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The Effect of Caring and Spirituality Mental Health Training (*Keswacarri*) on Commitment and Role of Mental Health Cadres in The District Of Widang Tuban, Indonesia

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Abstract--- *The mental health cadres have several roles to play, in this case focusing on mental health issues, either in people with mental disorders or families. Negative stigma in public about mental disorder, occupying its own space in providing services to the community so it is also necessary an intake to cultivate a good commitment to the health cadres, in this case, is Keswacarri training. Experiment research with quasi-experiment. The Population of the research is 34 cadres. Collecting samples using questioner and checklist and analysis using Mann Whitney test and Wilcoxon signed rank test with a significant level of α=0,05. Result and Analysis: there was an increasing percentage of pretest and post-test. The result of Wilcoxon Signed Rank Tests for commitment and role obtained value p=0,000, and the mean there is an effect of caring and spirituality mental health training (Keswacarri) on commitment and role of mental health cadres. Keswacarri training can affect the commitment and role of mental health cadres, so hopefully Keswacarri training can be used as a reference to conduct training elsewhere.*

Keywords--- *Cadres, Commitment, Mental health, Caring, Spirituality*

I. INTRODUCTION

Mental health cadres is a group of individuals from the community itself and plays an important role in improving the mental health community. The mental health cadres have a role to play: early detection of families, mobilizing communities, home visits, referrals ,and documentation. The role of mental health cadres is more emphasis on psychosocial issues. For example, in early detection families will be classified into healthy family groups according to their psychosocial flowering, as well as risk groups and disorder groups[1], [2]

According to Tuban District Health (2013), the prevalence of severe mental health patient 0.22% and mild mental health people is 6.50% of the population, while the prevalence of mental health people still restrained 14.3% of severe mental health people. Mental health people is severe in East Java of 83,600 people and mild mental health people of 2,470,000 people, while the prevalence of severe mental health people still restrained is 11,955 people. Prevalence of severe mental health people in Tuban Regency is 2,530 people and mild mental health people J is 74,750 people, while the prevalence of severe still restrained is 362 people[3].

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Data obtained from the Tuban District Health Office that the number of severe mental health people in Widang District is estimated to be 72 people, and mild mental health people is estimated at 213 people, while the prevalence of severe mental health people still restrained is 30 people. mental health people data obtained by researchers from Puskesmas Widang both severe mental health people and mild mental health people currently identified as many as 83 people (Documentation The District of Widang).

The burden of families living with mental health people includes several factors both economically and verbally, one of which is a stigma[4]. Stigma is a collection of attitudes, beliefs, mind, and negative behaviors that affect individuals or the general public to fear, reject, avoid, prejudice and differentiate a person[5]. Start from the definition of stigma above, the commitment to mental health cadres occupies its own space in providing services to the community. A good commitment to the cadres is also needed so that the role of cadres can run optimally.

Efforts to build self-commitment within an organization include many things, one of which is caring. Caring is central to nursing practice by maintaining relationships and respecting the values of others, in which one can feel a commitment and personal responsibility. Caring may be more pronounced when accompanied by their spiritual element because the spiritual dimension there are elements of the meaning of life, that fosters a desire to imitate others and pass on something of high value to life. The next spiritual dimension is a positive emotion, which is always grateful for everything that has been given by God Almighty without going through own business[6], [7].

The above explanation proves that caring and spirituality can give a positive benefit to increase commitment, especially to mental health cadres, because in a component of caring and spirituality there are dimensions that can be done to build and increase commitment to an individual in their group.

I. METHODS

The design of this study was experimental, with its type of quasi-experimental. The population in this study was a cadre in the village of Ngadipuro and Patihan in the Widang district totaling 34 cadres of the treatment group (Patihan village) and 30 cadres of the control group (Ngadipuro village). Sampling techniques with simple random sampling were administered to 31 respondents of the experimental group and the control group as many 28 respondents.

The independent variable in this study was the training of mental health caring and spirituality (Keswacarri), while the dependent variable in this study was the commitment and the role of mental health workers. The instrument of research in this study was a questionnaire and checklist as well as the research material using Keswacarri training modules.

This study was conducted over four days on 27 March to 03 April in the village of Patihan (the treatment group) and Ngadipuro village (control group). The two sites have similar demographic which is equally prone to flooding. This study was conducted over four days, the 1st and 2nd day were for delivering the training material, in the 3rd day the cadres did early detection and presented the result, and on the 4th day, a roadshow was held with the mental health people family group. Data analysis used in this research is Mann Whitney test and Wilcoxon sign rank test with a significant level of $\alpha = <0.005$.

II. RESULTS

Based on the demographic data of respondents, the major characteristics of respondents was age, sex, work, last education, and experience.

A. Commitment Of Health Cadres After Keswacarri Training

Table 1. Commitment Of Health Cadres After Keswacarri Training

Role Of Mental Health Cadre	Treatment		Control	
	Pre test	*Post test*	*Pre test*	*Post test*
	Freq **%**	Freq **%**	Freq **%**	Freq **%**
Optimal	0 0	28 90	0 0	0 0
Non optimal	31 100	3 10	28 100	28 100
Total	31 100	31 100	28 100	28 100
Wilcoxon Signed Rank Test	*Asymp. Sig (2-tailed) = 0,000*		*Asymp. Sig (2-tailed) = 1,000*	
Positive ranks	28		0	
Negative ranks	0		0	
Ties	3		28	
Total	31		28	
Mann Whitney Test	*Asymp. Sig (2-tailed) = 0,000*			

The result of the research on the commitment of volunteers denoted that almost all cadres of mental health who were given training in mental health caring and spirituality (Keswacarri) had good commitment (28 respondents or 90%) and almost all cadres of mental health who were not given training in mental health caring and spirituality (Keswacarri) had good commitment (25 respondents or 90%). It showed that caring and spirituality mental health training (Keswacarri) gave effect to the commitment of mental health cadres.

B. Role Of Mental Health Cadre After Keswacarri Training

Table 2. Role Of Mental Health Cadre After Keswacarri Training

Role Of Mental Health Cadre	Treatment		Control	
	Pre test	*Post test*	*Pre test*	*Post test*
	Freq **%**	Freq **%**	Freq **%**	Freq **%**
Optimal	0 0	28 90	0 0	0 0
Non optimal	31 100	3 10	28 100	28 100
Total	31 100	31 100	28 100	28 100
Wilcoxon Signed Rank Test	*Asymp. Sig (2-tailed) = 0,000*		*Asymp. Sig (2-tailed) = 1,000*	
Positive ranks	28		0	
Negative ranks	0		0	
Ties	3		28	
Total	31		28	
Mann Whitney Test	*Asymp. Sig (2-tailed) = 0,000*			

The result of research on the role of a cadre of mental health showed that as many 28 respondents (90%) of those who were given training in mental health caring and spirituality (Keswacarri) had the optimal role. On the other hand, as many 28 respondents (100%) of those who were not given training in mental health caring and spirituality (Keswacarri) were not optimal in their role. The results showed there was an effect of caring and spirituality mental health training (Keswacarri) on the role of mental health workers.

III. DISCUSSION

A. Commitment Of Health Cadres After Keswacarri Training

The commitment of health cadres to treatment group before being given the majority Keswacarri training is adequate and after being given Keswacarri training the majority is good. The commitment of health cadres to the control group before and after being given Keswacarri training the majority was good.

Keswacarri training is a training that is given to all health cadres, be it mental health cadres or other health cadres in the village with the aim to increase cadre knowledge about what role should be run as a cadre of Mental Health. Keswacarri training here not only provides training to health cadres about the role of mental health cadres only, but in it also contains elements Caring and Spirituality to build the commitment of mental health cadres so that in carrying out the role of a cadre of Mental Health, health cadres are not only able to cognitively but are able to apply affective and psychomotor aspects.

Commitment to health cadres that have been well before given Keswacarri training one of them because the experience / old factor into a health cadre so that the sense of ownership and emotional attachment has been formed in and not even willing to give up his position as health cadres. The age factor is also one of the factors of good commitment, the majority of health cadres in Patihan and Desa Ngadipuro are 26-35 years old. The older enough a person's behavior is also more mature in work[8].

The more age someone has, the more mature someone's behavior at work. The more sufficient level of maturity and strength of a person will be more mature in thinking and working. Someone who is more mature will be more trusted than someone who is not yet high enough this maturity is in accordance with public trust. This is as a result of the experience and maturity of his soul[9], [10]

According to Meyer (2002), there are three components in organizational commitment: affective commitment,continuance commitment and normative commitment. The three forms of commitment are negatively related to the withdrawal of cognition and turnover, and affective commitment has the strongest and most beneficial correlation with those relevant to the organization (attendance, performance, and organizational citizenship behavior) and those that are relevant to employees (stress and work – family conflict)) results.[11]

Commitment formed within the health cadres after being given Keswacarri training is normative commitment. Normative commitment can develop from the amount of pressure felt by the individual during the socialization process, besides the normative commitment is also evolved because the organization provides something that is very valuable for individuals who can not be returned back [11]as in this study the changes appear to be seen in the post-test results of the commitment of health cadres (pre-test) on the normative commitment component of many respondents who expressed doubt or disagreement, but when done post-test, many health cadres chose to

agree on the questionnaire commitment component of normative commitment and that is why the health cadre initially committed enough to be a good commitment.

The mental health cadres must have good commitment before performing the role of mental health cadres, because of the negative stigma from society about mental disorder, so that the commitment of the mental health cadres is the first priority.

Hope after the establishment of health cadre's commitment as a cadre of Mental Health can little by little eliminate negative stigma about mental disorder in society starting from health cadres first. The cadres will meet directly with people with mental disorders, this aims to eliminate the negative stigma that often circulates in the community[12].

If the negative stigma of community mental health can be eliminated gradually by health cadres, the surrounding community will also be able to gradually eliminate the negative stigma about human mental health. It is necessary for the community to realize that it is very important for Mental Health and requires Mental Health for mental protection patients and other exposed people.

B. Role Of Mental Health Cadre After Keswacarri Training

The results of research on Keswacarri training showed that the role of mental health cadres before being given Keswacarri training was not optimal yet. The role of the Mental Health cadres after being given Keswacarri training mostly has the role of the optimal Mental Health cadres (treatment group).

The results conducted to previous research by way of early detection by classification method shows the result that the cadre is aware of mental health problem, the cadre is able to explain about the Mental Health itself and the way it is handled , able to conduct early detection, mobilize the community to participate in the counseling of healthy groups, risks and disruptions. Movement of people with mental disorders to follow group activity therapy, cadres are also able to do case referral and reporting[1], [13].

The role of mental health cadres after Mental Health Caring and spirituality (Keswacarri) training has a positive impact. At first, the health cadres do not know at all about what is Mental Health and how the role that must be run by the cadres of Mental Health until finally, health cadres know what role should be run by health cadres as cadres of Mental Health. Mental health Caring and Spirituality (Keswacarri) Training conducted by the researcher in order to build commitment and increase the role of mental health cadres as well as provide insight into the role that must be performed by the cadre of Mental Health by combining cognitive, affective and psychomotor aspects.

The cognitive aspect in this research is how the cadre must know the role that will be run as the cadre of Mental Health so that with the cadre knowledge, the cadre can perform its role optimally. The affective aspect here is how health cadres use empathy in every action/ role that runs, for example when a home visit cadre should not only be present physically but also present emotionally, shows a sense of care and protection.

Psychomotor aspects here is how the attitude/behavior of cadres when running the role of cadres must show the behavior that respect/ respect the family/ community by showing a friendly attitude or polite.

Following the evaluation of Keswacarri training conducted for 4 days starting from March 27 to March 29, and 03 April from the three aspects of cognitive, affective and psychomotor visible changes in health cadres are in the aspects of cognitive/ knowledge and affective/ attitude. Knowledge of health cadres about the role of what should be run as a cadre of Mental Health and how health cadres in carrying out its role are not only present physically but also present emotionally and convincing in self that being a Mental Health cadres means to inherit something of value for life.

The affective/ health cadre attitude to the community especially people with mental disorder shows a change from the original health cadre fearing mental health people,, not daring to be adjacent to mental health people being daring to be adjacent to mental health people and having a conversation with mental health people. Among the health cadres, there are those who show empathy when engaging in conversations with mental health people and families, those who show indifference during conversations with mental health people and family[14].

The empathy of the health cadres when having conversations with mental health people and family is more visible to the cadres of Mental Health itself[15]. Adapting to mental health people is done through confident and steady in the heart "I am a cadre of Mental Health" and it is said over and over again in my heart, other than that it can be done to eliminate awkwardness on mental health people by likening if the mental health people is a member of the family of health cadres themselves, by having such beliefs then the health cadres can gradually eliminate fear to mental health people.

IV. CONCLUSION

Keswacarri training can affect the commitment and role of mental health cadres. Mental health cadres must have a good commitment first before carrying out their role as mental health cadres, this is due to the negative stigma from the public about mental patients. thus, drawing conclusions that good commitment from mental health cadres is a top priority. Keswacarri training is needed by mental health cadres because in it there is a dimension that can be used to build the commitment of health cadres caring and spirituality elements.

ETHICAL CLEARANCE

This research has earned ethic certificate with ethic number of 666-KEPK from faculty of nursing Universitas Airlangga.

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REFERENCES

[1] N. F. Hanim, "The Effectiveness of Cmhn (Community Mental Health Nursing) to Improve Mental Health in the Community: A Systematic Review," 2018.

[2] N. MAWADDAH, D. W. I. H. SYURANDHARI, and A. FARDIANSYAH, "EFFECT OF CMHN APPLICATION TOWARDS NURSES ABILITIES IN WORKING AREA OF MOJOKERTO HEALTH DEPARTMENT," *PUBLIKASI HASIL PENELITIAN*, no. 2, 2017.

[3] D. Putranti and L. Sulistyorini, "Hubungan antara kepemilikan jamban dengan kejadian diare di Desa Karangagung Kecamatan Palang Kabupaten Tuban," *Kesehatan Lingkungan*, vol. 7, no. 1, pp. 54–63, 2013.

[4] A. Yusuf, D. D. Fitriani, and F. Efendi, "Journal of Global Pharma Technology Interaction Model Parents-Adolescents in Adolescents are Risk Addiction of Drugs," pp. 226–233.

[5] J. K. Martin, B. A. Pescosolido, and S. A. Tuch, "Of fear and loathing: The role of'disturbing behavior,'labels, and causal attributions in shaping public attitudes toward people with mental illness," *Journal of health and social behavior*, pp. 208–223, 2000.

[6] C. M. Puchalski, B. Lunsford, M. H. Harris, and R. T. Miller, "Interdisciplinary spiritual care for seriously ill and dying patients: a collaborative model," *The Cancer Journal*, vol. 12, no. 5, pp. 398–416, 2006.

[7] M. E O'brien, *Spirituality in nursing*. Jones & Bartlett Learning, 2017.

[8] E. B. Hurlock, *Developmental psychology*. Tata McGraw-Hill Education, 2001.

[9] S. Agrigoroaei and M. E. Lachman, "Cognitive functioning in midlife and old age: combined effects of psychosocial and behavioral factors," *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, vol. 66, no. suppl_1, pp. i130–i140, 2011.

[10] R. G. Natelson, "The constitution and the public trust," *Buff. L. Rev.*, vol. 52, p. 1077, 2004.

[11] J. P. Meyer, D. J. Stanley, L. Herscovitch, and L. Topolnytsky, "Affective, continuance, and normative commitment to the organization: A meta-analysis of antecedents, correlates, and consequences," *Journal of vocational behavior*, vol. 61, no. 1, pp. 20–52, 2002.

[12] S. E. Estroff, D. L. Penn, and J. R. Toporek, "From stigma to discrimination: an analysis of community efforts to reduce the negative consequences of having a psychiatric disorder and label," *Schizophrenia Bulletin*, vol. 30, no. 3, pp. 493–509, 2004.

[13] D. J. DeWolfe, *Training manual for mental health and human service workers in major disasters*. US Department of Health and Human Services, Substance Abuse and Mental …, 2000.

[14] H. S. Adelman and L. Taylor, *Mental health in schools: Engaging learners, preventing problems, and improving schools*. Corwin Press, 2009.

[15] M. T. Walker, "The social construction of mental illness and its implications for the recovery model," *International Journal of Psychosocial Rehabilitation*, vol. 10, no. 1, pp. 71–87, 2006.