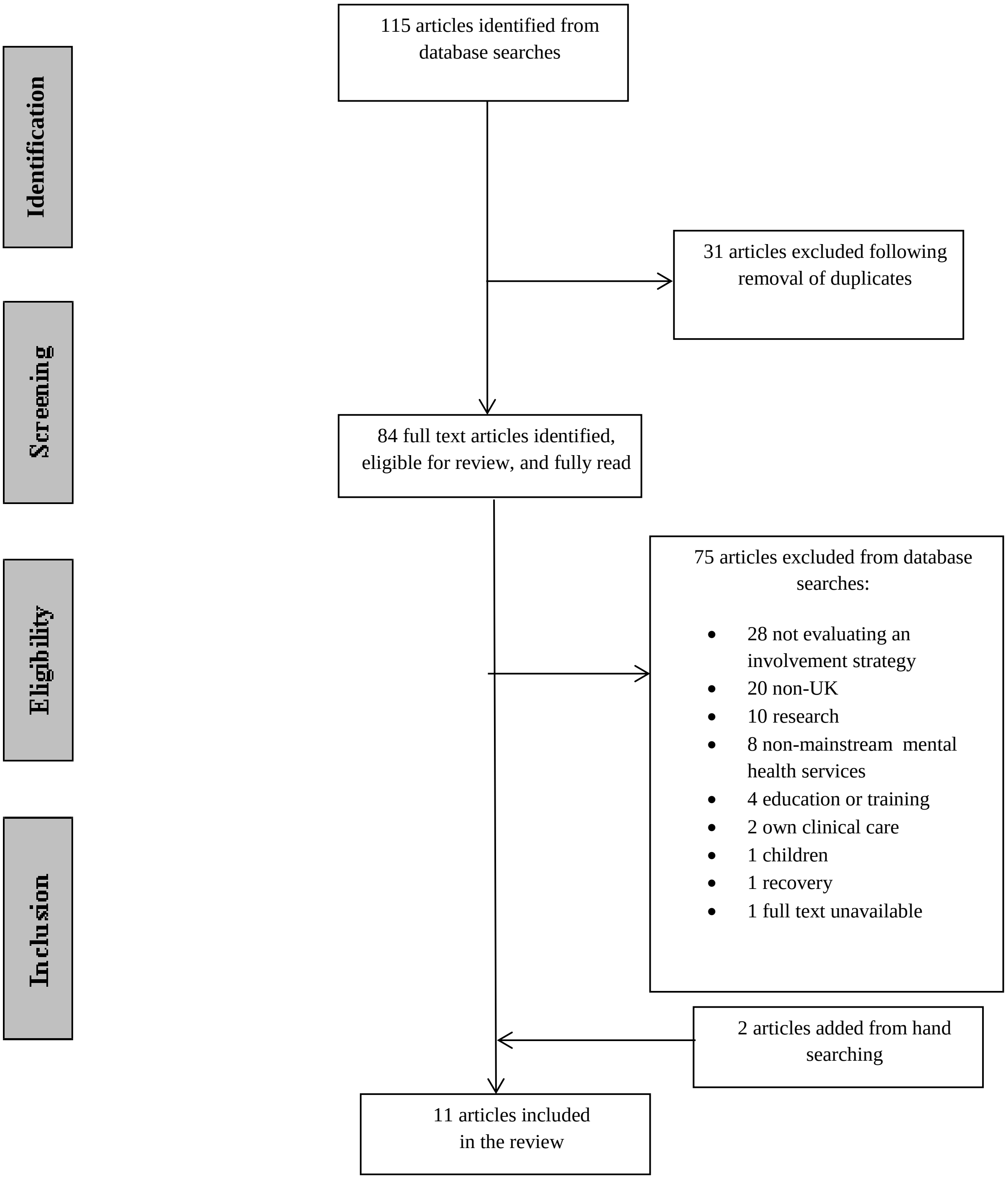

*Figure 1.* Flow chart depicting the identification and extraction of articles included in the review.

## Quality Assessment

Studies were quality assessed using criteria designed for this review in checklist format (see Table 3). The criteria were adapted from the Guidance for Reporting Involvement of Patients and Public (GRIPP) checklist (Staniszewska, Brett, Mockford & Barber, 2011; see Appendix B). Staniszewska et al. (2011) proposed that the underlying evidence base for involvement was poor, and poor reporting may be making it difficult to assess the impact of involvement strategies (Staniszewska et al., 2011). The GRIPP checklist was therefore designed to enhance the quality of patient and public involvement in research. However, this systematic review assessed research on involvement it did not assess user involvement in research processes. The GRIPP therefore needed adapting for this systematic review. The adapted GRIPP quality assessment tool utilised in this review was used as a guide in order to assess whether the studies had been designed, conducted and reported in a way that could be considered reliable, replicable and generalisable. It was thought that an assessment tool specifically designed for user involvement research would be more appropriate to the studies being assessed. It focused on assessing the quality of each section of the studies in general (e.g., aims, background, method, results, discussion, and conclusions) with a heavy focus on the method. The aim was to include all studies meeting the inclusion criteria. Poor quality studies were included in order to discuss areas of bias.

Table 3

*Quality Assessment Criteria*

| Assessment domains | Criteria |
|---|---|
| Aims | 1a. Clearly defined the research aim<br>1b. Clearly defined the aim of the involvement strategy |
| Background | 2. Described what the service user involvement activity was and gave an operational definition, or level or model of involvement* |
| Method - context | 3a. Described the setting the involvement took place in<br>3b. Provided the timeframe and stages (e.g., one or multiple) of involvement |
| Method - participants | 4a. Described the participant sampling<br>4b. Demographic details included (e.g., service users and/or providers, sample size, age, gender, ethnicity) |
| Method – design | 5a. Stated the research design<br>5b. Provided the method used to capture the impact |
| Results | 6. Reported impacts in a balanced way (e.g., both positive and negative) |
| Discussion/conclusion | 7a. Discussed the strengths and limitations of the research<br>7b.Discussed the wider implications of the results |

*Note.* *For example a co-production model aiming to build relationships and gain more equal distributions of power between service user and providers over time would differ from a consumerist model aiming for a single survey to be completed about service provision. It would also differ from a user-led model aiming for the transfer of power to service users.

## Data Extraction and Synthesis

Descriptive data were extracted from the studies. These included the research aim, characteristics of the sample, type of user involvement strategy and how the impact of involvement was captured in terms of research design. The included studies were combed for any impacts, or outcomes (either process or outcome), application of psychological theory to the impacts and involvement of clinical psychologists. The review adopted a low threshold in terms of the level of detail on the impact of involvement strategies. Any form of data was sought (e.g., qualitative descriptions and discussions regarding process outcomes). A narrative synthesis of the studies was provided in order to consider the review questions.

# Results

Eleven research studies met the inclusion criteria for this systematic review. All described a service user involvement strategy and evaluated and reported its impact. All studies were published in peer reviewed journals; two between 1997 and 1998 (18%), two between 2003 and 2005 (18%), and seven between 2010 and 2014 (64%). The findings from the quality assessment are presented first, followed by narrative summaries of the characteristics of included studies (sample, type of user involvement, and nature of the evidence), the impact of involvement, and application of psychological theory to the impacts and input of clinical psychologists.

## Quality Assessment

The methodological quality across the studies was poor. There were fundamental methodological flaws with eight of the 11 studies (see Crawford et al., 2011; Harding, Brown, Hayward & Pettinari, 2010; Hayward, West, Green & Blank, 2005; Lewis, 2014; Milewa, 1997; Owens et al., 2010; Pilgrim & Waldron, 1998; Robert, Hardacre, Locock, Bate & Glasby, 2003). Three studies (see Horrocks, Lyons & Hopley, 2010; Omeni, Barnes, Macdonald, Crawford & Rose, 2014; Rose et al., 2010) were good quality and contained only minor omissions. Overall, the studies presented considerable heterogeneity; they conducted and evaluated different involvement initiatives in different ways. A comparison of quality was not possible. Reporting was good with respect to the aim of the research, aim of the involvement projects, and the method used to capture the impact. The most problematic areas were the description of the involvement strategy, the description of the sample population and the research design. Six of the 11 studies did not operationally define what they meant by involvement or provide a description as to what level or model of involvement was being implemented (see Crawford et al., 2011; Harding et al., 2010; Hayward et al., 2005; Milewa, 1997; Owens et al., 2010; Pilgrim & Waldron, 1998) . In research terms, information about the “intervention” under evaluation was absent in these studies. In these six studies, the satisfactory reporting of the setting of the involvement and the timeframe and stages it occurred in becomes of little use without this. Moreover, it was not possible to assess what concept is being measured or whether the studies evaluated the impact of the same concept. A further issue is that information on impact is difficult to find in the studies. Information could locate anywhere in the papers. This resulted in multiple readings to extract information.

Details of the sampling technique used were provided in nine of the 11 studies, all of which adopted a purposive expert sampling (see Crawford et al., 2011; Harding et al., 2010; Horrocks et al., 2010; Lewis, 2014; Milewa, 1997; Omeni et al., 2014; Owens et al., 2010; Pilgrim & Waldron, 1998; Rose et al., 2010). That is, participants were sampled in order to gain a particular type of knowledge or perspective, relevant to the user involvement project. Two studies did not state the sampling technique (see Hayward et al., 2005; Robert et al., 2003). Eight of the 11 studies provided insufficient details of the sample (see Crawford et al., 2011; Harding et al., 2010; Hayward et al., 2005; Lewis, 2014; Milewa, 1997; Owens et al., 2010; Pilgrim & Waldron, 1998; Robert et al., 2003). Only three studies provided full information on four factors: sample size, age, gender and ethnicity (see Horrocks et al., 2010; Omeni et al., 2014; Rose et al., 2010). The research design was only stated explicitly in just over half of the studies (see Crawford et al., 2011; Harding et al., 2010; Hayward et al., 2005; Horrocks et al., 2010; Lewis, 2014; Omeni et al., 2014). Two studies highlighted reporting bias and only discussed positive outcomes (see Crawford et al., 2011; Hayward et al., 2005). Content validity was potentially compromised as it is not known whether all the relevant dimensions of involvement were assessed for impact. Five studies did not reflect on the strengths and limitations of the research (see Hayward et al., 2005; Horrocks et al., 2010; Milewa, 1997; Pilgrim & Waldron, 1998; Robert et al., 2003).

The quality assessment highlighted fundamental methodological flaws with the majority of studies. This potentially compromises validity and reliability as well as the ability to replicate the studies and to generalise from their findings. This must be taken into consideration when interpreting the findings of this systematic review.

Table 4

*Quality Assessment*

| | Aims | | Background | Method | | | | | | Results | Discussion/conclusions | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Context of SUI | | Participants | | Design/evaluation | | | | |
| Study | Research | SUI strategy | Description of SUI | Setting | Timeframe/stages | Sampling | Demographics* | Research design | Method of evaluation | Balanced impacts | Strengths and limitations | Wider implications |
| Crawford et al. (2011) | ✓ | ✓ | × | ✓ | ✓ | ✓ | P | ✓ | ✓ | × | ✓ | × |
| Harding et al. (2010) | ✓ | ✓ | × | ✓ | × | ✓ | P | ✓ | ✓ | ✓ | ✓ | × |
| Hayward et al. (2005) | ✓ | ✓ | × | ✓ | ✓ | × | P | ✓ | ✓ | × | × | ✓ |
| Horrocks et al. (2010) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | × | ✓ |
| Lewis (2014) | ✓ | ✓ | ✓ | ✓ | × | ✓ | P | ✓ | ✓ | × | ✓ | ✓ |
| Milewa (1997) | ✓ | × | × | × | ✓ | ✓ | P | × | ✓ | ✓ | × | ✓ |

| Study | Research | SUI strategy | Description of SUI | Setting | Timeframe/stages | Sampling | Demographics* | Research design | Method of evaluation | Balanced impacts | Strengths and limitations | Wider implications |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Omeni et al. (2014) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | × |
| Owens et al. (2010) | ✓ | ✓ | × | ✓ | P | P | P | × | ✓ | ✓ | ✓ | × |
| Pilgrim & Waldron (1998) | ✓ | ✓ | × | × | ✓ | ✓ | P | × | ✓ | ✓ | × | ✓ |
| Robert et al. (2003) | ✓ | ✓ | ✓ | ✓ | ✓ | × | P | × | ✓ | ✓ | × | ✓ |
| Rose et al. (2010) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | × | ✓ | ✓ | ✓ | ✓ |

*Note.* Please refer to Table 3 for further interpretation. SUI = service user involvement; ✓ = met quality assessment criteria; × = did not meet quality assessment criteria; P = partially met quality assessment criteria; N/A = not applicable. *These assessment criteria will be marked with a✓ if the sample size, age, gender, and ethnicity of the sample is provided, a × if all of these elements are missing, and a P if at least one is reported.

## Summary Characteristics of Included Studies

Table 5 provides an overview of the characteristics of the studies. Some studies either did not report, or only partially reported, some elements of their research. Summaries are therefore provided for studies where possible.

### Characteristics of the samples.

In seven of the studies, participants were service users (Crawford et al., 2011; Harding et al., 2010; Horrocks et al., 2010; Owens et al., 2010; Pilgrim & Waldron, 1998; Rose et al., 2010). In four studies participants were both service users and service providers or other stakeholders (Hayward et al., 2005; Lewis, 2014; Milewa, 1997; Omeni et al., 2014; Robert et al., 2003). In 10 studies, sample sizes ranged from small (*N* = 8; Owens et al., 2010) to large (*N* = 445; Omeni et al., 2014). One study did not specify its sample size (Robert et al., 2003). Three studies recruited service users with specific experience of self-harm (Owens et al., 2010), psychosis and/or affective disorders having had used secondary care mental health services (Crawford et al., 2011), and for group membership (being absent or present in service user activist groups; Rose et al., 2010). In the seven studies that specified gender, the ratio of females to males varied, with females comprising various proportions of the samples (n = 11, 44%, Crawford et al., 2011; n = 5, 50%, Harding et al., 2010; n = 56, 54%, Horrocks et al., 2010; n = 7, 38%, Lewis, 2014; n = 219, 49%, Omeni et al., 2014; n = 6, 75%, Owens et al., 2010; n = 17, 42%, Rose et al., 2010). Five studies reported age. Age across the five studies ranged from under 18 (Horrocks et al., 2010) to 66 years (Crawford et al., 2011).  Participants from children’s services are excluded from this review. The Horrocks et al. (2010) study included seven participants who were under 18. This study was still included in this review. This was because of a lack of information on the seven participants and the service they accessed, an inability to remove this data, and because they comprised less than 1% of the sample. Only five studies reported ethnicity, the majority of the samples were white British (n = 15, 60%, Crawford et al., 2011; n = 10, 100%, Harding et al., 2010; n = 91, 74%, Horrocks et al., 2010; n = 298, 67% Omeni et al., 2014; n = 24, 60% Rose et al., 2010).

### Type of service user involvement.

Limited specific information was provided in some studies as to the level or model and definition of involvement, as stated in the quality assessment. All 11 studies reported the overall type of involvement. This could be located anywhere in the article. Involvement types consisted of: training on psychosis (Hayward et al., 2005), development of NICE guidance (Harding et al., 2010), development of a clinical intervention (Owens et al., 2010), selection of outcome measures (Crawford et al., 2011) and general service development (Horrocks et al., 2010; Lewis, 2014; Milewa, 1997; Omeni et al., 2014; Pilgrim & Waldron, 1998; Robert et al., 2003; Rose et al., 2010).

### How the impacts were captured.

Five of the 11 studies used mixed methods to evaluate the impact of the involvement strategy with the analysis consisting of both qualitative and quantitative approaches (see Crawford et al., 2011; Horrocks et al., 2010; Milewa, 1997; Omeni et al., 2014; Rose et al., 2010) . Six studies used a qualitative approach (see Harding et al., 2010; Hayward et al., 2005; Lewis, 2014; Owens et al., 2010; Pilgrim & Waldron, 1998; Robert et al., 2003). No studies used a quantitative approach only. Of the qualitative studies, two used an action research approach (Pilgrim & Waldron, 1998; Robert et al., 2003), two conducted interviews (Harding et al., 2010; Hayward et al., 2005). One conducted interviews and participant observations using an ethnographic approach (Lewis, 2014) and one used focus groups (Owens et al., 2010). Of the five mixed method studies, one conducted a cross-sectional survey and analysed the responses using descriptive and inferential statistics and thematic analysis (Omeni et al., 2014). One study used various methods to capture the impact. This included analysing service user forum meeting minutes, and concurrent minutes from mental health planning meetings, as well as recordings of annotated focussed discussions (Milewa, 1997). The Milewa (1997) study used a qualitative approach in the main but reported frequency data for issues raised and their outcomes. One study used a survey to establish the priorities of service users and carers in the locality, and reported the data using thematic analysis and frequency data (Horrocks et al., 2010). The study then analysed documents from partnership board meetings to establish whether the service user representatives were able to advocate for the needs of the people they represented. The study analysed this using themes and frequencies of themes (Horrocks et al., 2010). One study used a nominal group technique to gain consensus from a service user group on the appropriateness of clinical outcome measures and also recorded qualitative comments (Crawford et al., 2011). The only user-led study used both thematic analysis and inferential statistics to compare the views of the impact of involvement between service user activists and non-activists (Rose et al., 2010).

Table 5

*Characteristics of Included Studies*

| Reference | Research design | Aim of research | Characteristics of sample | Type of service user involvement |
|---|---|---|---|---|
| Crawford et al. (2011) | MM. Nominal group method and analysis of notes from meetings | To identify service user perspectives on the relevance and acceptability of treatment outcome measures | Type: service users<br>Number of participants: 25<br>Additional "expertise": experience of: psychosis and/or affective disorders and secondary mental health services<br>Most (*n* =22, 88%) more than 10 years' contact with services, most (*n* =22, 88%) with previous experience of involvement in research<br>Gender: 11 female, 14 male<br>Age: 26-66 (mean 44)<br>Ethnicity: 15 White British, five Black British, three Asian British, and two "other" | Expert advisory groups |
| Harding et al. (2010) | Q. Semi-structured interviews analysed using Grounded Theory | To explore service users' experiences of the developing National Institute of Health and Clinical Excellence (NICE) guidelines | Type: service users<br>Number of participants: 10<br>Additional "expertise": not specified<br>Gender: five female, five male<br>Age: not specified<br>Ethnicity: 10 white British | Guideline Development Groups (GDGs) developing NICE guidelines |

| Reference | Research design | Aim of research | Characteristics of sample | Type of service user involvement |
|---|---|---|---|---|
| Hayward et al. (2005) | Q. Individual interviews | To co- deliver a "Psychosis-Revisited" training session | Type: service user trainers, service provider trainers and delegates of the training session<br>Number of participants: 20<br>Additional "expertise": not specified<br>Gender: not specified<br>Age: not specified<br>Ethnicity: not specified | A single training session delivered on 'service user perspectives' to multi-disciplinary professionals |
| Horrocks et al. (2010) | MM. Case study using surveys and document analysis | To examine the outcomes of involvement of service users on Partnership Boards and whether service users on the board can advocate for the needs of the wider population of service users | Type: service users<br>Number of participants: 123 (survey)<br>Additional "expertise": not specified<br>Gender: 56 female, 47 male, 20 missing data<br>Age: seven under 18, 58 19-60, 29 over 61 and 29 age not stated.<br>Ethnicity: 74% white British<br>No details of characteristics of service users on Partnership Boards | Surveying service users to establish their perspective on priorities for services<br>Service user involvement in design of the questionnaire<br>Involvement on Partnership Boards |

| Reference | Research design | Aim of research | Characteristics of sample | Type of service user involvement |
|---|---|---|---|---|
| Lewis (2014) | Q. Ethnographic study using participant observations and interviews | To illuminate some of the political discursive processes of user involvement and highlight effective processes | Type: service users and providers<br>Number of participants: 20 service users, five service providers<br>Additional "expertise": not specified<br>Gender: service users - seven female, 13 male; providers; three male, two female<br>Age: not specified<br>Ethnicity: not specified | Policy planning groups for in-patient services |
| Milewa (1997) | MM. Case study using an analysis of forum meeting minutes, concurrent minutes from mental health planning meetings, and recordings of annotated focussed discussions. Frequency data of issues raised reported | To measure the impact of five local mental health and social care forums. Forums had the aim of identifying needs, preferences and priorities for mental health care | Type: various stakeholders (users, carers, social workers, community psychiatric nurses, psychologists, voluntary sector workers).<br>Number of participants: 93 sets of meeting minutes obtained encompassing 645 individual attendances by 123 stakeholders over a two-year period. Nineteen executives and managers interviewed and 31 members of the mental health forums interviewed.<br>Additional "expertise": not specified<br>Gender: not specified<br>Age: not specified<br>Ethnicity: not specified | Involvement in mental health and social care forum meetings |

| Reference | Research design | Aim of research | Characteristics of sample | Type of service user involvement |
|---|---|---|---|---|
| Omeni et al. (2014) | MM. Cross sectional survey consisting of open and closed questions. Analysis used both quantitative (frequency data, descriptive and inferential statistics) and qualitative (thematic analysis) approaches | To examine service users' and providers' views on the impact of involvement activity across three mental health trusts | Survey – Quantitative<br>Type: service users and providers<br>Number of participants: 302 service users, 143 service providers<br>Additional "expertise": not specified<br>Gender: service users: 125 female, 177 male; service providers: 94 female and 49 male<br>Age: service users: 71 aged 34 or less, 136 aged 35-49 and 95 aged 50 or over. Service providers: 21 aged 34 or less, 82 aged 35-49 and 40 aged over 50<br>Ethnicity: service users: 193 white British service providers: 105 white British<br>Survey - Qualitative<br>Qualitative analysis of the surveys', 97 service users and 67 service providers. | Trust boards. Involvement commissioned in from community user-led organisations. Multitude of involvement activities across three mental health trusts at individual, service and organisational levels but further specifics not provided |

| Reference | Research design | Aim of research | Characteristics of sample | Type of service user involvement |
|---|---|---|---|---|
| Owens et al. (2010) | Q. Focus groups | To develop a text messaging intervention to reduce repetition of self-harm | Type: service users<br>Number of participants: eight<br>Additional “expertise”: experience of self-harm<br>Gender: six female, two male<br>Age: two aged 18-25, one aged 26-35,three aged 36-49 and two over 50 years<br>Ethnicity: not specified | Focus groups to develop a clinical intervention |
| Pilgrim & Waldron (1998) | Q. Action research | To evaluate the impact of user involvement in mental health service development via the setting up of a new users’ group | Type: service users<br>Number of participants: 14 (range of 8-12 attendees at meetings). Users’ group was also attended by the action researchers evaluating the group.<br>Additional “expertise”: not specified<br>Gender: not specified<br>Age: not specified<br>Ethnicity: not specified | Users’ group |

| Reference | Research design | Aim of research | Characteristics of sample | Type of service user involvement |
|---|---|---|---|---|
| Robert et al. (2003) | Q. Action research case study comprising semi-structured interviews, participant observations of team meetings and a process mapping exercise | To explore the impact of user involvement in service redesign across several mental health trusts | Type: service users and service providers<br>Number of participants: not specified, various service users, and members of the multi-disciplinary team from six mental health trusts<br>Additional "expertise": not specified<br>Gender: not specified<br>Age: not specified<br>Ethnicity: not specified | "Mental health collaborative" defined as; a group that brings healthcare organisations together into a mutual support and learning network working together for one year improving a specific clinical or operational area |
| Rose et al. (2010) | MM. Interviews. Analysis used both quantitative (descriptive and inferential statistics) and qualitative (thematic analysis) approaches. This study was user-led | To investigate service users perceptions of the impact/outcome of involvement in their services | Type: service users<br>Number of participants: 40<br>Additional "expertise": (20 active in user groups, 20 were not). eight diagnosis of schizophrenia, seven bipolar disorder and six depression, 10 diagnosis was not known.<br>Gender: 58% male<br>Age: 18-65 range (median 48)<br>Ethnicity: 24 white ethnic, 12 black, four other | Various service user involvement initiatives across services. Not explicitly stated |

*Note.* Q = qualitative approach; MM = mixed methods; both qualitative and quantitative approaches.

## Summary of the Impact of Involvement, Psychological Theory and Involvement of Clinical Psychologists

Table 6 provides an overview of evidence of the impacts and outcomes of user involvement within each study. This is followed by narrative summaries of the impacts, theory and psychology involvement across the studies.

### What is the evidence for the impact, or outcomes of mental health service user involvement in the design, delivery, commissioning or evaluation of mental health services?

Overall, the 11 studies reported positive and negative impacts for individuals and services, and some that could be considered process outcomes. Most studies reported both negative and positive impacts with the exception of three studies. Two of the three studies reported only positive impacts (Crawford et al., 2011; Hayward et al., 2005); and one reported only negative impacts (Lewis, 2014).

#### ***Positive impacts – individual level.***

*Service users.*

Positive impacts reported for the individual service users involved consisted of: increased confidence, power to influence others, skill acquisition such as presentation skills (Hayward et al., 2005), administration skills, group working and negotiation skills. Further impacts consisted of: increased ability to navigate service structures (Pilgrim & Waldron, 1998) and use of knowledge and expertise constructively (Harding et al., 2010). Therapeutic benefits consisted of feeling a sense of being valued, a sense of connectedness to others (Hayward et al., 2005), increased self-esteem (Omeni et al., 2014) and improved recovery and relationships with clinicians (Hayward et al., 2005; Omeni et al., 2014; Robert et al., 2003). A sense of feeling listened to (Pilgrim & Waldron, 1998), having difficult experiences validated (Hayward et al., 2005), and a reduction in feelings of “them and us” (Robert et al., 2003) were also reported. Two studies reported that the involvement had resulted in an overall sense of empowerment for service users (Omeni et al., 2014; Pilgrim & Waldron, 1998).

Positive impacts reported for future service users as a consequence of the involvement initiatives consisted of: the creation of accessible information (Pilgrim & Waldron, 1998), simplified in-patient admission routes, and routine service user involvement in care planning (Robert et al., 2003). Gender segregated wards (Rose et al., 2010), more service user centred and rated outcome measures (Crawford et al., 2011), service user input into NICE guidance (Harding et al., 2010), and a service user designed crisis intervention for people who self-harm (Owens et al., 2010) were also reported.

#### *Service providers.*

Positive relational gains were evident for the individual service providers who took part in the involvement consisting of improved relationships with service users (Omeni et al., 2014), a reduction in "them and us" boundaries (Robert et al., 2003) and a sense of gaining new perspectives and valuing different types of knowledge (Harding et al., 2010; Hayward et al., 2005; Omeni et al., 2014).

### ***Negative impacts – individual level.***

#### *Service users.*

Negative impacts reported for the individual service users involved consisted of a lack of access to information and technical knowledge, having less knowledge and a lower educational level, a feeling that collaboration was exclusionary and oppressive, a feeling like their voices were delegitimised by their perceived mental health status, fraught relationships due to service providers not compromising, and uneven distributions of decision making power and status (Lewis, 2014; Owens et al., 2010; Omeni et al., 2014). This was reported in the studies as resulting in a perceived lack of ability to negotiate with service providers and subsequently influence decisions Negative impact on mental health was reported (Omeni et al., 2014) with some service users unable to contribute continually due to fluctuations in mental state (Owens et al., 2010). Some service users realised that they were not prepared for the demands of the task which resulted in a reduction in their confidence (Robert et al., 2003).

### *Service providers.*

Very few negative outcomes were reported for service providers. The process of involving service users was described as challenging (Owens et al., 2011). Service providers were viewed by service users as holding an incomplete account of mental distress and were challenged on this (Robert et al., 2003). Other providers felt uncomfortable hearing about service users having received care that was deemed unacceptable (Hayward et al., 2005; Robert et al., 2003).

### ***Positive impacts – strategic level.***

Many of the studies reviewed reported user involvement and overall inclusion and presence (and political presence) of service users as a positive outcome in its own right (Horrocks et al., 2010; Lewis, 2014; Omeni et al., 2014). Other positive impacts consisted of NICE guidance (Harding et al., 2010), clinical outcome measures (Crawford et al., 2011), training (Hayward et al., 2005) and a clinical intervention for self-harm (Owens et al., 2011) that were reported to be more service user-centred. General service improvements were reported that meant services were perceived to be more responsive to the needs of future users (Crawford et al., 2011; Omeni et al., 2014; Milewa, 1997), and there was the creation of a new job role, accessible information, and expanded day centre opening times (Pilgrim & Waldron, 1998). In addition, there was streamlining of in-patient admission routes, improvements in continuity of care, inclusion of routine service user involvement built into service structures (Robert et al., 2003) and gender segregated in-patient wards reported (Rose et al., 2010).

Some studies reported only partial successes. In one study, three out of seven issues raised by service users were addressed (Horrocks et al., 2010). In another study, 11 out of 57 issues raised by service users were classified as successful in outcome (Milewa, 1997). One study concluded that 92% of a sample of service users stated that involvement had improved services (Rose et al., 2010). A further study required service providers to abandon completely the planned intervention and replace it with one designed by service users. Funders and researchers had to tolerate a degree of uncertainty and place trust in the project achieving a positive outcome, which it did achieve (Owens et al., 2010). Across the studies were reports that users introduced different ways of thinking about mental illness. This included challenging ways of doing things which required providers to revise firmly held ideas and assumptions and re-evaluate taken-for-granted routines and practices. This was said to encourage broader perspectives and thinking.

### *Negative impacts and barriers– strategic level.*

Within the studies reviewed, there were examples of negative or no impact. This included users involved in Partnerships Boards having limited success in representing the interests of the wider population of service users and no strong evidence that collaboration affects the dynamics of power, influences decisions or results in benefit to wider service users and services (Horrocks et al., 2010). Further examples included suggestions that service changes were illusory (Lewis, 2014), evidence of limited impact of service user forums with 46 out of 57 issues raised either not pursued, deferred, not responded to or rejected (Milewa, 1997), and a further example of services only partially responding to issues raised by service users (Rose et al., 2010).

Within the studies, various difficulties appeared to constitute barriers to the collaborations between providers and users of services. Whilst these are not overt negative impacts, they could be perceived as constituting process issues which are hidden and which may create negative impacts. Barriers are therefore reported in this review. Barriers consisted of: conflicting views of what should constitute evidence (e.g., users' views, randomised controlled trials) and whether anecdotal evidence extends scientific contributions (Harding et al., 2010). Uneven distributions of power and inequality in decision making capacity (Horrocks et al., 2010; Lewis, 2014; Omeni et al., 2014; Owens et al., 2010; Rose et al., 2010) were also cited. Tokenism was widely reported and service users feeling they were at the lowest rung of power status hierarchies (Lewis, 2014; Owens et al., 2010; Robert et al., 2003; Rose et al., 2010), providers not compromising their position, user voices being delegitimised by their mental health status (Lewis, 2014) and involvement de-authenticated by the ultimate powers under the Mental Health Act (Robert et al., 2003). Structural inequalities such as class, knowledge and educational level were also reported (Lewis, 2014) and use of scientific language and jargon hampered some service users' understanding and, therefore, their contribution (Harding et al., 2010; Lewis, 2014). Studies also cited issues with representation and generalisation and the view that the service users involved were not representative of the views of wider service users (Omeni et al., 2014; Owens et al., 2010; Robert et al., 2003).

### Were clinical psychologists involved in the research?

Involvement of clinical psychologists was evident in only three of the 11 studies. Three studies were authored by clinical psychologists (Harding et al., 2010; Hayward et al., 2005; Pilgrim & Waldron, 1998) who also had various roles in the research process. In the first study the author was the main researcher and a trainee clinical psychologist who identified as having experience of mental illness (Harding et al., 2010). In the second study the training was co-facilitated by the author; with clinical psychologists as recipients and subsequently participants of the research. In the third study the authors were the action researchers conducting the study. A further study reported that clinical psychologists were involved in the service user forums and were therefore, potential participants but no details were provided.

### Were there any attempts to apply psychological theory to involvement impacts?

No studies applied psychological theory to the impacts of user involvement. Two studies applied theory: one (Lewis, 2014) applied theories of power and discourse from a sociological perspective. Lewis (2014) made reference to the British Psychological Society’s (BPS) response to the publication of the new Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) and is stating the need for a “paradigm shift” in understanding of mental distress and for psychologists to advocate for wider social perspectives (BPS, 2012). Another study (Pilgrim & Waldron, 1998) applied bio-medical theory.

Table 6

*Reported Impact, Theory and Involvement of Clinical Psychologists*

| Reference | Reported impact of service user involvement | Psychological theory | Involvement of clinical psychologists |
|---|---|---|---|
| Crawford et al. (2011)* | Service users:<br>-gave their perspective on appropriateness of outcome measures<br>-added service user developed measures<br>-advocated for patient-rated, as opposed to clinician-rated, measures, the removal of intrusive questions, inclusion of open questions, and questions to capture the positive and negative effects of interventions<br>-raised concerns about singly scored measures<br>-wanted appropriate staff training on use of measures<br>-stressed that the personal qualities of clinicians was important for dignity and respect<br>-concluded that the development and refinement of a patient-rated outcome measure was required | No | No |
| Harding et al. (2010) | -Service users used their experience and knowledge as ‘expertise’ and introduced other perspectives<br>-Involvement was said to enable movement between micro and macro levels of analysis<br>-NICE guidance perceived to increase in usefulness to other service users<br>-Use of jargon created a barrier<br>-Conflicting views as to the usefulness of service user experiences and anecdotal evidence as opposed to scientific evidence from randomised controlled trials | No | Yes. Author was a trainee clinical psychologist. Research was conducted during clinical training |

| Reference | Reported impact of service user involvement | Psychological theory | Involvement of clinical psychologists |
|---|---|---|---|
| Hayward et al. (2005) | -Users' confidence increased with the power to influence services, acquired presentation skills<br>-Positive regard from training delegates "encouraging"<br>-Delegates valued service user views and the sharing of their journey through mental health services<br>-Mutual outrage over negative experience of services | No | Yes. Training delivered by a clinical psychologist. Training delegates included clinical psychologists and lead author of the paper was a clinical psychologist |
| Horrocks et al. (2010) | -Service user presence on partnership boards viewed as positive outcome<br>-Partial success (Three out of the seven issues raised by service users were addressed)<br>-From the document analysis, the top three themes most frequently addressed in the board meetings were different issues to the top three priorities service users wanted addressing, suggesting users on the board had limited success in representing the interests of the wider population of service users<br>-Power differentials noted to be an issue;<br>-No strong evidence that fostering a working relationship with service users affects the dynamics of power, influences decision, or results in benefit and gain for wider service users and services | No | No |

| Reference | Reported impact of service user involvement | Psychological theory | Involvement of clinical psychologists |
|---|---|---|---|
| Lewis (2014) | Service users:<br>-struggled with illusions of change<br>-lacked technical knowledge and access to information<br>-felt the collaboration was exclusionary and oppressive<br>-felt their voices were delegitimised by their perceived mental health status<br>-had to adapt, the committee did not adapt their practice or compromise<br>-experienced structural inequalities e.g., social class, knowledge, and education level<br>-felt they were not able to negotiate due to an uneven distribution of decision making power and influence by hierarchies of status<br>-Service users involved in policy planning groups stated to be a positive outcome in itself due to "political presence" | Yes. Theories of power and discourse | No |
| Milewa (1997) | -Fifty-seven issues were raised by the mental health forum meetings: 11 (19%) issues were classed as successes as tangible objectives were achieved, 11 (19%) were accepted but not pursued, five (9%) were deferred, 29 (51%) were not acknowledged, responded to or recorded, and one (2%) was rejected<br>-Authors concluded that the mental health forums had limited impact | No | Psychologists were reportedly involved in the mental health forums and could potentially have been participants in the study, but no details provided as to numbers |

| Reference | Reported impact of service user involvement | Psychological theory | Involvement of clinical psychologists |
|---|---|---|---|
| Omeni et al. (2014) | -Over 70% thought the service user involvement had a positive impact and was empowering for all and a small minority of service providers felt involvement was having no or a negative influence<br>-Therapeutic benefits (self-esteem, recovery and social interaction) were reported<br>-Service users heralded as a valuable source of knowledge by seven mental health professionals<br>-Improvement in services and relationships reported<br>-Tokenism and inability to influence change reported<br>-Negative impact on mental health<br>-Issues of representation<br>-Involvement in training having a positive impact<br>-User input afforded low status<br>-Providers stated service users made unrealistic demands and were too negative and critical of services | No | No |

| Reference | Reported impact of service user involvement | Psychological theory | Involvement of clinical psychologists |
|---|---|---|---|
| Owens et al. (2010) | -The originally planned intervention was abandoned and replaced by one designed by service users. The new intervention saw clients self-authoring their own text messages which were stored in a personal message bank for withdrawal by clinicians if required later. The final intervention:<br>-highlighted a previously unmet need for service users who self-harm, was more likely to be useful, safe and effective and was appropriate for the cultural context<br>-fitted with agendas such as the Recovery Model, self-management and cognitive restructuring<br>-accounted for the heterogeneity of the clinical population<br>-overcome the limitations of the research it intended to replicate<br>-provided service users with a sense of ownership<br>-was reported to be challenging and required providers to radically revise firmly held ideas<br>-Unequal involvement in decision making processes, power differences<br>-Fluctuations in the mental state and therefore non-attendance of service users stated to prolong the lifespan of the project and result in repeatedly bringing non-attendees up to date<br>-Project took longer than expected<br>-Funders and research teams had to tolerate a degree of uncertainty with the project (with the method not stated explicitly from the outset) and place a great deal of trust in a positive outcome | No | One author is a researcher from a School of Psychology |

| Reference | Reported impact of service user involvement | Psychological theory | Involvement of clinical psychologists |
|---|---|---|---|
| Pilgrim & Waldron (1998) | -Day centre opening times extended<br>-Paid advocacy role created and employee appointed<br>-Finance obtained to create accessible information<br>-Individual gains for users taking part: group and strategic working, negotiation, administration skills<br>-Service users given a valued social role which was being recognised explicitly by the facilitators and respected by managers. It was stated that this might constitute service user empowerment<br>-Requests to employ a female psychiatrist denied despite repeated attempts<br>-No action regarding improvement of a local private residential facility | Yes. Biomedical theory | Yes. Both authors and action researchers evaluating the impact of the users' group are clinical psychologists |
| Robert et al. (2003) | -Users sharing their journey resulted in providers re-evaluating taken for granted routines/ practices<br>-Service users challenged providers' incomplete accounts of mental distress resulting in providers questioning their own assumptions, some of which were mis-assumptions<br>-Procedural changes: routes to admission simplified, and continuity of care improved<br>-Reciprocal gains for service users (experienced collaboration and support) and providers (impressed by the service users level of debate and ability to think systemically)<br>-Reportedly reduced feelings of "them and us"<br>-Administration procedures changed (satisfaction surveys administered as routine, service users involved in their own care planning and a record made of their involvement or non-involvement and service user community meetings were set up on in-patient wards) | No | No |

| | | | |
|---|---|---|---|
| | -Involvement shifted from low to high priority<br>-A feeling that involvement will stop without a dedicated person championing it<br>-Issues of representation and generalisation (learning only limited to those involved)<br>-Service users lack of confidence<br>-Providers uncomfortable hearing the service users had received less than acceptable care<br>-Tokenistic involvement an issue (involvement tarnished by service providers' ultimate powers under the Mental Health Act)<br>-Some providers felt service user involvement didn't work well in practice | | |
| Rose et al. (2010) | - 92% of users stated involvement has improved services resulting in actual influence and service change such as gender segregated in-patient wards.<br>-However, there was a view that involvement was tokenistic, with issues of power and inequality, only partial response to the issues service users raised and fraught with lack of resources and support for service users involved. There was also some suggestion that providers try to transfer decision making power to service users on issues that don't matter | No | No |

*Note.* *When reviewing this study the focus was on the impact of the involvement strategy and not on the reporting of the specific outcome measures selected.

# Discussion

This systematic review aimed to identify empirical research reporting the impact and/or outcomes of a service user involvement strategy. It identified and analysed 11 studies, published between 1997 and 2014. The studies highlighted both positive and negative impacts of service user involvement in mental health services and barriers to its implementation. No studies applied psychological theory to the impacts of user involvement. Clinical psychologists were involved in a small portion of the studies in various roles. Overall, the research in this area was limited, methodologically flawed, and heterogeneous. The studies evaluated very different user involvement strategies in very different ways. The findings of this review should be considered in light of the implications and limitations discussed here and interpreted tentatively.

Following application of the inclusion criteria, the small number of studies identified was surprising considering the political and legislative impetus to involve service users. However, this was unsurprising given the existing reports of a lack of research evidence base for the impact of involvement (Campbell, 2008; Crawford et al., 2003; Haigh, 2008; Rose et al., 2002; Rose et al., 2010). The amount of research in this area has been significantly enhanced by the publication of recent good quality studies in the last five years (see Horrocks et al., 2010; Omeni et al., 2014; Rose et al., 2010). Yet, the studies did not draw on relevant psychological theories or psychological thinking to understand their findings. The methodological flaws of the included studies fits with previous findings and requests for urgent enhancement of the reporting of involvement impacts in order to strengthen the evidence base (see Staniszewska et al., 2011). Research studies expected to be found were successfully captured by the search terms. Various factors decrease the confidence that all empirical studies implementing and evaluating involvement strategies were located due to overall poor reporting and the fact that user involvement research does not always accurately headline its coverage (e.g., in the title, abstract or keywords). However, it is possible that even the most comprehensive of searches will fail to locate studies. Processes maximised the chances of the empirical research evidence being found such as careful piloting of the search strategy, ensuring that the terms were sensitive yet specific, conducting searches on full-texts, supplementing electronic searching with extensive hand searching, and combing reference lists for additional studies.

This review located a diversity of evidence of positive and negative impacts of service user involvement at an individual (e.g., for service users and service providers) and strategic level (e.g., for services and organisations). The studies also reported process outcomes. Negative impacts at a strategic level included various barriers emergent in the collaborations between providers and users of services which may suggest underlying issues.

## Strengths and Limitations of the Included Studies

Of the included studies, eight poorly reported multiple aspects of their research. Therefore, there were more limitations than strengths in the included studies. Staniszewska et al. (2011) have previously highlighted poor reporting of involvement research as an issue. They refer to the empirical evidence base for involvement as an iceberg: only partly visible within the literature, with information hidden, poorly reported or not reported at all. This review is in support of this statement. It was difficult to locate information in the included papers resulting in multiple readings. Important information, such as a definition of involvement, was missing. Authors have raised this issue before (see Purtell, Rickard & Wyatt, 2012) suggesting that this leads to other issues such as the lack of consensus as to its meaning, aims and remit. This lack of clarity and transparency leads to research flaws. The quality of reporting in this systematic review is, therefore, impaired by the quality of the research reviewed. It also makes it difficult to have confidence in the results, interpret them accurately and suggest implications from them.

The model, level or type of involvement strategy which was being implemented was largely missing. Under the rubric of involvement, multiple models exist such as consultation (e.g., surveys), representation (e.g., partnership boards), co-production (e.g., development of NICE guidance), and user-led (e.g., training). All require different approaches, skills and relationships to be fostered. Therefore, implementation of one model of involvement may imply different levels of power and influence, and the differential impacts of one may be more significant than another. A co-production model (Needham & Carr, 2009) assumes close collaborative working and equality between users and providers of services. A consultative approach means asking service users for their opinions about a service, usually once, and at a distance. A user-led approach assumes service users lead a project and power is held with the service users whom are involved usually without service providers. Without definitions, descriptions and information about the model or type, the concept or intervention under empirical testing is lacking. This lack of information leads to various repercussions. The research cannot be appraised or replicated, and other information that is reported well is not reliable, such as reporting of setting, timeframes and stages of involvement. Therefore, the reported impacts cannot be interpreted as valid or reliable, and ability to generalise from the findings is not possible. The empirical evidence base may remain weak and the positive and negative impacts of involvement easily disregarded.

The lack of information about the demographics of the sample and the biased way in which participants were selected for inclusion into the studies, compromises representativeness and ability to generalise. Most studies used expert sampling. This way to select participants for involvement projects presents unique challenges for research. Selecting participants with past experience of self-harm to design an intervention for people who self-harm (e.g., Owens et al., 2010) may mean the participants' experiences are more useful in representing the needs of the target population and the impacts of research using this sampling technique may be more generalisable. Horrocks et al. (2010) state that representativeness, in the area of user involvement, should mean just this: the ability to represent the voices of others. This is different to statistical representativeness. Mays and Pope (1995) state that "statistical representativeness is not a prime requirement when the objective is to understand social processes" and advocated for the identification of people who "possess characteristics or live in circumstances relevant to the social phenomenon being studied" (p. 109). But, the sampling technique is still biased as all service users do not have equal opportunities to take part. This is important given the findings of one of the included studies (see Omeni et al., 2014) which found that service users using services the longest, men and people from black multi ethnic backgrounds were more likely to engage in user involvement activities. Research in the area of user involvement presents unique challenges.

The studies reviewed are non-comparative. Whilst they report impacts, they do not report the difference service users make to a project over and above that of a group of service providers. The need to assess the impact service users make is being advocated for by the national user-led charity. The “4Pi National Involvement Standards” (NIP & NSUN, 2015) is a framework to measure, monitor and evaluate all involvement activity in terms of principles, purpose, presence, process and impact. They highlight that assessing service users’ proportional contribution to an involvement project is important (NIP, 2013).

Comparing impacts from the studies reviewed is difficult because of the heterogeneous methods used, poor reporting and impaired quality. Purtell et al. (2012) highlight the lack of an agreed measure of success as problematic because comparisons across studies cannot be made. The design of a general outcome measure of involvement would help to capture all relevant aspects of the concept of involvement. Collating this information would allow comparison across studies and would enable a future meta-synthesis of the outcomes of involvement strategies.

## Impacts of User Involvement

The positive impacts reported in the empirical studies are consistent with the anecdotal, non-empirical literature. Also, the barriers highlighted in the studies are widely reported in the non-empirical literature (DCP, 2010a; Pilgrim & McCranie, 2013; Rogers & Pilgrim, 1991; Rose et al., 2002; Simpson & House, 2003; Tait & Lester, 2005). What this systematic review does add is impacts and barriers from the empirical research and reports both positive and negative impacts. A recent report providing an overview of involvement (see NIP & NSUN, 2015) does not state any negative impacts of involvement.

## Power, Empowerment and Impacts of User Involvement

Although the studies were not homogeneous, certain themes were reported consistently across the studies. An overarching theme of power and empowerment and, therefore, powerlessness and disempowerment was evident.  As Carl Rogers’ theories suggest, empowerment from a psychological perspective is said to be cultivated through genuine and nurturing relationships (Gilbert, 1995). The reported impacts of the 11 studies reviewed provide evidence of relational benefits for both service users and providers who took part. These include improved relationships between users and providers, a reduction in “them and us” boundaries, a sense of connectedness, feeling listened to and valued. There is an overall sense that users can feel empowered in the process of being involved and helping to effect change. That said, it is not known whether the sense of empowerment of those involved is generalizable to other areas of their lives or results in the empowerment of other service users. It is also not known whether the positive effects of empowerment would withstand the structural inequalities of society, of people with mental illness.

Psychological empowerment is also said to arise when people’s knowledge, skills, self-confidence and self-esteem are increased (Falk-Rafael, 2001). The impacts from the studies reviewed in this paper provide evidence of service users acquiring new skills and benefitting psychologically through increased confidence and self-esteem. There was also evidence of providers gaining different perspectives and types of knowledge. Whilst on the surface this could symbolise psychological empowerment for service users, whether they continue to feel empowered, and whether other service users at the receiving end of the designed interventions in the future are empowered by them, is not known. It is also unknown whether service users (those involved and not) are more able to take control of their own lives because of the proportional contribution of users’ input into the co-design of some aspects of a service. Tangible outcomes were evident such as: outcome measures being more service user-centred, NICE guidelines having service user input, procedures being more ethical and clinical interventions being more useful to future service users. It is, however, likely that future service users are likely to benefit from the tangible outcomes such as gender segregated wards, streamlined admission procedures and accessible information.

There were some tangible negative outcomes that are seldom reported in the user involvement literature which in itself raises the issue as to whether a reporting bias exists. It could be true that people who morally agree with the principle of involvement only report its positive impacts and not the negatives. There were examples of service users having limited or no success on certain issues, and reports of limited success in representing the interests of the wider population of service users. Some of the studies reported involvement as being unable to shift the balance of power and affect any change at all.

The overarching theme of the reported barriers to involvement reported explicitly was the inequality in power. Foucault's theories (1971) state that within the psychiatric system, power is wielded through the language employed. Discourse is the medium in which the language is relayed to others and the power exerted. Some studies' findings reflect this with reports that service users felt that their experiential knowledge was being relegated to a subordinate position. They felt that their experiences were discounted as not extending the contributions of science. This resulted in them, not being afforded power to make decisions on important issues and feeling that class, knowledge and educational level was a barrier to them contributing. It was apparent that involvement practices were happening but process issues were providing structural obstacles to engagement and could have skewed impacts. Scientific language referred to as "jargon" was reported to be the discourse in which matters were discussed. Masterson and Owen (2006) report that language and the educational attainment of service providers at the pinnacle of the institutional hierarchy excludes those who have not been exposed to this language through education. Involvement is said to encompass the relatively powerless offering or being invited to learn the language of the dominant discourse (Masterson & Owen, 2006; Stickley, 2006). However, they are expected to compete unequally (Barnes & Bowl, 2001). Service users remain relatively powerless and lack the ability to influence those in power. Those in power reportedly do not share their power which appears to result in feeling like the practices are tokenistic, and that providers are not compromising. Tokenistic involvement is unlikely to be psychologically empowering due to lacking authenticity. The studies clearly state that dominant discourses remain powerful by relegating competing discourses to a subordinate position by being unable to compete using "the language". This raises the question as to whether authentic engagement has occurred at all.

Weber suggests that where one group is dominant and another disempowered, as is the case with mental health service users, the powerful need to transfer their power to others in order for them to be empowered. This could be argued as a disincentive to people holding power and may present a reason to resist genuine service user empowerment (Kumar, 2000; McDougall, 1997). As the impacts from this review state, there are barriers and resistances to this. Psychological empowerment offers a different perspective. This enables power to be generated within individuals through personal growth and cultivated through relationships resulting in increased knowledge, self-esteem and confidence. A humanistic discourse is said to foster personal growth, personal power and, therefore, empowerment (Gilbert, 1995; Katz, 1984; Ryles, 1999). The aim is that service users are empowered to change their situations. Masterson and Owen (2006) state that being psychologically empowered may enable service users to become powerful in a Weberian sense and exert power and influence on a wider scale. The psychological model may be more effectual given the resistances to share power and the structural obstacles in the system such as the Mental Health Act. The psychological approaches to empowerment at the individual level have been criticised on the grounds that they do not involve the shift of power from one place to another and thus may serve to maintain power imbalances (Ryles, 1999). What is required is for service users to become psychologically empowered, claim power and begin to exert influence through user involvement strategies. Service providers and services would then need to adopt an approach of power-to and power-with.

## Psychological Attitudes, Stigma, Intergroup Contact and Impacts of Involvement

Attitudes as barriers or facilitators to involvement were not reported explicitly in the included studies. However, both positive and stigmatised attitudes were implicit in the accounts of the process of user involvement. Positive attitudes were implicit in the accounts of service providers valuing service users' experiences and having a sense of solidarity. Service providers were reported to re-evaluate their own assumptions and practices; this may suggest an authenticity to the collaboration which may have been supported by positive attitudes. Some studies highlighted a general devaluation of the service user experience which may suggest stigmatised attitudes. These consisted of: delegitimising the service user voice due to mental health status, affording users unequal decision making capacity, presuming incompetence, not compromising and engaging in mere tokenistic involvement.

Intergroup contact theory asserts contact between an in-group and out-group reduces stigmatised attitudes; assisted by Allport's (1954) four primary conditions said to be required to reduce prejudice.  It is difficult to deduct whether there were any changes in attitudes during the involvement strategies and whether Allport's primary conditions were met in the collaborations.

Assessing attitudes pre and post involvement strategies may be a promising area for future research. Reducing prejudice would require equality of status between user and providers, co-operation, joint goal setting and support from authorities to enable user involvement projects. As the impacts of involvement yielded in this review suggest, it appears that there are barriers to be overcome first.

## Clinical Implications

The clinical implications of this review relate to how service user involvement can be utilised to improve the psychological well-being and recovery of service users, or protect service users from involvement that may result in a detrimental impact upon psychological well-being. Some of the studies reported that, in some cases, service user involvement led to therapeutic benefits consisting of improved self-esteem, confidence and skill acquisition for service users. These positive impacts of involvement may support improved psychological well-being and foster recovery from mental distress for service users involved. Some studies reported service changes that would appear to have enabled them to be more responsive to the needs of future service users in order to enable recovery from their psychological distress. However, some studies reported negative impacts of involvement at individual and systemic levels, and barriers that prove difficult to navigate and overcome. Clinical psychologists have a duty to protect service users from harmful practices or practice that has a detrimental effect upon their psychological well-being. The findings of the review highlight the need for clinical psychologists to adopt a questioning stance towards user involvement, as the findings highlight a mixed profile of both positive and negative impacts. It is hoped that this review highlights the need for more quality research, and application of psychological theory. This would ensure involvement is both evidence-based and supported by theory and research. It is important to know whether at the very least, involvement is not psychologically harmful.

## Involvement of Clinical Psychologists

Three of the studies reviewed contained some clinical psychologist involvement. Within these studies there is some representation from clinical psychology as a discipline. User involvement research is being conducted across disciplines. Other disciplines involved within other studies were health researchers, nurses, and sociologists. The purported lack of theory and evidence base for involvement may leave psychologists with little guidance as to the ‘how to’ of involvement.

## Strengths and Limitations of the Review Process

The systematic review is thorough and replicable and its search strategy comprehensive and systematic. Strengths consist of combining various multi-disciplinary electronic database searches with extensive hand searching. Searching covered two journals particularly inclusive to involvement research (“Journal of Mental Health” and “Health Expectations”). Applying search terms to the full-text studies, and assessing the quality of the studies improved the overall quality of the review. Combining a sensitive search strategy with refined inclusion criteria enabled specific and relevant studies to be found.

The review process could have been improved by the inclusion of psychometric data on the quality assessment tool, by cross checking all extracted data with another person, and by contacting experts in the field for further empirical research. However, contacting “experts” brings unique challenges for collating information on the impact of involvement, as there would inevitably be a debate about what type of expert to contact and what type of expertise is required. It is also acknowledged that utilising different search terms such as “participation”, “co-production” or “recovery” may have yielded different results.

## Implications for Clinical Psychologists and Future Research

Clinical psychologists have a multitude of skills, psychological knowledge, research and theory that could be drawn on to advance thinking in the area of service user involvement. Involvement should not be implemented for involvement’s sake or due to policy rhetoric. For it to be meaningful, it should lead to the improvement of services and the well-being and recovery of service users and carers. Whether user involvement is or should be the remit of clinical psychologists or not, there is a duty to follow policy, legislation and professional practice guidelines. Clinical psychologists as scientist-practitioners have research skills to help improve the quality and reporting of user involvement research and advance its evidence base. In addition, skills in psychological and systemic formulations and the application of theory to practice could potentially help understand its barriers and provide psychologically and theoretically informed ways to overcome them. Empowering service users in a system than can at times be inherently disempowering may be challenging.

Future research should focus on comparative research to assess the proportional contribution users make to a project. More empirical research is required to enable meta-studies on impact to be conducted. Research studies exploring psychological attitudes which may be a barrier to involvement are also required. To enable future research there needs to be a conceptual model of involvement, clear definitions and descriptions of involvement models, levels and types, and a single unified outcome measure to assess impact across studies. Research would do well to utilise the GRIPP checklist for designing and reporting user involvement impacts which will help improve the quality, content, detail, consistency, transparency, and completeness of reporting. This will also serve to strengthen the evidence base for involvement and enable a clearer understanding of what involvement works, for whom and in what circumstances.

## Conclusion

This systematic review included 11 empirical studies that reported and evaluated the impact of mental health service user involvement initiatives. Despite reports to the contrary, the review highlighted that there is an empirical evidence base for the impact of user involvement but it is small given that involvement has featured in policy and legislation for over four decades. The research is poorly reported and most studies have significant methodological flaws. The review's findings need to be considered in light of the implications and limitations and interpreted tentatively. The evidence for the impact of service user involvement in mental health services is diverse; a wide range of negative and positive impacts at individual and strategic levels were highlighted, together with process issues, and barriers and resistance to involvement. The impacts reported in the studies reviewed lacked application of psychological theory with only a few having input from clinical psychologists. Psychological theories of power and empowerment were discussed in relation to the impacts.

In order to have confidence in the reliability and validity of empirical research studies on the impacts of involvement, they require significant enhancement in the quality of reporting in the area. The evidence base is small but on the increase with studies clustering in recent years. High quality research into the impact of user involvement initiatives is required to enable a meta-synthesis of the findings and future systematic reviews. Establishing what works for whom, and in what circumstances using empirical research is essential, especially in times of fiscal constraint where support for user involvement based on values and experiential knowledge is harder to defend. Clinical psychologists as scientist-practitioners are well placed to research and theorise user involvement. This could provide psychological understandings of the barriers and resistances of collaborative working between users and providers of services.

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# CHAPTER 2: EMPIRICAL PAPER

## Therapists' Attitudes to Mental Health Service Users, Service User Involvement, and Relationship to Therapeutic Alliance

Word count: 4998

# Abstract

**Objectives.** In the socio-political landscape of the United Kingdom (UK) National Health Service (NHS), service user involvement is an imperative. Negative attitudes and organisational cultures are widely reported to hinder involvement strategy. This research aims to ascertain: (a) whether there are relationships between psychological therapists' explicit attitudes to people with mental illness, perceptions of organisational culture, and implicit attitudes to involvement, and (b) whether there are relationships between these and the quality of the client-rated therapeutic alliance.

**Design.** The research employed a cross-sectional design comprising psychological therapist-client dyads in mental health services within two North West NHS Trusts in the UK.

**Method.** Twenty eight therapist-client dyads[4] completed measures of explicit attitudes to mental illness, implicit attitudes to service user involvement and organisational culture, whilst clients completed a measure of working alliance.

**Results**. Explicit and implicit attitudes were positive. Most therapists perceived NHS organisational culture as market-driven. No significant relationships were found between therapists' explicit attitudes to mental illness, implicit attitudes to service user involvement, and client-rated alliance.

**Conclusions.** This study is the first of its kind to research implicit attitudes to service user involvement and NHS cultures. Further research is required.

*Keywords:* Service user involvement, attitudes, therapeutic alliance, organisational culture, mental health services.

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[4] The word "dyad" is defined as: "a couple - two individual units, things, or people linked together as a pair" (Oxford English Dictionary, 2013). The word has been used in this research to describe therapist-client pairs. If both the clients and therapists in the dyad completed the research, they are referred to as matched dyads. If only the client completed the research, they are referred to as unmatched dyads.

# Therapists' Attitudes to Mental Health Service Users, Service User Involvement, and Relationship to Therapeutic Alliance

This study aims to gain a deeper understanding of the barriers to service user involvement. It refers to the evidence base on attitudes, organisational culture and working alliance and explores these within the context of the psychological therapist-client dyad.

For over four decades, the need to involve service users in the UK NHS has pervaded the policies and legislation of each subsequent Governmental administration (see Department of Health, 2000, 2008a, 2008b, 2009, 2011, 2012; Health and Social Care Act 2012; NHS and Community Care Act 1990). Professional practice guidelines for clinical psychologists stress the need to incorporate involvement in clinical psychology services (Division of Clinical Psychology, DCP, 2010). Since the 1980s, an accumulation of both "top-down" and "bottom-up" demands (see Barnes & Cotterell, 2012) has culminated in a strong legal obligation to plan, commission, design, implement, and consult *with*, and not *on behalf of*, people experiencing mental health difficulties. In the socio-political landscape of the NHS, involvement is no longer discretionary or avoidable; nor is it negotiable.

Despite this, service user involvement is consistently faced with challenges. The literature is dense with discussion of factors hindering involvement strategy. The most widely cited barriers are the culture of organisations (Crawford et al., 2003; Harding, 2010; Rose, Fleischmann, Tonkiss, Campbell & Wykes, 2002), and the negative attitudes of service providers (see Crawford et al., 2003; DCP, 2010; Harding, 2010; Rose et al., 2002; Rutter, Manley, Weaver, Crawford & Fulop, 2004).

An attitude is referred to as "a mental and neural state of readiness, organized through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related" (Allport, 1935, p. 810). Negative and stigmatising attitudes towards people with mental illness are widely reported in both the general population (Chambers et al., 2010; Corker et al., 2013; Corrigan & Shapiro, 2010; Evans-Lacko, Henderson & Thornicroft, 2013) and within some health professionals (Chambers et al., 2010; Friedrich et al., 2013; Link & Phelan, 2001; Nordt, Rossler & Lauber, 2006). Intergroup contact theory (Allport, 1954), and subsequent empirical research show that increased social contact with people with mental illness is successful in reducing negative and stigmatised attitudes (Corrigan & Shapiro, 2010; Evans-Lacko et al., 2012; Pettigrew &

Tropp, 2006) and seems a promising strategy for reducing stigma and discrimination against people with mental illness (Corrigan & Shapiro, 2010; Evans-Lacko et al., 2012).

Within the evidence base on attitudes to mental illness, there are gaps. First, whilst there is an evidence base on explicit attitudes to mental illness, there is much less research on implicit attitudes that is, the role that implicit, less intentional processes contribute to attitudes (Teachman, Wilson & Komarovskaya, 2006). Teachman et al. (2006) highlighted that explicit attitudes to mental illness were neutral but when implicit measures were used, were negative. Second, there is a relative absence of research on explicit attitudes to service user involvement. Finally, and interconnected, there appears to be no research on implicit attitudes to user involvement. Researching explicit and implicit attitudes to involvement is important; it may illuminate implicit prejudice influencing people's behaviour, and aid in understanding the barriers.

The culture of NHS organisations is cited as a barrier to involvement strategy, but it lacks a single unified definition (Mannion, Davies & Marshall, 2005). It is generally referred to as the composite beliefs, values, attitudes, behavioural norms, established routines and traditions of an organisation (Davies, Nutley & Mannion, 2000). Reportedly, NHS culture is notoriously difficult to articulate, assess, and change (Mannion et al., 2008). Organisational change strategies can fail if the values, attitudes and culture of the workforce are not a primary focus, and/or incongruent with new approaches and paradigms (Casali & Day, 2010; Davies, 2002), a situation whereby "culture eats strategy for breakfast, every day, every time" (Davies, 2002, p. 142).

Arguably, it is within the psychotherapeutic relationship where close relational, proximal contact, and collaborative working with clients is greatest. The therapist-client dyad enables research into aspects of this relationship. Many common factors are reported to account for the success of therapy, one of the largest contributing common factors is the therapeutic alliance (Hubble, Duncan, Miller & Wampold, 2010). Therapeutic alliance is generally referred to as to the quality and strength of the collaborative relationship between client and therapist. It is measured by an agreement on therapy tasks, goals, and in the development of a relationship bond (Bordin, 1979; Horvath & Greenberg, 1994). Good alliance requires "starting where the client is" (Hubble et al., 2010, p. 38).

A smaller but increasing body of research suggests that therapist characteristics matter to the alliance-outcome relationship (see Ackerman & Hilsenroth, 2003; Baldwin, Wampold & Imel, 2007; Kim, Wampold & Bolt, 2006; Wampold & Brown, 2005). The variance of outcomes due to therapists (8-9%) is larger than the variability amongst treatments (0-1%), and the therapeutic alliance (5%; Wampold & Brown, 2005).

Utilising the psychological therapist-client dyad, this research aims to: (a) ascertain whether there are relationships between psychological therapists' explicit attitudes to people with mental illness, implicit attitudes to service user involvement, and organisational culture, and (b) ascertain whether there are relationships between these and the quality of the therapeutic alliance as rated by clients. In short, do therapists with better attitudes to mental illness and service user involvement foster more positive working alliances, and does the culture of the NHS affect this?

# Method

## Participants

In total, 517 packs were distributed across two North West NHS Trusts. Forty-six service user research packs (8.9%) and 28 therapist research packs were completed. However, the procedure allowed therapists to complete the research up to two times, if two different service users approached the same therapist. The author was only aware of two therapists who completed on two occasions, and several therapists who completed once. It is not clear how many separate therapist-client dyads comprised the research sample.  Therapist response rates comprised 61% of total service user completions. This culminated in 28 full therapist-client dyads comprising the sample for this research. Inclusion criteria required service users to be over 18 years old, currently receiving psychological therapy and having met with their therapist at least twice. The research adopted a bottom-up recruitment process, that is, service users opted in first, in order to minimise power differentials, and selection bias. Participants were recruited via Trust service user involvement forums, service user representatives; via contacting individual services and at conferences; between the 1st November 2012 and the 5th June 2013.

Demographic characteristics of all service user participants and those comprising the matched dyad sample are provided in Table 7 below.

Table 7

*Demographic Characteristics of Service Users – Whole Sample and Dyad Sample*

| | Whole sample *N*=46 (*N*, %) | Dyad sample *N*=28 (*N*, %) | Non-dyad sample; service users of therapist non-completers *N*=18 N, %) |
|---|---|---|---|
| Gender | | | |
| Female | 30 (65) | 19 (68) | 11 (61.1) |
| Male | 15 (33) | 9 (32) | 6 (33.3) |
| Did not wish to disclose | 1 (2) | - | 1 (5.5) |
| Age | | | |
| 18-30 | 11 (23.9) | 6 (21.4) | 5 (27.8) |
| 31-50 | 19 (41.3) | 13 (46.4) | 6 (33.3) |
| 51-65 | 12 (26.1) | 7 (25) | 5 (27.7) |
| 65+ | 4 (8.7) | 2 (7.1) | 2 (11.1) |
| Ethnicity | | | |
| Asian/Asian British | 1 (2.2) | 1 (3.6) | - |
| Mixed White/Asian | 1 (2.2) | 1 (3.6) | - |
| White British | 43 (93.5) | 25 (89.3) | 18 (100) |
| White Irish | 1 (2.2) | 1 (3.6) | - |
| Received therapy before | | | |
| Yes | 35 (76.1) | 21 (75) | 14 (77.8) |
| No | 10 (21.7) | 7 (25) | 3 (16.7) |
| Missing | 1 (2.2) | - | 1 (5.5) |
| No of sessions in current therapy | | | |
| 2-5 | 8 (17.4) | 2 (7.1) | 6 (33.3) |
| 6-10 | 10 (21.7) | 8 (28.6) | 2 (11.1) |
| 11-16 | 9 (19.6) | 6 (21.4) | 3 (16.7) |
| 17+ | 19 (41.3) | 12 (42.9) | 7 (38.9) |
| Received a diagnosis | | | |
| Yes | 33(71.7) | 22 (78.6) | 11 (61.1) |
| No | 11 (23.9) | 6 (21.4) | 5 (27.8) |
| Missing | 2 (4.3) | - | 2 (11.1) |
| Diagnosis | | | |
| Mood disorder | 18 (54.6) | 14 (64) | 4 (22.2) |
| Personality disorder | 7 (21.2) | 5 (23) | 2 (11.1) |
| Mood and personality disorder | 4 (12) | 2 (9) | 2 (11.1) |
| Developmental disorder | 1 (3) | 1 (4.5) | - |
| Missing | 3 (9.1) | - | 3 (16.7) |
| Sessions took place | | | |
| NHS site | 36 (78.3) | 20 (71.4) | 16 (88.9) |
| Community | 3 (6.5) | 3 (10.7) | - |
| Both | 7 (15.2) | 5 (17.9) | 2 (11.1) |

Table 7 highlights a roughly comparable spread of demographic characteristics of service users across the whole sample, dyad sample, and non-dyad sample. Demographic results are in the main, comparable within the sample of service users whose therapists did and did not complete the research with two notable exceptions. The dyad sample comprised more people with a diagnosis of a mood disorder (64%) than in the non-dyad sample (22.2%); and more people with a personality disorder diagnosis (23%) than the non-dyad sample (11.1%).

Demographic characteristics of the sample of therapists are provided in Table 8.

Table 8

*Demographic Characteristics of Therapists*

| | Sample of therapist completers *N*=28<br>(*N*, %) |
|---|---|
| Gender | |
| Female | 22 (78.6) |
| Male | 6 (21.4) |
| Age | |
| 18-30 | 8 (28.6) |
| 31-50 | 17 (60.7) |
| 51-65 | 3 (10.7) |
| Ethnicity | |
| Mixed White/Asian | 2 (7.1) |
| White British | 26 (92.9) |
| Job title | |
| Clinical psychologist | 21 (75) |
| Assistant psychologist | 2 (7.1) |
| Trainee clinical psychologist | 1 (3.6) |
| High intensity CBT therapist | 2 (7.1) |
| Low intensity CBT therapist | 1 (3.6) |
| Psychotherapist | 1 (3.6) |
| Time since qualification (in years) | |
| 0-1 | 6 (21.4) |
| 2-5 | 7(25) |
| 6-10 | 6 (21.4) |
| 11-20 | 4 (14.3) |
| 20+ | 5 (17.9) |
| Mode of therapy provided | |
| Group | 7 (25) |
| Individual | 21 (75) |
| Therapy model | |
| CAT | 1 (3.6) |
| CBT | 9 (32) |
| MBT | 5 (17.9) |
| DBT | 2 (7.1) |
| Schema Therapy | 6 (21.4) |
| Integrative | 5 (17.9) |
| Service type | |
| Adult | 24 (85.7) |
| Older Adult | 2 (7.1) |
| Learning Disability | 1 (3.6) |
| CAMHS | 1 (3.6) |
| IAPT service? | |
| Yes | 2 (7.1) |
| No | 26 (92.9) |

Table 8 highlights the therapist sample consisted of predominantly white British, female, clinical psychologists in the 31-50 age range. Therapists had varying years' experience, were predominantly providing individual therapy in non-IAPT, adult services using a variety of psychological models.

## Measures

### Client measure.

#### *Working Alliance Inventory- client version (WAI-C; Horvath, 1981).*

The WAI-C (see Appendix C) is a 36-item self-report measure based on Bordin's (1979) theoretical conceptualisation of working alliance. The scale comprises three 12-item subscales: "Task" the agreement on therapy tasks; "Goal" the agreement on goals, and "Bond" assesses the therapist-client bond (Horvath & Greenberg, 1989). The scale comprises both positively and negatively worded items rated on a 7-point Likert-type scale from 1 (*never*) to 7 (*always*). Following reversal of scores, total subscale scores can be summed to yield scores from 12-84 which can be further summed to obtain a total scale score ranging from 36 to 252. Higher scores denoting positive working alliance.

The WAI-C is a well validated and extensively used scale. Studies (e.g., Hanson, Curry, & Bandalos, 2002) and large scale meta-analyses (e.g., Ackerman & Hilsenroth, 2003; Horvath & Symonds, 1991; Martin, Garske & Davies, 2000) have consistently highlighted good internal consistency for the full scale and subscales (α .77 to .97; Hanson et al., 2002), and convergent validity through its relationship with other scales and characteristics (see Ackerman & Hilsenroth, 2003). In this research, internal consistency for the total scale was excellent (α = .93).

### Therapist measures.

#### *The Community Attitudes to Mental Illness scale (CAMI; Taylor & Dear, 1981).*

The CAMI (see Appendix D) is a 40-item self-report instrument that measures attitudes towards people with mental illness across four factors: "Authoritarianism" reflects the view that people are inferior and require a coercive approach; "Benevolence" reflects a sympathetic view towards people experiencing mental distress; "Social Restrictiveness" reflects a view that the mentally ill are a threat to society; and "Community Mental Health Ideology" reflects a concern with the therapeutic value of the community for people experiencing mental illness together with an acceptance of de-institutionalisation. Each factor comprises 10 statements (five positively worded and five negatively worded), rated on a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly* *agree*). Following reverse scoring, higher scores denoted more positive attitudes. The scale has good internal consistency for each of the four subscales (α = .68 to .88; Taylor & Dear, 1981) and reliability (α = .90; Schafer, Wood & Williams, 2011). In this research, internal consistency for the total scale was good (α = .80). However, 13 low item-correlations of less than .3 were found, raising doubts about the scales' reliability. Computing internal consistency with the low-item correlations removed, only marginally increased the overall alpha for the total scale to .85. Pallant (2009) suggests removing these items from the scale only if the alpha for the total scale is less than .7, which was not the case. Therefore, the full scale was used.

#### ***Organisational Culture Assessment Instrument (OCAI; Cameron & Quinn, 1999).***

The OCAI (see Appendix E) is based on the Competing Values Framework (CVF; Cameron & Quinn, 2011; Quinn & Rohrbaugh, 1981) and comprises six questions relating to factors contributing to organisational culture, for example: leadership, management of employees, organisational glue and criteria of success. The scale is ipsative, participants are asked to distribute 100 points amongst four alternative statements (A, B, C and D), for each question depending upon the degree of similarity with their organisation. Each statement represents one of four subtypes. The highest mean score indicates the person's dominant cultural subtype.

The four culture types are defined as: "Clan" (Collaborate) which places value internally with a focus organically on teamwork, participation, and morale building; "Hierarchy" (Control) which focusses internally placing value on stability, order and control; "Adhocracy" (Create) is focussed externally and places value on flexibility, and adaptability and "Market" (Compete), also externally focussed, which places value on reputation, competition and results (Cameron & Quinn, 2011).

Reportedly, the OCAI has good internal consistency reliability for the four culture subtypes when using Likert scale responding (α .71 to .79; Quinn & Spreitzer, 1991; α.76 to .08; Yeung, Brockbank & Ulrich, 1991) and good discriminant and convergent validity (Quinn & Spreitzer, 1991). The OCAI is being used extensively in large scale studies in the UK NHS, specifically to investigate culture-performance links (see Davies, Mannion, Jacobs, Powell & Marshall, 2007; Jacobs et al., 2013). In the present study, alpha reliabilities were good for market (α =.89); adhocracy (α = .88); and clan (α = .83), and slightly under the level considered acceptable (α = .7) for hierarchy (α = .67).

### *The Implicit Association Test (IAT; Greenwald, McGhee, & Schwartz, 1998).*

The Implicit Association Test (IAT; Greenwald et al., 1998; Nosek, Greenwald & Banaji, 2007) is a flexible computerised reaction time analysis that assesses the presence of implicit attitudes that are both unconscious and automatic: that a person may be unwilling to accept, are unaware of (Lincoln, Arens, Berger, & Rief, 2008), or have a vested interest in concealing due to social norms. The IAT has been used to measure implicit attitudes towards various socially sensitive topics and stigmatised behaviours (see Greenwald et al., 1998; Swanson, Rudman & Greenwald, 2001; Teachman, Wilson & Komarovskaya, 2006).

The IAT measures the ease or difficulty with which a person associates a “target concept” with an “attribute dimension” (Greenwald, Poehlman, Uhlmann & Banaji, 2009). The speed of response relates to how closely associated the targets and attributes are for the person and rests on the premise that it is easier to make the same response to two things when they are related (congruent), than when they are unrelated (Smith & Nosek, 2011). Faster responses denote stronger associations. The IAT consistently yields large effects (Gregg, 2008) and displays good internal consistency and test-retest reliability (median value of $r = .56$; Greenwald et al., 2009; Nosek et al., 2007).

This research utilised a single-target IAT (ST-IAT; see Wigboldus, Holland & Van Knippenberg, 2004) which is non-comparative and associations can be measured independently of the association with a second “target category”. This was due to involvement lacking a naturally occurring opposite category. The ST-IAT is reported to have good overall reliability and validity estimates, and convergent validity when compared with explicit measures of the same attitude construct (Bluemke & Friese, 2008). It also has comparable internal consistency ($r = .69$) to the original IAT (Karpinski & Steinman, 2006).

The service user involvement-single-target-IAT was utilised in this research to ascertain implicit attitudes to service user involvement. The attribute words used in the critical test blocks underwent a process of development. Words/terms reflecting user involvement were generated via collaboration between the author and a mental health service user. Twenty-three cue words were then presented to three clinicians with strong knowledge of user involvement. They were then inter-rated for strength and representativeness; using categories of “strong” and “weak” with the final selected eight cue words/terms deemed strong, representative of user involvement, and with clinicians in complete agreement ($\kappa = 1$). Therefore, the words/terms were deemed reliable for use in this research.

Online completion required participants to respond to the same positive and negative words as the original IAT (e.g., “marvellous” and “horrible”) and categorise them into categories of “good” and “bad”. In the critical test blocks, participants also categorised words representing attributes of service user involvement (e.g., collaborative, power-sharing, inclusive, partnership, empowering, equality, co-production, and recovery-focussed). Shorter response latencies on the congruent (e.g., “service user involvement” + “good”) in comparison to the incongruent (e.g., “service user involvement” + “bad”) block was assumed to indicate more positive implicit associations to involvement; denoted by the “difference-measure” (d measure). Scoring followed the procedures recommended by Greenwald, Nosek and Banaji (2003). Appendix F provides the instructions given to participants.

## Procedure

### Client procedure.

Individually coded packs were distributed to service users in each NHS Trust. Packs contained a consent form, an information sheet, a demographics sheet and the WAI-C in paper version (see Appendices G-I). The service users’ information sheets contained tear off slips with a code, which they were asked to give to their therapists.

### Therapist procedure.

The tear off slips directed therapists to a secure online website comprising an information sheet, a consent form, demographics sheet (see Appendices J-L), the OCAI, IAT (Inquisit v.3), and CAMI. Dyads were formed by matching the codes. Due to the potential for therapists being approached to take part by multiple service users, completions were capped at two times.

## Ethics Approvals

Various ethics approvals for the research were received from: (a), Research Governance at the University of Liverpool who acted as sponsors, (b) the NHS Research Ethics Committee, and (c) Research and Development departments at both NHS Trust sites. For the purposes of the thesis, ethical considerations are provided in Appendix M.

## Data Screening and Data Analytic Procedures

Prior to statistical analysis using parametric tests, missing data was assessed and the assumptions of normality of data distribution, homogeneity of variance, and assumptions of independence were tested. Missing values were only present for the client-rated WAI-C scale due to paper and pencil version; therapists' measures were complete. Little's – "Missing Completely at Random Test" was computed for the WAI-C scale. The test was non-significant ($p$ = .65) suggesting missing values were random; however, due to nine of the subscale items exceeding more than 2% missing, the "Expectation Maximisation" algorithm was performed to correct and replace missing values with the total scale mean.

Field (2009) suggests that samples under 30 are more likely to be non-normal. Therefore, normality of distribution was assessed using graphical representations, box plots, normal Q-Q plots, detrended Q-Q plots, and skewness, kurtosis and Z scores. For all measures, Z-scores were checked and using absolute values (all z's: 1.96 to 3.29; Field, 2009) were within normal limits. Kolmogorov-Smirnov and Shaprio-Wilk tests highlighted normal distribution ($p$ >.05). Collectively, this suggests the assumption of normality was met for all scales.

Homogeneity of variance between the dyad and non-dyad group was assessed prior to conducting *t*-tests. Levene's test for the WAI-C scale ($p$ = .03) indicated the data violated the assumption of equal variance and *t*-tests were reported accordingly. Finally, the assumption of independence was not met, as it was known that at least two therapists completed twice, and therefore the data from these participants were not independent. Appendix N provides further information on exploring assumptions.

### Sample Size, Statistical Power and Statistical Tests

At least 85 participants were required for the correlational analyses (for a medium effect size *r* = .30 with α set at .05 and power .8); and at least 64 participants were required for tests of differences between the dyad and non-dyad group (for a medium effect size *d* = .50 with α set at .05 with power at .8; Cohen, 1992). Ninety-seven participants were required for multiple regression analyses in order to detect a medium effect size (f = .15), with an alpha of .05, and power of .8 based on six predictors (Cohen, 1992). The sample size was not large enough to provide adequate power and therefore, it was not possible to conduct multiple regression analyses, as planned. The relationships between organisational culture, alliance and attitudes could not be assessed and descriptive statistics were instead used to report data on perceptions of organisational culture.

Exploration of parametric assumptions suggested that parametric tests were appropriate, for independent samples t-tests and Pearson's correlations which were performed to address the research questions. However, the research was also significantly underpowered for these tests, potentially limiting the findings. All analyses were conducted using SPSS version 20.

## Results

Initial preliminary analysis was conducted on the whole sample of clients (*N* = 46) to assess whether client-rated working alliance differed between the dyad group (matched pairings; *N* = 28) and non-dyad group (unmatched pairings; *N* = 18). Total working alliance scores between dyads (*M* =212.1, *SD* =22.74) and non-dyads [*M* =186.59, *SD* =36.55; *t*(44) =2.65, *p* =.014] highlighted significant differences. The magnitude of the variance in alliance using Cohen's (1992) parameters was large (eta squared= 0.14; Field, 2009). The results show that clients of therapist non-completers rated the working alliance significantly lower than clients whose therapists took part. Analyses also showed that client-rated working alliance between the dyad (*N* =28; matched pairings) and non-dyad (*N* =18; unmatched pairings) group was significantly lower on each subscale: task [*t*(44) =2.45, *p* =.019]; bond [*t*(44) = 2.64, *p* =.012], and goal [*t*(44) =2.74, *p* =.009]. The magnitude of the variance in alliance on each respective subscale was large (eta squared: 0.12 to 0.15; Field, 2009). From this point onwards, the results will refer to the sample of matched therapist-client dyads (*N* = 28) only. Descriptive statistics pertaining to explicit attitudes, implicit attitudes and working alliance are presented in Table 9.

Table 9

*Descriptive Statistics for Working Alliance, Explicit Attitudes to Mental Illness, and Implicit Attitudes to Service User Involvement*

| Measure (*N=28*) | Mean total score *(SD)* | Minimum total score | Maximum total score | Maximum total score for the measure |
|---|---|---|---|---|
| | Clients | | | |
| Working alliance (WAI-C) | 212.1 (22.74) | 168 | 245 | 252 |
| Goal subscale | 71.05 (9.03) | 56 | 84 | 84 |
| Task subscale | 68.29 (7.60) | 53 | 78 | 84 |
| Bond subscale | 72.73 (9.40) | 50.02 | 84 | 84 |
| | Therapists | | | |
| Explicit attitudes (CAMI) | 182.86 (8.48) | 162 | 196 | 200 |
| Authoritarianism subscale | 44.64 (1.95) | 40 | 48 | 50 |
| Community mental health ideology subscale | 44.57 (4.38) | 35 | 50 | 50 |
| Benevolence subscale | 46.79 (2.41) | 41 | 50 | 50 |
| Social restrictiveness subscale | 46.86 (2.19) | 42 | 50 | 50 |
| Implicit attitudes (IAT) | .35 (.36)* | -.55 | .97 | +2 |

*Note.* *This score represents the mean total d (or difference) measure. This ranges from -2 to +2; the difference being between positive responding in relation to negative responding. The higher the ‘difference score’ the more positive the association.

As Table 9 illustrates, client-rated working alliance scores were relatively high both on the total scale, and its respective subscales, denoting overall strong positive working alliances. **S**elf-reported explicit attitudes to mental illness were also very positive. With respect to implicit attitudes, 21% of the sample (*n* = 6) yielded a negative score and 79% (*n* = 22) yielded a positive IAT effect showing a positive association. Interestingly, all the positive scores ranged between 0 and 1, with no scores ranging between 1 and 2. However, whilst implicit attitudes were also positive, they were less so than explicit attitudes[5].

Table 10 provides the results of therapists' perceptions of their organisational culture.

Table 10

*Frequency Data for Organisational Culture*

| Organisational culture (*N*=28) | *n* (%) | Trust A | Trust B |
|---|---|---|---|
| Market (Compete) | 18 (64.3) | 7 (63.7) | 11 (64.8) |
| Hierarchy (Control) | 6 (21.4) | 3 (27.3%) | 3 (17.6) |
| Clan (Collaborate) | 3 (10.7) | 1 (9.1%) | 2 (11.8) |
| Adhocracy (Create) | 1 (3.57) | 0 | 1 (5.9) |
| Total | 28 | 11 | 17 |

As Table 10 highlights, the majority of therapists in each NHS Trust rated their organisational culture, as market; that is, competitive, results orientated, mechanistic, and an approach whereby people work very fast (Jacobs et al., 2013). All correlational analyses conducted to address the specific research questions are provided in Table 11.

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[5] The frequency of therapist total scale scores ≥ the mean for implicit attitudes was 13, and for explicit attitudes was 17.

Table 11

*Pearson's Correlational Analyses for Working Alliance, Explicit Attitudes to Mental Illness, and Implicit Attitudes to Involvement*

| Scales (*N*=28) | WAI-C total Scale | Goal subscale | Task subscale | Bond subscale | CAMI total scale | IAT Total test |
|---|---|---|---|---|---|---|
| 1.Working Alliance (WAI-C) | - | | | | | |
| 2.Goal subscale | **.88**** | - | | | | |
| 3.Task subscale | **.90**** | **.78**** | - | | | |
| 4.Bond subscale | **.84**** | **.55**** | **.63**** | - | | |
| 5.Explicit attitudes (CAMI) | .21 | .24 | .15 | .16 | - | |
| 6.Implicit attitudes (IAT) | .25 | .12 | .16 | .36[a] | .16 | - |

*Note.* [a]roughly equates to a medium effect size, but non-significant; **significant at $p<.01$

### Therapists' Explicit Attitudes to Mental Illness, Implicit Attitudes to Involvement, and Working Alliance

The first research question aimed to ascertain whether explicit attitudes to mental illness and implicit attitudes to user involvement are related to client-rated working alliance. As Table 11 highlights, no significant relationships between explicit attitudes and working alliance [$r = -.21$, $N = 28$, $p = .28$], or implicit attitudes and working alliance [$r = .25$, $N = 28$, $p = .20$] were found.

### Therapists' Explicit Attitudes to Mental Illness, and Implicit Attitudes to Involvement.

The second research question asks whether there were relationships between therapists' explicit attitudes towards people with mental illness, and implicit attitudes to involvement. As can be seen in Table 11, there were no significant relationships between explicit attitudes to mental illness and implicit attitudes to involvement [$r = .16$, $N = 28$, $p = .43$], suggesting the constructs were relatively independent of one another.

## Discussion

Counter to expectation, the research found no relationships between therapists' explicit attitudes to mental illness, implicit attitudes to involvement, and client-rated working alliance; and the hypotheses were unsupported. Preliminary results showed clients whose therapists did not participate (unmatched dyads) rated the working alliance significantly lower than therapists who did participate (matched dyads). Descriptive results highlighted: strong positive working alliances; positive explicit attitudes to mental illness; implicit attitudes to involvement that were positive, but slightly less positive than explicit attitudes. Moreover, these results show a strong perception of NHS organisational culture as market, that is, mechanistic, and results orientated. This study found no significant relationships between explicit attitudes, implicit attitudes and working alliance.

Research has suggested some healthcare professionals harbour negative attitudes towards people with mental illness. Whilst it was hoped explicit attitudes to mental illness within psychological therapists would be positive, the extent of the positivity was unexpected. Attitudes were more positive than that of the nurses in a large (*N* = 810) international study spanning five European countries (Chambers et al., 2010), and a large study (*N* = 288) of UK nursing students (Schafer et al., 2011). This could have been due to social desirability bias. Or alternatively, it could have been possible that the research topic appealed to a sample of therapists with pre-existing positive attitudes.

Implicit attitudes to involvement were also positive. Research investigating implicit and explicit attitudes to mental illness (Teachman et al., 2006) and other “socially sensitive” topics such as racial prejudice (Greenwald et al., 1998) report positive explicit and negative implicit attitudes. It is important to note that this research may have been investigating two different factors: attitudes towards people with mental illness and attitudes to service user involvement, which may be independent constructs. Table 11 highlighted non-significant relationships between implicit and explicit attitudes of therapists and client perceptions of working alliance. These constructs may not be related at all, thus accounting for the non-significant correlations. However, the relationship between implicit attitudes of therapists and client rated bond warrants further research.

Descriptive statistics on organisational culture were expected to show a more even spread of cultures. The highest rated culture type was market depicting a competitive, results orientated, mechanistic NHS culture. The similarities in the different Trusts were interesting. Both Trusts were unified in what their cultures are not, namely, clan or adhocracy. This suggests that therapists perceive the NHS to have a lack of focus on collaboration, teamwork, participation, and people development, together with lacking flexibility and adaptability.  This distribution of perceived culture matches the most recent large scale longitudinal (2001-2008) research reporting organisational culture across 140 UK NHS Trusts (see Jacobs et al., 2013), which highlighted a steady rise in market and a steady decline in clan cultures.

These findings also have clinical relevance for clinical psychologists. Given that culture was rated low on collaboration and teamwork, therapists are expected to work collaboratively in therapy and teams daily. The clients in the dyad sample rated working alliance as positive. This leads to the question whether therapists are expected to do a difficult job of fostering and maintaining alliances when the culture is perceived not to facilitate this way of working. Casali and Day (2010) state that when individual values are not consonant with the organisational culture this can negatively impact on people’s ability to make ethical decisions and can lead to unhealthy cultures.

Working alliance was expectedly high, and similar to client-rated working alliance pre and post Cognitive Behaviour Therapy (Preschl, Maercker & Wagner, 2011), and higher than clients receiving counselling (see Taber, Leibert & Agaskar, 2011). Preliminary analyses on the WAI-C highlighted an unexpected result. Client-rated working alliance score was significantly lower in the non-dyad than the dyad group, an effect that was consistent across all three subscales. Bearing in mind clients completed the WAI-C first, the results suggest a strong positive working alliance, facilitated participation in and involvement with the research. Collaboration led to a positive outcome.

## Methodological Considerations

The research had several noteworthy limitations comprising issues related to methodology, procedure, sampling, independence and statistical analysis. The main issue is that the research was significantly underpowered. The sample size was not sufficient to adequately power multiple regression analyses to explore predictor (implicit and explicit attitudes, and organisational culture) and outcome variables (working alliance) as planned. This also meant that the hypothesised relationships between organisational culture, attitudes, and therapeutic alliance could not be tested, and therapists’ perceptions of organisational culture could only be reported as a descriptive statistic. The violation of the assumption of independence precluded any further non-parametric analysis (e.g., Chi-square), and the hypothesis relating to organisational culture was not able to be tested. The sample of 28 dyads was underpowered for the analyses conducted, which potentially resulted in a lack of findings and the hypotheses being un-supported. It was also not known how many separate therapists comprised the dyads. Also, the research had different response rates at various points in the recruitment process. The research utilised a bottom-up recruitment process; that is, service users opted in first. Just under 9% of the research packs originally distributed were completed and returned by service users; a relatively low response rate. However, whilst the service user response rate was 9%, 61% of therapists contacted by service users completed the research.

The research sample also lacked diversity. Participants were predominantly female and may have comprised a group of clients and therapists, amenable to research, working together within collaborative cultures potentially illuminating positive attitudes and strong alliances from the outset. This is linked with procedural issues of bottom-up recruitment which, in attempting to level power differentials and reduce bias, may have resulted in a sample comprising therapists who had a pre-existing strong bond with their clients. An additional complication was that bottom-up recruitment per se, was compromised at times, with the researcher having to contact therapists to gain permission to contact their clients; thus introducing an element of top-down. This way of recruiting may have resulted in therapists selecting the clients they had a strong positive working alliance with, thus biasing the sample. Recruitment was therefore, more fitting with a “negotiated bottom-up process”.

The dyadic data presented further challenges. Assumptions of independence are reportedly problematic in dyadic research (Kenny, Kashy, & Cook, 2006). Kenny (1996) suggests that sample sizes can be halved with dyadic data, and each individual can be classed as one unit if the assumption of independence within the sample is met. However, this research violated the assumption of independence due to the notion of therapists and clients being in more than one dyad; referred to as a one-with-many design (Marcus, Kashy & Baldwin, 2009). Subsequently, the assumption of independence was not met, as two therapist completions were built into the study design in order to maximise recruitment. It was known that at least two therapists completed twice but dual client completion was unknown.

An additional methodological limitation is that a single isolated score on the Working Alliance Inventory-client version (WAI-C; Horvath, 1981) may not have accounted for the nuances within the therapeutic relationships; one rating may not give an accurate picture of the quality and strength of therapeutic alliance over time (Crits-Cristoph, Connolly Gibbons, Hamilton, Ring-Kurtz & Gallop, 2011).

The implicit attitude scores were slightly less than the explicit attitude scores with 17 scores above the mean for explicit attitudes and 13 above the mean for implicit. There may be several reasons for this: psychological therapists have an inherent positive implicit association towards user involvement or the sample was biased comprising a sample of therapists with particularly positive views on collaboration. Also, the IAT requires further development.

Further issues in terms of the CAMI measure used may have contributed to non-significant findings. The scale was reliable in this sample, but some items were outdated and led to conflicted answers. For example, question five asks: “mental illness is an illness like any other?” Respondents wanting to avoid bio-medical assumptions of mental illness would score as if their attitudes are negative whilst those *with* bio-medical assumptions would score positively.

In conclusion, counter to expectation, no significant relationships were found between all variables in this study: explicit attitudes to mental illness, implicit attitudes to involvement; and working alliance. Therefore, the hypotheses were not supported. Both implicit and explicit attitudes in this sample were positive. Positive attitudes and organisational cultures are essential in embedding service user involvement strategy and fostering close, more equal working relationships with mental health service users. For organisational cultures to facilitate this paradigm shift in equality of relationships, positive attitudes would be required across all professional groupings and not just a sample of psychological therapists. Therefore, further research is required to ascertain attitudes towards people with mental illness and service user involvement, from all other professional groups of clinicians.

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# CHAPTER 3: EXTENDED DISCUSSION

# Discussion

This chapter comprises a discussion, a summary version of the empirical study for service users and a proposal for subsequent research. The discussion provides a brief overview of the previous chapters and further discusses methodological, ethical and policy issues. It considers the nature of evidence, research paradigms and the relationship between user involvement, clinical psychology and leadership. It is argued that clinical psychologists' skills as scientist-practitioners make them well placed to research, theorise, implement and lead involvement initiatives. It concludes by suggesting that building the relationship between service user involvement and clinical psychology could be synonymous with a recently proposed paradigm-shift for the discipline.

## Chapter One Overview

The systematic review in chapter one highlighted the political and legislative imperative to involve service users which was juxtaposed with a lack of an evidence base and theoretical underpinnings. It was suggesting this as problematic for clinical psychologists as scientist-practitioners. In highlighting the need to establish what evidence base for user involvement exists, it aimed to systematically search for, collate and review the empirical evidence for the impact of involvement. Following debates around whether user involvement is or should be the remit of clinical psychologists, the review also ascertained whether psychological theory had been applied to user involvement and whether clinical psychologists are involved in this research. It discussed the findings of the review in relation to psychological theory including theories of power and empowerment, attitudes, stigma and intergroup contact.

Eleven empirical research studies were reviewed. These highlighted a wide range of negative and positive impacts of service user involvement at individual and strategic levels, process issues and barriers to involvement. Despite reports to the contrary, the review highlighted that there is an empirical evidence base for the impact of user involvement but it is small, the research is poorly reported and most studies have significant methodological flaws. The implications of this were discussed. The included studies lacked application of psychological theory. The impacts of the user involvement strategies were discussed and psychological theories of power and empowerment, attitudes, stigma and intergroup contact applied in order to gain a psychological understanding of them. Three of the included studies had input from clinical psychologists in various forms and so there is representation from clinical psychology as a discipline. The review discussed the methodological limitations of the included studies and review process and concluded with implications for clinical practice, for clinical psychologists and areas for future research. More high quality, better reported research on the impacts of user involvement is required to enable future meta-syntheses of the findings. The poor quality of the majority of the research means the overall findings of this systematic review have to be considered in the light of the implications and limitations and interpreted tentatively. The more recent studies are better quality and give hope that the empirical evidence base will continue to grow in size and quality. The review concluded that clinical psychologists as scientist-practitioners are well placed to progress this area of research.

## Chapter Two Overview

The empirical research in chapter two was the first of its kind to study, empirically, attitudes to service user involvement. It was also the first to explore implicit attitudes to involvement, that is, the role of less intentional processes of implicit social cognition. Counter to expectation, the empirical study failed to detect significant relationships between therapists' explicit attitudes to mental illness, perceptions of NHS organisational culture, implicit attitudes to user involvement, and client-rated working alliance. The hypotheses were not supported. The empirical paper's discussion section identified factors inherent within the research design, methodology, sampling and measurement, for the non-significant findings. It did, however, on the whole, find positive implicit and explicit attitudes of therapists and strong working alliances between service users and therapists (as rated by service users).

### Methodological considerations.

In the design of the empirical research aspects pertaining to sampling and procedure were considered comprehensively from the outset. Different approaches to recruitment were debated and, in hindsight, decisions made more on ethical as opposed to pragmatic grounds. The bottom-up recruitment approaches attempted to level power differentials between service users and service providers and, reduce selection bias. Top-down recruitment may have resulted in therapists selecting the clients with whom they had a strong positive working alliance with, thus biasing the sample but possibly yielding a larger sample. Structural and institutional barriers existed which meant that attempting to "change" traditional power relationships, albeit temporarily, was difficult. Arguably, this was indicative of attitudes and cultures from the outset. A top-down approach may have resulted in a larger sample but, by way of a less ethical process. Bottom-up recruitment may be where client consent is truly informed.

Whilst the author believes ethical decision-making is paramount, especially in user involvement research, structural and institutional barriers rendered bottom-up recruitment difficult to implement. Bottom-up recruitment felt as if it was marginalising therapists and top-down recruitment marginalising clients. Further notable obstacles included access. For example, permissions from numerous service leads in various services, sites and Trusts were required to gain access to clients, also introducing an element of top-down. Additionally, ethics committee policies and procedures prevented the researcher allowing the therapist-client dyad to collaborate in decisions to take part in the research together due to demands on therapy time. The procedural decision to level power and reduce bias introduced an element of bias which may have contributed to low recruitment numbers. Therefore, the sample may have comprised a group of amenable clients and therapists in collaborative cultures potentially illuminating positive attitudes and strong alliances from the outset. In this instance a dilemma persisted. Attempts to disrupt traditional power relationships, work ethically, and reduce bias had to be balanced with the need to reduce different selection bias and recruit sufficient numbers. This tension was unresolvable. Recruitment was therefore, more fitting with a "negotiated bottom-up process".

### Ethical concerns.

The process of conducting the empirical research raised some ethical dilemmas, resulting in considerable learning for the author. First, the author was contacted by four different mental health service users, spanning both Trusts who wanted to take part in the research but who were not receiving, but wanted, psychological therapy. This is interesting given that psychological therapies are only available at best, to a quarter of the people who need them (Kinderman, 2013). The immediacy of the dilemma was resolved by thanking the potential participants, and redirecting them to their GPs to request referrals for psychological therapy.

Second, whilst the design of a new scale was progressive and a relative strength of the research and its potential future directions, it may have required piloting before first use, perhaps with people without a strong knowledge of user involvement, and with service user groups. Furthermore, the IAT software is programmed to generate the difference score but it is then presented to participants following completion. This raised a further ethical dilemma as the author was contacted by five psychological therapists concerned that their scores were lower than they had anticipated. In hindsight, scores should not have been provided to participants at this early stage.

Finally, some service users stated that their participant information sheet (see Appendix H) was not accessible, for example; stating it was unnecessarily long, and visually unappealing. This raises an interesting dilemma for future research; whilst the format for information sheets adhered to Research Ethics Committee regulations, they may not have helped to encourage service users to participate.

## Research Paradigms and the Nature of Evidence

The systematic review in chapter one presented studies where the source of knowledge came mainly from service users.  The studies highlighted that jargon, scientific language and educational level provided a barrier to authentic engagement between service users and providers. It also highlighted tokenism, service users’ voices being delegitimised and their credibility questioned.  This leads to a much larger debate about how knowledge is produced. It also raises the discussion as to whether service users’ experiences and perspectives constitute “evidence” and if so, the weight that should be attributed to them.

Service users do not hold as much power and status as service providers. In user involvement impact research, the status of service users may be more about the status and credibility of their knowledge. The systematic review in chapter one reported that some service users were unable to relate to providers using the scientific discourse. This may highlight potential structural obstacles to involvement and explain why some of the barriers exist. It may also highlight why users' voices are discounted as not legitimate or credible. The Cochrane Collaboration advocates for the credibility of evidence to be judged according to the source type when assessing for the effectiveness of an intervention. This locates randomised controlled trials (RCTs) at the top of the hierarchy, providing evidence that is thought to be unbiased and objective. The "evidence from experts" locates at the bottom. In this instance "experts" are clinicians. As Rose (2008) suggests, evidence from expert clinicians is categorised as the weakest form of evidence, but it is still evidence. The views of service users are no evidence at all. The experiential knowledge of users may be valued for its authenticity in one respect but when set aside forms of knowledge which may claim the status of "evidence", voices could be seen as biased, subjective and easily disregarded.

That said all research is biased. Researchers have an investment in their work and adopt an epistemological stance that results in a certain type of knowledge (Rose, 2008). RCT evidence can be overstated with data selectively reported and subject to publication bias (Merlander, Ahiqvist-Rastad, Meijer & Beerman, 2003).

The history of service user involvement is not a scientific one. Authors suggest that reducing it to something that looks like an RCT would be wrong (Purtell, Rickard & Wyatt, 2012). Involvement should be about the development of rights and assessing its impact should be concerned with whether being involved makes a difference to people's lives and improves the quality of services. However, whether we should and indeed could reduce the service user voice to measurable outcomes is a "live and active debate" (Purtell et al., 2012, p. 209).

The debate about what constitutes evidence was considered heavily when designing the research presented in chapter two of this thesis. One of the necessary critiques should be its research paradigm and epistemological stance. The decision was made to conduct the empirical research within a positivist, and arguably, a reductionist paradigm, using quantitative methods, and generating numerical outcomes. The decision to do this was led by the increasing political and legislative focus on outcomes within the NHS. In times of fiscal constraint, providing evidence for user involvement based on experiential knowledge of service users alone, may be easier for others to discount.

For user involvement to be fostered continually in an increasingly outcome-led, economics-driven NHS, it was thought that the effectiveness of user involvement, so prevalent anecdotally in service users' recovery stories, needed to "speak" to policy-makers and commissioners. In order to do this, it needed to demonstrate its effectiveness in a "language" which was understood and accepted by decision-makers. Subsequently, following considerable thought, the decision to research the barriers to user involvement using quantitative methods was made on political grounds. Most importantly, it does not necessarily mean it was the right approach. As Mitchell and Purtell (2009) suggest, sometimes there is a need to face another direction in order to understand your own position.

Representing a profession of clinical psychologists who are scientist-practitioners and whose core identity is based on fundamental values of expert skills, a distinctive ethos, a solid evidence base, and skills in collating large amounts of information into a psychological formulation (Kinderman, 2013) provides an ideal opportunity to consolidate various types of knowledge. This may enable voices of service users and their unique preferences, concerns and expectations to be heard. Combining service user voices with empirical research evidence may be the added value brought by clinical psychologists to this area of research.

### Clinical Psychology, Leadership and User Involvement.

Clinical psychologists are well placed to expedite service user involvement via leadership. Like user involvement (see Soffe, 2004) leadership is referred to as being the remit of clinical psychologists (Skinner, 2011). The importance of transformational leadership is increasingly being discussed in the clinical psychology arena (see Alimo-Metcalfe, 2013; Alimo-Metcalfe & Alban-Metcalfe, 2008; Skinner, 2011) and is applicable to involvement. Leadership behaviour in mental health services is said to require building relationships within and between individuals, teams, systems and organisations. Fostering relationships and working in genuine partnership are defined as a two-way process (Alimo-Metcalfe, 2013). Embedding strong leadership based on a critical principle of engagement is the key to effective and sustainable organisational cultures (Alimo-Metcalfe, 2013). Reportedly, what service users want is genuine partnership working and therapeutic relationships

(Locker, Alimo-Metcalfe & Bell, 2011). Clinical psychologists are well placed to facilitate, nurture and lead on user involvement initiatives.

## Policy

In an extremely difficult NHS organisational culture, that is beleaguered, fraught with uncertainty, experiencing radical reorganisation, a deficit-reduction agenda, and redundancies and redeployments, asking service providers to radically shift ways of working to involve service users in all aspects of design and delivery of services is not an easy task. It will need to be implemented sensitively. Also resonating with this is the fact that involvement is a democratic right. There is no better way to improve the quality of services provided to clients than learning from those who have experienced or are experiencing the condition (Britt, 2013). Whilst service user involvement may eventually lead to the production of new knowledge, service providers may experience the fragmentation of *them* and *us* boundaries, experience considerable (implicit and/or explicit) fear, and feel threatened by loss of the position of expert (Greenhill, Roberts, & Swarbrick, 2013). Whilst government policy and legislation are clear, user involvement is no longer thought of as a bolt-on innovation; policy rhetoric on involvement remains (see Hui & Stickley, 2007). In referring back to therapists' perceptions of organisational culture in chapter two, whilst these are perhaps understandable given the shift towards activity-based funding and privatisation of the NHS (Mannion & Street, 2009), and commissioning operating via strategy of "any qualified provider", if these perceptions are accurate and generalisable, then they are worrying in the light of the fact that clinical negligence expenditure is highest in market cultures (Jacobs et al., 2013). They also widen the gap between policy on user involvement and practice and render collaborative practice between providers and recipients of services problematic.

There is a much wider concern, however, providing structural barriers to the meaningful involvement of mental health service users. Attempts to contain will always legally override human rights legislation and attempts to empower (Pilgrim & McCranie, 2013). Therefore, authentic whole-system involvement may require a complete eradication of Mental Health Law in order to facilitate non-tokenistic inclusion of mental health service users (Pilgrim & McCranie, 2013).

# Thesis Conclusion

This thesis includes a systematic review of the empirical evidence base for the impacts of mental health service user involvement in the design, delivery, commissioning and evaluation of services.  It highlighted positive and negative impacts, process issues and barriers to its implementation. It ascertained that no psychological theory was applied within the 11 studies reviewed. Therefore, attempts to apply psychological theories of power, empowerment, attitudes, stigma and intergroup contact to the impacts and barriers of involvement were made. Clinical psychologists were involved in a few of the research studies.

Following this, utilising the psychological therapist-client dyad this thesis presented findings from empirical research which investigated the relationships between psychological therapists' explicit attitudes to people with mental illness, perceptions of organisational culture, implicit attitudes to involvement, and working alliance as rated by clients. The research yielded non-significant relationships between the variables and due consideration was given to account for the non-significance. It was suggested that further research is essential.

Reportedly, the smaller the gap between service users' experience of distress and its interpretation, the more accurate the perceptions are likely to be (Beresford, 2005). Involvement is therefore pivotal to the provision of psychologically supportive cultures. Clinical psychologists should be concerned with involvement, and moreover, have a multitude of skills spanning individual, clinical, group, organisational, and societal levels, to aid the understanding of the multi-level barriers to its implementation. Clinical psychologists are well placed to improve the empirical evidence base for user involvement via research; lead and support individuals and teams to work through the resistances to user involvement using psychologically-informed approaches. Subsequently, clinical psychologists may be able to expedite user involvement strategy and strengthen the collective voice of service users.

To conclude, there are many grounds to be hopeful about a paradigm-shift for clinical psychology. The British Psychological Society's Division of Clinical Psychology (DCP) has very recently published its position statement on "functional psychiatric diagnoses" (DCP, 2013).  The

DCP clearly states it is time for a paradigm-shift. It pledges to work with all professions and, most notably, service user and carer movements to develop a new paradigm for mental health services to enhance understanding of the complex interplay of social, psychological, and biological factors and resilience (Whomsley, 2013).

It is also time for service users and service user groups to make increased demands on mental health services to provide more appropriate care that enables people on a journey to recovery in their psychological distress.  “Only power that springs from the weakness of the oppressed will be sufficiently strong to free both” (Freire, 1996, p. 26).

# Future Research Proposal

The research in chapter two was the first of its kind to study empirically, the widely cited attitudinal and organisational barriers to service user involvement. It was also the first to explore implicit attitudes to involvement, that is, the role of less intentional processes of implicit social cognition. The research yielded statistically non-significant findings between therapists' explicit attitudes to mental illness, perceptions of organisational culture, implicit attitudes to involvement, and client-rated working alliance. Whilst it was entirely possible that implicit attitudes, explicit attitudes and working alliance are not related, methodological flaws, and a small sample size that was significantly underpowered for the tests it computed, may have contributed to the non-significant findings. Therefore, the research conducted in chapter two would need to be replicated before research progresses into new areas; largely as it is, with due consideration given to addressing the methodological flaws. Further research would be able to provide additional evidence as to whether the constructs are indeed related or unrelated.

## Research Rationale

Attitudes and collective organisational cultures act as both barrier and facilitator to service user involvement strategy (see Crawford et al., 2003; Hickey & Kipping, 1998; Read & Wallcraft, 1992; Rose, Fleischmann, Tonkiss, Campbell, & Wykes, 2002; Rutter, Manley, Weaver, Crawford & Fulop, 2004). Psychological theory such as intergroup contact theory (Allport, 1954), and subsequent research (Pettigrew & Tropp, 2006) suggests that involving mental health service users in the design and delivery of mental health services could be a promising strategy to reduce prejudice, and stigmatised negative attitudes. Furthermore, Allport (1954) suggests that by working in close relational proximity with equal status, generating joint goals and co-operating together, akin to the principles of co-production, an even greater reduction in stigmatised attitudes and prejudice is possible.

The research in chapter two found psychological therapists' explicit attitudes to people with mental illness and implicit attitudes to service user involvement were, on the whole, positive. However, this was from one professional group of clinicians only, and from a very small potentially biased and unrepresentative sample. Future research into attitudes towards involvement will need to consider the collective attitudes and organisational cultures of the NHS mental health workforce. In addition, it will need to assess the attitudes of clinicians within and between various professional groups in order to highlight consistency and variation in attitude where it occurs. It is important to know more about attitudes of different professional groups to close collaborative working with mental health service users. If negative attitudes are highlighted like research suggests, then interventions can be devised to attempt to change these attitudes.

## Research Aim

To ascertain whether explicit attitudes to mental illness and implicit attitudes to service user involvement differ between three professional groups (psychologists, psychiatrists, and nurses) working within multi-disciplinary teams within mental health services.

### Hypotheses.

**Hypothesis 1:** Explicit attitudes to mental illness differ significantly between professional groups.

**Null hypothesis 1:** Explicit attitudes to mental illness do not differ significantly between professional groups.

**Hypothesis 2:** Implicit attitudes to user involvement differ significantly between professional groups.

**Null hypothesis 2:** Implicit attitudes to user involvement do not differ significantly between professional groups.

## Design

The research will be a between-subjects experimental design as it will investigate between group differences.

## Ethics Approvals

As the research will run within an NHS mental health service, an ethics application will have to be made to the appropriate Research Ethics Committee (REC). Additionally, local site specific approvals to Research and Development department, and to the managers of the mental health teams at the NHS Trust sites will be required.

## Measures

### The Implicit Association Test (IAT; Greenwald, McGhee, & Schwartz, 1998).

The IAT is a flexible computerised reaction time analysis that measures implicit attitudes that are both unconscious and automatic; that a person may be unwilling to accept, are unaware of (Lincoln, Arens, Berger, & Rief, 2008), or have a vested interest in concealing due to social norms. The IAT measures the ease or difficulty with which a person associates a "target concept" with an "attribute dimension" (Greenwald, Poehlman, Uhlmann & Banaji, 2009). The speed of response relates to how closely associated the targets and attributes are for the person and rests on the premise that it is easier to make the same response to two things when they are related (congruent), than when they are unrelated (Smith & Nosek, 2011). Faster responses suggest stronger associations. The IAT yields large effects (Gregg, 2008) and displays good internal consistency and test-retest reliability (median value of r = 0.56; Greenwald et al., 2009; Nosek, Greenald & Banaji, 2007).

A single-target version of the implicit association test (ST-IAT; see Wigboldus, Holland & Van Knippenberg, 2004) will be utilised to measure implicit attitudes to service user involvement. Single-target IATs are non-comparative and associations can be measured independently of the association with a second target category, or where an opposite category is not naturally occurring; as is the case with service user involvement. The ST-IAT is reported to have good overall reliability and validity estimates, and convergent validity when compared with explicit measures of the same attitude construct (Bluemke & Friese, 2008). It also has comparable internal consistency (r=.69) to the original double-target IAT (Karpinski & Steinman, 2006). The words/ item attributes of service user involvement co-produced for use in the research in chapter two of this thesis will be utilised following piloting.

### Mental Illness Clinicians' Attitudes Scale (MICA; Kassam, Glozier, Leese, Henderson & Thornicroft, 2010).

The MICA (see Appendix O) is a 16-item scale designed to measure explicit attitudes of health care professionals towards people with mental illness. It is scored on a 6-point Likert scale from 1 to 6 (1=strongly agree, 2=agree, 3=somewhat agree, 4=somewhat disagree, 5=disagree and 6=

strongly disagree). Following reversal of items 1, 2, 4-8 and 13-15, scores are summed to yield a range of scores between 16 and 96; with the lowest total score representing less stigmatising attitudes towards people with mental illness. The scale shows good internal consistency (α = .79), and test retest reliability (.80 over 2 weeks; Kassam et al., 2010).

## Procedure

The research will attempt to recruit as many clinicians working within multi-disciplinary mental health teams as possible. Initially, the researcher will present the study at the respective team meetings and prepare posters to advertise the research. The teams will then be provided with information sheets containing the research overview, the web link to access the research online, and an access code. The online programme will contain: an information sheet, consent form, a demographics sheet containing brief non-identifiable information (age, gender, job title), the single-target IAT and the 16-item MICA. All data will be submitted electronically. The results of the IAT will not be given at the end of the test but, if participants wish to obtain their individual scores, they would be required to provide the researcher with their unique access code.

## Recruitment

The study will aim to recruit as many clinicians within mental health services as possible; first, by approaching the team managers, and second, by attending multi-disciplinary team (MDT) meetings to disseminate information about the research and to hand out information sheets.

## Statistical Analysis, Statistical Power, and Data Analysis

The research will aim to recruit a sufficiently large sample size to adequately power two one-way (one categorical independent variable: comprising three different clinician groups) between-groups (different participants) ANOVAs. The first ANOVA will have a continuous dependent variable of implicit attitudes and the second explicit attitudes. However, there will need to be equal samples sizes in the three different groups. For an ANOVA that compares the means of three groups at alpha of .05, and a medium effect size (*f*= .25) the necessary sample size is 52 in each group (Cohen, 1992). ANOVA would be necessary to ascertain whether the groups differ; post hoc tests would also be required to explore the data and ascertain which of the groups differ.

## Service User Involvement in Research

Any subsequent follow-on research from that presented in chapter two would do well to have it critiqued by service user research and evaluation groups. Following completion, there could be dissemination to various stakeholders in various formats appropriate for various audiences including service users, carers, clinicians, researchers, managers and policy makers.

## Dissemination

### The research title

What are the attitudes of therapists' towards service users, and service user involvement like?

### What was the research aim?

The NHS is required to involve service users in aspects of their own care and in the design and delivery of services. This is different to the traditional way of working and requires NHS workers to have a positive attitude to mental health service users and a positive attitude to joint partnership working with service users. If we know more about what makes joint working with service users easier, we can do more of it, so that service users receive care that helps them to recover from their mental health difficulties. It will also help NHS services to learn about the best way to provide care.

### What questions was the research trying to answer?

**Question 1:** Are attitudes of therapists to people with a diagnosis of mental illness negative or positive?

**Question 2:** Are attitudes of therapists towards joint working with service users negative or positive?

**Question 3:** What do service users who are receiving therapy say the alliance with their therapists is like?

**Question 4:** Are therapists' attitudes related to the quality of the therapy relationship, as rated by service users?

**Question 5:** What do therapists say about the NHS environment that they work in?

### What did people who took part do?

Mental health service users filled in 1 questionnaire first about their therapy and then asked their therapists whether they would complete 3 questionnaires about their attitudes. The service users and their therapists' responses were matched together. The research was anonymous; this meant that no one got to know who took part in it. The therapists did not get to know what the service users had said about their therapy and the services users did not find out their therapists' attitudes. The research was also optional. No one had to take part if they did not want to.

### What type of people took part?

The research ran in two different NHS Trusts. Forty-six service users took part but only 28 of their therapists took part in the research. This meant that the main results could only refer to the 28 therapists and 28 service users who took part.

***Service users:*** 68% of service users that took part were female, 89% were white British, 50% had received a diagnosis of anxiety or depression and 18% had a diagnosis of a personality disorder.

***Therapists:*** 79% of therapists were female too, 93% were white British, 75% were clinical psychologists, 18% had more than 20 years' experience, 86% were working in services for adults.

**What did the research find?**

**Answer 1:** Therapists' attitudes to people with a diagnosis of mental illness are on the whole **very positive**

**Answer 2:** Therapists' attitudes to working closely with service users are also, on the whole, **positive**

**Answer 3:** On the whole, service users receiving therapy said that their therapists asked them what they wanted to get out of therapy (their goals) and what they thought they should do in therapy (the tasks). Service users also said that they had a **good relationship** with their therapists (the bond) and that they **agreed on things** together.

**Answer 4:** The research did not find any relationship between the quality of the therapeutic alliance as rated by service users, and the attitudes of therapists. Therapists with better attitudes do not generate either a better or worse working alliance with service users.

**Answer 5:** Therapists said that they feel like they are working in NHS environments that are not really working together with service users at the moment. The therapists in this research feel **like the NHS is trying to do things really fast** and seems to be more focussed on competition, results (in terms of numbers) and its reputation.

**Thank you to all the people who took part in this research. It is very much appreciated. If you have any questions or would like a full copy of the report please email: X**

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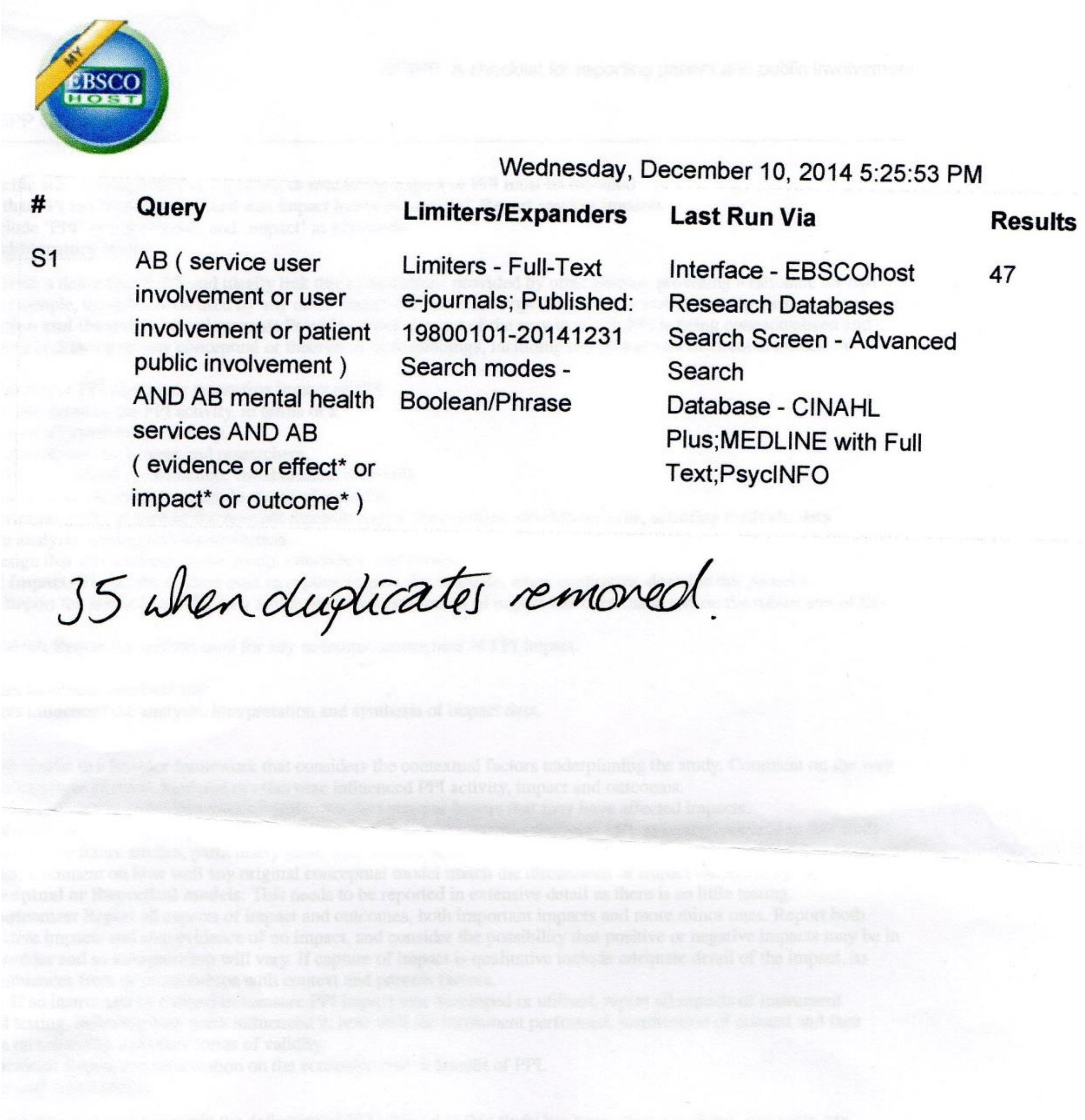
# APPENDICES

# Appendix A: Electronic database search outputs

\# 1 68 TOPIC: ("service user involvement" or "user involvement" or "patient and public involvement") *AND* TOPIC: ("mental health services") *AND* TOPIC: (evidence or effect" or impact" or outcome")

*Timespan=1980-2014*

*Search language=English*



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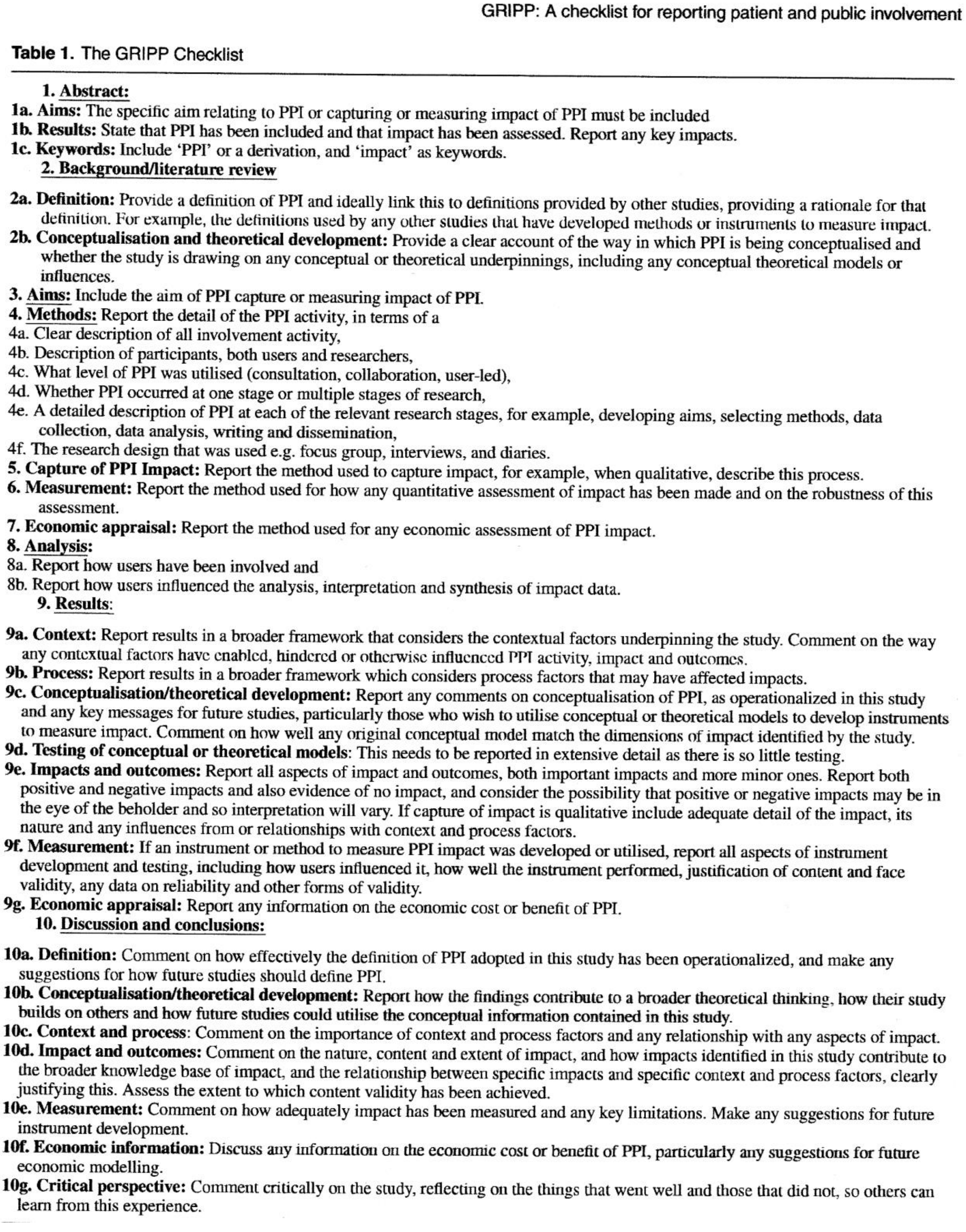
| # | Query | Limiters/Expanders | Last Run Via | Results |
|---|---|---|---|---|
| S1 | AB ( service user involvement or user involvement or patient public involvement ) AND AB mental health services AND AB ( evidence or effect* or impact* or outcome* ) | Limiters - Full-Text e-journals; Published: 19800101-20141231<br>Search modes - Boolean/Phrase | Interface - EBSCOhost Research Databases<br>Search Screen - Advanced Search<br>Database - CINAHL Plus;MEDLINE with Full Text;PsycINFO | 47 |

35 when duplicates removed.

# Appendix B: Guidance for Reporting in Patient and Public Involvement (GRIPP) Checklist (Staniszewska et al. 2011)



GRIPP: A checklist for reporting patient and public involvement

**Table 1.** The GRIPP Checklist

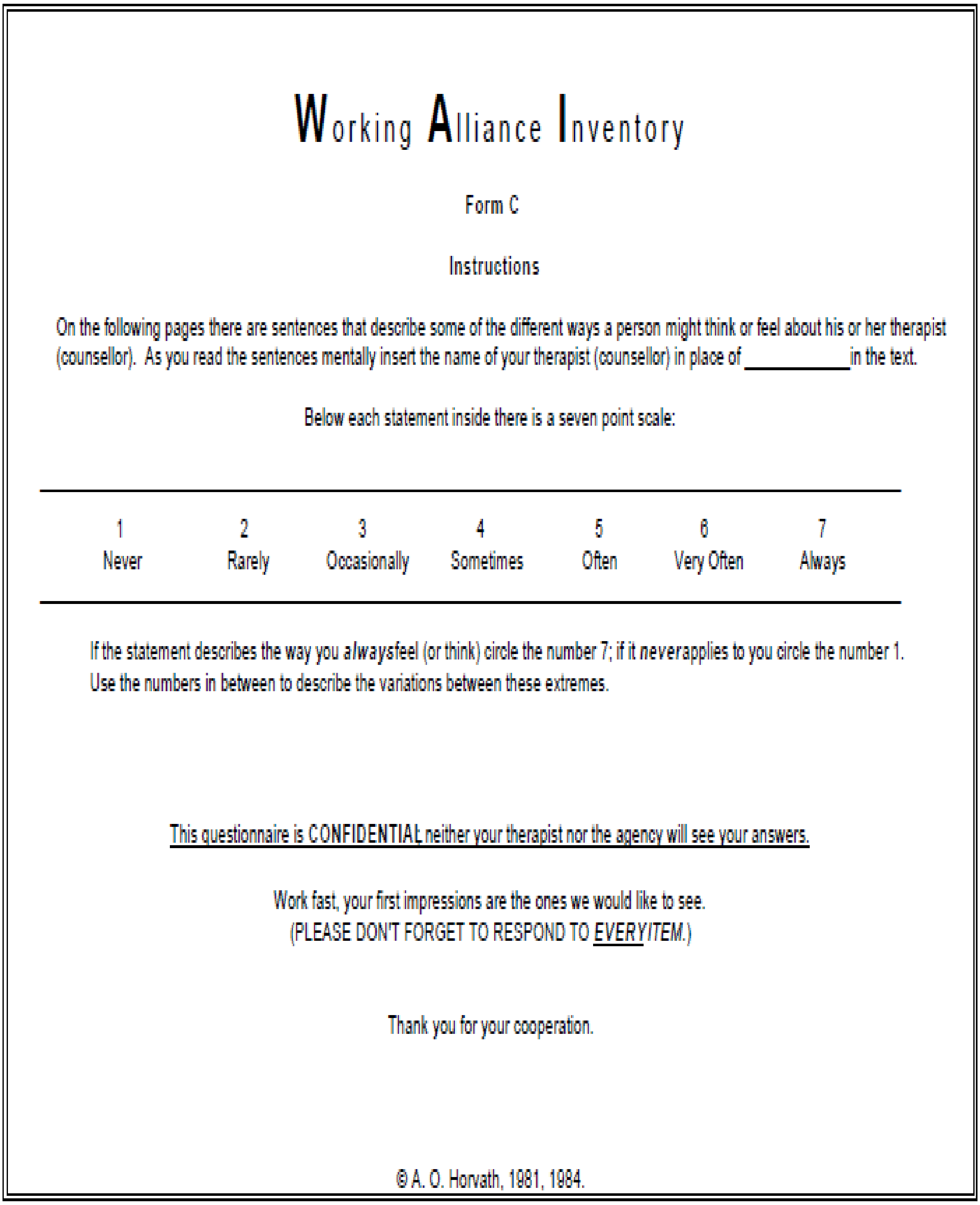
**1. Abstract:**
**1a. Aims:** The specific aim relating to PPI or capturing or measuring impact of PPI must be included
**1b. Results:** State that PPI has been included and that impact has been assessed. Report any key impacts.
**1c. Keywords:** Include 'PPI' or a derivation, and 'impact' as keywords.
**2. Background/literature review**

**2a. Definition:** Provide a definition of PPI and ideally link this to definitions provided by other studies, providing a rationale for that definition. For example, the definitions used by any other studies that have developed methods or instruments to measure impact.
**2b. Conceptualisation and theoretical development:** Provide a clear account of the way in which PPI is being conceptualised and whether the study is drawing on any conceptual or theoretical underpinnings, including any conceptual theoretical models or influences.
**3. Aims:** Include the aim of PPI capture or measuring impact of PPI.
**4. Methods:** Report the detail of the PPI activity, in terms of a
4a. Clear description of all involvement activity,
4b. Description of participants, both users and researchers,
4c. What level of PPI was utilised (consultation, collaboration, user-led),
4d. Whether PPI occurred at one stage or multiple stages of research,
4e. A detailed description of PPI at each of the relevant research stages, for example, developing aims, selecting methods, data collection, data analysis, writing and dissemination,
4f. The research design that was used e.g. focus group, interviews, and diaries.
**5. Capture of PPI Impact:** Report the method used to capture impact, for example, when qualitative, describe this process.
**6. Measurement:** Report the method used for how any quantitative assessment of impact has been made and on the robustness of this assessment.
**7. Economic appraisal:** Report the method used for any economic assessment of PPI impact.
**8. Analysis:**
8a. Report how users have been involved and
8b. Report how users influenced the analysis, interpretation and synthesis of impact data.
**9. Results:**

**9a. Context:** Report results in a broader framework that considers the contextual factors underpinning the study. Comment on the way any contextual factors have enabled, hindered or otherwise influenced PPI activity, impact and outcomes.
**9b. Process:** Report results in a broader framework which considers process factors that may have affected impacts.
**9c. Conceptualisation/theoretical development:** Report any comments on conceptualisation of PPI, as operationalized in this study and any key messages for future studies, particularly those who wish to utilise conceptual or theoretical models to develop instruments to measure impact. Comment on how well any original conceptual model match the dimensions of impact identified by the study.
**9d. Testing of conceptual or theoretical models:** This needs to be reported in extensive detail as there is so little testing.
**9e. Impacts and outcomes:** Report all aspects of impact and outcomes, both important impacts and more minor ones. Report both positive and negative impacts and also evidence of no impact, and consider the possibility that positive or negative impacts may be in the eye of the beholder and so interpretation will vary. If capture of impact is qualitative include adequate detail of the impact, its nature and any influences from or relationships with context and process factors.
**9f. Measurement:** If an instrument or method to measure PPI impact was developed or utilised, report all aspects of instrument development and testing, including how users influenced it, how well the instrument performed, justification of content and face validity, any data on reliability and other forms of validity.
**9g. Economic appraisal:** Report any information on the economic cost or benefit of PPI.
**10. Discussion and conclusions:**

**10a. Definition:** Comment on how effectively the definition of PPI adopted in this study has been operationalized, and make any suggestions for how future studies should define PPI.
**10b. Conceptualisation/theoretical development:** Report how the findings contribute to a broader theoretical thinking, how their study builds on others and how future studies could utilise the conceptual information contained in this study.
**10c. Context and process**: Comment on the importance of context and process factors and any relationship with any aspects of impact.
**10d. Impact and outcomes:** Comment on the nature, content and extent of impact, and how impacts identified in this study contribute to the broader knowledge base of impact, and the relationship between specific impacts and specific context and process factors, clearly justifying this. Assess the extent to which content validity has been achieved.
**10e. Measurement:** Comment on how adequately impact has been measured and any key limitations. Make any suggestions for future instrument development.
**10f. Economic information:** Discuss any information on the economic cost or benefit of PPI, particularly any suggestions for future economic modelling.
**10g. Critical perspective:** Comment critically on the study, reflecting on the things that went well and those that did not, so others can learn from this experience.

# Appendix C: Working Alliance Inventory- Client Version (WAI-C; Horvath, 1981)



## Working Alliance Inventory

### Form C

### Instructions

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her therapist (counsellor). As you read the sentences mentally insert the name of your therapist (counsellor) in place of __________ in the text.

Below each statement inside there is a seven point scale:

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

If the statement describes the way you ***always*** feel (or think) circle the number 7; if it ***never*** applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes.

This questionnaire is CONFIDENTIAL; neither your therapist nor the agency will see your answers.

Work fast, your first impressions are the ones we would like to see.
(PLEASE DON'T FORGET TO RESPOND TO *EVERY ITEM*.)

Thank you for your cooperation.

1. I feel uncomfortable with __________.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

2. __________ and I agree about the things I will need to do in therapy to help improve my situation.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

3. I am worried about the outcome of these sessions.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

4. What I am doing in therapy gives me new ways of looking at my problem.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

5. __________ and I understand each other.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

6. __________ perceives accurately what my goals are.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

7. I find what I am doing in therapy confusing.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

8. I believe __________ likes me.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

9. I wish __________ and I could clarify the purpose of our sessions.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

10. I disagree with __________ about what I ought to get out of therapy.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

11. I believe the time __________ and I are spending together is not spent efficiently.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

12. ____________ does not understand what I am trying to accomplish in therapy.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

13. I am clear on what my responsibilities are in therapy.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

14. The goals of these sessions are important for me.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

15. I find what ____________ and I are doing in therapy is unrelated to my concerns.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

16. I feel that the things I do in therapy will help me to accomplish the changes that I want.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

17. I believe ____________ is genuinely concerned for my welfare.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

18. I am clear as to what ____________ wants me to do in these sessions.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

19. ____________ and I respect each other.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

20. I feel that ____________ is not totally honest about his/her feelings toward me.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

21. I am confident in ____________'s ability to help me.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

22. ____________ and I are working towards mutually agreed upon goals.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

23. I feel that ____________ appreciates me.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

24. We agree on what is important for me to work on.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

25. As a result of these sessions I am clearer as to how I might be able to change.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

26. ____________ and I trust one another.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

27. ____________ and I have different ideas on what my problems are.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

28. My relationship with ____________ is very important to me.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

29. I have the feeling that if I say or do the wrong things, ____________ will stop working with me.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

30. ____________ and I collaborate on setting goals for my therapy.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

31. I am frustrated by the things I am doing in therapy.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

32. We have established a good understanding of the kind of changes that would be good for me.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

33. The things that ____________ is asking me to do don't make sense.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

34. I don't know what to expect as the result of my therapy.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

35. I believe the way we are working with my problem is correct.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

36. I feel ____________ cares about me even when I do things that he/she does not approve of.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

# Appendix D: The Community Attitudes to Mental Illness (CAMI; Taylor and Dear, 1981) measure

The following statements express various opinions about mental illness and the mentally ill. The term “mentally ill” refers to people needing treatment for mental disorders but who are capable of independent living outside a hospital.

Please answer each question by circling one of the five responses provided (for example, if you strongly agree with the statement, circle **SA**. If you agree with the statement, circle **A**. If you neither agree nor disagree, circle **N**. If you disagree with the statement, circle **D**. If you strongly disagree with the statement, circle **SD**).

Please circle the response which most accurately describes your reaction to each statement. It's your first reaction which is
important. Don't be concerned if some statements seem similar to ones you have previously answered. Please be sure to answer all statements.

1. As soon as a person shows signs of mental disturbance, he should be hospitalized.

   **SA A N D SD**

2. More tax money should be spent on the care and treatment of the mentally ill.

   **SA A N D SD**

3. The mentally ill should be isolated from the rest of the community.

   **SA A N D SD**

4. The best therapy for many mental patients is to be part of a normal community.

   **SA A N D SD**

5. Mental illness is an illness like any other.

   **SA A N D SD**

6. The mentally ill are a burden on society.

   **SA A N D SD**

7. The mentally ill are far less of a danger than most people suppose.

   **SA A N D SD**

8. Locating mental health facilities in a residential area downgrades the neighbourhood.

**SA A N D SD**

9. There is something about the mentally ill that makes it easy to tell them from normal people.

**SA A N D SD**

10. The mentally ill have for too long been the subject of ridicule.

**SA A N D SD**

11. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.

**SA A N D SD**

12. As far as possible mental health services should be provided through community-based facilities.

**SA A N D SD**

13. Less emphasis should be placed on protecting the public from the mentally ill.

**SA A N D SD**

14. Increased spending on mental health services is a waste of tax dollars.

**SA A N D SD**

15. No one has the right to exclude the mentally ill from their neighbourhood.

**SA A N D SD**

16. Having mental patients living within residential neighbourhoods might be good therapy, but the risks to residents are too great.

**SA A N D SD**

17. Mental patients need the same kind of control and discipline as a young child.

**SA A N D SD**

18. We need to adopt a far more tolerant attitude toward the mentally ill in our society.

**SA A N D SD**

19. I would not want to live next door to someone who has been mentally ill.

**SA A N D SD**

20. Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community.

**SA A N D SD**

21. The mentally ill should not be treated as outcasts of society.

**SA A N D SD**

22. There are sufficient existing services for the mentally ill.

**SA A N D SD**

23. Mental patients should be encouraged to assume the responsibilities of normal life.

**SA A N D SD**

24. Local residents have good reason to resist the location of mental health services in their neighbourhood.

**SA A N D SD**

25. The best way to handle the mentally ill is to keep them behind locked doors.

**SA A N D SD**

26. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.

**SA A N D SD**

27. Anyone with a history of mental problems should be excluded from taking public office.

**SA A N D SD**

28. Locating mental health services in residential neighbourhoods does not endanger local residents.

**SA A N D SD**

29. Mental hospitals are an outdated means of treating the mentally ill.

**SA A N D SD**

30. The mentally ill do not deserve our sympathy.

**SA A N D SD**

31. The mentally ill should not be denied their individual rights.

**SA A N D SD**

32. Mental health facilities should be kept out of residential neighbourhoods.

**SA A N D SD**

33. One of the main causes of mental illness is a lack of self-discipline and will power.

**SA A N D SD**

34. We have the responsibility to provide the best possible care for the mentally ill.

**SA A N D SD**

35. The mentally ill should not be given any responsibility.

**SA A N D SD**

36. Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services.

**SA A N D SD**

37. Virtually anyone can become mentally ill.

**SA A N D SD**

38. It is best to avoid anyone who has mental problems.

**SA A N D SD**

39. Most women who were once patients in a mental hospital can be trusted as baby sitters.

**SA A N D SD**

40. It is frightening to think of people with mental problems living in residential neighbourhoods.

**SA A N D SD**

**Thank you very much**

CMI
Pos: 4,12,20,28,36
Neg: 8,16,24,32,40

BEN
Pos: 2,10,18,26,34
Neg: 6,14,22,30,38

AUTH
Pos: 5,13,21,29,37
Neg: 1,9,17,25,33

SR
Pos:7,15,23,31,39
Neg: 3,11,19,27,35

# Appendix E: Organisational Culture Assessment Instrument (OCAI; Cameron & Quinn, 1999)

## 1. DOMINANT CHARACTERISTICS

A. The organization is a very personal place. It is like an extended family. People seem to share a lot of themselves.

B. The organization is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risks.

C. The organization is very results oriented. A major concern is with getting the job done. People are very competitive and achievement oriented.

D. The organization is a very controlled and structured place. Formal procedures generally govern what people do.

## 2. ORGANIZATIONAL LEADERSHIP

A. The leadership in the organization is generally considered to exemplify mentoring, facilitating, or nurturing.

B. The leadership in the organization is generally considered to exemplify entrepreneurship, innovating, or risk taking.

C. The leadership in the organization is generally considered to exemplify an aggressive, results-oriented, no-nonsense focus.

D. The leadership in the organization is generally considered to exemplify coordinating, organizing, or smooth-running efficiency.

## 3. MANAGEMENT OF EMPLOYEES

A. The management style in the organization is characterized by teamwork, consensus, and participation.

B. The management style in the organization is characterized by individual risk-taking, innovation, freedom, and uniqueness.

C. The management style in the organization is characterized by hard-driving competitiveness ,high demands, and achievement.

D. The management style in the organization is characterized by security of employment, conformity, predictability, and stability in relationships.

## 4. ORGANIZATIONAL GLUE

A. The glue that holds the organization together is loyalty and mutual trust. Commitment to this organization runs high.

B. The glue that holds the organization together is commitment to innovation and development. There is an emphasis on being on the cutting edge.

C. The glue that holds the organization together is the emphasis on achievement and goal accomplishment. Aggressiveness and winning are common themes.

D. The glue that holds the organization together is formal rules and policies. Maintaining a smooth-running organization is important.

## 5. STRATEGIC EMPHASES

A. The organization emphasizes human development. High trust, openness, and participation persists.

B. The organization emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.

C. The organization emphasizes competitive actions and achievement. Hitting stretch targets and winning in the marketplace are dominant.

D. The organization emphasizes permanence and stability. Efficiency, control and smooth operations are important.

## 6. CRITERIA OF SUCCESS

A. The organization defines success on the basis of the development of human resources, teamwork, employee commitment, and concern for people.

B. The organization defines success on the basis of having the most unique or the newest products. It is a product leader and innovator.

C. The organization defines success on the basis of winning in the marketplace and outpacing the competition. Competitive market leadership is key.

D. The organization defines success on the basis of efficiency. Dependable delivery, smooth scheduling,

# Appendix F: Supplementary Information on the Single-Target IAT

## IAT Instructions

You have agreed to complete the Service User Involvement IAT in which you will sort words into categories as quickly as possible. You should be able to complete the tasks in less than 5 minutes in total. When you finish, you will receive your results.

You will be presented with a set of words to classify into a group. Classify the items as quickly as you can whilst making as few mistakes as possible. Going too slow or making too many mistakes will result in an un-interpretable score. Please enter the access code that was included on the bottom of the slip of paper you received from the service user. Please enter this twice. Your time is very much appreciated.

---------------------------------------------

| **Target Category** | **Attribute** |
|---|---|
| Good | *Marvellous, superb, pleasure, beautiful, joyful, glorious, lovely, wonderful* |
| Bad | *Tragic, horrible, agony, painful, terrible, awful, humiliate, nasty* |
| Service User Involvement | *Collaborative, power sharing, inclusive, partnership, empowering, equality, co-production recovery focussed.* |

Good –v- Bad

Put your middle or index fingers on the E and the I keys of your keyboard. Words representing the categories at the top will appear one by one in the middle of the screen. When the item belongs to a category on the left, press the E key. When the item belongs to a category on the right, press the I key. Items belong to only one category. If you make an error, an X will appear – fix the error by hitting the other key.

This is a timed sorting task GO AS FAST AS YOU CAN whilst making as few mistakes as possible. Going too slow or making too many mistakes will result in an un-interpretable score. This task will take about 5 minutes to complete. Press the SPACE bar to begin.

Good or Service User Involvement –v- Bad

See above a new category now appears together along with one of the previous categories you saw. Remember, each item belongs to only one group. For example, if the category Service User Involvement and Good appeared on the separate side, words meaning Service User Involvement would go in the Service User Involvement category not the Good category. The green and white labels and items may help you to identify the appropriate category. Use the E and I keys to categorise items into the three groups left and right and correct errors by hitting the other key. Press the SPACE bar to begin.

-----------------------------------------

Good or Service User Involvement –v- Bad

Sort the same three categories again. Remember to GO AS FAST AS YOU CAN whilst making as few mistakes as possible. The green and white labels and items may help you to identify the appropriate category. Use the E and I keys to categorise items into the three groups left and right, and correct errors by hitting the other key. Press the SPACE bar to begin.

------------------------------------------

Good –v- Bad or Service User Involvement

See above, the three categories now appear in a new configuration. Remember, each item belongs to only one group. The green and white labels and items may help you to identify the appropriate category. Use the E and I keys to categorise items into the three groups left and right, and correct errors by hitting the other key. Press the SPACE bar to begin.

------------------------------------------

Good –v- Bad or Service User Involvement

Sort the same three categories again. Remember to GO AS FAST AS YOU CAN whilst making as few mistakes as possible. The green and white labels and items may help you to identify the appropriate category. Use the E and I keys to categorise items into the three groups left and right, and correct errors by hitting the other key. Press the SPACE bar to begin.

------------------------------------------

# Appendix G: Service User Consent Form

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## CONSENT FORM – Service Users

## Investigating NHS organisations and service user involvement

Name of researcher: X

Please tick box

1. I confirm that I have read and understood the information sheet (version 2.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my medical care or legal rights being affected. ☐
3. I understand that this consent form will be separated from my questionnaire to ensure anonymity. ☐
4. I understand that no medical records will be accessed for the purposes of this study. ☐
5. I agree to take part in the above study. ☐

Researcher's Contact Details

X

Access Code

# Appendix H: Service User Participant Information Sheet

## Investigating NHS organisations and service user involvement

You are being invited to take part in this study, if you would like to do that. To help you decide, we are providing you with details about the study in this information sheet. Please take the time to read the information carefully before you make up your mind.

### What is the purpose of the study?

The NHS is required, more than ever before, to involve service users in aspects of their own care and in the design and delivery of services. This is different to the traditional way of working and requires services to work in partnership with service users.  This study is interested in exploring the factors that make joint working easier and more difficult. If we know more, about which factors make joint working easier, these can be maximised so that service users receive care that helps them to recover. It will also help NHS services to learn about the best ways to create an environment that nurtures good relationships with service users.

### Why have I been invited to take part?

We are looking for people over 18 years old, who are currently receiving psychological therapy from an NHS psychological therapist (psychologist or CBT therapist) in Trust A, Trust B. We feel that people receiving therapy are in a very good position to comment on the nature of joint working.

### Do I have to take part?

No. It is entirely up to you. You should not feel any pressure to make the decision. The care, which you receive, will not be affected in any way by your decision. If you do choose to join in the study, you can also withdraw at any point without giving a reason and again without your care being affected at all. Your responses on the questionnaire will be completely anonymous.

### What will be involved if I decide to take part?

If you decide to take part, you will need to complete the consent form and questionnaire, place them in the envelope provided and either hand it to a member of staff (the receptionist at your clinic or an administrative worker) or hand them back to the researcher. The staff member will place the anonymous questionnaire in the internal mail to the research team. When they are received, the consent form and questionnaire will be separated to ensure your name is not associated with the data. You will then need to tear the slip off at the end of this information sheet and hand it to your therapist to complete the second part of the study. This contains a code that will enable the researcher to anonymously match your questionnaires with that of your therapist. Remember your answers will be anonymous, so please be as honest as possible.

Your questionnaire is in two parts. In part A you will be asked for some brief information about yourself, for example your gender and your age. Part B contains 36 questions and asks about the different ways in which a person views their therapist. We are interested in whether you and your therapist have agreed on what you will work through in therapy, what your goals for therapy are, and in your opinion, the quality of the bond with your therapist. You will need to circle the appropriate answer from a number of options given. Full instructions will be given at the beginning of the questionnaire. We would not expect the questionnaire to take more than 20 minutes to complete.

### What are the benefits and risks in taking part in the study?

It is unlikely that there will be any direct or immediate benefit to yourself. If you take part in the study, it is hoped that the researcher will gain valuable information regarding the factors that make joint working easier and more difficult. It is hoped that the study will increase our understanding of the relationships between service users, their therapists and the NHS environment in which people are receiving care.

It is unlikely that the questions will upset you. If this happens, we have provided the researcher’s contact details at the end of this information sheet. The researcher is happy to be contacted should you have any worries or would like to discuss anything related to the research, at any point.

### Will taking part in the study cost me anything?

No. Taking part in the study will not cost you anything other than approximately 20 minutes of your time.

### What if I am unhappy or there is a problem?

The researchers will do everything they can do to make sure that things go well. If you are not happy, however, please let us know so that every effort can be made to put things right for you and to prevent such errors in the future.

*Complaints*

If you have a concern about any part of this study, you should, first ask to speak to the researcher X who will try to answer your questions. If you are unable to resolve your concern and remain unhappy and wish to make a complaint than please contact The University of Liverpool, and a complaint will be addressed. To do this, please contact the research supervisor X, contact details below.

*Harm*

It is very unlikely that you will experience harm because of taking part in the study. However, in the event that you feel you have been harmed by taking part, there are no special grounds for compensation. If you are harmed, and this is due to someone's negligence, then you may have grounds for legal action for compensation against the University of Liverpool, but you may have to pay legal costs.

**What will happen to the results of the study?**

After the study is completed, the anonymised results will be analysed and written up for the researchers' Doctoral Thesis and for publication in a scientific journal. Presentations may also be given at professional conferences. The researcher will also ensure that the results of the study are given to service user and carer leads/forums within each of the 3 NHS Trust sites.

**Who has reviewed the study?**

The study has been reviewed by members of the University of Liverpool Research Ethics Committee, the Department of Clinical Psychology Research Ethics Committee and by the X Research Ethics Proportionate Review Sub-Committee. Research Ethics Committees are groups of independent people who review research to protect the dignity, rights, safety, and well-being of participants and researchers.

**Who is organising the research?**

The Chief Investigator of the study is X from the Department of Clinical Psychology at the University of Liverpool. X is the second supervisor from the Department of Clinical Psychology at the University of Liverpool. X is the researcher conducting the research as part of her qualification to receive a Doctorate of Clinical Psychology.

**If you have any questions or want to discuss the study further, then please do not hesitate to contact the researcher or supervisor on:**

**X**

**This is the end of the information sheet. If you would like to take part in the study, there are two things you need to do:**

1. **Please complete the attached questionnaire and consent form, place it in the envelope provided and hand it to a member of staff who will place in the internal mail.**
2. **Tear the below slip off and hand this to your therapist for her/him to decide whether to complete the second part of the research.**

**Thank you for taking the time to read this information sheet.**

---

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Dear Therapist

You are being invited to take part in a research study. Your client has already kindly agreed to complete the first part of the study and has handed you this slip in order to make an informed decision as to whether you will agree to complete the second part.

All further details, information sheets, consent forms etc, and the anonymous study itself can be found at http://survey.liv.ac.uk/NHSCULTURE In order to access the site you will need to type the code below. This allows the researcher to connect, anonymously your questionnaires with your clients' questionnaire.

**Access code:**

## Appendix I: Service user demographic information sheet

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### Investigating NHS organisations and service user involvement

Before you complete the questionnaire please would you provide us with some brief, non-identifiable information about yourself.

Please tick the boxes that apply to you below:

**Gender:** Female ☐ Male ☐ Do not wish to disclose ☐

**Age:** 18-30 ☐ 31-50 ☐ 51-65 ☐ 65+ ☐

**Ethnicity:**

***Asian or Asian British***

Bangladeshi ☐ Indian ☐ Pakistani ☐ Other ☐

***Black or Black British***

African ☐ Caribbean ☐ Other

***Mixed***

White & Asian ☐ White & Black African ☐ White & Black Caribbean ☐

Other ☐

***White***

British ☐ Irish ☐ Other ☐

***Other Ethnic Group***

Chinese ☐ Other ☐ Do not wish to disclose ☐

**Have you received therapy before?** Yes ☐ No ☐

**How many sessions of therapy have you received from your current therapist?**

2-5 ☐ 6-10 ☐ 11-16 ☐ 17 or more ☐

**Have you been given any mental health diagnoses?**

Yes ☐ (please state)____________________ No ☐

**Where have the sessions with your therapist taken place?**

In an NHS site ☐ At your home ☐ Both ☐

# Appendix J: Therapist Consent Form

## CONSENT FORM – Psychological Therapists

## Investigating NHS organisations and service user involvement

Please tick box

Name of researcher: X

1. I confirm that I have read and understood the information sheet (version 2.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
3. I understand that this consent form will be separated from my questionnaire responses, to ensure anonymity. ☐
4. I understand that no medical records will be accessed for the purposes of this study. ☐
5. I agree to take part in the above study. ☐

Researcher's Contact Details

X

Access Code:

# Appendix K: Therapist Participant Information Sheet

## Participant Information Sheet for Psychological Therapists

## Investigating NHS organisational culture and service user involvement

You are being invited to take part in a study. To help you decide, we are providing you with details about the study in this information sheet.

### What is the purpose of the study?

The NHS is required, more than ever before, to involve service users in aspects of their own care and in the design and delivery of services. This is different to the traditional way of working and requires services to work in partnership with service users.  This study is interested in exploring the factors that make service user involvement and joint working easier and more difficult. If we know more, about which factors make joint working easier, these can be maximised so that service users receive care that helps them to recover. It will also help NHS services to learn about the best ways to create an environment that nurtures good relationships with service users.

### Why have I been invited to take part?

You are being invited to participate in a research study that is in two parts. One of your clients has already completed the first part of the study and has handed you this slip in order for you to decide whether to complete the second part. You must be a psychological therapist (psychologist, CBT therapist) providing therapy to clients in Trust A, Trust B for inclusion into the study.  We have asked service users and the service providers to whom they are connected in therapy to, to complete the study as we feel you are both in an ideal position to comment on the nature of joint working.

### Do I have to take part?

No. It is entirely up to you. The service users you are providing therapy to have completed the first part of the study already. If you choose not to complete the second part of the study, we can partially use the data but will be unable to investigate fully, the research questions related to joint working.  It is possible that you will be approached by more than one service user to complete this study. If this happens, please complete in the order in which you were approached; using the first access code you were given. You can complete the study up to 2 times.

**What will be involved if I decide to take part?**

If you decide to take part, you will be asked to complete all measures via this web link. Remember your answers will be anonymous, so please be as honest as possible.

In part A, you will first be asked for some brief non-identifiable information relating to you as a therapist (e.g., age, gender, job role, mode of therapy provided, preferred therapeutic modality/type of therapy model utilised with client), and the service in which you are providing therapy within (e.g., which NHS Trust, type of service/tier). In part B there are 3 questionnaires and a task which involves responding to a series of words presented to you on the computer screen. Collectively, they are designed to ascertain your perceptions and experience of working with people with mental illness, together with your perception of the NHS organisational culture in which you are currently providing the therapy in. The web link with give you clear instructions on how to complete each measure. This should take approx 30 minutes to complete.

**What are the benefits and risks in taking part in the study?**

It is unlikely that there will be any direct or immediate benefit to yourself. If you take part in the study, it is hoped that the researcher will gain valuable information regarding the barriers and facilitators to joint working. It is hoped that the study will increase our understanding of the relationships between service users, their therapists and the NHS environment in which people are receiving care.

It is unlikely that any of the questions will cause you any distress. If this happens, we have provided the researcher’s contact details at the end of this information sheet and the researcher is happy to be contacted, if you have any worries, or if you would like to discuss anything related to the research at any point.

**Will taking part in the study cost me anything?**

No. Taking part in the study will not cost you anything other than approximately 30 minutes of your time, for each completion.

**What if I am unhappy or there is a problem?**

The researchers will do everything they can do to make sure that things go well. If you are not happy, however, please let us know so that every effort can be made to put things right for you and to prevent such errors in the future.

*Complaints*

If you have a concern about any part of this study, you should ask to speak to the researcher X, who will do her best to answer your questions. If you are unable to resolve your concern and remain unhappy and wish to make a complaint than please contact The University of Liverpool, and a complaint will be addressed. To do this, please contact the research supervisor; X, contact details below.

*Harm*

It is very unlikely that you will experience harm because of taking part in the study. However, in the event that you feel you *have* been harmed by taking part, there are no special grounds for compensation. If you are harmed, and this is due to someone's negligence, then you may have grounds for legal action for compensation against the University of Liverpool, but you may have to pay legal costs.

**What will happen to the results of the study?**

Full analysis will be possible if both therapist and service user take part in the study. If you as therapist decide you do not wish to take part, the data from the service user will be used to report attrition rates and is not able to be used to answer the research questions. After the study is completed, the anonymised results will be analysed and written up for the researchers' Doctoral Thesis and for publication in a scientific journal. Presentations may also be given at professional conferences. The researcher will also ensure that the results of the study are given to service user and carer leads/forums within each of the 4 NHS Trust sites that the research is being conducted in, in appropriate formats.

**Who has reviewed the study?**

The study has been reviewed by members of the University of Liverpool Research Ethics Committee, the Department of Clinical Psychology Research Ethics Committee and by the X Research Ethics Proportionate Review Sub-Committee. Research Ethics Committees are groups of independent people who review research to protect the dignity, rights, safety, and well-being of participants and researchers.

**Who is organising the research?**

The Chief Investigator of the study is X from the Department of Clinical Psychology at the University of Liverpool. X is the second supervisor from the Department of Clinical Psychology at the University of Liverpool. X is the researcher conducting the research as part of her qualification to receive a Doctorate of Clinical Psychology.

**If you have any questions or want to discuss this study further, then please do not hesitate to contact the researcher or supervisor on:**

**X**

**Thank you for taking the time to read this information sheet. If you would like to take part in the study please continue to the consent form. You may wish to print or save this information for future reference.**

**Access code:**

# Appendix L: Therapist demographic information sheet

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## Investigating NHS organisations and service user involvement

Please tick the boxes that apply below:

**Gender:** Female ☐ Male ☐

**Age:** 18-30 ☐ 31-50 ☐ 51-65 ☐ 65+ ☐

**Ethnicity:**

***Asian or Asian British***

Bangladeshi ☐ Indian ☐ Pakistani ☐ Other ☐

***Black or Black British***

African ☐ Caribbean ☐ Other

***Mixed***

White & Asian ☐ White & Black African ☐ White & Black Caribbean ☐

Other ☐

***White***

British ☐ Irish ☐ Other ☐

***Other Ethnic Group***

Chinese ☐ Other ☐ Do not wish to disclose ☐

**Job title:**

Clinical psychologist ☐ Forensic psychologist ☐

Trainee psychologist ☐ Assistant psychologist ☐

High intensity CBT therapist ☐ Low intensity CBT therapist ☐

Psychotherapist ☐ CAT practitioner ☐

Other (please state)___________________________________

**Time since qualification:**

0-5 years ☐ 5-10 years ☐ 10-20 years ☐

20+ years ☐

**Mode of therapy provided to client:**

1:1 ☐ Group ☐ Couple ☐ Family ☐

**Type of therapy model utilised with client** (e.g., CBT, CAT, DBT etc..)

Please state:__________________________________________________

**NHS Trust:** Trust A ☐ Trust B ☐

**Is the service an IAPT service?:**

Yes ☐ No ☐

# Appendix M: Ethical Considerations

An application for ethics approval was submitted to the NHS Research Ethics Committee (REC) ‘Proportionate Review’ service. Whilst the *Proportionate Review* service is an expedited approval route due to minimal risk and burden to participants, considerable thought was given to ethics in order to adhere to REC procedures and professional practice guidelines (Ethics Committee of the British Psychological Society, 2009).

## Service User Involvement in the Research Design

Conducting research into service user involvement, without involvement, would not have been acceptable. Therefore, involvement was integrated into the research method in two ways (a) the service user involvement-single-target-IAT was co-produced by the author and a mental health service user, and (b) the research employed a bottom-up recruitment process to minimise power differentials.

## Informed Consent

The research was optional. This was made clear on the participant information sheets. Informed consent was sought from all participants. For service users, a paper copy of the consent form was attached to the questionnaires, which included a series of boxes to tick to indicate consent. These were separated from the questionnaires. For therapists, online completion meant the participant could not proceed without checking the consent boxes to consent.

## Confidentiality and Anonymity

No personal identifiable information was collated, as per Caldicott Principles 1 and 2, this was not justifiable, nor necessary. Whilst demographic data was collected this did not identify participants. All data storage procedures were adhered to.

## Data Removal

As each dyad had a unique 5-digit code, should any participants later decide that they wanted to withdraw consent and remove their data from the study, this process was easily facilitated and their responses tracked via the individual codes. Should participants wish to do so, they were asked to provide the researcher with the code from their information sheet that they had retained.

## Accessibility of Measures

The researcher was more than aware of the need to ensure that people with differing abilities or language were able to take part in the study, should they wish to do so. Every effort was made to try and ensure service users with additional needs received the questionnaires in a format accessible to them. However, scale permissions for the WAI-C did not allow the scale to be adapted.

## Risks, Burden and Cost

The proposed research was thought to pose minimal risk of harm, burden, and intrusion and it was deemed unlikely to upset participants. However, the risk still existed. All information regarding the purpose, procedure, risks, costs and benefits of the study was detailed on both therapist and service user versions of the participant information sheets (see Appendices G and J). The information sheets also contained information on confidentiality, anonymity, risk of harm, complaints procedures should harm occur, dissemination of findings, storage of materials, the extensive ethical review process, and full contact details of the researcher and supervisor in the unlikely event that any other matters emerged throughout the process.

In the unlikely event that participants felt they had suffered a detrimental effect from taking part in the study, clear mechanisms were in place for reporting and managing this risk. First, participants were asked to contact the research team. No issues were reported, if they had, they would have been responded to immediately.

Risks to the researcher were also considered. It was deemed that data collection posed no more risks for the researcher than everyday clinical practice.

## Benefits

There were no immediate, direct benefits to participants, and this was clearly stated on the participant information sheets.

## Time Demands

The researcher was aware of the demands on time, and that time equals money, especially for services. Every effort was made to select questionnaires that could be completed in the minimum amount of time that would still address the aims of the study. Service user completions took 10 minutes, and therapist completions no longer than 18 minutes. This was deemed reasonable.

## Dissemination

Clear methods of dissemination were detailed on the information sheets. Various methods of dissemination was planned, to various academic, clinical and service user audiences.

# Appendix N: Exploring Assumptions

Before data analysis, the data was screened for inputting errors, missing data was addressed and assumptions for parametric tests were explored. In order to make informed decisions on normality of distribution, and due to the fact that with small samples under 30 distribution is more likely to be non-normal (Field, 2009); graphical representations using box plots and Normal Q-Q plots were explored, skewness, kurtosis and Z scores checked, and Shapiro-Wilk tests performed. Levene's test was used throughout to assess homogeneity of variance.

## Missing Values

The therapist dataset was 100% complete which was due to online completion using the University of Liverpool SelectSurvey software.

Missing values were only present for the client-rated WAI-C scale due to paper and pencil version. Little's *Missing Completely At Random* Test (MCAR) was computed for the WAI-C scale. The test was non-significant (*p* =.65) suggesting missing values were random. However, due to nine of the subscale items exceeding more than 2% missing, the *Expectation Maximisation* algorithm was performed to correct and replace missing values with the total scale mean.

## Normality of Distribution

### Dyads and non-dyads – WAI-C.

For the WAI-C total scale the 5% trimmed means were no different. There was slight positive skew showing scores clustered at the high end for working alliance for both dyads and non-dyads. Kurtosis showed flat distribution with scores in the extremes. Histograms for the WAI-C subscales of task and goal (just for dyads), and bond (non-dyads) highlighted the positive skew. The distributional shape of the WAI-C total scale scores suggested slight negative skewness for the dyad (-.159, SE = .441; Z = 0.36) and non-dyad sample (-.614, SE = .536; Z = 1.14) suggesting scores were clustered at the high end; and negative kurtosis for the dyad (-1.126, SE =.858; Z = 1.31) and non-dyad sample (-.200, SE = 1.038; Z=0.19) suggesting a relatively flat distribution with cases in the extremes. Histograms depict the high end skew. Normal Q-Q plots depict points adhering closely to the diagonal line (for the total WAI-C dyads). Detrended Normal Q-Q plots depicted most scores clustered around the zero line (for dyad WAI-C sample), less so for non-dyad sample. Box plots did not suggest the presence of any potential outliers. Z-scores were checked and using absolute values (Field, 2009) were within normal limits.

Both Kolmogorov-Smirnov and Shaprio-Wilk tests were performed. The WAI total scale scores were normally distributed for dyads and non-dyads. The Shaprio-Wilk test suggested a normal distribution for the dyad (.947, df28, $p$ = .17) and non-dyad sample (.954, df18, $p$ = .49), suggesting both were significantly normal. Collectively, this suggests the assumption of normality was met for the WAI-C. Internal consistency was reported in main paper. Subscales on the WAI-C (*r*s .84-.90), were highly correlated.

### CAMI

For the full scale, 5% trimmed means were no different. The distributional shape suggested negative skewness (-.362, SE = .441; Z= 0.82); scores were clustered at the high end which is to be expected. Positive kurtosis (.386, SE =.858; Z=0.45) suggested a peakedness. Histograms were normal. Normal Q-Q plots depicted points adhering closely to the diagonal line. Z-scores were checked and using absolute values (Field, 2009) were within normal limits.

Both Kolmogorov-Smirnov and Shaprio-Wilk tests were performed. The CAMI total scale score was normally distributed . The Shaprio-Wilk test suggested a normal distribution (.942, df28, $p$ = .12), suggesting significant normality. Collectively this suggested the assumption of normality was met for the CAMI scale. Internal consistency was reported in the main empirical paper.

Internal consistency was acceptable for scale overall (α = .80). Certain low item-correlations of less than .3 were highlighted. The questions and the subscales they belonged to were as follows: CMI: 4 (1 item), AUTH: 1, 25, 29, 33, 37 (5 items), BEN: 2, 10, 26, 30, 34 (5 items), SR: 3, 11 (2 items). This highlighted doubt about the reliability of two of the subscales (AUTH and BEN). Pallant (2005) suggests that you may need to consider removing these items from the scale but only suggests this is necessary if the alpha for the total scale is less than .7, which was not the case. Without these items included, the reliability of the scale was .85. Z-scores were checked and using absolute values (Field, 2009) were within normal limits. The full scale was used. Subscales on the CAMI (*r*s .58 to .90) were highly correlated.

### IAT

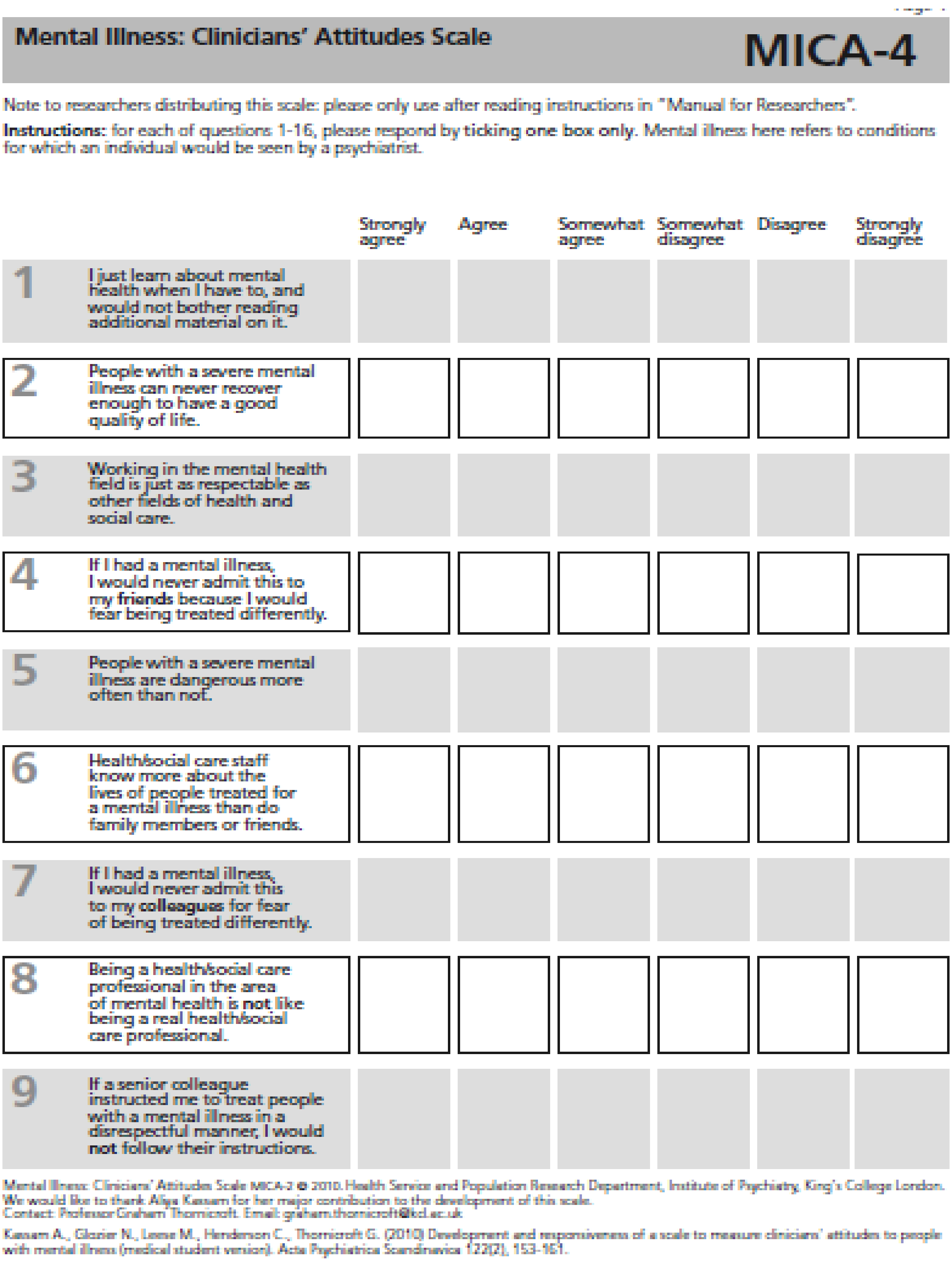
5% trimmed means were no different. The distributional shape of the IAT total scale scores suggested negative skewness (-.486, SE = .441; Z=1.10) suggesting scores were slightly clustered at the high end; and negative kurtosis (-0.81, SE =.858; Z=-.94 ) suggesting a relatively flat distribution. Histograms were observed to be normal. Normal Q-Q plots depicted points adhering very closely to the diagonal line.

Both Kolmogorov-Smirnov and Shaprio-Wilk tests were performed. The IAT total scale score were normally distributed . The Shaprio-Wilk test suggested a normal distribution (.969, df28, $p$ = .55), suggesting significant normality. Z-scores were checked and using absolute values (Field, 2009) were within normal limits. Collectively this suggests the assumption of normality was met for the IAT.

## Recruitment Timeframe

Recruitment for phase I commenced on the 1st November 2012 and finished on the 5th June 2013. Phase II recruitment is continuing until September 30th 2013.

# Appendix O: Mental Illness Clinicians' Attitudes Scale



## Mental Illness: Clinicians' Attitudes Scale

## MICA-4

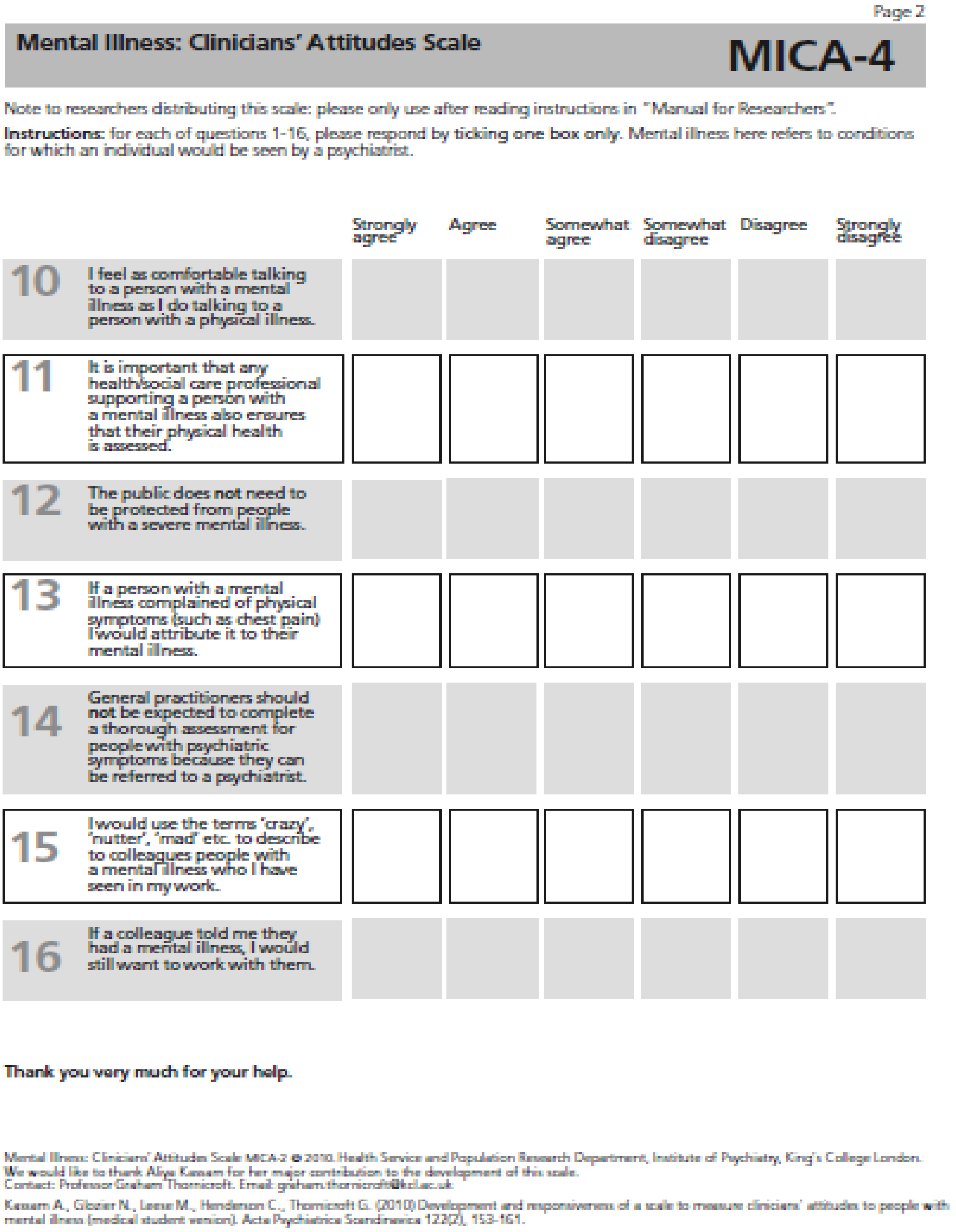
Note to researchers distributing this scale: please only use after reading instructions in "Manual for Researchers".

**Instructions:** for each of questions 1-16, please respond by **ticking one box only**. Mental illness here refers to conditions for which an individual would be seen by a psychiatrist.

| | | Strongly agree | Agree | Somewhat agree | Somewhat disagree | Disagree | Strongly disagree |
|---|---|---|---|---|---|---|---|
| 1 | I just learn about mental health when I have to, and would not bother reading additional material on it. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2 | People with a severe mental illness can never recover enough to have a good quality of life. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3 | Working in the mental health field is just as respectable as other fields of health and social care. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4 | If I had a mental illness, I would never admit this to my **friends** because I would fear being treated differently. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5 | People with a severe mental illness are dangerous more often than not. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6 | Health/social care staff know more about the lives of people treated for a mental illness than do family members or friends. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7 | If I had a mental illness, I would never admit this to my **colleagues** for fear of being treated differently. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8 | Being a health/social care professional in the area of mental health is **not** like being a real health/social care professional. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9 | If a senior colleague instructed me to treat people with a mental illness in a disrespectful manner, I would **not** follow their instructions. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

We would like to thank Aliya Kassam for her major contribution to the development of this scale.
Contact: Professor Graham Thornicroft. Email: graham.thornicroft@kcl.ac.uk

Kassam A., Glozier N., Leese M., Henderson C., Thornicroft G. (2010) Development and responsiveness of a scale to measure clinicians' attitudes to people with mental illness (medical student version). Acta Psychiatrica Scandinavica 122(2), 153-161.



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**Mental Illness: Clinicians' Attitudes Scale** **MICA-4**

Note to researchers distributing this scale: please only use after reading instructions in "Manual for Researchers".

**Instructions:** for each of questions 1-16, please respond by **ticking one box only**. Mental illness here refers to conditions for which an individual would be seen by a psychiatrist.

| | | Strongly agree | Agree | Somewhat agree | Somewhat disagree | Disagree | Strongly disagree |
|---|---|---|---|---|---|---|---|
| 10 | I feel as comfortable talking to a person with a mental illness as I do talking to a person with a physical illness. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11 | It is important that any health/social care professional supporting a person with a mental illness also ensures that their physical health is assessed. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12 | The public does not need to be protected from people with a severe mental illness. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13 | If a person with a mental illness complained of physical symptoms (such as chest pain) I would attribute it to their mental illness. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14 | General practitioners should not be expected to complete a thorough assessment for people with psychiatric symptoms because they can be referred to a psychiatrist. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15 | I would use the terms 'crazy', 'nutter', 'mad' etc. to describe to colleagues people with a mental illness who I have seen in my work. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16 | If a colleague told me they had a mental illness, I would still want to work with them. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Thank you very much for your help.**

Mental Illness: Clinicians' Attitudes Scale MICA-2 © 2010. Health Service and Population Research Department, Institute of Psychiatry, King's College London.
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