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Training matters

Leadership development for mental health: an educational workshop in Africa

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Community leadership for mental health is of increasing importance in developing areas of the world. As changes such as urbanisation and industrialisation affect these areas, their mental health problems are becoming more apparent. These include conditions requiring either curative or custodial care in an often distant hospital, but probably most others are more appropriately managed by integrating mental health into primary health care, closer to patients' homes (Giel & Harding, 1976; Harding, 1980; WHO, 1984a).

Some governments do formulate policies for such integration and some districts implement innovative mental health programmes at the community level; they recognise that a health service includes leadership at all levels, including the local community. In many areas, however, resources are very scarce and people unsure how to proceed (Ayonrinde, 1987; Beigel, 1980; Climent, 1983; Edgell, 1983).

Educational workshops can contribute to community mental health. Firstly, they can help to assess community needs, set objectives and priorities, formulate plans, and implement actual programmes. There are several approaches to enhance mental health in the community, but since few local areas have the resources to plan these systematically, new initiatives are needed to increase their capacity to do so. Workshops can also prepare people for effective practice. Many mental health workers receive training just to provide treatment for patients who come to their clinic, rather than to take leadership roles. They rarely receive training to prevent mental disorders, promote mental health, organise groups for supportive social action, or involve people in mental health activities that can affect their lives (WHO, 1982, 1987b).

This paper describes a World Health Organization (WHO) workshop on leadership development for mental health, held in August 1987 in Arusha, Tanzania, with financial supprt from the Danish Agency for International Development (DANIDA). Participants included both teams of regional and district mental health workers as well as more general health and community workers from East and Central African countries.

Several African countries recognise the importance of mental health as an area that requires planning and development. Africa has many of the same mental health problems as other continents, though with differences in prevalence due to malnutrition, parasitic and infectious diseases, as well as particular neurological and other disorders (Sartorius, 1980).

Africa also has special problems relating to poverty, geographical maldistribution of facilities, overcrowding, unemployment and changes in social structure and family support from urbanisation. For example, the infant who is mentally retarded due to prenatal subnutrition in pregnancy, the adolescent who forms peer relationships which cause anxiety at home, the elderly person who is viewed as a burden and abandoned by the family, the migrant displaced from the village who finds hardship in the city, and the unemployed worker who falls into alcohol abuse and drug dependence (WHO, 1985, 1986a).

However, most African countries give priority to serious physical health problems and to unmet needs for food, water and the eradication of infectious disease, rather than to mental health. The countries that do allocate limited resources tend to emphasise curative care in centralised, custodial hospitals, rather than primary, preventive, or promotive care at the local level. Hospital facilities are usually few in number, economically inaccessible to most people, and uneven in quality. A few countries, however, recognise that mental health care should be provided primarily by general health workers in the community. They develop programmes to provide care, involve families and other forms of social support, increase collaboration between services, and integrate these with broader economic and social developments.

WHO has recognised the importance of leadership development for mental health, in accordance with its global principles (Sartorius, 1988; WHO, 1987a).

The African Mental Health Action Group, convened by WHO and composed of representatives from Eastern and Southern Africa, has advocated holding courses locally to strengthen the skills of mental health workers and of those with whom they work in other disciplines and sectors (WHO, 1982; 1984b, 1986c).

By the mid-1980s, Tanzania was well situated to provide such training: its national mental health programme began as a joint venture between the government, WHO and DANIDA in two pilot regions – Kilimanjaro and Morogoro. This aimed to improve mental health care, integrate it into primary health care at the district level, and concentrate on policy formulation, programme planning, and the development of coordinating groups (Jablensky & Hauli, 1983; WHO, 1986b). The pilot project was completed, favourably evaluated, and proposed for extension to other areas of Tanzania and Africa. It was hoped that Kilimanjaro and Morogoro could demonstrate the Tanzanian model and provide examples of community-based care at an international workshop.

Planning before the workshop

Planning assumed that invited countries were interested in developing mental health plans and programmes; that regions and countries would each send one mental health professional and one regional administrator or community worker; that participants would come prepared with information on mental health in their home area; and that they would be willing to share their experiences.

The broad aims were to:

(a) provide knowledge and skills for the effective leadership and management of mental health programmes
(b) strengthen the capacity of regional and national administrators and mental health professionals
(c) demonstrate the Tanzanian model to visitors from other countries
(d) incorporate experiences from the pilot areas into other areas of Tanzania
(e) test a course structure for use in other workshops or seminars
(f) produce training materials.

As well as providing leadership training and management skills through interdisciplinary dialogue about solving mental health problems, the workshop would improve knowledge of methods of developing community mental health activities. The emphasis would be on community involvement and on the Tanzanian national mental health programme as an example.

At the end of the course, participants were expected to demonstrate some combination of knowledge and skills to:

(a) understand the broad scope of a mental health programme, including the psychosocial components of health and development activities
(b) understand the methods used to integrate mental health components into the health activities of the Tanzanian pilot programme regions, as well as ways to adapt these strategies to their own areas
(c) plan and implement community needs assessments, set goals, select priorities, formulate organisational strategies, recognise power structures, and ensure community participation
(d) apply leadership and management skills to foster inter-sectoral collaboration, train community-based leaders and managers, monitor and evaluate programmes in action, and strengthen supportive organisation.

The teaching faculty represented a range of resources and areas. A psychiatric nursing officer and medical officer came from the Tanzanian pilot projects. The coordinator of the Tanzanian national mental health programme provided national perspectives. The WHO African Regional Adviser in Mental Health put the activities into a broader context. The Director of the Mental Health Department in the Ministry of Health & Social Assistance of Turkey, brought experience from a more developed nation. The Director of the WHO Division of Strengthening of Health Service put the learning into a wider WHO context. The Senior Medical Officer of the WHO Division of Mental Health, in Geneva, contributed information about mental health programmes in several countries around the world. One facilitator from the University of Michigan had extensive experience in education for community planning, and another from Chapel Hill, North Carolina had previously served in programme administration and consultation in Somalia.

During the workshop

The workshop began with a social gathering, an orientation session covering the context and objectives, reports by participants on their home situations, and an official opening which included the local authorities. Group process exercises were used to help participants meet one another, exchange their experiences and expectations, and build a sense of community.

Participants reported on mental health coverage in their home areas; each had previously been provided with guiding questions. One team described their

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local estimates of the prevalence of epilepsy, schizophrenia, acute psychosis, alcoholism and drug abuse, affective disorder, brain damage, and depression, as well as the mental health care available in a mental hospital, dispensaries, and health centres, including shortages of equipment, transport and personnel. Another described their country's system of hospitals and health centres, few of which have personnel trained in mental health, as well as their mental health activities carried out by police, teachers, magistrates, social agencies and church groups. Yet another, representing the African National Congress in Zambia, described the mental health impacts of apartheid and of exile from South Africa. These included the 'comb test', used to classify families as white or black, the 'tot system' by which whites offer shelter or food in exchange for tots of wine from blacks, child removals and family separations, and surveys of hypertension, depression, paranoia, and 'the disorder of the whole person' in those affected by apartheid.

First week

The first week emphasised:

(a) general concepts and techniques of community mental health programmes
(b) the programme planning process
(c) evaluation of experiences and implications of the Tanzanian pilot programme.

Participants discussed definitions of mental health based on principles of public health, community involvement, linkages with traditional healing, and the use of non-specialist health workers. Emphasis was placed on the integration of mental health into primary health care, on education, promotion, and prevention in addition to direct treatment and curative care; and on the mobilisation of resources at the community level. There was also discussion of methods for analysing problems and generating solutions: the process of developing a project proposal was presented as a way to plan and evaluate a project.

In evaluating the Tanzanian mental health programme, participants divided into groups, each combining different nationalities and specialties to analyse and assess one aspect each:

(a) community participation
(b) evaluation
(c) the peripheral mental health worker
(d) management and administration
(e) planning and budgeting
(f) training.

Each group developed questions to gather information on its particular component, and received briefings by Tanzanian faculty members.

Participants visited a rural health centre in Kilimanjaro where community health workers reported on maternal and child health, family planning, nutrition and parasite control, essential drugs, tuberculosis, leprosy, and integrated mental and physical health services. Some of its workers spend much time giving school talks, church sermons, and other presentations integrating physical and mental health. Their mental health activities began with community meetings attended by local authorities, and religious and village leaders. They organised a district mental health committee, and sponsored informal education in schools in conjunction with nurses, mental health workers, and agricultural and community-development auxiliaries.

Participants also visited a town council dispensary, where community health workers described collaborative mental health services, with mutual referrals among various health centres, traditional healers, etc. They met local leaders, public officials, regional planners, religious leaders, traditional healers, and hospital administrators all of whom were familiar with community health in Kilimanjaro.

Following the field visits, the participants worked in teams, wrote up the findings, and presented reports evaluating components of the Tanzanian programme. The field visits provided opportunities for them to look carefully at what happened in Kilimanjaro, describe it as objectively as possible, evaluate the experience, and relate it to their home situations. The process enabled them to discuss a common experience and to build mutual support.

Second week

The second week emphasised skills to ensure effective community participation in mental health and to develop plans which could be implemented on return home. Sessions emphasised community participation as a process of involving individuals and groups to assess community needs, identify and sensitise influential people, form and develop committees, plan and run meetings, build support, collaborate with other organisations, educate the community, and develop leadership through workshops. They included practical exercises to develop content knowledge, employ process skills, and prepare programme plans.

Wherever possible, community participation techniques were used as learning activities to develop content knowledge and demonstrate process skills simultaneously. For example, participants made lists of community participation methods for their home areas, and averaged five methods per person. Then, in small groups, they 'brainstormed', so that 32 methods were reported to the workshop, after which all participants employed the 'nominal group process', in which they first wrote individual responses

and then circled the room for ideas to promote mental health in their home areas. After 20 minutes, the full group had generated more than 100 new ideas for the implementation of programmes.

As individuals, participants also made lists of 'sensitisation statements' to support a community mental health programme in their home areas. They then contributed their strongest statements to the full group to use in building support for programme implementation. After this, they made lists of statements which might be used against a mental health programme, wrote positive responses in an adjacent column, and connected the opposing statements and positive responses with a continuous line back-and-forth down-the-page, to visualise sensitisation as an active dialogue and interactive process.

Two participants were selected for role-playing the process: one as a staff member whose agency was planning a meeting to discuss a possible programme. She had been asked to contact another participant, communicate the importance of the proposal, and encourage him to attend the meeting. The other played the role of a village leader who did not believe there was a problem and would not easily change his point of view. After this, the participants described their feelings about it and the observers gave their views. Together, these exercises identified specific sensitisation statements about mental health, rehearsed responses to actual situations, and practised forms of behaviour that might build support for implementation.

Developing programme plans

Participants worked in teams to develop written proposals for planning and implementing a community mental health programme into primary health care, on their return home. They received worksheets which were designed to help generate ideas and organise information about elements which involved either few or no new resources.

Participants then presented their plans to the workshop. For example, one team planned to sensitise key persons in their ministry of health to form a national mental health committee, develop curricula and conduct workshops for the training of trainers, and sensitise the community through informal discussions with influential people, meetings with health committees, and mass public campaigns. Another planned to form mental health committees at regional and district levels, design curricula and workshops to train mental health workers from districts, and conduct talks with schools and village leaders. Yet another planned to assess mental health needs, visit community health centres, identify traditional healers, and train health workers to integrate mental health into primary health care.

Evaluating the workshop

Evaluation was emphasised before, during, and after the workshop. Firstly, the curriculum included a session with practical exercises by teams, each of which was to evaluate a component of the Tanzanian pilot programme, their own programme plans, and the workshop itself. The session included both individual and group exercises on continuous, periodic, final, before-after, and follow-up types of evaluation.

Secondly, participants evaluated the workshop throughout, both by formal and informal methods, as well as in special sessions at the midpoint and on the final day. Methods included review of the workshop according to its original objectives, discussion of evaluative 'words' describing the workshop, and use of an informal questionnaire analysing major points of learning. Participants were asked about the administrative arrangements and content material, and for suggestions for improvement.

Thirdly, participants evaluated their own learning through a written pre-test and post-test questionnaire, seeking both open- and close-ended responses on content and process. Participants reviewed a list of areas of knowledge and skills, indicated those most essential to their progress, and assessed their levels of adequacy. They also wrote down what they had expected would take place at the workshop, what roles they thought both organisers and they themselves would play, and in what ways they would use new knowledge and skills on returning home.

Fourthly, WHO provided support for participants to evaluate and report progress on implementation, 6 and 12 months after the workshop.

Fifthly, faculty members evaluated the workshop, both as a formal and an informal process. They applied evaluation in the evenings, at the end of the workshop, and by mail afterwards.

Finally, facilitators compiled a report (WHO 1987c) and resource package (WHO 1987d) to describe the workshop, communicate its findings, and stimulate possible applications elsewhere. They compiled materials in the hope that these would be extended to other countries in Africa and elsewhere in the world.

After the workshop

Participants reported progress and faculty compiled information in a newsletter – *Leadership Development for Mental Health* – with information such as the following:

Participants from Iringa sensitised both regional and government authorities about introducing a mental health programme; they formed mental health committees at the regional level and for each of five districts, which developed plans to implement the programme, including a psychiatric unit and

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rehabilitation village. They conducted workshops for village leaders and non-health workers, and for committee members, who then held meetings in schools, police barracks, etc. They introduced psychiatric community services into five district government and three Catholic mission hospitals.

Participants from Morogoro selected an urban district for mental health education in religious societies. They had discussions with regional health officials and religious leaders, and held a community mental health conference.

Participants from Lindi briefed regional medical officers on the programme, and formed a regional mental health steering committee, chaired by the regional development director. They held a workshop for participants from four districts including local government members, hospital workers, medical assistants, and the district medical coordinator. They also visited traditional healers, church leaders and schools.

Participants from Malawi briefed authorities in the Ministry of Health, who identified an area for a pilot project, and staff in seven district hospitals to promote mental health. They collaborated on an educational programme to make primary school children more aware of alcohol abuse, drug dependency, and other mental health problems.

Participants in Uganda formed the Community-Based Mental Health Care Association.

Participants from Zambia visited rural health centres and discussed plans to sensitise the village health committees about mental health with community health workers.

Participants from Zanzibar briefed officials in the Ministry of Health, whose planning committee formed a national mental health committee. They conducted several one-week courses on primary health care, including units on mental health, and conducted a mental health survey in two villages, with plans to survey the whole of both islands.

Lessons learned

Educational workshops can provide knowledge and skills to integrate mental health into primary health care

Many mental health professionals work at district or provincial levels of the health system, but they rarely receive training to take a leadership role in ensuring that the health service within a district contains a mental health component.

The workshop started with analysis of a large-scale community-based mental health programme, included within primary health care. It dealt with ways in which local projects could be planned, including the need for community involvement. It provided opportunities for participants to prepare written proposals for a project at home, and to report progress after the workshop. The emphasis was on knowledge and skills which are not usually available in traditional training; as a result, a number of participants have begun to integrate mental health into primary health care.

Participatory learning can strengthen leadership development for mental health

In contrast to an approach in which the teacher talks and students listen, this workshop involved participatory learning in which facilitators asked questions and posed problems, and the participants exchanged ideas and shared solutions. Each session included information on content and process, through a combination of pedagogical and practical methods.

Learning activities included readings, discussions, written assignments, individual and group exercises, while pedagogical techniques included lectures, seminars, panels, field trips, case studies, problem-solving exercises, preparation of reports, and programme planning. They included role playing, story telling, special sessions for participant-initiated unmet needs, open periods for the preparation of assignments, and synthesis sessions with presentations to the group. Participants analysed a common programme and assessed applications for their own situations.

Training and learning activities were selected to develop knowledge and skills for problem solving, and for the planning and implementation of projects. For example, time-limited lectures analysed knowledge, group discussions generated ideas and developed proposals, field trips provided in-depth coverage of practical experiences, role playing simulated real-world situations, case examples and scenarios illustrated process dynamics, and discussions drew out lessons for future practice. The aim was not just to provide information but to strengthen skills for leadership development.

Participant involvement in a workshop can prepare people for practice in the field

Workshop planning included pre-course consultations with participants and facilitators to discuss the programme priorities and learning needs of the participants. A questionnaire sought information on their own levels of capacity, the knowledge and skills most essential to them, and on their roles and responsibilities. They were asked to assess their community conditions and to prepare a presentation. The workshop began by asking participants to introduce themselves, their work, and their home areas. Course process included informal educational techniques: staff encouraged them to discuss their expectations, and to identify unmet needs which could be dealt with in special sessions. Participants

were asked to evaluate the workshop before, during, and after its proceedings.

Workshop involvement in the community can have mutual benefits for experiential learning and community action

This workshop was closely connected to the community in which it was held. It offered opportunities for participants to consider perspectives different from their own, to develop practical skills, and to relate experiential learning to their own situation; they were encouraged to undertake new projects based on learning from others.

Protocol visits to local authorities allowed the mayor to communicate concern for mental health and direct the regional medical officer to initiate a programme. Presentations to hospital officials stimulated a commitment to promote mental health, while field visists to health centres and local authorities had mutual benefits. Workshop activities were attended by journalists, were reported in the media, and contributed to public awareness. When the national party chairman came to inaugurate a nearby facility, participants were invited to take seats in the front. The workshop report was used to help disseminate results and to extend activities to other areas around the world.

Community involvement in a workshop can strengthen the scope and quality of learning

Special efforts were made to involve the community in the workshop; the Tanzanian national mental health coordinator participated in pre-course planning. Participants were asked to assess community conditions and to prepare a presentation about them in the workshop. Regional and district authorities participated in proceedings, and made presentations on relevant topics, while media representatives attended and reported developments in local newspapers.

There are obstacles and opportunities to educational workshops

There are obstacles in the way of educational workshops such as this one. It is difficult to plan details when distances are great, or when transport and communications are unpredictable. Some participants experienced delays in travel, unscheduled changes in arrival and departure, lost luggage, and missing materials. Letters of invitation and travel authorisations were late in reaching some destinations. Reference books, mailed months before, had not arrived by the end of the workshop, so that some participants wanted more time to read resource materials and prepare programme proposals. However, others had to remain for days after the workshop because of travel difficulties.

Although participants were expected to come prepared with information on mental health coverage in their home areas, necessary data were not always available to them. Faculty members prepared extensive resource materials to complement curricula, but recognised the need for case studies of exemplary community mental health programmes. However, despite such obstacles, participants were highly positive in their various evaluations of the workshop, as were faculty members. They indicated that this type was an effective model for replication elsewhere, that participants were receptive to an expanded definition of mental health emphasising community participation, and that Africa offers fertile ground for expanding effective community-based mental health programmes.

Comment

Educational workshops can strengthen leadership development for mental health. This workshop provided opportunities for personal and professional development. Many mental health workers operate in isolation, work in health systems that emphasise other needs over mental health, or receive training to treat patients rather than to plan programmes. In contrast, these participants completed the workshop with the expectation that they would take the initiative and implement a programme.

The workshop also provided opportunities for organisational development. It is difficult to organise around mental health when resources are scarce, or when other needs have priority, or when curative care for disease is emphasised rather than measures to promote and protect health. This does not mean that educational workshops are the only means towards leadership development; they operate in an organisational and community context, but require other resources to be truly effective. The challenge is to recognise their uses, integrate them with other approaches, and make them effective.

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The Cardiff Liaison Psychiatry Study Group

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We decided to evaluate the recommended reading for US consultation liaison fellowships (Mohl & Cohen Cole, 1985). Our group was open to interested doctors who had either passed Part I or who had relevant previous experience. The seminar group met in the evenings every two weeks for six months and all members shared the synopsis and presentation.

Initially there was some scepticism regarding the definition of the role of liaison psychiatrists which the initial two meetings addressed. The origins and relevance of CL psychiatry were wider then expected and Lipowski's 1974 paper was an interesting account defining the development of a role beyond the familiar territory of deliberate self harm. There was comparability between the US and UK but members felt that US style liaison was rarely present in the UK and consultation patchy. The following questions arose from the discussion:

(a) Is there a demand for such services in the UK?
(b) Is there the interest and expertise to meet any such demand?
(c) Is this a speciality area?

The various papers on psychotherapy were well received. Most British psychiatrists recognise the widespread deficiencies of training in this area and the application of various dynamic models in the medical setting provoked stimulating discussion, in particular regarding Kohut's 'Self Psychology' (Baker & Baker, 1987). Psychotherapy was felt to be an important treatment modality in the application of a biopsychosocial model. Case discussions clearly illustrated the psychodynamic insights commonly utilised in US practice and these provoked thoughtful discussion (Meyer & Mendelson, 1961).

The need for a liaison role was illustrated by the repeated occurrence of particular clinical problems (e.g. DTs) on certain wards where staff education is clearly needed. Although the acceptability of a staff orientated approach was questioned, its relevance was readily accepted.

The existence of a body of knowledge in areas such as somatisation disorder was felt to support the