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Original Research Article

Acceptability of mental health toolbox talk in primary health care service: a case study of Oshodi/ Isolo local government area, Lagos state, Nigeria

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ABSTRACT

Background: Mental health services at the primary healthcare level remain at their lowest ebb in most developing countries. Mental health toolbox talk is a way to solve mental health needs in the community. This study aimed at assessing the acceptability of mental health toolbox talk in primary health care (PHC), in Oshodi/Isolo, local government area (LGA).
Methods: This is a descriptive cross-section study conducted among 119 PHC staff. A multistage sampling technique was used to select participants for the study. Data were collected and analyzed using the statistical package for social sciences (SPSS) 26 and the EPI Info application.
Result: Findings revealed that the majority 79% of respondents were females and were within the age range of 40-60 years of age. Also, 76% of PHC staff showed poor knowledge of mental management, while 94% of the respondents accepted the integration of mental health toolbox talk into PHC. Findings revealed that professions (χ^2=12.998, $p<0.05$) had a significant association with the respondents' knowledge about mental health. However, the analysis of variance shows there is a statistically insignificant difference in knowledge between the professional groups of PHC staff on the provision of mental health services in the PHC facilities, ($f=0.616$; $p=0.688$) ($p>0.05$).
Conclusions: Lack of knowledge on mental health was observed to mitigate PHC staff in the management of mental health disorders, and the need for training on mental health toolbox talk was determined.

Keywords: Mental health, Mental health toolbox talk, PHC, Community health practitioners

INTRODUCTION

The concept of PHC emerged after the embroilment of the United States of America and world political wrangling, that emphasized the marginalization of healthcare services to the developing nations. A call for change in medical elitism was proposed, and at that instance, the world health organization (WHO) was forced to concede to the new proposal called PHC.[1] These new proposals for health and development appeared and questioned the transplantation of the hospital-based healthcare system to developing countries and the lack of emphasis on prevention of diseases were raised.

The Alma-Ata declaration on PHC which was made in 1978 became the new bride and it was meant to address the main health problems in communities by providing promotive, preventive, curative, and rehabilitative services.[2] Nigeria was among the 134 signatories to this invaluable idea. Subsequently, several re-organizations of the Nigeria health structure to align with the new vision were made.[3]

The WHO defined health as: "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity".[4,5] Mental health was an integral part of the definition. The goals and traditions of public health and health promotion can be applied just as useful in the field of mental health as they have been in infectious diseases and tobacco control.[6]

Mental health services at the primary healthcare level remain critical in most developing countries, especially in resource-poor and crisis-stricken communities.[7] Mental health was described by WHO as a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to his or her community.[4,5] It has always remained a neglected public health problem in low and middle-income countries (LMICs). This core concept of mental health is consistent with its wide and varied interpretation across cultures.[2]

For the successful integration of mental health into PHC, primary care health professionals are the key personnel who are responsible for the management of mental, neurological, and substance use disorders.[8-10] The use of less specialized general health workers to deliver defined tasks such as identification, treatment, delivery of psychological therapies, or family psycho-education termed 'task sharing' or 'task shifting' which has been demonstrated to be successful LMIC.[11-14] In addition, part of the tools suggested to be offered in the facilities is a mental health toolbox talk.[15-17]

A mental health toolbox talk is a great way to deliver information on mental health and raise awareness.[16,18] The mental health toolbox talk has been designed to help everyone improve their mental wellbeing.[19] Toolbox talk is holistically defined as an informal group discussion that focuses on a particular safety issue. These issues bother mostly on mental health and behavioral health problems.[20-22]

The WHO estimates that close to one billion people live with a mental disorder out of the eight billion inhabitants worldwide, and 25% of the population will suffer from mental illness at some time in their lives.[23] Epidemiological work has demonstrated that the burden of disease associated with mental and neurological illness is among the highest for all disorders globally.[24] A study conducted in South Africa reported that, among the general public, knowledge of mental illness was low and stigma was high.[25] Despite the high level of disability, more than 85% of people with severe mental illness in LMICs do not receive the care they require.[26,27]

Nigeria, however, experiences critical health workforce shortages, with a current health workforce density of 2.2 per 1000 population-far less than the threshold of 4.45 per 1000 population required to achieve the United Nation's sustainable development goal.[28] The WHO estimates of mental healthcare manpower for a population of 213.4 inhabitants, as 0.10/100,000 for psychiatrists, 0.70/100,000 for psychiatric nurses and 0.02/100,000 for psychologists.[29,30] In addition, over 45% of the population which is about 89 million inhabitants, lives below the poverty line and with the barrage of skilled workers leaving the country.[31] While payment for health care services is largely out-of-pocket.[3,11] However the traditional views on the etiology of mental disorders still suffice, most people with mental disorders never receive effective care while a wide range of stigmatization still exists even when the financial obligations are met by the families.[7,25,30,32]

It is therefore paramount to integrate mental health toolbox talk into PHC services with a sustainable model to solve the anomaly.

Objectives

Objectives were to evaluate the level of knowledge of the toolbox talk approach among PHC staff in Oshodi/Isolo LGA, to evaluate the competence level on the use of the toolbox talk approach among PHC staff in Oshodi/Isolo LGA and to explore the perception of PHC Staff in Oshodi/Isolo LGA toward the mental health toolbox talk approach in PHC services.

Hypotheses

H_0: There is no significant association between respondents' professions and knowledge about mental health toolbox talk.

H_0: There is no significant knowledge difference among cadres of PHC staff toward the provision of mental health services.

METHODS

This is a cross-sectional study with a quantitative approach to evaluate their knowledge, competence level, and perception toward mental health toolbox talk approach. Respondents were chosen from the three local council development areas (LCDA) in the LGA.

Study population

The study population comprises of community health practitioners (junior community health extension workers, community health extension workers, and community health officers) 49, nurses, 47, medical doctors, 15; medical records, 17; pharmacy technicians, 26; and medical laboratory technicians, 18, that amounted to 172 PHC workers serving at 3 LCDA's in the LGA.

Period of study

The study started from 17/07/2023 and a total of fourteen days were used for data collection, which ended on 31/07/2023, while additional 10 days were also used for

compilation and analyzing of data and did end on 10/08/2023.

Inclusion

The cadre of health workers that were included in the study were community health practitioners (JCHEW, CHEW, and CHO), nurses, medical doctors, medical records, and pharmacy technicians, who are working in the LGA.

Exclusion

Another cadre of health workers who are not mentioned above and all cadre who are mentioned above but did not give their verbal consent were excluded.

Sample size determination

The EPI Info version 1.4.3, statistical application was used to calculate the sample sizes of a known population sizes.

Setting the confidence level at 95%; setting confidence limits at 5%; population size of respondents=172 and sample size=119

Sampling technique

A multistage sampling technique was deployed to enable every member of the population have a chance of being selected since they are from different PHC facilities in the LCDAs, and every cadre was proportionally represented in the sample.

First Stratified sampling technique was used to divide the LGA into three LCDAs.

Stratified random sampling formula=total sample size/entire population×population of subgroups.[33,34]

Let N=total population=N (172 PHC workers)

n=Sample population= n (119 respondents)

Sub groups=A, B and C

$= \frac{n}{N} \times A$; $\frac{n}{N} \times$ B; $\frac{n}{N} \times$C

Calculation for sub group A (PHC workers in Oshodi LGA)

$\frac{119}{172} \times 63 = 43.6$ (44 respodents)

Calculation for sub-group B (PHC workers in Isolo LCDA)

$\frac{119}{172} \times 55 = 38.1$ (38 respondents)

Calculation for sub-group C (PHC workers in Ejigbo LCDA)

$\frac{119}{172} \times 54 = 37$ (37 respondents)

Secondly, the simple random sampling technique was used to recruit the number of participants from each stratum (LCDA) for the study.

Instrument

The instrument for this study was adapted with some modifications. The instrument comprises two sections; section '1' covers the personal data of the respondents, while section '2' is divided into three distinct parts, namely; (knowledge of mental health) which consists of eleven items that seek to examine respondent knowledge of mental health. **(**Service rendered in PHC*)* which consisted of 10 variables that appraised the services in the PHC. And respondents' views toward toolbox talk in approach PHC, which consisted of four items that seek respondents' views on the intrusion of mental toolbox talk in PHC services.

Validity and reliability of instrument

The study tool was examined and pretest, and the items were valid at α=0.05, using a bi-variate correlation with a Cronbach's Alpha of 0.77, which made the questionnaire to be adapted.

Data management and analysis

Descriptive statistics were presented in a frequency distribution table and charts; and measures of central tendency and variability. multivariate analysis was carried out which included Chi-square (for categorical variables) and t test (for continuous variables). The level of significance was set at $p<0.05$, and the data were analyzed using SPSS version 26.0.

Measures of knowledge on mental health

Five questions were used to test for knowledge with a four (4) point Likert scale, with "strongly agree and agree" coded as good knowledge while "strongly disagree and disagree" was coded as poor knowledge. The scores range from four to twenty (4-20). Respondents who scored between 4 to 12 were adjudged to have poor knowledge while those with 13 to 20 were regarded to have good knowledge in mental health. This was coded because knowledge is absolute.

Ethical consideration

Ethical approval was obtained from the health research ethics committee (HREC) at Lagos state university teaching hospital (LASUTH), and a letter of introduction was also obtained from the school of post graduate

studies, university of medical science, Ondo State. This study adhered to ethical guidelines, ensuring participant confidentiality, anonymity, and right to withdraw at any point.

RESULTS

Background characteristics of respondents

The study revealed the socio-demographic characteristics of the respondents which showed that more than three-quarter of the respondents were females (78.8%). While 57% of participants were between age 40 and 60 years. And majority of respondents were married (92.4%).

However, a higher percentage of the respondents were community health practitioners (28.8%), closely followed by nurses and pharmacists' technicians at (27.1%) and (15.3%) respectively. The majority of the respondents were between 13 and 16 grade level (61%), this depicts that participant had experience.

Information in the study depict that a handful of respondents had attended mental health training programs (28%). Similarly, about 32% of them had attended to mentally ill patients in their practices, of the mental concerned patients seen, 65% were referred to psychiatric hospitals while 35% were referred to general hospitals. The study also revealed that about 31% of the PHC staff acquired the knowledge and skill on how to manage mentally retarded patients through a structured setting and they were issued certificates for participation or diploma for studying the course, and 30% of them acquired experience on-job. However, the study did show that 64% of the participants had poor knowledge about mental concerns.

The study revealed that a high proportion of the participants (87.3%) agreed that mental health toolbox talk approach is needed in PHC.

Also 94% of the participants agreed that the approach will eliminate the stigmatization and improved the knowledge and skills of the PHC practitioners.

Hypothesis one

Association between respondents' socio-demographic characteristics and their knowledge about mental health

H_0: There is no significant association between socio-demographic characteristics and their knowledge about mental health.

The study depict association between respondents' socio-demographic characteristics and their knowledge about mental health. It was observed that age (χ^2=25.223, p<0.05), marital status (χ^2=10.941, p<0.05), and grade level (χ^2=34.349, p<0.05) had significant association with the respondents' knowledge about mental health. While gender (χ^2=3.725, p>0.05) did not had significant association with respondents' knowledge about mental health

Hypothesis two

Association between respondents' profession and knowledge about mental health

H_0: There is no significant association between respondents' professions, knowledge about mental health.

Study showed association between respondents' professions and knowledge about mental health, profession (χ^2=12.998, p<0.05) significant association with respondents' knowledge about mental health.

Staff knowledge toward mental ill clients

H_0: There is no significant knowledge difference among cadres of PHC staff toward the provision of mental health services.

Information in table; it was observed both, between and within groups whether there is significant knowledge difference among cadres of PHC staff toward provision of mental services. Table showed that there is no significant knowledge difference among cadres of PHC staff toward provision of mental services (p>0.05).

Table 1: Socio-demographic characteristics of the respondents.

Characteristics	N	Percentage (%)
Gender		
Male	25	21.2
Female	93	78.8
Age (in years)		
18-25	23	19.5
26-40	28	23.7
40-60	67	56.8
Marital status		
Single	6	5.1
Married	109	92.4
Divorced/ separated/ widowed	3	2.5

Continued.

Characteristics	N	Percentage (%)
Occupation		
Doctor	10	8.5
Nurse	32	27.1
Community health practitioners	34	28.8
Records	12	10.2
Pharmacist	18	15.3
Lab. scientist	12	10.2
Grade level		
4-7	32	27.1
8-12	14	11.9
13-16	72	61.0

Table 2: Respondents' exposure to mental health courses.

Statements	Responses	N	Percentage (%)
Have you attended any mental health training program recently?	Yes	32	27.1
	No	86	72.9
if attended, duration	Weeks	27	84.4
	Month	2	6.3
	Year{s}	3	9.4
Have you ever come across mentally ill patients in your practice?	Yes	37	31.4
	No	81	68.6
if "yes" what is there common complain?	Two or more complain	26	70.3
	No comment	11	29.7
How did you manage the patient/client?	Referred to general hospital	13	35.1
	Referred to psychiatric hospital	24	64.9
How did you acquire the skill and knowledge to manage mentally retarded patients	Personnel training	27	22.9
	Certificate/diploma	36	30.5
	On-job-training	35	29.7
	No response	20	16.9

Table 3: Respondents' knowledge about what mental health services.

Statements	Response	N	Percentage (%)
Identify community members at risk of mental disorders and refer them as appropriate	Agreed	98	83.1
	Disagreed	15	12.7
	Neutral	5	4.2
Be "friend sufferers" to stop stigmatization of fully recovered patients	Agreed	104	88.1
	Disagreed	10	8.5
	Neutral	4	3.4
Discourage marginalization of children with epilepsy from acquiring education because of local beliefs	Agreed	77	65.3
	Disagreed	23	19.5
	Neutral	18	15.3
Domestic violent intervention is not part of the PHC job description	Agreed	65	55.1
	Disagreed	40	33.9
	Neutral	13	11.0
Outreach services to mentally deprived patients or clients are not for PHC workers	Agreed	61	51.7
	Disagreed	45	38.1
	Neutral	12	10.2
Without mental health, PHC is still a comprehensive one-stop-shop that focuses on the whole person.	Agreed	75	63.6
	Disagreed	30	25.4
	Neutral	13	11.0
School visitation to educate teachers on mental health is part of PHC services	Agreed	93	78.8
	Disagreed	20	16.9
	Neutral	5	4.2

Table 4: Steps consider when creating a mental health toolbox talk approach.

Statements	Responses	N	Percentage (%)
Stay positive. Recognize wins and provide credit where it's due	Agreed	103	87.3
	Disagreed	2	1.7
	Neutral	13	11.0
Consider creating a mental health committee in the community	Agreed	90	76.3
	Disagreed	18	15.3
	Neutral	10	8.5
Build awareness through proper education and mental health outreach programs	Agreed	111	94.1
	Disagreed	4	3.4
	Neutral	3	2.5
Eliminate the stigma by starting conversation	Agreed	111	94.1
	Disagreed	4	3.4
	Neutral	3	2.5
Mental health training intervention for PHC workers resulted in improved knowledge and clinical practice	Agreed	106	89.8
	Disagreed	9	7.6
	Neutral	3	2.5

Table 5: Association between respondents' socio-demographic characteristics and their knowledge about mental health.

Socio-demographic	Knowledge, n (%)		Total, n (%)	X^2	Df	P value
	Poor	Good				
Sex						
Male	12 (15.8)	13 (31.0)	25 (21.2)	3.725	1	0.054
Female	64 (84.2)	29 (69.0)	93 (78.8)			
Age (in years)						
18-25	8 (10.5)	15 (35.7)	23 (19.5)	25.223	2	<0.001*
26-40	12 (15.8)	16 (38.1)	28 (23.7)			
40-60	56 (73.7)	11 (26.2)	67 (56.8)			
Marital status						
Single	0 (0.0)	6 (14.3)	6 (5.1)	10.941[f]	2	0.002*
Married	74 (97.4)	35 (83.3)	109 (92.4)			
Divorced/ separated/ widowed	2 (2.6)	1 (2.4)	3 (2.5)			
Grade level						
4-7	12 (15.8)	20 (47.6)	32 (27.1)	34.349	2	<0.001*
8-12	3 (3.9)	11 (26.2)	14 (11.9)			
13-16	61 (80.3)	11 (26.2)	72 (61.0)			

*f=Fisher exact.

Table 6: Association between respondents' profession and knowledge about mental health.

Respondents	Knowledge, n (%)		Total	X^2	Df	P value
	Poor	Good				
Profession						
Doctor	9 (11.8)	1 (2.4)	10 (8.5)	12.998[f]	5	0.019*
Nurse	24 (31.6)	8 (19.0)	32 (27.1)			
Community health practitioners	20 (26.3)	14 (33.3)	34 (28.8)			
Records	3 (3.9)	9 (21.4)	12 (10.2)			
Pharm	13 (17.1)	5 (11.9)	18 (15.3)			
Lab	7 (9.2)	5 (11.9)	12 (10.2)			

*f=Fisher exact.

H_0: There is no significant association between respondents' professions and knowledge about mental health. Table 6: showed association between respondents' professions and knowledge about mental health. It was observed in the table that profession (χ^2=12.998, p<0.05) had significant association with the respondents' knowledge about mental health.

Table 7: ANOVA table for different in the knowledge of PHC staff on patient with mental condition.

Knowledge	Sum of squares	Df	Mean square	F	P value
Between groups	16.390	5	3.278	0.616	0.688
Within groups	595.577	112	5.318		
Total	611.966	117			

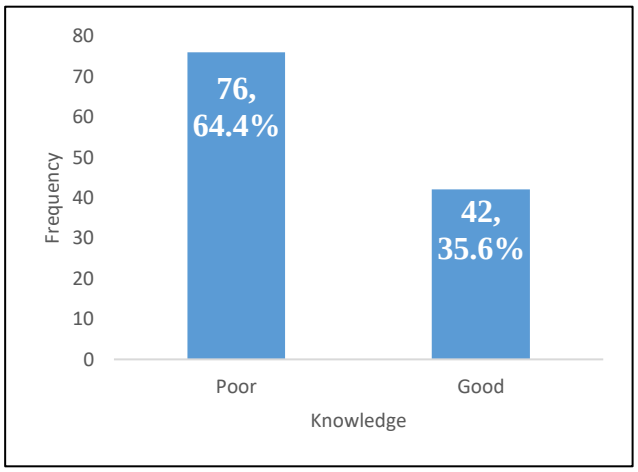

Figure 1: Knowledge PHC staff on the management of mental cases.

DISCUSSION

This study is novel in its attempt to explore the knowledge and exposure amongst PHC workers in relation to mental health toolbox talk. The study did unravel that majority of the PHC staff were community health practitioners, a presentation that most PHC workers comprises of mainly community health practitioners, nurses with sparse doctors.[11,35,36] From this study, it was observed that the worker has sufficient experience, however one of the major obstacles to the integration of mental health care is that most PHC workers have minimal mental education which is insufficient for effective mental health service delivery. The study also unravels respondents' knowledge about the management of mental cases which indicated that majority of them had poor knowledge in the management of mental disorder clients and patients. Our study did collaborate the findings of other scholars that enunciated that PHC workers had very poor knowledge of mental disorders and virtually this mitigated the offering of mental health services in the primary healthcare facilities.[19,34]

It is an applaudable gesture that practitioners are willing to seek for a new approach in providing mental health services this affirmed other scholar studies, which meant to contextualized mental health gap in the country, the study also showed the need for innovative approach to improve coverage and access to mental health services and the participants agreed to be trained to acquire the skills to manage mental, neurological and substance abuse conditions in Nigeria setting.[11,30] Likewise there is a significant relationship between profession and knowledge of mental health care services among PHC workers, and it is noted clearly in this study, that mental health promotion depends on a collective responsibility and not just an arm of medicine or a single profession.[4,26] Hence, the study proposed statistically significant knowledge difference between the groups of PHC staff on the provision of mental health services was rejected by the respondents. It was also observed that task-shifted interventions for mental health services delivered by lay health workers were effective, equally pragmatic and potentially useful components of primary mental health care in resource-poor settings and can be ascribed as an acceptable model in solving mental health illnesses in LMIC.[4,34]

Limitations

The limitation observed was the intra professional wrangling among PHC professionals which hindered the full participation of respondents.

CONCLUSION

PHC in developing countries continues to rely heavily on paramedical personnel. Human resources (HR) are the most valuable asset of a mental health service. Such a service relies on the knowledge competence and motivation of its personnel to promote mental health, prevent disorders, and provide care for people with mental disorders. The results from this study indicated that respondents support the approach of the novel therapy, mental health toolbox talk, which is cost-effective and encourages community participation. Though majority of them lack the knowledge in mental health management, there is an urgent need to start developing more effective awareness-raising, training and education programme among health care providers. In solving this enigma, there should be an increased consensus, commitment and political-will within and around government in monitoring and adhering to standard practices of mental health care.

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REFERENCES

1. Cueto M. origins of primary health care the and selective primary health care. Am J Public Health. 2004;94(11):1864-74.
2. Alenogbena IO, Isah EC, Isara AR. Availability and type of human resources for health in public primary health care facilities in selected communities, Edo State. J Community Med Primary Heal Care. 2016;28(2)11-8.
3. Ola BA, Olibamoyo O. COVID-19 in Nigeria: implications for prevalent public mental health challenges. Mental Heal Rev J. 2020;26(1):32-41.
4. WHO. Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders, 2024. Available at: https://iris.who.int/. Accessed on 12 April 2024.
5. Eaton J, Gureje O, De Silva M, Taiwo LS, Ekpe EE, Mohammed A, et al. A structured approach to integrating mental health services into primary care: development of Mental Health Scale Up Nigeria Intervention (mhSUN). Int J Ment Health Syst. 2018;12:11.
6. Wada YH, Rajwani L, Anyam E, Karikari E, Njikizana M, Srour L, et al. Mental health in Nigeria: A Neglected issue in Public Health. Public Health Pract (Oxf). 2021;2:100166.
7. World Health Organization 2020, Doing what matters in times of stress: an illustrated guide.
8. Ayano G, Assefa D, Haile K, Chaka A, Haile K, Solomon M, et al. Mental health training for primary health care workers and implication for success of integration of mental health into primary care: evaluation of effect on knowledge, attitude and practices (KAP). Int J Mental Health Systems. 2017;11:1-8.
9. Wyandini DZ, Maslihah S, Kosasih HM. The urgency of social support and being productive people: Public service reports. InBorderless Education as a Challenge in the 5.0 Society, CRC Press. 2020;77-80.
10. Caulfield A, Vatansever D, Lambert G, Van Bortel T. WHO guidance on mental health training: a systematic review of the progress for non-specialist health workers. BMJ Open. 2019;9(1):e024059.
11. Gureje O, Oladeji BD, Montgomery AA, Araya R, Bello T, Chisholm D, et al. High-versus low-intensity interventions for perinatal depression delivered by non-specialist primary maternal care providers in Nigeria: cluster randomized controlled trial (the EXPONATE trial). Brit J Psychiatr. 2019;215(3):528-35.
12. Dotimi DA, Wamanyi Y, Silas JU. Community health practice: the Nigerian model. Int J Community Med Public Health. 2024;11:560-5.
13. Federal Ministry Of Health. Task-Shifting And Task-Sharing Policy For Essential Health Care Services In Nigeria, Abuja, 2014. Available at: https://drpcngr.org/taskshiftingtasksharing/#:~:text=The%20Task%2DShifting%20and%20Task,workers%20especially%20in%20underserved%20populations. Accessed on 12 April 2024.
14. Harris DC, Davies SJ, Finkelstein FO, Jha V, Bello AK, Brown M, et al. Strategic plan for integrated care of patients with kidney failure. Kidney Int. 2020;98(5):S117-34.
15. National Primary Health Care Development Agency, Minimum Standards For Primary Health Care In Nigeria. NPHCDA Plot 681/682 Port-Harcourt Crescent, Off Gimbiya Street, Garki II, Abuja. 2020.
16. Rice SP, Rimby J, Hurtado DA, Gilbert-Jones I, Olson R. Does sending Safety Toolbox Talks by text message to Residential Construction Supervisors increase Safety Meeting Compliance? Occupational Health Sci. 2022;6(3):313-32.
17. Conversation Guide: Talking to someone about mental health© Mental Health UK, 28 Albert Embankment, London, SE1 7GR. Registered Charity no. 1170815. Available at: https://euc7zxtct58.exactdn.com/wp-content/uploads/2021/10/04131954/Mental-Health-UK-Coversation-Guide-Talking. Accessed on 12 April, 2024.
18. World Health Organization. 2014. Mental Health: a State of Well-Being. Available at: http://www.who.int/features/factfiles/mental_health. Accessed on 12 April 2024.
19. Squire L, Slingsby L, Bailli S. The Mental Well being Toolbox Handbook, University of Bristol, 2020. Available at: http://www.bristol.ac.uk/students/wellbein. Accessed on 12 April 2024.
20. Toolbox Talks | EH and S (harvard.edu).
21. Kaskutas V, Jaegers L, Dale AM, Evanoff B. Toolbox talks: Insights for improvement. Professional safety. 2016;61(01):33-7.
22. Harrington D, Materna B, Vannoy J, Scholz P. Conducting effective tailgate trainings. Health promotion practice. 2009 Jul;10(3):359-69.
23. Wada M, Suto MJ, Lee M, Sanders D, Sun C, Le TN, et al. University students' perspectives on mental illness stigma. Mental Health Prevent. 2019;14:200159.
24. Jombo HE, Idung AU, Iyanam VE. Attitudes, beliefs and social distances towards persons with mental illness among health workers in two tertiary healthcare institutions in Akwa Ibom State, South-South Nigeria. Int J Health Sci Res. 2019; 9(6):252-259.
25. Kebede MA, Anbessie B, Ayano G. Prevalence and predictors of depression and anxiety among medical students in Addis Ababa, Ethiopia. Int J Mental Health Systems. 2019;13(1):1-8.
26. Labinjo T, Serrant L, Ashmore R, Turner J. Perceptions, attitudes and cultural understandings of mental health in Nigeria: A scoping review of published literature. Mental Health Religion Culture. 2020;23(7):606-24.
27. Adewuya AO, Adewumi T, Ola B, Abosede O, Oyeneyin A, Fasawe A, et al. Primary health care

workers' knowledge and attitudes towards depression and its management in the MeHPric-P project, Lagos, Nigeria. Elsevier Inc. 2017;47:1-6.
28. United Nations Department of Economic and Social Affairs, Population Division 2022. World Population Prospects 2022: Summary of Results.
29. World Health Organization, Depression and Other Common Mental Disorders: Global Health Estimates, World Health Organization, Geneva, Switzerland, https://apps.who.int/iris/bitstream/handle/10665/254610/WHO-MSD-MER-. Accessed on 12 April 2024.
30. Abdulmalik J, Olayiwola S, Docrat S. Sustainable financing mechanisms for strengthening mental health systems in Nigeria. Int J Ment Health Syst. 2019;13:38.
31. GOI. Demographic statistics bulletin, 2020. Available at: "https://nigerianstat.gov.ng/pdfuploads/DEMOGRAPHIC BULLETIN 2020. Accessed on 12 April 2024.
32. Fitzpatrick SJ, Perkins D, Handley T, Brown D, Luland T, Corvan E. Coordinating Mental and Physical Health Care in Rural Australia: An Integrated Model for Primary Care Settings. Int J Integr Care. 2018;18(2):19.
33. Dhikav V. Basic and Clinical Epidemiology Second, 2019. Available at: https://efaidnbmnnnibpcajpcglclefindmkaj/https://www.aitbspublish. Accessed on 12 April 2024.
34. Silas U, Oladunni MR Perceived factors affecting the involvement of community health practitioners on mental health toolbox talk in primary health care in Ilorin Metropolis, Kwara State. 2020. Available at: www.academia.edu/resource/work/48872372. Accessed on 12 April, 2024.
35. Ajisegiri WS, Peiris D, Abimbola S. It is not all about salary: a discrete-choice experiment to determine community health workers' motivation for work in Nigeria. BMJ Global Health. 2022;7:e009718.
36. Ibama AS, Dennis P. Role of Community Health Practitioners in National Development: The Nigeria Situation Int J Clinical Med. 2016;511-8.

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