Psychosocial Health Education Within Community Mental Health Inpatient Recovery Wards In UK: Patients' Voices

Joy M. Rooney[1,2,3], Phil Brain[4]

[1]Retired from Herefordshire and Worcestershire Health and Care NHS Trust, UK

[2]Retired from Institute of Health and Society, University of Worcester, UK

[3]Workers' Educational Association (WEA), West Midlands Region, & UK-wide, UK

[4]Independent Statistical Consultant, UK

Correspondence: Joy M. Rooney, c/o Herefordshire and Worcestershire Health and Care NHS Trust, Kings Court 1, Charles Hastings Drive, Worcester, WR5 1JR, UK.

Abstract

Societies include people vulnerable to mental health distress; such people may find themselves detained. Mental health recovery wards seek to rehabilitate individuals who suffer severe, and enduring mental health distress, through community living, to re-establish, or learn new life-skills. The National Institute of Clinical Excellence (NICE) recommended more structured group activity to improve interpersonal functioning, including psychologically informed approaches. Psychosocial health education is qualified teacher-led, rather than psychoeducation, psychology, or interventions implemented by other health professionals, peer support workers, or storytelling by patients to each other. This study outlines patients' evaluations of psychosocial education within inpatient recovery/rehabilitation wards during 2016-2021. Patients (87%; n=82) who opted to attend 12 courses, provided anonymous voices through use of a numerical rating scale, manuscript written free text (n=93), and completed a short questionnaire (n=10), across two National Health Service (NHS) wards in the West Midlands, England, UK. Patients' voices were qualitatively analysed thematically. Ten distinguished themes suggested that psychosocial education was interesting, enjoyable, sociable, transformative, of decent quality, and projected to be of much benefit to patients' future lives. Ratings (n=270) were hierarchically analysed using GENSTAT to distinguish patients' preferences. Preferences for courses from patients' voices were exercise and mental health, wellness planning, feelings and emotions, Tai chi, mood and food, steps to confidence, stress busting, hearing voices, peer recovery, self-esteem, motivation, and bite size psychology. Patients believed education, with goal setting supported by all staff, provided new embedded knowledge, applicable to integration into society, with improved interpersonal functioning.

Keywords: consumer education, recovery/rehabilitation, psycho-emotional distress, patients' views, qualitative/quantitative survivor research

1. Introduction

There are many vulnerable groups of people in society, for example, homeless, living in poverty, disabled, mentally ill, indigenous, and ethnic minorities, religion, substance users/addicts, physically ill, young or old in age, pregnant women, LGBDQ identifying people, and those gender reassigned. Vulnerable people are sometimes members of such vulnerable groups, and may be exploited by others in society, possibly resulting in their abuse. Abuse occurs in different ways: physical, domestic violence, psychological or emotional, sexual, technological, financial, or material, immigrant status, modern slavery, discrimination, organisational or institutional, neglect or acts of omission, and self-neglect.

Abused, traumatised, vulnerable people may then suffer health challenges, including mental distress, often resulting in self-neglect. Co-occurring with vulnerability through abuse may be index offences, diagnosed substance and/or alcohol dependence/misuse, or other addictions, for example, gambling. Such people may find themselves homeless, in detained mental health services, or prisons, often through no real fault of their own. Due to the complexity of their health challenges, those who find themselves in mental health services may then experience severe, treatment-resistant (with psychiatric medications) symptoms, and cognitive impairments that affect self-care, self-motivational, organisational,

and social skills. They may also suffer other mental, neuro-developmental, and physical health conditions. It is for these people that mental health recovery/rehabilitation wards were designed.

1.1 Literature Review

1.1.1 Provision of Effective Recovery/Rehabilitation for those Vulnerable People Suffering Severe, and Enduring Mental Distress

The Recovery Model approach, in mental health services, suggests that patients fulfill their hopes, dreams, and aspirations for a self-determined healthy life, with choice and control (Davidson, Campbell, Shannon, & Mulholland, 2016; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011; Pilgrim & McCranie, 2013). In fact, a narrative review of world-wide rehabilitation services suggested possible reduced acute inpatient admissions, although further research comparing other groups was recommended (Dalton-Locke, Marston, McPherson, & Killaspy, 2021). Also, a study of Tsoutsoulis, Maxwell, Menon Tarur Padinjareveettil, Zivkovic, and Rogers (2020) showed reduced acute inpatient admissions following discharge from mental health rehabilitation units. Another study in Australia, one-year post-discharge demonstrated beneficial outcomes in many measures related to patients' coping and their reduced use of services (Parker et al., 2020). In addition, Parker, Arnautovska, Korman, Harris, and Dark (2023) demonstrated that an integrated model of including peers with lived experience, as staff, within rehabilitation services was no worse than 'treatment as usual' with only clinicians. These authors' analyses resulted in the integrated model demonstrating patients experienced reduced challenges, and increased socialisation.

However, mortality rates for these vulnerable people are high: a reported 21 per cent risk of these people dying after 10-years' discharge from rehabilitation wards, and/or a reduced life expectancy of up to 20 years (Chesney, Godwin & Fazel, 2014; Edwards, Meaden & Commander, 2023).Therefore, during 2020, The National Institute for Health and Care Excellence (NICE) published guidelines on the mental health rehabilitation of adults with complex psychosis (NICE, 2020a, b). Amongst their recommendations, structured group activities aimed at improving patients' interpersonal skills were included, NICE (2020a). Also recommended were behavioural activation through goal setting, initiating activity schedules, and implementation of psychological informed approaches, for example, relaxation, mindfulness, stress workshops and attending recovery colleges. However, NICE (2020a, b) recommendations for rehabilitation ward staffing did not include a non-clinical, qualified further education teacher, preferably with lived experience of mental distress.

The United Nations (UN, 2007) recognised psychosocial disability within the framework of the UN Convention on the Rights of Persons with Disabilities (CRPD). Linked to this CRPD framework, more recently, The World Health Organization (WHO) of the UN published Psychosocial Rehabilitation Guideline 8 for interventions for those with entitlements under CRPD (WHO, 2023). These interventions suggested wide-ranging assessments and activities that were holistic, and person-centered. They included work, housing, relationships, and community functioning (WHO, 2023).

Recently reported psychological interventions provided by mental health professionals are building an evidence base that demonstrates successful outcomes following rehabilitation (Killaspy, Craig, Dark, Harvey, & Medalia, 2021). These authors also suggested that there is a paucity of peer-led intervention research, despite there being employed peer involvement in services (inpatient/community services, and recovery colleges; Killaspy et al. 2021).

An underlying need for teaching and learning by patients within recovery/rehabilitation wards is alluded to in both sets of guidelines, also including reference to a need for more published evidence from those providing lived experience inputs on such wards. However, there was no suggestion of employing a qualified further education teacher, preferably with lived experience.

1.1.2 Psychosocial Health Education

Psychosocial health education is a psychologically informed approach and may be defined as teacher-led health education in which patients are encouraged to interact, and engage in experiential, growth mind-set learning (Yeager & Dwerk, 2020). It originates from complex family therapy (Biringer, Davidson, Sundfør, Ruud, & Borg, 2016). A randomised control trial (RCT) demonstrated its effectiveness (Graham et al., 2016). Models for psychosocial education emerged through supported education in rehabilitation services. These involved the integration of skill development and environmental support into an enabling approach, designed to assist people to learn functional skills necessary to achieve independent living (Mowbray et al., 2005). Within psychosocial health education, goal setting is important because it was shown to promote hope and motivation (Clarke, Oades, Crowe, & Deane, 2006). However, a RTC designed to increase patient engagement in activities during their stay in recovery rehabilitation wards through specialists training an existing staff team demonstrated no differences compared with standard care (Killaspy et al., 2015).

Psychosocial health education and psychoeducation are often used interchangeably in the literature, sometimes even within the same article. However, psychoeducation is distinguishable because it provides information and management techniques to people diagnosed with mental health conditions; by psychiatrists (Zhao, Sampson, Xia, & Jayaram, 2015), psychologists (Gibbons. Higgins, Hevey, Monahan, & O'Connor, 2016), either profession (Bäuml, Froböse, Kraemer, Rentrop, & Pitschel-Walz, 2006; O'Sullivan et al., 2023) or nurses (Colom, 2011; von Maffei, Görges, Kissling, Schreiber & Rummel-Kluge, 2015). It is not peer support (Faulkner & Basset, 2012; Gillard et al., 2017; Longden, Rea, & Dillon, 2018) or story telling by patients (Lindstrom Sofija & Riley, 2021). Nurses occasionally provided group psychosocial interventions/training (Yıldırım, Hacıhasanoğlu Aşılar, Camcıoğlu, Erdiman & Karaağaç 2015; Yıldırım, Hacıhasanoğlu Aşılar & Karakurt, 2013). Mowbray, Campbell, Lee, Fatehim and Disney (2021) systematically reviewed psychosocial-based outcomes in peer-support services; however, a psychosocial educational role for peer support was not considered.

1.1.3 Recent Evolution of UK-based Mental Health Wellbeing and Recovery Colleges

Increasing numbers of health-commissioned, community-based well-being and recovery colleges are appearing for self-referral of anyone experiencing mental distress and their associates. Courses are designed for people to experience new ideas based on mental health recovery supported by a range of health professionals, and those with lived experience (Kay & Edgley, 2019; McCraig, McNay, Marland, Bradstreet, & Campbell, 2014; Whisk, Huckle, & Mason, 2022). Originating in psychoeducation/broadening peoples' range of interests, they are developing into psychosocial education of wellbeing and personal development. Students' interactions increase their socialisation, modifying behaviours, often resulting in lifestyle changes. Such changes enhance wellbeing and mental health through practicing embedding new knowledge (Kay & Edgley, 2019; McCraig et al., 2014; Whisk et al., 2022). However, they are often not accessible to those people who are inpatients, for example, patients within community recovery inpatient rehabilitation wards, the subjects of this study. This may be because of there being none in that Trust's catchment area, logistics and accessibility of venues of attending in person courses, and/or patients' fluctuating health and co-existing challenges.

1.1.4 Relationship between Psychosocial Health Education, International Movement of Service Users/Carers/Persons with Disabilities, and the Social Model of Disability

The service user and carer/disability international movement relies on the social model of disability (Oliver, 2013). It is a society and community responsibility to provide vulnerable people, disabled through their mental distress, with, provision so that they can live an equitable life. People within this movement, and allies, have devised and published an evidence base of single taught health interventions, to aid recovery from mental distress, for future wellbeing (Cook et al., 2009; Copeland, 1997; Jonikas, Grey, & Copeland, 2013). A RCT successfully distinguished improvement in depression, hope, self-advocacy, and self-esteem (Cook et al., 2012; Pickett et al., 2012). Outcomes from this RCT developed into a Whole Health Action Management (WHAM) for participants within communities (Cook et al., 2020). It is this international movement which influenced the preparation/implementation of psychosocial health educational courses to those people within mental health recovery/rehabilitation wards, by a lived experience, qualified teacher.

1.2 Background to this Research Study, Curriculum Learning Outcomes, Research Question and Hypothesis

This study was designed to offer optional psychosocial teaching and learning to patients, within community inpatient mental health recovery/rehabilitation wards, from a qualified further education teacher with lived experience. The teacher, also the senior author, was employed by this NHS Trust as a part-time peer support worker. An early, small, qualitative, thematic study of patients' views, soon after involvement of peer support on an inpatient recovery/ rehabilitation ward, provided new insights for a then rare evidence base (Rooney, Miles, and Barker, 2016). Over the next two years, patients' early warning signs, and bite size psychology groups provided by peer support, evolved into taught courses because a peer support worker successfully studied teacher further education, and training (DET) part-time. The design/implementation of all courses relied on the learning theory of Bandura (1977), Freire (1970), Kolb (1984), Rogers (1969) and Shor (1992). Patients requested education in topics they believed to be important, voiced their suggestions for improvement in discussion with their teacher during sessions, and for this study, made anonymous quantitative, and qualitive assessment of sessions.

The learning outcomes of the whole curriculum were: I can have fun; I can learn new stuff to aid with future lifestyle choices, I can socialise with my newly learnt interpersonal skills, I can improve my communication. In addition, the UK further education philosophy of learners being able to apply new, embedded knowledge in their use of English, maths, and British values (Education and Training Foundation [EDF], 2014). These were woven into all teaching and learning courses. As part of course preparation/delivery a sense of worth, and the importance of their involvement were incorporated.

The research question was "Do patients believe they benefited from psychosocial health educational courses, and if so, how?"

In addition, a hypothesis was proposed that this original study through employing a qualified teacher with lived experience would complement the recovery ward staff mix, supporting patients, and staff to benefit from a more enabling environment. In future, the delivery of teacher-led psychosocial education across whole wards, rather than individualised patient psychiatric, psychological, nursing, and occupational therapy interventions could lead to people in mental health recovery/rehabilitation services being recognised under the social model of disability. A vision is that these vulnerable people will return to society with potentially greater quality, and longevity in life.

2. Method

A mixed methodology of patients' rating scale-scores of quantitative data, and patients' manuscript written free text produced voices of qualitative information was chosen. These proven methodologies were straightforward for patients and teacher, when time was very limited, and with much variability in the health of patients.

2.1 Participants

All patients who were admitted to two recovery rehabilitation wards, in one NHS Trust, West Midlands, England, UK were invited, and encouraged to join psychosocial educational courses for one day a week over a four-year study period. Patients stayed for up to two years to complete their rehabilitation as an inpatient in either a 10-bedded, or 15-bedded ward. A range of psychiatric diagnoses suggested they experienced severe, and enduring mental distress, often with other challenges, for example, severe, treatment-resistant (with psychiatric medications) symptoms, and cognitive impairments (affecting self-care, self-motivational, organisational, and social skills), and other mental, neuro-developmental, and physical health conditions. Co-occurring were sometimes index offences, diagnosed substance and/or alcohol dependence/misuse, or other addictions, for example, gambling. Equity, diversity, and inclusion considerations of patients for designing/embedding teaching and learning included: development disabilities, for example, learning disabilities, attention deficit hyperactive disorder; age; gender; English as a second language (ESOL); and differing religious beliefs.

2.2 Data Collection Procedure

The NHS Trust's Research and Development Department approved all research in this study involving patients, including use of summary, anonymised demographic information. All participating patients provided verbal, informed consent at the beginning of each teaching session, and before providing anonymously written feedback at the end, as witnessed, and formally noted on electronic attendance registers. Thus, the authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008.

A proforma containing headings for date, and name of course were inserted by the patient prior to completing a rating scale measure and providing manuscript written free text. As patients left each activity room, they deposited completed data collection sheets together. In addition, patients were offered an optional, short, anonymous questionnaire to complete at leisure, to be handed in at the ward office, and deposited in a designated drawer. An electronic attendance register of names of all patients for each session, of every course, ensured demographic information from patient records could be cross-referenced with patient anonymous assessments of courses.

The NHS Trust's Information Department representative extracted relevant demographic information from Trust electronic records, in Excel spreadsheet form, following an information access request. The resulting demographic information was matched for each patient whose admission was longer than 21 days to teaching attendance registers. Standard deviations, and student t-tests were determined from Excel for mean patient age and length of admission. The percentage of those patients who attended courses compared with all those patients admitted for more than 21 days was also determined from the Excel spreadsheet of all admissions during the study period. A minimum, 21-day admission period was chosen to collect study information because some new patients had very short admissions which were of insufficient duration for them to settle into rehabilitation wards, and choose optional courses from a questionnaire, following an informal meeting with the teacher.

2.3 Psychosocial Educational Courses

Sessions were prepared as curricula/schemes of work with each session having an individual lesson plan with learning outcomes (Table 1). Weekly courses were 30–50 minutes in duration, for two to 17 weeks in length. There were up to three courses available to patients each day, depending on rehabilitation ward dynamics, and all were accessible. Between three and 13 patients dipped into optional sessions depending on their health, and motivation. There were three ways to encourage attendance: the teacher facilitated morning planning meetings on the day she attended; there were weekly timetable activity planners completed by patients, and patients engaged with each ward staff team, from which there was a named nurse for a daily, one to one session, during which time person-centered goals were discussed/encouraged.

Teacher-designed courses used a wide range of learning theory, and an inclusive further education philosophy (Professional Standards for Teachers and Trainers: EDF, 2014).Therefore, considerations for creating/delivering/ assessing/modifying each session depended on the intersectionality of patients, their abilities, including recap, active questioning, and timed activities for generating social interactions/discussion, resources, demonstrations, active participation, use of multimedia expression by patients, worksheets, short videos accompanied with checks/discussions on learning. Patients discussed consent, catch-up, fulfilment of individual weekly goal setting and learning objectives at the beginning of each session. There was also a proforma for each patient to write a person-centered learning log for each session attended designed to answer: What did I learn during this session? How am I going to put this learning into practice? – patients formulated goals to be reviewed in class the following week; these were retained by patients. Teacher, or students on placement (when present) became scribes for those patients who were offered/requested support to complete a written learning log. Activities leading to succeeding at goals, set week-by-week during a course, were supported by health staff on both wards. A colourful certificate of attendance and achievement was awarded to individual patients for longer courses.

A daily electronic reflective diary recorded by the teacher captured patients' voices: their ideas, feedback, and suggestions for improvements. Updated schemes of work, and lesson plans were implemented by the teacher from this reflective diary.

2.4 Measures

Numerical rating scale: a blue, printed line, with markings crossing this line, numbered from zero to ten was printed four times, double-sided on a proforma A4 sheet. Dotted lines were also printed as headings for each rating scale for date and name of course to be inserted; thus, each assessment was anonymous (Appendix). Chimich and Nekolaichuk (2004), Geoff (1994); Mahdi et al. (2018); O'Neill, Chimowitz, Leveille, and Walker, (2019) and Thomson, Wilson, Collerton, Freeston, and Dudley, (2017) justified and used numerical rating scales. This measure was chosen because patients had fluctuating good health, making reading, comprehension, and writing almost impossible at times, despite continuing to be present in class. Zero (0) represented "awful, I'll never attend again ", while ten (10) was "excellent, please give me more".

Manuscript written free text: patients were also optionally encouraged to make a note of their views of the session just attended for which there was a space on a proforma sheet beside each numerical rating scale.

Questionnaire: patients were optionally offered a short proforma A4 printed sheet to complete during longer courses. The questions were: What was my learning? What did I enjoy? What did I find difficult? What changes do I wish for? Which topics do I wish to see taught?

2.5 Analytic Plan

Statistical analysis of patients' numerical ratings was by means of hierarchical ANOVA, with individuals' scores nested within 71 evaluation dates, nested within 12 courses (n=270). This analysis provided means and 95% confidence intervals, and Fisher unprotected lsd also gave pair-wise comparisons between courses. GENSTAT (VSN International, 2020) was the analysis program used.

Patients' anonymous, manuscript written free text (n=93) was step-by-step thematically analysed following Braun and Clarke (2006, 2019). Once themes were exhaustibly established, manuscript written free texts within each theme were counted (n).

Completed patients' anonymous short questionnaires (n=10; three courses) were also thematically analysed according to Braun and Clarke (2006, 2019).

3. Results

3.1 Demographic Information of Patients who Participated in Psychosocial Educational Courses

Of those patients whose admissions were longer than 21 days, 87 per cent opted to attend courses. There were no differences in demography between the two wards. Across both wards 82 participants joined courses; there were 59 male and 23 female patients of mean age 39 (sd±12.7) Seventy-three were white British, one white Irish, three another white background, one Indian, two Pakistani, and two did not state. Seventy were single, three married, five divorced, one widowed and three did not state. Their average length of stay was 226 days (sd±190).

3.2 Recruitment and Psychosocial Educational Courses

Choices of courses of interest to new patients, following an informal discussion meeting with the teacher, and the views of existing patients during daily community meetings informed which existing, or new courses would run. A brief outline of course learning outcomes appears in Table 1.

Table 1. Learning outcomes, and sources of teaching materials of psychosocial health educational courses, of length (in weeks), devised/delivered by further education teacher (West Midlands, UK, 2016-2021)

Learning outcome	Source of teaching materials
exercise and mental health–(5w) I can discuss my current fitness level. I can discuss how and why exercise and good mental health are linked. I can watch and take part in in-class live demonstrations of appropriate exercises, receive resources so that I can practice outside of class to increase my fitness level. I can recall a range of local sports' facilities and exercising opportunities of interest to me to increase my level of fitness outside my rehabilitation ward. I have booked/undertaken a taster session; patient suggested course.	demonstrations and practicing from NHS-recommended online exercising resources, outdoor exercise sourced from sports' facilities included swimming and gym equipment in a local centre, football, walking, and cycling
wellness planning-(3w) I can discuss how I describe myself, what helps me keep well, my vulnerability challenges and the action I will take when they occur, signs that I may need some extra support, what might be helpful and unhelpful support when returning to everyday routine, if a hospital admission was required what I would like to happen. I can use multimedia to explore these learning outcomes (for example, various art techniques, sound/my voice, photography, textiles, and yarns), Together, outcomes of these learning objectives can be provided to me as copies of a two-sided, A4 document for sharing with whom I choose.	template for wellness planning (personal communication, E. Watson, England, UK, 2012) following intentional peer support accredited training provided by Implementing Recovery through Organisational Change (ImROC) organisation to NHS Trust
feelings and emotions–(5w) I can discuss, and list meanings, and differences between the terms 'feelings' and' emotions' providing examples. I can personally experience feelings and emotions, expressing how they affect me through using colour. I can discuss and list a variety of triggers for a wide range of feelings. I can identify body-language in others. I will optionally express my views of feelings and emotions by producing a poster, for laminating, which I will keep (possibly displaying in my room enabling me to remember); patient suggested course.	prepared by teacher independently, and/or through adapting resources freely available on internet
Tai Chi–(5w) with the support of my teacher, I will discuss, observe, and participate in short online video teaching sessions of Tai Chi to understand, learn, and practice Tai chi, independently. Optionally, I will also be able to discuss, and can recall the relationship between mental health and spirituality with reference to Eastern religions; patient suggested course.	on-line videos of Tai chi were widely available on YouTube, prepared by teacher independently, and/or through adapting resources freely available on internet
mood and food–(6w) I can discuss and list food groups, which constitute healthy food and why, and how to eat good food on a budget. I appreciate the importance of the volume of my fluid intake, and how many calories I need to eat each day. I can recall which foods boost wellbeing for a variety of my moods, and why. I can make a list, buy foodstuffs/ingredients, and follow recipes to prepare the MIND well-balanced meal to boost my mood, following identifying which parts of the meal contain mood boosting vitamins and minerals; I can share and eat this MIND meal with others for my lunch. I can personally assess the impact of this MIND meal on my mood and discuss this with others; patient suggested course.	recipe for MIND meal was downloaded from UK MIND website prepared by teacher independently, and/or through adapting resources freely available on internet
steps to confidence-(8w) understand why I do not feel self-confident in a particular situation. I can identify two practical skills I will use to improve my confidence in that situation. I can identify two tools I will use to accept, and love myself, challenging my negative thoughts. I can identify two benefits of dealing with stress positively. I can identify the importance of setting a specific, measurable, achievable/appropriate, relevant, time-bound (SMART) goal for improved self-confidence and follow this goal through to its success.	prepared for Workers Education Association (WEA) while teacher was on secondment from NHS on return to NHS, course was adapted for recovery/rehabilitation wards
stress busting–(7w) I understand why I am stressed, and how this is presented in me. I can distinguish good and bad stress, and recall concepts regarding stress, appreciating my self-talk, and overcoming my negative thinking. I can consider, discuss, and recall techniques to reduce stress, deciding on what's 'just right' for me, and plan my lifestyle changes, including selecting my chosen relaxation skills and techniques; patient suggested course.	prepared by teacher independently, and/or through adapting resources freely available on internet
hearing voices -(13w) I can discuss, and list types of voices people hear, where they originate from, and famous people who hear voices, together with some statistics regarding voice hearing. I have the opportunity at the beginning of each session to discuss/ share my voices. I will learn a wide range of coping strategies	some resources for this course were adapted from national and international Hearing Voices Networks websites/publications

for hearing voices, testing these skills and techniques between sessions, and report on their relative effectiveness during initial weekly discussions. I will study, and discuss the writings of other voice hearers, relating these to my own experiences, especially how they coped. I will list those coping strategies I have tried, week-by-week, I believe will make a difference to my voice hearing for my teacher to produce an individualised 'My Hearing Voices Coping Strategies' poster for my wall/document/wallpaper for my mobile phone to remind me of my choices, should my voices become challenging for me. Based on my attendance of this course, I will hold hope that even if medication does not stop my voice hearing, I will be able to live a self-determined life using my chosen coping strategies; patient suggested course.	prepared by teacher independently, and/or through adapting resources freely available on internet
peer recovery- (17w) I understand my distress. I can empower myself. I can increase my wellbeing and I am connecting with the world.	a long course with multiple learning outcomes, that built week-by-week, and distinguished by four themes, was adapted from Mary O'Hagan's PeerZone website
	this website contains freely available online resources; many more were created for this course, with activities, demonstrations, role plays, library visits/online research
self-esteem–(7w) my self-esteem can increase through my ability to distinguish my negative/unhelpful thinking/core beliefs so that I may overcome these through self-compassion. I can list and discuss my strengths, abilities, and talents. I know how to employ positive thinking to increase my self-esteem. I know when to use gratitude in my daily living; patient suggested course.	prepared by teacher independently, and/or through adapting resources freely available on internet
motivation-(17w) I can use activity-based published resources for discussion, completion and sharing. I can build up a treasure/toolbox of motivational techniques and skills. I can increase my communication, written use of English, and concentration skills through discussion, successful goal outcomes, and support from my teacher.	long course encouraging motivation adapted from a manual of activities by Day, N. (2005). *Strategies for motivation.* New York: Wellness Reproductions and Publishing, personally purchased while in Canada, 2015
bite size psychology–(14w) I can use activity-based published resources for discussion, completion and sharing. I can build up a treasure/toolbox of life skills/techniques. I can increase my communication, written use of English, and concentration skills through discussion, successful goal outcomes, and support from my teacher.	long course encouraging increased life skills adapted from a manual of activities by Korb-Khalsa, K. L., and Leutenber, E. A. (2002). *Life management skills VII.* New York: Wellness Reproductions and Publishing, personally purchased while in Canada, 2015

3.3 Qualitative Data Analysis

Ten, semi-quantitative themes of 82 patients' voices, including verbatim examples of manuscript writings of free text generated from attending course sessions appear in Table 2. Themes suggested that patients successful achieved learning outcomes for each course. Table 2 also provides information which demonstrates, for most, there was new embedded learning, increased socialisation, behavioural changes and mind-set growth. Most patients also thought courses were fun and enjoyable to attend. There were three patients present, during the four-year period of study, who provided negative voices-manuscript written free text whose theme 'this course is not for me' was three per cent of the total number of patients' voices.

Table 2. Themes (in bold) of patients' voices, number of occurrences (n; total n=93), and selected, verbatim quotes from qualitative thematic analysis of manuscript written free text on numerical scale rating sheets, following patients' assessments of 12 psychosocial educational courses (West Midlands, UK, 2016-2021)

> **interesting** (n=22): *got something out of it; to do more confirming in myself; interesting and beneficial; it was a very interesting, positive session, learnt how to engage with others; interesting-how to be more confident in myself;*
>
> **a learning process** (n=17): *I learnt about myself; eating foods can alter your mood–good information; easy to understand;*
>
> **enjoyable** (n=13): *it was a very productive session, I enjoyed it very much; fun and clear; enjoyed the session, will use 'relentless determination' again;*
>
> **were good, or went well** (n=13): *all is well; good show, went well; good session, got an idea about trauma and how one can manage it; well done;*
>
> **inclusive-patients felt included, interacting with peers** (n=11): *good interaction with others; good to hear other people's views;*
>
> **worthwhile** (n=5): *worthwhile and built up ourselves in several topics; worthwhile; worth knowing;*
>
> **helpful** (n=4); *very helpful and interesting; was quite helpful;*
>
> **challenging/change in thinking** (n=4): *thinking a bit differently; good learning to think about;*
>
> **eager for next week** (n=1): *eager for next week;*
>
> **not for me** (n=3): *a bit boring, pointless, and could be better.*

Ten anonymous patient-written evaluations of three longer courses, demonstrated a belief in their value (Table 3). Patients thought there was learning of benefit, particularly enjoying the social interaction and discussions with other course members. Sometimes patients gave examples of sessions they recalled. Dissent from two patients did not centre around any course. It was due to non-enjoyment of either reading aloud in a session, which was optional, or completing worksheets in the session, for which a scribe was always available (Table 3).

Table 3. Patients' voices (n=number of patients making one, or more themed comments) from anonymous short questionnaire, of three longer psychosocial health education certificated courses (West Midlands, UK, 2016-2021)

Questions?	hearing voices course (n = 2)	recovery peer course (n = 4)	bite size psychology course (n = 4)
what was my learning	listening skills; sharing with other session, members– not alone (n=1); other people hear voices too (n=1)	mindfulness and strategies to cope with all aspects of mental distress (n=1); recovery and what it means to me (n=1); stigma and self-stigma (n=2); risks of drugs and alcohol (n=2); diagnoses and medication (n=1)	lots over weeks and months (n=1); motivation and confidence–helpful (n=1); be more proactive and be more positive to get on with everyone around me (n=1)
what did I enjoy	listening and discussing (n=1); learning about famous people who hear voices (n=1)	visiting the library (n=2); enjoyed activities (n=1); definitions and psychology (n=1)	reading out loud (n=1); using and remembering names session (n=1); saying nice things about each other (n=1)
what did I find difficult	no responses	remembering teaching and learning from week to week due to meds. (n=1); paperwork/worksheets (n=1); none (n=2)	completing worksheet (n=1); not interested in sleep hygiene (n=1); reading out loud during sessions (n=1)
what changes do I wish for	no responses	less paperwork/worksheets (n=1); none (n=3)	less worksheets (n=1); none (n=3)
which topics do I wish to see taught	no responses	emotions, for example, fear, love, sadness, happiness (n=1; course created/evaluated by patients)	no responses

3.4 Quantitative Statistical Data Analysis

Patients' voices analyses from numerical rating scale-scores demonstrated that there was a significant difference in preferences of patients between the 12 courses (p=0.02). The mean and 95% confidence interval (CI) for each course demonstrated that most were highly rated, with exercise and mental health being the highest. hearing voices, peer recovery, self-esteem, motivation, and bite size psychology were significantly less than the exercise and mental health course at least the p=0.05 level (Figure 1). There were also significant differences between: wellness planning and bite size psychology (p=0.033); feelings and emotions and motivation (p=0.021) or bite size psychology (p=0.002); mood and food and motivation (p=0.032) or bite size psychology (p=0.002); steps to confidence and peer recovery (p=0.038) or motivation (p=0.017) or bite size psychology (p=0.000) courses. Patients also rated this bite size psychology course significantly lower than stress busting (p=0.001), hearing voices (p=0.009) and peer recovery (p=0.006) courses.
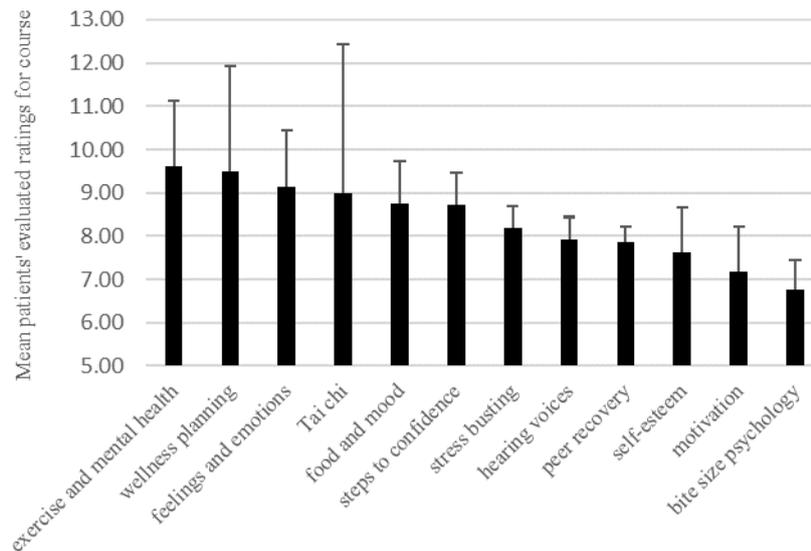

Figure 1. Evaluation of mean patients' numerical rating scale analysis (total number=270; including 95% confidence intervals, CI, as bars) of 12 psychosocial education courses delivered by further education teacher (West Midlands, UK, 2016-2021)

4. Discussion

This study's research question "Do patients believe they benefited from psychosocial health educational courses, and if so, how?" was almost unanimously answered in the affirmative. "How?" emerged from nine out of ten themes distinguished from patients' manuscript written voices, following their attendance of up to 12 psychosocial education courses, led by a qualified further education teacher with lived experience of mental distress (Table 2). Three of these courses were taught on one day a week, within two mental health recovery rehabilitation wards, over a four-year period. In addition, similarly, analysed answers to a short questionnaire added weight to a yes answer to this research question (Table 3). Involving patients in generating ideas for new course, providing feedback, together with teacher-led implemented learning outcomes (Table 1) resulted in patients' experiential, growth mind-set learning (Yeager & Dwerk, 2020).

Whereas outlined in the introduction, and background to this study, teaching followed a recovery approach (Davidson et al., 2016; Leamy et al., 2011; Pilgrim & McCranie, 2013). While Bandura (1977), Freire (1970), Kolb (1984), Rogers (1969) and Shor (1992) were relied on during course preparation to encourage engagement, motivation, community, and to overcome oppression experienced through being a vulnerable person. In addition, support came from members of an international service user/carer movement, and their allies. Goal setting/achieving, also used here as part of learning, was reported to promoted hope and motivation (Clarke et al., 2006). Psychosocial health education research through RCT single intervention studies of participants living in community, rather than hospital settings, suggested increased self-advocacy, associated with greater hopefulness, better environmental quality of life, fewer psychiatric symptoms, improvement in depression, increased self-esteem, and general health (Cook et al., 2009, 2012, 2020; Copland 2007; Jonikas et al., 2013).

Patients provided their voices to distinguish preferences of differing psychosocial education through a hierarchy of significance in differences from patients' numerical ratings (Figure 1; Appendix). All 12 course rating scores were in the range 9.60 (95% CI=1.53) to 6.77 (95% CI=0.67), with a maximum of score of 10 (Figure 1). Shorter courses with lots

of differing activities, for example, exercise and mental health, wellness planning, feelings and emotions, Tai-chi, mood, and food, were preferred by most patients, rather than those adapted from published activities, for example, motivation and bite-size psychology. However, longer courses also included peer recovery, originating from New Zealand, and hearing voices were not rated lowly. Teacher-prepared steps to confidence course was adapted following return from a secondment with The Workers' Education Association. An exercise and mental health course was the most preferred by all, possibly due to taster sessions in the community, away from the ward, and learning/practicing physical exercises, relaxation, and mindfulness techniques on the ward (Table 1; Figure 1). The hearing voices course was popular, especially for those whose medication was ineffective in removing auditory hallucinations; it was anecdotally described as "life-changing" (Table 1; Figure 1). Literature for making comparisons with a current evidence base was unsuccessfully sought, possibly making this study a first indication of patients' preferences of psychosocial educational courses within mental health recovery/rehabilitation wards.

All courses encouraged patients to increase their interpersonal functioning through both conscious and subconscious learning of social skills. There were activities, discussions, role plays, sharing new knowledge with each other, trying out, and practicing new ways of behaving. Patients identified this new learning through their expressed voices (Tables 2 & 3). NICE (2020a, b) recommended such outcomes as the development of interpersonal functioning and increased behavioural activation.

Mental health recovery colleges now provide a wide range of psychoeducation and interest courses (Kay & Edgley, 2019: McCraig et al., 2014; Whisk et al., 2022). However, even a recovery college offering remote online courses may not be accessible to those patients within recovery/rehabilitation wards due to their fluctuating health and co-existing challenges. Thus, within such wards, teaching and learning remains important for some patients.

Concerns over effectiveness of rehabilitation, due to risk of early death, and high mortality rates following discharge (Chesney et al., 2014; Edwards et al., 2023), resulted in guidelines produced by NICE (2020a, b) and WHO (2023). These organisations recommended psychosocial approaches, including employing those with lived experience as peers. Killaspy et al. (2021) also suggested research was needed to support such approaches, developing an evidence base. Then, a systematic psychosocial-based review of outcomes in peer-support across all services was published (Mowbray et al., 2021). However, peer support linked to psychosocial educational outcomes was not considered, despite it being known that there are peer educators (personal communication, Lisa Walter, Manitoba, Canada, 2023).

Learning outcomes of the whole curriculum followed selected learning theory, and EDF (2014). These included: I can have fun; I can learn new stuff to aid with future lifestyle choices, I can socialise with my newly learnt interpersonal skills, in particular, the philosophy of further education so that I can improve my communication, use of English, maths, and apply British values. It was not possible to demonstrate improved use of English, maths, and British values from this patient voices' study. However, it was believed that use of English naturally increased in patients attending courses; simple arithmetic was introduced at every opportunity, and British values were taught during the peer recovery course. However, patients' voices provided evidence that fun happened, new embedded future-focused learning occurred, and social skill/techniques were acquired (Tables 2 & 3).

It was not possible to provide sufficient information from a single, small study to prove, or refute a hypothesis that "through employing a qualified further education teacher with lived experience would complement the recovery ward staff mix, supporting patients, and staff to benefit from a more enabling environment". However, there may be a link between using a qualified teacher with lived experience, and increased patient engagement in activities (87% of patients engaged in psychosocial educational courses, whose recovery/rehabilitation stays were not less than 21 days, omitting readmissions, over this four-year study). This outcome contrasts with no discernable effect of specially trained, existing staff teams from within many similar settings, increasing patient engagement (Killaspy et al., 2015).

4.1 Future Perspectives

More research is necessary to determine whether a lived experience, qualified further education teacher delivering psychosocial education might be added to a recommended list of staff employed in recovery/rehabilitation wards (NICE 2020a, b).

Future research could include a large-scale funded study across recovery/rehabilitation wards in the UK, and even possibly, internationally to determine whether psychosocial education benefits patients through improved quality and longevity of life. Such research might be envisaged to include all stakeholders' voices. Thus, ethical approval, and patient and staff consent across whole recovery/rehabilitation wards would be necessary to ensure meaningful comparisons could be made between those patients experiencing psychosocial educational courses and 'treatment as usual'. Longitudinal comparisons of consultations, number, and length of future admissions to any health and social services of current and discharged patients, could be studied, along with straightforward measures of perceived health and wellbeing of all stakeholders. The economic implications of teacher salary costs versus cost savings across accessed

services would be an important factor within such future research. Follow-up research of peer mentors engaging with patients from discharge to into society could assess peer mentors' and past patients' abilities to practice embedded new health learning, socialising, behaviours, and successes in their future lives.

4.2 Limitations and Precautions

While the principal researcher was also the teacher, the second author validated data collected from anonymous patients' voices, and university and NHS-based mentors supervised teaching, and practice of this teacher. Both authors have in-depth knowledge, and experience of quantitative, and qualitative research methodologies, and publishing. Not all patients who were admitted for longer than 21 days opted to join taught courses, although a high proportion did (87%). Possible reasons for non-attendance of courses included fluctuating health, motivation, and possible social anxiety (an undiagnosed fear of interacting with other patients). Fear of attending teaching sessions was slightly overcome by the teacher making time to provide limited one to one sessions. These were not the focus of this study, especially as any recorded patient voice would not be anonymous to the teacher. The data set was small because the total number of patients who could attend courses was 25, even when both distributed wards were fully occupied, turnover (discharge-admission time) of patients within recovery/rehabilitation wards was low even though this study was for four years. A patient was counted once despite any readmissions to either recovery ward; one NHS Trust was involved in this study. Patients' challenges of communication, reading, writing and comprehension, when health was limiting, were overcome to capture their voices through using a numerical rating scale and manuscript written free text; both were widely evidence-based methods (Appendix). Patients' learning on how to use both methods was reinforced at the end of each session prior to their assessments. There are very many patient assessment methods, and published scales available, including interviews, focus groups, specifically designed/tested questionnaires, and Likert scale ratings. There was insufficient patient health, motivation, and time to undertake other types of assessment. The teacher believes some tick-box questionnaires, designed for patients' assessments do not provide any depth or clarity, and meaningful outcomes of studies, should they really be wished for. The teacher often worked alone, with up to thirteen patients taking part in a course session. She wore a personal alarm, which was never needed for class management, despite this challenging environment. There were no adverse events; patients were encouraged to temporarily leave and return to class; they were provided with a sense of worth, and the importance in their involvement. Two hours a week preparation time was allowed; all time dedicated to research was voluntary. The whole ward staff team supported teacher-led psychosocial education, particularly in encouraging patients' attendance at course sessions, and in goal implementation. Without the whole local NHS Trust support in all professional health disciplines, administrators, managers, CEO, and Board, this initiative would have failed.

5. Conclusions

An exceedingly high proportion of patients (97%) endorsed psychosocial health education within two recovery/rehabilitation wards, with 87 per cent of all patients admitted opting to learn and practice new knowledge, increase their socialisation, and change their behaviours. Such education aimed to improve the quality and longevity of patients' future lives on discharge.

Using a qualified further education teacher with lived experience of mental distress enabled patients to engage, learn, and apply new knowledge. Patients' worth and potential were also appreciated and recognised; their ideas, and feedback from courses were invaluable. An exercise and mental health course was the most highly rated of the 12 courses assessed by patients, although all were rated, on average, at more than 67 per cent. Philosophies of health recovery, social disability modelling, selected learning theory and the international service user/carer/persons with disabilities movement, enabled a strengths-based, growth mind-set approach in setting and implementing each course's learning outcomes. These approaches contrast, although, complement: psychiatric profession prescription of medication and maintenance, including nursing care; psychological and occupational therapy interventions.

Competing interests

The authors declare that they have no known competing financial interests that could have appeared to influence the work reported in this paper; intermittently, from 1977 to 1995, Dr PB & Dr JMR worked professionally undertaking agricultural plant science research. In late 2020, Dr JMR contacted Dr PB who analysed the data remotely during 2021; a personal relationship developed during 2023.

Informed consent

Obtained.

Ethics approval

The Publication Ethics Committee of the Redfame Publishing.

The journal's policies adhere to the Core Practices established by the Committee on Publication Ethics (COPE).

Provenance and peer review

Not commissioned; externally double-blind peer reviewed.

Data availability statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Data sharing statement

No additional data are available.

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