Original Article

The rationale and guiding principles to design a psychiatric curriculum for primary care nurses of India

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Abstract

Background: The National Mental Health Survey reports a huge treatment gap for all mental disorders. There is an acute shortage of mental health professionals in India. Hence, there is a dire need to support task-shift interventions by nurses in providing non-pharmacological interventions for persons suffering from mental health issues. The traditional psychiatric nursing curriculum emphasizes nurses' knowledge and skills rather than their competency in providing mental health care. We designed an innovative, digitally driven, modular-based primary care psychiatry program for nurses (PCPP-N) to incorporate mental health with physical health and emphasize redesigning nursing practice. In this paper, we discuss the rationale and guiding principles behind designing the curriculum of PCPP-N. **Discussion:** The PCPP-N program is based on nine guiding principles to provide skill-based, pragmatic, and feasible modules of a higher collaborative care quotient (CCQ) and translational quotient (TQ) that are essential for upskilling primary care nurses. In this program, nurses are trained through telemedicine-based 'on-consultation training' augmented with collaborative video consultations. A tele-psychiatrist/tele-psychiatric nurse will demonstrate how to screen, identify, and plan treatment for patients with psychiatric disorders from patients coming for general medical care using the manual Clinical Schedules of Primary care psychiatry Nursing (CSP-N). The CSP-N manual includes a screener, simplified diagnosing guidelines relevant for nurses and primary care settings, nursing management, pharmacological management, and related side effects, counseling, and follow-up guidelines. This program helps the nurses in identifying the most commonly prevalent adult psychiatric disorders presenting to primary care. **Conclusion:** This PCPN curriculum contains pragmatic modules with higher CCQ and TQ. This curriculum is dynamic as the learning is interactive. Upskilling primary care nurses in integrating mental health with physical health may reduce the mental health burden. Further, the policymakers and administrators plan to integrate mental health along with physical health in national health programs.

Keywords: Curriculum, guiding principles, India, nurses, rationale, primary care psychiatry

Introduction

The Global Burden of Disease Study 1990–2017 reported that mental disorders were the second leading cause of disease burden in terms of years lived with disability (YLDs) and the sixth leading cause of disability-adjusted life-years (DALYs).

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Received: 09-05-2023 **Revised:** 28-06-2023
Accepted: 29-06-2023 **Published:** 30-09-2023

Access this article online

Quick Response Code:

Website: http://journals.lww.com/JFMPC

DOI: 10.4103/jfmpc.jfmpc_775_23

How to cite this article: Ohri U, Paul J, Vijayalakshmi P, Govindan R, Manjunatha N, Kumar CN, *et al*. The rationale and guiding principles to design a psychiatric curriculum for primary care nurses of India. J Family Med Prim Care 2023;12:2114-9.

It poses a serious challenge to health systems, particularly in low-income and middle-income countries.[1] Mental disorders have always been a low priority compared to communicable diseases and non-communicable disorders, such as cancer or cardiovascular disease in India. Human and financial resource allocation for mental, neurological, and substance use disorders has traditionally been much less than the proportion of burden attributable to these disorders, resulting in extensive treatment gaps. There is a need to expand mental health services in India. Looking at the socio-cultural and demographic diversity across the states of India, we need the policies and interventions to be appropriate to all contexts. This will only occur if mental health care tasks are undertaken by varied non-specialist health workers, including those responsible for primary health care. Therefore, it is vital to train primary care nurses, which helps them in identifying and referring people with mental disorders to appropriate mental health services. Primary care nurses will be present to identify and refer the people with mental disorders for primary care physicians for early mental health interventions. This in turn reduces the treatment gap and improves positive health outcomes.

Primary care mental health provision is not a new phenomenon. Managing mental health and mental illness in primary care has been steadily increasing as health policy has moved to deinstitutionalize people with mental illness from hospitals into the community.[2] Primary health care is the first point of contact with individuals, families, and communities in health systems. Therefore, primary care is a precious point of delivery of community-based interventions. The WHO Mental Health Gap Intervention Guide (WHO 2010) supports non-mental health specialists to task-shift in interventions in non-specialized health care settings so that mental health care is delivered to a larger population. The mental health GAP materials contain ample referrals to psycho-social interventions, but in practice, these often prove to be unfeasible within general health care settings without additional human resources. It is, therefore, necessary to invest in human resources to produce health interventions of high quality. Such investments must ensure that the proper categories and numbers of health care staff, such as primary care nurses, are trained and maintain their productivity, quality, and competency. However, integration of psychiatric care in primary health services is still facing challenges. A systemic review demonstrated that the most frequently reported barriers to integration of mental health services into primary health care include a) attitudes regarding program acceptability, appropriateness, and credibility; b) knowledge and skills; c) motivation to change; d) management and/or leadership; and e) financial resources.[3]

Our focus is to change the delivery design through better links between health care services and community resources and improve the management and coordination of these services. The long-term objective is to incorporate mental health with physical health and emphasize redesigning practice, including functions of the existing health workforce. With the increase in the need to integrate physical and mental health services to optimize treatment opportunities, we must distribute the responsibility for mental health care across the health workforce.[4] The dispersal of mental health responsibilities can be done by engaging generalist primary care doctors and nurses. They can be trained to provide initial assessment, refer to specialist care as required, collaborate with specialist services, and deliver services to those requiring lower-level care.[4] Nurses can play a significant role and provide support in early intervention, screening, and monitoring to identify people at risk of mental health disorders and targeted appropriate care for those living with mental health disorders. Inter-disciplinary team-based approaches synchronized across segments of the health system enhance effective management of chronic disorders. Coordination of care (with inter-sectoral collaboration and facilitation of access) results in patient-centered care. There is also evidence that care coordination benefits both patient care processes and patient outcomes.[5] There are 1.5 lakh wellness centers under the Ayushman Bharath Health Infrastructure Mission across India. The majority of the Community Health Officers (CHOs) appointed in these centers are nurses, who can provide basic psychiatric nursing care at the community.

A specialized primary care psychiatry program was designed, innovated, and implemented by NIMAHNS Bengaluru across India for primary care doctors.[6] This program was designed based on 10 rationale and guiding principles discussed elsewhere.[7] Authors tend to believe that nurses are one among the four pillars of primary care workforce. Based on this experience, authors describe the rationale and guiding principles to design a psychiatric curriculum for primary care nurses with respect to working culture of India. In this paper, primary care nurses refer to registered nurses and registered auxiliary nurse midwives (ANMs) working at Health and Wellness Centers (primary health centers and sub-centers) with minimum qualification of auxiliary nurse midwifery.

Training location

The conventional method of organizing a training program for nurses is unquestionably at higher health centers or tertiary care institutes. Nurses from different work areas and geographical locations travel to these institutes for training purposes. Although there are better facilities at higher centers, moving from the workplace hinders routine clinical practice and involves time and effort. Moreover, their training and environment are different from their real work environment during the training period. Nurses work in various clinical areas, and their training requirements differ accordingly.[8] Suppose the organizers shift the training location to their working area, where the nurses work with general patients. It ensures a lesser amount of interruption in their routine practice and provides an opportunity for nurses to get exposure to how they can apply what they have learned in training. This method develops their skills and also helps to boost their confidence to work with psychiatric patients. The onsite training is better accepted among the nurses as it saves their time and effort. Training experts can also tailor their teaching and

training activities according to the requirements of the nurses and their working environment.

Training methods

Generally, if we look at traditional learning methods, they focus on class room teaching methods (CRTs) such as didactic lectures and presentations. The trainers plan them, and mostly, the learners do not play an active role in the training process. There are advances in teaching methods such as case discussions, real-time and recorded patient interviews, role-playing, demonstrations, and clinical visits. While all these systems are successful in some ways, the literature does not conclusively point to which training mode is best. Engaging the learners in training can be one positive factor.[9,10] We need to understand that adult learners prefer to be a part of the learning process rather than taught. They need to perceive training as something that will improve their skills and knowledge as individuals. Adult learners like to control their training or play a role in it. We are talking here about nurses who have already completed their primary nursing education and have an established working pattern. Changing or adding something new to these patterns requires time and effort. We need equal support of nurses to implement such training programs, and we have to be ready for the resistance that we might face from their end. That is why it becomes more important to involve them in the training process. These training programs follow a top-down approach without exploring the functioning of primary health care service delivery.[3] Ultimately, this does not result in any changes over a long time. The CRT method is more successful for improving knowledge rather than building skills and confidence. The training programs conducted for short periods do not provide continuous clinical support and provide no feedback.

In the new curriculum, we introduce on-consultation training (OCT) physical and tele variants (state it is being implemented this innovative work among primary care doctors, cite few articles of ours) and the live training of nurses on how to screen and plan to manage patients with psychiatric disorders. In this method, a tele-psychiatrist/tele-psychiatric nurse will train the nurses in a primary care hospital setting through video consultation. They will demonstrate how to screen, identify, and plan treatment for patients with psychiatric disorders from patients coming for general medical care using the manual Clinical Schedules of Primary care psychiatric Nurse (CSP-N). The training will also involve counseling the patient and the family and referring them to the Medical Officer. The nurses will also be trained to follow up a patient and use the manual to assess and manage side effects. This OCT can also be done by a Medical Officer trained in primary care psychiatry.

Integrate the curriculum within the routine practice of nurses

A curriculum for primary care nurses should be simple and easy to understand and apply and should be such that it can be easily integrated into their routine clinical practice.

Identification time

Stress and burnout due to workload are common in nursing.[11] Nurses in primary care are involved in various activities like organizing health camps, maintaining records, and providing nursing care. When we try to add to their responsibility, it should be such that it does not take extra time or effort to integrate psychiatric care into their clinical routines. The criteria for identifying and screening patients for psychiatric disorders should be short (as short as a few minutes), simple, culturally appropriate, and less time-consuming.

Developing a straightforward management approach

As discussed, the identification criteria for primary care nurses should be brief and straightforward; the next step for a nurse would be to diagnose the patient. The curriculum includes classifying psychiatric disorders into common mental disorders (CMDs) and severe mental disorders (SMDs). It incorporates easy-to-follow diagnostic guidelines for all disorders. When the nurse has diagnosed the patient, the next step would be to focus on nursing management of the diagnosed psychiatric disorder. The curriculum involves nursing management, which has an emphasis on non-pharmacological management. The curriculum includes general and specific disorder-related counseling, management of side effects, and follow-up guidelines. For this purpose, authors developed CSP-N.[12]

Focus on the adult population in the beginning

The curriculum is planned such that the initial focus is on the adult population. Most of the studies focus on the adult population, and there are very less data about the presentation of the child population at primary care in India. The children presenting at primary health centers with psychiatric disorders have a complex presentation and are challenging to diagnose. They require a multi-modal treatment beyond the level of primary health care providers. Several studies conducted in India indicate that adults constitute a significant part of health service users in primary care.[13-15] All prevalence studies of psychiatric disorders at primary care are focused on adults. Once this curriculum achieves reasonable success, we plan to integrate childhood psychiatric disorders.

Synchronizing psychological interventions with prevalent practice of medication first approach

In India, people believe only medications to be the cure for any disease at the community level, and a hospital visit must end with prescribed medications. The patients at the primary care level are mainly prescribed pills that get along with community people's perception. While this can work well for most disorders, when we discuss psychiatry, psychological interventions are the first choice of treatment according to standard guidelines at the primary level.

The ideal choice for treating psychiatric patients in primary care is to shift from existing pill-based treatment to a combination of medications and simple brief interventions and counseling

for prodromal, mild, and mixed presentations. Although psychological interventions are suggested to be the first line of treatment at primary care, it becomes difficult due to a lack of workforce. Another important aspect is the lack of insight in the Indian population regarding psychological interventions. The acceptability of psychological interventions as the only treatment seems beyond reality.[16] The attitude of Indian patients toward psychotherapy and counseling is stigmatized. People do not consider counseling as a treatment, and it is considered mere talking. To change the attitude, we will have to begin with increasing awareness of our primary care health professionals regarding counseling. Nurses and other primary health professionals can act as a force of change in the attitude of patients. The attitudinal change will happen only over time, but this step can be the beginning of it. Counseling can be incorporated as an everyday practice into nurses' routine along with PCDs providing pharmacological treatment. The curriculum aims to make psychological interventions and counseling a vital aspect of psychiatric disorder treatment at the primary care level. The curriculum will involve cultural and linguistic adaptations and simplification of the original psychotherapy methods.

Focus on the higher prevalent psychiatric disorders in primary care

The principal focus of psychiatric training programs is SMDs. In contrast, if we look at the National Mental Health Survey, it reports a higher prevalence of alcohol (4.6%) and tobacco use disorders (13%), along with CMDs (3.5%) compared to SMDs (less than 1%). Global Burden of Disease Study from Indian states (1990–2017) had reported the higher prevalence of CMDs (3.3%) over SMDs (0.4%).[1] Epidemiology of psychiatric disorders among the general population in India suggests that alcohol and tobacco disorders are the highest, followed by CMDs, and SMDs are the last. *In the primary care population,* CMDs are highly prevalent, as reported in various studies between 17 and 46%. Around 30% of the patients attending *general medical care* also have co-morbid CMDs. Patients in primary care rarely seek treatment for psychiatric disorders.[17] They generally present and seek help for physical symptoms like disruptions in daily activities, sleep disturbances, fatigue, and body aches. Several times, it is seen that even when patients with psychiatric complaints visit a hospital, the psychiatry aspect is not looked upon due to a lack of awareness or knowledge. Sensitizing nurses to these symptoms of psychiatric disorders would help in early recognition and management. The PCP-N curriculum is designed to focus primarily on the commonly prevalent illnesses. It includes alcohol, tobacco disorders, and CMDs on priority. In CMDs, a triad of depressive, anxiety, and somatization disorders is included. Among anxiety disorders, only the most prevalent anxiety disorders at primary care, such as generalized anxiety disorder and panic disorder, are added to the curriculum.

Point of care manual

Nurses have efficient exposure to psychiatry in their undergraduate curriculum. They learn both theoretical and practical aspects of psychiatric nursing. Although the nurses have gained the required knowledge and skills, we try to integrate psychiatry into their routine practice in non-psychiatric settings. Psychiatry care is usually not focused upon in general health care settings. To make psychiatric care an integral part of regular care, we need to generate awareness among the nurses and add to their knowledge and skills. We do not have any simplified psychiatry manuals for nurses working in general health care settings. We need a manual that briefly, concisely, and straightforwardly explains the psychiatric concepts. A screener for screening psychiatric patients from general patients is also essential. The screening tool must be such that it takes minimal time to screen patients and does not add to the nurses' workload. The primary care psychiatry curriculum consists of a brief and concise point of care (usable at the time and place of patient care) manual called "Clinical Schedules for Primary care psychiatry" (CSP) for the use of nurses. The manual includes a screener, simplified diagnosing guidelines relevant for nurses and primary care settings, nursing management, pharmacological management, and related side effects, counseling, and follow-up guidelines. The CSP-N manual is adapted from the CSP manual for primary care doctors.[18] Similarly, authors developed CSP-N and implemented among primary care nurses.[12,19]

To empower primary care nurses to identify and screen patients with psychiatric disorders within their general practice

Nurses undergo training in psychiatric care during their academic program graduation, but they lose touch with psychiatry as they get posted in different clinical areas. They might still have retained the knowledge, but they lack the skills required to provide psychiatric care. Even if they work in psychiatric settings, their work gets limited to medication administration. We aim to change the approach to identifying, screening, referring, and follow up. While working in general settings, nurses identify cases with possible psychiatric issues, screen them, and refer them to the primary care doctor. This can be the first big step in integrating psychiatric services into their general practice. The curriculum likewise allows them to screen patients, plan treatment, provide basic counseling, and prepare a follow-up plan.

Outcome indicators

There is a need to develop real-time skill-based, pragmatic, and valid outcome indicators to assess the curriculum's effectiveness and training methods used for nurses. Trainee nurses will have to undergo eight criteria-based formative evaluations throughout the year, on-camera theory, and clinical final/exit summative assessment exams. Among these criteria, two pragmatic outcome indicators are derived in this newer curriculum to assess the training program's effectiveness: **collaborative care quotient (CCQ)** and **translational quotient (TQ)**. CCQ is defined as the proportion of psychiatric cases [as identified and referred to the primary care doctor (PCD) by nurses] among all the general cases managed. It will be calculated based on self-reports from nurses on monthly patient reports or from

the register maintained at their hospitals. The authors consider CCQ of 30% as adequate as it is comparable to the prevalence of psychiatric disorders at primary care. The outcome indicators help understand the curriculum's efficiency and provide solutions to enhance the curriculum.

Strengths and limitations

The curriculum presents a simplified way of identifying and screening cases with mental illness. It is easy to use along with the routine practice of nurses. The curriculum would help in improving the outreach of mental health services. Nurses will act as a bridge between the people with mental health disorders and their treatment. They will increase the chances of people getting the proper treatment and can help in making sure that the patient follows up regularly. The curriculum focuses on early identification and referral to the primary care doctor. Therefore, it also promotes collaboration between the nurse and the PCD. Although the curriculum's focus is to identify and refer patients to the PCD for early treatment, it also focuses on the area that the general public starts believing in the concept of therapy for psychosocial issues and mental illness along with the pill-based mindset. The curriculum's focus is not only to identify cases with mental health disorders but also to improve the general public's awareness regarding mental health. It involves planning and conducting mental health awareness activities. As discussed, the identifying criteria are simplified, which might lead to over-identification and diagnosing the patients. Over time, the online consultations and hand-holding of the nurses will help overcome this limitation.

Future direction

As the curriculum comes into action, there is a scope for modifications based on learners' and cultural requirements. Once success is achieved for the current curriculum, other complex mental health and illness aspects can be inculcated.

Conclusion

Training nurses in primary mental health care is the need of the hour. The concept of integrating mental health care along with the routine practice of nurses is the right step in this context. A specialized curriculum and training program for nurses across the country can help reduce our country's mental health burden. The curriculum is open to changes and provides insight into the learners about their requirements and what more can be added. It also offers an opportunity for the policymakers and administrators to plan for other such programs in the field of mental health as well as other non-communicable diseases, reproductive and child health, etc., It provides new learning opportunities for nurses and might be a foundation for future e-learning programs.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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