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INTERCOUNTRY WORKSHOP ON TRAINING IN MENTAL HEALTH IN PRIMARY HEALTH CARE

Islamabad, Pakistan, 7-12 March 1987

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EDITORIAL NOTE

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TABLE OF CONTENTS

1. INTRODUCTION

A WHO Intercountry Workshop on Training in Mental Health in Primary Health Care was held in Islamabad, Pakistan, from 7-12 March 1987. It was attended by participants from thirteen Member States in the Eastern Mediterranean Region of WHO and one representative from UNRWA in Jordan. The Workshop was organized with the collaboration of the Department of Psychiatry, Rawalpindi Medical College and the Federal Ministry of Health, Pakistan. The list of participants is given in Annex II.

1.1 Inauguration of the Workshop

The Workshop was inaugurated by H.E. General Mohammad Zia-ul-Haq, President, Islamic Republic of Pakistan. He called upon the participants to ensure the provision of comprehensive health care for the mentally ill through the existing primary health care infrastructure.

Dr Hussein A. Gezairy, Director, Eastern Mediterranean Region of WHO, in his message to the Workshop mentioned the significant and rapid changes in the organization of mental health services that are taking place in many countries of the Region. He urged the organization of extensive training programmes in mental health relevant to the needs of primary health care for all categories of health staff. Such training programmes should not place too much emphasis on sheer acquisition of knowledge but rather should recognize the importance of acquiring psychosocial skills.

1.2 Election of officers

The following persons were elected to serve as officers during the workshop:

Chairman: Professor Dr Hyder A.G. Kazi (Pakistan)
Vice-Chairman: Dr Ihsan Raafat (Jordan)
Rapporteur: Dr Ahmed Mohit (Islamic Republic of Iran)

The proposed Agenda and Programme of Work were adopted. (See Annexes I and V).

1.3 Objectives of the Workshop

The objectives of the Workshop were:

- To assist participants to plan training programmes in mental health for primary health care physicians and other health personnel, relevant to local needs.
- To familiarize the participants with WHO policies and programmes in mental health in primary health care.
- To review the progress in mental health training programmes in primary health care in the countries of the Region.
- To familiarize the participants with the manuals and other teaching materials for training of primary health care physicians and other health personnel and to assist them to modify and adapt such training material for use in their countries.

To demonstrate the use of more up to date educational technology (e.g. TV equipment, role-playing, etc) for the training of primary health care physicians and other health personnel.

- To demonstrate assessment and evaluation techniques which can be used to assess the effectiveness of training primary care physicians and other health personnel.

1.4 An outline of the proceedings of the Workshop

The Workshop was planned to consist of a series of plenary sessions every morning followed by small-group discussions in the afternoons. One day was specially reserved for demonstrating the use of lectures, role playing, criss-cross discussion and use of videocassettes and TV for actual training exercises on a group of specially invited 25 primary health care physicians. The last day of the Workshop was spent on a visit to field areas in Rawalpindi Division where participants witnessed the impact of training on actual services in primary health care.

The Workshop began by reviewing the progress of national programmes of mental health in the countries of the Region. In preparation for the workshop, all country representatives had been asked to prepare reports outlining their plans and progress in training of primary care physicians (PCP) and other health care personnel. These country reports were included as working papers. Individually and collectively they provided an overview of mental health training programmes in the Region.

This was followed on the second day by in-depth discussion on the actual organization of such training courses. The topics covered were: contents of curricula, selection of priority topics, duration of training, methods of practical training, techniques of evaluation, etc. The next day was devoted to the discussion of the advantages and limitation of various educational methods such as lectures, small group discussions and use of audio-visual aids. Newer techniques, e.g. use of videocassettes and television were demonstrated, using carefully selected videotapes. Manuals commonly used in the countries of the Region were discussed and demonstrated.

The fourth day of the Workshop was reserved for live demonstration of various training techniques. A group of 25 local primary care physicians were specially invited. Among the techniques demonstrated were:

a. A model-simplified lecture especially aimed at primary care physicians.

b. A psychiatric interview in which the role of the patient was played by a doctor.

c. A criss-cross discussion in which primary care physicians volunteered their personal experiences of management of such cases.

d. Demonstration of teaching with the help of videocassettes which had previously recorded live doctor/patient interaction in a clinical setting involving some doctors who were present and participating in demonstration. Such demonstration of various training techniques was considered very useful by the participants.

On the fifth day of the Workshop, participants concentrated on the techniques of evaluation. Various methods of assessment, before and after the training, were discussed. It was pointed out that good training should not only increase the knowledge and change the attitudes of health staff but should also be reflected in its impact on primary health care services. Additional topics covered on that day were: special aspects of training of PHC personnel other than doctors, e.g. nurses, health assistants, health guides, etc. The development of suitable health education material especially for teaching of community leaders was also emphasized.

1.5 Visit to the field area

On the sixth and last day the participants were taken to rural field areas in Rawalpindi Division, to a rural health centre and to a subdistrict hospital where mental health services are functioning at primary care level. It was demonstrated that almost all the health staff of these rural health centres had been trained in mental health in small batches during the preceding year; they are now able to deal with common mental health problems at these centres without the help of specialists.

The participants put many questions to the working doctors and health staff in these PHC centres; their knowledge about mental health (for limited priority conditions) was impressive. The participants were also shown patients with mental disorders, both in outpatient departments and admitted in wards, who were being adequately managed in these general health services. Perhaps the most impressive part of the field trip was the visit to a number of rural schools where teachers have been provided with mental health training. With the help of teachers a very interesting and useful mental health training programme has been started in schools. For five minutes every day children in all classes receive mental health education from teachers.

2. ROLE OF TRAINING IN THE CONTEXT OF NATIONAL PROGRAMMES IN MENTAL HEALTH

The Intercountry Meeting on Mental Health held in Damascus, Syrian Arab Republic, in November 1985, highlighted the importance of developing comprehensive national programmes of mental health with clear objectives, targets and plans of activities, based on the principle of integration of mental health into general health services at primary health care level. The main strategy to achieve these objectives would be to rapidly provide short, goal-oriented mental health training for primary care doctors and other health personnel working in primary health care in rural and district centres. It has been convincingly demonstrated in a number of countries during the last decade that, with appropriate training, health staff at primary care level can adequately look after a limited number of serious and common mental disorders with the aid of two or three essential neuropsychiatric drugs. Furthermore, such training in psychosocial knowledge and skills can improve the quality of the general health services.

Table 1. NATIONAL PROGRAMMES OF MENTAL HEALTH IN SIX COUNTRIES OF THE EASTERN MEDITERRANEAN REGION

	Draft of national programme prepared	Programme adopted at national multisectoral workshop/or by special committees	Programme accepted in principle by the Ministry of Health	Mental health services started functioning at primary health care	Mental health training for PHC doctors and workers conducted in 1985-1986
AFGHANISTAN	Yes	National workshop expected September 1987	———	———	Yes
DEMOCRATIC YEMEN	Yes	Adopted at a multisectoral workshop	Submitted to Ministry of Health	In Hadhramout Governorate	Yes
EGYPT	Yes	Adopted at an expert consultation	Submitted to Ministry of Health	In Fayyoum Governorate	Yes
ISLAMIC REPUBLIC OF IRAN	Yes	Adopted by a national committee October 1986	Submitted to Ministry of Health	———	———
PAKISTAN	Yes	Adopted at a multisectoral workshop March 1986	Yes	In Rawalpindi Division	Yes
SOMALIA	Yes	Prepared by STC along with nationals September 1986	Yes	Lower Shabella	Yes
YEMEN	Yes	Adopted at a multisectoral workshop December 1986	Yes	Proposed at Taiz 1987	Yes

Since November 1985, a number of countries of the EM Region, namely, Democratic Yemen, Egypt, Islamic Republic of Iran, Pakistan, Somalia, and Yemen, have taken steps to develop national programmes at various WHO-supported national consultations and/or multisectoral national workshops. The present state of development of these programmes is shown in Table I.

As already stated, one of the main strategies in this programme is to provide rapid mental health training for various categories of health staff working in PHC. This is an enormous task because very little of such training exists at present. Only some countries have just made a beginning. Ideally, such mental health training should be provided at the training schools at the point of entry for medical doctors and other health workers. Unfortunately, it is either not done at all or done in such an unsatisfactory way that mental health and behavioural sciences appear to have no relevance to primary health care, while the opposite is the truth. The second approach is to provide short courses of in-service training which are task-oriented and related to the day-to-day problems dealt with by health staff in PHC. The Workshop concentrated on the latter approach.

To impel such a large programme there is urgent need to train the trainers in all the countries concerned. The present Workshop has been convened to fulfil this need. It is hoped that the participants will subsequently be able to organize similar workshops in their own countries.

3. REVIEW OF NATIONAL ACTIVITIES IN MENTAL HEALTH TRAINING RELATED TO PRIMARY HEALTH CARE

In preparation for this Workshop, all country representatives were invited to prepare reports outlining their plans and progress in developing integrated mental health care, with special emphasis on the training of primary health care physicians and other health personnel. These country reports were included as working papers. Individually and collectively, they provide an overview of the progress of the process of integration of mental health care into primary health care.

3.1 Country reports

3.1.1 Bahrain

Primary as well as secondary health care is provided by 18 health centres in Bahrain. These health centres are staffed by family physicians, community nurses, social workers and a variety of paramedical staff. The family physicians are expected to deal with all categories of mental illness and also refer patients to specialist services whenever there is a need for expert assistance for management or if hospitalization is required. A mental-hospital-based service also covers the whole country.

Training is provided for all levels of clinical personnel. Undergraduates attend the psychiatric hospital for lectures and clinical experience. They also attend a course in communication skills. The hospital also runs postgraduate courses for all its residents and has initiated a diploma in mental health for nurses.

At the PHC level, all physicians have three years' general training which includes six weeks' attachment to the hospital-based mental health services. This is supplemented by additional lectures in their health services. New residents and older GPs who qualified before the training scheme have eight weeks' training in mental health at the hospital. Paramedical PHC workers, social workers and policewomen receive a lecture programme. Consultative advice and in-service supervision is offered to members of multidisciplinary teams which are responsible for mental handicap services. The hospital-based community team provides educational material for patients and their families.

3.1.2 Democratic Yemen

The first mental health service was established in 1966. Services are currently based at two mental hospitals but in the long term it is planned to decentralize services and to fully integrate mental health care into PHC. Due to shortage of qualified specialist medical manpower, special programmes to train general physicians, nurses, social workers and medical assistants have been started. Training includes a six-day course for medical assistants on case detection and management of psychosis, epilepsy and mental retardation. Mental officers also receive a 12-day training course covering aspects of case detection, treatment approaches and follow up, together with instruction on education of health guides and the wider community.

Additional training programmes for medical students, newly employed doctors and postgraduates are also under review. Teaching materials have been developed for both doctors and medical assistants. A multisectoral national workshop was organized in Aden in December 1986 which developed a comprehensive national programme of mental health for Democratic Yemen, based on the principle of integration of mental health into primary health care.

3.1.3 Islamic Republic of Iran

Since the WHO Intercountry Meeting in Damascus in 1985, there have been two significant developments relating to mental health in Islamic Republic of Iran. One is the formation of a combined Ministry of Health and Medical Education. This Ministry has now taken over all the medical, nursing and health schools and institutes. The second development was the preparation of a draft of a comprehensive national mental health programme, in collaboration with WHO.

The drafted programme which is under consideration for final approval by the Government has outlined various mental health activities for different levels of health personnel, from the health houses in the villages to the level of specialized hospitals and university-affiliated centres. The national programme includes detailed job descriptions for each level of health worker, according to which their mental health training is to be carried out. Considering the fact that there are 6000 health houses, 1500 rural health centres, plus 36 inpatient and outpatient psychiatric facilities with 200 psychiatrists in the country, once started, the programme has a good chance of success.

Training programmes for primary care physicians and other health personnel are being planned in collaboration with all the teaching institutions of the country. A pilot training project will start in 1987. Mental health curricula have been prepared and will be included in the manuals for secondary and tertiary health workers.

3.1.4 Iraq

Although mental health care is currently being provided through specialist mental hospitals, general hospital psychiatric units and outpatient clinics, integration of mental health with primary health care is the long-term goal of the national mental health policy.

Work has started to establish a national mental health programme and efforts have been made to improve teaching and training at all levels of health care. Currently, training is being provided for undergraduate medical students, nurses and psychologists. A postgraduate "diploma in psychological medicine" is under consideration. At the PHC level, one training course in mental health for general physicians was organized in 1986. There is also a programme of general mental health education for the wider community, at schools, centres for mentally retarded children, prisons, homes for elderly patients, etc.

3.1.5 Jordan

Significant progress has been made since the WHO Intercountry Meeting in 1985. The National Committee for Mental Health has completed its task and submitted its recommendations. As a result, a National Mental Health Programme was scheduled to start in May 1987. As part of this programme, a 200-bed national centre for mental health has been set up. This centre has a recognized teaching and training role, promoting training of hospital residents, nurses, social workers, psychologists and medical students. At the PHC level, it is hoped that training of physicians and paramedical staff will be initiated later in 1987.

These developments have been achieved despite some resistance to integrated services. It is hoped that the proposed launching of the National Mental Health Programme will overcome the few remaining obstacles to the development of an integrated mental health component in primary health care.

3.1.6 Kuwait

Facilities for mental health care are available in the outpatient department of some hospitals, a few PHC clinics and selected school health services. Inpatient care is available only in mental hospitals. The official mental health policy favours the decentralization of services and the integration of mental health into PHC. Training of PHC workers in mental health issues is a recognized priority. At present, training includes a five weeks' clinical attachment for medical students and appropriate courses for nurses. For primary care physicians, attempts are being made to increase awareness of psychiatric disorders and to improve detection, referral practice and treatment of less severe disorders. Primary care physicians are attached to specialist mental health services for a four-week period. Each course is attended by 2-4 physicians depending on interest, background and availability.

3.1.7 Libyan Arab Jamahiriya

At present mental health services are concentrated in mental hospitals in Benghazi, Tripoli and Sebha. So far services and training have been concentrated predominantly on developing specialist care. There are courses for undergraduate medical students, psychologists and social workers. Visiting teachers from other countries have provided an important teaching resource. Now there are plans to develop a national mental health programme. Priorities are to develop a national training programme for general physicians and other personnel and to progress towards decentralization of mental health services.

3.1.8 Pakistan

The mental health programme in Pakistan has made significant progress since the WHO Intercountry Meeting in Damascus in November 1985. When Pakistan came into existence, in 1947, it inherited three mental hospitals which remained for a long period the sole providers of mental health care. More recently, in addition to the mental hospitals, psychiatric units have been established in every teaching hospital and in many general hospitals. Pakistan has the distinction of being the first country in the Eastern Mediterranean Region to have successfully organized, formulated and adopted a National Programme of Mental Health. In March 1986, the Ministry of Health, Special Education and Social Welfare, in collaboration with WHO, organized a national workshop in which representatives of various intersectoral disciplines related to mental health participated and finalized the National Programme of Mental Health. The specific objectives of this programme in the immediate future include making essential mental health care available and accessible to all, with special emphasis on the unserved, underserved and inappropriately served rural population, and to encourage community participation.

Since 1986, the Department of Psychiatry, Rawalpindi Medical College, has started a major programme for integration of mental health into the existing primary health care structure, as advocated in the National Programme. Under this programme more than 100 primary care physicians and over 600 health workers have been provided with mental health training. Similar programmes are now being planned in Sind and Baluchistan provinces.

3.1.9 Saudi Arabia

Until recently, the major advance towards developing mental health services has been the expansion of specialist hospital facilities.

There are now 15 hospitals of 30-150 beds and 20 outpatient clinics. Training is available for medical students, mental health nurses, psychologists and social workers. There is a specialist postgraduate course leading to a diploma in psychological medicine. There are now plans to develop a comprehensive mental health programme based on integration of mental health into primary health care.

3.1.10 Somalia

With the help of a WHO consultant, national experts have recently developed a comprehensive national programme of mental health. Integration of mental health with PHC is an important goal of this programme. The PHC team comprises a regional training officer, midwives, nurses, sanitarians and various other technical staff. Mental health will be provided for all these workers to enable better recognition of mental illness, to encourage early treatment and to streamline the referral pathway from PHC through specialist psychiatric services at regional level. Under this programme all regional hospitals will have a specialist mental health unit with responsibility for planning and conducting training programmes and liaison services. At district level, each medical officer will be trained to recognize psychiatric disorder and to supervise case detection among other PHC workers. Community health workers and nurses will be trained to recognize certain forms of mental illness as well as epilepsy and to manage some disorders under the supervision of the district medical officer. They will also provide the community with programmes of mental health education. Training courses on mental health in primary health care for general physicians and health workers were organized during 1986.

3.1.11 Sudan

Community mental health care in Sudan was pioneered in the 1950s under the guidance of the late Professor Tigani El Mahi. Rural services and open-door policies were introduced. Further expansion came with the introduction of the Psychiatric Medical Assistants' School" and training for social workers and psychologists.

The current National Plan and Policy for mental health includes the objectives of decentralization of services to district general hospitals and to the PHC level. Recently, programmes for training PHC physicians have been added to those existing for undergraduates, nurses, social workers and psychologists. A national workshop to develop a mental health programme is planned for 1987.

3.1.12 Yemen

A National Mental Health Plan was drawn up in 1984/1985 with the objectives of establishing decentralized services and integration of mental health care into primary health care. An essential first step involved the training of PHC workers to enable them to be better able to detect and manage mental illness.

The first training course for PHC physicians was conducted in October 1986. In November 1986, training was extended to include courses for non-physician PHC staff. This course course had similar objectives but was specially tailored to fit the specific abilities and roles of these workers. These pilot projects will form the basis of a country-wide training programme. Other courses have been developed for various medical officers working in general hospitals, midwives and important decision-makers in the Ministry of Health.

A multisectoral national workshop was organized in December 1986 to adopt a national programme of mental health based on the principle of integration of mental health into primary health care.

3.2 An overview of Regional progress towards integration of mental health with primary health care

The report of the WHO Intercountry Meeting on National Programmes of Mental Health (Damascus, November 1985) drew attention to the fact that although decentralization of mental health services and their integration with primary health care was an important step toward HFA/2000, progress toward the attainment of this goal is hampered by a number of obstacles.

One of the recurrent themes of the Damascus meeting was the acute shortage of trained manpower. The shortage of senior professionals in almost all the countries of the Region continues to hamper progress, even though a number of countries have almost doubled the number of professionals during the last decade. Training leading to a postgraduate qualification in psychiatry is now available in Egypt, Islamic Republic of Iran, Jordan, Pakistan and Saudi Arabia but most of the remaining countries continue to be dependent on overseas training and the importation of expatriate professional staff to man their mental health programmes. A number of countries of the Region have expanded the mental health component of their medical undergraduate training programme, for example, Bahrain, Democratic Yemen, Jordan, Kuwait, Libyan Arab Jamahiriya and Sudan all reported an increased emphasis on practical, clinically-based courses for medical students.

Pakistan, with a long tradition of high-quality undergraduate training, still has only 95 psychiatrists for a total population of some 90 million and even the most conservative mental illness prevalence estimates place the bulk of those with mental illness beyond the reach of these highly skilled professionals. Even allowing for the expansion of specialist services through the promotion of clinical psychologists, social workers with special interest in mental illness and dedicated nursing services, it is clear that most of the mental morbidity will continue unrecognized, untreated and neglected, unless some different solutions are sought and implemented.

The retraining of general physicians, general hospital residents and family doctors is the first step towards such a radical solution and a number of countries have started special training programmes for their general medical staff. In Bahrain, for example, each resident by the end of an eight-week attachment at a hospital and specialist outpatient clinics, will be sufficiently experienced to be able to deal with the psychological aspects of physical illness and to be capable of distinguishing between psychological and physical problems. The training covers essential aspects of more common disorders, simple counselling skills and the use of essential pharmacotherapy. Similar training courses for newly qualified doctors are now being organized in Democratic Yemen and are planned or have been partially implemented in other countries. Training is also being gradually extended to established family physicians who may have completed formal medical school education several years ago. The models for achieving this retraining vary considerably between countries, depending on the organization of their postgraduate facilities and the presence of established systems of release from their service routines, to attend specific training courses.

In Kuwait, for example, such training is limited to those who can be spared from their routine duties to attend a four-week period of attachment and training by the Department of Psychiatry, while in Pakistan established family physicians have been enrolled in brief, goal-oriented and highly-focused training programmes. Islamic Republic of Iran has launched special "relearning of psychiatry" workshops of a brief and intensive nature, allowing 200 family physicians to pass through a course in three weeks.

In summary, it is becoming more and more obvious that, in the context of developing countries, appropriate training of all categories of health personnel is an essential step toward bringing mental health into the mainstream of health services. However, there are still a number of serious barriers in implementing this programme, some of which are noted below:

1. Delays in launching national programmes of mental health. Several countries have now reached the point where such programmes have passed beyond the initial phase. A detailed programme exists for example in Democratic Yemen, Pakistan, Somalia and Yemen, and is planned for early launch in several other countries, for example, Jordan.

2. Resistance to integrated health care amongst administrative and senior health officers, compounded by a lack of appreciation of the extent and importance of mental ill health in the general population.

3. Similar resistance from mental health professionals who remain sceptical about the value of paramedical assistants, despite the evidence of international research, or who fear the impact this policy may have on the development of specialized facilities.

4. Lack of experience and expertise in setting up, running and evaluating training programmes, educational materials and supportive supervision both for primary care physicians and for non-medical workers in the mental health services.

The present Workshop set out to find a solution to this last obstacle, drawing upon the experience of those countries which have made a start in involving paramedical staff in a screening capacity: Democratic Yemen and Pakistan, for example, have both conducted training of several levels of workers and several other countries are to begin pilot projects in the immediate future. Not surprisingly, given the very different nature of service provision, availability of manpower and indeed commitment to National Programmes of Mental Health, several different methods of training have been practised and were advocated at this Workshop. Yet, despite these differences, there was sufficient common ground to enable the Workshop to outline the fundamental requirement of primary mental health training in primary health care.

4. TRAINING OF PRIMARY CARE PHYSICIANS (PCPs)

4.1 Objectives of training

In the course of the Workshop, it became clear that the countries in the Region differ from each other in terms of the availability of resources, the number of senior trainers and the existing levels of knowledge and skills amoung their PCPs. In spite of these differences, all participants agreed

on the necessity of PHC training as the first step towards developing and implementing their National Programmes of Mental Health.

The following objectives for training emerged through the Workshop:

1. Training should be relevant to the daily work of PCPs. Emphasis should be on acquisition of skills rather than only on acquiring knowledge.

2. The course should affect the attitude of the trainees. As a result, there ought to be increased awareness of the importance of psychosocial factors in health and disease.

3. Training should increase the knowledge of mental illness and enhance correct management while avoiding unnecessary complexity or the use of technical jargon which bears no meaningful relationship to the everyday work of the primary care physicians or worker.

4. Training should have an impact on existing services by decreasing the number of unnecessary secondary referrals, laboratory tests and hospitalizations.

4.2 Training methods

The discussion document circulated before the Workshop formed the basis for a fruitful exploration of the wide variety of training approaches needed to successfully implement the educational programmes. The various methods which have been tried and whose efficacy in imparting the required skills has been ascertained were discussed in detail. During the course of the Workshop there was demonstration of a model lecture, case demonstration techniques, role-playing, criss-cross discussion and the use of TV and videotapes. The following is a brief account of the discussions on various training methods:

(a) The lecture

The lecture is a time-honoured method of teaching. In spite of all its faults, it is still an economical and useful method in the hands of a good teacher. For the training of PCPs the following points should be conveyed to the trainers:

- PCPs should not be treated as undergraduate students and expected to listen and make notes during long didactic lectures. Nor should they be treated as postgraduate students of psychiatry preparing for their final examination who are to be told all about the latest theories of the aetiology of mental disorders and the newest drugs in the market. Such lectures may be easy to deliver by psychiatrists but they are largely a waste of time for PCPs.

- Each lecture should be prepared carefully, keeping in view the need of the PCP, linking it with the tasks which are required of him in his daily practice.

- It is always useful before the start of the lecture to ask a few general questions from the PCPs, related to the topic of the lecture, to assess their existing knowledge, and their general style of handling such problems in their practice.

- The lecture should not be long - almost never beyond 40 minutes. At the end of the lecture sufficient time should be left for a question-and-answer session, which is often the most important part of the exercise.

- Appropriate teaching aids, like a blackboard, chart or overhead projector, should be used to illustrate the important points of the lecture. Slides or transparencies, if used, should be specially prepared for PCPs (and not simply taken from the pool of slides for medical students). It should be remembered that too many slides in a lecture, with lights going on and off, reduce communication, which is essential for a good lecture.

(b) Case demonstration

Next to the lecture, perhaps the most common method of teaching is case demonstration. It is an extremely useful and important method. Here again, the essential part is that cases should be selected very carefully. Patients with gross psychotic symptoms are easy to find in psychiatric services but these are not the best material to teach PCPs. As far as possible, patients who are commonly seen by PCPs in their daily practice should be selected. At the same time, symptoms and psychopathology should be sufficiently clear and obvious for demonstration.

(c) Training in interview methods

Perhaps the most important new skill which PCPs should acquire during these training courses is the technique of psychiatric interview: in short, how to listen and how to talk to the patient, in day-to-day practice. A good interview with a patient can be utilized for various purposes - for obtaining history, for assessing mental state or for providing counselling. All these three elements often exist together in the average doctor-patient encounter in general practice.

Interview training can be provided in various ways. In the absence of a TV or other audio-visual facility, one simple technique is to conduct a live interview in a group setting. In a small group, a patient (or a role player) is invited and interviewed by one physician in his usual style. The teacher and other participants listen attentively, observe the behaviour of the interviewing doctor and patient, take notes but do not interrupt in any way. After about 10-15 minutes the patient withdraws. After the patient has left, the participants comment on the good and bad points of the interview which they have just witnessed, e.g. "doctor was too dominant and did not let the patient talk" or "after mentioning chest pain, patient referred to work problems; this was not followed up by interviewing doctor" and so on. At the end, the teacher makes his comments summing up both the inadequacies and strengths of the interview and giving advice about improvement, etc. If necessary, the patient is called back to demonstrate the points which were missed by the interviewing doctor. Such an exercise is usually followed by a demonstration in which the teacher interviews another patient, in front of the group, and which is again followed by analysis and discussion by the group.

More important than the content of the interview, the trainees should learn the art of interviewing - how to make the other person comfortable, how to make him relax and talk about his personal problems, how to pick up hints about underlying psychological and social problems, etc.

In some psychiatric centres, a one way mirror-screen is used for interview training, especially for psychotherapy. However, for brief interview training for PCPs there is generally not much difficulty in a live interview in a small group setting. It is one of the simplest and best techniques of mental health training.

(d) Case conference

In this classical teaching exercise, the case is examined by one or two students and then presented to the teacher in a group. It is a useful exercise but, since the teacher does not watch the student taking history and conducting examination, many of the deficiencies in interview skill remain unexposed. It should be combined with the exercise of interview training as mentioned above.

(e) Criss-cross discussion

This is a very useful low-cost technology in which the PCPs present their problem-patient's history in a group setting with a trainer acting as a resource person. They are encouraged to describe patients they have seen with problems similar to those about which they have been taught. The teacher is passive, but provides information to the group on requested, and corrects errors if this is necessary. Other members of the group interact by citing their experiences and difficulties with similar problems. Such discussions become very animated and the method has been called "criss-cross fire" by those experienced in it.

(f) Role-playing

As is well known, psychiatric patients are often difficult to get when needed for teaching, e.g. they have already recovered from their illness, they are too disturbed to be shown in a group, they do not speak the right language or simply cannot keep the appointment when you want them. A good alternative technique which has become quite popular in recent years is "role-playing". In this training method another person, e.g. a staff member (a doctor, nurse or social worker), acts or plays the role of a patient. The advantage is obvious. The "role player" can be tutored to present specific symptoms and history which heightens the effect of a short training interview. With a little practice, role-playing can be made into a very useful addition to training of PCPs and it can be used in almost all settings.

(g) Use of audiotapes

Audiotapes are now available in every country. These can be usefully employed in training, especially for demonstrating a sample of patient's talk or conversation between patient and doctor. Their use is particularly helpful when the patient's symptoms and improvement are being demonstrated over a length of time. The PCP can also make a recording of his own inter-

view of his selected patients in his practice which can be brought for group discussion.

(h) Use of television and videotapes

The use of television and videotapes has revolutionized modern teaching and training techniques. In recent years, television sets, videorecording and projecting machines have become widely available in many countries of the Region. Many universities and teaching centres have developed special studios and have trained technicians to prepare technical video films for teaching.

Video films and television are very well suited for training of PCPs. With a simple videocamera, interviews of patients by PCPs can be recorded in their own clinic settings. These videotapes can be replayed later in the group sessions. The great advantage of the videotape is that it can be stopped at any point or a sequence repeated when required, till the teacher has clarified the essential message. This technique is particularly useful for training in interviewing skills, especially if the PCP can see the film of himself interviewing in his own setting. It is also a great learning exercise for the teacher who is faced with the reality of the actual primary health care setting which is considerably different from specialist clinics.

Another interesting technique demonstrated during the Workshop was the usefulness of a common psychological test administered to all patients who were later interviewed on videotape. Information about high scores on this test enables the teacher to pick up interviews where patients are more likely to have psychological problems in their presentations. The general format of training in these sessions is that the teacher begins showing the interview which is to be discussed, then stops the machine. The physician who has conducted the actual interview briefly gives information about the patient. The recording is started and stopped whenever teacher or audience wants to make an observation or ask a question. If the patient was not handled well, the physician is asked how else he could have handled the situation. The teacher makes constructive suggestions when required but remains in general non-judgemental and helpful.

(i) Use of manuals

Manuals have become an integral part of short-term training programmes in health in many countries all over the world. A list of manuals, which are available and have been commonly used in the Eastern Mediterranean Region during recent years to organize mental health training programmes for primary care physicians and other health personnel, is given in the list of background documents (Annex IV).

Manuals differ from standard textbooks in that they are smaller and briefer. They can be easily carried around and consulted in day-to-day work both during and after training, but more important than their size is their emphasis on practical training. The focus is more on acquisition of skills rather than on only acquiring knowledge. For example, whereas a standard textbook of psychiatry, while describing a mental disorder, would use the conventional medical format of aetiology, signs and symptoms, differential diagnosis, treatment, etc, a manual would directly describe the

specific mental health tasks which a primary health care physician or worker is to perform during his/her duties, i.e. how to recognize and manage epilepsy or acute psychosis with a limited number of drugs or when to refer a case to a specialist centre, etc. The second essential feature of a manual is that is must be in simple language without excessive use of technical jargon. It is also important that it should be available in the local language in which the health staff have been educated.

The contents of a manual vary according to the objectives of the training programmes. For short training courses of one to two weeks' duration, it is obvious that only a limited number of topics and clinical conditions can be included. Hence priorities must be carefully chosen. As discussed earlier, from the public health point of view, priority must be given to those clinical conditions which are common, cause serious personal distress and social disability, and for which management is relatively simple, cost-effective and can be delivered at the community level. In mental health programmes it is important that the training is not only confined to recognition and management of diseases but also includes communication skills, e.g. interviewing, evaluating psychosocial factors in history, simple counselling measures such as reassurance and emotional support, etc. These skills can help the trainees in many situations of mental as well as general health problems. It is useful to have a summary of points to remember at the end of each chapter. Flowcharts have also proved very useful in many training programmes but they should be prepared carefully, keeping in mind the general educational background of the trainees and their familiarity with such methods.

Depending on whether a manual is to be used only by trainees or is planned for the use of trainers also, it should provide information on how to organize such training programmes including advice about pre- and post-training assessment of knowledge, attitudes and skills of the trainees.

5. EVALUATION AND MONITORING OF TRAINING PROGRAMMES

The development of a comprehensive training programmes is never achieved at the first attempt but evolves through progressive reinforcement by means of several courses. Measurements of improvement in the trainee's knowledge, skills and attitudes to mental disorders at the beginning and end of each course provides the only certain measure of checking the efficacy of the programme.

Trainees should be asked to comment freely on the content, organization and delivery of the course, indicating which elements of training they found helpful and which may have been unhelpful or confusing. This, together with the results of objective evaluation of trainee skills/knowledge, provides all the material necessary to refine the course for the next batch of trainees.

The Workshop set out a number of steps for evaluation:

1. All courses could include the following <u>baseline</u> observations:

- Trainees should provide a record of their "psychiatric" diagnoses during the previous month.

- Their attitude to mental illness should be assessed, using an appropriate scale.

- Their knowledge of mental disorders should be assessed, using specially constituted multiple choice questions.

- If the acquisition of interview skills is to be measured, each PCP should take a 10-minute history from a trained role-player who portrays a straightforward mental illness. Measures of the number of items of information extracted and interview behaviour are taken. However, it is to be noted that this procedure is time-consuming and is not recommended for all centres.

2. All courses should collect observations at the end of training (e.g. on the last day):

- Repeat measures of attitudes to mental illness.

- Repeat measures of knowledge of psychiatry.

- Get each trainer to rate the relevance and quality of each component of the training course.

3. Optimally, at least one month after course completion, trainees can be surveyed by postal questionnaire to ascertain the impact of training on their practice.

In addition to these direct measures of the impact of training, it is possible to use health services statistics to monitor the impact of newly trained personnel on the existing services. Health administrators, in particular, would find such data invaluable. The information administrators are looking for can be conveniently summarized as: educational research evidence (evidence that the training has achieved the objectives set for it), health service evaluation (evidence that training has had an impact on services, e.g. number of referrals to secondary care) and systematically collected information on the number of cases identified by trained PCPs. If this last is collected for the broad diagnostic groupings taught in the course, the administrators will have the information they need to determine resource allocation.

5.1 Constraints in the implementation of the training programmes

As the Workshop progressed, it became clear that although widely available techniques now existed to meet the training needs of primary care physicians and other workers, yet a number of constraints still remain.

(a) The first and most serious is a lack of enthusiasm among mental health professionals as well as among senior administrators. Much has already been said in the report of the Intercountry Meeting at Damascus in 1985 about the importance of evolving a national mental health programme as a vital first step to overcome these obstacles. The present Workshop reiterated the need to develop such national programmes at an early date.

(b) The second major constraint is the lack of senior trainers in the Region. Some countries only have a handful of specialist workers with the basic skills to initiate training. The shortage of psychiatric manpower both creates the need for novel approaches and threatens their implementation. Yet, even in some of the most deprived centres, pilot work has begun. The establishment of two or more Regional resource centres where potential trainers might gain skills and experience through short-term fellowships would greatly assist the spread of trainers.

(c) Some participants expressed concern about the lack of technical support. Yet as the Workshop aptly illustrated, much can be achieved without needing to resort to complicated audiovisual material. Lectures and case demonstration, combined with criss-cross discussion and role play, can be substitutes for the television camera and monitor. In the near future, however, the value of television as a comparatively inexpensive technology cannot be overestimated.

6. SPECIAL ASPECTS OF TRAINING OF AUXILIARIES AND OTHER HEALTH PERSONNEL WORKING AT PHC

Along with primary care physicians there is a large number of other health personnel working at PHC level. However, there is as yet no uniform pattern of staffing of such health personnel in all the countries of the Region. Different categories of health staff with varying duties and responsibilities have evolved in different countries. Different names, such as health guides, health workers, birth attendants, health technicians, sanitarians, vaccinators, dispensers, nurses, health assistants, etc., appear in the lists of health services of each country. In recent years there has been a tendency in most of the countries to reduce the categories of health staff in PHC services and encourage multiple functions for different categories. As yet there has been no agreement on the mental health tasks which these health personnel should perform; indeed, in most countries, there is at present no clearly defined mental health role for these workers. Some countries have proposed preventive and health promotive roles while some others have suggested limited curative roles for such staff. Decisions about mental health tasks to be performed by these workers depend on many factors, e.g. the educational background of workers and availability of other trained manpower. In countries where the number of primary care doctors and specialists is limited, health workers are bound to be given added responsibility. Recent evidence in some Regional countries, e.g. Democratic Yemen and Pakistan, suggests that, with appropriate training, health workers can adequately handle a limited number of neuropsychiatric conditions such as epilepsy, psychosis and severe depression, with one or two drugs and also provide counselling for mental retardation and drug abuse.

Principles of Training of Auxiliaries

After discussion in the Workshop, the group recommended the following principles for training of auxiliaries or other health personnel working at PHC level:

1. The mental health training programme for auxiliaries should be made even simpler than that which has been proposed for primary care physicians.

2. More emphasis should be laid on preventive and promotive aspects. Only a limited number of mental disease conditions should be discussed, e.g. epilepsy, psychosis, depression, drug dependence and mental retardation.

3. Psychosocial skills, such as the art of listening, assessing psychological or social stress, emotional support to the family in time of crisis, etc. should form an essential part of training.

4. Techniques of working with the family and community should be included in training. Linkage of mental health training with other preventive and curative tasks at PHC level must be emphasized.

5. The main training can be done by short lectures, case demonstrations and group discussion. Audiovisual aids including videotapes should be used where feasible.

6. Pre- and post-assessment of knowledge, skills and attitude should be an essential part of training.

7. Training should preferably be done at the PHC centre or rural health centres. Cases for demonstration should preferably be from the same community.

8. Simplified manuals and other teaching aids should be specially prepared for PHC workers in local languages.

9. Such training courses should not be conducted only by psychiatrists from distant university centres; physicians and administrative staff working in the health centres should be involved in it. Particular emphasis must be given to the tasks which the workers have to subsequently perform.

7. MENTAL HEALTH INFORMATION FOR HEALTH ADMINISTRATORS

Health administrators play a vital role in developing mental health care; their commitment and cooperation is essential if any broader training of PHC workers is to be achieved. At times there may be resistance and difficulties encountered with health administrators while organizing training programmes. These difficulties are attributed to poor understanding of the necessary components of mental health programmes and the persistence of the view that mental health issues must take second place to other important public health concerns. It is therefore essential that health administrators be provided with adequate information on mental health.

The objectives of such an information programme, which by its nature must be ongoing and situation-oriented, are as follows:

1. To convince the administrator about the necessity of national mental health programmes. This should be done in terms of statistics, health expenditure, and the overall effect of such a programme on health without excessive financial demand.

2. To convince administrators and decision makers that mental health is not a speciality branch of health but an integral part of PHC. The principles of mental health are applicable in all general health services.

3. To overcome administrators' resistance to mental health and to demonstrate to them the effectiveness of mental health activities.

4. To demonstrate to them that the old concept of "mortality-oriented" health is not correct. Mental health needs a "morbidity-oriented" approach. Mental illnesses may not have high mortality but they represent one of the largest causes of personal and social disability, with tremendous suffering for the individual, family and society.

The following approaches can be taken for training administrators:

(a) Using all opportunities of meetings with them to provide some information about mental health. This should not be in lecture form but can be done by engaging them in friendly discussion and answering their questions.

(b) Inviting them on occasions to mental health facilities and showing them the condition of the mentally ill and ways to change it.

(c) Initiating pilot programmes, even in very limited areas, doing research on the effects of mental health training and convincing administrators of the cost-effectiveness of such programmes.

(d) Providing them with small brochures containing some epidemiological data regarding mental health, with a description of the social and public health consequences of mental illness. Such brochures could also delineate the beneficial effects of national mental health programmes and training.

(e) Inviting them to take active part in deliberations relating to mental health planning, including planning for training.

8. MENTAL HEALTH EDUCATION OF IMPORTANT GROUPS IN THE COMMUNITY

8.1 School teachers

School teachers and, in many countries, school health technicians, are among the best resources for mental health. Teachers are particularly worthy targets for health service education as, next to parents, they play the most vital role in forming the value systems and attitudes of future generations. Very simple education, in the form of a one-hour discussion per week, for a 12-week period, and adoption of a mental health component in the curriculum of every primary and secondary school, would go a long way toward ensuring lasting changes in the attitudes of present and future generations. Training programmes should be prepared for all school teachers. The objectives of such programmes are mainly to instil in pupils the value of mental health. Special emphasis should be laid on recognition of learning disabilities, epilepsy, drug addiction, early detection of severe mental illness and mental retardation, etc.

The following approaches can be useful:

- inclusion of mental health training in curricula of all "teacher training" institutes;
- regular visits of mental health personnel to schools or giving regular, relevant lectures for teachers;
- inclusion of mental health training for school health technicians;
- preparing relevant booklets, pamphlets and wall posters, explaining the common mental health problems in schoolchildren and the role teachers can play in finding, helping or referring them.

8.2 Police

Police officials in almost all countries often get involved in mental health problems. The objectives of mental health training for police personnel are to familiarize them with the relationship of crime and mental illness, alcohol- and drug-abuse, and dealing with mental patients in emergencies. Also, such issues as the effect of alcohol on road accidents are important.

Inclusion of relevant mental health material in the curricula of police academies and providing training, with case demonstration and using of pamphlets and booklets, are useful.

8.3 Community and religious leaders

A very influential means of mental health promotion is through community and religious leaders. Their influence can get the public involved in mental health activities. This also helps in taking mental health messages to the public and is particularly important in rural areas.

Mental health workers and primary care doctors in each area should be trained to regard the community and religious leaders of his area as his best helping hands in promoting health. In Muslim countries which constitute the majority of the Eastern Mediterranean Region, mosques are the centre for many social activities and can act as influential centres for mental health promotion.

8.4 Community health committees

It has been repeatedly shown that locally respected citizens can have a substantially influential effect on the uptake of modern medical services. In a number of Regional countries, these figures have been enlisted in the service of health education, and in some (e.g. Pakistan) they have been brought together as a local committee, linked with PHC facilities, to stimulate members of the community to utilize PHC services, and to encourage patients and their families to cooperate in matters of treatment and follow-up. For the most part, these committees are made up of individuals who have already gained some distinction and respect in their local community, e.g. religious leaders, teachers, policemen, retired professionals and ex-servicemen. Such volunteers can be provided with basic training in the recognition of mental disorders; these trained "health guides" are then encouraged to escort patients to health centres, to ensure humane treatment and generally promote the re-integration of former patients into their communities. Such guides may also be taught to recognize high-risk groups, for example children living with sick parents, people with chronic disabilities or sensory defects. They can also be in touch with traditional healers.

Community education in mental health is one of the most important aspects of any mental health programme. The general objectives should be:

1. To provide the community with easy, relevant knowledge of mental health applicable to their daily lives.

2. To remove the stigma attached to mental illness, and promote the idea that mental illnesses are like any other health problem.

3. To promote public participation in mental health activities.

The media can also play an important role in mental health programmes. Newspapers and popular magazines can be used to provide an on-going flow of information regarding mental health. In this regard the press should also be encouraged to control misinformation on mental illness. Radio and television are very strong influential media. Carefully planned popular programmes should be used for mental health education.

9. RESEARCH IN TRAINING

In the section describing the training of PHC physicians and other PHC workers, it will be seen that the Workshop stressed the importance of monitoring and evaluation of training programmes as a means of guiding the development of more efficient and effective programmes. In describing the education of administrators, attention was similarly drawn to the importance of demonstrating the relative success of these programmes in terms of their effect on health service utilization and efficiency. Although so far

described as essential components of training, it is clear that such evaluation provides the basis for more extensive research activities.

The Workshop particularly emphasized the techniques and methods loosely referred to as "health services" research. The basic aims of such studies are to provide information which can guide the development of health care delivery and assist with the difficult task of resource allocation. Specifically, such research should provide information on:

(a) Who are the current users of mental health services?

(b) What numbers, of which type of disorders, are seen by which components of the services?

(c) What are the processes of referral to specialist care? Can these be simplified?

(d) Which disorders require the most input from specialist services and what is the nature of specialist intervention?

(e) Has the introduction of new mental health services and training programmes affected the number of patients seen and the efficiency of the services or changed the way in which mental disorders are managed?

(f) What are the most cost-effective techniques of organizing mental health services at PHC level?

The Workshop acknowledged that there was a paucity of mental health services research and strongly advocated such research to be undertaken by nationals with suitable support by WHO.

RECOMMENDATIONS

The Workshop made the following recommendations:

1. Mental health training programmes must be part and parcel of the comprehensive national programmes of mental health. The Workshop urged the countries of Eastern Mediterranean Region who have not yet developed national mental health programmes to do so urgently for protection and promotion of mental health. These national programmes should be based on the principle of integration of mental health into primary health care. Appropriate mental health training for all categories of health staff is the main approach for the success of the programmes.

2. To provide the necessary impetus for future trainers in mental health in PHC and to evolve a suitable methodology and contents of such training programmes, countries are urged to organize national workshops for training of trainers of PCPs. For this it is recommended that countries request WHO assistance.

3. In many countries of the Region, the trainers available in mental health are limited in number and those who are available may not have had appropriate training and experience in providing suitable training for PCPs and other personnel. Therefore, the group recommends that WHO assist by providing short-term fellowships (1-3 months' duration) for training of trainers in mental health at PHC level. These fellowships should preferably be in centres which are running established training programmes in PHC suitable for developing countries.

In view of the different pattern of PHC in different countries of the Region, it is further recommended that the needs of each country be kept in mind when selecting such centres.

4. Realizing the goals and targets of training programmes, the Workshop emphasized the need for training in PHC setting and recommended that at least part of the training be carried out at PHC level.

5. In order to sensitize the communities and further extend training programmes, the Workshop recommended that health education material suitable for the community needs be prepared.

6. In view of the scarcity of training facilities in various countries of the Region, the Workshop recommended developing national resource centres for training at country level and an advanced centre for training and research in community mental health at a Regional level.

7. Realizing the importance of training, the Workshop recommended that each country adopt the tried and proven training techniques and methods which are outlined in this report. Whenever feasible, countries should develop specialized training centres with all the necessary audiovisual equipment, including television and video-cassettes for teaching.

8. Realizing the importance of task-oriented manuals as an essential instruments for training programmes, the Workshop recommended that appropriate manuals for various categories of health staff in local languages be urgently prepared. WHO is requested to help in developing such manuals and to supply copies of existing ones which are commonly used in the countries of the Region.

9. Since there is great paucity of suitable audiovisual material for mental health training in PHC, the Workshop recommended that WHO collaborate with various countries for development of suitable audiovideotape material. WHO should identify centres in the Region which have facilities for production of such material and facilitate exchange of Regional expertise and material.

10. Realizing the fact that a basic principle of PHC is an integrated approach to all health-related matters, mental health becomes the concern of all health personnel. Therefore, the Workshop recommended that mental health training programmes be provided for all health personnel. The objectives of such programmes should adjust to the needs of each group but all programmes should cover skills in human communication to enhance the abilities of trainees in their communities.

11. Mental health promotion calls for an intersectoral approach and the involvement of many community groups, e.g. administrators. teachers, religious leaders and police; therefore, the Workshop recommended that mental health training programmes include training of these groups together with the development of special approaches suitable for them.

12. Recognizing the importance of developing means of determining the efficacy of such training programmes, the Workshop recommended that the training programmes be carefully monitored and evaluated by the course leaders. This evaluation should include measures of trainees' attitudes, knowledge and skills, both before and after training.

13. Realizing that health services research can provide an important basis on which to develop, evaluate and expand training programmes, the Workshop recommended that research on various aspects of mental health training and its impact on delivery of services be carried out and that collaborative work at both national and Regional level be encouraged.

ANNEX I

AGENDA

1. Inauguration of the Workshop.

2. Election of officers.

3. Adoption of the Agenda and the Programme of Work.

4. Review of national activities in mental health training for general practitioners and other health staff at PHC level.

5. Objectives and curriculum for mental health training programmes in PHC in developing countries.

6. Application of newer educational methods:

   6.1 Use of lectures
   6.2 Use of audiovisual aids
   6.3 Use of television
   6.4 Use of manuals
   6.5 Other methods

7. Demonstration of training methods on a group of PHC doctors.

8. Methods of evaluation of training programmes of mental health in PHC.

9. Training of other health personnel working in PHC.

10. Evaluation of the Workshop.

11. Visit to field areas of community psychiatry near Rawalpindi.

ANNEX II

LIST OF PARTICIPANTS

Bahrain	Dr Mohammad Khalil Al-Haddad Ministry of Health Manama
Cyprus	Dr Vagos Pyrgos * Specialist Psychiatrist Mental Health Services Ministry of Health Nicosia
Democratic Yemen	Dr Abdullah Hassan Al-Kathiri Director Mental Health Programme Ministry of Health Aden
Egypt	Dr Ahmed Nayer Kotry * Director-General Mental Health Department Ministry of Health Cairo
Islamic Republic of Iran	Dr Ahmed Mohit Director Teheran Psychiatric Institute Teheran
	Dr Jafaar Bolhari * Ministry of Health Teheran
Iraq	Dr Ibrahim Al Adhmawi Consultant Psychiatrist Ibn Rushd Hospital Baghdad
Jordan	Dr Ihsan Raafat Director National Centre for Mental Health Ministry of Health Amman
Kuwait	Dr Hussein Ahmed Darwish Consultant Psychiatrist Safat Kuwait

* Invited but did not attend.

Libyan Arab Jamahiriya	Dr Abduraouf Aburkes Psychiatrist and Director Gargarish Hospital Tripoli
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Syrian Arab Republic	Dr Muhamed Ruslan Fares Kamha Physician Ibn Sina Mental Hospital Damascus
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WHO SECRETARIAT

Dr N.N. Wig	Regional Adviser on Mental Health and Secretary of the Workshop	Eastern Mediterranean Regional Office, Alexandria
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Dr M.H. Mubbashar	Temporary Adviser	Professor of Psychiatry Rawalpindi Medical College Rawalpindi, PAKISTAN
Dr T.K.J. Craig	Consultant	Director, National Unit for Psychiatric Research and Development Lewisham Hospital London, UNITED KINGDOM

ANNEX III

LIST OF BASIC DOCUMENTS

1.	Provisional Agenda	EM/INC.WKP.MNH.PHC/1
2.	Provisional Programme of Work	EM/INC.WKP.MNH.PHC/2
3.	Provisional List of Participants	EM/INC.WKP.MNH.PHC/3
4.	Aims and Objectives	EM/INC.WKP.MNH.PHC/4
5.	Course for training primary care physicians in mental health skills	EM/INC.WKP.MNH.PHC/5
6.	Educational methods suitable for training courses	EM/INC.WKP.MNH.PHC/6
7.	Objectives and evaluation	EM/INC.WKP.MNH.PHC/7
8.	Realization of training goals and objectives	EM/INC.WKP.MNH.PHC/8
9.	Mobilizing resources for training	EM/INC.WKP.MNH.PHC/9
10.	Criss-cross fire - A new technology to impart training to PCPs	EM/INC.WKP.MNH.PHC/10
11.	Training of other health care personnel in mental health in PHC	EM/INC.WKP.MNH.PHC/11
12.	Review of model training programme	EM/INC.WKP.MNH.PHC/12
	12.1 Pre-training assessment	EM/INC.WKP.MNH.PHC/12.1
	12.2 Practical guidelines and clinical exercise I	EM/INC.WKP.MNH.PHC/12.2
	12.3 Practical guidelines and clinical exercise II	EM/INC.WKP.MNH.PHC/12.3
	12.4 Practical guidelines and clinical exercise III	EM/INC.WKP.MNH.PHC/12.4
	12.5 Practical guidelines and clinical exercise IV	EM/INC.WKP.MNH.PHC/12.5
	12.6 Practical guidelines and clinical exercise V	EM/INC.WKP.MNH.PHC/12.6
	12.7 Course evaluation proforma	EM/INC.WKP.MNH.PHC/12.7
	12.8 Suggested format of a typical day's training	EM/INC.WKP.MNH.PHC/12.8

ANNEX IV

LIST OF BACKGROUND DOCUMENTS

1. Manuals:

1.1 Manual of mental disorders for primary health care physicians; Wig, N.N. and Parhee, R.; All India Institute of Medical Sciences, Ansari Nagar, New Delhi; 1984.

1.2 Manual of mental health for medical officers; Isaac, M.K., Chandrashekar, C.R., Murthy, R.S.; Community Mental Health Unit, Department of Psychiatry, National Institute of Mental Health and Neurosciences, Bangalore, India; 1985.

1.3 Manual of mental health for multipurpose workers; Murthy, R.S.; National Institute of Mental Health and Neurosciences, Bangalore, India; 1985.

1.4 Drug dependence and alcohol-related problems; a manual for community health workers with guidelines for trainers; WHO Geneva, 1986.

1.5 Zehni Sehat (Urdu); A training manual for multipurpose workers; Department of Psychiatry, Rawalpindi Medical College, Rawalpindi.

2. Report of the Seminar on Community Psychiatry, Rawalpindi General Hospital, 16-17 December 1986.

3. Community-based rural mental health care programme; Report of an experiment in Pakistan; Mubbashar, M.H., Shakeel J. Malik, Zar, J.R. and Wig, N.N.; EMR Health Services Journal, 1986; 1; 14-20.

4. A model for rural psychiatric services - Raipur Rani experience; Wig, N.N., Murthy, R.S., and Harding T.W.; Indian Journal of Psychiatry; 1981; 23, 275-290.

ANNEX V

PROGRAMME OF WORK

Saturday, 7 March 1987

09.00	- Inauguration
10.00	- Coffee break
10.30	- Plenary Session I
	- Election of officers
	- Adoption of agenda and approval of plan of work
	- Introduction of participants
	- Introduction and scope of working (includes a general account of the recent progress and activities of training in mental health care in primary care settings in countries of the Region)
	- Description of national activities in mental health training in primary health care setting by each participant; needs for training and previous experiences of offering training (ten minutes each country)
	- Summary of national presentations
13.00	- Lunch
14.00	- Group Session I
	- Small group workshop (two groups, eight countries each - rapporteur to be appointed; a resource person allocated - explanation of the task for each participant)
17.00	- Close

Sunday, 8 March 1987

09.00	- Plenary Session II
	(Topic: objectives and contents of training programmes courses)
	- Introductory remarks - mobilising resources for training programmes
	- Objectives of training programmes
	- Importance of gaining new skills
	- Importance of changing attitudes
	- Contents of courses: determination of priorities
	- Demonstration of training programmes; Pakistan, Egypt, Yemen, UK
13.00	- Lunch
14.00	- Group Session II
	- Small group discussion
17.00	- Close

Monday, 9 March 1987

09.00	- Plenary Session III
	(Topic: Educational methods)
	- Use of lectures; adapting style and content for PCPs assign tasks to participants: each group to take a topic, e.g. detection of depression, epilepsy, psychosis
	- Use of audiovisual aids in training
	- Criss Cross Fire (description and audiovisual demonstration)
	- Use of television (improving detection skills, clinical decision exercises and other uses)
	- Use of manuals (demonstration of existing manuals; value of modifying and adapting for local use)
13.00	- Lunch
14.00	- Group Session III
	- Small group discussion
17.00	- Close

Tuesday, 10 March 1987

09.00	- Plenary Session IV
	(Topic: Joint meeting with local primary care physicians)
	- Introduction
	- Presentation by consultants
	- Lectures by participants
	- Demonstration of some uses of television in training primary care physicians
	- Demonstration of "Criss Cross Fire"
	- Feedback from primary care physicians
13.00	- Lunch
14.00	- Group Session IV
	- Small group discussion
17.00	- Close

Wednesday, 11 March 1987

09.00	- Plenary Session V
	(Topic: Evaluation)
	- Evaluation of indicators of efficacy
	- Training other health personnel in mental health in primary health care
11.00	- Group Session V
	- Presentation by each participant of detailed proposal for a training workshop
13.00	- Lunch
14.00	- Plenary Session VI
	- Evaluation of the workshop
	- Recommendations
16.00	- Closing Session

Thursday, 12 March 1987

Visit to field areas to see community psychiatry programme.