Social Work Education

Dialogue and Challenge: Involving Service Users and Carers in Small Group Learning with Social Work and Nursing Students

Jerry Tew[a]; Tracey Holley[a]; Pat Caplen[a]
[a] University of Birmingham, UK

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Jerry Tew, Tracey Holley & Pat Caplen

This paper examines the rationale for service user and carer involvement in professional education and reflects on an initiative in which social work and nursing students undertook a sequence of joint learning in relation to mental health theory and practice. Central to this initiative was the promotion of opportunities for dialogue, both between students from different professional disciplines and between students, service users and carers. To enable this, much of the learning took place in small groups facilitated by either a service user or a carer.

Evaluation of this initiative indicated that, for the majority of social work and nursing students, learning from this shared experience had a major impact on their professional development. However, a small but significant minority found it hard to enter into a dialogue with others on a basis of equality and a sharing of their human as well as their professional experience. Some students indicated that they would have preferred a focus on acquiring more specialist professional knowledge and skills. This raises important issues in relation to the changing expectations of professionalism and professional education—and what really makes someone 'fit for practice'.

Keywords: Service User/Carer Involvement; Multi-disciplinary Learning; Collaborative Learning; Evaluation

Although progress can be somewhat patchy, service user and carer involvement is becoming more widespread in social work and mental health teaching, and many

Jerry Tew, Tracey Holley & Pat Caplen, University of Birmingham, UK.

Correspondence to: Jerry Tew, Senior Lecturer, Institute of Applied Social Studies, University of Birmingham, Edgbaston, Birmingham B15 2TT, UK Email: j.j.c.tew@bham.ac.uk

innovative approaches are being piloted across the United Kingdom (Levin, 2004; Tew *et al.*, 2004). Similarly progress is being made in setting up opportunities for interdisciplinary learning—although again this is far from mainstream within the education of all mental health professions (Barr *et al.*, 2005). This paper reviews the experience gained in a Collaborative Learning Initiative over two years that has involved service users and carers working with social work and nursing students specialising in mental health. We sought to move beyond some of the more conventional 'teaching from the front' approaches to involving service users and carers in the learning process—such as people telling their stories—to more interactive ways of engaging with students' learning, including discussions and activities in small interdisciplinary groups facilitated by service users and carers.

Working in this way can raise complex issues of personal and professional identities, with students and lecturers potentially also having experience of using services or caring for others, those identified as carers potentially also using services and those identified as service users potentially also caring for others. This links into a wider debate that problematises the use of terms such as 'service user'—although using more general terms such as 'expert by experience' may also be problematic as they fail to specify what this experience may be (McLaughlin, 2009). For the purposes of this article, we have decided to retain the terms service user and carer to denote particular standpoints and areas of expertise, while acknowledging that particular individuals may well have experiences that fit more than one category.

The authors of the paper are three members of the teaching team: a social work lecturer and educators with, respectively, service user and carer backgrounds.

Service User and Carer Involvement in Professional Education

With the introduction of the new social work degree in England in 2002, it became a requirement that service users be involved in the design and delivery of teaching and learning, and this principle has been reiterated (now with the explicit inclusion of carers) in current proposals for social work reform (HM Government, 2010, p. 30). Within the field of mental health, the Government specified 'working in partnership' with service users *and* carers as the first of the *Ten Essential Shared Capabilities* that should be core learning for all disciplines—and recognised that this would involve 'working positively with any tensions created by conflict of interest or aspiration that may arise between the partners in care' (Department of Health, 2004, p. 3).

These initiatives set the context for a fundamental change in the culture of professional education in which traditional hierarchical power relationships are broken down and service users and carers are beginning to be involved as equals within the design and delivery of educational programmes. This is occurring both in social work (Beresford *et al.*, 2006; Anghel and Ramon, 2009) and across other disciplines involved in providing mental health services (Livingston and Cooper, 2004; Fadden *et al.*, 2005; Lathlean *et al.*, 2006). However, the broader policy context in which these changes are taking place may not always be driven by emancipatory intent and it is

important to explore whether participation is indeed serving the interests of service users and carers, or whether it has become incorporated (perhaps tokenistically) into other policy or professional agendas (Carey, 2009).

The rationale for service user and carer involvement is not always straightforward and may include a number of explicit or implicit aims. At its most basic, this may involve helping students to be more aware as to what it may be like to be on the receiving end of services through hearing and learning from people's testimonies of their personal experiences (Reynolds and Read, 1999; Manthorpe, 2000). If such messages are delivered first hand by service users and carers, rather than indirectly using more traditional educational approaches, they may engage 'the heart as well as the head' (Basset, 1999, p. 8)—and thereby impact upon students' subsequent practice in terms of their ability to be sensitive to the needs and preferences of service users and carers.

Building on this, the rationale for involvement may also be to provide a more 'live' environment in which to explore (and critique) implicit assumptions that may be inherent within traditional professional value bases—encouraging students to challenge more conventional orientations of 'doing to' and 'caring for', and espouse instead the importance of 'being alongside' and 'doing together' (Alexander, 2008). The aim would be to

> move students beyond the culture of viewing users as inadequate in some way, but rather to see them as people with strengths. (Taylor, 1997, p. 181)

Alongside developing more collaborative values, students may also need to learn the skills that go with this—in terms of *how* to relate to service users and carers as equals (Molyneux and Irvine, 2004). Central to this can be developing the confidence to share one's humanity rather than hiding behind a professional role. It is service users and carers *as trainers* who may be best placed to help students to learn the skills of partnership working:

> The immediacy of input from service users and carers is likely to mean that students taught *by* users and carers will be equipped to work in a more effective or qualitatively different way than those taught *about* relating to users and carers. (Tew *et al.*, 2004, p. 11)

Perhaps most contentious is the question of knowledge. Some approaches to involvement have been criticised as using service users and carers to support and 'flesh out' existing academic/professional knowledge and theories, rather than offering an opportunity for them to develop and articulate their own experientially-based perspectives which may potentially be challenging of such orthodoxies (Beresford and Croft, 2001). As Taylor argues,

> Learning from service users challenges the whole notion of expertise, who holds it, and on what basis. (1997, p. 177)

However, both students and academics may be reluctant to accept such a challenge to the assumed superiority of their 'professional' knowledge, and a recent survey of

psychiatric trainees found that a substantial majority did not favour service user or carer involvement in their academic assessment because it would be

> Undermining of doctors' knowledge and ... users/carers may be biased and may place too much emphasis on what is important from their perspective. (Babu *et al.*, 2008, p. 30)

There has been little systematic evaluation of how service user and carer involvement in professional education impacts upon subsequent practice, although the wider literature suggests that many students see it as beneficial (Morgan and Jones, 2009). Any evaluation of impact is complicated by the likelihood that many newly trained practitioners will find work in settings where a more traditional professional culture remains dominant. Even where lip-service may be paid to partnership approaches, these may actually be frowned upon or undermined within many workplace discourses and procedures which may still be dominated by more hierarchical managerialist or professional agendas. However, where opportunities may exist in the field for implementing more user- and carer-focussed approaches, many practitioners are able to implement new ways of working that reflect what they have learned from service users and carers as part of their training (Khoo *et al.*, 2004).

Models of Learning

Although much has been written about the principles of service user and carer involvement, there is a relatively small literature on 'what works' in terms of models for learning together (Repper and Breeze, 2007). Early approaches tended to involve individual service users or carers standing up in front of a class of students and sharing their experiences. While this can have its value, its lack of interactiveness is less likely to engage students in a way that will fundamentally change their attitudes or practice. When trainers have shared difficult or negative experiences of services, students may become defensive or even shut off completely—and thereby learn very little from what is being shared:

> We initially made the assumption that professionals can deal with the impact and emotional content of our testimonies ... Clearly this is not the case, and over time we realised that some people found it extremely difficult to respond or react to what we had said. In some instances this led to complete silence ... We tend to live with so much pain and distress, and learned to speak about it very openly and honestly— not appreciating that what was normal for us could be very distressing and perhaps shocking for other people. (Highland Users' Group, quoted in Tew *et al.*, 2004, p. 16)

More recent practice has tended to involve service users and carers in the design and delivery of whole modules or courses (Masters *et al.*, 2002), giving them the opportunity to integrate their inputs and perspectives within a planned learning sequence that is more interactive and where students are not left 'high and dry' with unresolved feelings and experiences after a one-off session, but have support in taking their learning forward. By using structured exercises and discussions, students may be invited to access their own lived experience or imagine how they would feel or react if

they faced similar situations—and then share and debate with service user and carer facilitators. Such approaches can situate service users and carers in a very different relationship with students: instead of taking on a role as 'teacher' (with the inevitable distancing that can come with this), they may be able to build up more of a role as a collaborator in a process of learning together (McAndrew and Samociuk, 2003).

It is such an approach that informed the small group learning model that provided the core learning experience for the Collaborative Learning Initiative that is discussed in this paper.

The Collaborative Learning Initiative

The Collaborative Learning Initiative brought together social work and nursing students who were mostly in their final year of their pre-qualification training and were specialising in mental health. In the first cohort, there were 10 BNurs students and 19 final year social work students (11 BA and eight MA). In the second cohort, there were 15 BNurs and 25 social work students (eight BA and 17 MA). The stated aim of the initiative was to 'develop an interdisciplinary dialogue on improving service delivery of mental health care', through an exploration of roles and values, and different ways of understanding (and hence working with) mental distress. Within this, service users and carers were seen as having their own disciplinary expertise deriving from their lived experience.

The planning group for the collaborative learning comprised a social work and a nursing lecturer, an e-learning specialist (also from a social work background) and a relatively stable group of around six service users and carers, all of whom had substantial prior experience of involvement in education and training. Although there was a broad consensus as to the purpose of the joint learning, we did not start with any preconceived ideas as to how to deliver it—and the current model emerged through putting together original ideas that came from all contributors, and modifying this in the light of our experience of the first year of delivery.

We deliberately sought to avoid a more traditional 'delivery from the front' approach and the idea that students would be there to absorb uncritically the knowledge and views that might be imparted to them by professionals or other 'experts'. Instead we wanted to promote dialogue and critical discussion—but we nevertheless needed to find ways of getting over a range of perspectives and ways of understanding—some of which might be more or less familiar to social work or nursing students.

Partly for timetabling reasons, but also to allow more flexible learning at a student's individual pace, we opted for a blended learning approach, with much of the input on different perspectives being web-based, leaving most of the face-to-face contact time for group discussions and activities so as to maximise the opportunities for dialogue. The overall sequence of learning comprised

- on-line learning using specially commissioned videos featuring different perspectives on mental distress;

- questions and discussion points in relation to these (individual workbooks in the first year of delivery and web-based group discussions in the second);
- four days of face-to-face learning—mainly in the same interdisciplinary 'base' groups. This explored values, professional roles and perspectives on mental distress, and linked these to practice issues such as responding to self-harm and the impact of in-patient experiences. These 'base' groups were facilitated by either a service user or a carer; and
- preparation and delivery of informal presentations by students in their interdisciplinary 'base' groups (on a topic of current interest in the first year of delivery and responding to a case scenario in the second).

One way in which we sought to embed ideas of dialogue and challenge from the outset was in the way in which we constructed the video material on different theoretical approaches and perspectives. Instead of recording 'talking head' mini-lectures featuring each perspective, user and carer colleagues suggested an interview format in which they would interview an academic or professional 'champion' and ask them about the relevance of each perspective to service users and carers. A set of questions and prompts were devised and used throughout, as indicated below.

1. From your perspective, what do you see as causing or contributing to mental distress?
    - What do you see as potentially relevant within a person's history?
    - What do you see as potentially relevant within a person's current situation?
    - Is this the same or different for more common experiences (e.g. depression) and for more unusual experiences (e.g. hearing voices)?

2. How does your perspective give meaning to people's distress experiences, such as hearing voices

    (a) in relation to assessing what they may need in terms of treatment, therapy or support;
    (b) in relation to providing self-understanding for service users; and
    (c) in relation to providing understanding for carers?

3. How can your perspective help to promote people's recovery?
    - How can this provide tools or strategies that service users can use in taking charge of their recovery?
    - How can this provide tools or strategies that carers can use in supporting people's recovery?
    - How can this provide tools or strategies that practitioners can use in enabling people's recovery?
    - At what stage in a person's recovery journey may your perspective be most useful?

While this strategy was helpful in ensuring that each contribution was relevant and (relatively) jargon-free, and in getting over the message that a perspective may only be as useful as it is useful to those whose lives are directly affected by mental health difficulties, there was still an underlying imbalance of power. Although the service

users and carers had the power of framing the questions on their terms (normally the prerogative of professionals), the service user and carer interviewers did not feel confident enough in front of the cameras to challenge and debate as much as they would have liked. Furthermore, the video material allowed the professional perspectives to define the territory, in terms of what approaches were to be seen as important, with service user and carer perspectives being left to the face-to-face part of the learning sequence.

In order to redress this imbalance, a further video was made featuring a dialogue between a service user and a carer in which they explored their own experiences, perspectives and ways of understanding. The dialogue allowed some blurring of roles, with the carer stepping 'outside the box' in revealing that she hears voices and that they had been very important to her as part of her coping strategies in surviving in her (often very unsupported) role as a carer.

Evaluation Methodology

From the outset, it had been agreed that the Collaborative Learning Initiative would be independently evaluated and ethical approval for this was gained via the university. Each of the cohorts of students completed anonymous questionnaires before and after the process of joint learning. Rather than using a quantitative approach (for example, using Likert scales to rate responses to pre-determined questions), the chosen methodology invited free-text responses so as to provide greater depth of understanding—and to capture the unexpected as well as the expected in terms of student experiences.

The questionnaires explored expectations, hopes and anxieties beforehand and an evaluation of what had been learned—and what had facilitated this—after the learning sequence was completed. Particular questions addressed both students' perceptions of learning jointly with another professional group and of the value (or otherwise) of service user and carer involvement—the focus of this paper.

In order to research the experience of those delivering the learning sequence, an independently facilitated focus group took place after the first year of delivery, involving teaching staff, service users and carers. After the second year of delivery, this was changed to allow a focus group for service users and carers that was separate from that set up for staff. The focus groups explored individual aims and motivations for becoming involved as well as participants' evaluations of what worked well or could have been improved.

Aims, Expectations and Motivations

Service users and carers who contributed to the learning identified broadly similar objectives, seeing its purpose primarily in process terms as 'challenging and breaking down barriers' between different groups. From their perspective, this did not just involve barriers between students and those with lived experience, but also barriers

between nurses and social workers, and between service users and carers. In relation to content, they identified the wish to:

- share service user and carer perspectives with students;
- 'join up' medical and social perspectives;
- challenge attitudes, assumptions and belief systems—leading to changes in perspective; and
- humanise professional practice—'professionals should not leave their hearts in the drawer in order to practise'.

They saw it as important that the model of delivery reflected these objectives and demonstrated that service users and carers could be 'on a par' with professional colleagues, with their views and knowledge being situated on an equal level with the more established perspectives of academia and medicine. Although the collaboration aimed to treat everyone as an equal, and value all individuals' expertise and experience whether they were professionals, service users or carers, this could feel confusing at a personal level. One author (a carer) found that she did not initially *feel* equal because of her previous experience with professionals. However, this began to change as the project progressed.

Each service user and carer had their own motivations for becoming involved. One carer stated that her motivation was 'because one of the most frustrating parts of my caring role was the inability of professionals to see my husband as a whole person' and the problems that were caused by different professionals only relating to part of what was going on. A service user reflected that, in her experience of service delivery, a professionalised 'procedural' discourse can get in the way of listening to users and carers, and people can feel unheard when 'theories and our experiences do not match up'. Professionals hiding behind theories may not acknowledge or validate what people may need, so it is important for students to learn about how to use theories to inform, but not to dominate, their working relationships with service users and carers.

Within the teaching staff, there was a consensus that enabling the *process* of interdisciplinary dialogue was most important and that there could be some flexibility in relation to precise content. Fortunately, neither the social work nor the nursing curricula were over-prescriptive in relation to specific 'knowledge' outcomes, as long as students developed an understanding of multidisciplinary working and how to negotiate between different theoretical perspectives, and how to learn from the knowledge and experiences of service users and carers.

Although analysed separately, no consistent or significant differences emerged from the responses of social work and nursing students in relation to their experience of service user and carer involvement. The majority of both groups expressed the desire to become involved in a dialogue in which some of their attitudes and preconceptions might be challenged, not only by students coming from a different professional background, but also by the contribution of service users and carers:

> Good chance to challenge my own thoughts and constructs re mental health. (Social work student)

I hope to learn the viewpoints of others in regard to mental health services, in particular service users and carers, and to identify ways in which I can work better with people to provide a better service. (Nursing student)

I am hoping that through working with carers and service users I will gain … valuable knowledge into the effects of mental distress and how they feel negative stereotypes may be challenged. (Social work student)

Service users and carers are experts in providing evidence as they have first hand experience. (Nursing student)

Some also raised concerns that there might be 'clashes of theory and knowledge bases'. One social work student articulated a concern that there might be some 'difficulty in communication as there may not be shared language [by which] to understand a person's experience of mental distress'. However, the student approached this positively, writing that 'it will be interesting to try and find a shared language as this will be important in practice'.

Process of Dialogue within Small Groups

In both cohorts, students were assigned to small interdisciplinary 'base' groups of around six members in which many of the discussions and activities took place. Each group was joined and facilitated by a service user or carer. In the first year of delivery, working around the availability of different service users and carers, some base groups kept the same service user or carer throughout, whereas others had a different facilitator for each session. The feedback from service user and carer contributors was that, although there was less opportunity for students to engage with different service users and carers if the same facilitator stayed with a group, this was more than counterbalanced by the ability to build up trust and explore issues more deeply.

Therefore, we decided that we would go for continuity of service user or carer input with each group for the following year, and see whether this facilitated a deeper level of learning. The groupwork started with on-line discussions of issues raised by the videos—which was student-led, but the service user or carer that was working with that group could also post comments and observations. This then fed in to the four days of face-to-face learning. The subsequent evaluation from service user and carer contributors was overwhelmingly in support of this continuity of facilitation as it meant that they were more 'able to open dialogue and explore tensions and conflicts' and to explore the 'incoherent and inconsistent aspects of mental health services'.

Dialogue is not something that necessarily happens spontaneously. It requires the establishment of mutual trust and 'parity of participation' (Fraser, 2004) which, in turn, requires the acknowledgement of power issues and the implications of our different roles and identities. There is a need to find a shared language which is accessible to all participants—as had been flagged up by one of the students before the start of the joint learning. From a service user perspective there is also the need to preserve the 'raw language' of lived experience and for it not to become adopted and adulterated by fitting in with more 'professional' forms of expression. Crucially,

dialogue depends on how difference is negotiated within the group: do people hold on defensively to their particular (disciplinary) identities or do they, at the other extreme, try to hide any potential points of difference in order to merge into a more comfortable common ground?

What service users and carers saw as crucial to the process of dialogue was for each member of the group to be able to be a person first, rather than having to stay stuck in a particular role: 'face to face and on equal terms, myths, archetypes and preconceived ideas could be challenged'. Language did not emerge as a difficult issue. Probably through the presence of the service user and carer facilitators, there was little recourse to exclusive forms of 'professional' language or jargon—and if this did occur, it could be challenged. Similarly, cultures were established in which it felt safe to come out of the restrictions of particular identities and many students felt comfortable to share personal experiences as carers and some their own experiences of mental distress (although difference in wider professional cultures and the handling of 'fitness to practise' issues may have made self-disclosure of experiences of mental distress easier for social work than nursing students). However, sometimes this breaking down of preconceived identities could be harder. For example, although dress codes did not in general distinguish the different participating groups, one student arrived on the first day wearing a university departmental sweatshirt which had the effect of defining their identity as a 'professional in training' rather than a 'person' at the point of first contact.

One exercise involved group members placing themselves within a triangle whose corners were defined by allegiance to social, cognitive behavioural and biomedical perspectives, respectively—but where they also had the option of situating themselves outside the triangle if they felt that other perspectives were more important or relevant. Interestingly, in all groups, nursing and social work students tended to be jostling for similar mid-point 'psychosocial' locations—and it was sometimes the service user or carer who challenged this by situating themselves outside the zone of comfortable consensus and thereby introducing a more challenging debate. This suggested that, even with the continuity of working with the same group over several days, there may not have been sufficient safety for raising and discussing more potentially contentious differences in understanding or orientation.

Some facilitators found that there might be one member of the group who never let their guard down and retained a professional distance. To the service user or carer, they could come over as arrogant, as if they already knew everything that they needed to know—but their body language sometimes suggested that they felt threatened by the possibility of opening up. We are left unsure as to what extent such individuals reflect a more traditional professional culture of superior 'expert' practitioners (which may still be reinforced within certain placement experiences) or whether their reserve was a way of containing unresolved personal issues—potentially to the detriment of their future work with service users and carers. Either way, such self-presentation raises serious professional issues—although we also recognised that opening up within the groups may have been difficult for some, and therefore an invitation to raise more personal issues one-to-one with a member of the teaching team may have been helpful.

The great majority of the feedback from both nursing and social work students valued the opportunity for more intimate discussions with colleagues across disciplines and with service users and carers. There was also strong support for the model of working with the same service user or carer throughout:

> Very valuable, enabled development of relationship and allowed for sharing of experience. (Social work student)

> Much better than working with different people each time. (Nursing student)

> Although this meant that we mainly gained understanding from one main source it enabled us to gain a ... deeper understanding of their experiences. (Social work student)

However, there were also some dissenting voices:

> This was nice, but would have been nice to change as well as everyone has such different views. (Nursing student)

> It would have been nice to get to know other service users/carers more. (Social work student)

From both the student feedback and from the service user/carer focus group came the suggestion that a further improvement would be to have a service user and a carer working with each group to provide different perspectives.

Overall, students expressed some relief that group norms had led to a constructive process of exchange and dialogue:

> There were no conflicting ideas—thought there would be. Everyone brought an interesting perspective to case studies and everyone's perspective was respected. (Nursing student)

> Helped emphasise ... many similarities between us and that any differences can be complementary. (Social work student)

However, one (nursing) student commented that 'at times the service user could not see other points of view because they appeared too rooted in their own negative experiences'. This raises potential matters of concern. On the one hand, the service user *may* have failed to engage in dialogue with other points of view (but this was not backed up by any other student responses). If this were the case, this would raise issues of training and appropriate briefing for facilitators. On the other hand, the particular student *may* have felt unable to engage positively with contributions that were challenging or reflected critically on previous experiences of professional interventions. The latter issue has been found elsewhere, with a minority of students seeming unable to embrace the full range of what is being shared by service user or carer educators, and only being able to 'hear and focus on the negative stories' (Baldwin and Sadd, 2006, p. 352). However, if students are unable to engage with more challenging material in educational settings, this may raise concerns as to their potential capability to listen to service users and carers in their subsequent professional practice, particularly if this is their final year of qualification training.

Evaluating the Impact of Learning

Unfortunately, we are not able to evaluate the longer term impact of the collaborative learning on students' subsequent practice. However, the feedback from the great majority of students suggested that they had been moved and taken forward by their experience of dialogue and their encounter with a range of different perspectives. For some, the learning helped to confirm and consolidate their existing approach to practice, while providing some additional knowledge and insights.

> [The collaborative learning] reinforced my belief that service users are experts, not the professionals. (Social work student)

For the majority, the impact appeared to be more 'life-changing'. Assumptions had been challenged and barriers broken down—both between social work and nursing students and between students and service users and carers. Typical comments from social work students included:

> I am able to look beyond just the social model and in practice I will be able to consider all models where appropriate.

> [I have learned to] be mindful of the individual/unique experience of the person— not to focus on the label.

> Working with service users and carers has given me a lot of insight into their perspectives on the work we do, and has identified areas where current practices may need to adapt ... It has also helped me to change the way I approach things in my work.

> Helped open my eyes to experiences, reasons for experiences, explanations etc not always covered by prominent theories.

> This provided me with a greater understanding of how mental distress impacts on the individual and those around them. This cannot be learnt from a book.

> The main skills and knowledge learning has come from working alongside service users and carers. Their input has been invaluable.

> Made me feel more positive for the future.

Similarly, nursing students commented:

> I think it has taught me a lot about my own approach to the care that I give and the way in which I involve service users/carers/professionals in the day-to-day services of the team that I work in.

> It will make me question how practice is seen by service users and their families.

A number of students commented that the experience was a little rushed and that they would have liked more time to take the dialogue further:

> Not long enough—a very complex module to cover in such a short period. (Social work student)

Interestingly, for a number of both social work and nursing students, this particular learning experience had helped them to acknowledge 'the role of the carer ... and the

importance of their perspective'—which suggests that this can still be a neglected area within the education programmes for both professional groups.

However, there was a small minority of both nursing and social work students who considered that this experience of learning collaboratively was less helpful—and that their time could have been better devoted to 'specialist training such as around legislation, diagnoses, etc.' (social work student). Similarly, a nursing student commented that they had heard 'service user and carer stories before' and so this could be 'repetitive' and the time could 'have been better spent actually learning about areas of speciality nursing which were not covered because of [the collaborative learning]'.

In Conclusion

A split between 'those students who "got it" and those who did not', in terms of appreciating the value of learning *with* and *from* service users and carers, has been identified as an issue elsewhere (Baldwin and Sadd, 2006, p. 352). The majority of the student feedback evidenced a deeper understanding of mental health issues, with theoretical perspectives being 'fleshed out' and also challenged by the perspectives of service users and carers. For these students, processes of dialogue *both* enabled their learning *and* prepared them for collaborative models of practice. However, a minority of students did not see this sort of learning as a priority—and would instead have preferred a more conventional approach to acquiring further 'specialist' knowledge.

This raises some basic questions as to the philosophy that should underpin mental health education, given changing expectations of practitioner roles and what may be seen as best equipping someone to be 'fit for practice'. Should we still be preparing students for a 'clinical' model of practice in which they would make decisions and deliver care plans on the basis of their specialist knowledge and expertise; or should we be inducting them into a form of practice which is framed in terms of co-production (Needham and Carr, 2009)? Clearly, a balance has to be struck between learning different forms of knowledge that may be relevant, but it is becoming increasingly accepted that the foundation of effective practice is an ability to work in partnership and learn from the direct experience of service users and carers—an orientation that is embodied in the *Ten Essential Shared Capabilities* and is central to recovery approaches in mental health (Slade, 2009; Tew, 2011). However, it is important to recognise that there are still some students reaching the end of their professional training who may see their role in more traditional terms as an 'expert' practitioner who can 'do unto' service users and carers. This, in turn, may have been reinforced by more traditional attitudes around 'professionalism' encountered within other aspects of their overall learning experience, including practice placements.

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