



DESIGN, IMPLEMENTATION, MONITORING, AND
EVALUATION OF CROSS-CULTURAL HIV-RELATED MENTAL
HEALTH AND PSYCHOSOCIAL ASSISTANCE PROGRAMS:
A USER'S MANUAL FOR RESEARCHERS AND PROGRAM
IMPLEMENTERS
(ADULT VERSION)

MODULE 5:
INTERVENTION SELECTION, ADAPTATION, AND IMPLEMENTATION

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ACRONYMS

AIDS	Acquired immunodeficiency syndrome
AMHR	Applied Mental Health Research
ART	Antiretroviral therapy
BA	Behavioral activation
CBT	Cognitive Behavior Therapy
CD4	T-helper cell targeted by HIV
CDC	Centers for Disease Control
CETA	Common Elements Treatment Approach
CPT	Cognitive Processing Therapy
CSA	Child sexual abuse
DHS	Demographic health survey
DIME	Design, implementation, monitoring and evaluation
DRC	Democratic Republic of Congo
EBT	Evidence Based Treatment
FG	Focus Group
FL	Free List
GBV	Gender Based Violence
HIN	Health information network
HIV	Human immunodeficiency virus
IDU	Injecting drug user
IPT	Interpersonal Therapy for Depression
IRB	Institutional Review Board
JHU	Johns Hopkins University
KAP	Knowledge, attitudes and practices
KI	Key Informant
LGBT	Lesbian, gay, bisexual, transgender
LMIC	Low and middle income countries
MEMS	Medication Event Monitoring System
MI	Motivational interviewing
MOH	Ministry of Health
MSM	Men who have sex with men
NGO	Non-governmental organizations
OVC	Orphans and vulnerable children
PE	Prolonged Exposure
PLWHA	People living with HIV/AIDS
POFO	Positive Outcome for Orphans Study

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PPS	Probability proportional to size
PRA	Participatory rural appraisal
PTSD	Post traumatic stress disorder
R2P	Research to Prevention
RCT	Randomized Controlled Trial
REC	Research Ethics Committee
SEARCH	Supporting Evaluation and Research to Combat HIV/AIDS
SES	Social economic status
SMS	Short Message Service
SOW	Scope of Work
SRP	Stress related response
STI	Sexually transmitted infections
SW	Sex worker
USAID	United States Agency for International Development
TFCBT	Trauma Focused Cognitive Behavior Therapy
VCT	Voluntary counseling and testing
VOT	Victims of Torture Program
WHO	World Health Organization

INTRODUCTION TO THE MANUAL

The Manual for Design, Implementation, Monitoring, and Evaluation of Cross-Cultural HIV-Related Mental Health and Psychosocial Assistance Programs: A User's Manual for Researchers and Program Implementers has been written to assist researchers and organizations developing and implementing programs in HIV affected populations to 1) identify and measure the impact and prevalence of mental health and psychosocial problems in the populations they seek to serve; 2) to develop or adapt appropriate interventions to address these problems; and 3) to measure the impact of these interventions. The Manual consists of 6 modules. Collectively, the modules describe a process of program **d**esign, **i**mplementation, **m**onitoring, and **e**valuation (DIME) that has been developed and used by the authors since 2000. The modules may be used in sequence, to follow the life of a project, or as stand-alone units to address a specific project need.

- **Module 1** describes procedures for qualitative assessment to identify priority problems from the local perspective.
- **Module 2** provides guidance in the development and validation of tools to measure these priority problems.
- **Module 3** describes population-based assessments to gauge prevalence and severity of the priority problems using the instrument developed in Module 2.
- **Module 4** describes a process for overall design of an intervention program to address the priority problems, including design of program monitoring and evaluation.
- **Module 5** outlines the selection, adaptation, and implementation of interventions.
- **Module 6** describes procedures for assessing intervention impacts.

Definition Box

Intervention(s): Service(s)/activity(ies) directly benefitting the client

Program: The intervention(s) and all ancillary activities necessary to support the intervention(s): logistics, finance monitoring and evaluation, etc.

LAYOUT OF THE MANUAL

Modules are presented in narrative form, with extensive use of subheadings. With the exception of text boxes, each section and each paragraph is meant to be read sequentially. Additional material that is useful as examples of concepts or expansion on subjects discussed in the text has been included in text boxes. Examples of study materials which may be adapted for use in an actual study are placed separately as appendices.



This symbol indicates that what follows is a critical requirement or constraint.

INTENDED USERS

This manual is primarily intended for researchers and groups responsible for mental health and psychosocial interventions for HIV affected populations, such as government providers and non-governmental organizations (NGOs).

The methods described in each module are intended to be within the typical budget, resources, and time constraints of organizations that normally focus on implementation rather than data collection. The approach is designed to be used in a limited area among a population with a homogenous language, culture, and similar circumstances. In areas containing populations with a variety of languages, cultures, and environments, the approach described in this manual should be used separately with each group. For this reason, the authors have focused on developing a process that is rapid and relatively inexpensive.

This is meant as a ‘user’ manual rather than a training manual. It is intended for use in the field by those who have previously received field-based training in its methods (or have similar training experience) and are now leading teams in their own sites. Such persons should either have some prior experience in qualitative and quantitative data collection methods (depending on the module being used) or lead teams with persons who have such experience.



THIS MANUAL IS NOT APPROPRIATE FOR ‘OFF THE SHELF’ USE WITHOUT PRIOR ON-THE-GROUND TRAINING OR SIMILAR EXPERIENCE. THOUGH WHAT IS PRESENTED HERE REPRESENTS WHAT THE AUTHORS HAVE FOUND TO WORK WELL TO DATE, FIELD SETTINGS VARY. USERS OF THE METHODS PRESENTED HERE NEED FIELD EXPERIENCE TO INTERPRET AND ADAPT THESE METHODS TO DIFFERENT SITUATIONS.

The authors have found that even with prior experience in data collection, individuals and organizations attempting to use the methods described here for the first time will have many important questions during the process that cannot be addressed in the manual itself.

Answering these questions as they arise—and developing the skills required for using the approaches in different settings—is best done in a field-based training situation, with direct instruction in the course of supervised use of this approach among a local population. Even after training, organizations using this approach may want guidance and ad hoc assistance.

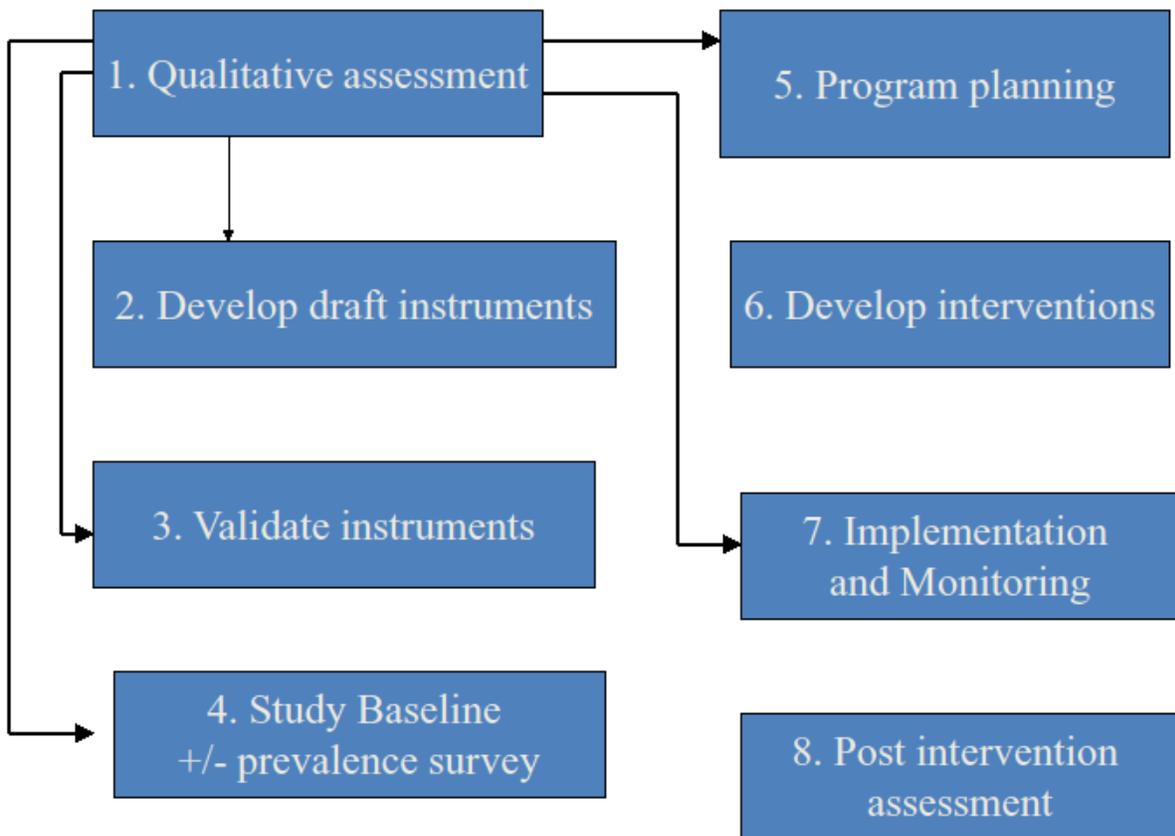
The authors would be pleased to discuss training and technical assistance with any interested organization or individual. **For this particular module focused on mental health interventions, formal clinical training in mental health (e.g., a clinical psychologist) is required so readers are encouraged to request technical assistance.**

The manual does not contain detailed descriptions of commonly done research activities, such as quantitative interviewing, partly due to the expectation that organizations have persons experienced in these activities and partly because there are many other manuals available that describe these activities. Instead, the manual focuses on research activities or methods that are different from commonly used approaches. For example, Module 1 contains much more information on interviewing than the other modules because the qualitative methods used in Module 1 are less commonly used than quantitative methods.

THE DIME MODEL

The diagram below outlines the steps of the **d**esign, **i**mplementation, **m**onitoring, and **e**valuation (**DIME**) process described in this manual. Qualitative data collection (Module 1) is the first step in the process and the diagram indicates which of the subsequent steps (2-8) are informed by qualitative data. A brief description of each step follows.

Figure 1: Steps of the DIME Process



1. Qualitative Assessment to identify and describe priority HIV-related mental health and psychosocial problems: (Module 1)

Variations in culture and environment affect how people understand the mental health and psychosocial problems related to HIV. By *understand*, we mean how these problems are described, how they are prioritized, their perceived causes, and how people currently cope with them. This information is vital in selecting problems that are important to local people, accurately communicating with them about these problems, and identifying interventions that are likely to be acceptable and feasible for local people and therefore effective and sustainable.

2. Develop draft instruments to assess priority HIV-related mental health and psychosocial problems: (Module 2)

Having decided which problems the program will address, we then draft quantitative assessment instruments to address these problems. These instruments have various uses, depending on the program: conducting community or clinic-based surveys; screening persons for inclusion in a specific intervention program (for programs where not all people will be served); identifying those with severe problems who may need specialized services including referral; and monitoring and evaluating the effectiveness of services by tracking changes in severity and/or prevalence of the problems identified.

The process of drafting appropriate instruments includes reviewing the published literature for measures that have already been developed for the selected problems and comparing available measures with the qualitative data to select the measure or measures that best match how local people describe the problem. These measures are then adapted to better fit local concepts.

Drafting includes translation. Terminology suggested by translators often differs from that used by local populations, particularly by poor and uneducated people. Therefore, qualitative data is preferred as the best source for translating key concepts. Employing the words and phrases that local people actually use (as identified in the qualitative data) will improve the clarity of the instruments, thereby improving their acceptability and accuracy. The translators are instructed to utilize the qualitative data to directly translate all signs, symptoms, problems and topics in the instruments that were mentioned by interviewees in the qualitative study using the same words found in the qualitative data. Only where concepts are not mentioned in the qualitative data do the translators themselves choose the appropriate terms.

3. Validate draft instrument(s): (Module 2)

Once translated, the draft instrument(s) must be piloted and tested for ease of use, clarity, acceptance (both by interviewers and interviewees), and accuracy in the field. Accuracy refers to reliability and validity, which in turn refer to whether the instrument gives the same result with repeated use or use by different interviewers (reliability), and whether it measures what it is supposed to measure (validity). Testing involves interviews with members of the target population using the assessment instrument and analyzing the results.

Validity and reliability testing are particularly important with psychosocial and mental health measures, where assessment is based on the interview alone (i.e., there are no laboratory or other tests). A tool that is not accurate can lead to inappropriate inclusion/exclusion of intervention participants and also provide incorrect conclusions about need and program impact.

4. Study baseline +/-prevalence surveys: (Module 3)

Both baseline assessments and prevalence surveys are based on the instruments developed in steps 2 and 3. Baseline assessments refer to interviews done using the instrument in order to establish the eligibility of individuals for participation in an intervention program. Prevalence surveys perform the same function at the population level to measure the percentage and numbers of eligible (i.e., affected) persons in the population as well as giving some indication about the variation in severity of problems at the population level.

5. Overall program planning: (Module 4)

This includes planning the program goals and objectives and the strategy and the type of intervention(s) for achieving these. It also includes the development of process and impact indicators and the overall program work plan.

6. Develop interventions to address the identified HIV-related mental health and psychosocial problems: (Module 5)

The qualitative data on the perceived causes of problems and how those affected cope with the problems are critical to intervention design. Interventions need to address the perceived causes of priority problems (or explain why they do not) in order to make sense and therefore inspire both confidence and cooperation. The more closely interventions can match the ways in which people currently think about and address the

selected problems, the more likely the interventions are to be acceptable to them. Where there are differences, they need to be explained and agreed upon by the local population. For example, using counseling to address a problem that is thought to be caused by poverty will take some explaining.

7. Implementation and monitoring: (Modules 4 and 5)

This refers to the implementation and monitoring of the intervention and the overall program. It includes procedures for iterative changes in the planned activities as needed, according to the monitoring data.

8. Post intervention assessment: (Module 6)

Upon completion of the intervention, participants are interviewed using qualitative methods to identify potentially important unexpected impacts of the program. They are also re-interviewed using the baseline quantitative instrument, to measure changes in the outcome indicators such as problem severity and function. Where possible, the amount of change is compared with the amount of change experienced by a control group, to determine the true program impact.

MODULE 5:
INTERVENTION SELECTION, ADAPTATION, AND
IMPLEMENTATION

A. INTRODUCTION TO MODULE 5

A.1 PURPOSE OF MODULE

The purpose of this Module is to outline the process for selecting, adapting and implementing a clinical mental health intervention, with specific reference to HIV-affected populations. It is important to note that mental health intervention selection, adaptation and implementation vary greatly across setting and populations. We have attempted to outline decision points that could be flexible based on different circumstances within a program.

A.2 BACKGROUND

In their 2010 global report UNAIDS estimated that over 33.3 million people were infected by HIV and AIDS of which 51% were women and 2.5 million of whom were children (UNAIDS, 2010). The HIV/AIDS epidemic also produced another 15 million orphans and vulnerable children (OVC) with 23 million predicted in 2020 (UNAIDS, 2010; USAID, 2009). Research shows that HIV-infected and –affected populations experience high rates of stressors and trauma affecting behavior including HIV risk behavior, mental health, function, relationships, and substance use (UNICEF, 2006; Miller et al., 2006; Andrews et al., 2006; Nyambedha et al., 2003; Atwnie et al., 2005; Cluver & Gardner, 2007; Lester et al., 2006; Murray et al., 2010; Whetten et al., 2009; Whetten et al., 2008a-b). To create a better future for populations affected by HIV, it is important to focus on addressing some of these problems to aid in quality of life and help mitigate the spread of HIV (i.e., particularly HIV risk behaviors) (Sikkema et al., 2010; Fisher & Smith, 2009; Schenk, 2009).

Populations affected by HIV have been subjected to the trauma and stresses of parental loss and/or other HIV-related problems. The latter are often repeated and severe: The Positive Outcomes for Orphans Study (POFO) found that over 90% of orphans or abandoned children experienced one or more additional traumatic events and over 40% experienced at least two (Whetten et al., in press). The majority had been physically or sexually abused. In a preliminary study, 99.7% of randomly sampled Zambian OVC reported at least 1 traumatic event and many had 6 or more (Murray et al., 2010). OVC are more vulnerable to child sexual abuse (CSA) which is strongly associated with HIV in both child and adult populations (Senn & Carry, 2010; Senn et al., 2008; Greenberg, 2001; Koenig et al., 2004). As an example, one study found that compared to adults who were not sexually abused, women who experienced chronic sexual abuse in early childhood exhibited a 7-fold increase in HIV risk behaviors in adulthood (Bensley et al., 2000). In the same study it was found that men who were sexually abused in childhood exhibited an 8-fold increase in HIV risk behaviors. In a qualitative study in Zambia, HIV-affected women mentioned child sexual abuse, domestic violence, and drinking as major problems

closely connected to HIV. Many HIV-affected populations experience chronic AIDS illness of family members including having to care for a dying spouse or parent, major life changes with a family member's death, separation from siblings, child labor to provide extra income, and child abuse (Miller et al., 2006; Whitten et al., in press). Other traumas and stresses include lack of food security, reduced access to healthcare and other services, poverty, reduced access to school, lack of adult care, unstable living situations, loss of social support, and stigma, prejudice and/or alienation associated with AIDS (Miller et al., 2006; Adnrew et al., 2006; Atwine et al., 2005; Case et al., 2003; Kamali et al., 1996; Muller & Abbas, 1990; William et al., 2008; St Lawrence et al., 1994; Culver et al., 2009; Whetten et al., 2008a; Culver et al., 2008; Nyamukapa, 2010). **Psychosocial well-being is compromised by these pervasive stressors and traumas.**

HIV-affected populations have many stress-related problems (SRP) (Atwine et al., 2005; Cluver & Gardner, 2007; Cluver et al., 2008; Nyamukapa et al., 2010; Oburu, 2005; Thompson et al., 1998; WHO, 2008). In 2008 the WHO reported that prevalence of mental health illness was higher in those infected by HIV than in the general population. Specifically, rates of depression in low and high resource countries have been found to be significantly higher in the HIV infected population. It has been estimated that approximately 60% of people living with HIV and AIDS suffer from major depression and that they are two times more likely to have major depression than HIV negative populations (Treisman et al, 2001; Ciesla & Roberts, 2001; Warren & Stern, 1995; Treisman et al., 1994 Lyketsos et al., 1994; Atkinson et al., 1988; Perkins et al., 1994). Trauma and chronic stress increase biologic predisposition to drug and alcohol use, and risky sexual activity (Gordon, 2002; Palermon & Peterman, 2009; Adinoff, 2007; Birdthistle et al., 2008).

There are few data on effective mental health interventions for HIV/AIDS affected populations in low- and middle-income countries (LMIC) (Schenk, 2009; USAID, 2009). HIV-related programs often focus on: 1) income-assistance (e.g., educational support, vocational training or other income-related skills); 2) food aid; 3) HIV/AIDS prevention, and/or treatment (e.g., HIV education and anti-retroviral therapy); or 4) psychosocial (e.g., support groups and/or home visits incorporating psychosocial support) (OVC, 2010; Williams et al., 2008; REPSSI, 2010). A recent review concluded that psychosocial programs only slightly improve some outcomes (e.g., will writing, HIV status disclosure, perceived support) but all studies have serious limitations (Schenk, 2009; USAID, 2009). The literature is clear that HIV-affected populations would benefit from mental health interventions.

The lack of mental health programs for HIV-affected populations may, in part, be due to lack of knowledge about mental health interventions, and how to select and implement them. It may also be due to the limited resources LMIC have by way of personnel to deliver mental health

services to HIV-affected populations. This manual strives to explain some methods for training and implementation that may help with these challenges. The authors hope this manual will encourage readers to consider implementing mental health treatments to improve the quality of life of HIV affected populations.

B. METHODOLOGY

B.1 INTERVENTION SELECTION

B.1.1 DRAWING CONCLUSIONS FROM THE QUALITATIVE DATA

Qualitative data collected via research methods described in Module 1 will offer research teams or organizations a wealth of information about local perceptions of certain problems, as well as how local populations discuss and describe them. Two groups should thoroughly review the qualitative data in preparation for intervention selection. First, a local implementing partner should review the data from the perspective of someone with knowledge of the local setting, the focus of nearby service organizations, and their own organization's funding and interests. For example, the local implementing partner may recognize that substance use and abuse is a major problem found in connection with HIV in the qualitative data, but note that there is another organization actively addressing this issue.

Second, the research team reviews the qualitative data to identify the priority mental health problems in the population. It is often helpful to have a mental health professional on one of the teams so the data can be read with an eye towards the types of problems different mental health interventions can address. For example, a qualitative study may indicate that there is a problem around adults fighting in relation to HIV. A mental health professional would know that there are different interventions to use depending on whether the fighting is more similar to a domestic violence situation (e.g., hitting, verbal abuse), or whether the description resembles a communication problem (e.g., disclosure disagreements). Different programs may incorporate different team members or groups into the review in order to draw more informed conclusions.

The goal at the end of the review is to reach an understanding of which major mental health problems will need to be addressed by the intervention.

B.1.2 LITERATURE REVIEW

An important step in intervention selection is reviewing the current literature. The scientific literature (including gray literature and reports) can provide an important overview of which interventions have already been tried for certain mental health problems, and with what success. While the literature base on mental health interventions tested in LMIC with HIV-affected populations is still quite limited, there is significant research from developed countries on various interventions addressing different problems. For example, it may be difficult to find

a mental health treatment that has been tested specifically for depression among HIV-affected adults, but there is a wealth of data on interventions for depression in North America and Europe, including some that focus on HIV populations.

When reviewing the literature on different interventions, there are some characteristics that are important to note. One of the most important considerations is that the intervention is evidence-based. *Evidence-based treatments* (EBTs) are defined as psychological interventions that have been evaluated scientifically (i.e., using a randomized controlled trial {RCT}). For the most part, EBTs utilize cognitive behavioral therapy (CBT) approaches and tend to be short-term in nature (i.e., 12-20 weeks). There is significant research from developed nations indicating that EBTs are more effective for mental health problems than psychosocial programs or supportive counseling. This suggests that EBTs are a good place to begin searching for a possible intervention. Recent global mental health research suggests that specific mental health interventions can be effectively adapted for use across cultures and in low resource environments (UNAIDS, 2010; UNICEF, 2006; Miller et al., 2006; Andrews et al., 2006; Nyambedha et al., 2003; Atwine et al., 2005). For both of these reasons, examining EBTs before developing a new intervention makes sense. Another consideration is whether the intervention has been used cross-culturally, and/or shown that it can be adapted or modified. Ideally, this adaptation would have occurred among HIV population in the area in which you are working. However, it could also have occurred in a similar area, or with another HIV-affected population.

B.1.3 SELECTING POSSIBLE INTERVENTIONS

Once the qualitative data and the literature have been reviewed, the research team, local implementing partner, and local stakeholders would ideally come together to select and discuss possible interventions. In some programs there may be multiple possibilities; in others, there may just be one. A few commonly-used EBTs are highlighted in the box below and described in further detail in Appendix A.

It is sometimes possible to obtain copies of the manuals for these EBTs from the developers so that they can be reviewed. We also encourage active discussion with a developer about her/his EBT, or with a certified trainer in the therapy.

Some commonly-used EBTs (Details and specific references in Appendix A)

Cognitive Processing Therapy

Cognitive Processing Therapy (CPT) is a 12-session therapy that was originally designed to reduce Posttraumatic Stress Disorder (PTSD) in victims of rape and sexual assault ^[66]. Since this initial study, CPT has been tested and used successfully with a range of traumatic events including rape, sexual assault, domestic violence, military combat and torture.

Components Based Intervention

A Common Elements Treatment Approach (CETA) approach is based on the fact that most EBTs (most of which are cognitive behavioral) are made of similar therapeutic components (Chorpita, 2007; Chorpita & Daleiden, 2009; McHugh, Murray & Barlow, 2009). The idea is to train counselors in a range of different components that are similar across EBTs, and then teach them how to select components, put them in certain sequences and appropriate “doses” per component based on a client’s presenting problems. This approach therefore affords counselors the skills to treat at least the three most common mental health problems of trauma, depression and anxiety (and behavioral problems for youth). Treatment lasts between 10-12 sessions and is appropriate for males or females. The treatment has been used with adults as well as adapted for use with children (Murray et al., in press)

Prolonged Exposure Therapy

Prolonged Exposure (PE) Therapy for PTSD is a cognitive-behavioral treatment program for adult men and women (ages 18-65+) who have experienced single or multiple/continuous traumas and have PTSD. As developed, treatment consists of 8-15 sessions conducted once or twice weekly for 90 minutes each. The duration of treatment can be shortened or lengthened depending on the needs of the client (NREPP, 2007).

Behavioral Activation

Behavioral Activation (BA) therapy for depression is a behavioral treatment for adolescents and adults who suffer from depressive symptoms. BA focuses on helping clients understand and identify outside sources that may impact their depression and helps them then focus on changing these environmental factors. The treatment consists of 10-12 1 hour sessions with associated homework assigned at each session. As a client becomes more skilled, session length may decrease to 15-30 minutes.

Motivational Interviewing

Motivational Interviewing (MI) is a goal directed therapy that can be used for male and female adults ages 18 + who suffer from a wide range of problem behaviors. While the original concept for MI and the majority of the research with MI is related to alcohol and substance abuse, the treatment can also be used for problems associated with health promotion, medical treatment adherence and other mental health issues.

B.1.4 UNDERSTANDING INTERVENTION OPTIONS

There are a number of intervention options that accompany most mental health treatments. The following options are appropriate for consideration by implementers.

B.1.4.1 GROUP VS INDIVIDUAL FORMAT

Many EBTs have the option to be delivered either in individual or group format. Both formats have pros and cons that should be considered in the specific context or setting of the program. Individual counseling sessions are most common in developed nations. They provide the best confidentiality and focus on individual needs. Individual work necessitates coordination with only one individual and is therefore often easier logistically. Group modality offers the ability to reach and serve more clients at the same time, and maximizes the use of peer support and co-learning.

Logistically, it can be more difficult to coordinate schedules for multiple clients. In addition, for some treatments, such as trauma, group work often requires some similarities among members (e.g., all female for rape victims). This can complicate recruitment in some instances and/or delay services if programs have to wait to reach a target number of similar group members before beginning. Given the common issue of transport in low-resource countries, a group intervention may be easier if all clients are able to travel together, or may be more difficult and costly to a program if all members need to come



Case Example: Intervention Selection Process in Democratic Republic of Congo

In the Democratic Republic of Congo (Eastern), our team has worked in collaboration with International Rescue Committee, to infuse sound mental health interventions into their existing GBV programs. The population was largely women that had been raped, with a high incidence of physical complications (e.g., fistula repair) and STDs (e.g., HIV). Clearly this was a population of trauma survivors, but also a population that presented with significant depressive symptoms. A literature review was conducted on evidence-based mental health treatments (EBTs) that showed good effectiveness for trauma, and specifically rape. Two treatments had very strong evidence (e.g., multiple randomized controlled studies with various populations and significantly positive outcomes) for treating mental health symptoms in this population: Prolonged Exposure (PE: Dr. Edna Foa) and Cognitive Processing Therapy (CPT: Dr. Patricia Resick). The team also considered Interpersonal Therapy for Depression (IPT, Dr. Myrna Weissman), which had been adapted to be used with trauma populations but not yet extensively tested. The research team reviewed all the treatment manuals, and spoke to national trainers in these EBTs (approved by the developers) in the models. Following this, multiple conference calls were arranged to discuss the possible advantages and challenges with each intervention from the trainer's perspective, in collaboration with program members. In this setting of DRC, the local program partners felt it was important to run the mental health treatment in group format. Therefore, the group format was also discussed as a possibility with the treatments. Based on this process, CPT was collaboratively chosen as the intervention to test in this program.

in separately. Often a group would not start without all its members, so transport issues can be a significant problem.

Confidentiality is an issue of great importance when choosing between individual and group formats with HIV-affected populations. Depending on the design of the program, some groups may be ideal if HIV patients have already disclosed their status and can use the intervention group as additional support. Clients may find additional comfort in hearing other group members who struggle with the same HIV-related issues as they do, and they may be able to help each other problem-solve. However, in some programs, clients are worried about confidentiality and others *not* knowing their HIV status, or may be specifically struggling around disclosure. In these instances, it may be more advantageous to implement an individual treatment format.

B.1.4.2 TYPE OF COUNSELOR AND SUPERVISOR

In most low-resource settings, the counselors trained in these interventions have little to no mental health training or background. It is important to keep this in mind when choosing an intervention. A team must ask questions such as: *“Is this an intervention that can be broken down into easily trainable steps? How long is the learning period estimated to be?”* It is generally easier to teach an intervention in discrete steps, rather than trying to teach abstract principles such as bonding with the client. In looking at any one intervention, planners must question how feasible for counselors and supervisors to learn the intervention methods, and consider whether the intervention has been previously taught to laypersons.

It is also important to consider the interaction between gender and culture and whether cross-gender therapy would be acceptable. This may be particularly important when dealing with HIV-affected populations, as usually some relational (e.g., marriage) or sexual (e.g., disease, sexual practices) issues will need to be discussed.

B.1.4.3 TYPE OF CLIENT

Understanding the type of clients the counselors will be helping is a critical step, and may influence certain intervention choices. For example, are the clients literate? What language(s) do they speak? Are they of a culture that seems to work better with group interactions or individual? Are the clients in an area where HIV stigma is high and needs to be considered in the intervention arrangements?



Example situation:

A program is working with an HIV-affected population of adults in a community where HIV is still highly stigmatized. In fact, the initial qualitative study showed that many people had to hide their HIV medication, and often did not tell their spouses – contributing to high prevalence of domestic violence in the homes. As a culture, emphasis is placed on social and group activities and bonding. However, the program decides to offer individual treatment given the secrecy around HIV status and the risk that word of an individual’s status would travel around the small, tight-knit community.

B.1.4.4 AMOUNT, FREQUENCY, AND DURATION OF MEETINGS

Most EBTs are short-term in nature (12-20 meetings). Scientific evidence shows that in most instances, mental health symptoms can be alleviated within this time period. Many cognitive-behavioral treatments (which constitute most EBTs) are focused on empowering the individual. The interventions promote skill-building in sessions so that the individual learns to cope with ongoing stresses and traumas. Many people do not have the time or resources to continue attending therapeutic treatments beyond this short period. This is particularly true in low-resource settings where there are demands on time that are critical to survival (e.g., time needs to be spent fetching water, selling at the market, etc.).

The frequency of meetings in most EBTs is typically once per week. This is flexible in some mental health interventions, depending on the program, setting, client needs, and counselor availability. A program will need to consider whether clients are able to travel to a session every week, or whether transport will be a problem. In some cases, the counselor may be the one travelling to and from the client’s location (e.g., home, a local church or other designated area in the community) and the program must consider how frequently this will be possible. If travel time is long (e.g., sometimes 1-2 hours in very rural places), a client or counselor may prefer to meet for a longer session rather than for 1 hour, thereby limiting the number of times she/he has to travel. Safety and/or other issues that might cause termination of the treatment (e.g., an upcoming relocation) are also factors that may contribute to considering different frequency and/or duration of sessions. For example, a client who needs to relocate for a job in 3 weeks may increase the meeting times to twice a week to complete treatment before leaving town. In our experience, this flexibility can be very helpful in engaging the client, and is often a necessity when working in LMIC.



Case Example: Scheduling Clients in Zambia

Scenario 1

Gift had been meeting his counselor Hope for an hour a week every week for therapy. At session 6 of the intervention, Gift's mother reported to Hope that they were moving out of Lusaka to the village in just over 3 weeks. Gift had had a long history of trauma and it was felt by both Gift's mother and Hope that finishing treatment would be beneficial to his health and well being. After the session, Hope met with her supervisor to discuss options given the timeline for her client's move. They agreed that the best way to ensure that Gift received the full treatment was to increase sessions to twice weekly or increase the session time to 2 hours with a break in between. In her next session, Hope presented the options to the client and his mother. Both agreed that meeting for 2 hours once a week would be best, since transport to sessions was expensive and coming and the additional travel time would cut into the time needed for packing. Over the next three weeks, Hope was able to meet with Gift and successfully complete the treatment prior to the family's move.

Scenario 2

Victor had just started the first session with his client when she informed him that she sometimes felt like ending her life by taking a bottle of ROBOS (ROBOS is a form of rat poison in Zambia). Following the high-risk protocol that the organization had in place, Victor asked the client several questions to find out more information and then phoned his supervisor in order to develop a plan. After speaking with his supervisor, Victor met with the client and her auntie. The client was able to give her word that she would be safe, and the aunt and counselor set up a plan for a safety watch. Given the safety concerns, Victor also developed a plan with the family to come more frequently—at least twice a week—until the client's suicidal ideation stabilized. Both the client and auntie agreed that they would come in again that week and would do the same the following week.

B.1.5 EXPERT CONTACTS

Experts in mental health interventions, including the developers of specific treatments, are integral in the selection process. They can provide more detailed explanations of the treatment and be able to assist program staff in thinking through some of the options above. They can also discuss the scientific evidence for a treatment, and often refer to ongoing studies that may not yet be publicly available. In addition, experts who have implemented EBTs in low-resource settings be familiar with strategies and their effectiveness in similar settings with HIV-affected populations. Finally, experts in HIV programs advising on implementing an intervention in your setting are valuable in helping to consider all the possible challenges or considerations with various interventions, formats, duration, and frequency.

B.1.6 MAKING A DECISION

Decision making via consensus is encouraged. Pulling together all the steps and information above, a multidisciplinary team should work together to decide what mental health intervention to try. The group responsible for making the decision on the intervention should include the local implementing partner's staff (e.g., program managers, clinical directors, counselors, supervisors), local experts (e.g., local psychologists, university professors, mental health specialist at the Ministry of Health etc.), other international staff at the implementing partner (e.g., directors of the NGO who are not based at the implementation site), the research team, and any other expert or stakeholder who may contribute to the discussion and decision (e.g., local NGO staff with knowledge of the community).

B.2 FEASIBILITY CONSIDERATIONS

There are several important aspects to consider prior to launching an intervention to ensure that the intervention is well planned. Areas considered important to the planning phase are listed below. Thoughtful attention to these programming areas will greatly increase the feasibility of running this study and/or program.

B.2.1 GETTING BUY-IN FROM KEY STAKEHOLDERS

Buy-in from the community and key stakeholders is one of the first steps that an organization should complete before starting an intervention. If there has not been communication between the organization and key stakeholders during the earlier stages of the DIME process, intervention plans, should be discussed with the identified stakeholders before startup. Coordinating services is particularly useful when working with an HIV-affected population. In many countries, HIV-related care is more advanced than mental health care, which is advantageous if coordination is possible (e.g., access to population already seeking services). Dedicating time to explaining the connection between mental health and HIV, as well as the mutual advantages of coordination and cooperation can help stakeholders understand the importance of coordination.

Key Stakeholders may include: Ministry of Health (MOH), Ministry of Social Welfare, HIV-focused programs in the area, other ministries related to your population (e.g., if the population of focus is children, the organization may want to meet with the Ministry of Sport, Youth and Child Development), local government, community leaders (e.g., Chiefs and Headman) or other key community members (e.g., Headmasters, Health Center Clinic Officers), other NGO's (i.e., YWCA) and partner organizations.

Buy-in from stakeholders is important on many levels as it can:

- Provide resources and referrals for areas not covered by the program (e.g., HIV testing and medication follow-up; higher level of care for suicidal cases, shelter services for victims of domestic violence, etc.).
- Ensure sustainability through integration of the program into key government level structures.
- Assist the partnering organizations in integration of the intervention into their existing services. For example, you may “attach” this mental health intervention into existing HIV service clinics.
- Help partner organizations gain a better understanding of what/how much human and material resources partners will need to successfully run the program.

Meetings with stakeholders can take place individually or as a group. If the organization chooses to meet with each stakeholder individually, the organization should follow the individual meetings with one attended by all stakeholders. This will help to coordinate services and clarify referral networks. The meeting(s) should include an overview of the intervention and study as well as address the following issues:

- Background on the qualitative study and previous steps of DIME
- Overview of intervention selection process
- Program description
- Description of how the program will benefit clients as well as other organizations
- Background on the services offered by the stakeholders and how current services are run
- Discussion of how the organizations could either implement the program into their services and/or assist/complement the efforts of the implementing organizations
- Formation of a contact/resource booklet describing all services and contact information for each stakeholder

Obtaining and maintaining buy-in does not end after these initial meetings. Once the program is running the organization should try to hold, at minimum, quarterly meetings in order to report on the progress of the program, update the resource list as well as to get input and feedback from the partners and stakeholders. (See Appendix C for example resource list.)

B.2.2 UNDERSTANDING CURRENT SERVICES

In order to integrate a new intervention into existing services (e.g., HIV), it is important to understand how the organization's existing services are operationalized. This is especially true when working with partnering/implementing organizations. There are several key components to consider when determining how to integrate an intervention into current services. These key components are discussed below.

B.2.2.1 INTAKE SYSTEMS

Most organizations already have an intake system in place, with staff designated to completing and recording intakes or initial evaluations. In order to prevent duplication, it is best to understand how this process already occurs at the organization/partner level. When integrating your mental health assessments and intervention, there may be additional training and/or resources needed. We recommend that you discuss the following questions with any partnering organization:

- What populations does the organization serve? (e.g., age, gender, HIV status)
- How does the organization identify and refer clients for services?
- Who is responsible for performing intakes/initial evaluations? What training does that person(s) have?
- What form of documentation do they use? What questions are asked on the intake sheet?
- Is the system computerized or only in paper hard copy?
- How is data stored? Is there a database?
- How does the organization track what services the client has been referred to? How does the organization know if these services have been received?
- How do cases get assigned after intake?
- What additional training would be needed for staff to perform the new tasks of intake for the study/intervention?
- What additional resources would be needed (human i.e., extra personnel or material, e.g., locked cabinets)?

B.2.2.2 MENTAL HEALTH ASSESSMENTS

We have found that while most programs operating in LMIC's have specific intake forms for medical data and general demographics, very few programs use any type of validated

assessment forms that are specifically designed for mental health. The validated measures used in your program should be outputs that the program has already developed in earlier stages of the DIME process (See Modules 1 - 4).

Before beginning any intervention, it is necessary to establish a method to measure mental health syndromes and related symptoms in order to determine which participants may need the intervention. If the organization has not yet developed and validated these measures, we strongly encourage you to do so before moving through the steps outlined in this module.

B.2.2.3 REFERRAL SYSTEMS

In most cases, clients who access services in low resource countries need more than just specific mental health interventions. They may require medical attention (e.g., HIV testing or treatment, treatment for STIs), nutritional support, economic/employment opportunities, higher-level mental health care such as inpatient hospitalization, and so on. It is often not feasible for one organization to provide all of these services. Therefore, before starting the program, the organization should consider developing a referral network with other NGO or governmental organizations in the area that provide services outside the range of the organization's scope (See Section B.2.1 "Getting Buy in from Stakeholders" for more information).



Example:

A woman comes into a Voluntary Counseling and Testing (VCT) clinic, and mentions that she never sleeps and feels very depressed. She also tests positive and needs HIV treatment. The referral list is used to also give the woman information about where she can receive mental health treatment.

B.2.2.4 STAFF AVAILABILITY

Program success is largely influenced by the ability of the organization(s) to retain staff who are capable of being trained, skilled enough to implement the intervention and have enough time to do dedicate to the project. If the organization and/or implementing partners do not have such staff, the organization may need to bring on additional human resources. Here are some questions to discuss when thinking through staff availability:

- Is there an existing organization chart that lays out current workload?
- What staff would be available to participate as assessors? Counselors? Supervisors?
- What is the background and training for each of these personnel?
- What are the current scopes of work for each of these staff members?

- What does a typical day look like for each staff member being considered for the program?
- How much time would they realistically have to dedicate to this program?
- Who would take over other tasks if tasks related to this specific program are added to their Scope of Work (SOW)?

B.2.2.5 CAPACITY FOR MONITORING

Continuous monitoring to determine the quality of work and effectiveness of services provided is key to ensuring fidelity to the intervention model. Before beginning the intervention, we recommend that each organization consider the following questions to verify that the Monitoring and Evaluation (M&E) team and proper systems are in place:

- Are there experienced M&E staff at the organization already?
- Do these staff members have time to be a part of this program?
- Are there resources to hire new staff?
- Can new staff be supervised by a higher-level program staff/officer at the organization?
- Are staff trained in qualitative and quantitative data collection methods?
- Would the team have access to computers? To database software (i.e., EPI Info, Access, SPSS, etc.)?
- What forms are currently used to monitor activities at the organization? Are there any forms used specifically to monitor indicators for Mental Health? HIV risk behaviors? Wellbeing? If there are, how often are they used? How are data currently tracked?

After gathering this information, the U.S. based trainers should provide the organization with specific monitoring forms for the intervention (e.g., case notes, supervision tracking forms) (See Appendix D). For more information on how to set up an M&E system including what information should be tracked. Please (See section B.4:” Setting up monitoring systems”).

B.2.3 OVERVIEW OF REQUIRED RESOURCES

This section of the manual reviews the essential human and material resources needed to successfully implement the intervention. We have found that organizations often need to prepare and secure additional resources before the start of the program and that short changing resources can be detrimental to the success and/or quality of the services delivered.

B.2.3.1 HUMAN RESOURCES

Successful implementation of a mental health intervention depends largely on the ability and availability of program staff. A lack of human resources can lead to problems such as staff burnout, long client wait lists, poor service delivery, poor quality work, and overall lack of sustainability for the program. Before starting an intervention, it is important to think through how the intervention fits into current staff roles/SOW and whether more human resources are needed for this program. There are five major roles in which the availability of human resources is essential to the success of this type of program: interviews/assessors, counselors, supervisors, field management team members and program management team members. When contracting partners for particular aspects of the work, it is important for the organization to ensure that the partners have planned for sufficient human resource capacity as well.

B.2.3.2 INTERVIEWERS/ASSESSORS

Interviewers/Assessors are those who will be trained in the validated mental health assessment tools (See Module 2 on Developing and Validating Mental Health Measures). Assessors can be either the counselors themselves or another party working with the program. Unlike clinical interviews, the validated mental health assessment tools require only minimal training in mental health or psychology. Assessors in previous programs have included doctors, clinical officers, traditional birth attendants, counselors, nurses, students, teachers, community health workers and volunteers from the community. As long as personnel are trained in administering the instrument and there is ongoing monitoring and supervision, almost anyone working on or with the program can become an assessor/interviewer. Most likely the organization has already decided on those who will participate in the program as assessors through the previous stages of the DIME process. Those staff selected to be assessors for the program will be trained by a team in basic mental health information, the assessment tools, interviewing methods and ethical issues.

B.2.3.3 COUNSELORS

Counselors are those responsible for providing the intervention for the selected populations. (See section B.3.1.1 Selection of Staff for more information on counselor's roles and responsibilities, as well as the selection process)

B.2.3.4 SUPERVISORS

Supervisors are responsible for providing weekly supervision on their cases to the counselors as well as ensuring fidelity to the treatment model through weekly monitoring of case notes and fidelity checklists. If selected beforehand, supervisors may also be asked to assist the U.S.-based trainers during the training. (See section B.3.1.1 “Selection of Staff” for more information on supervisor’s roles and responsibilities as well as the selection process)

B.2.3.5 FIELD MANAGEMENT TEAM

The Field Management team is often overseen by a field manager, and may consist of data collectors, a QA specialist, an M&E officer, and data review supervisors. This team is responsible for all aspects of monitoring and evaluating the program, including, but not limited to, managing local data collection, quality assurance, process monitoring, and evaluating outputs and outcome (See section B.4 for more information on the M&E systems). The M&E officer is responsible for on-going, mid-, and end-of-program evaluation activities. She/he must ensure that data for specific monitoring indicators are collected, and that day-to-day processes are working. The data review supervisors may help to confirm that all forms are complete before collection by the data collectors.

The staff within the Field Management team should be experienced in their respective tasks, such as data collection, entry, and cleaning methods, as well as data ethics, qualitative survey development, and interviewing skills. The team will be responsible for tracking, monitoring and assessing the progress, completeness, and accuracy of the assessments. Some Field Management team members may also be responsible for assisting the assessors in conducting all follow-up qualitative interviews with the participants and their families and, when needed, help with monitoring families to assure retention.

In cases where the team is not trained in these aspects of M&E, it is recommended that they receive outside training in qualitative and quantitative data collection methods, preferably from the Johns Hopkins University Applied Mental Health Research Group (AMHR). Training may include topics such as qualitative interviewing skills, research ethics, consenting clients, data safety and storage, using a specific database (i.e., EPI Info) and more. This training will vary depending on the skill set of those employed to fill this role. This should be discussed on an individual basis with the implementing organization prior to start up. Training by a specific group may be necessary because indicators and data management in mental health programs often involve different variables than traditional health programs.

B.2.3.6 PROGRAM MANAGEMENT

In our experience, interventions run more smoothly when there is an experienced program manager overseeing activities. This is especially true during the start-up of the intervention. While the program manager does not necessarily need to be full time on this one specific intervention, she/he needs to have enough time allocated to the program to oversee the daily operations of the program. Several staff already in management positions could also divide this role. However, this is not ideal. If the organization chooses to split the responsibilities across staff, very clear roles and responsibilities must be specified so that tasks are not overlooked.

The program manager is often responsible for supervising the data collection team, training staff and undergraduate assistants in data collection, organizing clinical trainings and supervision groups, and helping to submit local human subjects applications and renewals. This person(s) will conduct weekly research meetings and trouble-shoot problems that arise with data collection and/or implementation. He/she will also coordinate activities and maintain relationships with community agencies, therapists, and other stakeholders (i.e., MOH). Although it is not necessary, it is beneficial to have someone with technical experience/training in mental health interventions to assist in developing high-risk case protocols, handling of high-risk cases (i.e., suicide) and assisting with the supervision of the treatment.

B.2.3.7 OTHER HUMAN RESOURCES

In order to address all aspects of the program the organization may also have to outsource to other organizations, universities, etc., for assistance with some technical aspects. Additional support for the program will depend on the organization's current capacity to address specific issues. These include training in EBTs, skill in high-risk case monitoring, high-level abilities in M&E, proficiency in qualitative and quantitative data collection, experience in cleaning and analyzing data, and database development. Recommended workload or staff/client ratios may be helpful for each of the role types described above.

B.2.3.8 MATERIALS

In addition to the human resources needed to run the intervention, there are also several material resources that the organization should budget for before starting the program. These include equipment, transportation, and telecommunications, as well as the development, translation, and printing of all training and program-related documents. A description of each of these resources is provided below.

B.2.3.8.A EQUIPMENT

Several staff on the program will need access to a computer including the program manager, clinical supervisors, and the M&E team. Computers can be purchased specifically for the program or the organization may use computers it already owns. In either case, staff on the program should be guaranteed access throughout the duration of the program, according to the requirements of their role. The program should have access to a printer/copier in order to produce all necessary documents (e.g., assessment measures, training materials, reports, etc.). Depending on the organization's capacity to print larger jobs in-house, some printing may have to be outsourced.

B.2.3.8.B TELECOMMUNICATION

Phones

Purchasing/access to mobile phones will depend on the organization's policies. However, we recommend that essential staff (PM, Supervisors and M&E staff) have access to phones in case of emergencies or client crisis.

Talk time

Talk time allowances should be allocated to all staff on the program to ensure smooth communication and so any high-risk cases/client crises are dealt with immediately. In our experience, *talk time* is often an overlooked issue that comes up as a problem in programs. We recommend that organizations plan ahead and allocate an appropriate amount of talk time to staff members based on the following needs:

- *Program Manager*: The Program Manager is not only responsible for being in constant contact with the program staff (supervisors, counselors assessors and M&E team), but must also be able to contact outside consultants in instances of high risk cases. The person in this position must also maintain contact with all partnering organizations and stakeholders on a regular basis to provide updates, give reports on high-risk cases, and schedule meetings.
- *Supervisors*: Supervisors require a larger amount of *talk time* to enable them to communicate with counselors and problem-solve when presented with difficult cases. They must also contact counselors and/or clients in crisis situations.
- *Assessors*: Assessors are responsible for coordinating with the partners to setup initial recruitment meetings with families. They should also contact families throughout the study to ensure retention and participation in follow-up assessments.
- *Field Management Team*: Team members require *talk time* to contact assessors and partners in order to gather necessary data and to schedule and conduct qualitative interviews for the study.

- *Counselors:* Counselors require *talk time* to call families to schedule appointments for treatment. They must also follow up on participants who miss scheduled appointments, as well as Short Message Service (SMS)/text supervisors when clinical issues or crises arise in treatment.

B.2.3.8.C SUPPLIES

Office and Computer Supplies

Resources need to be set aside for all office and computer supplies including printer cartridges, paper, pens, notebooks, paperclips, files and at least one locked file cabinet in order to keep confidential records.

Therapy supplies

Counselors often have limited access to therapy supplies. Counselors will need a minimum of a ream of paper, case notes, fidelity checklists, file folders to keep case records, contact note forms, writing utensils, a bag to carry their supplies in if they are going to different clinics, and copies of the monitoring and case documentation forms.

Therapy supplies are particularly important in organizations implementing interventions for children, as well as adult populations that are illiterate. Counselors in low resource contexts will require child-friendly supplies for use in counseling sessions. Supplies for child interventions can include markers, crayons, and paper, though specific supplies for these treatments will depend on the intervention. Adults that are illiterate may require similar materials, such as utensils for drawing pictures in lieu of writing. We recommend that the organization speak to the U.S. trainers prior to purchasing therapy supplies to make sure they have everything needed.

B.2.3.8.D TRANSPORTATION

Transportation is another resource often overlooked during the set up for new interventions. The needs of each program will vary depending on how and where services are set up. For example, if the services are offered in a small refugee camp where everything is in walking distance, there will be limited transportation needs. However, when services are offered in clinics based in a larger city, families may need assistance with transport. Other programs may need funds to transport supervisors out to clinics in hard-to-reach rural areas.

Transport for Families

Some organizations may need to budget for additional transport allowances for families. These

allowances may be provided to all families during the study period, or may only be provided for families who have moved out of the program area in order to ensure program retention. Previous experiences have taught us that some communities can be highly transient. In order to ensure that families who are enrolled in the study and/or program complete the treatment as well as subsequent follow-ups, this extra allowance may be necessary. In thinking through how to best allocate transport allowances to families, we caution organizations to consider the sustainability issues involved in providing all families transport allowance all of the time.

Transportation for Program Staff

Program staff may also need a mode of transportation and/or an allowance for transport. Transportation needs will vary depending on how the program is set up. Factors to consider when budgeting for this include: (1) distances between program offices and intervention sites; (2) whether counselors are based at the sites or must travel to the sites on a weekly basis; (3) whether supervisors are based at the sites with counselors or must travel to the sites on a weekly basis; (4) how often members of the M&E team need to travel to the field for data collection; (5) how often the PM and/or other staff need to travel to conduct site visits and/or attend meetings with partners or stakeholders. In some cases organizations may already have vehicles for staff use. In other cases, this is an additional cost that should be considered.

B.2.3.9 ADDITIONAL COSTS/RESOURCES

In addition to the human and material resources listed above, there are a few other resources that the organization may consider before starting the intervention. They are described below.

B.2.3.9.A VENUE OR SPACE FOR COUNSELING SESSIONS



It is important to think through where the counselors will meet with their clients.

The venue should be a quiet, safe, and confidential place. Careful thought should be given to whether it would be advantageous to meet in the same space as the HIV services (i.e., for convenience), or if that would create challenges for confidentiality. In some cases, clients may prefer to be seen at a “general” clinic, or even at neutral places within their community (e.g., a school, a church).

B.2.3.9.B DATABASE SET UP AND MAINTENANCE

The program will need a database for data collection and storage. This will also help with data analysis. Unless there is someone on staff experienced in setting up databases, the organization should allocate funds for the initial development and setup of the database and for the

installation of the system on local computers. Extra resources may also be required for recording the items in local languages and for database maintenance. For programs with limited budgets, we would recommend using the freely available program Epi Info (<http://www.cdc.gov/EpiInfo/>) developed by the Centers for Disease Control and Prevention (CDC) rather than purchasing specific software for the database.

B.2.3.9.C TRANSLATION OF FORMS AND TRAINING MATERIALS

During the start-up phase of the intervention, several documents will be created for training sessions on the intervention and program monitoring. If the training/program is held a language other than the language of the trainers, all training materials will need to be translated ahead of time. This may include translation of power point presentations, handouts, monitoring forms, manuals, databases, etc. The organization will need to plan ahead of time in order to hire translators and review all translated documents and presentations prior to trainings.

B.2.3.9.D ALLOWANCES AND RAISES

In some instances the assessors, counselors and/or supervisors will be volunteers and/or will be required to take on these new responsibilities on top of their current jobs. Asking staff to take on these additional roles without compensating them for doing so can prove to be problematic. The organization may consider providing staff with a small stipend to cover costs related to running the program (e.g., transportation costs, materials, lunch while working in the field, etc.).

B.2.3.9.E TRAINING COSTS

Intervention trainings are typically held for 10 days. Costs associated with the training include fees transport and per diem for the trainer(s), a facility for the training, training supplies (e.g., handouts, markers, flip charts, folders, notebooks and pens), equipment for trainings (e.g., computers and projectors), lunch for the participants, and transport fees for the participants. Interpreters should also be present at all trainings (minimum of 2-3 interpreters). Additionally, trainers of different interventions may have specific needs for their training activities.

B.2.3.9.F STAKEHOLDER AND DISSEMINATION MEETINGS

The organization may also want to include additional resources for stakeholder and dissemination meetings. Such meetings are important in providing the community and stakeholders time to discuss and give input on the progress of the study, review preliminary

results, phase-out of the study, and discuss continuation of the treatment (if found effective). Costs may include monies for a facility, teas and/or lunch for participants, transport, printing of materials, and presentation supplies.

B.2.4 ORGANIZATIONAL SUPPORT

Implementation literature from the West strongly supports the importance of pre-training work with organizations and communities to identify supports for mental health treatment implementation by supervisors and counselors (Glisson & Hemmelgarn, 1998). A recent review found that successfully implemented mental health intervention programs commonly included an upfront assessment of needs and barriers to intervention implementation (McHugh & Barlow, 2010). Since implementation of mental health programs using the Apprenticeship Model (i.e., consistent supervision at multiple levels, practice monitoring) is usually novel in LMIC, organizational supports are even more critical.

The investment of an organization in supporting the implementation of MH programs is essential for success of the program during the training and post-training phases, but also greatly increases the likelihood of sustainability. Another useful strategy in this regard is to develop an organizational plan of how psychosocial counseling fits into the overall care system of the organization and/or even the greater HIV system of care in the area. Such a plan should clearly delineate who is responsible for which type of care (or parts of care) and ensure that proper methods of referral and internal collaboration are in place.

It is helpful to discuss many of the logistical details that can cause significant problems in LMIC implementation **before** the initial training on the interventions. These include transport, communication supports (e.g., for counselors: mobile phones; for supervisors, access to computers for remote communication with trainers during the post-training phase), and space/locations to provide services, among others. It may be helpful to have a program director that lives in the community and is able to have regular meetings with local partnering organizations during the pre-training phase. This will help to assure a thorough understanding of the time commitment of the training, and post-training activities.

B.3 IDENTIFYING & TRAINING COUNSELORS AND SUPERVISORS

B.3.1 OVERVIEW OF APPRENTICESHIP MODEL OF TRAINING AND SUPERVISION

An Apprenticeship Model is becoming increasingly popular for building local capacity in the field of global mental health services (Murray et al., in press). This approach is grounded in the idea that apprenticeship models that have been historically used to train people in different trades can be applied to the training of lay mental health workers (i.e., individuals with minimal or no previous mental health training and/or experience). The steps of this model include:

- *Selection of Staff*: selecting apprentice counselors and supervisors who demonstrate interest and aptitude for the profession;
- *Counselor Training*: initial training in specific intervention skills and techniques provided by expert trainers as well as continued application of knowledge “on the job” under direct supervision and coaching from supervisors;
- *Supervisor Training*: advanced training on intervention specific supervisor skills as well as application of knowledge “on the job” under direct supervision and coaching from the expert trainers;
- *Ongoing Training*: expansion of knowledge and skills with supervision and mutual problem solving by “master” or expert trainer and apprentice.

We describe the aspects of these steps below, and visual depictions of the apprenticeship models can be found in Appendix I.

B.3.1.1 SELECTION OF STAFF

B.3.1.1.A MENTAL HEALTH COUNSELOR SELECTION

One of the first stages of the Apprenticeship model involves identifying individuals who could be trained as counselors and supervisors. These individuals can be from the local community, nearby partner organizations, the implementing organization, the MOH or other health care institutions, or any combination of these. The criteria used to select counselors and supervisors will vary depending on the environment and resources. In most LMIC countries, there are limited, if any, trained mental health providers, and thus lay persons are used. This use of *laypersons* is referred to in the literature as *task shifting*.

Definition Box

Task shifting: the movement of the primary provision of mental health intervention from mental health specialists (e.g., psychiatrists, psychologists, masters-level providers) to lay counselors (i.e., no mental health training or experience). This approach was developed in response to the reality that addressing the mental health services gap requires an emphasis on a lay counselor workforce. Otherwise, given the limited number, and unequal distribution, of mental health specialists in LMIC, scaling up mental health services for population-level impact is an unrealistic goal (Kohn et al., 2004; Wang et al., 2007; WHO, 2010).

The following are indicators of aptitude and interest in selecting potential mental health counselors:

- ✓ At least a high-school equivalent education (to ensure adequate literacy)
- ✓ Strong interpersonal skills
- ✓ An interest and desire to learn how to help those with mental health disorders

In some locations, there may be individuals already identified as “counselors” in HIV-related areas such as Voluntary Counseling and Testing (VCT). The training these individuals have received often varies, but it usually provides some useful background in interpersonal communication skills about difficult subjects. In growing numbers of HIV programs in LMICs, there are psychosocial trainings offered. These programs vary, but may cover topics such as child development, family systems, communicating with children, disclosure and adherence, as well as legal/ethical issues (See summary of the Elizabeth Glaser Pediatric AIDS Foundation {EGPAF} *Psychosocial Care and Counseling for HIV Positive Children & Adolescents* Appendix B). Individuals who have already been through such a program may make ideal counselors and/or supervisors, as they have already shown evidence of the skills and interest needed for successful implementation. A thorough, objective and transparent selection process would require potential candidates to participate in an interview, a role-play activity, and a group discussion with other candidates. This will help to ensure selection of people with high potential.

Another key component of counselor selection includes consideration of available time to dedicate to the program. This includes time spent learning and apprenticing in the intervention, and then actively providing mental health services. Many potential counselors who meet the initial criteria described above may already have multiple responsibilities in their organization or community. Though these candidates may have a high socio-cultural understanding of the community, they will have to make time available to fulfill the role as a mental health counselor in addition to their other responsibilities. It is important to ensure that the individual and

her/his organization commit the time necessary for the Apprenticeship model. (See also Section B.2: “Feasibility Considerations”).

B.3.1.1.B SUPERVISOR SELECTION

Following the Apprenticeship model, local supervisors, rather than expatriates, should be identified to provide on the ground supervision of the mental health counselors (whenever possible). Supervisors who are intimately familiar with the local culture and language(s) are



Example:

In Colombia, a program was based in two very dangerous towns. The program needed to decide on how counselors should explain confidentiality and its limits, as well as how and when to ask about suicide and/or homicidal ideation. They also needed to develop a safety plan for those that were in danger. Expatriate supervisors were able to make some suggestions that seemed reasonable. However, local supervisors and counselors quickly saw that certain ideas would create danger for the client and counselor.

In Zambia, a case presented in which an HIV-positive client was engaging in very high-risk sexual behavior that was possibly putting others in the community at harm. The local supervisors were notified immediately and were able to reach out to their own contacts within the community and arrange for the client to be held in a shelter for a short time.

important to both the adaptation process and program sustainability. Local people are more likely to stay in the areas and invest themselves in a community program, while expatriates tend to move away after a limited amount of time. Local people also usually understand the services available in the area and have connections to other services.

Basic requirements for supervisor selection are the same those for counselor selection:

- ✓ At least a high-school equivalent education (to ensure adequate literacy)
- ✓ Strong interpersonal skills
- ✓ An interest and desire to learn how to help those with mental health disorders

In addition, it is preferred that supervisors speak the language of the trainers (usually English). This will make consultations and supervision easier between the trainers and the local supervisors during treatment. Of course, these are only the basic requirements. Having supervisors with some

leadership and/or teaching skills, as well as any experience as a counselor, has proven to be helpful in our past projects.

Supervisors can be selected from a variety of settings. Organizations may decide to select supervisors from the implementing organization itself, local health institutions, the MOH, other local organizations/institutions working specifically with issues of health or mental health, or

even from within the group of counselors being trained. In considering whom to train, it is important to consider not only the supervisor's skill level, interest, and investment, but also the long-term sustainability goals for the program. In our experience, implementing organizations often choose to have staff at their organization already trained and working in a supervisory position in order to increase capacity and sustainability within the organization.

The selection of supervisors can either occur prior to or during training. In the event that there is a good sense of who would make a strong supervisor, that individual is usually chosen before the initial in-person training. If there is uncertainty, supervisors can be chosen by the trainers during the training. In this case, trainers would be looking for counselors that show particular skill and uptake of the ideas of the intervention model, as well as an ability to help teach other counselors. A minimum of two supervisors should be chosen (with another 1-2 as back-ups) in case that one does not meet the requirements of the trainers. Keep in mind that the number of supervisors needed varies depending on the number of counselors and the location of staff. For example, if an intervention is administered at three separate centers, you may need to have a supervisor at each center.



Case Examples: Choosing Supervisors

Zambia

At the time of the initial training on Trauma Focused Cognitive Behavioral Therapy in Zambia there was only one local clinical PhD level psychologist in Lusaka. While, this psychologist consulted and remained a part of the program on a higher level, it was not possible or feasible to have him take on a role as supervisor for the intervention given the time commitment needed. The team ran the training and chose to select 2-3 counselors from the participants who stood out as 1) grasping the skills of the intervention quickly, and 2) leaders within the group. Given that these counselors had no previous clinical mental health experience, the program also brought on consultants to assist with non-TF-CBT related clinical issues such as suicidal cases or legal issues.

Iraq

Unlike the situation in Zambia, Iraq has a large population of highly trained Psychiatrists. When implementing a randomized controlled trial on Cognitive Processing Therapy and Components Based Intervention, the implementing partner had a pool of qualified candidates to choose from. In order to select supervisors the team had to look at other factors such as 1) the psychiatrist's availability to run regular clinical supervision, and 2) interest in participating in a therapeutic approach that did not include psychotropic medication. Since two psychiatrists were highly trained in clinical issues, such as handling of high-risk cases, there was no need to bring on other consultants. However, even in this case, the local psychiatrists had little experience with talk therapy or supervising it. Training these supervisors focused on the intervention models, as well as how to supervise.

All supervisors need to be able to commit to the counselor training program and additional supervisor training time. In addition to participating in the training with the counselors, the supervisors need to receive additional training and support on **how** to supervise and begin setting up the ongoing supervisory and monitoring processes.

B.3.1 1.C INTERVENTION TRAINERS

Trainers are critical to effective implementation of a mental health treatment. They need to be recognized experts in the treatment of choice who have themselves been trained by experts. They must also have extensive field experience. Hiring a trainer who has educated herself/himself on a treatment and/or has not used the intervention extensively is not recommended. In keeping with the Apprenticeship model, the trainer needs to be a highly skilled teacher with experience in cross cultural settings (e.g., training lay workers, working with a translator). At a minimum, at least one person on the training team should have experience training in these contexts. We suggest contacting the actual developer of the treatment model to receive recommendations of people who fit these needs. Trainers need to understand the level of commitment the Apprenticeship Model requires and be willing to commit not only to training, but also ongoing supervision. It usually takes some time to juggle the contracts and schedules of trainers, as well as to prepare materials and translate them (if required). **It is therefore wise to begin the search for trainers as early as possible.**

Trainers with less experience should work with an experienced group to learn the steps necessary for the preparation of the activity. Sensitivity to the culture is important in preparing the materials. All material should be in simple language and cleaned of colloquialisms and slang. These materials should be prepared with the understanding that they will need to be translated; keeping things concise will help to keep translation costs down. (For example, suggesting that a 200 page manual be translated is often not realistic relative to cost, nor is the expectation that laypersons will read all of it.) Pre-training coordination with the field staff is necessary to ensure that all the requirements for training are arranged —from room-set-up to time commitments. We suggest preparation calls with the research team to confirm that there is understanding of the larger program and how the specific intervention fits into that. Preparation also often includes familiarizing individuals with the field. Logistical preparations include approving travel and dates, receiving necessary immunizations and medications suggested for the area of travel (if needed), and assuring current passports and visas.

During the training in the field, trainers are required to work closely with the translators and local staff to assure understanding and track any changes that might need to be made in the translation of the manual. Trainers should be individuals with enough energy to run an active 10 day training (at least), and enough patience to work effectively with a translator. Trainers

must be able to connect with local individuals; this has been shown to be critical for buy-in. Many times during the training, there will be additional meetings necessary to help with organization and/or implementation. In-the-field training time is a very intense activity for trainers.

Following an on-site training, trainers will have absorbed significant information that should be shared with the wider team. The trainer will have seen how the local team and partner function in the field and can perhaps make suggestions about weaknesses in the team to be addressed or strengths that can be used to advantage. A trainer may report that the team is in need of some additional organizational help after observing that multiple training needs were not accomplished. Trainers may be able to assess strengths and weaknesses of individuals (counselors, supervisors, or even program staff), and suggest minor role changes to ensure that each person is being utilized effectively. For example, a counselor who enjoyed speaking with clients but does not demonstrate a mature understanding of therapeutic concepts may be better suited to the role of outreach worker. After being in the field, trainers may also be able to offer new insight into administrative decisions that had already been made. A trainer may suggest that an additional supervisor is needed to manage the counselors. As this feedback is essential to program success, trainers need to commit to ongoing supervision and monitoring (See below).

B.3.2 COUNSELOR TRAINING

While quality training in the specifics of the selected intervention is necessary, it is not sufficient to build the basic skill-level of mental health providers (Beidas & Kendall, 2010). In our Apprenticeship model, training is conceptualized as the building of a foundation for successful service provision—the first step in learning the skills to successfully implement an evidence-based model. For many trainees, the in-person training is their first exposure to mental health and mental health treatment. **As in apprenticeship models, *on the job* training is a critical element.** Here, the initial skills being developed will facilitate *on the job* efforts.

B.3.2.1. TECHNICAL PRE-REQUISITES FOR TRAINING

There may be activities and supplementary trainings that need to be implemented prior to the formal intervention training. For example, some treatments now have online trainings that offer a useful introduction to the intervention. Where this is not available, some trainers may suggest a short reading that offers an overview of the treatment. We have found in working with lay mental health workers that if there are technical pre-requisites for a program or intervention, it is best to arrange a meeting where a local program director can review the required information with the participants before the trainer arrives. This allows for extra time

to provide guidance on the materials and to address any preliminary questions and/or concerns.

Another pre-training activity may be an informational meeting about the mental health treatment and how it interfaces with HIV and local HIV services. This could be a combined meeting with the counselors and supervisors as well as others involved with HIV services to provide a more thorough understanding of how the mental health and HIV services intersect. When technologically possible, it may be worthwhile to Skype or conference one of the trainers to the informational meeting to answer questions that may arise.

B.3.2.2 LOGISTICS/DESIGN OF TRAINING

In planning the training, we recommend that trainers and local implementing partners discuss issues of timing, training agenda, and related logistical issues beforehand. Discuss the timing and spacing of the training. Set dates for the training based on availability of trainers and ability of the organization to have staff available at that time. For example, ensure that there are no scheduled local holidays during the training dates. Discuss the length of the training (5 days, 10 days, etc.) and if there will be breaks in between (e.g., training for 1 week, then 1 week off to practice the initial material, followed by a second week of training). The next area of discussion should be the agenda and schedule for the training. Review what the training days would look like: scheduled breaks (e.g., in certain countries breaking for tea during the morning and afternoon is customary), when lunch is typically held, how long lunch runs for, and when additional training time for supervisor training will be scheduled. Finally, the trainers and local team need to discuss logistical issues such translating and copying materials, procuring training supplies and/or equipment needed, determining the location of the training, securing transportation to and from the training, and calculating costs food and transportation allowances. (See “Feasibility Consideration” B.2 for more information.)

Initial in-person trainings usually last approximately 8-10 days. This longer length ensures that trainers have adequate time to convey the information, while counselors and supervisors have the necessary time to practice the skills. Adult learning studies show us that purely didactic trainings (i.e., someone speaking while trainees sit and listen) are an ineffective means of teaching specific skills. Therefore, it is useful for the didactic portions of training to be limited and straight-forward, particularly when working with counselors who may not have much formal classroom experience. Trainers will need to simplify slides they may have used with Western trainees (e.g., 2-3 lines per slide, with each slide introducing only a single concept), and will want to alternate teaching and practice-based activities more regularly than they might in settings with more advanced trainees (e.g., spending only 30 minutes talking before switching to a practice activity). All training materials need to be developed with simplified

concepts and presented as clearly as possible. For example, terms commonly used in training and talking about EBTs with highly educated trainees will need to be simplified to allow for more accurate translation and better understanding. “*Cognitive restructuring*” can become “*thinking about things differently*”, and “*gradual exposure*” can become “*talking about the most fearful times, step by step*”.

A minimum of two trainers are necessary to allow for regular, coached practice (see below in Training Techniques for more details on coaching), as well as proper documentation of all activities and adaptations/modifications. Trainees in all settings initially make mistakes or struggle with components and immediate feedback is critical (Joyce & Showers, 2002). To determine whether more than two trainers are needed, consider the maximum ratio of 10 trainees per trainer, with even lower ratios preferred (but not always possible given limited resources).

B.3.2.3. TRAINING TECHNIQUES

Training efforts should be active, experiential, and incorporate various learning strategies, while keeping contextual challenges in mind (e.g., lower educational attainment, limited/no mental health training). Strategies should include observation of skills, active practice with coaching and feedback, and instructional activities designed to solidify learning (e.g., small group work, individual assignments). In our experience, approximately every 30 minutes of didactic teaching on a treatment component should be balanced by about one hour of small-group, coached role-play practice. For example, after a didactic presentation of a component of treatment (e.g., relaxation training), the trainers can do a role-play in front of the trainees to demonstrate how the component might look when done with a client. The trainers then break the trainees into small groups (usually about 3-6 depending on the size of training) and instruct participants to practice exactly what the trainers just demonstrated. Additional role-play time may include variations of the client presentation and/or component of treatment – all explicitly laid out by the trainers. As trainees practice, the trainers spend time with each small group and actively provide feedback and coaching. This focus on practicing skills is in line with the trade apprenticeship model, in which learning is achieved by actually utilizing new skills, with supervision and coaching from an expert.

Practice and coaching are essential not only for trainee skill development, but also for trainers to assess which material and skills are understood and which concepts remain unclear. The trainers can then use this information to modify the training—slowing things down if necessary and repeating sections as needed. Trainers can also use the practice sessions to assess the skills of individual counselors. In addition, active learning methods generally keep learners engaged over an extended training period (Lawson, 2001).

In these small group practice sessions, trainers are actively coaching and giving feedback. True to the Apprenticeship model, the trainer initially takes responsibility for guiding and teaching of the main skills—directly giving answers and direction. For example, the trainer may first demonstrate the skill via a role-play or show a training video. When counselors try the skill, the trainer gives significant guidance on the technique and answers questions as they arise for the first role-play. As more trainees practice, the trainer will ideally want to shift to asking questions of the trainees themselves, to elicit answers and suggestions. This training technique, common in the adult learning literature, allows for skill transfer, rather than enabling the trainees to become dependent on the trainers (Lawson, 2001).

Active, experiential training is enhanced by trainers repeating and reviewing components and skills through “quizzes” and homework exercises. This can be done throughout the training process. Often trainers select topics from the training that participants have more difficulty grasping and use this content to form open ended or multiple-choice questions in order to quiz the group on that topic. For example, if trainees are struggling to grasp the concept of trauma during a morning presentation, the trainer may have a quiz after lunch in which they ask each trainee to write down on a piece of paper what trauma is. Homework may also be assigned to trainees during the training. Homework may include something simple such as reviewing the day’s lesson, or worksheets can be handed out to help counselors practice particular skills or techniques.

We suggest taking a phased approach to teaching the skills for implementing a new mental health intervention. A phased approach begins with training on all the basic techniques, components and skills of the treatment. Variations and “what if” scenarios should be covered during supervision groups (see below) only **after** trainees have achieved some competency with basic skills. Mental health treatments can be challenging to teach because there are often great differences in the problems and personalities of clients: flexibility in implementing the different components of a treatment is necessary. Although flexibility is often seen as a positive in terms of meeting the needs of diverse clients, trainees who are not familiar with mental health may be confused and overwhelmed by these “if, then” exercises.

B.3.2.4. TRAINING ON SAFETY AND SELF-CARE

All trainings—regardless of their focus—must include strategies for dealing with client safety (e.g., suicidality or homicidality) (See Section B.4.3 for more details). Given the often insufficient mental health systems in most LMIC, along with a lack of higher-level mental health training, client safety is always a serious concern. Counselors need to be trained on the basics of identifying risk for suicide, and how to handle someone who indicates suicidal intent. Talking about suicidal thoughts is challenging in many cultures. Therefore, providing skills and actual

practice in asking concrete questions and taking steps towards enhancing safety is critical. While less common than suicidal intent, it is also counselor’s responsibility to ensure that the client is not at risk for hurting others. Counselors must be trained on how to identify risks for homicidality and how to handle a situation in which a client exhibits homicidal intent. Danger to self or others can take multiple forms and are a risk factor for HIV positive individuals. For example, an individual recently diagnosed with HIV may say, “I just want to kill myself, or kill the person that infected me.”

★ **TIP: What to do when there are no higher level services to handle high-risk cases**

A. Have the client give their safety word

- “We want to make sure you are safe. I know this might be hard. Can you give me your word that you will keep yourself safe for a short period of time – just over the next day?”

B. Set up a safety watch

- “We want to help you keep yourself safe. Many times we use family members to do this. Can you help me think of who in your family can be around you?”
- “Can we work together to bring these family members in to agree to help be with you so that you stay safe?”

In addition to training on client safety, counselor self-care is an important and necessary component of any training (see Section B.5.3: “Vicarious Trauma and Counselor Self Care” for additional details). The counselors themselves may have experienced traumas, may be HIV-infected or HIV-affected, and/or other challenges that they will need to cope with. Because of their jobs, they will be speaking with clients about difficult issues. Thus, it is critical to give the counselors skills and strategies to take care of themselves as they help others.

B.3.2.5 ADDITIONAL MONITORING-RELATED TRAINING:

In programs where M&E and/or research is being conducted, additional training should be conducted on monitoring forms and research ethics. Section B.4 on Monitoring has additional information about Monitoring Forms and other research-related evaluation. Research ethics should always be a part of training if there is research being conducted.

B.3.3 SUPERVISOR TRAINING

B.3.3.1 SUPERVISOR-SPECIFIC ACTIVITIES IN INITIAL TRAINING

Both research and our experience suggest that supervision is one of the most critical factors for effective mental health service implementation. **All supervisors must attend all of trainings**

with the counselors in order to understand all aspects of the intervention itself. Supervisors will also receive additional training in the specific skills they will need to supervise the implementation of the services. When supervisors are identified prior to the training, additional time should be set aside during each day of the training (e.g., 1-2 hours) for the trainers to work directly with the supervisors. When supervisors are chosen during the training, this time is consolidated after the initial training, or may start mid-training. This additional training time with supervisors is used to cover a variety of supervisory topics that they will be responsible for after the training is complete. The supervisors will need to be trained to work with the counselors to: (a) review components of the intervention and engage in more role-plays to ensure an acceptable level of skill; (b) give constructive feedback on role plays to improve counselors' skills; (c) use probes and questions to help counselors learn the skills (rather than simply giving them the answers); and (d) run efficient and effective supervision groups (e.g., setting agendas, guiding case presentations). This additional time spent with supervisors allows for a faster progression in skill building, as local supervisors will advance their knowledge of the components at a quicker pace while simultaneously learning supervisory skills.

Supervisors take an active role during the live training with the counselors. This, in fact, is the first opportunity for *on the job* learning with direct supervision and coaching from the trainer. The supervisors role in the training is two-fold: (1) to learn the treatment components along with the counselors, and (2) to carefully observe the trainers and shadow them in small groups also in order to learn about supervision and coaching techniques. In this way, throughout the training, supervisors take on an increasing supervisory and leadership role, with coaching from the trainer. After a few days of learning, the trainers may ask the supervisors to observe how the trainers teach, coach, and give feedback to the counselors. As the training progresses, trainers begin to directly coach supervisors in giving feedback to the counselors (e.g., sitting close to them and guiding them on what to say). The trainers are then able to observe the supervisors' skills and provide feedback on their initial supervisory efforts. For example, when counselors are practicing in small groups, the trainer sits next to the local supervisor and provides coaching ("in the ear") on when to interject and suggestions on what to say, but lets the supervisor deliver the actual supervision and feedback.

During these exercises, the trainer should focus equally on the counselor's practice of the intervention as well as what the supervisor is saying and doing. We have found that this process also begins the transition of the role of teacher and expert from the trainer to the local supervisors. This is a critical step in the process: when the trainers leave, the counselors should feel that they can confidently turn to the supervisors.

B.3.3.2 RUNNING PRACTICE AND SUPERVISION GROUPS

A key element of the in-person supervisor training includes how to run practice and supervision groups. For each intervention and set of trainers this may be described somewhat differently. Where some trainers may have the supervisors run the supervision sessions using the same structure as the intervention itself (i.e., setting an agenda, learning how to give praise as well as constructive feedback, and the active use of role-plays), other trainers may work from different models. Trainers will provide advice on the number of counselors per supervision group, and possibly even which counselors should be paired with which supervisor as they learn more about their skills.

B.3.3.3 PRACTICE CASES

To promote the active learning of the intervention model, supervisors are expected to take on a practice case similar to the case required of the counselors. When it is possible, it is also helpful for supervisors to provide services to a small number of cases on an ongoing in order to maintain their clinical knowledge. This expectation is reviewed in the in-person supervisory training with the trainers, and any possible challenges or barriers are discussed. One challenge that often comes up is that supervisors may be very busy in their positions and lack the time required to see a case, or they may travel frequently. These challenges should be resolved on-site with the implementing service provider, to assure that the supervisors are able to find and begin seeing their cases immediately following the initial training. We have found it helpful for supervisors to be a few sessions ahead of the counselors if possible. This allows them to speak about what they did during the counselor supervision sessions, and to recognize the challenges of implementing a new treatment.

B.3.3.4 SETTING UP ON-GOING SUPERVISION

Training for supervisors does not end with completion of the live training. In addition to the live training and requirement of seeing at least one case using the treatment model, supervisors are also required to have regular (often weekly) calls with the expert trainers for a set amount of time during the implementation of the intervention. This should last at least through the completion of first cases by all counselors, but will often extend beyond this. These calls are used to ensure fidelity to the model as well as to help supervisors problem solve around difficult cases and/or counselors (see section B.4.4 “Ongoing Training” below for more information about these calls). During the initial training, it is important to set up the communication systems between supervisors and trainers. These often take the form of Skype and long-distance phone calls, depending on the communication systems in-country. The

regular communications will begin immediately following the training, as the supervisors (and then the counselors) begin their practice cases.

B.3.3.5 REVIEWING SUPERVISOR MONITORING FORMS

Supervision training on-site should include a review of the trainers' preferred monitoring forms, instructions on who completes them, and if/how the trainers may have access to them (see Section B.4 and Appendix D for additional information).

B.3.4 ONGOING TRAINING

As stated above, the goal of the initial in-person training is not only to provide training on the intervention, but also to set up mechanisms to support the intervention delivery post-training. The formal training, coached practice, and training in supervision with supervisors set the stage for the actual Apprenticeship—or “on the job”—training that occurs once the in-person training is complete. Following the model, the supervisor apprentices to the trainers, getting weekly feedback on their work, and the counselors apprentice to the supervisors, who provide them with feedback directed by the trainers. The idea is to increase, over time, the local supervisors' responsibility for the intervention implementation, as well as the monitoring of the quality of services provided by the counselors.

Supervision calls with trainers also provide the opportunity to teach additional skills such as setting agendas, coaching counselors on delivering concise case presentations, and using questions to help counselors find answers themselves. Supervisors often need training and support on time management skills. Local supervisors will eventually have to manage the review of multiple cases for each counselor, so their ability to efficiently and effectively set up role-plays, re-direct the group, and summarize key learning objectives is important. One technique often used to help teach this is for trainers to create agendas to help supervisors structure the first two to three practice groups (e.g., delineating time limits and topics to cover), and then begin letting the supervisors take this over. We have found it helpful for the trainers to provide clear suggestions of what the supervisor should be looking for in the role plays (e.g., micro-skills, goals, potential challenges) in order to facilitate the supervisor's ability to effectively coach the counselors.

B.3.4.1 PRACTICE GROUPS

To facilitate the “on the job” learning aspect of the apprenticeship model for both supervisors and counselors, practice groups should be held immediately following the in-person training. Ideally, these should be held within 1-2 weeks, and should continue while the practice clients

are seen. The purpose of these practice groups is to review material from the training and continue role-play practices on the components.

Practice groups primarily focus on additional role-plays of intervention components and skills (e.g., relaxation skills, cognitive triangle), solidifying skills learned in the training. During the practice groups, the supervisors provide support and coaching to the counselors and report to the trainers, typically via Skype or phone, to receive feedback on the sessions and on how they are providing supervision. As described above, these calls provide additional opportunities to enhance the skills of local supervisors and allow the supervisors to serve as a conduit of information from counselors to trainers and from trainers to counselors.

This apprenticeship model requires very clear communication between the supervisors and trainers, as the trainers are now one step removed from the counselors. To obtain information on counselor practice, supervisors must be encouraged to provide **objective** (rather than subjective) reporting on what occurs in practice sessions. In other words, the trainers strive to “see a video” of what happened in the practice groups so that they can track not only counselor progression, but also the supervisory techniques of the supervisors-in-training. The ability to provide objective feedback is one that generally needs to be developed. Supervisors need to be coached to report specifically how they introduced and explained a role play activity, exactly what the counselors said within the role-play, and the feedback the supervisor gave, rather than simply reporting that “the role play went well”. Based on this objective reporting, the trainer can provide feedback and re-direction based on fact (rather than interpretations), and the supervisor then relays this to the counselor(s) (see text box below for more information on objective reporting). Over time, as supervisors gain skills, they will take increasing responsibility for making their own suggestions about counselor practice rather than relying only on the trainers’ feedback.

It is equally important to direct the supervisors to provide objective reporting on counselor activities as it is for them to objectively report the feedback they themselves gave during the practice groups (e.g., what the supervisor is telling the counselors during the role plays). Hearing the supervisor’s feedback to counselors allows for accurate assessment of the supervisors’ understanding of the intervention. Hearing objectively **how** the supervisor conveyed this information provides information on supervisory techniques (e.g., was positive feedback given first before constructive feedback? Did the supervisor model the correct way to do the skill?).



Case Example: Objective Reporting

In one program, all counselors were required to give a brief case presentation each week to remind the group of their case. This brief included the following elements, and took counselors less than five minutes to complete:

- Age and sex of client
- Brief family/living situation
- Reason for treatment (trauma history in brief)
- Identified symptoms/ clinical diagnosis
 - Chosen flow for the case and why
- How many sessions did the client agree to/ are you planning on doing
 - E.g., 8 sessions for 1.5 hours or 12 1 hour sessions
- What components you've done so far
- What questions you have
- What is your plan for next week

Here is an example:

1. 45-yr old man seen in clinic for torture living with his wife and 2 children
2. His house was raided and he was taken to a prison, and stayed for 2 months and was tortured there (physically and sexually)
3. Symptoms: He has anger outbursts, is having trouble in his marriage, is fearful of anyone in a uniform, and has a lot of trouble sleeping. He reports feeling afraid, angry, and "out of control" a lot. He also is HIV positive, and currently on ARVs. He is compliant only sometimes.
4. I am treating with CETA, focusing on trauma. We will integrate some HIV risk behaviors in the cognitive work.
5. The client prefers 8 sessions of 1.5 hours.
6. So far, I have done psychoeducation with just the client as he chooses not to have his family involved. I have also done 1 session of cognitive coping.
7. I'm not sure where to go with this case. I think he may need some more work on the cognitive coping but I won't know for sure until he returns with his homework. Not sure if I should prepare for gradual exposure or not.

B.3.4.1.A PRACTICE CASES

Consistent with the apprenticeship, counselors and supervisors should take on one or two practice cases before actively seeing a large number of clients, or before starting an evaluation study of an intervention. It is quite different to talk about how to do a component, or practice a component with a colleague, than it is to sit in front of a real client and do so. For example, in

role-plays, one often practices with another counselor or supervisor—someone who knows the components—and can therefore present as an easier case to the counselor than an actual client would be. Counselors must truly understand a component in order to teach it to a real client. Towards the completion of practice cases, the supervisor and trainers work together to assess the counselors' ability to implement the intervention effectively and their potential for taking on additional cases.

During practice cases, counselors are closely supervised by their local supervisors. The local supervisors (and accordingly, the counselors) are closely monitored by the trainers. Trainers seek to hear the details of what was done in each counselor's sessions, re-directing and re-teaching as needed. Practice cases serve as the opportunity when the counselors and supervisors get used to the intervention monitoring and reporting system.

This is often the time when counselors and supervisors learn about cultural adaptations or variations that need to be made to the intervention, and trainers learn which components are less understood or not detailed enough. Thus this is also a time where training (i.e., manuals) and monitoring materials may be updated.

B.3.4.1.B SUPERVISION GROUPS

Weekly supervision is necessary throughout a counselor's practice case, with sufficient time during each supervision session spent going over the details of the case and the actions of the counselor. The amount of time needed for the supervision sessions can vary from 1-2 hours, with some supervisors and counselors spending additional time certain weeks on more challenging components and the amount of review needed.

The process begun with the practice clients will continue during the implementation of the treatment with ongoing clients. By this point, trainers will need to have adequate confidence in the supervisors' skills in the intervention. Supervisors will continue weekly contact with the trainers, as supervisors are increasingly apprenticing to be the local experts in the intervention. All cases will continue to be reviewed carefully, and feedback will be provided on: (1) the counselors' implementation of the components of the intervention, and (2) on the supervisor's supervision skills (e.g., response and guidance of counselors). The supervisors will continue to use the objective reporting skills they have developed with the trainers as counselors take on additional cases.



Case Example: Changing a Thought in Zambia

A counselor in Zambia told a supervisor that she/he was having difficulty with changing a client's unhelpful thought: "I am not worth anything now that I have HIV". The supervisor asked for an objective report of what the counselor tried in session, and heard many statements about the religious beliefs of the client. The supervisor suggested using more logical questioning, and then try asking, "What would God say about this thought?" The trainer and supervisor further discussed this on a call, and decided that this was in-line with the intervention and also fit with the local population, individual, and culture.

As the counselors continue to provide services to more clients, supervisors begin to take on more responsibility for directing feedback, and mutual problem solving is undertaken by the trainer and supervisor. For example, a counselor may report on some cognitive restructuring he/she had difficulty with, and the supervisor would report to the trainer what was suggested to the counselor. Together, the trainer and supervisor would discuss how that suggestion is true to the treatment, and also seems likely to work in the culture with this client. In this way, the local supervisors, together with the trainers (with input from the counselors), collaborate in making decisions that promote "flexibility within fidelity". Developing this capacity within the system provides a program the critical ability to balance the creativity and adaptation necessary to fit the population (or cross-cultural modifications) with fidelity (delivery of essential components) to the intervention model.

Towards the completion of practice cases, the supervisor and trainer(s) should be working together to assess the counselors' abilities to implement the intervention effectively, and take on additional cases. In addition, as the supervisors' competency in the intervention and supervisory techniques continues to develop, the supervisor takes on increasing responsibility over the course of the supervision groups. For example, after pilot cases, two supervisors in Southern Iraq ran some "review sessions" on certain components of an intervention. They created the agenda themselves, directed the discussion, led role-plays and responded to questions from the counselors themselves. After objective reporting to the trainers, challenges were discussed and minor suggestions were made. As the supervisors' skills advance, the trainer's role on calls shifts. Eventually, trainers ask questions of the supervisor to elicit counselors' own conceptualization of cases and challenges or concerns the supervisor has identified.

B.4 SETTING UP MONITORING SYSTEMS

Setting up monitoring systems is not only important for the initial evaluation of the intervention but also necessary in ensuring effectiveness and quality throughout the life of the program. While monitoring services is not only necessary during the testing phase of a new intervention, the monitoring may be more intensive during this formative stage than it is once an intervention is determined to be effective and ready for scale up. Monitoring systems should adapt as the program evolves.

B.4.1 COMMUNICATION SYSTEM

Setting up a new intervention often involves multiple partners, stakeholders and funders. These parties can include local NGO partners, local research institutions, local government offices, technical working groups, consultants, technical experts, US based trainers and funders. Given the many players involved in the setup, training and implementation of an intervention, it is important to form clear roles and responsibilities for each of the parties involved as well as a clear communication system between these parties.

B.4.1.1 ROLES AND RESPONSIBILITIES

The first step in setting up a communication system is clarifying the roles and responsibilities of each party. When working on implementing mental health interventions there are certain key roles and staff that must be involved. These include:

- Interviewers/assessors
- Field Management staff/team
- Counselors
- Clinical Supervisors
- Clinical Director/Program Manager
- Intervention Trainers
- Senior Staff from Implementing Organization (i.e., Head of programs, Chief of Party, etc.)

(See section B.2.3 “Overview of Required Resources” for more information)

B.4.1.2 REPORTING SYSTEM

Once roles and responsibilities have been defined, a clear reporting system should be instituted so that all parties involved in the program know who to pass which information off to.

Depending on the staff involved and where staff are based (i.e., often times there is a lead organization working with multiple partners), this communication flow can vary. For example, certain information pertaining to the clinical intervention will need to be passed to higher level clinical staff, including the U.S.-based trainers to monitor for safety and fidelity to the model. Meanwhile, other information, such as when a client completes treatment and needs a post-treatment assessment, needs to be passed on to M&E staff. In order to clarify what information gets reported to whom, a clear communication flow chart should be developed and distributed. (See Appendix E for an example communication flow chart).

B.4.2 SUPERVISION SYSTEM

Supervision is a critical and ongoing component in the implementation of an intervention. Consistent supervision (i.e., monitoring of the clinical intervention) helps to ensure quality work, prevention of counselor burnout, adherence and fidelity to the treatment model, as well as the needed support for high-risk case management and other clinical issues or crises. Prior to starting the intervention, a system for supervision should be set up in which the location, timing, formation of groups and supervision monitoring forms are developed. The supervision system should be re-evaluated on a regular basis to ensure it is meeting the needs of the service providers and the program. If the intervention is found to be effective it will need to be adapted as it becomes more integrated into the current programming.

B.4.2.1 SUPERVISION SESSIONS

Supervision of counselors can be held on an individual or group basis, or using a combination of these strategies. Deciding on which model will work best for your location/organization will depend on:

1. *Weighing the pros and cons of group versus individual supervision format:* There are pros and cons to each format. In group supervision, counselors often learn from fellow counselors as they share their cases. In addition, a group format allows a supervisor to review a component of the intervention just once, rather than many times. However, if there is one counselor who is struggling in group supervision, it is possible that others will not receive due attention to their cases, and may become bored with repeated teaching with one counselor. Individual supervision therefore allows for more concentrated attention to each counselor and more hands-on practice of skills. It is also possible to do a combination of group and individual supervision. For example, in some contexts programs have opted to rotate individual and group supervision each week. This will depend on the other considerations listed below.

2. *Location:* A program will need to consider whether or not counselors are located in a place where they can easily come together in a group (2 or more counselors); whether they have the resources (i.e., car, funds for transport) to travel to a location where they can meet together as a group; and/or whether it is culturally appropriate or safe for counselors to travel on their own to where a group will be held.
3. *Supervisor availability:* An important consideration is whether supervisors have time to meet with each counselor individually or if their current workload is too high to allow for this. Additional considerations are similar to those above, in regard to safety and available resources.
4. *Ratio of counselors to supervisors:* When there is a limited number of supervisors for a high number of counselors (e.g., 1 supervisor for 20 counselors), individual supervision is probably not possible. However if there are multiple supervisors (e.g., 4 supervisors for 8 counselors), it may be simpler to design a system of individual supervision.
5. *Skill level or need of counselors:* In considering the supervision design, it is helpful to assess the needs and skill levels of the counselors. There may be some counselors who need individual attention or a combination of individual and group supervision to augment their intervention skills.



Case Example: Traveling Limitations for Female Counselors and Clients in S. Iraq

In a program studying the effects of Components Based Intervention on torture survivors in Southern Iraq, an issue was raised during training that affected implementation on several levels. The female counselors brought up the issue that women in Southern Iraq could not travel without accompaniment from her husband, male relative or family member of her husband. While, the female counselors attending the training had all been accompanied to the training site in Kurdistan, they feared that they might not be able to have a relative accompany them each time they needed to attend a supervision group outside of their area. In order to address this issue it was decided that supervision groups would be held at the sites of the female counselors so that the male counselors and two male supervisors would be the only ones needing to travel.

B.4.2.2 LOCATION

Supervision sessions should be held in locations that are safe, confidential and consistent. When considering where to hold supervision sessions, organizations should consider the following factors:

1. If the organization is considering group supervision it is important to factor in where the supervisors and counselors are located. If supervisors are located in different areas than the counselors, it is often more feasible and requires less resources for the supervisor to travel to the counselors.
2. For group supervision, it is also important to consider whether the counselors are located in one area or whether they are spread out. If counselors are spread out, then extra resources will need to be budgeted to transport them to the location of the supervision sessions. Setting up a supervision system in which multiple people are coming from different places requires including contingency plans for missed supervision. For example, if someone misses a scheduled supervision meeting, the supervisor may provide individual supervision, or plan a supervision session over the phone. Certain techniques, such as providing tea/biscuits prior to the supervision (and taking them away once it starts), may help in getting everyone there on time.
3. Individual supervision sessions can be held either at either the counselor's office or the supervisor's office. In a situation where the supervisors and counselor are not located in the same place, you must budget for one party to travel to the other location on a weekly basis.
4. Phone supervision may be necessary for certain programs depending on location/distance to travel and issues relating to security. For example, if there is ongoing violence on or near a site where counselors are located, supervisors may be restricted from traveling to that area because of the risk of personal danger. Phone supervision is not the recommended form of supervision, but at times it is a necessary fallback plan. Phone supervision may also be a possibility in the later stages of a program once counselors become more skilled and require less in-person supervision (although it is important to note that in-person supervision should never be eliminated completely).

Supervision does not necessarily need to be held in one place. It may vary depending on each site and supervisor.

B.4.2.3 LENGTH AND TIMING OF SUPERVISION

Length and timing of supervision may vary depending on the needs of counselors and their experience level. When an intervention is first introduced, counselors and supervisors should meet on a regular basis (at least weekly) at a consistent time (i.e., same day, same time every week). Typically, supervision can last anywhere between 1 to 3 hours. This will depend on whether the supervision is run as a group or individual session. If group supervision is selected, the size of the supervision group and the counselors' experience with the intervention will both impact the time length. When counselors are newly trained, they are still learning the fundamental skills, so supervision may take longer (3 hours) than for counselors who have been using the intervention for several years (1 hour). This may also need to be adjusted throughout the life of the program, as there may be fluctuations in the numbers of cases each counselor has. In designing a supervision monitoring system, it is wise to plan for some flexibility in time.

B.4.2.4 MONITORING OF THE INTERVENTION

Monitoring of an intervention should include multiple levels. At a minimum, the following components should be included:

- Process monitoring (e.g., number of clients, number of visits to each client...etc.)
- Fidelity to the treatment model monitoring
- Clinical monitoring (weekly symptom ratings)
- Safety monitoring (see the following section)

Each area of monitoring usually has its own monitoring form, or cluster of questions on a form (see sample monitoring forms Appendix D). Most monitoring reporting is presented and reviewed at the weekly supervision meetings. As discussed above, all counselors seeing active cases need to participate in weekly supervision during which cases will be closely monitored through verbal report, case notes, and/or fidelity checklists. Most forms include both *process monitoring indicators* (e.g., number of session a counselor has held with each client), and also *fidelity monitoring indicators*. Fidelity monitoring includes a brief report of what happened in session, which component or skill counselor and client are currently working on, any questions or concerns, and recommendations for the next session. Clinical monitoring is often used to track the symptoms of a client on a week-to-week basis. This additional case information helps guide the intervention, as well as monitor the client for progress and safety. Finally, in all case summaries, there is usually a check-box to indicate that the counselor monitored for safety issues. If there are concerns about a client's safety, extensive documentation is required on what was done, and by whom, with what follow-up plan.

All monitoring forms are reviewed each week by local supervisors, and also by trainers in their contact with the supervisors each week. This review provides a double- and triple-check on the various areas of monitoring. For example, if a counselor only has one case but is supposed to have 3-4, the supervisor would notice this at the weekly meeting and follow-up on this. Or if a client's clinical monitoring scores are increasing rather than decreasing throughout the intervention, supervisors and trainer(s) would assess the possible problems and brainstorm solutions during their weekly phone call.

B.4.2.5 DEALING WITH EMERGENCIES

When working directly with populations in need of mental health interventions, there is a high likelihood that counselors will come across clients in crisis and/or situations in which the counselor themselves face an emergency. Crisis situations can include outside crises such as security issues in which the client and/or counselor are in danger due to outside forces (e.g., military attacks on a village), domestic violence, or other community violence. They can include crises associated to a person's mental health, such as suicidal and/or homicidal ideation. In order to handle these cases, systems need to be put in place so that counselors can receive immediate support and supervision from a clinical supervisor and/or the organization (depending on the emergency at hand). For a full description on how to develop a high-risk case monitoring protocol, see Section B.5.3: "High Risk Case Monitoring" below).

Once identified by a counselor, all high-risk cases should be closely monitored for safety by the counselor, supervisor, and clinical director/program manager. When the intervention is part of a formal evaluation, information on high-risk cases, including identification and follow-up, should be sent to trainers and the research team. Log forms and databases should be developed to track high-risk cases (See Appendix F for example log form).

B.4.3 HIGH RISK CASE MONITORING

In dealing with mental health, particularly in low-resource countries and among high stress populations (i.e., HIV-affected), assessors and counselors will most likely face high-risk cases and/or situations (such as suicidal or homicidal ideation or acts, ongoing sexual abuse, domestic violence, on-going physical violence, psychotic breaks, and/or death). The management of high-risk cases can be particularly challenging when working in low-resource settings that do not have existing infrastructures providing immediate protection for the clients, such as shelters, child protection agencies, or advanced health infrastructures (e.g., emergency rooms, psychiatric services in a hospital). **Therefore, all assessors and counselors must be trained on a protocol specifically developed for high-risk case monitoring for each context.** Although each organization's protocol may vary depending on access to resources, location, etc., we

recommend that all protocols include the following basic steps for all assessors, counselors and supervisors:

- 1) Immediate additional assessment
- 2) Contact with a supervisor and/or clinical director
- 3) Development of a plan for the immediate time
- 4) Follow-up with client by phone or in person

B.4.3.1 IDENTIFYING EXISTING SYSTEMS

The first step in creating a high-risk case monitoring protocol is to determine what systems and services currently exist within the organization(s) and within the community. Each organization will want to consider the following points before setting up a protocol:

- Does the organization have an existing system in place for dealing with high-risk cases?
- Are there specific laws in that country or area on how to deal with any of the forms of high-risk cases (e.g., what are the laws around child sexual abuse)?
- How do other service providers currently deal with high-risk cases?
- Are there any governmental structures or systems in place (e.g., inpatient level of care, victim support units, police, shelters, hospices, etc.)?
- Are there any NGOs or private hospitals in the area that have the capacity to deal with high-risk cases?
- What is the capacity within the organization to clinically assess high-risk cases? (e.g., does the organization have someone with mental health training?)
- What do local community centers and/or community members do when they know someone is suicidal? Experiencing ongoing abuse? Experiencing domestic violence?

Setting up a protocol for high-risk cases may include using a variety of governmental and non-governmental resources as well as resources within the NGO or partner organizations.

B.4.3.2 DEVELOPING A PROTOCOL

(See also section B.3 for additional information on training)

There are multiple situations that can put the client or others at risk and should be addressed when developing a high-risk protocol. These situations include suicidal ideation, homicidal

ideation, and the client living in a dangerous situation at risk for future harm (e.g., child sexual abuse, domestic violence, etc.). The following section reviews the four major steps that all assessors, counselors, and supervisors should follow.

1) Immediate Additional Assessment:

If the client indicates **suicidal** ideas, it is necessary to assess the severity and immediacy of these thoughts. One way to do this is for the person doing the assessment to ask these four simple questions:

- a. "Have you ever tried to kill yourself before?"
- b. "Do you think about killing yourself?"
- c. "Do you have a plan for killing yourself?"
- d. "Do you have access to that plan?"

If the client indicates **homicidal** ideas, it is necessary to assess the severity and immediacy of these thoughts. To do this, the person doing the assessment can ask these four simple questions:

- a. "Have you ever tried to kill/harm someone else before?"
- b. "Do you think about killing/harming this person?"
- c. "Do you have a plan for killing/harming this person?"
- d. "Do you have access to that plan?"

If the counselor observes psychotic symptoms or the intensification of substance abuse (e.g., alcohol, hemp), she/he can use the following to gather additional important information to determine immediate risk:

- a. "How often does this problem occur, in terms of frequency?"
- b. "Which substances are being used?"
- c. Are psychotic symptoms present? (e.g., hallucinations, delusions) (See Appendix G Psychosis Screening Form.)

2) Contact the supervisor and/or clinical director:

If the client states 'yes' to any of the above questions, or if a counselor or assessor otherwise observes that the client is at risk, **the counselor or assessor must speak with a designated supervisor or clinical director while the client is still present.** This step in the monitoring plan assures that there are multiple layers of protection for the client, and various people thinking through the high-risk situation. It also allows for careful and detailed documentation of each step taken.

3) Make a Plan:

During the call with the supervisor or clinical director, they should **decide or agree on a plan before the client leaves**. These plans will vary depending on the context, personnel, situation, etc. This plan may involve increased monitoring of the client, requiring a client contract for safety, increasing sessions with the client, referring the client to be evaluated by a professional psychologist/psychiatrist, or in extreme cases of risk, having the client placed somewhere safe for 24 hour surveillance (or longer). In low resource contexts clients may not have access to a psychologist or higher level of care services. In these instances counselors and supervisors may need to work closely with the client, their family, and the community to ensure that the client is safe (see text box below for two methods for keeping clients safe when there are no higher level services available).

4) Follow-up for High Risk Cases

Once a high-risk case has been identified and a decision has been made on disposition, the counselor's job does not end. Cases that are determined to be high-risk should be followed up with on a more frequent basis (usually daily) until it is determined that the level of risk has decreased and the client is no longer "high-risk." Cases should be dealt with on an individual basis and each organization should ideally consult with a licensed professional (e.g., LCSW, Licensed Psychologist, Licensed Psychiatrist) when determining disposition and follow up for each case. (See section B.4.2 "Training Counselors" for further information on how to train counselors on safety issues).

B.4.3.4 REFERRAL SYSTEM

When beginning the use of mental health assessment tools and introducing a new intervention in any community, it is important to have a referral list for clients who are in-need of services outside of the intervention's scope. Particularly when working with HIV-affected populations, counselors may receive disclosures that will require that they know where to refer the individual for HIV-related care. One technique in generating a list of referral options is to hold a workshop of key stakeholders. Key stakeholders invited to this meeting should include local government offices (e.g., MOH, Ministry of Social Welfare), partners, and other non-governmental organizations and stakeholders. Stakeholders should be informed about the mental health program that will be offered by the organization, including the extent to which it does and does not address certain areas. For example, a mental health intervention may be described as capable of reducing risky sexual behavior that can lead to HIV and providing community based education about HIV, but not capable of providing detailed information about how anti-retrovirals (ARTs) work or giving blood tests. The meeting is used as a forum to

discuss the current status of possible referral networks for the organization and partner organizations in order to assure that the client's needs that are identified are met.

As a result of this meeting, a reference booklet can be created and distributed to all assessors and counselors working on the program as well as other stakeholders involved in the meeting. The booklet may include references for:

- Legal assistance
- General medical assistance
- Disability
- HIV-related services
- Social welfare agencies
- Community drop-in centers
- Orphanages and shelters
- Advocacy groups
- Support groups

It is often of interest to track referrals, particularly as mental health treatments may result in individuals seeking help they need but would not previously acknowledge. To track referrals, a referral log should be created for the assessors and counselors to track and follow up with those services/organizations. In some cases, referral slips may also need to be developed and distributed to the family so that the providers can track the referrals (See Appendix H for example referral log and referral slips). Furthermore, in order to monitor the referral systems, regular meetings may be held with the stakeholders and other partnering organization (e.g., 3-4 times a year). During these meetings, discussions can focus on collaboration and coordination of care for clients and the referral networks, as well as continually updating the referral booklet.

B.5 IMPLEMENTATION

Implementation of mental health interventions requires some careful considerations around case assignments, caseloads, actual treatment, and the supervision structure. This section addresses some options and considerations around implementation.

B.5.1 CASE ASSIGNMENT

One of the first considerations for implementation of specific mental health interventions is case assignment. Case assignment will vary based on how each organization decides to set up their assessment and intake process. One option is for the intake and assessment process to be

done by separate individuals (e.g., assessors, intake worker, outreach worker, nurse, etc.) who then pass on the information on to the clinical supervisors for case assignment to the counselors. Another option is for counselors themselves to conduct the intake and assessments, and take on the cases for which they conduct the intakes.

When an intake system is set up so that a separate individual (e.g., intake coordinator, nurse, outreach worker) does the assessment, it is necessary to have a system to ensure that the assessment was completed correctly and that all information gets passed on for case assignment. This can be coordinated by an M&E officer, field supervisor, or program manager. Once the assessment has been completed and scored, it can either be brought to a field manager, or else picked up from sites on a weekly basis. All assessments will need to be checked for completeness, accuracy of the summary score, and verification that some form of invitation letter to join the program and/or consent form was read and signed. If an organization is conducting a research program, inclusion criteria/score for treatment needs to be confirmed, and then passed onto a clinical supervisor and/or a program manager to help determine who will take the case. In non-research programs, the scores from the intake may help triage the individuals into various programs.

When a counselor does the assessment and intake for her/his own cases, she/he will need to bring the assessments to her/his clinical supervisor for review to ensure completeness and accuracy (as above). It is also possible for a program manager or M&E officer to review the assessments, although most often it is easiest to bring them to regularly occurring clinical supervision. The only major difference in this case is that counselors will determine their own cases and assess new clients only when they have openings in their caseload.

No matter which process an organization chooses for intake, it is vital that the counselor and supervisor discuss each case to confirm clinical appropriateness for treatment prior to the first session. It is the supervisor's role to work with the counselor to ensure that the client is eligible for treatment from a clinical perspective. The supervisor should review the intake with the counselors or on their own prior to case assignment to check for the following:

- The client is of the appropriate age for the treatment
- The client meets inclusion criteria if the intake is for a study and/or inclusion criteria for the treatment (e.g., if the treatment is specifically for trauma survivors that the client has experienced a trauma)
- The client is above the cut off score for treatment
- The client is not in crisis or does not present with any contraindications of the treatment (e.g., suicidal with intent, psychotic symptoms)

Some clients who are assessed may not meet the criteria, or may not be eligible for a particular mental health treatment being offered. Other clients may meet criteria but may opt not to receive the intervention offered by a particular program. In these cases, it is important to still provide all families and clients with the information needed to facilitate access of services of other local organizations.

What is a reasonable caseload?

While an average caseload for an experienced counselor in a Western setting may range from 20 to 30 clients, this may not be a reasonable caseload in low resource contexts where providers often have little to no formal mental health training. When implementing a new intervention, a program must determine a reasonable caseload specific to the clinical training and scope of work of each counselor. In general, it is beneficial for each counselor and supervisor to take on one practice case following the intervention training. Practice cases give the counselors and supervisors time to practice the intervention, and the supervisors and trainers an opportunity to observe skills and abilities. Following the pilot cases, the intervention trainers and supervisors can make recommendations on caseload size per counselor based on their observations of each counselor's clinical skills and ability to adhere to the model and the intervention. Programmatic leaders may also weigh in on client caseload, as they have a greater understanding of logistical considerations (e.g., travel time, scope of work).

It is important to remember that in the beginning, counselors are still learning new clinical skills. In order to prevent the counselors from becoming overwhelmed or burnt out, it is often helpful to stagger case assignment. Staggering case assignment allows the supervisors, trainers, and/or program managers to slowly build each counselor's caseload while at the same time monitoring the counselor's quality of work, fidelity to the model, and ability to remain calm under pressure. Different levels of severity among cases and should be considered when determining caseload. As counselors (and supervisors) gain more experience and become more adept at delivering treatment, they can increase their caseloads.

B.5.2 TREATMENT

Once cases are assigned, treatment should follow according to the protocol of the intervention being used. Most EBTs are manualized and suggest 8 to 16 one hour sessions on a weekly basis (see section B.2. "Intervention Selection" for more information on the different forms of treatment and what they include). There are several points that all counselors, supervisors, and organizations should be aware of. We review these below, including client engagement, scheduling and keeping appointments, and planning around leave.

B.5.2.1 CLIENT ENGAGEMENT

Client engagement is vital to the success of any intervention, and particularly important for mental health (McKay & Bannon, 2004). For many clients it is difficult to come to a counselor and open up about their problems. Many clients who have had traumatic experiences may also avoid talking about them, and thus may have even greater difficulty attending sessions. In many low-resource countries, talk-therapy mental health interventions (i.e., non-medication) may be a fairly new concept, and people receiving care for a mental illness may be stigmatized. By spending some time encouraging participation in the mental health treatment, counselors can help prevent problems with attendance and participation. While interventions may vary, all treatments should include client engagement strategies. To engage clients in the mental health treatment, counselors may emphasize the following points:

- *Explain to clients that this is a special opportunity:* Describe this treatment as something that the client would **want** to be part of. This may be done by describing it as an opportunity to be part of a special program. In some cases, it can be important to explain who is involved in the startup of this program and emphasize how this may impact treatment for people with similar problems throughout the area.
- *Tell them about the program (what it helps with, how much time it takes):* The counselor may explain what the program will teach, what the counselor and client will work on, and what the client will learn that will directly help her/his individual problems. In many evidence-based mental health treatments, there is an emphasis on linking the treatment to each client's goals.
- *Problem-solve potential barriers of coming to treatment:* It is helpful to ask clients if they have any concerns about coming to treatment (McKay et al., 1996). Once the client has shared her/his concerns, the counselor can try to help with some of the immediate barriers. Sometimes this means giving the client more information about the therapy, or answering questions. Other times this means helping the client problem-address challenges, such as transportation. For example, a counselor may ask questions to find a way that the client may be able to get to the therapy session each week, help them with a bus schedule, or arrange for an organization to help with transport funds.

B.5.2.2 SCHEDULING AND KEEPING OF APPOINTMENTS

Clients often have difficulty understanding why they need to meet with a counselor multiple times for treatment. Depending on the location, the population may be used to counseling that lasts only 1-2 sessions, or perhaps they are used to taking a pill to help with a problem rather than attending therapy. It is important to explain how long a client will need to meet with a

counselor, and **why** this is important. Explaining “why” tends to be easiest when using an analogy. One of the most common analogies is when someone needs to take a medicine for a week in order to cure an infection. A counselor might say, “Have any of you or someone in your family ever taken medicine for an infection? What did the doctor say about taking the medicine? For example, did the doctor say take it only 1 time and you are healed or take it as you wish? [Let client answer]. No, you had to take it 1 or 2 times a day for a week or so, right? So you had to take it on a schedule and take it for a period of time, not just 1 day?” Explain that this is the same type of treatment in that they have to come in for a period of time. Another example used is going to school. “Did you go (or send your children) to school just one day, or did you (your child) have to attend school daily to learn?”

B.5.2.3 PLANNING AROUND VACATION, LEAVE AND HOLIDAYS

Just as it is important for clients to come consistently for treatment, counselors must also understand the importance of keeping their appointments with clients. Vacation, leave time, and holidays are inevitable in any organization with full time staff, and are important in preventing staff burnout. While we would not want counselors to stop taking vacation and/or holidays, it is important to plan treatment around these times so that clients do not have long gaps between sessions. Gaps in treatment are not good for the client. Treatment gaps can impact the effectiveness of the intervention as well as cause the client unnecessary distress. If the counselor is unavailable during specific times, it can be very harmful for the client. For example, when using an intervention for trauma (e.g., sexual abuse that has led to an HIV diagnosis) that includes a gradual exposure component, counselors need to plan carefully. It can be detrimental to the client to start the gradual exposure component, in which they discuss the intimate details of their trauma, and stop in the middle because their counselor is on leave and inaccessible. It is very easy to prevent such issues. For leave time and vacations, counselors should plan carefully and use one of two options: (1) take leave time when there is a gap in case assignment (this can be used in cases where counselors are assigned all clients at once) or (2) stop treatment before entering particular components (e.g., gradual exposure) and wait until after the counselor’s leave time to begin these components. In situations where neither of these options is possible, a counselor may want to increase the frequency of client visits to complete the treatment prior to their vacation or leave. It is possible to have another counselor “check-in” or monitor clients to ensure safety for another counselor while they are on leave. However, having the alternate counselor temporarily take over the case and continue the intervention is not recommended.

While holidays are still of concern, they tend to be less of an issue than vacation or leave. In instances where there is a public holiday it is recommended that counselors still see their

clients that week; those scheduled on the day of the holiday may need to be rescheduled for a different day.

B.5.3 VICARIOUS TRAUMA AND COUNSELOR SELF CARE

B.5.3.1 WHAT IS VICARIOUS TRAUMA?

Vicarious trauma (VT) is the process through which the counselor internalizes the client's traumatic experiences to the extent that it impacts the counselor's functioning and ability. It can also be described as the cumulative transformative effect upon the professional who works with victims of trauma (Saakvitne & Pearlman, 1996). In any setting, VT can lead to negative effects such as burnout, depersonalization, and feelings of reduced personal accomplishment as well as chronic fear/anger, resentment, posttraumatic stress symptoms, and difficulty functioning in work and in personal relationships. All counselors working in the field may be exposed to traumatic content. It is not a question of whether or not the counselors will be affected by VT but when and how severely.

B.5.3.2. ADDRESSING VT AT YOUR ORGANIZATION

It is especially important to attend to counselor self care and issues of VT in low-resource contexts where the counselors have often been affected by situations similar to clients' experiences (e.g., in conflict settings, areas with high prevalence of HIV and AIDS, poverty etc.). The impact of VT can vary based on the counselor's own mental health, social supports, coping skills, and support within the organizational structure.

In order to prevent VT, burnout and high levels of attrition, the organization should work with each counselor to set up a personalized self-care plan prior to starting work that is then tracked by the supervisors.

B.5.3.2.A. STEP ONE: ORGANIZATIONAL PLANNING

Before helping individual counselors create their self-care plan, it is important to have organizational structures and supports in place to prevent staff VT. Organizational recognition of the occurrence of VT is important not only for staff working in the program but for all staff working with vulnerable populations. Steps each organization should take before counselors begin treatment include:

- Acknowledgement by organizational structures of the possibility of VT

- Creating opportunities for staff to receive consistent ongoing professional development and treatment
 - Supervision, peer consultation, seminars
 - Personal psychotherapy (if needed)
- Developing a collegial support network at the organization
- Ensuring balance in employees work loads
- Providing outlets for stress reduction such as exercise programs or social activities

B.5.3.2.B. STEP TWO: INFORMING STAFF ABOUT VT AND ASKING THE RIGHT QUESTIONS

Once the organization has systems in place to help prevent and treat VT, it is recommended that supervisors inform each of their staff (specifically counselors or those working directly with trauma) on VT, including the symptoms, risks, and early warning signs. These educational sessions should focus on prevention strategies, including steps each individual can take to protect against VT. Supervisors should also work with each counselor to write up an individual plan to help them identify their personal warning signs of VT as well as recommended coping strategies. In order to do this, supervisors should have each counselor identify the following:

- Who/what organizations serve as her/his support?
- What are her/his familiar coping strategies?
- What is her/his emotional style?
- What are her/his vulnerabilities?
- What are personal warning signs that she/he is feeling stressed (i.e., drinking more, not sleeping well, etc.)?
- Write down three things she/he can do to address vicarious traumatization for each arena:
 - Professional
 - Organizational
 - Personal

It is then the supervisor's responsibility to monitor each counselor's level of stress and signs of VT. If a counselor is found to have high levels of VT, we recommend that the supervisors immediately bring it to the attention of their supervisor and seriously consider having the counselor stop treating clients, as the counselor's state may put the client at further risk.

B.5.4 TROUBLE SHOOTING

As with any new program, there are bound to be challenges and problems that arise during the implementation process of a new mental health intervention. Problems can include programmatic issues such as the need for extra resources or they can be related to technical issues surrounding the implementation of the program itself. For purposes of this manual, we will focus on the technical implementation issues, which include how to handle difficult counselors and cases, as well as how to address no-shows and dropouts. Each issue is described in detail below.

B.5.4.1 COUNSELOR SKILLS AND ABILITIES

In low resource contexts, those trained in the evidenced based mental health intervention often have less training than those using these interventions in developed country settings. In the west, counselors typically have to be licensed social workers, licensed mental health counselors, psychologists, and psychiatrists to be trained in and actively implement EBT's. As a result, programs using less trained counselors may face difficulties with the counselors' ability to grasp the intervention model. In order to prevent this from happening, the trainings and supervision of EBT's in low-resource contexts are adjusted for the skill level of the counselors, allowing extra time for training and supervision (see Section B.3 for more information on training and supervision). If, however, a counselor continues to struggle with the application of a treatment model following training and supervision, we recommend that the supervisors and U.S. trainers discuss the case on an individual basis to determine the counselor's specific needs and whether or not the program can meet those needs (e.g., would the counselor improve with one-on-one intensive time with the supervisor and is the supervisor available to do this?). If the program cannot provide the extra support for a particular counselor and that counselor is unable to use the model correctly, we advise that the counselor be taken off the specific program (i.e., she/he can continue counseling but not using this particular model). This is done in order to prevent harm to clients since most EBTs deal with very sensitive topics and/or clients in vulnerable states. If used incorrectly, an EBT could cause harm to the client.

Another major issue that may arise is the issue of motivation. Although this is infrequent, it sometimes happens that the newly-trained counselors expect or want some compensation for participating in the training and/or for using the treatment. For example, a counselor could refuse to use the treatment after participating in the training unless she/he receives additional payment for work. It is important to differentiate this issue from the need to supply counselors with additional *talk time*, supplies, or increased compensation to reflect their mastery of new skills since (i.e., they have a higher skill set) (See section B.2 Feasibility Considerations for more information on additional resources that may be needed to successfully implement the intervention). It is important to keep these concerns in mind when selecting staff to train (see

section B.1.1). This should prevent hiring counselors that are motivated by money alone. However, if a counselor is brought on to the program that has expectations of making above what is feasible or sustainable for the program, we would urge the program to not use them in the program and that the counselor not be certified in the treatment (see section B.3 Training and Supervision for more information on the apprenticeship model and requirements for certification). Continuing to use counselors who are extrinsically motivated may decrease the quality of work and/or put clients at risk for harm. For example, there was one case that JHU AMHR worked with in which the organization agreed to pay a counselor who was demanding extra payment for work. The counselor went on to see more cases than any other counselor in the program. It was found out later that the counselor did not actually see any of the clients and instead made up case notes and supervision reports solely to receive payment. In order to avoid such situations, we recommend implementing a rigorous interviewing process prior to starting the intervention and discontinuing the use of any counselors who are solely motivated by the money she/he will receive.

B.5.4.2 DIFFICULT CASES

In any situation where mental health treatment is being offered, there are bound to be a few difficult cases or times when a case becomes challenging. Issues that may arise include situations ranging from crisis (i.e., suicide/homicide risk) or other safety concerns (current domestic violence or military attacks) to issues such as clients showing up consistently late for sessions or homework non-compliance. In these situations, counselors should turn to supervisors for assistance with problem solving. In every intervention, supervisors are trained in how to handle these situations as well as other difficult/challenging situations that may arise while using the treatment model. Supervisors are also encouraged to contact the U.S. trainers and/or the AMHR team (see examples below.)



Example A:

A female adult recently found out she was HIV positive, and was told that she was no longer supposed to have sex and should not have children. She presented at the first meeting with the counselor expressing suicidal thoughts. She said, “This is the reason I am here – to please my husband and to have children. If I cannot do these things, there is no point to living.” She had a planned to kill herself. The counselor followed the safety plan laid out for his program, and instituted a 24-hour safety contract with the client. The supervisor helped the counselor make regular visits to the client’s house to assure safety, while working through the treatment that has been shown in other studies to decrease depressive symptoms. The client continued to be very high risk and to have a strong desire to kill herself. The local supervisor arranged for her to be seen by a psychiatrist who was able to prescribe her an anti-depressant drug to help.



Example B:

A female child client was receiving mental health treatment due to past traumatic experiences including being physically abused by her biological parents (not her current caregiver) and sexually abused by a local minibus driver. She was also known to be HIV positive. The client was not complying with home-practice as part of treatment, and was continuing to engage in very high-risk behavior such as engaging in sex work and taking the minibus with the person who abused her. The counselor felt that, given her HIV status, the client was a danger to herself and others. The counselor and supervisor followed the specific safety plan developed for their area, but the high-risk behavior continued. The supervisor spoke with the trainer and together they decided that the caregiver was having trouble keeping the child safe (the caregiver had stated this), and that more help was needed. Their first idea was to see if the child had a relative that might be able to take her for a short time. Unfortunately, there were none found. The supervisor then contacted different shelters in the area, asking if one of them could take the child for a short time until she received more sessions of treatment and hopefully started improving. The child was sent to a shelter, and stayed there for the majority of the intervention (8 weeks), at which point she returned home.

B.5.4.3 DEALING WITH NO-SHOWS AND DROP-OUTS

Dropouts and no-shows are inevitable in any clinical setting. However, there are actions that can be taken in order to prevent or limit the number of dropouts and/or no shows. Initially counselors should be sure to engage clients. This can be done by working through any barriers to treatment that may result in dropouts or no-shows (see section B.5.2 Treatment, Client Engagement). In addition to working on engaging the client at the start of treatment, counselors may also perform weekly reminder calls or throughout the treatment. Clients may not always have a phone; in these cases, visits to the home may be more feasible (although also more time consuming).

Every program should also integrate a monitoring system to track attendance and dropouts. Through simple monitoring forms (e.g., attendance list with space for reasons that client did not attend), a counselor can monitor client attendance patterns and reasons for no-shows and/or dropouts. This system will inform the program so that adjustments can be made to reduce the number of dropouts/no-shows in the future. For example, a counselor may be running a group therapy session for women every Wednesday at 9 a.m., and every week only half of the women show up. If the counselor inquires as to why there are so many no-shows, she/he may find out that Wednesdays are actually market day, and having the group at that

time prevents the women from being able to sell their goods to make money each week—which is why half of them do not come. Once the counselor is aware of this, she/he can change the day so that the group does not fall on such an important or inconvenient day; this should increase the attendance in her group.

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APPENDIX A: EXAMPLES OF EVIDENCED BASED PRACTICES

BEHAVIORAL ACTIVATION

Behavioral Activation (BA) therapy for depression is a behavioral treatment for adolescents and adults who suffer from depressive symptoms. BA focuses on helping clients understand and identify outside sources that may impact their depression and helps them then focus on changing these environmental factors. The treatment is based on the principle that people experiencing depression are often isolated and do not partake in activities that bring them pleasure, joy or a feeling of self efficacy. BA works by helping clients identify pleasurable activities to improve their mood and start activities that make him or her feel useful or efficacious. Changing these behaviors can help improve an individual's mood, feelings and thoughts. The treatment consists of 10-12 one- hour sessions with associated homework assigned each session. As a client becomes more skilled, session length may decrease to 15-30 minutes.

Program Description

Behavioral Activation involves several stages of treatment: psychoeducation, identifying potential activities, creating the activity hierarchy, charting progress and rewarding progress.

Psychoeducation

Clients are provided with information on common behaviors exhibited in depression as well as an explanation of how the treatment works by focusing on improving feelings/mood and thoughts through changing their behaviors. Clients are also provided with a summary and goals of the treatment.

Identifying Potential Activities

The counselor works with the client to identify enjoyable or pleasurable activities or things that she or he would like to do that would bring pleasure. Clients can consider activities related to their family, social or intimate relationships, education, training, employment, career, hobbies, recreation, volunteer work, physical or health issues or psychological issues. These activities can vary and include anything from daily tasks such as getting up at 7 a.m. more frequently to more complicated activities such as visiting distant relatives.

Creating the Activity Hierarchy

After creating a list of activities the counselor works with the client to rank the activities from easiest to accomplish to hardest to accomplish.

Charting Progress

The counselor and client develop a plan on how and when the client should complete the activities each week that is based on the client's goal for how frequently they would eventually like to complete this activity on a weekly basis. They also work together to develop some way of tracking these activities as well as the client's feelings while doing the activities.

Rewarding Progress

The counselor assists the client in choosing a reward for completing their goals and developing a schedule for the rewards. Rewards are obtainable activities or items but should not be items that are on the client's activity list.

Homework

At the end of every session the client is asked to pick one activity to try in the next week as homework. Ideally the client needs to try the activity 3-5 times, depending on the activity, during the week and notice feelings or mood before and after.

In BA, homework is a key aspect of the treatment since most of the activities are not things that can be accomplished in the office. The success of the treatment relies on the client's ability to engage in the activities set forth in therapy on their own at home. If a client is unable to complete their homework the counselor works with them to problem solve and develop a specific plan of action for this homework.

Client Requirements for BA (in the West)

- Clients must be able to attend 10-12 sessions with the counselor
- Clients must do weekly homework assignments
- Clients must be between the ages 18 and 65
- Has been used for other mental health problems such as Post Traumatic Stress Disorder

Estimate of Counselor requirements in BA (in the West)

- Counselors must have some experience in counseling or mental health
- Counselors need to attend a 2-week training
- Counselors have to meet with clients on a weekly basis
- While actively seeing cases, counselors must participate in weekly supervision

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PROLONGED EXPOSURE THERAPY

Prolonged Exposure (PE) Therapy for Posttraumatic Stress Disorders is a cognitive-behavioral treatment program for adult men and women (ages 18-65+) who have experienced single or multiple/continuous traumas and have posttraumatic stress disorder (PTSD). The program consists of a course of individual therapy designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety. As developed, treatment consists of 8-15 sessions conducted once or twice weekly for 90 minutes each. The duration of treatment can be shortened or lengthened depending on the needs of the client (NREPP & SAMHSA, 2007).

PE directly targets trauma-related avoidance and re-experiencing of the trauma memory through repeated revisiting of the trauma memory and approaching things that have been feared and avoided since the trauma. This helps get control of the memory and enhances regaining one's life.

Program Description

CPT includes four components: education/rationale, breathing retraining, behavioral exposure and imaginal exposure. Each are described below:

Education and Rationale

PE starts with education about the treatment. Clients learn about common trauma reactions and PTSD. Clients are also given an overview of the goals of the treatment. This education provides the basis for the next sessions.

Breathing Retraining

Clients are taught breathing retraining which is a skill that will help them to relax. When people become anxious or scared, their breathing often changes. Learning how to control their breathing can help in the short-term to manage immediate distress.

Behavioral Exposure

In vivo exposure is introduced to clients. *In vivo exposure* includes having clients systematically practice approaching situations, buildings, people that are safe but that they may be avoiding because they are related to the trauma. An example would be a person who avoids walking down a particular street because that is where they had been attacked previously but it is also the same route they need to take to get to work. The goal is to lessen the distress that resulted from the trauma and to allow the client to have more control over their life and environment. This would not be used in cases where the environment, person or place is still a threat/dangerous.

Imaginal Exposure

Clients are asked to remember the traumatic event and talk about it in detail with the counselor. Through this process clients also identify their thoughts and feelings about the trauma. Continuously talking about the event in a safe controlled environment will help decrease the client's level of physical arousal and distress when thinking about or remembering what happened. Typically, sessions are audio-recorded and clients receive homework to listen to the stories throughout the week.

Processing the revisiting of the trauma:

This is used to consolidate the new perspectives/new learning that occurs during the revisiting. This focuses on salient themes that emerge from the revisiting, including beliefs about oneself, others, and the dangerousness of the world.

(US Department of Veterans Affairs, <http://www.ptsd.va.gov/public/pages/prolonged-exposure-therapy.asp>)

Client Requirements for PE (in the West)

- Clients must be able to attend 8-15 sessions with the counselor
- Clients must be between the ages 18 and 65
- Can be used for a range of traumatic events (i.e., military combat, sexual assault)

Estimate of Counselor requirements in PE (in the West)

- Counselors must have some experience in counseling or mental health
- Counselors need to attend a 2 week training
- Counselors have to meet with clients on a weekly basis
- While actively seeing cases counselors must participate in weekly supervision

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COGNITIVE PROCESSING THERAPY (CPT)

Cognitive Processing Therapy (CPT) is a 12-session therapy that was originally designed to reduce Posttraumatic Stress Disorder (PTSD) in victims of rape and sexual assault (Resick & Schnicke, 1992). Since this initial study CPT has been tested and used successfully with a range of traumatic events including rape, sexual assault, domestic violence, military combat and torture.

Theory Behind CPT (taken from CPT Manual)

CPT focuses on how a person who has experienced a traumatic event, like torture but also other traumatic events (rape, motor vehicle accidents, combat, domestic abuse, child abuse), thinks about what happened and how that person tries to cope with what happened. CPT focuses on both thoughts about the trauma itself and also thoughts about safety, trust, power/control, esteem, and intimacy. Traumatic events can affect people's thinking about both what happened and what it means about them, other people, and the world, in ways that are extreme or unhelpful. These thoughts lead to strong emotional reactions. Often people avoid trauma-related feelings, memories and reminders because they lead to strong emotional reactions. These avoidance behaviors affect the person's life and become problems in themselves. For example, a person might avoid other people to not have to think about the trauma. By doing so, that person becomes socially isolated, which is also a problem. Avoidance behaviors can lead to both the avoidance symptoms of PTSD and to depression. According to the theory behind CPT, if people stop avoiding, feel their emotions about the event, and learn skills to help them think about the traumatic event (the torture) in a way that is more balanced and helpful, their emotions will become less intense, it will lead to more positive behaviors, and their symptoms will improve (Kaysen, D. & Lindgren, K, 2010). The goal of CPT is to teach clients skills so that they can change their own trauma-driven beliefs to improve emotions, behavior, and functioning.

Program Description

SESSION 1

During the first session, clients are given an overview of the treatment as well as a description of trauma related symptoms and rationale for those symptoms. They are then given a homework assignment to write about the meaning of the event to them, referred to as the impact statement.

SESSION 2

Clients read the impact statement with the counselor. Clients are also taught to identify and differentiate feelings from thoughts and are given a homework assignment that helps them see

the connection between thoughts and emotions.

SESSION 3 and 4

Clients are asked to write an account of the worst traumatic event and identify emotions and thoughts they have relating to this event.

SESSION 5

Clients identify inaccurate and unhelpful thoughts and beliefs. Using open-ended questions, counselors help clients examine their thoughts.

SESSION 6

Clients are taught to identify mental short-cuts or patterns they use that tend to lead to more extreme or rigid thinking. Clients are assigned a worksheet on patterns of problematic thinking.

SESSION 7

Counselors teach the client how to test his or her own beliefs to see whether they are extreme or unhelpful using the Challenging Beliefs Worksheet (CBW). Clients are also taught how to generate new more balanced thoughts and to notice the change in emotions. During this session, safety, one of 5 main themes in CPT, is introduced. The five themes are areas that are often affected by trauma and include safety, trust, power and control, esteem and intimacy. The client is asked to consider how the trauma could have negatively affected his or her thoughts in each of these areas as well as to notice how those thoughts are affecting his or her feelings, behavior, and symptoms.

SESSIONS 8-11

The remaining themes (trust, power, control, esteem and intimacy) are examined. At the end of the 11th session clients are asked to write another impact statement without referring to their initial impact statement

SESSION 12

Clients discuss the intimacy them and read their new impact statement. The therapist and client discuss gains that the client has made through treatment and identify the client's goals for the future and/or any areas he or she wishes to continue working on.

Client Requirements for CPT

- Developed for people with a wide range of comorbid disorders and extensive trauma histories
- Can be used 3 months to 60 years after the worst trauma

- Should not be used with those who do not have trauma symptoms
- If a client is a danger to themselves or others treatment of trauma symptoms is not the most immediate treatment goal as well as if someone is in imminent danger- safety planning is the first goal. However, just because someone might experience another traumatic event does not mean that he/she could not be treatment successfully
- Requires homework but does not require client literacy.
- Designed for clients 18 years or older

Estimate of Counselor requirements in CPT

- Counselors must have some background/experience in counseling or mental health
- Counselors must attend a 2-week training (for international settings)
- Following the training, counselors will meet with clients on a weekly basis
- While actively working with CPT, counselors must attend weekly supervision meetings. Supervisors of those meetings speak weekly to CPT trainers.

References for Research on CPT

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TRAUMA FOCUSED COGNITIVE BEHAVIORAL THERAPY (TF-CBT)

TF-CBT is a therapy that helps children/youth ages 5-18 years and their families who have been affected by traumatic events and/or traumatic grief. Traumatic events include physical and sexual child abuse, rape or assault, exposure to domestic or community violence, serious accidents, natural or human disasters, violent crime, violent or sudden death, or any other experience that creates threat or fear. The child/youth may actually experience the event, witness the event or have a close loved one who experienced the event.

How to tell if TF-CBT is the right treatment

TF-CBT is mainly a treatment for traumatic stress, but it works for depression and other anxieties that might go along with the traumatic stress. Traumatic stress is reactions to a trauma event that are very upsetting and cause problems for the child/youth at home, school or other activities. Traumatic stress includes having upsetting memories or being upset at trauma reminders, sleep problems or nightmares, avoiding people or situations that are reminders of the trauma, becoming numb, having concentration problems, being irritable or being overly alert or jumpy, and/or having difficulty with relationships.

The selection of an appropriate treatment plan is usually decided through the use of an evidenced-based assessment of the child/youth to find out how much traumatic stress s/he has experienced. If the child/youth has significant traumatic stress symptoms then TF-CBT may be the right therapy.

Evidence-based assessment tools that have been validated for use in Zambia include:

1. Child Behavior Checklist (CBCL): A Parent/Guardian measure that assesses issues caregivers can observe in their child – behavior problems, school problems, somatic complaints, depression, and anxiety.
2. PTSD-Response Index (PTSD-RI): A measure that allows the child to report the traumas they may have experienced and a range of symptoms associated with those traumas.
3. Shame: A child measure of symptoms of shame specific to sexual abuse.

How do we know that TF-CBT is effective?

Many studies have shown that children/youth's traumatic stress and depression improve more with TF-CBT than non-specific therapy or generally counseling. These studies have also shown that TF-CBT benefits Children/youth with all kinds of different traumas, boy and girls, and children/youth from different ethnic backgrounds.

What does TF-CBT involve?

1. *Psychoeducation.* The child/youth and parent/caregiver learn about traumatic stress, typical reactions, why they happen, and what is involved in the therapy. An important piece of information is that most children/youth will recover especially if they have effective treatment.
2. *Emotion regulation.* The child/youth and parent/caregiver identify typical trauma-related emotions such as fear or anxiety, sadness or grief, anger, and shame and learn specific skills to handle these negative emotions in constructive ways.
3. *Correcting unhelpful thoughts.* The child/youth and parent/caregiver identify unhelpful trauma-related thoughts/beliefs such as: “this is all my fault”, “I am not worth anything”. They learn more accurate and helpful ways to think about what happened.
4. *Trauma narrative.* The therapist helps the child/youth to talk about what happened in a slow, safe way. This allows the child and family to stop avoiding the trauma and learn how to handle trauma reminders.
5. *Positive parenting.* This component is for parents/caregivers who are involved in the healing of the child/youth. The therapist will help them learn to handle the child/youth’s difficult to manage behaviors and behaviors that interfere with family relationships.

What to expect in TF-CBT:

This is a structured intervention where the child/youth and parent/caregiver learn new and better ways to handle negative feelings and problem behaviors and more helpful ways to think about what happened. The trauma-focused part means that the child/youth and parent/caregiver talk about what happened and the child/youth becomes able to share the experience. This is sometimes hard in the beginning because both the child/youth and the parent/caregiver may have strong feelings when they remember or think about the trauma. It is understandable that both the child and their parent/caregiver may want to avoid remembering or worry that having to remember will make things worse. But remembering the experience in a safe environment is the best way to reduce the negative feelings. When the feelings become less strong and more manageable it makes it possible to put the trauma into perspective and make it a part of the past.

How long does TF-CBT take?

Many children/youth complete TF-CBT in 12-15 sessions. Some families need fewer sessions, and others need more. TF-CBT is flexible and individualized to the needs of each child/youth and family.

Requirements

Since evidence-based mental health assessments and therapy are relatively new in low resource contexts, implementation requires a process of training, regular clinical supervision, and monitoring and evaluation.

COMMON ELEMENTS TREATMENT APPROACH (CETA)

A Common Elements Treatment Approach (CETA) is based on the fact that EBTs (most of which are cognitive behavioral) are made of similar elements. For example, most EBTs for a variety of disorders all contain psychoeducation and cognitive coping. The idea is to train counselors in a range of different components that are similar across EBTs, and then teach them how to: 1) select which components to use; 2) sequence the components; and 3) decide on a “dose” of each component (or how many sessions might be needed). These decisions are based on a client’s presenting problems. Thus, rather than training on one packaged approach specifically for one disorder (e.g., Depression), a components based approach allows counselors to have the skills to treat at least the three big mental health problems of trauma, depression and anxiety (and behavioral problems for youth). This approach could be particularly helpful in low-resource countries where the ability to train counselors in multiple EBTs is not likely, and there are limited counselors available.

CETA or a “modular approach” was developed in the United States and is currently being tested, with good outcomes so far (Barlow et al., 2008; Ellard et al., 2010; Farchione et al., 2012; Borntrager et al., 2009; Weisz et al., 2012). The prevailing thought is that this approach is NOT a new treatment but is instead a new way of teaching counselors how to treat multiple problems with the same components that have already been shown to be effective. CETA is the same approach, but developed specifically for use in LMIC, utilizing fewer components and simplified decision rules. Below is an example of some components used in CETA.

What are some Components included in CETA?

Core Components:

Pre Treatment

- *What:* Counselors conduct the intake, assessment and consent forms as well as begin to engage the client in treatment.
- *Why:* This session is used to assess who needs the treatment and who does not as well as to build the foundation for the treatment, get buy-in to treatment from the client/family, establish common goals of therapy and reduce resistance to participating in the treatment.

Encouraging Participation

- *What:* Counselors talk to the client and family about why mental health services are important, identify attitudes about mental health treatment and problem solve around practical barriers to care (both logistical/concrete barriers as well as subjective/perceptive barriers).

- *Why:* By openly discussing a client’s attitude to mental health treatment a counselor can more easily engage the client in active problem solving around barriers to treatment and decrease the client and their family’s resistance to treatment.

Psychoeducation

- *What:* Counselors provide information about the problems the client reported during the pre-treatment session as well as information about the treatment process (length of treatment, goals, etc).
- *Why:* By teaching clients that their symptoms are normal and experienced by many people, we hope to de-mystify the idea of a “mental health problem”, reduce self-blame and other negative or inaccurate thoughts around the problem.

Cognitive Coping

- *What:* Counselors talk with clients about how thoughts, feelings, and behavior are connected in order to focus on how they can think in different ways about a situation, which will then change their feelings and behaviors or actions.
- *Why:* In this component, the focus is specifically on learning to change thoughts. We want the client to understand that how someone *thinks* about an event or situation (and not just the event/situation itself) can impact feelings and behavior – and ultimately help the client feel better.

Gradual Exposure - Memories (for Trauma)

- *What:* The counselor engages the client in a direct detailed discussion about the traumatic events they have experienced.
- *Why:* Talking about the details of traumatic events, and connected thoughts and feelings helps reduce fear, sadness, avoidance and anger associated with times when a client remembers or is reminded of what happened.

Cognitive Reprocessing

- *What:* Counselors challenge client’s unhelpful and/or inaccurate thoughts using a series of techniques.
- *Why:* When a person thinks unhelpful and inaccurate thoughts it makes them feel bad. If a client thinks differently about these unhelpful thoughts, they will feel better.

Enhancing Safety

- *What:* Counselors ask clients specific questions about safety and suicidal ideation.

- *Why:* A client's safety is our first priority. Asking questions about safety often also normalizes the fact that individuals who have been through trauma sometimes think about or wish to die.

Extra Components:

Live Exposure (for Fear based Anxiety of a specific place/thing)

- *What:* Counselors talk with clients about slowly facing a place/thing that they are afraid of, step-by-step.
- *Why:* The best way to reduce feelings of fear/anxiety is to stop avoiding the feared/avoided thing. This way, it stops causing the client a lot of fear and they will not have to avoid it anymore.

Relaxation (for physiological anxiety)

- *What:* Counselors teach clients skills and activities to help them relax their bodies.
- *Why:* Some common mental health problems include arousal, tension, anxiety, etc. It is important to learn ways to cope with this and reduce the stress a client feels physically in their body.

Behavioral Activation (for more depressive symptoms)

- *What:* Counselors work with the client to identify activities that they can do that are enjoyable.
- *Why:* People that experience mental health problems often show maladaptive behaviors. One of these is stopping doing things they like to do. Starting to do things that are enjoyable can help change feelings and thoughts. Doing things that the client likes can help them feel better.

Behavioral Intervention for Substance Use

- *What:* Counselors talk directly with clients about their use of alcohol or other substances in a confidential environment in order to provide feedback about questions the client answered (from their AUDIT score) on their substance use, risks related to drinking/substance use and in order to give clients some options and choices. Substance use is assessed in the initial stages of treatment along with other safety issues and then comes in each subsequent session if needed.
- *Why:* It is important that clients are able to talk openly about their use of alcohol or other substances in order to begin to make changes to their substance use. This is done

because it can be important for their health and for relationships in the family and community.

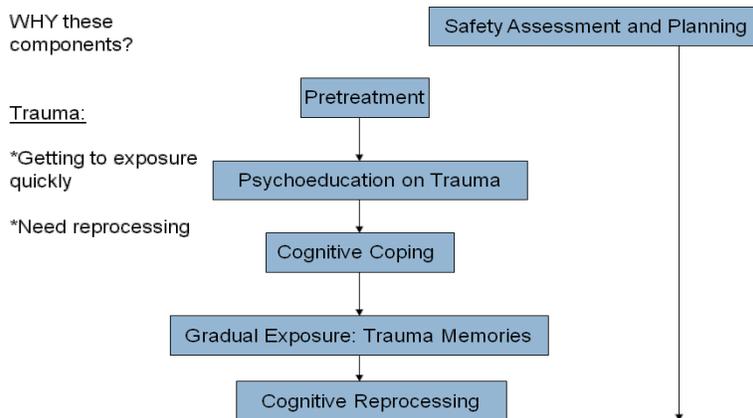
Choosing which components to use

As part of the training for the components based treatment, counselors are taught how to identify what is/are the primary clinical condition(s) causing the most impairment and distress to the client. This process is data driven and counselors arrive at their decision based on information gathered from clinical interviews, the assessment measures and discussion with the counselor’s supervisor.

What does treatment look like?

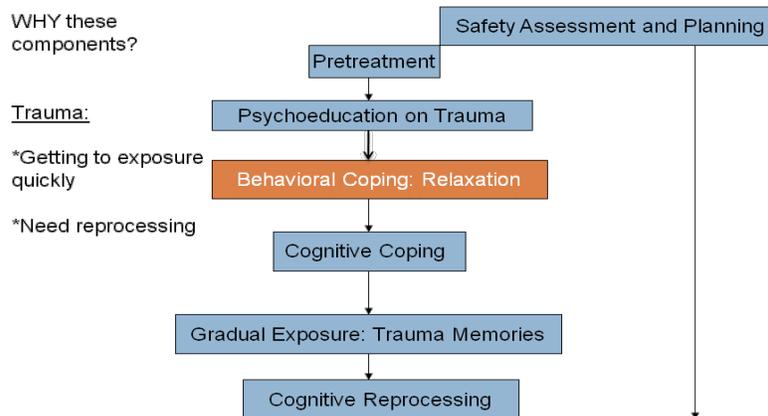
The course of treatment varies depending on the client’s primary problems. For example, research shows that for those clients who have experienced a traumatic event and as a consequence have high trauma symptoms (i.e., avoidance, arousal and re-experiencing symptoms) gradual exposure is the most important component and therefore should be done as soon as possible in the treatment. The graphic displayed below shows a sample “flow” that may be chosen for a trauma case.

Predominantly Trauma Syndrome



If for example this same presentation came in, but the person was also highly nervous, physiologically aroused, etc., we would add in relaxation to help this person learn skills to calm him or herself physiologically. This type of case may need the behavioral coping skill of relaxation in order to move through the other components, and also to function in their daily life. This flow may look like the image on the following page:

Predominantly Trauma Syndrome



Client Requirements for CETA

- A CETA client is considered an active participant to ensure a teamwork approach.
- Much of the work takes place out of session. Homework is a key component to most EBTs and thus also of CETA treatment and will be given on a weekly basis.
 - However, this is flexible, and homework assignments vary given the context and capacity of the individuals.
- Usually, CETA treatments meet weekly for a one hour session with the therapist for 12 plus weeks (in either group or individual format)
 - Again, this is flexible.
- Coming to session is important and clients must be able to attend sessions on a regular basis.

Estimate of Counselor requirements in CETA

- We have trained those with little to no MH background and only high school equivalent educational backgrounds.
- Most important is willingness and desire to learn, and help patients.
- A good skill is to be good with people (e.g., empathetic, understanding, etc.)

- Thirty minutes preparation for client session in the beginning when they are still learning the model is required.
- Weekly one hour sessions with the client, or 2 hour sessions with meeting fewer times.
- Fifteen minutes post session for documentation (case notes).
- Weekly one to two hour group supervision meetings.

MOTIVATIONAL INTERVIEWING

Motivational Interviewing (MI) is a goal directed therapy that can be used for male and female adults age 18 + who suffer from a wide range of problem behaviors. While the original concept for MI and the majority of the research with MI is related to alcohol and substance abuse the treatment can also be used for problems associated with health promotion, medical treatment adherence and other mental health issues. The treatment works by increasing a client's intrinsic motivation through exploration of and resolving any ambivalence or resistance to changing as this ambivalence is the main obstacle that prevents them from changing their behaviors and/or achieving goals.

Program Description (taken from NREPP, SAMSHA)

MI counseling style generally includes the following elements:

- Establishing rapport with the client and listening reflectively.
- Asking open-ended questions to explore the client's own motivations for change.
- Affirming the client's change-related statements and efforts.
- Eliciting recognition of the gap between current behavior and desired life goals.
- Asking permission before providing information or advice.
- Responding to resistance without direct confrontation.
- Encouraging the client's self-efficacy for change.
- Developing an action plan to which the client is willing to commit.

Client Requirements for MI (in the West)

- Clients must be able to attend face to face sessions with the counselor although length of treatment may vary.
- Clients must be age 18 or above.

Estimate of Counselor requirements in MI (in the West)

- Counselors must have some experience in counseling or mental health
- Counselors need to attend at least 7 days of training
- Counselors have to meet with clients on a weekly basis
- While actively seeing cases counselors must participate in weekly supervision

APPENDIX B. PSYCHOSOCIAL CARE AND COUNSELING FOR HIV-POSITIVE CHILDREN & ADOLESCENTS

Meeting the Psychosocial Needs of HIV Infected Children and Adolescents: An Overview of the Psychosocial Care and Counseling Program

SUSAN STRASSER, TECHNICAL ADVISOR - EGPAF ZAMBIA

Children living with HIV struggle with many psychosocial issues which could benefit from competent basic counseling and support. While psychosocial support is commonly mentioned as an important component of comprehensive care for children living with HIV infection, it is often vaguely defined, given lip-service or perceived as an “add-on” activity. In addition, there has been a lack of training curriculum and job aids to enable health care workers to provide meaningful psychosocial support to children in need.

A number of issues affect children’s psychological and social wellbeing. As parents and caregivers we often misread children’s attempts at communicating intense feelings and worries and in the process children’s voices go unheard or misunderstood. Many children do not know their HIV positive status, receive conflicting messages about their chronic health care needs, and are dealing with parents’ deaths, property grabbing, stigma and discrimination. This breakdown in communication can affect a child’s ability to trust and develop positive self-esteem, confidence and ability to problem solve. To address this gap, a new psychosocial care and counseling training program has been developed and field tested in a number of African countries by the CRS AIDSRelief PEPFAR funded care and treatment program in partnership with ANECCA.

Developed as a two week training program titled, ***Psychosocial Care and Counseling for HIV Positive Children & Adolescents***, the course includes a series of modules as well as an accompanying video. The 14 modules cover key topics such as child development, family systems, communicating with children, disclosure and adherence as well as legal/ethical issues. The video, developed for educational purposes only, includes actual sessions with HIV positive children and adolescents as they work through such burning issues as disclosure, stigma, and sexual abuse. The course explores and challenges common barriers to pediatric care and treatment such as caregivers’ fear and reluctance to disclose an HIV positive diagnosis to a child, discussing adolescent sexuality as well as practical issues such as inadequate legislation governing the rights of children.

This new course is meant to be adapted and modified to fit the local context and priority needs of local healthcare workers and counselors. For example, in the first training here in Zambia, we adapted the curriculum to include time to make simple tools to improve communication with

children such as dolls, puppets, modeling clay, rattles and mobiles as these are not commonly available in the clinic setting. Also, a job aid on the benefits of disclosure was developed through group work and made into a handout for each participant.

Participants have described the course as an “An eye opener” and as “... a milestone in my life!” as they learned to help children tell their stories and make their own decisions. When asked about specific skills gained, people expressed simply; “how to say it”, talking *with*- not talking *to* children, “speaking the language that the children are familiar with” and active listening with the eyes, ears and heart!

APPENDIX C: RESOURCE LIST

	Name of Organization	Contact Person	Contact Number	Address	Services Provided
Legal					
Community Drop-Ins					
Shelters					
Orphanages					
Medical – HIV Specific					
Medical – Palliative Care					
Medical - General					
Education and Information					
Social Welfare					
Disability Care					
Child Help Line					

APPENDIX D: EXAMPLE MONITORING FORMS

EXAMPLE CLIENT MONITORING FORM FOR CETA

	:Site		:Date
	: Client ID		: Client Name
	: CMHW ID		: CMHW Name
	:Duration of Session		: Session Number

Problem Review - review for change from prior session (Check all that apply)

Very often (more than 5 times a week)	Often (3-5 times a week)	Sometimes (1-2 times a week)	Never or No	Symptom
3	2	1	0	BD04. Nervousness
3	2	1	0	BD10. Feeling restless, can't sit still
3	2	1	0	BD11. Feeling low in energy, slowed down
3	2	1	0	BT19 Blaming yourself for things
3	2	1	0	BD22. Worrying too much about things
3	2	1	0	BT01. Recurrent thoughts or memories of the hurtful or terrifying events
3	2	1	0	BT06. Feeling jumpy, easily startled

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Very often (more than 5 times a week)	Often (3-5 times a week)	Sometimes (1-2 times a week)	Never or No	Symptom
3	2	1	0	BT11. Avoiding activities or things that remind you of the traumatic or hurtful events such as the police
3	2	1	0	BT18. Difficulty performing your work or daily tasks
3	2	1	0	BT23. Spending time thinking about why these events happened to you

Gender		Main Symptoms		Behavior Act Need Score (/9)	
Trauma Type		Total Score		Functioning Items (general)	
Client Age		Relax Need Score (/12)		Live Exposure Score (/3)	
Clinical Observations:					

# Sessions:	<input type="checkbox"/> 12 Sessions	<input type="checkbox"/> 8 sessions
Flow	<input type="checkbox"/> Standard	<input type="checkbox"/> + Relaxation <input type="checkbox"/> + Behavioral Activation <input type="checkbox"/> + Live Exposure

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Check Components covered in this session

	Encouraging Participation		Cognitive Processing
	Safety		Relaxation
	Psychoeducation		Live Exposure
	Cognitive Coping		Behavioral Activation
	Gradual Exposure		

For each component covered, explain what you did

	Main Component
	Other Component
	Other Component
	Other Component

List any other things you discussed with the client this week:

Describe any challenges you had in this session:

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Describe client’s homework

	What
	When
	For how Long
	Reminder
___ I reminded the client to list and rate feelings	Feelings: Rate before and after

Any suicidal ideation? NO YES

(if yes, explain below what they report, how you assessed, and what the plan forward is)

Any homicidal ideation? NO YES

(if yes, explain below what they report, how you assessed, and what the plan forward is)

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Please mark if the client is taking any medication

Diazepam (Valium)		Fluoxetine (prozac)	
Chlodiazipoxide (librium)		Setraline (Zoloft)	
Lorazepam (ativan)		Paroxetine	
Imipramine (tofranil)		Largactil (chlorpromazine)	
Amitriptyaline (tryptizol)		Stelazine (trifluoperazine)	
Maprotiline (ludiomil)		Olanzipin (olan)	

Other meds: _____

Additional Comments:

EXAMPLE SUPERVISION NOTE FOR C.B. CPT

C.B. CPT Supervision note Example:

Counselor Name: _____ Client ID: _____

Date of Session: _____ Session Number: _____ Component: _____

Goal for session: _____

Technique Used:

Summary of session:

Counselors reported challenges:

Challenges Identified by supervisor:

Plan:

Counselor Name: _____ Client ID: _____

Date of Session: _____ Session Number: _____ Component: _____

Goal for session: _____

Technique Used:

Summary of session:

Counselors reported challenges:

Challenges Identified by supervisor:

Plan:

EXAMPLE SUPERVISION RECORD FOR CETA

Counselor Name: _____ Client ID: _____

Client Information

Gender		Main Sxs		Behavior Act Need Score	
Trauma Type		Total Score		Functioning Items	
		Relax Need Score		Live Exposure Score	
		Clinical Observations:			

# Sessions:	<input type="checkbox"/> 12 Sessions	<input type="checkbox"/> 8 sessions
\Flow	<input type="checkbox"/> Standard	<input type="checkbox"/> + Relaxation <input type="checkbox"/> + Behavioral Activation <input type="checkbox"/> + Live Exposure

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Weekly session:

Date	Component	Questions and score	Plan for the next session

EXAMPLE SUPERVISION FORM FOR CETA

The goal of this form is for YOU to track cases (what component are they on, any problems, following decided upon “flow”) and for you to communicate with trainers (so we can see where your counselors ARE and to make calls easier/more efficient).

Name of Supervisor:

Name of Counselor:

Client ID:

Client Information:

Gender:		Gradual Exposure Live:		Functioning Women:	
Trauma Type:		Relax Need Score:		Functioning Men:	
Client Age:		Behavioral Act Score:		Total Score on Measure:	
Clinical Observations:					

Flow / Order

Flow /Order:	
Additional Component 1:	
Additional Component 2:	
Additional Component 3:	
# of Sessions:	

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Client Information:

Weekly Session Information

Date	Component	Score on Form	Problems or Questions	Plan for Next Session

Example Case Notes for TF-CBT

TF-CBT Case Notes

Therapist ID _____

Date: _____

Session #: _____

What did the child report about her/his problems?

Any suicidal ideation? NO YES (if yes, explain below)

Any homicidal ideation? NO YES (If yes, explain below)

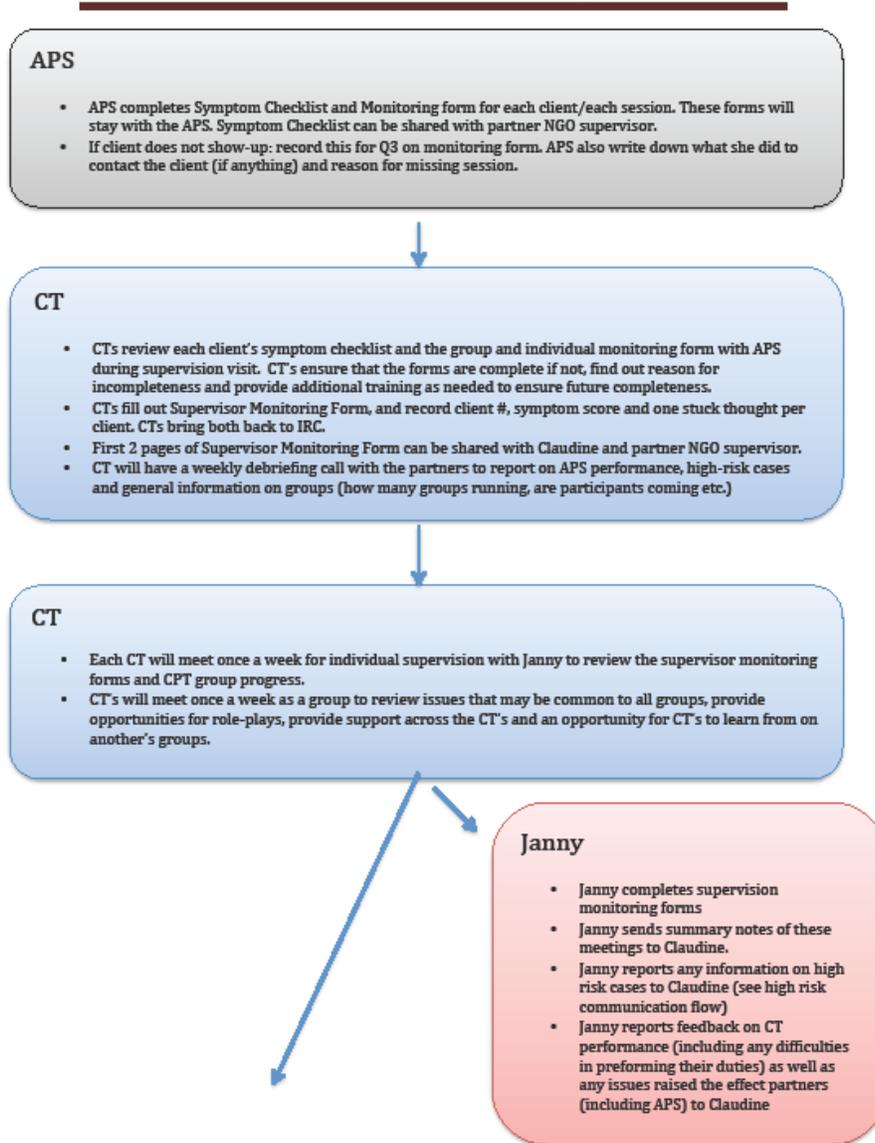
What TF-CBT component(s) did you implement today?

How did you implement it/them? (Describe the technique{s} you used in detail)

What other activities did you do with the child (if any) during this session? (Describe in detail)

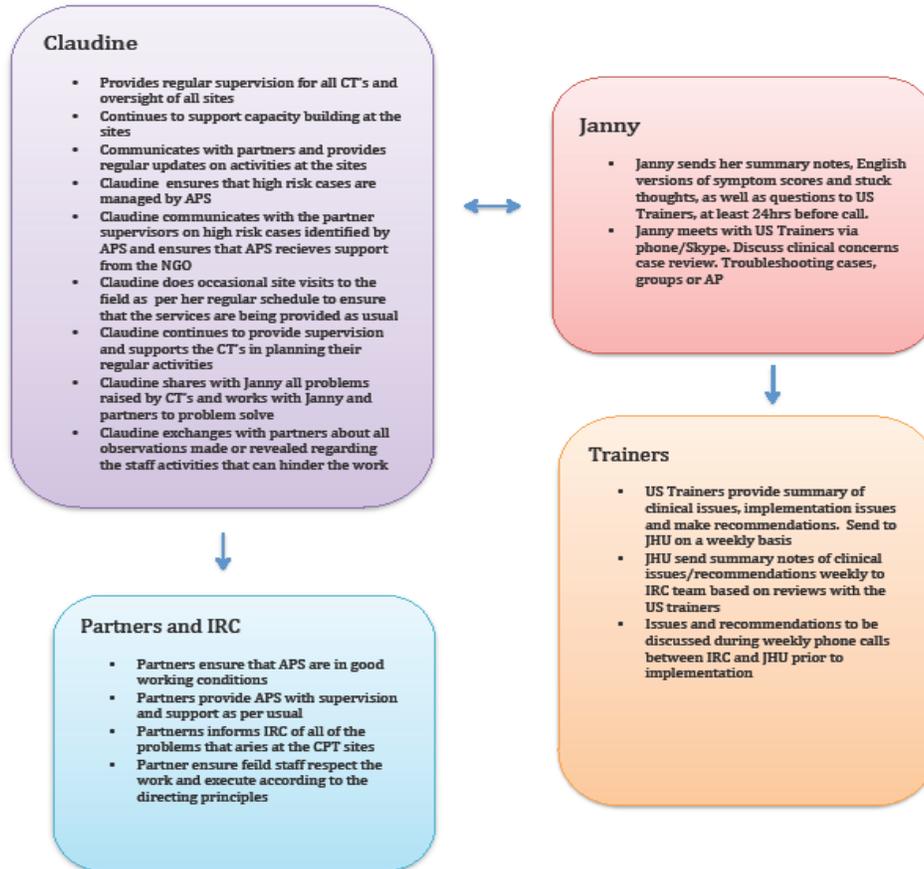
APPENDIX E: EXAMPLE CPT COMMUNICATION FLOW CHART

CPT REGULAR COMMUNICATION PROCESS



(cont., next page)

CPT Regular Communications Process (cont.)



APPENDIX F: EXAMPLE HIGH-RISK CASE MONITORING FORM

High-Risk Case Monitoring Form

Client ID	Supervisor	Site	Date	Thinking (Y/N)	Tried (Y/N)	If tried, # of times	If tried, date of last attempt	Plan	Means	Follow-up

APPENDIX G: EXAMPLE PSYCHOSIS SCREENING

Recognizing Psychosis:

Psychosis can look very different in different people, but here are some common things to think about if you suspect a person is experiencing psychosis.

If someone is experiencing a loss of contact with reality or a lack of shared reality with other people we call that psychosis. The person is unable to determine what is real and what is imagined.

People experiencing psychosis often have (1) delusions or (2) hallucinations.

- 1) *Delusions* are fixed, firm and false beliefs about what is currently taking place or a person's identity.
 - a. Examples of common delusions in the Burmese community
 - The person believes she/he is being followed by someone who is out to get him or her in trouble or to take her or him away
 - The person believes that someone has tried to poison her or his food
 - The person believes that people are trying to steal her or his personal things
 - b. Examples of common delusions in the United States
 - The person believes she or he is being persecuted when she/he is not, such as believing she/he is being followed, tricked, ridiculed, or tormented
 - The person believes that things in the media or popular press are about her/him
 - The person believes that a person they are interacting with is someone else entirely

- 2) *Hallucinations* are things that a person feels are around them, but are not really there.
 - a. Hallucinations can take the form of hearing, seeing, tasting, touching and smelling things that don't exist in reality.
 - Hearing voices in their heads that no one else can hear
 - Believing that the TV or Radio is talking directly to you
 - Seeing and/or talking to someone or a person that no one else can see.

Sometimes if an individual is experiencing psychosis and they are psychotic then they may not admit things are difficult in their lives because they do not believe they have any problems.

In these cases, look for the following signs of mental health problems:

- Serious disruptions in social and family relationships, and loss of functioning in daily tasks (going to school, work, volunteer, keep house etc.)
- A disorganized and/or messy appearance

*****IF YOU ARE UNSURE WHETHER A PERSON IS EXPERIENCING PSYCHOSIS CALL YOUR CLINICAL SUPERVISOR AND DISCUSS THE SITUATION*****

APPENDIX H: EXAMPLE OF REFERRAL LOG AND REFERRAL SLIPS

Referral Log

Assessor ID	Client ID	Study Site	Client Need	Organization Made Referral to	Date Referral Made	Did Family Follow Through with Referral Y/N

Referral Slips

Referral Slip

At this time your child does not require TF-CBT however, through the assessment we found that you had the need for the following service _____

Please contact the following organization to see if you meet criteria for their services:

Name: _____

Address: _____

Phone Number: _____

Service offered: _____

Through the assessment we found that you had the need for the following service _____

Please contact the following organization to see if you meet criteria for their services:

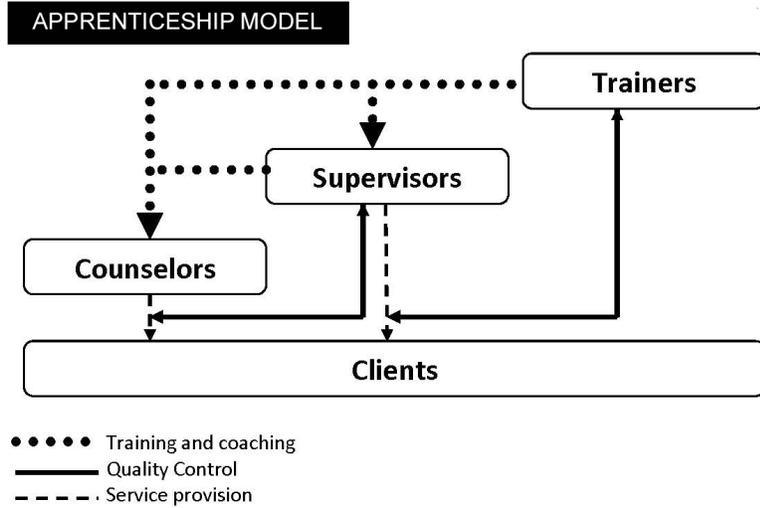
Name: _____

Address: _____

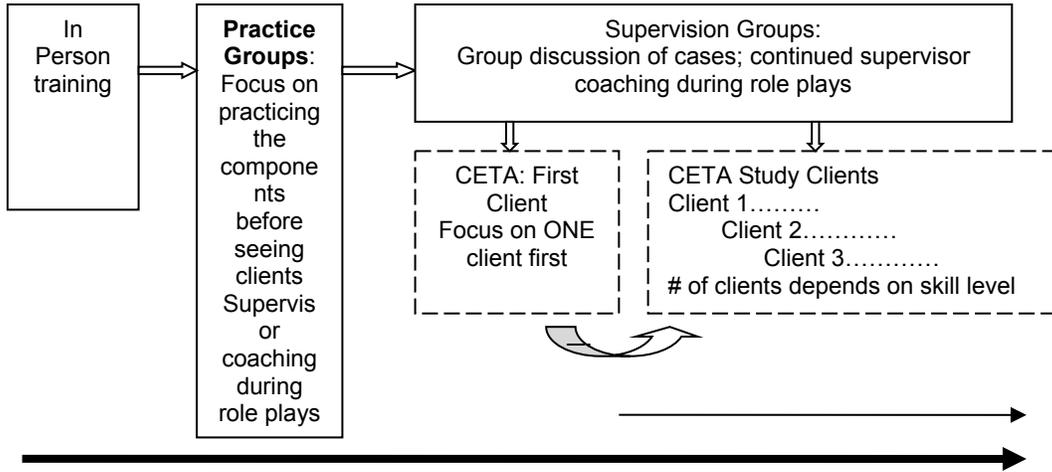
Phone Number: _____

Service offered: _____

APPENDIX I: EXAMPLES OF APPRENTICESHIP MODELS



Apprenticeship Model: Colombia



Two weeks.....Four weeks..... Varies: 8-12