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# Global mental health commentary: using innovation to create a workforce to deliver and implement culturally adapted CBT in Pakistan

Nagina Khan ,[1] Mirrat Gul Butt,[2] Falahat Awan,[3] Sadia Abid,[4] Madeeha Latif,[3] Muhammad Aslam,[4] Saiqa Naz,[5] Peter Phiri,[6] Zainab Zadeh,[7] Saeed Farooq,[8] Iqbal Afridi,[9] Muhammad Ayub,[10] Nusrat Husain,[11] Afzal Javed,[12] Muhammad Irfan,[12] Farooq Naeem[13,14]

For numbered affiliations see end of article.

**Correspondence to**
Dr Nagina Khan, Division of Law, Society and Social Justice, Centre for Health Services Studies (CHSS), School of Social Policy, Sociology and Social Research, University of Kent, Canterbury, UK; N.Khan-523@kent.ac.uk

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## ABSTRACT

Most low- and middle-income countries (LMICs) have poor or non-existent mental healthcare. Many of LMIC countries allocate less than 1% of their health budgets to addressing mental illness, making large-scale public health interventions not a practical option, at least for the foreseeable future. Psychiatric services are limited to large urban centres, and mental health literacy is low. There is increasing international recognition of the need to build capacity to strengthen mental health systems in LMICs.

The aim of this paper is to offer a reflective commentary on our research undertaken over 15 years in Pakistan psychiatric services to create a workforce and culturally adapted cognitive behaviour therapy (CBT) model for LMICs that works for diverse communities served. The exemplar of our work discussed in this article can be used as lessons for developing mental health therapies for LMICs and other countries with diverse communities globally. Our discussion is based largely, if not, on all aspects describing the key barriers and facilitators to implementation of a workable culturally adapted CBT model for use in Pakistan or any similar LMICs. We report on the implementation of culturally adapted CBT in Pakistan over the past 15 years to improve the identified gaps in evidence. We also highlight the successful dissemination strategies our group employed for successful adaption and implementation.

## BACKGROUND

Building sustainable mental health systems in low- and middle-income countries (LMICs) has been a long-term concern.[1] Philanthropy's support of health services, even in high-income countries, has been criticised as unsustainable.[2]

In 2008, six of the master trainers, along with FN, founded the Pakistan Association of Cognitive Therapists (PACT) (pact.com.pk), along with the sister organisation, the Pakistan Academy of Cognitive Therapies, which started a cognitive behaviour therapy (CBT) diploma to produce accredited CBT therapists in Pakistan. In 2019, the online national CBT service (Dilkibaat.ca) was launched– on a no-profit, no-loss basis. At the time of its inception, PACT was the first national CBT organisation in Asia and the Middle East. Our focus was on the training and accreditation system and production of therapists. So, our commentary is focused on culturally adapted CBT development and on the development of a sustainable system that trains a new workforce of therapists.[1] During the implementation phase, the above named organisations were instrumental in supporting our work, which trained nine CBT master trainers in Pakistan between 2006 and 2009. Along with the therapists, we produced high-quality but low-cost CBT therapists on the one hand and developed and disseminated culturally adapted CBT-based self-help manuals in local languages that were used to deliver guided self-help interventions.[3]

The team's key priority was to develop a sustainable and efficient system for LMICs that was not dependent on philanthropy. The PACT's initial funding source was the CBT training courses in Pakistan and other countries in the region. As well as culturally adapted CBT-based self-help books (eg, a paper version of the culturally adapted CBT-based self-help manual), Khushi Aur Khatoon (https://pact.com.pk/self-help/) sold over 1 million copies.[4] We used the maximum potential of technology to cut costs, creating PACT as a 'paperless' organisation.

Culturally adapted CBT model[5] made it easy to promote CBT in Pakistan, where there was very little knowledge of CBT when our work started. The original model of adaptation at inception was the Southampton adaptation framework which was developed in 2009 for depression and anxiety.[1] Over the years, the model has been used for psychosis, populations and with individuals who experience obsessive-compulsive disorder. The details of these studies are noted in the most recent[2 6] publications.

The points in this article include references to all our research conducted through a 15-year implementation period to adapt CBT using qualitative or mixed-methods approaches, involving the following sample groups in collaboration: patients, their caregivers, therapists or mental health professionals working with them, and community leaders. These studies have been reported elsewhere.[7] The knowledge gained during the cultural adaptation of the CBT process was lengthy (we have documented this in our other published papers) and led to successes in developing workforce capacity to roll out culturally adapted CBT in LMICs, helping us to

cultivate a culture of sustainability.[8] Our driving principle was to use an inclusive equitable and 'respectful democratic' approach towards decision-making and team functioning. This approach cultivated frank discussions, with participation from all the team members, balanced by gender, without any implied hierarchy, while maintaining social norms.

Our work building and using this principle to underpin our methodology has highlighted three areas of cultural competence (the triple-A principle) in CBT: (1) awareness of culture and religion, (2) addressing barrier assessment and engagement and (3) adjustments in therapy techniques ('technical adjustments'). The methodology we refer to in this article has been used in six countries to adapt CBT and in more than 20 randomised controlled trials that tested adapted therapy.[7]

Our commentary is based on our combined experience of practically setting up an organisation to promote CBT in Pakistan and narrates our efforts to locally implement and produce low-cost, low-intensity CBT therapists, while maintaining high standards of training and accreditation.

## DISCUSSION

Through the development of PACT, and with its developed presence now in all four provinces of Pakistan and with its current developed presence. We increased the capacity building of talking therapies in LMICs, making it easily accessible by having 15 000 participants who attended training events organised by PACT over the 15 years of its development and simultaneous implementation in Pakistan. The network development and increased capacity meant that we provided clinical supervision to more than 2000 trainees in our partner organisations. The accumulative impact of our research in building a sustainable workforce and the LMIC ready culturally adapted CBT model led to improvement in the use of CBT for the local population needs. Another success of our LMIC culturally adapted CBT model was also embedded as part of the College of Physicians and Surgeons of Pakistan's curriculum for psychiatry trainees. Most significantly, CBT therapists from many different backgrounds to provide low-cost culturally adapted CBT models throughout the health and social care workforce in Pakistan. See table 1 for the barriers to implementation that were derived from our previous research on the development and implementation of culturally adapted CBT.

Looking over the main lessons from our work, for implementation of such models elsewhere, the lessons to be learnt for other LMICs in psychological therapy development and implementation, centre on the following key points of success. These included successful engagement of psychiatrists, psychologists and other stakeholders, focusing on other elements related to social change, funding, mobilising a workforce, sustainability, using a broader framework to include business and management delivery skills and applying to the clinical healthcare context rather than the scientific evidence lens only. Similarly, the increasing use of the internet and social media in Pakistan has helped disseminate and engage both the workforce and those requiring treatment. Finally, the key factor in our succesful implementaion was to provide support and skills that local professionals found helpful in practice and for CBT implementaion, and the importance of using an equitable lens to develop our culrurallt adapative CBT model from an LMIC context.

## CONCLUSIONS

The objective of implementing the culturally adapted version of CBT was intended to make psychological therapies widely available and accessible through local therapists in a language their clients would understand, available in their own communities. This helped us to win the confidence of both therapists and the public.[9]

Over the past decade, our team has developed and tested culturally sensitive CBT using mixed-methods research.[7 9–15] Our commentary highlights the creation and the availability of culturally appropriate mental health talking therapies to

**Table 1** Barriers to implementation of CBT in Pakistan

| Barriers | Actions/activities/strategies |
|---|---|
| The first was to overcome a lack of awareness of mental health problems and their non-pharmacological treatments, especially CBT.[17] | We ran training workshops, seminars and conferences to generate funds and sold self-help manuals. In addition, we developed a lean organisation[18] with a focus on cost savings. |
| The second barrier was the lack of funds. | Team focus was on raising awareness of CBT by establishing partnerships with local media outlets to educate the general public on the role of CBT in treating mental health problems. This was also when social media became popular in Pakistan due to a younger population, affordable smartphones and broadband internet. We used the potential of these media to spread the word about CBT in Pakistan. |
| Third, the lack of government concern, despite our contacts with politicians and civil services, and the lack of a state-funded workforce delivering CBT was initially a critical roadblock. | The primary issue in securing funding was to secure and prioritise the physical and emergency health budget. We planned to develop an alternative care delivery model based on the US model, in which CBT was not accessible for all to compromise on ground realities. |
| Fourth, the lack of trained CBT professionals. In 2009, only a few psychologists in Pakistan were trained in rational emotive behaviour therapy (REBT). | Due to ongoing Taliban terrorism, the foreign trainers were not able to visit Pakistan. A small team of trainee psychiatrists and psychologists were trained as master CBT trainers and champions. Finally, as the security situation improved, we engaged foreign trainers and academics to provide regular training in Pakistan. We have produced more than 300 CBT therapists in Pakistan. |
| The fifth barrier was access to therapy materials such as information sheets, therapy manuals and training in local languages. The terminology was especially hard to translate. | Language is the medium used to deliver therapy and to make the therapists connect with their clients using terminology available in local languages.[10] This was resolved in two ways. First, we wrote Urdu self-help manuals in easy-to-understand Urdu,[19] and second, we used the 'Name the Title technique' to translate terminology.[20] |
| The sixth and last barrier was a lack of trust among the mental health professionals. They included both psychology and psychiatry trainees. | Since these trainees were engaged in the organisation from the start, they became a bridge between two specialties. They were able to establish and maintain training and research collaborations with colleagues from all backgrounds. |

CBT, cognitive behaviour therapy; LMICs, low and middle income countries; PACT, Pakistan Association of Cognitive Therapists ; REBT, Rational emotive behaviour therapy.

support implementation by our team in Pakistan. We were able to provide skills that local professionals found helpful and they could continue to work in their local communities. Our work provides a broad exemplar of what provision is possible in LMIC mental health, to disseminate and implement CBT that can be delivered at the national level in a low-income country by working closely with all stakeholders, gathering a team of dedicated and motivated young professionals and planning with a long-term sustainable vision. Despite this, people in LMICs often demand the best tests and medication and tend to go to large hospitals in urban centres.[16] However, we believe, as evidenced by our work, that the systems in LMICs can be changed if the government cannot afford formal services. Even in the Western world, not all psychotherapy services are free. Strengthening existing secondary health services in LMICs is the best way to strengthen health systems in low-income countries.

The extensive hurdle, which we experienced over the years, in the dissemination and especially during the implementation periods, was the need for more awareness of CBT or non-psychopharmacological interventions. Engagement in psychotherapy required a certain degree of awareness of the problem and recognition of distress. People would often seek help because they were distressed; we overcame this barrier through increasing education, information and using translational materials. Due to our limited resources, we found that only young, socially literate persons primarily self-referred for therapy. There were times when more extensive media campaigns were required using multiple social media platforms. Ultimately, we found that team leaders can motivate, help and grow their teams through training and innovation, which can help them realise a common goal that can be developed through innovative work. Additionally, understanding the system by working within the system can help embed new models and adapted versions of treatments in other communities. We also shared responsibility and glory equally within our team, building a workforce ethos that worked effortlessly to disseminate and implement culturally adapted CBT in one low-income country.

We emphasise that financial resource issues can be overcome if a team of dedicated individuals who are persistent. The critical issue is to balance 'an equitable gain' with' a financial gain' for everyone.' Financial gains can have a positive influence and are a significant incentive for increasing motivation, especially in LMICs. Those accessing the culturally adapted CBT therapy training used these incentives, suggesting—'We received training to improve our earning skills.' The accumulative success of our diverse team was innovative; our most valid step in this process was identified by the creation of a new profession in Pakistan's mental health system: 'the culturally adapted CBT therapist'. This model is similar to the one used to deliver evidence-based interventions at affordable rates in North America (psychology.com). When Pakistan can afford it, a ready force of therapists will be available for publicly funded therapy to work anywhere (eg, in the UK, Australia and Canada).

**Author affiliations**
[1]Centre for Health Services Studies (CHSS) |Division of Law, Society and Social Justice |School of Social Sciences, University of Kent, Canterbury, UK
[2]Department of Psychiatry, Mayo Hospital, Lahore, Pakistan
[3]Dow Institute of Physical Medicine & Rehabilitation, Dow University of Health Sciences, Karachi, Sindh, Pakistan
[4]Pakistan Association of Cognitive Therapy, Lahore, Pakistan
[5]Sheffield Health and Social Care NHS Foundation Trust, Sheffield, UK
[6]Faculty of Medicine, University of Southampton, Southampton, UK
[7]Pakistan Institute of Living and Learning, Karachi, Pakistan
[8]Faculty of Medicine & Health Sciences, School of Medicine, Keele University, Keele, UK
[9]Jinnah Post Graduate Medical Centre, Karachi, Pakistan
[10]University College London, London, UK
[11]The University of Manchester, Manchester, UK
[12]Department of Mental Health, Peshawar Medical College, Peshawar, Pakistan
[13]Psychiatry, CAMH, Toronto, Ontario, Canada
[14]Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada

**X** Nagina Khan @DrKhan_do

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**ORCID iD**
Nagina Khan http://orcid.org/0000-0003-3870-2609

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