Challenges of a Program for Public Mental Health Education with an Emphasis on Self-Care in Primary Health Care: A Qualitative Study

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ABSTRACT

Background: Mental health education aims to increase mental health literacy (MHL) and plays a crucial role on mental health of community members. However, its implementation in primary health care (PHC) faces obstacles and problems. Therefore, this study was conducted to explain the challenges of the public mental health education program with an emphasis on self-care in Iran's PHC.

Methods: This was a qualitative study with a content analysis approach. The research sample consisted of 20 stakeholders through purposive sampling with maximum diversity. This study was conducted in Tehran and Alborz, Iran. Data were collected through in-depth and semi-structured interviews and analyzed by Graneheim and Lundman approach.

Results: By analyzing data, the challenges were categorized into six main themes and 15 categories. The six main themes included educational challenges, inefficiency of the educational method, unsuitable intersectoral collaboration, infrastructural challenges, inadequate resources and barriers to participation in education.

Conclusions: Given multidimensionality challenges and obstacles, reform and adoption of appropriate implementation methods using mental health experts seem necessary. Future research and policies could explore ways to optimize program implementation in PHC.

Keywords: Mental Health Education, Mental Health Literacy, Primary Health Care, Health Centers

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Introduction

The high prevalence of mental illnesses in the world(1, 2), as well as the high rate of inadequate health literacy in many countries, turned health literacy into a high priority(3, 4). Lack of mental health literacy (MHL) potentially contributes to the high prevalence of mental disorders. At the same time, MHL is a prominent determinant of mental health and is considered to be half of the battle against mental disorders(5, 6). In addition, health education is essential for the success of health programs(7).

Modern health systems in modern societies may also result in the emergence of new and complicated demands from their users, who are expected to engage in information seeking and understanding, and making appropriate decisions(8). The importance of providing health information has been emphasized by the WHO. Moreover, the International Conference on PHC has also stressed the importance of empowering and supporting people in acquiring knowledge, skills, and resources to maintain their health(9, 10).

Poor MHL is the main cause of therapeutic gap (up to 70%) between people in need of mental health care and people receiving the care(11). WHO's solution is the integration of mental health into PHC(12). This is because better access to the PHC system is the most efficient and cost-effective method to achieve global health coverage(13).

Great steps have been taken for the integration of mental health into the PHC system of Iran to maintain the mental health of the public. It ranges from the most external to the most specialized level of identification and diagnosis, referral, treatment, and follow-up of patients with serious psychiatric diseases(14). Now, extensive and comprehensive services are followed within different prevention programs(15). They include a “public mental health education program with an emphasis on self-care” as one of the first-level prevention programs. It has been integrated into the PHC to enhance MHL and the ability of people to acquire, interpret, and understand basic information, use health services, and maintain their mental health. This service is provided to clients by clinical psychologists and paraprofessionals in both individual and group training sessions at PHC centers and outside for non-health sectors (such as schools, companies, factories, mosques, and government offices).It is followed by required screening procedures performed by health care providers and doctors. Moreover, patients, their families, as well as the general population, should be provided with complete information about mental disorders, signs and symptoms, health care procedures, and treatment.

Although there are scientific works on mental health disorders, few attempts have been made to study mental health measures and education programs. In contrast to the studies on health education, mental health education has been neglected. Despite its importance in the PHC system, it has not been studied in Iran. Moreover, in spite of its strengths and effectiveness, it has always been faced with barriers in implementation. Therefore, timely studies and problem-solving based on scientific methods are required. This is because ensuring the right action based on predetermined goals is one of the concerns of health system policymakers. Having a clear insight into the health systems of countries is essential to effectively plan for and promote health care systems(16). Therefore, this study investigated the challenges of public mental health education program with an emphasis on self-care regarding PHC in Iran.

Methods

This was a qualitative study with a conventional content analysis approach. Consolidated criteria for reporting qualitative research (COREQ) checklist was used to describe the methodology(17). Data were collected using semi-structured in-depth interviews (items 9 in COREQ checklist). All interviews were conducted by the first author, who was a master's degree student in mental health and carried out the work under the supervision of experienced professors in qualitative studies. (items 1–5 in COREQ). Coordinating and scheduling the interviews were done through

phone calls and messages, during which the research subject and objectives were explained to the participants, and the researcher was introduced to them (items 6–8 in COREQ).

The participants were selected using purposive sampling with a maximum variation. The inclusion criteria were working at urban and rural health centers with at least one year of relevant working experience. All interviews were conducted only in the presence of the interviewer and the interviewee. They were conducted in an appropriate place and at the participants' convenience after obtaining their informed consent. In total, 22 interviews were conducted, two of which were excluded because they were very busy and did not complete the interviews.

Eighteen participants were interviewed at the PHC centers and two interviews were conducted through video calls. Eight participants were males (40%) and twelve (60%) were females. The interviewees consisted of two mental health policymakers and planners with 11-28 years of relevant work experience, seven psychologists with 2-5 years of relevant, three managers of the PHC centers (doctors) with 10-24 years of related professional experience, six care providers (bachelor's degree in midwifery or public health) with 2-30 years of relevant work experience, and two paraprofessionals with 10 years of relevant professional experience (items 10–16 in COREQ).

The interview questions were designed based on the research objectives, literature review, and consultation with specialist instructors in the field of mental health services and programs at the PHC centers. The interview guideline included questions about public mental health education and its challenges. They i were recorded and transcribed as soon as possible. In addition to recording the interviews, important notes were also taken during the interview sessions. Each interview was conducted once and lasted between 31 and 88 minutes. The interviews continued until data saturation was achieved (items 17–22 in COREQ).

The content of each interview was considered a unit of analysis and was analyzed based on the Graneheim and Lundman model. It included: 1- reading transcribed interviews several times; 2- extracting meaning units (including concepts and meanings derived from the interview texts), 3- coding - attaching labels to the compressed meaning units; 4- categorizing codes based on similarities and differences of contents; 5- creating themes or relating the underlying meaning of categories to each other(18). Although feedback was not obtained from the participants, their notes and opinions were reviewed after the interviews. All these stages were conducted by one person. Data analysis was done manually. Themes, categories, and direct quotes from the interviews were provided in the results section (items 23–32 in COREQ). The analysis stages are shown in Figure 1.

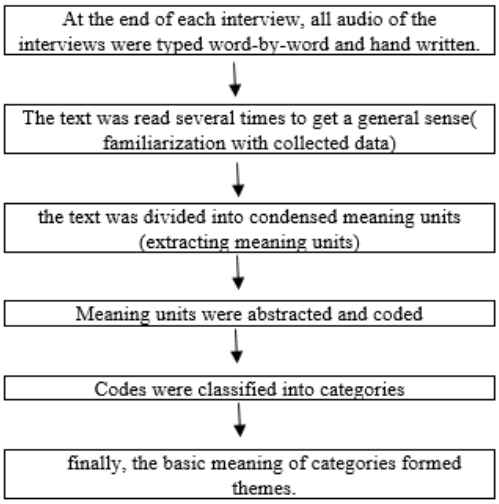

Figure 1. Flow chart of Graneheim and Lundman analysis (2004)

* All the stages of the analysis were reviewed and discussed by the instructors.

In addition to COREQ, the rigor and trustworthiness of the data were examined based on Guba and Lincoln's criteria(19), including: 1- long-term involvement through the immersion of the researcher in the research topic and the research process 2- peer review;the first author conducted the coding, which was then reviewed by the instructors and some codes were modified. Moreover, data analysis was done by the first author after stages 4 and 5, and the results were reviewed and revised by the instructors who also analyzed all the stages of the analysis and expressed their opinions. 3- triangulation of the data sources by interviewing stakeholders (policymakers, planners, and service providers). 4- searching for disconfirming evidence by purposive sampling; selecting individuals with contradictory views resulted in a comprehensive description of the phenomenon.

Results

In addition to pointing to the effective integration and provision of mental health services in PHC, informants expressed the challenges facing mental health education program. In total, six main themes were extracted from the data analysis, the most important of which were mentioned in Table 1.

Table 1. Themes and categories identified

Theme	Category
Educational challenges	Busy staff and lack of time for training Difficulty in reaching the target population Weakness in staff empowerment
Inefficiency of the educational method	Lack of basic education Inefficient educational method Compulsory education
Unsuitable intersectoral collaboration	Lack of required cooperation and coordination Lack of agreement
Infrastructural challenges	Lack of appropriate infrastructure Health education unappreciated by health authorities
Inadequate resources	Inadequate budget Lack of staff, facilities, and equipment
Barriers to receiving education	Misconceptions Deterrent norms Stigma and worry

Educational challenges

- ***Busy staff and lack of time for training***

Busy service providers in PHC centers have insufficient time for educating, which is often neglected. An excessive workload at these centers, staff with multiple jobs, overcrowded centers, focus on screening and referral and preoccupation of the psychologists at these centers with therapeutic measures and their lack of opportunity for prevention and education are factors that result in marginalization and undesirable implementation of education. As reported by manager of the PHC center (who is a doctor):

"Given the multiplicity of services, we may not spend as much time and money on education as we should, because the health system has to deal with many more urgent problems and hence lacks the time for conducting educational programs. "

- ***Difficulty in reaching the target population***

From the participants' point of view, not feeling the need to receive education, patients' preference for quick treatments, their lack of interest in education, not visiting a mental health ward despite the referral, and the need to do so, are among the factors which make education difficult.

- ***Weakness in staff empowerment***

The low level of knowledge; lack of the required

skill and expertise, mastery, and community-based service provision attitude; nonconformity of education with duties, and nonconformity of attitudes with PHC goals hamper the educational ability of the staff.

Moreover, the health deputy's programs for empowerment are not adequate and desirable. Lack of courses related to community-based services and health education in educating university students has failed to empower the graduates in PHC.

Inefficiency of the educational method

- ***Lack of basic education***

Lack of influence regarding mental health in all areas, such as during childhood in elementary schools, and disregard for mental health issues in high school textbooks and university curricula and syllabuses, have made it difficult to educate adults and correct their misconceptions about mental health problems. This was also reported by the manager of the PHC center (who is a doctor):

"Now, if you look at the textbooks from elementary school to senior high school, you will not find anything about mental health. If a 7-year-old or older child is sexually abused, it will remain a permanent challenge in his/her entire life. Nobody teaches this for the child to be able to cope with it, because it is supposed to be impolite. There is nothing in textbooks about mental health based on the age of children. It remains untouched until the age of 30 and 40, when it is very difficult for a mental health specialist to deal with it, because this education cannot be easily accepted at this age, which is a serious problem."

- ***Inefficient educational method***

Traditional, face-to-face, classroom education, not using modern teaching methods, and failure to utilize the media have inhibited extensive education and awareness. Moreover, it has prolonged the achievement of goals determined for programs. The need to use modern educational approaches, clearly shown during the COVID-19 pandemic, was emphasized.

- ***Compulsory education***

Using clinical psychologists in PHC for education and the lack of a community-based attitude have resulted in a dramatic deviation towards treatments instead of prevention and education. Furthermore, due to the compulsory education and the lack of interest and motivation, there would be job dissatisfaction.

Unsuitable intersectoral collaboration

- ***Lack of required cooperation and coordination***

Lack of coordination and communication with other organizations, negative attitudes and false beliefs about mental health, failure to recognize the importance of mental health, the necessity of addressing it, and introducing a plan and explaining its importance and benefits have played a considerable role in inhibiting inter-organizational collaboration.

- ***Lack of agreement***

Differences in views, objectives, priorities, educational needs, and educational content and method are among other challenges. Using various methods by different organizations to achieve such objectives has resulted in numerous cases of duplication.

Infrastructural challenges

- ***Lack of appropriate infrastructure***

This category reflects lack of attention to designing educational space at PCH centers, lack of appropriate facilities for each program, and nonconformity of the infrastructures of the current educational system with the progress of technologies and the needs of the communities.

- ***Health education unappreciated by health authorities***

Based on what the participants said, the views of health authorities have not changed towards long-term, preventive, and health literacy improvement programs. They have not properly recognized the importance of addressing the mental health of society and the role of education. Thus, patient-seeking and doctor-oriented approaches are still in place. Superficial views and lack of cooperation

make it difficult to adopt and implement educational programs. A mental health policymaker stated:

"It is important to measure the height and weight of some of the newborn babies, give them maternal care and vaccination orders, and visit some patients. This incorrect patient-seeking and doctor-oriented approach is still dominant."

Inadequate resources

- ***Inadequate budget***

The provision of extensive education and services which fit the needs of society has been disrupted due to inadequate budgets. Spending a major portion of the budget on treatment while not allocating sufficient resources for prevention and mental health programs has resulted in the failure of attempts made to implement this program. As reported by a healthcare provider:

"Financial resources allocated to educational programs relative to the needs of the communities are limited, 98% of the budget goes to treatment and 2% to prevention"

- ***Lack of staff, facilities, and equipment***

Lack of enough staff, particularly education specialists, visual equipment and public self-help resources are among the problems that affect provision of effective education.

Barriers to receiving in education

- ***Misconceptions***

There are still many misconceptions in the minds of people about mental health that prevent them from visiting specialists. Beliefs such as "spontaneous healing" of mental disorders which do not require interventions, the idea that mental health problems are natural events in life or, conversely, interpretation of mental health problems as mental illness have been reported as other barriers. According to one healthcare provider:

"If someone gets diabetes, he/she will definitely come here and ask me what to eat and what not to eat. But many people think depression and anxiety are natural in life and are treated spontaneously; thus, they do not come for information as if they do not believe in it"

- ***Deterrent norms***

Attribution of mental health problems to destiny, the belief that prayer, magic, and superstitions can solve health problems, taboos in the society, and disbelief in the usefulness of prevention and education in solving the problem were among the deterrent factors.

- ***Stigma and worry***

Due to their lack of knowledge regarding the causes of mental disorders and the way that they are treated and dealt with, people negatively label patients with mental disorders. On the other hand, these patients try to hide their problems and avoid receiving services due to fear of others' judgments, stigma, and mistreatments. Even healthy people who are interested in relevant education and acquiring knowledge do not participate in educational sessions due to their fear of negative attitudes and labels. One of the psychologists reported that:

"People feel that if they visit a mental health specialist, they will be negatively labeled but not if they participate in diet sessions. Therefore, they do not come to visit a psychologist"

Discussion

The findings of this study gave a view of mental health education challenges at PHC, obtained through interviewing the most knowledgeable people at the highest level (in the Ministry of Health) to the lowest level (local health centers).

Unlike other studies(20, 21), the positive attitude of other team members, such as doctors and health care providers, towards the importance of education and awareness, particularly in the field of mental health, was encouraging. However, in line with previous studies(22, 23) workload and lack of time prevented from paying attention to educational programs. As in Zhang et al. and Ferreira et al.'s study(24, 25), the lack of adequately experienced staff, along with the multiplicity of services they have to offer, lead to the lack of time and negligence in providing some services. Lack of access to the target population for

educating is another problem service providers face in providing the determined levels of services. Performing interventions and integrating various programs without taking basic measures to reach the target population and required staff lead to an increase in the number of programs and services which are poorly executed and implemented. Reduced efficiency followed by the marginalization of the educational program, and most importantly, failure to solve problems and achieve the determined goals, result in designing and integrating more mental health programs to solve those problems. Thus, the vicious cycle continues.

The findings suggested that the staff were without the required competence and specialization. This could be due to the fact that the staff trained in various fields of mental health was not put in the right positions. A clinical psychologist not trained to provide community-based services and education, or a midwife not trained for mental health screening, are employed for these purposes instead of mental health graduates trained in these areas. The employed staff who are not suitable for the objectives of the educational program suffer from job dissatisfaction, feel compelled to provide services, and damage service provision due to their unsuitable attitudes and approaches. This finding is consistent with the literature results, suggesting that the lack of expertise among the staff of these centers prevented from effective implementation of the program and achievement of desired results (24-26). Given the growing number of mental health graduates, not using them in the right positions defined in PHC, and using graduates of other disciplines instead, raise serious questions.

Consistent with Nutbeam (27) and Heshmati's study(23), the findings of this study emphasized the necessity of changing the traditional implementation of the program. This is because communicational instruments have changed with the advent of digital communications. Therefore, more attention should be paid to the use of modern educational methods such as virtual networks, applications, and online games to facilitate the distribution of health information, reduce costs, and make mental health information more accessible to the public based on WHO's recommendations(28). Moreover, it is essential to use all the capacities of the society including those of the Ministry of Education, universities, textbooks, curricula, media, news agencies, and out-of-home and urban advertising, and anything that helps to convey the message related to mental health improvement. The findings by Iammarino and O'Rourke concerning responsibilities and opportunities to promote health education(29) are consistent with those of this research.

According to the literature(24, 30), some measures require interaction with institutions and organizations outside the health sector which have a different view about this problem. Hence, by taking over the responsibility of the legal and professional authority regarding the health of the country (i.e., the Ministry of Health), the implementation of the program and achievement of its objectives were prevented. Systems that are engaged in duplication of work due to their poor communication with each other have fragmented service delivery. These findings confirm that some problems have roots outside of the health system; and thus, mere modification and revision of the program within the health system (the Ministry of Health) is a continuation of what is already going on. It is recommended to make proper consultations with organizations and institutions outside the field of health, aiming at correcting misconceptions, explaining the necessity of education and prevention in upgrading, providing and maintaining mental health. Moreover, the program and its implementation methods as duties of those responsible for mental health were introduced. Although these factors were presented as barriers in the current study, this problem was not found in some studies on health education(31, 32). This can be due to misconceptions, negative attitudes, and stigma which are still associated with mental health issues. In addition, there are limited studies in the field of mental health education, and on the other hand, there is a difference between countries in the structures of the PHC service

delivery system.

Consistent with previous studies (22, 33), the treatment-oriented and patient-seeking attitude of some health system authorities result in the lack of support for the implementation and establishment of the program. Therefore, before the implementation of the program, the executive authorities, heads of departments, and managers should be justified about the importance of such objectives and programs in health promotion and disease prevention.

The problem is also partially due to the lack of infrastructures and limitation of resources and equipment, and not using virtual systems and technology at the same pace with progress in communities. This is consistent with the findings of different studies (24, 34). Since resources allocated to the field of mental health are few, compared to today's mental health needs and conditions, the in-person provision of services, increasing number of staff, provision of educational space, facilities, and equipment, etc. are too costly. Even where educational space and equipment are available, workload and multiple duties of staff act as barriers to the implementation of mental health education program. Overcrowded centers, long waiting lines, and inappropriate working hours of the centers that interfere with working hours of clients result in lower than expected amount of using these services. Accordingly, using modern technologies which accelerate global access to information can facilitate this matter.

From the health service providers' view, unfortunately, many people are unwilling to use mental health services. Fear of stigma, misconceptions, and deterrent norms are among the key barriers to clients' poor cooperation, which were mentioned in various studies (35, 36). Since people make choices in the context of societal norms and social context, societal norms also limit these choices. It can be said that the deterrent norms inhibit achieving health standards in society, and thus, disrupt its related activities. Changes in cultural and behavioral norms often need taking extensive measures beyond health services in different sectors of society. Due to deficiencies in building mental health culture in the community, this issue also needs to be improved. In this regard, given the prominent role of the media and virtual space, using this potential to increase public knowledge, which has been successful (37, 38), should be considered by policymakers.

Among the limitations of this study was not receiving the opinions of service users and authorities of organizations outside the health sector. Therefore, it is recommended to collect their opinions about the barriers and challenges.

Conclusion

The applicability and effectiveness of the program require a major revision of the implementation process. This is because due to the entanglement of multiple challenges, the elimination of problems at one level does not remove all barriers and problems. It is essential to use mental health and health education specialists to provide high-quality education through changing the execution methods. In addition, mental health services should be developed from expansion of superficial services to higher levels of mental health services. Since the data from the present study were collected from the views of all specialists at all levels of the health system and addressed more extensive and deeper dimensions of the matter, they can contribute to planning mental health policies.

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Conflicts of interest

The authors declared no conflict of interest.

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