STRONGMINDS MENTAL HEALTH AFRICA

OPERATIONAL MANUAL

Contents

Preface: Overview of the StrongMinds Toolkit package

This Operational Manual is one of two documents that make up the StrongMinds Toolkit, created with the aim of supporting partner organizations to implement the StrongMinds model. It complements the Facilitation Team Manual, which is specifically oriented to Mental Health Facilitators (MHFs), Mental Health Supervisors (MHS) and other field-based staff who facilitate StrongMinds IPT groups.

This Toolkit package has been developed as part of StrongMinds' strategy to expand the impact of this proven model for treating depression. The toolkit contains information, procedures and training tools that will enable facilitators, supervisors, and directors to implement the StrongMinds model. The two Toolkit manuals have been designed to assist new partners in bringing this model to scale. The StrongMinds model has shown promising success in helping to treat depression in Africa. Now that you have been trained as an official implementing partner of the StrongMinds model, together we can reach the goal of treating two million African women suffering from depression by 2025.

The Operational Manual provides implementing organizations with a comprehensive understanding of how to be a StrongMinds partner and representative. It also provides administrative guidance and context to organizations who are implementing the StrongMinds model. Accordingly, it highlights our logistical approach as a strategic guide for new partners as they navigate their own set-up and early implementation challenges.

Sections I and 2
Introduction & StrongMinds Evidence Base
Provides CEOs, Executive Directors, and other key decision-makers with an overview of the evidence and rationale behind the StrongMinds model.

Section 3
Partnership with StrongMinds
Presents information that will enable CEOs, Executives and Program Managers to gain a clearer sense of what a decision to partner with StrongMinds means for their organization. This section clarifies the roles and responsibilities of StrongMinds and its partners, and highlights points of flexibility and opportunities for decision-making when adapting the model to new contexts. Where there are points of decision, the manual provides principles and guidelines to assist partner organizations with strategic planning to ensure quality and consistency.

Section 4
Implementing the StrongMinds Model
Provides guidance for Program Managers and Trainers of Trainers (ToTs) that will assist them in planning for and implementing the StrongMinds model.

Glossary

Co-morbidity
The existence of more than one disease or disorder at the same time. Psychiatric co-morbidity refers to the presence of more than one mental health disorder or condition.

Depression
A common mental disorder that involves persistent sadness or loss of interest or pleasure. Some of its symptoms include: disturbed sleep or appetite, guilt or low self-worth, tiredness or extreme fatigue, inability to concentrate or make decisions, agitation or physical restlessness, anxiety, a general loss of interest in life and suicidal thoughts or acts.

Depressive episode
Refers to the period of time when a patient experiences symptoms of depression. Depression can be recurrent, which means that even after recovery, a patient might experience a depressive episode again.

Evaluation
Is an assessment that happens at one point in time to measure the impact and investigate the results of a program.

Group Interpersonal Psychotherapy (IPT-G)
A model for treating depression that focuses on the interpersonal relationships of group members. It is led by a facilitator who uses a structured model during 12-16 weeks to help group members identify and understand the root causes and triggers of their depression, and formulate strategies to overcome them.

Implementing Organization
The unit or group of people in charge of carrying out or bringing into action the StrongMinds model.

Mental Health Facilitators (MHFs)
Lay workers hired and trained by StrongMinds and supervised by staff mental health experts. They conduct numerous Therapy Groups per week.

Monitoring
Is the routine process of data collection and measurement of progress toward program objectives.

Mental Health Supervisors
Workers that recruit, manage and support the Mental Health Facilitators (MHFs). They also facilitate therapy group themselves and also help to identify partnerships with other organizations as well as additional resources and services.

Patient Health Questionnaire (PHQ-9)
A tool used to formally diagnose an individual with depression by asking a series of 9 questions. This scores the severity of depressive symptoms for a patient and provides and overall Raw Score for a patient's level of depression.

Psychosocial factors
These are things that influence a person's mental and physical health, and involve a combination of both psychological and social elements. Psychological elements refer to individual-level processes and meanings, and social elements refer to the structures and processes present in a society. The term 'psychosocial' refers to the interaction between these two levels.

Screening
In mental health it refers to the process of identifying possible existence of a mental health condition's symptoms in a person.[1] The PHQ-9 is an example of a screening tool.

Stigma
Negative perceptions that are attached to person based on a certain characteristic or condition. In many places, there is a stigma associated with people suffering from mental illnesses such as depression. This stigma may lead to discrimination, and can prevent people from seeking treatment.

Termination
The process of concluding the IPT-G cycle. It is explicitly addressed during sessions 11 and 12 with the aim of reviewing what happened during the treatment and closing the process.

Therapeutic Process
The course of therapy treatment undertaken by patients. In StrongMinds therapy, this process begins with an individual pre-group session, and continues until termination of group therapy, generally in Session 12.

Therapy group members
Participants or clients that are part of a therapy group. Usually a group includes 8-12 members.

1. Mental Health America (2017) Retrieved October 31, 2017 from http://www.mentalhealthamerica.net/mental-health-screening-tools

1 Introduction

1.1 About StrongMinds

StrongMinds is a social enterprise founded in early 2013 that provides life-changing mental health services to impoverished African women. Since many African women cannot even begin to tackle issues like poverty and economic development until they overcome depression, StrongMinds has initially focused on treating women who suffer from this pervasive and debilitating mental illness.

OUR MISSION is to improve the mental health of women in Africa.

OUR GOAL is to treat and improve the lives of two million African women with depression by the year 2025.

OUR VISION is for every African woman suffering from depression to have access to mental health treatment, which enables her and her family to lead healthy, productive and satisfying lives.

By adapting a proven therapeutic model, StrongMinds is the only organization scaling a cost-effective solution to the depression epidemic in Africa. We are guided by an ambitious and unique goal of treating two million depressed African women by 2025—enabling these women and their families to lead more healthy, productive and satisfying lives. StrongMinds presently operates in Uganda, a post-conflict and highly impoverished country, where 1 out of every 4 women suffers from depression.

1.2 Scaling the StrongMinds Model

To achieve our goal, StrongMinds needs to scale up its work in a rapid and cost-effective way. Our strategy therefore involves building on the local knowledge and capacity of organizations who share our analysis of the problem and want to be involved in tackling it. We form partnerships with suitable organizations that can implement the StrongMinds model in the places in Africa where they work.

Central to this strategy are three key elements. The first is the StrongMinds Toolkit, of which the manual you are reading is one part. The Toolkit provides the key information that partners require to be able to implement the model. The second component is the Partnership Agreement that defines with care and precision the roles and responsibilities of StrongMinds and its partners in a business-like manner that enables the work to proceed with clarity. The third element is the support that is available from StrongMinds to its partners through training, coaching, advice and guidance as they work to meet the needs of vast numbers of African women affected by depression.

2 Strong Minds Evidence Base: Addressing Mental Health in Africa

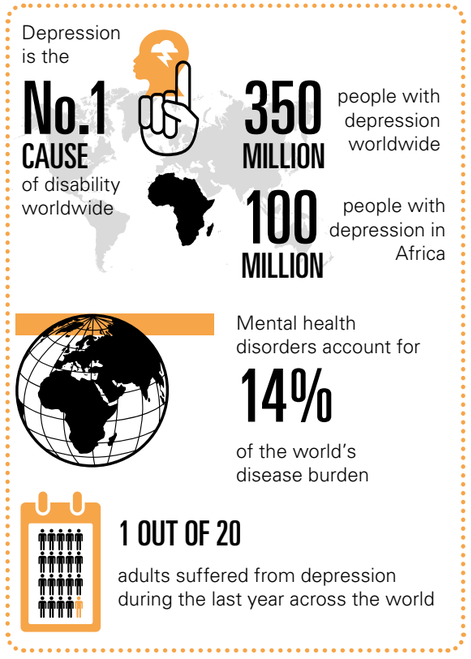
Depression is the number one cause of disability worldwide. Nowhere is that more clear than in Africa where approximately 100 million people suffer from this disease. This debilitating mental illness prevents individuals from fully engaging in society, creating a barrier to development that disproportionately affects women, children, and the poor.

StrongMinds has demonstrated, in Uganda, how treating depression can help organizations bring down this barrier. Their unique, community-based approach to delivering talk therapy has proven effective in both reducing the occurrence of depression, and improving the health, nutrition, and economic situation of women and their families.

2.1 The Need

"If the extent of human suffering were used to decide which diseases deserve the most medical attention, then depression would be near the top of the list…"[2]

"Measured by the years people spend disabled, depression is the biggest blight on human society—bar none"[3]



What is depression?

Depression is a common mental disorder, involving persistent sadness or loss of interest or pleasure. It is a condition that affects the mind and the body that involves debilitating symptoms such as disturbed sleep or appetite, feelings of guilt or low self-worth, tiredness or extreme fatigue, inability to concentrate or make decisions, agitation or physical restlessness, talking or moving more slowly than normal, anxiety, hopelessness, a general loss of interest in life and, in some cases, suicidal thoughts or acts.

Depression affects how people take care of themselves and their families, having an impact not only on the person but also on her family, her work and, ultimately, on her community. Depression can afflict people when they are young, affecting them from their formative stages and throughout their most productive years. Episodes of depression can be long lasting and recurrent, continuing for weeks, months or years.

How does depression differ from stress?

Depression is different from usual mood changes and short-lived emotional reactions to challenges in everyday life. When depression is long lasting it may become a serious health condition as the affected person continues to suffer greatly and function poorly at work, at school and in the family and community. Depression can lead to suicide. However, it is very important to keep in mind that depression is treatable.

A global burden

Mental health disorders account for 14% of the world's disease burden.[4] Of these disorders, which affect emotional, psychological and social well-being, depression is at the forefront, accounting for at least 4%, with women being affected more than men. Globally, 350 million people suffer from depression and on average about 1 out of 20 adults suffered from depression during the last year across the world.

By 2030, depression is expected to become the leading cause of disease worldwide.[5] Yet mental illness is one of the most overlooked problems in global health service delivery.[6] Most people affected by depression (~75%) reside in low-income countries and have no access to treatment and care.[7]

2. Ledford, H. (2014) Medical research: If depression were cancer. Nature: International weekly journal of science. Volume 515. Issue 7526.
3. Nature (2014) The burden of depression. Nature: International weekly journal of science. Volume 515. Issue 7526.
4. WHO Mental Health Gap Action Programme (mhGAP). (n.d.). Retrieved May 27, 2017, from http://www.who.int/mental_health/mhgap/en/;
5. WHO Mental Health Gap Action Programme (mhGAP)." World Health Organization. World Health Organization, n.d. Web. 26 May 2017. http://www.who.int/mental_health/action_plan_2013/mhap_brochure.pdf?ua=1
6. Mental Health Africa | Treating Depression In Women | UGANDA." StrongMinds. StrongMinds, 25 May 2017. Web. 25 May 2017.https://strongminds.org/
7. WHO mhGAP: http://www.who.int/mental_health/mhgap/en/

2.2 Depression and development in Africa

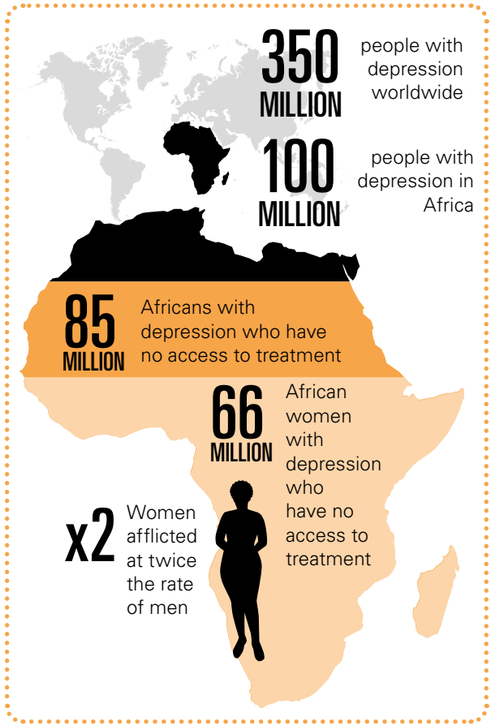
In Africa, approximately 100 million people suffer from depression and women are afflicted at twice the rate of men. About 85% of these people, including 66 million women, have no access to effective treatment. These rates are several times higher than those in Europe and the U.S. and indicate a depression epidemic intensified by extreme poverty, terrorism, conflict, and instability. However, despite its growing prevalence funding to support mental healthcare is often not available among many national health care budgets. Additionally, within Ministry of Health structures, the continent has a significant shortage of practitioners who are trained and qualified to deliver mental health care to those in need.

Depression has been considered the major cause of mental and physical disability for women[8] in Africa and therefore, an obstacle to development.

Many African women will be unable to overcome issues such as poverty or economic development until they overcome their struggle with depression.

The impact of depression on the life of an African women is significant, affecting her mental health and therefore her emotional, psychological and social well-being.

- When compared with her healthy peers, an African woman with depression is less productive, has a lower income and exhibits poorer overall physical health.
- Children of depressed mothers are more likely to have poor health including malnutrition, delayed learning and more bouts with routine colds or other common maladies. They form less secure relationships with their parents; struggle in or miss school, and suffer from depression.
- Depression sufferers exhibit more maladaptive parental behaviors such as harsh punishment and spending smaller amounts of time with their children.
- Depression has been identified as a development obstacle for 20% of Ugandan women, based on a StrongMinds prevalence survey completed in March 2017.
- Women with depression find it more difficult to engage in training programs (such as those teaching livelihood skills or promoting safe sex), since depression sufferers usually experience difficulty concentrating and difficulty retaining learned information.
- In addition to all of the other tangential effects of depression highlighted above, research has also found that people with mental disorders, including depression, are at a heightened risk of contracting HIV/AIDS.[9]



StrongMinds has developed a model to treat depression which, based on the evidence above could also have a powerful impact on progress towards addressing other health concerns and development objectives. This model provides an effective way for partner NGOs to treat depression in target populations, enabling vulnerable and disenfranchised individuals to better engage with their core development work.

8. Institute for Health Metrics and Evaluation. Retrieved December 1, 2016: http://vizhub.healthdata.org/gbd-compare/#
9. Blank, M.B., Himelhoch, S., Walkup, J. and Eisenberg, M.M. (2013) Treatment Considerations for HIV-Infected Individuals with Severe Mental Illness. Current HIV/AIDS Reports. Vol. 10 Issue 4.

2.3 Addressing depression in Africa

The StrongMinds approach is a low-cost, proven methodology that has reduced depression symptoms for over 80% of the women treated in Uganda. In our first three years of fieldwork, StrongMinds treated almost 10,000 women with depression. Over 82% of these women were depression-free at the conclusion of treatment and the majority of these women showed strong gains in their physical health, employment, and the ability to save part of their income. Importantly, their children also benefitted by showing improvements in school attendance and nutrition.

The StrongMinds model has delivered positive results in terms of both depression reduction (primary impact) and development-related outcomes (secondary impact).

Primary impact

Changes in depression prevalence and symptoms among women treated.

Primary impact indicators

Using the Patient Health Questionnaire (PHQ-9), a tool that is supported by the World Health Organization for use in the developing world, depression scores are calculated to quantitatively measure changes in the severity of a patient's depressive symptoms.

Primary outcomes

Results of StrongMinds' evaluations, using the PHQ-9, have consistently shown significant and lasting reduction in depression symptoms. In 2016, 82% women were depression-free at the conclusion of their talk therapy groups, and 80% were still depression-free six months later.

Secondary Impact

Impact on the lives of the women treated as well as on their families and social networks.

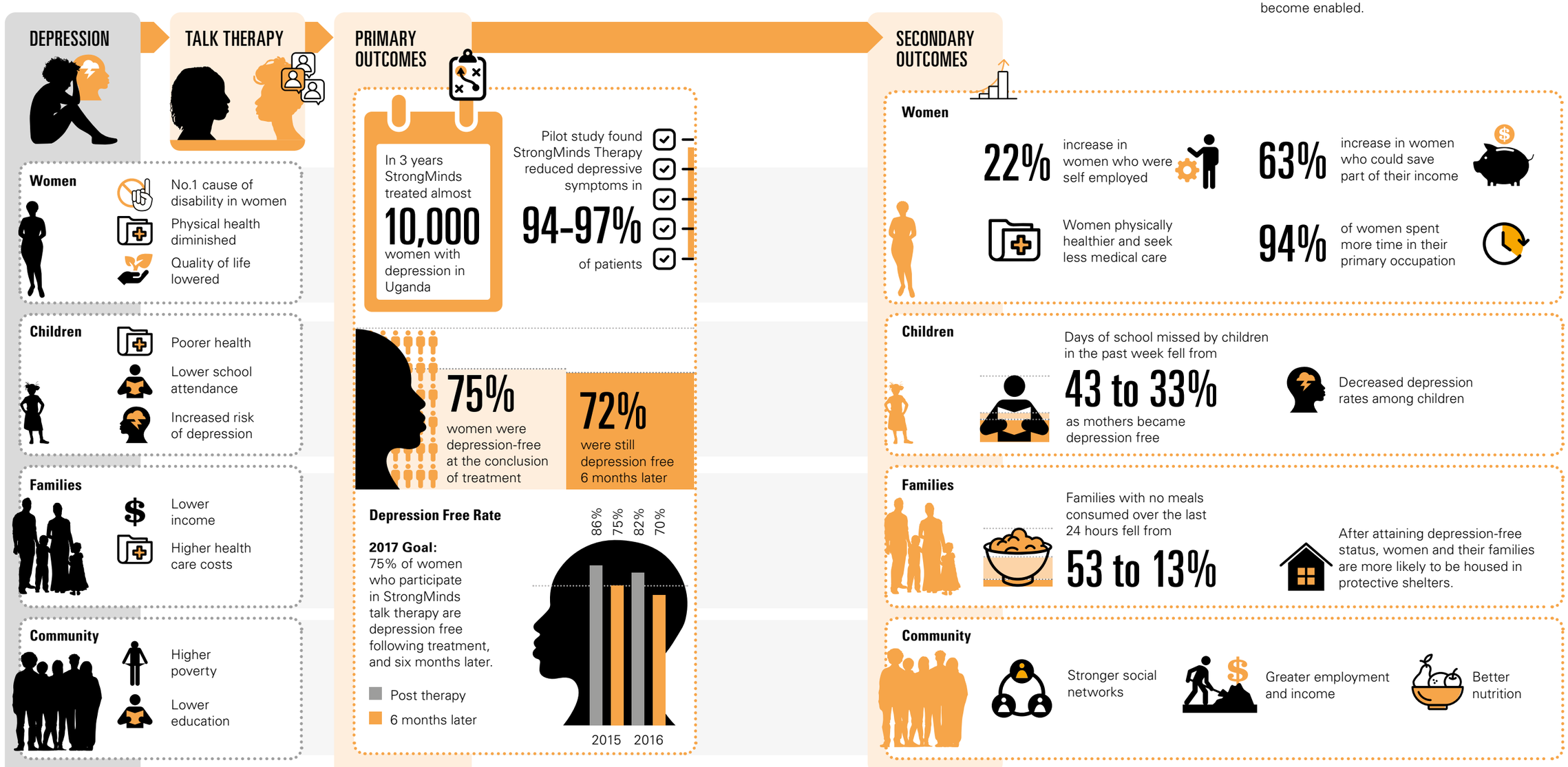
Secondary impact indicators

Questionnaires conducted before and after talk therapy measured a range of indicators related to participants' ability to function in family and social life. These included measures of economic productivity, access to social support, health-seeking behavior, and ability to support their children's health and wellbeing.

Secondary outcomes

Improved functioning and physical health among women treated. For children and other household members of women treated, the intervention led to improved health, nutrition, and education, as well as decreased depression rates among children.

Since depression is the number one cause of disability for women in Africa, reducing depression means reducing disability. In other words, by reducing their depressive levels, the women become enabled.



2.4 Rationale for the StrongMinds intervention

StrongMinds empowers impoverished African women by treating depression at scale and enabling these women and their families to lead healthy, productive, and satisfying lives.

Recognizing the need, StrongMinds developed a culturally appropriate model based on the IPT-G (Interpersonal Psychotherapy Group) approach. IPT-G is a simple, proven and cost-efficient community-based model to treat depression that focuses on interpersonal relationships among group members. Groups are led by Mental Health Facilitators (MHFs) who use a structured therapy model over a period of 12 weeks, to help members identify the root causes and triggers of their depression, and formulate strategies to overcome those triggers. Since depression is episodic and recurrent throughout most people's lives, these newly acquired skills have both an immediate, and a long-term preventive impact on the lives of those suffering from depression.

IPT was initially developed at Yale University for use by mental health professionals to help adults with depression.[9] The IPT model has been used with a wide range of socio-cultural groups and within many different contexts. It has been implemented in more than 20 countries around the world and its effectiveness has been demonstrated in numerous clinical trials in high, middle- and low-income countries.

IPT-G was first tested in Uganda by Johns Hopkins University (JHU) in a randomized controlled trial in 2002 and has proven effective in the African context.[10] Delivered by lay community workers with only a high school education, the researchers found IPT-G was remarkably successful, reducing the depressive symptoms of 93% of patients treated.

Group therapeutic methods have been found to be well suited to the strong communal values that characterize African contexts. On average, 81% of StrongMinds therapy groups continue to meet informally after the 12 weeks of facilitation ceases. This ongoing peer support provided by group members and community connection, provided by group members, allows women to continue developing skills to manage their depression, empowering them to prevent future episodes.

The ability of IPT-G to produce lasting results, without reliance on psychiatric treatment, hospitalization, or medication, makes it an attractive option for treating people who currently lack access to mental health services. Given that access is problematic for most of the African population, IPT-G is particularly well suited to meet this challenge.

9. By Myrna Weissman, Gerry Klerman, and colleagues at: https://iptinstitute.com/about-ipt/
10. Bolton, P., Bass, J., Neugebauer, R., Verdeli, H., Clougherty, K.F., Wickramaratne, P., Speelman, L., Ngodoni, L. and Weismann, M. (2003). Group Interpersonal Psychotherapy for Depression in Rural Uganda: A Randomized Controlled Trial. JAMA. Vol. 289, No. 23.

2.5 The StrongMinds Model

Since its inception, StrongMinds has continuously learned, improved and refined its model to deliver talk therapy. Using Group Interpersonal Psychotherapy (IPT-G) as its foundation, StrongMinds has adapted and enriched this approach with real life practical application techniques including role playing activities and interactive visuals.

Most importantly, StrongMinds has found that simply providing a therapy service is not enough: communities first need to understand why that service is valuable. For this reason, the StrongMinds model incorporates awareness-raising, mobilization, and screening activities in communities to ensure that the stigma is reduced for those suffering with depression and that services can reach those most in need of treatment.

Key features in the StrongMinds approach to breaking the cycle of depression include:

Mental health facilitators (MHFs)
Talk therapy groups are led by trained MHFs. MHFs are local workers who are trained and certified to deliver the StrongMinds model of therapy.

Sensitization
The process of community education, mobilization and engagement. The StrongMinds team explains what depression is and how it can be treated through our talk therapy group model.

Screening
The process of screening is used to identify those in the community who may be experiencing depressive symptoms or who may suffer from depression. The tool used to screen, identify and ultimately diagnose an individual with depression is the PHQ-9 (Patient Health Questionairre-9). Use of the PHQ-9 as a screening and diagnostic tool in the developing world is supported by the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) and by the World Health Organization (WHO).

Pre-Group sessions
Women whose initial PHQ-9 scores indicate depression are invited to attend a one-on-one pre-group session to conduct a second, more in-depth screening. In this session, MHFs build rapport, identify what has triggered the patient's depression, and help her define therapeutic goals to address those triggers.

Therapy
Group therapy sessions build bonds between women and encourage them to actively engage and support each other to explore the triggers of their depression and how to manage them. (For a more comprehensive overview of the therapeutic process, please see Section 3 of the Facilitation Team Manual.)

Referrals
A small percentage of patients will not respond fully to IPT-G and may need other care. These patients are referred to other mental health services to receive comprehensive treatment.

Planning and continuity
Members of StrongMinds therapy groups form strong social bonds with their peers, and 81% of groups continue to meet after formal sessions end. This continuation permits members to reinforce the skills they have learned and enables them to manage and prevent future depressive episodes.

Breaking the cycle of depression

MENTAL HEALTH FACILITATORS
Local people hired and trained to run therapy groups, conduct outreach, and measure patient progress.

Diagnostic tool
Patient Health Questionnaire (PHQ-9), which is contained within the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and supported by the World Health Organization for use in the developing world.

Psychiatric medical personnel
Provide supervision and referrals to ensure quality care.

Mobilization
Reaching out to the community to talk about depression and engage them to take action

Screening
Identifying women suffering from depression

Therapy
Treating depressed women through interpersonal group therapy (IPT-G)

Planning
Preparing women to manage their depression after therapy is finished. Many groups continue to meet informally to support each other.

Target population
Poverty-stricken women suffering from depression

Referrals
A small percentage of patients will not respond fully to IPT-G and may need psychiatric care. These patients are referred to other mental health services to receive comprehensive treatment.

3 Partnership with StrongMinds

3.1 Partnership guidelines

3.1.1 Partnership as a building block for StrongMinds

StrongMinds works with other organizations to implement its model in locations where we do not have a direct presence. The purpose of this section is to set out the scope and nature of the arrangements that we propose for these future partnership efforts.

Partnership is critical to StrongMinds' vision to scale our work and reach millions of African women with depression. As partnership is so central to the way we function internally as an organization, we have a clear vision of how we see it operating in practice.

More about StrongMinds

Let us begin by describing the current structure of StrongMinds. Our organization operates as two distinct entities, StrongMinds US and StrongMinds Uganda, bound by a memorandum of understanding. StrongMinds Uganda is staffed by over fifty Ugandan nationals, which ensures that our Therapy Groups are locally led and culturally appropriate. Similarly, StrongMinds Uganda's Board of Directors comprises of local representatives from the Uganda Ministry of Health and community mental health advocates.

StrongMinds US and StrongMinds Uganda are both distinct entities that are bound by a Memorandum of Understanding and work together through a partnership structure that is defined by a Master Collaboration Agreement. Both agreements are designed to clarify roles and responsibilities for each partner and reflect ongoing efforts to formalize organizational systems and procedures.

3.1.2 The role of partnership

The ways in which partnership plays a key function in the work of StrongMinds are based on certain fundamental principles. Partnership is aligned with our strategic vision and operating plan for the coming years, ensuring that the time and resources needed from StrongMinds to pursue a partnership are in harmony with the potential benefits to be gained.

Our partnership efforts always need to serve our organizational core values:

Patient first
As far as possible, a partnership should serve the best interests of patients and should never compromise or harm our patients or the communities where we work. Implicit within this principle is the right of a patient to privacy and confidentiality.

Transparency
Within practical limits, StrongMinds is open and transparent with partners, patients, and other stakeholders about our work, our data, and our plans.

Learning
We are a learning organization and we prioritize learning opportunities in our work and in our pursuit of partnership opportunities.

Non-competitive environment
All quality work by any actor that serves to alleviate the depression epidemic around the world is in service to our vision. This means that, when feasible, and in keeping with our value of transparency and learning, StrongMinds makes our methods and results available to all organizations. This includes partners and 'competitors' alike.

Sustainability
After our implementation period has concluded, we hope that our impact creates opportunities for continued community education about depression and the long-term empowerment of patients to better address their own mental health needs.

Partnership therefore plays a part in projecting our values, in agreement with partners, to ensure that patients benefit accordingly. Partnership also acts as a means of learning about ways in which these values can be applied and adapted to conditions in different localities.

3.2 Roles and Responsibilities

3.2.1 Types of partners

StrongMinds categorises its partnerships according to the purpose they serve on both sides of the agreement. The categories are:

Informational partners
Like-minded or supportive partners and peer providers with a similar mission but which may have limited resources or opportunities for actual collaboration. Interactions are geared around information-sharing and learning, seeking opportunities for joint campaigns and education outreach, as well as shared policy or advocacy platforms at local, national, regional and global levels. Examples of informational partners include local health advocates, NGO networks, MHIN.

Collaborating partners
Potential partners or organizations with similar or complementary work or access to resources. Collaborators can include organizations serving the same communities or populations with different services, referring partners, community stakeholders, district and sub-district level authorities, and others. Examples of collaborating partners include district level Ministry of Health personnel, and the non-governmental organization Francois-Xavier Bagnoud (FXB).

Transactional partners
Entities that provide a business service to StrongMinds, usually contractually, including consultants. Examples include MedicMobile and website developers.

Strategic partners
Current and prospective collaborators that directly allow us to reach patients and meet our strategic goals. This includes partners who implement the StrongMinds model, receive technical support, participate in capacity-building processes or use resources from StrongMinds to assist them in reaching more patients. Examples include BRAC, IRC and UNHCR.

3.2.2 The StrongMinds Partner Offer

In forming a partnership agreement with an organization, StrongMinds will provide the following support to them to implement the model where they are working:

- A package of materials that includes: Operational Manual, Facilitation Team Manual, and the newest StrongMinds tools and resources that can be accessed via www.xxxxxxxxx
- Accreditation: Training courses and training of trainers courses.
- Systems: Supervision/quality/relationship management. Involves data, network, QA + Knowledge.

The offer includes the standard Partnership Agreement itself, which defines responsibilities and obligations on both sides. The agreement covers sharing of data, quality, financial arrangements, reporting and standards for working with patients, among other key aspects of the work that the two organizations agreed to do together.

Through the agreement, we seek to develop a collaboration whereby StrongMinds, our partners, and women in need can all benefit from the arrangements established in the following ways:

Strong Minds

- Greater impact through more partners reaching more individuals, families and communities
- A stronger model, tested and adapted to a larger and more diverse number of situations
- Credibility through greater reach and profile
- Increased knowledge through learning from partners on efficiency, adaptation, development of tools and greater innovation.

Partner

- Higher returns on investment in their work
- Greater positive impact
- Potential learning and efficiency gains to apply to other program areas, better impact
- Better forward thinking, including in mental health
- Innovative and new approaches and services for existing clients
- Access to a knowledge network, especially through the StrongMinds portal
- Support for staff self-care
- Potential new partners
- Greater profile and potential interest to funders

Patient

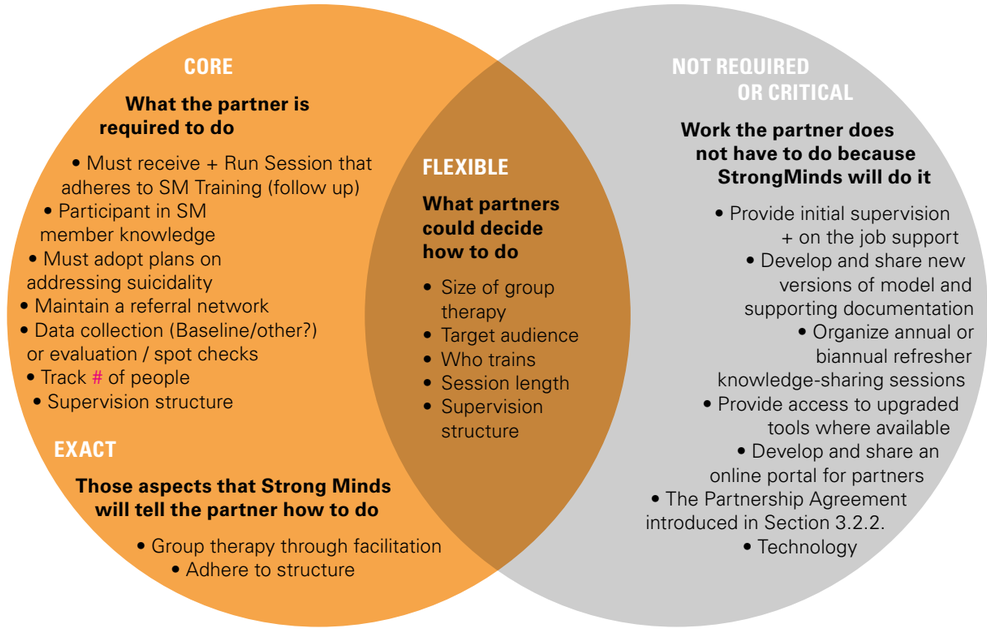
- Access to an evidence-based and validated service enabling an alternative to treatment that may not have been effective
- Participation in a thriving support group, potentially over a long-term period
- Better knowledge and awareness, including reduced concerns about stigma
- Access to coping strategies
- Inter-generational and intra-family prevention
- Less isolation and improved and strengthened relationships
- Increased productivity, ability to earn and personal accomplishment.

3.2.3 Partnership in practice

In our partnerships, we consider the key role of StrongMinds to maintain a lead in knowledge on group-based therapies for people affected by depressive disorders. This work includes maintaining awareness of relevant technological innovations and improvements that can assist in achieving better quality in our work and that of our partners.

The role of strategic partners of StrongMinds, those described above as implementing the model, is fundamentally to provide access to group-based therapy the meet the methods and standards required.

Taking this analysis of roles and responsibilities to a level of greater detail, it is useful to consider the core, exact and flexible components of the StrongMinds model, as illustrated in the diagram below:



3.3 Other details

Partners are expected to share data with StrongMinds by having a constant interaction with a member of StrongMind's team. This would include:

- **Impact data**
  Number of women participating in therapy groups
- **Efficacy data**
  Rates of responses, recovery, and symptom alleviation, for example depression-free rates, should be shared with StrongMinds on a semi-annual basis.

Case Study

Examples of how StrongMinds uses technology to manage data

Daily communication
Smartphones are used by field staff to communicate regularly with their colleagues, either through phone calls or through a whatsapp group, and for keeping in touch with therapy group members. The leadership in both offices communicate with each other on a regular basis primarily through emails, electronic work scheduling and activity planning. They currently prepare internal and external reports using a data technology platform that compiles information collected on hand-held mobile devices in the field.

Reporting (internal and external reports)
Reporting has been an integral place where StrongMinds has used technology. We currently prepare internal and external reports. The team has used a combination of Medic Mobile and Excel for their internal reporting.

Internal reporting
The internal reporting includes a weekly report, monthly report and narrative reporting. There are also finance, administration and operations reports. Data is collected daily and aggregated weekly with a focus on PHQ9 scores. The weekly reports accompany the weekly team interactions and review the number of women in therapy and number of groups in progress. The weekly reports are then rolled up into monthly aggregate reports which also include cumulative data on the number of patients in therapy. The narrative reports provide context to some of the routinely collected data and the teams also uses narrative reports to learn and share with each other.

External reporting
StrongMinds external reports include quarterly donor reports, new reports for funders and new proposals.

Data collection
StrongMinds uses handheld tablets and an integrated technology platform to record and monitor patient data on a routine basis.
The information collected includes client numbers, PHQ-9 results, weekly symptom checks, and functionality scores. This data is then brought together as part of a centralized system that can be accessed online.

Implementing organizations that choose to use tablets or other technologies to collect data should ensure that all staff members receive adequate training and feel confident in using these tools.

Data Flow

1. Mental Health Facilitators enter data into handheld tablets while in the field
2. MHFs send information to the Monitoring and Evaluation (M&E) team
3. M&E officers collect data, consolidate it on a dashboard, and print it for facilitators
4. MHFs and MHSs receive the printout and discuss in team meetings

The M&E team observes and analyzes data in conjunction with Mental Health Supervisors as needed.

StrongMinds Uganda is committed to applying the newest innovations in technology to ensure the accuracy and efficiency of data collection. For the newest information on technologies available to support StrongMinds partners, please visit the following link: [www.....].

3.4 The StrongMinds Brand

3.4.1 The significance of our brand

In replicating the StrongMinds model to new locations, it is critically important that consistency is achieved in the way the brand is used. The reasons are that people coming to us need to feel confident about the quality of reliability of the services we offer. They may have heard about StrongMInds from other people and places, for example. When they see the brand, it has to represent what we stand for. Consistent use of the brand builds trust.

Branding is about more than a name and a logo. It describes the way in which we present ourselves to the rest of the world including our behaviours, the language we use, the way in which we talk about ourselves and other people and the way we work with others.

The agreement StrongMinds invites its partners to sign describes in detail how the brand is to be used. These requirements may change over time and as we gain more experience. Rather than repeat those details here, this section provides more information on the brand itself.

3.4.2 Defining the StrongMinds Brand

The StrongMinds brand represents our core values:

- Teamwork
- Respect
- Integrity
- Innovation
- Accountability

It also reflects the organizational culture we have developed which emphasises patience, especially in working with people who may be struggling with their mental health or be vulnerable, and empowerment of individuals to move forward in their lives.

Our culture of patience also applies to the way in which staff members treat each other in order to create a healthy and supportive work environment.

Clearly, in places where the StrongMInds logo is prominent, in vehicles and uniforms carrying the brand, we expect the conduct of staff and volunteers to reflect the values and culture of StrongMinds. This includes the finer points of:

- Learning about and respecting neighbours and the wider community
- Following appropriate protocols in addressing people, communicating and listening respectfully
- Demonstrating accountability through strong systems for continuous performance management
- Always leaving contact details with people we meet and work with
- Driving company cars carefully, safely and lawfully
- Avoiding any kind of prejudice and discrimination on grounds of age, race or ethnicity.

Adherence to these basic rules is also a requirement of the agreement between StrongMinds and our partners.

3.4.3 Maintaining the quality of the brand

The reputation of StrongMinds and its partners depends on the quality of our brand being maintained. This means that the values set out in Section 3.4.2. must be reflected in the way all staff, volunteers and other associates of StrongMinds go about their work. The most critical opportunities to maintain the brand consistency are the following:

- During services provided to patients, especially in the way we interact with them, the extent to which we listen and understand their needs and respond to particular challenges or problems they may be facing.
- In the way we communicate with others, especially patients, but also local organisations, health services, suppliers, government officials and people in the community. This includes our approach to handling disputes and complaints.
- The level of professionalism that we demonstrate in the systems and processes that StrongMinds maintains for referrals, group sessions, handling problems and delivering the program.
- Many aspects of brand quality are about the quality of relationships that StrongMinds seeks to establish and maintain with all kinds of individuals, families and organizations we encounter while doing our work. Partners of StrongMinds have the same responsibility of care for these relationships.

3.4.4 Using the brand

As described in Section 3.4.1. the visual identity of StrongMinds is expressed through the name, logo and colours associated with our organization. The agreement that partners sign with StrongMinds describes the way in which the logo is to be used for local fundraising and marketing including mailings, advertising, public relations, social media, websites and promotion of services.

3.4.5 Support from StrongMinds

StrongMinds is responsible for supporting its partners. These responsibilities are set out in the partnership agreement. They include the provision of the Facilitation Team Manual and Operations Manual (together with updates over time) and access to advice and guidance through email, telephone and our website.

Branded StrongMinds tools are included in the manuals:

- Attendance check-list
- Sample screening tool
- Supervise check-list
- Rate burden scale
- Visual images and aids

Overall, we prioritize the achievement of quality support for people who need it. Supporting our partners to achieve this aim is therefore very important.

3.4.6 Circumstances in which StrongMinds does not form a partnership

Although StrongMinds believes that we can best fulfll our mission through an active and diverse partnership network, we have defined circumstances in which we do not enter into partnerships. These include:

- Where there may be real or apparent conflicts of interest. Examples may be where the partner is providing other services that contradict with the values of StrongMinds or where the partnership could enable opportunities that are not consistent with our objectives
- Where the partnership could lead to situations in which the mission, programs, and independence of StrongMinds could be compromised, such as the use of our model to serve party political aims, corruption or to serve people seeking to foment violent conflict.
- Where the mission of partners contradicts our own or whose activities harm patients or communities where we work should be avoided.

If at any time, a partnership appears to pose a conflict of interest for StrongMinds, and/or contradicts our vision, mission, or core values, it should be brought to the attention of the StrongMinds US and StrongMinds Uganda Boards.

4 Implementing the StrongMinds Model

Implementing the StrongMinds model will require partner organizations to consider how to best adapt the intervention to their own local and organizational context. This section of the manual is designed to help program managers strategically target service delivery to align with local and organizational strengths, needs, and objectives.

In doing so, it will provide guidance on:

Pre-implementation

Factors to establish before the intervention begins to operate, such as capacity, recruitment, budget, and referral networks;

Implementation

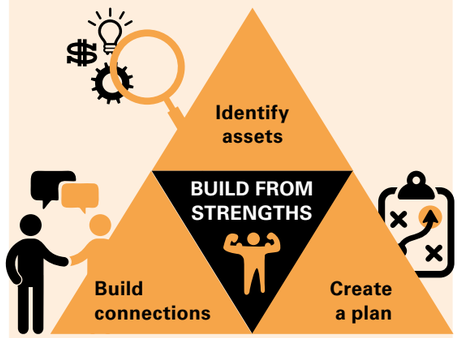
Essential elements of operation, such as managing staff, community engagement, organizing therapy groups, and risk management;

Monitoring, evaluation, and learning

Systems put in place to measure progress and impact, and feed that information back to improve practice

To ensure that partner organizations make best possible use of structures, systems, and other resources already in place, the guidance provided here draws from a strengths-based framework. This approach can help partner organizations define a strategy for implementation by focusing on existing assets as the starting point and foundation of your plan. The follow the key steps of a strengths-based approach for each aspect of implementation discussed in this section, partner organizations are encouraged to:

- Identify the existing assets, facilities and strengths of your organization in relation to the topic you are planning
- Analyse how your organization could build upon them when implementing SM's model
- Define how these assets will be used as part of the implementation



This process will be illustrated further for particular aspects of implementation in the sections that follow.

4.1 Pre-implementation

Before implementing the StrongMinds model, partner organizations will need to prepare staff, systems, and structures for operating a high quality mental health service.

Key elements to consider will include staff capacity, operating budget, and referral networks.

Staff capacity

Before the intervention can begin to operate, implementing organizations will have to establish core staff members to deliver and oversee therapy groups. If following StrongMinds structure, the core team of therapy facilitation staff consists of therapy facilitation staff consisting of at least one Mental Health Facilitator, Mental Health Supervisor, Program Manager, and Mental Health Advisor. For small organizations the Mental Health Advisor and the Program Manager could be the same person if they are properly trained. It is also highly recommended that a Monitoring and Evaluation Officer is appointed before implementation to ensure that systems for measuring progress and impact are integrated into planning. Implementing organizations that plan to use information technologies to collect data should also consider appointing an IT officer who is capable of maintaining, altering, and generating reports from the back-end of the system.

Mental Health Facilitator (MHF)
An MHF is a lay worker trained to deliver IPT-G and supervised by a Mental Health Supervisor on an ongoing basis.

Once trained, MHFs can generally conduct about 10-12 therapy groups per week, each consisting of 8-12 participants.

Groups generally meet once a week for 90 minutes, for 12 weeks. At full capacity, an MHF can treat approximately 350-400 depressed women annually.

Mental Health Supervisor (MHS)
An MHS recruits, manages and supports Mental Health Facilitators (MHFs). He or she can also facilitate therapy groups, and identify useful partnerships with other organizations. An MHS is supervised by a program manager, and both draw from advise provided by Mental Health Advisors. They are responsible for providing weekly guidance and case supervision for MHFs on their team. They should be available to help process and trouble shoot hard client cases or any other implementation challenges that may arise with one of the MHFs that they supervise.

Program Manager
The Program Manager oversees the day-to-day operations of the StrongMinds intervention, and provides support and supervision to MHSs. They may also be responsible for overseeing or completing any necessary program reporting, for supporting program design needs and for ensuring that opportunities for advanced and continuing education are made available to members of their facilitation team. Program Managers do not need to be certified mental health practitioners, but they do need to be well-versed in the delivery of IPT-G. For this reason, Program Managers must familiarize themselves with the content of the StrongMinds Facilitation Team Manual before beginning operations, and refer to it as needed to ensure high quality delivery of this mental health service.

Mental Health Advisor (MHA)
A mental health expert who oversees quality assurance and provides training and guidance when needed. MHAs generally contribute on a part-time or contractual basis, and work closely with the Program Manager.

Monitoring and Evaluation (M&E) Officer
Measuring progress and impact of the StrongMinds intervention requires putting systems in place for constant data collection and analysis. Thus, it is recommended that the implementing organizations appoint a staff member to be responsible solely for M&E planning and implementation of processes and procedures.

Operating Budget

The cost of operating the StrongMinds model is expected to vary greatly depending on local economic factors, organizational capacity, scale and geographic reach of the intervention. Key costs to account for when putting together an operational budget include:

Staff salaries
Including MHFs, MHSs, managers, mental health advisors, monitoring and evaluation staff, and other support staff such as administrative assistants and groundskeepers.

Training costs
In addition to initial training completed by MHFs, it is important to allow for regular refresher training, as well as specialized sessions with the Mental Health Advisor or other outside experts that support MHFs to deal with particular challenges (such as domestic violence).

Transport costs
A key element of the StrongMinds model is that it ensures therapy is easily accessible to women within their neighborhoods and communities. This requires MHFs (and sometimes also MHSs and Program Managers) to travel, often to different locations throughout the day. Implementing organizations are encouraged to cost different transport options to find the most efficient way of ensuring that facilitation staff arrive safely and promptly to deliver therapy.

Office space and maintenance
Although therapy generally takes place within target communities, office space will be need to be maintained as a central point for operations. There should be sufficient space for regular meetings of facilitation teams, training sessions, and the day-to-day duties of program managers, administrators, and monitoring and evaluation staff.

Community education, engagement and mobilization
Money should also be set aside for the costs involved with getting the word out about the intervention. Some organizations may find it useful to employ local mobilizers, for example, to encourage groups to gather and learn about depression so they can identify people in their community who will benefit from the service. Other costs may include events to engage community leaders, and development of awareness-raising resources such as posters, fliers, radio, or digital media announcements. (See Section 4.2.2 for further guidance on creating a cost-effective strategy for community engagement and mobilization.)

Technology
Implementing organizations that plan to use digital information technologies for data collection will also need to factor in costs associated with using their chosen platform, such as purchase of IT devices and system maintenance.

Referral networks

Before beginning any implementation activities, organizations will need to set up referral networks to ensure that patients beyond the scope of the StrongMinds therapy model have access to quality care. Patients who fall outside of StrongMinds purview will need to be referred to other types of psychiatric care, which may include:

- Specialists who can prescribe medications;
- Hospitals with psychiatric care wards;
- Emergency services.

Implementing organizations may also choose to include other types of social support services in their referral network to assist patients with specific situations, such as:

- Domestic violence shelters;
- Disability services;
- Refugee and resettlement support;
- Rape counseling; and
- Housing assistance.

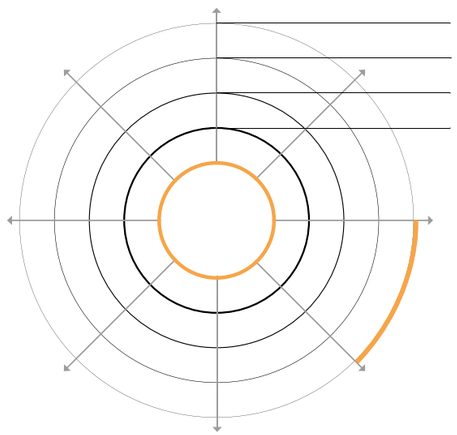
To guide a strengths-based approach to building referral networks, a stakeholder mapping exercise is provided here. A case study of how referral networks have been developed at StrongMinds Uganda is also provided as an example.

Stakeholder mapping to build referral networks
Stakeholder mapping is a necessary activity that should be used to identify existing community actors that may be needed to support clients who do not fit within your current model of care. For example, when defining a referral strategy it will be crucial to identify possible mental health hospitals, clinics, and individual contacts. To identify and map out your available community resources, ask your team the following questions:

1. **Who are the key stakeholders?**
   List all key individuals, groups and organizations.
2. **Why are they important?**
   Write one or two words beside each name to note their relevance.
3. **How are they related?**
   Analyze how these individuals and groups relate to each other and with your organization.
4. **Draw your map:**
   You can organize them in different ways depending on your priority. Some ideas:

- Circular: put your organization at the center and then other stakeholders around it according to their proximity
- Hierarchical: According to scale (for example national, district or local level) or level of importance in relation to your organization.
- Iterative: Write them all up and see what happens. As a picture emerges, it may reveal connections that you had not previously thought about.

5. **Analyse the map:**
   What might be some possible conflicts, power issues, and easiness in these relations? What strategy can your organization use to best build upon these existing relationships?



Case Study

Building up referral pathways /networks

At StrongMinds Uganda, a strong referral network has been built by cultivating relationships with key individuals working for government and non-government services operating at local, district, and national levels. These include:

- Psychiatrists;
- Hospital staff members;
- District health officers;
- Police officers;
- Child welfare officers;
- Uganda Human Rights Commission representatives.

In building this network, StrongMinds Uganda has found that close communication with district-level health services has enabled them to ask questions and identify which local hospitals and clinics are best equipped to deliver psychiatric care. It has also led to StrongMinds taking part in local health fairs, which enables them to broaden and deepen their relationships with other health service providers.
StrongMinds has also found that recruiting staff with experience in clinical settings can also benefit their referral network. Each staff member brings with them information about existing networks and past professional relationships that can be drawn upon to refer patients to trusted services.

One of the most important lessons learned by StrongMinds Uganda is the importance of being able to refer patients to a specific person rather than an overall entity, such as a hospital or other organization. Patients suffering from mental health problems are likely to be scared when referred for clinical treatment, and may face further barriers posed by age, disability, or literacy level. Developing relationships with individuals working in these settings has allowed StrongMinds to call trusted staff members, and reassure patients that someone will be there to meet them at the door and help them through the admission process. Trust in SMU is then extended to the new organization – thus increasing the likelihood of adherence and success for the patient with their treatment model.

Therapy Structure and Materials

The Facilitation Team Manual provides an in-depth overview of the StrongMinds therapy intervention, as it has evolved in Uganda. Implementing organizations may find it necessary, however, to adapt certain elements of this model to better suit the social and cultural contexts in which they work. Key elements to consider for possible adaptation include the duration and scope of therapy, interactive visuals, and language used to discuss the intervention with stakeholders.

Social and Cultural Adaptation

Recommendations for adapting the model to specific populations:

Duration of therapy
Think about how many sessions will be required when working with a specific social group or population. IPT-G can be delivered over a time period of 12-16 weeks. At StrongMinds Uganda, 12 weeks has proven to be sufficient to help the vast majority of its patients become depression free. Organizations working with specific population groups, however, may find that more time is needed.

Scope of therapy
Think about which members of the population will be included in therapy groups. Implementing organizations may choose to target specific populations (such as adolescent girls, new mothers, or refugees) or to offer the intervention to everyone diagnosed with depression. Although the target population for StrongMinds Uganda has always been women, they have found strategic advantages to also offering the therapy to men. (See the case study on this page.) Whatever choices are made in terms of scope, it will be important to make the parameters clear to all staff members, to ensure that they understand who should and should not be invited to join therapy groups.

Interactive visuals
Go through the materials to check if they will work in the social and cultural setting where you work. Will any adjustments be needed?

Language
Depending on the socio-cultural group, think about how depression and its triggers might be presented in a way that is clearer for participants. For example, among bantu speaking, there are two syndromes that refer to depression: 'y'okwetchawa' – self loathing and 'okwekubaziga' – self-pity. Section 4.4.5 of the Facilitation Team Manual provides further guidance on explaining depression in culturally relevant ways.

Case Study

Working with men at StrongMinds Uganda

Many of the depressed women we treat asked us to provide a similar service to men in their lives, namely their spouses, brothers or sons. In 2016, StrongMinds treated a small cohort of men for depression, as part of a pilot, to determine whether treating men had a strategic benefit. By the end of the year, we treated just over 500 men and learned that recognizing and treating depression in others within the women's households supports those women's wellbeing.

Other lessons learned were that:

- Men had lower attendance and participation rates, requiring additional incentives, such as livelihood and agricultural skills, to encourage them to participate in talk therapy.
- Men tended to be less forthcoming about their depression, requiring more time in pre-group sessions.
- Men typically assume community leader and decision-maker roles in the communities where we work. Making services available to male peers allows us to build our credibility among these leaders, allowing us to operate more effectively.

Although StrongMinds' mission focuses on aiding the depression crisis affecting women in Africa, IPT-G is also an appropriate treatment for depressed men. We have found that treating a small portion men, approximately 5% of our total patient count, strategically enables us to continue successfully treating women by providing us access to otherwise closed communities or by gaining the trust of key decision makers in the family and community structures.

4.2 Implementation

Implementing the StrongMinds model requires careful planning and ongoing support systems to ensure that a high quality therapy service is delivered to the individuals and communities that need it. This section provides guidance to assist implementing organizations in setting up and maintaining these systems.

In particular, the following processes will be discussed:

- Community engagement – including identifying communities to engage, building relationships with local leaders, raising awareness, and mobilizing communities;
- Managing staff – including recruitment, training, and supervisory procedures;
- Organizing therapy groups – including logistics, budgeting staff time, and linking patients to other forms of support
- Risk management – including minimizing risks to both patients and staff

Throughout this section, case studies from StrongMinds Uganda will be used to illustrate how systems for supporting these processes have evolved based on their experiences. Implementing organizations are encouraged to consider these lessons, but also to adapt the model as necessary to suit the local contexts in which they operate.

4.2.1 Community engagement

In order to bring StrongMinds therapy to the people who need it most, the service must be introduced in a way that engages communities to take action against depression. Active community engagement will be required by implementing organizations in order to provide community education, reduce stigma and raise awareness about depression, identify people needing treatment and invite them to join therapy groups.

The time and effort to mobilize community support and involvement should not be underestimated. Activities for mobilizing community participation and involvement often include individual meetings with local government leaders, larger meetings with community leaders, and community events where people can learn about depression and its treatment.

To support implementing organizations in developing community engagement processes, this section will discuss strategic ways to:

- Identify communities to engage
- Build relationships with community leaders
- Raise awareness
- Plan for mobilization; and
- Address mobilization challenges.

Identifying communities to engage

At StrongMinds Uganda, the decision of which communities to engage generally rests in the hands of the Program Manager and Executive Director, based on information gathered from facilitation field staff, government health officials, and other sources.

Key factors taken into consideration when identifying new communities to engage are:

- **Need**
  Determined based on evidence and information indicating particular communities that have a high prevalence of depression. This information may be gathered from government health agencies, NGOs, district or local officials. In places where no evidence is available, implementing organizations may choose to conduct their own studies in local neighborhoods using the PHQ9 diagnostic tool.
- **Demand**
  Based on requests from community members or other stakeholders that have heard about the service and report potential benefits of providing it in a particular community. In cases where demand outweighs an organization's capacity to deliver the service, program policies may be needed to establish fair and consistent criteria for deciding which communities are served first.
- **Logistics**
  The realities of geographic distance, organizational capacity, and logistical challenges such as traffic and transport must be taken into account. When committing to work in new locations, it is important to ensure that the expansion will not interfere with the ability to continue serving communities in which the service is already established.
- **Partnerships**
  Program Managers and Executive Directors can explore opportunities to engage new communities through partnerships. Local partner organizations can often offer valuable insight about which groups of women in their communities might be suffering from depression.

In identifying communities to engage, implementing organizations are encouraged to consider, as a matter of priority, where the StrongMinds model will best compliment their existing programs and services. For example, organizations that have had trouble delivering programs or services to women (or particular groups of women) may wish to explore whether depression is an obstacle. Since this mental health condition can interfere with social skills, concentration, and ability to retain information, treating depression first may enable women make better use of other resources and opportunities these organizations provide.

Building relationships with community leaders

The first communication with a community is often the most important and paves the way for a successful relationship. The person in charge of this communication must approach community leaders respectfully, first researching local protocol carefully by consulting people who are familiar it. In many communities, the most appropriate course of action will be to approach community leaders first to gain their support, trust and participation.

Once a relationship has been established with community leaders, it is important to follow through with the role those leaders have chosen in the process of addressing depression in their community. Advice and support from community leaders can be especially useful in rolling out a strategy for mobilization. In particular, they can help connect implementing organizations with:

- **Existing local groups and networks**
  Building upon groups of people who already work together in some way provides a higher degree of efficiency for both organizations and community members. Instead of setting up a separate community meeting about depression, local community leaders may be able to organize for a StrongMinds implementer to attend a meeting that has already been called for a different reason. For example, if a training session is being conducted to promote livelihood or microfinance programs in the community, a StrongMinds representative may be invited to speak to the group about depression at the end of session.
- **Local events or spaces**
  Similarly, community leaders may be able to organize for a StrongMinds representative to be positioned in local places where they are able to educate people about the service. One example of strategic local spaces is the local public health clinic waiting area, where many people tend to sit waiting for long periods. Another opportunity may be local community centers, associations, or religious groups where leaders might agree to introduce depression as a topic for discussion. Leaders may also agree to invite a StrongMinds representative to a meeting, and point him or her out to the community as someone who is available to speak with them further. In Uganda, for example, this has been done at local church services.

Case Study

Building relationships with community leaders in Uganda

StrongMinds Uganda (SMU) has developed a system for building relationships with community leaders based on local protocols. First, the Executive Director contacts local government leaders with a brief letter to introduce the organization and express its offer to provide talk therapy to treat depression in their community. If local government leaders are interested, a representative from SMU (generally the Executive Director or Program Manager) meets with them to talk about high-level objectives and ask for advice on how to best roll out the intervention. Together, they agree on a strategy for getting the word out and, specifically, for connecting with people suffering from depression. This generally involves identifying respected individuals within the community who can then be employed as local mobilizers to organize public meetings. These meetings are attended by MHFs, who sensitize community members to the meaning and challenges of depression, and conduct an initial screening session to assess whether any people present may benefit from talk therapy treatment.

Raising awareness

Once a community has been identified, and its leaders are engaged and interested in rolling out the intervention, a process of raising awareness among community members can begin. The StrongMinds model, based on its years of experience talking to communities about depression, has developed three main processes for raising awareness: public education campaigns, sensitization, and screening.

Public Education Campaigns

StrongMinds public education campaigns aim to promote greater understanding among the general population about depression, its impact, and its treatment. Strategically, this part of awareness-raising is important because it helps the public understand the value of the service being provided, and helps reduce the stigma that often serves as an obstacle to mental health treatment. Thus, public education campaigns can help garner support for depression treatment programs, and help people overcome barriers to connecting with services that they need.

Public education campaigns can be delivered through:

- Posters;
- Fliers;
- Public speaking events;
- Booths at community festivals or health fairs;
- Radio or television shows;
- News or newsletter articles;
- Social media sites; or
- Mobile phone text messages.

Whatever the method of delivery, the key message of public education campaigns should be: Depression is a health condition that can be devastating, but there is help and treatment available.

Sensitization

Sensitization is a term used by StrongMinds to describe an interactive process of explaining to groups and communities what depression is, what its impact can be, and how it can be treated. Generally, sensitization is conducted at events organized by community mobilizers. These events can take place in a public space, such as outside in a neighborhood commons, at someone's house, or as part of another group meeting or event.

Depression is first explained using local idioms and visual aides to promote discussion among participants, who are encouraged to ask questions and voice any pre-conceptions or myths that have characterized their understanding of the disease. Bringing these misconceptions into the open is important to the process of supplying communities with evidence-based information, and reducing stigma for those suffering.

StrongMinds therapy is then presented as an option for treatment, with emphasis on the concept of talk therapy, and the ability to address this mental health concern without medication in the vast majority of cases. Some examples of success might be shared with the group, as well as some of the main aspects of IPT-G such as attendance, confidentiality and duration. It is important to clarify, at this point, that the service is limited to treating depression and does not involve any financial services or incentives such as cash transfers or provision of material goods.

Participants are encouraged to identify other members of the community who may be suffering from depression, and bring them along to future sensitization and screening sessions. People who want further information can continue discussions immediately thereafter and/or request a follow-up with a StrongMinds facilitator.

Sensitization is often immediately followed by an initial screening process in order to identify people exhibiting the symptoms of depression. In order to promote accurate diagnosis, it is important to refrain from talking in too much detail about the specific symptoms that are measured on the diagnostic tool. The main discussion during sensitization should, instead, focus squarely on explaining that depression is a disease, dispelling myths and preconceptions, and presenting talk therapy as an option for treatment. Section 3.2 of the Facilitation Team Manual provides more specific guidance on ways of doing this.

Screening

Once sensitized, all participants are invited to take part in a one-on-one pre-assessment screening session. The Patient Health Questionnaire (PHQ-9) is the diagnostic tool used during the screening process, and it is administered orally by reading out the symptoms and asking patients to rate them. (Appendix of this manual provides a pre-assessment screening form.)

Contact details are collected from all participants who are screened, and MHFs follow up with people whose scores indicate they may be depressed. These community members are invited at that point to attend a pre-group session with a Mental Health Facilitator, who will administer the test again to either confirm or disconfirm the diagnosis. Pre-group sessions also explore the factors that have triggered an individual's depression, and begins preparing the person for the therapeutic process. This process is discussed in more detail in Section 3.3 of the Facilitation Team Manual. (See also Appendix of this manual, which provides a pre-group session data collection form.)

Case Study

Example of a sensitization event in Uganda

Toward the end of a group therapy cycle in the Kampala District, the woman who had served as her therapy group's chairperson volunteered to mobilize people in her neighborhood, as she feared that more people were suffering from depression. This woman was part of a savings club, made up of local women who pooled their money together to keep a common savings account. She organized for a Mental Health Facilitator (MHF) to join their group meeting one day.

The group met outside on the front veranda of one member's house, and ten women attended. Once the group had completed its core business for the day, the MHF was invited to speak. She introduced herself, explained depression briefly, and then held up a visual tool that uses cups to depict how depression takes up space in one's life.

(See Facilitation Manual, Appendix). She asked the women what they saw in the picture, and a discussion emerged. When the discussion came to a close, she invited the women to take turns speaking with her individually to respond to the items on PHQ-9 diagnostic tool. The entire process of sensitization and pre-assessment took around 40 minutes.

Planning for mobilization

Setting up a strategy for mobilization will enable your organization to set up a smooth and productive process for working with new communities over time.

Key elements of planning include:

Identify opportunities for mobilization
This could be an existing group or community in the area; women participating in a club or joint project, or a program already being delivered by an NGO or government agency.

Define a communication plan
Decide who is going to be the person your organization will contact and the best mechanism for communication (such as by mail, phone, or email).

Decide who will carry out mobilization activities
There are different ways of doing this. Below we present two options; implementing organizations are encouraged to choose the one that best suits their context.

Mobilization by MHFs	Mobilization outsourced to other outreach workers
In this model, Mental Health Facilitators are in charge of mobilization, including all sensitization and screening processes. This option may be favorable for organizations just starting out with the intervention, or those that wish to keep staff structures simple and straightforward. **Advantages:** Potential clients will receive information directly from MHFs, who have been trained in treating depression. Thus, they can provide more detailed information and responses to questions emerging from the sensitization and screening process. **Disadvantages:** Mobilization takes a large amount of MHFs time, which could instead be used to run additional therapy groups. Mobilization is an activity that requires less training, and can often be performed more cheaply by local community members that require no transport MHFs who are mobilizing in a new area may have no connection to the community or the local community leadership at all – thus they are essentially outsiders.	In this model, mobilization is undertaken by local people trained specifically to sensitize and conduct initial screening, but who are not trained to facilitate therapy. Larger organizations with mobilization strategies already in place may find this option preferable. **Advantages:** This strategy requires less investment in training, and allows MHFs to focus on therapy facilitation. **Disadvantages:** Outreach workers might have a more limited information about depression and the therapy model. Potential clients will only have the opportunity to meet a facilitator if they are invited to participate in a pre-group session. Outreach workers who are recruited from within a specific community will know everyone in the community well and will know how to find and access the most people. In addition, they may already know the local community leaders and have access to traditionally closed groups of people who may be experiencing depression

In planning for mobilization, a strengths-based approach is encouraged to help implementing organizations define the best strategy for them. To use this approach, first identify assets available to your organization that might support and enrich mobilization. For example:

- Campaigns, activities or events that your organization already uses or has access to;
- Staff from your organization that already performs outreach activities;
- Awareness-raising materials such as website, flyers, publications;
- Databases of potential patients and/or local partners;
- Contacts of community leaders, 'gatekeepers' or key stakeholders that might help facilitate community entry;
- Partnerships or other relationships with governmental or NGOs that may connect the service with particular groups or communities that need it.

Once these assets have been listed, consider how to best build connections between them to form a mobilization strategy, and plan accordingly.

Case Study

Mobilization at StrongMinds Uganda

The mobilization strategy for SMU has shifted as it has expanded the scale of its service. When the program began, Mental Health Facilitators conducted all elements of mobilization. This enabled potential patients to have direct contact with MHFs from their first point of contact with StrongMinds.

However, as the project has expanded and now treats a much larger number of women, greater demands have been placed on MHFs in terms of therapy facilitation and data collection. As mobilization can be a time-consuming process, it was identified as an element of the job that could potentially be outsourced to workers with less specialized training and experience. Thus, managers have made the decision to begin contracting outreach workers to lead the mobilization process, allowing MHFs to concentrate on delivering therapy.

SMU now combines both approaches, and will continue to blend the two in response to shifting needs and demands. Rather than relying solely on community mobilizers, the process will continue to involve participation by MHFs as necessary.

Addressing mobilization challenges

Mobilization can be a challenging and time consuming process. Some of the typical challenges involved are listed here to help implementing organizations think through how to manage them.

Stigma around depression

Both personal and public stigma exist around depression. This stigma can prevent some of the women who are suffering from depression from completing a PHQ-9 survey or from joining a therapy group.

Broad community education can help combat this stigma, especially regarding depression rates in Africa. Normalization is a tool that helps fight stigma and allows those suffering to understand that they are not alone – thus minimizing some of the associated fear, isolation and guilt.

Dealing with pre-conceptions or misconceptions about talk therapy

When arriving to a new community or group, mobilizers should expect to encounter several pre-conceptions about depression, group therapy and the implementing organization. In Uganda, for example, people have the idea that joining therapy will 'bring money' in any way.

To face these preconceived ideas it is helpful that mobilizers provide very clear information and come prepared to answer many questions about what the program is and is NOT and that professionals are trained on how to deliver this information in a creative way.

Socio-cultural and power relations that might inhibit participation

Depending on the socio-cultural context, potential clients might be restricted or motivated to participate according to social structures. For example, in some cases, women might not be able to attend therapy sessions without the approval of their husbands. In other cases, women might not feel comfortable attending sessions with other wives the same husband or with other women from their community

Having previous information about this context will help prepare mobilizers. Previous contact with community leaders, other NGOs working with the group, or other people that can give an insight into the socio-cultural dynamics of the group will facilitate the understanding of the context. During the sensitization process, different options can be offered to help plan for or address these socio-cultural factors. For example, the possibility of joining a different therapy group.

4.2.2 Managing staff

Delivering the StrongMinds intervention is a challenging enterprise that relies on strong, supportive teamwork. Facilitation team members, especially, engage in emotionally demanding work on a day-to-day basis. For this reason, managers should carefully consider how to create a work environment that is safe and supportive to ensure that therapy groups are facilitated in the best way possible: by staff members who are confident, empowered, and comfortable asking for advice when needed.

Key components to consider in creating this type of work environment include:

- Recruitment – how to hire staff members that will work to reflect the core values of teamwork, respect, and integrity;
- Training – how to teach staff IPT-G delivery in a way that is engaging, empowering, and encourages continuous learning;
- Supervision – how to support staff to share and learn from each others' experiences in a way that encourages constructive feedback and mutual support.

In considering all of these components, it is important to keep in mind the nature of the service being delivered. StrongMinds delivers group therapy that aims to empower women to work as a team and support each other to manage depression. Managing staff in an effective way will require a style that models the principles of empowerment, teamwork, and mutual support.

Recruitment

Implementing organizations are encouraged to build from existing networks and human resources when recruiting staff. Facilitation staff, especially, may be recruited internally or through community networks known to the organization. It is essential that facilitation staff, MHFs in particular, are either local or very culturally attuned to the population where the intervention is planned. MHFs require at least a high-school diploma; previous experience working in mental health settings is desirable, but not required.

Section 4.2. of the Facilitation Team Manual describes, in detail, a set of skills that are desirable for facilitators to possess. Additional characteristics to look for when recruiting include:

- High motivation to help others: The facilitator has to be genuinely interested in assisting people who may be feeling distressed, scared or confused.
- Attitude: Applicants should approach the job with respect for patients and an eagerness to learn and work in a team.
- Dedication: Facilitators should be committed to empowering women to manage their depression.
- Experience: Applicants with previous experience in delivering mental health services is an advantage. This might contribute to therapy facilitation as well as to the referral process when the therapeutic needs of patients are beyond the scope of StrongMinds therapy. In the case of Uganda, MHFs that are familiar with referral hospitals and their staff have played a key role in helping patients follow through with referrals.

It is important to note the challenges that often accompany recruitment of staff to mental health positions. In many African countries, including Uganda, mental health has traditionally been viewed as an unattractive field of potential employment. For this reason, it is important to plan ample time for recruitment processes, and consider which incentives will be most effective in attracting high quality facilitators. For example, the prospect of receiving intensive facilitation training on the job may be an exciting opportunity for many local applicants who are dedicated to helping their communities.

Training

Mental Health Facilitators receive rigorous and practical training to ensure they feel confident when facilitating therapy groups. High quality training for facilitators is essential to providing a mental health service that consistently achieves a high standard of care.

Initial training for MHFs typically takes ten full days. After their initial training, MHFs continue to receive weekly supervision, guidance, and periodic refresher trainings that allow them to reflect on their experience along with other members of their facilitation team.

Training should be highly participatory in nature, engaging the new facilitators' own thoughts, experiences, and ideas. Facilitation of training should model the type of facilitation the trainees are expected to perform in therapy groups – inclusive, supportive, and empowering, with plenty of constructive questions and feedback. To keep training practical and focused, it is essential to use role-plays and other exercises to simulate group therapy settings and provide facilitators a safe space to practice new skills.

The core curriculum of IPT-G training for MHFs includes modules on the following topics:

- Overview of mental health and mental illness in general
- Depression: Understanding depression, its triggers and symptoms, and how to explain to group members in culturally located ways.
- IPT-G: Principles and practice of interpersonal group psychotherapy.
- Suicidality and co-morbidity: How to identify group members with these conditions and how to manage these cases.
- Referral processes: The role of facilitators in referral processes.
- Health and safety measures: How to implement these in daily practice to protect patients and staff.
- Data collection process: The concept and importance of monitoring and evaluation procedures, and the role of facilitators, including all methods and technologies used.
- Logistics: Including scheduling and other specifics for arranging therapy groups.
- Planning and goals: How to plan for each weekly session in a way that assists individual therapy group members in achieving their therapeutic goals.

These topics are discussed in detail in the Facilitation Team Manual, with which all people involved in training facilitators should be familiar.

Atmosphere and format for training

In addition to the content of StrongMinds training, creating the appropriate atmosphere and format is crucial to its success. The elements listed below have been identified as essential to promoting confidence, learning and motivation among new facilitators:

- Practical and participatory format: Training should be an opportunity for MHFs to apply and practice the information and content they are receiving from trainers. This fosters motivation as well as guarantees knowledge and skills appropriation. Role-playing is an essential tool for enabling this format. The Facilitation Team Manual provides practical exercises and role-play examples to achieve particular learning objectives.
- Reflect the core values of StrongMinds: Training should transmit empowerment, teamwork and respect.

Empowerment
Encourage facilitators to think about what they would do in specific situations, rather than to memorize every detail from the trainer.
To encourage active learning and contribute to building empowerment, try beginning each new topic with questions and thanking the participants for sharing their thoughts, questions and feedback.

Teamwork
It is important to set up this value from the very beginning of training since, on many levels, teamwork is a key element of delivering therapy. Coorperation among MHFs and between MHFs and supervisors will be essential to promote the continuous reflection and learning that is required to deliver high-quality therapy. In addition, MHFs should inspire teamwork among the women in their therapy groups. Teamwork can be encouraged during training by dedicating ample time to small group exercises that allow all members to participate and build rapport.

Respect
Training should be a space where MHFs feel safe and respected. Different ideas and perspectives should be welcomed at all times. It is also important to ensure that each participant's questions are valued – to encourage this, trainers should make sure that every thought or questions should be treated like an important question or a valuable contribution that will bring insight into the learning process.

- 'Modelling the message': The way training is conducted will influence and inspire the way MHFs implement group therapy. Therefore, it is important to think about how to orient training sessions in a way that reflects how the group sessions are expected to operate. For example:

Questions before answers
In both therapy and training settings, empowerment comes from asking, not dictating. Before telling trainees about a new topic, try introducing the topic first and asking some questions that will help the group think it through themselves. Example questions have been provided in the Facilitation Team Manual at the beginning of each section, where applicable.

All group members participate
Just like all therapy group members must participate in order to work on their goals, it is essential that all trainees take part in discussions and practice their facilitation skills. Trainers should encourage trainees to look after each other to make sure that everyone has a chance to participate.

Constructive feedback
Therapy group members and trainees alike sometimes need guidance to apply the techniques of IPT-G appropriately. Every effort should be made to keep criticism constructive and, where possible, to enable trainees to figure things out themselves. For example, instead of telling a trainee 'You didn't use the right technique' after a role-play, trainers should ask a targeted question to help the team reflect, such as 'What are the advantages of the technique that was used here? What are the disadvantages/risks? What would have happened if the other person had responded differently, like…?'

Rules, roles, and responsibilities
Just as in therapy groups, agreeing on a set of rules can help training groups run more productively. Trainees should agree on guidelines for matters such as confidentiality, punctuality, and mobile phone usage. It can also be useful to ask for volunteers to assume certain roles and responsibilities for the training group, much like the roles and responsibilities that are assumed within therapy groups. For example, training groups may choose to appoint a Group Chair, Vice-Chair, and support roles such as Welfare Officer (who makes sure water pitchers are filled, and that the training venue is physically comfortable), and Materials Officer (who passes out handouts, and other learning tools).

Sample Training Format

I. Introduce a new subject or set of techniques (2-3hrs) – including initial thoughts from trainees, followed by in-depth explanation and discussion of examples from the field.

Break

II. Small group work to practice (2hrs) – role-play exercises in groups of 3-6, trainers circulate among groups to listen, provide feedback, and suggest alternative scenarios.

Break

III. Debrief and share lessons learned (90min) – talk about what happened in small group exercises, review key learning points from the day.

Tips on training logistics:

- **Provide writing materials**
  Giving trainees a dedicated notebook and pen encourages them to record their thoughts.
- **Take breaks**
  This will give women time to absorb the information and content of the therapy session as well as give space for informal and rich conversations to happen.
- **Use a flexible venue**
  It is important that the training venue is flexible enough to allow participants to move about and work in small groups. Seats should be easy to move around in different formations for different parts of the training. Arrange seating in circles when possible.

Supervisory procedures

The StrongMinds approach to supervision operates from a position of guidance, management and direction, rather than from a position of control. Supervision practices should align with the core values of the program, with the aim to provide support and orientation that empowers staff to deliver a high quality mental health service.

Some examples of supervisory practices at StrongMinds Uganda are presented below, highlighting how they contribute to successful implementation of the model:

- **New MHFs are supervised carefully**
  After training, new MHFs are paired with an experienced MHF or MHS for their first therapy sessions, and continue to work in teams with other MHFs that can provide them with ongoing support. This enhances their confidence as facilitators and enriches their learning process with regular feedback that allows them to continually improve their practice.
- **Spot checks**
  MHSs regularly sit in on therapy sessions and provide feedback via standardized feedback/review forms and informal verbal guidance. This happens at least twice per therapy cycle, and more often for new MHFs. Spot-checks help facilitators improve their practice and allows supervisors to have a sense of what is happening across groups in order to inform decisions about the program concerning changes and improvements.

  During these spot-checks, supervisors look both for general facilitation skills (such as interpersonal and group management skills) as well as IPT-G specific skills (such as how the facilitator addresses patients' triggers of depression).

  Supervisors may also use this opportunity to identify an area of growth for the MHF that may require additional practice or strengthening.
- **Team meetings**
  StrongMinds Uganda has allocated one day per week (Fridays) in order for teams to meet at the office and discuss subjects that have come up over the week. Each team is formed by 5-7 Mental Health Facilitators and is led by a Mental Health Supervisor or senior MHF.

  This is a weekly opportunity for MHFs to learn from each others' experiences, access support from supervisors, ask questions, discuss tricky cases, and plan for their next sessions.

  During this weekly meeting, opportunities may also be taken to discuss and teach advanced skills that may be needed by the MHFs in order to deal with common challenges exhibited from the women in the group such as addressing domestic violence, addiction or the stages of grief and loss.
- **Other supervision practices**
  Mental Health Supervisors (MHSs) are supervised by Program Managers, who receive guidance and supervision from trained psychologists working as Mental Health Advisors.

  Further detail about support expected from supervisors is presented in Section 6.2 of the Facilitation Manual.

4.2.3 Managing therapy groups

Once communities have been mobilized and participants have been enrolled, therapy groups are set up and run for a cycle of 12-16 weeks. The Facilitation Team Manual provides an in-depth look at how therapy sessions are set up and facilitated by field staff. This section provides an overview of the management considerations involved with implementation of therapy groups, including:

- Logistics;
- Budgeting staff time;
- Connecting patients with additional services.

Logistics

Venue

A key component of the SM model is its basis within the community and its accessibility to women needing services. This accessibility is first offered during the mobilization process. Thus, clients are not expected to come to the service, but the service goes to them. This makes the scenario different than a clinical setting.

Once a group has been assembled, Mental Health Facilitators will decide with the women from each therapy group where the session will be held. It could be at a client's house, outside under a tree or in a community space such a church or cultural center. The key aspect of the venue is guaranteeing a space where the women will feel comfortable meeting.

Transport and schedule

Managers will have to consider how to safely transport their therapists to the communities or places where they work and how to organize group times to allow therapists to travel from place to place. Transport logistics will be defined in relation to therapy group schedules as well, depending on who needs to be where each day.

Case Study

Transport at StrongMinds Uganda

In the case of Uganda, full-time drivers have been hired to drive company cars, which are used to transport MHFs to therapy sessions. However, sometimes it is a challenge to get all facilitators on time to their destinations. Sometimes additional drivers are hired for the day in order to meet transport needs. In some cases, it is cheaper and easier for MHFs to travel directly to therapy venues from their home using public transport or their own private vehicles. In these cases, petty cash is distributed to MHFs to cover expenses incurred.

It is recommended that managers develop a scheduling system for organizing therapy groups that allows all MHFs to keep track. This will guarantee effective implementation and contribute to the MHFs well-being and efficiency. Scheduling systems should keep track of both:

- Daily activities: The days and times that each therapy group meets, plus any mobilization activities that require MHFs to be present.
- Therapy cycle: How many total weeks have been completed by each group and when each cycle and group will terminate.

Budgeting staff time

Budgeting staff time is a key factor for successful implementation. This guarantees quality service delivery as well as protects and supports personnel to prevent burnout. Some aspects for managers to consider:

- **Mental Health Facilitators**
  It is important to consider that therapy implementation also requires time for planning, travel to venue, data collection, de-briefing with team and/or supervisors, and reporting. This comprehensive view of what a MHF does will keep expectations of MHFs performance realistic and reasonable, as well as prevent the risk of 'staff burn-out'. Note how their times might be affected if engaging them in mobilization processes. Being healthy throughout the therapy cycle will allow MHFs to offer a consistent support to each group. It is recommended to avoid changing the MHF during the course of group therapy, since this can result in a negative impact on patients' progress.
- **Monitoring, Evaluation and Learning (MEL)**
  Depending on the scope of the model implementation and MEL strategy that your organization defines, the number of people involved will vary. It is important to keep in mind how MHFs will bring data from patients every week as well as monthly reports. In case of doing an evaluation, this will require more people and time.
- **Mental Health Supervisors (MHS)**
  Usually MHS supervise groups of 5-7 Mental Health Facilitators. This implies facilitating weekly team meetings and doing regular spot checks. Spot checks involve observing therapy group sessions facilitated by MHFs and providing feedback to MHFs. It is recommended that each MHF should receive at least two spot checks each therapy cycle, with more added in cases where MHF require additional support. Time allocation for MHS will vary depending on whether they also facilitate therapy groups themselves.

  A systemic view of staff management will allow managers to understand how quality therapy depends on a balanced time allocation between the different roles or levels.
- **Termination**
  Program managers and supervisors should oversee with special attention the termination phase of therapy to guarantee that the therapy cycle is concluded in a proper way.

Linking patients to other forms of support

During the course of therapy

Group talk therapy encourages women to discuss a range of aspects of their life that might raise different needs or interests that might exceed StrongMind's therapy model. Based on this experience, SM has recognized the value of building strong networks with other governmental and NGO services, in order to present other possibilities for women to approach their process in a comprehensive way.

Participation in district government 'health fairs' has been an effective strategy for building such networks in Uganda. Holding stalls in such events serves as an opportunity to present the service we offer as well as learn about other support available to patients. Getting specific names and contact details from people working as part of these other organizations or services is recommended to facilitate future communications when desired by a patient.

Post-termination

As part of the termination process, women are encouraged to continue meeting as a way of enhancing community support, based on the fact that depressive episodes might be recurrent. In some groups, women have proposed initiatives such as learning a new skill or craft to continue working as a group. This can provide motivation for women to continue meeting and supporting each other to manage their depression.

However, it is recommended to manage this possibility with extremely caution to avoid giving the wrong idea to potential patients about the focus of the therapy service. At all times it must be explained that therapy groups do not provide economic remuneration of any kind. The focus of the service must be firmly placed on delivering therapy for depression, and not be distracted by skills, crafts, or economic endeavors pursued jointly by therapy group members.

StrongMinds recognizes the importance of supporting women's post-termination initiatives. As well as when 'linking patients to other forms of support', this implies acknowledging broader interest, requirements and needs that help women continue to manage their depression. However, clarity around this possibility is fundamental when presenting the model to potential patients. Be careful when and how to mention this possibility.

Case Study

Candle Making in Mukono, Uganda

This is an example of an activity that emerged from discussions taking place during the termination phase of therapy. One therapy group in the Mukono District of Uganda wanted to do something special to wrap up and celebrate completion of their therapy cycle. They learned that their MHF knew how to make candles, and proposed pooling their money together, and using it to buy molds and ingredients to make candles, which they could then try selling at the local market. Although this type of activity is not part of the IPT-G model, their MHF talked to his supervisor about whether he could play a role in this activity. The MHF offered to stay on after the therapy session to teach them how to use the molds, and the supervisor agreed to move forward with this plan.

On that final day of therapy, as the group melted the wax over a small burner, they continued speaking with the MHF about what the therapy had meant to them. Some group members were sad that the facilitator would no longer be coming to work with them. The facilitator reassured them that they had all made great progress during therapy, and they would be able to continue supporting each other to apply the depression management skills they had learned. The women also discussed how the candle-making would provide them with a good reason to keep meeting up in the weeks that followed, especially if they were able to sell them and bring some extra money home as a result.

Risk management

Establishing plans to address suicidality, co-morbidity; health and safety (staff and client); integrating this into staff training

Dealing with depression involves high risks such as patient suicide. It is strongly recommended, therefore, that implementing organizations establish a strategy for a risk management. This section presents some key elements to have in mind when thinking about risk management, suggesting precautions to protect clients as well as staff members.

Suicidality

Anytime work is being done with people who are experiencing symptoms of depression, suicidality is a risk that must be considered. Accordingly, the StrongMinds model addresses any suicidal thoughts or ideas seriously and requires that any implementing partner organizations also do the same.

Suicidality should be a topic that is openly discussed within your organization between all levels of staff and with patients. It is important that suicide is discussed in a clear and direct way that normalizes language around the topic and helps remove some of the stigma. Patients should be asked about any suicidal thoughts or ideas during their screening process and MHFs will continue to query patients about their risk of suicide throughout the therapeutic cycle. MHF will receive basic training about suicidality including how to openly discuss it, what questions to ask in order to assess the seriousness of a suicidal threat and how to handle patients who may be at risk of suicide within StrongMinds policies and procedures. This information is also printed in greater detail within the Facilitators' Manual – for any needed future reference. Moreover, MHFs are asked to read the Suicide Risk Assessment Guide. Within the organizational model, MHFs are seen as the first line of defense against the risk of suicidality among our group members. However, MHSs are ultimately the people responsible for handling any patient cases that have been reported by MHFs. Therefore, when identifying warning signs of suicidality among patients, MHFs are advised to immediately inform their supervisor in order to seek further assistance with assessment and proper handling of the situation.

In the case of Uganda, we developed a Suicide Risk Assessment Guide with the aim of orienting MHFs and MHS on how to approach this topic.

Complementary to this Guide is the 'Suicide Management Policy' a one page document that MHFs and MHSs should sign acknowledging they were provided with detailed guidelines on how to deal with suicidality and affirming they have read them. This policy protects staff members, patients as well as the implementer organization.

- Managers should guarantee that all the staff members have read the necessary information about suicidality and received training in order to be capable of identifying the warning signs. Also, signed the policy if the implementer organizations decides to use this as a safety measure or tool.
- Managers should assure a referral pathway has been set up before beginning any therapy cycle. This will allow your organization to respond in an effective way when identifying a patient who may be at risk of committing suicide.

Co-morbidity

Co-morbidity is when a patient suffers from one or more health problem in addition to depression. These may include physical illnesses, mental illnesses, or substance abuse problems. MHFs are trained to recognise co-morbidity, but ultimately it is the staff supervisors who must make the decision about whether to refer a patient for clinical services.

The decision to refer should be made in consultation with a Mental Health Advisor, who is a qualified mental health specialist, and the Program Manager who oversees fieldwork.

Generally speaking, once a patient has received (or is undergoing) treatment for her other mental health problems, she is able to return to group therapy. The main exception to this rule is if any threat of violence is perceived.

Safety measures to protect staff

- **Transport**
  Define how staff is going to be transported to and from therapy groups safely.
- **Family violence**
  Analyse how your organization could manage risks posed by violent family members of patients.
- **Security**
  Identify the need of security guards, ID badge and other precautions at the office or installations.
- **Support for self-care**
  The nature of the job poses emotional and psychological risks for staff members, especially for MHFs involved in therapy implementation. Two ways to offer support are:
  - **Instruction on setting boundaries**
    This is mentioned in Section 5.3. of the Facilitation Manual. This should be constantly reinforced during recruitment, training sessions and weekly meetings.
  - **Access to therapy**
    For some MHFs, therapy will bring up psychological challenges. In the case of SMU, MHFs have access to internal, one-on-one therapeutic support.

Safety measures to protect patients:

- Confidentiality rules
- Referral systems in cases where self-harm, suicide, and other forms of violence are a risk
- Ongoing supervision and training of MHFs to deliver high-quality therapy

4.2.4 Monitoring progress and Measuring Impact

Using quantitative and qualitative methods; interpreting and reporting on results

Monitoring therapy implementation will allow your organization to have updated information about your staff and clients progress. As a regular practice, monitoring serves as a constant provider of information that might feed other evaluation and learning processes, assisting decision-making processes when needed.

Some of the monitoring strategies and tools that have worked for SMU are presented in Section 6.1. of the Facilitation Team Manual:

- **PHQ-Form**
  StrongMinds chose this form since it is an internationally accepted tool used in scientific and medical communities to measure depression. As such, it should not be modified, shortened or changed unless it is vetted by research or a medical professional that has tested its long-term reliability for continued testing.

  StrongMinds Uganda uses this form during pre-group and again in therapy sessions 1, 6 and 12. It is used again after therapy finishes, but usually by an independent evaluator rather than an MHF to avoid response bias. It is recommended that the PHQ-9 be used a minimum of three times throughout the therapy cycle. However, implementing organizations may choose to use it more often.

  Results of the PHQ-9 should be used to gauge therapeutic progress of individual patients and serve as a guide to potential risk for suicidality. The proper implementation of this form is seen as integral to the long-term success of the SM model, and to the success of the implementing organization.
- **Functionality Assessment Tool**
  StrongMinds Uganda uses a functionality assessment tool during pre-group and therapy session 4 to measure how patients are coping with day-to-day activities. Implementing organizations are advised to develop culturally appropriate tools to measure the general functionality and wellbeing of clients, and to link therapy outcomes to other aspects of their work. Functionality assessment tools should include questions that measure the following key aspects of wellbeing:
- **Group process form**
  Used to keep weekly track of patients. It is completed for each client in every session to check progress on particular symptoms of depression.
- **Client Session Attendance form**
  To keep track of how many people are present at each group therapy session.

  Measuring impact can serve as a basis for evidence-based decision making and can provide important communication to key stakeholders. Implementing organizations are advised to utilize both process and outcome evaluation measures to inform decision making within their operations.
- **Process evaluation**
  Focuses on how a program operates, how activities were implemented in relation to how they were planned, and how operations can be improved in future.
- **Outcome evaluation**
  Focuses on measuring changes resulting from the program. In the context of StrongMinds, this includes measuring changes in the lives of therapy group members, their families, and their communities. (Section 2.3 outlines primary and secondary impacts measured in Uganda.)

Outcome Evaluation

- The PHQ-9 is the main tool used to measure primary impacts related to changes in the status or intensity of depressive symptoms.
- Functionality indicators have been used to measure secondary impacts related with the following areas: physical status and health, nutrition, economic status and occupation, household and child well-being.
- Since StrongMinds' talk therapy both reduces current symptoms and helps patients learn to avoid triggers that may lead to experiencing depression, we remain in contact with the women in order to measure the degree to which our intervention prevents future depressive episodes.

Case Study

Responding to MEL findings

At StrongMinds Uganda, an important finding learned through monitoring and evaluation was that MHFs were finding it especially hard to treat patients with grief effectively. This became apparent from information gathered through weekly team meetings, bi-weekly supervisory meetings and monthly reports. In order to respond to this challenge, program leaders decided to organise professional development sessions that included specialised training in grief counselling for MHFs.

Strengths-based approach to measuring progress and impact

Possible existing assets that your organization could look for:

- Monitoring procedures that are already functioning
- Data collection forms or technologies
- Staff with experience implementing monitoring and evaluation strategies
- Spaces or routine meetings that are used for reflection and incorporating lessons learned into practice
- What existing tools, procedures, or strategies for monitoring and evaluation from your organization could be used as a starting point?
- How can your organization encourage the delivery of high quality and timely data to ensure pertinent decisions are made on time?

4.2.5 Improving practice

A system that allows your organization to feed knowledge back into practice is a key element for ensuring continuous improvement in implementing the StrongMinds model. This system should include the use of qualitative and participatory methods that encourage discussion about the findings of monitoring and evaluation.

Implementing organizations are required to incorporate weekly facilitation team meetings into staff schedules. These meetings serve as a space for teams of facilitators and their supervisors to regularly reflect, learn, and share feedback for improving practice.

Strengths-based approach to improving practice

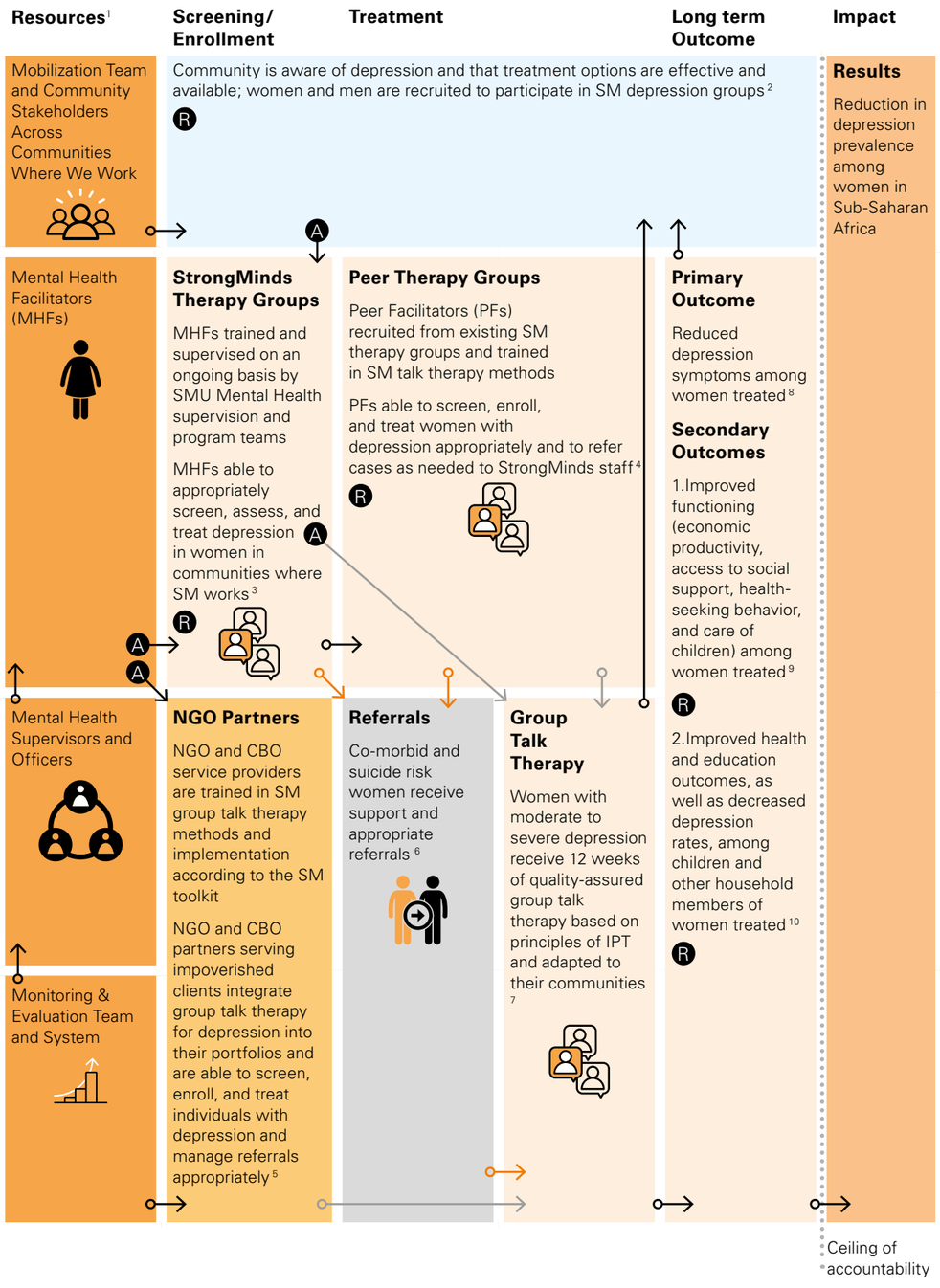
Which of your organization's existent practices could serve as a space to feed knowledge into practice? (Eg. Meetings, Feedback sessions).

- What type of new spaces, practices or systems could be implemented by your organization in order for this reflection to happen?
- What methods might facilitate this process of feedback and reflection? (Eg. Team discussions, individual reflections, group listing of lessons learned).

Appendix

StrongMinds Theory of Change

StrongMinds Theory of Change shows the primary and secondary outcomes that are expected to result from our model of Group Talk Therapy. This graphic shows the people, activities and assumptions involved in our theory of how change is generated through cause and effect.



Key

- StrongMinds Staff
- StrongMinds Interventions
- NGO Partnership
- Community
- Referral Needed
- Impact/Results
- A — Assumption
- R — Rationale
- [2] — Indicator
- Progression of intervention
- Co-morbid psychosis/suicide risk
- No co-morbid psychosis/suicide risk

Example assumptions

- Pool of suitable MHF candidates available as team grows
- Peer Facilitators are willing to be trained and motivated to continue to provide counseling in their communities
- NGO and CBO partners convinced by our value proposition and by the evidence and agree that addressing depression in their client populations helps extend their impact
- A StrongMinds Talk Therapy toolkit is developed and appealing to partners
- Communities and partners/stakeholders are willing to host and support StrongMinds' work

Example rationale

- Evidence of efficacy of intervention in context: Bolton et al. Group Interpersonal Psychotherapy for Depression in Rural Uganda. JAMA, June 18, 2003: 289; 3117- 3124. (Kakuma 2011. Lancet 378. p1654-63).
- Evidence of prevalence and disabling effects of depression: Institute of Health Metrics and Evaluation. Retrieved March 22, 2016: http://vizhub.healthdata.org/gbd-compare/.
- Internal impact evaluations: http://strongminds.org/wp-content/uploads/2013/07/StrongMinds-Phase-Two-Impact-Evaluation-Report-July-2015-FINAL.pdf and http://strongminds.org/wp-content/uploads/2014/11/StrongMinds-Impact-Evaluation-Report-November-2014.pdf.
- Evidence of efficacy of task shifting (Think Healthy Program) and internal findings.
- Multiple sources of evidence of benefits for children of depression resolution in mothers.

Example interventions

- Recruitment and training of MHFs.
- Supervision of MHFs.
- SMU and MHFs jointly conduct mobilization and awareness sessions in targeted communities.
- MHFs and mobilization teams screen and form groups.
- MHFs provide 12 week group talk therapy to women with depression.
- Of women treated, ~10% trained as Peer Facilitators who in turn can screen enroll, and treat depression in their communities.
- Supervision, support, and motivation for PFs.
- Proper referral plans and suicide management plans followed by MHFs and PFs.
- Women treated are monitored and evaluated according to M & E strategies to ensure quality and determine impact.

Example indicators

6. # of staff, operational budget, and funding growth; cost per patient
7. # of individuals who participate in community-based awareness events; are screened for depression; screen positive for depression; depression prevalence rates district by district according to HH surveys or other resources
8. # groups/MHF; # patients/MHF
9. # of PFs trained; # of patients/PF
10. # of NGO partners trained; # of women treated via NGO partners
11. Total suicide risk cases and referrals
12. 75% of women treated self-report minimal depression per the PHQ-9 following treatment
13. 75% of women treated self-report minimal depression per the PHQ-9 6 months after treatment concludes
14. % of women reporting improved economic productivity, employment, income and savings levels, and access to social support
15. % of women reporting improved household nutritional intake and education continuity for their children

IPT-G Pre Assessment Form

Informed consent

Hello, my name is .....

I am working with a team from StrongMinds in this area. In order to get more information about development issues and feelings about life in this community, we are conducting an assessment. You have been selected by choice to participate. I would like to ask you a few questions. The information you provide will be useful to supporting you deal with life challenges and future developments of this community. Participation in this assessment is voluntary; you can choose not to take part. All the information you will provide will be confidential.

Assessment Date ☐☐/☐☐/☐☐

1.	Name of Respondent				
2.	Name of Sub County				
3.	Name of Parish				
4.	Name of Village				
5.	Gender of Respondent (Write appropriate, **do not ask**)	Male	☐	Female	☐
6.	How old are you? (Age in completed years)				☐
7.	What is your marital status?	Married	☐	Single/ Never married	☐
		Divorced/ separated	☐	Widowed	☐
8.	Position of respondent in the household	Head	☐	Spouse	☐
		Relative	☐	Daughter/ son	☐
		Laborer	☐		
		Other (Specify)			
9.	What is your primary occupation/ source of income? (Choose only one)	Employed by family member	☐		
		Employed by non family member (salaried)	☐		
		Housework	☐	Self-employed	☐
		Unemployed	☐		
		Other. (Specify)			
10.	On average, how much money in Uganda shillings do you make each week from your primary occupation (if not in formal employment assist person make a good average)	Not paid	☐	Btn 100-5,000	☐
		Btn 5,001-10,000	☐	Btn 10,001-15,000	☐
		Btn 15,001-20,000	☐	Btn 20,001-25,000	☐
		Btn 25,001-30,000	☐	Above 30,000	☐
11.	What is the main source of the staple food currently being consumed by your household?	Home grown	☐	Buy from market	☐
		From relatives/friends	☐	Food aid	☐
		Casual laborer	☐		
		Other (Specify)			
12.	What kind of shelter do you live in?	Mud & wattle wall, banana fibre/ grass roof	☐		
		Mud plus wattle wall, tarpaulin roof	☐		
		Unbaked bricks wattle wall, bananas/ fibre/ grass roof	☐		
		Unbaked bricks mud wall & iron sheets roof	☐		
		Baked bricks mud wall and iron sheet roof	☐		
		Cement baked bricks & iron sheets roof	☐		
		Other (Specify)			

Patient Health Questionnaire-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "✓" to indicate your answer)

		Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
	Add columns	+ ☐	+ ☐	+ ☐	
	Total	☐			

10. If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all ☐
- Somewhat difficult ☐
- Very difficult ☐
- Extremely difficult ☐

1 - 4	Minimum Depression
5 - 9	Mild Depression
10 - 14	Moderate Depression
15 - 19	Moderately Severe Depression
20 - 27	Severe Depression

Clients' Session Attendance Tracking Form - 2017

NAME OF MHF:
GROUP NAME:
SITE:
ZONE/ VILLAGE:

GROUP No:
VENUE:
MEETING TIME:

S/N	NAMES OF CLIENTS	CLIENTS PHONE NUMBER	CLIENT ID	Date SEX (M/F)	AGE	Pre Asst	Pre Grp	CLIENT'S ATTENDANCE TREND OF IPT-G SESSIONS 1	2	3	4	5	6	7	8	9	10	11	12	Post Asst
1																				
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
eg	Sarah Book			F	26	P	P	P	P	O	P	P	O	P	P	P	P	P	P	O

Group Process (weekly symptom check) Tracking Tool

NAME OF MHF			
GROUP NAME		GROUP No	
SITE/ ZONE/ VILLAGE	SESSION No	DATE	
VENUE	MEETING DAY/TIME		

Record status of each group member for this week/ session. Check only overall impression that applies.

Group Member Name	Overall Impression	Notes
	◯ Improved ◯ Got Worse ◯ Stayed the same ◯ Not in attendance	
	◯ Improved ◯ Got Worse ◯ Stayed the same ◯ Not in attendance	
	◯ Improved ◯ Got Worse ◯ Stayed the same ◯ Not in attendance	
	◯ Improved ◯ Got Worse ◯ Stayed the same ◯ Not in attendance	
	◯ Improved ◯ Got Worse ◯ Stayed the same ◯ Not in attendance	
	◯ Improved ◯ Got Worse ◯ Stayed the same ◯ Not in attendance	
	◯ Improved ◯ Got Worse ◯ Stayed the same ◯ Not in attendance	
	◯ Improved ◯ Got Worse ◯ Stayed the same ◯ Not in attendance	

Reason for not attending

1. Sick
2. Casual employment
3. Got a job
4. Moved away (why?
5. Family obligation (why?)
6. Lack of transportation
7. Did not want to come
8. Patient died
9. Other (specify)

IPT-G Pre-Group Session Form

Client's Name: _____ Age: ☐☐ Date: ☐☐/☐☐/☐☐

Client's Village: _____ Sex: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use a circle to indicate your answer)

		Not at all (0 – 1 Day)	Several days (2 – 6 Days)	More than half the days (7 – 11 Days)	Nearly every day (12 – 14 Days)
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling sad, depressed or hopeless	0	1	2	3
3.	Trouble sleeping/ staying asleep, sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself – or that you are a failure (worthlessness) or that you have let yourself of family down (guilty)	0	1	2	3
7.	Trouble concentrating on things, such as work, care of your children or other activities	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed or the opposite of being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting/ killing yourself in some way	0	1	2	3
	Add columns		+ ☐	+ ☐	+ ☐
	Total		☐		

Client's problem area (Triggers)

☐ Grief/ death of a loved one

☐ Life change

☐ Disagreement (What stage?) Renegotiation ☐ Impasse ☐ Dissolution ☐

☐ Shyness/ Loneliness/ Social deficit

Duration of trigger (Calculate number of days): ☐

Briefly explain the problem

_____

_____

_____

Patient's goals (List one or two, these may change during the 12 weeks

1 _____

2 _____

3 _____

Measuring Women's Functionality in Context

S/No	Level of difficulty in performing core tasks	None=0	Little=1	Moderate=2	Substantial=3	What causes this problem?
1	Keeping yourself clean	0	1	2	3	
2	Taking care of children	0	1	2	3	
3	Cooking food	0	1	2	3	
4	Washing clothes and household items	0	1	2	3	
5	Cleaning the house/ compound	0	1	2	3	
6	Digging or able to cultivate food	0	1	2	3	
7	Participating in community development activities	0	1	2	3	
8	Attending meetings	0	1	2	3	
9	Supporting other community members who lose their beloved/ participate in funerals	0	1	2	3	
10	Other symptoms. Specify					