Telephone-Delivered Psychological Treatment for Children in Humanitarian Settings: Results of the t-CETA Study

Queen Mary University of London

Médecins du Monde

Johns Hopkins Bloomberg School of Public Health

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Programme

14:00 – 14.05	**Welcome and Introduction to the Webinar:** Prof Michael Pluess (QMUL)
14:05 – 14:15	**Introduction to CETA:** Stephanie Skavenski (JHU)
14:15 – 14:25	**Introduction to t-CETA:** Prof Michael Pluess (QMUL) & Nicolas Chehade (MdM)
14:25 – 14:45	**Presentation of Research Results from the t-CETA study:** Dr Fiona McEwen (QMUL)
14:45 – 14:55	**Practical Challenges and Solutions when Delivering t-CETA:** Dr Tania Bosqui (AUB)
14:55 – 15:00	**Presentation of the Guidance Document for Phone-Delivered Treatment:** Dr Fiona McEwen (QMUL)
15:00 – 15:10	**Practical Experience with CETA over phone in Lebanon:** Joelle Wehbe (Restart)
15:10 – 15:15	**Information on Providing t-CETA in your Organisation:** Stephanie Skavenski (JHU)
15:15 – 15:30	**Q&A:** Prof Michael Pluess & t-CETA study team
15:30	**Final Comments and End:** Prof Michael Pluess (QMUL)

Common Elements Treatment Approach (CETA)

Laura Murray, PhD (lmurra15@jhu.edu)

Stephanie Skavenski, MPH, MSW

Johns Hopkins Bloomberg School of Public Health

Department of Mental Health & International Health

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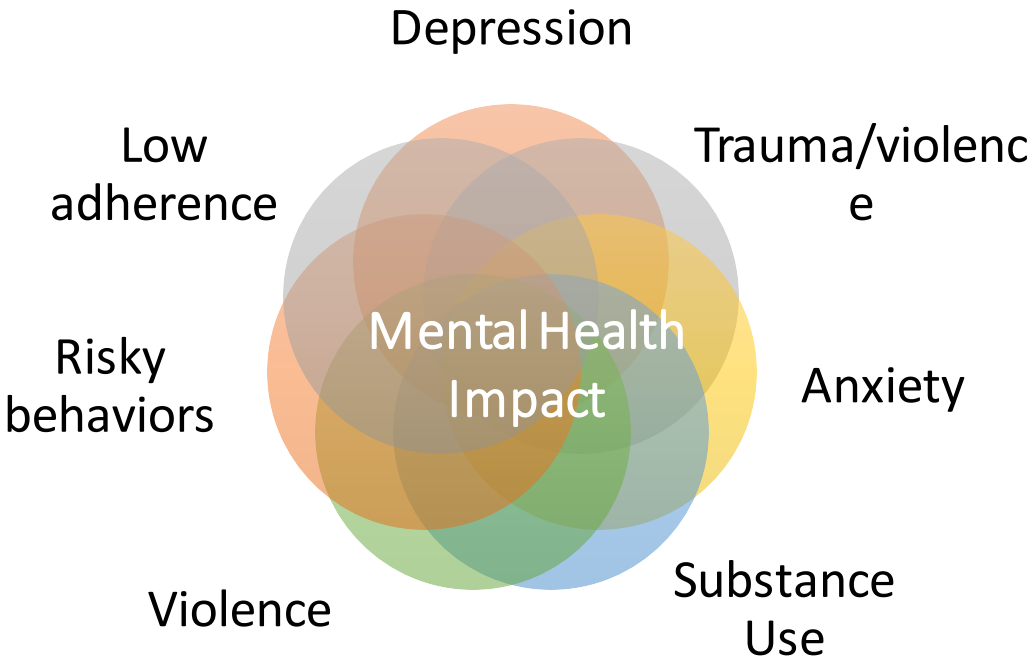
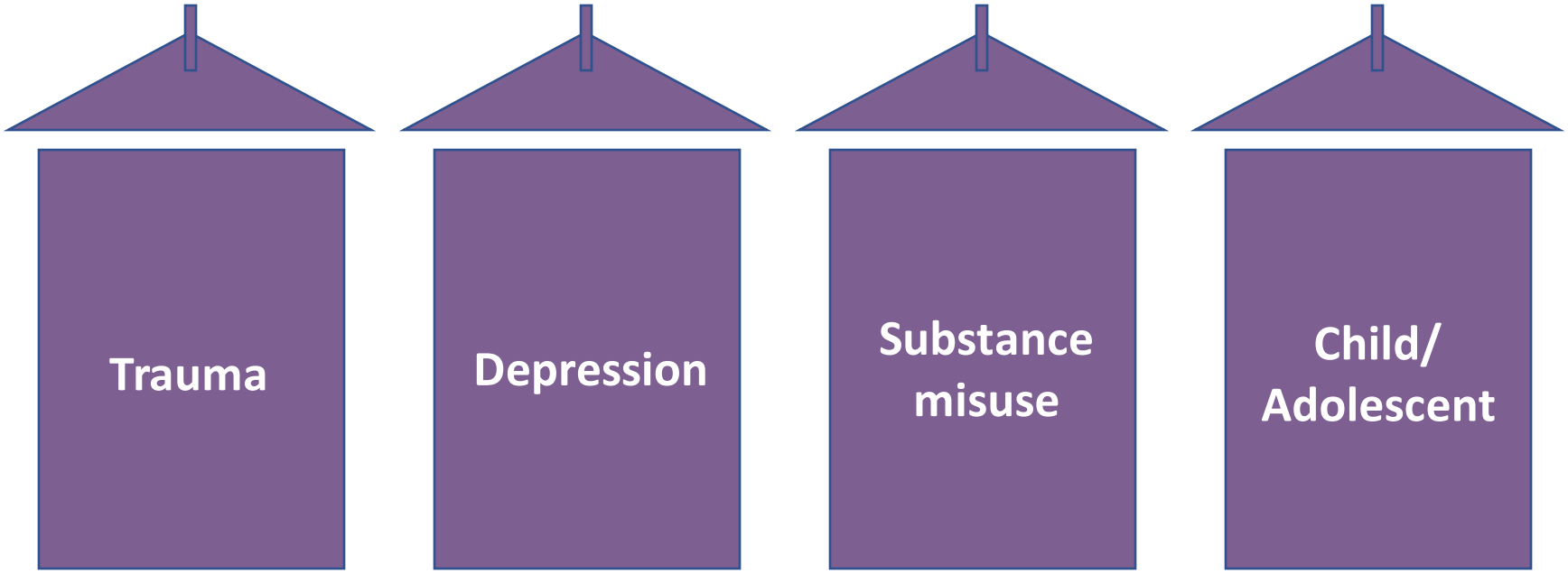
CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

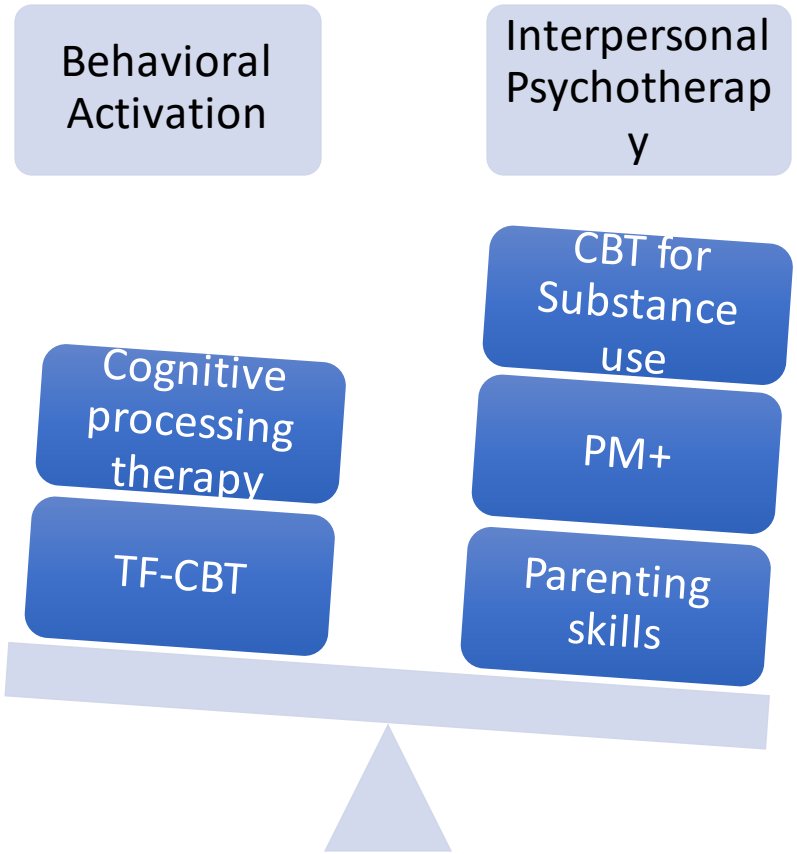
WHY?



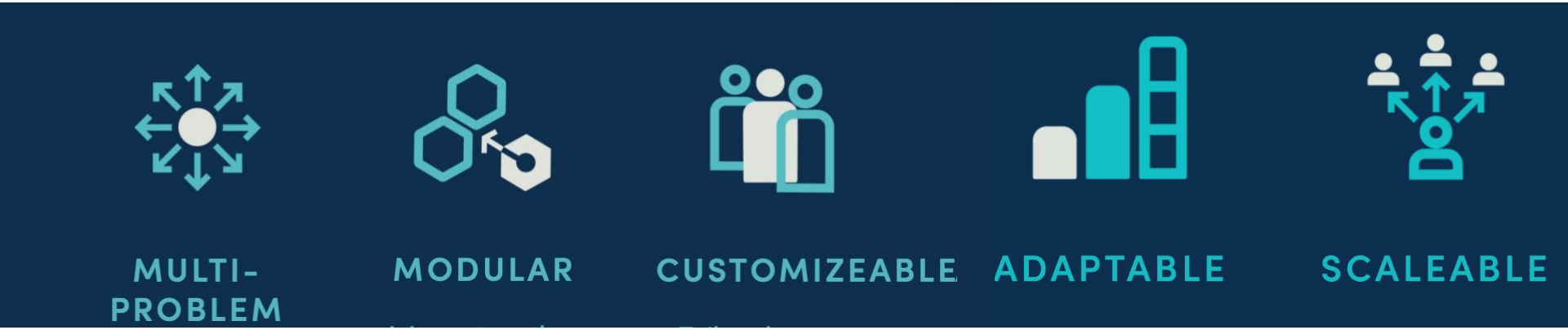
Comorbidity!

Current Approach – Siloed




Behavioral Activation
Interpersonal Psychotherapy
CBT for Substance use
Cognitive processing therapy
PM+
TF-CBT
Parenting skills

CETA



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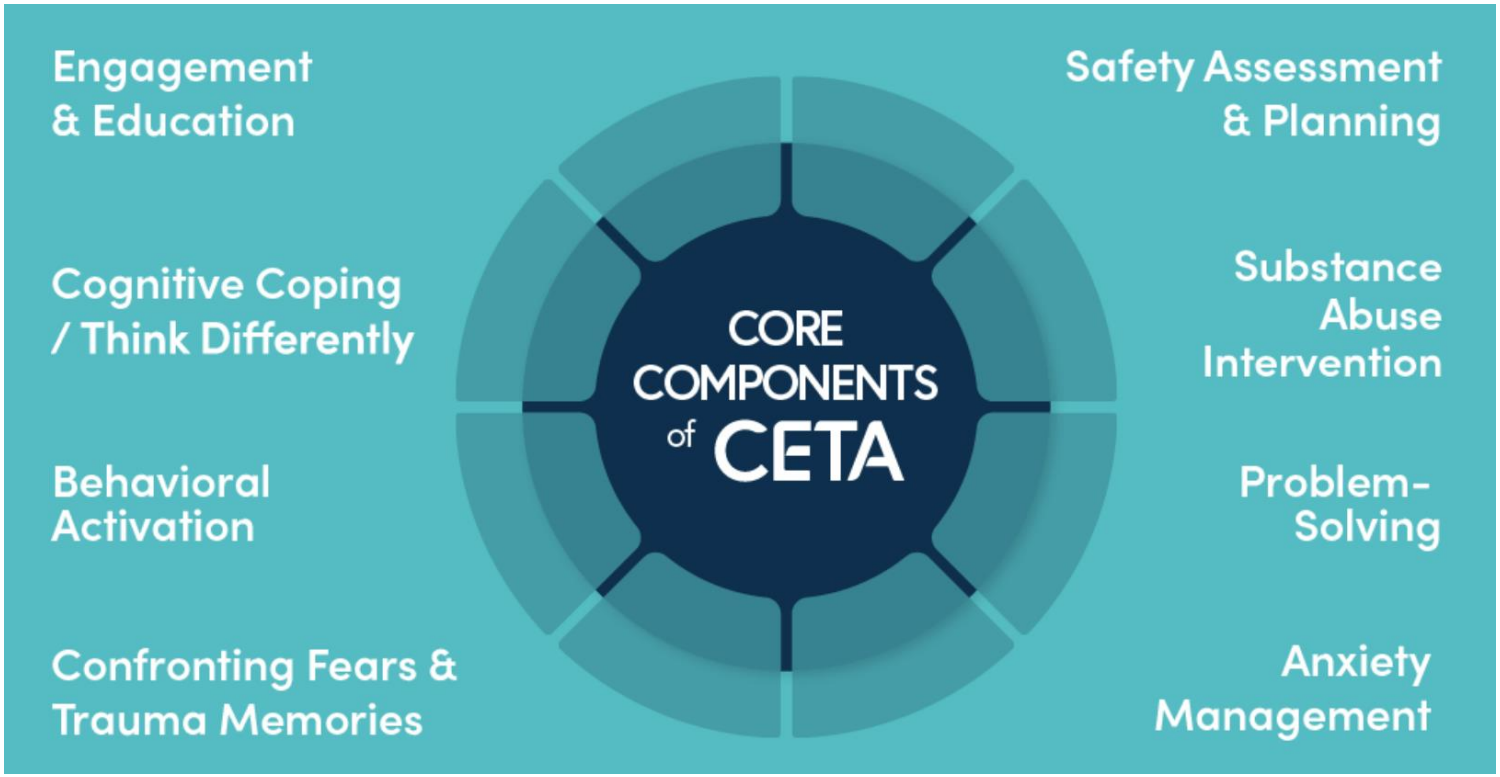

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Clinical Decision Making for Lay Providers

- **3 Choice points:**

1. **Selection** – What is the primary problem?

2. **Sequence** – What order and why?
   What do you do when there is “interference”?

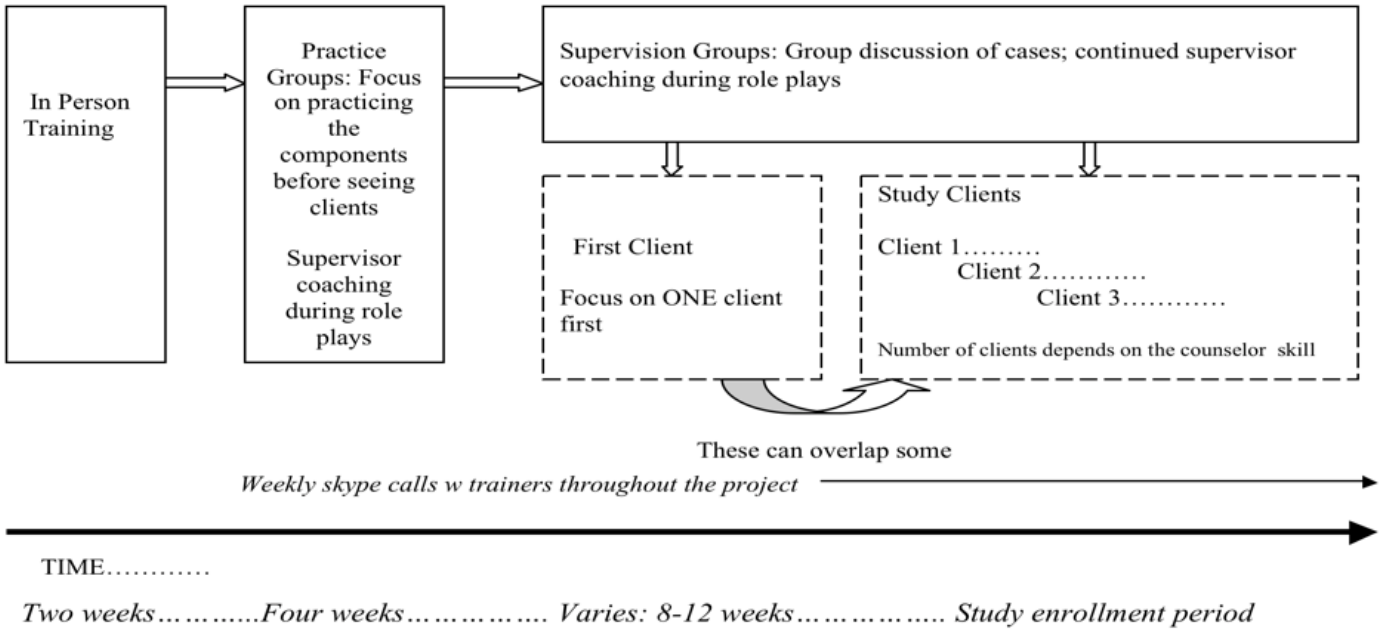
3. **Dosing** – How many sessions of each component?

How to Make Choices…

1. Assessment Results

2. What client says/does

3. Discussion with your Supervisor



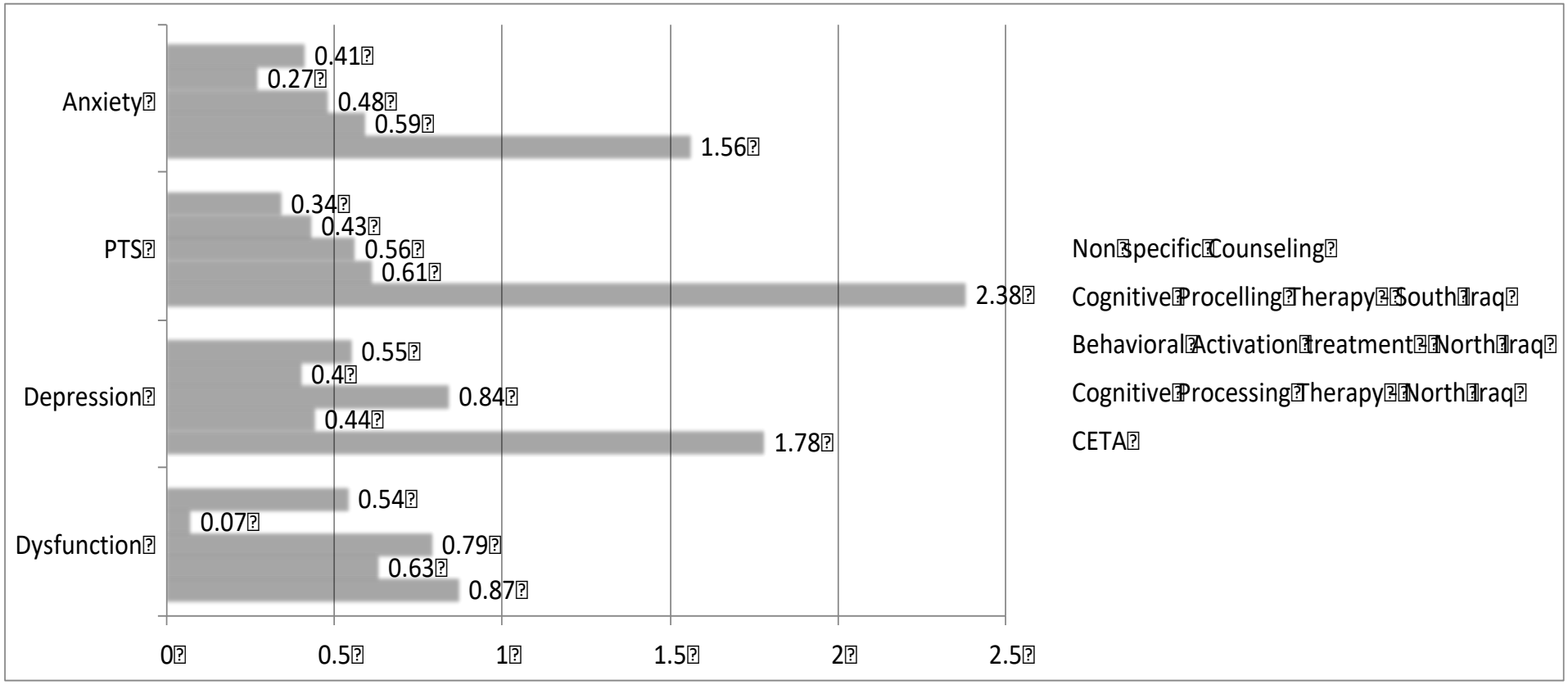
Process of learning:

Apprenticeship model

What is the Evidence for CETA?

Citation	Site	Population	N		Impact (Effect sizes)
Bolton et al. (2014)	Mae Sot, Thailand	Adult; Burmese Refugees	CETA: 182 Wait-list: 165	CETA vs. Wait-list RCT	Depression: 1.16 PTS: 1.19 Impaired Function: 0.63 Anxiety: 0.79 Aggression: -0.58
Weiss, Murray et al. (2015)	Southern Iraq	Adult; Survivors of systematic violence	CPT: 99 Wait-list: 50	CETA vs. Wait-list RCT	PTS: 2.40 Depression: 1.82 Dysfunction: 0.88
Murray et al., (2018)	Jijigga, Ethiopia	Somali refugees in camps; Youth	CETA: 37	Open trial	Internalizing 1.37 Externalizing 0.85 Posttraumatic stress 1.71 Improvements in well-being 0.7
Murray et al., (2019)	Lusaka, Zambia	Women, Men, Children (Family units)	CETA: 123 couples TAU Plus Safety: 125 couples	CETA vs. TAU + safety RCT	Violence (SVAW sub-score): 0.49 Substance use: 0.43 *DSMB stopped trial 1 year early due to strong treatment effectiveness
In preparation	Ukraine; 3 locations	Adult, Veterans, IDPs, male and female	Short-CETA n=117, Standard CETA n=129, Control=56	5 session CETA vs. standard CETA vs. waitlist	Standard CETA vs. Control: large effect sizes (*d* = 0.60-1.06) Short CETA vs. Control: medium effect sizes (*d*=0.46-0.62). Standard more effective than short

CETA is more Effective than Single Focused Treatments



Introduction to the t-CETA Study

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t-CETA Webinar, 24.02.2021

Introduction to the t-CETA Study

(Prof Michael Pluess)

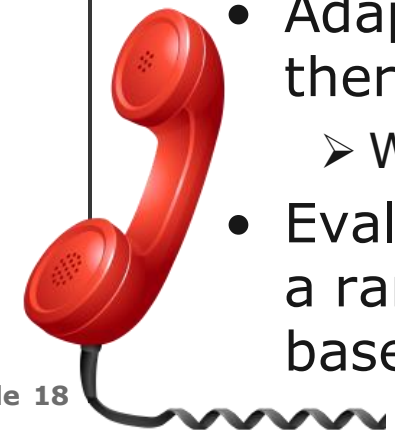
t-CETA Study

- **Research Partners**
  - ***Queen Mary University of London***
    - Michael Pluess, Fiona McEwen, Kristin Hadfield, Karen Pluess, Claudinei Biazoli
  - ***Johns Hopkins University***
    - Laura Murray, Stephanie Skavenski, Paul Bolton
  - ***Médecins du Monde***
    - Nicolas Chehade, Stephanie Saad, Diana Rahman, Hania El Khatib, Patricia Moghames (and support staff)
  - ***American University of Beirut***
    - Tania Bosqui and phone assessors
  - ***Medical School Hamburg***
    - Roland Weierstall
  - ***Institute for Development, Research, Advocacy & Applied Care***
    - Elie Karam
- **Funding:**

t-CETA Study

- **Background**
  - Children exposed to war are at increased risk for the development of mental health problems
  - Suitable treatment is often not easily available
  - Established reasons:
    1. **High cost of providing new services**
    2. **Difficulty recruiting qualified staff**
    3. **Limited mobility of refugee population**

- **Study Objectives**
  - Adapt an existing transdiagnostic cognitive-behavioural therapy approach (CETA) for delivery over phone
    - ➢ With the help of trained and supervised lay counsellors
  - Evaluate feasibility of the new treatment (t-CETA) with a randomised controlled trial with Syrian refugee children based in Lebanon



t-CETA Study

- **Research Approach**
  - Project linked to the BIOPATH study (*N* = 1,595)
    - ***QMUL, IDRAAC, MdM***
    - Funded by NICHD NIH *Eunice Kennedy Shriver* National Institute of Child Health and Human Development
  - **Sample**
    - BIOPATH children aged 6-19 years who requested mental health services from MdM during BIOPATH data collection
  - **CETA: C**ommon **E**lements **T**reatment **A**pproach
    - Modular-based transdiagnostic psychotherapy for common disorders based on the most effective CBT components
  - **Phase I: Development Stage**
    - Recruit and train staff with CETA and develop t-CETA manual
  - **Phase II: Piloting Stage**
    - Evaluate feasibility of t-CETA in a pilot randomised controlled trial (RCT)

t-CETA Phase I

- **Development Stage**
  - **Translation** of CETA manual into Arabic
  - **Recruitment** of two lay counsellors
  - Initial CETA **training** (JHU) and practice sessions
  - **Recruitment** of children with mental health problems
  - Delivery of **face-to-face CETA** to Syrian refugee children
  - **Adaptation** of manual to phone delivery (t-CETA)
  - First **testing** of t-CETA with Syrian refugee children in the clinic

t-CETA Phase II

- **Piloting Stage**
  - Evaluation of **feasibility** with a small pilot RCT
    - **Sample**
      - Small number of Syrian refugee children from the BIOPATH study who requested services and screened positive for mental health problems during clinical intake interviews
    - **Stratified Randomisation**
      - Randomly allocated to t-CETA or treatment as usual (TaU) provided by MdM
      - Stratified for age (8-12 years, 13-16 years) and gender
    - **Blinding**

Participants	Treatment team	Assessment team	Data analysis team
No	No	Yes	Yes

    - **Assessment**
      - Independent assessments over phone (pre-post)
      - In-session assessments by counsellors (throughout treatment)

Practical Aspects

(Nicolas Chehade)

Practical Aspects

- **Recruitment of Lay Counsellors**
  - **Interview**
    - technical questions
    - case scenarios role play and feedback
  - **Practical Test**
    - case management, ethics and child protection

- **Training of Lay Counsellors**
  - **10 Day CETA Training** (JHU)
  - **CETA Practice**
    - 12 CETA components over two months
    - 2-3 sessions per week (1.5-2.5 hours)
    - Theory
    - Role plays of case scenarios and feedback
  - **Treatment of first CETA case**

Practical Aspects

- **Recruitment of Participants**
  - **Recruitment**
    - **Phone Screening (MdM)**
      - Initial follow-up phone call for all BIOPATH referrals
      - Ask about current mental health problems and needs of child
      - If positive, invitation for intake assessment
    - **Intake Assessment (MdM)**
      - Informed consent
      - MdM Patient intake form
      - Clinical assessment (MINI-Kid)
      - CETA Client Monitoring Form (CMF)
      - Visual aides
    - **Phone Assessment (AUB)**
      - Pre-post treatment independent assessment over phone
      - Set of locally validated mental health measures used in BIOPATH (CESD for depression, SCARED for anxiety, CPSS for PTSD, SDQ for externalizing problems, WHO-DAS for impairment)

Practical Aspects

- **Supervision of Lay Counsellors**
  - **Supervision of CETA Research Manager:**
    - 1 CETA supervision session per week by CETA trainer Stephanie Skavenski (JHU; online)
  - **Supervision of CETA Counsellors:**
    - 1-2 CETA supervision sessions per week provided by research manager Nicolas Chehade
    - 1 intake assessment supervision session per week by Dr Tania Bosqui (AUB)
  - **Shadowing**
    - Research Manager and CETA counsellors shadow each other during intake assessments and CETA sessions
    - 1 to 3 sessions each

Practical Aspects

- **Adaptation Process of CETA to t-CETA**
  1. First draft of t-CETA manual
  2. Trying out content with healthy volunteers
  3. Revising draft of t-CETA manual
  4. Applying t-CETA manual with children that meet inclusion criteria but in MdM clinic
  5. Further revision of t-CETA manual
  6. Evaluation of feasibility with RCT in settlements

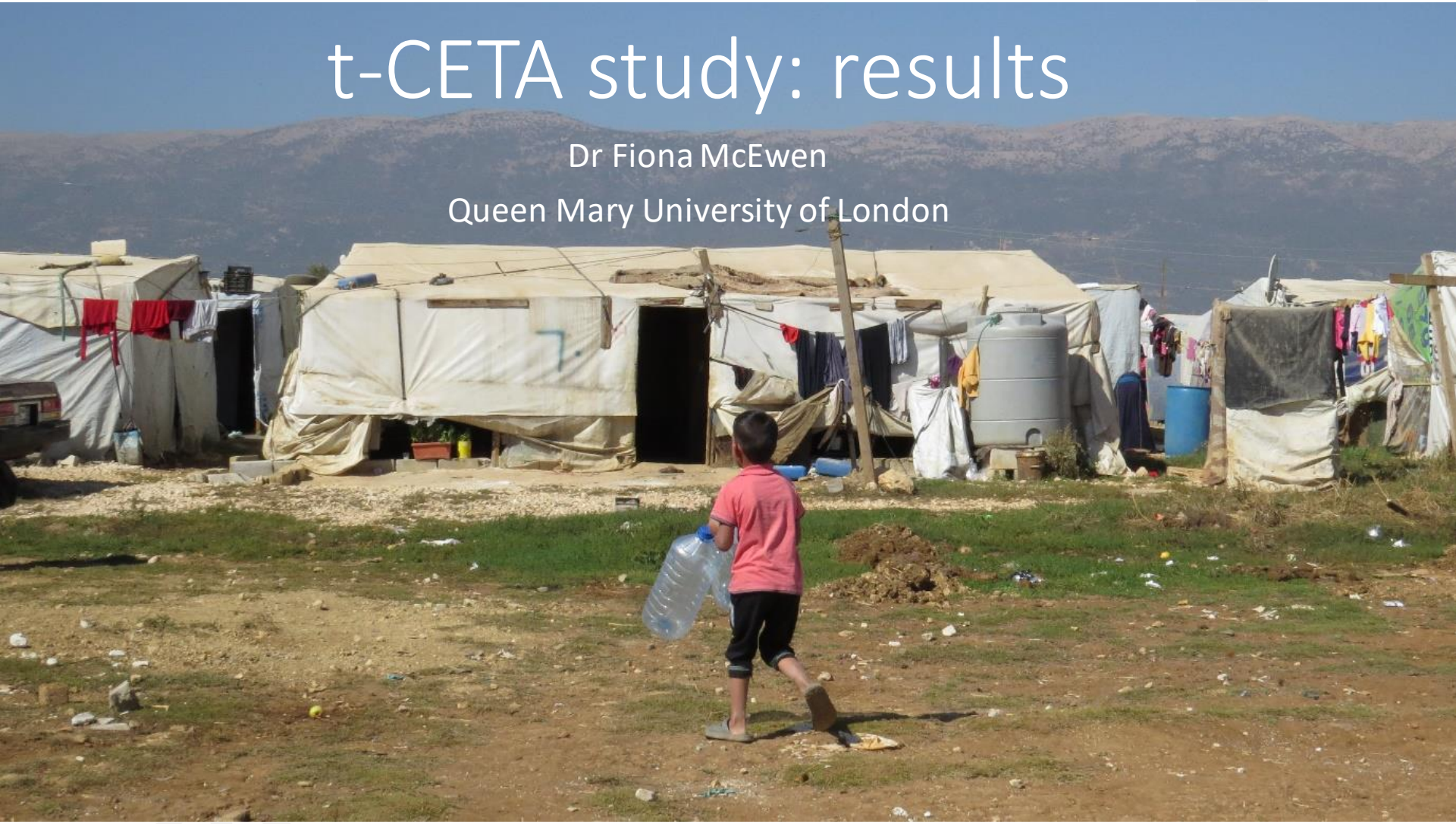
- **Adaptations:**
  - The regular 8 to 12 CETA sessions were divided into shorter sessions (approx. 30 min)
  - Use of games to engage children
  - Use of visual aides (booklet)
  - Use of moment by moment monitoring for certain activities

Thank you very much!

t-CETA study: results

Dr Fiona McEwen

Queen Mary University of London



Key research questions

- Is it *feasible* for *lay counsellors* to delivery CETA *via phone* in a *humanitarian setting*?

- Is t-CETA *acceptable* to Syrian children and their caregivers?

- Does t-CETA help to *overcome barriers* to children accessing mental health services?

- Does t-CETA *reduce symptoms* of mental health problems in children?

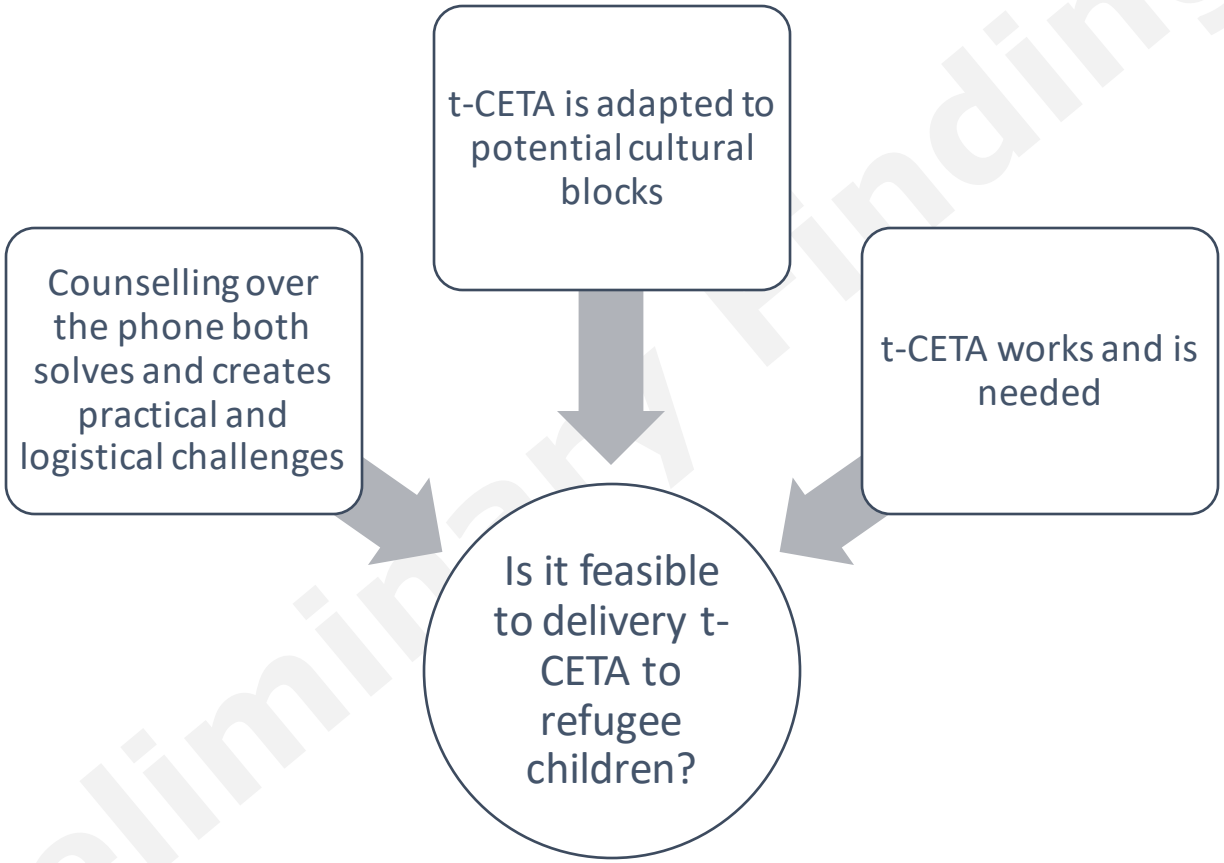
Overview of research data

- *Mixed methods – quantitative + qualitative data*
- Pilot randomised controlled trial (RCT)
  - Attendance and adherence data
  - In-session assessments
  - Independent assessments
- Case series of children offered t-CETA
  - Case / supervision notes
- Thematic analysis of interviews with counsellors
- Thematic analysis of interviews with children and caregivers

Is it feasible for lay counsellors to deliver CETA via phone in a humanitarian setting?

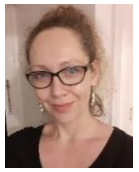
- Individual interviews conducted with counsellors and local supervisor (n=3)
  - Diana Abdul Rahman, Stephanie Saad, Nicolas Chehade

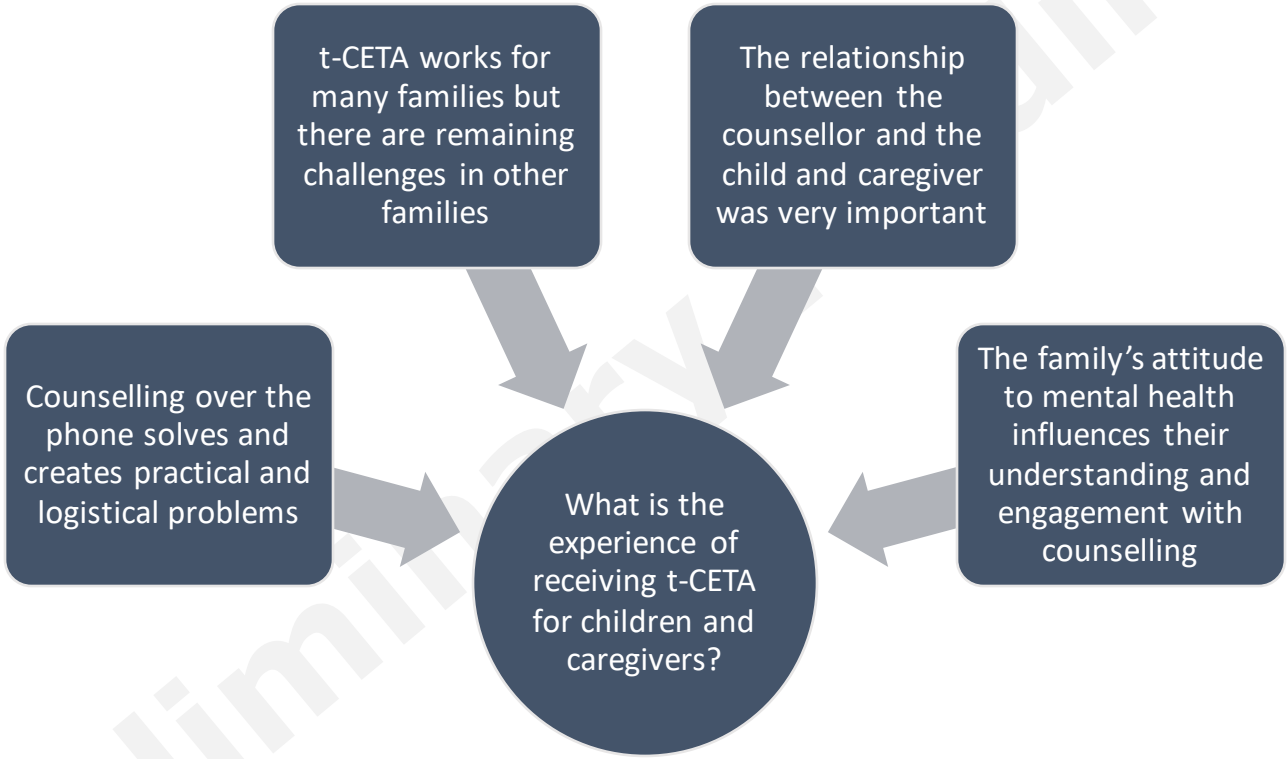
- *What are the perspectives of counsellors on the delivery of CETA to Syrian refugee children over the t*
- Audio recorded, transcribed, thematic content analysis conducted
  - Dr Kristin Hadfield & Karen Pluess
- 3 themes identified



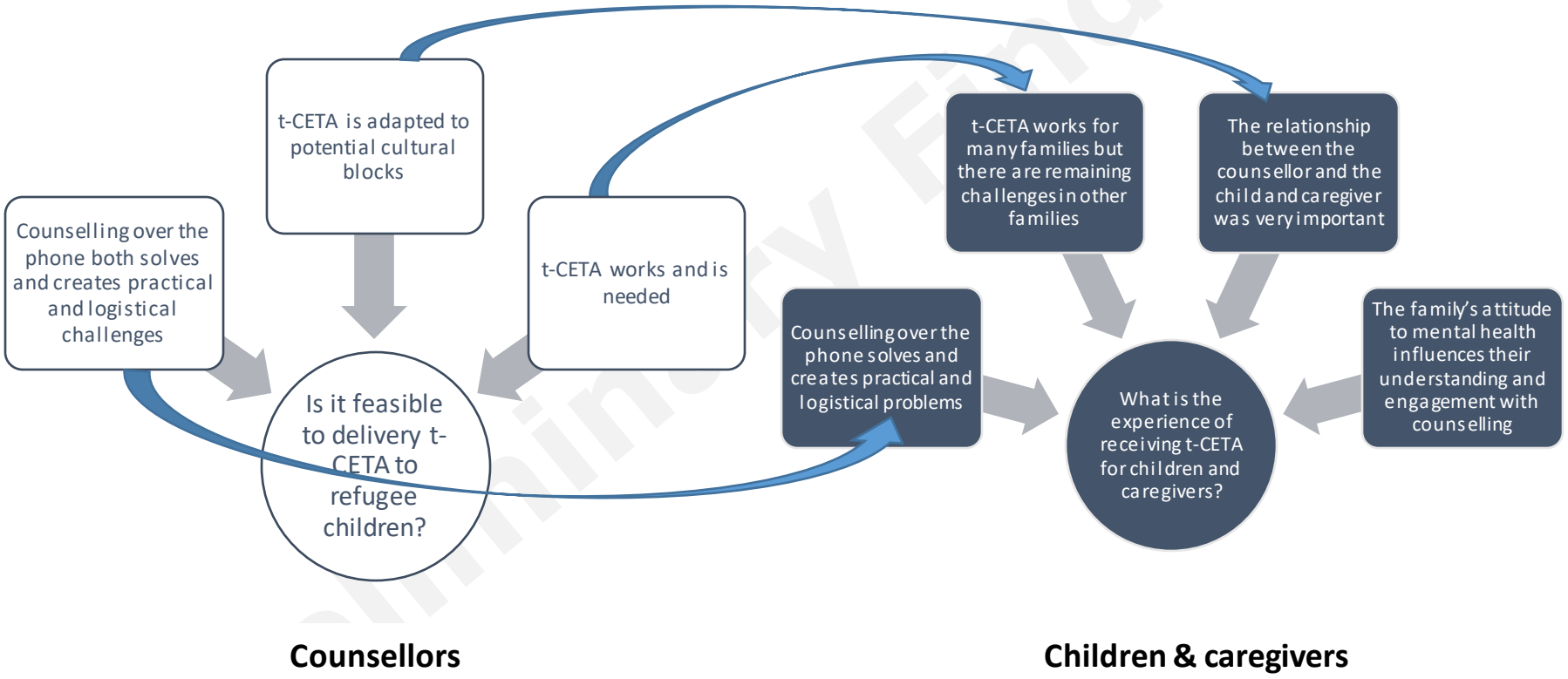
Is t-CETA acceptable to Syrian children and their caregivers?

- Individual interviews with children who received t-CETA (n=11) and caregivers (n=11)
- *How did Syrian refugee children and their caregivers experience receiving psychological treatment (t-CETA) over the phone?*
- Audio recorded, transcribed, translated, thematic content analysis conducted
  - Hania El Khatib, Dr Fiona McEwen & Dr Kristin Hadfield
- 4 themes identified

Feasibility and acceptability of t-CETA



t-CETA solves problems

Travelling is "a big challenge"

Telephone delivery reaches more children, is logistically flexible, can hold more appointments, follow up more easily and rapidly when sessions missed

Some children found it easier to *"feel free to talk about everything"* over the phone

Counsellors

Phone delivered therapy was practical: access to therapy is easier than travelling to a clinic

- Transport is expensive
- Other children to take care of (not safe to leave them in the camp)
- Takes a long time (difficult if attend school)
- Road closures
- Bad weather

Many were comfortable using the phone, might be easier for shy children

Children & caregivers

t-CETA creates challenges

Difficulties with calls

- High phone costs
- Only one phone per family
- Poor network coverage, phone charging
- Worries about calls being recorded/spying
- Lack of privacy
- Challenges to communication without visual cues or in-person tools

"No, sometimes my siblings would scream a lot and stuff . . . I could not hear a lot … around the camp, many people pass and play and scream and stuff, I would not hear well."

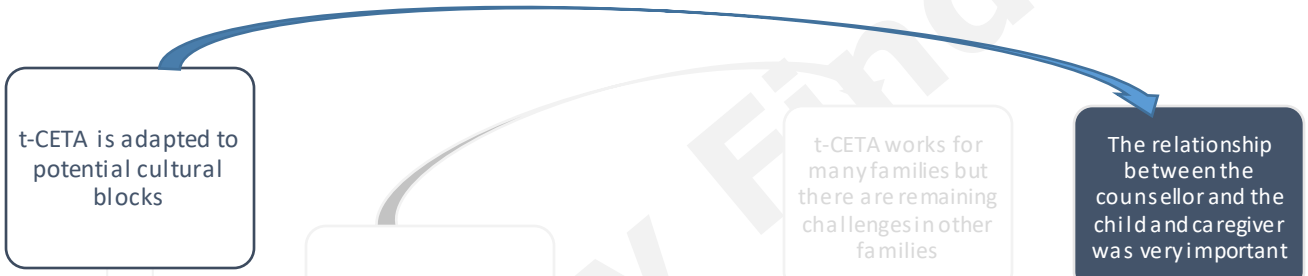
"He gets bored … like a child is used to getting up moving, playing."

On balance, many families were very accepting of phone delivery because of the barriers to attending a clinic

Counsellors

Children & caregivers

t-CETA is adapted to cultural blocks



Lay counsellors with experience in social protection and working with refugees

- Local knowledge resulted in sensitivity to context and beliefs
- Phone delivery helps to reduce stigma and increase adherence
- *Phone delivery* and *lay counsellors* enabled counsellors to be more informal with children than typical in therapy

Counsellors

Relationship and rapport with counsellor influenced child's ability and willingness to engage with sessions

- Children and caregivers said that counsellors made them feel comfortable and relaxed
- Possible to build rapport over phone

Some children found it hard to talk over the phone

- Often became easier over time
- Counsellors would repeat, re-explain, try to be sure that child understood

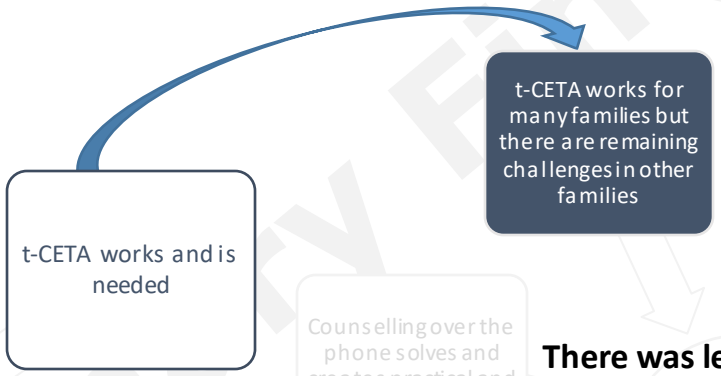
Children & caregivers

t-CETA works and is needed

Counsellors were positive about t-CETA

- Efficacy & logistical issues
- Multiple success stories of children whose debilitating mental health problems were alleviated through t-CETA

But, major structural and environmental challenges faced by refugees will limit effectiveness of any form of mental health treatment



Children enjoyed sessions

- Learned things
- Able to apply to real life situations
- Improvement in range of symptoms, including fewer nightmares, calmer, reduced fatigue, improved play and peer relationships, decreased anger and fighting

There was less improvement where there were substantial other problems

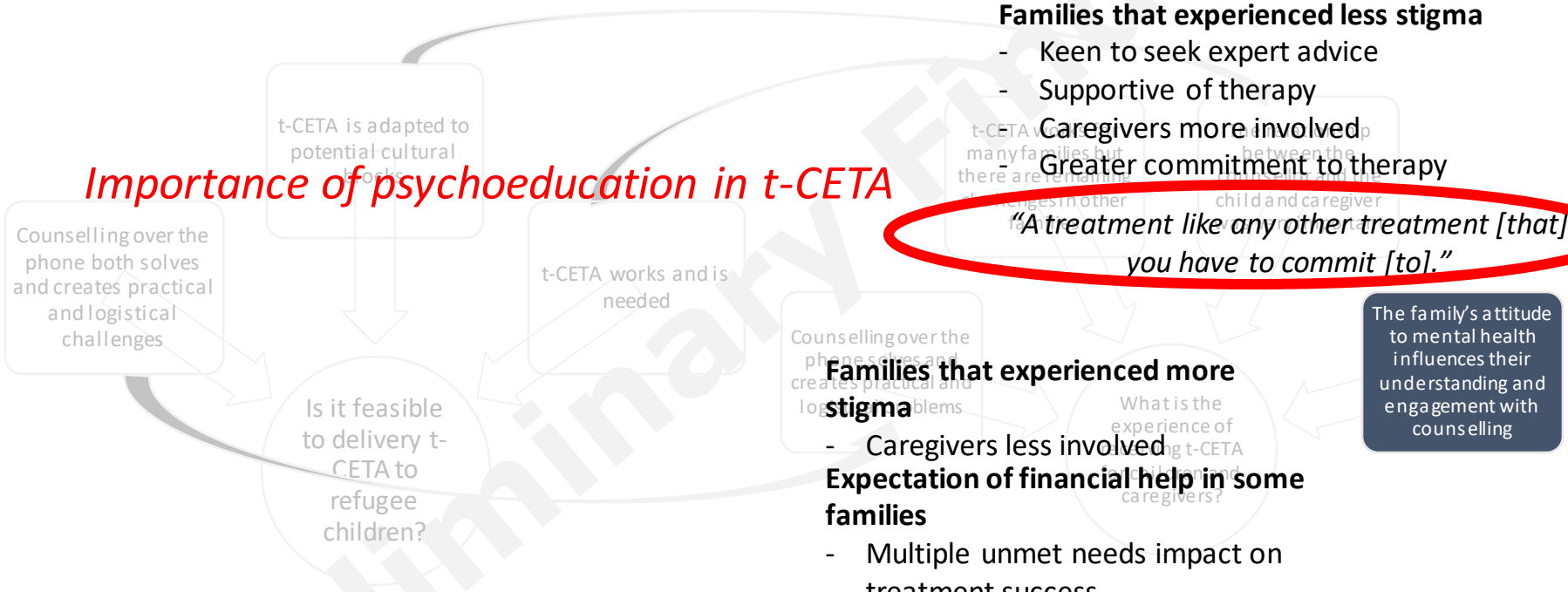
- Physical ill health
- Financial difficulties
- Current living conditions
- Family separation
- Lack of access to school

Counsellors

Children & caregivers

Family's attitude to mental health influences engagement

Importance of psychoeducation in t-CETA



Families that experienced less stigma

- Keen to seek expert advice
- Supportive of therapy
- Caregivers more involved
- Greater commitment to therapy

"A treatment like any other treatment [that] you have to commit [to]."

The family's attitude to mental health influences their understanding and engagement with counselling

Families that experienced more stigma

- Caregivers less involved

Expectation of financial help in some families

- Multiple unmet needs impact on treatment success

Counsellors

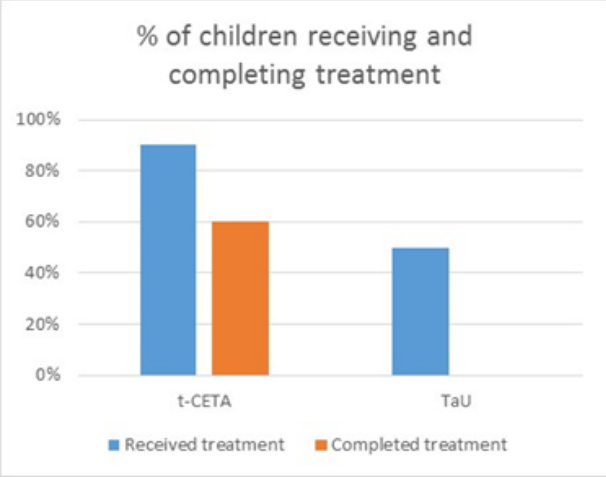
Children & caregivers

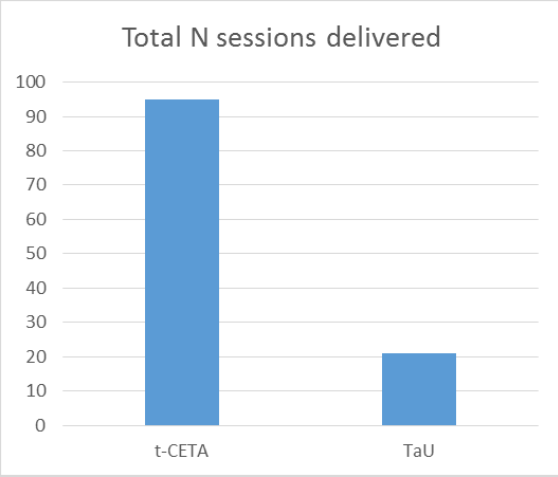
Key research questions

- Is it *feasible* for *lay counsellors* to delivery CETA *via phone* in a *humanitarian setting*?
  - *Yes, with cultural adaptation and modification of CETA for phone delivery*
- Is t-CETA *acceptable* to Syrian children and their caregivers?
  - *While some families said they would prefer face-to-face therapy, in reality they could not travel to clinic and telephone delivery was an acceptable and effective alternative*

Does t-CETA help to overcome barriers to children accessing mental health services?

Pilot RCT: n=20 children randomised to t-CETA or treatment as usual (TaU)

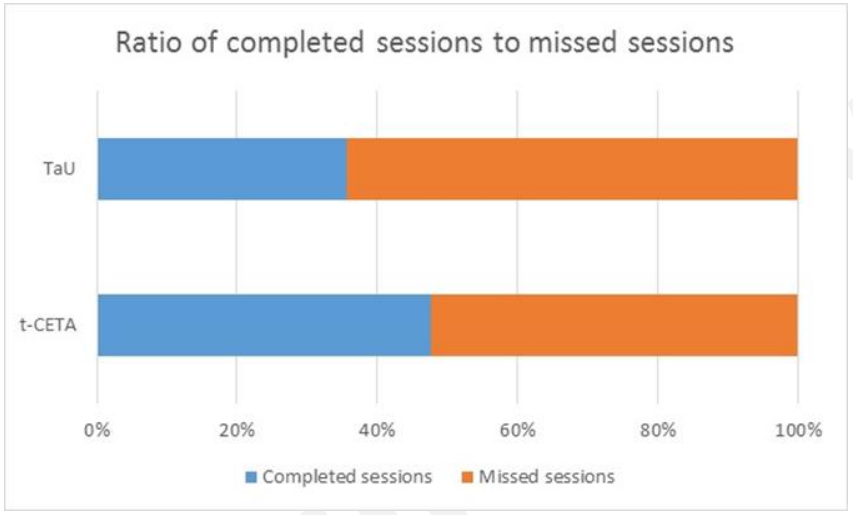




Nationwide protests ('October revolution') started during trial

- *Able to continue to deliver t-CETA and* ***60% completed treatment despite clinic closures***

Does t-CETA help to overcome barriers to children accessing mental health services?



TaU 1:1.8 (reflects period before clinic closures)

t-CETA 1:1.1

Missed sessions for t-CETA were less disruptive than those for TaU

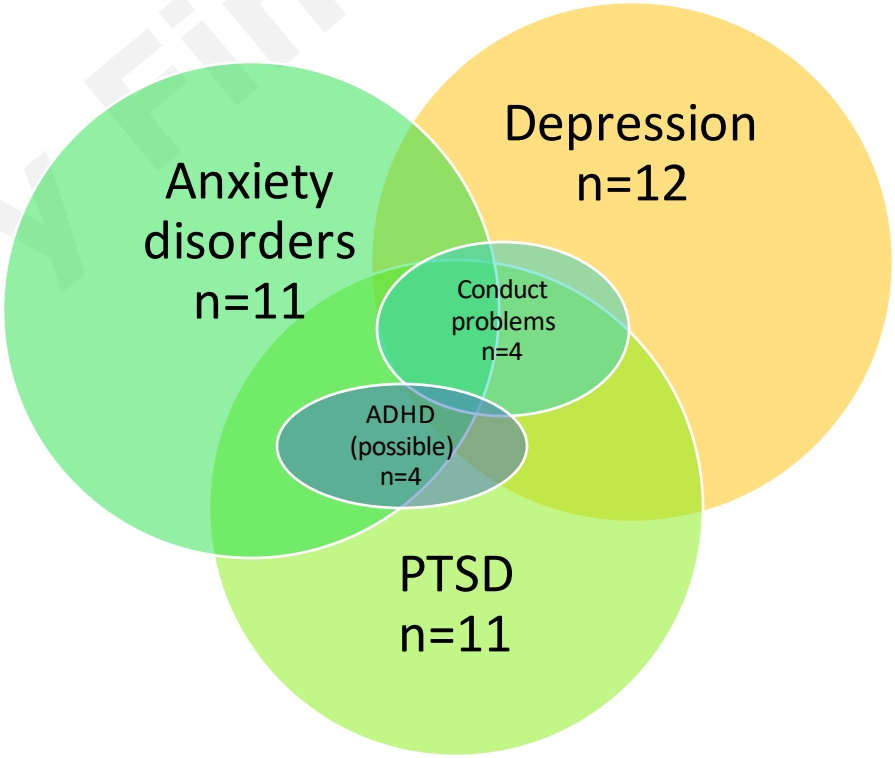
- *Flexibility with scheduling, e.g., calling back later if bad time, so did not necessarily have to wait a week for next appointment*

Key research questions

- Does t-CETA help to *overcome barriers* to children accessing mental health services?
  - *Yes, increase in sessions delivered, children treated, and treatment completion*
  - *Corroborates qualitative results suggesting that it overcomes barriers attending clinics*

Does t-CETA reduce symptoms of mental health problems in children?

- N=16 children offered t-CETA (n=10 randomised into RCT)
- 9:7 boys:girls
- Age 9-17 years
- n=9 completed treatment
  n=4 partial course
  n=3 did not start
- 8-12 sessions each

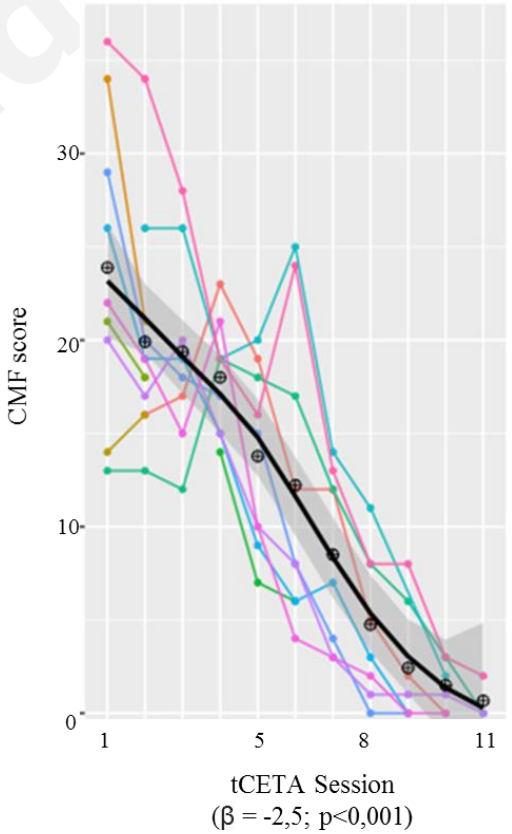


Does t-CETA reduce symptoms of mental health problems in children?

- Pilot randomised controlled trial (RCT), n=20
- Two measures completed by ***counsellors***
- **Client Monitoring Form (CMF)**: measures symptoms of PTSD, anxiety, depression, externalising behaviour problems, substance use
- **PSYCHLOPS**: measures problems, functioning, and wellbeing
  - Baseline mean: 7.78
  - Mid-point mean: 4.00
  - Final session mean: 0.67

p=.02

p<.001

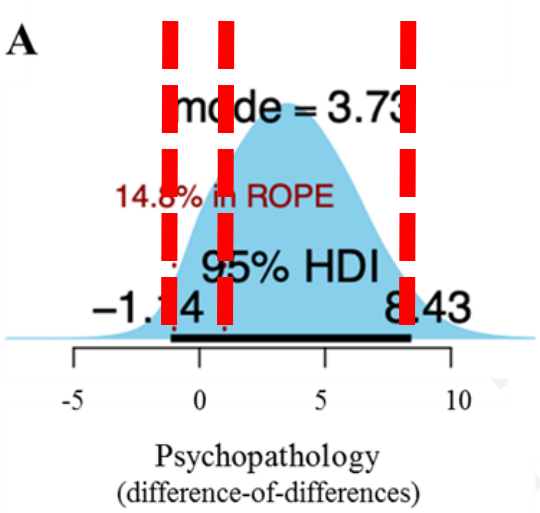


Does t-CETA reduce symptoms of mental health problems in children?

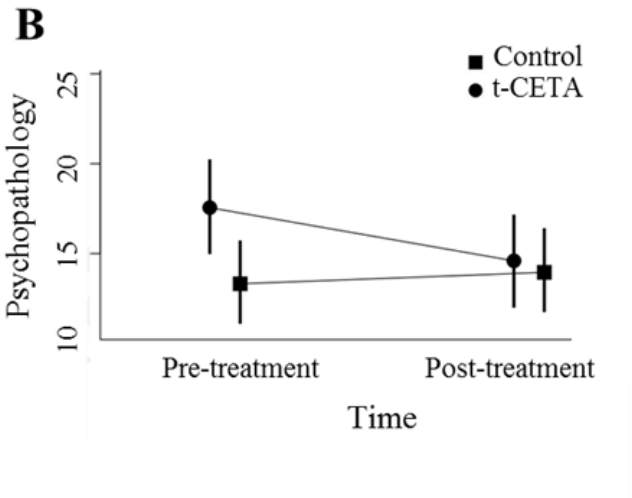
- Independent assessments:
  - ***Interviewers blind to treatment allocation***
  - Intention to treat design
  - **Psychopathology composite** (culturally adapted and locally validated questionnaires; PTSD, anxiety, depression, externalising) and measure of **disability** (WHODAS)
- Bayesian model analogous to repeated-measures ANOVA
  - Bayesian 2 (treatment) x 2 (time) rm-ANOVA
  - Meaningful change defined as equivalent to 20% change in individual outcome or 10% change in two outcomes

Dr Claudinei Biazoli

Does t-CETA reduce symptoms of mental health problems in children?



(A) Whole posterior distribution of the interaction between time and treatment (difference-of-differences) for the composite psychopathology score



(B) Mean of the posterior distribution of composite psychopathology scores for the control and t-CETA groups before and after treatment; vertical lines represent 95% HDI

Moderate effect size
d = 0.33

Sensitivity analysis removing outliers did not change results

Driven primarily by improvement in depression symptoms

No significant effect on disability scores (WHODAS)

Key research questions

- Does t-CETA *reduce symptoms* of mental health problems in children?
  - *In-session assessments showed significant decline in symptoms*
  - *Independent assessments provided suggestive evidence for reduction in psychopathology (but not disability)*
  - *Converging evidence from case series and interviews with counsellors and families*

Strengths and limitations

Strengths

- Mixed methods – quantitative and qualitative data
- Converging evidence on feasibility, acceptability, and efficacy from in-session assessments, independent assessments, clinical judgement, and qualitative interviews
- Ecologically valid setting, tested t-CETA during challenging period of clinic closures

Limitations

- Small sample size
- Variable delay between final treatment session and post-treatment assessment
- Onset of protests between pre- and post-treatment assessments

Conclusions

- It is *feasible* for lay counsellors to delivery CETA via phone in a humanitarian setting and *acceptable* to many children and caregivers
- Phone delivery *increases access / adherence* to treatment amongst Syrian refugee children
- There is suggestive and converging evidence that t-CETA *reduces symptoms* of mental health problems in children
- *However, phone delivery in a humanitarian context throws up specific challenges that require imaginative solutions*

Case example: success

- 9-year-old boy, "Ousama"*
- Witnessed bombing in Syria at age 5; symptoms noted at age 7; past self-harm but no current intention for self-harm or suicide
- Presented with evidence of:
  - Depression, PTSD, panic disorder, social phobia, conduct problems
- t-CETA Trauma flow:
  - Talking about Difficult Memories
  - Parenting Skills (behavioural problems)
  - 10 sessions with child
  - 8 sessions with mother

* Pseudonym

- CMF from 24 ➔ 0
- PSYCHLOPS from 9 ➔ 4 ➔ 0
  - First session: "[I'm] afraid of being kidnapped, I'm so nervous [angry] on my brothers and sisters… I can't go outside, I just go and come from school."
  - Last session: "[Therapy was] amazing and I love the sessions… [I most liked] how to get out from the trauma and my problems."
  - Counsellor: "This child is a very successful story, he changed a lot in a short time."
- Positive factors
  - Child was active and liked to share over the phone
  - Picked up concepts quickly
  - Could role play successfully over phone, good at coming up with helpful thoughts

Case example: challenges

- 11-year-old girl, “Farah”*
- Raised by grandmother after parents divorced; mother has significant difficulties and ignores daughter
- Presented with evidence of:
  - Depression with psychotic features, panic disorder, ADHD (inatt. type)
- t-CETA Depression flow:
  - Getting Active
  - 10 sessions with child
  - 1 sessions with grandmother

* Pseudonym

- CMF from 31 ➔ 3
- PSYCHLOPS 9 ➔ 5 ➔ 3
  - First session: “[I’m] worried about exams at school.” [Also reported that caregiver hits her]
  - Last session: “[Therapy was] good… [I liked] everything.”
  - Counsellor: “[This child] has severe depression, now she is good [improved] but needs follow up.” [Noted that family circumstances had not changed]
- Challenges
  - Did not like using phone (for any purpose)
  - Anaemia
  - Poor concentration over phone
  - Inexpressive
  - Avoidant / defensive
  - Caregiver did not take part

Dr Tania Bosqui, American University of Beirut

Practical Challenges and Solutions when Delivering t-CETA

t-CETA Webinar
24th February 2021

Photo credit:
UNHCR

Scheduling phone calls

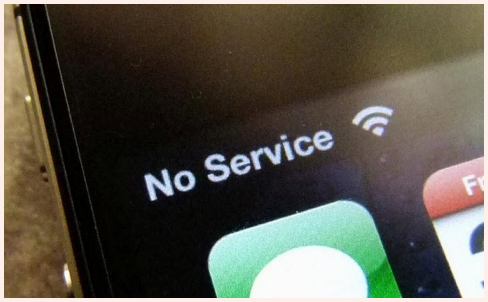
Challenge	Recommended solutions

➢ Appointment based 9-5 Mon-Fri schedules less accessible
➢ High cancellation/no shows
 	
 
	Flexibility in scheduling and re-scheduling sessions, including:
	
	• Weekend/evening sessions (set up service to include flexible working)
	
	• Plan session based on:
	  • current daily schedule of the family i.e. afternoon after school
	  • short term i.e. not 'next Thursday at 3pm'
	  • when family has access to a phone and when connection is best

Preparing for Phone Sessions

Challenge	Recommended solutions
➢ Less control over level of privacy of phone calls on both ends	Prepare **appropriate spaces** for the counsellor and the family: • Explain and agree with the family where the child will be able to speak as privately as possible • Build a routine of speaking with the caregiver before/after - ensure caregiver can be nearby but also allows the child their privacy • Inform parents there are no 'right' answers and they do not need to check/correct what children are saying

Preparing for Phone Sessions

Challenge	Recommended solutions
➢ Technological problems (calls do not connect, lose connection, someone else answers, phone doesn't work etc) 	Counsellors prepare a **back-up plan**: • Ensure phone is functioning, charged and has a headsets (use a checklist) • Always have a back up phone/connection Agree a **back-up plan with families** early on: • Obtain alternate phone numbers to call when primary numbers lose connection • Plans include calling back several times, trying alternative numbers, calling back in 15 mins/1 hour

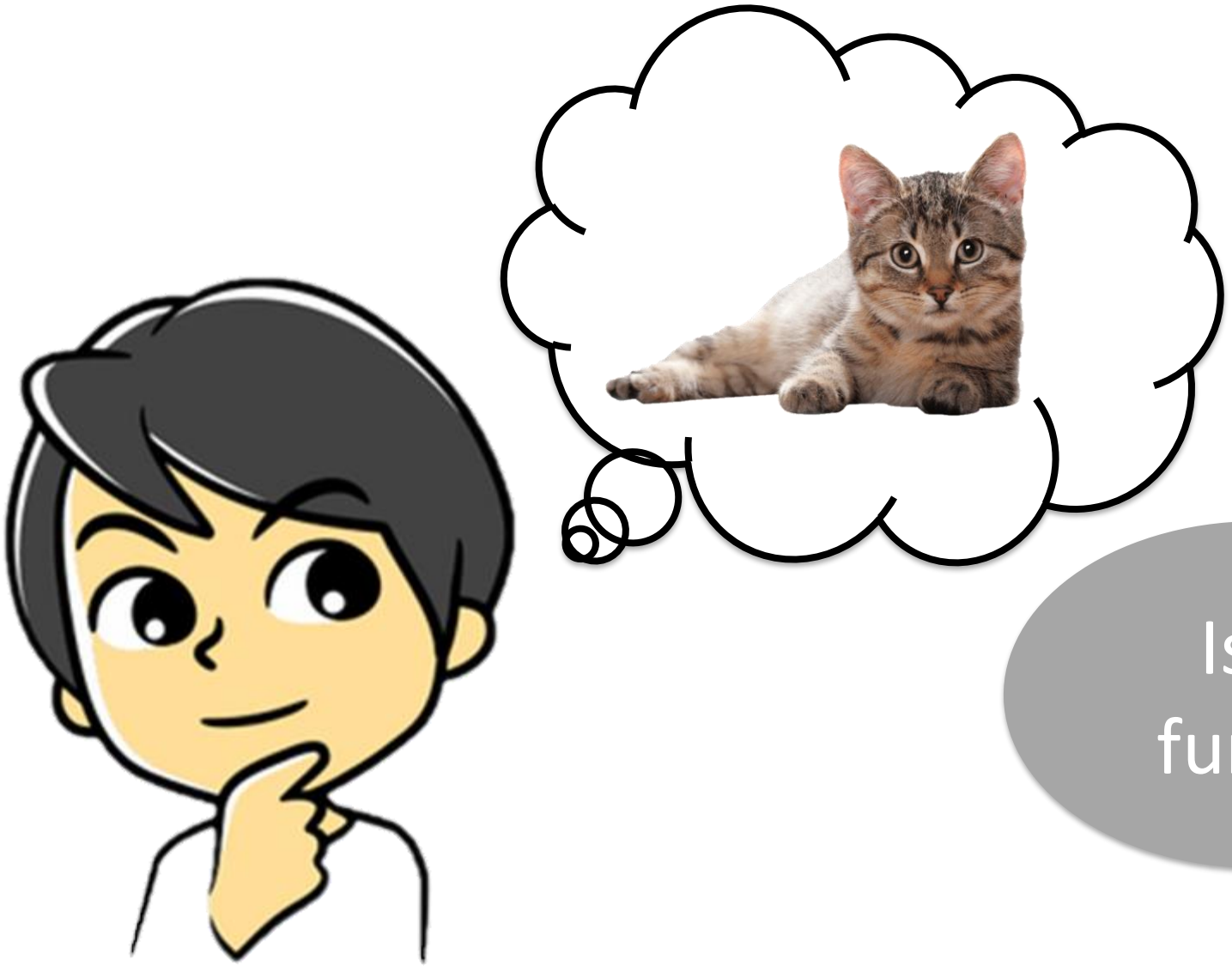
Safeguarding

Challenge	Recommended solutions
➢ Identification and referral of safety concerns more difficult without physical presence/visual contact	Amend **safeguarding protocols** for phone delivery: • Do not disclose any information until you can be certain of the identity of the responder • Service mapping ready for the child's physical location • Add procedures for maintaining confidentiality and privacy in the home • Train on safety planning with child and caregiver over the phone • Ensure there is an on-call supervisor available • Check in more often than face to face to ensure understanding of ground rules (contracting) • Follow-up and explore any sudden changes, noises, hesitancy (do not ignore it and persist)

Delivering therapeutic content

Challenge	Recommended solutions
➢ Session content and duration is too long on the phone compared to face-to-face ➢ Higher likelihood of boredom, poor concentration or low engagement	Telephone sessions need to be **shorter and more frequent:** • Divide content intro smaller components • Across multiple sessions Send **visual materials** to look at and support during calls Pay **extra attention to non-visual cues**, and give more verbal feedback (validation, warmth, normalization, that cannot be 'seen' by the child) Keep clear **consistent routines** during calls • Provide fun incentives and break up content with breaks and games (e.g. guessing game)

Example of a guessing game



Thank you!

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Information on Providing T-CETA in your Organization

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CENTERS FOR DISEASE CONTROL AND PREVENTION

Pre-Implementation Planning

- All team orientation
- Implementation requirements and budget
- Site selection
- Decide on target population
- Plan for training
- Staff up

Who can provide CETA?

- LAY PROVIDERS!
  - No advanced education needed (e.g., 4th grade)
  - Speaks local language(s)
  - Passion to help community
  - Good with people
  - Understand their communities
  - Those with TIME
  - Those that have organization skills
  - Responsible
  - Basic knowledge of how to use a phone or computer
  - Private space to conduct sessions

CETA training and implementation

- **Training**
  - 8-10 days
  - Live or through technology
  - Ongoing after the live training through supervision

- **Implementation is Flexible!**
  - Client sessions are 30min – 90 min
  - Clients receive between 5-12 sessions depending on severity of symptoms
  - Counselors can work as little as 1-2 days a week or full time with 2 hours supervision per week

Creation of a Safety Protocol and Referrals

Created by the organization

When the provider learns about a safety situation:

- Who should the provider contact (e.g. supervisor, team leader, other resources)
- When should the provider contact them (e.g. during the session, after the session)
- How should the provider contact them (e.g. via phone, via email)
- What information should the provider share (e.g. all information, partial)

Developing an M&E system that works for you!

- Client recruitment and tracking system
- Client Monitoring Forms
- Case assignment and disposition

Special Considerations for Telehealth

SPACE

EQUIPMENT

TRAINING

Thank you!

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