

Targeted Cognitive Behavioral Therapy Interventions among Most-at-risk Adolescents in Georgia: Findings and Next Steps

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1. Introduction

According to the Georgian Infectious Diseases, AIDS, and Clinical Immunology Research Center (IDACIRC), registered HIV cases among youth aged 15 to 24 are increasing: the HIV incidence rate among youth increased from 2.48 per 100,000 in 2008 to 5.77 per 100,000 in 2012.¹ Before 2011, no current, reliable data and information were available about the knowledge, attitudes, and behaviors of secondary school pupils aged 15 to 17 and university students aged 18 to 24 concerning HIV-associated drug and sexual risk behaviors. In 2011, within the framework of the USAID Georgia HIV Prevention Project (GHPP), RTI International administered the Youth Behavioral Surveillance Survey (BSS)² among students at secondary schools and universities in Tbilisi in an attempt to fill this knowledge gap.

The BSS did not generate data and information about high-risk behavior and protective factors among the most-at-risk Georgian youth population—youth who abuse alcohol or drugs or who are involved in the justice system. In 2012, GHPP initiated the Adoption of Healthy Lifestyle Behaviors Research Study (also referred to as the MARA Study) in partnership with the Ministry of Corrections (MOC) to examine the factors associated with initiation of high-risk behaviors, past prevention experience, and knowledge-level regarding risk behaviors among male MARA who are detained or are under probation in Georgia. The findings of this qualitative study indicated that youth have easy access to certain injection drugs, oral stimulants such as ecstasy and marijuana, and alcohol. The initiation of drug use among MARA was mostly related to extensive leisure time, personal interest and curiosity about drug use, and social pressure from peers. Unsafe sex was more common following episodes of heavy alcohol consumption or oral stimulant use. Condom use was more common with sex workers and less common with girlfriends or occasional partners. Youth had limited and inaccurate knowledge about the increased risk of contracting HIV/AIDS and sexually transmitted infections as a result of injecting drugs or having unprotected sex.

According to the study results, youth who are at high risk have inadequate knowledge about the risks of drug abuse, including injection drug use, as well as unprotected sex. However, youth show a strong interest in receiving adequate information on these topics through school settings or through extracurricular educational activities. It was recommended that, in partnership with international donor-funded programs, the MOC and the Ministry of Education and Science (MOES) make efforts to design, pilot test, and implement targeted education interventions tailored to the needs of various groups of MARA.

Taking into account these findings, in 2013, GHPP, in collaboration with MOC and MOES, designed and piloted targeted prevention interventions among incarcerated youth, youth on probation, and at-risk youth outside of the penitentiary system to increase their awareness of behavioral health risk, engage them in nonrisky recreational activities, and encourage their healthier lifestyle decisions.

2. Objective

The overall objective was to support positive lifestyle changes among at-risk youth with regard to tobacco, alcohol, drug use, and other HIV-associated risky behaviors.

3. Materials and Methods

GHPP developed and implemented a psychosocial educational pilot intervention based on elements of cognitive behavioral therapy (CBT)³ for incarcerated youth, youth on probation, and at-risk youth outside of the penitentiary system who are referred to MOES's psychological center. The intervention consisted of 10 CBT sessions focusing on healthy lifestyle topics. Psychologists and social workers were trained in implementation of the prevention intervention for at-risk youth based on the CBT guide.

Effectiveness of the pilot was evaluated through quantitative and qualitative methods. There were three evaluation instruments developed for the pilot program:

1. Survey questionnaire, which assessed knowledge on HIV-related risky behaviors among targeted youth before and after CBT sessions.
2. Youth feedback form, which provided feedback from prevention intervention clients.
3. Psychologist's self-evaluation form, which informed the pilot implementation process.

4. Results

Overall, 6 cycles of intervention programs, covering 50 beneficiaries, were conducted during the pilot implementation; 36 participants completed the questionnaire before and 29 completed it after the CBT classes.

Quantitative Results

The results demonstrated an increase in knowledge of healthy lifestyle topics. Proportion of respondents reporting correct knowledge about different topics is given in the figures below.

Figure 1. Proportion of Respondents with Correct Knowledge on Tobacco, Alcohol, and Drugs

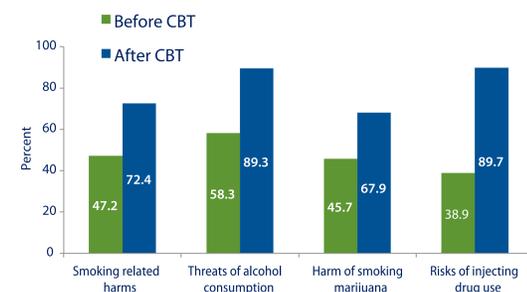
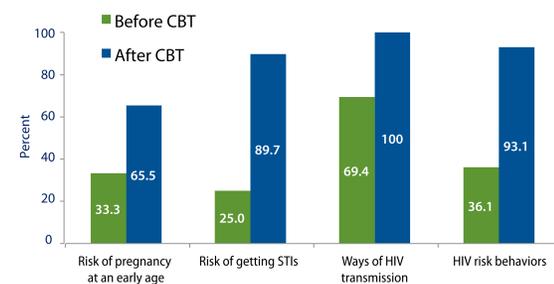


Figure 2. Proportion of Respondents with Correct Knowledge on Reproductive Health, Sexually Transmitted Infections (STIs), and HIV



4. Results (continued)

Qualitative Results

Youth feedback

Every session was assessed by three randomly selected participants to give feedback on different aspects of the information provided. The form had 12 statements, and participants had to assess each statement according to the 5-level Likert scale: (5) strongly agree, (4) agree, (3) partially agree, (2) disagree, or (1) strongly disagree.

The majority of students were satisfied with the information discussed. All topics were assessed as understandable and interesting. Discussion of taboo topics was a challenge; however, psychologists and social workers expressed satisfaction with students' engagement in courses covering sensitive topics such as drug abuse, sexual and reproductive health, sexually transmitted infections, and HIV.

The mean scores for major statements for each session are given below:

Importance of Information Provided during the Sessions	
Topic	5-level scale/mean score
Introduction	4.27
Adolescence	4.20
Addiction	4.07
Tobacco/Alcohol	3.90
Drugs	4.67
Reproductive Health	4.77
HIV/AIDS	4.50

Interest in Practical Exercises	
Topic	5-level scale/mean score
Introduction	4.30
Adolescence	3.95
Addiction	4.07
Tobacco/Alcohol	4.30
Drugs	4.56
Reproductive Health	4.50
HIV/AIDS	4.38

Opportunity to Use Knowledge in Real Life	
Topic	5-level scale/mean score
Introduction	4.36
Adolescence	3.45
Addiction	4.07
Tobacco/Alcohol	4.30
Drugs	4.22
Reproductive Health	4.46
HIV/AIDS	4.13

Trainer's self-evaluation

After each session, trainers had to complete a self-evaluation form to report the advantages and disadvantages of the session and provide recommendations for future sessions.

5. Conclusions and Recommendations

Overall, the pilot interventions had a positive effect on participants' knowledge, which can be applied by MARA to protect their own health and well-being. Based on GHPP recommendations, MOC and MOES started a prevention program institutionalization process to make it part of routine practice in Georgia. Additional recommendations include

- Explore through a follow-on evaluation whether increased participant knowledge led to better decision making and healthier behavior change.
- Carefully plan and organize the educational process: a compilation of the group, time schedule, attendance.
- Establish small group sessions (6 to 8 participants).
- Include more visual aids and materials.
- Spend more time on reproductive health issues.

References

1. Personal communication with National AIDS Center epidemiologist, August 2013.
2. Gibbs, J. C., Potter, G. B., & Goldstein, A. P. (1995). *The Equip Program—Teaching youth to think and act responsibly through a peer helping approach.*
3. *HIV/AIDS Knowledge, Attitudes, and Practices among School Pupils and University Students in Tbilisi, Georgia, 2011.* Youth Behavioral Surveillance Survey, Georgia HIV Prevention Project.

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More Information

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