

# DEVELOPMENT, DELIVERY AND EVALUATION OF MICRO-CERTIFICATE MENTAL HEALTH AMBASSADORSHIP COURSE

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Submitted: January 28, 2023

Accepted: February 17, 2023

## ABSTRACT

Mental illnesses can impact anyone. However, those who suffer from mental ill health can face stigma contributing to a barrier in help-seeking behaviour. The Brain and Mind Institute at the Aga Khan University (BMI AKU) aims to create a small 'army' of mental health ambassadors for mental health awareness, identification, and referral for those in need of help for their mental well-being. This is a narrative of designing, approving, standardising, delivering, evaluating and proposing the future evolution of a unique Micro-certificate Mental Health Ambassadorship course.

## KEYWORDS

Awareness, Identification, Mental Health Ambassadors, Referral, Stigma, Wellbeing

## INTRODUCTION

Mental illness can impact all spheres of life.<sup>1</sup> The Brain and Mind Institute at the Aga Khan University (BMI AKU), aims to approach mental well-being and ill health as a public health message, and strives to reduce stigma towards mental ill health and psychiatric illnesses. The BMI endorses the concept of no health without mental health.<sup>2</sup> Our intention as an institute is to ensure that all our engagements are meaningful and lead to transformation.<sup>3</sup>

There is a significant need for public awareness, engagement and appropriately signposting those who need further help for mental well-being. The newly designed Micro-certificate Mental Health Ambassadorship course aims to train members of the public to become mental health ambassadors who will listen without judgement, start an empathetic conversation to identify and signpost those in need for help with their mental health concerns.

A high prevalence of mental health symptoms in the public accounts for an enormous burden of disease of approximately 1 in 4 people<sup>4</sup> suffering from mental ill health. They can present with a wide spectrum of symptoms, including changes in behaviour, mood disorder, psychosis, substance misuse, dementia and more. Some presentations are typical, while others are atypical. Many do not seek help. Stigma prevents many from crossing the threshold for seeking help. Although one would expect the primary health system to be the initial portal to mental health care, lack of knowledge and skills in identifying mental illnesses among healthcare providers<sup>5</sup> pose a barrier to integrating mental health in primary care health services.<sup>6</sup> In low- and middle-income countries, where primary care system is disjointed the resources are even more restricted<sup>7</sup>, the problems get further amplified.

In clinical practice, the first presentation and follow-up of those suffering from mental health conditions are likely to be assessed and managed in General Practice or by non-health professionals in the community. These pathways are not well developed<sup>8</sup> and are often dealt with by faith and traditional healers, among other alternative medicine approaches, partly because of the lack of access to adequately trained mental health practitioners.<sup>9</sup>

Mental health concerns, traumatic experiences,<sup>10</sup> social deprivation,<sup>11</sup> unemployment<sup>12</sup> and poor physical health<sup>1</sup> have an intimate link. Mental health concerns are long-term conditions<sup>13</sup> that can impact overall well-being. Early intervention can significantly improve outcomes.<sup>14</sup> For timely intervention, understanding the biopsychosocial model is imperative, to identify individuals at risk within the community and who may show signs and symptoms of mental ill health.

Besides fighting stigma related to mental health concerns, we aim to address the parity of esteem between mental and physical health. Establishing the interconnectedness of mental and physical health will bridge the existing gap and improve overall health outcomes. It is acknowledged that other courses train professionals and members of the public in identifying intricate mental health problems.

Hence, our long-term goal is to increase awareness of the public, which should lead to earlier identification and intervention for better outcomes.

This paper is a narrative account of designing this course and its evaluation.

## METHOD

The BMI's 8-week Micro-certificate Mental Health Ambassadorship course was designed in campuses of Nairobi (Kenya) and Karachi (Pakistan).

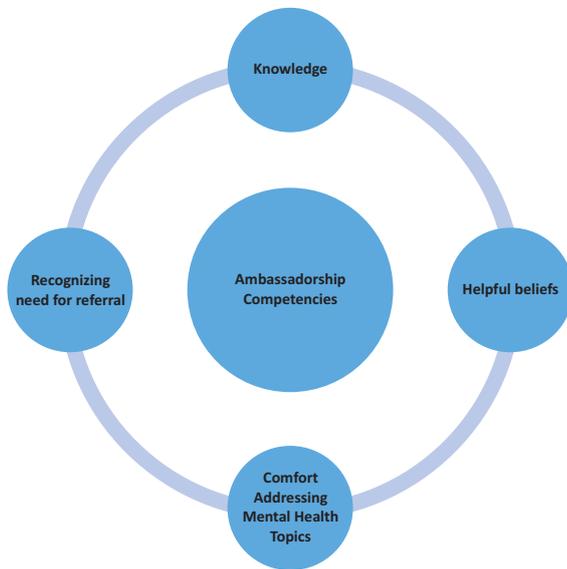
### Course aims and learning objectives:

This course aimed to equip the members of the general public to recognise individuals with mental health concerns. The following were the learning objectives and competencies of the course:

Examine and understand the symptoms of mental illness, and demystify the causes of mental illnesses by understanding the biopsychosocial determinants (Competency 1 - Knowledge).



1. Improved recognition of signs and symptoms of distress and mental illnesses to improve early detection and to facilitate signposting and crafting a pathway of care (Competency 2 -Recognising Need for Referral).
2. Application of biopsychosocial approach to recognise the signs of distress and mental illnesses (Competency 1- Knowledge).
3. Map out strategies for the inclusion of persons suffering from mental illnesses and to reduce the stigma associated with mental illnesses (Competency 3 - Comfort addressing mental health topics).
4. Discuss the difference between pity, sympathy, compassion and empathy to inform inclusive behaviour (Competency 4- Helpful Beliefs).

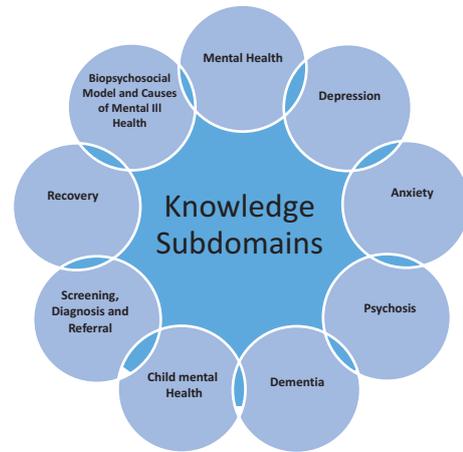


**Figure 1: Concepts underpinning the competencies of the Mental Health Ambassadorship course**

**Course content:**

The course content was based on clinical scenarios, webinars, and introductory videos. The course content was discussed in the focus group of Educational Working Group (EWG) of BMI. This group included psychiatrists, psychologists, community mental health educators, and digital learning experts. The group was in a consensus to include the following topics:

- Module 1: Recognising psychiatric disorders using a biopsychosocial model.
- Module 2: Stress and anxiety-related presentations.
- Module 3: Symptoms of depression and mood disorders.
- Module 4: Recognition of psychotic illness
- Module 5: Special presentations, such as addiction/substance misuse, mental health in old age and children



**Figure 2: Course Content Underpinning the competencies of the Mental Health Ambassadorship course**

**Clinical scenario-based modules on VLM:**

The clinical scenarios were written by a psychiatrist (TT) using simple, jargon-free and non-clinical language. Clinical scenarios were piloted and further edited by and members of the Education Working Group of the BMI (KM, MI, RM, WN and EB).

These clinical scenarios encouraged participants' critical thinking, individual work, and group discussions.

The scenarios were available on an online virtual learning platform (VLP). All written content also had audio files to increase access and reach, ensuring that literacy level was not a barrier to learning. Both groups had mentors (WN, MI, RM & EB). These mentors have mental health work experience and academic background. They encouraged interactive discussion on the VLP and responded to the contributions of participants. For consistency, model responses to every scenario were also made available to the mentors and tutors involved in the course.

These clinical scenarios also facilitated group discussions and individual activities centred on enhancing the understanding of symptoms and biopsychosocial aetiology.

Any questions raised were brought to a weekly session with an experienced psychiatrist (TT) for further discussion.

**Webinars:**

Each week's content was supplemented with webinars<sup>15</sup> with internationally recognised speakers who discussed key mental health topics of depression, epigenetics, stress and trauma, anxiety disorders, gut microbiome and brain axis. These webinars were open to a broader audience through AKU BMI.

**Tutor facilitated interactive sessions:**

A weekly group session for the ambassadors was facilitated by a psychiatrist (TT). A psychologist (RM), a medical anthropologist (EB) and mentors (WN & MI) also enabled simplification by translating information from webinars for the



ambassadors into layperson's language. This weekly session also provided an opportunity for the participants to interact with each other, ask questions and seek clarifications from each other and the psychiatrist on concepts underpinning the topic of the week and mental health presentations.

**Training videos:**

A repository of introductory videos for each module was developed on the key topics, highlighting the importance of recognising mental health symptoms, anxiety, depression, medically unexplained symptoms, substance misuse, psychosis, maternal mental health and eating disorders.

**Course workbook:**

To ensure delivering a consistent message, a course workbook was developed. This included additional information on topics of relevance and space for the participants to write their own notes.

**Course Participants:**

The participants for two groups from two centres, Karachi and Nairobi, were invited to join via an open email through the Aga Khan University network and partner organisations were informed. Enrolment was on a first come first serve basis for 10 participants for each group.

**Course evaluation and feedback:**

Each module had a pre and post module assessment to evaluate the course and participants' perception of the course, along with their knowledge and practices.

These questionnaires explored participants' views on each module's content and its impact on their knowledge and practice related to each module. The responses were obtained using a Likert scale. Additional open-ended questions were asked about the content of the course and how to strengthen the course.

Pre and post test questions were sorted into the thematic domains of knowledge, recognising the need for referral, supportive beliefs, and comfort discussing mental health topics.

On the Likert Scale, higher scores were assigned to options signalling comfort around mental health topics, correct theoretical knowledge of major mental illnesses, and beliefs that support help-seeking, destigmatising mental ill health conditions, and referring onward. A shift in scores from pre to post-test denoted change. It was possible for an item to be included in more than one thematic area.

A post-course debrief session was also undertaken for feedback.

As a final group activity, ambassadors summarised their learning in a poster. These posters also provided a source of feedback.

**RESULTS**

**Group composition:**

After dropouts, the first final cohort comprised 12 participants from two distinct groups (Table). One group is from Kenya and the other is from Pakistan.

**Table 1:**  
**Details of group composition**

	Karachi	Kenya	Total
Age	5 (18 – 25) 1 (41 – 49)	1 (18 – 25) 3 (26 – 33) 2 (34 – 40)	6 (18 – 25) 3 (26 – 33) 2 (34 – 40) 1 (41 – 49)
Gender	2 Males 4 Females	3 Males 3 Females	5 Males 7 Females
Occupation	1 CEO 1 Banker 1 Research Associate/Student 1 Project Manager/Student 2 Students	1 Operations Manager 1 Country Director 1 Executive Director 1 Administrator 1 Sign Language Consultant 1 Associate	1 Operations Manager 1 Country Director 1 Executive Director 1 Administrator 1 Sign Language Consultant 1 Associate 1 CEO 1 Banker 1 Research Associate/Student 1 Project Manager/Student 2 Students

The Kenyan group had six participants, three females and three males. Of these six participants, one was between 18 and 25 years, three were between 26 and 33 years, and two were between 34 and 40 years old. The group in Pakistan had six participants, two males and four females. Of these six participants, 5 were between 18 and 25 years, and one between 41 and 49 years. Both groups were diverse, with participants coming from varied walks of life and occupations. For example, we had managers, Country Directors, CEOs, Executive Directors, Consultants, Administrators, and Psychology Students.

Our pre and post-test quantitative questions evaluated key “Ambassadorship Competencies”, of knowledge, comfort in addressing Mental Health Topics in community settings, supportive beliefs (beliefs promoting help-seeking behaviour and integration into society of those with mental illnesses) and identifying need for referral.

**Knowledge:**

The knowledge domain of the pre and post-tests captured a shift in knowledge regarding the biopsychosocial model and causes of mental ill health, screening, diagnoses, referral and recovery broadly and mental illnesses including childhood and geriatric illnesses, depression, anxiety, psychosis (bipolar disorder and schizophrenia), aligning with modules contained within the course.

Figure 3 shows that overall, participants showed an increase in knowledge scores from pre to post-test, as evidenced for selected items by Fig. 3. Of the 29 items in this domain, 21 showed an upward shift. The shift in scores ranged from an increase of 3-7 points for the majority of items, with a median increase of 5 and no clear pattern for which items showed a greater increase. The greatest increase was on the item “Anxiety is only an emotional response”, with post-test scores improving by 15 points for this item. We also noted an improvement in understanding of the biopsychosocial model as the course progressed, with both pre and post-test scores for questions on this domain rising with progressive modules.



Exceptions to this upward shift included the items “Serious Mental Illness can be passed from one person to another” and “Medication is the only option for treatment for depression.” There was no shift on the item “People with psychosis have more than one personality existing within them” and a decrease in “Schizophrenia and Bipolar Disorder cannot be treated.” This may be an artefact due to a small sample size or may reflect a need for further discussion on these topics during the modules.

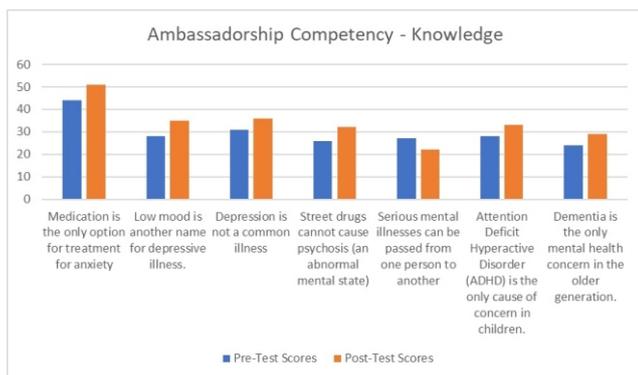


Figure 3: Change in Pre and Post Test Knowledge Scores

**Recognising Need for Referral:**

Figure 4 shows that all 12 items in this domain showed an upward shift in scores from the pre-test to the post-test, as demonstrated for selected items. This ranged from an increase of 3-10 points. The median increase was 5 points. The biggest increase (10 points) was on the item “I am able to recognise symptoms related to mental illness.”

Figure 4 also shows that there was an upward shift in 10 out of 12 items measuring this competency from the pre-test to the post-test. The upward shift ranged from 1 to 15 points, with a median for the upward shift of 4.5. The biggest shift was in the item “Medications are the only treatment options”.

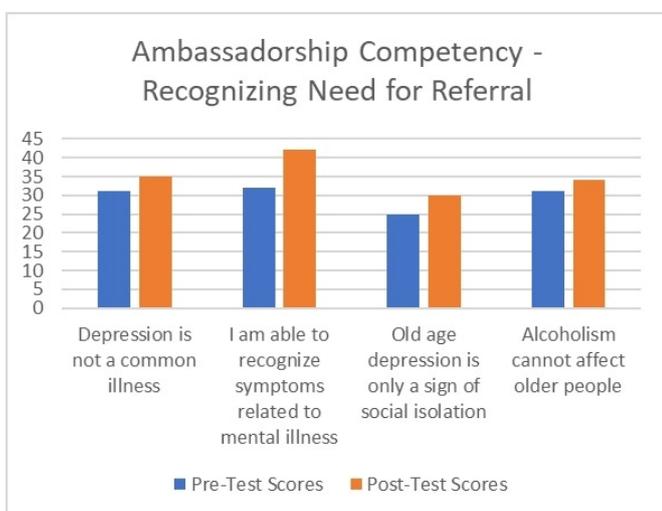


Figure 4 : Change in Pre and Post Test Recognising Need for Referral Scores

The exceptions to the upward shift were the items “Being worried is another name for anxiety” and “People experiencing psychotic symptoms like hallucinations, delusions are dangerous.”

**Supportive Beliefs:**

There was an upward shift in 10 out of 12 items, measuring this competency from the pre-test to the post-test. The upward shift ranged from 1 to 15 points, with a median for the upward shift of 4.5. The biggest shift was in the item “Medications are the only treatment options”.



Figure 5: Change in Pre and Post Test Supportive Beliefs Scores

Figures 5 and 6 show that for selected items from the domain “Supportive Beliefs” there was an increase in scores in the analysis indicating an increase in “correct responses” and not an increase in agreement with the given statement.

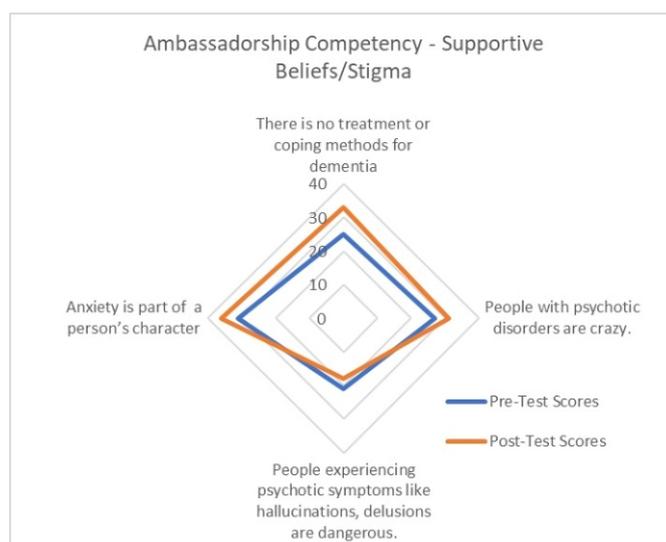


Figure 6 : Spider graph of pre and post test scores on beliefs and stigma.

The exceptions to the upward shift were the items “Being worried is another name for anxiety” and “People experiencing psychotic symptoms like hallucinations, delusions are dangerous.”



### Comfort Discussing Mental Health Topics

There were four items in this competency, with all showing an upward shift in perceived comfort. The increase ranged from 2 to 11, with a median increase of 6.5, the highest median increase among all the competencies. The greatest increase was in the item "I feel comfortable in dealing with stigma related to depression and other similar mental health problems" (11 points), followed by "I feel comfortable in dealing with stigma related to anxiety". Visual representation of the results from this domain is presented in Fig. 7.



Figure 7: Change in Pre and Post Test Comfort Addressing Mental Health Topics Scores

### Qualitative information:

Qualitative information focused on two main areas, learning (What I have learnt?) from the course, and its application (What I will use the information from this course for?). These responses were captured by the ambassadors on a poster. Some prominent and self-explanatory comments are as below:

- "Mental ill health is more common and prevalent than society assumes"
- "Mental health cannot be separated from our daily lives; it plays a huge role"
- "Mental health can be tracked using the bio-psycho-social model"
- "Mental ill health is not madness – it is a disease just like diabetes"
- "This course has broadened my mind in terms of mental health disorders"
- "Mental health is a culmination of biopsychosocial factors which are inseparable."
- They referred to weekly supervision sessions with psychiatrists as "fireside chat" with a positive learning experience.

The following key themes for the application of learning reflected enthusiasm:

- "Create awareness about mental health in my community."
- "Eradication of stigma."
- "Defend and protect people struggling with mental ill health from ostracization."
- "To work with youth, women and vulnerable groups by providing them a platform for sharing, reflective listening and psychosocial support."
- "Educate others and provide a safe space to those struggling with mental health difficulties."
- "Offer psychoeducation on mental health to help find the right support."

Furthermore, we identified three themes from this feedback.

**Theme 1: Knowledge and perceptions of mental Health/illness after training** Ambassadors demonstrated a clear understanding of mental health. In their narratives, it was clear that they were able to understand that mental illnesses were common in their communities – something that was not commonly perceived so by community members. Others demonstrated that mental illnesses were broader than they thought before the course and needed attention or seriousness, like other physical health conditions.

### Theme 2: Perceptions towards the Ambassadorship course

All ambassadors demonstrated a positive perception towards the course and cited that the course would be beneficial and applicable in their communities. For example, a majority discussed how they would use the knowledge gained in creating awareness of mental health in their communities, work with others in the community to reduce stigma towards mental illnesses among others.

Others were specific and cited that they will work with women, children and other vulnerable groups to ensure that they had a platform where they could be heard and or provided necessary support or referrals to care.

### Theme 3: Recommendations for future courses

Towards the end, ambassadors provided various recommendations that could improve future courses.

## DISCUSSION

Our results, even though in small numbers, show that there is a positive shift in knowledge and confidence in skills for the participants in both groups. In particular, there is a shift towards the ability to use the biopsychosocial model in all domains. The ambassadors reported improvement in their understanding of mental health symptoms. Also, the responses to open-ended questions on participants' learning and how they will use the information from this course have been very encouraging. The ambassadors from this course wish to destigmatise mental health concerns and educate those in their community settings. They want to help others and improve and promote mental health and mental health well-being.

We believe that these key competencies will support the Ambassadors in performing their intended action item from this course – engaging, educating and referring forward where indicated, meeting our end goal of early identification and intervention for better outcomes. While all demonstrated an upward trend, we saw the greatest increase in perceived comfort in addressing mental health topics.

Importantly, this course was free at the point of delivery for this cohort. This was only possible through an anonymous donor, pre-existing resources of AKU and the dedication of multi-professional faculty.



We used several real-life case scenarios to encourage, explore, and improve knowledge of these Mental Health Ambassadors. Participation in this Micro-certificate Mental Health Ambassadorship course required no prior experience or knowledge, as long as they had a genuine passion and desire to improve mental health.

This unique Micro-certificate Mental Health Ambassador course helped the participants expand their knowledge and expertise. They had the opportunity to attend webinars presented by international experts and had interactive weekly group sessions with an experienced psychiatrist and regular mentoring supervised through a VLP. In a short period, they equipped themselves with specific and basic knowledge to enhance their knowledge and skills.

The participant feedback from the course will further help in evolving and developing the course. This will form a regular PDSA cycle (Plan, Do, Study and Act cycle). Regular feedback from each cohort will help plan the next iteration. It will also help to study the improvements and shortcomings of the course for further improvements.

Very meaningful feedback was given to evolve the course by the participants. In particular, the clinical scenarios were reported as important learning aids for a better understanding of biopsychosocial models for aetiology. However, they wished for the language to be consistently simple and jargon free.

Making this unique course accessible and beneficial for a larger cohort will require an expansion, and the number of mentors and facilitators will have to increase. A more robust online virtual learning platform will ensure frictionless access for participants and mentors.

There will be an ongoing engagement with the first cohort ambassadors to help and mentor them.

**CONCLUSION**

One of the objectives of the BMI at the AKU is to destigmatise mental illnesses and to promote help-seeking behaviour when needed. One such measure is by forming a volunteer workforce of Mental Health Ambassadors through a Micro-certificate Mental Health Course, trained to recognise symptoms of mental ill health and provoke a supportive and empathetic response. Even though the first pilot cohort was small, the two groups provided positive quantitative and qualitative feedback for its success. We have designed and evaluated this course for evolving future training approaches and cohorts.

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