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Person-centred care (PCC) to improve DR-TB treatment outcomes:

Assessing a multidisciplinary psychosocial support (PS) and harm reduction intervention in a cohort of MDR/RR-TB patients with harmful use of alcohol in Minsk, Belarus

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Background

- Belarus has one of the highest alcohol consumptions in the world
- The involuntary isolation and treatment of patients with poor treatment adherence
- The MSF OCA project in Minsk, Belarus started in 2014.
- Aim: incorporating multidisciplinary psychosocial support for disorders due to the use of alcohol as alternatives to forced hospitalization and other punitive measures for MDR/RRTB patients.
- Newer approaches/possibilities

Rationale of the study

- AUD >> negative outcomes of the treatment
- MSF program brings patients with disorder due to the use of alcohol to the center of the activities by providing multidisciplinary psychosocial support and harm reduction interventions
- Intend to generate scientific evidence for the feasibility, acceptability and benefits of PS interventions among DR-TB patients
  - Specific to the region
  - To document the good practices
  - Provide scientific evidence to what we are doing already

Research question

- To what extent does a patient centred multidisciplinary psychosocial support and harm reduction intervention contribute to better outcomes for MDR/RR-TB patients, in Minsk? (Quantitative part)
- How is a perception of the multidisciplinary support by patients and health care practitioners (Qualitative part)

Overall aim

- To assess feasibility, acceptance and the benefits (improvements in treatment adherence, TB treatment outcomes and patient wellbeing) of a person-centred multidisciplinary psychosocial support and harm reduction intervention in patients with disorder due to the use of alcohol and MDR/RR-TB patients in Minsk.

  - I.e. We hope to be able to share the good practices here with other practitioners and policy makers, so that they can also implement the programme

Study design

Mixed-method study

- Qualitative study
- Quantitative study
  - Retrospective (Jan-Dec 2019) &
  - Prospective (Jan 2020 – Dec 2021)

Study population

All newly diagnosed MDR/RR-TB adult patients (diagnosed and resident in Minsk) and starting treatment from January 2019 to December 2021 who have alcohol use disorder are eligible to take part in the study.

Primary outcome

- The primary outcome will be **the adherence to TB treatment**. Being adherent will be defined as taking **90% or more** of all prescribed TB treatment doses (pills) All patients are treated under directly observed treatment.
- We will also calculate the average adherence to treatment of all patients included in the cohort

Secondary outcomes

- Final outcome, for the TB treatment: 1) cured, 2) treatment completed, 3) treatment failure, 4) lost to follow up, 5) died, and 6) not evaluated (including transfer out).
- Scoring of psychosocial tests: AUDIT, ASSIST, PHQ9, GAD-7, and self-motivation score (measure as changes in this scoring at 6, 12, 18 and 24 months). All the tests are completed by the staff, by interviewing the patient.

Qualitative data collection

- Following the first analysis of the quantitative research component (final trimester 2020) ,
- A sub group of participants have been interviewed privately to gain an understanding of issues arising around acceptance and experience of the intervention.
- All MOH and MSF practitioners involved in the programme were also invited to focus group discussions to understand their understanding of the programme and their thoughts on its acceptability
- Open questions will allow participants to direct the discussion towards those subjects most pertinent to them, and help the researcher to understand the main challenges and priorities with regards the treatment approach.

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Quantitative component

(mid term analysis)

December 2020

Adherence is good or better than for other patients

For the 59 patients we will include in the study the median adherence is 94.9 (IQR:681-98) and 64.4% have adherence >=90%

Figure 3a: Mean adherence by month of treatment

Light red = linear trend, Dark red = LOESS

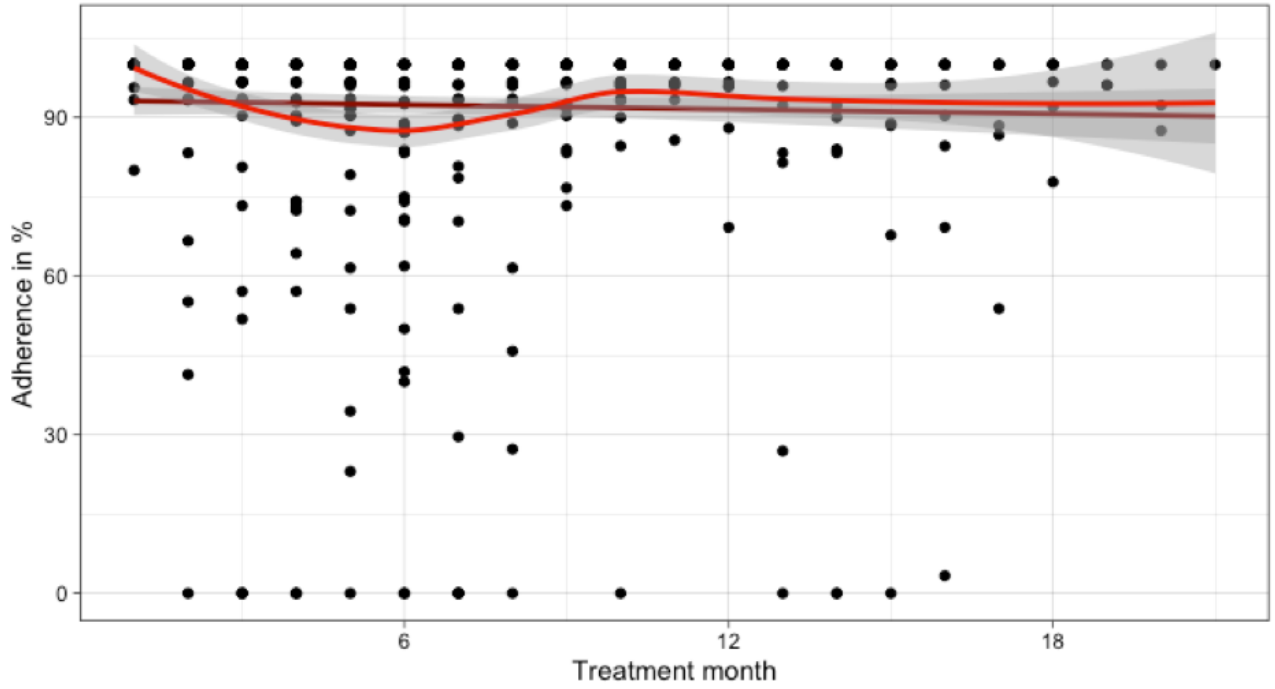
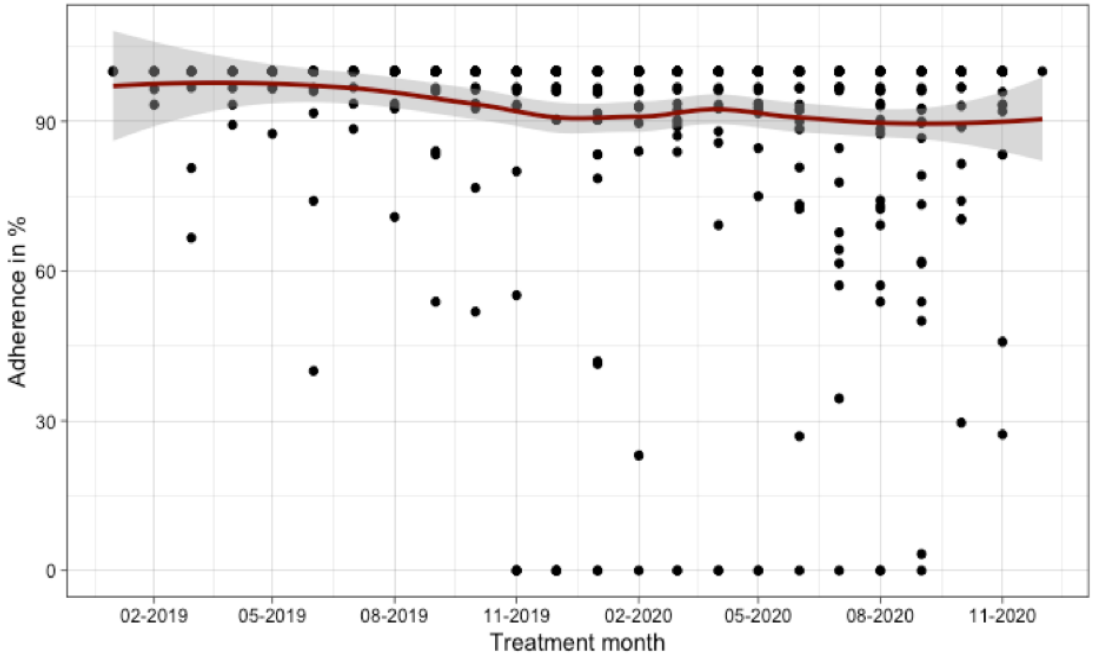
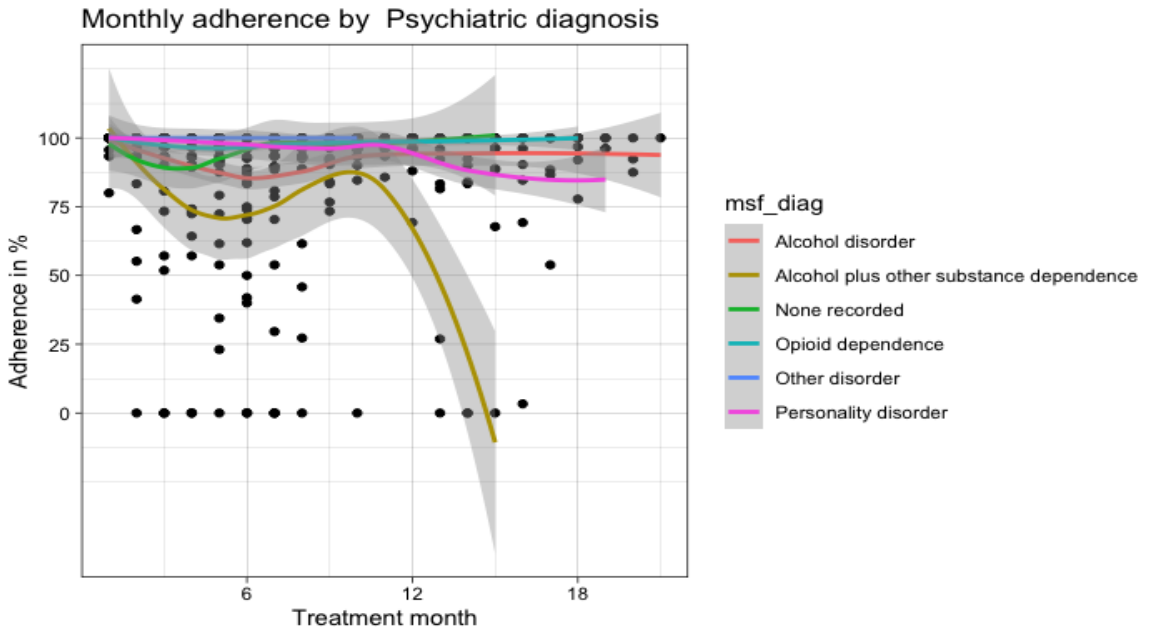


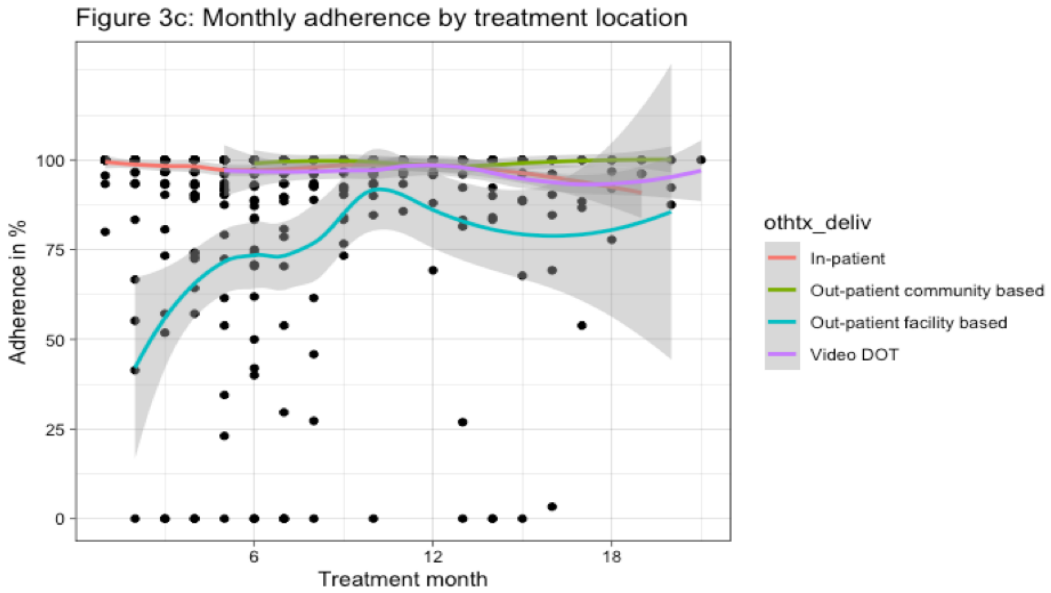
Figure 3b: Mean adherency by calender month of treatment

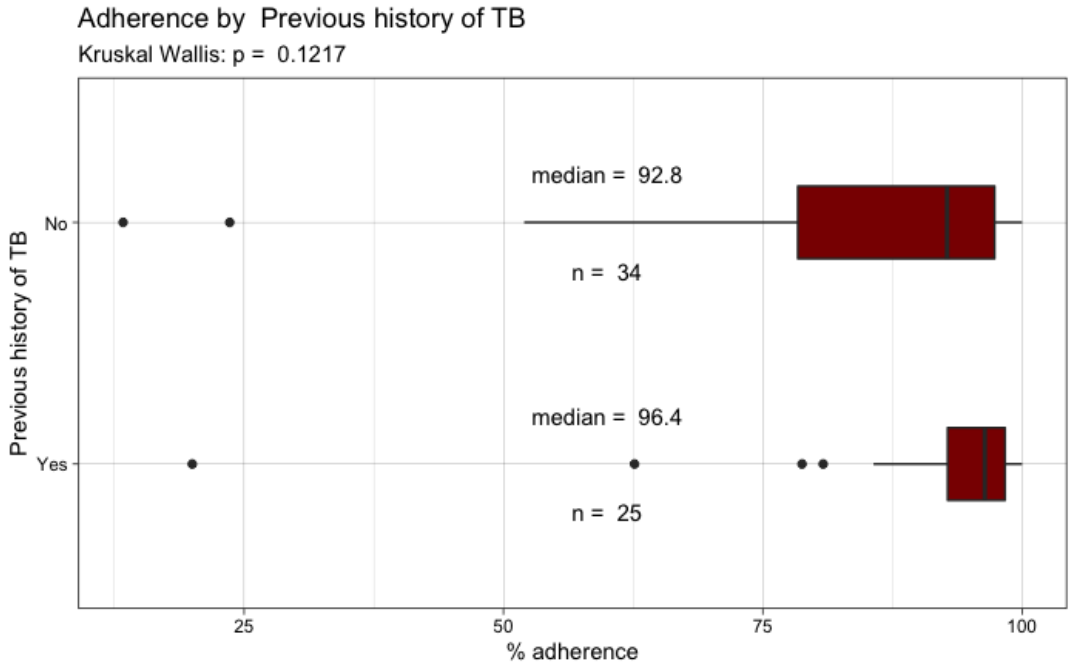


What factors are associated with adherence < 90%?

- Other substance dependence
- Hepatitis C
- Not being single
- No previous TB diagnosis
- Facility based OPD treatment







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Qualitative results

These arching themes emerged:

Sickness and death

Prejudice and marginalisation

Fragile social situations

Isolation and loneliness

Use of alcohol and other drugs

The benefits of guidance received in the programme

Self-determination of patients

A state of health:

the outdoors and freedom

Vulnerability and despair

"Well, I was shocked that could happen to me. Firstly, I didn't know how to survive it, how to break it to my family. Secondly, I worried so much about my kids, so that they didn't get it. I worried about my husband… Psychologists were treating me at the hospital, as I couldn't get over it, bad stuff kept coming to my mind."

"I don't know, I feel tired, weak, and I don't want anything. It's hard to move. Everything gets hard [after taking the pills]"

"If you take tuberculosis, HIV, Hepatitis C and social issues all intertwined, it is a heavy load altogether."

"I want to put it behind me as a nightmare."

"I can't get a regular job. I can't get a pass from the medical commission to get a job if it can harm me in any way. But then, harm can happen at any job. Well, I don't understand why they don't give me a disability group for the time being. You're left to pull through it, the best you know."

I don't pay [for my apartment] now. It's just I'll get out of here and I don't understand how I'll live there, how I'll find a job. ….. When I am discharged… how I will live in general. I just don't understand this.

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Loneliness  Prejudice

"It is just that I had a psychological trauma. Everyone wants to be healthy, but the thing is that I faced the situation when the closest people let me down…I was in such a mental state that I felt that no one needed me and they did not care about me. However, whatever happens, we have gone through thick and thin together with my wife (deep breath). I'm sorry. Well, next… It's a long story. It's hard to understand it all at once. One has to live this life fully. Many people betrayed me, but all is fine. This is a sore point. Better not touch"

"Maybe I'd keep drinking if not meeting my girlfriend who provided some support. I don't know. It happened…. Of course, I have others. I have my mother. I have a wonderful mother. She always supports and helps me"

"Well, if you want my honest opinion … (laughs) I don't want to say that I have no friends. All are only sympathizing. Many are afraid."

"Well, no, I had a family once, but we aren't close 'cause… whatever"

"You know, I cannot say anything [about loved ones], unfortunately. They were buried long ago – my mother, father, grandparents. I'm left here alone."

"We have problems only with the patients from the risk group – drug addicts, alcoholics, and individuals with an imprisonment history… but well, trust me, not just healthcare practitioners are challenged by those patients. They are a burden to other healthcare facilities as well, I mean the policlinics, as well as to their families and, in fact, to the whole world."

"They want to have it their way. (Indignantly) They want to live as they like, as they have lived before, not having to change anything and in terms of alcohol – yes, they all want to have fun, they want to enjoy themselves, they don't want to work… Well, it looks so elementary to us all to get it, doesn't it?"

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Self determination

"We, Belarusians, are like this: if we serve [in the army], we do serve. If we have fun, we do have fun" or according to the Belarusian proverb: "A quick mare is in time everywhere"

"I would say if someone does not need that support, drinks throughout the treatment. You'll not help them until they start wanting it."

Health

"not smoking, doing sports, riding a bicycle, fresh air. I saw happiness on this man's face. I mean, he defeated the disease."

"I don't lose heart… and once a day I exercise – I go out to over there. Well… I keep my spirits high, telling myself everything's going to be just fine." I

The benefits of good guidance

"If you just technically follow some guidelines, I believe the efficacy will be pretty low. … you have to turn on your personality… your charm and emotions, like you smile or tackle some patient's personal issues if he's eager to talk about it. So, you build up trust. In fact, this is the first step, so to say. The patient then opens up and begins to trust you. Your word gets value and meaning. Then you can move on to such issues uh… concerning adherence or some medical stuff."

"Here, when I had some issues with my wife and nuances, I also contacted [the counsellor]. Well, it is he who helped me. I am glad that I have someone to contact, to talk, to seek advice. Sometimes even not about the disease, but about real life, as they say, situations. So, I've got his phone number, we are always connected. Well, it means I am glad that there is such an organization and I have someone to address."

"We need to work with the patient's concept of the world, so that he could accept his disease and treat it like a disease and not like his own fault, like he is guilty for his illness. Very often it damages family relations when there's no support or acceptance from the family. We need to work with the patient on the acceptance of the disease. Then we need to work with the family."

"Sometimes it happens in the case of patients with a drug addiction that they want to talk, and one has to, well, dig deep into their souls to try and stabilize them from a psychological point of view, and the MSF team helps a lot along these lines by assigning counsellors, psychiatrists who come and talk with the patients, sometimes for hours, trying to uncover their deepest fears. And in fact, they often manage to do it"

Conclusions

- Patients in the programme are often very vulnerable, marginalized and lonely
- Patients possess a strong sense of self-determination which can lead to good outcomes OR heavy alcohol and drug misuses
- Acceptance of the programme is high for most practitioners and patients
- LTFU is still quite high – the programme isn't right for everyone
- Treating personality disorders might help deal with the more difficult patients
- Improved personal relationships, and socio-economic situations (which are destroyed by forced hospitalization) thanks to the programme helps lead to positive outcomes

Recommendations for discussion:

POLICY

- Consider rolling out the programme to patients with drug sensitive TB
- Inclusion of patients (either expert patients or the patient in question) into the consilium decision making process
- Scale up

Recommendations for discussion:

PRACTICE

- Reinforce the importance of regular systematic psychological tests
- Capture quantitative data on the presence of a support person during TB treatment going forwards
- Enhanced health promotion and contact tracing among drinking partners of people with TB
- Increase in group and family interventions within the programme
- Adaptation of the programme for patients with suspected or confirmed personality disorders
  - incentive or a token system, behavioural work or in-depth psychotherapy.
- Increased utilisation of video DOTs for patients with poor adherence, as well as those with good adherence.
- Reduce turnover or change of staffing from the patient perspective
- Increased sensitisation for MOH to understand the benefits of the programme

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Comments?