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Don't fault RCTs for not testing systems of care

Andrew Rasmussen

Among Mundt and colleagues' (2014) criticisms of NET is that testing a particular intervention implies that it is meant to be delivered irrespective of systems of care. But trauma-focused treatments should be judged based on the specific problems they target; larger sets of problems are the purview of health systems research.

Mundt and colleagues' (Mundt et al., 2014) critiques of the research on Narrative Exposure Therapy (NET) are various and wide ranging. These critiques include: modest effect sizes; concerns about privacy protection; disapproval of the practice of applying North American and European diagnostic categories in nonEuropean cultures; and doubts about the reliability of randomised control trials (RCTs) in low and middle income countries (LMICs), in general. Although some of these critiques may have merit, I am troubled by the undercurrent of enmity towards RCTs in LMICs as there are good examples of successful RCTs in LMICs. Additionally, RCTs are one of a powerful set of evaluation techniques, and it is unclear to me why any researcher, or monitoring and evaluation team, would want to limit the number of tools in their methodological toolbox. However, rather than attempt a cogent defense of RCTs here, I refer readers to the wealth of literature defending experimental designs in our field (e.g., Meffert & Ekblad, 2013) and the ethical arguments concerning withholding RCT results (e.g., Neuner, Schauer, & Elbert, 2014, in their response to Mundt et al., this issue). Suffice it to say that those who accept the argument that RCTs cannot be undertaken reliably in LMICs unnecessarily handicap their programmes' accountability.

My comments here primarily concern Mundt et al.'s (2014) criticism that NET, and by extension all trauma focused treatments with RCT support, are somehow

necessarily disconnected from larger health systems. Before going further, I should make my biases clear. I have spent a fair amount of academic energy critiquing the emphasis on trauma focused treatment in psychosocial interventions, specifically, its use at the expense of other measures aimed at reducing the pervasive daily stressors that arise in post disaster settings (Miller & Rasmussen, 2010). Mundt et al. (2014) accurately describe the sequenced approach to systems of care that Ken Miller and I advocated: address the distress associated with daily stressors and provide specialised care where needed. However, specialised care includes (though certainly is not limited to) trauma focused treatment, of which NET is one example. Within my own clinical work with asylum seekers, for example, I used NET as part of a care package that also included social services, legal advocacy and medical care. At no point did my social service, legal, or medical colleagues (or I, for that matter) suppose that NET would solve all of my clients' psychosocial problems. This did not mean that any of us felt that its use was not justified for cases with severe posttraumatic stress. Mundt and colleagues (2014) criticise NET RCTs for not addressing all aspects of psychosocial wellbeing, but trauma focused treatments are not designed to address all aspects of psychosocial wellbeing, and therefore should not be evaluated on those terms. Nor should the fact that RCTs of trauma focused treatments have been shown to be reduce only trauma related outcomes (i.e., those for which they are designed to reduce) be interpreted as meaning that those treatments are, *sine qua non*, '*stand-alone intervention[s]*' (Mundt et al., 2014).

I believe Mundt et al. (2014) are faulting RCTs for not producing findings more in line with health systems research. This is clearly problematic, but it is useful in that it reflects a common mistake in the field that can be corrected, as well as highlighting a large gap in the literature. There are few examples of structured interventions in the psychosocial literature that attempt to address multiple levels of wellbeing, and that have been subject to rigorous evaluation (see Nickerson et al., 2011). Our field desperately needs empirical health systems research. Such research might examine how components of care packages affect each other (e.g., how livelihood activities affect treatment outcomes and vice versa), how empirically supported therapy might be complemented, or replaced, by existing local healing practices, and even how different political or bureaucratic structures might affect the delivery of interventions. Although this type of research has begun in one or two LMIC settings (e.g., Bass et al., 2013b), as a field we are generally ignorant of how our multilevel systems of psychosocial care really work. Notably, consistent with multilevel interventions with empirical support in high income host countries (e.g., trauma systems therapy; Ellis et al., 2011), those that have been evaluated in LMICs include trauma focused components supported by RCTs (e.g., Bass et al., 2013a).

Despite fruitful advances in the past decade, there are still only a handful of rigorous studies from low income settings to help practitioners decide how they should treat the multiple psychological problems that arise in emergency settings (e.g., Bass et al., 2012; Bolton et al., 2007). A number of these studies are RCTs, while fewer are more comprehensive evaluations of systems of care. Yet, the fact that health systems research is less common than RCTs in no way negates the findings of RCTs to date. Indeed, RCTs (or at least the information gleaned from RCTs) complement evaluations of care packages, and thus play an important role in health systems research. The answer to the critique that trauma focused interventions with empirical support are not worthy of consideration because they are limited in scope is not to reject RCT findings and foreclose upon the interventions, but rather to research the systems of care in which they can be integrated. LMIC practitioners

should consider findings from RCTs in making informed decisions about what treatments they can and should use within their own systems of care, and examine how multiple components of those systems interact.

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