Acknowledgements

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Collaborators

Funders

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## Abbreviations and Acronyms

<table>
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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>APC</td>
<td>Adult Primary Care</td>
</tr>
<tr>
<td>CCS</td>
<td>Clinical Communication Skills</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CMD</td>
<td>Common Mental Disorders</td>
</tr>
<tr>
<td>COBALT</td>
<td>CO-morBidity of AIDS/HIV Affective disorder, and Long-Term Health</td>
</tr>
<tr>
<td>CQI</td>
<td>Continuous Quality Improvement</td>
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<tr>
<td>DHMT</td>
<td>District Health Management Team</td>
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<tr>
<td>DMHCP</td>
<td>District Mental Health Care Plan</td>
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<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DSP</td>
<td>District Support Partner</td>
</tr>
<tr>
<td>HAST</td>
<td>HIV/AIDS, Sexually Transmitted Infections, and Tuberculosis</td>
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<tr>
<td>HCW</td>
<td>Health Care Workers</td>
</tr>
<tr>
<td>HSRC</td>
<td>Human Sciences Research Council</td>
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<tr>
<td>I-TECH</td>
<td>International Training and Education Center for Health</td>
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<tr>
<td>KTU</td>
<td>Knowledge Translation Unit</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>mhGAP</td>
<td>mental health Gap Action Programme</td>
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<tr>
<td>MhINT</td>
<td>Mental health INTEGRATION</td>
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<tr>
<td>MhINT TSU</td>
<td>MhINT Technical Support Unit</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>NCD</td>
<td>Non-Communicable Diseases</td>
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<tr>
<td>NDOH</td>
<td>National Department of Health</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>The United States President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PHCs</td>
<td>Primary Health Care Facilities</td>
</tr>
<tr>
<td>PRIME</td>
<td>Programme for Improving Mental Health care</td>
</tr>
<tr>
<td>QI</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>RTC</td>
<td>Regional Training Centre</td>
</tr>
<tr>
<td>UCT</td>
<td>University of Cape Town</td>
</tr>
<tr>
<td>UKZN</td>
<td>University of KwaZulu-Natal</td>
</tr>
<tr>
<td>UW</td>
<td>University of Washington</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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Purpose of this Manual

This operations manual is designed to be a practical guide for The United States President’s Emergency Plan for AIDS Relief (PEPFAR) District Support Partners (DSPs) to implement the Mental Health INTegration (MhINT) programme at a district level in South Africa in designated PEPFAR focus areas with high HIV burden. It serves as a roadmap, connecting the various components of the intervention that support districts to strengthen non-specialist delivery of integrated mental health services for adult primary health care, with an emphasis on persons at risk of or living with HIV. DSPs will work closely with the MhINT Technical Support Unit, which will provide technical support, training, guidance, and supervision to the DSPs and provincial and district mental health teams, while coordinating implementation and scale-up with stakeholders at the national level. The MhINT Technical Support Unit comprises MhINT programme implementers with the experience and technical capacity to guide successful scale-up. DSPs will establish written workplans and collaborative agreements with the MhINT Technical Support Unit. While no single document can comprehensively detail the intricacies of implementing a complex, large-scale intervention, this manual provides an outline and introduction to the package of strategies and interventions that was developed through the MhINT programme. The structure of this manual is loosely borrowed from the World Health Organization’s (WHO) mental health Gap Action Programme (mhGAP) Operations Manual. As seen in the following figure, the manual is organized into three project phases: Plan, Prepare, and Provide. This figure is used throughout the manual to guide readers through the growth of the MhINT programme during the lifecycle of the implementation process. The MhINT tools and instruments referenced in the manual are compiled in an accompanying MhINT Toolbox.
CQI
Continuous Quality Improvement
Using Performance Indicators for Monitoring and Evaluation

PLAN

PREPARE

PROVIDE

ENGAGE
National Department of Health
Provincial Government
District
Sub-District

Situational Analysis
District Mental Health Care Plan

CAPACITY BUILDING
Facility Managers
Nurses
Doctors
Clinical Psychologists
Registered Psychological Counsellors
Lay Counsellors

SUPPORT
Supervision
Emotional Support
Mentoring
Reporting

MhINT
MENTAL HEALTH INTEGRATION PROGRAMME
Background

The burden of chronic disease in South Africa is staggering. The epidemics of HIV and tuberculosis are now joined by the rise of non-communicable diseases (NCDs). Approximately 16.5% of South Africans suffer mood, anxiety, or substance use disorders each year, and these rates are elevated among persons living with HIV, TB, and other chronic diseases. These common mental disorders (CMDs) pose a significant threat to the success of treatment programs, contributing to lower adherence and poor retention, and compromising investments in antiretroviral therapy and NCD care. A recent study outside Johannesburg found that individuals diagnosed with depression or alcohol use disorder at antiretroviral therapy initiation were less likely to be retained in care. Nonetheless, only one in four South Africans with CMDs have access to mental health treatment of any kind.

The South African National Department of Health (NDOH) has responded to the growing burden of chronic conditions through the introduction of an integrated chronic disease model at the facility, community, and population levels. At the facility level, this model aims to strengthen the quality of care for chronic conditions by serving all chronic care patients collaboratively, at one service point. A central aspect of this model is strengthening decision support through the adoption of nurse-led clinical guidelines for the identification and management of multiple chronic diseases, called Adult Primary Care (APC), previously Primary Care 101 (PC101). In addition, the South African National Mental Health Policy Framework and Strategic Plan 2013-2020 emphasizes the integration of mental health into primary care facilities, embracing a task-sharing approach to mental health service delivery. There

Recent Literature on the Relationship between CMDs, Substance and Alcohol Misuse, and HIV in South Africa.

Kagee A, Saal W, Bantjes J. The relationship between symptoms of common mental disorders and drug and alcohol misuse among persons seeking an HIV test. AIDS Care
Cichowitz C, Maraba N, Hamilton R, Charalambous S, Hoffmann CJ. Depression and alcohol use disorder at antiretroviral therapy initiation led to disengagement from care in South Africa. PLOS ONE
Yemeke TT, Sikkema KJ, Watt MH, Ciya N, Robertson C, Joska JA. Screening for Traumatic Experiences and Mental Health Distress Among Women in HIV Care in Cape Town, South Africa. Journal of Interpersonal Violence
is strong evidence for cost-effective interventions utilising non-specialist health care providers, under supervision by specialists, to provide effective treatment and management of CMDs such as depression.13

To meet South Africa’s mental health needs, the PRogramme for Improving Mental health careE (PRIME) has been working in collaboration with the NDOH to incorporate mental health into the integrated chronic disease platform in Dr Kenneth Kaunda (KK) District, North West Province.14 The Dr KK District was chosen as the study site by the NDOH because it is one of three districts where integrated chronic disease management, now known as Integrated Clinical Services Management (ICSM) was being piloted in the country. The Dr KK District was also a pilot site for national health insurance and the re-engineering of primary healthcare. When the need for increased identification and management of patients with comorbid common mental disorders was identified, PRIME developed and successfully evaluated a collaborative care model involving:

1. Strengthening the capacity of the nurse’s role in identification and case management of depression through additional clinical communication skills and training in APC, focusing on mental health components of the guide.

2. Expanding referral pathways for depression management by using project-employed, facility-based lay counsellors to provide evidence-based, manualized psychosocial counselling for mild depressive symptoms (8 sessions) and adherence counselling (1 session).

In the PRIME model, lay counsellors are trained, mentored, and supervised by project-employed psychologists/registered psychological counsellors; doctors are provided supplemental training to improve their capacity to initiate antidepressant treatment for moderate to severe depression; and referral pathways to existing mental health specialist services within the district for severe depression remain in place. Working alongside PRIME, the CO-morBidity of AIDS/HIV Affective disorder, and Long-Term health (COBALT) study is a pragmatic cluster randomized controlled trial of 40 primary clinics. The COBALT study is evaluating the effectiveness of the PRIME intervention strategy for HIV patients on anti-retroviral treatment, assessing the outcomes of changes in depressive symptoms and viral load suppression.

Through PEPFAR funding from the United States Centers for Disease Control and Prevention (CDC), the MhINT programme is a collaboration between the NDOH, University of KwaZulu-Natal (UKZN), University of Cape Town (UCT), The University of Washington (UW), and the International Training & Education Center for Health (I-TECH) to translate the integrated collaborative care package developed through PRIME and COBALT into one that could be scaled up nationally, with an emphasis on improving HIV treatment outcomes. The MhINT intervention package is designed to be adaptable to local contexts and can be scaled in diverse settings to improve the health and wellbeing of South Africans throughout the country.
What is MhINT?

The MhINT programme is an evidence-based scale-up of an integrated care package for CMDs in South Africa. Its primary aim is to support the integration of mental health care into existing primary health care systems. The core components of the intervention are nurse-centered clinical diagnosis, and referral of CMDs to various health care providers within the collaborative care model. Depending on symptom severity, this care includes lay counselor-provided psychosocial counselling for depression and adherence, using capacity-building cascade training models. Patient flow of the MhINT team-based collaborative care model for depression is outlined on the following page in Figure 1. The roles of key personnel in the MhINT programme are outlined below.

Collaborative Care Model Roles and Responsibilities

1. **Facility-based PHC Nurses** are at the core of the model. Trained in APC and Enhanced APC Mental Health to assist in standardization of screening, diagnosis, treatment, and referral, their role is that of case manager. The PHC nurse:

   a. Identifies patients who have psychosocial problems that could have an impact on adherence;

   b. Provides basic psychosocial support and brief advice;

   c. Refers patients within the stepped collaborative care system according to severity of symptoms to: the facility-based lay counsellor trained to provide psychosocial and expanded adherence counselling; the doctor for initiation of psychotropic medication; or a mental health specialist/outpatient department for further assessment and medical/psychological treatment;

   d. Monitors patient progress and response at follow-up visits and refers onwards within the collaborative care model, as needed.
Collaborative Care Package for Depression

- **PHC Nurse**
  - Identifies depression, other mental disorders, communicable, and non-communicable diseases using APC Guidelines
  - Provides basic psychosocial support and brief advice
  - Refers patients within the stepped collaborative care system according to severity of symptoms
  - Monitors patient progress and response at follow-up visit

- **Community Health Worker**
  - Conduct case detection and referral

- **Mild Depression**

- **Moderate to Severe Depression**

- **Other mental disorders and inadequately controlled communicable/non-communicable conditions**

- **Severe depression with suicide risk**

- **Psychologist (including interns/community service personnel)**
  - Provide training, supervision, and support to registered psychological counsellors, psychological support to the lay counsellors, and referral service for moderate to severe cases

- **Lay Counsellor**
  - Provide on-site psychoeducation (morning talks) and counselling for depression and medication adherence for chronic conditions

- **PHC Doctor**
  - Diagnose, initiate treatment of antidepressant medication, and review complex or severe cases

- **Psychiatrist/Family Physician**
  - Train and support PHC doctors and provide referral for complex mental disorders

- **Registered Psychological Counsellor**
  - Train and supervise lay counsellors and provide individual counselling for patients with complex cases

- **CQI Mentor**
  - Support PHC facilities implementing mental health care integration using CQI and provide training support and mentorship to facility trainers

**Figure 1. MhINT Collaborative Care Model**

**Collaborative Care Package for Depression**
2. **Facility-based Lay Counselors** provide:
   
   a. Onsite psycho-education (morning talks) on psychosocial problems such as depression that may interfere with adherence;
   
   b. Referral service to patients with common chronic conditions for one-time expanded adherence counselling that assists patients to understand the importance of taking their medication, possible side effects, and any difficulties they may have with adhering to their treatment regime;
   
   c. Referral service for individual and group psychosocial counselling over a number of sessions that addresses key psychosocial problems (e.g., poverty, stigma, interpersonal conflict) that may trigger and maintain depressive symptoms and interfere with adherence.

   The lay counsellors can consult with patients aged 18 years and older. They do not provide counselling for patients with severe mental disorders, suicidal tendencies, couples, or victims of trauma, such as rape or other crimes.

3. **Registered Psychological Counsellors** (Bachelors level) (where available) are based at the sub-district level and are under the supervision of the district psychologist. They provide:

   a. On-site in-vivo individual supervision of the lay counsellors;
   
   b. Group supervision and emotional support to the lay counsellors;
   
   c. Individual counseling for patients with trauma or complex cases that cannot be managed by the lay counsellors.

4. **District Clinical/Counselling Psychologists** (Masters level, including interns/community service personnel) are based at the district level and provide:

   a. Training and supervision to the registered psychological counsellors;
   
   b. Psychological support to the lay counsellors;
   
   c. Referral service for psychological treatment for patients with moderate to severe or treatment-resistant mental disorders.
5. **Continuous Quality Improvement Mentors** facilitate interventions that promote the integration of mental health care services in primary health care facilities (PHCs) using continuous quality improvement (CQI) tools. In districts where a CQI mentor does not exist, a PHC supervisor or similar cadre of healthworker can fulfill this role. The CQI mentor champions activities geared at different levels of the health system to create a framework for troubleshooting and devising creative solutions to bottlenecks that may hinder programme integration. The role of the CQI mentor includes:

a. Overseeing the formation of CQI committees at different levels to facilitate the implementation and monitoring of mental health services in PHCs until the intervention is entrenched;

b. Ensuring that the mental health treatment cascade is aligned with all the clinical programmes being implemented at PHCs;

c. Supporting the identification of source documents for mental health care services so that data on the provision of mental health services is routinely collected and captured in the health systems;

d. Supporting the development of a system to monitor mental health indicators as well as indicators for other clinical programmes implemented at PHCs.

6. **District PHC Doctors** diagnose mental disorders, prescribe psychotropic medication, monitor response and titrate psychotropic medication, and review complex or severe cases.

7. **Provincial Psychiatrist/Family Physicians** provide training, supervision, and mentoring support to PHC doctors in the identification and management of mental disorders. They also provide a referral service for poorly stabilized, complex, and treatment resistant disorders requiring tertiary outpatient/in-patient care.

8. **Community Health Workers** conduct home visits and facilitate:

a. Tracing of non-adherent patients to return them to care;

b. Community case detection and referral.
### Summary Tables of Key MhINT Roles and Responsibilities:
Department of Health Employed Staff Within the MhINT Programme

<table>
<thead>
<tr>
<th>Title</th>
<th>Role</th>
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<tbody>
<tr>
<td>Facility-based Lay Counsellors</td>
<td>• Provide psychoeducation, psychosocial counselling, and adherence counselling to chronic care patients</td>
</tr>
<tr>
<td>Facility-based PHC Nurses</td>
<td>• Assess and identify CMDs using APC guidelines, refer patients appropriately, provide supportive counselling, continue prescribed medication, review response to treatments</td>
</tr>
<tr>
<td>Registered Psychological Counsellors (Bachelors Level)</td>
<td>• Provide training, supervision, and emotional support to lay counsellors and referral service for more complex cases</td>
</tr>
<tr>
<td>District Clinical Psychologists (Masters Level, including interns/community service personnel)</td>
<td>• Provide training, supervision, and emotional support to registered psychological counsellors and referral for severe/treatment resistant cases</td>
</tr>
<tr>
<td>District PHC Doctors</td>
<td>• Diagnose and review complex/moderate severe cases, prescribe psychotropic medication</td>
</tr>
<tr>
<td>District CQI Mentor or PHC Supervisor</td>
<td>• Support facility managers and promote the integration of mental health care by championing CQI interventions</td>
</tr>
<tr>
<td>Facility Managers/Operational Managers</td>
<td>• Manage facility programmes and support the integration of mental health services</td>
</tr>
<tr>
<td>Facility Information Officer</td>
<td>• Consolidate, interpret, and report on facility clinical data</td>
</tr>
<tr>
<td>Provincial/District Psychiatrist/Family Physician</td>
<td>• Provide support for PHC doctors’ orientation to APC guidelines • Provide remote supervision and guidance to district doctors • Provide referral service for severe mental disorders</td>
</tr>
<tr>
<td>District Mental Health Coordinator</td>
<td>• Coordinate mental health services in the district and support their integration with other NCD Programmes • Support mental health trainings</td>
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<table>
<thead>
<tr>
<th>Title</th>
<th>Role</th>
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</thead>
</table>
| **Sub-District Mental Health Coordinator** | • Coordinate mental health services in the sub-district and support their integration with other NCD Programmes
• Support mental health trainings           |
| **District Training Coordinator (RTC)**    | • Coordinate and monitor training activities in the district
• Provide training support and mentorship to APC master trainers and facility trainers and their training of PHC nurses |
| **APC Master Trainers**                     | • Train and support implementation of the CCS and APC guidelines at district and sub-district level
• Provide mentoring and support to facility-based trainers |
| **Facility Trainers (PHC Nurses)**          | • Deliver facility-based APC trainings and the Enhanced APC Mental Health module, which includes CCS                               |
| **District Mental Health Specialist Team (Including some of the previously listed positions)** | • Psychiatrist
• Psychologist
• Psychiatric nurse
• Social Worker
• Occupational Therapist
                                     | • Facilitate and support implementation of the objectives outlined in the "National Mental Health Framework and Strategic Plan 2013–2020" in their respective district |
## Summary Tables of Key MhINT Roles and Responsibilities:
District Support Partner Employed Staff Within the MhINT Programme

<table>
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<tr>
<th>Title</th>
<th>Role</th>
<th>Distribution</th>
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</table>
| MhINT Programme Manager | • Oversee program implementation and project administration  
• Build and maintain stakeholder relationships with the various levels of the DOH  
• Lead monitoring and supervision | One per DSP |
| MhINT Programme Coordinator | • Provide capacity building and support to district based psychologists and/or registered psychological counsellors for training, supervision, mentoring, and emotional support of lay counsellors | One per district |
| MhINT Registered Psychological Counsellor | • Assist with the general planning of the project in collaboration with the study team  
• Mentor the district registered psychological counsellor  
• Train, supervise, and support lay counsellors  
• Collect and manage monitoring and evaluation data | One per sub-district |
| MhINT Continuous Quality Improvement Mentor | • Mentor and collaborate with district CQI mentors  
• Provide orientation to CQI approach as a vehicle for implementation  
• Facilitate the formation of CQI Committees  
• Support district and facility quality improvement initiatives  
• Assess progress of mental health integration using routine data as part of CQI | One per district |
| MhINT Data Manager | • Train and support district facility information officers in the utilization of District Health Information System data  
• Support the development of data flow process maps and data management and auditing processes | One per DSP |
| MhINT APC Training and CCS Expert | • Facilitate all APC trainings, including the Enhanced APC Mental Health Module  
• Provide APC training updates as required  
• Mentor and support master and facility trainers  
• Provide recommendations for APC implementation to the RTC | One per DSP |
PHASE I: PLAN

CQI
Continuous Quality Improvement
Using Performance Indicators for Monitoring and Evaluation

PLAN

ENGAGE
National Department of Health
Provincial Government
District
Sub-District

Situational Analysis
District Mental Health Care Plan

PREPARE
CAPACITY BUILDING
Facility Managers
Nurses
Doctors
Clinical Psychologists
Registered Psychological Counsellors
Lay Counsellors

PROVIDE
SUPPORT
Supervision
Emotional Support
Mentoring
Reporting

MhINT
MENTAL HEALTH INTEGRATION PROGRAMME
Plan

The PLAN phase of MhINT is an essential process of planting the seeds and preparing the soil, ensuring successful growth of the intervention. At the heart of the planning process is establishing long-term sustainability by engaging all stakeholders and creating a collaborative plan for implementation. After all government and implementing partners agree to integrate the package of interventions into the existing health system, a comprehensive situational analysis is conducted in order to develop a District Mental Health Care Plan (DMHCP) that is tailored to the resources in each district. It is essential that this plan becomes integrated into the district health plan to prevent unsustainable verticalization of services. The final element of the planning phase is the establishment of a monitoring and evaluation framework and CQI strategy using performance indicators, enabling rigorous, evidence-based scale-up and analysis of progress toward integration and impact on overall health outcomes. In the figure, CQI is represented by the sun because it is an essential component of MhINT, without which the intervention would not be able to grow and thrive.

Engage Partners

Engaging the Departments of Health at the national, provincial, district, and sub-district levels is instrumental to the successful implementation of sustainable, high quality integrated care programs. Thus, the initial process of planning the MhINT intervention is attaining agreement with and endorsement by key implementing partners and stakeholders from the public health system at the facility, district, provincial, and national levels. Senior leadership in the MhINT Technical Support Unit engage and collaborate with the National and Provincial Departments of Health to identify target districts for scaling up the intervention. Background information on the engagement process at the national and provincial levels is described below to provide context for DSPs who begin collaborating with the MhINT scale-up after these important first planning phases. DSPs with previously established memorandums of understanding (MOUs) with provincial governments are then tasked with engaging district and sub-district departments of health in their respective communities.

National Department of Health

By design, MhINT is integrated into an existing health care system, and support from and collaboration with the NDOH is critical for implementation. Although this process will be conducted by the MhINT Technical Support Unit, a description is provided here to help DSPs understand the policy and health system context in which the intervention is scaled. The NDOH developed The National Mental Health Policy Framework and Strategic Plan 2013-2020 as part of ongoing efforts to...
The role of the Provincial DOH is to translate national policy into provincial strategic and operational plans. Additionally, it provides monitoring and evaluation of the implementation of national mental health policy and legislation. Therefore, engaging the Provincial DOH is the logical next step.
in the process after achieving NDOH endorsement. Provincial departments work closely with district health managers to promote the equitable provision of resources and services for mental health at the district level, facilitating the next stage in the MhINT engagement cascade. Similar to national level engagement, engagement with the Provincial DOH is conducted by the MhINT Technical Support Unit and the description is provided here for context.

Some key components of engaging with the Provincial DOH include:

- Collaborating with heads of departments to identify relevant district-level managers with whom to coordinate the intervention;
- Engaging with provincial representatives from various departments including: NCDs, HIV/AIDS, Sexually Transmitted Infections, and Tuberculosis (HAST), PHC, Mental Health, and Human Resources to form a Steering Committee to oversee the implementation of clinical programmes and integrate the mental health care programme accordingly;
- Integrating mental health indicators into the health information system for the routine monitoring and evaluation of mental health care;
- Coordinating health worker training activities with Regional Training Centres (RTCs);
- Establishing written work agreements formalizing a partnership between Provincial DOH and DSPs.

District and Sub-District Departments of Health

The District Department of Health is an important partner in implementing MhINT. It is at this point in the intervention that DSPs take a lead role in engaging with district and sub-district departments of health. Intervention components are integrated into existing services at the district and sub-district level and day-to-day collaboration is essential. The District Health Management Team (DHMT) is a crucial partner, ensuring that the MhINT programme integration aligns with district implementation plans. The team also plays a key role in health system decision making and determining availability of facility-level human resources for trainings/workshops. District level coordination is a key criterion for the following steps in the engagement cascade: situational analysis and subsequent DMHCP. The DHMT also functions as a district level CQI Committee that can facilitate the adoption of change ideas developed at sub-district and facility level to support the integration of mental health services at PHCs.

Some key components of engaging with the District DOH include:

- Engaging with district representatives: District Directors, the District Manager, the District Mental Health Coordinator, the District Training Coordinator, the District PHC Manager, the HAST Manager, the Data Manager, and others, as needed;
- Ensuring the inclusion of mental health in the core package of district health
treatment and rehabilitation services;
• Conducting mental health training programmes for all general health staff to include basic screening, detection, treatment, and referral of complex cases;
• Establishing and maintaining district specialist mental health teams;
• Establishing and maintaining referral and back-referral pathways for mental health care;
• Implementing clinical protocols for assessment and interventions at PHC level;
• Improving the capacity of DHMT teams for planning, implementing, supervising, and monitoring and evaluation of mental health programmes at district and community levels;
• Developing intersectoral collaboration between a range of sectors involved in mental health through the establishment of District Multi-Sectoral Forum for mental health;
• Ensuring the provision of psychotropic medication to all appropriate levels of the district health system as determined by the essential drugs list.
Conduct a Situational Analysis

A situational analysis is the starting point for the integration of mental health services. Situational analyses provide relevant local context regarding the current mental health burden, assess mental health treatment coverage and potential gaps, identify existing resources and policies, and synthesize this information to engage stakeholders and establish priorities and targets. The MhINT intervention utilizes the PRIME Situational Analysis tool, which was adapted for the South African context (see MhINT Toolbox). The tool was developed specifically for low- and middle-income country (LMIC) district and sub-district settings in which mental health integration projects like MhINT are implemented.\textsuperscript{15}

The situational analysis should be completed by the District Mental Health Coordinator with the support of a district mental health task team and technical support from the MhINT programme, where necessary. The district mental health task team plays an important role in involving stakeholders and increasing buy-in and collaboration with local partners. The team is responsible for identifying mental health care gaps through the situational analysis and addressing those needs through development of the subsequent DMHCP. The district mental health task team should be multisectoral in composition, including representatives from the DOH and other departments or organizations (e.g., Department of Social Development, South African Police Services, Department of Education, civil society, etc.). Stakeholders involved in each district mental health task team will vary by location and context, but DOH staff that typically play a role in the process include:

- Mental Health Coordinator
- Psychiatrist
- Psychologist
- RTC Manager
- Professional Nurse
- Social Worker
- Occupational Therapist
Develop a District Mental Health Care Plan

DMHCPs\textsuperscript{14} are developed for each district based on the results from their respective situational analyses. DMHCPs are consistent with the national mental health policy’s emphasis on decentralization and task sharing. The purpose of a DMHCP is to develop a contextualized, evidence-based mental health integration plan with engagement from all stakeholders. To facilitate the development of DMHCPs and provide a template, we have developed the MhINT Mental Health Planning Tool (See MhINT Toolbox).

One of the primary components of developing a DMHCP are multi-stakeholder workshops that provide rich context for mutual understanding. Engaging key stakeholders in participatory planning for mental health services is critical in order to integrate services, utilize resources, establish responsibilities for and endorsement by all stakeholders—from frontline health workers to high-level policy makers—and develop culturally and contextually appropriate strategies with attainable outcomes.

Once an orientation to the DMHCP workshop has been completed with the provincial and district management teams, the District Mental Health Specialist team takes on the responsibility of developing the plan. The team will identify gaps and opportunities within existing mental health services and resources and address these topics with relevant DOH personnel at the provincial, district, and sub-district level. In districts where a District

Additional Resources on District Mental Health Care Plans


Lund C, Tomlinson M, Patel V. Integration of mental health into primary care in low- and middle-income countries: the PRIME mental healthcare plans. \textit{The British Journal of Psychiatry}.\textsuperscript{16}


Mental Health Specialist Team does not exist, a District Mental Health Forum of local mental health providers and stakeholders can be developed to serve in this role.

**Roles of the Different Stakeholders in the DMHCP Workshops**

1. The workshops should be facilitated by a mental health specialist, with technical support from MhINT, to help in the development of a logical evidence-based plan.
2. Mental health specialists provide details on technical issues such as functioning of existing mental health care provision in the district, the need for prioritisation of disorders, and the provision of feasible and evidence-based interventions.
3. The support of provincial MH managers, who often introduce the workshops, provides senior management endorsement of the MhINT project and the MHCP workshop.
4. District level management contributes to developing the overall structure of the DMHCP, as well as providing contextual information about what they feel may or may not work. This includes identifying current challenges, needs, and potential solutions.
Establish a Monitoring and Evaluation Framework

It is vital that Monitoring and Evaluation (M&E) plans are established during the early processes of integration in a new district. Such plans provide valuable information on how integration is progressing towards its intended objectives, inform future integration activities, and provide an critical source of accountability for all stakeholders. Monitoring is the routine collection of data, and is important for assessing how well integration implementation activities are proceeding as well as enabling the district authorities to identify challenges and opportunities and to adapt strategies. Evaluation is the systematic collection of data to assess whether the integrated activities are achieving the intended objectives, such as improvement in overall health of the population. MhINT provides technical support to the district for the establishment of M&E components, which play an important role in the planning phase of the programme. A MhINT M&E framework facilitates the tracking of intervention inputs, outputs, outcomes, and impact to evaluate the intervention's overall effectiveness. The plan is a collaborative process among key stakeholders incorporating findings from the situational analysis and strategies outlined in the DMHCP.

The MhINT programme uses a CQI strategy, adapted from the Institute for Health Improvement Toolkit, as a primary vehicle for implementation, monitoring, and evaluation. In our figure, CQI is the sun, without which the growth of the intervention would not be possible. The CQI process is led by the MhINT CQI mentor, who collaborates with the sub-district PHC supervisors that monitor facility performance and adherence to health policies. The MhINT CQI mentor supports the district CQI mentor and facility managers as they develop CQI teams and frameworks at their respective facilities. In districts where a CQI mentor does not exist, a PHC supervisor or similar cadre of healthworker can fulfill this role. These frameworks ensure quality data collection in order to track the performance of mental health care services and other clinical programmes through the monitoring of key indicators. CQI teams routinely review data to ensure that clinical processes and potential bottlenecks are captured, recorded, and addressed. These teams are well-suited to quickly respond to system factors that may hinder effective service provision. CQI teams are created during the Facility Managers Workshop.

More information can be found on the M&E Framework and CQI strategy in the PHASE III: PROVIDE section of this operations manual.
PHASE II: PREPARE

CQI
Continuous Quality Improvement
Using Performance Indicators for Monitoring and Evaluation

PLAN

PREPARE

SUPPORT

ENGAGE
National Department of Health
Provincial Government
District
Sub-District

Situational Analysis

District Mental Health Care Plan

CAPACITY BUILDING

Facility Managers
Nurses
Doctors
Clinical Psychologists
Registered Psychological Counsellors
Lay Counsellors

Supervision
Emotional Support
Mentoring
Reporting

MhINT Operations Manual 25
Prepare

The MhINT programme provides technical support for: a) strengthening referral pathways; and b) capacity building of existing service providers within the health system. As such, the trainings, workshops, and support materials and tools that make up the PREPARE section of this operations manual are at the heart of the technical support provided by the MhINT intervention. The MhINT package of trainings is specifically designed to orientate and familiarize different cadres of the health system workforce to the intervention and capacitate them with the skills necessary to play their unique role within the collaborative care model. All trainings and workshops are coordinated with the RTCs, as the principal entities responsible for all health workforce trainings and skills development. The trainings are introduced through a train-the-trainer cascade model. This model focuses on building the skills and capacity of master and facility trainers to be able to provide facility-based trainings and continued support and supervision. This facilitates the entrenchment of skills in real-world settings and contributes to the intervention’s sustainability.

MhINT builds off the foundation laid by the national APC training and guidelines. APC training coverage forms part of the situational analysis because if this training is not in place, it needs to be instituted for the MhINT programme to build upon. Once facility trainers have been trained in basic APC, they begin onsite training to gain confidence in facilitation, and instruct staff to start implementing the use of the guidelines in consultation. The same Facility Trainers are then trained in the Enhanced APC Mental Health Module, which they cascade to the facility staff in the same manner as the basic APC training, as seen in Figure 2. Clinical Communication Skills (CCS) are integrated into the Enhanced APC Mental Health training cases, where the PHC nurses use the APC guidelines to manage the case, and use CCS prompts to discuss the approach with the patient, thereby building awareness of the impact of communication on patient management. The referral pathway to the lay counsellor is also built into the Enhanced APC Mental Health training, where after every case, the PHC nurse fills out a referral form. This training technique is designed to embed knowledge into practice, ensuring familiarity with the new systems that MhINT institutes. As seen in Figure 3, a similar train-the-trainer cascade model, in which psychologists and registered psychological counsellors capacitate lay counsellors, is used to implement the MhINT intervention.

This manual provides an outline of the training and workshop activities. Each component is discussed in further detail, with links to manuals and resources in the MhINT Toolbox, throughout the PREPARE section of the manual.
Figure 2. APC Train the Trainer Cascade Model

MhINT

Master Trainer

Facility Trainer

PHC Nurse

PHC Nurse

Use APC Guidelines to Assess Patients and Initiate Treatment

Facility Trainer

PHC Nurse

PHC Nurse

PHC Nurse

Figure 3. Lay Counsellor Train the Trainer Cascade Model

MhINT

Master Trainer (Psychologist)

Registered Psychological Counsellor

Lay Counsellor

Lay Counsellor

Provide MhINT Intervention in Facilities

Registered Psychological Counsellor

Lay Counsellor

Lay Counsellor

Lay Counsellor

Lay Counsellor
### Summary Table of MhINT Trainings

<table>
<thead>
<tr>
<th>Training</th>
<th>Target Group</th>
<th>Purpose of Training</th>
<th>Training Duration</th>
<th>Training Materials</th>
</tr>
</thead>
</table>
| **Facility Managers Workshop**          | Facility Managers and DOH staff responsible for overseeing implementation    | To introduce the intervention to Facility Managers and prepare them to oversee its implementation | 1 day             | • Facility Managers Implementation Toolkit  
• Facility Manager Workshop Programme |
| **Basic APC Nurse Training**            | Facility Trainers                                                             | To re-orientate Nurses to APC guidelines, which are a prerequisite for the Enhanced APC Mental Health component, where needed | Varies, as needed | • Adult Primary Care Guidelines  
• Adult Primary Care Facility Trainer Manual |
| **APC Master and Facility Trainers: Enhanced Mental Health Training** | Facility Trainers and Master Trainers                                         | To equip the Facility Trainers and Master Trainers to run 5 onsite sessions focusing on clinical communication skills for person-centered care, self-care, assessment, diagnosis, treatment, and referral of CMDs | 4 Days            | • Adult Primary Care Mental Health Programme Facility Trainer Manual  
• Adult Primary Care Guidelines  
• Clinical Communication Skills Participant Handout |
| **Doctors Orientation**                 | PHC Doctors                                                                   | To introduce the MhINT intervention and collaborative care model to PHC doctors and train them to use APC guidelines and manage psychiatric patients | 1 Day             | • Doctor Orientation Programme  
• Adult Primary Care Guidelines |
<table>
<thead>
<tr>
<th>Training</th>
<th>Target Group</th>
<th>Purpose of Training</th>
<th>Training Duration</th>
<th>Training Materials</th>
</tr>
</thead>
</table>
| Clinical Psychologists Training  | District Clinical Psychologists   | To capacitate the Clinical Psychologists to fulfill their role as trainer, supervisor, and emotional support provider to the different role players in the collaborative care package | 4 Days            | • Clinical Psychologist Master Trainer Manual  
• Clinical Psychologist Master Trainer Training Programme  
• Registered Psychological Counsellor Training Manual  
• Lay Counsellor’s Guide to Depression and Adherence Counselling |
| Registered Psychological Counsellors Training | Registered Psychological Counsellors | To capacitate Registered Psychological Counsellors to their role of training, supervision, and mentoring Lay Counsellors in the collaborative care package | 4 days            | • Registered Psychological Counsellor Training Programme  
• Registered Psychological Counsellor Training Manual  
• Lay Counsellor’s Guide to Depression and Adherence Counselling |
| Lay Counsellors Training        | Lay Counsellors                   | Introduces the counsellors to the MhINT programme and the central role they play within the intervention | 5 days            | • Registered Psychological Counsellor Training Manual  
• Lay Counsellor’s Guide to Depression and Adherence Counselling |
Facility Managers Workshop

Objective: The Facility Managers Workshop is a one-day orientation to the various components of the MhINT intervention for operations/facility managers, clinical programme coordinators, facility based APC Trainers, and other DOH staff responsible for overseeing the implementation of the programme within the health system. It introduces the intervention, the collaborative care package, and the role of key players in the provision of mental health care services. The main objective of the workshop is to ensure that the facility managers are properly orientated in their role of overseeing the implementation of the intervention in their facility; are aware of the capacity building interventions that will take place; are orientated to the mental health cascade of care and engaged in how this will be accommodated in their facilities; and are orientated to CQI and the framework for monitoring and implementing the intervention. Another key component of the workshop is to situate the intervention within existing clinical programmes and provide clarity on how the intervention can support the district in achieving its targets and performance indicators in all clinical programmes, particularly mental health. The practical components of the workshop involve negotiating and coordinating intervention logistics including identifying physical space for the intervention and planning future training sessions. During this workshop, a CQI team is created and facilities start to develop process maps and identify where MhINT components can be integrated.

Facilitator(s):
- MhINT Programme Manager or Coordinator
- MhINT CQI Mentor

Attendees:
- District: Mental Health Coordinator
- Sub-District: Mental Health Coordinator
- District: Training Coordinator
- District: Information Officer
- District: PHC Member of District Specialist Team
- Sub-District: Facility Information Officer
- District: HAST Manager (where appropriate)
- Sub-District: PHC Supervisors
- Sub-district: Operational Managers
- Sub-district: Lay Counsellors
- Others stakeholders, as needed

Materials:
(See MhINT Toolbox)
- Facility Manager Implementation Toolkit
- Facility Manager Workshop Programme
Basic APC Nurse Training

Objective: The APC onsite training is designed to be run by trained APC Facility Trainers and is a pre-requisite for the staff to be trained on the Enhanced APC Mental Health training. There are 12 sessions covering 27 cases, the purpose of which is to orientate staff to the APC guidelines and build their confidence in navigating through them. These skills and knowledge are needed for the Enhanced APC Mental Health training to be successful. Nurses do not need to have completed all 12 sessions to be eligible to do the Enhanced APC Mental Health training, however, completion of some of them is imperative. Ideally, there should be APC Master trainers in all districts who can provide basic APC refreshers for facility trainers. Alternatively, representatives from the Knowledge Translation Unit (KTU) may be available to provide support.

Facilitator(s):
• District APC Master Trainers

Attendees:
(See MhINT Toolbox)
• PHC Nurse per facility using PHC Nurse Selection Criteria

Materials:
(See MhINT Toolbox)
• Adult Primary Care Guidelines
• Adult Primary Care Facility Trainer Manual
**APC Master and Facility Trainers: Enhanced APC Mental Health Training**

**Objective:** The Enhanced APC Mental Health training introduces the core components of the MhINT intervention to master and facility trainers. The training integrates CCS and introduces the referral pathways for management of patients with CMDs according to the MhINT collaborative care model. The training introduces the 5 enhanced APC sessions that focus on mental health using trainer modelling, practice sessions, supportive feedback, and structured reflection. The activities and cases used during the training mirror what will take place on site, empowering facility trainers to become confident to facilitate the onsite trainings.

**Facilitator(s):**
- MhINT APC Training and CCS Expert

**Attendees:**
- Master Trainers
- Facility Trainers

**Materials:**
(See MhINT Toolbox)
- Adult Primary Care Mental Health Programme Facility Trainer Manual
- Adult Primary Care Guidelines
- Clinical Communication Skills for Patient-Centered Care
- Participant Handout
Doctors Orientation

**Objective:** The Doctors Orientation introduces the MhINT intervention and collaborative care model to PHC doctors. The purpose of this one-day session is to make doctors aware that nurses will be screening for CMDs using the APC guidelines and making referrals for treatment where appropriate. As initiation of psychotropic medication is by doctors, it is important that they are aware of this from a systems perspective. The orientation workshop trains doctors to use APC guidelines and promotes the integration of mental health services. Facilitators in the workshop introduce the doctor’s role in the collaborative care model relative to identifying, referring, and treating patients with CMDs and severe mental disorders. The session includes a structured presentation and discussion about managing psychiatric patients and prescribing medications at the PHC level. The interactive orientation utilizes videos, case studies, and group discussions. As part of the workshop, a platform is created for the development of a remote supervision system for the PHC doctors to be provided by the district psychiatrist or family physician.

**Facilitator(s):**
- MhINT APC Training Expert
- MhINT Programme Manager and/or Coordinator
- District Psychiatrist

**Attendees:**
- District Mental Health Coordinator
- RTC Training Coordinator
- District Psychologists
- District Family Physician
- PHC Doctors

**Materials:**
(See MhINT Toolbox)
- Doctor Orientation Programme
- Adult Primary Care Guidelines
Clinical Psychologists Training

Objective: The aim of this training is to capacitate the clinical psychologists to fulfill their dual role as trainer and supervisor to the registered psychological counsellors. The training is therefore two-fold and encompasses the following:

- Training the psychologists to capacitate registered psychological counsellors to then train and supervise the lay counsellors, who provide the structured depression and adherence psychosocial intervention.
- Training the psychologists to provide administrative and clinical supervision to registered psychological counsellors, using a framework that reinforces the supervision structure of the programme.

Facilitator(s):
- MhINT Programme Manager and/or Coordinator

Attendees:
- District Clinical Psychologists

Materials:  
(See MhINT Toolbox)
- Clinical Psychologist Master Trainer Manual
- Clinical Psychologist Master Trainer Training Programme
- Registered Psychological Counsellor Training Manual
- Lay Counsellor’s Guide to Depression and Adherence Counselling
Registered Psychological Counsellors Training

**Objective:** The training for registered psychological counsellors introduces them to their essential role in the MhINT intervention. The four-day training capacitates registered psychological counsellors to train, supervise, and provide mentoring and emotional support to the lay counsellors.

**Facilitator(s):**
- MhINT Programme Manager and/or Coordinator
- District Psychologist

**Attendees:**
- Registered Psychological Counsellors

**Materials:**
*(See MhINT Toolbox)*
- Registered Psychological Counsellor Training Programme
- Registered Psychological Counsellor Training Manual
- Lay Counsellor’s Guide to Depression and Adherence Counselling
**Lay Counsellors Training**

**Objective:** Lay counsellor training introduces the counsellors to the MhINT programme and the central role they play within the intervention. The training program consists of 3 main components: 1) Structured offsite group training, 2) *In vivo* supervision and competency assessment, and 3) Continued remote and monthly group supervision. The structured group training is informed by adult learning and teaching theories using experiential, interactive, and reflective learning to provide counsellors with skills to facilitate psychosocial counselling sessions for patients with chronic medical conditions. The offsite group training relies on 8 structured, manualized sessions that serve as a comprehensive overview of their responsibilities as part of the MhINT intervention, basic counselling skills, and how these skills are used to facilitate the sessions. Counsellors-in-training are then paired with experienced counsellors for the second phase of training where they will receive peer training using the apprenticeship model and will be provided with a safe space in which to use their newly acquired skills and practice administrative work. In vivo supervision is then provided by registered psychological counsellors once counsellors are placed in facilities where they will be providing the counselling service. After lay counsellors are determined to be competent and appropriately fulfilling their responsibilities, they will receive remote supervision from the registered psychological counsellor. Additionally, lay counsellors will participate in monthly group supervision sessions where cases are discussed, data is reviewed, and emotional support is provided, as needed.

**Facilitator(s):**
- MhINT Programme Manager and/or Coordinator
- Registered Psychological Counsellors

**Attendees:**
- Lay Counsellors

**Materials:**
(See MhINT Toolbox)
- Registered Psychological Counsellor Training Manual
- Lay Counsellor’s Guide to Depression and Adherence Counselling
PHASE III: PROVIDE

CQI
Continuous Quality Improvement
Using Performance Indicators for Monitoring and Evaluation

PLAN
ENGAGE
National Department of Health
Provincial Government
District
Sub-District

PREPARE
Situational Analysis
District Mental Health Care Plan

CAPACITY BUILDING
Facility Managers
Nurses
Doctors
Clinical Psychologists
Registered Psychological Counsellors
Lay Counsellors

PROVIDE
SUPPORT
Supervision
Emotional Support
Mentoring
Reporting

MhINT MENTAL HEALTH INTEGRATION PROGRAMME
**Provide**

In this PROVIDE section, we detail the management processes of oversight, evaluation, and reporting that are essential for implementing the MhINT programme. The integration of programmes at the primary health care level, including mental health, necessarily embraces task sharing. Task sharing requires that when services previously provided by specialists are shared with general health care providers, these service providers are adequately trained, supervised, and mentored. Additional provisions must also be made for onward referral should a case be too severe or complex for a lay health care worker. Due to the potential for personal emotional burden involved with providing care for patients with emotional problems, emotional support for these lay health care providers is an essential component of the integrated package. To avoid task dumping, the collaborative, stepped, team-based model described in the background section was endorsed by the NDOH and is in line with the National Mental Health Policy Framework and Strategic Plan 2013-2020. In addition to supporting personnel, systematic data collection and reporting are key components of the PROVIDE phase of the intervention. Data are used within the continuous quality improvement approach to identify and rectify bottlenecks and evaluate quality of care and health outcomes. The data are then used to inform dissemination and reporting strategies for policy makers and other key stakeholders wishing to evaluate the value and cost benefit of the integration process.

**Supervision and Mentoring**

To promote faithful implementation of evidence-based practices, systems must be in place for ongoing supervision and mentorship of general health workers. Initial trainings are a necessary first step towards building the confidence and competence of mental health clinicians, but are insufficient alone. Supervision and mentorship are essential to developing the feedback loops that correct negative behaviors and reinforce positive behaviors as part of the cycle of learning, doing, and reflecting. Programs without ongoing supervision result in low intervention fidelity and clinician competency, and established programs without supervisory support risk significant declines in service delivery within two years.

MhINT uses a collaborative care and apprenticeship model in its approach to supervision. The MhINT supervision frameworks for nurses and lay counsellors are included in their respective trainings and manuals and follow the same structure as the train-the-trainer cascade model.
Supervision of Nurses

APC facility trainers are mentored by the MhINT APC training and CCS expert and the RTC coordinator/APC master trainer. The MhINT APC training and CCS expert attends onsite training sessions immediately after facility trainer training to support them as they themselves conduct training sessions. After observing these sessions, the MhINT APC training and CCS expert provides feedback on strengths and areas for improvement using a mentorship template (See MhINT Toolbox) and a reporting tool that is shared with facility trainers beforehand. Continued mentorship and supervision visits are conducted approximately every 6-8 weeks, depending on the individual needs of facility trainers. WhatsApp groups are also utilized to supplement in-person facility visits and streamline communication between the MhINT CQI Mentor, district RTC coordinator, and facility-based trainers. These communications occur during and after trainings on a regular basis.

Once the training sessions are completed, mentoring visits continue with a focus on implementation. This includes a meeting with the facility trainers, facility manager, lay counsellor, data capturer, and MhINT registered psychological counsellor, to assess how referral systems are functioning and address any challenges that the facility may be facing. An implementation mentorship template is used to guide this discussion (see MhINT Toolbox).

Supervision of Lay Counsellors

The lay counsellors participate in a layered supervision process that also uses an apprenticeship model focusing on counselling skills, administrative work, and emotional support. A registered psychological counsellor oversees the work of the lay counsellor in the facilities and offers group supervision, such that lay counsellors share key accomplishments and challenges with other lay counsellors working at nearby facilities. Registered psychological counsellors also make regular facility site visits to support lay counsellors within their working environment. These registered psychological counsellors are overseen by a clinical psychologist who uses his/her experience in public mental health to suggest strategies for smoothing bottlenecks in the system and addressing challenges that occur. The registered psychological counsellor manages the program across facilities, monitors referral data, and regularly liaises with the PHC CQI teams to address challenges in implementation. The lay counsellors’ supervision and support package is designed as a resource-filled process of receiving professional and peer support in order to:

- Ensure the delivery of high quality counselling service
- Develop counselling skills, and
- Create a positive work environment

Supervision of Doctors

As part of the orientation of doctors to their role in the collaborative care model, MhINT facilitates the development of a remote supervision structure for doctors to be provided by the district psychiatrist or family physician. The recommended supervision structure includes:
1. **Quarterly supervision and support meetings**
   - Continuous psychiatrist/family physician training sessions
   - Case presentation and peer-to-peer in-service training
   - Case discussion

2. **Intern doctors supervision and monthly support**
   - Orientation of interns to the collaborative care model and their role clarified
   - Routine supervision including mental health case discussion

3. **Remote supervision**
   - Availability of psychiatrist/family physician/intern supervisor remotely (primarily, by phone), as needed

---

**Caring for the Caregiver and Support**

The registered psychological counsellors play a key role in providing emotional support for the lay counsellors who deal directly with patient’s emotional concerns, which may oftentimes be difficult to handle. The services that lay counsellors provide make them vulnerable to psychological distress, including taking on patients’ stress themselves. Some of the justification for establishing support programs for lay counsellors include:

- Lay counsellors come from the same communities as their patients and often experience similar challenges related to HIV/AIDS, poverty, and grief;
- Ongoing exposure to stories of suffering and pain can be distressing;
- Due to limited training, counsellors might not possess the skills to respond to some of the complexities presented by patients;
- A potential lack of respect and/or support for lay counsellor work due to perceived low levels of education and competency;
- Lay counsellors may carry a higher burden of job insecurity and anxiety about the future than professionals.

As part of their initial training, lay counsellors are educated on the emotional responses that they may manifest when providing different components of the depression and adherence counselling intervention. Counsellor emotional support is intended to provide a worker-centred, respectful, non-judgmental, and developmental experience. The registered psychological counsellor provides structured emotional support as part of supervision. The primary goal of this support is to ensure that lay counsellors develop sufficient coping skills to prevent burn-out and to enable continued provision of appropriate mental health services. As part of emotional support the following skills are imparted:

- Caring for self, sometimes described as self-care
- Managing stress using similar technique to those taught to patients (e.g., deep breathing)
- Seeking support for personal issues
- Maintaining healthy work-life balance

Lay counsellors who present with more significant symptoms of distress are referred to the district clinical psychologists for further intervention and care.
Monitoring, Evaluation, and Continuous Quality Improvement

Routinely collected performance indicators along the cascade of care are used for the monitoring and evaluation framework of MhINT. These indicators are also used within a CQI framework to promote quality and improve performance.

**MhINT Monitoring and Evaluation Framework**

For purposes of reporting to policy makers and funders, MhINT has an independent monitoring and evaluation framework that combines a logic model with a set of core indicators at each level. DSPs will routinely collect and report MhINT output indicators that documents the progress of programme implementation and ongoing service delivery. These indicators are identified in Figure 4.

### Figure 4. MhINT Output Indicators

<table>
<thead>
<tr>
<th>Outputs</th>
<th>Indicators</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counsellors deliver morning talks to chronic care patients</td>
<td>% of clinics open days where morning talk has been delivered</td>
<td>Counsellor reports</td>
</tr>
<tr>
<td>Enrolled Nurses screen patients for CMDs</td>
<td>% of patients screened over headcount</td>
<td>District health office</td>
</tr>
<tr>
<td>Nurses assess, diagnose and refer patients with CMDs</td>
<td># and % of patients referred to counsellors</td>
<td>Counsellor reports</td>
</tr>
<tr>
<td>Patients receive individual- or group-based counselling</td>
<td>% of referred patients attending all recommended counselling sessions</td>
<td>Counsellor reports</td>
</tr>
<tr>
<td>Establish a functioning district mental health team</td>
<td># of district mental health team meetings per year</td>
<td>District health office</td>
</tr>
<tr>
<td>Conduct situational analysis</td>
<td>Situational analysis conducted</td>
<td>District health office</td>
</tr>
<tr>
<td>Develop district mental health care plan</td>
<td>District mental health care plan adopted and disseminated to all relevant stakeholders</td>
<td>District health office</td>
</tr>
<tr>
<td>Train all relevant health providers in MhINT programme</td>
<td># of trainees attending respective trainings and workshops</td>
<td>Training reports</td>
</tr>
</tbody>
</table>
Continuous Quality Improvement

The MhINT programme is embedded within a learning health system approach where patients, providers, and researchers work together to co-produce new knowledge and share decisions regarding best evidence, using CQI PDSA (Plan, Do, Study, Act) cycles. The CQI approach facilitates the embedding of the intervention in the districts, adapting to each district’s unique character and composition, as well as to facility-level variations. CQI training and mentorship provides operational staff at different levels with practical and accessible tools for identifying bottlenecks in programme implementation, and empowers them to devise creative solutions. The Provincial DOH Steering Committee then plays a critical role in validating the solutions to programme implementation blockages by adopting them and developing them into provincial standards of practice (SOPs) and guidelines.

The MhINT CQI approach is guided by the Institute for Healthcare Improvement Model for Improvement,27 which is a simple, powerful framework for accelerating process improvement. The approach aims to improve health system functioning and health outcomes by engaging all stakeholders through data-driven processes. The model applies different methodologies that ensure that district aims are in line with their mental health targets. Data are reviewed through various CQI tools, including run charts in order to reflect the performance of the district in their mental health indicators over time, to enable charting and tracking implementation and improvement in service delivery progress, using programme indicators. The development and monitoring of key dashboard indicators facilitates swift implementation of interventions using process maps to identify bottlenecks, conducting root cause analyses, and then formulating PDSA cycles to guide implementation. More information on the IHI model and tools for improvement can be found [here](#).

The CQI process is led by the MhINT CQI mentor in collaboration with the district CQI mentor, the MhINT data manager, sub-district PHC supervisors, and facility information officers, who monitor facility performance and adherence to health policies. A CQI Mentorship Template ([See MhINT Toolbox](#)) is used to support the formation of a facility based CQI Committee, which should ideally include: the operational/facility manager, facility trainer, lay counsellor, data capturer, and any other role deemed relevant to the collaborative care package.

The MhINT CQI mentor provides mentorship to the district CQI mentor or PHC supervisor, who in turn mentors the facility managers in the process of utilizing CQI tools in their respective facilities. The sub-district CQI Committee, chaired by the PHC supervisor, meets on a weekly basis to review dashboard indicators for all clinical programmes, including mental health, and identify gaps to improve integration. The facility information officer leads intervention data collection and interpretation and provides updates at sub-district data review meetings. The MhINT CQI mentor provides support for these weekly meetings. Additionally, every six weeks, the MhINT CQI mentor facilitates an extended learning session, during which district data is reviewed collectively and change ideas are generated and presented to the district-level CQI team.

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The MhINT programme is a complex intervention with myriad partners and stakeholders. Comprehensive, standardized communication strategies with all stakeholders are essential to successful implement an effective intervention. In addition to programmatic updates, the indicators collected as part of the M&E components should be regularly disseminated to various stakeholders. These reporting mechanisms serve within a CQI framework, informing local and national policy and improving project outcomes. Although establishing communication standards is a collaborative process among different stakeholders, some suggested reporting levels and timeframes include:

- MhINT Technical Support Unit on an agreed upon basis
- National, Provincial, District Departments of Health on a quarterly basis
- Funding agencies (e.g., CDC) on a quarterly basis
References


MhINT Toolbox

1. PRIME Situational Analysis Tool
2. MhINT Mental Health Planning Tool
3. Facility Manager Implementation Toolkit
4. Facility Manager Workshop Programme
5. PHC Nurse Selection Criteria
6. Adult Primary Care Guidelines
7. Adult Primary Care Facility Trainer Manual
8. Adult Primary Care Mental Health Programme Facility Trainer Manual
9. Clinical Communication Skills for Patient-Centered Care Participant Handout
10. Doctor Orientation Programme
12. Clinical Psychologist Master Trainer Training Programme
13. Registered Psychological Counsellor Training Manual
14. Lay Counsellor’s Guide to Depression and Adherence Counselling
15. Registered Psychological Counsellor Training Programme
16. Nurse Mentorship Template
17. Nurse Implementation Mentorship Template
18. CQI Mentorship Template