Community Informant Detection Tool:
Detecting People with Mental Health Problems in the Community

Prasansa Subba[1], Nagendra Prasad Luitel[1], Mark JD Jordans [2]

1 Transcultural Psychosocial Organization, Baluwatar, Nepal, 2 King's College, London, United Kingdom

Background

It is estimated that four out of five people with mental illness in Low and Middle Income Countries (LMIC) receive no effective treatment [1] . Task shifting, a new model of care has been widely advocated strategy by World Health Organization, to reduce the gap in mental health care by training the frontline workers with a brief training on mental health Global Action Programme (mhGAP) [2]. As the supply-side challenges (related to lack of mental health services) are being addressed, there continues to be demand side challenges , where people with mental health problems do not seek care. Part of this demand side challenges is contributed by lack of awareness about service availability and lack of recognition of mental health problems [3]. Detection of people with mental illness through routine primary screening has been recommended to increase service utilization but this approach may be problematic in LMICs as it fails to reach those who infrequently use primary care services. In such case, community case finding by lay community workers could be advantageous. The two-staged case finding approach recommends identification and referral of potential case through community workers to the health facility, where the diagnosis is reconfirmed by the health professional [4]. It is against this backdrop, the Community Informant Detection Tool (CIDT) was developed for five mental health problems - depression, epilepsy, alcohol use disorder, psychosis and child behavioral disorder.

Development of the draft tool

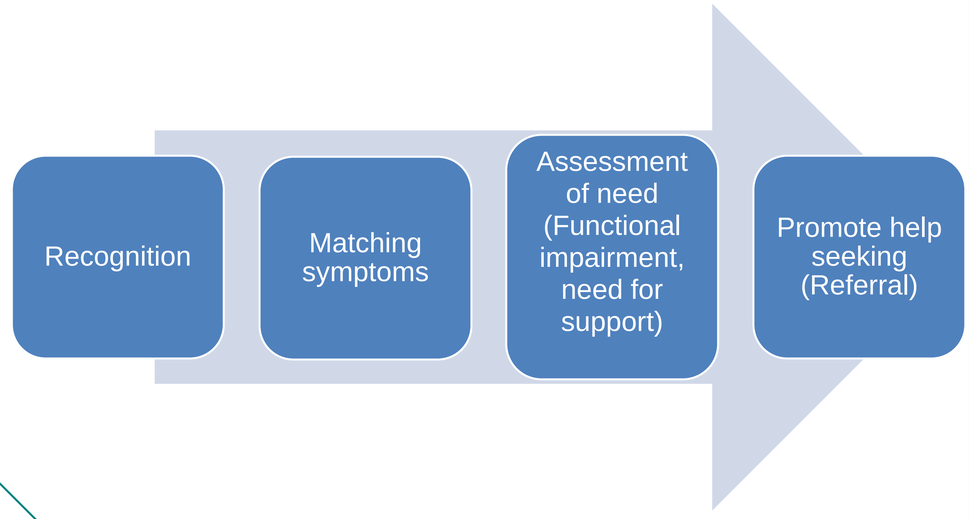
25 mental health experts rated a list of symptoms prepared from the mhGAP vignette and previous ethnopsychological study. Case vignette was prepared incorporating 8-10 most relevant symptoms. In local non-stigmatizing idioms. Three questions on the degree of match of symptoms, functional impairment and need for support were added.

Focus group discussions (n=2) and in-depth interviews (n=6) conducted with community informants such as Female Community Health Volunteers (FCHVs), mothers group, traditional healer and pharmacists to assess the comprehensibility, usability of the tool and to collect feedback.

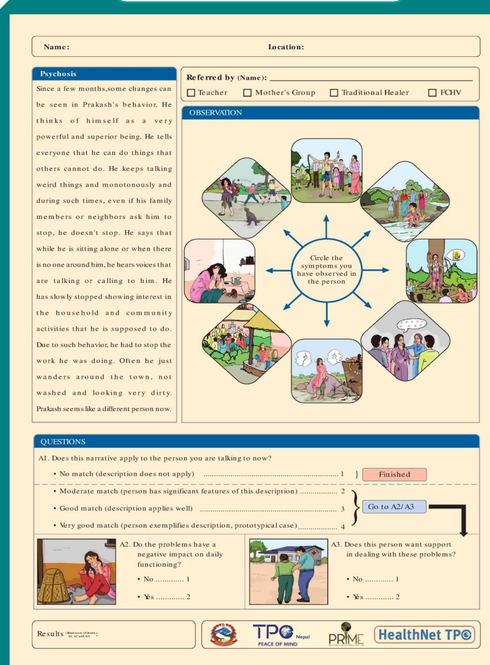
8 community informants were trained on the tool administration and sent off to use in the community for 1 week. Experiences shared and recommendations were made based on which the tool was modified.

Pilot test conducted with 105 community informants to explore their perception of the tool, right person to take up the task, need for incentives, suggestions and recommendations

CIDT process



CIDT tool



"The goal of the CIDT procedure IS NOT for community informants to make a specific diagnosis, but rather to IDENTIFY someone with any mental distress that would benefit from treatment. It is therefore intended as a proxy indicator for people with mental disorders." - **Jordans et. al (2015)**

Validation of the tool

A validation study was conducted to assess **how accurate the CIDT procedure** is in identifying people with mental health problems. Twelve community informants' (FCHVs=8, members of mother's group=4) conducted an assessment of 195 probable cases using CIDT across 6 wards of Meghauli and Dibyanagar VDC of West Chitwan, where basic mental health service was available. The community informants' assessment was compared against the Composite International Diagnostic Interview (CIDI) performed by para-professional counselors.

Results:

- The CIDT has **a positive predictive value of 0.64** (64% of people that community informants identified as probable cases using the CIDT were actually positive cases based on clinical interviews)

- The CIDT has a **negative predictive value of 0.93** (93% of people that community informants identified as probable non-cases were indeed found negative) [5]

Effectiveness of the tool

A cross sectional study was conducted in Chitwan and Pyuthan where the CIDT positives were visited and follow-up interviews were conducted **at one month of detection.**

The study focused to find out answers to following questions:

- Did the person **visit the health facility because of the CIDT procedure**?
- What problem did they seek help for? **Was treatment initiated**, and if so what treatment?

Results:

- Of the total 509 identified positive on CIDT, **67% accessed health care facility as a result of the CIDT procedure.**

- Among the group that accessed health care, **77% were diagnosed having mental disorders and started treatment** by primary health care workers.

Conclusion

The CIDT was developed to increase demand-side help seeking in Nepal. The CIDT consists culturally appropriate case vignettes using local non-stigmatizing idioms for each problem accompanied by illustrations. The tool can be used by lay community members with low literacy levels. The tool has already been validated and has been proven effective to increase detection and care utilization for mental health problems in settings with limited treatment engagement. Although CIDT is not an alternative to the standard screening tool, we believe that the use of the CIDT can play an important role to increase help seeking behavior of people with potential mental health problems through detection and referral from the community level. Provided with brief training, the FCHVs are successfully carrying out this task in several districts of Nepal. After the earthquake of April 2015, the CIDT was adapted for additional two disorders: suicide and post traumatic stress disorder (PTSD), in five earthquake affected districts- Gorkha, Sindhuli, Ramechhap, Dhading and Dolakha.

References

1. Kohn R, Saxena S, Levav I, Saraceno B. The treatment gap in mental health care. Bull World Health Organ. 2004;82(11):858-66. 2.
2., WHO. Mental Health Gap Action Programme (mhGAP): Scaling up care for mental, neurological and substance use disorders. Geneva: World Health Organization; 2008.
3. Saraceno B, van Ommeren M, Batniji R, Cohen A, Gureje O, Mahoney J, et al. Barriers to improvement of mental health services in low-income and middle-income countries. Lancet. 2007;370:1164-74.
4. Shibre T, Kebede D, Alem A, Negash A, Kibreab S, Fekadu A, Fekadu D, Jacobsson L, Kullgren G: **An evaluation of two screening methods to identify cases with schizophrenia and affective disorders in a community survey in rural Ethiopia**. *International journal of social psychiatry* 2002, **48**(3):200-208.
5. Jordans MJ, Kohrt BA, Luitel NP, Komproe IH, Lund C: **Accuracy of proactive case finding for mental disorders by community informants in Nepal**. *The British Journal of Psychiatry* 2015, **207**(6):501-506.