RESEARCH BRIEF

Women's Protection and Empowerment /
Child and Youth Protection and Development [April 2014]

The **Caring for Child Survivors** initiative included the design, implementation and evaluation of a components-based mental health treatment for Somali refugee children in Ethiopia.[1] The International Rescue Committee (IRC) and research partners from Johns Hopkins University (JHU) and Duke University found that **the intervention was feasible and acceptable in the refugee camp context and children participating in the intervention experienced an average decrease of over 70% in traumatic stress and emotional and behavioral problems.**

Project Overview

Country	Ethiopia
Research Partners	Paul Bolton, Laura Murray and Brian Hall, Johns Hopkins University; Eve Puffer, Duke University
Funding	The Bill and Melinda Gates Foundation
Sample	37 children and their caregivers
Policy Goal	Promotion of child mental health and resilience

Children make up almost half of the world's displaced and refugee populations, and are at high risk of developing mental health problems.[2] Four of the leading risk factors for mental health problems in children are common in humanitarian settings: transitions, community disorganization, discrimination or marginalization, and exposure to violence.[3] Children who have experienced sexual abuse or other trauma are at particularly high risk for traumatic stress, depression, anxiety, and behavioral problems.

Mental health symptoms that go untreated in childhood and adolescence can lead to lifelong and intergenerational consequences for physical and mental health, family relationships, and functioning. Yet effective response to the issue of child mental health and resilience remains stymied by the weak evidence base on mental health interventions for children in humanitarian settings, and the lack of trained mental health service providers in low-resource environments.

The IRC and JHU implemented the Caring for Child Survivors (CCS) evaluation in three refugee camps in the Somali region of Ethiopia: Kebri Beyah, Sheder and Aw Barre. The camps hold a combined population of 39,190 registered refugees, of which 59% are under the age of 17.[4] Findings from a qualitative study conducted by the IRC and Johns Hopkins University in 2011 revealed that adults and caregivers identified three main categories of mental health problems: internalizing symptoms such as fear and hopelessness; externalizing symptoms such as aggression; and, traumatic stress, known as *didsan* in Somali (lit: a person who fears everything because s/he remembers bad experiences).[5] Mental health problems were associated with environmental stressors (e.g. camp conditions), as well as particular to specific forms of trauma and abuse (e.g. war exposure, physical or sexual violence).

[1] For more information about the Caring for Child Survivors literature review and technical guidelines, please see gbvresponders.org.
[2] Reed, R.V., Fazel, M., Jones, L., Panter-Brick, C. & Stein, A. (2012). Mental health of displaced and refugee children resettled in low-income and middle-income countries: risk and protective factors. *Lancet 379:* 250-65.
[3] Prince, M., Patel, V., Saxena, S. Maj, M., Maselko, J., Phillips, M. & Rahman, A. (2007). No health without mental health. *The Lancet 370*, 9590: 859-877.
[4] UNHCR, Somali Displacement Crisis, accessed online 21 February 2014 at http://data.unhcr.org/horn-of-africa/region.php?id=11&country=65.
[5] International Rescue Committee (2011). Community perspectives on children's mental health in Somali refugee camps in Ethiopia.

Evaluation

The mental health intervention, known as the Common Elements Treatment Approach (CETA),[6] consists of components found in many evidence-based mental health treatments. CETA allows trained counselors to select a different order and dosage of components based on the client's presenting symptoms, and enables them to treat clients with a range of mental health problems such as traumatic stress and depression. The IRC and JHU contextualized CETA for implementation in the Somali refugee camps using findings from the qualitative study.

Components of CETA

- Encouraging participation
- Psycho-education
- Relaxation and behavior activation
- Cognitive coping
- Cognitive restructuring
- Gradual exposure to trauma memories
- Problem solving
- Parenting

Nineteen lay counselors from the three camps and three IRC local supervisors were trained to deliver CETA using the apprenticeship model developed by JHU. The apprenticeship model consisted of a live two-week training conducted by JHU psychologists, followed by several months of group practice sessions before counselors took on a first case. JHU psychologists provided remote clinical supervision throughout implementation.[7]

The IRC and JHU implemented the DIME (Design, Implementation, Monitoring and Evaluation) Program Model developed by the Applied Mental Health Research Group at JHU. The DIME model consists of a series of activities starting with a qualitative assessment to identify and describe mental health problems, followed by developing and validating mental health instruments, designing and implementing the intervention, and assessing feasibility and effectiveness.[8] As this was a pilot project, the IRC and JHU conducted a feasibility study using a quantitative pre/post-test assessment and qualitative interviews with participating children, caregivers and counselors. The pre/post-test assessment measured the following child outcomes: traumatic stress; internalizing/emotional problems; externalizing/behavioral problems; social problems; attention problems; thought problems; and, child wellbeing. Children were referred by IRC social workers and screened for eligibility using a locally validated instrument.[9] A total of 17 pilot cases and 37 study cases completed the intervention and the pre/post assessment. Results presented below are from the study cases only.

Baseline child characteristics

Gender	44% female
Average age	11 years
Education	27% out of school
Trauma exposure	78% exposed to war; 43% witnessed violence; 38% physically abused; 11% sexually abused
Type of symptoms	86% internalizing; 86% externalizing; 78% traumatic stress

Results

1) High uptake and completion of the intervention suggest that it was acceptable to children and their caregivers. Out of 46 eligible children, 38 consented and were enrolled into the intervention (82.6% uptake). All 38 children completed the intervention, which suggests a high level of acceptability among children and their caregivers.

2) Children and their caregivers reported an average decrease of 70% and 61% respectively in children's internalizing or emotional problems. Specifically, children reported a 51% decrease in symptoms of anxiety/depression, a 70% decrease in symptoms of withdrawal/ depression, and a 66% decrease in somatic complaints (i.e. physical problems with no known medical cause that may be due to psychological factors). Caregiver-reported results showed similarly large reductions in these symptoms.

[6] Murray, L. (2014). A Common Elements Treatment Approach for Adult Mental Health Problems in Low- and Middle-Income Countries. *Cognitive and Behavioral Practice 21*, 2: 111-123.
[7] For more information about the apprenticeship model, please see Murray et al. (2011). Building capacity in mental health interventions in low resource countries: an apprenticeship model for training local providers. *International Journal of Mental Health Systems* 5:30.
[8] For more information about the DIME model, please see http://www.jhsph.edu/research/centers-and-institutes/center-for-refugee-and-disaster-response/response_service/AMHR/dime/index.html.
[9] Hall, B. J., Puffer, E., Murray, L., Ismael, A., Bass, J.K., Sim, A., & Bolton, P. (in press). The importance of establishing reliability and validity of assessment instruments for mental health problems: An example from Somali children and adolescents living in three refugee camps in Ethiopia. *Psychological Injury and Law.*

3) **Children and their caregivers reported an average decrease of 74% and 70% respectively in children's externalizing or behavior problems.** Specifically, children reported a 79% decrease in rule-breaking behaviors and a 72% decrease in aggressive behaviors. Caregiver-reported results showed similarly large reductions in these problems.

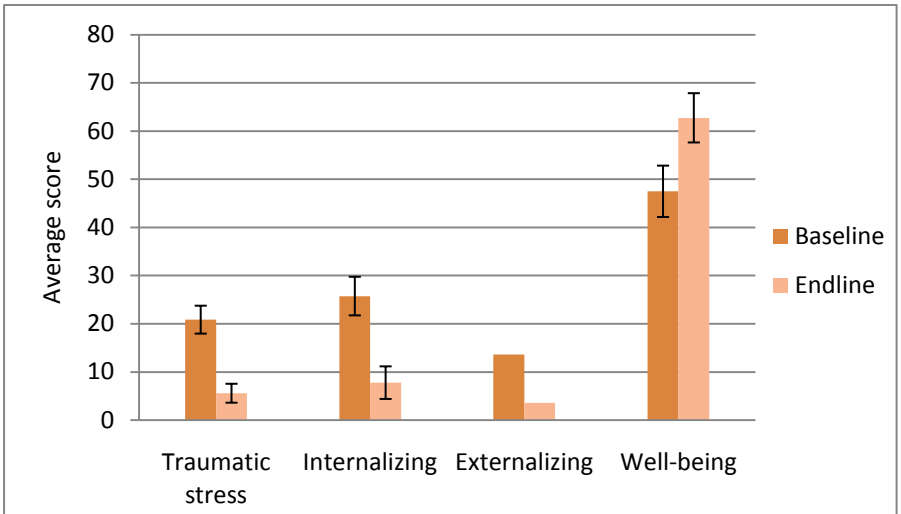

Figure 1. Child-reported symptoms at baseline and post-treatment. Confidence intervals: 95% (distribution for Externalizing scores was non-normal)

4) **Children and their caregivers reported a large reduction in children's attention, thought and social problems.** Caregivers reported a decrease of 66% in their children's attention problems such as lack of concentration. Children reported a decrease of 83% in thought-related problems such as seeing or hearing things that are not there. Children and their caregivers also reported a decrease of 71% and 59% respectively in children's social problems such as difficulty getting along with peers.[10]

5) **Children reported an average increase of 32% in their wellbeing.** Child wellbeing was assessed with a measure developed for this study from qualitative research, which included locally relevant indicators of wellbeing such as eating well and playing with friends.

6) **Qualitative interviews with children and caregivers who participated in the mental health intervention suggest that children experienced changes in their mood and emotions, including decreased worry and fear.** Both children and caregivers also reported improvements in children's behavior, as well as in their relationships with their caregivers and peers. In some cases, children and caregivers described how specific skills they learned in the intervention facilitated these changes. As one example, a child said, "I now tell myself good things," which corresponds with the goals of the treatment to help children think about themselves and their circumstances in a different, more positive way.

> *The counseling changed this in me. I used to worry but not now. I used to fear but not now. I used to be afraid but not now. I used not to play with other children but I am playing with other children now.*
>
> - 10 year-old boy

7) **Qualitative interviews with counselors suggest that the intervention was generally feasible and acceptable in the refugee camp context, but several challenges arose during the course of implementation.** In general, counselors agreed that the intervention was a good fit for the mental health needs of children in the refugee camps. Several counselors pointed out that the intervention was mainly suitable for children exhibiting high levels of distress, recalling that some of the children they had assessed were not eligible for treatment due to low reporting of symptoms. Counselors described mixed reactions to the intervention in the refugee camps. While some families were open and welcoming, others did not understand the purpose or benefits of counseling. In particular, counselors described challenges in convincing families that the counseling program was not related to resettlement or aid distribution, and that it required repeated explanations throughout the program to help families understand how counseling could benefit their children. Although some families grew to appreciate and look forward to the counseling sessions, others were not interested when they realized that the program would not result in any material assistance. Counselors

[10] Child-reported results for attention problems and caregiver-reported results for thought problems were excluded due to the poor performance of these scales.

reported that the intervention content was generally appropriate for the Somali culture, in part due to cultural adaptations that were made during the training. One issue that caused concern was the length of the mental health assessment and the inclusion of some sensitive questions regarding children's problem behaviors, which created suspicion and discomfort among some respondents.

Implementation challenges mainly revolved around families' expectations of material assistance or resettlement, and difficulties in ensuring children and their caregivers regularly attended counseling sessions. One counselor mentioned the difficulty in maintaining confidentiality in a refugee camp setting where regular visits by the counselor attracted attention to the child and family. All counselors found the intervention manual, training, practice sessions and supervision to be extremely useful. The main suggestion was for counselors to have more opportunities for training, practice and support, particularly in the form of refresher trainings. Many counselors noted positive changes in the children and caregivers who participated in the intervention. Some also described using the skills they had learned to improve their own thoughts and relationships with family members and colleagues.

Lessons

1) **The mental health intervention has potential for effectively treating a range of mental health problems among Somali refugee children in Ethiopia.** Results from the pre/post assessment of children's mental health symptoms found large reductions in traumatic stress, internalizing, externalizing, attention, thought and social problems. Further research, including the use of experimental or quasi-experimental methods, is necessary to attribute these positive results to the intervention.

2) **The mental health intervention was generally acceptable to a refugee population unfamiliar with mental health issues, but more extensive community outreach and education are necessary.** Qualitative findings suggest that greater investment in community outreach and education about mental health is necessary to promote acceptance of the intervention and encourage children and families to participate. Engagement of caregivers is particularly important to ensure support and participation of children in the intervention. The provision of small material incentives such as notebooks, pens and blankets would be useful in encouraging participation and retention, given the high levels of poverty and deprivation in the camps.

3) **Given sufficient resources, it is feasible to train lay counselors to deliver a mental health intervention in a chronic refugee context.** The project successfully trained 19 refugee staff with no prior counseling experience to deliver a mental health intervention within six months, suggesting that the apprenticeship model is feasible in a refugee context given sufficient investment in training and supervision. High turnover of counselors due to resettlement is an important consideration in refugee settings, and contingency plans should be put in place from the beginning of the project to enable retention or replacement of counselors.

4) **Ensuring continued implementation and scalability of the intervention requires careful consideration of ongoing referral and clinical supervision systems.** The intervention is a specialized mental health treatment designed for children experiencing high levels of psychological distress, and most appropriate when delivered as part of an efficient referral and screening system for identifying and enrolling eligible children into treatment. Plans for transition from remote to local clinical supervision should be established from the beginning of the project in order to ensure continued delivery of the intervention.

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