Youth Psychotherapy Interventions in Low- and Middle-Income Countries and Throughout the World: Beyond Efficacy, towards Accessibility

Lauren C. Ng, PhD

Dept. of Psychology; University of California Los Angeles

laurenng@ucla.edu

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Youth Psychotherapy Interventions in Low- and Middle-Income Countries and Throughout the World: Beyond Efficacy, towards Accessibility

It is estimated that 13% of the world's children and adolescents have a mental health disorder.[1] Fortunately, psychotherapy interventions are effective at improving mental health symptoms and associated functional difficulties.[2] However, while the research literature on the efficacy of youth psychotherapy is robust, it may not be generalizable to all populations and across all contexts, particularly given the limited diversity of the research samples with which they have been tested.

Although more than 90% of youth in the world live in low- and middle-income countries (LMICs), less than 10% of youth psychotherapy intervention research is conducted in LMICs.[3] The disparity in mental health research generated in high-income countries (HICs) compared to LMICs, is so persistent and pervasive that is has been termed the 10/90 divide.[3] The gap is particularly pronounced for low-income countries, which account for only 1% of research on mental health interventions.[3] As a result, little is known about the effectiveness of psychotherapy for the overwhelming majority of the world's population.

The study discussed in this editorial, "Meta-analysis: The Effectiveness of Youth Psychotherapy Interventions in Low- and Middle-Income Countries" by Venturo-Conerly et al. (2022),[4] contributes to the dearth of intervention research in LMICs by using a meta-analysis to estimate the pooled efficacy of psychotherapy to improve mental health symptoms in youth living in LMICs. Included studies were randomized controlled trials (RCTs) published between 1960 and 2021 conducted in countries designated as low- or middle-income by the World Bank. The included psychotherapies had to be designed to alleviate anxiety (including posttraumatic stress disorder and obsessive-compulsive disorder), depression, conduct disorders, or attention problems in youth aged 3 to 18 years old.

Venturo-Conerly and colleagues identified 34 studies consisting of 43 treatment-control effect sizes from 4,176 participants in 20 out of 136 LMIC countries.[4] The lack of any data at all from 116 countries highlights the massive gap in understanding of mental health interventions throughout much of the world. Moreover, the number of identified RCTs and effect sizes from LMICs pales in comparison to the 447 RCTs and 6,941 effect sizes of youth psychotherapy that were identified in a meta-analysis with similar inclusion criteria that included studies from HICs.[2] Clearly, much more research is needed on mental health treatment in youth from LMICs. Although the data pool is limited, results indicated that the youth psychotherapy interventions conducted in LMICs were efficacious with large effect sizes when compared to active and waitlist control conditions.[4] These findings provide critical support for the potential of psychotherapy to reduce mental health symptoms of youth in LMICs.

However, while establishing efficacy of interventions is necessary, it is not sufficient. It is also critical to assess the effectiveness and implementation of interventions delivered pragmatically, by the providers who are best positioned to deliver the intervention sustainably and with fidelity, in the contexts, settings, and circumstances that are most feasible and accessible for youth and their families. Indeed, more than 50% of the 43 interventions were developed elsewhere and adapted to the local context, while a quarter were developed locally. Only 14% of interventions were developed elsewhere and not adapted to the local context, including three interventions that were included in the same research study. The fact that the great majority of interventions were either developed locally or were adapted to the local context suggests that researchers believed that local adaptations may have been necessary to increase the cultural and contextual acceptability, feasibility, sustainability and scale-ability of the interventions.

Indeed, formal and informal modifications or adaptations of evidence based interventions is common when interventions are utilized in settings where they were not originally developed, including in routine care settings.[5] Adaptations may be made to increase the fit or effectiveness of the intervention or to increase client engagement with, and understanding of, the therapy content. However, evaluating the utility of these adaptations is challenging as there are very few studies that have compared the efficacy of adapted vs non-adapted interventions,[5] and none were identified in this meta-analysis.[5]

However, one of the reasons why adaptation of interventions developed in HICs may be particularly relevant when disseminated to LMICs, is the scarcity of trained mental health professionals in LMICs.[6] Indeed, low and lower-middle-income countries have fewer than four mental health providers per 100,000 people (compared to more than 60 in high-income countries and 15 in upper-middle income countries).[7] The mental health workforce that serves children and adolescents is even more limited, with almost no providers available in low and lower-middle-income countries.[7] The lack of trained mental health professionals has led to an uptake in LMICs in the use of "task-shifting" or "task-sharing," in which non-mental health professionals (including but not limited to community members, primary care providers, health extension workers, or community health workers) are trained to deliver the interventions themselves.[8] Venturo-Conerly et al (2022) found that of the 28 treatments that reported on the type of interventionist, only 46% were delivered by mental health professionals, while 43% were delivered by lay providers and 11% were delivered by students or trainees.[4] Notably, lay provider delivered mental health treatment resulted in medium effect sizes,[4] which is consistent with other meta-analyses of lay provider delivered psychotherapy[8] and is comparable to the effect sizes of youth psychotherapies generally.[2] The efficacy of lay health provider delivered

intervention is highly significant given that the use of lay providers to deliver mental health treatment has the potential to greatly expand access to sorely needed care worldwide.

Participants receiving therapy from trained mental health providers had better outcomes than participants receiving care from lay providers.[8] While this disparity may be expected given the additional training, experience, supervision, and resources that the trained providers had received and could leverage, more research is needed to determine whether the efficacy of lay provider delivered therapy could be improved with more training, supervision, and resources. Investment in understanding how to optimize lay provider delivered mental health care is critical, not just for reducing the treatment gap in LMICs, but also in HICs such as the United States, which has significant shortages of mental health care providers in more than 70% of the country.[9]

Increasing access to, and awareness of, mental health care is critical throughout the world. More research is needed on ways to not only make interventions efficacious, but also to ensure that they are feasible, acceptable, scale-able, and sustainable, and that they reach as many youth as possible, particularly the most vulnerable. Ultimately the interventions that meet this standard may not have the largest effect sizes in RCTs, but they may be the most accessible. Reaching this goal may require adaptations or modifications to the traditional psychotherapy models that have been utilized in HICs, and movement towards a more preventative public mental health model that seeks to increase early identification and intervention, embraces stepped care approaches, and capitalizes on non-specialist providers such as lay health workers, primary care providers, teachers, and indeed community members and peers. LMICs are leading the way in embracing and testing these approaches, and the rest of the world must catch up if we hope to improve youth mental health globally.

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