A Qualitative Study on the Implementation Practices and Policies for the Delivery of Mental Health Treatment in Low- and Middle- Income Countries

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Introduction

- Up to 75% of people in low- and middle-income countries (LMICs) who need mental health treatment do not receive care[1]
- Children are particularly vulnerable to be impacted by trauma-related mental health issues[2-3]
- There is a lack of evidence-based treatment (EBT) for mental health in LMICs due in part to lack of trained mental health professionals[4]
- EBTs can be effectively delivered using a method of task-sharing, an approach where non-specialist workers are trained to provide care under the supervision of a specialist[5-7]
- There is a need for qualitative research to explore lay-counselor perspectives in LMICs[6]
- In the current study, qualitative interviews were conducted with the lay-counselors to determine facilitators and barriers to the implementation of Trauma-focused Cognitive Behavioral Therapy (TF-CBT) in Kenya
  - The implementation and practices and policies (IPPs) of resource provision were specifically examined

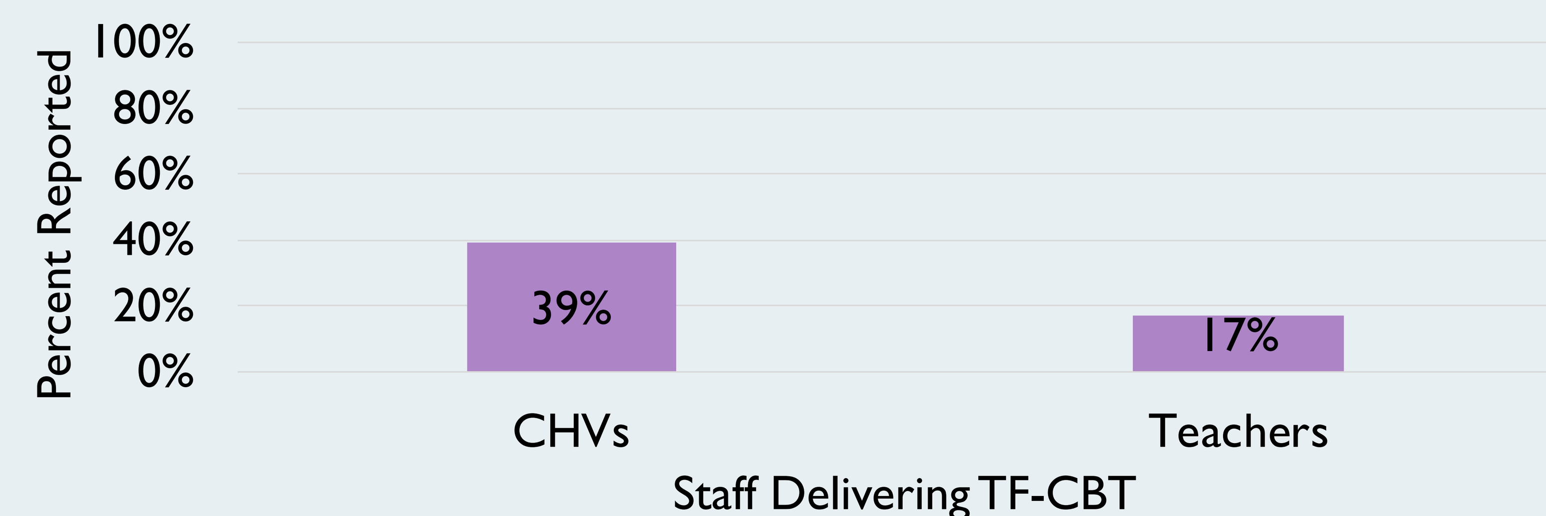
Methods

- Group-based (TF-CBT) was implemented in 10 schools and 10 communities in Kenya
- Existing staff in each sector (teachers and community health volunteers [CHVs]) served as lay-counselors to deliver TF-CBT
- Primary supervision was provided by a local team of TF-CBT experts promoted from the counselor role after years of experience
- Secondary supervision was provided weekly by a PI who is a certified TF-CBT expert
- After delivery of treatment, qualitative interviews were conducted with the lay-counselors from 6 of 10 sites to identify effective IPPs, such as those within resource provision
- Interviews (N = 32) were conducted in both English and Swahili and were audio recorded
- Notes were taken and reconciled with the audiotape in a method similar to RA (rapid analysis)[8]
- The codebook was created iteratively by a coding team consisting of one PI
- The codebook was thematic and was designed to capture IPPs
- Interviews were double-coded and reconciled when discrepant
- Interviews conducted in Swahili were coded by a member of the coding team fluent in both languages, then verbally translated and reconciled with a PI

Results

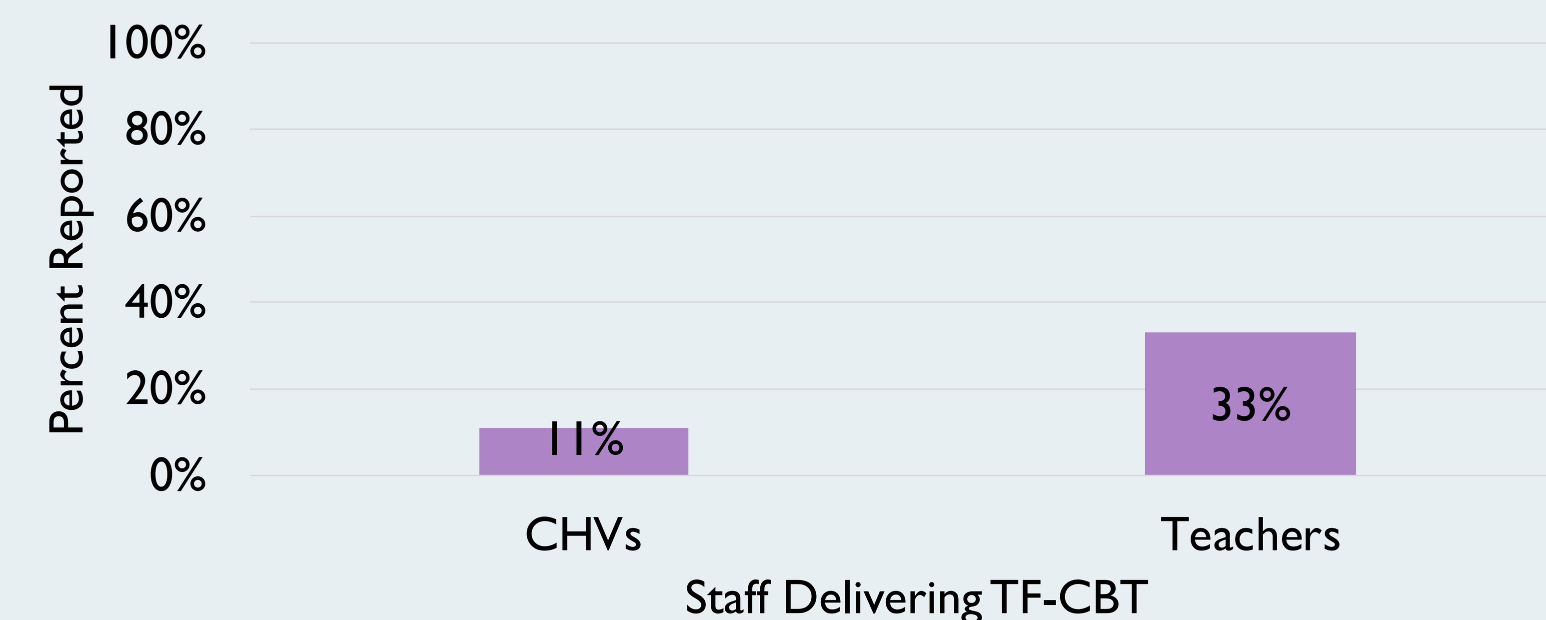
- Resource Provision: Barrier
  - CHVs reported that using their own money for TF-CBT was more of a barrier compared to teachers (Figure 1)

Figure 1. Using Own Money for TF-CBT as a Barrier



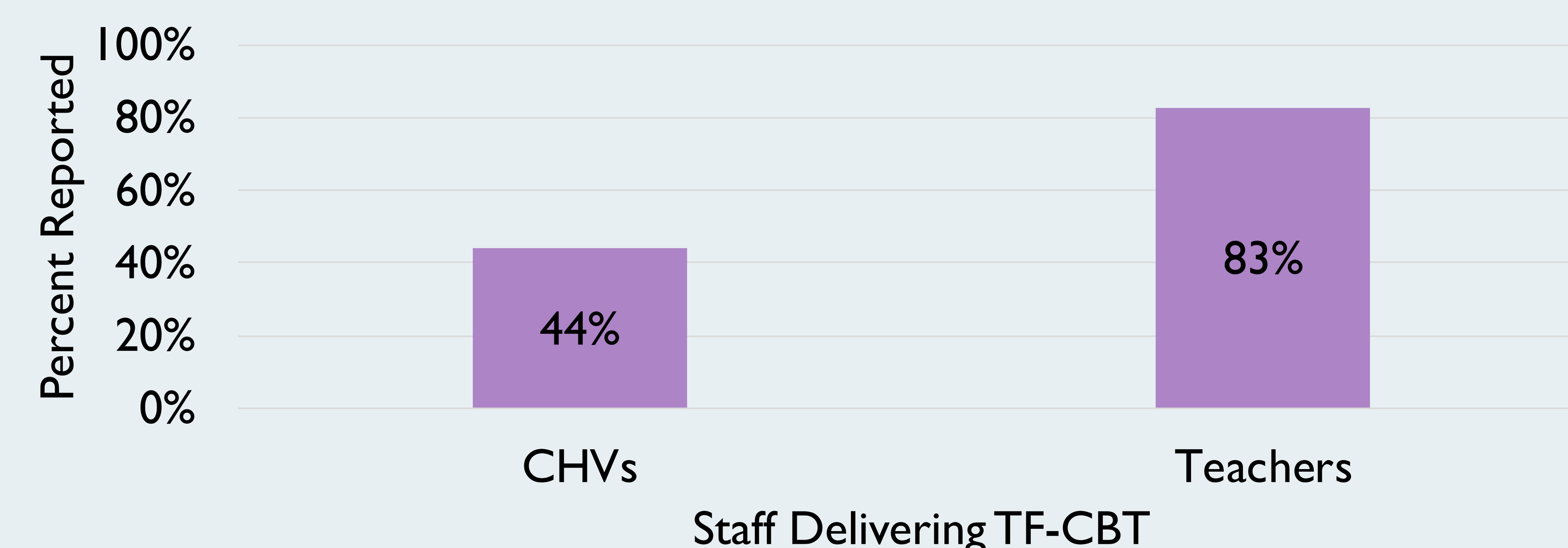
- Resource Provision: Facilitator
  - Teachers reported that materials provided was more of a facilitator compared to CHVs (Figure 2)

Figure 2. Materials Provided for TF-CBT as a Facilitator



  - Teachers reported that airtime provided was more of a facilitator compared to CHVs (Figure 3)

Figure 3. Airtime Provided for TF-CBT as a Facilitator



Discussion

- CHV's report of using their own money for TF-CBT may be due to their greater integration into the community
  - Delivering TF-CBT is their primary focus; teachers have other responsibilities outside delivery of TF-CBT
- Teacher's report of airtime and materials provided may be due to a greater appreciation of provided materials, given that the teachers have classrooms of their own
- These findings suggest that IPPs for the implementation of TF-CBT differ in resource allocation based on which sector is delivering the EBT
- This has implications for future tailored implementation support for those sectors and settings for certain IPPs, including resource provision
- By pinpointing which IPPs are critical for the implementation of TF-CBT, this can allow for a better understanding of task-sharing interventions for scale-up in LMICs
- Task-sharing in mental health care can help to bridge the mental health gap in these LMICs
- **Limitations**: Limited to exploring TF-CBT and did not consider other EBTs; had a small sample size, larger sample of lay-counselor perspectives are needed; limited to western Kenya, perspectives from other LMICs are needed
- **Future directions**: Utilize said implementation strategies to establish sustainable methods to bridge the mental health treatment gap in LMICs

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