Low intensity ACT interventions for people living in adversity: Global mental health perspectives

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ACBS World Conference 2015, Berlin

Overview of Talk

- Overview of work at WHO on evidence based-low intensity interventions
- Introduction to Self Help Plus- an ACT-based guided self help programme
- Discussion of planned adaptations to culture and context

Research/Development Team

Academic collaborators:

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International Organisation collaborators:

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  Development of Training Materials

Local (Ugandan) collaborators:

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Lynda Nakalawa
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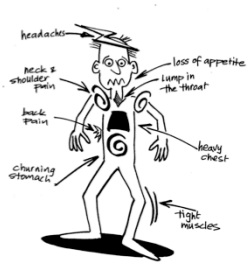
The problem

- Hundreds of millions affected by mental health problems
  - All countries
  - All communities
  - All age groups



- Exposure to adversity is a global problem
  - Armed conflict
  - Natural disaster
  - Displacement
  - Poverty
  - Interpersonal violence

- If untreated, substantial **disability** and **economic loss**

  (Ferrari et al., 2013; Whiteford et al., 2013)
  - 22.7% of global Years Lived with Disability (YLDs)
  - Hundreds of billions of dollars in lost productivity

The problem

- >80% in low- and middle-income countries (LAMICs) do not receive needed mental health services.

  (WHO, 2012)

- "Treatment Gap"

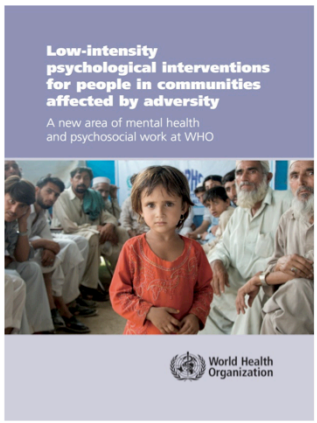
World Health Organization. 16 March 2012. Report by the Secretariat for the Sixty-fifth World Health Assembly (document A65/10). Global burden of mental disorders and the need for a comprehensive coordinated response from health and social sectors at the country level.

Ferrari et al (2013). Burden of Depressive Disorders by Country, Sex, Age, and Year: Findings from the Global Burden of Disease Study 2010. Plos Medicine: 10,11

Whiteford HA, Degenhardt L, Rehm J, et al. Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *Lancet.* 2013;382(9904): 1575-1586.

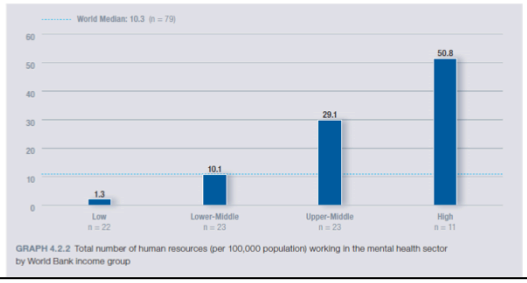
WHO Response

- mhGAP –Integrating mental health care into primary health care (PHC) services in LAMICs
  - Implemented in over 50 countries
  - mhGAP Intervention Guide- Humanitarian – a version of mhGAP Intervention Guide for humanitarian settings -Due for launch in 2015
- Building Back Better – Guide to implementing mental health care after emergencies
- **Development of evidence based low intensity psychological interventions for LAMIC**



Why low intensity psychological interventions for LAMIC and humanitarian settings?

- Many LAMICs do not have the resources to deliver traditional psychological treatments:
- The increasing lack of humanitarian access in certain settings (e.g. South Sudan, Syria or Central African Republic) is the primary barrier of care for those who need it. (ODI, 2012)
- 90% of world lives in developing countries, 90% of health resources are found in developed countries.



GRAPH 4.2.2 Total number of human resources (per 100,000 population) working in the mental health sector by World Bank income group

Collinson S, Elhawary S. *Humanitarian space: A review of trends and issues.* Vol 32. London: Overseas Development Institute; 2012.

Why low intensity psychological interventions for LAMIC and humanitarian settings?

- "The key is limited resources…" (Patel, 2014)
- There is great need for innovative, strengths-based and low-resource intensive solutions
- **Promising new direction in terms of efficacy and research priority setting**

Patel, Vikram. "Global mental health: an interview with Vikram Patel." *BMC medicine* 12.1 (2014): 44.

Towards low-intensity interventions

Conventional high intensity interventions

- By specialists
- One manual per problem
- Often many sessions

Innovative low intensity interventions

- Reduced reliance on specialists (rather: lay people, IT, self-help guides)
- One manual for multiple problems (where possible)
- Fewer sessions
- Explicit focus on skills for self-management

Update on the evidence base

- Rapidly growing evidence base for psychological interventions from an increasing range of contexts
  - Before 2003, no LAMIC trials
  - Now : 30+ trials from LAMIC that confirm generalizability of many previous findings
    - E.g. CBT also appears to work outside West
    - Increasing evidence for low-intensity interventions
- **Research increasingly suggests that psychological interventions can be effectively delivered by non-specialists, using limited resources** (Murray et al., 2011; Van Ginneken et al., 2013; Fuhr et al., 2014)

References:

Murray, Laura K., et al. "Building capacity in mental health interventions in low resource countries: an apprenticeship model for training local providers." *Int J Ment Health Syst* 5.1 (2011): 30.

Van Ginneken, Nadja, et al. "Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low-and middle-income countries." *The Cochrane Library* (2013).

Fuhr, Daniela C., et al. "Effectiveness of peer-delivered interventions for severe mental illness and depression on clinical and psychosocial outcomes: a systematic review and meta-analysis." *Social psychiatry and psychiatric epidemiology* 49.11 (2014): 1691-1702.

WHO Objectives

- Develop and test a range of different interventions with focus on increasing access to effective care
- All tested through partnerships (2 RCTs per intervention)
- WHO Press as publisher to put manuals in public domain (serving dissemination and quality control of any translation)
- WHO to work with national governments and civil society towards implementation and scaling up of interventions

Five Phase Model for Intervention Testing

- **Phase 1:** Cultural adaptation of psychological intervention (qualitative research)
- **Phase 2:** Implementation of intervention in test sites to explore feasibility, safety and delivery of the intervention through exploratory randomised pilot trials
- **Phase 3:** Process evaluation of administering the intervention (qualitative research)
- **Phase 4:** Definitive randomised controlled trial
- **Phase 5:** Process evaluation of administering the intervention (qualitative research) to prepare for scaling up

So, how does ACT fit with these aims?

- Trials showing efficacy in:
  - Low doses
  - Self-help formats
  - Other cultures
- Transdiagnostic
  - Applicable to distress in general, not just diagnosable conditions
- Focus on skill development rather than reliance on therapist

SH+ Development and Review

- WHO scoping review of existing interventions and approaches that might fulfill main objectives
- Developed with experts in psychological care and global mental health, and colleagues in the humanitarian field
- Extensive peer review (43 experts) and subsequent revision

Introducing SH+: Objectives

Self-Help Plus: For Managing Stress and Coping with Adversity

- Brief and low-intensity **(Guided Self-Help)**
- Helpful across a wide range of people and settings
- NOT for the treatment of mental disorders, but meaningful and safe for those with or without diagnosable mental health conditions
- Easy to adapt locally, implement, and scale
- No need for a trained professional facilitator

What is SH+ exactly?

- Five workshop sessions (≈120 minutes per session)
  - Prerecorded, highly scripted multimedia material
  - Skill building with opportunities to practice
  - Facilitator's main roles are to organize group, keep time
- Illustrated pictorial guide
  - Designed for low literacy
  - Reinforces key concepts
  - Can be used as standalone product
- Facilitator guide
  - Assists briefly-trained lay facilitators to conduct the workshop

The Guided Self-Help Approach

- Recent review found it produces effects similar to face-to-face psychological treatment for depression and anxiety
  (Cuijpers et al., 2010)
- Prior use in low-resource settings
- Suitable for settings where extremely limited access for mental health services

Guided self help references:

Cuijpers P, Donker T, van Straten A, Li J, Andersson G. Is guided self-help as effective as face-to-face psychotherapy for depression and anxiety disorders? A systematic review and meta-analysis of comparative outcome studies. *Psychological Medicine.* 2010;40(12):1943-1957.

Haug, T., Nordgreen, T., Ost, L.G., & Havik, O.E. (2012). Self-help treatment of anxiety disorders: A meta-analysis and meta-regression of effects and potential moderators. *Clinical Psychology Review*, 32, 425-445.

Overview of sessions

1. Introduction
   - Grounding and present moment awareness
2. Unhooking from difficult thoughts and feelings
3. Identifying and acting on values
4. Being kind to self and others
5. Making room for difficult thoughts and feelings
   - Troubleshooting and ongoing practice
   - Conclusion

Feasibility testing planned

- South Sudanese refugees living in Uganda
  - Pilot RCT (funded)
  - Large RCT (funded)
- Hard to reach Syrians
  - Small focus group Nov 2014
  - Translation commenced

CULTURAL/CONTEXTUAL ADAPTATION OF SH+

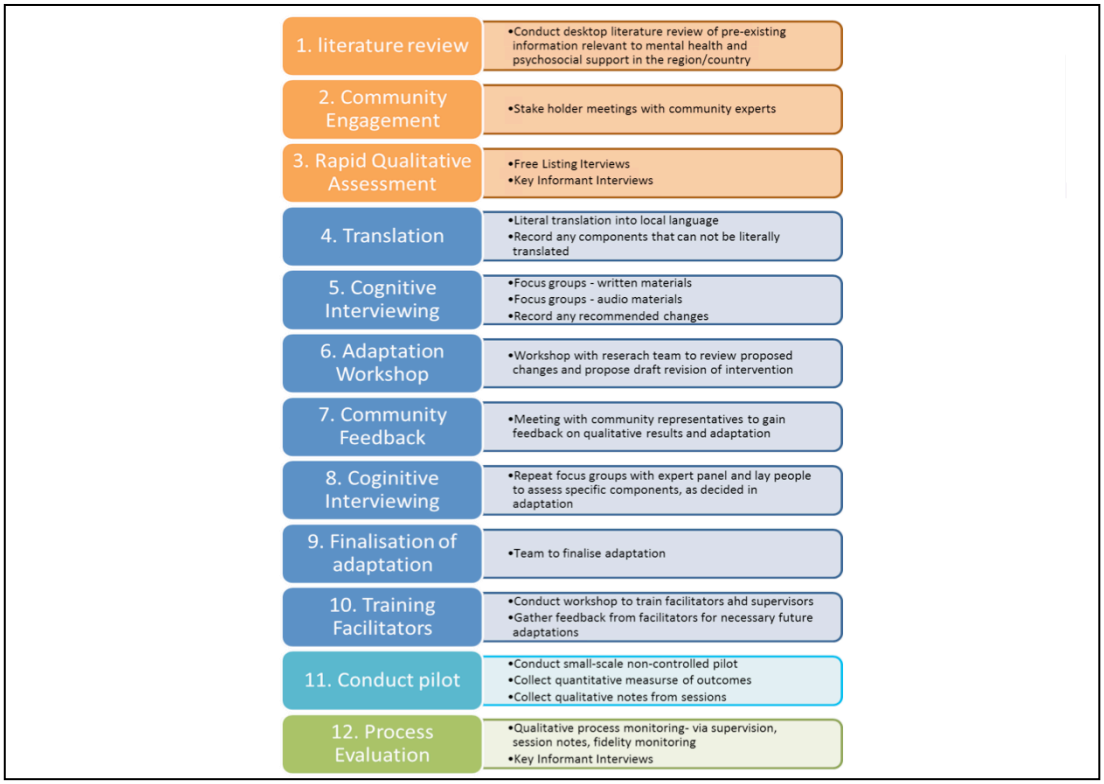
Introduction to Adaptation

- *Adaptation* is the process of deciding on and producing the changes needed in the programme and training materials to fit a particular set of circumstances
- Balance between maintaining fidelity versus cultural and contextual 'fit'
- Recommended that core components maintained, while minor changes can be made to improve: acceptability, comprehensibility, relevance, and accessibility/feasibility
- Examples of minor changes:
  - Illustrations
  - Examples
  - Stories
  - Terminology/ inclusion of local idioms

Introduction to Adaptation

- Evidence that culturally-adapted interventions more effective (SMD= 0.72; Chowdary et al 2014)
- But often adaptations not done systematically, or not documented.
- No clear consensus on *HOW* to do this
- WHO currently field-testing a systematic way to implement adaptations and document them

Chowdhary N, Jotheeswaran AT, Nadkarni A, et al. The methods and outcomes of cultural adaptations of psychological treatments for depressive disorders: A systematic review. *Psychol. Med.* 2014;44(6): 1131

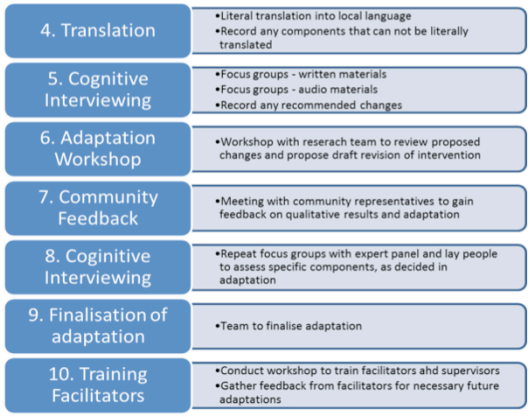

1. literature review
•Conduct desktop literature review of pre-existing information relevant to mental health and psychosocial support in the region/country
2. Community Engagement
•Stake holder meetings with community experts
3. Rapid Qualitative Assessment
•Free Listing Iterviews
•Key Informant Interviews
4. Translation
•Literal translation into local language
•Record any components that can not be literally translated
5. Cognitive Interviewing
•Focus groups - written materials
•Focus groups - audio materials
•Record any recommended changes
6. Adaptation Workshop
•Workshop with reserach team to review proposed changes and propose draft revision of intervention
7. Community Feedback
•Meeting with community representatives to gain feedback on qualitative results and adaptation
8. Coginitive Interviewing
•Repeat focus groups with expert panel and lay people to assess specific components, as decided in adaptation
9. Finalisation of adaptation
•Team to finalise adaptation
10. Training Facilitators
•Conduct workshop to train facilitators ahd supervisors
•Gather feedback from facilitators for necessary future adaptations
11. Conduct pilot
•Conduct small-scale non-controlled pilot
•Collect quantitative measurse of outcomes
•Collect qualitative notes from sessions
12. Process Evaluation
•Qualitative process monitoring- via supervision, session notes, fidelity monitoring
•Key Informant Interviews

Phase 1: Needs Assessment

1. literature review	•Conduct desktop literature review of pre-existing information relevant to mental health and psychosocial support in the region/country
2. Community Engagement	•Stake holder meetings with community experts
3. Rapid Qualitative Assessment	•Free Listing Iterviews •Key Informant Interviews

- Following procedures documented in WHO/UNHCR Toolkit:
  - Literature Review
  - Community Engagement
  - Qualitative Assessment
    - Free Listing
    - Key Informant Interviews

Phase 2: Translation and Adaptation



- Iterative process
- Seek community feedback
- Systematic documentation of changes

So what is 'cognitive interviewing'?

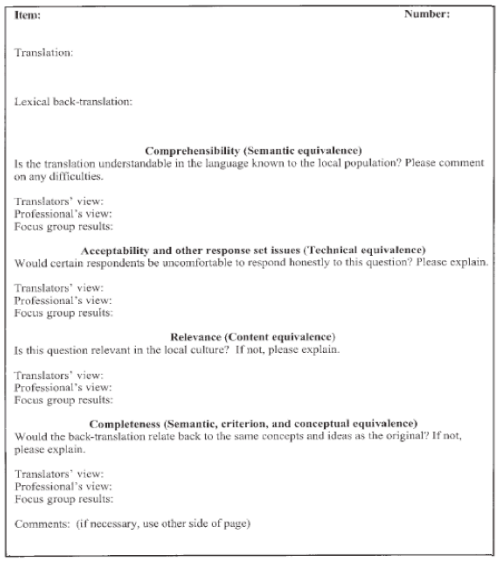
- A process described for culturally adapting psychometric tests for use in different cultures.

".. refers to a method to evaluate whether the target audience properly understands, processes, and responds to the test items. Cognitive pretesting uses think-aloud and verbal probing procedures, and has been mainly applied to evaluate surveys; yet, it can be used to test any type of test material. A criterion for the success of a judgmental procedure such as cognitive pretesting is that all items of the battery are interpreted as intended."

- We will apply this technique to psychological intervention- reviewing each piece of intervention in focus groups or individual interviews and ask:
  - Comprehensibility
  - Acceptability
  - Relevance

Transler, C, Prathima, S, Kirthi R. (2008). Adapting a cognitive test for a different culture: An illustration of qualitative procedures. *Psychology Science Quarterly*, 50, 451-468.

Van Ommeren Translation Monitoring Form 1999



Item: **Number:**

Translation:

Lexical back-translation:

Comprehensibility (Semantic equivalence)
Is the translation understandable in the language known to the local population? Please comment on any difficulties.

Translators' view:
Professional's view:
Focus group results:

Acceptability and other response set issues (Technical equivalence)
Would certain respondents be uncomfortable to respond honestly to this question? Please explain.

Translators' view:
Professional's view:
Focus group results:

Relevance (Content equivalence)
Is this question relevant in the local culture? If not, please explain.

Translators' view:
Professional's view:
Focus group results:

Completeness (Semantic, criterion, and conceptual equivalence)
Would the back-translation relate back to the same concepts and ideas as the original? If not, please explain.

Translators' view:
Professional's view:
Focus group results:

Comments: (if necessary, use other side of page)

Reference:

van Ommeren M, Sharma B, Thapa S, et al. Preparing instruments for transcultural research: Use of the translation monitoring form with Nepali-speaking Bhutanese refugees. *Transcultural Psychiatry.* 1999;36(3):285-301.

Intervention Adaptation Monitoring Form (WHO)

Item/Segment/Picture:

Comprehensibility (Semantic Equivalence):

Is the translation/picture understandable in the language/perspective of the local population? Is the understanding as intended?

Acceptability and other issues (Technical Equivalence):

Would certain respondents feel uncomfortable or offended by this picture/segment?

Relevance:

Is this picture/segment relevant in the local culture? Please explain why or why not.

Bernal Framework for Psychological Intervention Adaptations (2006)

"The framework serves to "culturally center" a given intervention, and it includes eight elements or dimensions that must be incorporated into treatment to augment both the ecological validity and the overall external validity of a treatment study."

Language of intervention
- Colloquial terms, conceptually equivalent idioms

Therapist matching
- Match therapists to clients
- Cultural competence training in therapists
- Less directive style? Therapeutic boundaries?

Cultural symbols and sayings
- Health calendars, stories and local examples, idioms and symbols

Cultural knowledge/content
- Stressful circumstances, local remedies and practices

Treatment conceptualization
- Communication of presenting problem
- E.g. somatic conceptualisations, avoiding psychiatric labels, medical illness.

Treatment goals
- Client-derived Tx goals
- E.g. health of family rather than one person

Treatment methods
- Simplifying, reducing need for literacy

Consideration of treatment context
- Removing barriers, flexibility in scheduling, convenient setting, telehealth, family.

Bernal G, Sáez-Santiago E. Culturally centered psychosocial interventions. *J. Community Psychol.* 2006;34(2):121-132.

Adaptation Documentation Form

Adaptation principle	Implementation (what changed)	Rationale (why it changed)	Evidence-base	Adaptation phase
LANUGAGE (emotional expression, mannerisms, verbal style; objective: culturally centred language)			(i.e. local piloting, literature, qual study etc)	(Date added to this chart)
Translation into local language				
Use of local idioms				
Technical terms replaced by colloquialisms				

Phase 3: Pilot testing

11. Conduct pilot

- Conduct small-scale non-controlled pilot
- Collect quantitative measurse of outcomes
- Collect qualitative notes from sessions

- Quantitative measures to test suitability
- Collect qualitative information from session notes

Phase 4: Pilot testing

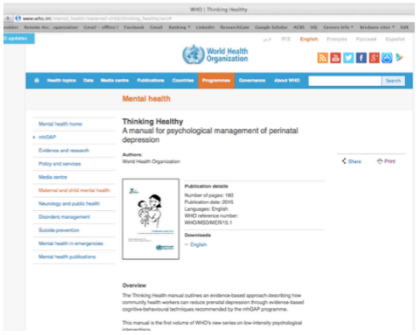
12. Process Evaluation

- Qualitative process monitoring- via supervision, session notes, fidelity monitoring
- Key Informant Interviews

- Key informant interviews with participants and facilitators, as well as key stakeholders- strengths/ weaknesses, barriers/facilitators, thoughts on integration into existing health structures and service delivery
- Assess for fidelity

Next steps (following WHO process)

- Exploratory and definitive RCTs- as gold standard to assess efficacy of adapted intervention
- Followed by process evaluations
- WHO Press as publisher to put manuals in public domain
- WHO to work with national governments and civil society towards implementation and scaling up of interventions



Summary

- Psychological distress is a worldwide problem
- Many people don't have access to appropriate psychological services
- Development of evidence-based low-intensity interventions is vital
- Cultural adaptations increase effectiveness of interventions
- Systematic approach to adapting interventions key to maintaining fidelity to evidence-based components
- Documentation of adaptations is crucial, to enable replication and comparison

Stay tuned

- Results of SH+ trials
- Results of systematic approach to cultural adaptation

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Questions or Comments?