WORK IN PROGRESS

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LAY-DELIVERED TALKING THERAPIES FOR SURVIVORS OF HUMANITARIAN CRISES IN LOW- AND MIDDLE-INCOME COUNTRIES: A SYSTEMATIC REVIEW

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BACKGROUND

Fig. 1

137.5 million people are in need of humanitarian aid

(OCHA 2018). By 2030, 46% of people in poverty around the world will be living in fragile- and conflict-affected states (FCAS) (World Bank 2017). Exposure to conflict, natural disasters and other situations of extreme adversity increases the risk of developing common mental disorders such as depression, anxiety and other stress-related disorders [Fig.1], as well as alcohol and other substance use disorders (Ventevogel et al. 2015, Charlson et al. 2019).

Specialist care is extremely scarce in these settings.

For example, Sub-Saharan Africa and South Asia are among the poorest performing regions on the Global Peace Index (IEP 2019), and also have the fewest mental health workers (WHO 2018). After the Ebola Outbreak, Sierra Leone had only two practicing psychiatrists (Brown 2017) [Fig. 2].

Prevalence of common mental disorders in conflict settings

Charlson et al. (2019) estimate a 22.1% point-prevalence for common mental disorders (depression, anxiety, post-traumatic stress) in conflict-affected populations, after adjusting for comorbidity. 8.3% of the population have moderate (4.0%) or severe cases (4.3%).

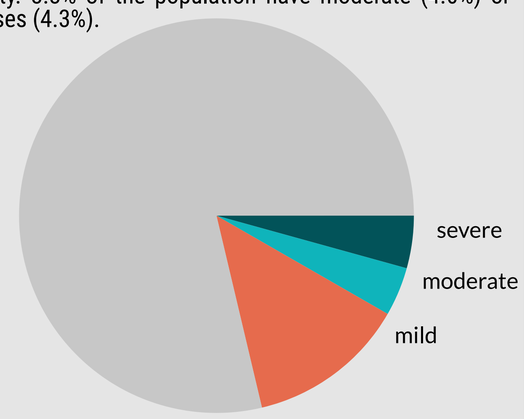


Fig. 2

Task-sharing with non-specialists is a common strategy.

In low- and middle-income countries (LMICs) affected by humanitarian crises, mental health interventions are often delivered by people with no formal training in mental health. Sometimes called "low-intensity" or "brief" psychological therapies, popular talking therapies like cognitive behavioural therapy (CBT) have been modified for delivery by non-specialists in these settings. The World Health Organisation (WHO) is now actively promoting these talking therapies as "scalable psychological interventions" for use in situations of adversity (WHO 2017).

But non-specialists are not all the same.

Neither are the interventions they deliver nor the settings in which they are working. These and other factors have important implications for the implementation and effectiveness of talking therapies, but have not been adequately addressed in previous reviews (Ryan et al. 2018). **This systematic review will focus explicitly on lay workers, a subset of non-specialists with no tertiary education or formal professional or paraprofessional certification in mental health** (Mutamba et al. 2013).

METHODS

We are conducting a systematic review of qualitative, quantitative and mixed-methods studies assessing the implementation or effectiveness of lay-delivered talking therapies for common mental disorders (including alcohol and other substance use disorders) provided to adult survivors of humanitarian crises in LMICs.

Search

Our search strategy covered five domains: talking therapies, lay workers, LMICs, common mental disorders and humanitarian crises. In May 2017 we searched seven electronic databases: MEDLINE, Embase, PsycINFO, PsycEXTRA, Global Health, Cochrane Library and ClinicalTrials.gov. We also searched two online mental health newtorks for grey literature (MHPSS.net, MHInnovation.net) and hand-searched contents pages of three academic journals: *World Psychiatry*, *International Journal or Mental Health Systems*, and *Conflict and Health*.

Screening

Results of all searches were double-screened according to pre-specified eligibility criteria [Fig. 3]. Disagreements between screeners were discussed and referred to a third screener as needed.

Fig. 3

Include	Exclude
Population/Setting	
• Adults (age 18+) with first-hand experience of a humanitarian crisis/FCAS • LMICs	• Children & adolescents • Not present at time of crisis • High-income countries
Intervention	
• Evidence-based psychotherapy • Targeting common mental disorders (including alcohol/subtance use) • Delivered via face-to-face dialogue • By a lay worker	• General psychoeducation, Psychological First Aid, etc. • Targeting other disorders (e.g. schizophrenia, bipolar disorder) • Self-help interventions • Delivered via phone or computer • By someone with tertiary education/formal certification
Design/Outcomes	
• Qualitative, quantitative or mixed-method studies of relevant intervention • Reporting patient outcomes or implementation outcomes	• Ecological studies, prevalence studies, etc.

What's next?

Our initial list of studies for inclusion is being circulated for expert review. When this is complete, we will finalise our forward and backward reference search, queries to study authors, data extraction, quality appraisal and synthesis. All data extraction will be checked by a second reviewer, and quality appraisal will be repeated by a second reviewer using standardised checklists. Any disagreements between reviewers will be discussed and referred to a third reviewer as needed.

Read more!

The methods for our full review were protocolized and published in an open-access peer-reviewed journal (Ryan et al. 2018). **Access the protocol by scanning this code with your smartphone.**

INITIAL RESULTS

Fig. 4

Countries and regions

3,933 records were returned by the database search. To-date, we have identified 22 studies of lay-delivered talking therapies across 15 LMICs [Fig. 4-5]. One study was carried out in two LMICs (Iraq, Thailand) (Murray et al. 2014), and a second examined programmes involving lay-delivered talking therapies in six LMICs (Central African Republic, Democratic Republic of Congo, India, Pakistan, Papua New Guinea, Russia) (Shanks et al. 2013). 13 other studies were carried out in the WHO's African region (AFRO; Guinea, Sudan, Uganda, Zimbabwe), four in the Eastern Mediterranean region (EMRO; Afghanistan, Egypt, Pakistan), two in the South East Asia region (SEARO; India, Thailand), and one from the Americas (AMRO; Haiti).

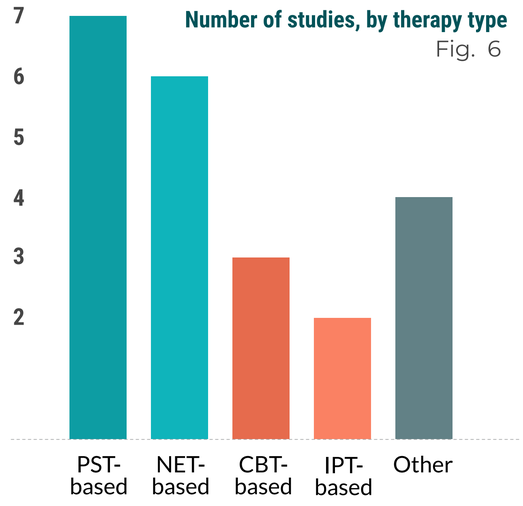
Interventions

A variety of evidence-based talking therapies were delivered by lay workers [Fig 6]. Seven studies investigated problem solving therapy (PST) and related interventions, such as Problem Management Plus (PM+). Three used narrative exposure therapy (NET), and three used locally-developed therapies based on similar principles: Tree of Life and testimonial therapy. One used cognitive-behavioural therapy (CBT), and two used the CBT-based common elements treatment approach (CETA). Two used interpersonal psychotherapy (IPT), and four used other forms of manualised psychosocial counselling. The different types, qualifications and training of lay workers were not always described in-text, requiring follow-up with authors for clarification.

Is Africa leading the way?

Fig. 5

Fig. 6



Included studies, by WHO region

AFRO

- **Abas et al. (2016)** 'Opening up the mind': problem-solving therapy delivered by female lay health workers to improve access to evidence-based care for depression and other common mental disorders through the Friendship Bench Project in Zimbabwe. *Int J Ment Health Syst*, 10 (39).
- **Chibanda et al. (2011)** Problem-solving therapy for depression and common mental disorders in Zimbabwe: piloting a task-shifting primary mental health care intervention in a population with a high prevalence of people living with HIV. *BMC Pub Health*, 11(828).
- **Chibanda et al. (2014)** Group problem-solving therapy for postnatal depression among HIV-positive and HIV-negative mothers in Zimbabwe. *J Int Assoc Provid AIDS Care*, 13(4): 335-41.
- **Chibanda et al. (2016)** Effect of a Primary Care-Based Psychological Intervention on Symptoms of Common Mental Disorders in Zimbabwe: A Randomized Clinical Trial. *JAMA*, 316(24):2618–2626.
- **Ertl et al. (2011)** Community-implemented trauma therapy for former child soldiers in Northern Uganda: a randomized controlled trial. *JAMA*, 306(5):503-12.
- **Mpande et al. (2013)** Community intervention during ongoing political violence: What is possible? What works? *Peace and Conflict: J Peace Psychol*, 19(2), 196-208.
- **Neuner et al. (2008)** Treatment of posttraumatic stress disorder by trained lay counselors in an African refugee settlement: a randomized controlled trial. *J Consult Clin Psychol*, 76(4):686-94.
- **Onyut et al. (2004)** The Nakivale Camp Mental Health Project: Building local competency for psychological assistance to traumatised refugees. *Intervention*, 2, 90-107.
- **Reeler et al. (2009).** The Tree of Life: a community approach to empowering and healing the survivors of torture in Zimbabwe. *Torture*, 19(3): 180-93.
- **Sondereggeret al (2011)** Trauma rehabilitation for war affected persons in northern Uganda: A pilot evaluation of the EMPOWER Program. *BJ Clin Psychol*, 50 (3):234-249.
- **Souza et al. (2009)** Mental health treatment outcomes in a humanitarian emergency: pilot model for the integration of mental health into primary care in Habilla, Darfur. *Int J Ment Health Syst*, 3(17).
- **Stepakoff et al. (2006)** Trauma healing in refugee camps in Guinea: a psychosocial program for Liberian and Sierra Leonean survivors of torture and war. *Am Psychol*, 61(8): 921-932.
- **Verdeli et al. (2003)** Adapting group interpersonal psychotherapy for a developing country: experience in rural Uganda. *World Psych*, 2 (2): 114-120.

AMRO

- **Legha et al. (2015)** Taskshifting: translating theory into practice to build a community based mental health care system in rural Haiti.

EMRO

- **Atif et al. (2016)** Barefoot therapists: barriers and facilitators to delivering maternal mental health care through peer volunteers in Pakistan: a qualitative study. *Int J Ment Health Syst*, 10 (24).
- **Ayoughi et al. (2012)** Provision of mental health services in resource-poor settings: a randomised trial comparing counselling with routine medical treatment in North Afghanistan (Mazar-e-Sharif). *BMC Psych*, 12 (14).
- **Meffert et al. (2014)** A pilot randomized controlled trial of interpersonal psychotherapy for Sudanese refugees in Cairo, Egypt. *Psychol Trauma: Theory, Res, Pract, and Pol*, 6(3), 240-249.
- **Rahman et al. (2016)** Effect of a Multicomponent Behavioral Intervention in Adults Impaired by Psychological Distress in a Conflict-Affected Area of Pakistan: A Randomized Clinical Trial. *JAMA*, 316(24):2609-17.

SEARO

- **Bolton et al. (2014)** A transdiagnostic community-based mental health treatment for comorbid disorders: development and outcomes of a randomized controlled trial among Burmese refugees in Thailand. *PLOS Med*, 11 (11).
- **Agger et al. (2009)** Testimonial therapy. A pilot project to improve psychological wellbeing among survivors of torture in India. *Torture*, *19*(3), 204-217.

DISCUSSION

While this review is still in progress, we have already identified some key take-aways relevant to colleagues working in this area:

1 This is a fast-growing area of research.

We have already identified many more studies than originally expected from our initial scoping review. Lay workers are delivering a range of different talking therapies, in diverse populations and settings affected by humanitarian crises. Synthesising this evidence will help us to advise on where further research could have the most impact.

2 Use of pseudoscientific approaches is concerning.

We excluded several LMIC studies of interventions like Thought Field Therapy that have been widely criticised in high-income countries as pseudoscience. LMICs affected by humanitarian crises may be seen as less highly regulated environments in which this sort of research is more likely to gain traction.

3 Reporting in this area needs to be more rigorous.

Many studies do not specify whether or not they use lay workers, and do not provide necessary information about previous education, qualifications, or other training. Many also report "counselling" or "psychotherapy" interventions, without specifying the type or the principles on which the intervention is based. It has also proven difficult to determine whether populations may have been previously exposed to a humanitarian crisis, particularly in FCAS contexts.

Get involved!

We are currently at the expert review stage of this review. **If you would like to be added to our list of experts, or if you know of a study that you think we have missed here, get in touch!** mhin@lshtm.ac.uk

MHIN Mental Health Innovation Network

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- **WHO (2017)** Scalable psychological interventions for people in communities affected by adversity: A new area of mental health and psychosocial work at WHO. Geneva: World Health Organisation.
- **WHO (2018)** Mental health atlas 2017. Geneva: World Health Organisation.
- **World Bank (2017)** Fragility, conflict and violence. Washington, D.C.: World Bank Group.