EXPERIENCE FROM A COMMUNITY PSYCHIATRIC EDUCATION VENTURE IN THE NAVY

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Abstract

Naval Headquarters had directed the psychiatrists in the three commands of the Navy to conduct a series of lectures followed by question-answer sessions to the divisional officers and senior sailors. The purported reason was to reduce the incidence of various psychiatric illnesses, drug abuse, alcoholism and suicide among service personnel and their families. A power point presentation was prepared and six interactive sessions conducted with divisional officers and senior sailors. The logic followed in the preparation of the presentation is explained. The audience was requested to fill in a questionnaire to evaluate their demographic profile, their understanding and attitude to psychiatry and efficacy and their suggestions to improve upon the current presentation. Psychiatric awareness among the targeted population was low but receptivity to the presentation was enthusiastic. This effort is preliminary and further studies are called for in this important field of health education.

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KEY WORDS : Community; Experience; Navy; Psychiatric Education.

Introduction

In June 98, Naval Headquarters directed the psychiatrists of three commands of the Navy to deliver a lecture followed by question-answer session with the purported aim of reducing the incidence of psychiatric illnesses, drug abuse, alcoholism and suicide among service personnel and their families. The lectures were to be directed at the divisional officers and senior sailors of the Command. The divisional officers and senior sailors are the first rung leaders in the Navy and are mostly in the rank structure of Petty officer to Lieutenant commander (equivalent to Havaldar to Major in the Army and Sergeant to Squadron leader in the Air Force). The aim of this paper is to share with service medical professionals the logic followed while making a standard power point presentation to the first rung leaders of the Navy. Audience feedback in the form of a non-standardized questionnaire is analyzed in terms of audience demographic profile and its attitude towards and understanding of Psychiatry. Audience opinion on the presentation and their suggestions for further refinement were sought and discussed. Health education is recognized as an effective means of secondary prevention, in that, it goes a long way in early recognition and treatment of mentally ill. Focussed secondary prevention makes more sense in mental illness as most mental disorders start at such an early age that it is very difficult to envision broad based programs to prevent their occurrence and interventions to prevent

chronicity are highly complex [1]. In the short run, there may be increased incidence of cases of minor psychiatric illness and substance abuse because of referral of cases earlier neglected in the community.

Material and Methods

The audience : A series of 6 lectures + question - answer sessions were delivered by the principal author in Mumbai and Goa in Aug 98, which were attended by a total of 146 divisional officers and 553 senior sailors. Each lecture involved a 45 minute power point presentation followed by 30-45 minute free-floating discussion.

The presentation : A very limited number of readymade presentations are available on the Internet [2,3] to educate lay persons in psychiatry. None was found appropriate for unmodified presentation to the targeted audience. A customized power point presentation was prepared keeping the following in focus :

Presentation to be short : It was decided to keep the lecture at less than 45 minutes to sustain audience attention.

Topics Covered : It was decided to focus on those psychiatric disabilities, which evade referral to a psychiatrist. The decision was based on clinical experience of the principal worker and included conditions like alcohol dependence, depression, anxiety, obsessive compulsive disorder and sexual dysfunction. Major psychiatric disorders were referred to in passing to highlight that they form only a minority of illness treated by a psychiatrist.

Authenticity of the content presented : All statistics quoted have been extracted from standard textbooks. Temptation to sensationalize incidence of psychiatric illnesses by presenting inflated statistics was avoided to retain credibility in the long run. However, WHO authenticated figures like 5 of 10 leading causes of disability worldwide (major depression, schizophrenia, bipolar disorders alcohol and obsessive compulsive disorders), being mental disorders [4] was emphasized to highlight relevance of community psychiatric education.

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Highlighting of signs and symptoms : Signs and symptoms of chosen psychiatric disabilities were highlighted in an easy language to enable their recognition in the community.

Removal of commonly held myths : While interviewing patients in clinical practice the principal author has found patients being concerned over certain issues. These include notions like :-

- (i) Psychiatric illnesses are by and large untreatable.
- (ii) All psychiatric disabilities are chronic and persist for life.
- (iii) Hospitalization is imperative for psychiatric disability in the Armed Forces.
- (iv) Psychotropic medicines are universally sedative and produce dependency. Psychotropic medication needs to be continued for life.
- (v) Anyone who goes to a psychiatric clinic is psychotic or mad.
- (vi) Psychiatric diagnosis leaves a life long stigma.
- (vii) Psychiatric illnesses are genetic and diagnoses of such disability in a family, stigmatizes other members.

The presentation addressed all these issues by highlighting short lasting psychiatric disabilities, drawing comparison between chronic psychiatric and physical disabilities, placing stress on OPD management of minor psychiatric ailments and principles followed in planning and terminating psychotropic medication. Stigma was dealt by emphasizing the medical model of psychiatry.

The feedback : The lecture was followed by an open house discussion. Efforts were made to encourage audience participation, which lasted 30-45 min. in each session. All audience discussion was carefully recorded for further analysis. Audience was requested to fill a short non standardized proforma to help analyze the demographic profile of the audience, its attitude, the amount and source of understanding of psychiatry prior to this exercise and its impression and suggestions for further refinement of the current exercise.

Results

A total of 699 performa returned have been statistically analyzed. Of the 699, 57 were blank and excluded from analysis. Significantly 56 of 57 blanks were returned on one particular day of the 6 day presentation.

Demographic profile of the audience : The rank structure of audience is given in Table-1. The audience was predominantly male with only 6 female officers attending the series. The mean age of sailors was 34.38 years with the age range being 28 to 53 years. The mean age of the officers was 28.59 years and the age range was 21 to 47 years.

TABLE 1

Rank distribution of officers and sailors

Sailors (n=496)		Officers (n=146)	
Rank	Number	Rank	Number
Petty officers	127	Sub Lieutenant	06
Chief petty officers	154	Lieutenant (male)	88
MCPO II	147	Lieutenant (female)	06
MCPO I	67	Lieutenant Commander	43
Hon. SL/Lt.	01	Commander	03

Self-assessment of psychiatric awareness (Fig-1) : Just short of 10% of the audience confessed to being totally unaware of psy-

chiatry. Surprisingly double the percentage of officers (14.48%) compared to sailors (7.44%) expressed such total lack of awareness. A large percentage of the audience (85%) confessed to having heard of psychiatric illnesses and psychological causation of disease but considered their knowledge inadequate for divisional work. Only just over 5 percent of audience believed that they knew enough psychiatry to handle their divisional work. Unsurprisingly nearly double the percentage of officers (8.28%) compared to sailors (4.63%) considered their psychiatric awareness as adequate.

Source of psychiatric awareness (Fig-2) : We were interested to know from where service personnel acquire their awareness. We were disappointed that unit doctor was credited with providing them psychiatric awareness by less than 10% of the audience. Taking into consideration the large strides made by the print media it was unsurprising that nearly 47 percent of audience credited their psychiatric awareness to newspapers and periodicals. Officers tended to credit books, newspapers and periodicals much more than sailors indicating a healthy reading habit among officers. Friends and acquaintances turned out a close second to newspapers and periodicals as source of psychiatric awareness. Signifi-

Fig. 1 : Self assessment of psychiatric awareness

Fig. 2 : Source of psychiatric awareness

Fig. 3 : Receptivity to the lecture series

cantly old psychiatric patients were cited as source of psychiatric awareness by over 17 percent of the audience.

Receptivity to the lecture series (Fig-3) : Over 95% of the audience found the lecture series useful while carrying out their divisional work.

Discussion

A studious Internet search of International psychiatric journals listed on www.docguide.com revealed no reference to a similar standardized presentation for use in lay general public. Certain US Armed Forces sites listed associated topics but even abstracts of these topics could not be accessed as they were probably classified. This study therefore suffers from lack of comparison with a similar study done before.

Presentations listed in reference [2,3] were on restricted topics, did not offer any logic in their preparation nor has their effect on targeted audience been analyzed. It was therefore left to the authors to define principles for preparation of the presentation from their own clinical experience. The logic followed in the preparation of the presentation is therefore arbitrary and not based on any comprehensively analyzed need of the targeted population.

The audience response was collected on a non-standardized but specifically formatted questionnaire for the current presentation and the selected audience. Verbal interaction with the audience was also recorded to ferret out the felt needs of the targeted audience and areas to be refined in the future. This procedure though statistically weak is expected to give a deeper understanding of the felt need, usefulness and scope for refinement of the presentation.

The significant return of 56 of 57 blank performa

on one particular day was analyzed. The same power point presentation was used on all 6 days of the lecture series. Equal effort went into each lecture to make it as interesting as possible and special emphasis was laid on audience participation. The only variable on the day of poor performance response was that speaker was not introduced to the audience, by a significant senior officer due to reasons beyond control. Associating community leaders of the Armed Forces like senior serving and retired Generals and their equivalents in other services and their spouses can perhaps evoke audience interest in this very important health education venture.

Unit doctors turning out a poor fifth as source of psychiatric information to the audience is a matter of concern. The authors believe that the best way of improving psychiatric knowledge of unit doctors is by inclusion of a qualifying test in Psychiatry at the MBBS level in the Armed Forces Medical College (AFMC). A similar suggestion was made by the Indian Psychiatric Society to the Medical Council of India. In the short run selected audience of the service community can be health educated on psychiatric topics by psychiatrists periodically and such a program would be best co-ordinated through the office of the DGAFMS in consultation with Consultant Psychiatry. The audience profile can be enlarged by addressing unit commanders, adjutants, senior officers and families of officers and other ranks. The current presentation on floppy is available and can be further improved upon. Officers' healthy reading habits could be utilized by placing books and journals elaborating on psychiatric topics in unit libraries.

This work is preliminary and surprisingly similar studies on such an important area of health education have not been undertaken either in the Armed Forces or in general population. Future studies in this area are expected to validate or refute some of the conclusions drawn by the authors of this study. However the authors venture to make the following observations and suggestions for follow up.

1. Community psychiatric awareness in the Navy is minimal.
2. Low psychiatric awareness causes unwarranted fears, tendency to ignore or hide psychiatric disability, avoidable discomfort to the individual and manpower wastage to the Navy.
3. Receptivity of Naval community to psychiatric education is positive.
4. No organised effort is on to improve psychiatric awareness in the Armed Forces community by the

psychiatrists.

5. Office of DGAFMS in consultation with Consultant (Psychiatry) can work out details for a continued community psychiatric education program in the three services,

6. Acceptance through association, targeting opinion makers in the community, taking advantage of reading habits of officers, making available books, newspapers and periodicals touching on psychiatric topics and educating the medical students at AFMC with the added incentive of a separate examination in psychiatry at the final year MBBS level are some of

the worth while tactics to improve Armed Forces community psychiatric awareness.

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