Mental Health Indicators

Mental Health Indicators for Community and Primary Care Mental Health Delivery

Value Chain			
Value Chain Component	***Indicators for measuring progress***	***Data collection tools***	***Timing & frequency of data collection***
***Crisis Response:* Strengthen the incident and emergency preparedness and response**	***Output Indicator:*** *# of health care workers trained in psychological first aid (disaggregated by type of healthcare worker, MoH)*	*In a patient register or record keeping, examples include:* • ***ICRC Monitoring & Evaluation Framework*** • ***IASC MHPSS IN EMERGENCY SETTINGS***	*After each training*
	Output Indicator: *# of people provided with psychological first aid (PFA) (disaggregated by gender)*		*After each session*
	Output Indicator: *# of isolated contacts who are provided with psychosocial support (disaggregated at the community and health facility level, types of support)*		*After each session*
	Output Indicator: *# of remote (phone) based mental health visits delivered*		*After each session*
***Prevention:* Address social determinants and risk factors associated with mental health disorders**	***Output Indicator:*** *#/% of mental health patients receiving social support (disaggregated by gender, type of support)*	*Community Health Activity tracker and forms* *Examples can be found in* ***Clinical Guideline Development***	*After each activity*
	Output Indicator: *# of education/awareness and stigma reduction activities done in the community (disaggregated by type of activity)*		
	Outcome Indicator: *% of eligible children enrolled in school-based mental health programming (disaggregated by gender)*		*At time of enrollment*
	Outcome Indicator: *% of eligible children enrolled in early childhood education programs (disaggregated by gender)*		*At time of enrollment*
***Case-finding:* Increase the case detection and referral of mental health disorders in the community**	***Output Indicator:*** *#/% of people screened for mental health disorders (special focus on key clinical programs, Community Health, Oncology, HIV/TB, NCD, Maternal Health)*	*Community Health Screening Tools* *Examples can be found in* ***Clinical Guideline Development***	*Ongoing, per quarter*

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<table>
<tr><td></td><td>Outcome Indicator: # of people referred from the community (disaggregated by type of community referral)</td><td>Community Health Referral forms

Examples can be found in Clinical Guideline Development</td><td>Ongoing, per quarter</td></tr>
<tr><td rowspan="3">Assessment & Enrollment:
Increase the number of patients with mental health disorders enrolled into care</td><td>Output Indicator: # of persons who receive mental health services (disaggregated by age, gender, mental health condition)</td><td rowspan="2">Electronic Medical Records, Patient Registers, Matercards

Examples can be found in MEQ and Research</td><td>Ongoing, per quarter</td></tr>
<tr><td>Output Indicator: # of persons newly enrolled in mental health services (disaggregated by age, gender, mental health condition)</td><td>Ongoing, per quarter</td></tr>
<tr><td>Outcome Indicator: % of expected mental health patients (based on burden of disease estimates) who have received mental health treatment (disaggregated by mental health condition)</td><td>The burden of mental health conditions can be obtained from Assessing System Readiness</td><td>Ongoing, per quarter</td></tr>
<tr><td rowspan="4">Treatment:
Provide quality evidence-based interventions to patients with mental health disorders</td><td>Output Indicator: # of patients who have received evidenced-based psychotherapeutic treatment ((disaggregated by age, gender, mental health condition, type of intervention)</td><td rowspan="2">Examples of interventions can be found in Psychosocial and Psychological Interventions</td><td rowspan="2">Measured at first visit and at every month until last visit</td></tr>
<tr><td>Output Indicator: Of those who have started evidenced-based psychotherapeutic, % who have completed evidenced-based psychotherapeutic treatment over the recommended period</td></tr>
<tr><td>Outcome Indicator: #/% of persons with mental disorders reporting an improvement in functioning (disaggregated by age, gender, mental health condition)</td><td rowspan="2">Client functioning and/or symptoms measures (measures of daily functioning, symptoms of distress, well-being, beneficiary feedback). Examples can be found in Clinical Guideline Development</td><td rowspan="2">Measured at first visit and at every month until last visit</td></tr>
<tr><td>Outcome Indicator: #/% of persons with mental disorders reporting a reduction in symptoms (disaggregated by age, gender, mental health condition)</td></tr>
<tr><td>Follow-up:
Improve the management of patients with mental health disorders</td><td>Output Indicator: #/% of patients who received a home visit in the community</td><td>Community Follow-up forms

Examples can be found in Clinical Guideline Development</td><td>Ongoing, per quarter</td></tr>
</table>

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	***Output Indicator**: # of follow visits, by gender and age, mental health condition (disaggregated by age, gender, mental health condition)*	*Electronic Medical Records, Patient Registers, Matercards* *Examples can be found in **MEQ and Research***	*Ongoing, per quarter*
	***Output Indicator:** Protocols and care pathways in place for management of mental health disorders*	*Examples can be found in **Clinical Guideline Development***	*Ongoing, per quarter*
	***Outcome Indicator:** % of patients lost to follow-up (disaggregated by age, gender, mental health condition)*	*Electronic Medical Records, Patient Registers, Matercards* *Examples can be found in **MEQ and Research***	*Ongoing, per quarter*
Reintegration: Ensure patients with mental health disorders are integrated into the household/community	***Output Indicator:** #/ % of people with mental health conditions part of social rehabilitation groups (disaggregated by age, gender, mental health condition)*	*Community level registration and tracking sheet*	*Ongoing, per quarter*
	***Outcome Indicator**: % of beneficiaries enrolled in psychosocial rehabilitation program who complete their recovery plans (disaggregated by age, gender, mental health condition)*	*Community level registration and tracking sheet*	*Ongoing, per quarter*
	***Outcome Indicator**: #/% of people with mental health conditions taking part income generating activities (disaggregated by age, gender, mental health condition)*	*Community level registration and tracking sheet*	*Ongoing, per quarter*
	***Outcome Indicator**: #/% people with improved social functioning (disaggregated by age, gender, mental health condition)*	*Social Functioning Scales*	*Ongoing, per quarter*
	***Outcome Indicator:** #/% of family and caretakers with a decrease in care taking burden*	*Scales such as the Burden Assessment Scale (BAS)*	*Ongoing, per quarter*
Cross-Cutting Themes			
Component	***Indicators for measuring progress***	***Data collection tools***	***Timing & frequency of data collection***
Training and Capacity Building:	***Output Indicator:** # of health care workers trained by type (disaggregated by gender, health care worker cadre)*	*Training records*	*After each training*

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Health care workers trained in identification, management and referral of mental health conditions	***Output Indicator:*** *# of supervision sessions conducted for each trained staff*	*Supervision Tracker* *Examples can be found in* ***Training, Clinical Mentorship, Supervision and Competency Assessment***	*After each supervision session*
	Outcome Indicator: *Percent of trainees who demonstrate at least 80% competency scores on post-knowledge tests (disaggregated by gender, health care worker cadre)*	*Training Pre and Post tests* *Examples can be found in* ***Training, Clinical Mentorship, Supervision and Competency Assessment***	*At the start and end of the training program*
	Outcome Indicator: *Percent of trained health care workers who show improvement in clinical practice (disaggregated by gender, health care worker cadre)*	*Examples can be found in* ***Training, Clinical Mentorship, Supervision and Competency Assessment***	*Each Supervision session, analyzed every quarter by supervisor*
Stakeholder feedback and support: ***Mental health program design and implementation informed by engagement of stakeholders and communities***	***Output Indicator****: # of meetings held with key stakeholders during program implementations (ministry, community, providers etc)*	*Project activities' monitoring form*	*Ongoing, per quarter*
	Output Indicator*: # of program review meetings held where data and information are analyzed and programmatic changes are made*	*Project activities' monitoring form*	*Ongoing, per quarter*
	Outcome Indicator: *Percent of persons with mental health conditions and/or their families who report satisfaction with mental health services*	*Patient satisfaction surveys and Informal interviews*	*At baseline and every year after that*
	Outcome Indicator: *Communities and key stakeholders are actively involved in different phases of program*	*Focus group discussion and Key informant interviews*	*At baseline and every year after that*
Mental Health Integration: ***Increased level of mental health integration in the primary health care system***	***Outcome Indicator:*** *# of health facilities and/or communitiees that show improved institutional integration of mental health services*	*In-depth interviews with selected clinic managers and trainees* *Situtational Analyses- Examples can be found in* ***Assessing System Readiness***	*At baseline and every year after that*

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