



# Therapist competence in global mental health: Development of the ENhancing Assessment of Common Therapeutic factors (ENACT) rating scale



Brandon A. Kohrt<sup>a, b, c, d, \*</sup>, Mark J.D. Jordans<sup>a, e, f</sup>, Sauharda Rai<sup>a, d</sup>, Pragya Shrestha<sup>a</sup>,  
Nagendra P. Luitel<sup>a</sup>, Megan K. Ramaiya<sup>d</sup>, Daisy R. Singla<sup>g</sup>, Vikram Patel<sup>h, i, j</sup>

<sup>a</sup> Transcultural Psychosocial Organization (TPO) Nepal, Kathmandu, Nepal

<sup>b</sup> Department of Psychiatry and Behavioral Sciences, The George Washington University School of Medicine, Washington, DC, United States

<sup>c</sup> Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine, Durham, United States

<sup>d</sup> Duke Global Health Institute, Duke University, Durham, United States

<sup>e</sup> Centre for Global Mental Health, Institute of Psychiatry, Psychology and Neuroscience, King's College London, United Kingdom

<sup>f</sup> Research and Development, HealthNet TPO, Amsterdam, The Netherlands

<sup>g</sup> Department of Psychology, McGill University, Montreal Quebec, Canada

<sup>h</sup> Centre for Global Mental Health, London School of Hygiene & Tropical Medicine, Keppel Street, London, United Kingdom

<sup>i</sup> Public Health Foundation of India, New Delhi, India

<sup>j</sup> Sangath Center, Alto Porvorim Goa, India

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## ABSTRACT

Lack of reliable and valid measures of therapist competence is a barrier to dissemination and implementation of psychological treatments in global mental health. We developed the ENhancing Assessment of Common Therapeutic factors (ENACT) rating scale for training and supervision across settings varied by culture and access to mental health resources. We employed a four-step process in Nepal: (1) *Item generation*: We extracted 1081 items (grouped into 104 domains) from 56 existing tools; role-plays with Nepali therapists generated 11 additional domains. (2) *Item relevance*: From the 115 domains, Nepali therapists selected 49 domains of therapeutic importance and high comprehensibility. (3) *Item utility*: We piloted the ENACT scale through rating role-play videotapes, patient session transcripts, and live observations of primary care workers in trainings for psychological treatments and the *Mental Health Gap Action Programme (mhGAP)*. (4) *Inter-rater reliability* was acceptable for experts (intraclass correlation coefficient, ICC(2,7) = 0.88 (95% confidence interval (CI) 0.81–0.93), N = 7) and non-specialists (ICC(1,3) = 0.67 (95% CI 0.60–0.73), N = 34). In sum, the ENACT scale is an 18-item assessment for common factors in psychological treatments, including task-sharing initiatives with non-specialists across cultural settings. Further research is needed to evaluate applications for therapy quality and association with patient outcomes.

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## 1. Introduction

Availability of evidence-based psychological treatment (PT) in low-resource settings is crucial to reduce the global burden of disease attributable to mental disorders (Fairburn & Patel, 2014). This requires task-sharing (WHO, 2008) which involves training non-specialists, such as individuals without professional mental

health clinical degrees, to be competent in PT delivery.<sup>1</sup> In both high and low resource settings, non-specialists can effectively deliver a

<sup>1</sup> Task-sharing, also known as task-shifting, refers the involvement of non-specialist service providers to collaborate in delivery of health care services traditionally relegated to experts with professional degrees or certification (WHO, 2008). In the context of global mental health, 'non-specialist' refers to a person who lacks specialized professional training in fields such as psychology, psychiatry, or clinical social work. Non-specialists in both low- and high-resource settings may include community health volunteers, peer helpers, social workers, midwives, auxiliary health staff, teachers, primary care workers, and persons without a professional service role.

\* Corresponding author. Duke Global Health Institute, 213 Trent Hall, 310 Trent Drive, Durham, NC 27708, USA.

E-mail address: [brandon.kohrt@duke.edu](mailto:brandon.kohrt@duke.edu) (B.A. Kohrt).

range of PT (Montgomery, Kunik, Wilson, Stanley, & Weiss, 2010; van Ginneken et al., 2013). However, a lack of reliable and valid measures of therapist competence impedes the dissemination of evidence-based PT (Fairburn & Cooper, 2011; Muse & McManus, 2013; Rakovshik & McManus, 2010). Such measures are crucial to (1) interpret outcomes of effectiveness studies, (2) evaluate and refine training and supervision models, and (3) scale-up and disseminate PT in real-life context. Our goal was to develop a tool to evaluate competence in PT delivery across settings varied by culture and availability of professional resources.

Therapist competence is “the extent to which a therapist has the knowledge and skill required to deliver a treatment to the standard needed for it to achieve its expected effects,” (Fairburn & Cooper, 2011, p. 373). Therapist competence also should be reflected in therapy quality, which is “the extent to which a psychological treatment was delivered well enough for it to achieve its expected effects,” (p. 373), and, ultimately, in patient outcomes. Variability in therapists' training and competency may explain the lack of significant differences in some comparative treatment studies (Brown et al., 2013; Ehlers et al., 2010; Ginzburg et al., 2012). Because training and background of specialists and non-specialists may vary considerably, reliable and valid competence and quality assessment tools are crucial for global mental health research.

Miller's (1990) hierarchy of clinical skills includes 4 levels (Muse & McManus, 2013): Level 1 “knows” refers to conceptual knowledge of a PT and typically is assessed through multiple-choice questions. Level 2 “knows how” refers to knowledge of how to apply theory, which can be assessed through decision-making questions following clinical vignettes. Level 3 “shows” refers to competence in demonstrating the ability to apply skills, which can be assessed through role-plays with standardized patients. Level 4 “does” refers to how therapists apply skills in practice, which reflects therapist quality and is typically assessed through rating treatment sessions. Measurement of competence (Level 3, “shows”) is one of the least examined skill domains (Muse & McManus, 2013) and is especially lacking in training and research conducted in low- and middle-income countries (LMIC).

A major question in assessment of competence is *what skills should be measured*. Competence typically entails “limited domain intervention competence” (Barber, Sharpless, Klostermann, & McCarthy, 2007), which refers to specific practices for particular interventions, such as facilitating activation in cognitive behavior therapy. However, research has demonstrated that *common factors* in psychotherapy are vital for successful outcomes. Common factors have been categorized differently by scholars (Frank & Frank, 1991; Lambert & Bergin, 1994; Rosenzweig, 1936; Wampold, 2011): the main domains relate to therapist qualities and therapeutic alliance, mobilization of client and extra-contextual factors, promoting hope and expectancy of change, collaborative goal setting, ritualized procedures to work toward that goal, eliciting feedback, explanation for treatment grounded in a patient's belief system, and a healing setting.

In practice and research, it is difficult to disentangle common factors as distinct processes (Wampold, 2011). Common factors are interrelated, and they overlap with specific practice elements. A key distinction is that practice elements have a demonstrated evidence base for a specific patient population and typically are administered from selected manualized modules whereas common factors refer to those practices assumed to be universal for delivery of any effective PT (Barth et al., 2012). Therefore, if one is starting with non-specialists, they need to be competent in these common factors first before teaching them the required treatment-specific skills. Competency in common factors contributes to phenomena such as the “primary care paradox”, the observation that some conditions can be well treated by generalists despite delivery of

manualized care that is of lesser technical proficiency (Stange & Ferrer, 2009). Unfortunately, common factors have received limited attention in LMICs (Jordans, Komproe, Tol, Nsereko, & de Jong, 2013; Kabura, Fleming, & Tobin, 2005) despite importance for care delivered by non-specialists.

Although tools to assess common factors are available in high-income countries (HICs), application of these tools are limited across settings varied by culture and professional resources. Barriers to applying these tools include experts required for scoring, narrow focus on content, reliance on patient feedback, length of tools, and high costs to administer some copyrighted tools. Moreover, although common factors are important across cultures (Frank & Frank, 1991; Othieno et al., 2013), instruments developed for use by educated professionals in HICs might overly represent values and treatment philosophies that are not associated with outcomes across cultures, such as an emphasis on biomedical models (Kleinman, 1988).

This study is part of a larger endeavor to improve mental health care in low resource settings (Lund et al., 2012) and to strengthen measurement of competence and quality for and by non-specialists in global mental health (c.f., Singla et al., 2014). The focus of the current study is to develop a tool to assess competence in a manner that is not restrictive to HIC specialists and is relevant across cultural settings. We employ a four-part process to (1) collect a range of items related to common factors, (2) determine their face validity in a South Asian cultural context, (3) pilot the tool for feasibility and acceptability, and (4) establish psychometric properties. This is a systematic description of a procedure that can be replicated for developing common factors assessments across a range of interventions, provider disciplines, and cultural context.

## 2. Methods

We developed this tool within a task-sharing initiative in a low-income, non-Western cultural setting. Nepal, a post-conflict country in South Asia with high prevalence of depression (Kohrt, Hruschka, et al., 2012) and suicide (Jordans et al., 2014), is participating in the Programme to Improve Mental Health Care (PRIME), an initiative in LMICs to develop mental health care in primary and community health settings (Jordans, Luitel, Tomlinson, & Komproe, 2013; Lund et al., 2012). In Nepal's Chitwan District, primary care and community health workers are being trained with a locally developed Mental Health Care Package (Jordans, Luitel, Pokharel, & Patel, in press), which includes the *mental health Gap Action Programme—Intervention Guide (mhGAP-IG)* (WHO, 2010), psychosocial skills modules, and brief modified versions of behavior activation (the Healthy Activity Program, HAP) and motivational interviewing (Counseling for Alcohol Program, CAP) from the Programme for Effective Mental Health Interventions in Under-resourced Health Systems (PREMIUM) (Patel et al., 2014; Singla et al., 2014). The Nepal Health Research Council approved the protocol.

In the context of our study, ‘non-specialist’ refers to the primary care workers being trained in PT through PRIME. ‘Expert therapist’ refers to individuals who have completed a six-month training and have been practicing therapy for more than five years. Their six-month training course includes 400 h of classroom learning, 150 h of clinical supervision, 350 h of practice, and 10 h of personal therapy (Jordans, Tol, Sharma, & van Ommeren, 2003). All role-plays in the study were 15–20 min and covered a range of common patient presentations including depression, harmful drinking, sexual violence, other traumatic experiences, academic stressors, and self-harm. We generated role-plays based on actual patient interactions. Role-plays used with the common factors tool were designed for all items to be applicable. Expert therapists were trained to perform as standardized patients for all role-plays.

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