Peer-groups Led by Peers among Mental Health Rehabilitation

- Peer-instructor`s Experiences-

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Laurea University of Applied Sciences **Abstract**
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Peer-groups Led by Peers in Mental Health Rehabilitation – Peer-instructor`s Experiences-
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The experiences of mental health rehabilitees regarding voluntary led peer to peer groups are examined in this study. The working life partner was Tukiyhdistys Majakka Ry. Majakka is the day center for mental health rehabilitees located in Helsinki. The study's purpose was to make the operations model of Majakka more known and examine the benefits of their strong visitor orientated operations model from the perspective of inclusion. The study was qualitative research. The objective of the study was to produce information about the essential factors that promote inclusion and social participation based on peer-instructors experiences.

In the theoretical framework, I introduce the mental health work in Finland in general basis, as well as the history of It. The working life partner is a third sector association, so I describe the role and the benefits of the third sector in Finland. I open up some challenges faced by mental health rehabilitees and introduce the scientifically proven methods to promote inclusion.

By implementing my study, I interviewed four peer-instructors and the chairman of the executive committee of Majakka. To find out more about the subject, I also interviewed two staff members. All interviews were implemented during Autumn 2020. The results were analyzed by using content analysis. Four main themes rose from the content. Those were Inclusion, Peer-support, Challenges and Meaningful Things to Do. Based on the study results, a conclusion can be drawn, that leading peer to peer groups promotes the inclusion by increasing the social encounters, promoting a sense of belonging and togetherness, as well as increasing the possibilities to use one's abilities.

For further research, it might be interesting to examine more of the factors that make the operations model in Majakka so functional and easy to run. Based on this knowledge, perhaps it could be found out how this model could be implemented and built somewhere else.

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Tässä tutkimuksessa tarkastellaan mielenterveyskuntoutujien kokemuksia vapaaehtoisesti johdetuista vertaisryhmistä. Työelämänkumppani tutkimuksessa oli Tukiyhdistys Majakka Ry. Majakka on mielenterveyskuntoutujille suunnattu päiväkeskus Helsingissä. Tutkimuksen tarkoituksena oli tehdä Majakan toimintamallia tunnetuksi, sekä tutkia heidän kävijälähtöisen toimintamallinsa etuja osallisuuden näkökulmasta. Tutkimus oli laadullinen tutkimus, ja tavoitteena oli tuottaa vertaisohjaajien kokemusten perusteella tietoa keskeisistä osallisuutta ja yhteisöllisyyttä edistävistä tekijöistä.
Opinnäytetyön teoriaosuudessa kuvaan mielenterveystyötä ja sen historiaa Suomessa, hyvän mielenterveyden ominaispiirteitä, mielenterveyskuntoutujien kohtaamia haasteita, sekä tutkittuja menetelmiä osallisuuden lisäämiseksi. Työelämän kumppani on kolmannen sektorin yhdistys, joten avaan kolmannen sektorin roolia yleisellä tasolla, sekä erityisesti mielenterveyskuntoutuksen näkökulmasta.
Tutkimustani varten haastattelin neljää vertaisohjaajaa sekä Majakan hallituksen puheenjohtajaa. Saadaksesi lisätietoa aiheesta, haastattelin myös kahta henkilökunnan jäsentä. Kaikki haastattelut toteutettiin syksyllä 2020. Tulokset analysoitiin sisällönanalyysin avulla. Aineistosta nousi esille neljä pääteemaa. Nämä olivat osallisuus, vertaistuki, haasteet ja mielekäs tekeminen. Tutkimuksen tulosten perusteella voidaan tehdä johtopäätös, että vertaisryhmien ohjaaminen edistää osallisuutta lisäämällä sosiaalisia kohtaamisia, edistämällä yhteenkuuluvuuden tunnetta sekä lisäämällä mahdollisuuksia käyttää kykyjään ja vahvuuksiaan. Jatkotutkimusta varten olisi mielenkiintoista tutkia lisää tekijöitä, jotka ovat Majakassa tehneet toimintamallista toimivan ja itseohjautuvan. Tämän tiedon pohjalta voitaisiin selvittää, kuinka tämä malli voitaisiin toteuttaa myös muualla.

Keywords: mental health rehabilitation, inclusion, peer to peer groups, peer-support, Tukiyhdistys Majakka

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1. INTRODUCTION

Mental health problems are the most common reason for disability pension in Finland, and the annual cost for society is prominent. During the last decades, mental health rehabilitation has changed its form, turning more and more open care, where the rehabilitees active role is essential (Lönngvist & al, 2017, 31). World Health Organization`s (WHO) Mental Health Action Plan highlights the need to develop low-threshold services, where service user's active participation and inclusion are supported and promoted, and their resources and strengths are recognized (2013, 32). Mental health is a recourse which requires constant care. A good mental health manifest itself by the ability to solve problems, control anxiety, work, learn, love and care. The core of mental health builds in early childhood where the warmth is a significant component. The society can support mental wellbeing in many ways: Investing in education possibilities, supporting parents, reducing school bullying and loneliness, are all influential preventive acts. (Lönngvist & al, 2017, 31-33, 39: Sameroff & al, 2000, 117)

On the 21st century, inclusion, social participation and peer-support are emphasized themes in mental health rehabilitation and legislation and government programs include inclusion. Supporting communities as well as self-oriented ways to influence, are important acts in establishing inclusion. Low threshold associations are needed to organize activities and thereby increase the individual's experience of inclusion. (Jämsen & Pyykkönen, 2014, 19-21; Elstad & Eide, 2017,2 ; Lönngvist & al, 2017, 31)

In my study, I examined the inclusion from the perspective of the service-users. I concentrated on the peer-instructors, as my working life partner's operations model bases on the activity led by them. In the theoretical framework, I introduce the mental health work in Finland in general, and the history of it. I describe the role and benefits of the third sector providers in Finland. I also discuss the most common mental problems, the causes behind them, and some of the risk factors and preventive acts on a general basis. I discuss the challenges people with mental health issues face, and scientifically proven acts to tackle these issues. Using and measuring the acts, and understanding the need for them, must also be known what good mental health means. These are introduced in the theoretical framework.

The working life partner in my study was Tukiyhdistys Majakka Ry (later on Majakka). My first practice placement among social services studies was implemented in Majakka, and therefore it felt natural to choose Majakka as a working life partner. Majakka is the day centre for mental health rehabilitees located in Helsinki. The purpose of the study was to make the

operations model of Majakka more known and examine the benefits of their strong visitor orientated operations model from the perspective of inclusion. The study was theoretical, and it was implemented as qualitative research. The objective of the study was to produce information about the essential factors that promote inclusion and social participation based on peer-instructors experiences.

2. MENTAL HEALTH WORK IN FINLAND

In a way or another, mental disorders have always been connected to society, and their treatment have been a reflection of the culture and its historical era. (Ihanus, 2019) In Finland, from the 17th century until the end of the 18th, parishes were responsible for taking care of the mentally ill. Back then, illnesses were seen as a punishment and the consequence of the sin. Treatment methods were prayers and repentance exercises. The facilities where mentally ill were kept, were combined mental asylums and house for the poor people. On the beginning of the 19th century, mental hospital and prison were under the same institutions (Ihanus, 2019). At the end of the 19th century, the attention was started to be paid to the brutal conditions, and softer treatments started to emerge. In Finland, the first legislation regarding the treatment of the mentally ill was given in 1840. At the same time, the Lapinlahti mental hospital was opened. Still, on those days, the development of treatments was slow, and coercive measures were used frequently. In the early 20th century diagnostic was progressing, and psychotherapy had begun to be given for patients. (Lönngvist & al, 2017, 25-29).

Since the government had taken the lead of taking care of the mentally ill at the end of the 18th century, it was gradually transferred to municipalities in the 20th century. (Lönngvist & al, 2017, 27-29) Training of professionals specialized for psychiatric care was started at the end of the 19th century. (Forsius, 2011) At the 1930s, brain surgeries were getting more commonly used treatment in psychiatric problems, and also in Finland, these brutal surgeries - where some of the nerve connection in the brain were cut-, were widely used from the 1940s until the 1960s (Forsius, 2011; Ihanus, 2019). At the same time, genetics and racial issues were topical, and the law which enabled the forced sterilization for the mentally ill was also degreed in Finland. This practice was in use until the 1950s. (Forsius, 2011)

Living in difficult conditions are connected to mental health problems, and efforts have been made to alleviate these problems. Charity work, folk civilization, developing childminding and -protection, reducing poverty, unemployment and alcohol consumption, are all effective preventive measures. Efforts to prevent mental health problems were already made in the 19th century, and the Finnish "Sielunterveysseura" (Later "Mielenterveysseura") established at

the end of the 1800s by a doctor of Lapinlahti`s hospital, was probably the first in the world association it`s kind. (Forsius, 2011)

At 1952, Mentally ill law (Mielisairaanhoitolaki) was degreed, and by the law, mental hospital districts and -hospitals ran by municipalities were established. But only in the 90s - when Mental health law replaced the Mentally ill law-, the responsibility of psychiatric treatment was transferred to municipalities. It meant that the municipalities were able to decide how to arrange the treatment and services. Later on it has become clear that this act has caused wide differences between the municipalities when it comes to secure the health care services for inhabitants. Because of these problems, Mieli 2009- program organized by a Finnish Institute for Health and Welfare (THL), began to promote the ongoing social- and health care reformation, which will transfer the responsibility back to the government and provinces. (Lönngvist & al, 2017, 765). With the 1990s amendment to the law -where Mentally ill law was replaced by the Mental health law-, psychiatric care was defined as a part of the wider concept, which among the treatment of mental problems, also included preventive measures written in the legislation. The reformed law also brought psychiatric care alongside other specialized medical treatments. This was a positive change, but at the same time, the responsibility of arranging open care services transferred to municipalities with the lack of adequate reconciliation has led to scattering services and funding (Lönngvist & al, 2017,770).

2.1 Finnish Health Care Service System

Based on constitutional law in Finland, the government must secure adequate social- and health care services for everyone and promote health. (Lönnqvist & al, 2017, 763). The core of the social- and health care system is municipal social- and health care implemented with government`s support. Among the public sector, a private sector is also providing social- and health care services. There is also a broad field of third sector providers offering both paid- and free of charge services. (Sosiaali- ja terveydenhuollon järjestelmä ja vastuut, n.d)

The laws related to social- and health care are prepared and supervised by the Ministry of Social- and Health Care. Preparing reforms, defining of guidelines and promoting the development of services, are also the tasks of the Ministry. (Sosiaali- ja terveydenhuollon järjestelmä ja vastuut, n.d). The responsibility of the organization of social- and health care services lies with municipalities. The municipality can decide whether it is organizing all services required by law, by its own, buying them from other municipalities or private sector providers, or supporting third sector providers. The requirement is that the services must meet the standards expected from the corresponded provider. (4§,13.12.2003/1309; Lönnqvist & al, 2017, 764).

By municipality level, the social- and health care providers are guided and monitored by the Regional State Administrative Agency. They are also granting the licenses for new providers. On the national level, supervising belongs to a Social and Health Licensing and Supervision Agency Valvira. (Sosiaali- ja terveydenhuollon järjestelmä ja vastuut, n.d).

Mental health services in primary health care include basic health care: Child health clinics, health care for students and schoolchildren. The mental health services in primary health care also include preventive acts. These acts are underlined in school health care and child health care clinics, where it is possible to recognize and support the children living in risk conditions. To get the entity functional, development of mental health work requires increasing cooperation with social services. (Lönngvist & al, 2017, 767-769).

By a Mental health law, mental health services also include the development of the living condition of the population to the direction it has a preventive impact on mental health problems (1§, 14.12.1990/1116). These actions include promoting healthy diet and lifestyle, improving living conditions and - environments, reducing unemployment, promoting access to education, reducing school bullying, preventing violent and strengthening the communal safety nets. (Lönngvist & al, 2017, 33-36)

2.2 Rehabilitation in the Third Sector

The concept "third sector" means that it is the third in relation to public organizations and private companies. Third sector association`s principles and mode of action differ from public organizations where public sector`s operations are defined in legislation and lead by government officials. The private sector mainly functions around profitability, while the third sector has its base on citizens voluntariness, altruism and compassion. (Nykäsenoja, 2015, 141-145, 159)

Rajavaara and Lehto underline that to maintain the functioning of individuals, rehabilitation is a necessary activity and therefore plays an important role in well-being, productivity, ability to work and independent living (2013, 6). In Finland, statutory rehabilitation started in 1946. Before that, rehabilitation services were mainly arranged by non-profit-making associations ((Ala-Kauhaluoma, Henrikkson, Saarinen, 2013, 92). These associations got involved in the first negotiations regarding statutory rehabilitation, and since then, they have kept their central position in the field of rehabilitation. Among non-profit-making associations, the third sector is formulated by charity organizations and other non-governmental organizations (NGO`s). Despite the fact that the third sector`s activities are not defined in legislation it has a prominent role in rehabilitation in Finland. (Ala-Kauhaluoma & al, 2013, 92-95). The third sector services and activities became more common in 1980 and

1990, when institutional care was run down. (Nykäsenoja, 2015, 158-159; Ala-Kauhaluoma & al, 2013,93)

Seppelin remarks that the importance of the third sector providers on social- and health care is economically and socially significant. The Finnish model, where the third sector is funded by government and municipalities, has proven it`s functionality, and there is a strong bond between the public- and the third sector. A particularly important role for the NGO´s and other providers in the third sector is to support the most vulnerable and marginalized groups. (2011,5). Almost all third sector providers include preventive work to prevent exclusion (Ala-Kauhaluoma & al, 2013, 93 cited Vuorinen & al, 2007), and they have a major influence in providing social capital to society. This has a positive impact on health and individual`s functional capacity. This also means economic benefits by reducing and preventing social problems and health issues. (Seppelin, 2011,5).

Seppelin notes that the Ministry of social- and health care emphasizes the importance of an individual`s participation, opportunities to influence and possibilities of developing these. Low threshold services, peer-support and voluntary activities organized by the third sector are well supporting these aims. The activities of the third sector associations are helping to create conditions for a good life, and possibilities to contribute to building the society (2011,6).

Third sector providers vary a lot by size and activities. Sports clubs, neighborhood associations, churches, charity organizations, professional organizations, recreational associations, aid foundations and various welfare associations are all examples of third sector operators. Common characteristics in the third sector are volunteering and non-profit civic actions. (Konttinen, 2015). Ala-Kauhaluoma & al are citing Pihlaja (2010) in their study where they note that the third sector creates services in situations where other service providers are absent because of the lack of funding or preconditions for business (2013, 94). Typically, the third sector associations collect their funding from various sources, but the largest donors are municipalities and STEA with income from Veikkaus. (Ala-Kauhaluoma & al, 2013, 94-95)

Overall, third sector operator`s activities are found to be effective and useful: by Mielenterveysbarometri, a yearly research made by The Mental Health Association in Finland, Nearly 80 per cent of the mental health rehabilitees think that with the help of third sector associations and volunteers, they can live a normal life despite their illness (2019,24). According to Hokkanen, over 80 per cent of the responders of her study, think that activities organized by third sector mental health associations speed up their recovery and improve their overall health. Over 90 per cent believes that with the acts of the associations, the stigma linked to the mental health problems can be minimized and attitudes of the general populations turned to more tolerating way. (2014, 24-29).

Nykäsenoja states that the third sector mental health associations are functioning as a therapeutic community for mental health rehabilitees and their family members. An essential part of the third sector associations are peer activity and being together. He adds that in the western world, these therapeutic communities should be seen as a concrete component to take care of people who suffer from mental health problems (2015, 142). The WHO`s Mental Health Action Plan (2013, 10-13) highlights the need to develop low-threshold services where people can access cost-free and without doctor referrals. Where service user`s active participation and inclusion are supported and promoted, resources and strengths are recognized. Elstad & Eide state that the resource base created by low threshold services can support social inclusion and interaction of individuals who have a mental illness (2017, 2-3). By WHO, the development of these kinds of services is also marked as a strategy in promotion for health (2005, 8-10).

2.3 Working Life Partner Tukiyhdistys Majakka Ry

The study is done in cooperation of Tukiyhdistys Majakka Ry. Majakka is a third sector provider in mental health rehabilitation established in 1970. It provides low-threshold activities for mental health rehabilitees, like various recreational groups, discussion groups, peer-support, sport- and exercise groups, as well as affordable lunch which fills the dietary recommendations. (Tukiyhdistys Majakka Ry:n toimintasuunnitelma, 2019)

The main objectives of Majakka`s activities are to reduce loneliness, promote inclusion and social functionality. One of the major goals of Majakka is to create a community for mental health rehabilitees, where everyone's resources are believed and trusted. Majakka`s objective is to be inclusive for everyone involved. This has meant planning and building activities in collaboration with visitors. The aim is to harness the strengths of visitors to the community, and the basis for action is trust in people's abilities. The core of all services and activities is to create inclusion and communality for all participants.

The executive committee of Majakka consists of six members and the chairman. All the members are chosen among Majakka`s visitors every two years, and the exclusive committee is responsible for decision making. It is consciousness choice, that the committee entirely consists of mental health rehabilitees. The chairman notes that this kind of arrangement promotes the equality between the staff members - who are social- and health care professionals-, and visitors. (Tukiyhdistys Majakka Ry:n toimintasuunnitelma, 2019; Kaarna, 2020)

Majakka`s clubhouse is located in northern Helsinki, but it has activities also outside the clubhouse. The base of the group activity is built on voluntary peers. They act as instructors

in the groups and trips and are also participating in daily activities. All the excursion groups are mainly designed and implemented by Majakka`s visitors who have become peer-instructors. Majakka is offering recreation activities and lunch-coupons for peer-instructors. (Tukiyhdistys Majakka Ry:n toimintasuunnitelma, 2019)

Majakka aims to harness visitor`s strengths and abilities for the common good. Group activities rely on voluntary peer- instructors. The possibility to become a peer-instructor is available for everyone who takes part in Majakka`s activities. (Tukiyhdistys Majakka Ry:n toimintasuunnitelma, 2019). Becoming a peer-instructor is a low threshold process, where the visitor brings up his or her willingness and ideas about the possible group activity. Majakka`s staff is making the group activity possible by promoting, supplying the feasible things, arranging the space etc. According to Majakka`s executive manager, a yearly budget for group activity is 6000 euros, but the actual annual cost is less than that. Funding comes from STEA and the City of Helsinki. The common rule for the group's costs is that it should not cost more than 100 euros per month. Most groups in Majakka cost a lot less than that. The most expensive ones are the sports and hobby-groups outside Majakka`s clubhouse. (Wallinheimo, 2020)

3. MENTAL HEALTH

Lönnqvist & al (2017)state that good mental health means a state of wellbeing, where an individual understands his or her abilities, can adjust them into challenges of everyday life, is able to work efficiently and give his or her contribution to the society. Mental health can be seen as a resource that we both use and accumulate all the time. That we would understand the nature of mental health, we need to know what is normal and what is not. What are the elements mental health is dependent on, and on average, how mental health manifests in people's lives? To get the picture of what is normal and what is not, the prevalence of the symptoms is mapped at the population level. A line between a healthy person and a person with a mental disorder is determined by evaluating a person's ability to look after him or herself, social adaptability, and possible symptoms of mental disorder. The boundary between the person with a mental health disorder and a healthy person is always relative, and it is important that the behavior which is the result of the conflicts between the individual and society, or the behavior which is not accordance of the norms followed by some religious, sexual or political views, is not seen as a mental problem unless it is clear that it is a symptom of person's functional ability.(2017, 30-33).

What is good mental health and how its achieved? Which are the factors influencing its development? According to Lönnqvist & al, the nature of mental health is partly indefinable and continuously changing, and the clear definition of what mental health is, cannot be

given. Even so, some of the characteristics of good mental health can be defined: The ability to create satisfying relationships, the ability to interact with others, social participation, the ability to love and care, the ability to control anxiety and tolerate losses when facing difficulties, ability to work and be prepared for life changes, are all essential for mental wellbeing. One of the qualities of good mental health is the ability to experience life fresh and new even thou life has its regular routines. Mental wellbeing is a renewable source, which needs to be constantly taken care of. (Lönngvist & al, 2017, 31-33)

The core of mental health is built in early childhood. Fulfilled basic biological needs are the key factor in developing mental health. Obtaining food, love and physical security in a sufficiently good interaction, as well as the continuity of everyday activities, shape the core of mental health. (Lönnqvist & al, 2017, 31). Warmth is found to be a very pertinent component of the aspects of family interaction, and children whose parent/parents have handled them with warmth and respect while they were infant, are socially competent later in life. (Sameroff & al, 2000, 117). The abilities, personality, and individual`s competencies and disturbances are the results of various states of development. Genetics play a major role, but its relevance is often understood too narrowly. Genes are activated by the impact of the environment and are able to communicate with each other. Also, the impact of environmental factors depends on how strong and how early they have been influencing the development. (Lönngvist & al, 2017, 30-33; Sameroff, Lewis, Miller 2000, 34).

Other significant stages of development are adolescence years when the identity is built. Developmental crises in adulthood require adaptability and capability to find new directions in life. These can be a risk in developing a mental disorder. In addition to individual`s personal traits and abilities, many studies have shown that close relationships and person`s social framework, are factors which support the adaption in sudden changes and setbacks in life. (Lönnqvist & al, 2017, 32). Vuorilehto & al are discussing the importance of safety, equality, meaningful work and social relationships. They underline that mental health can be protected in everyday life situations by reducing school bullying, supporting parents, improve working conditions and alleviating loneliness. (2014, 243-244)

Mental health promotion can be any activity that reduces or strengthens the determinants of mental health. Protective factors for mental wellbeing can be divided into external and internal factors. Good physical health and genotype, self-esteem, ability to learn, problem- and conflict solving skills, good relationships in the early stage of life, social interaction skills, feeling of being accepted and ability to built relationships and maintain them, are all internal protective factors. Addition to basic physical needs, external factors include education possibilities, safe environment, social support, positive role models, employment and functional society. (Lönngvist & al, 2017, 33-34, 39)

3.1 Mental Health Problems

Currently, every 5th adult is suffering from mental health problems in Finland, and a lifetime prevalence is nearly 50 per cent. That means that nearly half of the population suffer from mental health issue at some point in their lives. The estimation is that only around 20 per cent of the people suffering from mental health problems are under proper psychiatric treatment. The most common diagnosed mental health problems are depressive disorders, anxiety disorders, substance abuse disorder and personality disorders. During the last two decades, the number of depressive disorders has been significantly increasing, especially among women. Most mental health problems are associated with general deprivation, low education level, unemployment and being single, while among people living in relationships, they are less common. Mental disorders are the most common reason for disability pension (Terveys 2000, 2002; Lönngvist & al, 2017, 724-727). The decrease in functional capacity and the working years lost because of it generates the highest cost. (Suomalaisten mielenterveys ei ole kohentunut fyysisen terveyden tahtiin, 2018)

Mental health disorders cause a lot of human suffering, decrease in quality of life and functional ability. Depressive and anxiety disorders are on the top among the most impairing life quality- disorders. Mental health problems usually start a lot earlier than other chronic diseases, and often a person with mental health disorder has other overlapping mental issues. (Lönngvist & al, 2017, 724)

In Finland, one of the current problems is increasing inequality: Quality of life keeps improving among many people, but more and more people are left outside of the development. This can be seen by increasing mental problems, especially among people with low-income. Damaging experiences in childhood are the most significant factors for most common mental health problems. It is estimated that if a parent has a depressive disorder, without any preventive acts, the probability that children will have a mental disorder later in life, is around 60 per cent. (Suomalaisten mielenterveys ei ole kohentunut fyysisen terveyden tahtiin, 2018; Lönngvist & al, 2017).

3.2 Loneliness and Exclusion among Mental Health Rehabilitees

Mann & al describe (2017) loneliness as an unpleasant feeling that arises when an individual's desire and wishes about meaningful social relationships, and the actual situation he or she is into, are not in balance. Persistent feeling of loneliness links to eating disorders, sleeping problems, poor overall health and increased mortality, and it is a significant issue in societies

and public health. Loneliness among mental health rehabilitees has studied relatively little. Still, few studies show quite clearly, that loneliness among them is quite a lot more common than it is among the general population. One study showed that as much as 80 per cent of people diagnosed with schizophrenia reported loneliness as a "major challenge" in their lives. (2017)

Elstad & Eide (2017) state that also when living outside the institutions, people with mental health problems likely lack participation in the mainstream society (2017, 2). For several reasons, people with mental health issues are at greater risk of experiencing social exclusion and loneliness. (Mann & al, 2017; Saarni& Pirkola, 2010) Lönngvist & al (2017) underline that many mental disorders are accompanied by poor social- and cognitive skills and a lack of initiative, motivation and energy (2017, 254, 143-148). Saarni & Pirkola (2010) note with reference to Salokangas & all, that unmarried men diagnosed with schizophrenia have the highest risk for exclusion compare to other population groups (2010). Addition to these, general attitudes towards people with mental disorders are often negative. Even thou the attitudes have been getting a slightly more tolerant direction during the last decade, this fact shows well in Mielenterveysbarometri - a yearly research made by Mental Health Association (MTKL). More than half of the population believe that individuals in need of hospital care, are a nuisance for others, and nearly a quarter of the population would not want mental health rehabilitee as a neighbor. Around 30 per cent of the rehabilitees feel that other people avoid them and do not want to get to know them, and nearly half feel that they are stigmatized because of their illness. (Mielenterveysbarometri, 2019, 14-19). Schizophrenia is often accompanied by poor social and cognitive skills, while people with depressive disorders have lost their self-confidence and tend to think maladaptive way about their capabilities and social attractiveness (Lönggvist & al, 2017, 151-152, 254). In their study Mann & all have listed proven methods to reduce loneliness among mental health rehabilitees: With interventions to changing cognitions among lonely people have got results where a person has been able to change their thoughts and behavior regarding social relationships. These interventions have led to increasing social connections. Psychoeducation - where the person is given information about his or her illness and its symptoms-, and training social skills, such as learning body language recognition and improving conversational skills, have had a positive impact on reducing loneliness (2017)

3.3 Inclusion and Peer-support

While institutionalized care and isolation used to be the way mental disorders were dealt with, interaction and inclusion are the current central activities in mental health (Elstad & Eide, 2017, 2-3). Särkelä-Kukko & Rouvinen-Wilenius (2014) describe inclusion as one's

subjective feeling of belonging in the community and society. Trust, commitment and being heard are key factors. Inclusion creates security, justice and a sense of belonging. Possibility to influence in one's own life, self-motivated action and taking the responsibility, are all essential factors in inclusion. (2014, 35-37). Hobbies, organizational activities and work are examples of activities which creates inclusion. Inclusion is also a counterforce for the exclusion. For this reason, it is important to strengthen the inclusion of the marginalized groups (Jämsen & Pyykkönen, 2014, 9-11)

On 21st century inclusion includes in the legislation and government program. The possibility to influence in matters concerning one`s own life, is an essential factor in creating inclusion. Social media has increased the ways of influence. On the other hand, those who are left outside are even more excluded while developing technology (Jämsen & Pyykkönen, 2014, 19). The studies that were the base for “oSallisuushanke Salli”, revealed that supporting the people's communities as well as self-oriented ways to influence, are important acts in establishing inclusion. Low threshold associations are needed to organize activities and thereby increase the individual's experience of inclusion. Receiving recognition and contribute to others increases individual's self-respect and so can forward the rehabilitation. (Jämsen & Pyykkönen, 2014, 19-21; Elstad & Eide, 2017, 2-3). Elstad & Eide (2017) referencing a study made by Yilmaz & all (2009), which was made with people diagnosed with schizophrenia. It showed that for experiencing participation and inclusion, the central factor was the possibility to give something for others. (2017, 3)

Vuorilehto & al (2014) note that the peer-support is often a voluntary and unpaid duty, where people with similar experiences and problems are discussing and supporting each other (2014, 243-244). According to Hokkanen, the peer-support is usually face to face encounters, but different kind of internet-based chat-services and discussion groups have been increasing fast in recent years (2014, 39). Taskinen (2017) notes, that social support is one of the basic human needs, and peer-support - either on face to face or on the internet-, responds to this need. The most important factor in peer-groups is the feeling it gives; that participants can feel included and feel that they are not alone with their issues (2017, 23-25). The study of Hokkanen emerged that the support received from someone who has gone thru similar experiences might have a bigger impact on recovery than any other act made to improve rehabilitation. Rehabilitees who participated in the study found presence and mutual discussion with peers, the most effective form of support. It also seemed that receiving support and help, and giving it to others, made some of the participants more willing to help others also in a broader context. (2014, 20-23).

According to the study of Hokkanen - which examined the opinions of active members of mental health associations-, the most significant change linked to the activities of mental health associations was the increase of meaningful doing. Also belonging to a community and

being heard were perceived important factors. A significant part of the responders (80%<) also mentioned that during their active participation in the mental health association's activities, their relationships to family and friends were improved and the possibility of making choices had increased. New courses to act had been found, and health, happiness and self-worth had enhanced. Over 90 per cent of the responders also stated that being an active member of associations is a good way to build a society. The same number of responders also felt that they are useful as peers, and because of their own experiences they can help others. As a whole, the activities organized by mental health associations appear to be very effective and positive among active members. (2014, 24-27). Peer-groups and the study related to it, have a long history, especially in North- America. In the 21st century, the studies' focus has been on values, inclusion, empowerment, reciprocity and communality. In the studies of peer-groups, experiential knowledge is often highlighted. (Nylund, 2005, 196-197)

Hietala-Paalasmaa & al (2007) note that the handprint of rehabilitees should be seen in all the activity around rehabilitation. The expertise of rehabilitees should be utilized in planning and peer-activity. Respecting one's expertise and knowledge helps individuals to find their strengths and personal goals (2007, 11-12). Peer-groups are often thought as discussion groups, but in practice, they can be anything between sports groups and the groups with specific aims or functions (Hokkanen, 2014, 39 referencing to Nylund, 2005). In her study, Hokkanen found that the peer-instructor is expected to have experience harnessed for the group. Suitable personality traits of the person for the task were perceived as important. One's own experience of overcoming difficulties and a balanced life situation were also raised as meaningful factors. Psychological support, respect, sharing and listening, as well as the possibility to influence were the factors form the core for the peer-groups. (2014, 36-41)

3.4 Communality and Quality of Life

The health-related quality of life is an individual's assessment of his or her social and psychological wellbeing. Life satisfaction means an individual's ability to enjoy his or her own life and oneself. It is strongly connected to good physical and somatic health. (Koivumaa-Honkanen & al, 2001, cited in Saharinen, 2013, 12-13). According to Saharinen (2013), individuals with mental problems are doing poorly in all areas when measuring the health-related quality of life (HRQL). HRQL measures psychological, social and physical domains. In the study of Saharinen, factors related to poo HRQL were the poor financial situation, reduced working ability, low education level, excessive alcohol consumption, dissatisfaction with life, symptoms of depression, psychiatric or somatic diseases and alexithymic personal traits. Major depressive disorder, alcoholism and personality disorders seem to lower the quality of life significantly. It is important to reach the best possible quality of life on the

population level, as the poor life quality is associated with higher usage of health care services, overall morbidity and mortality. By studying the quality of life, it is possible to find factors that can be affected. Examples of the factors can be influenced, are prevention of diseases, management of symptoms and unhealthy habits related to illnesses (2013, 3-4, 10-14). Finnish health politics aims to lengthen the functional ability and life expectancy, reducing the health-related inequalities and secure the best possible quality of life among all citizens. Improvement of the health-related quality of life is already a set goal on the public level. However, the tools to support the people with long-term illnesses, and get them to enhance their living habits, still need to be developed and improved. (STM, 2001, 2003, 2006 cited in Saharinen, 2013, 2). The self-assessment evaluations about one's health and quality of life, made by patients and general populations are essential to reach these goals. The plan of mental health- and substance abuse underlines strengthening the client's position, right treatment and prevention of disadvantages. (Partanen & al, 2010, cited in Saharinen, 2013, 3).

According to the study Terveys-2000, including all age groups, the poorest quality of life was those suffering from mental problems (Terveys-2000; Saharinen,2013, 3). Depression is a significant perpetrator when it comes to low life satisfaction. It is lowering the HRQL more extensively than somatic diseases, and its overall disadvantage at the population level is equivalent to hypertension and diabetes. Personality disorders also significantly lower life quality, as they are accompanied by a lack of functional ability in the emotional area. Saharinen (2013) agrees that it is essential to bring out the perspective of the people suffering from mental problems. This knowledge can be used in health promotion, reducing health inequalities and planning well-functioning interventions. (2013, 4). It is also essential to pay attention to social and physical wellbeing as well as acknowledge people's own experiences according to their mental health and life satisfaction. Doing so also creates inclusion and the feeling of togetherness and increases life quality (Saharinen, 2013; Vuorilehto & all, 2014, 31).

3 THESIS IMPLEMENTATION

3.1 Research Questions and Objectives

The research method I used was qualitative research. I choose a qualitative method because I wanted to find out about the thoughts and opinions of the interviewees. The qualitative method is appropriate, when research questions are defined by questions "how", "what kind

of" or "what". (Nummenmaa & al, 2017, 15-16). The study emphasized the client's subjective point of view.

My thesis aims to make visible Majakka's methods to create inclusion and examine how peer-instructors experience them. In my study, I observed this based on peer-instructors point of view. I particularly emphasized Majakka's strong visitor orientation and peer- agency and the ways these are carried out. To open up the Majakka`s operations model, I also interviewed the staff.

The research questions of my thesis are:

1) How the peer-instructors experience Majakka's operation model of strong visitor orientation, how the staff is experiencing it?

2) What is the meaning of social participation for peer-instructors of Majakka?

3) How does peer agency promote inclusion?

3.2 Focused Interview

The structure of the focused interview places between a form interview and an open interview. The focused interview proceeds more loosely than a form interview, but the frame is a particular, pre-designed topic, and so it is more structured than an open interview. Participants interpretations are taken into account, and there is also a room for free speech. The topic and the sub-topics are discussed freely. The focused interview is a good choice to acquire material when collecting information about less known phenomena. The interview requires that the topic and the situation of the interviewees are well understood. The questions and the selection of interviewees should be well considered. Interviewees should be chosen based on their information about the subject (Teemahaastattelu, n.d). Hirsjärvi & Hurme (2011) state that the focused interview is suitable when it is known that the interviewees have experience of the topic or situation and the person responsibly of the study has made him or herself familiar with the phenomenon in the study. Interviewees experiences and definitions are highlighted. The essential matter in a focused interview is that the interview builts around on focal themes. (2011, 11-14).

The focused interview can include several types of questions. Typically, the questions divide into fact-based questions and opinion-based questions. Regarding the types of questions, all the questions must be open-ended. (Hirsjärvi & Hurme, 2011). In my interviews, I have divided the questions between the main questions and complementary questions. Main questions are written in black and complementary questions in green (Appendices 2,3,4).I also left space for follow-up questions, which were not written down in advance. Hirsjärvi & Hurme (2011) note that the focused interview requires flexibility from the interviewer. The questions should be seen as a guideline to the interview rather than something which needs to be performed in a certain order or using the exact words written in advance. (Hirsjärvi & Hurme, 2011, 44-45, 64-65)

Hirsjärvi and Hurme (2011) are underlining that the interviewer should be clear about his/her aims for the interview on the planning stage (2011, 68-69). I aimed to find out more about the subjects of my research questions. I chose the focused interview as a data collection method because I wanted to discover informants` thoughts, experiences, opinions and values. I aimed to limit the subject around the chosen themes, so for this reason focused interview was a more suitable method to collect data for my study, than an open interview or a form interview.

For this thesis I interviewed four peer instructors, chairman of the executive committee and two staff members. Two of the peer-instructors had lead peer groups for more than five years, and two of them had been instructors between one and three years. The chairman had had his position a little bit over two years. All peer-instructors guided more than one group. The groups included discussion groups, sports groups and other hobby groups. Addition to these, a chairman has his discussion hour every week. Interviewees were between age 35 and 61. Two of them had been participating in activity arranged by Majakka less than three years, one of the interviewees had been involved ten years, and two for almost twenty years. At the time of the interviews, excluding staff members, all the interviewees were without gainful employment.

Except for the interviews with the staff, all interviews were conducted as individual interviews. The interviewees were given a cover letter before the interview (Appendix 1). I made one visit to the Majakka's clubhouse to promote my thesis. On this visit, I got four interviews scheduled. Two others I got via football club. The interviews were carried out in the Majakka's clubhouses premises. During my visit to Majakka, and when I arranged the interviews, I told the interviewees that taking apart is voluntary and they can cancel the interviews already scheduled. They were also informed about the anonymity. All interviews were recorded and transcribed later. With the Microsoft Word, using text form Calibri, font 12 with 1,5 spacing, I got 28 pages transcribed text. Participation in the interview was

voluntary, and the recordings were destroyed after the transcription. All interviews took place as planned, and they were all implemented as face to face interviews.

Executive director and organization secretary answered the questions about the operations model, how it has been created and how visitors are a part of it. The chairman opens the operation model a bit more and tells about the decision-making process in the association. This interested me because it is connected to the strong visitor orientated operations model Majakka based on its mission statement. In the peer-instructor`s interviews, I concentrated on the peer-agency.

3.3 Content analysis

The basic analysis method in qualitative research is content analysis. In the content analysis, the attention is in the context of words and the links between them. (Tuomi & Sarajärvi, 2018). For this reason, I chose content analysis as an analyzing method. I aimed to examine the certain factors from the content through the interviewees' interpretations, and for this purpose, content analysis was a suitable analyzing method.

Data collected by the focused interview was analyzed by using content analysis. In content analysis, data is reviewed as a whole and sealed up into a simple and easily understandable form. The content to be examined must be limited based on the pre-decided research questions. Everything else should be left outside the study. (Tuomi & Sarajärvi, 2009, 91-92)

According to Tuomi & Sarajärvi (2009), the results can be analyzed with an objectively and systematically. The data is usually in text form, but information can be collected and also shown in quantitative form. The analyses aim to create a clear verbal picture of the phenomenon—the qualitative processing bases on interpretation and logical reasoning (2009, 103-104).

Inductive content analysis has three stages (Figure 1). On the first stage, the content is transcribed and listened carefully. After this, the transcribed text is read, and original expressions are found and underlined. Original expressions are then listed, and links between the expression are searched. This stage is called reduction. On the second stage, which is called clustering, links between expressions are examined, and subclasses are built based on the original expressions. Abstraction is the third stage where conclusions and main themes form. (Tuomi & Sarajärvi, 2009, 108-109)

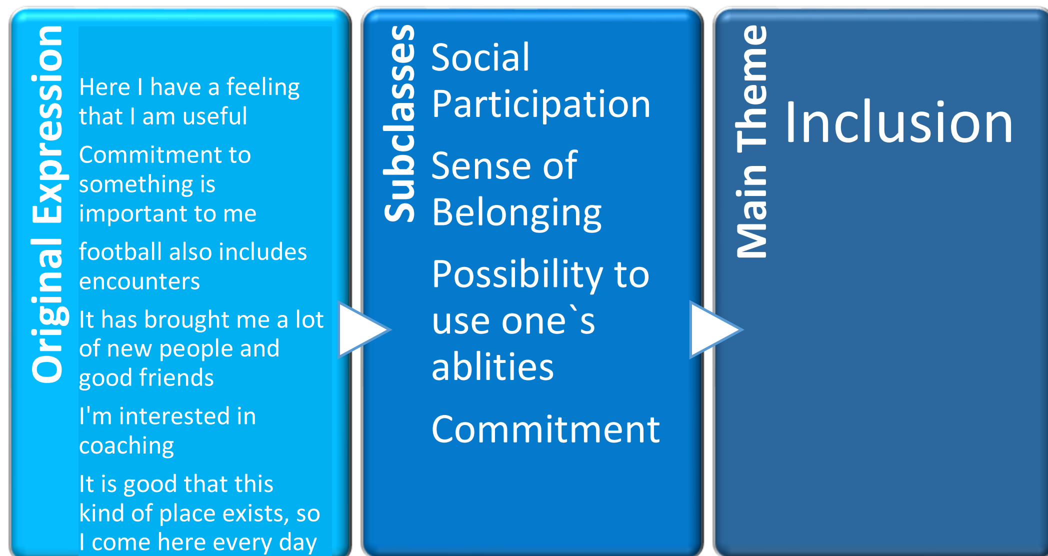

Figure 1: Example of the content analysis in my study

To implement the content analyses, I first listened and transcribed the content. Then I printed out the content and read it carefully. Next phase was to read it again and look for original expressions interested me and underline them. I used different colors to mark the original expression I had chosen to examine. The research questions were guiding the expressions I picked up under the examination. The second stage was to summarize the original expressions and build subclasses. Twelve subclasses were found in the content. On the third state, based on the subclasses, four main themes were standing out. I decided to make a separate content analysis from the staff members interview, as their position differs from the other interviewee's positions. I examined the material based on the same research questions. Six subclasses and one main theme were found from the content. These results are opened up more in chapter five.

3.4 Ethical Considerations

With my study, I followed the good research ethics and practices mentioned in TENK's guide. These are:

- Honestly, general precision and carefulness are considered in research. Research and evaluation methods need to comply with the criteria of scientific research and ethical sustainability, transparency and responsible scientific communication. Other studies

are taken into consideration so that they are respected, and references to publications are made appropriately.

- Other studies must be taken into consideration so that they are respected, and references to publications are made appropriately.
- The study is planned, implemented, reported and recorded as required in the requirements of scientific knowledge.
- The necessary research permits are obtained, and ethical pre-assessment has been made.
- The research project agrees on the rights, authorship principles, responsibilities and obligations of all parties, and the issues of access rights and retention; in a manner acceptable to all parties. (TENK, 2012, 6-8)

Based on these principles and guidelines, I arranged a private space for the focus interview and made sure that answers were handled anonymously. I also paid special attention to the client's right for self-determination, especially among the clients who might have had delusions due to their illness. Due to this reason, I did not put any extra pressure for anyone taking part in the interview. All the interviewees were told that the participation was voluntary. At the beginning of the interview, all participants were asked permission to record the interviews.

For validity and reliability, the study follows the ethical guidelines mentioned in the previous section. I followed the good research principles, built the study and analyzed the results by using evidence-based methods.

4 RESULTS

Based on the content, four main themes were found. These were Inclusion, Peer-support, Challenges and Meaningful Things to Do (figure 2). The subclasses found under the main title of Inclusion were a sense of belonging, social participation, commitment and possibility to use one's abilities. Under the Peer-support are discussion with others, positive approach and helping other people. Personal chemistry, psychological problems and the feeling of inadequacy went under Challenges, and pleasant activities and exercise were found important activities Majakka enables. These themes and subclasses are opened up more in chapter five.

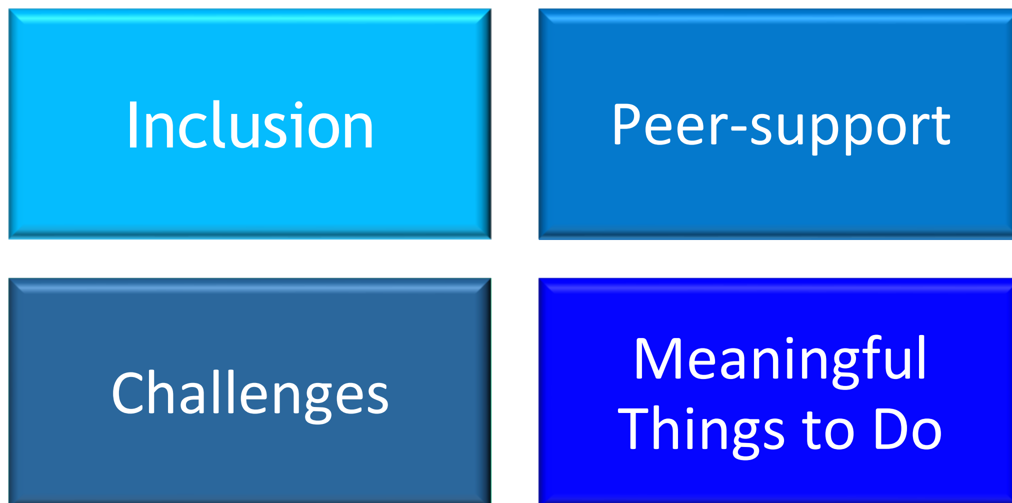

Figure 2: Main themes

4.1 Inclusion

The factors of Inclusion were raised quite clearly from the material (Figure 3). Sense of belonging and social participation seemed to be the main reasons for peer-instructors to participate in the activities and take the responsibility to plan and implement group activities. Based on the content, the peer-instructors seemed to be committed, and the possibility to use one's abilities and strengths came up in discussions. The material also shows that the peer-instructors trust themselves and their abilities, although they also experienced inadequacy feelings from time to time.

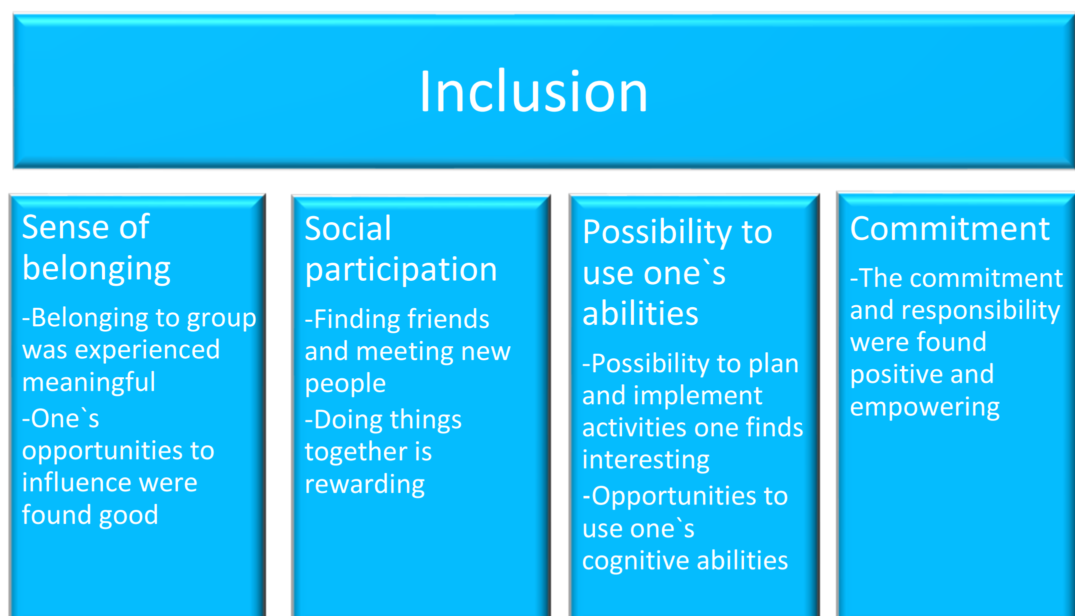

Figure 3: Results of the study; Inclusion

Being part of the community and being responsible for their groups, gives a structure to the day. Few interviewees said that without their groups and other activities in Majakka, they would probably just stay home alone. All in all, the social contacts and belonging to the group, were seen something meaningful and essential ingredient for a good life. All interviewees also mentioned that as a peer-instructor, they are able to use their abilities and strengths.

“I think my job is to do my part, carry my card in a pile and help us mental health rehabilitees, that we are doing something together.”

The feeling that one is doing something useful for the community, taking responsibility and doing his or her own share, was found empowering. It also was the factor bringing content and structure to one`s life.

“This has given content and meaningfulness to my life. These groups are important to me”

“Perhaps the best thing is to get some responsibility and be with people”

Content to one's daily life was something which was mentioned by all interviewees. Peer-agency was experienced to bring content and meaningfulness. The responsibility showed in a positive light, and some of the interviewees mentioned it's being the best part of leading a peer-activity.

4.2 Peer-support

All peer -instructions mentioned that they had got new friends during their participation in activities of Majakka. The atmosphere in the groups and Majakka's clubhouse was experienced a low threshold place to talk about all kind of issues. Three of the interviewees mentioned that it is easier to be and talk with the people who have experienced a similar situation, and one of the interviews mentioned that there are certain kinds of subjects she feels that cannot be brought up anywhere else.

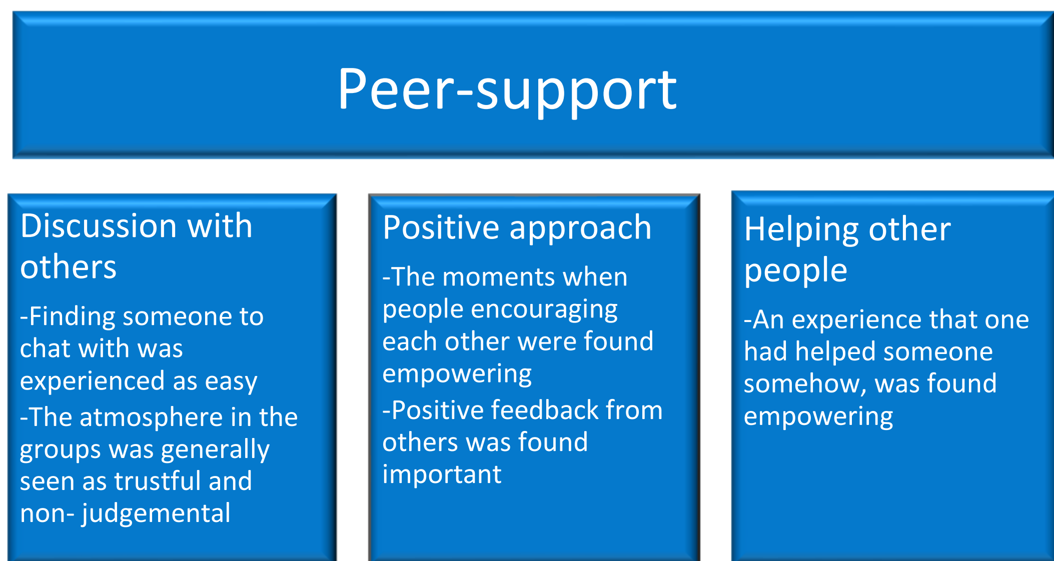

Figure 4: Results of the study; Peer-support

The feeling of being useful and helping other people were also matters which stand out from the content. Two of the interviewees said that the best part of being a peer-instructor is positive feedback from the participants and the feeling that they have done something useful and helped other people.

> *"It feels very nice when I have managed to get people in a good mood"*

The feeling of being useful seemed to carry some of the interviewees forward and increase their sense of belonging.

4.3 Challenges

Leading a peer-activity requires responsibility and commitment, but based on the material, the challenges experienced in leading groups seem to be quite minor (Figure 5). All interviewees mentioned that psychological problems are likely to be a challenge in general, but only one interviewee perceived it as a challenge related to the tasks she has as a peer-instructor. All the other interviewees did not experience to be so in their own situation as peer-instructors.

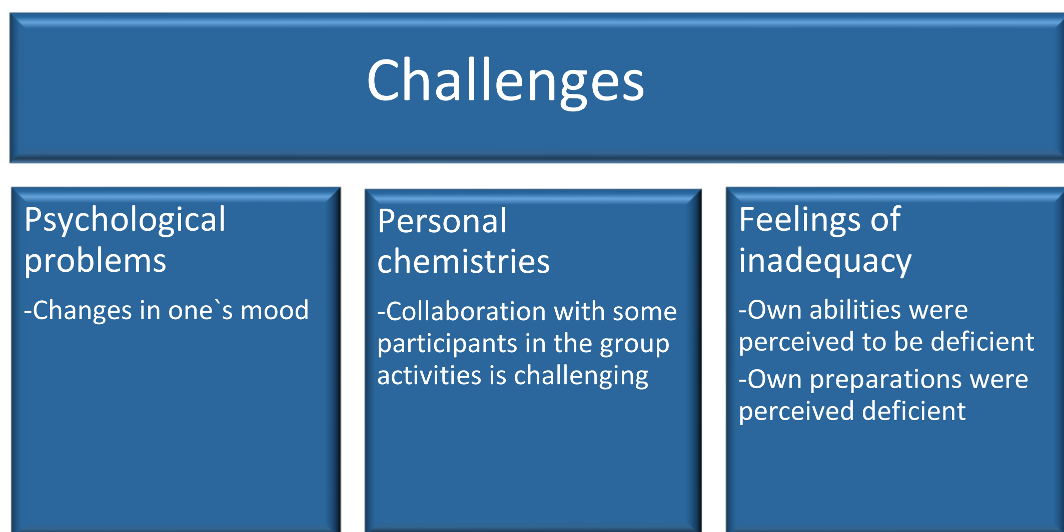

Figure 5: Results of the study; Challenges

Except by one interviewee, everyone agreed that the personal chemistries and communication issues were a challenge. Some interviewees experienced them as a bigger problem than others, and to some extent, powerlessness was felt related to this challenge. On the other hand, communication issues and dissenting opinions were also perceived as a chance to develop one's abilities to sort out conflicts. One of the interviewees mentioned that quite often there are situations where he has to be the one to sort out conflicts between other people. He has found this challenging time to time, but also beneficial as he has been able to use his social skills.

To some extent, feelings of inadequacy were experienced by all the interviewees. By some, such feelings were mainly related to poor preparation. One of the interviewees experienced that she lacks some of the essential abilities needed to lead a group. In general, feelings of inadequacy seemed to be related following experiences: Some of the participants had not felt comfortable during the activities, or some of the participants were not committed to the

group; their participation had been occasional, some might have left in the middle of the activity, or there are participants in the groups who do not get along with each other.

4.4 Meaningful Things to Do

All the interviewees pointed out, that because of Majakka, they have meaningful things to do (Figure 6). Two interviewees mentioned that activities they either lead by their selves or take apart as a participant are essential factors to have structure and content on their days. By some of the interviewees, leading and taking part in activities and spending time in Majakka`s clubhouse, were experienced as compensation for working life.

Figure 6: Results of the study; Meaningful things to do

Based on the content, possibilities to exercise was perceived as important. Three out of four peer-instructors led exercise group activities, and all of them were taking part to some. One of the interviewees underlined the possibility to exercise the best part of being a peer-instructor. The importance of exercise was generally agreed by interviewees.

“I wanted to play frisbee-golf myself, so I started the frisbee-golf group here”

"That there is some place to go and something to do"

Some of the interviewees experienced that because of Majakka, they can practice such an exercise they like, which would not necessary be the case without Majakka making it possible. Peer-instructors perceived Majakka as a low threshold place where one can go for lunch, participate in activities, or just spent time instead of being home alone.

5.5 Staff Members Interview

In discussion with the staff members, one main theme and six subclasses were found. Subclasses were the sense of belonging, the possibility to use one's abilities, social participation, commitment, trust and peer-support. Although I made the peer-support one of the main themes in the content analysis with other interviewees, I now decided to set it under the main theme. This was because the peer-support as a subject was not as much discussed with the staff as it was with the other interviewees. It is also something which is connected to inclusion, which was the main theme standing out from the content. (Figure 7)

"It is something which is carrying people forward, that here they can participate"

Peer-groups in Majakka are something which staff members rarely meddle with. Partly this is because there is no need, but there is also a conscious decision on the background: They want to keep peer-groups as visitor's own thing. Staff members rarely have had a need to intervene because of some problems in the groups or promote the groups for getting more peer-instructors. They underline that the system is working smoothly without interrupting. In fact, they have had quite the opposite experience, as there have been occasions where someone outside of Majakka have asked that if he or she could start a peer- group in their premises. When it comes to group activity, the staff role is mainly to support the activity by enabling it. All the ideas come from the visitors, and for example, this year several new groups have been started. The peer-instructors were described as being motivated and committed to the groups. They believe in themselves, and they're generally thinking that they are good in what

they are doing. Overall, Majakka's visitors were found very active and committed by the staff members. For example, the visitors have painted the clubhouse's walls.

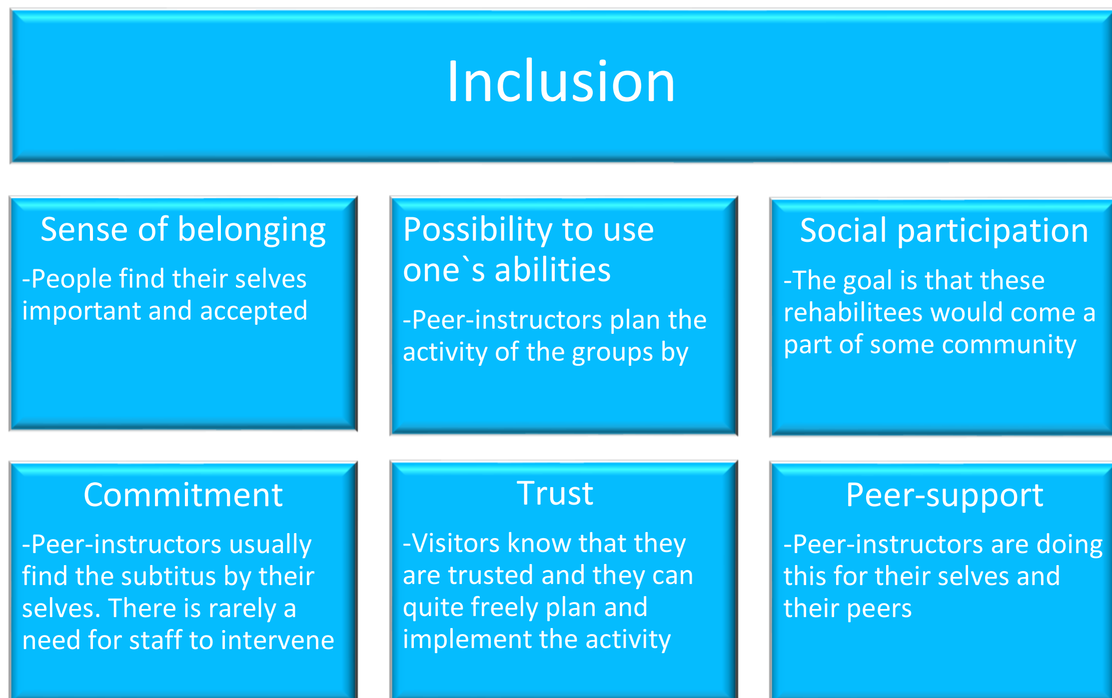

Figure 7: Results of the study, staff members interview

Social participation is one of Majakka's main goal: That the mental health rehabilitees would come as a part of some community where they are accepted and valued. This kind of sense of belonging and social participation was believed to bring the empowerment and meaningfulness in life. This was also believed to be the biggest benefit peer-instructors get by being responsible for planning and implementing the group activity.

“we are confident that things go smoothly here”

The phenomenon of mutual trust stands quite clearly out from the content. There seems to be the trust for people's abilities, and staff members also think that visitors are the best experts when it comes to arranging rehabilitating activities. Also, for this reason, Majakka is buying very little services from outside. They are rather using their visitor's expertise.

“Our visitors know that here they can set up a group on a low threshold basis, and it is their kind of activity, which we hardly meddle with”

The whole idea of the Majakka started originally from peer-to-peer meetings established by the group of mental health rehabilitees been in institutional care. They wanted to set up an association based on peer-support, where professionals would not be that much involved. That has been the base for Majakka`s operations model, and in recent years it has also been the direction where the activity has developed. This factor was underlined to be one of the main operating pillars of Majakka: Give freedom for visitors to plan and implement the activity. In discussion with the staff, came up the perspective, that the groups led by professionals do not meet the reality of the participants on the level the peer-groups do. That between professionals and rehabilitees lies a huge gap when it comes to a reality and life situation. This kind of gap does not exist in the groups led by peers. This factor was believed as being one of the reasons why Majakka has so many peer-groups and why they are functioning well.

5 CONCLUSIONS AND DISCUSSIONS

Although the data of my study was small, it showed quite clearly that being a peer-instructor supports inclusion with increasing social encounters, peer-support, feeling of belonging and the possibilities to use one's abilities and strengths. It also seemed to promote a healthy lifestyle by adding the exercise and dietary recommended lunch to peer instructor's everyday life. Mirroring the experiences of peer-instructors and Majakka's mission statement, I found both to be well in balance with the WHO's mental health action plan, which highlights the importance of the service users active participation where their strengths are recognized (2013, 10-13). I found it interesting that Majakka has been running with this kind of operations model long before it has been recognized as an effective way to promote rehabilitation process, at the time, where institutionalized care was still the norm. It seems that Majakka has been the pioneer. The strong visitor orientation of Majakka was somehow familiar to me, as I made one of my practice placements there. Still, the positive effect which leading the group activity seems to bring to the peer-instructors, was quite astonishing. I realized that I had not understood the impact of this kind of activity on the level I understand it now. Although I was familiar with the fact, that trusting people's abilities and giving them the freedom to use them, is empowering, during my practice, I was still rather little bemused how little professionals were used in Majakka's group activities. Nor I

understood, how they had managed to get so many peer-instructors willing to lead the groups.

Against my expectations, the challenges mentioned according to groups led by peers were quite minor. With the very few exceptions during the recent six years, staff members could not name problems regarding peer-led activity. Challenges experienced by peer-instructors were slight as well. When asked about the challenges, it was interesting that psychological reasons were mentioned every time, but those were generally not experienced as a challenge. Perhaps this tells about similar prejudices I myself also had: The mental problems would be the great challenge to plan, implement and commit to such a group activity. Based on the content, this seems to be only bias, not very often the reality. Another challenge which often rose from the content was personal chemistries. In my opinion, this could also be seen as evidence that probably the groups have a quite strong atmosphere of trust if people are bold enough to express their thoughts and opinions like they seem to be.

The learning process has also crystallized me the meaning of trust. This seemed to be the fundamental ingredient to explain why this operations model is working so smoothly in Majakka. Staff members seem to have strong trust for peer-instructors and other visitors. Their genuine opinion was that the rehabilitees know the best what is good for their rehabilitating process, and what kind of activity other rehabilitees want to join. During the discussion with the staff, this sounded quite simple, but I believe it requires a lot. It is not always easy to trust, and although because of the structure of the executive committee of Majakka - where the staff members do not have the main right of decision-, I think being so trustful and not to intervene, requires a considerable amount of understanding and knowledge. In my opinion, this demands strong understanding, that this is the way that benefits the rehabilitees probably more than professional's advice or guiding. It requires good professional self-esteem to be able to make oneself unnecessary this way.

In the 21st century, many studies and theoretical knowledge supports the benefits of the operation model built around peers. Majakka has been established rather by coincidence than thru of some plan or action based theory. In the future, it would be interesting to find out, could this kind of operations model to be built somewhere where the rehabilitees are not so active, and perhaps the activities are led by professionals. Which would be the central ingredients and steps to build a similar community than Majakka has, where people are able to use their abilities, feel valued and useful regarding their mental problems. For example, would it be possible to move such an operation model to a mental health rehabilitees housing services, where inhabitants are often quite inactive? The executive director described this mostly self-guided smooth flow of Majakka's peer-agency, as the kind of the phenomenon, that she cannot explain. Future studies would be interesting to examine this phenomenon a

little more deeply, chop it into parts and perhaps build a kind of operations model which could be used as a guideline.

Probably the biggest contribution I have got during this process of my thesis is the deepened understanding of the importance of trusting one's abilities, regarding his or her status of health, or previous choices in life. This process also allowed me to see Majakka` s operations model's main pillars by the rehabilitees` point of view and by so gave me some valuable information about promoting inclusion. I believe this gained knowledge will benefit me a lot in my future professions. I also got myself familiarized with the Finnish Health Care Service System, as well as the significant role of the Third Sector providers in Finland. I have got myself familiar with qualitative research and content analysis. I got some experience with the focused interview and got familiar with other interview techniques as well. These might benefit me in my future studies. Partly because of my previous profession in business, I cannot pass the obvious fact, that in addition the benefits regarding promoting inclusion, how cost-effective Majakka's operations model is. Regardless of the small yearly budget, plenty of different group activity is implemented on a daily basis.

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Appendix 1: Cover letter

Saatekirje 16.9.2020

Kiitos osallistumisestasi haastatteluun! Haastattelu on osa sosionomi opintojeni opinnäytetyön laadullista tutkimusta, ja haastateltavat pysyvät anonyymeina. Palkkioksi vaivastasi saat Majakan kahvilipukkeen. Haastattelut järjestetään yksilöhaastatteluina Majakan tiloissa. Kysymykset koskevat Majakan toimintaa ja vertaisohjaajuutta. Aikaa haastatteluun kuluu enintään 1 tunti.

Nauhoitan haastattelun haastateltavan ajan säästämiseksi. Nauhoitukset ja muistiinpanot hävitetään viimeistään 31.12.2020. Valmis opinnäytetyö julkaistaan Theseuksessa (www.theseus.fi), ja se on julkinen.

Maiju Rundman, maiju.rundman@student.laurea.fi

Appendix 2: Questions for peer-instructors

Kysymykset vertaisohjaajille

Ikä:

Pääkysymykset/ Tarkentavat kysymykset

Kuinka kauan olet ollut mukana Majakan toiminnassa?

Kuinka kauan olet toiminut vertaisohjaajana?

Mikä sai sinut lähtemään vertaisohjaajaksi?

Mitä teet vertaisohjaajana? / Mitä vertaisryhmää/ryhmiä ohjaat tällä hetkellä?

Oletko ohjannut vertaisryhmiä aikaisemmin? Minkälaisia?

Mitkä ovat vertaisohjaajuuden parhaat puolet?

Minkälaisia haasteita on tullut vastaan?

Millä tavalla uskot vertaisohjaajana toimimisen tukevan hyvinvointia?

Millä tavalla se on edistänyt omaa hyvinvointiasi?

Minkälaisten piirteiden uskot olevan hyödyllisiä vertaisohjaajana toimimiseen?

Mitä Majakan vertaistoiminta on tuonut sinulle?

Miten löysit Majakan?

Mikä Majakan toiminnassa on parasta?

Muuttaisitko jotain?

Appendix 3: Questions for staff members

Kysymykset henkilökunnalle

Pääkysymykset/ tarkentavat kysymykset:

Kertoisitteko omin sanoin vertaisohjaajuuteen perustuvasta toimintamallistanne?

Miten se on syntynyt?

Onkos sitä kehitetty tietoisesti?

Ketkä ovat osallistuneet mallin kehittämiseen?

Onko mallia arvioitu jollakin tavalla? Milloin ja miten?

Onko idea malliin saatu jostakin muualta, vai millä tavoin se on alkanut?

Miten vertaisohjaajaksi ryhtyminen käytännössä tapahtuu?

Mitä siihen kuuluu?

Tarjoatteko vertaisohjaajille jotakin?

Ovatko kaikki halukkaat päässeet vertaisohjaajaksi?

Onko vertaisohjaajia ollut joskus vaikea saada?

Yritättekö jollain tavalla motivoida kävijöitä vertaisohjaajiksi?
Miten suhtaudutte, jos joku haluaa perustaa vastaavanlaisen ryhmän, joka ei esim. edellisenä vuonna ole toiminut? kannustatteko silti kokeilemaan?

Mitkä ovat kävijälähtöisen mallin (Missä toiminta perustuu vertaisohjattuun toimintaan jne.) tavoitteet?

Mitkä uskotte olevan tämän toimintamallin parhaat puolet asiakkaan näkökulmasta?

Mikä tässä toimintamallissa on haastavinta?

Mitä toimintamallin ylläpitäminen vaatii henkilökunnalta?

Minkälaisia ongelmia tulee/on tullut?

Appendix 3: Questions for the chairman of executive committee

Pääkysymykset/ Tarkentavat kysymykset

Kuinka kauan olet ollut mukana Majakan toiminnassa?

Miten löysit Majakan?

Kuinka kauan olet ollut mukana Majakan hallituksessa?

Kuinka kauan olet toiminut puheenjohtajana?

Mikä sai sinut lähtemään puheenjohtajaksi?

Mitä puheenjohtajan tehtäviin kuuluu? Saatko työstä rahalista korvausta?

Kerro omin sanoin Majakan hallituksen toimintatavoista. Millä tavoin hallitus/puheenjohtaja valitaan? kuinka usein? ketkä voivat hakeutua hallituksen jäseniksi? Entä puheenjohtajaksi? Ovatko nämä samat toimintaperiaatteet olleet Majakan perustamisesta asti? Onko Majakan hallituksella ja puheenjohtajalla täysi päätäntävalta, vai miltä osin palkattu henkilökunta osallistuu päätöksen tekoon? Minkälaisista asioista keskustelette/päätätte kokouksissa? Kuinka usein hallitus kokoontuu?

Onko näin vahvasta kävijävetoisuudesta (Jossa hallitus muodostuu kokonaisuudessaan kävijöistä) jotain haittaa? Entä mitkä ovat parhaat puolet?

Onko Majakan hallituksella ja puheenjohtajalla täysi päätäntävalta, vai miltä osin palkattu henkilökunta osallistuu päätöksen tekoon? Minkälaisista asioista keskustelette/päätätte kokouksissa?

Millä tavalla uskot vapaaehtoistyön tukevan hyvinvointia?

Millä tavalla se on edistänyt omaa hyvinvointiasi?

Minkälaisia haasteita puheenjohtajan tehtävän hoitamisessa on tullut vastaan?

Mitä Majakan toiminta on tuonut sinulle? Onko puheenjohtajana toimiminen tuonut jotain lisäarvoa?; Oletko pystynyt vaikuttamaan asioihin enemmän?; lisää vastuuta?

Mikä Majakan toiminnassa on parasta?

Muuttaisitko jotain?