

2019

# Assessing contextual factors for implementing evidence-based care in a middle income country in the wake conflict: the Colombian mental health system

---

<https://hdl.handle.net/2144/39481>

*Downloaded from DSpace Repository, DSpace Institution's institutional repository*

BOSTON UNIVERSITY  
GRADUATE SCHOOL OF ARTS AND SCIENCES

Dissertation

**ASSESSING CONTEXTUAL FACTORS FOR IMPLEMENTING EVIDENCE-  
BASED CARE IN A MIDDLE INCOME COUNTRY IN THE WAKE OF  
CONFLICT:  
THE COLOMBIAN MENTAL HEALTH SYSTEM**

by

**AMANTIA AMETAJ**

B.A., Boston University, 2009  
M.A., Boston University, 2014

Submitted in partial fulfillment of the  
requirements for the degree of  
Doctor of Philosophy

2019

© 2019  
AMANTIA AMETAJ  
All rights reserved

Approved by

First Reader

---

David H. Barlow, Ph.D., ABPP  
Professor of Psychology and Psychiatry Emeritus

Second Reader

---

Shannon Sauer-Zavala, Ph.D.  
Research Associate Professor of Psychology

Third Reader

---

Cassidy Gutner, Ph.D.  
Assistant Professor of Psychiatry  
Boston University School of Medicine

## **DEDICATION**

To my parents, Dhurata and Arian Ametaj, who have taught me the value of education and perseverance in the face of challenges, and to the victims of the Colombian conflict whose resilience in the face of insurmountable obstacles is truly inspirational.

## ACKNOWLEDGMENTS

I would not have been able to complete this work without the guidance and support of many individuals. First and foremost, I would like to thank my mentor and first reader, Dr. David H. Barlow, whose guidance during graduate school has been and continues to be instrumental to my growth and professional development. Secondly, I would like to thank Dr. Shannon Sauer-Zavala who has been steadfast in her daily mentorship and embodiment of a productive, thoughtful, and considerate leader. I would also like to thank Dr. Cassidy Gutner for her continued guidance and copious amounts of patience in helping me to develop and shape this dissertation project. Similarly, I would like to thank Dr. Lauren Ng for the opportunity to participate in and learn from her research in global mental health. Lastly, I would like to thank Dr. Kristin Long, whose leadership and efforts on the BU Diversity Committee set an excellent example.

There are many others who were instrumental to my ability to conduct and complete this research project in Colombia. First, I would like to thank Dr. Fabio Idrobo and his wife Pilar Velásquez Londoño, who helped me a tremendous amount in completing my dissertation, from renting me their apartment in Bogota to assisting me in identifying participants for my study. Similarly, Dr. Leonidas Castro Comacho helped by allowing me access to participants from his trial. Vanessa De Castro Ogliastri and Juliana Pazmiño Delgado, thanks so much for your help with participant recruitment and scheduling and my adjustment to living in Bogota. In addition, to the study translator, Mauricio Restrepo Marino, thank you for your tireless dedication to my study. I could not have completed the project without your help with the countless daily study tasks,

driving, translations, and transcriptions. Also, thank you for helping me navigate life in Bogota. Santiago Marquez and Sara Bensadon Catalan, two undergraduate research assistants who transcribed and double-coded my interviews, were essential to this project. Santiago, in particular, I am indebted to your continued help even after you graduated from Boston University and started working. I would also like to thank Julian Moreno Villamizar and Santiago Zarate Guerrero for helping me translate and back-translate many documents to and from Spanish.

In addition, I would like to thank colleagues in my lab and cohort for their unwavering support. In particular, I would like to thank my “lab-twin,” Clair Robbins for her consistent words of encouragement and statistics’ consults. Similarly, I would like to thank my fellow lab members, Hannah Boettcher, Julianne Wilner, Brittany Woods, and Andrew Curreri for setting a culture that emphasized collaboration and team work. I would also like to thank my cohort fellows, Dana Bruck Segal and Ollie Barthelemy, for their friendship throughout graduate school.

Of course, I cannot thank enough my husband, David Roiter, and my family. I cannot describe in words how lucky I am to have Dave by my side in life. Similarly, I would like to thank my parents, Dhurata and Arian Ametaj, for all the sacrifices they have undertaken to support me and my brother, Erli Ametaj, in our pursuit of education. They have always been there to encourage me.

Last, but not least, I would also like to thank: the Clara Mayo Fellowship for funding this research, my study participants, and those working to improve the system for victims. I would like to thank the leaders and providers for their patience in answering, at

times, challenging questions. All of the leaders and providers I met truly care about providing the best services to victims. Most of all, I would like to thank the victims of the armed conflict who poured out their hearts and found time in the midst of their challenging living situations to talk to me about their experiences. I was surprised by the resilience of everyday Colombian people, but I was amazed by the strength of the human spirit that the victims of the armed conflict displayed.



**ASSESSING CONTEXTUAL FACTORS FOR IMPLEMENTING EVIDENCE-  
BASED CARE IN A MIDDLE INCOME COUNTRY IN THE WAKE OF  
CONFLICT:  
THE COLOMBIAN MENTAL HEALTH SYSTEM**

**AMANTIA AMETAJ**

Boston University Graduate School of Arts and Sciences, 2019

Major Professor: David H. Barlow, Ph.D., Professor of Psychological and Brain  
Sciences

**ABSTRACT**

The negative impact, or burden of disease, for mental health problems is high across the globe, especially in low- and middle-income countries (LAMICs) in the aftermath of violent conflicts. Evidence-based psychological treatments (EBPTs) are time-limited and cost-effective and potentially could be implemented across mental health service delivery systems in LAMICs. In addition, EBPTs that are culturally-adapted have been shown to be effective at alleviating mental health symptoms and improving individuals' functioning in LAMICs. Colombia has recently emerged from over 50 years of war, resulting in the largest number of internally displaced persons in any one country and 8 million officially recognized victims. As a result, the Colombian leadership has passed legislation to address the mental health needs of victims. The current study aimed to identify perceptions of EBPTs as well as barriers and facilitators

that may impact wide-scale dissemination of EBPTs in Colombia for victims of the armed conflict who suffer from anxiety, mood, and traumatic stress symptoms.

Data were gathered from 35 stakeholders (e.g., leaders, providers, victims) from the Colombian health care system utilizing mixed-methods of qualitative (i.e., semi-structured interviews) and quantitative measurement (i.e., questionnaires). Findings indicate that, at the individual level, victims of the armed conflict face many barriers to care (e.g., economic hardship; internalized stigma impairing treatment seeking). At the system-level, victims face barriers to access to care (e.g., few available services). In addition, system-level barriers include ineffectual applications of laws and policies for victims' care, ineffective quality checks for services, high turnover of providers and moderately unfavorable view of EBPTs at the provider and leader levels. Some mitigating factors that may facilitate care for victims include demonstrated satisfaction with treatment by victims as well as laws that ensure provision of care. At present, barriers outweigh facilitators to providing services, including EBPTs, to victims of the armed conflict. These barriers and facilitators should be taken into account when implementing services and should be the subject of future research and policy development to best provide highly needed services to the many victims of the armed conflict in Colombia.

## TABLE OF CONTENTS

DEDICATION .....	iv
ACKNOWLEDGMENTS .....	v
ABSTRACT .....	viii
TABLE OF CONTENTS .....	x
LIST OF TABLES .....	xvi
LIST OF ABBREVIATIONS .....	xvii
INTRODUCTION .....	1
Colombia .....	12
Current Study .....	14
Study aims .....	15
METHOD .....	16
Study Design .....	16
Recruitment and Sampling Strategy .....	16
Participants .....	17
Measures .....	19
Qualitative measures .....	19
EMERALD .....	20

EPIS .....	21
Quantitative measures .....	22
Brief ISMI.....	22
CSQ-8 .....	22
EBPAS-15.....	23
EMERALD Capacity Building Priorities .....	23
Study Procedures and Data Collection .....	24
Instrument translation procedures.....	24
Interview procedures.....	25
Participant compensation.....	26
Data Analytic Plan .....	26
Saturation/conceptual depth.....	27
RESULTS .....	28
Stakeholders .....	28
Victims .....	28
Providers .....	28
Leadership.....	29
Barriers.....	29

System level barriers .....	30
Barriers to access care across health system .....	30
Poor implementation of laws, policies, and programs .....	31
Low allocation of funds .....	32
Low regulation of quality.....	33
Organization level barriers.....	34
High provider turnover .....	34
Availability of trained professionals .....	35
Facilities and reaching victims.....	35
Service-user level barriers.....	36
Stigma .....	36
Logistical barriers to attending care.....	37
Transportation .....	38
Lack of knowledge about access to care .....	39
Lack of trust in the government .....	39
Avoidance of discussing traumas.....	40
Comparing themes across stakeholders .....	41
Care is not culturally adapted .....	42

Facilitators.....	42
System level facilitators .....	42
Laws and program design .....	42
Available manuals and revisions .....	43
Organization level facilitators.....	43
Offer for care.....	43
Rapport with provider .....	43
Institutional supports.....	44
Help with logistics .....	44
Service-user level facilitators.....	44
Recognizing need for help .....	44
Understanding of mental health and treatment .....	45
Refer others.....	45
Easing transportation burden .....	45
Comparison of themes across stakeholders .....	46
EBPTs Preference for Focus and Treatment Delivery.....	46
Victims .....	46
Psychological needs .....	46

Preference for treatment focus .....	47
Individual treatment format .....	47
Providers .....	48
Psychological needs .....	48
Willingness to provide EBPTs .....	48
Treatment format .....	48
Leaders .....	48
Importance of cultural context .....	49
Psychosocial care .....	49
Comparing themes across stakeholders .....	49
Quantitative Results .....	49
Victims .....	50
Providers .....	50
Leaders .....	51
DISCUSSION .....	52
Strengths and Limitations .....	58
Future Directions .....	64
TABLES .....	67

APPENDIX A.....	73
APPENDIX B.....	85
APPENDIX C.....	88
REFERENCES.....	91
VITAE.....	100



## LIST OF TABLES

Table 1. Demographic Information for All Stakeholders. ....	67
Table 2. Outcome Measures by Type. ....	68
Table 3. Barriers to Implementing Services by Stakeholder Group. ....	69
Table 4. Facilitators to Implementing Services by Stakeholder Group .....	70
Table 5. EBPTs Preference for Focus and Delivery by Stakeholder Group .....	71
Table 6. Quantitative Outcomes by Stakeholder Group .....	72

## LIST OF ABBREVIATIONS

Brief ISMI.....	Brief Internalized Stigma of Mental Illness
CBT.....	Cognitive-behavioral Treatment
CSQ-8 .....	Client Satisfaction Questionnaire - 8 items
EBPAS-15.....	Evidence- Based Practice Attitudes Scale - 15 items
EBPT.....	Evidence-Based Psychological Treatment
EMERALD .....	Emerging Mental Health Systems in Low- and- Middle Income Countries Program
EPIS .....	Exploration Preparation Implementation and Sustainment
EPS.....	Entidad Promotora de Salud (Health-Promoting Entity)
LAMIC.....	Low-and Middle-income Country
IRB .....	Institutional Review Board
MOH.....	Ministry of Health
NGO.....	Non-Governmental Organization
PAPSIVI .....	Psychosocial Care and Comprehensive Health for Victims of the Armed Conflict (Spanish Acronym)
PI.....	Principal Investigator
PTSD.....	Post-Traumatic Stress Disorder
WHO.....	World Health Organization

## Introduction

The burden of disease for mental health disorders is substantial across the globe. Millions of people suffer from mental illness, but only a small percentage receive treatment (Kazdin & Blasé, 2011; Patel et al., 2016; Thornicroft, 2007; Wang et al., 2007). Untreated disorders have negative effects, not only for those suffering, but for society as a whole. These disorders account for large losses in workers' productivity, worsening of concurrent medical problems, and overutilization of disability programs (Clark, 2018; Layard, Clark, Knapp & Mayraz, 2007). In addition, the low availability of care for mental health disorders is in sharp contrast to the resources dedicated to physical illness despite the high lifetime prevalence rates for some mental health disorders (e.g., 25% for anxiety disorders; Kessler et al., 2009; Kessler, Chiu, Demler & Walters, 2005).

The gap in care for mental health is especially troubling given that highly effective, evidence-based psychological treatments (EBPTs) are available for many disorders, including common conditions such as anxiety, mood, and traumatic stress disorders (Rachman, 2009). Unfortunately, the implementation and dissemination of EBPTs has been slow from the research contexts where these treatments were developed to those in need of care (Green, Ottoson, Garcia, & Hiatt, 2009). In fact, the gap between research and its translation to practice is estimated to extend between 15 to 20 years in healthcare fields (Balas & Boren, 2000; Green et al., 2009; Institute of Medicine, 2001). As a result, increasing efforts towards the dissemination and implementation of existing effective interventions is an imperative step toward alleviating the burden of mental health disorders (Collins et al., 2011).

The low availability and high need for care are particularly amplified in low and middle-income countries (LAMICs) given the scarcity of resources and low numbers of trained professionals in these settings (Collins, Insel, Chockalingam, Daar & Maddox, 2013). Research suggests that fewer than one in ten individuals in need of psychological services in a LAMIC receives any treatment, compared to one in three individuals in high-income countries (Patel et al., 2018; Thornicroft, 2007; Wang et al., 2007). Furthermore, this gap in care is particularly wide for regions of LAMICs that are coping with the aftermath of violent conflicts (e.g., civil war, extremist political factions; Murray et al., 2014). Given the current state of affairs in LAMICs, the World Health Organization (WHO) has developed several initiatives to encourage an increase in mental health services in these settings (WHO, 2016; WHO Commission on Social Determinants of Health, 2008).

However, increasing the availability of care in LAMICs is a complex process. From a public health perspective, implementing treatments that have empirical support may be beneficial for improving patient mental health outcomes at a comparatively low cost (Clark, 2018; Patel et al., 2018; Vos, Corry, Haby, Carter & Andrews, 2005). Given that LAMICs face shortages in resources and a wide gap in care, implementing treatments that will produce the fastest, most potent results in the least costly manner may be advantageous in these settings. However, when implementing an EBPT in a new setting, for a new population, or both a new setting and population, researchers must examine whether the EBPT is likely to produce similar results to the original population (i.e., whether the treatment is generalizable to a new population, setting, or both; Aarons,

Sklar, Mustanski, Benbow, & Brown, 2017). Aarons and colleagues (2017) delineate that two criteria must be examined: “(1) is there sufficient empirical evidence or justification from prior evidence that this EBPT would impact health as expected, and (2) whether system, organization, and/or EBPT adaptations are necessary, sufficient, and culturally and organizationally appropriate to make it feasible, practical, and acceptable in the new context” (p. 2). In relation to LAMICs, these two key questions arise with regard to closing the gap in care are as follows. The first question is whether evidence-based psychological interventions or treatment elements that were predominantly developed and tested in high income settings lead to similar improvements in outcomes for patients in LAMICs. The second question is how to best implement these interventions in LAMICs to assure both their effectiveness as well as their sustainability in the long-run. Though it is beyond the scope of the present study to answer these questions, their importance in global mental health research and how they shaped the aims of this study will be discussed in depth below.

The answer to the first question is relatively straightforward as some important advances have already been made in implementing psychological care in LAMICs. In the past decade, there have been several successful implementation efforts of EBPTs in a variety of LAMIC settings across the globe (Singla et al., 2017). In some instances, researchers adapted and implemented treatments that were developed in high-income countries (e.g., Kaysen et al., 2013). In other instances, researchers developed interventions specifically for LAMIC settings based on EBPT elements from high income countries (e.g., Murray et al., 2013). In addition, several of these research trials have

delivered EBPTs by training lay-workers or task-sharing psychological services with community health workers. As a result of these efforts, many patients demonstrated symptom reductions and improved coping with stressors when receiving care in these LAMIC settings (Bolton et al., 2003; Kaysen et al., 2013; Murray et al., 2013; Patel, Weiss et al., 2011; Patel et al., 2017). For example, survivors of torture and systematic violence in Iraq and Thailand who received cognitive-behavioral treatment (CBT) showed significant improvements in symptoms of depression and posttraumatic stress, as well as daily functioning (Murray et al. 2013). CBT also resulted in improvements in post-partum depression for mothers in Pakistan (Rahman et al., 2008), while interpersonal therapy led to significant reductions in depression and anxiety for patients in Uganda and India (Patel, Weiss, et al., 2011). Further, female survivors of sexual violence in the Republic of Congo undergoing group cognitive processing therapy also demonstrated decreases in depression, anxiety, and PTSD, as well as improvements in functional impairment (Bass et al., 2013). In addition, there has been a call for the use of EBPTs in LAMICs (WHO, 2009). For example, the WHO has published and disseminated the Mental Health Gap Action Program (WHO, 2010), comprising of broad assessment and treatment recommendations that are mostly evidence-based for use with mental health disorders in LAMICs. Thus, the empirical support is aggregating that EBPTs, especially when culturally adapted, can be effective in LAMIC settings even when delivered by non-specialists.

The second question, how to best implement EBPTs in a sustainable manner, has a more complex answer given the lack of clear guidelines for LAMICs (Wainberg et al.,

2017). Evidence suggests that once EBPT trials concluded in LAMIC settings, the progress achieved in mental health care also ended (Eaton et al., 2011). Although reasons for this limited maintenance of gains may differ from country to country, commonalities across LAMICs include few resources to absorb and sustain the trained workforce and underdeveloped health care infrastructures. Many LAMIC governments have passed laws to improve their mental health care infrastructure in response to WHO initiatives (WHO, 2016; WHO Commission on Social Determinants of Health, 2008); however, without expert help, they have run into difficulties achieving these goals (Sweetland et al., 2014). Several LAMIC governments face challenges in developing their mental health system due to insufficient resources, including ones for analyzing and assessing their health systems in order to develop an infrastructure that can provide and sustain effective psychological services (Saraceno et al., 2007; Sweetland et al., 2014).

An important step for stakeholders in LAMIC health systems for implementing services and closing the gap in care includes capacity building for both providers and policy makers (Saxena, Saraceno, & Granstein, 2013; Wainberg et al., 2017). Though the focus on capacity building has typically been on academic research, the capacity of health workers and policy makers has also been noted as a crucial step for addressing barriers to services for mental health disorders and strengthening health systems in LAMICs (Hanlon et al., 2018; Semrau et al., 2018; Wainberg et al., 2017).

Recent research has pointed to the need to embed efforts of implementation of mental health care into a country's existing health care system (Semrau et al., 2015; Semrau et al., 2018) through the collaboration of mental health experts and governments

(Sweetland et al., 2014). An example of the collaboration between governments and mental health experts is the Emerging Mental Health Systems in Low and Middle Income Countries program (EMERALD; Semrau et al., 2015). This research program is ongoing and aims to develop the best practices for increasing the coverage of care for mental health services in LAMICs while assessing and building capacity. One application of EMERALD is a pilot program embedding mental health treatment into primary care in a high-need, sub-region of Ethiopia. The Ministry of Health (MOH) in Ethiopia partnered with researchers and was able to successfully include mental health services within primary care in one region of the country by developing a mental health plan, improving demand, access, and care in community facilities in collaboration with local partners (Lund et al., 2012; Fekadu et al., 2016).

Secondly, the EMERALD researchers also studied sustainability of their collaboration by assessing their implementation efforts and capacity building. This pilot effort highlighted the importance of studying variables related to implementation of services, including pre-implementation readiness and implementation satisfaction and feasibility (Fekadu et al., 2016). Even though this project was on a smaller scale compared to a country's full mental health system, it provides some important lessons for future efforts, especially when considering the scarcity of research in implementing mental health services at a system level in LAMIC settings. Thus, the importance of evaluating capacity in a setting prior to implementation is apparent from the EMERALD project (Hanlon et al., 2018; Semrau et al., 2018).



In addition, research in implementation from high income countries also highlights the importance of pre-implementation assessment of a setting that may provide some helpful guidelines for LAMICs. As noted above, pre-implementation assessment of capacity and key context variables help stakeholders with implementation, capacity building, and increasing coverage of care in an effective manner (Semrau et al., 2018). Many models and frameworks have been developed for translating research into practice through implementation efforts in high income countries (Brown et al., 2017; Tabak, Khoong, Chambers & Brownson, 2012). One such framework is Exploration Preparation Implementation and Sustainment (EPIS; Aarons, Hurlburt, & McCue Horwitz, 2011), which identifies important stages over time for implementing evidence-based care, starting with the exploration phase. This first phase prioritizes assessing both outer context (e.g., policy, funding) and inner context (e.g., organization characteristics) of a broader health care system or organization. The exploration phase typically precedes the preparation phase where the implementation and other strategies are introduced across the outer and inner contexts at various levels of stakeholders within a system (Brown et al., 2017).

Similarly, based on research in high-income settings, Stetler and colleagues (2006) recommend a formative evaluation of a system or institution prior to implementing interventions within it. The authors refer to this process as formative research when an intervention has not been selected for implementation. Formative research typically starts with a diagnostic analysis of a setting or system, similar to the EPIS exploration phase, by assessing a) how far removed the system is from best-

practices, b) determinants of current practice, c) potential barriers and facilitators to changing practice and to implementation of new interventions, and d) the strategy feasibility, including perceived utility of a project or intervention. The first two parts of the diagnostic analysis may be only partially applicable to LAMICs given the scarcity of mental health services in many of these settings. However, the latter two parts of the analysis may be key for pre-implementation stages of understanding LAMICs' systems.

Research in global health in LAMICs has been criticized for under reporting important contextual and implementation factors (Luoto, Shekelle, Maglione, Johnsen & Perry, 2014). Yet, defining context in the dissemination and implementation literature has proven difficult. Context differs from setting in that the latter is typically a specific physical location where an intervention is introduced. Context, on the other hand, is comprised of dynamic and unique factors that surround an implementation effort, including setting as well as roles, interactions and relationships (Pfadenhauer et al., 2015). Contextual factors include stakeholders from various levels of a health system from the recipients of mental health care all the way up to the policy makers and government officials. It is key to compare and contrast how these different levels interact with one another through a pre-implementation formative research effort (Luoto et al., 2014). It is equally important to understand the context where interventions may be implemented, including outer and inner context factors that may affect its success (see EPIS framework description for more information on these).

Several steps appear crucial in order for those leading government systems in LAMICs to translate their needs and their policies into effective and sustainable mental

health care services, as suggested by the pilot work in Ethiopia through the EMERALD program and more broadly implementation research from high income countries, including EPIS framework (Aarons et al., 2011; Semrau et al., 2015). The first, and perhaps most important, step is a thorough assessment of the existing system's capacity to implement EBPTs. An important aspect of assessing the system prior to implementation is understanding a system's context by determining the specific barriers and facilitators at different levels of the system within a particular system. These barriers and facilitators can relate to EBPTs specifically or *to mental health services more broadly*. In addition, these barrier and facilitators can be specific to only one group of stakeholders (e.g., service users) or to the interaction between stakeholder levels (e.g., leaders and providers). In order to ascertain the specific barriers and facilitators that will impact service provision, governments can work to identify and address each of these within their own unique systems based on common factors from implementation efforts in similar settings.

Research on barriers to effective implementation of mental health interventions in post-conflict LAMICs is more limited than the literature for high-income countries; however, several researchers have documented key barriers and facilitators at various system levels (e.g., patient/recipient of care, practitioner, clinic, organization, governmental/policy) in these settings. Specifically, barriers at the government level in LAMICs include lack of public health knowledge regarding the challenges of mental health disorders and stigma toward these disorders by government officials (Abayneh et al., 2017; Acharya et al., 2017; Patel, Chowdhary, Rahman & Verdeli, 2011; Murray et

al., 2014). At the provider level, common barriers in these settings include low levels of training, lack of support structures for providing care, and lack of facilities for provision of services (Abayneh et al., 2017; Patel, Chowdhary et al., 2011 Murray et al., 2014). In addition, attitudes toward evidence-based care have been shown to be important in implementation efforts in high income countries (Shafran et al., 2009). Thus, in middle income countries with higher number of trained mental health professionals, attitudes toward more structured treatments may be important to assess. At the patient level, barriers include transportation difficulties, self-stigma, low socio-economic status, lack of a culture of involvement in health care, and lack of trust in the government (Abayneh et al., 2017; Murray et al., 2014; Samudre et al., 2016). Unfortunately, research on facilitators is more limited in LAMICs. One study by Abayneh and colleagues (2017) reported that facilitators at the system, provider, and patient levels in LAMICs respectively include willingness to enable national policy geared toward scaling up mental health services, willingness to collaborate with patients to improve care, and willingness to be involved in their care. It is important to note, however, that barriers and facilitators may vary across countries and health systems. Identifying the specific barriers and the facilitators for a given health system at these various levels is vital to increasing mental health services on a large system based-scale once introduced (Semrau et al., 2015).

In addition to efforts to solidify mental health infrastructures, LAMICs may benefit from considering more efficient types of treatments, such as EBPTs. These types of treatment have the most scientific support among mental health interventions and have

produced improved patient outcomes through randomized-controlled trials, the gold-standard for intervention research, in both LAMICs and high income countries (Singla et al., 2017). In addition, EBPTs are cost effective and have led to substantial mental health and economic benefits when scaled-up across high-income country's health system (e.g., United Kingdom; Clark, 2018). Given the beneficial mental health outcomes that typically result from these treatments in LAMICs and the success in scaling up these treatments in high income health systems, implementing these services may be most beneficial to LAMICs in terms of improving mental health outcomes in an efficient and cost-effective manner (Clark, 2018; Murray et al., 2014). In addition, the recently published Commission on Global Mental Health and Sustainable Development (Patel et al., 2018) recommends adopting the balanced care model, which is an evidence-based blue print to important variables and considerations in low-, middle-, and high- income settings (Thorncroft & Tansella, 2013). The Commission highlights that in low-resourced settings, the primary priority is to increase coverage of evidence-based care to the most individuals (Patel et al., 2018). Therefore, the capacity that exists within mental health systems to increase the coverage of care, especially EBPTs, across various settings is very important (Wainberg et al., 2017).

In summary, LAMICs face many challenges to providing mental health services in closing the gap in care, some that are common among countries and others that are specific to the individual country. As a result, it is important to assess the capacity of a healthcare system of a particular LAMIC to determine barriers and facilitators that will affect implementation of evidence-based services and their sustainability.

## **Colombia**

Colombia is an example of a post-conflict middle-income country with a wide gap in mental health care between those in need and those receiving services (Richards et al., 2011). Colombia has the largest number of internally displaced persons of any country in the world, most of whom have faced numerous traumas (La Mesa Psicosocial, 2016). In fact, there are over eight million victims, defined as individuals who reported victimization (e.g., human rights violations) as a result of the armed conflict, that have registered with the government (Victims Unit, 2017). Unfortunately, epidemiological information about victims specifically is not available (Idrobo et al., 2018). However, considering the significant impact of the social stressors that many victims have undergone (i.e., trauma and displacement), estimates suggest that a number of them are suffering from depression, anxiety, and/or post-traumatic stress disorder (PTSD; Richards et al., 2011). In addition, recent estimates suggest that victims are at least 5.1 times more likely to suffer from PTSD than non-displaced individuals (Lagos-Gallego, Gutierrez-Segura, Lagos-Grisales, Rodriguez-Morales, 2017). Therefore, the need for care for these persons is critical.

In addition, the Colombian government recently signed a peace treaty in 2016 ending a more than 50-year armed conflict with rebel forces. Included in the treaty were negotiated funds for mental health care. However, this is not the government's first attempt at increasing psychosocial treatment for victims. Prior to the peace treaty, in 2011, the Colombian government passed Law 1448 to make reparations for human rights infringements committed during the armed conflict and included the provision of

psychological services. As result, several programs were created outside of the formal health system to provide services to victims swiftly. The formal Colombian health system provides universal healthcare by combining public and private delivery of health care through public and private health insurance companies that function like managed-care companies in the United States (Webster, 2012). Individuals who fall below a certain income level are part of the subsidized regime but they choose an insurer, or Entidad Promotora de Salud (EPS, meaning health-promoting entity). These EPS-es bundle services, including health workers hired by the companies to provide care. Under Law 1448, victims should be able to access care both through the formal health system and through the transitional programs developed to meet their needs more rapidly.

One transitional program of care, Psychosocial Care and Comprehensive Health for Victims of the Armed Conflict (Spanish acronym of PAPSIVI) was developed specifically to provide services to victims through a decree from the MOH. PAPSIVI program has the following aims: 1) comprehensive healthcare including psychosocial care for victims of the armed conflict, 2) care based on coordinated strategies for implementation between different local governments, with the collaboration of the victims and their organizations, 3) training to increase human resources in this area, and 4) tracking and monitoring efforts to utilize as feedback for improvements (Ministry of Health, 2018).

Despite the promising aims of this initiative, preliminary reports suggest that the program has not had a wide reach (La Mesa Psicosocial, 2016). In its application, the program consisted mostly of providing supportive sessions (eight in total) to victims.

Specifically, an evaluation of the program completed by La Mesa Psicosocial, a consortium of victims' organizations, found that information about PAPSIVI was not well-disseminated to victims and the program was understaffed. This consortium of organizations made several general recommendations in their report, including the importance of developing services for victims with victims' cooperation in order to fully meet this population's needs. However, the suggestions for services were broad and stated that victims would benefit from effective care that was developed with their input. Overall, this report suggests that the PAPSIVI program may not have ensured an effective and sustainable implementation of services with sufficient coverage. Similarly, there have not been any program evaluations efforts that provide scientific evidence of their benefits (Idrobo et al., 2018). As a result, the current situation in Colombia is well-suited for a scientifically-informed assessment of the capacity of the existing system in order to inform future implementations of EBPTs for victims suffering from common mental health disorders.

### **Current Study**

The primary goal of the current study is to assess the capacity of the Colombian health system to implement evidence-based psychological mental health care services for victims of the armed conflict suffering from anxiety, mood, and traumatic stress disorders. This study focused on two criteria of formative research of the Colombian health system, identifying barriers and facilitators at different levels of the system as well as the perceived utility of evidence-based care at these different levels (i.e., the last two criteria from Stetler et al., 2006). The goals of the study will be reached by utilizing



qualitative (i.e., semi-structured interviews) and quantitative (i.e., self-report measures) methods to gather necessary information directly from key stakeholders in the Colombian mental health care system (e.g., government officials, providers, victims/patients).

**Study aims.** Standard practice in implementation exploratory research utilizing qualitative methods dictates identifying relationships between phenomena instead of testing *apriori* hypotheses (Beidas, Mehta, Atkins, Solomon & Merz, 2013). Given the exploratory nature of the present study, several aims were identified and no *apriori* hypotheses were included. Study aims were as follows:

***Aim 1.*** Identify barriers to implementing evidence-based psychological services across stakeholder groups in Colombia for those suffering from the sequelae of violent armed conflicts by utilizing mixed methods.

***Aim 2.*** Identify facilitators to implementing evidence-based psychological services across stakeholder groups in Colombia for those suffering from the sequelae of violent armed conflicts by utilizing mixed methods.

***Aim 3.*** Compare barriers and facilitators to implementing evidence-based psychological services across stakeholder groups in Colombia for those suffering from the sequelae of violent armed conflicts by utilizing mixed methods.

***Aim 4.*** Identify stakeholder (i.e., leaders, providers, patients) preferences for focus and delivery of psychological evidence-based mental health services.

## **Method**

### **Study Design**

Qualitative design methods were utilized for the present study given the exploratory nature of the aims. These methods of data collection and analysis are standard practice in the fields of dissemination and implementation for characterizing a new target context or population. In addition, quantitative methods were included to confirm and bolster qualitative methods as an additional way of exploring these questions (Palinkas, Horwitz, Chamberlain, Hurlburt, & Landsverk, 2011).

### **Recruitment and Sampling Strategy**

Recruitment occurred across stakeholders at various levels of involvement in providing care to victims of the armed conflict. Purposeful sampling, common in mixed-methods research, focused on broad inclusion of assorted stakeholder within each level with an emphasis on dispersion (Palinkas et al., 2015). This strategy was adopted in order to conduct a thorough investigation of barriers and facilitators to implementing EBPTs, including stakeholder perspectives of these services. Recruitment targets were identified in collaboration with Colombian researchers working at Los Andes University who also gave permission for the principal investigator (PI) to recruit from their study patients. In addition, leaders and providers who participated in the study were asked to refer others from their professional networks who worked with victims. Permission was also granted to contact administrators within PAPSIVI for participation. In addition, PAPSIVI administrators informed their providers in Bogota about the study and those that were interested in participating were contacted.

Leaders were recruited from government officials, governmental administrators, non-governmental organizations (NGO) leaders, and academic experts on mental health and psychosocial interventions. Unfortunately, despite several efforts to identify and contact individuals providing care to victims through the general health system (i.e., EPS-es), no contacts were reached in large part because few contacts were available to the PI. Health centers are somewhat independent and due to the limited time and resources available for a dissertation, greater outreach to these centers was not possible. Of the 24 individuals in leadership positions who were contacted and asked to participate in the study, 13 of them responded and agreed to participate.

The second group, providers, were recruited from PAPSIVI, international and local NGOs involved in treating victims, rural town providers, and an academic research project. Of the 15 providers who were contacted to participate in the study, 11 of them responded and agreed to partake. Lastly, victims who received mental health care were recruited from PAPSIVI, a rural town government clinic, and an academic research project. Of the 15 victims who indicated interest in the study and were contacted for participation, 11 agreed to enroll and complete the study. Overall, sample sizes were based on previously published research recommendations for qualitative data (e.g., Guest, Bunce & Johnson, 2006 recommendation of sample size of 12) and were limited due to time and resource constraints available for a dissertation study.

### **Participants**

Data were collected from 35 stakeholders at various levels of care institutions for victims of the armed conflict (see Table 1 for sample demographics). Participants

consisted of three stakeholder groups: mental health system leaders (n = 13); providers that treat victims (n = 11); and victims that received services (n = 11). All study participants were recruited between July and September 2017. Participants who enrolled in the study, completed procedures approved by the Boston University Institutional Review Board (IRB).

Victims identified predominantly as female (n = 9) and as male (n = 2). They were an average age of 48.27 (*SD* = 14.49) and identified as “mestizo” (n = 7), a commonly used term in Colombia and other Latin American countries for individuals of more than one race that make up the majority group within a society, “Afro-Colombian” (n = 3), or declined to respond (n = 1). The majority reported their marital status as single (n = 6), with several others indicating their status as married or cohabitating (n = 3), or widowed (n = 2). The majority of individuals completed high-school or technical school (n = 5), with some completing elementary school (n = 3), college (n = 2), or no schooling (n = 1). They represented various Colombian regions of origin (e.g., Caldas, Choco, Cundinamarca, Tolima, and La Guajira). Victims were those individuals who: received services from a research study of an EBPT at a university in Bogota (n = 5); received services from PAPSIVI (n = 4); or received services from a rural small town government sponsored care provider (n = 2).

Providers consisted of mostly individuals that identified as female (n = 8) and as male (n = 3). They were an average age of 38.27 (*SD* = 7.35) and identified “mestizo” (n = 4), “Afro-Colombian” (n = 1), or did not respond (n = 4). Providers consisted of psychologists (n = 3), clinical psychologists (n = 2), organizational psychologist (n = 1),

and undeclared (n = 5). Providers were from the following settings: providers who cared for victims through a research study at a major university in Bogota (n = 3); providers who cared for victims through PAPSIVI (n = 4); providers who cared for victims through NGOs (n = 3); and one governmental provider who cared for victims in a rural town (n = 1).

Leaders (n = 13) identified as female (n = 7) and male (n = 6) with a group average age of 33.46 ( $SD = 4.79$ ). The majority of individuals identified as “mestizo” (n = 8), with one individual identifying as “indigenous” (n = 1) and several others choosing not to respond to the question (n = 4). Leaders identified as psychologists (n = 3), social psychologists (n = 2), social workers (n = 2), and undeclared (n = 6). Leaders were predominantly from governmental organizations involved in providing care to victims (n = 10), two individuals were from NGOs who worked with governmental institutions in helping shape policy and care for victims, as well as one academic who was involved in victims’ care research and had worked with the governmental programs in this area.

## **Measures**

A summary of the outcome measures as they correspond to participant type can be seen in Table 2.

**Qualitative measures.** Semi-structured interviews, based on implementation frameworks, were administered to all stakeholders. Interviews focused on assessing capacity for implementation of EBPTs, including barriers and facilitators *to services generally and EBPTs specifically*. A standard definition of EBPTs (see Appendixes) were

used for each stakeholder group. Frameworks were utilized to guide interview questions (see below for more information). Interviews were conducted with all participants and ranged from 22 minutes to 127 minutes in duration, averages were as follows: 67.5 ( $SD = 27.2$ ) for all group, 79.1 ( $SD = 22.8$ ) for leaders, 84.5 ( $SD = 16.4$ ) for providers, and 36.8 ( $SD = 9.8$ ) for victims of the armed conflict.

**EMERALD.** Government policy makers' and administrators' views of barriers and facilitators to implementing EBPTs were assessed with interview questions developed for the EMERALD program (Semrau et al., 2015). Though these questions were not developed utilizing the EPIS framework, many themes from the EMERALD leaders' interview questions overlap with EPIS exploration themes (Aarons et al., 2011). Given that the EMERALD program was specifically designed to better understand capacity building for sustainably implementing services in LAMICs, it was utilized for assessing leadership's views of important system variables in Colombia (Semrau et al., 2015). This measure has been used across LAMICs (e.g., see Upadhaya et al., 2017) with interview questions for government policy makers and administrators in LAMICs. Even though EMERALD program focused on the implementation of mental health services in primary care settings, the questions from this research program were chosen due to the rigor and depth of assessing capacity to provide services and implementation factors in LAMICs. The interview questions have been made available by EMERALD researchers to the PI via electronic correspondence (see Appendix A). Minor changes were made to the original semi-structured interview to remove discussion of integration of mental health into primary care since that is outside the scope of this study.

**EPIS.** EPIS (Aarons et al., 2011), a widely known implementation framework, was utilized to guide interview questions to assess the views of care providers and victims on barriers and facilitators to evidence-based mental health care services. This study focused on the exploration phase of EPIS and its themes for the outer and inner context. The outer context themes for exploration phase include: sociopolitical context (e.g., legislation, policies, monitoring and review), funding (e.g., services grants, research grants, foundation grants, continuity of funding), client advocacy (e.g., consumer organizations), and inter-organizational networks (e.g., direct networking, indirect networking, professional organizations, clearing houses, technical assistance centers). The inner context themes outlined in EPIS exploration phase include organizational characteristics (e.g., absorptive capacity, culture, climate, leadership) and individual characteristics (e.g., values, goals, social networks, perceived need for change). EPIS has been primarily used to assess implementation efforts in high-income countries, though it is a flexible framework that may be utilized for LAMIC contexts. See Appendixes B and C for interview questions as a function of EPIS. Overall, semi-structured interviews were utilized to inquire about relevant areas where barriers and facilitators may be pertinent in addition to broadly asking stakeholders to identify barriers and facilitators to implementing EBPTs.

In addition, an iterative approach was utilized for all semi-structured interview questions. As data collection proceeded, a few questions were modified or added to capture the most relevant information. For example, participants were asked to define the difference between psychosocial and mental healthcare treatment given that some

providers and leaders pointed to a distinction between the two. This procedure is in line with standards of qualitative data collection in high income as well as LAMIC settings (Abayneh et al., 2017). However, no standardized follow-up probe questions were developed.

**Quantitative measures.** In addition, all participants were asked to fill out brief quantitative measures to further bolster information from interviews. Questionnaires varied by stakeholder group.

***Brief Internalized Stigma of Mental Illness (Brief- ISMI).*** The Brief-ISMI (Boyd, Otilingam & DeForge, 2014) is a 10-item version of the 29-item Internalized Stigma of Mental Illness (ISMI) that was administered to stakeholders who were victims. This measure examines the extent that individuals with mental illness internalize negative messages, stereotypes, and biases about themselves based on societal negative attitudes and discrimination. The measure has adequate internal consistency, reliability as well as external validity in relation to depression, self-esteem, recovery orientation, perceived devaluation and discrimination, and empowerment (Boyd et al., 2014; Hammer & Toland, 2017). A validation of this measure with Colombian samples was not available at the time this study was conducted. This measure was chosen given the identification of stigma as a potential barrier in LAMIC settings (Sweetland et al., 2014).

***Client Satisfaction Questionnaire (CSQ-8).*** CSQ-8 (Attkisson & Zwick, 1982; Larsen, Attkisson, Hargreaves, & Nguyen, 1979) assesses patients' satisfaction with mental health treatment that they received. This measure was administered to victims who had received care and participated in this study. A Spanish version of the measure



was developed in the United States with Spanish-speaking individuals (Roberts, Attkisson, & Mendias, 1984). The measure was tested with Mexican Americans, Cuban Americans, and Puerto-Rican Americans and showed high internal consistency (Roberts et al., 1984). Similar to other measure, psychometric properties of this measure with Colombian patients or with victims of the armed conflict are not available to date.

***Evidence- Based Practice Attitudes Scale-15 (EBPAS-15)***. The EBPAS-15 (Aarons, 2004) is a validated measure that assesses attitudes of mental health provider toward incorporating EBPTs into their practice. This measure was administered to stakeholders who were providers of care. These attitudes can be instrumental for determining if providers can serve as a facilitator or barrier to implementing quality psychological care. The EBPAS has four subscales: 1) willingness to uptake evidence-based interventions, 2) willingness to adopt mandatory new practices, 3) an open and accepting attitude toward new interventions, and 4) perceived differences between treatments developed in research settings and ones in community settings. Statements are rated on 0 (“not at all”) to 4 (“to a greater extent”). Overall, this measure has shown good internal consistency and reliability (Aarons, 2004). Of note, this measure has been validated for providers in United States but not with Colombian clinicians. No psychometric indices are available for the population in the present study.

***EMERALD Priorities for Capacity-Building Questionnaire***. The Priorities for Capacity Building scale developed for the EMERALD initiative was administered to government officials/policy makers, system administrators, and NGO leaders. Given the documented gap in public health knowledge of mental health challenges in leadership in

LAMICs, this measure was utilized to analyze the areas that stakeholders at the leadership level valued. This measure asked stakeholders in leadership positions to rank the relevance of a number of mental health system priorities for capacity building (e.g., evidence-based mental health care planning, anti-stigma campaigns). Responses are rated on a scale of 1 (“irrelevant”) to 5 (“an essential need”) for items that fall under following subscales: 1) mental health policy, planning and program development, 2) mental health systems, 3) mental health service implementation, and 4) mental health research. An example of an item under the third subscale (mental health service implementation) is “Developing partnerships with patients to involve them in quality control.” This measure has not been validated and no psychometric properties are available. The measure was made available to the PI from an EMERALD program researcher via electronic correspondence.

### **Study Procedures and Data Collection**

The PI traveled to Bogota, Colombia and completed all interviews and data collection during summer of 2017.

**Instrument translation procedures.** All study semi-structured interviews and measures were translated into Spanish in accordance with the rigorous steps delineated by Van Widenfelt and colleagues (2005). All measures were independently translated into Spanish by two Colombian graduate students studying psychology, who treated victims as part a clinical trial in Colombia and completed a summer semester of study at a university in the United States. Both students are native Colombian Spanish speakers and are fluent in English. In addition, both students had sufficient familiarity with the victims

of the armed conflict and the Colombian services for victims from treating victims. Following the initial translation, the PI and two graduate students met, identified, and discussed discrepancies in the Spanish translated documents until agreement was reached for each disputed area.

After a final Spanish version of each measure was derived based on both students' agreement, semi-structured interviews and measures were then translated back into English by the study translator in Colombia. The back-translated documents were compared to the original English version by the study translator and study PI, who identified discrepancies between these two versions. After discrepancies were identified, the study translator and PI revised sections of Spanish versions to be consistent with the intended meaning of the English questions. Finally, the modified version of the Spanish measures was reviewed by specialists working with victims at Los Andes University, and their suggestions for changes were incorporated to maximize clarity of language. The final Spanish version derived from this process was utilized for all interviews conducted in and questionnaires administered in Spanish.

**Interview procedures.** The majority of interviews were conducted in Spanish with a translator. Interviews were conducted by a native speaker to ensure reliability between interviews. In addition, the PI also speaks Spanish fluently and was present to clarify and follow-up on material covered during interviews, at times with the help of the translator. All interviews were audio recorded on two recorders. The translator, two undergraduates whose native language is Spanish, and the PI transcribed all audio recordings verbatim in the Spanish language. All transcription documents were then

checked for accuracy by one of the transcription team members that did not complete the original transcription. Of note, two interviews were conducted in English for two study participants whose English was fluent.

**Participant compensation.** All participants received a gift certificate or cash payment for study participation that consisted of \$15. In addition, victims received travel reimbursement for the cost of transportation to and from the study site at an urban university in Bogota or city hall in a rural area. All participants provided verbal consent, as approved from the Boston University IRB.

### **Data Analytic Plan**

All qualitative interviews transcriptions were coded utilizing NVivo 12.1 software for themes related to barriers, facilitators, and perspectives on EBPTs. A theme represents a pattern of responses within the data that is pertinent to the research question (Braun & Clarke, 2006). As such, key research questions and theory guided all aspects of the qualitative analyses. A thematic analysis was undertaken which used a combination of inductive and deductive methods (Braun & Clarke, 2006) to develop a codebook of themes. Conceptualization of the interrelationships among minor themes to identify major themes took place in discussions among the PI and two undergraduate level coders trained by the PI. Coding underwent continuous refinement through comparison with previously coded interviews using line-by-line coding. Themes for each stakeholder group were coded independently and then compared by the PI with each undergraduate coder until a consensus was reached. All data were analyzed in Spanish and each interview was coded by two coders, the PI and one of the undergraduates.

In addition, information from qualitative (i.e., interviews) and quantitative (i.e., questionnaires) measures was analyzed to explore study aims. The function of exploring several of the same aims with two different methods was convergence of the data through triangulation, the simultaneous exploration of one data method to confirm findings from another method of data (Denzin, 1978; Leech & Onwuegbuzie, 2009; Palinkas et al., 2011). The qualitative and quantitative outcomes were analyzed and presented separately, but were integrated and compared for points of convergence and divergence for the following aims 1) leadership's views of areas that require capacity building within the mental health system; 2) provider's perspectives of evidence-based care; 3) victim's views of internalized stigma and the care that they received.

**Saturation/conceptual depth.** A methodological guideline in qualitative data analyses, saturation, is typically utilized to steer data collection and analyses of themes (Nelson, 2016; Saunders et al., 2018). Given that saturation has been inconsistently defined in qualitative research and that there is no fixed point where completeness is achieved, Nelson (2016) has proposed assessing conceptual depth, which is defined by the following criteria: 1) a range of evidence supports themes, 2) complex connections between themes, 3) subtlety in meaning adds to richness of themes, 4) results align with previous literature and findings in an area, meaning there is resonance, 5) results display external validity. Saturation and conceptual depth were not used to steer data collection, but these criteria were utilized to identify conceptual depth of themes for the present study.

## Results

Common themes were identified that were related to stakeholders' perceptions of EBPTs as well as barriers and facilitators that may influence the implementation of these services. If a theme was prevalent across the majority of at least one stakeholder group (e.g., most providers), then the data were included here. Themes related to barriers and facilitators to capacity for implementing EBPTs are presented in three broad categories (i.e., system, organization, and service-user levels) while themes for EBPT preferences and quantitative data are presented by stakeholder group (i.e., victims, providers, leaders). In addition, themes were compared between stakeholder groups, as noted in Aim 3. Lastly, stakeholders scores on relevant quantitative measures are also compared to relevant themes in this section.

### Stakeholders

**Victims.** Responses from victims (n = 11) who participated in the present study were examined for common themes related to both barriers and facilitators to seeking and receiving care in the Colombian health system for victims. In addition, interviews were coded for themes related to views of EBPTs and service delivery preferences. Most of the interviewed victims received individual care (n = 8), an additional two victims received family care, and one victim attended a community workshop and a session of supportive care with a psychologist working with the mayor's office in a small rural town.

**Providers.** Common themes were identified from interviews with providers (n = 11) in relation to barriers and facilitators to implementing care in the Colombian mental health system for victims of the armed conflict. In addition, interview data from providers

were coded for views of EBPTs and preferences for service delivery. Providers consisted of those involved in psychosocial care through governmental programs, NGOs, or EBPTs through academic research.

**Leadership.** Transcribed interviews from a number of government officials, administrators, NGO leaders, and academics (n = 13) were coded for themes. These stakeholders provided their perspectives based on their involvement with programs for psychosocial care for victims of the armed conflict. Common themes were coded when related to barriers or facilitators that affected leaders' ability to implement services or victims' access to services - especially EBPTs.

### **Barriers**

In accordance with the first and third aims of the present study, themes were identified related to barriers to implementing services, including EBPTs, within and across stakeholder groups. Several of these barriers were broadly applicable to psychosocial interventions and others were specifically related to EBPTs. Despite this distinction, all themes related to barriers are reviewed together (see Table 3 for a summary of themes by stakeholder group). Barrier-related themes were organized into three broad categories: system, organizational, and service-user levels. System level includes all themes that are related to barriers faced by victims that exist across the various institutions and organizations charged with providing them care (i.e., from national laws to access to care). Organization level barriers include themes that were relevant to institutions and organizations providing care to victims. Lastly, service-user

level encompassed those themes that related to barriers in victims' daily lives or to individual variables that made seeking and receiving services challenging.

**System level barriers. *Barriers to access to care across the health system.*** A prevalent theme that was identified across stakeholder groups (n = 27) was the low access to care for victims. Among victims (n = 8), this theme centered around systemic barriers to access, such as long waits for care, lack of follow-up when requesting care, and lack of available care in rural areas. Five victims noted attempting to seek services through various institutions, only to be turned down, referred to another institution, or placed on a waitlist without ever hearing back. In addition, they noted gaps in directions for navigating a complex system, including filling out and tracking burdensome paperwork. An example of the difficulties of access to care is described below:

[I sought care] with the Victims' Unit and with the High Office [of Bogota] but the High Office had given me some support so then there no, I had closed the loop with them and they could not give me help. And, at the Victims' Unit, they told me that they no longer had the program or something like that...that they could not see me. No, they did nothing. ...[later] I went to the CLAV because I wanted them to help her [my sister] ...which they never ended up helping her. I was disappointed. But, there through PAPSIVI I heard a talk there in the waiting area and they told me that they were doing these projects and I told them that I wanted to be included and my sister to be included because I was feeling anxious and I was not sleeping well and that is how I got involved in the program. (Victim, Psychosocial care recipient, Female)

The theme of barriers to access was also common across providers (n = 8). They noted limited access for psychosocial care as well as mental health services within the formal EPS system (i.e., for complex or severe cases). Providers reported that victims could not easily access mental health services within the official mental health system due to long waits, short visits, and differing mental health professionals at each visit. As a



result, most providers noted that they referred complex cases to universities instead of the official mental health system. A representative view is as follows:

Many of them needed to be referred to a psychiatrist or clinical psychologist and we didn't have resources, or they have insurance that took a lot of time to get a psychologist or a psychiatrist. [Interviewer: through EPS? Ok, how long was the wait usually?] Yeah, sometimes you have to wait 3, 4, 5, 6 months. It was very difficult to see somebody. Because no, they weren't paying for the insurance, of course, they were subsidized. So it took a lot of time to get an appointment. And that was really a problem for our project but mostly, but for them especially. (EBPT provider, Female).

In addition, a majority of those interviewed at the leadership level (n = 11) noted that difficulties in accessing services for victims were present both through the official mental health system (i.e., EPS) and programs geared toward psychosocial services. The latter are only available 6 – 10 months of the year, and when they are available, victims may have to wait one and a half months to be seen. Districts outside of the capital and other major cities may face additional barriers due to low availability of services in those areas. Some leaders also noted that victims face institutional barriers to accessing care that are compounded by their circumstances as displaced persons. An explanation of the low access to care from a stakeholder at the leadership level follows:

Ok, the system exists. By law, the people do have the right to have health treatments, but they have to navigate the systems and especially for victims that have been displaced by the conflict, when they arrive to a new city, like getting connected to that system is tough. (Leader, Academic expert, Male).

***Poor implementation of laws, policies, and programs.*** A prevalent theme among providers and leaders (n = 16) included the limited development of policies and translation into satisfactory programs. Among providers, this common theme was centered around care programs not responding to true priorities. Many providers (n = 7)

noted that programs may fall short due to changes in political leadership or uninformed decisions by leaders that ignore real needs. One provider stated:

Let's say that the laws have strong conceptual support but what happens is that they are not applied concretely. So then, they create programs, but programs do not have sufficient coverage, or funding, or permanent professionals that would allow them to effectively treat all individuals and to do so in an adequate way. (NGO psychosocial provider, Female).

Similarly, most stakeholders at the leadership level (n = 9) pointed to either broad or specific deficits in the application of laws of mental health care relevant to victims. They noted that the judicial branch of government has ruled to enforce laws that were not put into effect by governmental institutions. In addition, most districts outside of the capital, may face even greater gaps between laws or public health policies and their implementation. For example:

In the territories, these strategies are not always effective or always applied. In addition, in other words, there are municipalities in which it is very difficult for territorial entities, in this case mayors' offices, to fulfill the need of all victims that are there that need psychosocial care. So, many of them never receive care, not when the events happen, nor years after. (Local government leader, Male).

***Low allocation of funds.*** The low availability of funding for care was another theme from stakeholders at the provider and leadership levels (n = 18). Stakeholders reported that allocated funds for services are a major barrier to providing sufficient coverage and quality of care for victims. Providers (n = 10) noted that low funding leads to several problems, including reduced coverage, reduced number of employees, low wages, and interruptions in care. One provider stated:

...then there has been a decrease in providers if funding decreases. Let's say that I would like to reach all localities within Bogota, but we can only rely on each center like this one, there are only 8 of us, and only car for all of us. (Psychosocial provider, Female).

According to leaders (n = 8), insufficient allocation of funds is problematic for providing adequate coverage of care. Also, low funding may be particularly challenging for rural areas where mayors are in charge of assessing needs, implementing psychosocial care, and funding both of these activities in accordance with technical guidelines from the MOH. In addition, several leaders noted that funding would likely be a barrier for implementing EBPTs given their initial training and implementation costs. An example discussing low funding broadly:

For psychosocial [care], there are two complex situations. The first, the source of funding. They are insufficient. We have said this in many places. The resources that are made available not only for general care, [but also] for implementing public policies for social assistance and reparations to victims are insufficient. Yes? They are scarce. (National government official, Male).

*Low regulation of quality.* Insufficient quality assurance of services for victims was a prevalent theme among leaders (n = 10) and some providers (n = 5) and victims (n = 4). Leaders noted that existing regulatory bodies should be strengthened to ensure service quality both through the official health system and transitory psychosocial programs for victims. A representative quote is:

...these mechanisms, yes, of control, related to obstacles in accessing health care that EPS-es administratively and IPS-es as service providers in health place, mechanisms of monitoring and control should be strengthened. Also for psychosocial care, including mechanisms for supervision of professionals who provide psychosocial care and their qualifications... (National government official, Female).

Additionally, several leaders observed that current program evaluation practices are a barrier to gathering evidence for existing services and for future efforts toward implementing EBPTs. Providers, also, noted that system leaders placed an emphasis on

coverage and volume of victims seen rather than quality of care. Lastly, some victims noted dissatisfaction with prior care through governmental organizations (e.g., length and quality of services).

**Organizational level barriers. *High provider turnover.*** A common theme at the organizational level was high turnover for providers. Stakeholders at the provider and leadership levels (n = 15) blamed contract-based employment for a high turnover of professionals in governmental organizations (e.g., PAPSIVI, Victims' Unity). They noted turnover was problematic due to cost and time spent retraining professionals and the resulting gaps in coverage from changes in personnel. Specifically, lack of continuous work was noted as major challenge for providers (n = 6). Providers also stated that funding and employment contracts led to gaps in the availability of care for victims. One provider discussed this theme as follows:

That there are changes, we do receive funding but this also affects us because we have professionals with many years of experience and also training new people again and again. This is also with the victims, because if you change people, 'I can't see a provider for three times and then the professional leaves and there arrives another one and another one and retelling them once again [my story].' (Psychosocial provider, Female).

Most leaders (n = 9) also pointed to high turnover among providers as a barrier to care coverage, resulting from contracting practices. Most providers have short-term contracts that are renewed on an annual basis. Due to contracting practices, providers may be unemployed for 2 to 6 months of the year depending on the institution. As a result, many seek employment elsewhere. One leader explained challenges with contracts:

...there is a matter of transient nature [of work] and of a form of contracting. These are barriers. We always start up in October of the previous year so that contracts can come out quickly but contracts are a nightmare, so, then, we always

finish in May or June, and signing them in August. ...So, coverage falls short or better said, in some territories almost half the year is without providers. It is a big barrier. (Government institution administrator, Female).

In addition, a few leaders noted that changes in political parties following elections often impact resources as well as who is hired to occupy governmental positions based on their political affiliation. Of note, a leader, working in a region of the country with high rates of violence due to the conflict, noted that hiring providers from the capital to transfer to these regions led to very high turnover rates.

***Availability of trained professionals.*** Many leaders (n = 7) discussed professionals' training as a barrier to care. Leaders stated that there are few mental health professionals that have received training on working with victims. As a result, program leaders dedicate significant amount of time to training activities for these providers. Leaders also noted that this barrier is magnified in other regions of the country outside of the capital. This barrier was noted both for care provided within and outside the official mental health system. Similarly, several leaders noted that few providers are trained in EBPTs and this gap would be a barrier toward implementing EBPTs. A representative quote follows:

The first barrier is the lack of capacity of professionals and this consequently is applicable also at the administrative level within institutions. But this low availability, is not only related to the low numbers of professionals, but the type of education and training that these providers have had. (NGO leader, Male).

***Facilities and reaching victims.*** Providers (n = 6) focused around a common theme that traveling to victims was at times burdensome. Providers in urban and rural areas both noted difficulties in traveling to victims to provide care. They stated that providing care in victims' homes was at times challenging due to lack of privacy from

others in the household. Providers, who worked with victims in remote areas, noted difficulties with access to rural areas due to infrastructural complication (e.g., “the road was too muddy to travel if it rained a lot”).

**Service user level barriers. *Stigma.*** A theme that was identified across stakeholders (n = 34) was that victims may be reluctant to seek or receive services due to stigma toward mental health. Most leaders (n = 12), all providers (n = 11), and all victims (n = 11) mentioned stigma about mental health as a potential barrier to accessing care for many. It should be noted that one victim of the conflict denied encountering stigma when he refers others to services, but he endorsed internalized stigma. The theme of internalized stigma in victims’ interviews was identified as shame in discussing their mental health difficulties (n = 9). Of note, all victims who received individual care and experienced shame (n = 7) noticed an improvement in their shame following treatment. An example from a victim who received treatment and noted a change in shame about her suffering is as follows:

It is like, if you had a lightness, like I was released. Now I don’t feel this fear anymore, this fear, because before, at first, I felt a lot of shame, talking about everything that I had gone through. So, but, now no more. Now, not anymore. This burden was lifted from my chest, like there was this tightness. And, now no, I feel free. Now I feel free. (Victim, EBPT recipient, Female).

Similarly, all victims stated that they experienced self-doubt due to their mental health difficulties in the past or at the time of the interview, which is also a strong indicator of internalized stigma. This internalized stigma may have served as barrier to seeking help. Once in care, a majority of victims who received individual psychological services (7 of 8 total) noted an improvement in their self-doubt. For example:

Now, I don't have these doubts. But, before I had them more, now I feel, I feel strong. I feel full of strength in terms of moving forward. I don't doubt anything. Now, with this like, strength, because I am rid of this fear, this anxiety, and in the end. Because I used to be afraid to leave the house. (EBPT recipient, Female).

Stigma as a theme emerged strongly across providers and leaders too. Their views were that victims turn down or do not seek services due to stigma related to mental health. For example:

People do not understand the importance of mental health. Yeah? Many, still you hear and still there is this understanding that if you go to the psychologist, it is because you are crazy. (Small town, government, psychosocial provider, Male).

I think that's very important and it's a really huge issue. People here, nobody says they're going to therapy, any kind. And if you say that you're going to talk to a – going to any kind of therapy, they think you're crazy. So I think that the stigma is a huge part here. (Academic expert, Male).

In addition, a theme was identified among leaders and providers about stigma within Colombian society toward victims as a group. These stakeholders noted that victims may face prejudice and discrimination if they disclose their victim status. Providers, specifically, noted that stigma toward mental health or societal prejudice toward being a victim may keep many from trusting that providers will treat them fairly or help them.

***Logistical barriers to attending care.*** A frequent theme among stakeholders (n = 21), including most victims (n = 7), providers (n = 8) and some leaders (n = 6), was that victims face many daily challenges that diminish their ability to seek or receive care. Employment, childcare, and household responsibilities were at times major barriers. Victims noted that given their precarious financial situation as displaced individuals, it was especially difficult to turn down work, find child care, or shift household responsibilities, including caregiving for elderly parents. Also, several victims noted that

hunger, working long hours, or difficulty affording or accessing housing were all factors that made receiving care difficult. In addition, almost all victims (n = 10) stated they would like help finding work or accessing available housing for victims when they were asked if they had any unmet needs following treatment. Two examples:

... well we are living a very difficult financial situation. I was working with a foundation, working to see what I could do to bring help home. And, they [government professionals] had to go to my house and I had to leave work early when I had pressure from this side to do this or this other and go to meet with them. Because, first of all, I couldn't go to them because they were very far away. And second, because as I was saying, they had to go to my house and the inconvenience of this because at my house there were a lot of people because there was my sister, all the children, my brother, everyone there. (Psychosocial care recipient, Female)

And since we are from a different community, we have to earn our living here however we can. They say we have a guarantee of no repetition [of violence against victims]. This is false. This is false because I have lived it. I have had to wake up at 2, 3 in the morning to sell recyclables, to gather what there is, where you can be stabbed for a cell phone, where they kill someone for whatever they have in their hand. I could be the victim of this. What is the guarantee of no repetition for me? Well, because they, or rather, we say don't give children fish, teach them how to fish. ... They should have clear policies for education. They should have clear policies for health for the Victim's Unit. (Psychosocial care recipient, Female).

Providers also noted that work, childcare, and other household tasks often impede victims from attending care continuously. A representative statement:

And, the dynamics of Bogota, it is very difficult because people will turn down treatment. 'I have to work; I have something I have to do.' So then, at times people don't have the time for treatment. (Governmental psychosocial provider, Female).

**Transportation.** Similarly, another related theme among stakeholders was transportation as a barrier to attending treatment. Most victims (n = 9), many providers (n = 6), and a few leaders (n = 4) mentioned transportation as a barrier due both to time



and cost of travel. All victims that identified transportation as a barrier lived in Bogota. Of note, two victims lived in a rural area where transportation was less burdensome than in Bogota, but both noted that transportation would be challenging if they had to travel to the capital to receive care given the limited availability of services in their area.

Examples of the difficulties faced by victims:

In my case, to come here, I need to have two available hours, the money for transportation to come and go, and another two hours to go back, plus the session time. Well, for me it was tough because I worked the night shift...I think it was a lot to sacrifice. (EBPT recipient, Female).

Transportation cost, both I guess because going in Bogota going from one place to another takes you one or two hours yes, it is very difficult and also money transportation, yeah, I mean with one bus I can buy a milk or other things so transportation. (EBPT provider, Female).

***Lack of knowledge about access to care.*** A common theme for all interviewed victims (n = 11), some providers (n = 5), and one leader included a lack of information about available services for victims (i.e., psychosocial or psychological) as a major barrier of access to care. In addition, three individuals noted that they considered seeking services but were discouraged by cost concerns given their unfamiliarity with governmental programs for care. An illustrative quotation is as follows:

And more information, it is missing in those centers for victims or more advertisements and notices to people that here is PAPSIVI. Many times, one has to be an intermediary, so that, I alone, I brought 20 people personally. I told them, "Go, brothers, because this is free. It [care] improves your mood." So, more information from the government, this is missing. (Psychosocial care recipient, Male).

***Lack of trust in the government.*** A theme from the majority of victims (n = 7) was victims' lack of trust in the system to provide psychological care. In addition, two other victims stated that they were disappointed with the government's response to

victims' needs but that they had faith in governmental institutions' capacity to provide appropriate care. However, two victims stated that they had full confidence in the government. An example of one of the victims who held a majority view:

Because the government, or rather, they, the government hasn't brought us this help. They haven't brought us, to say, the victims need psychologists, they need, no. In this aspect they have not done a good job. If I hadn't participated in this program [research study], I wouldn't have been able to go on. From the government, I wouldn't have been able to get help, the truth is no. ... Because it has not been seen, there has not been a woman who has said, "The government sent me a good professional for my problem." I have not witnessed this. (EBPT recipient, Female)

In addition, victims provided the following reasons for their lack of trust in the government to provide appropriate care: prior care from governmental institutions was inadequate (n = 4); the government failed to provide social protection and basic needs to victims (n = 3); the government lacks resources and personnel to meet victims' care needs (n = 2); the government failed to ensure their safety during the conflict (n = 1); and the government does not enforce the laws they have (n = 1).

***Avoidance of discussing traumas.*** Another important theme among stakeholders included avoidance of discussing traumatic experiences, which serve as a potential barrier to victims' care. Victims (n = 6) noted difficulty in discussing their past, including traumatic experiences. They stated that they or others experience fear and shame about these events in addition to distress that is evoked as a result of remembering them. Fear of judgment or insensitivity from others was also a concern for some. Of note, all the victims who identified this barrier stated that it was helpful in the long-term to talk to

someone about their experiences (see more about this in the EBPT section). A representative quote of views on this barrier is as follows:

First, because it was very hard to talk, to remember the past that still affected us, that did not stop being the past. And second, how to relate to strangers and tell them, let them know all that you have lived, with all the fear that we had when we arrived here for being persecuted, for having lost family members, well, loved ones. This was my barrier. (Psychosocial care recipient, Female)

Some providers (n = 4) and leaders (n = 6) noted concerns about “re-victimizing,” or causing harm to victims, by asking about their past traumatic experiences. They noted that seeing different providers and retelling the same traumatic experience is harmful to victims. Most viewed the repetition of the traumatic event as the problem, though one provider noted that being insensitive (e.g., blaming victims for their traumas) would be the harmful part.

**Comparing themes across stakeholders.** Several similarities emerged between stakeholder groups (see Table 3). Common themes for barriers across all stakeholder groups included stigma and low access to care across the health system. Providers and leaders shared themes for barriers that included: 1) poor implementation of laws, policies, and programs, 2) low allocation of funds, and 3) high provider turn-over. Providers and victims shared common themes related to logistical barriers to attending care and transportation. Themes for barriers that were mostly identified by victims included lack of knowledge about care, lack of trust in government, and avoiding discussing traumas. Mostly providers pointed to facilities and reaching victims as a barrier to care. Lastly, leaders’ themes for barriers consisted of low regulation of quality of services and low availability of trained professionals to work with victims. In addition, a theme that was

not prevalent among one stakeholder group but may be important, especially because many leaders reported it follows: care that is not culturally adapted.

*Care is not culturally adapted.* Additional information, that did not meet criteria to be considered a theme but was important (leaders (n = 6), one provider, and victim), included that current care was not culturally sensitive for minority groups in Colombia such as indigenous groups, Afro-Colombians or Roma people. Stakeholders noted a slow governmental response to these groups' call for care that is culturally informed. Some, also, stated that minority groups prefer treatment in a group format in a collective setting.

### **Facilitators**

In line with the second and third aims of the study, facilitators to implementing services broadly and EBPTs specifically were explored (see Table 4 for a summary) and compared across stakeholder groups. The same three categories (e.g., system, organizational, and service-user levels) were utilized for facilitators as for barriers.

**System level facilitators. *Laws and program design.*** A common facilitator theme for implementing services was established across most leaders (n = 8) that centered around effective and thorough laws and policies for providing care to victims. Laws, most policies, and technical guides for program development are well-developed and thoughtful according to most leaders. For example:

So, this is where, in Colombia we are experts in writing and building models that look really well and have a lot of sense but in the practice we fall short. That happens in other places but here we make an effort to design things and to make the law very well-done, like very complete but in the implementation, things fail because we promise too much or I don't know. (Academic expert, Male).

***Available manuals and revisions.*** Another facilitator theme among leaders (n = 7) was that psychosocial care that is provided to victims is manualized, lays out specifics techniques, and has undergone continuous revisions. For example:

In the construction of documents but also in gathering these experiences but also in constantly sharing these guides with professionals in a way that they can always provide feedback on the documents that allows us to edit them, or it has been an exercise in co-construction. (District government official, Female).

***Organization level facilitators. Offer for care.*** A common theme that many victims (n = 7) noted as a facilitator to victims receiving services was the offer for care from various governmental or non-governmental institutions. Once offered services, victims were able to access care with more ease. Of note, two of the victims had sought care previously but had not been able to receive an appropriate referral until they received an offer by chance.

But, she [government provider], gave me the opportunity to access this process. Through the dialogue I had with the people there, they realized that in my house there are psychological problems and things because my daughter still has not overcome her dad's death. So, because of this, they put us in the program. So, this way I got involved [in care] with them. (Psychosocial care recipient, Female).

***Rapport with provider.*** A common theme from a majority of victims (n = 8) was how the rapport that they developed with their providers helped them to attend care. Victims stated that their providers offered them emotional support and motivated them to continue treatment when they considered discontinuing. In addition, they noted that they trusted their providers and felt comfortable sharing their experiences. Five victims, in particular, commented on their providers' professionalism as a facilitator. An illustrative quote of the majority view is as follows:

...the person I worked with was excellent and we had a great connection. I think this woman had a lot of patience with me so that I could overcome what I overcame, because she saved a life. (EBPT recipient, Female).

***Institutional supports.*** A common theme among providers (n = 6) was how institutional support in providing care benefited them. Some providers stated that manuals were helpful. Others indicated that trainings and supervisions, when available, were helpful. In addition, some providers expressed that support from their administrators and coworkers with trouble shooting problems was helpful. Overall, providers appreciated institutional supports as facilitators. In many cases, they noted that these would be necessary in order to learn a new treatment such as an EBPT.

***Help with logistics.*** An additional theme from victims (n = 7) was that help with logistics of attending sessions served as a facilitator to receiving care. Help took the shape of flexibility in scheduling with a wide range of available times. In addition, victims noted that frequent calls from providers helped given the daily instability that they faced. Help with the cost of transportation or providers traveling to victims' homes were additional factors that victims mentioned that helped. One of the victims summarized the consensus about help with logistics:

... at least I worked and at times the scheduled time was inconvenient and I couldn't come. But, he [provider] was always there. He was there calling me, "Come this day, can you come?" He was always there, or rather this helped me to continue because another person could have said, "If she doesn't come, it's her problem." But, no he did his part in helping me to attend. ... Well, here since they are such professionals, they helped a lot because I was working sometimes all day. They helped me to find an exact time and a time in the afternoon because I got out of work at 5:00. (EBPT recipient, Female).

***Service-user level facilitators. Recognizing need for help.*** When asked about the factors that helped them receive psychological care, a major theme among victims (n = 8)

was recognizing their suffering and the need for psychological support. Chronic feelings of sadness and anxiety led victims to wish for change or to recognize the importance of feeling well. A representative quote:

Because I wanted change. I wanted change in my life, or a different change, not to be weighed down by the pressures that I felt. I needed the help of some person and in that moment I received it here. (EBPT recipient, Male).

***Understanding of mental health and treatment.*** Almost all of the victims that received care (n = 9) noted that an improved understanding of their suffering and treatment helped them to continue with care without ending prematurely. At first, victims were fearful of attending sessions, sharing traumatic experiences, and facing painful emotions, but through treatment they overcame this fear. For example:

At first, I thought it was difficult but when I started attending [sessions] these weeks with her, I already lost the fear. Then, I liked that my week would go by so I could attend this thing. (Psychosocial care recipient, Male).

***Refer others.*** A facilitator theme was that the majority of victims (n = 9) expressed high willingness to inform others about the care they received. Repeatedly, interviewed victims noted that they wished other victims would also receive care. Many of them offered to refer others and tell others their stories to incite them to attend care. Despite not being a direct facilitator for the victims toward their own care, this theme was conceptualized as a facilitator for the broader system. An example is below:

Because similarly I received a lot of information, a lot of help, and I could guide other people so that they could know about psychological help, or rather, this help, so that they could go. (Psychosocial care recipient, Female).

***Easing transportation burden.*** A facilitator theme emerged about easing the burden of transportation for victims to aid them in receiving care. Many providers (n = 6)

and victims (n = 6) mentioned information related to this theme. Stakeholders expressed that covering the cost of transportation or providers traveling to victims helped increase access to care, as noted in prior sections.

**Comparison of themes across stakeholders.** No common themes were found across stakeholder groups except for easing transportation burden, which was a facilitator theme found for both providers and victims. Otherwise, themes identified by leaders as facilitators included: established laws and program design, as well as available manuals and their revisions. For providers, a common theme was institutional supports from their organizations. For victims, common facilitator themes included the following: offers for care, strong rapport with their providers, help with logistics to attend treatment, recognition of need for help within themselves, improved understanding of their mental health and treatment, and referrals to care for other victims.

### **EBPTs and Preference for Focus and Treatment Delivery**

In accordance with the fourth aim of the present study, themes were identified across stakeholders for preferences of EBPTs' focus and delivery (see Table 5).

**Victims.** Several important themes were determined based on interviews with victims. These themes related to their mental health needs and their preferences for treatment delivery and type of care.

**Psychological needs.** A common theme among all victims (n = 11) was the emotional suffering that ensued from their experiences during the conflict. Victims noted: persistent fear, anxiety and sadness; negative thoughts and worry; avoiding people, places, or leaving their home; and suicidal ideations and attempts. An example:



These primordial fears that I had, this horrible fear. Now, it is going away. That's how it went. Overcoming barriers, the best barrier you can overcome as a human is your fears. (Psychosocial care recipient, Male).

***Preference for treatment focus.*** Victims who received different types of care responded differently in terms of their treatment preferences. A common theme among all victims who received an EBPT (n = 5) was that they would not change anything about their care. Two of these victims noted that the workbook that they received was somewhat complex but reported that it did not impact their care. Victims who received individual psychosocial care (n = 4) noted overall satisfaction. However, a common theme was that they wished to have received care for longer than eight sessions and they identified areas where they continued to have difficulties (e.g., trusting others, feeling like themselves). Two victims from a rural area noted that they wished to simply talk to someone or that they were unsure of what care would entail. In addition, several of the EBPT care recipients had undergone both types of care (n = 3) and noted a preference for EBPT. An example of the comparison of psychosocial care and an EBPT with the disclaimer for the small sample:

In reality, they do the job but not well. In other words, superficially, they have you go to meetings and all that, but your personal life for each person, they touch on it very lightly. In other words, "It is best not to have any conflicts with your family, be kind with others in your community," but in reality what you lived, all that suffering that you have, the effects, the traumas that you have buried down, they never touch on those. (EBPT recipient, Female)

***Individual treatment format.*** A common theme about treatment format was that most individuals (n = 8) preferred individual, though a majority of those who were interviewed had received care individually. The rest stated that they would like group and one stated that both would be good.

**Providers.** Themes related to preferences for focus of EBPTs and their delivery were explored for providers.

***Psychological needs.*** A common theme among providers (n = 11) was the psychological problems faced by victims they treated. They noted: nightmares, sleep difficulties, stress, anxiety, depression, PTSD, low functioning, and suicidal attempts. Providers also noted that common traumatic events faced by victims were sexual assault, especially for women, and “forced-disappearances” where family members disappeared and victims lack closure or information about whether their loved one is deceased.

***Willingness to provide EBPTs.*** A common theme from providers (n = 6) was their unwillingness to adopt EBPTs. Many noted that evidence is important to gather to assess patients’ improvement. However, a common concern included teaching techniques or following manuals. Some noted that discussing traumas would be harmful to patients due to the distress they would experience. Of note, three of the providers interviewed had administered EBPTs through a research study and noted that manuals along with supervision on how to implement them was very helpful.

***Treatment format.*** Providers mostly treated individuals. They noted that psychosocial care is available in individual, family, and group formats. However, psychosocial group consists of community activities rather than treatment. The maximum amount of sessions that were given were in the 8-10 range for most services.

**Leaders.** Common themes related to leaders’ perceptions of EBPTs’ were identified and are presented below.

***Importance of cultural context.*** A common theme across almost all leaders (n = 12) was noting the importance of the Colombian cultural context, at times to reject notions that EBPTs that were developed outside of Colombia could work there. Some leaders noted that context must be taken into account in order to adapt care, but this was a minority perspective.

***Psychosocial care.*** Another common theme found across leaders' interviews (n = 11) was the distinction of psychosocial from psychological care. Leaders differentiated psychosocial care as important because the victims faced unique circumstances due to the conflict that should be addressed. They noted that giving victims diagnoses, EBPTs, or clinical treatments, would be damaging to them because it would pathologize their pain. When asked to define how psychosocial care varied from clinical treatment, leaders noted that they did not focus on treatment but on the socio-political context of being a victim. Otherwise no common themes could be identified as to how psychosocial care differed from clinical care.

**Comparing themes across stakeholders.** In accordance with the third aim of the study, stakeholder themes were reviewed across groups. As noted above, a majority of leaders and some providers shared similar views about preferring psychosocial care, especially when compared to clinical care and EBPTs.

### **Quantitative Results**

Each stakeholder group filled out questionnaires measuring constructs similar to the ones assessed through semi-structured interviews (see a summary of results in Table 6).

**Victims.** Scores from the Brief-ISMI for victims ( $M = 2.20$ ;  $SD = 0.65$ ) who participated in this study were indicative of mild levels of internalized stigma with a range of scores (1.20 - 3.00) from minimal to moderate internalized stigma respectively (Lysaker et al., 2007). Overall, the sample was split with 4 victims scoring in the minimal internalized stigma range, 2 falling in the mild category, and 5 victims falling in the moderate internalized stigma range. T-tests showed that there were no significant differences in scores between groups of service users (e.g., psychosocial care or EBPT). These scores corresponded to the theme of internalized stigma that was found in the qualitative data.

In addition, scores for CSQ-8 on satisfactions with services were also calculated for victims. Overall, satisfaction with services ( $M = 28.73$ ;  $SD = 4.84$ ) was similar to a normative sample ( $M = 27.09$ ;  $SD = 4.01$ ; Nguyen, Attkisson, & Stegner, 1983). Scores on treatment satisfaction ranged from 17 to 32, with nine individuals falling above the average and three falling below. There were no significant differences in scores between groups of service users (e.g., psychosocial care or EBPT) based on T-tests. These findings aligned with themes of satisfaction with care from victims.

**Providers.** Stakeholders who provide services to victims filled out the EBPAS-15 based on their attitudes toward EBPTs. Scores were calculated for the four subscales, requirement ( $M = 2.0$ ,  $SD = 0.95$ ), appeal ( $M = 2.48$ ,  $SD = 1.0$ ), openness ( $M = 3.02$ ,  $SD = 0.47$ ), and lack of divergence ( $M = 2.54$ ,  $SD = 1.0$ ), as well as the overall score ( $M = 2.51$ ,  $SD = 0.64$ ). These scores fell in the moderate range for positive attitudes toward EBPTs (Aarons, 2004). These scores were contrary to a theme that emerged in the

EBPT section consisting of negative attitudes toward EBPTs from the majority of providers.

**Leaders.** EMERALD Priorities for Capacity-Building Questionnaire included several subscales. On this scale, a score of 3 signifies “important but not a priority,” a 4 signifies “a priority need,” and 5 signifies “an essential need.” Leaders’ average scores on the first subscale were 4.10 of 5 ( $SD = 0.86$ ) for prioritizing mental health policy, planning and program development, with averages for most individual items falling within a similar range (3.85 – 4.15). When compared to the qualitative data, scores for this subscale matched a theme found across stakeholders at the leadership level about efficient enforcement of laws into effective and wide-reaching programs. For the second subscale of building capacity within the mental health systems, leaders’ average ratings were 3.88 of 5 ( $SD = 1.11$ ), with individual item averages in the 3.77 to 4.08 range. This second subscale did not clearly correspond to common themes from qualitative data findings. The third subscale, prioritizing capacity building in mental health service implementation, was rated as average score of 4.34 of 5 ( $SD = 0.82$ ), with subscale item averages ranging from 4.0 – 4.85. Items that fell in “essential” category (4.5 or higher) included: “training for mental health workforce,” “implementation of mental health services in post-conflict settings,” and “community-based approaches to mental health care.” Overall, scores on this subscale aligned with the barrier of limited implementation of services, a common theme found among leaders when examining the qualitative data. Lastly, leader rated capacity building for mental health research an average of 4.10 of 5 ( $SD = 0.81$ ) in terms of priorities, with a range between 3.85 and 4.23 for individual item

average scores. This subscale did not clearly correspond to common themes from qualitative data findings.

### **Discussion**

The present study is the first formative research of barriers and facilitators that influence capacity to implement mental health services for Colombian victims of the armed conflict, to the author's knowledge. Based on mixed-methods results, stakeholders from various levels identified factors that would impact implementation of services generally (i.e., psychosocial or EBPTs), as well as some that might be specifically related to EBPTs. The study reported on both because general variables that would impede or facilitate implementing any services (e.g., transportation costs) also apply to EBPTs.

One of the primary aims of the current investigation was to establish common barriers to implementing services for victims of the armed conflict. Important barriers include those that hinder victims from seeking or attending psychosocial or psychological care. These barriers consist of victims' unfamiliarity with their right to available services as part of their reparations and their lack of faith in the system to provide needed care. When they sought help, victims faced barriers such as institutional obstacles for reaching care and precarious living conditions that precluded them from regular attendance (e.g., transportation, child care, unmet basic needs). Some stakeholders characterized these barriers as related to victims' and system's ranking mental health as a low priority. Though some of these barriers may not be considered high-impact in a high-resourced setting (e.g., help with forms), some of the victims indicated completing few, if any, years of formal education, which when compounded with additional barriers (e.g., lack of

paid time off) is significant. Lastly, these barriers are in line (i.e., display resonance, one of the conceptual depth criteria) with research from other LAMICs in the aftermath of violent conflicts (e.g., Murray et al., 2014), and with barriers to accessing care for low-income individuals in high-income countries (Lazar & Davenport, 2018). In addition, these barriers and facilitators should be considered in future efforts of implementing new mental health interventions in the Colombian setting and scaling out services (Aarons et al., 2017), especially for a strategic approach to improving and personalizing the effectiveness of mental health care for victims of the armed conflict.

Other important barriers present at the individual level included victims' internalized stigma and fear of discussing their past experiences, both of which increased victims' likelihood of not seeking or prematurely leaving care. These are important barriers that other stakeholders likewise noted for victims. Quantitative findings confirmed the presence of internalized stigma to some degree, even for victims who received care. On average, victims endorsed mild internalized stigma, but a closer examination of findings showed that close to half of the those interviewed had moderate levels of internalized stigma.

It is important to note that Colombian system leaders have developed policies aimed at almost all of these barriers at the individual level. For example, they engage community workers to offer victims care, or hold talks within victims' centers to provide information. Governmental programs also keep track of how many individuals are reached and informed. Despite these efforts, most victims within the current sample noted that efforts were not sufficient because most victims lacked the knowledge about access

to care. In addition, victims noted that when they attempted to access care, they were faced with many institutional obstacles to access due to fragmented institutional communication or follow through. Similarly, some leaders and providers noted that stigma is addressed in psychosocial care, which was developed to help victims recuperate from the events of the conflict but also to destigmatize victims' suffering. Through psychosocial care, according to providers and leaders, they inform victims that their reactions are normative given past experiences.

In addition to barriers faced by victims at the individual level, leaders and providers highlighted systemic barriers to access for victims, especially within the official mental health system (i.e., through EPS-es). These stakeholders highlighted that victims are supposed to receive mental health care through the official system at no cost. However, the availability of mental health services through EPS-es was scant at the time of this study, especially for the subsidized "insurance" for low-income individuals that covered most victims. This finding was one of the more consistently identified barriers by leaders and providers. As such, this barrier could likely be addressed when implementing services for victims. Of note, two leaders, one at the national level and one who worked with an NGO that collaborated closely with the government, stated that the MOH was collaborating with EPS-es to standardize health and mental health access and services for victims. As such, more information will be needed on these developments.

Additional barriers to implementing EBPTs or services at the system level were identified by leaders, providers, and some victims. These stakeholders noted that laws and policies for mental health or psychosocial care are not implemented well. Though a



facilitator, noted by most leaders and some providers, was that laws and policies are typically well-developed, their execution typically falls short. When programs are developed, they tend to be ineffective at responding to existing concerns within the context according to these stakeholders. Similarly, leaders and providers noted that regulating bodies existed but that these do not ensure proper implementation of programs or quality checks and assurances on care. In this vein, limited funds were indicated as a barrier for care for victims within urban areas and furthermore for rural areas. Lastly, stakeholders noted problems with the high turnover and availability of trained professionals working with victims. Stakeholders noted that employee contracts for providers were one of the main factors responsible for high turnover. In addition, several stakeholders noted that higher education institutions did not prepare providers sufficiently to work with victims.

Another major aim of the current investigation was to establish common facilitators to scaling out services for victims of the armed conflict. Important facilitators were identified by each stakeholder groups. Victims noted that recognizing the need for help with alleviating their suffering was a major facilitator. They also noted that rapport with providers, treatment itself, and their improved understanding of their mental health helped them to continue services. In addition, victims noted that it was easier to access services when they were offered them. Many of the interviewed victims also stated a wish to help others by referring them to receive care, a potential facilitator. Facilitators identified by providers included that helping victims with transportation costs or by traveling to them helped victims to attend care regularly. Also, providers noted that

institutional support, such as manuals or supervision, were helpful to them in order to provide care. They noted that these factors might be especially important for implementing EBPTs effectively. Of note, though providers tended to appreciate the availability of manuals within their institutions, a majority associated EBPTs with rigid conformity to manuals and noted concerns about EBPTs as a result. Lastly, leaders reported that facilitators to implementing care included their revisions of psychosocial care manuals to meet victims' needs. Lastly, leaders stated that laws and policies tend to be of good quality in that policy makers conduct thorough studies and develop good strategies. However, they noted these strategies may at times be idealistic, instead of grounded in reality, and thus potentially problematic.

As for EBPT perceptions and preferences, victims who received clinical services through Los Andes were very satisfied with their care. They reported that their suffering had been greatly reduced and they could manage daily challenges with ease. Victims from psychosocial programs also noted high satisfaction with care. Quantitative results on satisfaction ratings confirmed this qualitative finding for both groups. Almost all victims who received care (with the exception of one) rated quality of the services as high. However, victims who received psychosocial care also noted wishing their care had been longer and that there were additional areas they could address in treatment (e.g., trusting others, "feeling like myself"), though these differences were not apparent in the satisfaction with quality of services results. Of note, this was a very small sample of individuals and the limitations discussed in depth below should be considered when interpreting these findings.

An important theme that providers and leaders brought up consistently was the distinction between psychosocial and clinical care for patients. This distinction is salient because of its implications of these stakeholders' understanding of mental health and EBPTs. Most stakeholders at these levels stated that providing victims with diagnoses or clinical care means that victims are being "blamed" and pathologized for their normative reactions to the armed conflict. These views may be in line with the debate about the "medicalization" of mental health between cultural anthropologists and the medical establishment in the United States (Patel et al., 2018). However, the logical deduction from this view is the notion that those who have diagnoses of mental illness should be blamed for their suffering, and this betrays a level of implicit stigma toward mental health potentially held by some of these stakeholders.

A critical distinction must also be made between the etiology of suffering and its treatment. It is possible that some environments, such as the Colombian armed conflict, may be sufficiently extreme to engender mental health symptoms in a majority of those who experienced them, though research in high income settings suggests that most individuals who experience traumatic events recover and do not develop any symptoms (Galatzer-Levy, Huang & Bonanno, 2018). However, many leaders and providers highlighted the complex context of the conflict in Colombia, and how it may differ from high income settings, given its duration and its likely transgenerational effects (as one stakeholder mentioned). In addition to facing severe and continuous traumas, many victims were then confronted with chronic stressors due to their displacement that have likely impeded their post-traumatic adjustment. From an etiological perspective, it makes

sense to normalize victims' reactions to such extreme circumstances as was done in the writings of social psychologist Ignacio Martín-Baró, identified by most stakeholders as the inspiration for the psychosocial movement in Latin America. At the same time, victims should not be denied clinical care that would likely benefit them and aid them to advocate for themselves effectively within difficult living situations. As noted by many victims who received clinical services through Los Andes, their suffering was greatly reduced and they could manage systemic barriers within their context much better than previously, according to their report.

### **Strengths and Limitations**

The findings from the present study should be understood within their limitations. Despite efforts to include a wide variety of stakeholders from those involved in victims' care, the final sample of victims, providers, and leaders was restricted due to limited time, resources, and institutional constrictions on access to stakeholders. These restrictions may have limited the conceptual depth of some of the barriers and facilitators gathered during the present study. Limitations and potential strengths of the investigation are reviewed in depth below.

The sample of victims in this study consisted of those who: 1) completed a treatment course with PAPSIVI, 2) an EBPT at Los Andes University through a research study, or 3) engaged with psychosocial activities in a rural town outside of Bogota, Colombia. If victims were enrolled from a larger pool of individuals receiving or seeking care, study findings may differ. For example, the PI was restricted to only contact study participants who had completed treatment at Los Andes to avoid influencing active

research participants' views of their care and due to university IRB limits on contacting participants who left treatment prematurely. Similarly, PAPSIVI did not allow the PI to recruit patients directly and referred patients that had completed treatment. It is possible that patients who were referred to the study were only those who had a good experience with the program, and two victims who engaged with PAPSIVI and were referred from outside the program did indeed have less favorable views of the program.

Given the obstacles in the recruitment of victims, there might be limits to current sampling and findings compared to overall victim population. It is possible that this sample is not representative of victims of the armed conflict. The majority of victims who were interviewed included individuals who accepted treatment offers or sought out treatment. It is possible, as some leaders noted, that most victims are not interested in mental health care, and the sample from this study is unique. No information was readily available from the governmental entities on the number of victims seeking care compared to those who are offered care and accept or decline it. Thus, more research is needed for exploring these differences. Also, victims who completed a full course of care may differ from the general treatment seeking population in their priorities or other unknown variables. Overall, this sample of individuals may display higher treatment seeking behaviors and more satisfaction with care than most. Both of these variables may be correlated to their overall views of barriers and facilitators that impact care in Colombia and their views of EBPTs, which may skew positive. It is possible that a general population of victims may differ in their reactions or interest in psychological treatment or the barriers and facilitators that they would identify. However, a benefit of the

composition of this sample was identifying the variables that kept victims in treatment and what they perceived as useful in order to replicate these findings to maximize patients' chances of completing a full course of care.

An additional major limitation is that none of the patients, providers, or leaders were recruited from the formal health system. EPS-es, the main health system, is where victims, along with the rest of the Colombian populations, are supposed to receive mental health treatment and some stakeholders noted that certain EPS-es may provide EBPTs. The omission of EPS-es is important because providers in these institutions might have valuable information about implementing EBPTs in the Colombian mental health system with victims or other Colombians. However, considering that access to care at EPS-es was one of the most robust barriers across stakeholder groups, it is unlikely that a large percentage of victims are receiving care in these settings. Based on the findings from these interviews, victims are receiving their mental health care from psychosocial services that are technically outside of the health system and not designed to service mental health problems. Therefore, most victims are receiving mental health treatment *de facto* from governmental programs aimed at providing psychosocial care. Also, EPS-es that provide EBPTs may be those that are a part of high-end private hospitals or clinics that are out of victims' reach due to their subsidized insurance. Of note, one stakeholder at the leadership level mentioned that the MOH was working with EPS-es to improve care for victims within the formal health system. It is possible that this partnership has occurred within the last year and has improved access to care in this setting.

Another important limitation is that the sample of stakeholders consisted mostly of Colombians who belonged to majority group (i.e., White or “mestizo”). However, there are several large minority groups in Colombia, including indigenous Colombians, Afro-Colombians, and Roma Colombians. These groups have requested culturally adapted treatments that are in line with their customs and culture, often times in a group format. The Colombian government has been working to develop these treatments with representatives from these populations, but as several participants noted, including a representative from an indigenous tribe, the process has been slow. Despite several stakeholders discussing these groups and the researcher asking about cultural factors, this area was not explored in depth during this study. Similarly, stakeholders belonged mostly to the majority groups (i.e., White or “mestizo”). Though the researcher attempted to recruit a diverse sample and several stakeholders at each level self-identified as Afro-Colombian or indigenous, they made up a low number of the overall participant sample (3 victims, 1 provider, 1 leader; 14.3 % of the overall sample). Further research is needed that will assess views of minority stakeholders and their experiences with mental health treatment for victims of the armed conflict in Colombia.

Similarly, the investigation was focused and mostly conducted with stakeholders who resided in Bogota, Colombia, the capital of the country. The researcher made some attempts to include stakeholders from outside of Bogota by assessing several stakeholders (2 victims, 1 provider, 2 leaders; 14.3% of the overall sample) from a rural area within Cundinamarca (the district in which Bogota belongs) and one leader who worked in a conflict torn region of the country. These interviews contributed important information

about the context, especially the needs of rural and low-resourced areas in dealing with victims. Similarly, several stakeholders discussed variables that may impact rural areas or regions where the Colombian conflict had been most acute. In addition, no victims or providers were interviewed from Unidad de Vicimas, another governmental institution engaged in the transitional system set up to provide services to victims. However, a few leaders were included from this institution that reaches victims in many rural areas and discusses trauma more explicitly than PAPSIVI according to those interviewed. Overall, the information gathered for this study was limited in the characterization of barriers and facilitators in rural areas, but important findings may be applicable to these areas as well. Moreover, Bogota has a large number of victims and is an important focal point of the overall system given that leadership mostly resides here, and as such was a good starting point for a formative research effort.

A limitation of the quantitative data is that the questionnaires are not validated for use with the Colombian population. One of the questionnaires, CSQ-8, was validated in Spanish to be used with Latinx individuals in the United States, but not specifically with Colombians. Given the lack of validation studies for Colombians, there are no psychometric data available on the validity or reliability of these measures with this population. Validation of study measures was outside of the scope of the present study. However, the measures went through a rigorous process of translation, back-translation, and editing by Colombian providers who worked with victims.

In addition, limitations to the accuracy of the collection and coding of qualitative data should also be noted. This study did not utilize standardized follow-up probe



questions. This choice may have limited the saturation of the collected data by possibly not asking similar follow-up questions to everyone within a group. In addition, all data were analyzed in Spanish, though this is an acquired and non-native language for the PI. Furthermore, undergraduate coders, whose native language was Spanish, were trained by the PI and often deferred to the PI in deducing the meaning of statements since the PI was present for all interviews. These two factors combined may have led to a reduced subtlety of the conceptualization of some statements. However, given the PI's knowledge of the context and the undergraduate students' command of the language, most coded statements were categorized for themes likely with high accuracy. No inter-rater reliability was calculated because all interviews were coded by both coders and not all criteria for utilizing this method were met by this study (Morse, 1997).

Lastly, limitations related to the study design should also be noted. Though the PI utilized purposeful sampling in order to recruit a wide variety of stakeholder that are involved in victims' care, sampling practices may have also benefited from being iterative, meaning recruiting similar types of stakeholders to ensure that the sample is not so varied that everyone holds highly disparate views (Palinkas et al., 2015). A small sample may have limited several of the findings. It is possible that conceptual depth was limited at the provider level because the sample of providers was too varied given that fewer common themes were found within this stakeholder sample compared to other groups. Similarly, several sub-themes emerged within a sub-group of providers from one organization but were not reported here because they did not meet sufficient criteria for a theme. Sampling more providers from each type of organization might help with

achieving saturation or conceptual depth of qualitative data for this group. This was also true of limits to the conceptual depth for barriers and facilitators at the organizational level. Given that stakeholders from provider and victim groups were from varied settings, conceptual depth was limited for the themes that were identified relevant to each organization. Finally, an additional study design limitation was that the comparison between stakeholder groups was difficult given the small sample size and different quantitative assessment measures for each group.

### **Future Directions**

Further research is needed to understand and address many of the barriers, facilitators, and views of EBPTs found among stakeholders. For example, in order to understand victims' willingness to participate in EBPTs or care, focus groups with victims who experience mental health difficulties may be helpful. Given the limitations on the current sample of victims and that some leaders noted low interest in mental health services, more research is needed in this areas to elucidate the true interest of victims in care. Similarly, one stakeholder noted the scarcity of epidemiological data on victims' mental health as noted elsewhere (Idrobo et al., 2018). More research is needed to determine the true prevalence of mental health needs within this population. Some leaders noted that victims may not neatly fall within diagnostic categories. Given that this is likely the case, research is also needed to capture the culturally valid ways in which victims are experiencing distress. Thus, more research on both the quality and the quantity of their mental health is needed. This information will be crucial to plan and determine to type and amount of services that are needed for this population.

Any efforts to scale out care must account for additional methods to reach victims and aid them with knowledge about and access to care. As such, research should be conducted on methods for reducing victims' stigma toward mental health. Also, research may be needed for improved methods of disseminating information about available care to victims. In addition, given the low levels of trust that most victims have toward the government, research may be needed on how to best improve relationship between governmental institutions and victims' communities. One possibility for improving these relations may be for the government to augment its practices of hiring victims to do community outreach. Given the current research in global mental health (Patel et al., 2018), governmental programs may also consider hiring victims to directly provide services. Though some leaders noted that this was not possible due to Colombian laws defining who can provide psychological services, one stakeholder at the leadership level stated that a law passed in 2015 provided a loophole for allowing paraprofessionals to provide care.

Future research should also address several of the other limitations of this study. For example, studies of the Colombian mental health services for victims should focus on including EPS-es, their patients who are victims, their providers, and their leaders. This is particularly critical if there are EPS-es that provide EBPTs to victims that may be able to contribute their knowledge about these services for victims within the formal mental health system. In order to fully evaluate implementation factors for providing EBPTs, their views should be included in the future. Given the new information from stakeholders in this study about planned changes in EPS-es, it is also possible that

organizations affiliated with EPS-es play a more significant role in providing care to victims than at the time the study was conducted. Additionally, research of implementation factors in Colombia for victims' care should include stakeholders with similar backgrounds in order to identify organizational barriers and facilitators and to achieve convergence among themes. Similarly, future research should be focused on evaluating mental health barriers, facilitators, and overall contextual factors in rural areas as well as in urban areas that were severely affected by the Colombian conflict. This information may serve the development of public health policies, treatment adaptation, and implementation of care.

Lastly, more research is needed on the effectiveness of the psychosocial services that are being provided to victims. It is possible that these services may be working well and many victims noted being satisfied with them. In a recent article Kazdin (2016) put forth the view that increasing care is more important than the kind of care that is provided given that, at times, small differences exist in effectiveness between EBPTs and non-EBPTs. He noted that focusing on replacing services with EBPTs may be wasteful considering the large gap in care for most individuals around the world. Though his view is controversial, there is validity to the need to increase coverage for individuals suffering from mental health problems and not receiving any care. Of course, some may argue that if services will be implemented, only the most cost-effective and efficient ones should be considered (Clark, 2018).

Table 1

*Demographic Information for All Stakeholders*

	Victims (n = 11)		Providers (n = 11)		Leaders (n = 13)	
	n	%	n	%	n	%
Age	<i>M</i> (48.27)	<i>SD</i> (14.49)	<i>M</i> (38.27)	<i>SD</i> (7.35)	<i>M</i> (33.46)	<i>SD</i> (4.79)
Gender						
Female	9	81.82	8	72.73	7	53.85
Male	2	18.18	3	27.27	6	46.15
Other	0		0	0	0	0
Race						
White/mestizo	7	63.64	6	54.55	8	61.54
Indigenous	0	0	0	0	1	7.69
Afro-Colombian	3	27.27	1	9.09	0	0
Undeclared	1	9.09	4	36.36	4	30.77
Education						
None	1	9.09	0	0	0	0
Elementary	3	27.27	0	0	0	0
High school/ Technical school	5	45.45	2	18.18	1	7.69
College	2	18.18	1	9.09	1	7.69
Higher degree	0	0	8	72.73	11	84.62

Table 2

*Outcome Measures by Type*

	Government Officials <sup>a</sup>	Administrators <sup>a</sup>	Care Providers	Patients
Qualitative	EMERALD Policy Makers Interview	EMERALD District Level Interview	EPIS Interview	EPIS Interview
Quantitative	EMERALD Priorities for Capacity- Building Questionnaire	EMERALD Priorities for Capacity- Building Questionnaire:	EBPAS-15	CSQ-8 Brief ISMI

*Note.* EMERALD = Emerging Mental Health Systems in Low- and- Middle Income Countries Program; EPIS = Exploration Preparation Implementation and Sustainment; EBPAS-15 = Evidence- Based Practice Attitudes Scale-15; CSQ-8 = the Client Satisfaction Questionnaire-8; and Brief ISMI = Brief Internalized Stigma of Mental Illness.

<sup>a</sup> Government officials and administrators were both part of the leader group of stakeholders. The semi-structured interviews administered to them varied slightly in the order of questions and available follow-up questions.

Table 3

*Barriers to Implementing Services by Stakeholder Group*

Themes	Stakeholders			
	Leaders (n = 13)	Providers (n = 11)	Victims (n = 11)	Total (n = 35)
System Level Barriers	Theme (n)	Theme (n)	Theme (n)	Theme (n)
Barriers to access to care	11	8	8	27
Law implementation	9	7	2	18
Low funding	8	10	2	20
Low regulation of quality	10	5	4	19
Organizational Level Barriers				
High provider turnover	9	6	0	15
Trained professionals	7	0	2	9
Facilities and reaching victims	0	6	3	9
Service-user Level Barriers				
Stigma	12	11	11	34
Logistical barriers to care	6	8	7	21
Transportation	4	6	9	19
Lack of knowledge about care	1	5	11	17
Lack of trust in government	0	3	7	10
Avoiding discussing traumas	6	4	6	16

Table 4

*Facilitators to Implementing Services by Stakeholder Group*

Themes	Stakeholders			
	Leaders (n = 13)	Providers (n = 11)	Victims (n = 11)	Total (n = 35)
	Theme (n)	Theme (n)	Theme (n)	Theme (n)
<b>System Level Facilitators</b>				
Laws and program design	8	0	0	8
Available manuals and revisions	7	2	0	9
<b>Organizational Level Facilitators</b>				
Offer for care	0	3	7	10
Rapport with provider	0	1	8	9
Institutional supports	0	6	0	6
Help with logistics	0	1	7	8
<b>Service-user Level Facilitators</b>				
Recognizing need for help	0	2	8	10
Understanding of mental health	3	1	9	13
Refer others	2	2	9	13
Easing transportation burden	1	6	6	13



Table 5

*EBPTs Preference for Focus and Delivery by Stakeholder Group*

Themes		n
Victims (n = 11)	Psychological needs	11
	Preference for treatment focus	11
	Individual treatment format	8
Providers (n = 11)	Psychological needs	11
	(un) Willingness to provide EBPTs	6
	Treatment Format	11
Leaders (n = 13)	Importance of cultural context	12
	Psychosocial care	11

Table 6

*Quantitative Outcomes by Stakeholder Group*

Construct		Measure	<i>M</i>	<i>SD</i>
Victims (n = 11)	Internalized stigma	Brief ISMI	2.20	0.65
	Satisfaction with care	CSQ-8	28.73	4.84
Providers (n = 11)	Attitudes toward EBPTs	EBPAS-15	2.51	0.64
		EBPAS-Requirement	2.0	0.95
		EBPAS-Appeal	2.48	1.0
		EBPAS-Openness	3.02	0.47
		EBPAS-R-Divergence	2.54	1.0
Leaders (n = 13)	Priorities for capacity building	EMERALD-Policy & Planning	4.10	0.86
		EMERALD-Mental Health System	3.88	1.11
		EMERALD-Service Implementation	4.34	0.82
		EMERALD-Research	4.10	0.81

*Note.* Brief ISMI = Brief Internalized Stigma of Mental Illness; CSQ-8 = the Client Satisfaction Questionnaire-8; EBPAS-15 = Evidence- Based Practice Attitudes Scale-15; EBPAS-Requirement = subscale of EBPAS-15; EBPAS-Appeal = subscale of EBPAS-15; EBPAS-Openness = subscale of EBPAS-15; EBPAS-R-Divergence = reverse scored subscale of EBPAS-15; EMERALD = Emerging Mental Health Systems in Low- and- Middle Income Countries Program; EMERALD Policy & Planning = subscale of EMERALD Priorities for Capacity-Building Questionnaire; EMERALD-Mental Health System = subscale of EMERALD Priorities for Capacity-Building Questionnaire; EMERALD-Service Implementation = subscale of EMERALD Priorities for Capacity-Building Questionnaire; EMERALD – Research = subscale of EMERALD Priorities for Capacity-Building Questionnaire Research

## APPENDIX A

### EMERALD QUESTIONS FOR POLICY MAKERS AND PLANNERS

#### Aim of the interview

**While a number of low- and middle-income countries have policies and legislation which support the increase of mental health care to varying degrees, these are not sufficient to ensure transformation of the health care system towards increasing evidence-based mental health care. The aim of this interview is to get your opinions on factors within the institutional, legal and policy contexts of Colombia that will hinder or facilitate the implementation of service for victims of the armed conflict suffering from anxiety, depression, post-traumatic stress and related disorders.**

#### Research Questions

- a) **What are factors within the institutional, legal and policy contexts that are likely to facilitate the implementation of policy and service plans in LAMIC?**
- b) **What are potential barriers within the institutional, legal and policy contexts that will hinder the implementation of policy and service plans in LAMIC?**

### 1. SYSTEMS FOR PLANNING AND MANAGEMENT

- 1.1. How do systems for mental health care planning & management operate?

#### Probe for:

- a) How decisions regarding mental health service planning are made (e.g., additional specialist human resources/training of existing human resources to provide mental health care)
  - b) How are decisions regarding financing/budgeting for mental health services made (e.g. for both locally generated funds and donor funds)
- 1.2 What are the challenges encountered in health care service planning and management?
  - 1.3 What are the possible measures/mechanisms that can facilitate mental health service planning?
  - 1.4. Given that mental health care is a multi-sectoral endeavor, how does the MoH collaborate with other sectors at a national level in the development of mental health policies and plans?

#### Probe for:

- a) Mechanisms/structures that facilitate this. If there aren't existing mechanisms, probe for measures that can be put in place to facilitate this.

- 1.5.1 What is the extent of service user participation in the planning and delivery of mental health policies and plans at a national level?

Probe for:

- a) Are there any models of involving patients and/or caregivers in policy-making for mental health care in Colombia?
- Probe for involvement in service development and implementation?
  - Probe for participating in monitoring service quality?
  - Probe for whether they think this could be achieved? What would be needed?
  - Probe for what they see as the challenges?
- b) If there are no models for mental health care, what about for other health conditions?

## **2. INTELLIGENCE, INFORMATION**

- 2.1. How is information about the mental health system and mental health in the country used to inform the development of mental health policies, plans and the decision-making process?
- 2.2. How is implementation of mental health policies monitored? If it is too early for them to say, probe for how other implementation of other health policies (e.g. HIV/AIDS policy) is implemented as a proxy for how implementation of mental health policy may be monitored.

## **3. ETHICS**

- 3.1 What is the importance attached to better safeguards for mental health services (e.g., protection of people being given treatment against their will)?
- 3.2. In the case of research, what is the importance attached to safeguarding participants from potentially unethical research (e.g., that ethical clearance is acquired before research and that informed consent procedures are adhered to)?
- 3.3. Is there a policy and mechanism for promoting & enforcing safeguards for service users and enforcing codes of conduct for professional practice when it comes to mental health care?
- 3.4. Similarly, for research are their mechanisms for protecting participants from potentially unethical research?

## **4. GOVERNANCE**

### **4.1. Rule of law**

- 4.1.1. Where are laws relevant to mental health initiated?
- 4.1.2. Are laws/regulations related to mental health service provision, infrastructure, technology, human resources, pharmaceuticals in place?
- 4.1.3. How are the laws translated into rules, regulations, and procedures?
- 4.1.4. Does the MoH consult other line departments for laws/regulations pertaining to mental health?
- 4.1.5. What is the relationship of the MoH to the regulating bodies for mental health?
- 4.1.6. What is the capacity of MoH for contracting, regulating, accrediting, licensing of training programmes and mental health practitioners/organizations/bodies that deliver mental health services?
- 4.1.7. What procedures are in place for redressing grievances of (a) consumers and (b) contractors?
- 4.1.8. How are the relevant laws enforced?

### **4.2. Transparency**

- 4.2.1. Is information about financial and administrative procedures in the MoH readily available?
- 4.2.2. How transparent is the process of resource allocation in the MoH?
- 4.2.3. Are there monitoring mechanisms in place to ensure transparency of decisions?
- 4.2.4. How does monitoring of mental health services occur? Who is responsible?
- 4.2.5. How are the district/facility managers appointed/transferred?
- 4.2.6. What mechanisms are in place to ensure accountability of funds disbursed for mental health?

### **4.3. Responsiveness**

- 4.3.1. How are funds for health allocated?
  - a) Probe for whether it is based on health burden, mortality, disability.

- b) Probe for how these mechanism impact on the allocation of funds for mental health.
- 4.3.2 How does the MoH approach quality of health services and user satisfaction?
- a) Probe for mechanisms to monitor service user satisfaction generally and for mental health services more specifically
  - b) Probe for involvement of service users and careers in quality control. If none exist probe for openness to this possibility and possible suggestions on how this could operate.
- 4.3.3 How does the health system respond to regional/local priority health problems?
- a) Probe for how the health system responds to regional/local mental health problems specifically.

#### **4.4 Equity**

- 4.4.1 Are there any social protection schemes in place to address financial barriers for victims of the conflict?
- 4.4.2 What policies are in place for identifying issues of equity in provision and financing of health services and rectifying them?
- 4.4.3 Is allocation of public sector resources by states, provinces, districts equitable?

#### **4.5. Effectiveness & efficiency**

- 4.5.1 What is the turnover/tenure of the Mental health leadership at the MoH?
- 4.5.2 What is the training, qualifications, experience of this leadership?

#### **4.6. Accountability**

- 4.6.1 Are mechanisms for overseeing adherence to financial, administrative rules in place?
- 4.6.2 What evidence is present about the effective enforcement of accountability processes?

#### **4.7. Stigma**

- 4.7.1 What do you think is the proportion of burden of disease associated with mental health problems amongst service users and the victims' community in general?
- 4.7.2 How important do you consider the integration of mental health care into primary health care service delivery? Probe for possible gains of integration.
- 4.7.3 What percent of the health care budget is currently allocated to mental health care?
- a) Probe for whether they think this is appropriate.

- b) If not appropriate probe for reasons as well as barriers to more funding and how attitudes towards mental illness may play a role.

4.7.4 Are you aware of any anti-stigma programmes?

- a) Probe for whether they have been involved/would like to be involved.  
b) Probe for whether they think service users/ health professionals should be involved in these activities.

4.7.5 To what factors do you attribute depression, anxiety, suicide? How do you explain them? What do you think would be the best way to help those suffering from these problems?

**4.8. Capacity Building**

4.8.1. We have been discussing many aspects of health system strengthening, especially focusing on mental health systems. Are there any parts of health system strengthening where you would value (additional) training?

[Document spontaneous response]

	How important is it for your institution to build capacity in each of the following areas?				
	1 = irrelevant 2 = not a priority now 3 = important but not a priority 4 = a priority need 5 = an essential need				
	1	2	3	4	5
Mental health policy, planning and programme development					
Mental health policy development or policy review and re-formulation					
Evidence-based mental health care planning					
Mental health programme development					
Planning for a system of mental health in primary care					

Developing partnerships with patients for policy-making and service development					
Human resources projection and cost calculation					
Mental health systems					
Governance of mental health systems					
Mental health system leadership					
Mental health information systems					
Mental health system communication					
Mental health system advocacy strategies					
Mental health service implementation					
Training for mental health workforce					
Antistigma campaigns					
Monitoring and evaluation of mental health services					
Developing partnerships with patients to involve in quality control					
Implementation of mental health services in post-conflict settings					
Community-based approaches to mental health care					
Mental health research					
Priority setting in mental health systems research					
Conducting mental health needs assessments					



## **INTERVIEW SCHEDULE FOR DISTRICT LEVEL MANAGERS**

### **Aim of the interview**

**While a number of low- and middle-income countries have policies and legislation to increase mental health care, sometimes these are not sufficient to ensure transformation of the health care system towards increasing evidence-based mental health care. The aim of this interview is to get your opinions on factors within the functioning of the district health system of Colombia that will hinder or facilitate the implementation of service for victims of the armed conflict suffering from anxiety, depression, post-traumatic stress and related disorders.**

### **Research Questions**

- a) What district system level processes are likely to aid the implementation of mental health service for victims of violent conflicts in LAMICs?**
- b) What district system level processes are likely to impede the implementation of mental health service for victims of violent conflicts in LAMIC?**

### **1. AWARENESS OF THE IMPORTANCE OF MENTAL HEALTH AND REDUCED STIGMA**

1.1 What do you think is the proportion of burden of disease associated with mental health problems amongst service users and the victims' community in general?

1.2 How important do you consider the integration of mental health care delivery especially one that is evidence-based (based on scientific findings)?

- a) Probe for possible gains/disadvantages of evidence-based care.

1.3 How important do you think it is that staff are adequately trained and supported in evidence-based mental health guidelines to facilitate the implementation of the care?

- a) Probe for possible gains/disadvantages of this training.

1.4 Are you aware of any anti-stigma programmes?

- a) Probe for whether they have been involved/would like to be involved.

- b) Probe for whether they think service users/ health professionals should be involved in these activities.

## 2. HUMAN RESOURCE ISSUES

2.1. Is there a co-ordination function or mechanism that is responsible for overseeing mental health care? If yes, probe for whether this is the case for all health districts?

Probe for whether and how this co-ordination function (role or mechanism):

- a) Ensures the timely appointment of specialist staff
- b) Ensures ongoing training and supervision of staff in evidence-based care
- c) Ensures ongoing training and supervision of lay counsellors/community level staff in adjunct psychosocial interventions
- d) Adequately monitors the quality of services
- e) Ensures reliable and timely supply of adequate medication.

2.2 What are the possible barriers/facilitating factors to having maximum coverage of staff trained evidence-based care.

Probe for how the following affect coverage:

- a) Staff turn-over. Is there high staff turn-over? If so why? What measures can be taken to improve retention of staff?
  - b) Sufficient posts. Are there sufficient posts available at clinic level. If not, is this a result of lack of budget or authority to create additional posts?
  - c) Recruitment procedures. Are these procedures efficient (e.g., how long does it take to recruit and appoint new staff?). If not, what problems exist with recruitment procedures? What measures can be taken to improve these procedures?
  - d) Training procedures. Are there procedures in place that would ensure that new staff are timeously trained in evidence-based care. If not, how can these procedures be put in place? Are there procedures for refresher training? What measures can be taken to improve these procedures?
- 2.3. What are the possible barriers/facilitating factors for using non-professional health workers such as community health workers to help identify and/or provide interventions?

Probe for the following:

- a) Whether they are formally part of the health care system or not? If not, how this impacts on retention and staff turn-over, morale (as a result of low remuneration/volunteer work, lack of clear role definition and career pathways). What measures can be put in place to address these issues?
- b) Whether their role in mental health care (countries to insert specifics) is acknowledged and credited.

2.4. What are the possible barriers/facilitating factors to having sufficient specialist staff to provide ongoing/refresher training, supervision, support and a referral service for more complex/treatment resistant cases?

Probe for:

- a) Staff turn-over. Is there high staff turn-over of specialist staff? If so why? What measures can be taken to improve retention of specialist staff?
- b) Recruitment procedures. Are these procedures efficient (e.g., how long does it take to recruit and appoint new staff?). If not, what problems exist with recruitment procedures? What measures can be taken to improve these procedures?
- c) Training procedures. Are there procedures in place that would ensure that new specialist staff are timeously trained in evidence-based care so that they can provide supervision and support. If not, how can these procedures be put in place?
- d) Attitudes of specialist staff towards task sharing. Are specialist staff supportive of diversifying their roles to provide training, supervision and support to non-specialist staff in mental health care?

### **3. EQUIPMENT AND INFRASTRUCTURE FOR MHC**

3.1 Do you foresee any problems/is there a problem in the supply of guidelines and adjunct psychosocial manuals as well as their retention at the clinics? Probe for reasons for problems and possible procedures that can be put into place to overcome them.

3.2. If include high intensity counselling delivered by trained counsellors, is there adequate counselling space available at clinics? If not, probe for how this problem can be addressed.

### **4. SYSTEMS FOR PLANNING AND MANAGEMENT**

- 4.1. How do systems for planning & management operate? Probe for:
- a) Whether they centralized/decentralized?
  - b) The implications for scaling up the implementation of evidence-based care to other districts
- 4.2. Given that mental health care is a multi-sectoral endeavour, at a district level, how does the DoH at district level collaborate with other sectors to tackle mental health problems and its determinants? Probe for
- a) Mechanisms/structures that facilitate this. If there aren't existing mechanisms, probe for measures that can be put in place to facilitate this.

## **5. SERVICE USER PARTICIPATION**

- 5.1. What is the extent of service user/caregiver participation in the planning and delivery of mental health services?
- 5.2. How could service user/caregiver participation improve how mental health care is implemented in your district through the PRIME project [Nigeria equivalent]...

Probe for:

- a) How might patients and caregivers contribute to making the service development / implementation a success?
- b) How could patients and caregivers be involved in monitoring quality / improving services?
- c) How would you feel about working with patients and caregivers in this way?
- d) What type of training might help you to work with patients and caregivers in this way?

## **6. Capacity Building**

- 6.1. We have been discussing many aspects of health system strengthening, especially focusing on mental health systems. Are there any parts of health system strengthening where you would value (additional) training?

[Document spontaneous response]

- 6.2. Then probe with the following for the capacity-building priorities within their organisation [may be better if the respondent is given the paper and asked to complete as difficult to visualise]

### **PRIORITIES FOR CAPACITY-BUILDING**

	How important is it for your institution to build capacity in each of the following areas?				
	1 = irrelevant 2 = not a priority now 3 = important but not a priority 4 = a priority need 5 = an essential need				
	1	2	3	4	5
<b>Mental health policy, planning and programme development</b>					
Mental health policy development or policy review and re-formulation					
Evidence-based mental health care planning					
Mental health programme development					
Planning for a system of mental health in primary care					
Developing partnerships with patients for policy-making and service development					
Human resources projection and cost calculation					
<b>Mental health systems</b>					
Governance of mental health systems					
Mental health system leadership					
Mental health information systems					

Mental health system communication					
Mental health system advocacy strategies					
<b>Mental health service implementation</b>					
Training for mental health workforce					
Anti-stigma campaigns					
Monitoring and evaluation of mental health services					
Developing partnerships with patients to involve in quality control					
Implementation of mental health services in post-conflict settings					
Community-based approaches to mental health care					
<b>Mental health research</b>					
Priority setting in mental health systems research					
Conducting mental health needs assessments					

## APPENDIX B

### Domains, Constructs and Elicitation Questions of EPIS for Providers

Domains	Constructs	Clinician Interview Questions
Outer Context	Socio-political context: <ol style="list-style-type: none"> <li>1. Legislation</li> <li>2. Policies</li> <li>3. Monitoring and review</li> </ol>	<ul style="list-style-type: none"> <li>- What kind of local or national policies, regulations, or guidelines influence services? How?</li> <li>- Are there any political factors that make it harder for victims receiving mental health care? Any that make it easier?</li> <li>- Are you required to monitor if patients are improving? Do you think monitoring patients would be helpful?</li> </ul>
	Funding <ol style="list-style-type: none"> <li>1. Continuity of funding</li> </ol>	<ul style="list-style-type: none"> <li>- How are services for victims funded in your organization?</li> <li>- How does funding impact the types of services you are able to provide?</li> <li>- Is funding continuous? How does this impact the types of services you provide? What about how you deliver treatment (e.g., weekly, individual, etc.)?</li> </ul>
	Client Advocacy	<ul style="list-style-type: none"> <li>- What is the role of client advocacy groups for mental health care?</li> <li>- Are these groups effective? How?</li> <li>-What are the barriers these groups face in advocating for patients' mental health care?</li> <li>-What are factors that help these groups ?</li> </ul>
Inner Context	Organizational characteristics <ol style="list-style-type: none"> <li>1. Absorptive capacity (knowledge skills, readiness for change, receptive context)</li> <li>2. Culture</li> </ol>	<ul style="list-style-type: none"> <li>-What kind of care are your providing currently?</li> <li>- How is this serving victims? Are there any needs that are not being met?</li> <li>-Is there any aspect of current care you would change? If yes, what?</li> <li>- Do you think more mental health care is needed for victims across the system? Why or why not?</li> </ul>

	<p>3. Climate 4. Leadership</p>	<p>- Would you be willing to try new types of treatment for victims that have scientific support*? - How easy or difficult would it be to learn and deliver new treatments for you? -What would make it more difficult or easier to learn new treatment? - Is your clinic set up so that you can easily integrate new treatments like evidence-based practices* into clinical care? - To what extent might evidence-based services take a backseat to other high-priority patient needs or initiatives (center, country etc.) going on now? -Any factors that would improve the chance of new services being delivered? - How do evidence-based interventions fit into how you and your colleagues do therapy? -How supportive do you think administration would be of new treatments? -- What level of endorsement or support have you seen or heard from leaders about new treatments? - Do you receive any supervision? What kind?</p>
	<p>Individual characteristics</p> <ol style="list-style-type: none"> <li>1. Values</li> <li>2. Goals</li> <li>3. Social Networks</li> <li>4. Perceived need for change</li> </ol>	<p>-What is your job title? -What is your training? -How many years have you practiced? -How many patients do you treat each week? -What is most important in your work with victims? - What are your goals in your work with victims?</p>



		<ul style="list-style-type: none"> <li>-What gets in the way of your work?</li> <li>-What helps you in your work with victims?</li> <li>-Do you believe that interventions based on scientific knowledge would be helpful to victims?</li> <li>-Do you believe you have the knowledge /could obtain the knowledge to support evidence-based services in your day-to-day practice?</li> <li>-What would get in your way? What would help you?</li> </ul>
Additional Outer Context	Socio-political context: Patient needs/resources	<ul style="list-style-type: none"> <li>- What are victims' needs in your opinion?</li> <li>- What are victim's preferences for mental health care in your opinion?</li> <li>- To what extent is staff aware of the needs and preferences of the victims being served by your organization?</li> <li>- What barriers do victims being served by your organization face to participating in mental health services?</li> <li>-Any factors that make it easier for patients to seek services?</li> <li>- Have you elicited information from victims regarding their experiences with current services? What are they?</li> <li>- How much do you think services should be delivered with collaboration from victims?</li> <li>- Would you like to work with victims and victims organizations to tailor care to help them with all their needs?</li> </ul>

\* Description: Scientifically supported/evidence-based treatments are psychological treatments that are delivered to patients by teaching them skills to better cope with their mental health problems. The therapist is typically very active and like a teacher talks a lot to provide the information that patients need in order to get better. These treatments have been tested with lots of patients around the world and have produced good results in reducing symptoms and alleviating suffering.

## APPENDIX C

**Domains, Constructs and Elicitation Questions of EPIS for Consumers/Patients**

Domains	Constructs	Patient Interview Questions
Outer Context	Knowledge about access to care	- What information do you have about help for victims who have survived difficult situations and find themselves preoccupied and nervous? [follow up: How/where did you learn this information]
	Barriers to seeking care	- What has gotten in the way of you or your close family members seeking mental health services for problems of constant worry, feeling sad all the time and/or having lived through difficult situations?
	Facilitators to seeking care	What has helped you or your close family members to seek mental health services for constant worry, feeling sad all the time and/or having lived through difficult situations?
	Barriers to receiving care/Transportation	- [If sought care] What has gotten in the way of you or your close family members receiving mental health services for constant worry, feeling sad all the time and/or having lived through difficult situations? - How easy or difficult is it for you or a family member to attend treatment weekly for 2-3 months? - Would transportation be easy or difficult for attending care?
	Facilitators to receiving care	- [If sought care] What has helped you or your close family members receiving mental health services for constant worry, feeling sad all the time and/or having lived through difficult situations?
	Government trust	- Do you think the government agencies will do a good job of providing the right services?

		- Do you trust the government to provide what you need? Why or why not?
Inner Context	Perceived need for change: Needs meet/Satisfaction with care	- If you or a close family member has received any psychological services aimed at victims of the Colombian conflict, what was your experience? Did you feel that your needs and expectations were met? If so, what were your needs and expectations and how were they or weren't they met?  - If you or a close family member received care, what would you improve about the care you received, if anything?  - Would you recommend this care to others who are suffering from similar problems? Why or why not?
	Individual patient characteristics: 1. Willingness to seeking care	- If you knew that great services are available that would help you or a family member with constant worry, feeling sad all the time and/or having lived through difficult situations, would you seek them? Why or why not?
	2. Willingness to shape own care	- Would you like to participate in discussions with government and doctors about the treatment you would receive? Why or why not? - If you could receive any help you wished, what would it be?
	Values/goals: Evidence-based services	- Would you be willing to meet with someone every week who would teach you strategies and skills you can put into place in your life that will help you to feel better? - Would you prefer to do this one-on-one or in a group? - Are you embarrassed to speak with

		others about the difficulties that you are having? - Have your problems caused you to doubt yourself and your abilities?
--	--	---

## REFERENCES

- Aarons, G. A. (2004). Mental health provider attitudes toward adoption of evidence-based practice: The Evidence-Based Practice Attitude Scale (EBPAS). *Mental Health Services Research*, 6(2), 61-74.  
<http://dx.doi.org/10.1023/B:MHSR.0000024351.12294.65>
- Aarons, G. A., Hurlburt, M., & Horwitz, S. M. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research*, 38(1), 4-23.  
<http://dx.doi.org/10.1007/s10488-010-0327-7>
- Aarons, G. A., Sklar, M., Mustanski, B., Benbow, N., & Brown, C. H. (2017). “Scaling-out” evidence-based interventions to new populations or new health care delivery systems. *Implementation Science*, 12(1), 111. <https://doi.org/10.1186/s13012-017-0640-6>
- Abayneh, S., Lempp, H., Alem, A., Alemayehu, D., Eshetu, T., Lund, C., ... & Hanlon, C. (2017). Service user involvement in mental health system strengthening in a rural African setting: Qualitative study. *BMC Psychiatry*, 17(1), 187.  
<http://dx.doi.org/10.1186/s12888-017-1352-9>
- Acharya, B., Ekstrand, M., Rimal, P., Ali, M. K., Swar, S., Srinivasan, K., ... & Chwastiak, L. A. (2017). Collaborative care for mental health in low-and middle-income countries: A WHO health systems framework assessment of three programs. *Psychiatric Services*, 68(9), 870-872. <http://dx.doi.org/10.1176/appi.ps.201700232>
- Attkisson, C. C., & Zwick, R. (1982). The Client Satisfaction Questionnaire: Psychometric properties and correlations with service utilization and psychotherapy outcome. *Evaluation and Program Planning*, 5(3), 233-237.  
[https://doi.org/10.1016/0149-7189\(82\)90074-X](https://doi.org/10.1016/0149-7189(82)90074-X)
- Balas, E. A., & Boren, S. A. (2000). Managing clinical knowledge for health care improvement. *Yearbook of Medical Informatics*, 09(1), 65-70.  
<http://dx.doi.org/10.1055/s-0038-1637943>
- Bass, J. K., Annan, J., McIvor Murray, S., Kaysen, D., Griffiths, S., Cetinoglu, T., ... & Bolton, P. A. (2013). Controlled trial of psychotherapy for Congolese survivors of sexual violence. *New England Journal of Medicine*, 368(23), 2182-2191.  
<https://doi.org/10.1056/NEJMoa1211853>
- Beidas, R. S., Mehta, T., Atkins, M., Solomon, B., & Merz, J. (2013). Research methods of dissemination and implementation science in behavioral health. In J.S. Comer & P.

- C. Kendall (Eds.), *The Oxford handbook of research strategies for clinical psychology* (pp. 62- 86). New York, NY: Oxford University Press.
- Bolton, P., Bass, J., Neugebauer, R., Verdeli, H., Clougherty, K., Wickramaratne, P., ... Weissman, M. (2003). Group interpersonal psychotherapy for depression in rural Uganda: A randomized controlled trial. *Journal of the American Medical Association*, 289(23), 3117–3124. <http://dx.doi.org/10.1001/jama.289.23.3117>
- Boyd, J. E., Otilingam, P. G., & DeForge, B. R. (2014). Brief version of the Internalized Stigma of Mental Illness (ISMI) scale: Psychometric properties and relationship to depression, self-esteem, recovery orientation, empowerment, and perceived devaluation and discrimination. *Psychiatric Rehabilitation Journal*, 37(1), 17-23. <http://dx.doi.org/10.1037/prj0000035>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. <http://dx.doi.org/10.1191/1478088706qp063oa>
- Brown, C. H., Curran, G., Palinkas, L. A., Aarons, G. A., Wells, K. B., Jones, L., ... & Tabak, R. G. (2017). An overview of research and evaluation designs for dissemination and implementation. *Annual Review of Public Health*, 38, 1-22. <https://doi.org/10.1146/annurev-publhealth-031816-044215>
- Clark, D. M. (2018). Realizing the mass public benefit of evidence-based psychological therapies: The IAPT program. *Annual Review of Clinical Psychology*, 14, 159-183. <http://dx.doi.org/10.1146/annurev-clinpsy-050817-084833>
- Collins, P. Y., Insel, T. R., Chockalingam, A., Daar, A., & Maddox, Y. T. (2013). Grand challenges in global mental health: Integration in research, policy, and practice. *PLoS Med*, 10(4), e1001434. <http://dx.doi.org/10.1371/journal.pmed.1001434>
- Collins, P. Y., Patel, V., Joestl, S. S., March, D., Insel, T. R., Daar, A. S., ... & Glass, R. I. (2011). Grand challenges in global mental health. *Nature*, 475(7354), 27-30. <http://dx.doi.org/10.1038/475027a>
- Denzin, N. K. (1978). *The research act: A theoretical introduction to sociological methods*. New York, NY: Praeger Press.
- Eaton, J., McCay, L., Semrau, M., Chatterjee, S., Baingana, F., Araya, R., ... & Saxena, S. (2011). Scale up of services for mental health in low-income and middle-income countries. *The Lancet*, 378(9802), 1592-1603. [http://dx.doi.org/10.1016/S0140-6736\(11\)60891-X](http://dx.doi.org/10.1016/S0140-6736(11)60891-X)
- Fekadu, A., Hanlon, C., Medhin, G., Alem, A., Selamu, M., Giorgis, T. W., ... & Patel, V. (2016). Development of a scalable mental healthcare plan for a rural district in

- Ethiopia. *The British Journal of Psychiatry*, 208(s56), s4-s12.  
<http://dx.doi.org/10.1192/bjp.bp.114.153676>
- Galatzer-Levy, I. R., Huang, S. H., & Bonanno, G. A. (2018). Trajectories of resilience and dysfunction following potential trauma: A review and statistical evaluation. *Clinical Psychology Review*, 63, 41-55.  
<https://doi.org/10.1016/j.cpr.2018.05.008>
- Green, L. W., Ottoson, J. M., Garcia, C., & Hiatt, R. A. (2009). Diffusion theory, and knowledge dissemination, utilization, and integration in public health. *Annual Review of Public Health*, 30, 151–174.
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, 18(1), 59-82.  
<http://dx.doi.org/10.1177/1525822X05279903>
- Hanlon, C., Semrau, M., Alem, A., Abayneh, S., Abdulmalik, J., Docrat, S., ... & Mugisha, J. (2018). Evaluating capacity-building for mental health system strengthening in low-and middle-income countries for service users and caregivers, service planners and researchers. *Epidemiology and Psychiatric Sciences*, 27(1), 3-10.  
<http://dx.doi.org/10.1017/S2045796017000440>
- Idrobo, F., Hessel, P., Harker, A., Evans-Lacko, S., & Avendaño, M. (2018). Mental health of victims and ex-FARC members: A challenge for the peace process in Colombia. *The Lancet Psychiatry*, 5(6), 467- 468. [http://dx.doi.org/10.1016/S2215-0366\(18\)30134-2](http://dx.doi.org/10.1016/S2215-0366(18)30134-2)
- Institute of Medicine (U.S.). (2001). *Crossing the quality chasm: A new health system for the 21st century*. Committee on Quality of Health Care in America. Washington, D.C.: National Academy Press.
- Kaysen, D., Lindgren, K., Zangana, G. A. S., Murray, L., Bass, J., & Bolton, P. (2013). Adaptation of cognitive processing therapy for treatment of torture victims: Experience in Kurdistan, Iraq. *Psychological Trauma: Theory, Research, Practice, and Policy*, 5(2), 184-192. <http://dx.doi.org/10.1037/a0026053>
- Kazdin, A. E. & Blase, S. L. (2011). Rebooting psychotherapy research and practice to reduce the burden of mental illness. *Perspectives on Psychological Science*, 6(1), 21-37. <http://dx.doi.org/10.1177/1745691610393527>
- Kazdin, A. E. (2016). Closing the research–practice gap: How, why, and whether. *Clinical Psychology: Science and Practice*, 23(2), 201-206.

- Kessler, R. C., Aguilar-Gaxiola, S., Alonso, J., Chatterji, S., Lee, S., Ormel, J., ... & Wang, P. S. (2009). The global burden of mental disorders: An update from the WHO World Mental Health (WMH) surveys. *Epidemiologia e Psichiatria Sociale*, *18*(1), 23-33. <http://dx.doi.org/10.1017/S1121189X00001421>
- Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*(6), 617-627. <http://dx.doi.org/10.1001/archpsyc.62.6.617>
- La Mesa Psicosocial. (2016, May 18). *Psychosocial attention as a result of the armed conflict*. Report presented to the Seventh Commission of the House of Representatives of the Congress of the [Colombian] Republic.
- Lagos-Gallego, M., Gutierrez-Segura, J. C., Lagos-Grisales, G. J., & Rodriguez-Morales, A. J. (2017). Post-traumatic stress disorder in internally displaced people of Colombia: An ecological study. *Travel Medicine and Infectious Disease*, *16*, 41-45. <http://dx.doi.org/10.1016/j.tmaid.2017.02.008>
- Larsen, D. L., Attkisson, C. C., Hargreaves, W. A., & Nguyen, T. D. (1979). Assessment of client/patient satisfaction: Development of a general scale. *Evaluation and Program Planning*, *2*(3), 197-207. [http://dx.doi.org/10.1016/0149-7189\(79\)90094-6](http://dx.doi.org/10.1016/0149-7189(79)90094-6)
- Layard, R., Clark, D., Knapp, M., & Mayraz, G. (2007). Cost-benefit analysis of psychological therapy. *National Institute Economic Review*, *202*(1), 90-98. <https://doi.org/10.1177/0027950107086171>
- Lazar, M., & Davenport, L. (2018). Barriers to health care access for low income families: A review of literature. *Journal of Community Health Nursing*, *35*(1), 28-37. <http://dx.doi.org/10.1080/07370016.2018.1404832>
- Leech, N. L. & Onwuegbuzie, A. J. (2009). A typology of mixed methods research designs. *Quality & Quantity*, *43*(2), 265-275. <http://dx.doi.org/10.1007/s11135-007-9105-3>
- Lund, C., Tomlinson, M., De Silva, M., Fekadu, A., Shidhaye, R., Jordans, M., ... & Thornicroft, G. (2012). PRIME: A programme to reduce the treatment gap for mental disorders in five low-and middle-income countries. *PLoS Medicine*, *9*(12), e1001359. <http://dx.doi.org/10.1371/journal.pmed.1001359>
- Luoto, J., Shekelle, P. G., Maglione, M. A., Johnsen, B., & Perry, T. (2014). Reporting of context and implementation in studies of global health interventions: A pilot study. *Implementation Science*, *9*(1), 57. <http://dx.doi.org/10.1186/1748-5908-9-57>



- Lysaker, P. H., Roe, D., & Yanos, P. T. (2006). Toward understanding the insight paradox: Internalized stigma moderates the association between insight and social functioning, hope, and self-esteem among people with schizophrenia spectrum disorders. *Schizophrenia Bulletin*, 33(1), 192-199. <https://doi.org/10.1093/schbul/sbl016>
- Ministry of Health in Colombia. (2018). *PAPSIVI*. Retrieved on January 21, 2019 [https://www.minsalud.gov.co/proteccionsocial/Paginas/Victimas\\_PAPSIVI.aspx](https://www.minsalud.gov.co/proteccionsocial/Paginas/Victimas_PAPSIVI.aspx)
- Morse, J. M. (1997). " Perfectly healthy, but dead": The myth of inter-rater reliability. *Qualitative Health Research*, 7(4), 445-447. <https://doi.org/10.1177/104973239700700401>
- Murray, L. K., Dorsey, S., Haroz, E., Lee, C., Alsiary, M. M., Haydary, A., ... & Bolton, P. (2013). A common elements treatment approach for adult mental health problems in low- and middle-income countries. *Cognitive and Behavioral Practice*, 21(2), 111-123. <http://dx.doi.org/10.1016/j.cbpra.2013.06.005>
- Murray, L. K., Tol, W., Jordans, M., Sabir, G., Amin, A. M., Bolton, P., ... & Thornicroft, G. (2014). Dissemination and implementation of evidence based, mental health interventions in post conflict, low resource settings. *Intervention*, 12, 94-112. <http://dx.doi.org/10.1097/WTF.0000000000000070>
- Nelson, J. (2017). Using conceptual depth criteria: Addressing the challenge of reaching saturation in qualitative research. *Qualitative Research*, 17(5), 554-570. <http://dx.doi.org/10.1177/1468794116679873>
- Nguyen, T. D., Attkisson, C. C., & Stegner, B. L. (1983). Assessment of patient satisfaction: Development and refinement of a service evaluation questionnaire. *Evaluation and Program Planning*, 6(3-4), 299-313. [http://dx.doi.org/10.1016/0149-7189\(83\)90010-1](http://dx.doi.org/10.1016/0149-7189(83)90010-1)
- Palinkas, L. A., Horwitz, S. M., Chamberlain, P., Hurlburt, M. S., & Landsverk, J. (2011). Mixed-methods designs in mental health services research: A review. *Psychiatric Services*, 62(3), 255-263. [http://dx.doi.org/10.1176/ps.62.3.pss6203\\_0255](http://dx.doi.org/10.1176/ps.62.3.pss6203_0255)
- Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, 42(5), 533-544. <http://dx.doi.org/10.1007/s10488-013-0528-y>

- Patel, V., Chowdhary, N., Rahman, A., & Verdeli, H. (2011). Improving access to psychological treatments: Lessons from developing countries. *Behaviour Research and Therapy*, 49(9), 523-528. <http://dx.doi.org/10.1016/j.brat.2011.06.012>
- Patel, V., Chisholm, D., Parikh, R., Charlson, F. J., Degenhardt, L., Dua, T., ... & Lund, C. (2016). Addressing the burden of mental, neurological, and substance use disorders: Key messages from Disease Control Priorities. *The Lancet*, 387(10028), 1672-1685. [http://dx.doi.org/10.1016/S0140-6736\(15\)00390-6](http://dx.doi.org/10.1016/S0140-6736(15)00390-6)
- Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., ... & Herrman, H. (2018). The Lancet Commission on global mental health and sustainable development. *The Lancet*, 392(10157), P1553-1598. [https://doi.org/10.1016/S0140-6736\(18\)31612-X](https://doi.org/10.1016/S0140-6736(18)31612-X)
- Patel, V., Weiss, H. A., Chowdhary, N., Naik, S., Pednekar, S., Chatterjee, S., ... & Verdeli, H. (2011). Lay health worker led intervention for depressive and anxiety disorders in India: Impact on clinical and disability outcomes over 12 months. *The British Journal of Psychiatry*, 199(6), 459-466. <http://dx.doi.org/10.1192/bjp.bp.111.092155>
- Patel, V., Weobong, B., Weiss, H. A., Anand, A., Bhat, B., Katti, B., ... & Vijayakumar, L. (2017). The Healthy Activity Program (HAP), a lay counsellor-delivered brief psychological treatment for severe depression, in primary care in India: A randomized controlled trial. *The Lancet*, 389(10065), 176-185. [http://dx.doi.org/10.1016/S0140-6736\(16\)31589-6](http://dx.doi.org/10.1016/S0140-6736(16)31589-6)
- Pfadenhauer, L. M., Mozygemba, K., Gerhardus, A., Hofmann, B., Booth, A., Lysdahl, K. B., ... & Rehfuess, E. A. (2015). Context and implementation: A concept analysis towards conceptual maturity. *Zeitschrift für Evidenz, Fortbildung und Qualität im Gesundheitswesen*, 109(2), 103-114. <https://doi.org/10.1016/j.zefq.2015.01.004>
- Rachman, S. (2009). Psychological treatment of anxiety: The evolution of behavior therapy and cognitive behavior therapy. *Annual Review of Clinical Psychology*, 5, 97-119. <http://dx.doi.org/10.1146/annurev.clinpsy.032408.153635>
- Rahman, A., Malik, A., Sikander, S., Roberts, C., & Creed, F. (2008). Cognitive behaviour therapy-based intervention by community health workers for mothers with depression and their infants in rural Pakistan: A cluster-randomised controlled trial. *The Lancet*, 372(9642), 902-909. [http://dx.doi.org/10.1016/S0140-6736\(08\)61400-2](http://dx.doi.org/10.1016/S0140-6736(08)61400-2)
- Roberts, R. E., Attkisson, C. C., & Mendias, R. M. (1984). Assessing the Client Satisfaction Questionnaire in English and Spanish. *Hispanic Journal of Behavioral Sciences*, 6, 385-396. <https://doi.org/10.1177/07399863840064004>

- Richards, A., Ospina-Duque, J., Barrera-Valencia, M., Escobar-Rincón, J., Ardila-Gutiérrez, M., Metzler, T., & Marmar, C. (2011). Posttraumatic stress disorder, anxiety and depression symptoms, and psychosocial treatment needs in Colombians internally displaced by armed conflict: A mixed-method evaluation. *Psychological Trauma: Theory, Research, Practice, and Policy*, 3(4), 384-393. <http://dx.doi.org/10.1037/a0022257>
- Saraceno, B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J., ... & Underhill, C. (2007). Barriers to improvement of mental health services in low-income and middle-income countries. *The Lancet*, 370(9593), 1164-1174. [http://dx.doi.org/10.1016/S0140-6736\(07\)61263-X](http://dx.doi.org/10.1016/S0140-6736(07)61263-X)
- Samudre, S., Shidhaye, R., Ahuja, S., Nanda, S., Khan, A., Evans-Lacko, S., & Hanlon, C. (2016). Service user involvement for mental health system strengthening in India: A qualitative study. *BMC Psychiatry*, 16(1), 1. <http://dx.doi.org/10.1186/s12888-016-0981-8>
- Saxena, S., Saraceno, B., & Granstein, J. (2013). Scaling up mental health care in resource-poor settings. In G. Thornicroft, M. Ruggeri, & D. Goldberg (Eds), *Improving Mental Health Care: The Global Challenge* (pp.12-24). Hoboken, New Jersey: John Wiley & Sons. <http://dx.doi.org/10.1002/9781118337981.ch2>
- Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., ... & Jinks, C. (2018). Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality & Quantity*, 52(4), 1893-1907. <http://dx.doi.org/10.1007/s11135-017-0574-8>
- Semrau, M., Alem, A., Abdulmalik, J., Docrat, S., Evans-Lacko, S., Gureje, O., ... & Shidhaye, R. (2018). Developing capacity-building activities for mental health system strengthening in low-and middle-income countries for service users and caregivers, service planners, and researchers. *Epidemiology and Psychiatric Sciences*, 27(1), 11-21. <http://dx.doi.org/10.1017/S2045796017000452>
- Semrau, M., Evans-Lacko, S., Alem, A., Ayuso-Mateos, J. L., Chisholm, D., Gureje, O., ... & Lund, C. (2015). Strengthening mental health systems in low-and middle-income countries: The Emerald programme. *BMC Medicine*, 13(79), 1. <http://dx.doi.org/10.1186/s12916-015-0309-4>
- Shafran, R., Clark, D. M., Fairburn, C. G., Arntz, A., Barlow, D. H., Ehlers, A., ... & Salkovskis, P. M. (2009). Mind the gap: Improving the dissemination of CBT. *Behaviour Research and Therapy*, 47(11), 902-909. <http://dx.doi.org/10.1016/j.brat.2009.07.003>

- Singla, D. R., Kohrt, B. A., Murray, L. K., Anand, A., Chorpita, B. F., & Patel, V. (2017). Psychological treatments for the world: Lessons from low-and middle-income countries. *Annual Review of Clinical Psychology, 13*, 149-181. <http://dx.doi.org/10.1146/annurev-clinpsy-032816-045217>
- Sweetland, A. C., Oquendo, M. A., Sidat, M., Santos, P. F., Vermund, S. H., Duarte, C. S., ... & Wainberg, M. L. (2014). Closing the mental health gap in low-income settings by building research capacity: Perspectives from Mozambique. *Annals of Global Health, 80*(2), 126-133. <http://dx.doi.org/10.1016/j.aogh.2014.04.014>
- Stetler, C. B., Legro, M. W., Wallace, C. M., Bowman, C., Guihan, M., Hagedorn, H., ... & Smith, J. L. (2006). The role of formative evaluation in implementation research and the QUERI experience. *Journal of General Internal Medicine, 21*(S2), S1-S8. <http://dx.doi.org/10.1111/j.1525-1497.2006.00355.x>
- Tabak, R. G., Khoong, E. C., Chambers, D. A., & Brownson, R. C. (2012). Bridging research and practice: Models for dissemination and implementation research. *American Journal of Preventive Medicine, 43*(3), 337-350. <http://dx.doi:10.1016/j.amepre.2012.05.024>.
- Thornicroft, G. (2007). Most people with mental illness are not treated. *The Lancet, 370*(9590), 807-808. [http://dx.doi.org/10.1016/S0140-6736\(07\)61392-0](http://dx.doi.org/10.1016/S0140-6736(07)61392-0)
- Thornicroft, G., & Tansella, M. (2013). The balanced care model for global mental health. *Psychological Medicine, 43*, 849-863. <http://dx.doi:10.1017/S0033291712001420>
- Upadhaya, N., Jordans, M. J., Pokhrel, R., Gurung, D., Adhikari, R. P., Petersen, I., & Komproe, I. H. (2017). Current situations and future directions for mental health system governance in Nepal: Findings from a qualitative study. *International Journal of Mental Health Systems, 11*(1), 37. <https://doi.org/10.1186/s13033-017-0145-3>
- Van Widenfelt, B. M., Treffers, P. D., De Beurs, E., Siebelink, B. M., & Koudijs, E. (2005). Translation and cross-cultural adaptation of assessment instruments used in psychological research with children and families. *Clinical Child and Family Psychology Review, 8*(2), 135-147. <http://dx.doi.org/10.1007/s10567-005-4752-1>
- Vos, T., Corry, J., Haby, M. M., Carter, R., & Andrews, G. (2005). Cost-effectiveness of cognitive-behavioural therapy and drug interventions for major depression. *Australian and New Zealand Journal of Psychiatry, 39*(8), 683-692. <https://doi.org/10.1080/j.1440-1614.2005.01652.x>
- Wainberg, M. L., Scorza, P., Shultz, J. M., Helpman, L., Mootz, J. J., Johnson, K. A., ... & Arbuckle, M. R. (2017). Challenges and opportunities in global mental health:

A research-to-practice perspective. *Current Psychiatry Reports*, 19(5), 28.  
<http://dx.doi.org/10.1007/s11920-017-0780-z>

Wang, P. S., Aguilar-Gaxiola, S., Alonso, J., Angermeyer, M. C., Borges, G., Bromet, E. J., ... & Haro, J. M. (2007). Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. *The Lancet*, 370(9590), 841-850. [https://doi.org/10.1016/S0140-6736\(07\)61414-7](https://doi.org/10.1016/S0140-6736(07)61414-7)

Webster, P. C. (2012). Health in Colombia: A system in crisis. *Canadian Medical Association Journal*, 184(6), E289–E290. <https://doi.org/10.1503/cmaj.109-4124>

WHO Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health: Commission on Social Determinants of Health Final Report*, In World Health Organization (Ed.). World Health Organization.

World Health Organization. (2009). *Mental health systems in selected low and middle-income countries: A WHO-AIMS cross-national analysis*. Retrieved from: [http://whqlibdoc.who.int/publications/2009/9789241547741\\_eng.pdf](http://whqlibdoc.who.int/publications/2009/9789241547741_eng.pdf).

World Health Organization. (2010). *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: Mental Health Gap Action Programme (mhGAP)*. Geneva, Switzerland: World Health Organization.

World Health Organization (2016). Framework on integrated, people-centred health services. In WHO (Ed), *Sixty Ninth World Health Assembly* (pp. 10–12). Geneva, Switzerland: World Health Organization. Retrieved on January 4, 2019 from <https://www.who.int/servicedeliverysafety/areas/people-centred-care/framework/en>.

**VITAE**

