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Training School Teachers in Malawi about substance misuse and trauma: the need for a sustainable strategy

Journal:	<i>Journal of Mental Health Training, Education and Practice</i>
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Abstract

Purpose: The World Health Organisation found depression to be the fourth leading cause of disability in Malawi (Bowie 2006) with the prevalence of mental health need in children and young people in Malawi estimated between 10-30% (Kutcher et al, 2019). One option to address this was to provide schoolteachers with skills and knowledge related to mental health so they can better support children. There is generally a lack of evidence of the utility or feasibility of school-based mental health literacy programmes in low to medium income countries (LMIC). **Methodology:** The aim of this project was to determine the acceptability and feasibility of delivering a training initiative in Malawi to teachers to better enable them to recognise and cope with school children who had been exposed to trauma and substance misuse. **Results:** Feedback was generated through the use of a specifically designed pre and post measure, focus groups, interviews and observations of the teaching delivery. **Implications for practice:** Teachers found the training built on their existing knowledge and they requested further opportunities for training and consultation about how to manage difficult presentations. It was evident that teachers did not know how to access mental healthcare or support for children whose needs could not be met by schoolteachers alone. **Value:** For a sustainable improvement for children's mental health care in this context, further training becomes valuable when located as part of a network of joined up health and educational services.

Introduction and background

Globally, up to 14% of the burden of disease is attributable to mental illnesses, with the onset of most mental disorders occurring before the age of 25 (Patel et al. 2014; Prince et al. 2007), making youth mental health a global priority. Although mental health data on young Malawians is scarce, the World Health Organisation found depression to be the fourth leading cause of disability in Malawi (Bowie 2006). The World Happiness Survey further suggests that poor mental health is common in Malawi: Sub-Saharan Africa was found to have the lowest levels of life satisfaction of all world regions, and Malawi ranked 29th out of 44 countries for which there were data (Helliwell et al 2017). However, Malawi has a mental health provision of 2.5 psychiatric nurses and less than 1 psychiatrist per 100,000 population (Jacob et al, 2007) with only three psychiatric in-patient units available nationally two of which are owned by the Catholic church and one government run. The overwhelming majority of mental health treatment is provided in primary care, with those experiencing mental health problems residing within their local communities. They are no mental health services for the majority of the population, anyone showing signs of mental health problems at a district hospital or clinic is referred for admission at one of these three in-patient mental hospitals.

Given the amount of time young people worldwide spend in school, these are arguably ideal places in which to implement mental health promotional activities and interventions (Kieling et al. 2011; Purcell et al. 2011). Global efforts to address mental health in schools have been

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3 encouraged by international agencies such as the World Health Organization (WHO) and the
4 United Nations Educational, Scientific and Cultural Organization (UNESCO) and have focused
5 on introducing programmes into schools which address pro-social behaviours, mental health
6 promotion, suicide prevention and specific mental disorders, such as depression and
7 substance use disorders (Wei et al, 2013).
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11 In recent years mental health literacy, improving mental health knowledge and awareness,
12 has come to be seen as vital for improving access to care and reducing mental health related
13 stigma (Jorm et al. 1997; Reavley & Jorm, 2011; Jorm, 2012; Weiet al. 2013, Luke et al 2015).
14 There is some evidence of the effectiveness of mental health literacy in LMIC in relation to
15 specific disorders such as depression (Kutcher et al, 2019). However there has been an
16 absence of training regarding substance abuse and trauma specifically, which were the focus
17 of this present project. Substance misuse appears to be increasing within Sub-Saharan Africa
18 in general, with high rates of alcohol and cannabis use observed in particular (Destrebecq,
19 2007; WHO, 2014), particularly amongst young people (Bisika et al, 2004).
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24 Wright & Maliwichi (2019) have noted the increased emphasis on task shifting initiatives in
25 contexts where mental health facilities are limited. Task shifting involves the development
26 of standardised protocols (for example) to facilitate easier access to interventions where
27 mental health services are limited. Wright and Maliwichi found that non-mental health
28 professionals in pivotal roles were able to provide links between communities and services
29 upskilled in mental health literacy (for an example in relation to primary care health workers
30 in Malawi, see Wright and Chiwandira, 2016). However, given that current dominant mental
31 health literacy programmes are likely to carry various assumptions based upon Western
32 biomedical notions of mental illness, the cultural acceptability of this approach needed to
33 be determined as it had the potential to come into conflict with traditional understandings
34 and conceptualisations of psychological distress (Patel, 2014).
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43 **Cultural belief systems in Malawi**

44 Supernatural beliefs regarding the causes of mental disorder have been found to be
45 common in Africa (Adebowale, Ogunlesi, 1999; Kabir et al, 2004), although there is
46 variation, with some research indicating greater tendencies towards culturally specific
47 beliefs in rural regions (Quinn, 2007). A survey conducted in Malawi indicated a combination
48 of spiritual beliefs and more Westernised understandings of mental health problems
49 including notions of brain disease, psychological trauma and drug abuse. Similarly, a
50 qualitative study (Wright & Maliwichi-Senganimalunje, 2019) revealed the complexity of
51 social and cultural influences upon causal thinking in relation to mental health.
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55 Religious faith and indigenous medicine remain dominant aspects of Malawian cultural life
56 (Simwaka et al. 2007) and the population reportedly hold strong traditional spiritual beliefs
57 regarding all forms of misfortune, including health problems (Ott 2000). Biomedical mental
58 health models have been shown to have less resonance particularly within rural Malawian
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3 communities (Steinforth 2009). Healing practices therefore rely on traditional healers and
4 prophets to identify the causative agent and facilitate the appropriate treatment, usually in
5 the form of herbal remedies, rituals of observance, prayer or sacrifice to appease ancestors
6 or expel spirit possession (Simwaka et al. 2007; Steinforth 2009). Estimates suggest that
7 around 80% of Malawians seek help from traditional healers (Ministry of Health, 2005),
8 which has also been linked to delays in biomedical 'help-seeking' in Malawi (Chilale et al.
9 2014).
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16 **Context of the project**

17 During the visit to Blantyre, we were mindful that it would be useful to understand as much
18 of the context of mental health care that was available as possible. In order to do this, we
19 met the local Consultant Psychiatrist and visited the local mental health clinic in Queen
20 Elizabeth hospital in Blantyre, speaking with three of the four mental health nurses
21 employed at the clinic. This service was designed to respond to all ages. Those people who
22 were seriously ill would be admitted to an inpatient facility in Lilongwe. Others would be
23 offered brief outpatient appointments. Access to appropriate medication was limited. For
24 example, medications used for the treatment of attention deficit hyperactivity disorder for
25 children are not available in Malawi. The nurses used comprehensive screening
26 assessments for CYP and were able to draw on a range of therapeutic approaches to help
27 them, but only a few CYP attended the clinic. The nurses explained that a commonly held
28 belief system in Malawi is that those people experiencing mental health symptoms have
29 been affected by 'spirits' and thus medical or psychological intervention would be
30 incongruent. It was also challenging for nurses to work in mental health as they themselves
31 were subject to a degree of stigmatisation as a consequence. This made mental health as a
32 speciality an unpopular choice of speciality for nurses.
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41 **Aim of the project**

42 The focus for the project emerged from dialogue pre-dating our visit between mental health
43 nurses from the UK (NE, GSE) and Malawi (AS). There had been previous mental health
44 initiatives rolled out in Blantyre, but schoolteachers were reporting to our colleague in
45 Malawi (AS) that they were having particular challenges with CYP using substances and with
46 CYP reporting exposure to trauma such as violence and abuse. Teachers requested further
47 information on how to recognise and thence respond to CYP who had been exposed to
48 trauma, so that they were better prepared to respond to their emotional and educational
49 needs. Given that previous mental health initiatives had been conducted across Malawi (Kutcher et
50 al, 2019) we assumed teachers had a baseline knowledge but on asking the teachers none
51 seemed to have encountered any such interventions. The aim was therefore to develop a
52 training package for schoolteachers to increase their understanding of the impact of trauma
53 and substance misuse issues on CYP. This was designed as a practice development project,
54 with a focus determined by representatives of the local services.
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Objectives

To develop and deliver a package of training about trauma and substance use in CYP to two groups of schoolteachers

To invite their evaluation of the content delivered and the method of delivery in terms of acceptability and usefulness

To engage discussion how this might be adapted and further developed and disseminated

Approach

A process of negotiation and collaboration with schoolteachers and mental health nursing colleagues in Blantyre resulted in the creation of a bespoke training package to address their requested gaps in knowledge. The approach was using a cyclical process of plan, do, study, act, based upon a health improvement methodology (NHS Improvement). The principles underpinning this approach is to test potential interventions through small-scale, iterative projects, as this allows for quick feedback with sufficient flexibility to adapt the intervention according to feedback to ensure acceptable and usable solutions are found (Taylor et al 2014). Two schools had invited us to deliver the package: one was a government funded secondary school that admitted pupils who were able to pass their entrance examinations; the other was a church owned primary school. Both were situated in the city of Blantyre.

A training package had been designed that was anticipated would take two hours to deliver. In the planning stage, approximately half of the time as devoted to content related to trauma and half to substance misuse. We had been advised this was the amount of available time the teachers would have, and we were advised it was customary to also include time for a beverages and snacks. The teachers were staying after their normal school teaching day to engage in the training.

The training focussed upon the following topics: impact of trauma on children; post-traumatic stress disorder (PTSD); effects of substance use; psychological first aid; developing support systems in school; locating a mental health network outside school. The training was delivered by two UK trained mental health nurse lecturers with expertise in child and adolescent mental health (NE) and drug and alcohol use (GSE). A Malawian mental health nurse lecturer (AS) also collaborated in the course design and delivery so was present throughout and was able to modify ideas so that they met the local context.

Evaluation

Advance agreement had been reached that an observer could watch the training and make notes on its delivery. Particular attention was paid to responses to course material from Malawian teachers (e.g. answers to questions posed by the course facilitators). There was an attempt to interpret non-verbal responses from participants throughout the course delivery;

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3 however, this was particularly difficult – possibly due to cultural differences in expressions
4 of interest and differences in educational norms . Two brief one-to-one interviews (lasting 6
5 minutes and 15 minutes respectively) and one group interview (lasting 15 minutes) were
6 also carried out and recorded following the training in order to gauge responses to the
7 training. The interviews were brief due to contextual constraints; questions were asked
8 about how teachers found the training, and what aspects they felt were useful, as well as
9 what they thought was missing from the package. **A specifically designed pre and post
10 measure was created which intended to elicit evidence of new learning by the teachers. This
11 was administered at the beginning of the session and teachers were invited to complete at
12 the end. There was low uptake on completing these and so is not reported here.**

20 **Evaluation of the training**

21
22 This training appeared to be well-received and teachers demonstrated a desire for further
23 mental health training opportunities as illustrated by the following abstracts:

24
25 *“it was an eye opener on behaviours that the child may express after going through
26 some trauma”*

27
28 *“It was really useful – and we would prefer if much more than this would come”*

29
30 The mental health and wellbeing of pupils appeared to be a clear concern for teachers, who
31 were attuned to changes in pupils’ behaviour such as rudeness, withdrawal or
32 inattentiveness. Teachers displayed an awareness of many of the signs of mental health
33 difficulties, with some showing awareness of Western biomedical diagnostic concepts (e.g.
34 ADHD, PTSD). However, their approach to mental health appeared to be holistic,
35 incorporating spiritual and psychosocial dimensions in addition to diagnostic
36 understandings.

37
38 *One focus group member for example, stated: “We have added flesh to the skeleton
39 that we had as far as the information” (M1, focus group, Secondary School).*

40
41 Another teacher from the primary school group responded similarly:

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43 *“I have learnt most through (education?) How to help the child – and this (the course)
44 has added to – is just topping up to what I have had – so I am in a better condition to
45 help the child....”(I1, primary school)*

46
47 Rather than conflicting with cultural understandings of mental health, the above statement
48 suggests that the course added to and complemented teacher’s prior knowledge. **This could
49 indicate that Malawian cultural notions of mental health and illness are not necessarily
50 always incompatible with Western ideas and that it is possible that certain globalised
51 Western notions of mental health/illness have merged with local understandings in some
52 cultures. However, this needs to be interpreted with caution, due to both the small numbers
53 interviewed in addition to the potential cultural power dynamics at play (i.e. Western**

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3 academics teaching within an LMIC context). It is also important to note that the two
4 schools selected (one boarding and one private: both city based) are unlikely to be
5 representative of schools in Malawi.
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8 However, what was cited as useful was often the illustrative examples provided by
9 facilitators (e.g. the example of inappropriate sexual behaviour from teenagers as an
10 indication of previous sexual abuse). There were also positive responses to the idea of re-
11 conceptualising negative behaviours as signs of mental ill health (as opposed to moral
12 defects):
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16 (M1): *“and also that we have been told that the person and individual is good – it is
17 the behaviour we must condemn...”*
18

19 (M2): *“...Usually we say it is a bad person – But now we say it’s a good person...”*
20

21 The usefulness of illustrative examples and reframing of behaviour may indicate that it is
22 not straightforward knowledge that is useful, but the provision of tools to make sense of
23 and interpret a person’s behaviour in a more useful and less stigmatising way thus allowing
24 teachers to empathise with their pupils more.
25

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27 When asked what she had learnt from today one teacher stated:
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30 *“To treat the child with kindness, with love, with ...when a child is not doing
31 something that is not supposed to be done – it is not for me to say ‘stop this’, don’t
32 do this but find a better mechanisms of helping that child - if they are disrupting
33 other children in the class make that child busy doing something...have a bit of time
34 to (inaudible) with the child – just like the Bible says – “come let us resolve this
35 together come let us resolve everything that is wrong” – we have to encourage them
36 and give them the opportunity to digest what they are doing – if they are right or bad
37 – and then come with them to a better conclusion because as adults we know what
38 we are doing” (I1, Primary School)*
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45 The role of teachers in promoting young people’s mental health

46 It seemed clear that teachers believed they had a significant role to play in promoting the
47 wellbeing of their pupils.
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50 *“These guidelines will help us to understand what can we do in time of crisis....us as
51 teachers we can be creative – if I am a (learned?) Teacher then I have all the answers
52 – everything to help...”*
53

54 When asked if they believed teachers to be in a good position to help students with mental
55 health problems – one focus group member answered, “very much so”, although they
56 added that being based in a boarding school made them effective temporary parents for
57 pupils based at the school. However, in the following exchange it was also suggested that
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3 there might also be a need for individuals with a more specialised /formalised role in dealing
4 with pupils' mental health issues, whether this be a specialist teacher who is trained in
5 mental health or a psychologist /counsellor with the specific role of counselling students:
6
7

8 *M1: "With the post trauma counselling – as teachers this is something we can do. But*
9 *I feel like in ...this is happening more - Maybe there is a need to have someone – not*
10 *a teacher – but maybe just a psychologist – I don't know – someone who's role would*
11 *be providing counselling'...because I don't think we have a (case?) as teachers – but*
12 *we need specialists who may help in such cases..."*
13
14

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16 *M2: "...or teachers could be trained in ...to have a specialist teacher in that field who is well*
17 *trained – so the students will have to go to that particular individual'.*
18

19 They also suggested that mental health concerns would fit within their own curriculum,
20 which would make it easier for their pupils to confide in them:
21

22
23 *"We already have subjects which deal with such issues – e.g. life studies, social*
24 *studies –studies that are dealing with such issues – so it would be very easy"*
25

26 *RL: So they will be able to tell you...?*
27

28 *Yes – they will be open and they will be able to tell*
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33 **Local services**

34 While mental health services in Malawi are relatively underdeveloped compared with
35 Western nations, some local service were in existence; however, there seemed to be a
36 desire for greater links. For instance, teachers demonstrated a lack of awareness regarding
37 the local hospital mental health facility or the trauma counsellor at the One Stop Centre.
38 Following the training it was agreed that AS could act as a conduit, referring teachers to
39 appropriate services. This was taken up by several teachers in the weeks following the
40 training.
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46 **Discussion**

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48 Prior to visiting Malawi, we had been made aware of the lack of children's mental health
49 services in Malawi, specifically the city we were visiting. We had also located evidence from
50 the literature that attempts had been made to upskill teachers about mental health through
51 previous projects but we were mindful that we were unaware of the baseline knowledge
52 skills and attitudes of teachers about mental health given the cultural difference. It was also
53 important to ensure that any intervention offered could be sustainable within the resources
54 already available within the health and educational system in this location.
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58 This project met its initial aims to design and determine the usefulness and acceptability of a
59 bespoke training package for school teachers in two urban schools in Malawi but it became
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3 clear that the challenging issue of sustainability was the most important one. Expectations
4 had been raised through doing this training. Teachers expressed wanting and needing more
5 support and further access particularly to specialist with whom they could consult about
6 distressed children.
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9 The context was very important to consider. In this city, given there was only one outpatient
10 mental health service, with four mental health nurses providing care to an age blind
11 population, none with specialism in child mental health, teachers were not linked into the
12 mental health service so unaware what services could be available nor how to access or
13 signpost children there. We had been made aware of a weekly mental health forum that
14 met on a weekly basis throughout the academic term time that was linked to the university
15 medical school. We were also made aware of a psychologist providing mental health
16 education to some schools in the location but had not linked with the two schools we
17 visited. So, there were a number of possible agents and projects that were in place that did
18 not yet appear to be linked. One of the difficulties of working on short time limited projects
19 in LMIC are their temporary nature and thus potential for insufficient impact and
20 sustainability. In the feedback from both schools, it was suggested that each school could
21 have a mental health lead, a teacher with particular interest for co-ordinating support for
22 individual students, to arranging training and for linking with other agencies.
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28 It was interesting that the Kutcher et al study (2011) had reported on a total population of
29 schools having taken part in the MHGap training programme but our experience with these
30 two schools was that there was limited reference to this former training. This had been
31 delivered some years prior to this project, and possibly teaching staff had changed, had
32 forgotten the three-day training or not be available to attend. **Those that recalled it had
33 found it useful and our event had promoted their recall of it, but perhaps repeated
34 opportunities for recapping on that material or building on it as a foundation might have
35 been useful.**
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41 **Conclusion and recommendations for further work**

42 Discussions are ongoing with the project team and contacts in Malawi in an attempt to
43 create a meaningful children's mental health network that might meet on a regular basis.
44 **The aim of this group would be to build on the existing relationships and knowledge and skill
45 base of the professionals involved. They might do that by sharing knowledge, seeking advice
46 or consultation to clarify where specific referrals would be best being referred, the
47 outpatient mental health team based in the hospital, or independent counsellors. This is in
48 line with recommendations for utilising community based non health care workers in the
49 management of mental health difficulties (e.g. Hinkle, 2014). However, while developing
50 pathways for specialist help may be useful, the lack of available specialist mental health
51 services in Malawi is likely to remain an obstacle to the delivery of mental health care to
52 young people in need. As others have noted there is a gap between the prevalence of
53 mental health problems within communities and the limited health resources available**
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(Udedi, 2014), although programmes are being developed to improve the recognition and management of mental illness (Kauye, et al 2014).

Project limitations

This was intentionally a small scale project to establish how to develop a meaningful was forward of upskilling teachers in relation to specific mental health concerns; post abuse presentations and young people using substances. In order to ensure sustainability, longer term and larger scale interventions will be necessary (e.g. Luke et al, 2015). An assumption on which this project relied was that teachers had a baseline of mental health knowledge from previous initiatives, but it was found that this was variable. Ideally, we would have had more time to work with the teachers, to better establish their baseline knowledge and skill, and to maybe separate groups according to their learning need, but these were teachers who had accommodated the training sessions at the end of their normal working day, so time and availability was limited.

The schools receiving the training were likely different to other schools in Malawi, given that one was a fee-paying school and another was a boarding school accepting high performing pupils. They were also both based within the commercial centre of Malawi, and it is likely that such training would have been received differently in more rural settings, where biomedical health models hold less resonance (Steinforth, 2009) and where there is significantly less access to resources.

Additionally, the findings here have to be interpreted with caution since it is likely that the cultural status of the course delivery team shaped the teachers' responses to the course, meaning that there were significant cultural power-dynamics at play.

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All authors have met the four criteria for authorship:

- Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; AND
- Drafting the work or revising it critically for important intellectual content; AND
- Final approval of the version to be published; AND
- Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.