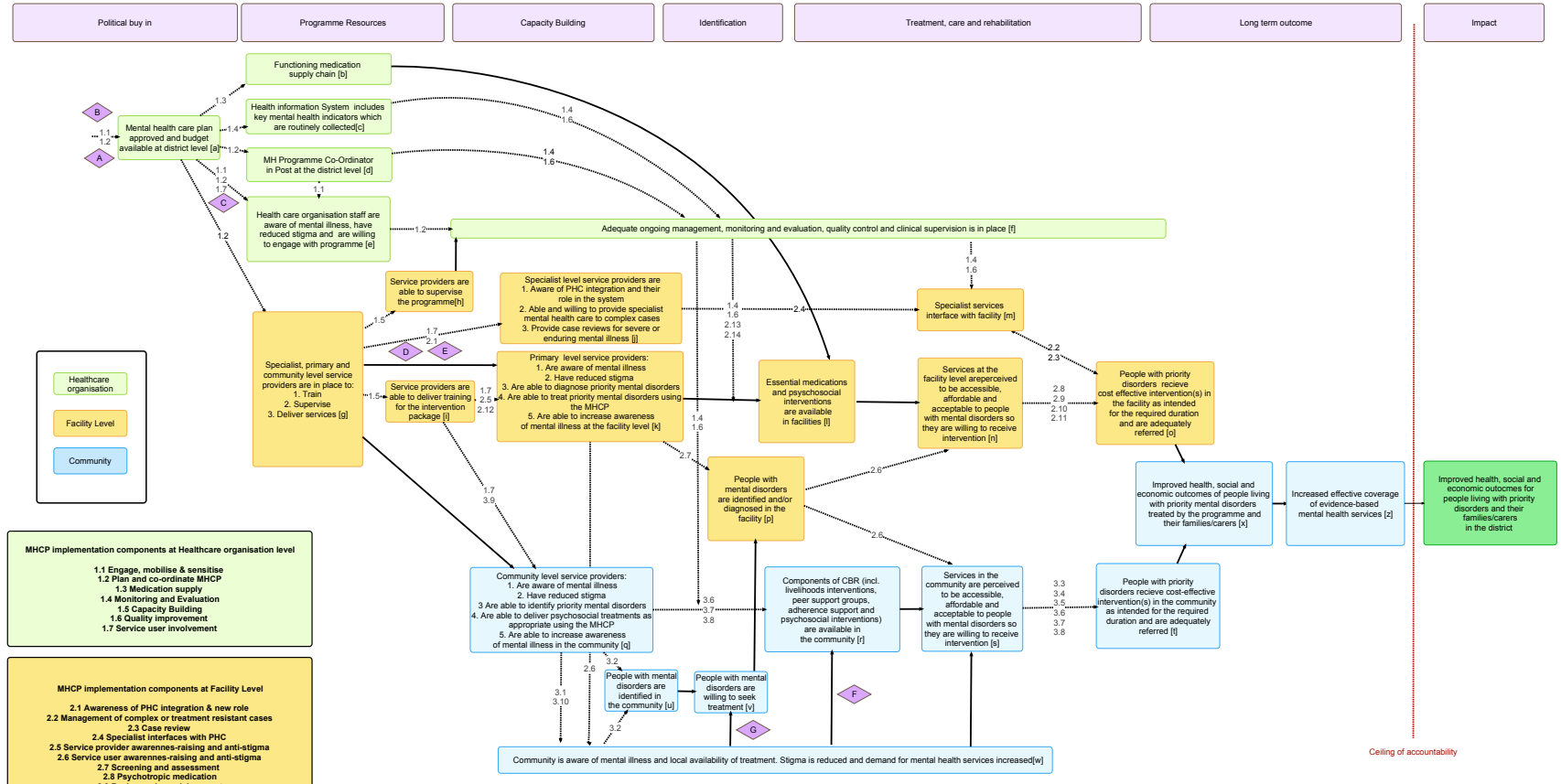
PRIME Cross Country ToC



MHCP implementation components at Healthcare organisation level

1.1 Engage, mobilise & sensitise
1.2 Plan and co-ordinate MHCP
1.3 Medication supply
1.4 Monitoring and Evaluation
1.5 Capacity Building
1.6 Quality improvement
1.7 Service user involvement

MHCP implementation components at Facility Level

2.1 Awareness of PHC integration & new role
2.2 Management of complex or treatment resistant cases
2.3 Case review
2.4 Specialist interfaces with PHC
2.5 Service provider awarennes-raising and anti-stigma
2.6 Service user awarennes-raising and anti-stigma
2.7 Screening and assessment
2.8 Psychotropic medication
2.9 Basic psychosocial support
2.10 Advanced psychosocial support
2.11 Continuing care
2.12 Health facility staff capacity building
2.13 Emotional support for PHC workers
2.14 Supervision for PHC workers

MHCP implementation components at Community Level

3.1 Community awarenness raising
3.2 Community detection
3.3 Basic psychosocial support
3.4 Advanced psychosocial support
3.5 Peer support groups
3.6 Outreach and adherence support
3.7 Rehabilitation and reintegration
3.8 User group mobilisation
3.9 Community capacity building
3.10 Inter-sectoral linkages

Assumptions

A. The district is adequately funded
B. Committed leadership at national, state and/or district level.
C. HCO staff are willing to participate in awareness and sensitization
D. Specialist, primary and community level providers are engaged with the programme and willing to participate in providing and/or receiving training and supervision without monetary incentives
E. Trained staff remain in post and new staff are trained
F. Community Based Organizations willing to collaborate in CBR
G. Opposition from complimentary healers does not cause undue influence

Indicators (Data collection method*)

a. Mental health integrated into the District Health Plan (Case study: district profile);
% increase in financial resources allocated to mental health released on time and available to spend (Case study: district profile)
b. # stock outs in last 30 days for essential psychotropic medications outlined in the MHCP (Case study: facility profile)
c. Health information system contains key mental health indicators as outlined in the MHCP (Case study: district profile);
Mental health data reported in district quarterly and annual health sector performance reviews in relation to service plans and used for ongoing planning in district (case study: district profile)
f. Mental health programme co-ordinator in post prior to MHCP implementation (Case study: district profile)
g. # health care organisation staff are aware of mental illness, have reduced stigma and are willing to engage with programme (Case study: district profile)
h. All staff receive quality supervision on a regular basis as defined by the MHCP and guidelines (Case study: training and supervision evaluation; Case study: process evaluation)
g. Adequate numbers of human resources as per the MHCP are available at primary and community levels (Case study: facility profile)
h. Appropriate content of supervision ; Feedback from participants on quality of supervision (Case study: training and supervision evaluation)
i. Able to deliver good quality training (Case study: training and supervision evaluation)
j. Mental health professionals aware of new system, configuration / new roles, and willing to provide specialist care to complex cases (Case study: process evaluation)
k. Change in knowledge and attitudes pre-and post training (Case study: training and supervision evaluation)
l. Medications are available at all clinics 95% of time (disaggregated by clinic and type of medication) (Case study: facility profile); Staff trained in psychosocial interventions are available at the facility (Case study: facility profile)

Indicators (Data collection method*) continued

m. Satisfaction with referral system from PHC service providers (Case study: process evaluation)
n. Service users' perception of accessibility and acceptability of services (Cohort: qualitative)
o. Increased no. of people correctly receiving evidence-based treatment (Facility Detection Survey); Referrals to specialists are made, % retained in care at 12 months or achieved remission by 12 months, Screening for side effects occurs (Cohort); Medication is changed in response to change in clinical status (Case study: training and supervision evaluation)
p. Increased no. and proportion of people correctly identified/diagnosed with depression and alcohol use (Facility Detection Survey); Increase in % mental health case load as a proportion of total PHC headcount (Case study: facility profile)
q. Change in knowledge and attitudes pre-and post training (Case study: training and supervision evaluation)
r. Components of CBR are being provided in the community as per the MHCP (Case study: community profile)
s. Service users' perception of accessibility and acceptability of services (Cohort: qualitative)
t. # of patients who received psychosocial interventions at community level % retained in care at 12 months or achieved remission by 12 months, CHW make referrals to PHC (Cohort)
u. Increased number of cases detected and managed by CHW (Case study: community profile)
v. Increase in help-seeking and earlier presentation at clinic (Facility detection survey)
w. Improved MH literacy and decrease in stigma, Community members are aware of local availability of treatment (Community survey), Decreased reported stigma by people with priority disorders (Cohort)
x. Improved health, social and economic outcomes of people living with priority mental disorders (Cohort)
y. Changes in environmental, policy, social and political contexts are monitored throughout implementation (Case study: district profile)
z. Increased coverage of evidence based mental health services (Community survey, Cohort)

*see De Silva et al 2014 for more details

Last updated: 20th June 2014