Opinion
Volume 7:3, 2022

International Journal of Public Health & Safety

ISSN: 2736-6189 Open Access

Development of a Community Mental Health Education and Detection

Ashfaq Ul Hassan*

Department of Anatomy, SKIMS Medical College, India

Introduction

Low demand for mental health services in sub-Saharan Africa is driven by poor mental health literacy, stigma, and poor service availability. To develop a Community Mental Health Education and Detection (CMED) Tool for adults for use by community health teams in South Africa aligned with their roles of health promotion, screening and linkage to care. Formative evaluation methods involving four processes: (1) Ongoing engagement with the KwaZulu-Natal Department of Health (KZN DoH) to ensure co-creation of the CMED tool and alignment with routine community health team activities; (2) Adaptation of the CMED tool from the Community Informant Detection Tool (CIDT), used to promote help-seeking of people with mental health problems in Nepal; (3) Review of the CMED vignettes and illustrations by a panel of local and international mental health care experts to establish accuracy and contextual and cultural relevance; (4) Process mapping and focus group discussions (FGDs) with community health teams in one district to establish cultural and contextual appropriateness as well as coherence and compatibility with existing community-based services.

Description

The resulting CMED tool consists of five case vignettes and related illustrations to facilitate psychoeducation and the detection of possible depression, anxiety, psychosis, harmful alcohol use, and drug use by community health teams. Based on prototype matching, it includes two structured questions to guide the community health teams in the detection and referral process. The tool was acceptable, culturally and contextually appropriate, and helpful for the services provided by community health teams. Challenges of working in households and the importance of self-care were highlighted as important considerations when developing training content and piloting the tool. Extensive consultation with the KZN DoH, community health teams, and the expert mental health panel resulted in developing a tool that was perceived to be culturally sensitive and relevant to the community package of services.

A mixed-methods approach informed by Normalisation Process Theory [NPT] was adopted as a broad framework to elucidate the factors needed to ensure a culturally and contextually relevant tool that would ease integration into routine CHW services (normalised). Regardless of the success of an intervention, its long-term impact depends on its effectiveness in the real-world context and how widely it is implemented. Implementation and sustainability of interventions need to be considered from the outset and can be evaluated using NPT. NPT is relevant in the early implementation stages to when an intervention becomes a part of routine services (normalised). The four components of NPT include i) coherence (meaning and sense-making by users), ii) cognitive participation (engagement), iii) collective action (work needed to ensure adoption, compatibility with the existing system), and iv) reflexive monitoring (benefits/costs of the intervention).

The study was conducted in the Amajuba District of KwaZulu-Natal province of South Africa, where the larger SMhINT study was being conducted. It is made up of three sub-districts – Newcastle (urban), Emadlangeni (rural), and Dannhauser (semi-urban). There are 53 community wards and, at the time of the study, a total of 15 community health teams. The study was conducted in the Newcastle sub-district [population of 3, 89,117] (Statistics South Africa, 2016). It comprises both urban and rural areas and is serviced by a district and provincial hospital with 14 PHC facilities and five fully formed (OTL and CHWs) community health teams.

The formative research involved four processes: (1) Ongoing engagement and collaboration with the KZN DoH to ensure co-creation of the CMED tool; (2) Development of the CMED tool materials; (3) Review by an expert panel; and (4) Process mapping and focus group discussions with community health teams in the Newcastle sub-district to inform a standard operating procedure for use in routine household visits. To ensure that the development of the CMED was aligned with the KZN DoH strategic vision, their needs, and priority areas with respect to the community health team roles, functions, and services provided for other conditions, we had ongoing engagements with the KZN DoH. To this end, a total of 10 joint meetings were held with the KZN DoH, as well as email communication. In tandem, we reviewed the current community health team guidelines (South African National Department of Health, 2017), the national mental health policy (South African National Department of Health, 2013), the existing community health worker curriculum and the community package of services [1-5].

Conclusion

The CMED tool was adapted from the Community Informant Detection Tool (CIDT) that was used to promote help-seeking of people with mental health problems in Nepal as part of the Programme for Improving Mental Health Care (PRIME). As with the CIDT, the CMED tool is based on the prototype matching approach. Prototype matching is where a diagnosis is made by matching a patient's presenting symptoms with a paragraph-length description of the disorder. It has been found to have several advantages relating to clinical utility over the traditional method of counting symptoms to diagnose patients. The format of the CMED and Nepalese CIDT consists of vignettes and illustrations for five mental health conditions. Each vignette (in the CMED and CIDT) is followed by three structured questions that aid the health worker in matching symptoms with the prototype vignette and determines if the family member requires a referral for further care. The mental disorders included in the CMED tool were depression, anxiety, harmful alcohol and drug use, and psychosis. These disorders were chosen on the basis of being the most common and high burden mental and substance use disorders in South Africa. As with the CIDT, although the symptoms of these mental disorders were drawn from the WHO mhGAP intervention guide local idioms of mental health problems were incorporated into the development of the vignettes drawing on the literature and the everyday rhetoric of the local context. Local idioms of distress refer to ways of expressing distress that may not involve specific symptoms or syndromes, but provide collective ways of experiencing and talking about distress in local contexts.

***Address for Correspondence:** Ashfaq Ul Hassan, Department of Anatomy, SKIMS Medical College, India, E-mail: ashhassan@rediffmail.com*

Received: 05 March, 2022, Manuscript No. IJPHS-22-63232; **Editor assigned:** 07 March, 2022, PreQC No. P-63232; **Reviewed:** 19 March, 2022, QC No. Q-63232; **Revised:** 20 March, 2022, Manuscript No. R-63232; **Published:** 27 March, 2022, DOI: 10.37421/ijphs.2022.7.272

References

1. Braun, Virginia and Victoria Clarke. "Reflecting on reflexive thematic analysis." *Qual Res Sport Exerc Health* 11 (2019): 589–597.
2. Hanusaik, Nancy, Catherine M. Sabiston, Natalie Kishchuk and Katerina Maximova, et al. "Association between organizational capacity and involvement in chronic disease prevention programming among Canadian public health organizations." *Health Educ Res* 30 (2015): 206-222.
3. Ennals, Priscilla, Ian Muchamore, Vicki Langan and Cristal Hall, et al. "Active 8: Promoting health beyond the absence of mental illness." *Aust J Rural Health* 28 (2020): 215-217.
4. Hennink, Monique M., Bonnie N. Kaiser and Vincent C. Marconi. "Code saturation *vs.* meaning saturation: How many interviews are enough?" *Qual Health Res* 27 (2017): 591-608.
5. Turner III, Daniel W. "Qualitative interview design: A practical guide for novice investigators." *Qual Rep* 15 (2010): 754-760.

How to cite this article: Hassan, Ashfaq Ul. "Development of a Community Mental Health Education and Detection." *Int J Pub Health Safety* 7 (2022): 272.