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Problem Management Plus: WHO's scalable psychological programme for psychological distress in humanitarian settings

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Overview

- General introduction: PM+/STRENGTHS/etc.
- Discussion: lay helpers should not be burdened..
- Training structure
- Role Play: giving instructions
- Break
- PM+ content, Exercise from training of helpers
- Supervision
- Exercise training of helpers
- Discussion: Scaling up, challenges in trainings lay-helpers/does Europe need a program like this?



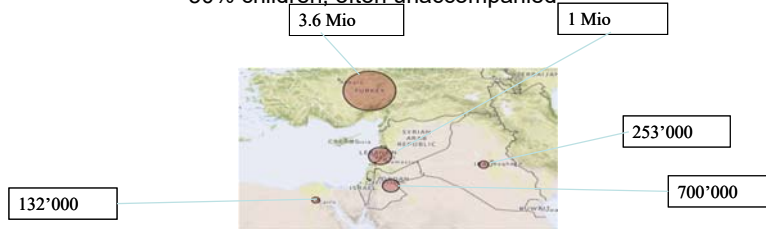
Short getting to know each other

- Challenges & Difficulties in the treatment of refugees/asylum seekers
- Experiences with similar programs etc.
- Professional background
- Expectations for the workshop



Syrian Crisis

- Unprecedented increase in refugees
- Over 5.12 million Syrian refugees registered by UNHCR
- 50% children, often unaccompanied



<http://data.unhcr.org/syrianrefugees/regional.php> ; May 09, 2019

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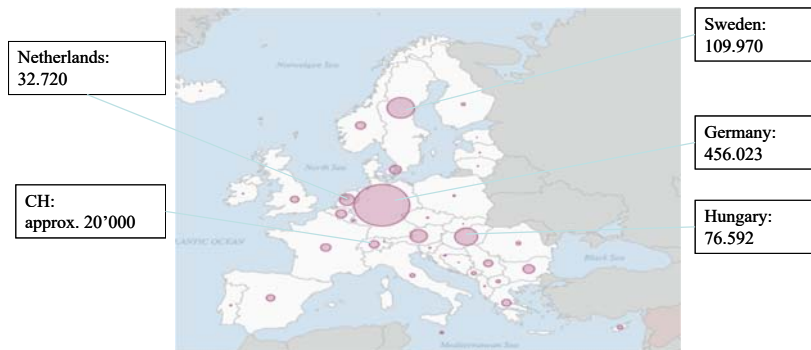
Highest number of people affected by emergencies since WW2

- Worldwide
- 68.5 million people displaced, including 41.8 million internally displaced, 23.4 million refugees, and 3.3 million asylum-seekers
- Estimation that 354 million adult war survivors globally suffer from PTSD and/or Major Depression (Hoppert & Morina, 2019)



Figure 3. World map with countries and regions marked which have a history of at least one war between 1989 and 2015. Retrieved from: https://www.amcharts.com/visited_countries/4. Regions added manually.

Asylum applications by Syrians in Europe: approx. 1 Million



<http://data.unhcr.org/syrianrefugees/asylum.php>; Feb 16, 2017

How common are mental disorders in humanitarian crises?

- Validity of current data are very loose
- **Absurd range of findings (for example PTSD range: 0%-99%)**
- Steel et al, JAMA (2009) Methods: higher quality of survey have lower rates (sample size, structured interviews, random sampling)

A broad range of mental health problems among refugees

- Mental health issues of refugees and asylum seekers are diverse and can range from
 - brief reactions to
 - stressful events and
 - hardships to chronic and disabling mental health conditions
- However, often overlooked in the professional psychiatric discourse, most refugees and asylum seekers do not have clinically relevant mental health problems (Silove, Ventevogel, & Rees, 2017).

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Continuum of problems: mental health and psychosocial support

- Many refugees and asylum seekers suffer from emotional distress that is strongly connected to the socio-economic circumstances in which they find themselves
- Post-migration living difficulties and mental health conditions mutually influence each other
- People 'one the move' or get stuck in places of transition → "*chronified tentativeness*"

(Laban, Gernaat, Komproe, Schreuders, & De Jong, 2004; Melamed, 2018; Human Rights Watch, 2017; Jones, 2017; Ventevogel, 2015).

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Challenges in accessing appropriate mental health care

Refugees and asylum seekers face particular challenges in accessing appropriate mental health care due to:

- unfamiliarity with therapeutic treatment approaches,
- Taboo and strong stigma around seeking mental health care
- language barriers

(Cavallera, 2016; Colucci, 2015; Hassan, Ventevogel, Jefee-Bahloul, Barkil-Oteo, & Kirmayer, 2016; Kuhn, 2018; Tay, Islam, Riley, Welton-Mitchell, Duchesne, Waters, Varner, Silove, Ventevogel, 2018)

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Challenges for the medical system

- Another key insight is that the broad range of mental health issues cannot be tackled by the health sector alone
- Mental health specialists cannot be the only providers of mental health interventions
- Mental health support is required across sectors such as social work, education, and livelihoods

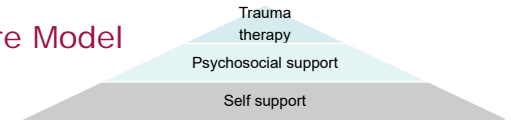
(Inter-Agency Network for Education in Emergencies, 2008; UNHCR, 2017; Weissbecker, Hanna, El Shazly, Gao, & Ventevogel, 2019).

Barriers to the delivery and uptake of mental health interventions for refugees

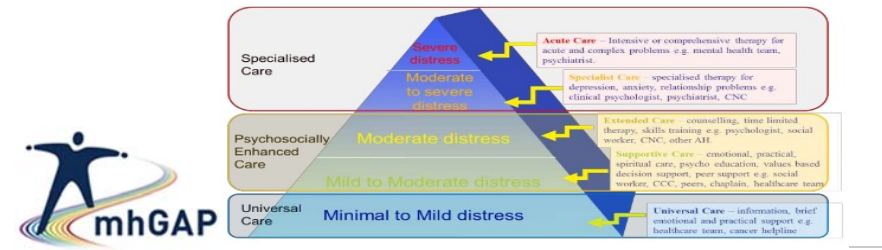
- Highly traumatized
- Limited capacity of mental health care specialists (CH)
- Lack of Interpreters
- Stigma - Taboo
- “Mentally ill asylum seekers are underdiagnosed and often inadequately treated” (Maier et al, 2010)

But, refugees and asylum seekers may not access mental health care

Stepped Care Model



The “Stepped” Model of Care



Towards scalable psychological interventions

Conventional psychological interventions

- By specialists
- One treatment manual per problem
- Often many sessions
- Often require diagnostic assessment

More scalable psychological interventions

- Innovative delivery: reduced reliance on specialists (rather: lay people, IT, self-help guides etc.)
- One treatment for multiple problems (where possible)
- May not require diagnostic assessment
- Fewer sessions
- Focus on skills for self-management

(Bryant, 2017)

Low-Intensity Intervention

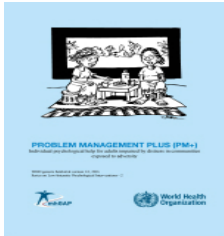
Problem Management Plus (PM+): Developed by WHO & UNSW



As a low-intensity intervention, PM+ seeks to uphold the following criteria:

1. Evidence-based strategies based on problem-solving and behaviour therapies
2. Simple:
 - Strategies selected are simple to deliver and learn
 - Practical application in session

Low-Intensity Intervention Problem Management Plus (PM+)



3. Brief
 - 5 weekly sessions
 - 90 minutes duration
4. Transdiagnostic
 - For adults affected by adversity, experiencing symptoms of common mental health problems & functional impairment (10-20 %)
 - Excludes severe mental & cognitive disorders, imminent suicide risk
5. Delivery
 - Lay-counselors with no mental health training/experience
 - Complete brief training in PM+ with ongoing supervision

Discussion

- What do you think?
- Non-professionals should not be involved in treating people with serious mental health problems
- ...

- RCT on effectiveness PM+ (N=346; n=172 PM+; n=174 enhanced usual care)
- Peshawar, Pakistan
- Political instability, regional conflicts
- RCT on effectiveness PM+ in females (N=421; n=209 PM+; n=212 enhanced usual care)
- Nairobi, Kenya
- Poverty, gender-based violence

Research

JAMA | Original Investigation

Effect of a Multicomponent Behavioral Intervention in Adults Impaired by Psychological Distress in a Conflict-Affected Area of Pakistan A Randomized Clinical Trial

Atif Rahman, PhD; Syed Usman Hamdani, MBBS; Nalia Riaz Awan, PhD; Richard A. Bryant, PhD; Katie S. Dawson, PhD; Muhammad Fraz Khan, MRCPsych; Mani Mukhtar-ul-Haq Azeem, MBBS; Parveen Akhtar, MPH; Huma Nazir, BS (Hons); Anna Chauramo, MSc; Mari Sjöstrand, PhD; Duoduo Wang, PhD; Saeed Farooq, PhD; Mark van Ommeren, PhD

IMPORTANCE The mental health consequences of conflict and violence are wide-ranging and pervasive. Scalable interventions to address a range of mental health problems are needed.

OBJECTIVE To test the effectiveness of a multicomponent behavioral intervention delivered by lay health workers to adults with psychological distress in primary care settings.

DESIGN, SETTING, AND PARTICIPANTS A randomized clinical trial was conducted from November 1, 2014, through January 28, 2016, in 3 primary care centers in Peshawar, Pakistan, that included 346 adult primary care attendees with high levels of both psychological distress and functional impairment according to the 12-item General Health Questionnaire and the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0).

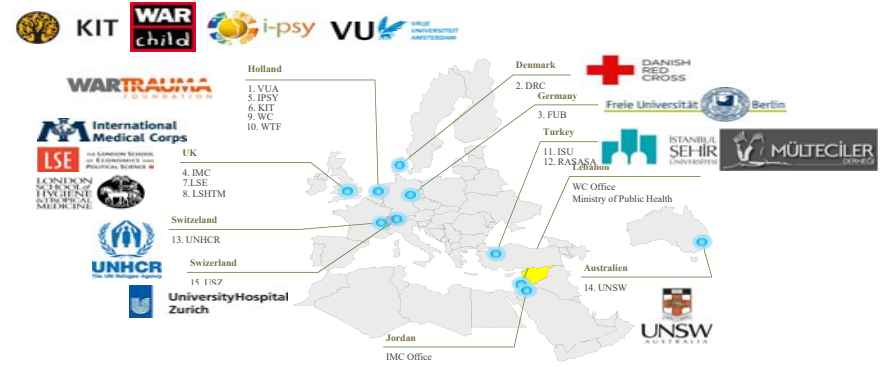
INTERVENTIONS Lay health workers administered 5 weekly 90-minute individual sessions that included empirically supported strategies of problem solving, behavioral activation, strengthening social support, and stress management. The control was enhanced usual care.

MAIN OUTCOMES AND MEASURES Primary outcomes, anxiety and depression symptoms, were independently measured at 3 months with the Hospital Anxiety and Depression Scale (HADS). Secondary outcomes were posttraumatic stress symptoms (Posttraumatic Stress Disorder Checklist for DSM-5), functional impairment (WHODAS 2.0), progress on problems for which the person sought help (Psychological Outcome Profiles), and symptoms of depressive disorder (9-item Patient Health Questionnaire).

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STRENGTHS (Syrian REFugees MeNTal Health Care Systems)



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STRENGTHS: Syrian REFuGees MeNTal Health Care Systems



Objectives

1. To assess the needs of stakeholders and end-users for the implementation and scaling-up PM+ within community health care
2. To **implement** and scale-up PM+ within community health care
3. To **evaluate implementation** and scaling-up of PM+ in terms of service provider-related and beneficiary-related outcomes
4. To **identify barriers and facilitators** specific to the chosen refugee setting (**individual adult Syrian refugees**) that affected successful scaling-up and implementation of PM+
5. (To measure the **cost-effectiveness** of implementing PM+)

Methods

- **Step 1: Adaptation**
Needs assessment, **interviews with refugees and Stakeholders**
- **Step 2: Pilot Study**
N=80, test feasibility of recruitment strategy
- **Step 3: RCT**
N=380 adult Syrian refugees, randomly allocated to either individual PM+ (N=190) or Treatment-as-Usual (eTAU; N=190)

The four versions

PM + individual	PM+ group	EASE	Step-by-step
Pre-Assessment (Screening: eligibility, inclusion, exclusion)			
Randomization (TAU control group / intervention group)			
5 sessions individual face-to-face 90 minutes per week	5 sessions small group face-to-face 2-3 hours weekly + storybook (male/female)	7 sessions adolescent group face-to-face (11-13 years old) 3 sessions caregivers	5 sessions Android, iOS and Web Contact-on-demand with e-helpers
Post and Follow-up Assessments			

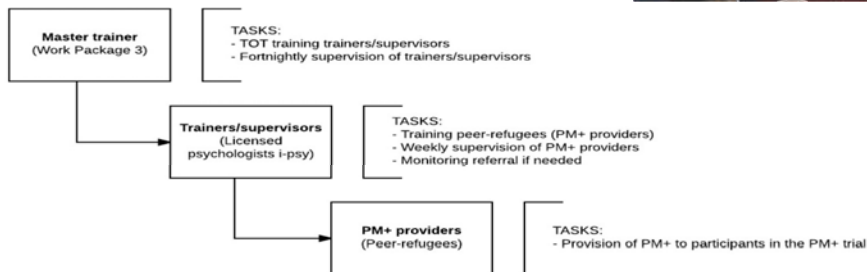
PM+ in the context of STRENGTHS

PM+ aims to provide participants with skills to manage emotional problems (depression, anxiety, stress) and practical problems.

Timeline 2017 - 2021



Training structure



Training of Trainers; aims

- Improve understanding PM+
- Know what and how to teach helpers/facilitators
- Improve knowledge of adult learning
- Identify, describe and apply different training techniques
- Apply basic helping skills to training's approach
- Competently deliver PM+ to helpers/facilitators

Training of trainers continued

- Understand/manage groups with no mental health experience
 - Manage helpers/facilitators when exhibiting challenging behaviors
 - Provide constructive feedback
 - Facilitate a structured supervision
-

Activity: role play

Giving instructions



Training of Helpers

- **Helpers**
 - Syrian (refugee) background
 - Completed high school and background in health care, education, social work or related field
 - Speaking Arabic and English/Dutch
 - **Weekly supervision**
 - Licensed health care psychologist and MSc psychologist
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Training of helpers

- Developed by WHO / UNSW / DRC
- Training: 8 days
- Respective language
- Helpers - „Lay-people“ – no medical or psychological background
- Learning helpers PM+ strategies
- Practice delivering PM+
- Building confidence

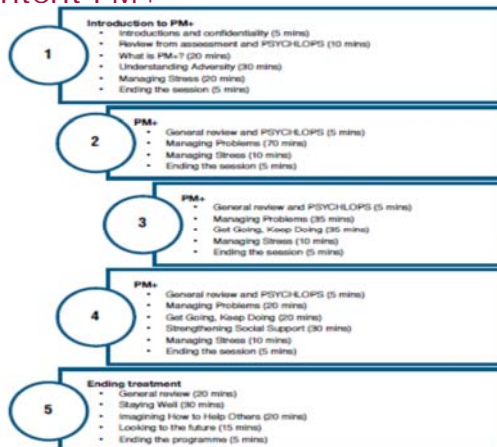
Problem Management Plus

4 Core Strategies of PM+

1. “Managing stress”
2. “Managing problems”
3. “Get going Keep doing”
4. “Strengthening social support”










Content PM+



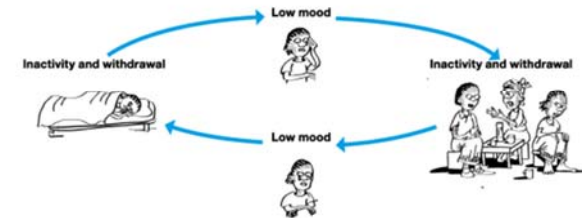
Session 1: Psychoeducation and Stress management



Session 2: Problem Management

	List Problems
	Choose a Problem
	Define the Problem
	Think of Ideas
	Choose Ideas
	Action Plan
	Review




Session 3: Get going, keep doing



Session 4: Strengthening social support



Sessions 5: Staying well and looking to the future

Day	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
 Early morning Think to think							
 Mid-morning Plan to think							
 Late morning Review to think							
 Afternoon Plan to think							
 Evening Plan to think							
 Late evening Review to think							

Activity: Basic helping skills

- Confidentiality
- Communicating concern
- Non verbal skills
- Praising openness
- Validating
- Putting aside personal values
- Not giving advice



Supervision

- Once a week for 2 hours
- Aims:
 - 1: Monitor and ensure participant welfare and right
 - 2: Support helpers who are providing treatment
- Support helpers in managing challenging participants presentations and problems
- Support development and skill building of helpers
- Improve helpers confidence in their abilities to deliver PM+

Supervision continued

- Monitor and prevent or respond to helper burnout
- 3: Ensure quality delivery of and adherence to PM+
- 4: Develop personal supervisory skills and experience



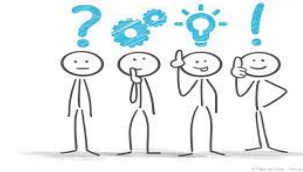
Supervisory activities

- 1. Supervision forms (online in NL)
- 2. Role-plays;
 - 1: supervisory model delivery
 - 2: helper role plays scenario as encountered with participant;
 - 3: Helpers roleplay delivery of a technique
- 3. Group discussion
- 4. Training specific topics (refresher)

Activity: role play

Staying well and looking forward

Questions?



SCALING UP

- Goals scaling up
 - Current places where PM+ is being implemented
 - STRENGTHS: Turkey, NL, SUI, Jordan, Egypt, Germany, Sweden
 - Liverpool
 - Paris
 - Vienna
 - ...
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Discussion/Conclusion

Challenges and Difficulties in:

- Strengths – Weakness of Low-Intensity Interventions
 - Training
 - Implementation
 - Scaling UP
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