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RELEVANCE AND METHODS OF TRAINING MULTIPURPOSE HEALTH WORKERS IN DELIVERY OF BASIC MENTAL HEALTH CARE

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Primary Health Centres (PHC) started in 1952, as part of the first Five Year Plan in our country have been playing a vital role in the delivery of health care facilities to the needy in the community. PHC staff consists of doctors, nurses, block health educators, pharmacist, health assistants and multipurpose health workers (MPWs). The health workers, usually with 8 to 10 years of schooling, are trained for a short period to do certain tasks related to specific assignments in the implementation of several "National Health Programmes". A population of 5000 is served by two health workers – one male and one female.

Though, promotion of mental health forms one of the eight components of 'Primary Health Care' (WHO 1978), till recently, there was not any effort to provide mental health care at the primary health centre level. Considering, the magnitude of mental health problems and limited mental health care facilities in the developing countries in general, and India in particular, it is unrealistic to expect that adequate services would be delivered through trained mental health professionals alone.

It has been suggested that basic mental health care which includes detection and management of all psychotics, mentally retarded and epileptics in the community, should be decentralised and well integrated with general health care services. The already existing medical and para-medical personnel in the general health care services, need to be trained to deliver 'basic mental health care' in the rural areas (Carstairs 1973, WHO 1975, Carstairs and Kapur 1976, Srinivasa Murthy et al. 1978).

The tenets or the National Mental Health Programme for India, (GOI 1982) envisages the integration of mental health services with general health services by provision of appropriate task oriented training to the Primary Health Care Personnel. The multipurpose health workers are expected to carry out the following tasks under the supervision and support of the PHC doctors. The tasks assigned to MPWs are:

1. To identify persons with severe mental illness, mental retardation and epilepsy.
2. To refer them to PHC for treatment.

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3. To offer 'first aid' in psychiatric emergencies.
4. To follow up and motivate the patients to be regular in the treatment
5. To provide mental health education.

Earlier attempts (Issac et al. 1982, Srinivasamurthy and Wig 1983) reveal that the knowledge of the untrained health workers about mental disorders is not adequate, and they have the same misconceptions which exist in lay people.

The Community Mental Health Unit of the Department of Psychiatry, NIMHANS, Bangalore, has been carrying out different training programmes for village leaders, community health guides, anganwadi workers, health workers and doctors. These programmes are planned, organized and evaluated by using standardized techniques. The training of MPWs and its implications form the pith of the present communication.

Material and Methods

The training programmes for MPWs was started at NIMHANS in 1982. The Government of Karnataka deputes the health workers, in batches of 6-15, every month, for this training course of 6 days duration. Till December 1985, 275 MPWs had been trained (Table). It is a residential programme, conducted in Rural Mental Health Centre, at Sakalawara village, about 15 kms. away from NIMHANS. A team of Psychiatrist, Psychiatric Social Worker, Clinical Psychologist, and Psychiatric nurses conducted this training programme. In this programme, the psychiatric nurses take the major responsibilities. A manual of Mental Health Care has been prepared for health workers in Kannada, the regional language.

Different methods of training and testing are used. Equal importance is given to theoretical contents as well as practical

Table
Background of health workers trained in different batches during April 1982 to December 1985.

Characteristics of health workers	Number (N = 275)
Age: (Years)	
Below 25	28 (10%)
26 – 35	142 (52%)
36 – 45	92 (33%)
46 and above	13 (5%)
Sex:	
Male	137 (50%)
Female	138 (50%)
Education:	
Less than X std.	12 (4%)
X Std	191 (70%)
PUC	45 (16%)
Degree	27 (10%)
Work Experience: (Years)	
≤6	43 (16%)
6 – 10	70 (25%)
11 – 20	137 (50%)
21 and above	25 (9%)

training. The classroom teaching involves traditional 'talk and chalk' method, audio-visual aids, and 'Role Play'. The language used is Kannada, technical words are avoided, and anecdotal clinical materials (video recordings of case interviews, vignettes) are used. In addition, movies on mental health are screened to the trainees. During the training period, the MPWs are taken to the villages, mainly to impart the knowledge and skills of identifying the patients and interviewing them and their family members. Three hours are allotted for the visit to psychiatric wards at NIMHANS for 'case demonstration'.

Similarly, a visit to the PHC or PHU is organised so that the trainees would get an idea about the 'modus operandus' of conducting a mental health clinic.

Trainees are required to actively

participate in the 'Role Play' sessions at the end of the training programme. This is planned mainly to enrich their skills in mental health education in the community. They form small groups and each group enacts a 'problem situation'. All the trainees are guided to discuss the role of MPWs in these situations.

Evaluation

The impact of the 6 days' training is evaluated by careful assessment of the theoretical knowledge gained by the trainees and subsequent attitudinal changes. This is achieved by comparing the post-training assessment of their attitudes and knowledge regarding mental health problems with that of the pre-training assessment.

The assessment is done using two methods. One method is to administer a KAB ('Knowledge, Attitude and Behaviour') questionnaire with 44 items, focussing on causation and methods of management of mental illnesses, epilepsy and mental retardation. Other method is administering a 30 items Multiple Choice Questionnaire.

The evaluations reveal that the trainees have limited knowledge about various aspects of mental health problems before the training. The post-training assessment shows that there is a definite change in their knowledge and attitudes towards positive direction as a result of the training.

An informal evaluation of the outcome of the training programme was carried out in April, 1983 and October 1985. Assessment was made on the efforts made by the MPWs to implement the programme, in terms of number of patients identified, and the number of patients on treatment in their respective PHCs. About 23 PHCs were visited and the workers were interviewed to know their achievements in basic mental health care. It was observed as follows:

1. None of the health workers felt that provision of basic mental health care was an additional burden.
2. They could carry out the tasks along with other routine activities and several patients were identified and referred to the PHCs. Many of the patients were on treatment given by the PHC doctors. (Each MPW had contacted 5 to 20 psychiatric or epileptic patients). They had maintained a record book for the patients.
3. Lack of training to other workers in the PHC, inadequate supply of required drugs, and lack of mental health educational materials were reported to be some of the difficulties in implementing the mental health programme.

Advantages and Disadvantages of Centralised Training Programme

The advantages of a centralised training programme are that the trainees have opportunity to examine patients in the hospital set up, rural clinics and in the villages. Since it is a residential programme, they could fully concentrate on different components of the training programme without any other distractions, and work for 6 to 7 hours a day. They are enabled to have free and healthy exchange of ideas and opinions with each other and also with training personnel during their stay.

However, certain limitations need to be taken into cognisance in this regard. Administrative problems associated with the process of deputation of the trainees from their respective places, are important. Besides, some of the MPWs tend to drop out because of the distance, and other personal problems. As only a small number of workers could be trained at a time, it requires an unduly long time to train all the health workers of a given block or district.

Further Developments

1. Important outcomes of the short term centralized training programme are the refinement of the training methodology, improvement in the contents of the manual, appropriate changes in the curricula and suitable modifications in the methods of evaluation.

2. Another outcome is organisation if 4 weeks training for the Trainers of Primary Health Centre personnel. Mental Health professionals from 12 different States and Union Territories (Rajasthan, Jammu & Kashmir, Haryana, Punjab, Madhya Pradesh, Gujarat, Maharastra, Andhra Pradesh, Goa and Pondicherry) have been trained and they subsequently, have started training programmes for PHC personnel in their respective places.

3. Yet another outcome is organisation of 2 days workshops on National Mental Health Programe for Health Secretaries and Directors of Health and Family Welfare Services and Senior Psychiatrists from the above 12 states and Union Terrritories in order to ensure their involvement in the implementation of the programme.

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