Original Article

Mental Health Training Needs Analysis in Thailand, Indonesia, and Cambodia: Challenges and Opportunities

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Objective: Even though the number of health professionals is growing in many counties in Southeast Asia, the shortage of mental health professionals remains a challenge. The current model of professional training needs to be changed to foster cooperative and collaborative skills, through interprofessional and transprofessional education, so professionals as well as non-professional service providers and operational personnel are trained to be members of the health teams. However, training needs in each Southeast Asian country remains unknown. The present study surveyed these needs using Hennessy-Hick's criteria and experts' opinions.

Materials and Methods: Fifteen representatives from Thailand, Cambodia, and Indonesia, mostly psychiatrists, nurses, and psychologists, attended the meeting and presented for 30 to 50 minutes on the condition of mental health services and training needs in their countries. All representatives were asked to complete an online-shared report of the adapted Hennessy-Hicks Training Analysis Questionnaires.

Results: According to the Hennessy-Hick's criteria, some teamwork tasks were required for Thailand, whereas most tasks were required for Indonesia and Cambodia. Training on special topics depended on the country's necessity. Basic skills are needed in all ranges of mental health issues. Thailand and Indonesia expressed quite similar needs, while Thailand had identified itself as having 'an aging society', which 'caring for patients with dementia and caregivers' in their training needs were more urgent than Indonesia. Training non-psychiatric professionals, such as primary physicians and nurses, concerning mental health issues, might help to address current mental health needs in Thailand, while Cambodia was concerned about recruiting mental health professionals and focusing on providing sufficient services for the country rather than training non-professionals to deal with mental health issues.

Conclusion: The training needs for mental health professionals centered on research, clinical tasks, and communication, while including non-professional mental health providers in training of basic skills such as communication and up-to-date technology are deemed important at the present.

Keywords: Training Needs Analysis; Thailand; Cambodia; Indonesia; Mental Health

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Southeast Asian countries are reported to be second ranked for serious shortages of health professionals, with less than two health professionals per 1,000 population(1). Although the number of health professionals in many counties are growing annually, the shortage of mental health professionals remains a challenge(1). In many countries, only a small fraction of total health budget is allocated for mental health(2).

Although Southeast Asian countries share some cultural and economic aspects, except for Singapore, it is different when comes to mental health issue. For example, the Philippines and Indonesia produce high numbers of doctors and nurses, but both countries have shortages at subnational levels(1) and have not yet established mental health policies and laws(3).

To address the shortage of mental health workers,

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several strategies have been undertaken. One of the most important key changes is the move towards competency-based education for health professionals and a change in the roles of health professionals so certain tasks can be performed by less trained professionals. Training individual professionals would not sufficiently promote understanding, respect, and knowledge of the allied professionals on a health team. On the contrary, interprofessional collaboration is essential for the successful management of health care systems. The current model of professional training, which does not emphasize teamwork, needs to be changed to foster cooperative and collaborative skills, through interprofessional and transprofessional education, so professionals are trained to be members of the health teams.

Mental health education in some Southeast Asian countries like Thailand is discipline-based and limited within healthcare disciplines. In other words, medical doctors pursue board certification in psychiatry, psychologists earn higher degrees in psychology, and nurses obtain specialties in psychiatric nursing. Mental health systems include both professional and nonprofessional service providers. In addition, mental health services include aspects of psychological, biological, and social factors. Cultural issues have been increasingly recognized as one of the most important considerations in diagnosis and treatment. One example concerning cultural influence was demonstrated by an attempt to develop a culturally adapted instrument to identify depression in Bangladesh, India and Nepal aiming for expanded use throughout the World Health Organization (WHO) Southeast Asia Region[4].

Given that Southeast Asian countries have a unique history and cultures, different issues relating to mental health needs may arise. Providing training according to existing needs is vital, as it offers reference points for developing countries whose backgrounds and health care environments are similar to each other[5]. A study showed that skills perceived as important for practicing in the mental health arena varied among nurse participants. Post basic training in mental health was significantly related to perceived competence in mental state assessment of patients. However, the current training was deemed insufficient because of its emphasis, which is placed on psychosocial skill[6]. The lack of understanding of training needs regarding mental health issues in Southeast Asian countries led to gaps in training strategies. The present study aimed to understand and identify training needs of mental health care in some ASEAN countries.

Materials and Methods

Ethics statement

The present study did not need ethical approval because it involved information freely available in the public domain, and the analysis of data obtained from the researchers.

Procedure

Meeting of country representatives: The present study was conducted and incorporated into the network, called "Network on Education and Training in Mental Health (nET-MH)". The first nET-MH forum was held in Chiang Mai, Thailand in September 2017. The host invited delegates from Southeast Asian countries to participate in the present survey. Three countries joined the study, namely Thailand, Cambodia, and Indonesia. Fifteen representatives from Thailand, Cambodia, and Indonesia, mostly psychiatrists, nurses, and psychologists, attended the meeting and presented for 30 to 50 minutes on the condition of mental health services and training needs in their countries. Following the presentations, all representatives were asked to complete an online-shared report of the adapted Hennessy-Hicks Training Needs Analysis Questionnaire. Comparison and discussion of each item of the questionnaire was then conducted extensively. Respondents comprised professional mental health care providers working for governments in Thailand, Cambodia, and Indonesia. For Thailand, four psychiatrists, which included two academic faculty members and two mental health administrators, a family practitioner, a community physician, two psychiatric nurses, a psychologist, and a pharmacist participated. For Cambodia and Indonesia, a psychiatrist, and a psychologist, respectively, participated. Two psychiatrists from Germany and Taiwan shared and provided suggestions regarding establishing the programs.

Measurement: Training needs analysis (TNA) was conducted using the Hennessy-Hicks Training Needs Analysis Questionnaire as a guideline[7]. The questionnaire comprised 30 basic items addressing five issues as research/audit with nine items, communication/teamwork with six items, clinical tasks with six items, administration with three items, and management/supervisory tasks with six items. Where appropriate, items were adapted to suit the context of participating countries. Four new items were added, namely no. 31 to 34, to the proposed questionnaire while item 5, getting on with your

Table 1. Summary of proposed adaptation for mental health

		Country		
		THA	IND	CAM
Clinical tasks items				
10	Treating patients (including selecting and applying appropriate interventions)	x	√	*
12	Applying relevant research to your clinical work applying research results to your own practice	x	√	√
17	Developing and implementing treatment plans (including interventions)	x	*	*
18	Assessing patients' psychological and social needs	x	√	√
22	Undertaking mental health prevention and promotion activities	x	*	*
24	Assessing patients' clinical needs and making appropriate patient referrals	x	*	√
Communication/teamwork				
1	Establishing relationships with patients	x	√	√
8	Communicating with patients face-to-face	x	√	√
13	Providing feedback to colleagues	√	√	√
14	Giving information to patients and/or caregivers, including psychoeducation	√	√	√
27	Working as a member of a multidisciplinary team	x	√	√
Research/audit				
3	Critically evaluating published research	x	√	√
6	Interpreting your own research findings	x	*	√
7	Applying relevant research to your clinical work	*	√	√
9	Identifying viable research topics	x	*	√
15	Statistically analysing your own research data	x	x	√
21	Writing reports of your research studies	x	√	√
25	Collecting and collating relevant research information	x	√	√
26	Designing a research study	x	x	√
28	Accessing research resources, e.g., time, money, information, and equipment	x	x	√
31	Developing and conducting multicenter research	x	x	√
Management/supervisory task				
4	Appraising your own performance	x	√	√
11	Introducing new ideas or innovations at work	x	√	√
16	Instructing, training, or supervising students/junior staffs	x	√	√
19	Organizing your own time effectively	x	√	√
23	Making do with limited resources	x	√	√
30	Personal coping with change in the mental health services	x	√	√
33	Undertaking budget planning activities	x	√	√
34	Personal coping with problems at work	x	√	√
Administration				
2	Completing paperwork and/or routine data inputting	x	√	√
20	Using technical equipment, including computers	x	x	√
29	Undertaking administrative activities	x	√	√
32	Using IT and new technology	x	*	√

THA=Thailand; CAM=Cambodia; IND=Indonesia

√=yes; x=no; *=yes, but conditional

colleagues, was dropped. The items tailored for the present study are shown in Table 1.

Qualitative analysis involving expert opinions was used to identify training needs among mental healthcare providers as well as non-professional providers. Mental health skills to be assessed included

Table 2. Training needs analysis categorized by basic skills and mental health issue for professional mental health providers

Mental health problems and intervention	Basic skills
• Unwanted pregnancy among adolescents (All)	• Interpersonal and behavioral skills (All)
• Substance abuse (All)	• Communication skills (All)
• Aggression, antisocial behavior management (T and I)	• Skills to change to new paradigm in mental health (e.g., depression) (All)
• Mental health promotion and prevention (e.g., resilience, hardiness, sense of coherence, suicide prevention in the community) (T and I)	• Skills relating to provision of effective psychoeducation using 21st century technology (All)
• Crisis & mental health interventions (e.g., Cognitive Behavioral Therapy, Problem-solving Therapy, Satir treatment model) (T and I)	
• Mental health caring and rehabilitation (e.g., caring for patients with dementia and caregivers) (T)	

T=Thailand; I=Indonesia; C=Cambodia; All=all countries

tasks that are central to the role of health care professionals and are categorized into six categories, research and audit, communication and teamwork, clinical skills, administrative, managerial, and supervisory and continuing professional education.

Results

General characteristics of Thailand, Cambodia, and Indonesia and their mental health services

Even though the representative countries were not random and were based on a priori selection, the authors found that Thailand, Cambodia, and Indonesia fairly represent Southeast Asia due to specific indicators. First, based on GDP per capita, the median per capita GDP in Southeast Asia in 2017 was 11,027.5, which is close to that of Indonesia, Thailand, and Cambodia. In terms of culture and religion, six countries (54.5%) are majority Buddhist, and three countries (27.3%) are majority Muslim in Southeast Asia. The 2:1 ratio of Thailand, Cambodia, and Indonesia corresponded to the 2:1 ratio of Buddhist to Muslim in Southeast Asia. Lastly, concerning population pyramid structure, Southeast Asia has all three types of population pyramids, "expansive", which involves young and growing populations and is represented by Cambodia with 15 million people, "stationary or near stationary", which involves not growing populations and is represented by Indonesia with 232 million people, and "constrictive", which involves elderly and shrinking populations and is represented by Thailand with 68 million people. In terms of mental health outpatient facilities/mental hospitals, Thailand has 93/18 and Cambodia has 63/0, respectively. The rate of mental health outpatient facilities per 100,000 population was 0.14 for Thailand and 0.42 for Cambodia. Data for Indonesia was unavailable. Ratio of psychiatrist per 100,000 population is 0.23 for Thailand, 0.23 for Cambodia, and 0.01 for Indonesia[8].

The Hennessey-Hicks TNA Questionnaire was used as a guideline to help identify the needs for each country. The items were subdivided into five categories as shown in Table 1. The experts from Thailand expressed needs for training in providing feedback to colleagues and giving information to patients or caregivers, whereas, Indonesia and Cambodia noted that most tasks were required.

Specifically required issues and special attention

In addition, training on special topics was required depending on the country's necessity. Table 2 shows the training needs regarding certain mental health issues, interventions, and basic skills expressed by each country, separated between professionals and non-professional personnel. Most of mental health problems and basic skills were consistent among three countries. For example, issues of unwanted pregnancy among adolescents should receive much greater awareness. Mental health promotion and prevention as well as some specific interventions were required for Thailand and Indonesia. All agreed that there should be more involvement from non-professional mental health/community workers to develop appropriate communication skills such as being able to use simple language to transfer knowledge, to use IT and media effectively, and to integrate culture and local wisdom. Non-professional health personnel was also required to be able to understand, evaluate, and apply research results and to transfer new knowledge to the community (Table 3). In addition to the specific needs stated in the Hennessy-Hicks items, basic skills were needed in all ranges of mental health issues.

Discussion

A comparison among the three countries provided a clearer picture of the service and training

Table 3. Training needs analysis categorized by basic skills and mental health issue for nonprofessional mental health providers

Mental health problems and intervention	Basic skills
• Common mental health problems, e.g., depression (All)	• Establish relationship (All)
• Public attitude to mental health problems and stigma (All)	• Skills to change to new paradigm in mental health (e.g., depression) (All)
• Identifying long term effects of trauma (e.g., from wars, natural disasters) (All)	• Skills relating to provision of effective psychoeducation using 21st century technology (All)
	• Integration of culture and local wisdom (All)

T=Thailand; I=Indonesia; C=Cambodia; All=all countries

needs for the respective countries, considering similarities and differences regarding fundamental factors. Even though Cambodia expressed urgent training needs for mental health professionals, non-professional education and training based on national or international level of cooperation, inside or outside the public health realm, might be a viable option, given the modern digital world. Thailand, which reported similar needs as Indonesia in terms of the size of economic factors, viewed that all needs were required despite some existing fundamental resources. Interestingly, Indonesia has a population pyramid that falls in the middle between Thailand and Cambodia. Yet, Thailand is the only country currently facing and addressing mental health issues related to aging. In fact, Thailand has identified itself as having 'an aging society', and so added the topic, 'caring for patients with dementia and caregivers' in their training needs. Experiences dealing with aging problems were shared by Cambodia and Indonesia, which have time to prepare for these upcoming problems.

Even though training for mental health professionals in each country is ongoing, such training does not appear to meet the current needs. Training non-psychiatric professionals, such as primary physicians and nurses, concerning mental health issues, may help to address current mental health needs in all countries. Complex mental health issues such as child abuse, suicide prevention, drug abuse, and depression should be prioritized among appropriate professionals. Non-professionals are now trained to identify or early detect common mental health problems such as depression[9]. Experts in the forum have suggested that more training should be encouraged regarding complicated cases such as abuse, and appropriate referrals should be provided to professional mental health providers for Thailand and Indonesia. Identifying long-term effects of trauma from wars was necessary for non-professional providers from Cambodia, whereas from natural disasters for Thailand and Indonesia.

Southeast Asia is vulnerable to natural disasters. Thailand and Indonesia have mental health and psychosocial support plans that included disaster preparedness, while Cambodia does not[7]. Both Thailand and Indonesia, however, need to consistently assess mental health professionals' perceptions and understanding of their roles, as well as training needs[10].

Cambodia is much concerned about recruiting mental health professionals and focusing on providing sufficient services for the country rather than training non-professionals to deal with mental health issues. A distinct example discussed by the Cambodian expert was that "their concern was on the medical students' motivation to register for this psychiatric training program and the value of the degree for practitioners in the mental health field". One of the present study contributors that expressed his concern over the chances for trainees to become qualified members of the mental health workforce, suggested that universities should form partnerships to help with this challenge. On the other hand, Cambodia's population pyramid consisted of mostly young labor, and hence does not have the aging burden as in Thailand. To produce personnel using traditional methods may take some time to produce sufficient medical doctors or psychiatrists for the mental health work. In this digital age, training non-professional and non-medical volunteers can benefit from the use of social media to attract and provide training about mental health, for example, training volunteers to use screening tools for depression[4].

The experts reached the consensus that basic skills are still required skills of mental health providers, whether professional or non-professional. In addition, knowledge and attitudes to mental health problems should be changed. For example, any form of violence/abuse should be unacceptable and not be allowed to be perceived as acceptable cultural practices. Depression or substance abuse should not be viewed because of individual's mental weakness.

More education regarding mental health problems can be provided using recent technology such as Facebook and other social media. Training need analysis has been used only for qualitative analysis in the present study, which may have minimized the effectiveness the tool could provide. More robust designs including a sufficient sample size, mixed techniques such as qualitative and quantitative, and random sampling are warranted[11].

Limitation

The respondents from Cambodia and Indonesia did not include all mental health disciplines, as did Thailand. The results may not genuinely represent the true mental health situations in Cambodia and Indonesia.

Conclusion

Training need analysis helps to identify similarities and differences in mental health issues facing different countries so that each country can consider the way forward in cooperating with other countries in Southeast Asia. Agreement among the three countries is needed concerning research, clinical tasks, and communication. Inclusion of non-professional mental health providers in training of basic skills such as communication is deemed important at the present. Up-to-date technology vis-a-vis social media is strongly encouraged to help with educating, training, and screening of mental health issues. However, further clarifications and suitable measurements should be added for future investigation.

What is already known on this topic?

The Southeast Asian countries are reported to be second ranked for serious shortages of health professionals. The shortage of mental health professional remains a challenge.

The lack of understanding of training needs regarding mental health issues in Southeast Asian countries led to gaps in training strategies.

What this study adds?

Training need analysis helps identify similarities and differences in mental health issues facing different countries so that each country can consider the way forward in cooperating with other countries in Southeast Asia.

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Availability of data and materials

The datasets used or analyzed during the current study are available from the corresponding author upon reasonable request.

Authors' contributions

Wiwatanadate P, Kanjanarat P, Wongpakaran N, Wongpakaran T, Thongpibul K, Sirithongthaworn S, Hidayat R, Heng M, and Tsai D designed the conceptualization. All analyzed and interpreted the data and were major contributors in writing the manuscript. All authors read and approved the final manuscript.

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Conflicts of interest

The authors declare they have no conflict of interests.

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