Beyond the training sessions… Does learning translate into practice? A post-mental health training feedback from the peripheral health workers of Dangahwa

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Abstract: Training in mental health is conducted for the peripheral health workers of Dangahwa under the District Mental Health Programme. It enhances their learning and inculcates a favorable attitude towards mental health issues. A focus-group discussion was carried out with the workers within 6 months of their training. The discussion revealed important factors that facilitated or hindered their work at the grass-root level, while they tried to put the learning into practice. The lesson learnt was that feedback from the community level was of crucial importance in modifying the training programme to make it more effective in yielding results.

Key words: mental health training, peripheral health workers, feedback

Introduction and Background:

The District Mental Health Programme (DMHP) functions across India with the objective of providing community mental health care. Under this programme, the Department of Psychiatry at Government Medical College, Surat is the nodal centre for Dangahwa, a tribal district of Gujarat, nearly 140 km away from Surat. One consultant psychiatrist and one resident doctor visit the district hospital at Dangahwa weekly once for outpatient consultation. The department also conducts annually, a 7-day residential training programme for the peripheral health workers (PHWs) in three batches of 20-25 participants each. The trained health workers are expected to identify patients in their villages and refer them to the visiting psychiatrist.

I have had an opportunity to work at Dangahwa under the DMHP for four years, under the guidance of the nodal officer and Head of the Department of Psychiatry. Reflecting upon the experience, we found that at the end of the training programmes, the PHWs could identify mental illnesses and were confident about referring patients from their villages. The number of patients attending the outpatient department at Dangahwa was also increasing. However, most of the new patients said that they came for consultation because their relative or neighbor got alright with treatment. The spread of awareness was largely by word of mouth. What role the trained PHWs were playing at the grass-root level was not clear. A need was felt to find out whether and to what extent was the training helping them to function in their villages and how much was it benefitting the patients. It was necessary to know what facilitated their work and what the perceived barriers were.

What we did:

We conducted a review meeting with 22 of the PHWs who were trained in the last 6 months. We carried out a focus group discussion to find out how they used the learning from the training at the grass-root level, the facilitating and the hindering factors, and their suggestions for the improvement of the services.

What we found:

All the PHWs reported that they were able to put to practice what they learnt during the training. They could identify patients, give them appropriate advice and carry out mental health awareness activity in small groups in their villages. The facilitating factors were close contact with the villagers and sharing the same cultural background. They seemed to be driven by feelings of altruism. Their motivation got enhanced by the social acclaim they received when someone got alright by following their advice.
The hindering factors could be classified under three categories: Patient's family related factors, the factors related to PHWs themselves and certain programme related factors.

The patient's relatives preferred to go to the faith-healers. They did not agree for medical treatment. Some of them had financial constraints such that they could not afford to travel from the interior of the village to the district hospital. Sometimes, transportation facility was not easily available. The relatives were afraid that the patient may get violent and unmanageable during the travel. Some relatives were apprehensive about the side-effects of medicines, while some had lost hope that the patient could ever get alright. The PHWs themselves were involved in many other programmes and complained of time constraints and difficulty in

convincing the reluctant families to seek treatment. The DMHP offered no targets. Also, there were no incentives offered for the work successfully accomplished. This was a perceived barrier. Some of them felt that there should be an exclusive workforce to work for mental health. Their suggestions included mental health education at the community level, especially to the care-givers of those with mental illness, liaison with the faith-healers of the region and home-visits of selected patients by the psychiatrist.

What we learnt:

Our training programme was successful in empowering the PHWs to work in their villages. An integrated review by Brunero et al(1) suggests that the mental health training programmes in mental health involving clinical experience and interactive teaching were more likely to be successful. We learnt this through our experience. A hands-on experience with patients and teaching by role-plays and demonstrations of interviews and therapy influenced their learning. If we review Kirkpatrick's four levels of program evaluation,(2) though the in-house trainings could result in satisfactory reaction and learning. In order to achieve the higher levels of behavior and result, it was important to review the field situation and take appropriate measures. For example, adding targets and incentives to the programme would result in more effective work.

Feedback is an important part of the communication loop. Van Ginneken N and colleagues reviewed the development of mental health services in India, and took feedback from bureaucrats, policy makers and psychiatrists that yielded important inputs to improve the programme.[3] In addition, if the training aims to facilitate the functioning of the PHWs, the feedback of what is happening at the community level is vital. For example, in addition to mental health literacy, we could put emphasis on training them to counsel the relatives of patients more effectively. At the same time, we could add a psycho-education module for the relatives of the mentally ill and for the faith-healers.

Provision of mental health services in rural India is a challenging issue. Various barriers such as unavailability of psychiatrists, concentration of psychiatrists in urban regions, huge treatment gap, traditional beliefs and stigma have been identified.[4] Thus, we understand that the success of a training programme in terms of the final results depends on many factors other than the training programme itself. Even then, crucial feedback from the actual workplace can help us improvise our training programme. It would emphasize a bottom-up approach and promote community ownership. Then we may facilitate the translation of learning into practice and come closer to our goal of improving the health of the society by improving education.

References:

1. Brunero S, Jeon YH, Foster K. Mental health education programmes for generalist health professionals: an integrative review. 2012 Oct;21(5):428-44. doi: 10.1111/j.1447-0349.2011.00802.x. Epub 2012 Apr 13.
2. Kirkpatrick DL, Kirkpatrick JD. Evaluating training programmes. 3rd ed. California: Berret Koehler Publishers; 1994.
3. Van Ginneken N, Jain S, Patel V, Berridge V. The development of mental health services within primary care in India: learning from oral history. International Journal of Mental Health Systems. 2014;8:30. doi:10.1186/1752-4458-8-30.
4. Kumar A. Mental health services in rural India: Challenges and prospects. Health. 2011:3(12):757-761.