Appendix 7.2 Process and outcome evaluation of the delivery of a mental health curriculum for the training and supervision of medical doctors in primary care clinics in rural Mexico

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Background

The majority of people who need mental health care have limited access to it. Two of the reasons for low access to healthcare worldwide are 1) a shortage of specialists and 2) the centralization of those specialists in urban areas. While almost 1 in 10 people globally have a mental health disorder, 1% of the health workforce are mental health care providers (1). This recognized gap between need and care is accentuated in low and middle income countries (2). In Mexico, the rate of psychiatrists to population is 3.68 psychiatrists per 100,000 inhabitants (3). There are 46 psychiatric hospitals, 13 psychiatric units in general hospitals, and 11 residential care facilities (4). Despite this relative insufficiency of resources, neuropsychiatric disorders represent the 5th largest burden of disease in the country (5).

Within countries of all income levels, members of marginalized communities are both more likely to suffer from a mental disorder and less likely to have sufficient access to care (2). This is true of rural populations. Of the available mental health services worldwide, many are centralized in urban areas and major cities (2). In the Mexican context this is reflected in the number of psychiatrists working in the largely rural state of Chiapas were the rate of psychiatrists to population is 0.57 psychiatrists per 100,000 inhabitants (3).

One effective approach to addressing mental health human resource shortages and the concentration of care in large cities is the integration of mental health care into primary health care services. There is evidence that the training of non-specialist health workers to detect and treat mental health disorders can improve access and clinical outcomes in low and middle-income countries (2). A comprehensive review of published work on strategies for action to address the human resources challenges contributing to mental health care gaps suggests that the training of non-specialist health workers, coupled with ongoing supervision, holds the potential to improve the detection and treatment of mental disorders (6).

Enhancing the ability and inclination of non-specialists primary care providers to integrate mental health services into their primary care practices through additional training and ongoing supportive supervision is a strategy relevant to the Mexican context. In Mexico, primary care providers represent the most common initial contact with between people with mental health disorders and the medical system. This point of contact is a currently underutilized opportunity to extend access to care in order to detect and treat mental disorders and to further provide a high quality of care by referring service users and consulting with mental health specialists (5).

There have been considerable efforts worldwide to equip primary care providers with continuing education and support to allow them to better serve service users with mental health disorders. Randomized control trials in in Pakistan (7) and India (8), have tested the potential of training community health workers to provide service users with care for

depression and anxiety. Randomized control trials in Iraq, Malawi, and Kenya have tested the results of programs designed to address primary care providers ability to identify, treat, and respond to mental health disorders more generally (9).

These studies provide useful insight as to the potential for training of non-specialized health workers to make advances in closing the gap in access to mental health care worldwide. There is a need, however, for the development of a curriculum to train primary care providers in mental health identification, treatment, and referral that is specific to the Mexican context in order to address the specific needs of service users and providers in a variety of settings in Mexico (10).

In 2013, only 30% of primary care facilities in Mexico had protocols to address mental disorders and less than 15% of health workers in the primary care setting received training on mental health topics (11). Given the tremendous diversity within Mexico and specifically the difference in access to care in urban vs. rural populations it is especially important to pursue further study and action on mental health curriculum that bolsters the capacity of rural primary care providers to care for their service users with mental health disorders.

Aims and objectives

Our overall aim is to evaluate a mental health (mh) curriculum developed for the training and supervision of medical doctors (MDs) in the diagnosis, treatment and follow-up of service users with mental illnesses in rural Mexico.

The specific objectives of this study are:

1. To evaluate changes on the the knowledge, skills and attitudes of MDs before and after the delivery of the mh curriculum.
2. To explore the perspectives of medical doctors and supervisors on the acceptability, appropriateness and feasibility of the implementation of the mh curriculum.
3. To assess the implementation of the mh curriculum through process indicators.
4. To assess the changes in the programme performance before and after the delivery of the mh curriculum.

Methods

- Study design

We will perform a before and after mixed-methods study and a process evaluation to assess the implementation and outcomes of the mh curriculum. Our primary outcomes are the change in knowledge, attitudes and therapeutic skills of MDs. Secondary outcomes include perceptions about the feasibility, appropriateness and acceptability of the mh curriculum. Process indicators include the dose and fidelity of the intervention. To assess changes in programme performance we will conduct a time series analysis of routinely collected data on the content of mental health consultations.

- Study setting

Located in Southern Mexico, the state of Chiapas has a population of 5.2 million people of which around 22% speak indigenous languages, half live in rural areas and more than two thirds live in poverty (12, 13). Specialist services for mental health are available at one psychiatric hospital and one ambulatory unit located in the capital city (14). Psychologists

support primary care clinics and social support centres which are located in urban areas of the state (14)

The study site includes ten PHC clinics that have been managed through a partnership between the State Ministry of Health and the NGO Compañeros en Salud/Partners in Health (CES/PIH) since 2012. These facilities, which are staffed with one medical doctor and one nurse or health auxiliary, reach a catchment area of 25,000 habitants and are located in the Sierra and Fraylesca regions of the state. Settlements in this mountainous region are difficult to access due to the poor quality of roads and limited telecommunications infrastructure. In order to reach secondary or tertiary health services, people need to travel 3-4 hours to the nearest hospitals 5-7 hours to the mental health units.

- CES/PIH programme

CES/PIH aims to strengthen the primary health care system to improve access to high quality care. The organisation uses a few strategies: (1) regular support and supervision of MDs in site by clinical supervisors, (2) monthly trainings on evidence-based care, (3) transportation of MDs, supervisors and medical supplies to the remote communities where clinics are located, (4) purchase of medical supplies that are not provided by the public health system, (5) recruitment, training and supervision of community health workers (CHWs) to conduct home visits and (6) support to MDs and service users to facilitate referrals to secondary or tertiary health services.

Services for mental health are delivered by MDs in the clinics and CHWs at the community, and include pharmacological treatments and psychoeducation. Clinical supervisors are in charge of supporting MDs at the clinic on a monthly basis. A mental health team is available for additional support upon request. All activities related to mental health are coordinated through a mental health programme which is led by a medical supervisor with additional experience in the treatment of mental disorders.

- Participants

MDs who staff these clinics are recent medical school graduates who are completing a one year placement in these health posts to fulfill the requirements of their educational degree. MDs are recruited from different Mexican universities, can be male or female and are generally between 23 and 25 years old. All MDs will be eligible for inclusion and will be recruited upon the start of their one year placement. All MDs who start placements between February, 2019 and August, 2019 will be recruited.

Clinical supervisors are MDs who completed a year delivering services at the clinics and were subsequently recruited. There is a mix of male and female supervisors and they are between 26 and 35 years old. All clinical supervisors who support MDs between February, 2019 and August, 2020 will be eligible for inclusion. Recruitment will take place upon the study initiation or once a clinical supervisor starts supporting an MDs, whichever takes place first.

Due to the nature of the intervention, only clinics where both MDs and clinical supervisors consent to participate will be included in the evaluation, however all health professionals will be trained and supervised under the same mh curriculum.

- Intervention

We developed a curriculum to train and supervise MDs delivering mental health services in PHC clinics. We identified the need for a curriculum through a mixed-methods case study, which was conducted to identify factors that were hindering or facilitating the implementation of the mental health programme. This case study included the views of MDs, clinical supervisors, and the directors of the organisation. Findings indicated that training and on site supervision delivered by clinical supervisors or members of the mental health team were key for the delivery of services. However, inconsistent supervision experiences were a common shortcoming. Furthermore, whereas trainings were viewed as important and necessary, many of those interviewed considered that the format could be more dynamic and the content could be simplified. Lastly, there was a common concern about the lack of agreement on what MDs are meant to learn and achieve.

Subsequently, we conducted literature searches through which we identified relevant guidelines, tools and previous studies related to the training of non-specialists in the delivery of mental health services. We organised two workshops in which members of the mental health team, including one medical doctor, two psychologists and one researcher, designed a first draft of the mh curriculum. We aimed to address three key needs of MDs, (1) the acquisition relevant knowledge in mental health (e.g. diagnostic categories and prescription of pharmacological treatment), (2) the development of necessary skills for the delivery of services (e.g. communication skills and psychoeducation strategies) and (3) their familiarisation with relevant organisational processes (e.g. use of information systems and referral mechanisms). In order to meet these needs, we developed a competency based curriculum based in the mhGAP guidelines (1) and the Enhancing Assessment of Common Therapeutic factors rating scale (ENACT) scale (15). The mhGAP guidelines were developed by the World Health Organisation (WHO) for the delivery of mental health services by non-specialist health workers and they include different algorithms to aid decision making about diagnosis, treatment and follow-up (16). The ENACT was designed for the evaluation of therapeutic skills of non-specialist health providers delivering services for people with mental illnesses in low resource settings (15). It encompasses a package of necessary skills and provides a scale to assess levels of proficiency, which is useful to evaluate progress and set benchmarks (15).

A first draft of the curriculum was shared with other specialists who suggested a few changes. Afterwards, the curriculum was presented and discussed in three focus groups, one with clinical supervisors and organisation directors, a second with MDs starting their yearly placement at the clinics and a third with MDs who had just completed their yearly placement. Interview guides can be found in Appendix 1. Key findings suggested that 1) the competencies based model was appropriate and the included competencies were considered crucial for establishing a positive rapport and environment in the mental health consultation, 2) clinical supervisors have the interest and the need to receive training in mental health topics and in how to assess the communication and therapeutic skills of the MDs; 3) there is a growing need for more frequent and regular on-site supervisions from the mental health team 4) participants appreciated that the contents of the trainings were contextualized in order to be more relevant to the daily work in this setting, 5) there is a need to develop systems to support staff to manage the emotional burden that arises from

working in underserved areas and treating people with mental illnesses with minimal prior training. The mh curriculum includes 24 competencies divided in five core areas: (1) Therapeutic skills, (2) Diagnosis and monitoring of clinical progress, (3) Complex cases, (4) Treatment allocation and delivery, and (5) Information management (figure 1). This content is delivered through 11 sessions of training, on site training and supervision. Training sessions have a duration of 1 to 1.5 hours and are comprised of lectures and practical exercises which are delivered by medical doctors with special training on the delivery of mental health treatments or by mental health specialists (i.e. psychologists or psychiatrists), topics and a brief description of contents are shown in Table 1.

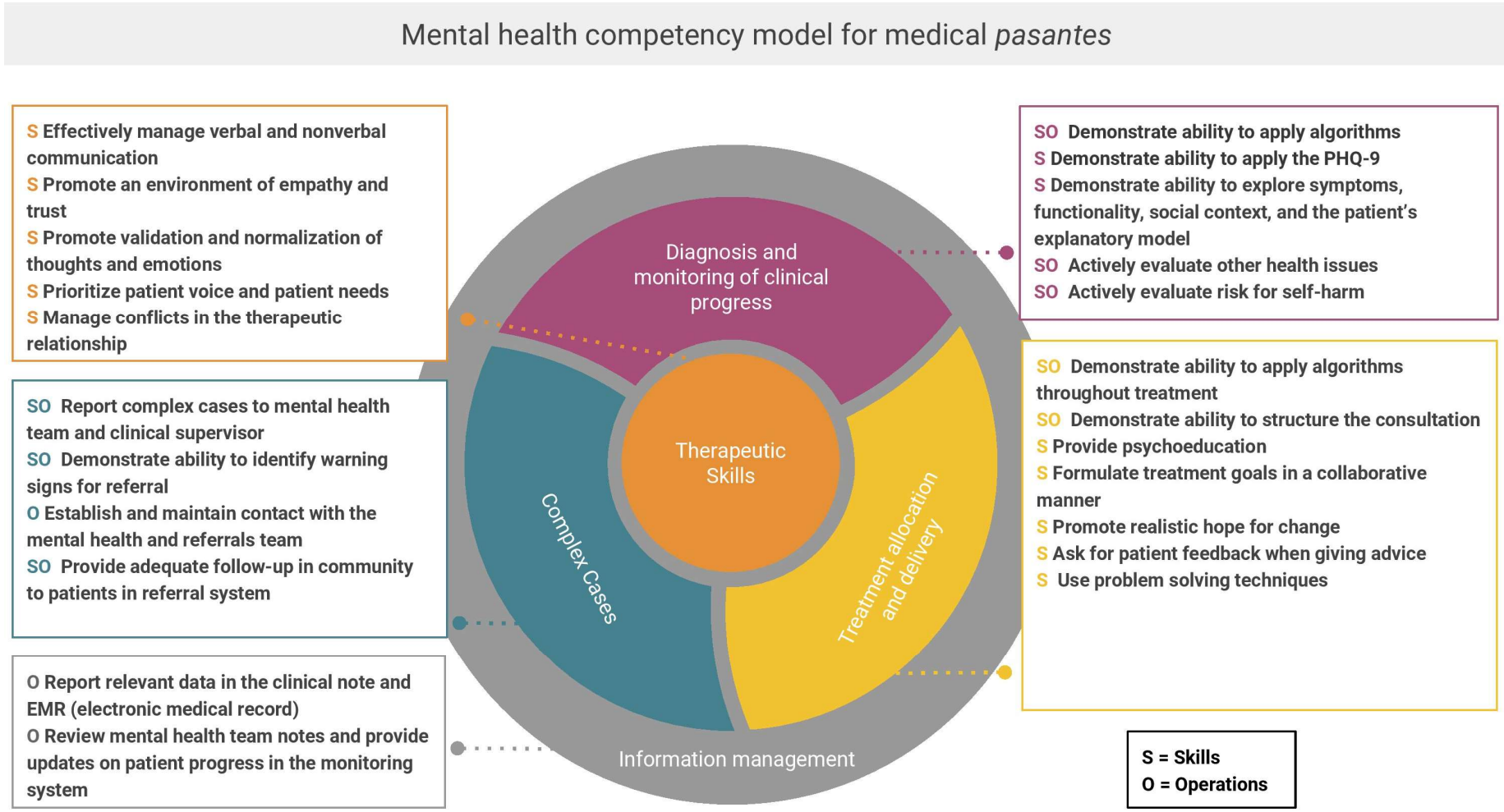

Figure 1. Mental health curriculum for the training and supervision of MDs for the delivery of mental health services

Session	Topic	Contents	Competencies			
			Month	February MD cohort	Month	August MD cohort
1	Introduction	Intro to the mental health programme, use of EMR (Access), GDrive resources	1	1. Communicate complex cases to the MH team and clinical supervisor 2. Report relevant data in the clinical note and the EMR 3. Review MH team annotations and provide updates of the progress of patients in the monitoring system	7	
2	Depression A	Use of clinical protocols to suspect and diagnose Major Depressive Disorder, differential diagnoses and psychoeducation	2	1. Effectively manage verbal and non-verbal language 2. Demonstrate ability to apply the algorithms 3. Provide psychoeducation	8	1. Demonstrate the ability to apply PHQ9/GAD7 2. Formulate treatment objectives collaboratively 3. Demonstrate ability to structure the query
3	Anxiety A	Use of clinical protocols to suspect and diagnose Generalized Anxiety Disorder, differential diagnoses and psychoeducation	3	1. Demonstrate the ability to apply the algorithms throughout the treatment 2. Promote realistic hope	9	1.Priorize the patient's narrative and needs
4	Psychosis A	Use of clinical protocols to suspect and diagnose chronic psychosis. Differential diagnoses, psychoeducatio and alarm signs	4	1. Promote an environment of empathy and trust within the consultation 2. Demonstrate ability to explore symptoms, functioning, social context and explanatory model of the patient 3. Establish and maintain contact with the referral team and mental health in complex cases	10	1. Actively assess other health problems
5	Trauma	What is trauma?, how to suspect?, how to ask?, the "DO´s y DONT´s", initial desescalation	5	1. Promote validation and normalization of thoughts and emotions 2. Provide adequate follow-up to patients with potential trauma histories 3. Request patient feedback	11	1. Management of conflicts in the therapeutic relationship
6	Psychiatry Emergencies	What is a psychiatric emergency?, clinical protocols for management and treatment of panic attacks, suicide thoughts, agitated patient, conversion disorder. Security plans	6	1. Actively assessself-harm risk 2. Demonstrate ability to identify warning signs for references 3. Provide adequate follow-up in the community to patients enrolled in the referral system	12	1. Use problem solving techniques
7	Introduction	Intro to the mental health programme, use of EMR (Access), GDrive resources	7		1	1. Communicate complex cases to the MH team and clinical supervisor 2. Report relevant data in the clinical note and the EMR 3. Review MH team annotations and provide updates of the progress of patients in the monitoring system
8	Depression B	Use of protocol for follow-up, basics of CBT, brief intervention cards, pharmacological treatment	8	1. Demonstrate the ability to apply PHQ9 /GAD7 2. Formulate treatment objectives collaboratively 3. Demonstrate ability to structure the query	2	1. Effectively manage verbal and non-verbal language 2. Demonstrate ability to apply the algorithms 3. Provide psychoeducation
9	Alcohol Use Disorder	AUD clinical protocol, risk factors, Motivational Interviewing.	9	1.Priorize the patient's narrative and needs	3	1. Demonstrate the ability to apply the algorithms throughout the treatment 2. Promote realistic hope
10	Anxiety C	Use of brief intervention cards for anxiety and other non-pharmacological treatments	10	1. Actively assess other health problems	4	1. Promote an environment of empathy and trust within the consultation 2. Demonstrate ability to explore symptoms, functioning, social context and explanatory model of the patient 3. Establish and maintain contact with the referral team and mental health in complex cases
11	Psychosis C	Pharamacological treatment and follow-up pf patient with psychosis, social reintegration, alarm signs monitoring	11	1. Management of conflicts in the therapeutic relationship	5	1. Promote validation and normalization of thoughts and emotions 2. Provide adequate follow-up to patients with potential trauma histories 3. Request patient feedback
12	Therapeutical and communication resources during the consultation	Problem solving techniques and other non-pharmacological resources developed by CES	12	1. Use problem solving techniques	6	1. Actively assessself-harm risk 2. Demonstrate ability to identify warning signs for references 3. Provide adequate follow-up in the community to patients enrolled in the referral system

Table 1. Mental health topics included in the yearly curriculum

Supervision is delivered at week-long visits to the clinic which are carried out each month by clinical supervisors or by members of the mental health team. Clinical supervisors are medical doctors with at least one year of experience working at primary care clinics and delivering mental health care and members of the mental health team include the

coordinator of the programme, psychiatrists or psychologists. Supervision includes at least 12 on site-visits a year by clinical supervisors and at least two on-site visits by members from the mental health team. Supervision includes at least one modelled session with service users and co-directed consultations. There is a mid-consultation case discussion amongst the MD and supervisor for tailoring the treatment plan based on their needs. The one carried out by the mental health team includes more frequent home visits to complex service users, promotion of the use of mental health consultation resources (algorithms, brief psychoeducation cards, security plans), revision of medication supplies in the clinics and case discussion of service users by using the mental health census as a framework. Supervisors use supervision formsto assess the level of proficiency MDsachieve in each competency according to a scale ("can improve", "basic" or "advanced") and provide feedback and support for improvement. These checklists were specially developed for this curriculum and are based on the mhGAP clinical guidelines and the Enhancing Assessment of Common Therapeutic factors rating scale (ENACT).

- Outcomes

Primary outcomes

Primary outcomes will be the increase in the knowledge and therapeutic skills to assess and treat mental illnesses, and the improvement of attitudes related to mental illnesses. Knowledge and skills increase will be measured through a written theory test and observations during the delivery of mental health services. Firstly, we will assess the percentage change in scores obtained in the written theory test before and after the intervention. This test was translated and adapted from the mhGAP- WHO assessment questionnaire, which was developed as part of the mhGAP training package for non-specialist health providers (16). It includes 20 multiple choice questions and covers diagnosis and treatment of depressive, anxiety, psychosis and alcohol use disorders (Appendix 1). Secondly, we will assess the percentage change in scores obtained in the ENACT during observations of mental health consultations at 1, 6 and 12 months. The ENACT was validated in Nepal and is suitable for adaptation to different contexts for implementation or research purposes (15). It includes 18 items which are rated according to a three point scale ("needs improvement", "done partially" and "done well") (15) (Appendix2).

Attitudes related to the provision of mental health services will be measured through the percentage change in scores obtained in the Mental Illness: Clinicians' Attitudes Scale (MICA-4) (17). The MICA-4 is comprised of 16 questions with a 6 point likert scale (ranging from "strongly agree" to "strongly disagree) and was developed to assess the attitudes of health care professionals towards people with mental illnesses and psychiatry (17) (Appendix 3). For the current evaluation we will use a Spanish versions of the MICA-4 and ENACT.

Secondary outcomes

Secondary outcomes will be the improvement in the programme performance before and after the delivery of the mh curriculum. Performance will be measured through clinical patient records. For each consultation we will record which of the following activities were performed by medical doctors: (1) PHQ-9 or GAD-7 application (for service users with depression or anxiety), (2) further assessment of relevant symptoms and functionality, (3)

exploration of life events during the month, (4) provision of non-pharmacological treatment, and (5) prescription of pharmacological treatment. Improvement will be measured through the increase in the proportion of consultations where all relevant activities are performed.

Qualitative measures

The perspectives of medical doctors and supervisors about the acceptability, appropriateness and feasibility of the curriculum, as well as challenges experienced during its implementation will be explored through focus groups and in-depth interviews. Focus groups with MDs will be held before and after the intervention. In-depth interviews with MDs and clinical supervisors will be held after the intervention. An overview of the topics that will be explored can be found in Table 2.

Table 2. Topics to be explored through qualitative methods

	Pre qualitative assessment	Post qualitative assessment
Medical doctors	*Acceptability* How do you feel about providing services for service users with mental illnesses? How do you feel about participating in a training and supervision curriculum to provide mental health services? To what extent do you think you are capable of providing mental health services? To what extent do you feel you are motivated to participate in this training and provide these services? What would you say are the main sources of your motivation? *Appropriateness* What do you feel are you mental health training needs? To what extent do you feel these services are appropriate for the population that attends the clinic? *Feasibility* To what extent do you think you will be able to fit this training and set of services considering your other responsibilities in the clinic? To what extent do you think you would be able to treat mental illnesses in your medical practice? What support or resources do you think you need to be able to provide these services?	*Acceptability* To what extent do you feel the provision of services for service users with mental illnesses is part of your role? How did you feel about participating in a training and supervision curriculum to provide mental health services? What do you think about your capacity to provide mental health services? How motivated were you to participate in this training and provide these services? *Appropriateness* To what extent did you feel the training and supervision met your needs? To what extent did you feel the services available at the clinic are appropriate for the service users that visit the clinic? *Feasibility* To what extent were you able to fit this training and set of services among your other responsibilities in the clinic? To what extent did you have enough support or resources to be able to provide these services? *Experiences with implementation* What aspects of the training and supervision did you find useful/not useful?

		What would you have liked to do differently? What challenges did you experience with the curriculum/service delivery? What were key positive aspects from your experience with the curriculum?
Supervisors		*Acceptability* How did you feel about participating in the training and supervision curriculum? What do you think about your capacity to support the delivery of this curriculum? *Appropriateness* To what extent did you feel the training and supervision meet your needs and the needs of the MSs? To what extent did you feel the services available at the clinic are appropriate for the service users that visit the clinic? *Feasibility* To what extent were you able to fit the curriculum among your other responsibilities as a supervisor? To what extent did you have enough support or resources to be able to provide the curriculum? *Experiences with implementation* What aspects of the training and supervision did you find useful/not useful? What would you have liked to do differently? What challenges did you experience delivering the curriculum? What were key positive aspects from your experience with the curriculum?

- Process indicators

We will assess the dose and fidelity of the intervention. Dose indicators will capture the number of training and supervision sessions that each MSs received. Fidelity indicators will assess the extent to which training and supervision were delivered as planned. Indicators can be found in Table 2.

Table 2. Process indicators for the delivery of the mh curriculum	
Indicator	Description

Dose of training	Proportion of monthly training sessions attended by each medical doctor measured through attendance sheets.
Dose of supervision	Proportion of bi-monthly supervisions in which mental health was addressed measured through the number of supervision forms completed by the clinical supervisors or members of the mental health team.
Fidelity of training	Proportion of monthly training sessions delivered following the training plan measured through lesson checklists.
Fidelity of supervision	Proportion of monthly supervision forms adequately completed.

- Data collection and analysis

Upon the start of the study, in January 2019, all MDs and clinical supervisors will be asked for informed consent. Individual meetings will be held with each member of the organisation to ensure everyone is able to decide freely and in confidentiality. Participants will be explained the objectives of the study and will be reminded that their participation does not have an impact on their relationship with the organisation or their ability to benefit from the mh curriculum. After this date, if any new members of staff are recruited, the same procedure will be followed upon their arrival to the organisation/clinics. The knowledge and skills test and and attitudes questionnaire will be completed before the start of the curriculum and after it is completed i.e. at months 1 and 12 of the training. Both of these assessments will be completed using pen and paper forms during monthly trainings.

Therapeutic skills will be assessed by researchers through observations of mental health consultations at the primary care clinics during the first and last months of training. These researchers will be psychologists or psychiatrists or will have experience in the delivery of mental health services, and will receive a one-day training in the use of the ENACT scale. Informed consent will also be requested of all service users who participate in these observations. Firstly, the MDs will identify which consultations are for service users with mental illnesses. Once these service users arrive to the clinic, they will be briefly explained by the MDs about the objectives of the study, the procedure (i.e. observation of consultations with an observer being present in the consultation room) and asked if they would be willing to participate. If service users agree, they will meet with the researcher who will explain in further detail the objectives and procedures of the study, clarify that their participation does not have an impact with their ability to benefit from the clinic services, and ask for informed consent. Observations will only take place if service users give their consent.

For all quantitative data analyses, we will use t-tests for independent samples to compare before and after scores from each measure.

Performance data from September, 2018 to April, 2121 will be extracted from the individual patient files stored in Access. We will remove any patient identifiers and code the content in the clinical notes. Data will be analysed using an interrupted time series analysis (18)to assess the extent to which changes can be observed overtime and infer whether the application of the mh curriculum had an impact.

Focus groups with MDs will be held before the start of the curriculum during the first monthly training. In-depth interviews will be held at 6 and 12 months of training with MDs and at 12 months of training only with clinical supervisors. In-depth interviews will be carried out when it is most convenient for participants, during visits to the clinics or at monthly trainings, and will be audio recorded. Research assistants with experience in qualitative research will conduct all qualitative data collection. Qualitative data will be analysed through framework analyses (19).

Monthly training checklists will be completed by research assistants who will also gather and assess bi-monthly supervision forms. All process indicators will be analysed through descriptive statistics.

- Ethics

There are a number of ethical considerations that are worth mentioning. First of all, the mh curriculum was developed after extensive consultation with both service providers and service users. Moreover, the objective of the mh curriculum is to improve the quality of the services that are delivered at the clinics for those who request services from them. It is unlikely that this intervention in isolation will meet all the mental health needs of the people who visit the clinics under study or who live in the catchment area targeted by these services but it is potentially a step forward in ensuring that all of those who come into the clinic are diagnosed and prescribed treatment appropriately.

Secondly, it is unlikely that MDs with no previous experience in the delivery of mental health services and clinical supervisors with one or two years of experience will be able to cope with all the needs of service users with mental illnesses. Therefore, the mental health team will provide close supervision to both clinical supervisors and MDs. The CES/PIH programme also has a team available to support patient referrals who actively supports the mental health team when needed.

Thirdly, evaluations of routine services can pose a burden on those who deliver services by taking some of the limited space and time available. To prevent this, we have designed an evaluation that primarily relies on routinely collected data. Primary data collection will mainly take place during monthly trainings (i.e. knowledge and attitudes tests). However, a few consultations will be observed to assess the skills of MDs. In the conduction of these observations, researchers will be flexible and adapt to the schedules of MDs and clinical supervisors, as well as prioritise the needs of service users.

Finally, we have established mechanism to request informed consent in a confidential manner. We will appoint a researcher to be available for any queries or clarifications during the course of the study, and all participants will be free to stop their participation at any point. As mentioned before, regardless of whether MDs or clinical supervisors accept or

decline to participate in the evaluation, all members of the organisation will be trained and supervised under the same mh curriculum.

Glossary:

ENACT(Enhancing Assessment of Common Therapeutic Factors): is a scale that includes 18 items which are rated according to a three point scale ("needs improvement", "done partially" and "done well"). It was designed for the evaluation of therapeutic skills of non-specialist health providers delivering services for people with mental disorders in low resource settings by Dr. Kohrt et al in 2015.

Knowledge assessment questionnaire (pre and post): 20 item questionnaire that includes some questions of the mhGap-World Health Organisation (WHO) assessment questionnaire and questions relevant to the annual curriculum in CES.

Lesson checklist: checklist of activities and topics that comprise a lesson according to the corresponding lesson plan that will be filled to assess fidelity.

Mental health curriculum: This includes 24 competencies divided in five core areas. It is based on competencies extracted from ENACT and other skills and operational based competencies relevant to CES work.

mhGap-World Health Organisation (WHO) assessment questionnaire: it includes 22 multiple choice questions as part of the mhGAP training package for non-specialist health providers

MICA-4: (Clinicians´Attitudes Scale) is comprised of 16 questions with a 6 point likert scale (ranging from "strongly agree" to "strongly disagree) and was developed to assess the attitudes of health care professionals towards people with mental illnesses and psychiatry.

Supervision forms: bi-monthly forms including the 24 competencies from the mental health curriculum that are meant to be used by clinical supervisors to assess performance of the pasantes and by the mental health team during on-site supervision (whenever that happens). There are three versions of these as they are divided in time: a) 1-4 months, b) 5-9 months, c) 10-12 months

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Appendix 1 (of protocol). Knowledge and skills pre and post test

Evaluation of knowledge and therapeutic skills for primary care physicians
Integration in the evaluation materials of the guides.

1. Which of the following is a core competency for establishing an effective communication with the patient?
a) ask family members to step outside of the office and assess the patient
b) Maintain eye contact and have an energetic tone of voice.
c) listen actively and ask open ended questions
d) rule out medical pathologies before establishing a psychiatric diagnosis

2. Which of the following exemplifies the best what psychoeducation in depression is?
a) name the disease, explain the biopsychosocial model and mobilize the support network
b) assign the role of the patient, preserve confidentiality and active listening
c) have an open position, maintain eye contact and modulate the voice volume
d) provide 8-12 sessions of cognitive behavioral therapy

3. Which of the following cluster of symptoms best describes what a depressive episode is like?
a) evident change in mood, aggressive and agitated behavior, fixed ideas
b) deficit in memory, disorientation, loss of emotional control.
c) inattention, hyperactivation, aggressive behavior.
d) low energy, loss of interest in usual activities

4. Which of the following is a good therapeutic combination for depression?
a) Intramuscular vitamins and physical activity
b) antidepressant and psychosocial intervention
c) antidepressant and mood stabilizer
d) hypnotherapy and relaxation exercises

5. Which of the following statements best describes an episode of acute mania?
a) confusion, disorientation in time, place and person and functional deterioration
b) alcohol consumption, slurred speech and uninhibited behavior
c) agitation, insomnia and sweating after stopping benzodiazepines
d) less need to sleep, increase in activity and reckless behavior

6. Which of the following statements about psychosis and bipolar disorder is more correct?
a) in people with psychosis and bipolar disorder there is no need to rule out other medical conditions
b) people with psychosis and bipolar disorder benefit more from inpatient care
c) people with psychosis and bipolar disorder are unlikely to work and contribute to society
d) people with psychosis and bipolar disorder are at high risk of suffering from stigma and discrimination

7. Which of the following is part of the psychosocial interventions in psychosis?
a) Encourage participation of service users in daily activities, but limit the involvement with work or serious relationships, as they can be too stressful.
b) Discuss with the caregiver and the family if long-term hospitalization may be appropriate.
c) Discuss with the caregiver the different ways in which he/she could challenge the delusions of the person
d) Provide psychoeducation, especially to avoid sleep deprivation, stress, drugs and alcohol

8. The following is the best thing to do in cases of alcohol withdrawal
a) Apply CAGE scale and, if willing to change, give naltrexone
b) Provide more ethanol to reduce withdrawal symptoms
c) Evaluate severity of abstinence with CIWA-score, channeling i.v. and consider giving benzodiazepine
d) Always provide benzodiazepines and intramuscular antipsychotic to prevent complications

9. Which of the following cases requires urgent referral?
a) patient who reports suicidal thoughts during the last week, without access or plan
b) patient with hyperthermia, limb stiffness and confusion after starting antipsychotic

c) patient with extrapyramidal symptoms after 1 week of starting haloperidol
d) patient with acute psychosis, with mild agitation who does not accept oral medication

10. 19-year-old female patient who refers having a feeling of restlessness, tiredness and worrying to much since 2 months ago, due to a public school presentation she has in 3 weeks. Her functionality is still preserved. You perform GAD7, which results in 12 points. It can be said that this patient:
a) she has moderate anxiety and requires you to start her on a selective serotonin reuptake inhibitor
b) she presents with generalized anxiety disorder (GAD7> 10) and requires to be started on fluoxetine or sertraline at high doses
c) she presents panic attacks associated with triggering events such as the public presentation
d) she has moderate anxiety, but it is not necessary to start her on medication yet

11. The following are elements needed to ask in order to assess patient´s functionality:
a) problems with sleeping, eating, working and how their interpersonal relationships develop
b) problems with memory and sleep and ask for social support network
c) problems with work and inability to organize speech
d) inability to be self-sufficient and judgment impairment

12. 17-year-old female patient shows up with cutting injuries on the forearm, with different evolution times. She refers low mood for 1 month. The following is the most appropriate thing to do:
a) Start antidepressant and assign a Community Health Worker
b) Assess suicidal thoughts and self-injury, classify risk and make a safety plan
c) perform PHQ9 and prescribe medication according to the score
d) discuss with a parent or guardian about suicidal ideation, since she is underage

13. The acronym "ANIMA" for treating people with trauma due to partner or sexual violence refers to:
a) active listening of the story, listen to expectations and advice to leave the perpetrator as soon as possible
b) medical approach with tests for STIs, HIV, VDRL and report to the Public Ministry
c) Normalize what happened, not judge the situation and communicate to a relative to be aware of the patient
d) Validate what the victim feels, learn about the patient needs, psychoeducate and make a safety plan

14. 29-year-old male patient with previous episodes of depression since youth who shows up to follow-up after starting him on fluoxetine 20 mg 1 month ago. He refers having a remarkable improvement and feeling more energetic to do things. His family member notes him with less need to sleep in the last two weeks and refers seeing him "different" than he was before. The best behavior to follow is:
a) stop the antidepressant and change to a mood stabilizer
b) continue with the antidepressant for 1 more month and reevaluate functionality
c) increase the dose of antidepressant to 40 mg per day to improve insomnia
d) stop fluoxetine and switch to sertraline to improve the situation

15. The following is the most appropriate thing to do with a patient with a conversion crisis:
a) Tell him/her that the problem is in his/her head and that if h/she does not get better we will have to take him/her to the hospital
b) explain that he/she is in a safe place and that he/she will be given an injection (injectable water) to wake him/her up
c) inquire with family about the triggers of the crisis, reduce environmental stimuli and communicate verbally and non-verbally with the patient
d) Perform painful stimulus and evidence that he/she is faking the episode

16. In case of having a patient with panic attacks, this is the first thing that should be done for their acute management:
a) provide a short-acting benzodiazepine orally

b) decrease environmental stimuli, check vital signs and stabilize patient's symptoms (breathing techniques)
c) give selective inhibitor of serotonin reuptake orally and give psychoeducation on the panic crisis
d) explain that he/she must be referred to a psychiatric unit immediately
17. 19-year-old male patient who started 1 year ago with social withdrawal and disorganized language, loss of appetite and has stopped going to school because he claims his classmates have "donkey ears" which frightens him. He also suffers from early insomnia. The best behavior to follow is:
a) perform a complete clinical examination and prescribe risperidone for suspected chronic psychosis and benzodiazepine for improvement of sleep
b) apply haloperidol decanoate shot since the patient comes from far away and follow up in one month
c) provide psychoeducation and start him on risperidone for suspected chronic psychosis after clinical assessment and follow up in 2 weeks
d) perform clinical examination and prescribe risperidone with olanzapine, which has a sedative effect that can improve insomnia

18. The following is the best initial approach for a 23-year-old patient who comes to the clinic with mild agitation, verbal threats, alleging that "they are persecuting him"
a) mind own and other people´s safety, do verbal de-escalation and inquire family about causes of agitation
b) mind own and other people´s safety and others and apply intramuscular diazepam
c) mind own and other people´s safety and give benzodiazepine orally
d) tell him that nobody is following him and ask him to calm down, because there are people who are getting scared

19. What is the most indicated thing to tell the caregiver about someone who has had an episode of suicide attempt?
a) that medications will be available to keep the person sedated
b) contact with family, friends and other people must be restricted if it is very overwhelming
c) remove potentially harmful objects and try not to leave the person alone
d) If unknown substance ingestion is suspected, induce vomiting as initial treatment

20. Which of the following is part of a psychosocial intervention when a person has experienced a loss due to the death of a loved one?
a) advise that he/she can talk about the incident as much as possible, even if they do not feel like it
b) explain that it is normal to be in mourning for such a big loss and that, in most cases, the symptoms will diminish over time
c) explain that he/she should not be sad or spend his days crying and that he should avoid situations that remind him of the deceased person in order to recover
d) referral to a specialist in case the symptoms do not improve after 1 month.

Appendix 2 (of protocol). ENACT scale

ITEM 1. NON-VERBAL COMMUNICATION & ACTIVE LISTENING: EYE CONTACT, FACIAL EXPRESSION, BODY LANGUAGE & GESTURES

○ 1 NEEDS IMPROVEMENT = does not make any eye contact or stares at patient; shows anger; laughs at patient; mocks patient; turns away from patient; repeatedly interrupts patient; ignores patient; answers mobile phone without permission

○ 2 DONE PARTIALLY = does not consistently use body language to express interest; rarely makes eye contact; shows limited emotion; appears artificial

◯ 3 DONE WELL = makes appropriate eye contact throughout interaction; smiles when appropriate; sits at appropriate angle from patient and leans in to show interest; use of 'uh-huh', 'hmm' or other culturally appropriate non-lexical utterances to signal interest

ITEM 2. VERBAL COMMUNICATION SKILLS: OPEN-ENDED QUESTIONS, SUMMARIZING & CLARIFYING STATEMENTS

◯ 1 NEEDS IMPROVEMENT = uses mostly 'yes/no' questions, e.g., "Will you? Can you?"

◯ 2 DONE PARTIALLY = uses open-ended questions but does not explore topics further or offer summaries for patient reflection

◯ 3 DONE WELL = uses open-ended questions, summarizing and clarifies statements, e.g., "What happened? Tell me more."

ITEM 3. RAPPORT BUILDING & SELF-DISCLOSURE

◯ 1 NEEDS IMPROVEMENT = clinician does not introduce him/herself or attempt to make the patient feel comfortable or clinician dominates the session talking about his/her own experiences

◯ 2 DONE PARTIALLY = clinician introduces him/herself but does not help the patient feel comfortable through small talk and informal conversation or clinician disclosure but it is not related to patient experience or needs

◯ 3 DONE WELL = clinician introduces him/herself, tries to make the patient feel comfortable and disclosure focuses on patient needs

ITEM 4. EXPLORATION, INTERPRETATION & NORMALIZATION OF FEELINGS

◯ 1 NEEDS IMPROVEMENT = clinician does not ask about patient's feelings or clinician is judgmental/critical about patient's emotions and feelings (e.g., "You shouldn't feel that way", "You should stop thinking or feeling that.")

◯ 2 DONE PARTIALLY = clinician asks about feelings but does not normalize/validate or does not explore feelings in detail with patient

◯ 3 DONE WELL = clinician explains that the patient's feelings in context and if appropriate, feelings are expected for a person in his/her situation

ITEM 5. DEMONSTRATION OF EMPATHY, WARMTH & GENUINENESS

◯ 1 NEEDS IMPROVEMENT = clinician is critical, hostile, or dismissive of patient's concerns or complaints

◯ 2 DONE PARTIALLY = clinician is generally warm and friendly to patient, but does not demonstrate the ability to put him/herself in the experience of the patient

◯ 3 DONE WELL = clinician demonstrates that he/she understands the experience of patient in a genuine and sincere manner

ITEM 6. ASSESSMENT OF FUNCTIONING & IMPACT ON LIFE

◯ 1 NEEDS IMPROVEMENT = clinician does not ask the patient about the impact on functioning and daily life from feelings, thoughts, psychosocial problems, etc.

◯ 2 DONE PARTIALLY = clinician asks about functioning and daily life activities but does not connect it to psychosocial/mental health concerns

◯ 3 DONE WELL = clinician explores the relationship between psychosocial problem and functioning

ITEM 7. EXPLORATION OF PATIENT'S & SOCIAL SUPPORT NETWORK'S EXPLANATION FOR PROBLEM (CASUAL & EXPLANATORY MODELS)

◯ 1 NEEDS IMPROVEMENT = clinician does not ask the patient about his/her own view of the cause or is judgmental/critical about patient's explanation (e.g. "Witchcraft doesn't cause these problems, that is an ignorant/backwards idea!)

◯ 2 DONE PARTIALLY = clinician asks patient about his/her own view of cause but does not explore if this the same as the family's view

◯ 3 DONE WELL = clinician asks the patient about cause and asks if family/support network have similar or different explanations

ITEM 8. INCORPORATION OF COPING MECHANISMS & PRIOR SOLUTIONS

◯ 1 NEEDS IMPROVEMENT = clinician does not ask the patient about how he/she has coped or clinician is judgmental about how patient has coped (e.g., "Why did you think that work?" or "That isn't helpful.")

◯ 2 DONE PARTIALLY = clinician asks about coping and prior solutions, but does not provide positive feedback

◯ 3 DONE WELL = clinician asks about coping and provides positive feedback in regard to agency or pathways thinking

ITEM 9. ASSESSMENT OF PATIENT'S RECENT LIFE EVENTS & ACKNOWLEDGEMENT OF IMPACT ON PSYCHOSOCIAL WELLBEING

◯ 1 NEEDS IMPROVEMENT = clinician does not ask about triggering life events

◯ 2 DONE PARTIALLY = clinician asks about life events but does not connect with current mental health issues

◯ 3 DONE WELL = clinician asks about life events and discusses connection with current mental health

ITEM 10. ASSESSMENT OF OTHER MENTAL HEALTH PROBLEMS, ALCOHOL/DRUG USE & PHYSICAL HEALTH PROBLEMS

◯ 1 NEEDS IMPROVEMENT = clinician does not ask about any related conditions, e.g., alcohol or drug use, physical health problems, injuries, head trauma, medications, etc.

◯ 2 DONE PARTIALLY = clinician takes partial history but does not explore positive responses in relation to mental health, e.g., clinician does not connect other health problems or substance use to current mental health

◯ 3 DONE WELL = clinician assesses related health issues and explains relationship to patient's condition when appropriate

ITEM 11. APPROPRIATE INVOLVEMENT OF FAMILY MEMBERS & OTHER CAREGIVERS

◯ 1 NEEDS IMPROVEMENT = *When family member is present*: clinician ignores family during session or clinician only talks to family members and ignores patient; *When family member is not present*: clinician does not ask about family at all

◯ 2 DONE PARTIALLY = *When family member is present*: clinician interviews both patient and family but does not facilitate interaction between family and patient during session; *When family member is not present*: clinician asks about family involvement but does not explore patient's reasons or preferences for involvement or non-involvement

◯ 3 DONE WELL = *When family member is present*: clinician helps both patient and family participate and encourages interaction between them; *When family member is not present*: clinician explores preferred family engagement with the patient and does role-plays or coaching

ITEM 12. COLLABORATIVE GOAL SETTING & ADDRESSING PATIENT'S EXPECTATIONS

◯ 1 NEEDS IMPROVEMENT = clinician does not ask patient about his/her goals and expectations for treatment, or clinician just tells patient what to do without asking his/her expectations

◯ 2 DONE PARTIALLY = clinician asks patient about goals but does not discuss if these are realistic or can be accomplished

◯ 3 DONE WELL = clinician asks about goals and discusses with patient what is and is not achievable through treatment, and clinician and patient collaboratively establish treatment plan

ITEM 13. PROMOTION OF REALISTIC HOPE FOR CHANGE

◯ 1 NEEDS IMPROVEMENT = clinician either gives no hope (e.g., you will never get better) or gives unrealistic expectations (e.g., you will be cured in a few weeks and never have problems again) for what to expect in treatment and recovery

◯ 2 DONE PARTIALLY = clinician vaguely tells patient what will happen during treatment

◯ 3 DONE WELL = clinician helps patient feel positive about the future and creates realistic expectations about what can and cannot be achieved through treatment, and clinician checks patient's understanding of realistic change

ITEM 14. PSYCHOEDUCATION INCORPORATING LOCAL (ETHNOPSYCHOLOGICAL) CONCEPTS & TERMS

◯ 1 NEEDS IMPROVEMENT = clinician uses technical jargon to explain mental health or uses stigmatizing terms or does not explain how treatment works

◯ 2 DONE PARTIALLY = clinician uses a limited amount of technical jargon and no stigmatizing terms, but clinician does not incorporate patient's explanatory model or other local psychological concepts into psychoeducation

◯ 3 DONE WELL = clinician conducts psychoeducation using local psychological concepts including patient's explanatory model (see Item 7), local terminology, and idioms of distress to explain mental health and treatment in non-stigmatizing language, and checks to see if patient understands

ITEM 15. USE OF PROBLEM SOLVING STEPS: PROBLEM FORMULATION, PRIORITIZATION, SOLUTION GENERATION & ACTION PLANNING

◯ 1 NEEDS IMPROVEMENT = clinician does work with patient to formulate key problem requiring help, support, or treatment

◯ 2 DONE PARTIALLY = clinician helps patient formulate and prioritize key problem, but does not complete steps #2-4 (see below)

◯ 3 DONE WELL =clinician helps patient (1) formulate and prioritize primary problem, (2) brainstorm solutions, (3) explores advantages and disadvantages, and (4) formulate action plan

ITEM 16. ELICITATION OF FEEDBACK WHEN PROVIDING ADVICE, SUGGESTIONS & RECOMMENDATIONS

◯ 1 NEEDS IMPROVEMENT = clinician lectures patient about what to do without asking if this is acceptable and comfortable for the patient, or clinician does not give any suggestions at all

◯ 2 DONE PARTIALLY = clinician gives focused advice but does not ask for feedback from patient to see if the advice is helpful

◯ 3 DONE WELL = clinician gives a few suggestions when asked by patient and asks for patient feedback about suggestions

ITEM 17. EXPLANATION AND PROMOTION OF CONFIDENTIALITY

◯ 1 NEEDS IMPROVEMENT = clinician does not address confidentiality or does not adjust topics of discussion based on setting

◯ 2 DONE PARTIALLY = clinician tells patient that everything is confidential without explaining exceptions such as harm to self or others, or clinician states everything is confidential while conducting session in non-private setting

◯ 3 DONE WELL = clinician explains that all clinician-patient discussions are confidential with the exception of harm to self and others, and clinician adjusts conversation topics based on private or non-private setting

ITEM 18. ASSESSMENT OF HARM TO SELF, HARM TO OTHERS, HARM FROM OTHERS & DEVELOPING COLLABORATIVE RESPONSE PLAN

◯ 1 NEEDS IMPROVEMENT = clinician does not ask about harm to self or others

◯ 2 DONE PARTIALLY = clinician asks about harm to self or others, but does not help patient develop a plan for safety

◯ 3 DONE WELL = clinician asks about harm to self or others and facilitates appropriate planning and actions to assure safety

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Appendix 3 (of protocol). MICA-4 scale

		Strongly agree	Agree	Somewhat agree	Somewhat disagree	Disagree	Strongly disagree
1	I just learn about mental health when I have to, and would not bother reading additional material on it.						
2	People with a severe mental illness can never recover enough to have a good quality of life.						
3	Working in the mental health field is just as respectable as other fields of health and social care.						
4	If I had a mental illness, I would never admit this to my **friends** because I would fear being treated differently.						
5	People with a severe mental illness are dangerous more often than not.						
6	Health/social care staff know more about the lives of people treated for a mental illness than do family members or friends.						
7	If I had a mental illness, I would never admit this to my **colleagues** for fear of being treated differently.						
8	Being a health/social care professional in the area of mental health is **not** like being a real health/social care professional.						
9	If a senior colleague instructed me to treat people with a mental illness in a disrespectful manner, I would **not** follow their instructions.						
10	I feel as comfortable talking to a person with a mental illness as I do talking to a person with a physical illness.						
11	It is important that any health/social care professional supporting a person with a mental illness also ensures that their physical health is assessed.						
12	The public does **not** need to be protected from people with a severe mental illness.						
13	If a person with a mental illness complained of physical symptoms (such as chest pain) I would attribute it to their mental illness.						
14	General practitioners should **not** be expected to complete a thorough assessment for people with psychiatric symptoms because they can be referred to a psychiatrist.						
15	I would use the terms 'crazy', 'nutter', 'mad' etc. to describe to colleagues people with a mental illness who I have seen in my work.						
16	If a colleague told me they had a mental illness, I would still want to work with them.						