

FEATURE ARTICLE

Development and evaluation of a training program in peer support for former consumers

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ABSTRACT: While mental health policy in Australia promotes the involvement of mental health consumers in service planning, implementation and evaluation, little has been reported on the training required for the new roles that consumers are being expected to undertake. In this study, 10 former consumers of mental health services participated in a 16-week training program in peer support. The impact of the program on the psychological well-being of the participants was assessed using a battery of self-evaluation questionnaires and focus group interviews. Findings suggest that exposure to people with acute mental health problems (i.e. inpatients), did not, in this instance, adversely impact on the psychological well-being of the participants. Barriers to consumer participation in the mental health field are discussed and recommendations for the content and structure of future consumer peer support training initiatives are proposed.

KEY WORDS: consumer participation, evaluation, peer support, training.

INTRODUCTION

Since the 1970s, user involvement in mental health services has increased worldwide, despite difficulties in the organization of user groups and barriers to action by service providers (Bastian 1998; Rudman 1996). In the USA, the Mental Health Service Reform Act (1986) acknowledged the importance of collaboration between mental health consumers and service providers. It is now clear that a growing number of mental health consumers are involved in the planning, evaluation and provision of services (Mowbray 1997; Nikkel *et al.* 1992; Sherman & Porter 1991; Silva 1990). While Australia has been slow to follow this trend, the National Mental Health Standards (National

Mental Health Working Group 1996) underscore the importance of consumer participation. The Standards emphasize the need to maximize consumer involvement through the introduction of effective policies and procedures, and the provision of training and support for consumers. It is also clear that consumers themselves are demanding a greater role in all aspects of mental health service provision (Berger *et al.* 1996; Champ 1998; Connor 1999; National Community Advisory Group 1995a, 1995b, 1995c). In Australia, the Lemon Tree Learning Project (Epstein & Shaw 1997) and a Toolkit for Mental Health Consumer Participation (Nolan 1997) are useful guides to establishing and maintaining significant consumer involvement. While consumer groups have demonstrated a desire to participate in the planning and delivery of services, the literature indicates that such involvement requires knowledge and skills that consumers may not already possess (Campbell 1990; Chamberlin 1988; Miller & Katz 1992; Pyke *et al.* 1991). Despite efforts to promote consumer participation, little detail has been published on the training of consumers for the new roles they are being asked to undertake.

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Peer support

It is now recognized that former patients of mental health services gain a unique and potentially valuable insight from their treatment experiences, and a growing literature supports their employment in an effort to improve service provision (Epstein & Wadsworth 1994; Felton *et al.* 1995; McGill & Patterson 1990; Segal *et al.* 1993). Moxley and Mowbray (1997) describe five attributes of the expansion of consumer roles in psychiatric rehabilitation services. These are: (i) helping and support activities; (ii) empowerment through recognition that consumers can offer special expertise, complementary to that of professionals; (iii) a recognition and legitimization of the credentials that consumers have gained through their contact with mental health services; (iv) a view that some services are best provided by consumers themselves (e.g. outreach); and (v) a perspective that the helper benefits as well as the recipient.

Nolan (1997, p. 9) also recognizes that former patients can offer a special kind of expertise, not normally available within the service. Likewise, by sharing concrete and practical skills learned during their own illness, former patients can act as positive role models for the patient in hospital (Champ 1998; Meehan & Blum 1994). Sherman and Porter (1991) demonstrated that former mental health consumers employed as case management aides in the community resulted in successful long-term outcomes for the former consumers. Other consumer support programs describe the value of peer involvement as counsellors, consultants and transitional aides to the client, both in hospital and community settings (Barry & Schaecken 1995; Felton *et al.* 1995; McGill & Patterson 1990; Turner *et al.* 1998). These reports, however, often lack detail of the training provided or of the outcome of the peer support program as experienced by the consumer.

Impact on former consumers

Manning and Suire (1996) discussed problems experienced by consumers employed as case management aides, and reported that the consumers themselves feared relapsing into acute mental illness because of the job stress. Nikkel *et al.* (1992) raise the question of the effect of stress and the level of support required to prevent relapse in former patients working as primary case managers. In the Community and Consumer Service Study undertaken in Sydney, O'Donnell *et al.* (1998, 1999) describe difficulties in setting up a consumer advocacy service (as part of the larger project). Despite many crises and setbacks, the service program was a useful learning experience for the advocates, and resulted in 'a strong cohesive group with solid views on how consumer advocacy should be carried out'. Full evaluation of the impact of the program on the advocates was not reported, although several advocates

required stress leave and two resigned to protect their own health (O'Donnell *et al.* 1998). A positive outcome for consumer participants was reported by Bentley (2000) who describes a peer leadership training program at a consumer-run drop-in centre in the USA. While the program was designed to facilitate both personal and organizational empowerment, most participants were primarily interested in personal improvement, and benefited greatly from the communication and problem-solving skills offered by the program.

Little other work has been reported on the training required for former consumers wishing to provide peer support to patients currently in hospital. Indeed, the impact of exposing former consumers to an inpatient population/environment on the well-being of the former consumers themselves is less clear.

The aim of this study was: (i) to develop a training program in peer support for former patients; (ii) to evaluate the impact of the program on the psychological well-being of the participants; and (iii) to identify barriers to effective on-going consumer participation.

METHOD

Setting/sample

The study was conducted at a large tertiary psychiatric facility in Queensland comprising adolescent, acute, rehabilitation and forensic services. Consumer peer support trainees were recruited from the community through a newspaper advertisement. An interview team consisting of a mental health consumer, the project facilitator and the chief investigator assessed the suitability of the 22 applicants, short-listing 18 to be interviewed for the 10 training positions. Selection criteria included: self-identification as a mental health consumer; a stated interest in helping others interpersonally; and a willingness to develop skills in peer support and advocacy. A desirable criterion was hospitalization at some time for their own illness. It was felt that consumers who had spent time in hospital would have a better understanding of the issues confronting people currently in hospital.

Of the 10 participants selected, eight were female and ages ranged from 21 to 60 years. One participant had a part-time job and the remaining nine were unemployed. While all participants had spent time in hospital for their illness, the severity of illness varied within the group. Length of time spent in hospital ranged from 2 months to 10 years.

Training program

The training program was developed by a planning committee which consisted of service providers, teaching staff and consumer representatives. The aim of the program was

to prepare former consumers of mental health services to provide peer support to current inpatients. The overall program consisted of a classroom component of 4 weeks duration and an experiential component of 12 weeks duration.

Classroom component

The aim of the classroom component was to provide the trainees with basic knowledge necessary to interact with staff and patients at ward level. It incorporated lectures and group work including role plays. Three main areas were covered: (i) basic legal and ethical principles governing inpatient treatment including the Mental Health Act, the Mental Health Review Tribunal, Official Visitors and Patient Rights; (ii) mental illness overview including history, treatment, and symptoms; and (iii) communication and counselling skills such as reflective listening, self-advocacy, assertiveness and conflict resolution to assist working with patients at ward level.

The classroom component was offered over a 4-week period in 16 sessions of 5 h each. Sessions were conducted 4 days per week, 10 am to 3 pm, with Wednesday free to allow for optimal assimilation of the material. In addition, breaks during the sessions for discussion and refreshments were provided in an effort to maintain consumer focus. Preference was given to lecturers who also identified as being consumers of mental health services.

Experiential component

The experiential component was designed to provide the trainees with experience of working with staff and inpatients at ward level. The trainees spent 4 weeks in each of three selected areas: acute, rehabilitation and activities. The trainees worked in pairs for mutual support, for approximately 4 hours per week. Prior to each ward session, each trainee was expected to check in at the consumers' room to discuss issues of concern, and this opportunity enabled the facilitator to assess (informally) their well-being. After each ward session the facilitator held a 45-min debriefing session for the group to discuss matters not covered in lectures, and to develop strategies for unforeseen events.

Evaluation: Data collection

The subjective experiences of the participants were captured through a focus group discussion held each month. These group discussions enabled the trainees to describe, in their own words, how they felt about different aspects of the program. Each group discussion was audiotaped to facilitate data analysis. In addition, the participants were asked to complete a battery of standard questionnaires at 4 weekly intervals throughout the program. These measures enabled the research team to

monitor the impact of the program on the psychological well-being of the participants. Stress was monitored through the Perceived Stress Scale (Cohen *et al.* 1983), a 14-item measure rated on a 5-point scale, where higher scores indicate greater levels of perceived stress. Anxiety was assessed using the Spielberger Anxiety Inventory (Spielberger *et al.* 1993). The inventory consists of 20 statements that evaluate how respondents feel 'right now, at this moment' (state anxiety) and 20 statements that assess how a person generally feels (trait anxiety). Self-esteem was assessed using the Rosenberg Self-Esteem Scale (Rosenberg 1965), a 10-item measure on a 4-point scale where higher scores indicate higher levels of self-esteem. Finally, perceived control over one's life was assessed through the Locus of Control Scale (Craig *et al.* 1984) a 17-item measure rated on a 5-point scale where higher scores indicate greater external control.

RESULTS

Focus group discussions

The trainees were generally satisfied with the format and content of the program. However, they felt that the classroom component could have included more information on topics such as counselling, patient rights, patient advocacy, and legal issues surrounding the regulation (under the Mental Health Act) of patients in hospital. While the opportunity to interact with the staff and patients in the wards during the experiential component was appreciated, some participants felt that this was more difficult than they had expected:

Working in the more disturbed wards was frightening at times and it brought back memories of my own problems.

The participants felt that they had gained much from their experience in the wards and that their contact with patients had unique value to both the patients and themselves. They performed a range of activities from escorting patients to the local shops, to organizing recreational activities for clients and cofacilitating ward groups with nursing staff. They quickly recognized the difference in the relationship between professional staff and patients, and their relationship with patients.

When the patients in the ward understand that we are former patients ourselves they tend to disclose more and realize that we are there to help them, we are on their side.

It was also apparent from the focus group discussions that lack of a clear job description created some problems for project participants at ward level. It was clear that they felt somewhat insecure when questioned by staff in the wards about their role.

TABLE 1: *Psychological assessment of trainees (n=10)*

Measure	Normal range	First day mean	4-weeks mean	8-weeks mean	12-weeks mean	16-weeks mean	P-value
State anxiety	35.1–40.0	39.6	39.6	37.8	36.6	35.6	0.86
Trait anxiety	37.9–41.6	43.7	42.7	41.3	40.2	40.6	0.95
Perceived stress	23.2–23.7	24.9	21.8	21.2	21.1	21.3	0.78
Locus of control	28.3–30.1	38.5	35.2	36.1	36.0	35.7	0.93
Self-esteem	34.5–35.0	29.5	32.1	33.8	34.2	35.1	0.40

I think that some of the nursing staff were afraid that we were going to take their jobs and that made me feel uncomfortable – they should have had more information about what it is we do.

Scale data

Table 1 provides details of the mean scores for the group on each instrument throughout the study period. The ‘normal’ ranges outlined in Table 1 are those provided by the developers of the scales. However, it should be noted that that these ranges are only approximations for the general population.

Changes in scores were assessed using a repeated measures analysis of variance (ANOVA) design. State anxiety (i.e. anxiety at this present moment) for the group was at its highest during the first 4 weeks of the program but decreased steadily as the trainees became familiar with their role in the hospital. Trait anxiety (i.e. anxiety that one generally experiences) was also elevated at the commencement of the program but decreased over the duration of the program. Stress levels for the group were outside the normal range on the first day of the program, however, levels decreased to within the normal range over the 4 weeks of classroom component and remained stable for the duration of the program. In relation to locus of control, the group had very high scores initially which indicates a perception that outcomes are within the control of powerful others rather than oneself. Scores tended to decrease as the program progressed indicating that the participants felt more in control of their own destiny. As a group, the trainees had below ‘average’ scores on self-esteem during the early part of the program. Again, as the program progressed, self-esteem climbed to normal levels. While the participants demonstrated improvement on all the measures employed, the changes obtained did not reach significance at $P = 0.05$.

DISCUSSION

We described the development and evaluation of a program for consumers wishing to be involved in the provision of peer support to clients in an inpatient setting. In keeping with the broad consumer advocacy model (Bastian 1998, p. 15), the trainees helped current patients

to consider choices and consequences within a wider context. They felt that their own experiences of the mental health system were of value in assisting current patients to master the immediate environment of the hospital and in planning for a future in the community. However, the impact of the program on clients at ward level was not fully assessed in the present study and attempts should be made to evaluate this in future studies.

The trainees were generally satisfied with the content and relevance of the classroom component. In particular the communication and counselling skills were found to be useful, as was reported also by Bentley (2000). However, the trainees did have difficulty assimilating the large amount of complex lecture material in the initial 4 weeks. A 2-week classroom component at the beginning of the course, followed by a second 2-week period midway through the experiential component could be a more effective way of presenting the information.

There was always a concern that contact with patients at ward level would have a negative impact on the well-being of the trainees themselves. Commonly held attitudes to the mentally ill would suggest that the stress and anxiety associated with exposing former consumers to patients currently receiving treatment in hospital could cause relapse in the former consumers (Nikkel *et al.* 1992). The present study, however, provides no evidence to suggest psychological well-being of the trainees suffered as a result of interacting with patients in hospital. Indeed, with the exception of a slight increase in stress on the final assessment, the group demonstrated considerable improvement in anxiety, self-esteem and locus of control. The slight increase in perceived stress on the final assessment may have resulted from break-up of the group, disappointment that the program had ended, and uncertainty about the future.

Some members of the group required considerable staff support, particularly in the early stages of the program. The extent of this support appeared to be dependent on the resilience of the individuals involved, and on the stress placed on them in the ward environment. Professional support in future programs should be provided on an ‘as required’ basis. It is likely, however, that a progression from reliance on professional support to self-supporting structures will eventuate as consumer empowerment increases and enables a greater independence of the ‘system’.

Segal *et al.* (1993) suggest that if true empowerment of consumers is to occur, then consumer groups must command the necessary skills to secure the desired outcomes. Thus, in addition to establishing self-support groups, former consumers are encouraged to develop their own expertise in the training of consumers in peer support (Epstein & Shaw 1997). While training programs continue to be provided by mental health services, they are likely to remain provider focused rather than consumer focused.

An important requirement for a successful working relationship between staff and consumer is a clearly defined job description for the peer support worker. Absence of this was a source of concern for the trainees (and staff) involved. As a result, there was some confusion about the role of the consumer trainees in the wards. The development of a job description was consciously delayed until the end of the program. By this time the consumer trainees had experience of the environment and were in a better position to contribute to the development of a job description.

An important and related issue is the relationship boundary between former patients working in a peer support role and current patients. It was clear that some of the trainees saw themselves as 'friends' to current patients in the ward. It is likely to be this lack of professional boundary that makes the relationship different, and the role of peer support worker more empathetic. However, accountability within the relationship between peer support worker and patient should not be neglected. Dixon *et al.* (1994) point out that consumer advocates are as accountable as any other member of the team. This problem of ill-defined roles and relationship boundaries for the peer support worker could be addressed through the development of a code of conduct that defines the scope of practice for peer support. While not prescribing exactly what a peer support worker can and cannot do, a code of conduct would ensure that peer support workers provide a service that is safe, confidential and ethical.

Finally, one indicator of the success of the program is the employment record of the participants. Within 6 months of the program ending, two members of the group gained paid positions within the present hospital preparing long-stay clients for community resettlement. Four others secured peer support positions in acute or community mental health facilities in the Brisbane area, and one member started a vocational training agency for people with mental illness.

Recommendations for future programs

To establish a successful consumer support program within an inpatient setting, more than education is required. Issues to be considered for future programs were highlighted during the present evaluation.

Consumer training programs should be 'consumer driven' as far as practicable, to provide a service that is consumer focused rather than organized for the convenience of providers.

Training programs should be of sufficient length to cover important topics such as the overview of the mental health service, mental illness and ethical issues, but avoid overload. Ward work should commence in 'easier' non-acute wards before progressing to more 'difficult' wards.

The consumer service providers in consultation with the mental health service should develop 'Guidelines for Practice' and a 'Code of Conduct' for consumer support workers. This information should be widely distributed among all staff, to ensure that professional staff have a clear understanding of the role of consumer support workers in service delivery. This will, hopefully, allay misconceptions of 'job-takeover' and negative attitudes among staff, and will contribute to effective working relationships.

Mental health services must ensure that structures are established to enable consumers to provide feedback to senior management on issues concerning patients at ward level, for example, consumer representation on the hospital executive and planning committees.

Attempts should be made to explore ways of funding on-going consumer participation that is separate and distinct from the hospital's funding.

CONCLUSION

The present study highlights the need for training and skill development for former patients wishing to participate in mental health service delivery. Well organized training programs, clearly defined job roles, and a code of conduct for consumer support workers will further facilitate the introduction of consumer participation. It is also clear that mental health service management has a key role to play in promoting consumer participation. Expressions of commitment must be followed by action in the form of financial support, recognition of consumer involvement, promotion of on-going education for consumer service providers, and development of policies that consider and value consumer participation. Only in this way can an effective partnership between mental health providers and consumers develop.

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