USAID FROM THE AMERICAN PEOPLE | VICTIMS OF TORTURE PROGRAM

NIMH National Institute of Mental Health

JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH

Implementation Evaluation in Zambia: A mixed methods approach

Protecting Health, Saving Lives—*Millions at a Time*

Acknowledgements

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  - IRI Implementation Science Fellowship (Murray, Beidas & Dorsey)

Global mental health treatment GAP

- MH disorders account for approximately 1/3 of years lived with disability (WHO, 2008).
- Depression 3rd on global burden of disease

- Despite this – 90% of those in need do not receive treatment.

Treatment Gap: Children

For each child with need…

.16% receive treatment

Saraceno et al., 2007

JHU AMHR Approach

To provide a single logical approach to the measurement and evaluation needs of programs, to result in effective and accessible services

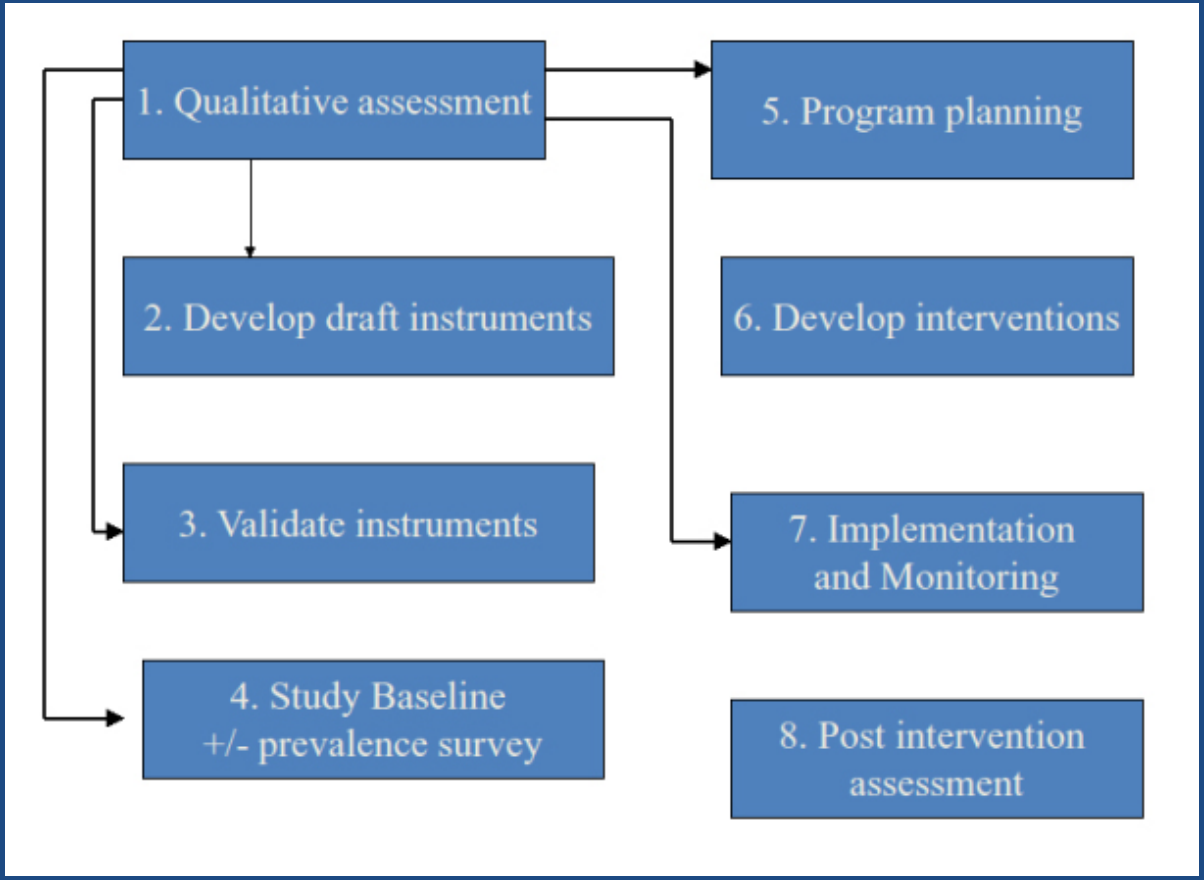
DIME process

- Design
- Implementation
- Monitoring
- Evaluation

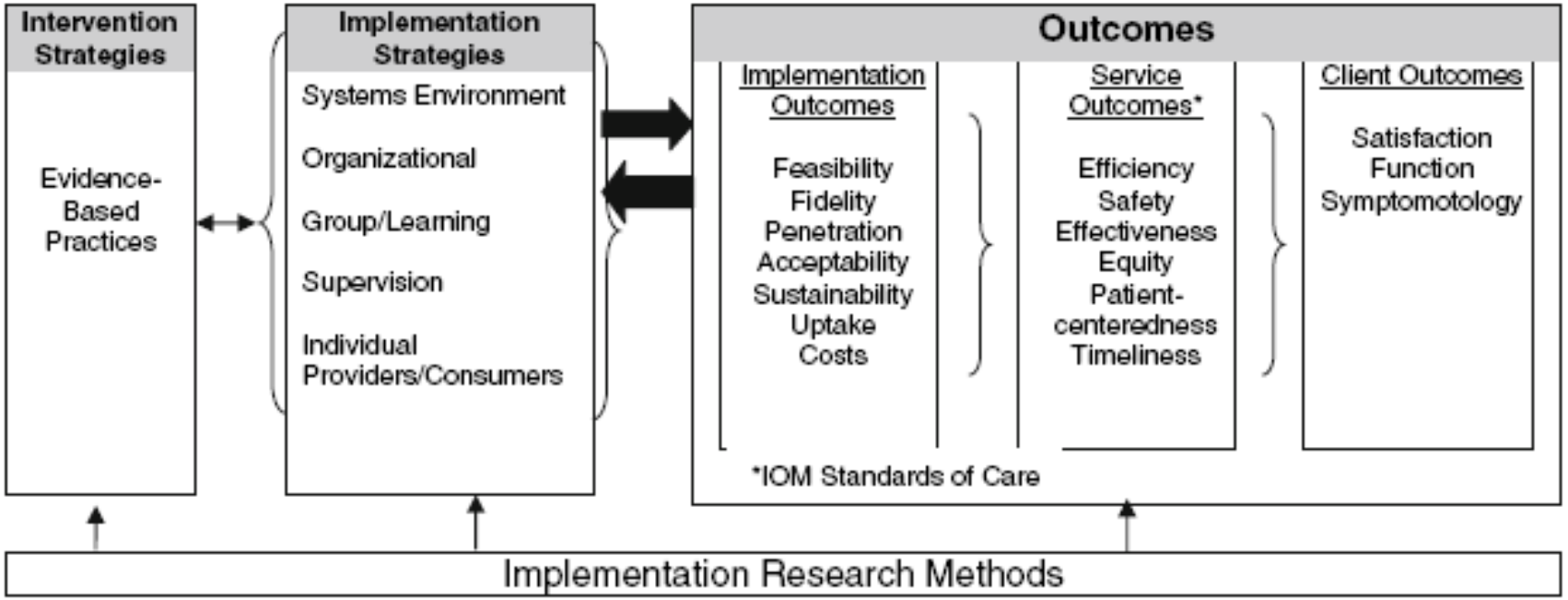
- **Uses empirically

Based assessments

And treatment



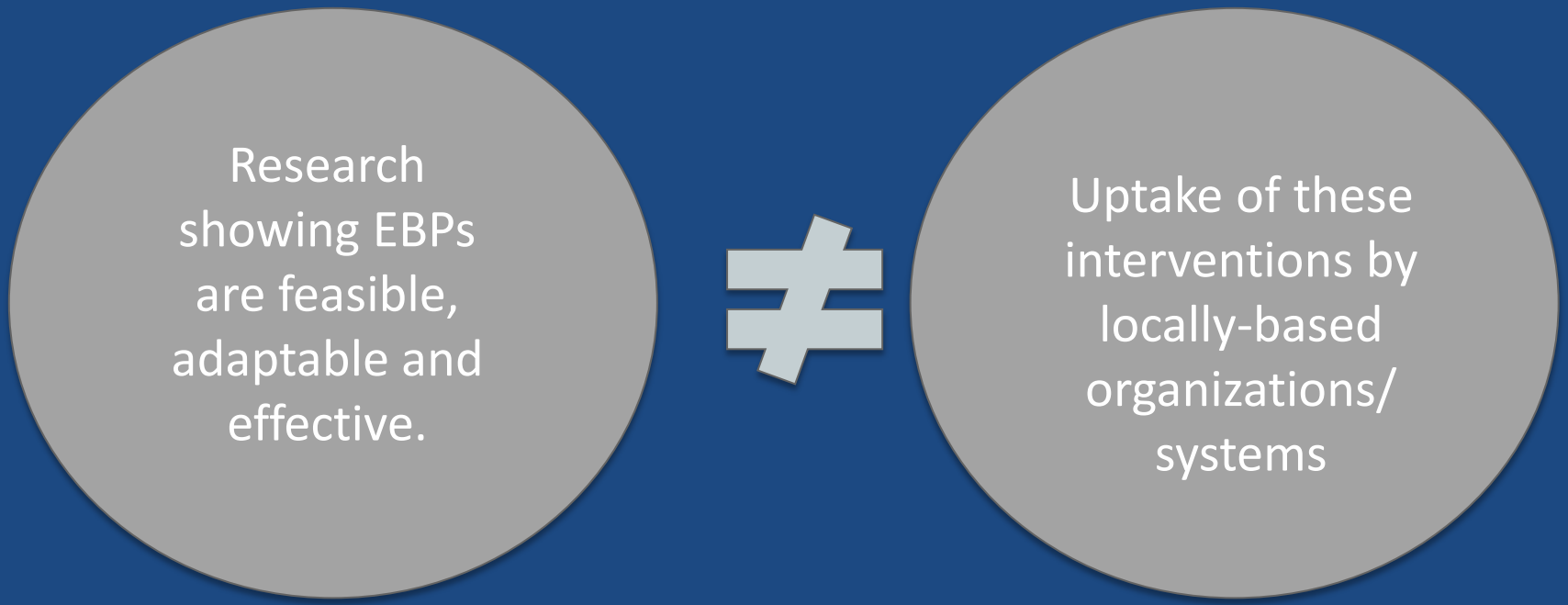
One Focus of Research: IMPLEMENTATION



Proctor et al., 2009

Implementation Research of MH in Low-Resource countries

- "Embryonic" to that of the West (Thornicroft et al., 2009)



Important to examine and learn from Implementation processes

Zambia


ZAMBIA
Lusaka
Kafue
Kabwe
Ndola
Kitwe
Mufulira
Chingola
Chililabombwe
Solwezi
Mwinilunga
Mwafwe R.
Zambeze R.
Angola
Zambezi
Kabompo R.
Lunga R.
Dongwe R.
Luswishi R.
Luanshya
Kapiri Mposhi
Lunsemfwa R.
Petauke
Chipata
Serenje
Mansa
Luapula R.
Lake Bangweulu
Chambeshi R.
Kasama
Mpulungu
Mbala
Lufuba R.
Mporokoso
Nchelenge
Kalungwishi R.
Mumpolokoso
Lake Tanganyika
Lake Mweru
Lake Upemba
Luvua R.
Lomami R.
Lulua R.
Kasai R.
Lubilash R.
Dem. Rep. of Congo
Lufira R.
Lubudi R.
Lualaba R.
Luangwa R.
Mpika
Lundazi
Tanzan
Mozambiqu
Feira
Chirundu
Mazabuka
Monze
Namwala
Mongu
Kaoma
Mumbwa
Kalabo
Senanga
Kataba
Cuando R.
Mulobezi
Machili R.
Choma
Kalomo
Kalomo R.
Kabanga
Lake Kariba
Manyame R.
Mazowe R.
Sesheke
Luiana R.
Kazungula
Livingstone
Namibia
Caprivi Strip
Sanyati R.
Sengwa R.
Harare
Zimbabwe
Shangani R.
Save R.
Pungoè R.
Okavango Delta
Botswana
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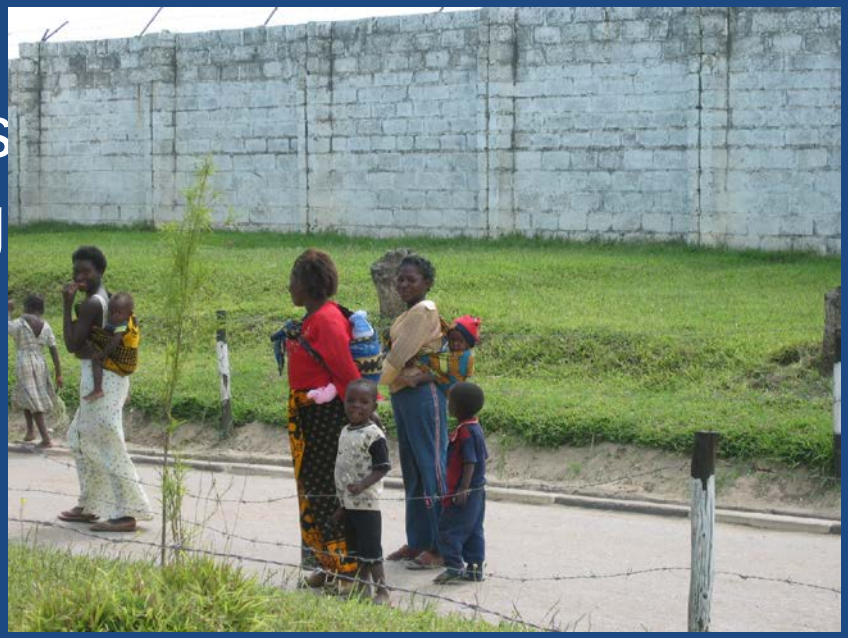
Brief Background

- 14.8 million youth orphaned by AIDS in sub-Saharan Africa
- Zambia is one of most affected – 801,000 AIDS-related orphans.

- OVC experience high rates stressors/traumas – leading MH problems, HIV risk behaviors, and problems in functioning.



History of Project

One Stop Centre for Sexual Abuse: PEP, Legal, Psychosocial, Medical Exams

- Qualitative study on local needs (Murray et al., 2006)
  - Results showed high reports of sexual abuse, physical abuse, DV and neglect
  - All trauma was closely linked to HIV and HIV risk behaviors
- Quantitative validation of Mental Health Assessment Tools
  - PTSD-RI measure showed good reliability and validity (Murray et al., 2011)
  - Shame measure (8 items) showed good reliability and validity

Choosing an Intervention

- Community-based Collaborative process with local stakeholders
- Based on multiple “data points”
  1. Results of local qualitative data
  2. Review of existing local services
  3. Review of existing local resources (e.g., staffing)
  4. Review of Evidence-Base

University Teaching Hospital

Ministry of Health

Treatment

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (www.musc.edu/tfcbt)
  - Evidence-based for traumatized children (4-18years)
  - 12-16 one-hour sessions (on average)
  - Components:
    - Psychoeducation
    - Relaxation
    - Affective Regulation
    - Cognitive Coping
    - Trauma Narrative
    - In-Vivo Exposure
    - Cognitive Restructuring
    - Con-joint Session
    - Enhancing Safety Skills

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IMPLEMENTATION STRATEGIES UTILIZED

1. Task – Shifting
2. Apprenticeship Model of Training and Supervision
3. Implementation with safety for suicide

IMPLEMENTATION STRATEGY

"Task Shifting/Sharing Approach"

Lay Counselors—
Little or No Mental Health Training

Apprenticeship Model: Zambia

1st In Person Training (10 days):

Adaptation

Practice Groups: Practice before seeing clients.

Leaders learn to "coach".

Adaptation

Supervision Groups:
Ongoing Adaptation

First Client: Focus on ONE client

Study Clients: Staggered

Ongoing weekly calls with trainers

Murray et al. International Journal of Mental Health Systems 2011, 5:30
http://www.ijmhs.com/content/5/1/30

INTERNATIONAL JOURNAL OF MENTAL HEALTH SYSTEMS

CASE STUDY Open Access

Building capacity in mental health interventions in low resource countries: an apprenticeship model for training local providers

Laura K Murray[1*], Shannon Dorsey[2], Paul Bolton[1], Mark JD Jordans[3], Atif Rahman[4], Judith Bass[5] and Helena Verdeli[6]

Abstract

Background: Recent global mental health research suggests that mental health interventions can be adapted for use across cultures and in low resource environments. As evidence for the feasibility and effectiveness of certain specific interventions begins to accumulate, guidelines are needed for how to train, supervise, and ideally sustain mental health treatment delivery by local providers in low- and middle-income countries (LMIC).

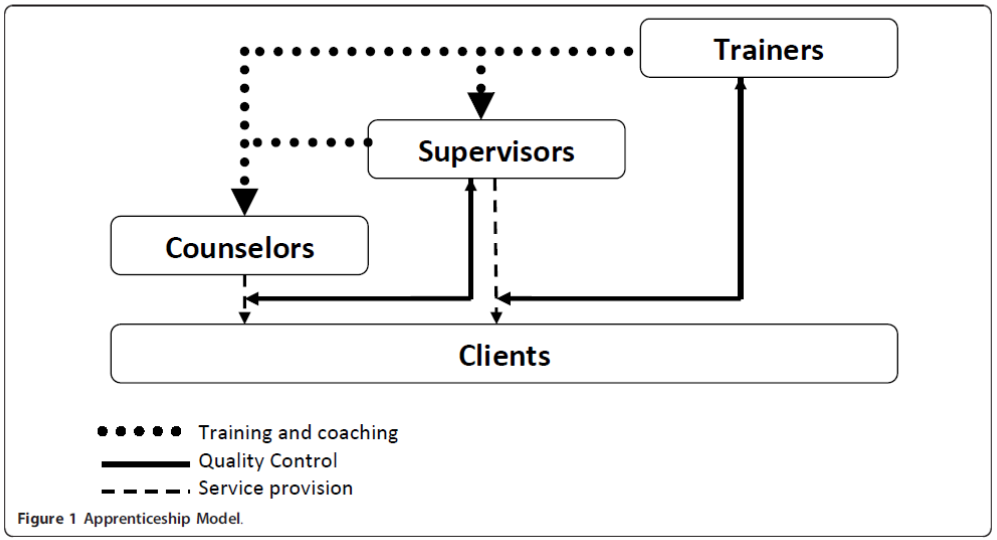

Figure 1 Apprenticeship Model.

Implementation Strategy: Safety

- No MH SYSTEMS
- Individualized for setting
- Appropriate for lay counselors

Safety protocol

Initial responses by the counselor

- The counselor finishes the checklist of symptoms form, and the follow-up form. Asks questions directly to the client with suicidal or homicidal ideation, who is victim of domestic violence or with psychosis or is abusing substances.
  - ***If the client indicates suicidal ideas….***

Further evaluate:

a. "Have you ever tried to end your life?"

b. "Are you thinking about ending your life?"

c. "Do you have a plan to end your life?"

d. "Do you have access to that plan, in other words, do you have the means to execute your plan?"

If the client answers YES to any of these questions, please move on to the following steps:-

- Say to the client: "Can we agree together that if you have thoughts of killing yourself, you will speak to me personally before carrying out a plan to harm yourself?" "How can we be sure that you be able to speak with me?"
- If the person says "yes" or "I don't know," to the questions c and d, Say: "What I am hearing is that you are in a lot of pain right now and thinking of ending your life, so I want you to come with me to SHARPZ offices right now and get some help to feel better right away. I will make sure you get there safely. Is there a family member or someone I can call to go with you?" Or tell the person you will go with them yourself.
- Arrange for the person to be accompanied to SHARPZ, and call ahead to tell Sr Roda that you are coming.
- If the person refuses, then ask the person to wait there with someone while you call Sr. Roda in another room to report that the person has threatened suicide. Ask Sr Roda to come and accompany the person to the SHARPZ offices.

Talk to your supervisor while the client is still working with you. Decide, or agree on a plan BEFORE the client leaves.

Study 1: Feasibility Study of TF-CBT

- 1st group of counselors trained in Zambia
- Counselors volunteered their time (not attached to ONE organization)
- Referrals from the One stop Centre for Sexual Abuse
- Children aged 6-18 years
- Implementation Outcomes
  - Audio recording of sessions coded for fidelity to model
  - Fidelity tracking forms
  - Monitoring forms to track cultural adaptations (what, HOW implemented)
  - Qualitative interviews counselor and client perspectives

Study 2: Evaluation of TF-CBT

- Partnership with Catholic Relief Services
- 7 centers (Lusaka and Kabwe)
- Focused on areas highly affected by HIV
- Inclusion:
  - Experience of at least one traumatic event
  - Trauma symptomatology (>39 on PTSD-RI)

Funder = USAID; Murray et al., in press

Study 2: Monitoring and Evaluation

- Symptom Reduction:
  - PTSD- RI
  - Shame measure
- Clinical Implementation:
  - Fidelity tracking sheets
  - Flexibility tracking sheets
  - Monitoring symptoms of client
- Supervision monitoring
  - Date, component, time spent, notes….etc.

TF-CBT Brief Practice Checklist

Child ID #:_____ Counselor ID # _____ *Write Y

Rate yourself on each grey box: 1 –Did only 1-3 steps; 2-Missed about half the steps, 3=Did most steps, missed only 1-2 steps, 4=Fol

TF-CBT Treatment Component	Session #:	1	2	3	4	5
	Date:	/	/	/	/	/
Caregiver participation: Therapist met (face-to-face or via telephone) with caregiver for 15 minutes or longer.						
P: Therapist provided psycho-education (e.g., directive education about the traumatic event, normal reactions to trauma, and instills hope.)						
Made normalizing and validating statements.						
Reviewed limits of confidentiality.						
Laid out components of TF-CBT, and the length of treatment time.						
Engaged family (e.g., found out what child liked, what motivates the family, worked out problems they might have with transport…etc.)						
P: Therapist reviewed Parenting Skills (e.g., time out, selective attention, praise, reinforcement plans.)						
Assigned homework (what, when, where, how long, reminder)						
R: Therapist explained physiology of relaxation; instructed on relaxation methods						
Practiced relaxation in session						
Assigned homework (what, when, where, how long, reminder)						
A: Therapist assisted the child in accurately identifying their feelings, and various ways of regulating their emotions (e.g., imagery, thought stopping, positive self-talk.)						
Named variety of feelings (positive, negative, in youth's words)						
Linked feelings to situations						
Linked feelings to feelings in body and/or facial expressions						
Reviewed intensity of certain feelings and ways to rate their intensity						
Developed ways to talk about feelings (e.g., colors, animals, music)						
Talked about feelings related to a traumatic event						
Assigned homework (what, when, where, how long, reminder)						
C: Therapist reviewed the cognitive triangle.						
Distinguished between thoughts, feelings and actions						
Educated child on connection between thoughts, feelings and actions						
Helped the child generate alternative thoughts that are more accurate or helpful, in order to feel differently.						
Reviewed cognitive triangle related to a traumatic event.						
Assigned homework (what, when, where, how long, reminder)						

Study 1: Implementation Outcomes

- Qualitative questions:
  - 1) Tell me about your experience with TF-CBT;
  - 2) Tell me about the challenges of the TF-CBT program;
  - 3) What did you like about the program?;
  - 4) What did you dislike about the program?;
  - 5) Describe any changes in the clients/family/child/self since starting the treatment;
  - 6) Tell me about any recommendations for the program.
- Interviewers used open ended, non-leading probes.
- Questions designed to be simple and broad

Study 1: Qualitative Implementation Outcomes

Caregivers/Children:

17 (81%) of the children; 15 (71%) of the caregivers who completed TF-CBT

- Decrease in symptoms, increase in functioning (clinical significance)
- Improvement in family relationships, enhanced communication
- Increase in safety (despite perpetrator remaining in home due to survival
- Should continue and expand

She has changed like I said she now does not drink alcohol, does household chores, she plays with friends and does sleep around with men

"I found the program to be helpful to the behavior of the youths. It changes bad behavior such as sexual behavior of boys and girls, drinking alcohol at a tender age…."

When I was raped I used to cry when I think about it. I would blame myself that it is because of me that's why I was raped. But due to the program and the counselor I should not be blaming myself about what happened to me because it was not my fault

Qualitative Implementation Outcomes

Counselors: Nineteen counselors were interviewed (12 F);

- TF-CBT culturally appropriate – modifications more around implementation (games, analogies)
- Used TF-CBT in their own lives
- Liked the structure AND flexibility
- Liked inclusion of families
- Should continue and expand

"On the role plays you know the teaching we are used to is lecture type, but what the trainer did was to enhance the role playing"

- Challenges – (Both Counselors and Families)
- Mainly organizational/systemic
  - Transportation, no location for services
  - High drop out due to moving and lack of understanding – need to improve engagement strategies

Study 2: Sample Demographics

Table 2: Sample Demographics

	Treatment completers with pre-post assessments (N=58)
SEX	
Male	50 (29)
Female	50 (29)
AGE (years)	
5	1.7 (1)
6-11	25.9 (15)
>12	72.4 (42)
EDUCATION STATUS	
Currently in school	84.5 (49)
Not in school	15.5 (9)
ORPHAN STATUS	
Non-orphan	20.7 (12)
Single orphan	44.8 (26)
Double orphan	34.5 (20)

*Note: some percentages do not add to 100% because of missing data

Study 2: Clinical Outcomes

Table 3. Average scores of PTSD scale (58 items) among children and adolescents completing pre and post-treatment assessments (N=58).

	Pre-treatment score		Post-treatment score		
N	Mean (SD)	Range	Mean (SD)	Range	p-value
Total (58)	67.7 (21.9)	36-120	27.6 (25.2)	6-131	<0.0001
Males (29)	69.3 (20.1)	38-120	27.5 (21.5)	9-100	<0.0001
Females (29)	66.1 (23.7)	36-117	27.8 (28.6)	6-131	<0.0001

*p-value for the difference in pre and post mean scores

Table 4. Average Shame scale scores among children and adolescents completing pre a post-treatment assessments (N=58).

	Pre-treatment assessment		Post-treatment assessment		
	Mean (SD)	Range	Mean (SD)	Range	p-value*
Total (58)	8.5 (8.1)	0-29	2.2 (5.4)	0-27	<0.0001
Males (29)	9 (6.9)	0-23	1.5 (5.4)	0-27	0.0001
Females (29)	8.1 (9.2)	0-29	2.8 (5.4)	0-23	0.01

*p-value for the difference in mean score comparing pre and post measures

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1) Zambian Perspective on Implementation
2) Data on Mixed-Method Implementation Study

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