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Mental Health Service Users' Experiences of Training Focused on Empowerment: Training Environment and the Benefits of Training

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A B S T R A C T

This qualitative study investigated the mental health service users' (MHSUs') experiences of empowerment training and it was based on individual interviews with 24 MHSUs. Findings showed that MHSUs described the training environment through three dimensions: social interaction, learners' internal resources and the pedagogical execution of training. The training reinforced their positive internal resources, stimulated their inner mind activity and gave meaning to their lives. The knowledge of the training environment helps to build environment, which will support MHSUs' training. Empowerment training could be used to strengthen MHSUs' positive internal resources giving them also a possibility to train their cognitive activities.

Mental disorders are highly prevalent throughout the world. At some point in life, mental disorders affect one third of the world's population (Steel et al., 2014). The prevention and treatment of mental health problems have a significant impact on society and public health.

According to a Finnish Health 2011 study during the last year 7% of women and 4% of men had depressive disorders whereas 1% of women and 3% of men had alcohol abuse. In addition, 17% of women and 14% of men felt to be significantly mentally burdened. Profuse annual fluctuation of mood and behaviour occurred among 20% of women and 12% of men (Suvisaari et al., 2012.)

Furthermore, in Finland, one in four sickness benefit days and one in three new disability pensions are granted based on mental health problems (Ministry of social affairs, 2012). Even if the total number of people receiving a disability pension has clearly decreased after 1995, disability pensions based on mental health problems have evenly increased. Furthermore, 38% (82,500 people) of all disability pensions in 2009 resulted from mental disorders, which have been the most common reason for disability pensions in Finland since 2000 (Hiltunen & Kiviniemi, 2010).

Among people with mental disorders, a higher education level enables a greater chance to enter competitive employment (Cook et al., 2008). Therefore, helping them complete educational milestones or receive special training in a particular area increases their competitiveness in the job market (Mueser & Cook, 2012).

However, psychiatric disorders have been proven to disrupt training and education at all educational milestones (Breslau, Lane, Sampson, & Kessler, 2008; Waghorn, Chant, Lloyd, & Harris, 2011). People with severe mental disorders often have difficulties in cognitive skills, such as paying attention, remembering, concentrating and learning, as well as reasoning and problem solving (McGurk & Wykes, 2008; Tan, 2009). Furthermore, fear of failure, stigma, fluctuating levels of illness and social discomfort were reasons that made education more difficult (Atkinson, Bramley, & Schneider, 2009). Schindler and Kientz (2013) found that the main reasons for disruption were the individual's internal barriers, such as the above-mentioned and including a lack of motivation and negative self-perception.

Various educational strategies are useful adjuncts to mental health rehabilitation, including structured educational interventions delivered at frequent intervals and behavioural interventions instead of verbal or written information (Fernandez, Evans, Griffiths, & Mostacchi, 2006). Learning enhances MHSUs' cognitive skills (Roe, Hasson-Ohayon, Salyers, & Kravetz, 2009), confidence and self-esteem (Atkinson et al., 2009). Education has been shown to improve individuals' health by increasing their functionality, which helps to develop essential psychosocial resources for building a better life (Zhang, Chen, McCubbin, McCubbin, & Foley, 2011).

Furthermore, education, among many other activities, increases the experience of meaning, which is central to recovery in mental health (Stickley & Wright, 2011; Zolnierek, 2011). An activity is regarded as meaningful when it gives a sense of contribution and a sense of being valued by or giving back to others (Hancock, Bundy, Honey, Helich, & Tamsett, 2013). A personal meaningful activity enables an individual to recreate his/her identity and sense of self (Carless, 2008).

Recent literature presents a number of studies where the self-management training of people with mental illness improved their wellbeing (Cyhlarova et al., 2015; Wynaden, Barr, Omari, & Fulton, 2012), promoted a healthier lifestyle (Bradshaw, Lovell, Bee, & Campbell, 2010), improved their self-esteem and self-advocacy-assertiveness, empowered them (Pickett et al., 2012), increased confidence and hopefulness and promoted recovery (Cook et al., 2012).

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Cook et al. (2012) concluded that training interventions focusing on recovery are a worthy adjunct to traditional mental health services. In one group, prior to and after evaluations of five weeks of peer support training of recovery, empowerment and self-concept promoted MHSUs' recovery, improved their employability, gave a sense of self-worth and empowered them (Hutchinson et al., 2006). A recovery course (a single group) led by a peers lasting eight weeks decreased psychiatric symptoms, as well as increased feelings of self-advocacy, hopefulness, recovery and empowerment (Pickett et al., 2010). A randomised controlled trial of training, which supported young people with mental health problems to participate in higher education, promoted postsecondary participation, hope, self-determination and mental health empowerment (Geenen, Powers, & Phillips, 2014). A randomised controlled trial of a 12-week peer-run course on recovery assessments showed improvements in empowerment, hope and self-efficacy beliefs but not in quality of life (van Gestel-Timmermans, Brouwers, van Assen, & van Nieuwenhuizen, 2012).

These studies showed that recovery-oriented training interventions very often have an empowering influence on people with mental illness. MHSUs and staff in mental health services have highlighted empowerment to be the most important aspect in health promotion (Svedberg, Hansson, & Svensson, 2009). This is in line with the World Health Organisation (2004), which describes principles of self-determination, participation and empowerment to be essential to mental health promotion. However, the importance of empowerment to the promotion of mental health has not been emphasised in research literature (Svedberg et al., 2009).

The focus of the previous studies has been more on a mental illness, where they focus more on self-care and information on illness, as well as promoting MHSUs' healthier lifestyles. There is a lack of studies of training interventions, which particularly have aimed to strengthen MHSUs' positive internal resources to empower them.

In addition, more knowledge is required about what sort of education in what kinds of settings would be ideal to help people with mental disorders to succeed in their education (Atkinson et al., 2009). There are no studies, to our knowledge, which explore MHSUs' training environments where learning and teaching take place. The knowledge of MHSUs' experiences of the training environment helps to create an environment that will support their success in training. Education was one of the most requested services when hospitalised people with psychosis were asked about their life and treatment goals (Ramsay et al., 2011).

MATERIALS AND METHODS

Aim

The purpose of this study was to describe MHSUs' experiences of a training intervention, which focused on their empowerment. The aim was to answer the following research questions:

1. How did MHSUs describe the training environment?
2. How did MHSUs benefit from the training?

Training Intervention

The training carried out in this study was developed in the EMILIA project (Empowerment of Mental Illness Service Users: Lifelong Learning, Integration and Action), which was funded during 2005–2010 by the European Union (for more information on the EMILIA project, see Nieminen et al., 2013). The training started with the introductory module followed by the 'Empowering People in Recovery' programme. The aims of the training were to increase the sense of control, to give tools to cope with stigma, to improve awareness of positive resources, to promote empowerment and to promote a process of lifelong learning. A mental health professional was a primary trainer who was assisted by a MHSU. Teaching methods included learning together, peer learning, problem-based learning and group discussions. The training was delivered once a week over seven weeks. The length of each session was 3.5 h. The participants were divided into four groups, with each group having five to six people. The description of topics and contents of the training is presented in Table 1.

Design

A qualitative design was used to explore MHSUs' experiences in the training. The context of the phenomenon under the study and the effort to gain a deeper understanding were highlighted (Beery, 2010). The data were analysed using an inductive content analysis to display a condensed description of the phenomenon (White & Marsh, 2006). A content analysis is a suitable method for scarcely explored and novel phenomena (Vaismoradi, Turunen, & Bondas, 2013), or when the knowledge of the phenomena is fragmented (Elo & Kyngäs, 2008). Because we also wished to focus on the selected aspects of the MHSUs' experiences, with our interest being in the training environment and benefits of the training, a qualitative content analysis was the most suitable method for our study (Schreier, 2012).

Settings and Participants

The participants of this study were Finnish MHSUs with severe, long-term mental illnesses.

To be included in the study, candidates had to meet the following inclusion criteria: a minimum age of 18, being unemployed, having used mental health services for at least three years before the study and being socially isolated or at risk of social isolation. The social isolation in this context means to be isolated from society because of unemployment.

Using a purposeful sampling, 24 MHSUs were selected for this study, of whom 16 were females and eight were males. Seven participants

Table 1
Description of the Topics and Contents of Training.

Day	Topic	Content/aim of training
Day 1	Introduction	Information on the EMILIA project Structure and aims of the training Common conversation about basic rules and practices during training sessions
Day 2	Recovery and empowerment	Background information on recovery and empowerment
Day 3	Interviews or metaphors	Getting to know each other Attitudes towards people with mental health problems Experiencing illness and hospitalisation
Day 4	Recovery and empowerment	Understanding the terms recovery and empowerment individually and commonly Finding the positive value in one's own life
Day 5	De-stigmatisation	Stereotypes linked to people with mental illness Re-defining self-portrait Coping with discrimination
Day 6	Responsibility	Exploring the term of responsibility Fields of responsibility
Day 7	Being empowered or empowering oneself	Finding one's positive traits