AMANI TRUST

Training nurses in the assessment and management of psychological disorders: Report of AMANI Trust's programme in Mashonaland Central Province, Zimbabwe.

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This report has been produced in order to summarise 5 years of training in Mashonaland Central Province. The AMANI Trust has been training nurses and other health workers in Mashonaland Central Province since 1995 and it seems appropriate to take stock of what we have learned over this time.

We started out with a model developed for the primary care setting and suitable for the development of a community-based mental health approach. This was originally developed during a project in Chiweshe based at Howard Hospital. The contributions of Helga Williams and Charles Todd were very important in developing the first model. The aim was to find an approach for managing common mental disorders - although we did not call them that at that time - which was so prevalent in the primary care setting in Zimbabwe. The model was epidemiologically driven and based on a solid research foundation.

The next phase involved applying the model to a novel setting: the Mozambican refugee population in Zimbabwe. This was the first activity of the soon-to-be formed AMANI Trust. This was a useful learning experience in so many ways. Firstly, it became clear that non-mental health professionals could become effective counselors, and, secondly, that the preferred methods of counselling were not what we had assumed. We learned that directive techniques seemed more acceptable to clients that non-directive techniques. Here, we have to thank Rhoda Immerman who had the vision to see that trauma counselling and mental health were important in the refugee setting, and the courage to try out a relatively untested approach.

Finally, we began in Mount Darwin, where Mount Darwin District Hospital and Karanda Mission Hospital gave us a warm and supportive start. Then the real learning began. We learned that problem solving is what nurses do best, and that we were effectively de-skilling nurses by not using their strengths. We learned even more from our clients about the continuously de-stabilising effects of poverty and disability. We learned that we had to find ways to counter the effects of poverty, and moved into community development in a small way. We have finally moved into trauma counselling and to the training of trainers.

Every year has brought new insights, and we hope that this has been reflected in the training and in the supporting manuals. We have to thank the Provincial Medical Directorate for all the support over the years and all the Districts that we have worked. We have to thank several hundred trainees for their persistence in very difficult circumstances and a demoralising work climate.

We also have to thank those who gave us the tools to do this work: the Oak Zimbabwe Foundation, DANIDA, the Embassy of Switzerland, the IRCT, and the RCT. This was not possible without your support: thank you all.

Background

The reported prevalence of psychological disorders in Zimbabwe is generally high, although this is not generally reflected in the surveillance statistics of most health authorities of the Ministry of Health and Child Welfare. The most reliable study to date also indicates that high prevalence rates are to be expected[1]. This study showed a range of prevalence from 22% to 32% in primary care clinics, with much higher rates being seen in the patients of general practitioners (35-47%) and traditional healers (50-73%). This study replicated many of the earlier findings, as well as implicating the important role of socio-economic variables. For example, it was found that those with psychological disorders had had fewer years in education, were more likely to be unemployed, reported more debt due to illness, with costs being incurred from consultations, medications for lost income. The study implicated the following features as being associated with Common Mental Disorders [CMD]:

- female gender
- older age
- chronicity of illness
- number of presenting complaints
- economic impoverishment
- infertility
- recent unemployment
- disability

In general, this study showed marked differences between those with psychological disorders as compared with ordinary patients, and this suggests that patients with psychological disorders may require a special focus for the health care system. Thus, lack of detection becomes a significant problem. A follow up study indicated that poor prognosis was most associated with disability and economic deprivation[2].

Previous research also makes it clear that patients who attend primary care facilities receive diagnoses and treatment, whether the diagnosis is physical or psychiatric[3]. Many of these patients may also have significant physical disorders, which must also not be overlooked. Primary care workers, of course, face considerable problems, for the population served by primary care is one in which the burden of physical illness is often heavy. Furthermore, it is usually a population in which most indices of social adversity are present: poor diet, poor housing, low education, and unemployment all figure highly in the general Zimbabwean population. Health workers are thus required to keep a decided focus on identifying and treating physical illness, and indeed many sufferers of

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1 **See** *Patel et al. [1997], Common mental disorders in primary care in Harare, Zimbabwe: associations and risk factors, BRIT.J.PSYCHIAT. 171, 60-64.*

2 **See** *Patel et al. [1998], Outcome of common mental disorders in Harare, Zimbabwe, BRIT.J.PSYCHIAT. 172, 53-57.*

3 **See** *Reeler et al. [1993], Psychopathology in Primary Care patients: A four-year study in rural and urban settings, CENTRAL AFRICAN JOURNAL OF MEDICINE, 39, 1-8;* **see also** Hall & Williams. [1987](A), *Hidden psychiatric morbidity Part I: study of prevalence in an outpatient population at Bindura Provincial Hospital. CENT.AFR.J.MED. 33, 239-245*

psychological disorders will also have concurrent physical disorders, albeit mostly minor illnesses. Furthermore, it should not be overlooked that physical illness can often precipitate psychological disorder or dysfunction. This last factor is more important when disorders due to organised violence are considered, since this group is likely to suffer from physical disability due to the violence experienced[4].

The contribution of organised violence and torture to overall psychological morbidity have not been well-researched in Zimbabwe, but there have been a series of studies carried out in Mashonaland Central Province and Mount Darwin District over the past 2 decades. The first studies were carried out in 1987 by researchers from the University of Zimbabwe[5]. The first of these studies, conducted at Karanda Mission Hospital, indicated a point prevalence rate of 38.7%, with the majority of the conditions being shown to be anxiety or depression[6]. The second study, carried out at Bindura Provincial Hospital, indicated a point prevalence of 16%, with a similar profile being shown for disorders[7]. These studies also indicated that nurses detected few disorders, with more than 90% of the psychological disorders being misdiagnosed as physical illnesses. Hall and Williams had no easy explanation for the difference in the rates found between these two settings, attributing them to differences in referral patterns.

The most recent studies, carried out by the AMANI Trust, indicate that psychological disorders due to organised violence and torture are approximately 1 adult in 10, over the age of 30, in the clinical setting in Mashonaland Central Province[8]. A detailed clinical study of more than 300 survivors shows a picture of mixed psychological and physical disability[9].

AMANI's Training Programme

Since 1995, the AMANI Trust has been in a collaborative relationship with the District Health Team of Mount Darwin District. Although the primary focus has been on developing assistance to survivors of torture and organised violence, the aim has also been to strengthen the District's psychiatric service. To this end, a series of small studies have been conducted, and, although these have been mainly concerned with examining

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[4] **See** *AMANI. [1997], Survivors of Torture and Organised Violence from the 1970s War of Liberation, HARARE: AMANI TRUST.*

[5] **See** *Hall & Williams. [1987](a) Hidden psychiatric morbidity Part I: study of prevalence in an outpatient population at Bindura Provincial Hospital. CENT.AFR.J.MED. 33, 239-245*; see **also** *Hall & Williams. [1987](b) Hidden psychiatric morbidity Part II: Training health care workers in detection: A pre- and post-study at Karanda Mission Hospital. CENT.AFR.J.MED. 33, 255-258*

[6] **See** *Hall & Williams. [1987](a) Hidden psychiatric morbidity Part I: study of prevalence in an outpatient population at Bindura Provincial Hospital. CENT.AFR.J.MED. 33, 239-245*

[7] **See** *Hall & Williams. [1987](B), Hidden psychiatric morbidity Part II: Training health care workers in detection: A pre- and post-study at Karanda Mission Hospital. CENT.AFR.J.MED. 33, 255-258*

[8] **See** *Reeler et al. [2000], The prevalence and nature of disorders due to torture in Mashonaland Central Province, Zimbabwe, TORTURE (submitted for publication).*

[9] **See** *AMANI. [1997], Survivors of Torture and Organised Violence from the 1970s War of Liberation, HARARE: AMANI TRUST.*

the effects of the violence in the 1970's on the survivors, these reports are relevant to the development of a District Psychiatric service. Following on an initial pilot study in 1995, AMANI introduced a community-based programme in Mount Darwin District to address these problems; both the ordinary psychological disorders, but also the disorders due to torture and organised violence. This programme has been running since March 1995, and this present report covers the time period from 1995 to 1998.

As a part of this community-based programme, the AMANI Trust has been running training courses in primary mental health care for nurses, as well as other health workers, since 1995. The basic training focuses on the basic knowledge and skills for detecting, assessing and managing psychological disorders presenting to primary care and hospital outpatient departments. The course also contains an input on the assessment and management of survivors of organised violence and torture. Manuals support this basic course[10]. About 150 nurses and health workers have been through this course in three Districts.

The Basic Skills Programme 1995 – 1998

The major objective of the Basic Skills Programme was to create awareness in the health team of the prevalence of CMD and to provide basic skills in the detection assessment and management of these disorders. There was also input on disorders due to organised violence and torture since these had been shown by epidemiological studies to a very common sub-set within CMD.

The programme revolved around the following areas and was supported by a manual[11]:

- Definition of the common psychological disorders
- Classification of psychological disorders
- Identification of the incidences of hidden psychiatric morbidity
- Detection of psychological disorders including the use of SRQ- 8
- Completion of the psycho-social histories of patients
- Selection and referral of clients appropriately
- Application of basic counselling skills and simple intervention methods

These were very successful courses, and strongly endorsed by both the trainees and the management. The training led to a much greater awareness about both CMD and OVT and to the formation of District Mental Health teams.

The Core Counsellors Programme 1997 – 1999

The next level of course was been offered to a smaller group, chosen from those who attended the basic training. This was a 12-month course, with monthly teaching sessions

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[10] **See** *AMANI. [1997](A), Survivors of Torture in Mount Darwin District, Mashonaland Central Province: Overview of Report and Recommendations, LEGAL FORUM, 9, 49-60.* ***see also*** *AMANI.[1997](b)], Report on Psychological Disorders in Clinics and Hospitals in Mount Darwin District, Mashonaland Central Province, HARARE: AMANI.*

[11] **See** *Reeler,A.P. [1995], The Chiweshe Nurse-Counsellor Programme: Resource Manual (revised), HARARE:AMANI; Reeler,A.P. (1995), Assessment of the Consequences of Torture and Organised Violence: A manual for field workers, HARARE:AMANI.*

and ongoing supervision of cases. About 18 nurses have been through this course in two Districts.

This programme was designed to increase the capacity of the District service and create a group of more experienced and better-trained counsellors who could back up those nurses who had been through the Basic Skills Programme. The course covered the following:

- To screen and make detailed assessments of patients with psychological disorders
- To apply the counselling tools/skills to a variety of situation that they come across
- To conduct individual counselling using the problems solving and single therapeutic interview techniques
- To apply the family therapy algorithm in the counselling of families
- To participate in peer counselling within working areas
- To supervise and assist colleagues on all aspects of counselling

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The Trauma Counselling Programme 1999 – 2000

The most recent training has represented a shift in AMANI's training philosophy. Following extensive discussions and a needs assessment, it was decided in 1998 to offer training on a Provincial basis revolving around a training-of-trainers approach. The needs assessment indicated that disorders due to trauma were a very common problem seen by Provincial health workers (1997 report) and that there was a need for generic trauma counselling training. It was not possible to mount this programme in 1998, and the Trauma Counselling programme was finally launched in March 1999.

The aims of the programme were several-fold and covered a variety of different forms of trauma. The course was mounted in conjunction with the Family Support Trust and the Musasa Project. The former is an NGO dealing with child abuse whilst the Musasa Project deals with domestic violence. Both these forms of trauma were indicated as common in the needs assessment.

The basic aims were as follows:

- *To identify 5 different types of trauma and their effects on individuals, families and communities*
- *To Assess trauma using at least 4 of the various instruments*
- *To Apply at least 3 intervention techniques to different types of trauma*
- *To Identify caring procedures for carers*

The course covered a wide area within trauma as follows:

- *Detection of psychological disorders*
- *Assessments*
- *Depression/Anxiety*
- *Trauma and violence*
- *Counselling and Communication*
- *Debriefing*

- *Family Therapy*
- *Problem solving therapy*
- *Brief Therapeutic Interview*
- *Care for caregivers*

This course was supported by several manuals[12] and the follow up consisted of monthly supervision visits for six months and a one-day Refresher course after the first three months post training. At the end of the six months, trainees were taken for a five-day Trainers' course. A total of 15 Health workers including Social Workers were trained as Trainers who are going to train others in Year 2000.

Nurse Survey[1999]

This was an attempt to evaluate the effects of the Basic Skills and the Core Counsellor programmes. A questionnaire survey was complemented by a more formal evaluation by an independent consultant, who interviewed a cross-section of the trainees and administrators in Mount Darwin District.

A questionnaire covering all areas of the training, including all previous training, of nurses was prepared.

A total of 245 questionnaires were sent out, virtually to all nurses in Mashonaland Central Province. A total of 28 completed questionnaires were returned, which is an extremely low rate of responding, only 11%. The questionnaires were distributed through the Provincial Nursing Officers Department via all senior staff in the Province.

Age[mean; s.dev]:	30.9[4.7]
Gender:	
Male	6
Female	22
Qualification:	
SRN	21
SCN	9
Specialism	4
Additional training	16

Of the respondents, about half had not received any training by AMANI. Of those reporting training, all had received the Basic Skills programme and three-quarters had attended the Core Counselling programme. These were acceptable numbers for evaluation purposes since the sample was 44% of the Core Counselling programme.

Received training	12
Not received training	17
Received basic training	12
Received core counselling	8

[12] **See** *Reeler,A.P. [199]), The Chiweshe Nurse-Counsellor Programme: Resource Manual (revised), HARARE:AMANI; Reeler,A.P., MBAPE, P., HLATYWAYO, E., MATSHONA-DUBE, J., & MHETURA, J. [1999], A Trauma Counselling Handbook, HARARE: AMANI.*

The trainees all indicated that the Basic Skills training was useful to their everyday work, whilst most (85%) indicated that the Core Counselling programme had been useful.

In answer to how often the trainees had used their skills in managing psychological disorders, most indicated using the skills on a near daily basis as can be seen from the table below.

How often acquired skills used

Never	1
Once a month	0
Once a fortnight	1
Once a week	1
Every day	9

As can be seen from the table below, the average number of clients seen was about 18 per nurse, with a total of 210 patients over the past six months. Three participants indicated that they had seen many patients, but have no numbers.

Number of patients seen

In the past week	32
In the past month	57
In the past six months	121
Total number seen	210

The trainees indicated that they had used a variety of approaches. Five participants indicated that they had used all three methods.

Treatment given

Counselling	11
Medication	7
Other	4

Torture and trauma were examined separately. The trainees were asked whether they had seen torture or trauma cases, and 11 of the 12 indicated that they had.

The trainees had not seen as much torture or trauma cases as ordinary cases of psychological disorder, but they had nonetheless seen a large number between them as indicated in the table below.

Number of patients seen

In the past week	11
In the past month	38
In the past six months	37
Total number seen	86

One participant indicated that he had seen many patients and had no figures. Of the kinds of treatment offered by the counsellors, counselling was the most frequent.

Treatment given

Counselling	10
Medication	8
Other	2

The majority [10] recommended this training to be part of all nurse training, whilst a small number thought the contrary [2]. A variety of reasons were offered for the recommendation, and a selection of their responses is shown below.

"It equips one with the necessary skills in dealing with torture victims."
"Helps in use of resources i.e., we won't prescribe unnecessary drugs in cases where counselling only can be effective."
"Every nurse meets a patient who needs counselling so it is easier when one has the skills instead of referring to nurses who did a counselling course who may be off duty."
"These skills should be incorporated into their training as nurses come across torture, rape and psychiatric patients."
"It enhances proper management of a patient using a holistic approach."
"It is useful in detection of anxiety and depression."
"Psychological problems can then be identified within the Community."
"A good guidance to correct diagnosis preventing patients from shopping around seeking treatment."
"A lot of patients seen present with psychological problems but nurses do not know how to manage them accurately."
"Counselling training gives the nurse an understanding of human behaviour and opens up channels of assisting clients with satisfaction and confidence."

AMANI also attempted to examine whether there were any differences between the two groups - those would have undergone AMANI training and those who had not - in their attitudes to mental health and patients with psychological disorders. This seemed useful since there is a large body of research indicating that attitudes are directly related to both detection of psychological disorder as well as determining whether health workers are motivated to manage psychological disorders[13]. Additionally the type of management preferred by health workers in the management of psychological disorders has been shown to be a function of attitudes[14].

Two questionnaires were administered: the Direction of Interest Questionnaire (DIQ) and the Attitudes to Treatment Questionnaire (ATQ). The DIQ is a personality inventory

[13] **See** *Goldberg & Huxley.[1980], Mental illness in the Community. LONDON; TAVISTOCK*
[14] **See** ***Caine et al.1977, Personal Styles in Neurosis: Implications for Small Group Psychotherapy and Behaviour Therapy, LONDON: ROUTLEDGE & KEGAN PAUL.***

measuring openness to experience along a dimension of Openness v Closedness. The DIQ correlates with other personality inventories such Locus of Control and measures the extent to which a person construes himself of herself as having control over life's events or not. The ATQ measures the attitudes of health workers to treating psychological disorders and contrasts two broad styles: a style that leans towards physical treatment as opposed to a style that leans towards psychotherapy or counselling. Openness to experience on the DIQ correlates with a psychotherapeutic orientation on the ATQ.

	Age	Gender	No of qualifications	Attitudes to treatment	Direction of interest
Untrained By AMANI	29.7	2	1.5	68.1	5.7
[N=16]	5.2		0.6	7.4	2.12
Trained by AMANI	32.6	5	2.3	70.3	6.3
[N=12]	3.3		1.2	9.9	2.01

There were some differences between the two groups, but only age was statistically significant. There were small trends for the trained group to have higher qualifications, and also to be both more open to experience and to favour psychotherapeutic interventions for psychological disorders. This can be interpreted as partial support for training having an effect upon attitudes, but this cannot be asserted conclusively in the absence of a pre-training baseline. However, it does accord with the self-report of the nurses themselves and also with the results of the independent evaluation, which reported that the nurses' managers saw a marked change in the psychological-mindedness of those who had received training from AMANI.

Client outcome studies

In addition to the nurse survey a series of studies were carried out in order to determine the effectiveness of the treatments offered by nurses. The first two of these were examinations of whether nurse-delivered treatment was effective, whilst the third was a random follow-up of clients seen over a three-year period.

1. Brief Therapeutic Interview

This study has been reported elsewhere in detail and will be merely summarised here.

The subjects were all torture survivors from Mt. Darwin District. All subjects have suffered from both physical and psychological torture, with some disorders being more than 20 years duration. One subject died during the course of the trial, and another 2 did not return for 12 month repeat assessments and were thus excluded.

Detailed assessment had previously been conducted on each survivor, using the instruments described below. These instruments are described more fully in a manual developed by the AMANI Trust [15] The CAPS is a clinical interview for Post-Traumatic

[15] **See** *AMANI Trust(1995) Assessment of the Consequences of Torture and Organised Violence: A manual for field workers, HARARE: AMANI..*

Stress Disorder (PTSD), developed in the United States[16], and used previously in a study of Zimbabwean war veterans [17].

* *Self-Reporting Questionnaire (SRQ-20)*
* *Structured Assessment Form*
* *Medical History*
* *History of violence*
* *Clinician Administered PTSD Scales (CAPS)*
* *Self-ratings of improvement*

Follow-up interviews were conducted at the hospitals at three, six and twelve months. Progress during the previous months was reviewed, new problems (if any) were noted and new solutions generated if necessary, and the measures were repeated. The outcome measures were of three kinds: the SRQ-20, the CAPS and Self-ratings of improvement. The Self-ratings used a simple 5-point scale (much better, better, same, worse, much worse), all answered on a "yes-no" basis. The scale was scored from 0 (much worse) to 4 (much better). A very simple scale was used due to the nature of the client population, most of who have very little education and are not very psychologically sophisticated.

Prior to beginning therapy all clients had received a lengthy assessment (described above), which lasted from two to three hours over two to three sessions.

This study was a clinical study of the effectiveness of a single counselling session on patients with psychological disorders due to torture. A comparison with an untreated control group would have allowed much stronger confidence in the results, but the ethical problem of using either an untreated control group or a waiting list group and thus denying the survivors of gross human rights violations treatment decided us against this design.

The therapy approach itself seemed to be acceptable to the clients, and was not difficult to implement. It followed logically on the detailed assessment procedure, and the combination of feedback, psycho-education and problem solving seems a useful approach to the management of trauma.

2. Problem Solving

Problem solving is probably one of the most common approaches to patient management used by nurses, and thus the AMANI Trust decided to examine the efficacy of problem solving for psychological disorders. In addition, problem solving is the most basic skill used in Basic Skills training programme.

The study was conducted at two health care facilities in Muzarabani District, Mashonaland Central Province. St Albert's Mission Hospital serves as the district referral hospital, whilst Muzarabani Clinic, a rural health centre in the Zambezi Valley, serves as a referral centre for four small clinics further out on the Valley floor.

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[16] **See** *Blake, D.D. (1993), Rationale and development of the Clinician-Administered PTSD Scales, PTSD RESEARCH QUARTERLY, 5, 1-2.*

[17] **See** *Reeler,A.P., & Mupinda,M. (1996), An Investigation into the Sequelae of Torture and Organised Violence in* Zimbabwean war veterans, LEGAL FORUM, 8, 12-27.

Health workers who had previously been trained by AMANI in detecting and managing psychological disorders identified patients. The criteria used for selection by these nurses were multiple vague complaints, frequent clinic or hospital visits, and an SRQ 8 score of 4 or more. The SRQ-8 is a short version of the Self-Reporting Questionnaire [SRQ-20], and has been previously validated for Zimbabwe[18]. Altogether eighteen patients were screened using the SRQ 8, and then referred to the AMANI therapist [EH].

All the referred patients were then further interviewed using the following instruments:

- S*RQ-20;*
- *The Structured Assessment Form;*
- *Genogram;*
- *Self-rating scale.*

The SRQ-20 is a self-reporting questionnaire designed by The World Health Organisation as a prescriptive screening instrument for use in epidemiological studies of non-psychotic mental illness. This instrument has been widely used in Africa, including Zimbabwe[19]. Previous research has indicated that scores on the SRQ-20 in excess of 10/20 are indicative of clinically significant disorder. The Structured Assessment Form elicited socio- demographic, personal and family data as well as information about the economic status of the individual. The Structured Assessment Form was taken from a manual developed for primary care workers, which has been widely used by the AMANI Trust[20]. In particular, note was taken of the following:

- *Number of presenting symptoms;*
- *Number of interventions in the past six months;*
- *Number of referrals to the doctors and medications being taken;*
- *Presence of any family problems;*
- *Presence of marital problems;*
- *Presence of financial difficulties;*
- *Life events in the past six months prior to the interview.*

The Genogram is a method of representing family structure and process, which enables the therapist to identify possible family disturbance and the supportiveness of the patient's family[21]. The Self-ratings used a simple 3-point scale (better, same, worse), all answered on a "yes-no" basis. The scale was scored from 3 (much worse) to 1 (much better). A very simple scale was used due to the nature of the client population, most of who have very little education and are not very psychologically sophisticated.

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[18] **See** *Patel,V. & Todd.(1996) The validity of the Shona version of the Self Report Questionnaire and the development of the SRQ-8, International Journal of Methods in Psychiatric Research,,* ***6*** *, 153-160.*

[19] **See** *Reeler AP, TODD CH (1995), An overview of psychological disorders and psychiatric services in Zimbabwe, in Y.Pillay & A Bhana (eds), "Proceedings of a Primary Mental Health Care Workshop", DURBAN: UNIVERSITY OF DURBAN-WESTVILLE.*

[20] **See** *Reeler AP (1997), The Chiweshe Nurse-Counsellor Programme: Resource Manual (revised), HARARE:AMANI.*

[21] **See** *Walrond-Skinner S. (1976), Family Therapy: The Treatment of Natural Systems. ROUTLEDGE & KEGAN PAUL: LONDON.*

After the initial meeting, the patient was seen two weeks later in order to complete assessments and start working out an action plan for whatever problems identified. The subsequent follow-ups were scheduled at one, three and six month's intervals from the time of the second session. The SRQ-20 and self-rating scale were completed on each occasion after the initial screening by the referral agent. Each session took between 45 minutes to an hour, depending on the patient`s openness and the issues under discussion.

If a patient did not attend for a session, it was rescheduled and a letter sent to the patient. Attempts were made for up to three invitations, and, if the patient did not attend, he or she would then be removed from the register and considered lost. As indicated above, the study began with eighteen identified patients. Eight were lost and ten were seen through to the six-month follow up.

The approach is very much linked to the Nursing Process, an approach with which nurses are very familiar, and which has been used internationally. The process has five stages and the nurse guides the patients through each of these stages as is described below:

- ***Problem Identification***
- ***Problem Exploration***
- ***Action Plan***
- ***Implementation***
- ***Follow-up***

A full report is described elsewhere[22].

The therapy approach itself seemed to be acceptable to the clients, and was not difficult to implement. The clients seemed to appreciate the focus upon their expressed problems rather than a purely symptomatic approach, which is the most common experience in the primary care or outpatient setting. The problem solving approach also differs from other forms of counselling or psychotherapy in that it uses the same method for all problems, although the solutions clearly differ from client to client.

The overall aim, that of finding a treatment method for the primary care setting, seems satisfied. The approach is simple to implement, makes sense to the client, and, most important of all, uses skills with which most nurses are already. This is important when it is considered that most psychological disorders will only ever attend at the primary care or outpatient level, and where virtually all these clients will not receive specialist mental health care. Thus, an approach that requires a minimum of skill re-training has decided advantages for the primary care setting, and follows the general approach already tried in the Zimbabwean setting [23].

3. Client Follow-up

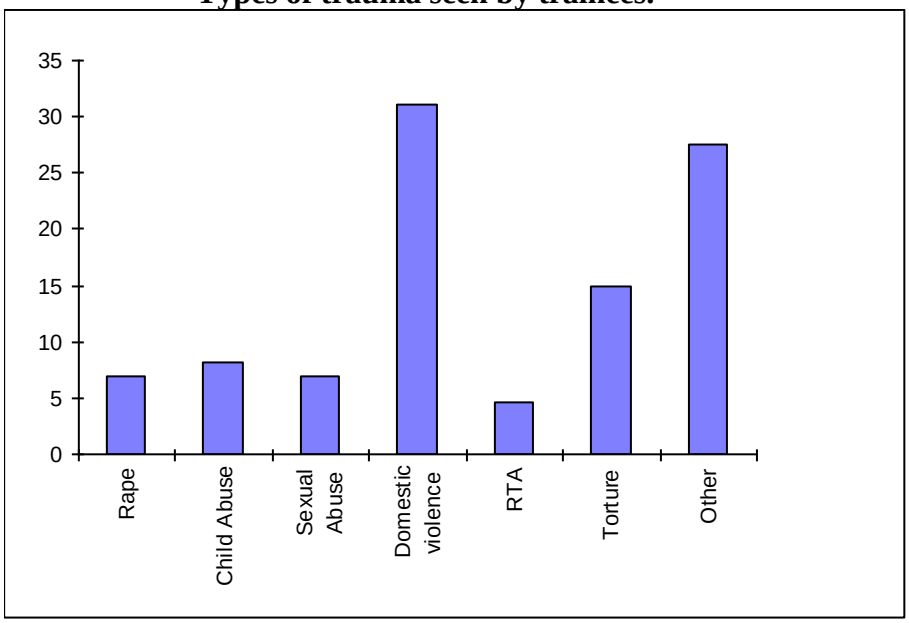
[22] **See** *Reeler, A..P., & Hlatywayo, E. (2000), A pilot study on the effectiveness of problem solving therapy on primary care patients with psychological problems, (in preparation).*

[23] **See** *Abas M.A., Broadhead J.C., Mbape P., Khumalo-Sakatukwa, G. (1994) Defeating depression in the developing world. A Zimbabwean Model. British Journal of Psychiatry, 164, 293-296.*

The second follow-up involved a study of the cases treated by the nurses and social workers that were members of the Trauma Counselling programme in 1999. AMANI staff examined the case files of all the patients seen by the Trauma Counsellor trainees and the findings are reported below.

A total of 79 case files were examined. The majority of the cases were female (54) and the mean age of the cases was 31 years (s.dev.12.6). There were a variety of types of trauma seen by the trainees with domestic violence and torture being the most frequent. The torture cases were all chronic cases from the Liberation War.

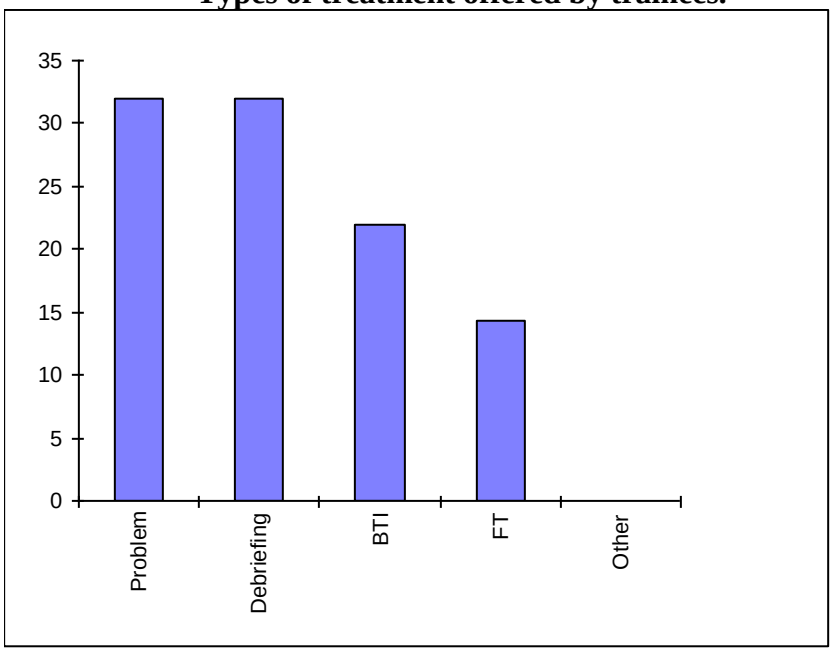
Types of trauma seen by trainees.



Of the types of therapy offered, problem solving and de-briefing were the most common. However the trainees did use all types that had been taught. It was interesting to see the preference for problem solving and de-briefing and discussion with the trainees indicates that they were using these for different types of cases.

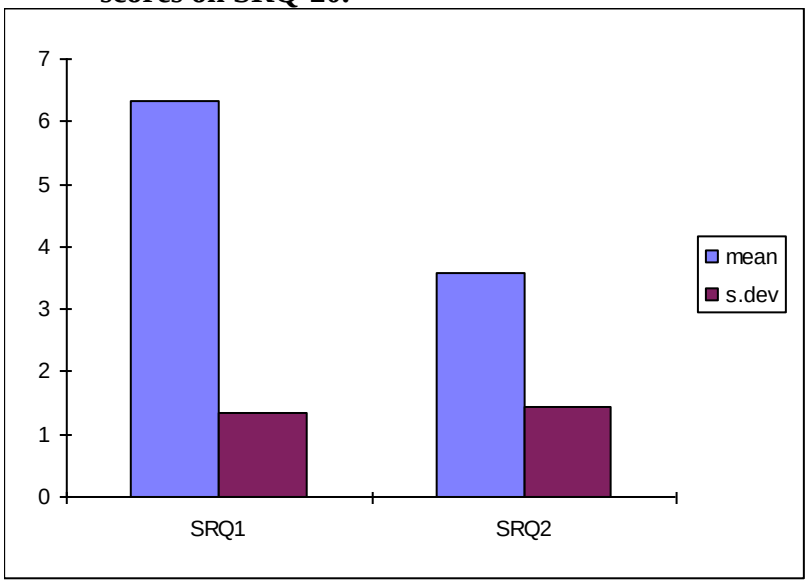
Problem solving was used in cases where the presenting problem was usually social or had an economic focus in the problem, such as lack of school fees. De-briefing was reserved for the more acute cases and used as an immediate method for dealing with the trauma. For example de-briefing was used in cases of rape or sexual abuse.

Types of treatment offered by trainees.



It was interesting to see the outcome of the clients treated by the trainees. It was hoped that the trainees would use the SRQ-8 or the SRQ-20 on a regular basis to assess outcome on follow-up, but for a variety of reasons this was not done. There were considerable differences between the trainees in the frequency with which they used objective measures to assess outcome, with at least two trainees doing this on a routine basis. Most relied on self-report to assess outcome.

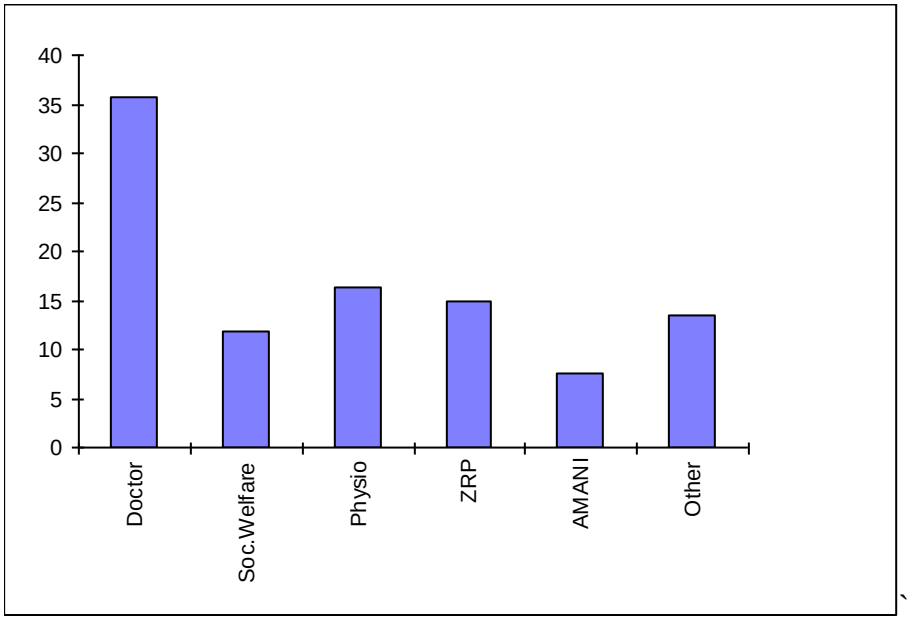
Outcome of trainees treatments: Pre and post scores on SRQ-20.



The results of those cases for whom self-report scores were kept show a strong effect for improvement: 85%(33 cases) were rated as improved as opposed to 15% (6 cases) that remained the same or got worse.

Referral agencies used by Trainees:
In addition to managing cases, the trainees also made referrals when they felt the need. As can be seen for the figure below, the major point of referral was to doctors, which is unsurprising. It was also gratifying to see that the trainees made use of most local resources, and did not show dependency upon AMANI as the major source of support. This can be interpreted as weak evidence for local sustainability.

Referral routes for trainees.



Conclusions:

From the scientific reports available, it has been shown that, although cases of psychological disorders are common, and possibly on the increase, identification, assessment, and management have been poor. Detection of disorders due to organised violence and torture (OVT) have also not been well-understood and this led to the training programme mounted by AMANI Trust

The training programme generally tried to boost the District capacity to manage both cases of psychological disorder and OVT. The overall framework was aimed to support a primary health care model, whilst the major aim was to create the capacity for a self-sustaining system in which both the District and the Province could continue training on its own. This proved difficult in the current climate of cost recovery and diminished expenditure on health. This forced a move from a District "roll-over model" to a training of trainers approach. This new approach will be completed in 2000, and the final phase is now underway.

The training was supplemented by small research studies on the outcome of nurse-driven psychological treatment. Two studies have provided persuasive evidence that such treatment is effective, and have, in particular, shown the effectiveness of brief forms of treatment. As far as we know, these two studies are amongst the first to be done in Africa, let alone in Zimbabwe.

The evaluation of the training and the treatment offered by the trainees indicates that the training was felt to be worthwhile, and that the treatment offered was effective. The views of the trainees were complemented by an independent evaluation in 1998, in which the views of the health managers was canvassed. The managers saw marked changes in both the attitudes shown towards patients, and also in better treatment being offered to patients with psychological disorders. As can be seen from the data summarized above, these were views shared by the trainees themselves.

Overall, this programme has shown that psychological disorders, including disorders due to trauma and OVT, can be managed effectively by non-mental health workers. Furthermore, the programme has shown that these skills can be taught effectively. The next stage will be to examine the efficacy of the training done by the trainees themselves, and to evaluate the treatments offered by their trainees. Only then will it be possible to claim that a sustainable system has been created, but the indications to date give some confidence that this can be achieved.