



South Africa - HIV  
**ATTAC** Addiction Technology Transfer Center Network  
Funded by the President's Emergency Plan for AIDS Relief through the Substance Abuse and Mental Health Services Administration

# Capacitating non-specialists in behavioral health and HIV

University of California Los Angeles  
09 December 2019



**Goodman Sibeko**, MBChB, PhD  
Co-Director: South Africa HIV ATTAC  
Head: Division of Addiction Psychiatry, UCT

1



## Outline

- Why the focus on behavioral health and HIV
- Why non-specialists and how does training capacitate them
- Factors and results of capacitating non-specialists



2



## At a glance: HIV in South Africa




- **Largest country epidemic** in the world
  - **19%** of the global total of people **living with HIV**
  - **15%** of all new **global infections**
  - **11%** of all AIDS related **deaths**
  
- **In South Africa**
  - **7.1 million** people living with HIV (44% not yet receiving treatment) (1.1. million in USA)
  - **270,000** new **HIV infections** each year (37,600 in USA)
  - **110,000** AIDS related **deaths** each year (6,721 in USA)



**South Africa (2016)**

**7.1** million people living with HIV

**18.9%** adult HIV prevalence

**270,000** new HIV infections

**110,000** AIDS-related deaths

**56%** adults on antiretroviral treatment

**55%** children on antiretroviral treatment

Source: UNAIDS Data 2017

<https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/south-africa#The%20future%20of%20HIV%20and%20AIDS%20in%20South%20Africa>

UNAIDS 2016 Country Report for South Africa (<http://www.unaids.org/en/regionscountries/countries/southafrica>)

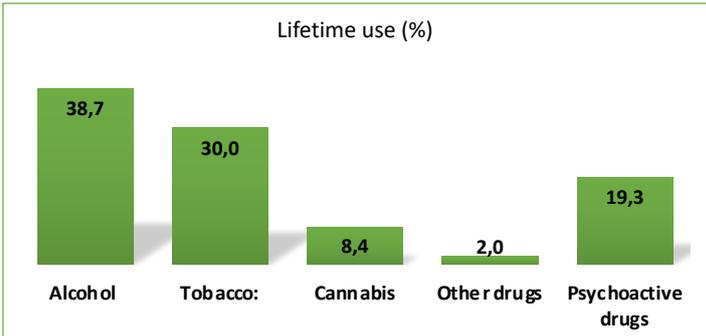
3



## At a glance: Drugs in south Africa




Lifetime use (%)



Substance	Lifetime use (%)
Alcohol	38,7
Tobacco	30,0
Cannabis	8,4
Other drugs	2,0
Psychoactive drugs	19,3

- **Higher rate of harms in South Africa compared to other global regions**

Herman AA, Stein DJ, et al. The South African Stress and Health (SASH) study.... S Afr Med J. 2009;99:339-44.

4

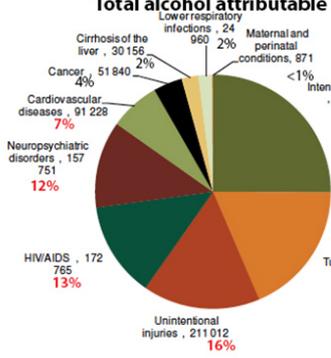


## At a glance: Alcohol in South Africa




- 41.5% of men and 17.1% of women reported current alcohol use
- 9% engaged in risky or hazardous or harmful drinking
- Alcohol use disorders: Top three most prevalent lifetime mental disorders in South Africa, at 11.4%.
- Fetal Alcohol Spectrum Disorders are alarmingly high, at 135-207 cases per 1 people in certain high risk communities

**Total alcohol attributable DALYs = 1 313 523**



Category	Count	Percentage
Intentional injuries	329 652	25%
Tuberculosis	242 928	18%
Unintentional injuries	211 012	16%
HIV/AIDS	172 765	13%
Neuropsychiatric disorders	157 751	12%
Cancer	51 840	4%
Cardiovascular diseases	91 228	7%
Cirrhosis of the liver	30 156	2%
Lower respiratory infections	24 960	2%
Maternal and perinatal conditions	871	< 1%

FAS falls within Neuropsychiatric disorders @ 3.5% contribution

Matzopoulos, R. G., S. Truen, B. Bowman, and J. Corrigan. 2014. "The Cost of Harmful Alcohol Use in South Africa." South African medical journal 104(2):127-32.

Peltzer, K. et al., 2011, Afr J Psychiatry 14(1): 30-37; Herman, A. et al., 2009, S Afr Med J 99:339-344; May, P. et al., 2007 Drug Alcohol Depend 88: 259-271.

5



## At a glance: Psychiatric Disorders in South Africa




- The most prevalent class of lifetime disorders was:
  - Anxiety Disorders (15.8%)
  - Substance use disorders (13.3%) and
  - Mood disorders (9.8%)
- Mental health
  - Higher risk of any disorder than general population
  - Less ill PLWH less likely to seek attention
  - Poor adherence to HAART

Herman AA, Stein DJ, et al. The South African Stress and Health (SASH) study.... S Afr Med J. 2009;99:339-44  
[https://www.rand.org/pubs/research\\_briefs/RB9300/index1.html](https://www.rand.org/pubs/research_briefs/RB9300/index1.html) .

6



## Combined Effects



Substance use disorders (SUDs), TB, and Psychiatric Disorders are all **more common** in people living with HIV and AIDS (PLWHA) than the general population

Dr. Rehana Kader

7



## Results



Patients reporting **hazardous or harmful use of alcohol and/or drug** use were significantly more likely:

- To be **non-adherent to ARVs** and have **lower CD4** counts
- To **miss taking ARVS** which in turn leads to **stopping ARVs**
- To report **psychological distress** (anxiety and depression) and **low levels of family support**

Understanding the Impact of Hazardous and Harmful Use of Alcohol and/or Other Drugs on ARV Adherence and Disease Progression  
R.Kader, R.Govender, S.Seedat, J.Koch, C.Parry. PLOS ONE 2015

Dr. Rehana Kader

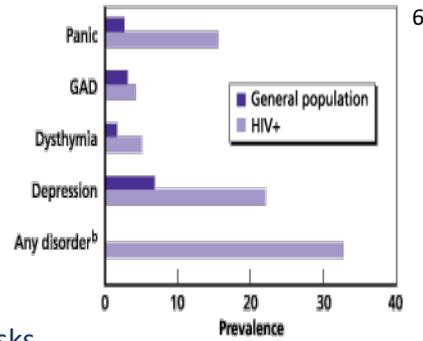
8



## Background



- Alcohol
  - Increased risk behaviour <sup>1</sup>
  - Increased risk of unprotected sex amongst PLWH <sup>2</sup>
  - Faster disease progression and depletion of CD4 cells <sup>3</sup>
  - Poorer adherence and lower service utilization <sup>4</sup>
- Mental health
  - Higher risk of any disorder than general population <sup>6</sup>
  - Less ill PLWH less likely to seek attention
  - Poor adherence to HAART
- Strong evidence of intersecting and reinforcing risks between alcohol, drugs, mental health, and HIV <sup>5</sup>



1. Scott-Sheldon LA et al. Alcohol Use Predicts Sexual Decision-Making: A Systematic Review and Meta-Analysis of the Experimental Literature. *AIDS Behav* 2016;20 Suppl 1:S19-39.  
 2. Scott-Sheldon LA et al. Alcohol Use and Sexual Risk Behaviors among Individuals Infected with HIV: A Systematic Review and Meta-Analysis 2012 to Early 2013. *Current HIV/AIDS Reports* 2013;10:314-23.  
 3. Parsons M et al. Effect of GSTM1-Polymorphism on Disease Progression and Oxidative Stress in HIV Infection: Modulation by HIV/HCV Co-Infection and Alcohol Consumption. *J AIDS Clin Res* 2013;4.  
 4. Azar MM, Springer SA, et al. A Systematic Review of the Impact of Alcohol Use Disorders on HIV Treatment Outcomes, Adherence to Antiretroviral Therapy and Health Care Utilization. *Drug Alcohol Depend.* 2010;112:178-93.  
 5. El-Bassel N et al. Drug use as a driver of HIV Risks: Re-emerging... issues. *Curr Opin HIV AIDS.* 2014;9:150-5.  
 6. [https://www.rand.org/pubs/research\\_briefs/R88300/index1.html](https://www.rand.org/pubs/research_briefs/R88300/index1.html)

9



## Recommendations



- Treatment of HIV, SUD and Psychiatric Disorders requires a **multifaceted, comprehensive and multidisciplinary** management approach to achieve optimal health outcomes for all these conditions
- Need for **proper screening** for harmful and hazardous use of alcohol and problematic drug use at HIV clinics to ensure better patient management and clinical outcomes amongst PLWHA
- **SBIRT** models can help to address these service needs.

Understanding the Impact of Hazardous and Harmful Use of Alcohol and/or Other Drugs on ARV Adherence and Disease Progression  
 R.Kader, R.Govender, S.Seedat, J.Koch, C.Parry. *PLOS ONE* 2015

Dr. Rehana Kader

10



# What is SBIRT?




**Screening**

Quickly assesses the severity of substance use and identifies the appropriate level of treatment

**Brief Intervention**

Focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change

**Referral to Treatment**

Provides those identified as needing more extensive treatment with access to specialty care

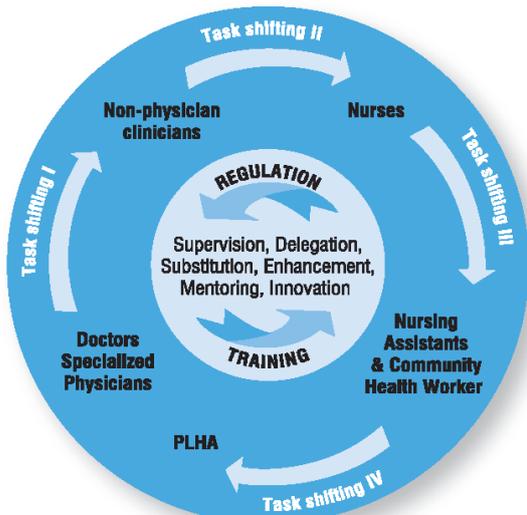
Dr. Tara Carney

11



# Task shifting/sharing



“...promising benefits in improving people’s outcomes for general and perinatal depression, PTSD and alcohol-use disorders, and patient- and carer-outcomes for dementia.”

van Ginneken N, Tharyan P, Lewin S, Rao GN, Meera SM, Pian J, Chandrashekar S, Patel V. Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries. Cochrane Database of Systematic Reviews 2013, Issue 11. Art. No.: CD009149. DOI: 10.1002/14651858.CD009149.pub2.

WHO

12



# Testing out Task Shifting

13



Sibeko et al. *BMC Res Notes* (2017) 10:584  
DOI 10.1186/s13104-017-2915-z

BMC Research Notes

RESEARCH NOTE

Open Access



## Improving adherence in mental health service users with severe mental illness in South Africa: a pilot randomized controlled trial of a treatment partner and text message intervention vs. treatment as usual

Goodman Sibeko<sup>1\*</sup>, Henk Temmingh<sup>1</sup>, Sumaya Mall<sup>1</sup>, Peter Williams-Ashman<sup>1</sup>, Graham Thornicroft<sup>2</sup>, Ezra S. Susser<sup>3</sup>, Crick Lund<sup>1,2</sup>, Dan J. Stein<sup>1</sup> and Peter D. Milligan<sup>1</sup>

14



## RCT - Setting



- **Setting**

- Valkenberg hospital (VBH)
  - 116 male, and 84 female inpatient beds
  - Average length of stay: 39 days.
  - MHSU admitted at VBH have diagnoses of schizophrenia (32,4%); schizoaffective disorder (15,5%); bipolar mood disorder (22,1%) and substance induced mood disorder 17,3%.
- Psychiatry outpatient clinics within catchment area
  - Located with PHC CHC's
  - Mental health nurses
  - New assessments and post-discharge care
  - Routine clinical support via VBH

15



## RCT - Participants



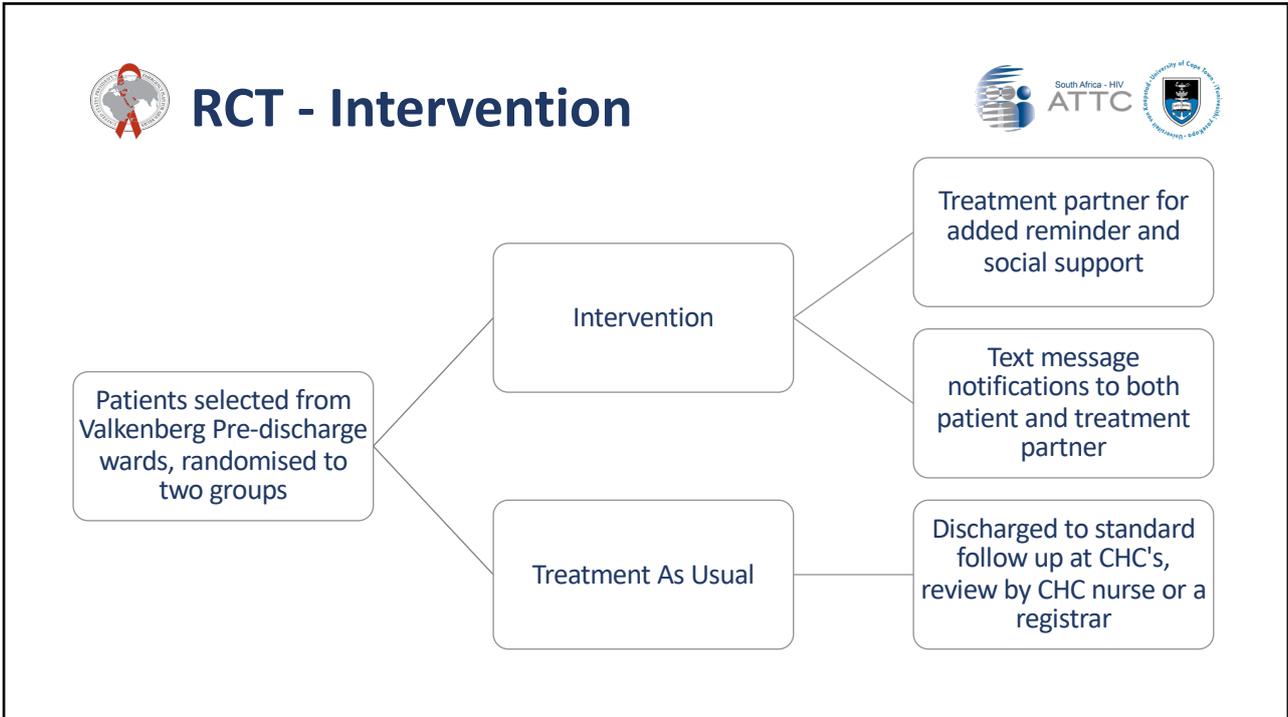
- **Included**

- Adult MHSU
- Severe mental illness
  - Schizophrenia; schizoaffective; schizophreniform; psychotic disorder NOS; SIPD; BPMD1;

- **Excluded**

- Psychotic d/o due to GMC; Dementia; Moderate to severe intellectual disability
- Suicidality/homicidality
- Inability to give informed consent

16



17

### RCT - Outcomes measures and associated instruments

Outcome	Measure	Instrument
Acceptability and feasibility outcomes	Acceptability and Feasibility of Intervention	Qualitative interview at 3 months.
Efficacy outcomes	Adherence to first clinic follow-up visit	Data collected via Community Health Centre using text message technology for intervention for 3 months and by retrospectively checking attendance register for both intervention and TAU
	Relapse (Any readmission)	Re-admissions noted via Clinicom
	Medication adherence	Medication Adherence Rating Scale (MARS)
	Quality of Life	EUROQUOL; Camberwell Assessment of Needs (CAN)
	Symptomatic Relief	Clinical Global Impressions (CGI) Global Assessment of Function Scale (GAF) <sup>4</sup> , Positive and Negative Syndrome Scale (PANSS)

18

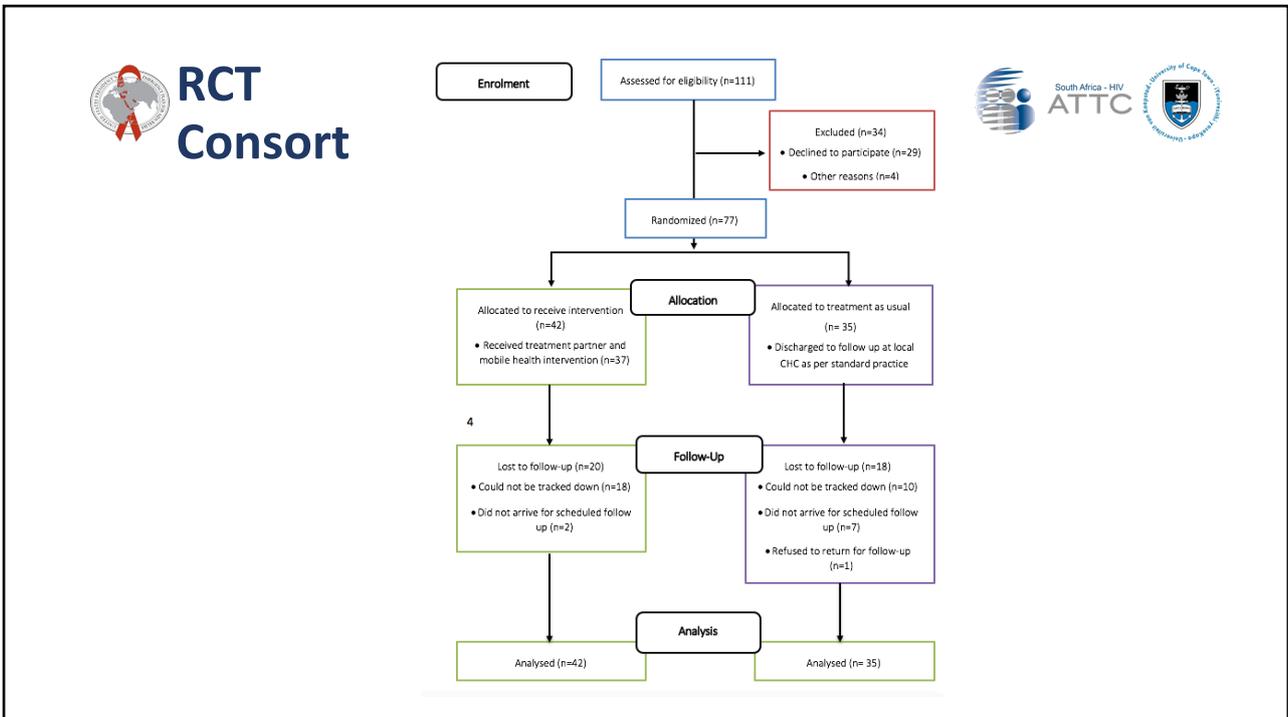


## RCT- Time frames and associated instruments




Initiation	3 Month Follow Up	9 month
<ol style="list-style-type: none"> <li>1. Participant selection as per inclusion criteria</li> <li>2. Randomisation</li> <li>3. Consent and contract</li> <li>4. Baseline instruments</li> </ol> <p>Structured Clinical Interview for DSM Disorders (SCID) CGI GAF MARS CANS PANSS EUROQUOL</p>	<ol style="list-style-type: none"> <li>1. Qualitative review:                             <ol style="list-style-type: none"> <li>a. MHSU perspective,</li> <li>b. Treatment partner or carer perspective.</li> </ol> </li> <li>2. Review appointment adherence</li> <li>3. Determine and record re-admissions via Clinicom</li> <li>4. Efficacy measures                             <ol style="list-style-type: none"> <li>a. MARS, CGI, GAF, PANSS, CAN and EUROQOL</li> </ol> </li> </ol>	<p>Determine and record re-admissions via Clinicom</p>

19



20



## RCT - Participant characteristics



Participant characteristics	Total sample <sup>1</sup> (N=77)		Intervention (N=42)		TAU (N=35)		Statistic(df)	p-value
	mean	(SD)	mean	(SD)	mean	(SD)		
Age	35.5	(10.2)	35.3	10.9	35.8	9.5	t= -0.35(75)	0.726
	<b>N</b>	<b>(%)</b>	<b>N</b>	<b>(%)</b>	<b>N</b>	<b>(%)</b>		
Diagnosis								0.604
Schizophrenia Spectrum	62	80.5	32	76.2	30	85.7		
Bipolar mood disorder	11	14.3	7	16.7	4	11.4		
Substance Induced Psychotic Disorder	4	5.2	3	7.1	1	2.9		
Substance use							$\chi^2= 0.18(1)$	0.671
Lifetime Substance Use Disorder	31	40,3	16	38.1	15	42.9		
Antipsychotic								
First generation	50	64.9	26	61.9	24	68.6	$\chi^2=0.37(1)$	0.542
Second generation	19	24.7	12	28.6	7	20.0	$\chi^2= 0.75(1)$	0.385
Long acting injectable	22	28.6	10	23.8	12	34.29	$\chi^2= 1.03(1)$	0.311

21



## RCT - Treatment partner selections



Selected Treatment Partner Type (n=37*)	n	%
Mother	21	56,8
Father	2	5,4
Sister	3	8,1
Brother	2	5,4
Aunt	1	2,7
Wife	2	5,4
Husband	1	2,7
Partner	2	5,4
Friend	1	2,7
Daughter	1	2,7
Son	1	2,7



22



## RCT - Findings

MHSU insights and attitudes (Of the 17 reviewed in each arm) at 3 months

	Intervention (n=17)		TAU (n=17)	
	n	%	n	%
Knows diagnosis	9	52.9	5	35.3
Understands illness	6	35.3	4	23.5
Understands the cause of illness	5	29.4	4	23.5
Knows medication regimen	10	58.8	8	47.1
Adherent to medication	10	58.8	11	64.7



South Africa - HIV  
ATTC



Treatment partner and caregiver perspective on MHSU adherence behaviour

	Intervention (n=17)		TAU (n=17)	
	n	%	n	%
Medication adherent	10	58,8	10	58,8
Clinic visit adherent	9	52,9	8	47,1
Found clinic helpful	11	64,7	5	29,4

23



## RCT - Findings

MHSU perspective of Psychoeducation session for Intervention and Standard pre-discharge psychoeducation for TAU

	Intervention (n=17)		TAU (n=17)	
	n	%	n	%
Recalls session	8	47.1	3	17.6
Session helpful for understanding diagnosis	6	35.3	2	11.8
Session helpful for understanding treatment	6	35.3	0	0.0
Recalls information on post-discharge follow-up	3	17.6	8	47.1



South Africa - HIV  
ATTC



Caregiver perspective of psychoeducation session for intervention and caregiver perspective of standard pre-discharge psychoeducation for TAU

	Intervention (n=17)		TAU (n=17)	
	n	%	n	%
Recall diagnosis	4	23.5	1	5.9
Understood syndromic features	8	47.1	0	0.0
Recalls medication information	2	11.8	2	11.8
Recalls post-discharge follow-up information	5	29.4	4	23.5
Found session helpful	9	52.9	1	5.9

24



## RCT – Efficacy findings



South Africa - HIV  
ATTC



Complete case and intention to treat analysis (ITT) of other efficacy outcomes at 3 months.

Outcome	Complete case analysis <sup>3</sup> (Intervention vs. TAU)				ITT (Intervention vs. TAU)			
	Mean difference <sup>4</sup>		p-value	95% CI	Mean difference <sup>5</sup> (n=77)		p-value	95% CI
	Unadjusted	Adjusted			Unadjusted	Adjusted		
PANSS score								
Total score	-9.4	-14.7	0.052	-29.71 – 0.16	-13.4	-13.1	0.062	-27.00 – 0.73
Positive subscale	-3.8	-6.4	0.011	-11.20 – -1.60	-5.6	-5.4	0.060	-11.16 – 0.25
Negative subscale	-2.6	-4.4	0.059	-8.99 – 0.18	-3.5	-3.5	0.078	-7.52 – 0.43
General subscale	-2.8	-3.9	0.350	-12.61 – 4.68	-4.4	-4.2	0.248	-11.67 – 3.19
MARS	-0.21	-0.75	0.425	-2.68 – 1.17	0.36	0.49	0.603	-1.44 – 2.43
CGI	-0.8	-0.58	0.346	-1.84 – 0.67	-	-	-	-
GAF	7.5	4.1	0.440	-6.90 – 15.17	-	-	-	-
CAN								
Total needs	-	-	-	-	-	-	-	-
Unmet needs	-3.2	-3.6	0.029	-6.74 – -0.49	-	-	-	-
Met needs	-	-	-	-	-	-	-	-
EUROQUEL-VAS	16.1	15.2	0.124	-4.59 – 34.99	-	-	-	-

25



## RCT - Conclusion



South Africa - HIV  
ATTC



- Acceptable
- Treatment partner and psychoeducation feasible
- M-health component not feasible
- TP/Caregivers obliged to care;
- TP/Caregivers understanding of mental illness is limited;
- TP struggled with environmental factors including substance abuse and violence, which increased risk for poor adherence and readmission to hospital, and that
- TP’s circumstances may change, , impacting on their direct availability to provide support.
- Tended towards efficacious

26



# Mental Health Training




Sibeko et al. *BMC Psychiatry* (2018) 18:191  
<https://doi.org/10.1186/s12888-018-1772-1>

BMC Psychiatry

RESEARCH ARTICLE
Open Access



## Piloting a mental health training programme for community health workers in South Africa: an exploration of changes in knowledge, confidence and attitudes

Goodman Sibeko<sup>1\*</sup> , Peter D. Milligan<sup>1</sup>, Marinda Roelofse<sup>2</sup>, Lezel Molefe<sup>2</sup>, Deborah Jonker<sup>1</sup>, Jonathan Ipser<sup>1</sup>, Crick Lund<sup>1,3</sup> and Dan J. Stein<sup>1,4</sup>



27



# CHW Training




- Research question: Does a manualized mental health training improve knowledge, and improve confidence and attitudes
- Development
  - Western Cape Department of Health
  - Based on “New Beginnings” brief curriculum,
  - South African National framework for CHWs as developed by the Health and Welfare Sector Education and Training Authority;
  - “UNESCO Training Guide and Training Techniques” and the “Best Practice Guidelines for Implementing and Evaluating CHW Programs in Health Care Settings” documents
- Format
  - Manualized, Eight 3-hour session
- Study design
  - Quasi-experiment (before-after cohort)





28



# CHW T – Sites and participants



- Sites selected in consultation with WC DoH
- First draft
  - 20 CHW’s supervised by The Caring Network Khayelitsha
  - 22 CHWs supervised by Arisen Women Foundation in the Klipfontein sub-district.
- Final draft
  - 27 CHW’s supervised by Masincedane in Strand and
  - 36 CHWs supervised by Opportunity To Serve Ministries (OTSM) in the Mitchell’s Plain sub-district.
- No exclusion criteria



# CHW - T: Outline of training



- Sensitizing CHW on mental health and management

Session	Topic	Elements
1	Introduction and Culture	Ice breaker session, pre-training evaluation forms, and discussion of culture.
2	Culture and Mental Illness	Introduction of mental illness and it’s overlap with local cultural constructs.
3	Mood and Anxiety Disorder	Discussion of the features of these components.
4	Psychotic Disorders, Older People, Intellectual Disabilities, Suicide and Aggression	Discussion of the features of these components and an approach to suicide and aggression.
5	Substance Use Disorders and Management of Mental Illness	Discussion of substance use, abuse and dependence and the management of previously introduced mental illnesses.
6	The Role of the CHW	Discussion of the role of the CHW, a review of mental disorders previously discussed, and a discussion of adherence and general support skills
7	The Mental Health Care Act and Admission Pathway	Discussion of the mental health act, evaluation and admission pathways and processes.
8	CHW Experiences, Case Vignettes, Evaluation Forms and Closure	The CHWs reflect on their training and experience in the field, and complete the post training evaluation documents.



# CHW T - Outcomes and measures



Outcome	Measure	Collection point
Knowledge and skill	Clinical case vignettes	Administered before the start of training, and at the completion of training
	Mental Health Knowledge Questionnaire	
Confidence	Mental Health Clinical Confidence Scale	
Acceptability	Daily Evaluation Questionnaire	Completed at the end of each session
Feasibility	Training Evaluation	Completed at the end of the training



31



# Participant characteristics



Characteristic	Masinedane	OTSM
	(N = 31) (Mean, SD)	(N = 27) (Mean, SD)
Age	32.3 (7.72)	41.48 (12.57)
Service	3.86 (3.94)	2.79 (2.44)
Highest Level of education in grades	11 (0.96)	10.81 (1.4)
Children	1.96 (1.16)	1.9 (1.16)
Dependents <sup>a</sup>	4.56 (3.71)	3.06 (2.34)
	%	%
Stable partnership <sup>b</sup>	40.74%	58.06%
Has own medical condition	22.22%	41.94%



32



## CHW Training Quantitative Outcomes




Outcome	Pre-training	Post-training	Statistic (df)	p-value
	(mean, SD, N)	(mean, SD, N)		
Knowledge (MAKS)	41.48 (5.85), N=58	45.57 (4.25) N=56	t = -4.523, (55)	< 0.001
Confidence (MHNCCS)	45.25 (9.97), N=58	61.75 (7.42) N=54	t = -8.749, (54)	< 0.001
	Pre-training	Post-training		
	(mean, SD) N=45	(mean, SD) N=45		
Attitudes (CAMI)				
Authoritarianism	27.87 (2.97)	26.38 (4.1)	t = 2.720 (44)	0.99
Benevolence	37.67 (4.46)	38.82 (3.79)	t = -1.818 (44)	0.04
Social Restrictiveness	24.73 (4.28)	22.4 (5.3)	t = 2.96 (44)	0.002
Tolerance to rehabilitation in the community	36.49 (5.11)	38.09 (4.22)	t = -2.18 (44)	0.02




33



## CHW T - Training Evaluation




Component satisfaction	Max Score	Total (n=58)		Masinedane (N = 31)	OTSM (N = 27)
		Mean score (SD)	% with Max Score	Mean score (SD)	Mean score (SD)
Overall	15	13.98 (1.35)	61.1%	12.44 (4.34)	13.71 (2.4)
Training Benefit	15	13.85 (1.41)	53.7%	12.26 (4.3)	13.65 (2.4)
Training Processes	15	13.57 (1.4)	42.6%	12.15 (4.55)	13.16 (2.37)
Training Setting	10	9.06 (1.14)	51.9%	8.04 (2.88)	8.94 1.59
Training Content	25	22.17 (2.65)	31.5%	19.37 (7.39)	21.9 (4.12)
Trainer	30	28.07 (2.58)	55.6%	25.07 (9.02)	27.35 (4.73)



34



## CHW T - Qualitative



- Training experienced as valuable and worthwhile.
- Informative and interesting.
- Content was perceived as important and applicable to the field of practice
- CHW's felt empowered to make a meaningful contribution to their communities.



35



## CHW T - Summary of findings



- Overall improvement in knowledge
- Improvement in confidence
- Overall positive change in attitudes, amongst the trained CHWs in all but the authoritarianism subscale,
- Satisfaction with the content and processes of the training and expression of sentiments of gratitude and feeling empowered.



36





# Implementation and The Natural Lab

37



## South Africa HIV ATTC




Funded by:	  <p style="font-size: small; margin-top: 5px;">Substance Abuse and Mental Health Services Administration</p>
Partnership between:	 <p style="font-size: small; margin-top: 5px;">New England (HHS Region 1)</p> <p style="font-size: x-large; font-weight: bold; margin: 0;">ATTC</p> <p style="font-size: x-small; margin: 0;">Addiction Technology Transfer Center Network Funded by Substance Abuse and Mental Health Services Administration</p> 
Goals:	<p>Training and Technical Assistance: Substance Use/HIV/Mental Health Care Providers/Policy-makers</p>

38



## Core training offerings



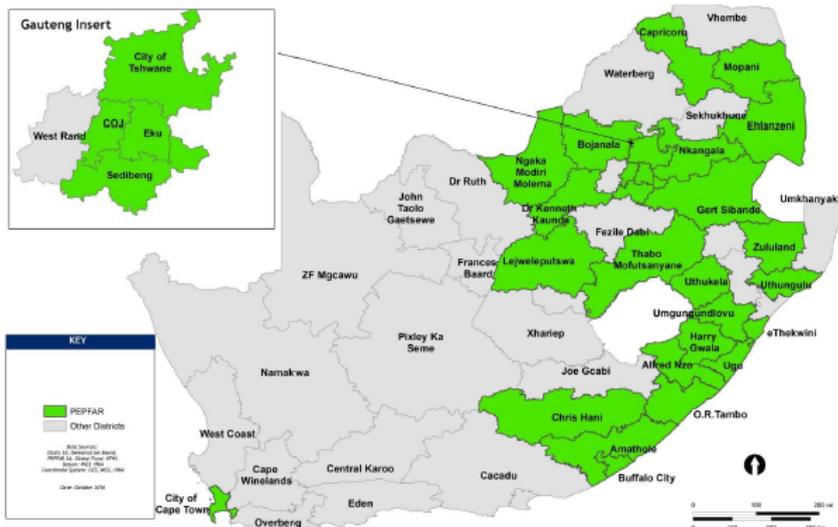
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Motivational Interviewing (MI)
- Mental health training for non-specialist providers of mental health care



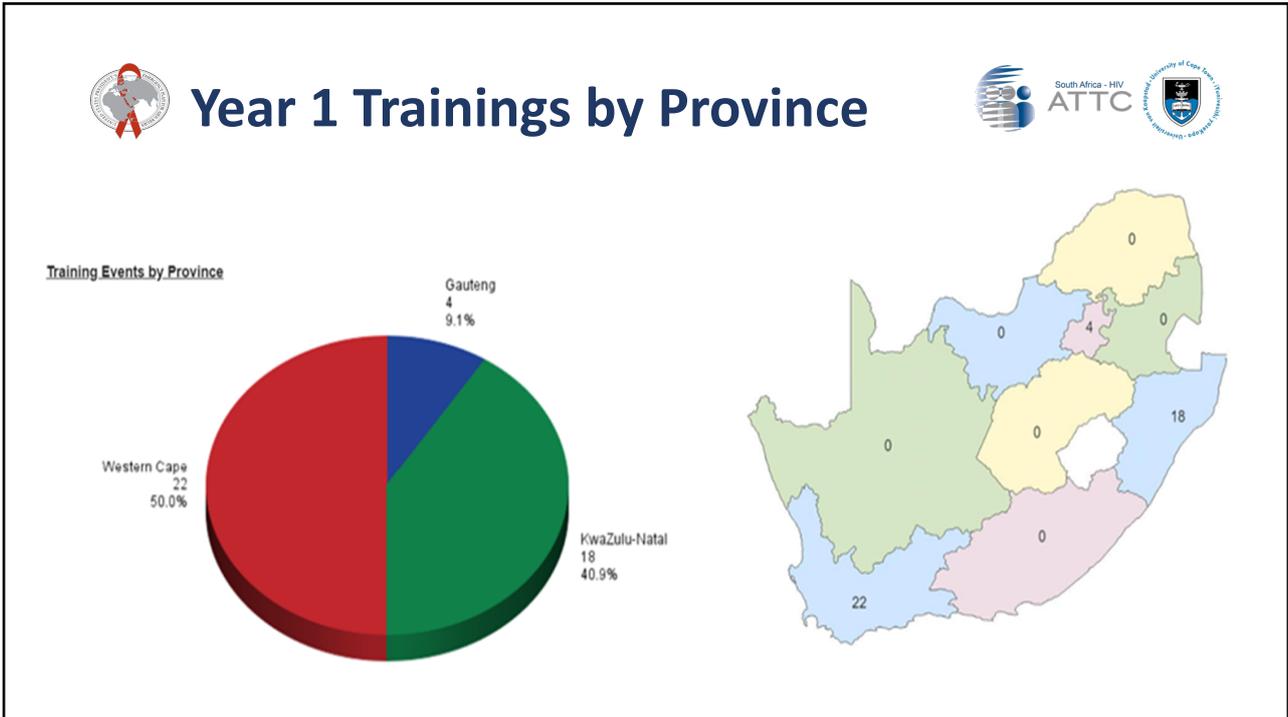
39



## Focus: 27 PEPFAR Priority Districts



40



41

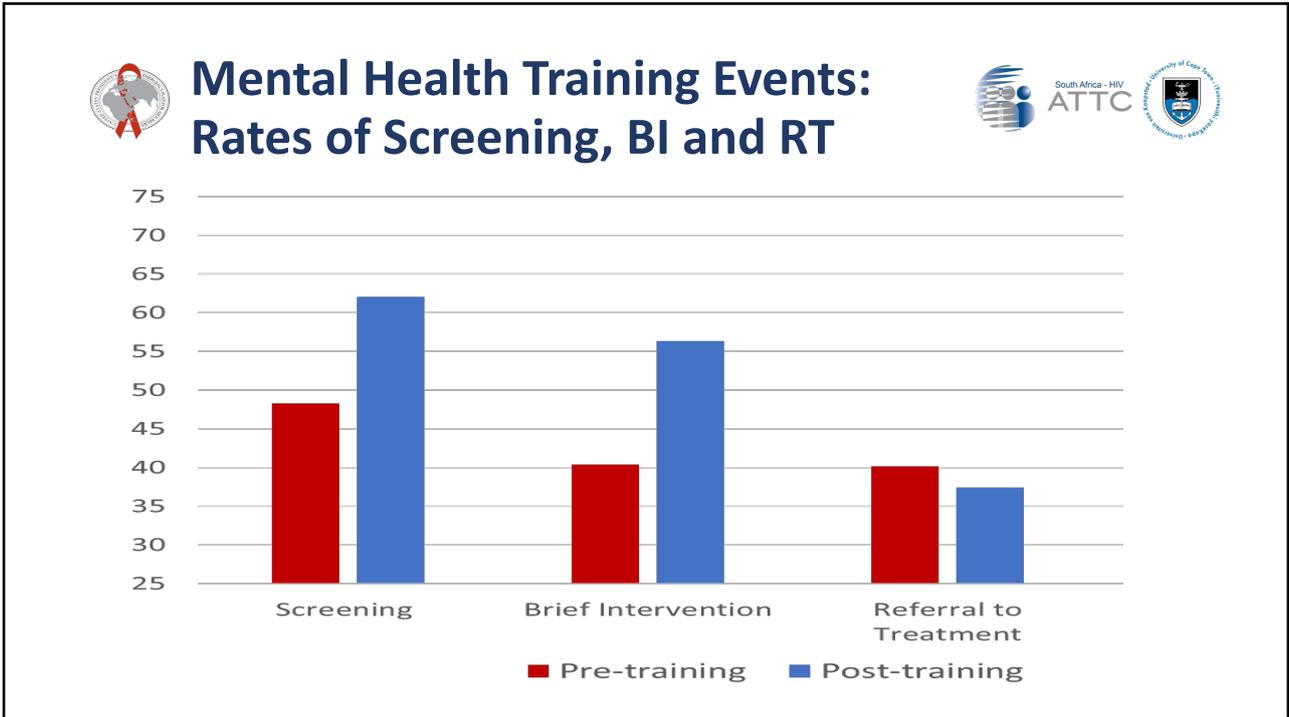
### Number of KZN Health Events

South Africa - HIV  
ATTTC  
University of Cape Town

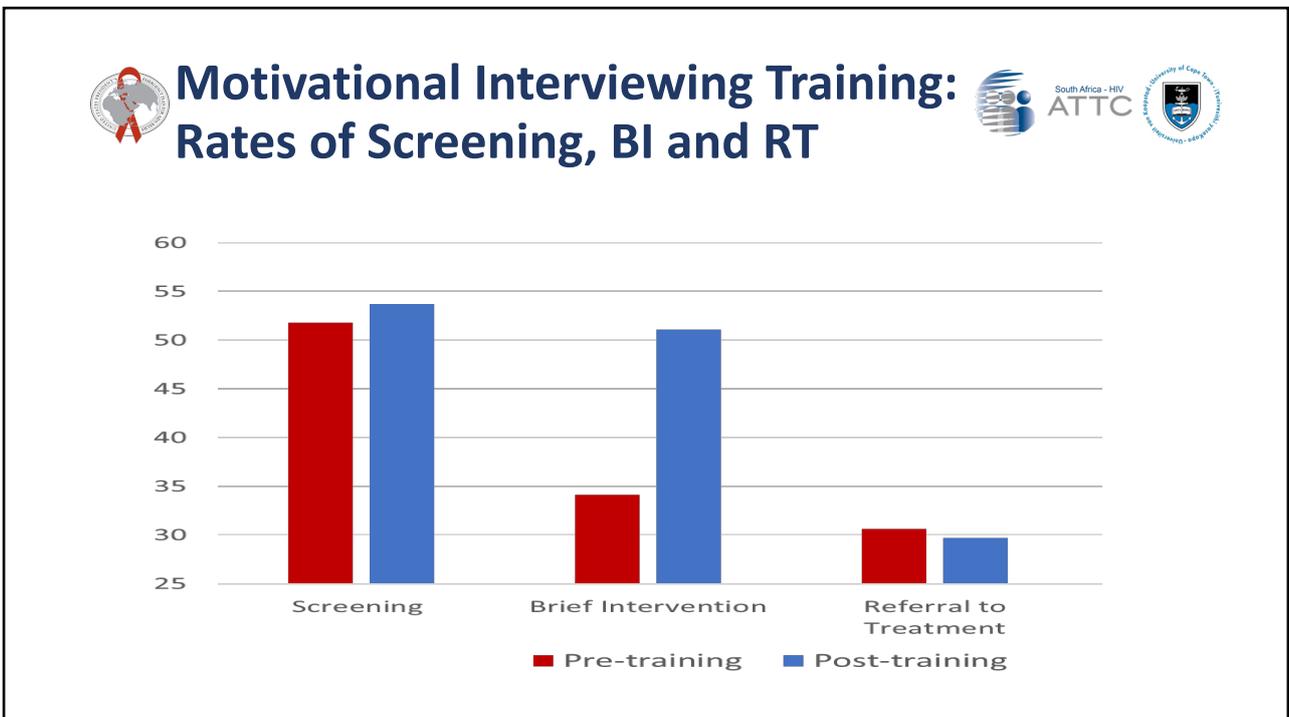
ATTC Year 1

- **Total Events: 16**
  - 4 Mental Health
  - 6 Motivational Interviewing
  - 6 SBIRT
- **Total Attendance: 498**
- **Total GPRAs Collected: 387**
- **Total Qualtrics Surveys: 38 started, 22 completed**

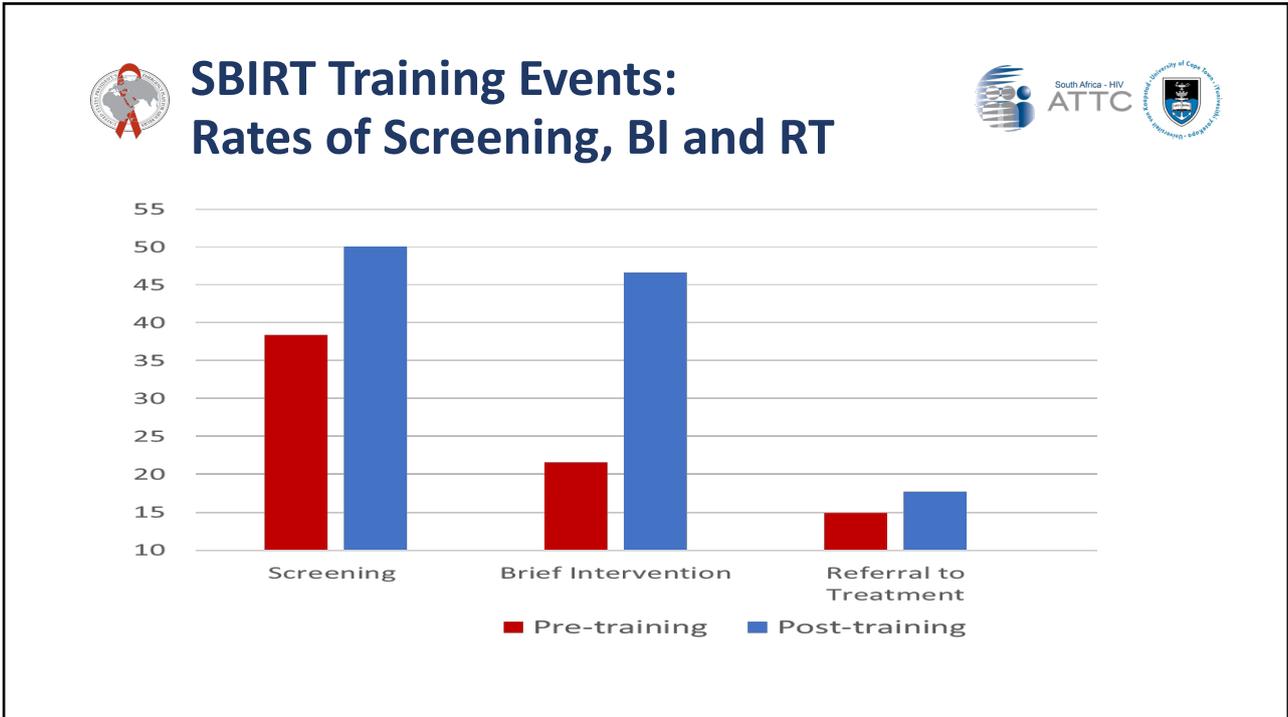
42



43



44



45

**Feedback: *Can you share an example or story of how the training you received from the South Africa HIV ATTC has affected the clinical care that you provide? (1)***

- “There was this client of mine who has problem with alcohol use and after we had session she decided on her own to reduce because her viral load was more than 1000. **[It is] now low[er] than detectable as she is taking treatment accordingly**”
- **“Helped me to identify affected clients**, proper screening, and approaching the clients with questionnaire used during training”

46



**Feedback: *Can you share an example or story of how the training you received from the South Africa HIV ATTC has affected the clinical care that you provide? (II)***



South Africa - HIV  
ATTC



- “It has assisted in realizing that substance abuse is **to be dealt with by all**, not just social workers and rehabs. It has also assisted in realizing that abstinence doesn't have to be the only goal and harm reduction is a more effective first step.”
- “All patients referred to psychology is now screened for current or previous substance use problems. As a result even those who don't think their substance intake is a problem, is now being counselled on the pitfalls of substance use.”

47



**Feedback: *Can you share an example or story of how the training you received from the South Africa HIV ATTC has affected the clinical care that you provide? (III)***



South Africa - HIV  
ATTC



- “**I identified the gap** that people with SUD are not receiving quality service due to many reasons i.e. lack of knowledge by service providers, attitudes, stigma, poor implementation of guidelines and lack of monitoring strategies therefore after ATTC presentation in our coordinators meeting I invited ATTC to train health care providers in my district not only to capacitate them but to change attitude towards SUDs.”

48



**Feedback: *Can you share an example or story of how the training you received from the South Africa HIV ATTC has affected the clinical care that you provide? (IV)***



South Africa - HIV  
ATTC



- “I was more aware of the questions asked and the way it was asked to ensure that the client or patient was comfortable in answering and I was not judgmental.”
- “It has **improved my knowledge and counselling skills.**”

49



**Feedback: *Can you share an example or story of how the training you received from the South Africa HIV ATTC has helped the patients that you serve? (I)***



South Africa - HIV  
ATTC



- “Client was able to accept that he is addicted and he needs help through our conversation.”
- “It has helped in allowing me to speak to patients on substance abuse with greater confidence in my knowledge on the area.”

50



**Feedback: *Can you share an example or story of how the training you received from the South Africa HIV ATTC has helped the patients that you serve? (II)***



- “The patient was comfortable and related easily. They were more receptive to our intervention.”
- “Post training I visited social workers and interviewed them and they were all grateful that we had that training and wish we extend it to doctors.”

51



**Feedback: *Can you share an example or story of how the training you received from the South Africa HIV ATTC has helped the patients that you serve? (III)***



- “Its helped a lot. I had patients who was suffering from depression and I discovered that she is having a problem. I referred her to the HCW and she got help. And the other one was defeated on psychosis treatment. I applied my knowledge and do referrals accordingly now. He's on treatment and still at the facility for help. Thanks to HIV ATTC.”

52



**Feedback: *Can you share an example or story of how the training you received from the South Africa HIV ATTC has helped the patients that you serve? (IV)***



- “Yes now I know what kind of mental illness that my clients have.”
- “Training helped a lot cause I've got 2 patients who admitted [to use] and now they doing so well.”

53



**Mental Health Training Outline**



Day 1	Day 2	Day 3	Day 4
Concerns and expectations Establishing a group culture My name, Myself Values activity Culture and mental health Depression - Nontobeko Reflection tool and connect with myself Closure and preparation for Day 2	Being a Guide on the Side – (Spirit of Motivational Interviewing) Bipolar Mood Disorder Wellness Wheel Psychosis: Schizophrenia OARS (Introduction) Anxiety disorders Change conversation Connecting with myself and closure	Suicide Aggressive and violent patients Substance Use Disorders Older persons Disability Connecting with myself and closure	Children’s Mental Health Issues Consolidation quiz Integration into practice – roles and responsibilities Journey exercise Post-training evaluation Closure/farewell/photo

54



# Navigating implementation



## • Enablers

- Engagement at outset
- “Natural lab” iterative evolution involving collaborators
- Doing what you say you will
- Champions and strong advisory panel

## • Challenges

- Human Resource limitation
- Large site to service
- Lack of time and resource for intensive quantitative formative
- Varying levels implementation across sites
- Varying cadre development program across sites
- Tension between funding and real-world need
- Proving the link between behavioral intervention and HIV outcome

55



# Key Takeaways



- Capacitation of non-specialists is feasible
- Training of providers has improved detection and early intervention
- Policy and implementer participation key drivers for success



Email:

**goodman.sibeko@uct.ac.za**

Tweet me:

**@DrGoodmanSibeko**

URL's:

<http://ATTCnetwork.org/SouthAfrica>

<http://www.psychiatry.uct.ac.za/psych/addiction-psychiatry>

56