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Commentary

Increasing access to Cognitive Behaviour Therapy in Low and Middle Income Countries: A strategic framework

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ABSTRACT

Cognitive Behaviour Therapy has been demonstrated to be an effective intervention in outpatient and inpatient settings for a wide range of presenting mental health problems including depression, Obsessive Compulsive Disorder, Post traumatic Stress Disorder, Social Anxiety Disorder, Panic Disorder and Somatorform Disorder. There is likely to be an unmet need for this therapeutic approach in most Low and Middle Income Countries (LMIC). However, the training of therapists to deliver this intervention has historically been a lengthy and expensive process, with already highly trained staff such as psychiatrists and psychologists undertaking additional training of up to one year duration in order to develop expertise in this area. This paper proposes that a model where training, supervision, leadership and service evaluation is provided by a small number of highly trained staff to front-line non-specialist staff who will then deliver manualised therapy. These front-line staff may also be conceptualised as part of a stepped care model where self-help and manualised therapy approaches are used in the first instance. Where patient functioning does not improve there is then the possibility of being stepped-up for treatment by a more specialised and highly trained therapist. This approach may help in meeting the huge mental health treatment gap in LMIC. This paper also suggests that lessons learnt from the dissemination of behaviourally informed parenting interventions internationally can be applied to the dissemination of this therapeutic approach.

1. Introduction

1.1. The impact and burden of mental health problems in Low and Middle Income Countries

Mental health and substance use disorders have a marked impact on the health of people living in Low and Middle Income Countries (LMICs). These disorders are the leading cause of all non-fatal burden of disease measured as Years Lost to Disability (YLD) and the fifth leading cause of an increased burden of Disability Adjusted Life Years (DALYs) (Üstün et al., 2004; Whiteford et al., 2013). Within the mental health and substance use disorders group, depressive and anxiety disorders account for most DALYs and YLDs. It is estimated that over 75% of mental health problems remain untreated (Whiteford et al., 2013) with the greatest burden of unmet need falling in LMICs. The vast majority of people with mental health problems do not have access to psychological or pharmacological treatments despite research evidence supporting the efficacy and cost-effectiveness of specific treatments in such settings (Chisholm et al., 2007). This paper will argue that one way to begin to address the unmet needs of people with mental health problems in LMICs is to develop an affordable model of therapy delivery and dissemination that relies on a small group of highly trained therapist-supervisors and a much larger workforce of non-specialist staff with minimal training but ongoing, high quality supervision.

As illustration of the difficulties in attaining population reach with interventions in LMICs countries, Mohandas (2009), for example, demonstrated that there is a considerable shortfall in the provision of state funded mental health services in India and

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proposed that the shortfall was unlikely to be met by private mental healthcare given current rates of unmet need and low levels of investment in mental health care. Rates of mental health problems in Asian community samples are at least equivalent to those found in studies in the UK. A large survey in Chennai, India, using a modified and validated Patient Health Questionnaire, reported the prevalence of depression to be 15% (Poongothai et al., 2009). Similar rates have been reported from China where the one month prevalence of any mental disorder was found to be 17.5% (95% CI 16.6–18.5) (Phillips et al., 2009). The largest diagnostic groups within this were depression (6.1%, 95% CI 5.7–6.6) and anxiety disorders, (5.6%, 95% CI 5.0–6.3). Among individuals with a diagnosable mental illness, 24% were moderately or severely impaired by their illness and 92% had never sought professional help of any kind for these problems. Similarly, high rates of anxiety and depressive disorders have been reported in rural Pakistan (66% of women, 25% in men) with these disorders being clearly associated with higher levels of social adversity (Husain et al., 2004). These findings have been confirmed in a systematic review, which found that socioeconomic adversity and relationship problems were major risk factors for depression (Mirza and Jenkins, 2004).

Despite the pressing need for services these examples make it clear that those who have the greatest need for mental health services are unlikely to be able to afford to access private treatment and that free to use State health services are unlikely to have the capacity to meet the level of unmet need for treatment. CBT delivered by existing local health workers who have received appropriate training and supervision as highlighted in this paper are likely to be in a strong position to address these unmet needs for psychological treatment for depression and anxiety disorders.

2. The current state of CBT in LMICs

2.1. CBT as a treatment of choice in LMICs

CBT is now recommended as a treatment option in National Treatment Guidelines in US and the UK (American Psychiatric Association, 1993; National Institute of Clinical Excellence, 2009). There is a robust evidence base for the effectiveness of Cognitive Behaviour Therapy (CBT) in treatment, prophylaxis and prevention of relapse of depression and anxiety (Embling, 2002; Fava et al., 1998; Paykel et al., 1999; Thase, 1997). However, despite this evidence in the West, limited progress has been made in evaluating the effectiveness of CBT in LMICs.

CBT can be delivered following a relatively short period of training, is time limited and can be provided in a variety of formats and using different media (Naeem et al., 2014a, 2014b). This paper will summarise the degree to which CBT has been successfully disseminated in LMICs. There is evidence that it is an effective treatment for a wide range of presenting problems including Obsessive Compulsive Disorder, Social Anxiety Disorder, Post-traumatic Stress Disorder, Panic Disorder, Health Anxiety, Somatisation and Depression and also in reducing the impact of psychotic symptoms. This flexibility and breadth makes it an ideal therapy for dissemination in LMICs.

2.2. Current evidence base for CBT in LMIC

In a recent review of culturally adapted interventions for the treatment of depression Chowdhary et al. (2014) identified 10 examples of interventions where adapted CBT was used successfully to treat depression. Of these 8 were delivered by specialists and 2 were delivered by non-specialist health staff. Chowdhary et al. (2014) conclude that where adaptions are made to existing psychological interventions these were in the method of delivery rather than the content of the therapy. They emphasise that this suggests it is possible to maintain fidelity to therapy models with appropriate adaptions and that these demonstrate similar rates of efficacy to interventions delivered in the context where they were developed. In these studies CBT was provided at different level of intensity, from community level to the secondary care.

The limited research so far points towards effectiveness of manualised CBT delivered by psychologists and other health professionals who had received training and supervision in CBT in primary care (Husain et al., 2013; Sumathipala et al., 2008; Naeem et al., 2011). Similarly, there is evidence to suggest that trained psychologists can further their skills in CBT after a short period of training and supervision in delivering CBT in secondary care (Habib et al., 2015; Naeem et al., 2014a, 2014b). This is supported by research by Naeem et al. (2011) which looked at the process of cultural adaption of CBT interventions and the therapy outcomes of this work. More recently brief CBT delivered by psychology graduates who had been trained over a one or two week period was tested and found to be effective in treating both depression (Naeem et al., 2014a, 2014b) and psychosis (Naeem et al., 2015). However in both of these instances the training was followed up with regular supervision delivered via video conference calls.

There is also evidence to suggest that CBT based interventions can be delivered by health workers after a very short period of training and under supervision with good clinical outcomes (Rahman et al., 2008). For example, both Afuwape et al. (2010) and Rahman et al. (2008) demonstrated positive outcomes in terms of a reduction in depressive symptoms in patients in community settings. In these studies CBT was delivered by health workers, using a CBT based manualised treatment, after a short period of training. Again ongoing supervision was seen as an important in ensuring fidelity to the model. A recent review of evidence based interventions in LMICs delivered by non-specialist health staff (van Ginneken et al., 2013) suggests that although there are evaluated programmes supporting the use of CBT-informed interventions the evidence base for the efficacy of these is poorly established. They do note promising areas in terms of treatments for PTSD and depressive disorders. Finally, guided self help for depression and anxiety supervised by carers has also been found to be effective (Naeem et al., 2014a, 2014b) in LMICs.

A stepped care approach is already being used in high income countries (Williams and Martinez, 2008). In the UK, Improving Access to Psychological Therapies (IAPT) services are now well established and play a vital role in providing therapy to a significant number of general population. Naeem et al. (2014a, 2014b) work in Pakistan supports the idea that a stepped care approach to CBT in LMICs may be a feasible way to deploy scarce therapy resources. Although these initiatives are impressive and begin to build a case for the feasibility of CBT in LMICs they have researched only a limited range of presenting problems in a limited range of cultures and contexts

2.3. Barriers to the delivery of CBT

Currently, there is growing interest in Cognitive Behaviour Therapy and other non-pharmacological treatment approaches for mental health problems in LMICs (Mohandas, 2009). There are a number of barriers to developing therapies in LMICS. These include the low priority on the assessment and treatment of mental health problems in many health services, the scarcity of human and financial resources necessary to develop mental health services and the difficulties in bringing about change in underfunded, marginal and poorly organised services (Saxena et al., 2007).

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