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The Role of Context in the Implementation of Trauma-Focused Treatments: Effectiveness Research and Implementation in Higher and Lower Income Settings

Jessica A. Chen[1,2,7], **Cecilia C. Olin**[3], **Shannon Wiltsey Stirman**[4,5], and **Debra Kaysen**[3,6]

[1]University of Washington, Department of Psychology, Seattle, WA

[2]VA Puget Sound Health Care System, Seattle, WA

[3]University of Washington, Department of Psychiatry and Behavioral Sciences, Seattle, WA

[4]VA National Center for PTSD, Dissemination and Training Division, Menlo Park, CA

[5]Stanford University, Department of Psychiatry and Behavioral Sciences, Palo Alto, CA

[6]University of Washington, Department of Global Health, Seattle, WA

Abstract

In recent years, the implementation of trauma-focused treatments has expanded across settings that vary widely in the availability of resources, infrastructure, and personnel. The present review aims to inform researchers, policy makers, trainers, and administrators about this diverse range of research. Taking a global health perspective, this review of effectiveness trials and implementation studies compares strategies used in high-income countries to those in low- and medium-income countries. A primary difference between studies in high-income and low- and medium-income countries is the relative emphasis placed on fidelity or adaptation. Adaptations used in low- and medium-income countries might offer useful ideas for increasing the portability, impact, and accessibility of evidence-based interventions in high-income countries.

Trauma-focused treatments (TFTs), i.e., those that ask patients to address memories of their trauma through exposure, construction of a trauma narrative, or examination of thought patterns that were shaped by the event(s), are the primary evidence-based psychotherapies (EBPs) for trauma-related mental health issues [1]. Some common TFT models include Cognitive Processing Therapy, Prolonged Exposure, Trauma-Focused Cognitive Behavioral Therapy, Narrative Exposure Therapy, Eye Movement Desensitization and Reprocessing, and the Common Elements Treatments Approach [1,2]. While TFTs have been identified as first-line treatments [3], they are not widely used in routine practice [4–6]. Implementation

Corresponding Author, Correspondence regarding this article should be sent to Debra Kaysen at 1100 NE 45th, Suite 300, Office 338, Box 354944, Seattle, WA 98105. < dkaysen@uw.edu>. Phone: (206) 221-4657.

[7]Present affiliation: University of Washington, Department of Health Services, Seattle, WA and VA Puget Sound Health Care System, Health Services Research & Development Center of Innovation for Veteran-Centered and Value-Driven Care, Seattle, WA

science aims to accelerate the translation of research findings into clinical practice by studying the methods and processes that promote or impede the use of EBPs in routine care settings [7].

This review briefly summarizes effectiveness trials and implementation studies of TFTs published since 2013. The focus is on comparing research efforts in high-income countries (HICs) to those in low- and medium-income countries (LMICs; World Bank; URL: https://datahelpdesk.worldbank.org/knowledgebase/articles/906519), as previous reviews of TFTs have acknowledged that insufficient attention has been paid to trauma treatment in LMICs [2]. Given that many TFTs have been developed and studied in the United States (U.S.), there is a great deal of research situated in the U.S. and other Western nations [8,9], while the literature in LMICs is nascent and growing. The goal of this review is to inform researchers, policy makers, trainers, and administrators about the diverse range of research on TFTs and to foster new ways of thinking about the portability and accessibility of these interventions.

This review focuses on the influence of a setting's resources on a specific aspect of implementation, namely the tension between treatment fidelity and adaptation. It should be noted that the implementation literature contains many important areas of study, such as implementation facilitators (e.g., training initiatives, technological innovations) and factors such as patient engagement and readiness, that cannot be covered in this brief review and have been discussed elsewhere [10,11].

In the following sections, we compare implementation barriers in HICs to those in LMICs; highlight the specific issue of workforce availability; define the terms fidelity and adaptation and discuss their relationship to each other; and then provide concrete examples of research efforts in an HIC and an LMIC.

Resources and Implementation Barriers

When comparing research efforts in HICs to LMICs, it becomes apparent that the clinical context and its available resources (e.g., organizational funding, health care infrastructure) influence the types of implementation barriers that arise. In HICs, barriers are often conceptualized in terms of characteristics of the organization where the treatment is being implemented. Variables such as organizational support for EBPs [10], a culture supportive of cognitive behavioral treatment models [12], funding for clinical programs and training [13], or how provider time is allocated [14] influence the relative adoption of TFTs . In contrast, in LMICs, implementation barriers are often linked to economic, political, and social variables that affect institutions beyond the organization itself, such as sociopolitical instability [15], limited mental health infrastructure and personnel [16], limited funding for social services [17], lack of familiarity with mental health concepts [16], and low literacy rates [15].

In implementation science, there is increasing recognition that implementing and sustaining evidence-based interventions requires attention to the climate, culture, and social context [11,18]. This perspective is just beginning to influence research on TFTs in HICs [19], while

it is often been at the core of research in LMICs [16]. There are similarities across contexts that, if addressed, could help expand access to TFTs. For example, increased organizational support, whether from specific organizations, international NGOs, or governmental agencies, for use of TFTs would likely increase access and utilization of these treatments [20]. Yet relatively little research in mental health focuses on best practices in engaging these types of key stakeholder groups. Similarly, funding constraints for personnel is a rate limiting factor across contexts, both in terms of hiring and training care providers [21][17] and retaining them [22,23]. A greater consideration of these contextual factors may help TFTs become more portable across settings.

Personnel

Across HICs and LMICs, sufficient staffing and workforce stability are required for successful implementation [17,24,25]. However, the types of individuals who fall under the umbrella of “staff,” “workforce,” or “health care provider” can vary widely between HICs and LMICs. In HICs, providers of TFTs are likely to be trained mental health professionals with advanced degrees and a specialized focus on a patient population or target condition [26]. Research in HICs has focused on how clinician characteristics, such as profession, theoretical orientation, or years of experience, influence clinical outcome [27] and willingness to implement EBPs [28]. Some implementation efforts in HICs have attempted to broaden the umbrella of “treatment provider” by examining whether parents [29] can be trained to deliver components of TFTs effectively to children.

In LMICs, limited mental health infrastructure often precludes the ability to deliver EBPs solely through trained mental health professionals [17]. A number of studies have examined the feasibility of training primary care staff [30] or paraprofessionals [15] to deliver EBPs, and some have found evidence for effectiveness [15,31]. A growing body of research has begun to examine and compare training models and methods [32,23], but there is often insufficient infrastructure to retain trained personnel after a particular project has been completed [17].

Given that training in TFTs requires a significant investment of time [5], sustained implementation requires not just therapist training but also training of supervisors or consultants [20]. A major challenge across HICs and LMICs is that supervision skills are rarely part of therapists’ training [23,33]. While the overall lack of resources and mental health infrastructure in LMICs has an obvious impact on the availability of personnel, even in HICs, implementation scientists are seeking to identify how much training, consultation, and expertise are necessary to effectively implement EBPs [34–36].

Tension Between Fidelity and Adaptation

As described in the implementation literature and detailed above, contextual factors such as resources, infrastructure, and personnel can present barriers to implementation. These barriers in turn can impact the relative emphasis placed on either fidelity or adaptation. Fidelity has been defined as “the extent to which core components of interventions are delivered as intended by the protocols” [37]. Adaptation has been defined as modifications

"to address differences between the context in which the intervention was originally designed and tested, and the one into which it is ultimately implemented" [38]. While fidelity-consistent adaptation is possible [38,39], it has been argued that one can come at a cost to the other [40]. Models adopted from treatment development research are more likely to narrowly define fidelity as adherence to a specific treatment protocol, while increasingly, implementation models consider adaptation a natural and perhaps even essential part of the implementation process [18,41].

In HIC settings that have funding to hire, train, and supervise professional therapists, adherence to specific treatment models is a more common goal [42]. Some implementation efforts include plans for fidelity monitoring [42] or test the effectiveness of supervision on fidelity [43]. In some HIC settings, treatment fidelity may be monitored in ways similar to randomized controlled trials, such as review of session audio or video tapes and use of standardized fidelity rating scales [42]. When more intensive methods are not feasible, review of session notes [10], use of therapists' self-reported adherence [5], or use of behavioral rehearsal [44] may be used as fidelity indicators.

In LMICs, implementation efforts are more likely to plan for adaptation beforehand [15,45], which has been described as "balancing fidelity and flexibility" [23]. Examples of adaptations to TFTs include the removal of technical terms and jargon, tailoring of language and examples to be culturally specific, removal of protocol elements, and replacing written handouts with oral and visual explanations [15,45]. Given the complexity of TFTs, some investigators have begun to test modular protocols that employ elements of these treatments or other cognitive behavioral interventions, which can be tailored to individual clients across a range of diagnostic presentations [46,47].

The implementation literature emphasizes the importance of balancing necessary adaptations that make implementation feasible with fidelity to core components that are necessary for positive outcomes. It will be important to identify the impact of specific types of adaptations on both clinical (e.g., effectiveness) and implementation outcomes (e.g., feasibility, sustainability).

Examples of Research Efforts in LMICs and HICs

Concrete examples of research efforts in an HIC and an LMIC may clarify how a setting's resources influence barriers, which in turn influence the types of adaptations needed to fit an intervention to its context. Sigel and colleagues [11] described a large-scale D&I effort of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for traumatized children through a publicly funded program in the state of Arkansas. The program offered TF-CBT training to an existing workforce of hundreds of skilled mental health providers (MHPs) working in community mental health settings. Training consisted of ten hours of web-based learning, a two-day, in-person training with one of the treatment developers, and biweekly consultation calls for seven months. Notably, Sigel and colleagues did not discuss any planned adaptations to TF-CBT for community mental health settings.

Barriers to successful dissemination of TF-CBT were related to provider buy-in and scheduling flexibility. Only 43% of MHPs completed the training, and those who did not said they struggled to make time for the consultation calls. The primary D&I adaptation was adding more consultation calls at varying times to decrease barriers to training completion. However, with regards to providers' the ability to implement TF-CBT, the authors stated, "MHPs perceived few barriers to implementation."

Bass and colleagues' [15] effectiveness trial in the Democratic Republic of Congo (DRC) provides a contrast in terms of barriers and adaptations. They tested a group-based, 12-session cognitive processing therapy (CPT) for 405 female sexual violence survivors in a country with ongoing political conflict, economic instability, and high rates of sexual violence. Due to the lack of formal mental health infrastructure in the DRC, the treatment was provided by paraprofessionals with at least four years of post-primary school education and one year of experience with case management and supportive counseling. Treatment providers attended a two-week CPT training in DRC and used an adapted and translated manual. They were directly supervised by local psychosocial staff of an NGO, who themselves were supervised by U.S.- based CPT experts via phone.

CPT was adapted for low literacy and illiterate participants by utilizing oral completion of assignments during group and by simplifying the materials to include visual representations of CPT concepts. For example, an "ABC (Activating event-Belief-Consequence)" sheet for teaching the relationship between thoughts, feelings, and behaviors showed a person thinking as a cue for "Belief." Participants were encouraged to memorize the skills, rather than using written practice. The authors reported positive implementation/feasibility outcomes (90% completed CPT) and clinical outcomes (<10% of participants met criteria for probably depression, anxiety, or PTSD at 6 months post-treatment).

Discussion

A body of research is emerging on ways to increase access to TFTs, but research in LMICs is less commonly referenced than research in HICs, even though LMICs may be particularly well situated to answer questions about intervention access and reach. While TFT development, testing, and implementation has typically begun in HICs and moved to LMICs, some have suggested that LMICs can inform implementation efforts in HICs [6]. Examples include expanding ideas about who may be competent to provide TFTs or making treatments more accessible by simplifying materials and language. There is a clear need for future research to examine whether these changes adversely affect clinical outcomes and whether they do indeed increase access to care.

It is likely that not all adaptations have the same impact. Some modifications may be necessary to improve cultural fit [48], whereas others may dilute treatment effects. Recent literature suggests that a significant percentage of TFT clinicians report making adaptations to core EBP ingredients, but the effectiveness of such adaptations is unknown [49]. Real-time data of actual practice may be useful for testing the impact of adaptations on client outcomes [39]. Some have proposed that providers be trained to implement small tests of change, such as continuous quality improvement [41]. Such an approach is contingent upon

the systematic collection and maintenance of practice-level data, which has not been formalized in many HIC or LMICs settings. Developing scalable and feasible systems for the routine collection of practice-level data may be an important path forward for implementation of TFTs.

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Highlights

- Evidence-based therapies for trauma are not widely used outside of academic settings.
- Implementation differs between high-income and low- and medium-income countries.
- Resources may influence the relative emphasis placed on fidelity or adaptation.
- Little is known about the impact of adaptation on clinical outcomes.
- Implementation efforts should consider the tension between quality control and accessibility.