The Impact Of Mental Health Education On The Knowledge And Attitude Of The Peripheral Health Workers Of Dang

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Abstracts: Background & Objective**:** Mental health needs of a society are ideally met by integration in primary care. Under the District Mental Health programme, Surat is the nodal centre for Dang, a tribal region. In order to make medical care available to the patients in need, it was vital to train the peripheral health workers of the region. The aim was to provide mental health education to the peripheral health workers of Dang and assess its impact on their knowledge and attitude regarding mental health issues. Methodology: 150 peripheral health workers were posted in the Department of Psychiatry in batches of 20-30 each for a 7-day, extensive, in-house training. The improvement in knowledge and attitude was assessed by a pre-post semi-structured questionnaire and structured feedback. Results: The training resulted in a significant improvement in scores related to clarification of myths. The knowledge and attitude related to mental health issues improved significantly and the participants reported that they were sensitized by the training and would identify and refer patients to the visiting psychiatrist. Conclusion: The training in mental health could bring about improvement in the knowledge and attitude of the peripheral health workers. However, to what extent does this change reflect in actual practice, needs to be ascertained. [Shah N. D NJIRM 2015; 6(6):6-10]

Key Words: district mental health programme, health workers, mental health education, training

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Introduction: Mental health is an important aspect of health worldwide, as around 14 % of the global burden of disease is attributable to neuropsychiatric conditions. It cannot be over-emphasized that there can be no health without mental health.[1] The best way to meet the mental health care needs of any society, globally, would be to integrate mental health into primary care.[2] In India, the District Mental Health Programme (DMHP) was started under the National Mental Health Programme in 1996, and is presently being implemented in 123 districts of the country. The aim of this programme includes training of a mental health team at identified nodal institutions, increasing awareness, reducing stigma and provision of services for early detection and treatment of mental illness in the community.[3]

Dang is a tribal district of Gujarat, nearly 150 km away from Surat. It is covered with high hills and dense forests. Under the DMHP, the Department of Psychiatry at Government Medical College, Surat is the nodal centre for Dang; and hence responsible for the provision of mental health services. One consultant psychiatrist along-with a resident doctor used to go to Dang on a weekly basis for out-patient consultation and for giving certificates of mental illness and mental retardation. However, it was found that there was poor awareness related to mental health issues in the tribal region. One of the reasons could be unavailability of a psychiatrist. As per the WHO-AIMS report, the total number of human resources working in mental health facilities or private practice per 100,000 population in Gujarat was only 1.43.[4] The tribal people sought help from the traditional faith-healers and/or resorted to herbal medications. There was a need to bridge the gap between the visiting psychiatrist and the people residing there. It was thought that this would be achieved by training the peripheral health workers (PHWs) of Dang-Ahwa so that they would identify the patients with mental illness in their community and convince and guide their families to seek psychiatric treatment.

Material and Methods: After taking the due permissions from the District Health Officer of Dang-Ahwa, 150 PHWs were posted in the Department of Psychiatry in batches of 20-30 each for a 7-day in-house training, spread over a period of two years. The training module consisted of the following:

1. Interactive sessions on various psychiatric disorders with demonstrations of doctor-patient interviews and role-plays.
2. One-one interaction of the PHWs with indoor psychiatric patients over the 7 day period, with case formulation and presentation on the last day.

3. Demonstration with explanation of the procedure of electro-convulsive therapy (ECT).
4. Observation of group-therapy sessions for patients suffering from Alcohol dependence and psycho-sexual disorders.
5. Guidance on how to use IEC (Information, Education, Communication) material provided to them. (Flip-charts and a manual on mental illness in Gujarati).
6. A quiz on the last day, using case vignettes and description of symptoms.

It was decided to assess the effectiveness of the training by a pre-tested, semi-structured pre-post questionnaire, which was filled up by the participants, after a written informed consent. The questionnaire consisted of demographic data, eight true-false type questions to check for myths related to mental illness and twelve open-ended questions to assess the knowledge and attitude towards mental illness. Additionally, a structured feedback was taken at the end of the training.

The data was analysed using Excel and SPSS version 16. Paired samples t-test and chi-square test were used as tests of significance, and a p value of 0.05 was considered as statistically significant.

Results: A total of 150 PHWs were trained. Their age ranged from 20 to 57 years, with an average of 37 years. 66 of them had high school education, 41 had higher secondary education, 35 were graduates and 6 were post-graduates. Their experience ranged from 1 to 36 years, with an average of 11 years.

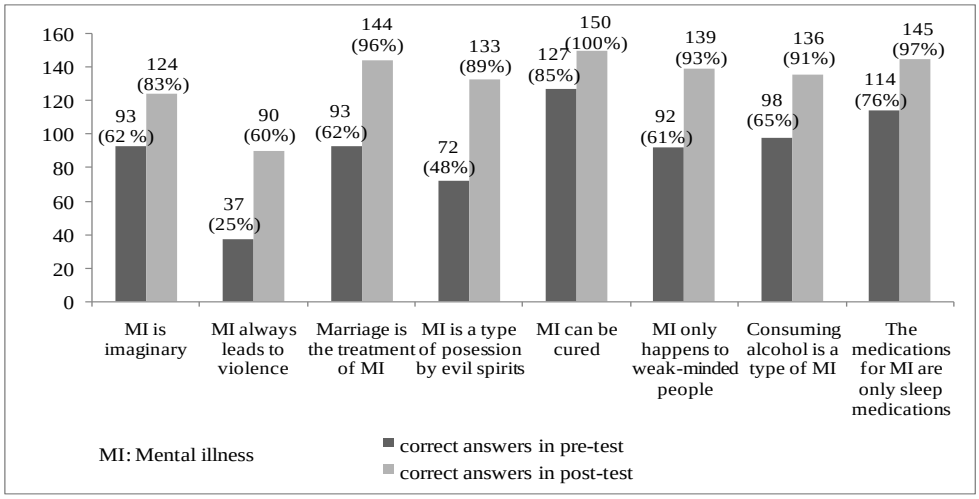
There was enthusiastic participation from all the PHWs in the training and the quiz programmes. There were eight statements in the section of myth clarification which were to be marked as true or false; the results of which are summarized in Table 1. There was a statistically significant difference in the scores of the PHWs before and after the training, indicating its effectiveness in myth clarification.

Table 1: Pre and post-test scores in myth clarification (N=150)

Pre-test: mean, SD	Post-test: mean, SD	t-statistic	p value
4.84, 1.99	7.07, 1.06	12.66	P<0.05

On comparing the number of health-workers who answered the question pertaining to each myth correctly, before and after the training period, there was a statistically significant difference in each of the eight questions. All the myths could be corrected as a result of the training. These results are depicted in Figure 1.

Figure 1: Number of PHWs who gave correct answers (true or false) in the section related to myths, before and after the training. (n=150)



The frequent answers by the PHWs to the questions regarding the knowledge and attitude related to mental health issues before and after the training are summarized in Table 2 . The feedback received on the last day of training was very encouraging, in each of the batches. The PHWs reported that they learnt a lot and that they would go back to their villages, get in touch with those who they thought had a mental illness and bring them for treatment to the visiting psychiatrist at the district hospital.

Some of their verbatim reports, which bring out the essence of the feedback are as follows:

"We commonly saw but did not know about mental illnesses… We already have a few patients in mind, who we now know have mental illness. We shall bring them to the hospital for sure"

"We hesitated to talk to people who behaved abnormally, now we feel there is no harm in talking to them, in fact, they are the ones who need help"

"Our people are extremely superstitious…Now we shall show them the right way"

"We will discuss mental health issues in our group meetings in the village and spread awareness"

"We were scared of ECT and thought that it was inhuman, now we know that it's good for the patients"

"We will create groups of people who consume alcohol and explain them the hazards"

"As we interacted with the patients ourselves, and saw them improve gradually, we feel confident

Table-2 : Summary of the knowledge and attitude of PHWs regarding various mental health issues before and after the training

S.No	Question	Before training	After training
1	What is mental health?	Mental well-being, being happy and peaceful.	Complete mental well-being that ensures optimum social and occupational functioning
2	What is mental illness?	A person goes mad, the brain stops working, the person behaves abnormally.	Feelings of anxiety/depression/ abnormal behavior making a person distressed or dysfunctional.
3	Name some mental illnesses	Mental retardation, madness, mental helplessness, craziness	Could name all the illnesses discussed during the training
4	What are the symptoms of mental illness?	Roaming on roads, collecting litter, begging, stealing, throwing stones, disrobing, talking irrelevantly.	Could describe illness-wise symptoms of the disorders taught during the training.
5	How would the patient be identified in your society?	'crazy', 'mad', 'screw has gone loose', 'unsteady mind', victims /culprits of black magic /evil eye, possessed by ghosts, witches or evil spirits	They may be having schizophrenia, mania or mental retardation.
6	According to you, what causes mental illness?	Unbearable shock, addiction, family stress, excessive anger, injury to the small brain.	Could explain the bio-psycho -social model of causation of mental illness
7	In your village, how would (pre)/ should (post) a mentally ill person get treated?	Faith-healing, herbal medications, branding, beating, tying up, making them smell chappals/onion (in case of epilepsy)	Ideally the person should be treated with medicines, psychotherapy or electroconvulsive therapy
8	What would you do if there was a mentally ill person in your village?	We would behave sympathetically, offer food, shelter and clean clothes	We would seek a doctor's opinion and get him/her treated.
9	Name some medicines used in the treatment of mental illness?	Could not name any.	Could name a few specific medicines, which were described during the training.
10	What does ECT mean?	To give shock therapy to the patients who are behaving abnormally	Could mention that it is an effective, scientific treatment, of giving electric current for 1-2 seconds under general anaesthesia and muscle-relaxation
11	Is treatment possible by	By talking affectionately, reassuring,	Taking history, convincing for

	way of talking? How?	consoling, understanding their problems and sympathizing.	treatment, stress reduction, psychoeducation, individual and group psychotherapy
12	What do you want to learn (pre) /what did u learn (post) from this training?	We want to learn about mental illness and its treatment	We received a detailed understanding of mental illness and its treatment.

It was noteworthy that the participants of two batches volunteered to give feedback by unique performances. One batch wrote a folk-song on mental health issues in Dangi language and sang it on the last day and another batch enacted a small skit on mental illness portraying a 'before and after' scenario of a patient with schizophrenia in their village. This conveyed that the training could sensitize them towards issues related to mental health.

Discussion: The most common myth encountered in the PHWs before the training was that mental illness always leads to violence, followed by the myth that it is a type of possession by evil spirits. Such false beliefs may be responsible for the discrimination and stigma faced by the mentally ill. It may also be the reason why the family seeks treatment by faith-healers who they believe would help in getting rid of the evil spirits.

A high level of stigma towards the mentally ill has been reported in various parts of India.[5,6,7] A study conducted by Jadhav S and colleagues comparing the stigma towards severe mental illness in rural and urban India shows that stigma is more in the rural community, with a punitive attitude towards those who are mentally ill.[6] This stigma acts as a barrier in seeking treatment; and ensuring mental health literacy, cultural competence and family engagement may be ways to overcome this.[8]

The training intervention involving a hands-on experience with the patients over a period of time brought about a significant change in the PHWs with respect to the myths of mental illness. Dharitri R and colleagues have shown in their study that there existed stigma towards mental illness, more in the community members than in the care-givers of mentally ill; and that it could be significantly removed by an intervention package consisting of psycho-education, poster exhibitions, question-answer sessions, distribution of printed materials and street plays.[7]

The questions related to knowledge and attitude revealed that before the training, the PHWs had inadequate knowledge regarding mental illness and its treatment, and their attitude was more suggestive of sympathetic behavior rather than a help-giving, guiding and directive one. They were willing to learn more about mental health. In other countries also, it has been reported that the front-line health care providers either have no training in mental health, or are desirous of more training and support;[9] and, inter-professional training in rural primary care has been found to effectively meet the community needs.[10]

After the training, the knowledge of the PHWs improved; they could describe the symptoms of various mental illnesses and felt confident in identifying and referring patients. An integrated review of 25 mental health education programmes by Brunero S and colleagues suggested that the knowledge, attitude and skills of general health professionals increased after the educational intervention in most of the studies, however, the programmes that involved supervised clinical practice, role-plays and case scenarios were found to be more effective.[11]

An educational intervention for clinical depression for the village health guides in rural India has been reported that enabled them to identify and assist in the treatment of depression, with ongoing training and supervision.[12] Mental health education of health-workers in Bangalore resulted in improvement in the participants' ability to recognize a mental disorder in a vignette, and reduced participants' faith in unhelpful and potentially harmful interventions. There was evidence of a minor reduction in stigmatizing attitudes also.[13] In China, even a single day workshop was found to be effective.[14] However, an intervention in Brazil showed that though knowledge and attitude improved after the training, it was not associated with a consistent improvement in the recognition or management of mental health problems. The authors speculated that instabilities in the local context may have been responsible.[15] Thus, it becomes vital to take feedback after a few months of the training, regarding the actual work happening at the grass-root level; and

further requirements for training and support. Only then, the larger goal of improving mental health service would be met.

Conclusion: A mental health training at a tertiary care centre, with a hands-on experience with the patients, witnessing various modalities of treatment and interactive sessions conducted by psychiatrists with the demonstrations of doctor-patient interviews and a variety of role-plays were effective in improving the knowledge and attitude of the PHWs. It was also effective in correcting myths, removing stigma, and in instilling trust and confidence. This re-inforces the importance of supervised field practice in mental health education. However, the number and type of referrals made by the trained PHWs would be the true indicator of change in practice of the PHWs based on the training, and that would mark the true success of the programme.

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