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A Common Elements Treatment Approach for Adult Mental Health Problems in Low- and Middle-Income Countries

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This paper describes the Common Elements Treatment Approach (CETA) for adults presenting with mood or anxiety problems developed specifically for use with lay counselors in low- and middle-income countries (LMIC). Details of the intervention development, training, supervision, and decision-making process are presented. Case vignettes are used as examples throughout. Preliminary findings are presented on counselor/supervisor performance and client outcomes from practice cases completed prior to randomized controlled trials (RCT) conducted at two sites for adult survivors of torture and/or systematic violence in (a) southern Iraq and (b) Thailand-Burma border. Data suggest that local supervisors and lay counselors with little prior mental health training or experience maintained fidelity to the model. The majority of pilot clients were retained in treatment, suggesting acceptability. Using the Reliable Change Index (RCI) for each individual we examined the number of clients above a minimal threshold ($z > 1.96$) for each outcome. In Iraq 100% of clients had RCIs above the threshold for depression and posttraumatic stress, and 81.8% for impaired function. In Thailand, 81.3% of clients had RCIs above minimum threshold for depression, 68.8% for posttraumatic stress, and 37.5% for impaired function. Implementation of CETA is discussed in relation to cultural issues within LMIC. These findings, combined with US-based evidence, suggest that a common elements approach warrants further development and testing as a means for addressing the treatment gap for mental health problems in LMIC.

Global mental health is an emerging priority in global health initiatives (World Health Organization [WHO], 2008). The burden of mental health disorders accounts for approximately one-third of years lived with disability (YLD) among individuals aged 15 and older (WHO, 2008). Depression is the third leading contributor to the global burden of disease. Despite the high prevalence and cost of mental health disorders, 90% of those with need do not receive treatment (Kohn, Saxena, Levav, & Saraceno, 2004; Wang et al., 2007). Some of the primary barriers to addressing the mental health treatment gap in low- and middle-income countries (LMIC) include: limited mental health infrastructure and policies, funding, and scarcity of mental health professionals (Knapp et al., 2006; Patel, 2009; Saraceno, 2007).

In the last decade, substantial advances have been made in global mental health. A growing body of findings from randomized controlled trials (RCT) and feasibility studies have demonstrated that evidence-based treatments (EBT) can be implemented in LMIC with positive clinical outcomes using a task-shifting approach (i.e., lay workers as counselors; limited formal mental health training; Patel, 2009) (e.g., Bolton et al., 2007; Patel et al., 2010; Rahman, Malik, Sikander, Roberts, & Creed, 2008). EBTs were recommended in the recent WHO (2010) Mental Health GAP Guidelines as front-line interventions. Substantial progress has also been made in overcoming barriers to addressing the global treatment gap (Patel, Chowdhary, Rahman, & Verdeli, 2011). First, the limited mental health workforce has been addressed by task shifting, with training, supervision, and adaptation procedures increasingly described in the literature (Murray et al., 2011; Verdeli et al., 2008). Second, studies have documented the acceptability of EBT cross-culturally, with necessary adaptations to

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peripheral aspects (e.g., terminology, analogies), and not to core treatment elements (Kaysen et al., 2011; Patel et al., 2011; Verdeli et al., 2008).

However, the singular focus of most EBTs on one diagnostic category (e.g., PTSD, depression) is a barrier to substantially reducing the treatment gap (e.g., Kazdin & Blase, 2011) that has received little attention, and presents challenges in LMIC. First, although singular focused EBT have demonstrated positive outcomes for a wide range of clinical outcomes (e.g., PTSD-focused interventions have a positive impact on depressive symptoms), most of these treatment protocols include limited options or guidance when flexibility is needed to incorporate treatment elements that explicitly target a wider range of symptoms. This is particularly problematic in a context in which mental health providers do not have prior mental health training, background, or experience on which to draw to make decisions on adding elements. Second, support for trainings in multiple EBTs is infeasible in most LMIC given limited funding sources and scarce personnel. Related, mastering multiple EBTs and keeping fidelity to each of them is a difficult task even for highly trained individuals. Third, if providers are trained in individual EBT focused on one clinical problem (e.g., depression), a referral system would be needed to link individuals with counselors trained to treat this problem area. Fourth, many studies in LMIC have demonstrated that comorbidity is common with limited distinction among diagnostic categories used in the United States and Europe (Bolton, Surkan, Gray, & Desmousseaux, 2012; Murray et al., 2006; Rasmussen, Katoni, Keller, & Wilkinson, 2011). After these types of qualitative studies, when various EBTs are being considered, the single diagnostic focus of these treatments forces the choice to treat only a certain group among those that need help. For all these reasons, a continued focus only on single-disorder EBT in LMIC may have limitations for substantially reducing the treatment gap.

The need for EBT that can address multiple-disorders/problems has become a part of the clinical and research dialogue in the United States (U.S.), where common elements, or transdiagnostic intervention approaches, are increasingly receiving attention (e.g., Chorpita, Daleiden, & Weisz, 2005; Weisz, Ugueto, Herren, Afienko & Rutt, 2011). Transdiagnostic interventions teach a set of common practice elements that can be delivered in varying combinations to address a range of problems. Decision rules based on research evidence guide selection and sequencing of elements, but allow for flexibility in individual symptom presentation (Chorpita & Daleiden, 2009). Exposure, for example, is the most common element in treatments for anxiety. Therefore, barring any "interference" (Weisz et al., 2012) to conducting exposure (e.g., safety concerns, debilitating anxiety or depressive mood), individuals should begin exposure as early in treatment as possible. Common elements interventions specifically include opportunities for flexibility and adaptation, allowing for treatment without specifying a disorder classification, and include guidance for delivering specific elements to clients with comorbidity.

Data on effectiveness of common element approaches is emerging. A RCT of a common elements approach for children resulted in better outcomes than individual EBT approaches (Weisz et al., 2012). Chorpita and colleagues have a nearly 10-year history of positive outcomes for a common elements approach for anxiety disorders (e.g., Chorpita, Taylor, Francis, Moffitt, & Austin, 2004). Barlow and colleagues developed and are testing a transdiagnostic approach for adults (Barlow, Boisseau, Ellard, Fairholme, & Farchione, 2008), with promising preliminary results from open trials and a small RCT (Ellard, Fairholme, Boisseau, Farchione, & Barlow, 2010; Farchione et al., 2012). In the U.S., common elements approaches have been found to be more acceptable to counselors (Borntrager, Chorpita, Higa-McMillan, & Weisz, 2009).

This paper describes the Common Elements Treatment Approach (CETA), a transdiagnostic intervention for adults presenting with mood and/or anxiety problems, developed specifically for use in LMIC. Like other common elements approaches, CETA is not conceptualized as a "new" intervention, but rather a new approach to training lay counselors—one focused on common elements of EBT and decision making for treatment focus, element selection, sequencing and dosing. The focus of this paper is on the development of CETA, the training and supervision, and the clinical decision-making processes. CETA was recently tested in two large RCTs, one in southern Iraq and one at the Thailand-Burma border with displaced Burmese. This paper subsequently describes the implementation of CETA in these two sites, where, due to funding and the research focus, the population was trauma/torture-affected adults. We also present preliminary findings on counselor/supervisor performance and client outcomes from pilot cases completed prior to each RCT.

Methods

Intervention Development

Development of CETA was based on a literature review of EBT and other common elements approaches. For LMIC, development required consideration of two main challenges. First, given the unavailability of a skilled mental health workforce in LMIC, developing CETA materials and the training involved using a simple, concrete format to ensure that local lay counselors with little or no previous mental health training could learn and implement the components. Second, as reliance on higher-level mental health professionals for clinical decision-making is usually not feasible in LMIC,