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TYPES AND ROLES OF AUXILIARIES

by

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INTRODUCTION

Mental health professionals are in short supply in countries in Africa, the Middle East and Asia. For an indefinite period of time auxiliary staff must be called upon to provide the major manpower in mental health endeavours. In truth the proper utilization of auxiliaries can form the most important part of a mental health network to benefit the entire community. Auxiliary staff in the psychiatric field includes those workers who supplement such professionals as occupational and recreational therapists, psychologists, social workers, nurses, medical doctors, and psychiatrists. In the past mental health auxiliaries have been associated entirely with the psychiatric hospital. With the recent trend towards preventive services the concept of the auxiliary working in the community has developed and will be emphasized in this discussion even as prevention itself will be high-lighted.

There has been very little written about the place of auxiliaries in the mental health field in developing countries. We must turn to the more general field of health auxiliaries for full discussion but even here we

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find disagreement as to basic concepts. M. King states positively that a medical auxiliary is a substitute rather than a complement to the full professional (1). Fendall observes that the medical auxiliary is not a replacement for the doctor but a complement to him, whether or not he acts as an assistant or a substitute. Fendall sees the auxiliary's role as being both complementary and supplementary (2). Even in WHO circles there is not unanimity. An Expert Committee in 1968 came up with the following definition: "An auxiliary worker is a paid worker in a particular field with less than full professional qualification in that field, who assists and is supervised by a professional worker" (3). But, meeting three years later, a Regional Seminar in Africa took exception with the subordinate connotation of the foregoing definition and suggested instead "A health auxiliary is considered as an essential, competent member of a health team, who performs complementary, well defined tasks within a supervisory framework and has received adequate training, designed in accordance with his future tasks (4). This latter definition seems a good statement of the ideal situation pertaining to auxiliaries. However, many times in practice an auxiliary must function as a substitute for a professional because of man-power shortages. This is especially true in rural medical settings.

As we consider the auxiliary in relation to other health workers, the following description of terms taken from Bryant's Health and the Developing World is worth noting (5).

Professionals - educated to the level generally accepted in a particular country. They function in their field of competence without supervision. Examples: medical officers, nurses, social workers.

Sub-professionals - education quite close to that of the professional. A term used only in connection with the sub-professional for medical care. Examples: the community health officer in Ethiopia, the assistant medical officer in Tanzania.

Auxiliary Workers - assist and are supervised by professionals. There can be different levels of auxiliaries within the same field. Examples of auxiliaries: nursing assistants, medical assistants, rural medical aids.

Ancillary Workers - have no formal training but work within the medical community. Examples: dressers, sweepers, cooks, drivers.

The auxiliary should make a unique contribution in his particular field. He can be more useful than doctors in simple health education (6). By virtue of his position as frequently the primary contact with both well people and sick people he is in an excellent spot to carry out preventive measures as well as early treatment.

Many variations in structure of health services, in patterns of mental health and psychiatric programming, and in actual cadres of staff exist throughout the developing world. Because of these local differences, it is not possible clearly to define the various contributions of auxiliaries. Nor can a discussion of the place of auxiliaries in a mental health programme be separated from the nature of the programme itself. Therefore, the following discussion must assume certain general foundation principles as related to mental health programming and planning. The following would seem to be the minimum statement of principles to be found in any country during the last quarter of the twentieth century:

A. Much psychiatric illness is preventable. The groundwork for educational efforts is hereby provided.

B. All psychiatric illness is treatable, and much is curable. This emphasizes the importance of early case finding.

C. Mental health and psychiatric services should be integrated with general health and welfare services.

D. Mental health efforts and psychiatric services should be decentralized. This implies that when hospitalization is necessary it should be in a general ward or in a small psychiatric ward in a general hospital, as near to the patient's home as possible.

E. Hospitalization should be for as brief a time as possible. Day and night hospital programmes, half-way houses, convalescent villages and domiciliary care should be utilized when indicated.

F. A high priority should be placed on training of both professionals and auxiliaries.

In order to appreciate the importance of auxiliaries in a mental health programme and in psychiatric services, it is essential to consider the kinds of auxiliaries needed, their functions, the nature and the content of their training, the method of teaching, and the location of training programmes.

KINDS OF AUXILIARIES NEEDED

The kind of auxiliaries needed in mental health programming is best determined by the existing pattern of auxiliary care in a particular country. It is generally neither practical nor judicious to introduce a new cadre for mental health services. This presumes the existence of at least one cadre of medical auxiliaries, a cadre of nursing assistants who are hospital based, and a cadre of community workers who are non-medical auxiliaries. This implies that it is usually unwise to train a separate cadre for mental health and psychiatric work. The trend throughout the world is in the direction of training the generalist professional and away from training separate cadres for such conditions as tuberculosis, leprosy and the psychiatric illness. The same principle holds true for auxiliaries. This is a generalization to which there are occasional exceptions (*). For some years

(*) Dr. A. Haworth, (Senior Medical Superintendent, Chainama Hills Hospital, Lusaka, Zambia) has trained mental health assistants without a background of general medical training.

WHO and other health organizations have advised a joining of mental health and general medical services. This is not the place to explain this particularly sound policy, but only to call attention to it since this policy forms the basis for the practice of training the generalist auxiliary. It follows that mental health principles should be introduced into the basic training of the auxiliary regardless of the nature of his future work.

We are now in a position to comment briefly on the specific types of auxiliaries who are needed in a comprehensive mental health and psychiatric service. These are logically divided into two main groups. The first group includes those auxiliaries working in the community or with outpatients. Auxiliaries needed in this type of mental health endeavour may be medical auxiliaries in which case they would work in a variety of settings including general hospital outpatient clinics, rural dispensaries, rural health centres, and mobile clinics. Such medical auxiliaries should have had comprehensive training in the broad field of medical care with special emphasis on preventive services and health education. Another group of auxiliaries working in these settings would be those assisting nursing personnel and social workers. Some social work auxiliaries or partially trained social workers perform important service in relation to courts (as probation officers), child care programmes, and general social welfare endeavours.

The second broad group of auxiliaries in the general mental health-field are based in hospitals where psychiatric inpatients are being treated. Such staff usually assist nurses but they may carry out work assisting an occupational therapist or a social worker as well. Medical auxiliaries are also utilized to help in the management of psychiatric inpatients. In some

countries there may be auxiliaries assisting psychologists who work with hospital based patients. Unfortunately, however, there are very few clinical psychologists in the developing world.

Although each country must evolve the system of auxiliaries which best suits its local conditions, at the same time each country can learn from the resourcefulness and imagination of other countries (7). Some of the innovative concepts of auxiliary care come from China and Cuba. In China the "peasant doctor" is chosen by the people from their midst and is then trained. In this way he retains a closeness to his patients, especially as half of each training year is spent in his home community (8). This closeness to the people certainly enhances the usefulness of these auxiliaries in preventing psychiatric disorders. Although relying much less on auxiliaries than most developing countries, Cuba has integrated the traditional doctors (curanderos) into the health services system and they are placed on the Ministry of Health's payroll. After a training period of two months they are given positions as educators and assistants to auxiliary personnel working in health centres (9).

FUNCTIONS OF AUXILIARIES

The mental health functions of the general medical auxiliary working in the community include the following:

A. To prevent psychiatric illness by strengthening mental health.

This is known as primary prevention. Such endeavours will usually take place outside of the hospital but can also be carried out in the course of general medical or nursing duties in a general hospital ward or outpatient clinic. This important function can be sub-divided as follows:

a) Mental Health Education. The goal of such education is to help the people in the community to understand that mental illnesses have identifiable causes and that these causative factors can often be modified to prevent illness. Another aspect of education is to stress the importance of early treatment since all mental illnesses are treatable and many curable. The important target populations for the mental health educator are those groups who might easily change their stereotyped attitudes towards mental illness. These groups include the patients themselves and their relatives both of whom are often highly motivated and receptive to new ideas. Young people at various levels of schooling also receive a fresh point of view with interest.

b) Crises or stress intervention. In this important aspect the auxiliary can often significantly assist the individual's mental health at a point of personal difficulty so that he is able to cope satisfactorily with the stress. Every person goes through certain periods of normal stress in his development; there are other difficult life situations which occur only to some people. An auxiliary of any cadre can frequently make the difference between someone coping satisfactorily or being overwhelmed by the stress experience. Examples of individuals whom the auxiliary can help in this regard are given in Appendix "A". It should be emphasized that when a personal crisis has been lived through successfully the individual is then better able to cope with subsequent crisis situations.

c) Enlisting the help of leaders in the community, such as teachers, religious leaders, political leaders and police in the preventive efforts mentioned above. These community leaders are often in contact with men,

women and children at times of crisis and can be assisted by the auxiliary to encourage the distressed individual. In this manner the auxiliary can considerably broaden his influence.

B. To identify individuals developing psychological problems.

The auxiliary is in a strategic position to detect disordered adjustment at a very early point. This is known as secondary prevention when treatment can be instituted promptly and the patient spared a serious or prolonged illness.

C. To function as a channel of referral to medical officers or psychiatrists when the psychological problem is greater than the auxiliary feels he can manage. Often the auxiliary must provide psychiatric first aid until the referral is effected.

D. To function as a treatment resource. Many psychiatric problems arising in the community or on the general hospital ward can be successfully managed by the auxiliary without referral.

E. To supervise the after care of patients following their discharge from the hospital. This is known as tertiary prevention and is important in reducing the relapse rate and the psychological disability of the individual patient. Viewed positively this service can greatly further the happy and productive adjustment of men and women who have returned home. The auxiliary is often the person who can most appropriately refer the ex-patient back to the hospital for more skilled outpatient help or for short rehospitalization.

The psychiatric functions of the hospital based nursing auxiliary are somewhat more clearly defined than those of the medical auxiliary who often

works in the community with little or no supervision. Although the nursing auxiliary may assist other hospital professionals, especially social workers and occupational therapists, traditionally these auxiliaries help the nurse to meet the physical needs of the patient. Their functions should be extended to include assisting in the social and psychological management of the patient. In this way these auxiliaries can become helpful in managing the various categories of patients and not merely relegated to bed making or supervising the patients' physical hygiene. To be an integral member of the treatment team the auxiliary must know the meaning of various behaviours and how to respond in a therapeutic manner. It is entirely appropriate to expect a nursing auxiliary who has had some in service training to know when and how to do the following: encourage a certain patient to be more self-reliant and expressive, encourage another type of patient to exert more self control, calm the frightened patient, modify the suspicions of a paranoid patient and provide some structure for the confused individual. Of course the degree of psychological awareness of the auxiliary is largely determined by the skills of the supervising professional.

KIND OF TRAINING PROGRAMMES AND THEIR CONTENT

In suggesting the kind of training programmes suitable for the auxiliary in the mental health field, it must first be mentioned that these programmes will necessarily vary from one country to another depending on several factors. Among the factors to be considered are the auxiliary cadres available in the country, the presence of qualified teachers, and the nature of medical and psychiatric services planned as well as the kind of work to be performed by the auxiliary (10). Two general types of training situations can be

suggested, however.

For the auxiliary undergoing a formal period of training before he starts work, there should be included a series of sessions devoted to a better understanding of mental health and the psychiatric illnesses. The best example of such a training programme would be that developed for the medical auxiliary. Such a course is outlined in Appendix "A".

For the auxiliary already on the job in a psychiatric setting, in service training sessions should be arranged. There are many auxiliaries who have worked with psychiatric patients for years without having had the benefit of explanatory or educational sessions given to them by staff members. This of course should be remedied as soon as possible. In service training should be organized by the professional staff in the facility in which the auxiliary is working. Sometimes it is advantageous to bring auxiliaries from several psychiatric units together for a short course at a central location. Details of a programme of in service training are laid out in Appendix "B". Occasionally it may be indicated to send an auxiliary for a full time extended course during his working career but usually one of the alternatives described in Appendix "A" or Appendix "B" is more practical.

A particularly important aspect of training is retraining and refresher courses which serve the dual purpose of increasing the capabilities of the auxiliary (11) and also raising his morale and motivation (12).

Mention should also be made of informal apprenticeships whereby an auxiliary may develop a specific skill without attending a formal course. Examples include a nursing assistant from a psychiatric unit in a general hospital where the only professionals are nurses and a medical officer who

is sent for six months to a larger psychiatric centre for informal training in occupational therapy or social work. Upon return the auxiliary would then function in the capacity of a substitute professional.

Supervision can be considered a form of continued training and should be provided wherever possible for the auxiliary. When it can be arranged the professional should be deployed into a supervisory role instead of giving direct service exclusively. Supervision offers support and clearer purpose to the auxiliary. The reality, unfortunately, is that frequently the auxiliary must work with only occasional or token supervision.

METHOD OF TEACHING

There is no single method of teaching subject matter to auxiliaries which is superior to another. Some relevant factors which might determine the method selected include the personal inclination of the teacher, his experience and competence, the previous learning experiences of the students, the nature of the subject matter, and the physical facilities available. Some general points which seem valid to the author include the following: lecturing by itself is rarely conducive to learning; there should be student participation in all learning situations whenever possible; a short lecture with subsequent small group discussions is a good means to ensure participation and student learning, another worthwhile method is student presentations on selected subjects with the teacher providing a mini-lecture as commentary connecting the presentations and also a summary at the close of the session.

The following illustration suggests two ways of presenting the same material to a class of auxiliaries with between 10 and 50 students. The teacher wishes the students to understand that there are various explanations

for childhood behaviours of lying or stealing. The teacher could list the causes of each type of behaviour and the students could copy the items; the same thing could be accomplished by giving the students a handout with the causes listed. An alternative method would be to get suggestions from the class as to reasons for lying and stealing. This would take longer but would be an exercise in which all students participate even if some never say a word. Interesting points would develop in the discussion, moreover it would demonstrate clearly to the students that they have within their knowledge the capacity to understand the various causes underlying behaviour.

In discussing various clinical types of illnesses it is helpful to interview a representative patient in front of the class. A student can be selected to conduct the interview. This can then serve as a basis for discussing interview technique as well as demonstrating the symptoms of the particular illness.

The subjects of mental health and the psychiatric illnesses involve the students' own belief system, social background and life experience. Ample opportunity must be provided early in any course for expression of the students' traditionally held ideas about the causes of mental illness. In a single class many such beliefs are represented so class discussions themselves become an experience in mutual understanding. Tolerance for different beliefs and points of view follow from wide participation in discussions; this is of course enhanced by the teacher's own acceptance of students' views and his integrating them into the course material to the extent that this is possible.

Assignment of readings before a particular class session should be carried out when practical. Certain features can then be highlighted by

student presentations and teacher commentary. To encourage all students to read the material a brief unannounced quiz may be given at the beginning of certain sessions. Objective type or brief answer questions are favoured.

WHERE THE TRAINING SHOULD TAKE PLACE

Training programmes should be located as far as possible where the staff is or will be working. The logical place for the general medical auxiliary to be trained is the general hospital or at least close by. It goes without saying that there should be ample opportunity for substantial field experience during the course. Patients available in the inpatient or outpatient populations can be used for illustrating the common psychological problems including the minor functional complaints which form so large a percentage of dispensary and outpatient attendances. If the staff being trained is working or will work in a psychiatric ward, then the training should take place near such a ward so that the trainee can acquaint himself with the patients and the problems encountered in such a setting. Of course availability of teachers and appropriate accommodation may have to determine a training location which is not ideal.

CONCLUSION

The mental health auxiliary will need to be relied upon for many years to provide most patient care and preventive services. Therefore, it is imperative to evolve adequate training programmes so that their substantial therapeutic and preventive potential may be realized. Student participation in task related training with a heavy preventive emphasis should be developed. When at all possible auxiliaries should be given adequate professional supervision since this is a prerequisite to their maximum usefulness.

In developing auxiliaries with some mental health and psychiatric expertise, flexibility and resourcefulness are important principles keeping in mind the needs of the country, existing staffing patterns of professionals and auxiliaries as well as the present and planned psychiatric and medical programmes. Gone are the days of isolating the psychiatric patient; preventive endeavours and patient care should be integrated with general medical and welfare programmes.

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APPENDIX "A"

COURSE OUTLINE FOR MEDICAL AUXILIARIES

NOTE This is a sample outline of a course for medical auxiliaries. It is intended that these discussion sessions would occupy between 30 to 40 hours including interviews with representative patients. This course would normally take place during the final year of two or three years of training for the general duty medical auxiliary. Student intake would be after 10 or 12 years of general education. This course outline is intentionally general; it should be adapted to fit the needs of the particular country. The purpose of the course is to prepare the auxiliary for general medical duties especially in outpatient clinics, dispensaries and health centres. The emphasis of the course should properly be on prevention and health education.

With some modifications this outline could be used as a course for non-medical, community based auxiliaries receiving certificate training in social work, welfare (probation) work and the like.

INTRODUCTION TO MENTAL HEALTH AND PSYCHIATRY

A. Student attitudes toward psychiatric illnesses

An initial opportunity for free student expression

Exploring belief in witchcraft, the stigma and fears

Acceptance of various views by teacher

Emphasis made that students don't need to choose between traditional beliefs and the content of this course.

B. Behaviour

Determinants of behaviour

Genetic factors

Environmental factors

C. Anxiety

Normal vs. abnormal anxiety

Origins of anxiety

Fear of abandonment

Fear of injury (death)

Fear of failure

Fear of consequences of one's own anger

D. Stress

Examples of stress in everyday life

Each stress experience results in

Mastery (adequate coping) or

Failure (inadequate coping)

How does a person cope with stress?

Healthy ways

Continuing usual life routines as much as possible

Obtaining encouragement from own past experiences

From friends and people important to the individual

(including health personnel)

By the use of identification, with parents and others

Talking about it with special friends

Reducing the stress

Less healthy ways

Withdrawal, avoidance of stress

Regression

Blaming others

E. How does an auxiliary strengthen mental health?

Some examples of patients an auxiliary can help in this regard (include specific techniques)

A child whose mother has died

A child whose father has become seriously ill

A child whose mother delivers a baby

A child who becomes ill and must go to the hospital

A secondary school student with complaints of loneliness and worry about family

An adult woman who cannot conceive

An apprehensive woman approaching childbirth

An adult with an acute serious illness

Any person whose close relative has died

Throughout, the preventive potential of an auxiliary is emphasized

F. Personality Development

The goal here is to give the auxiliary some knowledge of the phases of normal personality growth

Points of special emphasis

Development from dependence (at birth) to independence (at maturity)

Negative behaviour. Fears. Aggressive behaviour.

Growth of sexual feelings in childhood and adolescence

Social growth, especially during adolescence

The process of identification

Young adulthood, Middle age. Old age.

G. Abnormal Psychology (Psychopathology)

An introduction to the description and meaning of various symptoms of psychological disturbance

These will be discussed under disorders of:

Motor Activity	Thinking
Mood (affect)	Memory
Speech	Awareness
Perception	Intelligence

H. The Causes of the psychiatric illnesses

Brief presentation of genetic, physical and psycho-social factors

I. The Prevalence of psychiatric illness

Reference here to prevalence studies carried out in Africa and Asia

Purpose: to give the student an idea of the frequency

J. Introduction to interviewing techniques

Can often be done best in connection with actual interviews with patients

Few points to be emphasized

Importance of rapport with patient

Careful observation and listening (eyes and ears the best tools)

Importance of discovering the meaning of the patients' symptoms

Value of "open-ended" questions

Avoid judgements of behaviour

Listen carefully to delusional content

Avoid reinforcement by agreeing

Simple explanation of patient's problems to the patient

K. Clinical Psychiatry

A brief introduction to the common disorders found in one's country

Where possible to be illustrated by patient presentation

The following disorders will be discussed

Acute and chronic brain syndromes

Especially Acute confusional state

Nutritional deficiency states

Alcoholism and psychiatric conditions resulting

Epilepsy

Schizophrenia

Affective disorders, especially depression

Neurosis

Including impotence and frigidity

Including vague functional complaints

Psychophysiologic diseases

Malingering

L. Management of patients

Introduction to treatment

Importance of liaison with family

If patient is hospitalized, planning for his discharge

begins when he is first admitted

Education of family regarding the patient's illness

Importance of continuity of care

Emphasize again and again, the preventive role of the auxiliary

M. Traditional Beliefs and Psychiatric Illnesses

A return to the subject of student beliefs and attitudes

Traditional beliefs able to be integrated with main features of

this course

N. Mental Health and Psychiatric Programme in the Country

An outline of present programme and future plans

Emphasize the important place the auxiliary has in this programme

O. Closing Session(s)

Unsigned questions from students to be discussed by teacher

Student evaluation of the course by completing evaluation questionnaire

APPENDIX "B"

COURSE OUTLINE FOR NURSING AUXILIARIES

NOTE This is a sample outline for a course for the nursing auxiliary working with psychiatric patients in a hospital setting. The suggested course content is appropriate for the auxiliary who has little or no training, certainly none in the field of psychiatric illness or mental health. These sessions are intended to be in service in nature, held during the working day of the auxiliary, probably for one hour weekly for 10 to 15 weeks. It is suggested that the time be about equally divided between lecture and discussion. In the following outline only main topics are suggested. The local situation, the educational and work background of the nursing auxiliary, the interests and skill of the teachers will determine more specific course content.

INTRODUCTION TO MENTAL HEALTH AND PSYCHIATRY

A. Sessions Led by Medical Officer, Psychiatrist, or Experienced Medical Auxiliary

1) Discussion of causes of the mental illnesses

Traditional beliefs as suggested by students

Genetic, physical and psychosocial causes

Some integration of traditional and "scientific" approaches

2) Introduction to concepts of stress and anxiety

3) Types of Patients
(to be presented in symptomatic rather than diagnostic groupings)

Withdrawn	patients	(A simple explanation of
Overactive	"	symptoms can be undertaken:
Paranoid	"	visual hallucinations
Confused	"	usually associated with
Depressed	"	extreme fear; grandiose
Anxious	"	delusions often follow
Epileptic	"	feelings of insignificance, etc.)
Alcoholic	"	

4) Treatment considerations including prevention

B. Sessions Led by Social Worker

1) Social Background as Related to the Mental Illnesses

2) Importance of Family

As a source of information about the patient

As possibly a contributing stress to the patient

As important in follow-up planning and responsible for patient returning for outpatient visits

3) Importance of cooperation between ward staff and social worker

Means of facilitating planning for patient's future

C. Sessions Led by Nursing Staff

1) Purposes of Hospitalization

Patient's reaction upon entering hospital

2) Nursing Management of Various Types of Patients

Withdrawn	Alcoholic
Overactive	Confused
Paranoid	Depressed
Epileptic	Anxious

3) Introduction to Nursing, Psychiatric and Other Procedures

Admission routine

Physical therapies

Occupational and recreational therapy

Physical therapies (E.C.T.)

Concept of Milieu Therapy

Importance of nursing auxiliary's role

Drug treatment

Purposes

Side reactions and dangers

Other treatments; psychotherapy

Discharge routine

4) Nursing Auxiliary as a Member of the Treatment Team

Importance as observer and source of information to nurse and doctor

Importance as helper of patients

Auxiliary determines the atmosphere on the ward

Key role of auxiliary in treatment of patient