Staff Attitudes Towards Consumer Participation and Peer Worker Roles in a Community Mental Health Service

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KEYWORDS
Peer Workers, Consumer Participation, Community Mental Health

Abstract

Objective: To investigate the attitudes of community mental health staff towards consumer participation and peer workers in mental health services.
Methods: In this cross-sectional survey design study, community mental health staff completed the Mental Health Participation Questionnaire (MHPQ) which measures the attitudes of mental health professionals towards consumer participation at individual and systemic levels.
Results: 82 staff completed the questionnaire. Overall, staff expressed positive attitudes towards consumer involvement in mental health service care planning and treatment, with neutral attitudes towards the more systemic aspects of consumer involvement in management and consumers as educators. The results also demonstrated that staff do value lived experience expertise and change that consumer involvement and peer workers can bring to services to enable them to support recovery. Positive relationship qualities between mental health staff and peer workers were found to be important.
Conclusion: This study adds to existing research that has found community mental health staff generally have a positive attitude towards consumer participation in mental health services.

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Introduction

Consumer participation and peer workers are increasingly becoming part of the service mix for recovery-oriented mental health services internationally[1]. In this study, consumer participation refers to consumers taking part in decision making about their own mental health service needs, and the development, planning, and evaluation of mental health services[2]. Peer workers are people who have a lived experience of mental illness and who in their roles as peers share this experience to support others in their recovery journey[2]. This has been driven primarily by policy and consumer advocacy promoting the need for recovery-oriented services, as demonstrated by the National Framework for Recovery-Oriented Mental Health Services which guides practitioners and providers in Australia[2]. Whilst there is emerging evidence to support the positive impact that consumer participation and peer workers can have[1], staff attitudes towards the growing involvement of consumers in a range of participatory roles are mixed[3].
Peer workers are considered valuable for the services they provide to consumers, as well as the change they can bring about in transforming services towards the core function of supporting recovery[4]. A number of studies have investigated the impact of support provided by peer workers on consumer outcomes[5]. A recent review found that peer support increases hope, empowerment, and quality of life[6]. As hope and empowerment are considered essential aspects of recovery[7], these findings are relevant to mental health services that are striving towards a more recovery-oriented approach to service provision.

Despite these positive findings, peer workers have identified a number of barriers that inhibit them from being able to successfully fulfil their roles, including doubts by mental health staff that peer workers can cope with the stress of the roles[8]. In fact, staff attitudes have been identified as one of the main barriers to the success of peer worker roles in mental health services, specifically a lack of understanding of the role and discrimination[4,8-11]. This is important as there has been an inverse association found between stigmatizing beliefs of staff towards mental illness and the recovery-orientation of services[12].

Studies focusing on consumer participation have examined staff attitudes towards consumers participating in their own care and treatment, and consumers working in the mental health system as consultants, representatives, or advocates. Overall staff attitudes are positive; however, negative attitudes have been reported in some specific areas[13]. Staff generally have a more positive attitude towards consumer involvement in their own treatment, and a less positive attitude towards consumer involvement in service planning, service management, and consumers as staff[13]. Studies have found that staff value peer worker roles in services[13,14], whilst also identifying staff concerns such as boundary concerns about peer workers being both service users and providers[14]. These negative attitudes towards consumer participation and peer workers could create barriers to realizing the potential of peer worker roles in mental health services[3].

Most research has focused on student or staff attitudes towards peer workers in inpatient services. While there are accounts of peer workers practising in community teams[15], this study is the first that the authors could identify that focuses specifically on

the attitudes of community mental health staff towards consumer participation and peer workers. This study sought to answer the research question, “What are staff attitudes towards consumer participation and peer workers in community mental health teams?”

Research Design and Methods

This study used a cross-sectional survey design with the aim of investigating the attitudes of community mental health staff towards consumer participation in mental health services and towards newly introduced community-based peer worker positions. Ethics approval was granted by South Eastern Sydney Local Health District Human Research Ethics Committee as low/negligible risk 14/222 (LNR/14/POWH/506).

Participants

Participants were community mental health staff employed in public community mental health teams across a Local Health District in Sydney. All adult case management and rehabilitation teams were included. These multi-disciplinary teams provide care coordination, treatment, and rehabilitation for adults with mental illness and include registered nurses, social workers, psychologists, and occupational therapists. During the study period, new community-based peer worker positions were being established across all of these teams, working 16 hours per week. Most participants would have had previous exposure to peer workers employed by the service in inpatient settings or as representatives on committees.

Data Collection/Instrument

The Mental Health Consumer Participation Questionnaire (MHCPQ), developed by Happell and colleagues[16,17], was selected as a way of obtaining both quantitative and qualitative data from staff regarding their attitudes. Shown to have good face validity and adequate psychometric properties overall, the tool is recommended for use in mental health settings to measure the attitudes of mental health staff towards consumer participation at both individual and systemic levels. The first component of the tool consists of 24 statements on consumer participation that are rated using a Likert scale ranging from strongly disagree (1), to neutral (4) to strongly agree (7), covering the broad domains of consumer capacity, consumer involvement in processes, and consumers as staff. The second component of the tool asks 1 partly and 2 further open ended questions:

1. Do you think consumers should be active in the delivery of services? Yes/no. If so, in what way?
2. Please briefly describe what consumer participation in mental health care means to you.
3. Please list three factors you consider to be most important in developing collaborative relationships between health care providers and consumers.

All staff from the adult community mental health teams were invited to complete the MHCPQ over a 14-month period between January 2015 and March 2016. Participants

completed de-identified hard copies of the questionnaire, which were collected by administration staff and returned to the investigators in confidential envelopes, which were stored securely by the investigators.

Data Analysis

The 24 Likert scale questions were analyzed using IBM SPSS statistics, version 22.
The data were analyzed using descriptive statistics. Dependent variables were computed into four categories according to the questionnaire design[16]. To compute the average sum variables, negatively worded questions were scored inversely.

The open-ended questions were thematically analyzed using a realist, inductive approach[18].The written answers were typed and collated by question, then provided to each of the three investigators for independent analysis. Common responses were grouped according to frequency and similarity, enabling core themes to be identified. These interpretations were then compared and discussed to determine the final key themes. Thematic analysis offers a flexible and accessible approach that enables the summarizing and identification of similarities and differences within a large body of data, and can generate new insights and interpretations useful for informing policy[18].

Results

The response rate for the survey was 78%, with 82 out of 105 staff at the community mental health sites completing the questionnaire.

Attitudes of staff were favourable towards consumer involvement in their own treatment (mean 5.28, SD = 0.47) and involvement in service planning (mean 5.30, SD = 0.82). Attitudes towards consumers in management of mental health services were not as high (mean 4.86, SD = 0.82). The mean of staff attitudes towards lived experience educators (mean 4.13, SD = 1.03) was neutral according to the scale in the questionnaire.

Participants provided extensive answers to the open-ended questions, and these responses were coded into themes by the three investigators.

Ways in Which Consumers and Peer Workers Should be Active in the Delivery of Services

All participants except for two said that consumers and peer workers should be active in the delivery of services. Whilst the wording of the question pertained specifically to ‘the delivery of services’, participants described a much wider range of activities when responding to this question that emphasized the importance of consumer participation and the peer worker role not only in direct delivery of services, but also in guiding treatment/care planning, in service planning, and evaluation and in education.

Consumer Participation in the Delivery of Services

Consumer participation in guiding treatment and care planning emphasized the importance of consumers having input into their own care planning and decisions about treatment. Some participants described a collaborative process of participation whilst others thought consumers should be taking the lead: “Consumer's view should be taken into account and they should be encouraged to take active part in decision-making regarding their treatment options.”

Despite being outside the scope of the question, many participants highlighted the importance of consumer participation in service planning and evaluation. A wide range of activities was listed including membership of committees, involvement in staff recruitment, development of models of care, input into design of rehabilitation programs, and review and evaluation of services. The importance of lived experience was again highlighted in the context of influencing service planning and decision-making:

> “I think consumers should have as much input into the service strategy, structure, and delivery as they have expert knowledge of what it is like to be a consumer of the service, what works for them, and what didn't. It would break down stigma and improve the quality of care and the environment.”

Peer Worker Role in the Delivery of Services

Peer worker involvement in the direct delivery of services fell into two main areas: i) involvement in existing clinical processes, for example discharge planning and ii) the provision of specialist peer support services such as providing support, mentoring, engagement, advocacy, and being a role model who can inspire hope. Group work was an activity highlighted for peer worker involvement, which encompassed both clinical and peer support aspects.

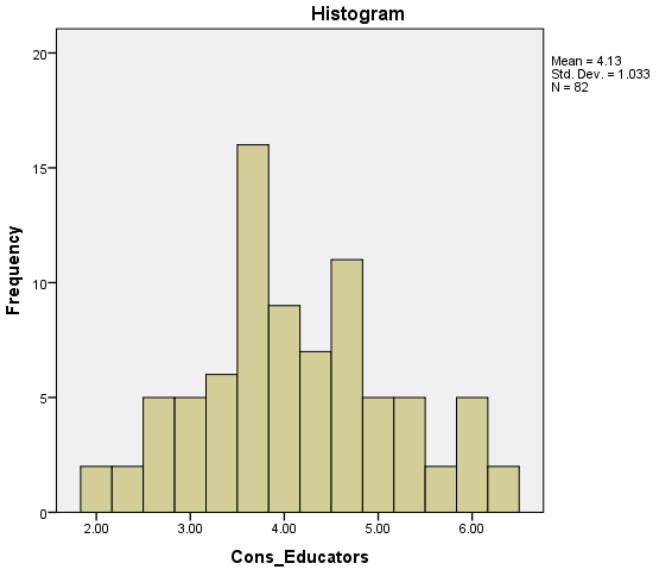
The most positive theme was the benefits brought to staff and the mental health service from the lived experience perspective of peer workers: “First-hand experience resonates well with consumers. It is affirming, powerful, encouraging, and hope*f*ul.”

Many staff also identified education as an important role for peer workers. Education could broadly be categorized as both a type of service delivery and a broader organizational development activity. It was viewed as valuable for peer workers to be involved in providing a wide variety of educational activities to a range of stakeholders including consumers, other peer workers, staff, community organizations, and universities: “Particularly in education of recovery-based interventions to address things like social isolation, managing symptomology, and wider community education to reduce stigma associated with having mental illness.”

Although in the survey lived experience education was found to have only neutral support, a positive theme was reported in the qualitative open-ended responses. This

could be explained by the distribution in the results in Figure 1, while some staff rated their attitude as neutral, some staff were positive towards lived experience while others were not. The attitudes for this aspect of the peer worker role had the highest standard deviation.

Figure 1. Category of Lived Experience (Consumer) Educators



What Does Consumer Participation Mean?

When reflecting on the meaning of consumer participation, participants identified collaboration/partnership between staff and consumers. Many participants also said that consumer participation meant consumers developing confidence, empowerment, and self-determination: “Develop confidence to determine their own health needs and motivation to maintain health both mental and physical. Get the best out of life.”

Participants viewed consumer participation as supporting person-centred, strengths focused, holistic, recovery-oriented mental health care. They described greater equity, respect, and dignity for mental health consumers, which were seen to represent meaningful and positive change: “It means meaningful change that will assist the journey of recovery, improve our use of the recovery model as a service, and will improve outcomes for people with lived experience and improve mental health care.”

Factors Important in Developing Collaborative Relationships Between Community Mental Health Staff and Peer Workers

Six key factors were identified relating to personal attributes and qualities of both staff and peer workers in developing collaborative relationships*:* trust and honesty ('authenticity and goodwill'), mutual respect, communication and listening, collaboration and willingness, understanding, and empathy.

Factors relating to the culture and approach of the mental health service included: consumer/recovery focus, empowerment and inclusiveness, education. “Change in power imbalance where consumers in the past have been given 'token positions' without power or real input; consumer roles need to be valued as does clinician input.”

Strategies that need to be put into place by the mental health service to support the peer worker role were also identified. These included: clear processes and roles, and systemic support.

The concerns raised by staff in relation to peer worker roles were role blurring, client lack of acceptance of peer worker roles, and problems with the mental health status of peer workers. One participant highlighted a concern regarding peer workers employed in the service from which they are receiving services, and another reported a lack of uptake of the peer worker services from people on their caseload:

> “Consumers may have a role to play in some cases. Most consumers (clients) I have worked with are not keen to talk to peer support persons. There have only been two out of 20 clients who accepted this offer; it was only for two sessions.”

Another participant suggested that peer workers needed to have achieved some degree of mental health stability/recovery:

> “Ability to self-manage (thoughts and emotions) in a wise way to allow interpersonal effectiveness. This naturally involves ability to reflect on own goals, behaviour, and empathize with each other and is mental state dependent; being acutely psychotic undermines this.”

Discussion

The results are more positive than a previous study using the same questionnaire to survey the attitudes of inpatient mental health staff in Australia[3]. The results align more closely with a recent survey from Finland that utilized the questionnaire with staff from multiple settings[13]. The current study had slightly less favourable attitudes towards consumer participation in treatment and education, with slightly higher positive results for participation in planning and management.

The results demonstrate that community staff have favourable attitudes towards consumer participation in their own care planning and treatment but still need convincing about consumer participation in management and provision of education. This shows that while staff seem to support self-determination and choice, they have not yet caught up with current policy developments supporting participation in more systemic aspects of mental health care, for example participation at higher levels of management and planning[2].

Regarding peer worker roles specifically, themes reported by staff such as empowerment and hope support the evidence for peer worker roles in bringing about a

shift in services to a recovery focus[7]. Staff valued and described numerous benefits that lived experience brings to services. This is important as peer workers are impacted by staff attitudes towards their roles, which has a relationship with the potential of services trying to steer themselves towards recovery-orientation [12]. Although themes related to peer workers providing services were mostly positive, there were concerns regarding peer workers that were raised in the current study which are similar to those previously reported in the literature, such as peer workers' wellness requirements for work and both providing and receiving services at the same time[8].

Our findings are in line with the literature that shows that community staff are more favourable towards consumer participation and peer workers than inpatient staff [13]. This has implications for the design and focus of recovery-based education initiatives and the work that needs to be undertaken to influence beliefs and assumptions of staff in inpatient settings.

Limitations of the study included not collecting demographic details for staff and the length of the data collection period. This limited further data analysis according to staff characteristics, such as disciplines or length of service.

Conclusions

The overall attitudes expressed by the community mental health team staff were positive towards consumer involvement and towards the meaningful change in shifting mental health services towards a recovery orientation that is associated with consumer involvement and peer workers.

A minority of staff expressed concerns regarding peer worker roles. It could be argued that these barriers need to be addressed before the full impact of peer workers on consumer outcomes and mental health services is realized. The impact of negative staff attitudes has been found to impede the establishment of the peer workforce and there have been calls to address staff attitudes in undergraduate education for mental health staff[19]. The need for processes to be in place for the new peer workforce has also been reported in the literature[8]. This study adds to this, by outlining positive relationship qualities including trust and honesty ('authenticity and goodwill'), mutual respect, communication and listening, collaboration and willingness, understanding, and empathy between mental health and peer worker staff as being important too.

Further research should determine the best time to measure and address negative attitudes of students and staff and whether attitudes change after staff have worked with peer workers for a period of time. Research exploring consumer attitudes towards service provision, management, planning, and education by peer workers is also recommended. Inpatient staff attitudes may require more targeted efforts for services that are striving to be recovery-oriented.

Acknowledgements

Leonie Dunn for assistance with data collection, Marcie Debaets for pilot testing the questionnaire at an inpatient rehabilitation unit and Dr. Michael Steele for the statistical

analysis. The authors report no conflicts of interest or financial support to be disclosed.

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