Training in Psychiatry for Community Health Workers in Nepal

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Abstract

In a previous paper the early stages of development of a community of a mental health programme were described. This paper documents in more detail the training aspects of that programme. A core block training is described along with aspects of in-service training and on-going supervision. A number of issues, that the training experiences have highlighted are discussed.

Introduction

In a previous paper the early stages of development of a community mental health programme, were described. (1) The need to integrate mental health into primary health care was highlighted.

At the present time, training of health workers of all levels in Nepal contains little neuropsychiatry, although the extent of serious mental illness in the community is comparable in size to the leprosy and TB combined. (2-4) The development of mental health care in the community therefore necessitates further training of health workers in this subject.

In several other countries, mental health programmes have addressed this need for supplementary training for their community health staff, and as a result a limited range of brief training blocks have been developed. (5-7) One of the pioneers in this area has been the Community Mental Health Unit of the Department of Psychiatry, WIMHANS Bangalore, from whom this programme has drawn many of its ideas. This paper describes an attempt to develop a relevant training package for the Nepali situation.

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The core training block will be described in some detail, though it should be noted that the community health workers involved already had some exposure to mentally ill persons before their training. After training, an on-going programme of supervision and inservice training was continued, in the context of the community mental health service.

Training aims

The following were the principle aims of the training programme:

- (a) To become aware of the mental health issues existing in the community.
- (b) To become aware, and confident that most mental health problems can be managed within a primary health care setting.
- (c) To become aware of existing community attitudes to mental health and how mentally disturbed people are treated in the community.
- (d) To be able to recognise the target psychiatric conditions including the keeping of adequate records and to be able to supervise others doing such work.
- (e) To be aware of preventive measures available for mental health issues and how they can be implemented, including the use of public education programs.
- (f) To have a knowledge of and an ability to initiate the basic treatment of the target psychiatric conditions, including the major drugs where this is appropriate according to training, counselling skills involving both patient and family, and follow up techniques.
- (g) To have a knowledge of the other facilities available within the community for treatment of mentally ill persons and appropriate referral methods.
- (h) To be able to manage psychiatric emergencies.
- (i) To seek positive changes in their attitudes to the mentally ill.
- (j) To become aware of the importance of psycho-social factors in the presentation, causation and management of general medical patients.

Description of block training

(a) Structure

Eight or nine days of training were given to each of three groups of staff from the community health programme, who were relieved of their normal duties for the period of the training.

Participants were expected to attend from 9 to 5 each day and it was felt important that staff of equivalent levels were trained together. The first group consisted of Health Assistants, the second of Community Medical Auxiliaries and one senior Auxiliary Nurse Midwife and the third group of one District Public Health Nurse, a Community Health Nurse and a Health Educator.

The content of the training was modified with each group according to their work.

The structure of the programme had a strong clinical emphasis allowing for at least three hours clinical attachment each day, either at the Langankhel mental hospital or in the community.

Class room teaching was based around cases actually seen with case reporting, group discussion, and role plays being used.

Participants were also encouraged to recount and reflect on personal experience of mental illness from their own communities.

(b) Content

Topics covered included an introduction to brain function and understanding of causes of behaviour; development of health worker/patient relationship and psychiatric history taking and examination; prevalence of mental illness and methods of identification; psychiatric assessment of general medical patients; practical aspects of the management of the mentally ill within a community setting; community education about mental health issues; rehabilitation of the mentally ill and on psychiatric syndromes deemed priority:

- Psychosis
- Depression
- Epilepsy
- Mental retardation
- Neurosis

In each of these priority conditions emphasis was given to identification within the community; aetiology; important referral criteria; simple treatment methods; follow up including rehabilitation; prevention and community education.

The days training on mental retardation was conducted at Nirmal Bal Bikas Kendra School for the mentally retarded, Banaswor.

One or two open sessions were also used. Subjects for these being suggested by course participants. This was found to be a useful means of extending flexibility of content according to the needs of the participants. Subjects requested included alcoholism, personality development, puerperal mental illness, drug abuse, and menopause.

Clinical attachments in the first course were entirely at the Government Mental Hospital and Nirmal Bal Bikas Kendra without whose help the training could not have taken place in this form. In the two later courses attachment also included mental health clinics within the Lalitpur community health structure.

Training materials

Simple aids such as black-board, pictures and a model of the brain were used. However the most important aid was a manual of mental health which was specifically prepared for use within a block training structure. This manual includes basic information on all the major topics covered and is available in both English and Nepali. A clinical emphasis is maintained including the use of short case histories and important points are highlighted.

Evaluation

Each group of participants were given written assessments to complete before and after training. These assessments were taken from Community Mental Health Unit NIMCANS' material and comprised six short case histories each of which was followed by nine questions, covering diagnosis and reasons for it; possibility of community based treatment or need for referral to specialist facilities; treatment issues of both counselling and medicines; and prognosis.

A clinical evaluation was also undertaken after training including the participants assessment of a psychiatric patient and his subsequent recommendations for management along with discussion on the psychosocial aspects of the case.

Assessment was continued in field visits following where use was being made of material covered.

Daily feedback on the structure and content of the course was also sought from the participants.

On going training programme

As the community mental health programme includes weekly mental health clinics these provided a focus for on-going clinic supervision and training of curative level staff, by the team psychiatrists.

Standard record keeping for mental health patients having been instituted, this allowed for monitoring and assessment of work done by the health workers at other times.

Team psychiatrist's regular visits incorporated motivation to previously trained health staff to carry out community education programmes in mental health and simple training programmes for lower levels of staff.

Especially when thinking of remoter areas it was felt helpful to circulate a monthly mental health newsletter. The aims of this are to revise basic information, to maintain interest and enlarge understanding by the use of new material and to allow a forum for the exchange of questions and ideas.

Occasional update seminars were also arranged.

Discussion

On the whole, participant's interest and motivation for the block training was encouragingly high. They varied in their level of health education background and previous experience which necessitated some adaptation on the part of teaching staff.

Some difficulties were encountered in attempting to simplify the material for instance in clearly defining rather complex diagnostic groups. Some revision in the course material was undertaken as these difficulties became evident.

Discussions about community attitudes to the mentally ill were found to be an excellent way of revealing personal attitudes of the participants in a non threatening manner and allowed for considerable attitude change. The open sessions were also found to be very valuable in allowing exploration of areas of particular work or personal interest to the participants.

The need for the participants to learn themselves to become trainers of lower levels of staff was also stressed. During the community education session of the course, role play was used to allow each participant the opportunity to develop their own educational skills. In addition Health Assistants from the first training block were used to assist the team psychiatrists in the second block training.

The programme of on-going training could not have taken place without the practical issues of supervision, update seminars and provision of basic psychotropic drugs.

Two areas that can be further developed in future training sessions are firstly relevant audiovisual aids, and secondly an increasing emphasis on community based clinical exposure.

Conclusion

This mental health training was seen as a rewarding exercise for both participants and trainers. It is felt that although this training block could occur in isolation, to maximize the benefits it needs to be a part of a larger programme.

While recognising the needs for certain modifications in different situations this training programme is offered as an appropriate and replicable for community health worker training in mental health.

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Note:- Training Manuals in Nepali and English are available on request.

Appendix

Day 1	9.00-11.00	Introduction / pre training assesment.
	11.00-	Orientation to Mental Hospital.
	11.30- 1.30	Mental illness - prevalence and identification.
	1.30- 2.30	Lunch
	2.30- 4.00	Brain and behaviour
	4.00- 5.00	Approach to the mentally ill (part I)
Day 2	9.00- 1.00	Approach to the mentally ill (part II)
	10.00- 1.30	Clinical attachments
	1.30- 2.30	Lunch
	2.30- 5.00	Psychosis
Day 3	9.00- 10.00	Psychosis
	10.00- 1.30	Clinical attachemants
	1.30- 2.30	Lunch
	2.30- 5.00	Epilepsy
Day 4	9.00- 10.00	Mental Health Assessment of General Medical Patients.
	10.00- 1.30	Community Mental Health Clinic.
	1.30- 2.30	Lunch
	2.30- 5.00	Depression
Day 5	9.00- 10.00	Review
	10.00- 1.30	Clinical attachments
	1.30- 2.30	Lunch
	2.30- 5.30	Neurosis
Day 6	9.00- 10.00	Introduction to mental retardation
	10.30- 1.30	Program at school for the mentally retarded.
	1.30- 2.30	Lunch
	2.30- 5.00	Mental retardation
Day 7	9.00- 10.00	Rehabilitation and community education
	10.30- 1.30	Clinical attachments
	1.30- 2.3g	Lunch
	2.30- 4.00	Practical aspects of health post management
	4.00- 5.00	Open session
Day 8	9.00- 10.00	Post training assessment
	10.30- 1.30	Clinical assessment
	1.30- 2.30	Lunch
	2.30- 3.30	Medications, referrals, records
	4.00- 5.00	Discussion of program and review

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