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Community-Based Mental Health Education in Empowering People with Mental Disorders in the Community

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Abstract--*The increasing numbers of mental disorders demand a mental health paradigm change from hospital-based services to community-based services. The community has an important role in contributing to both the healing and recurrence of clients with mental disorders in the community. Unfortunately, not all people have mental health literacy. Thus, the community-based education aspects should be a priority in promoting, preventing, curing, and rehabilitating efforts. The purpose of this study was to determine the effect of community-based mental health education in increasing knowledge and empowering clients with mental disorders in the community.*

This research employed the quantitative method with a post-test design of a quasi-experimental approach. The purposive sampling was used to determine the sample which consisted of 10 people in the experimental group and 10 people in the control group. The data was collected through questionnaires and observation by referring to the empowerment index proposed by Schuler, Riley, and Hashemi. Interventions for the experimental group were in the form of mental health education through home visits and group meetings by involving those responsible for mental health, health centers, families and mental health cadres. The interventions for the control group were in the form of mental health education through home visits using leaflets media.

The results showed an increase in cognitive abilities and the level of client empowerment after treatment, both in the experimental group (p-value of 0.036 and 0.015) and the control group (p-value of 0.041 and 0.048). it is recommended for mental health service providers in the community to carry out mental health education activities continuously through partnerships with government institutions, private, professional organizations, and the community in socializing the mental health problems and increasing the empowerment of clients with mental disorders in all aspects of life.

Key words*--mental health education, community-based, client empowerment, mental disorders*

I. INTRODUCTION

Mental health problem is a serious problem, both in developed and developing countries. According to WHO, mental disorders have already become the global carcinoma of the disease. The world is burdened by 14% mental disorders; this figure is higher than other diseases (Prince et al., 2007). Many people are not aware of this problem even though the productive days lost as a result of mental disorders are approximately 8.1% which is higher than tuberculosis (7.2%), cancer (5.8%), and heart diseases (4.4%) (Acharya et al., 2017)

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Indonesia, as a developing country, is still synonymous with problems of poverty, unemployment, crime, disaster, disease, low education, conflict, and other social problems. This condition is very risky to cause an increase in mental health problems. This is evidenced by the results of the Basic Health Research (Riskesdas) conducted by the Research and Development Center of the Ministry of Health. In 2007, exactly one year after the disasters that hit many cities in Indonesia, the number of mental disorders in Indonesia reached 4.6 per million, which means that out of 1000 people, an average of 4 to 5 people is having mental disorders. The provinces of Aceh and West Sumatra were the biggest contributors to the number of mental disorders. This data shows that the disaster contributed greatly to the problem of mental disorder in Indonesia. In 2013, there was a significant decrease in mental disorders up to 1.7 per million although the numbers rose to 1.8 per million in 2018 (Riskesdas, 2018).

This condition is quite alarming considering the impact of mental disorders that creates a considerable burden on individuals, families, communities, and government. The impacts can be either calculated or cannot be calculated with numbers, for example, psychological impacts such as shame, anxiety, fear, helplessness, hopelessness, and trauma both on individuals, families, and surrounding communities. The impact of this mental disorder also often causes the emergence of stigma, discrimination, and even to the stage of deprivation (Acharya et al., 2017). Mental disorders can be prevented and can be cured if they are treated quickly and accurately. Every individual, family, and community needs to have a learning process to help prevent and solve mental health problems in the community (Anderson & Pierce, 2012).

This is a challenge for health care providers, both in hospitals and health centers as the spearhead in health services in the community. The mental health service paradigm must change, not only focus on healing (curative) but also promotive, preventive, and rehabilitative to improve the quality of life of each individual.

The government, through the Ministry of Health, has sought to issue various policies to help to resolve mental health problems in Indonesia starting from the Minister of Health's Regulation, Minister of Health's Decree, and the Mental Health Act. The Mental Health Act No. 18 of 2014 emphasizes integrated and sustainable promotive, preventive, curative, and rehabilitative efforts involving governmental and private institutions as well as families and communities.

Clients with mental disorders who have received treatment both in mental hospitals, public hospitals, and health centers must be followed up with rehabilitative efforts. Mental Health Law No. 18 of 2014 article 26 states that rehabilitative efforts should include psychiatric rehabilitation and/or psychosocial rehabilitation and social rehabilitation. Article 28 explains that social rehabilitation can be carried out through, among others, vocational training and entrepreneurship development. The government has made the ideal policy based on the results of studies from various sources of theory and research results although the implementations differ from the expectation.

The interviews and documentation of re-treated patients in Lampung Province General Hospital discovered that the rehabilitation program in the community had not been given when the client returned home. Ongoing services from hospitals to Puskesmas (community health center) and the community have not been carried out optimally so that the empowerment activities to improve client independence have not been optimal.

Empowerment activities to increase the independence of clients who experience mental disorders require a lifelong learning process. The learning process gained while being treated in a mental hospital should ideally be continued in the community. Health workers in the Puskesmas as the leading sector, family as the

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main caregiver, and the community as a support system surrounding the client must have the ability to apply the appropriate learning process for clients who have returned home (Vukic, Rudderham, & Misener, 2009)

The results of literature studies from various related studies suggest that the community's understanding of mental health problems and the way to handle them is still low (Suryani, 2014). This can be seen from the high number of community misperceptions regarding mental health problems. For instance, there are still many people who think that mental disorders are caused by witchcraft, jinn possession, and other mystical phenomena. The results of interviews and documentation studies on one of the clients who had been treated at the Mental Hospital had experienced an unpleasant action from his family. The treatment he got was being smoked in a closed room because the client's mental illness was caused by evil spirits entering the client's body so it was necessary to do so.

Also, regarding a curative efforts toward mental disorder, there are still many people whose relatives suffered a mental disorder to be cured through the practice of shamans, sequestered into the forest, even to be put in stock (*IJMS - Indonesian Journal on Medical Science - Volume 1 No 2 - July 2014 - ijmsbm.org*, 2014). The majority of the patients were not immediately taken to the Mental Hospital when they are experiencing psychiatric symptoms (psychotic) but they are taken to the practice of shamans or other paranormal. Usually, people with mental disorders are only brought to health facilities when there is no improvement in their condition even though they have been taken to various shaman practices and do not have the cost to go to the shaman anymore.

This condition is very alarming because it is contradictory to human rights. Even the Mental Health Act No. 18 of 2014 article 86 provides a threat of criminal penalties for anyone who carries out, neglects, and resorts to violence toward people with mental disorders. The study by Idaiani and Raflizar (2015) in 1655 household samples reveals that the dominant factors in the inclusion of people with mental disorders in Indonesia are economic status, family ignorance about mental health problems, ignorance of health facilities, and their remote residencies.

People who experience mental disorders have far more severe problems because, in addition to having to adapt to various daily stressors, they also have to adapt to the risk of stigma or discrimination that they may receive in society (Hines-Martin & Yearwood, 2016) (Anderson & Pierce, 2012). This condition usually occurs because of the powerlessness of people with mental disorders. The powerlessness occurs because the majority of people who experience mental disorders are having medium to lower education, economically weak, do not have the skills to live properly in the midst of society, both social skills and life skills. Many people who have mental disorders can be cured, play a role in the community, and could become experts on the disorders. This condition is getting worse since no one is giving them trust and support. The environment has made the client feel insecure and increasingly feel helpless (Coffey & Hewitt, 2007)

This condition makes us aware of the importance of mental health literacy because anyone has the risk of experiencing mental disorders. No one has immunity to mental health problems. The community, especially the family, should also be the basis of the importance of lifelong learning because problems in life will never end. Thus, everyone needs to learn all their lives to improve their mental endurance to deal with these problems ((Hines-Martin & Yearwood, 2016)

This condition is the background to examine how the implementation of community-based mental health education can increase the empowerment of people with mental disorders in the community.

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II. RESEARCH METHODOLOGY

This study was conducted using a quantitative approach with pretest and posttest control group design. The research was conducted in Sri Bhawono Sub-district by involving 20 clients. The clients' criteria are cooperative, still undergoing treatment, and willing to take part in training activities. The 20 clients were divided into two groups; an experimental group consisted of 10 clients and a control group consisted of 10 clients. The experimental group got an intervention through individual and group educational training while the control group only got individual training.

Individual training was carried out at each client's home while group training was carried out at the Community Health Center by involving health workers in charge of the mental health program and trained mental health cadres. Individual training materials include the concept of mental disorders (understanding, causes, signs, symptoms, how to prevent a recurrence, care, and treatment) and life skills. The group training materials consisted of social skills training consisted of 4 sessions of material (training communication skills both verbally and non-verbally, the ability to make friend, the ability to joint activities, the ability to overcome difficult situations, and vocational skills through making food and drinks (Rushing et al., 2017)

The training approach used was humanistic because people who experience mental disorders is an adult who has a self-concept who is entitled to get the same treatment as the others (Wang, 2010). Tutors help clients set goals both individually and in a group.

III. RESULTS AND DISCUSSION

Measurement of the level of client empowerment was done using the modified Empowerment Index from Schuler, Hashemi & Riley, the activity of a daily living instrument, as well as questions about mental health issues. The results of the study in the experimental group and the control group showed the following results:

1.Demographic Characteristics of Clients with Mental Disorders

Table 1 Profile of Client Characteristics of the Experimental and Control Groups

Characteristics	**Experimental group (n = 10)**		**Control group (n = 10)**		**Total (n = 20)**	
	N	**%**	**N**	**%**	**N**	**%**
1. Age						
a. <25 years	0	0	1	10	1	5
b. ≥ 25 years	10	100	9	90	19	95
2. Gender						
a. Male	7	70	8	80	15	75
b. Female	3	30	2	20	5	25
3. Education						
a. Elementary school	2	20	2	20	4	20
b. Junior High School	5	50	5	50	10	50
c. senior High School		30	3	30	6	30
2. Occupation						
a. Working	4	40	5	50	9	45
b. Not working	6	60	5	50	11	55
3. Income						
a. <Rp 2,000,000;	10	100	8	80	18	90
b. ≥ Rp 2,000,000;	0	0	2	20	2	10
4. Marital Status						
a. Married	2	20	4	40	6	30
b. Unmarried	8	80	6	60	14	70

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Data source: results of preliminary study data processing

From table 1, it can be seen that clients in the experimental group who experienced mental disorders were in the productive age range (25 to 50 years old) while the group control only 1 person aged less than 25 years. This age is synonymous with independence in meeting the needs of life. Most of the clients who experience mental disorders were male (70% in the experimental group and 80% in the control group, mostly junior high school graduate (50% both in the experimental group and the control group), and most were unemployed and did not have income where the clients who were employed did not have a permanent job but already had a business to meet their needs independently. Most clients in the experimental group were unmarried (80%) and 60% in the control group.

Based on the results of exploration with clients and families, all clients had a strong desire to be independent and to be employed but the lack of skills possessed was a barrier for clients to work. The skills they did not possess were not only specific, but also social skills, and emotions management. Some clients still had difficulty interacting with others, had low self-confidence related to the condition of their mental health, some still had difficulty controlling their emotions when they were experiencing problems in everyday life.

The interviews show that the majority of these conditions were due to the client's and families' lack of knowledge. The lack of education about mental health problems in the community and how to prevent and deal with it makes the client, family, and community were unable to contribute optimally.

2. Profile of Cognitive Abilities of Mental Illness before Intervention

Table 2 The Profile of Cognitive Ability of Clients with Mental Disorders Before Treatment

Cognitive Aspects	Groups	N	Mean	Remarks
1. The aspect of Mental Health	Intervention	10	73	Fairly good
	Control	10	68	Poor
2. Relative freedom from family domination	Intervention	10	70	Fairly good
	Control	10	63	Poor
1. Freedom in mobility	Intervention	10	87	Good
	Control	10	77	Fairly good
4. Access to health services	Intervention	10	90	Very good
	Control	10	70	Fairly good
5. Ability to buy small commodities	Intervention	10	60	Extremely Poor
	Control	10	50	Very good
6. Ability to buy large commodities	Intervention	10	70	Fairly good
	Control	10	60	Poor
7. Involvement in household decision making	Intervention	10	70	Fairly good
	Control	10	50	Extremely Poor
8. Literacy ability	Intervention	10	100	Very good
	Control	10	70	Fair;y good
9. Legal and political awareness	Intervention	10	70	Fairly good
	Control	10	48	Extremely Poor

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10 K Engage in campaigns and protests	Intervention	10	10	Extremely Poor
	Control	10	60	Fairly good
11. Have economic security and contribute to the family	Intervention	10	80	Good
	Control	10	90	Very good

Remarks: very good (90-100), good (80- 89), fairly good (70-79), poor (60-69), Extremely Poor (<60)
Source: Results of the analysis of the cognitive abilities of the experimental group

Based on table 2, it can be seen that the initial cognitive abilities of the mental disorders of the experimental group are varied ranging from Extremely Poor to very good. This condition can be caused by the majority of clients having mental disorders for more than 2 years so that they already have sufficient knowledge about the disorders although Indonesian society in general still possesses poor perception toward mental disorders. All clients also said that they had never received formal education and education related to their rights and obligations as a client or as a citizen.

3.The Empowerment Level Profile of Client with Mental Disorders before Treatment

Table 3 The Empowerment Level Profile of Client with Mental Disorders Before Treatment

Dimensions of Group Empowerment		**N**	**Mean**	**Remarks**
1. Aspects of mental health	Interventions	10	10.18	Quite empowered
	Control	10	8.5	Less empowered
2. Relative freedom from family dominance	Intervention	10	10.8	Quite empowered
	Control	10	8.8	Quite empowered
3. Mobility	Intervention	10	9.7	Quite empowered
	Control	10	8.5	Less empowered
4. Health care access	Interventions	10	10.4	Quite empowered
	Control	10	8.4	Less empowered
5. The ability to buy small commodities	Intervention	10	9.2	Quite empowered
	Control	10	8.0	Less empowered
6. The ability to buy a large commodity	Intervention	10	7.6	Less empowered
	Control	10	6.8	Less empowered
7. Involvement in household decision-making	Intervention	10	8.8	Quite empowered
	Control	10	6.8	Less empowered
8. Literacy skills	Interventions	10	15.2	Empowered
	Control	10	9.6	Fairly empowered
9. Legal and political awareness	Intervention	10	8.0	Less empowered
	control	10	6.6	Less empowered
10. Involvement in the campaign and protests	Intervention	10	6.4	Less empowered
	control	10	5.2	Less empowered
11. Possessing economic	Intervention	10	9.2	Quite empowered

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security and contributing to the family	Control	10	8.4	Less empowered

Description: The average score of 13-16 means helpless, the averages score of 9-12 means quite empowered, the average score of 5-8 means less empowered, the average score of 1-4 means unempowered.
Source: The results of the empowerment level instrument analysis of the treatment groups

Based on table 3, it can be seen that the levels of empowerment of the clients in performing daily life are varied. The majority of clients are already in the empowered category for literacy skills but still lacking in the mental health, freedom of mobility, access to health services, ability to buy small commodities, ability to buy large commodities, involvement in household decision making, legal and political awareness, and involvement in campaigns and protests as well as economic guarantees and contributions to families (control groups). The experimental group was still helpless in terms of the ability to buy large commodities, legal and political awareness, and involvement in campaigns and protests. Campaign and protest activities in the sub-district/district area are still considered to be something less ethical. Buying large commodities is still a difficult thing to do considering that most of the clients do not have jobs and income while the legal and political awareness aspects are still lacking due to lack of socialization and education.

After obtaining data on cognitive abilities and the level of client empowerment, a treatment was given in the form of education about mental health including understanding of causes, signs, symptoms, ways of prevention, ways of treatment and care, signs and symptoms of recurrence, skills training as a form of psychosocial rehabilitation in society such as training in daily life skills (life skills and social skills training), and vocational skills. The education was given individually during the home visit. The group meetings were held in the health center hall involving mental health officials, clients' families, and mental health cadres. Family involvement will help the client's learning process (Wardaningsih, Keliat, & Susanti, 2008). The control group was given individual education accompanied by the family using leaflet media.

The treatment was carried out for approximately 4 months because each training material follows the stages of discussion, modeling, role-playing, feedback and transfer training, and evaluation. Each client was allowed to practice the results of the exercise in daily life with the guidance of family and mental health cadres and supervision from the health center staff. After that, the training results were measured using the same instrument as the previous instrument.

3. Profile of Clients' Knowledge and Empowerment Level after Training.
After treatment, measurements were taken to re-measure cognitive abilities and the level of client empowerment by using the same instrument as before with the following results:

Table 4 Cognitive and Empowerment Level in the Experimental and Control Groups before and after the Intervention

Group	**Ability**	**N**	**Mean**	**SD**		**value**
Experimental	Cognitive a. Before b. After **Difference**	10 10	70.9 88.2 1.	2.32 0.84	0.69 9 0.25 5	0.036

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	Empowerment a. Before b. After **Difference**	 10 10	 9.59 10.20 0.61	 2.27 2.44	 68 73	0.015	
Control	Cognitive a. Before b. After **Difference**	 10 10	 64.1 80.2 1.61	 1.27 1.39	 38 42		0.041
	Empowerment a. Before b. After **Difference**	 10 10	 7.78 8.52	 1.27 1.77	 38 53		0.048

Table 4 shows the increase in cognitive abilities and the empowerment of the clients after the interventions. Increased cognitive abilities and empowerment not only occurred in the experimental group but also occurred in the control group. The use of learning media, training methods and the use of andragogy theory during the training are believed to contribute to the improvement of clients' abilities. (Sharan B. Merriam, 2001).

The involvement of families and mental health cadres during the training also contributes to the improvement of clients' capabilities (Mubin, Riwanto, Soewadi, Sakti, & Erawati, 2019)

One indicator of the successful application of andragogy theory is that all clients are treated as adults who have the right to express their opinions, make decisions so that the clients look happy and do not experience pressure during training. Clients are involved in all stages of the training process (discussion, modeling, role-playing, feedback, transfer training, and evaluation). All clients followed the activities to the end.

The training was given in groups with 10 clients per group. The group functioned as a place to share experiences and to help one another to find ways to solve problems. A group is a laboratory to find good interpersonal relationships and to develop adaptive behavior. Group members feel their ownership, recognition, and existence are valued by other group members (Keliat & Akemat, 2005).

Each client session used notes or workbooks for the continuation of the training. The implementation of sessions 1-4 were implemented by using 4 (four) methods in social skills training, namely 1) modeling where the therapist demonstrated the skills to be performed, 2) role-playing where the clients were provided the opportunity to act out the skills that had been performed by the therapist, 3) performance feedback given as soon as the clients tried to act out, and 4) transfer training where the clients transferred the skills they acquired into daily practice. In session 5 (five), the clients were trained to express their opinions regarding the benefits of the training.

IV. CONCLUSIONS AND RECOMMENDATIONS

In community-based education, andragogy theory is very appropriate to be used. A pleasant and unstressed learning atmosphere made the clients' condition relaxed so that it was easier to absorb information. This condition was also felt by families and mental health cadres involved in the training processes. The use of

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role-playing methods in the experimental group was also one of the supporters in increasing cognitive abilities and empowerment. The use of leaflet media in the control group made it easy for clients to reread the material described. The involvement of families and mental health cadres in the control group also contributed to the improvement of the clients' ability before and after the training.

Lifelong learning activities for clients with mental disorders as a form of psychosocial rehabilitation are needed to increase independence and empowerment and should be done routinely and continuously. The involvement of families and mental health cadres as social support in the community to help clients in the process of lifelong learning in the midst of the community should always be done.

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