

pharmacotherapy, psychotherapy, or support groups). The parents may not agree on the need for medications or, if they do, they may not agree on what type or dosage is needed. They may need guidance in advocating for the child within the school system. Siblings may be confused as to their role in helping their ill brother or sister (or, at minimum, how not to trigger symptoms further).

A different set of questions may haunt young affected people during this period. These issues surround how the illness will impact their peer and school relationships or activities, or even how their identity has been changed by the illness. They may express considerable resentment toward their parents for seemingly overreacting to minor symptoms or for insisting on a regimented lifestyle. These issues can become intertwined with the young persons' struggle for autonomy. Psychiatric treatment may come to symbolize the last bastion of their parents' control over them, with the psychiatrist seen as an agent of the parents.

A key component of psychoeducation is the relapse prevention plan. The patient and the parents make a list of early warning signs of episodes and past stressors – major or minor – that appear to have triggered those episodes (e.g., the start of a new school year). Then, clinicians coach the family to make a list of potential coping strategies (e.g., try to regulate sleep and wake times) and potential obstacles to their implementation (e.g., foregoing late-night parties). The plan is modified over time as more data are collected on warning signs, eliciting stressors and effective coping strategies.

In later segments of psychoeducation, clinicians attempt to modify levels of expressed emotion by guiding families in effective communication and problem-solving. Clinicians elicit role-play interchanges between parents and offspring with practice of skills such as active listening, making requests for changes in each other's behaviors, and balancing positive and negative feedback. To reduce parent/offspring criticisms (e.g., "I resent the hours you keep"), clinicians can take several steps: a) reframe the criticism as coming out of positive intentions (e.g., "I am worried about you not getting enough sleep and getting ill again"); b) point out that the parent's manner of delivery is inadvertently alienating the offspring; and c) model for the parent how he/she might make a request for behavior changes (e.g., "I'd appreciate your helping me

manage my own anxiety by keeping to a regular bedtime"). These exchanges can be followed by problem-solving exercises in which family members offer practical input about how to keep consistent nightly routines.

Severe family conflict often grows out of parents' disappointments over failed expectations of the child. Input from the offspring about what they can or cannot accomplish while still symptomatic is essential. The offspring can be coached to make decisions that will enhance their chances of recovery (e.g., avoiding enrolling themselves in too many courses; discontinuing use of cannabis or psychostimulants). Recovery can be framed as an objective that must be achieved by the family as a whole, not only by the patient.

Randomized clinical trials indicate that, among youth in the early stages of bipolar disorder, a 12-session, 4-month protocol of family-focused therapy (psychoeducation, communication training and problem-solving) is associated with shorter depressive episodes, longer periods of wellness between episodes, and less suicidal ideation and behavior than briefer forms of education^{1,7}. The broader availability of psychoeducational therapy may do much to reduce the long-term personal, familial and societal burdens imposed by severe psychiatric disorders.

David J. Miklowitz

Department of Psychiatry and Biobehavioral Sciences, University of California, and Semel Institute for Neuroscience and Behavior, Los Angeles, CA, USA

The author is funded by the US National Institute of Mental Health, the Attias Family Foundation, the Max Gray Fund, the Baszucki Brain Research Fund, and the Milken Institute. The views expressed here are those of the author and not necessarily those of the funding bodies.

1. Miklowitz DJ, Chung B. *Fam Process* 2016;55:483-99.
2. Camacho-Gomez M, Castellvi P. *Schizophr Bull* 2020;46:98-109.
3. McFarlane WR. *Fam Process* 2016;55:460-82.
4. Hooley JM, Richters J. In: Cicchetti D, Toth SL (eds). *Emotion, cognition, and representation*. Rochester: University of Rochester Press, 1995:133-66.
5. *Depressive and Bipolar Support Alliance. Preferences for the treatment of bipolar disorder survey*. Chicago: DBSA Survey Center, 2017:1-4.
6. Valera S. Best mood tracker apps. www.verywellmind.com.
7. Miklowitz DJ, Weintraub MJ, Walshaw PD et al. *Curr Neuropharmacol* 2023; 21:1379-92.

DOI:10.1002/wps.21113

Putting psychological interventions first in primary health care

Task-sharing – in which specialists train, supervise and support non-specialist health care providers – is proven to be acceptable, feasible and effective in scaling up mental health care for depressive and anxiety disorders¹. In this perspective, we focus on reasons for and barriers to task-sharing of psychological interventions in primary health care. We also cover what the World Health Organization (WHO) does to address these barriers.

Task-sharing in primary health care is vital to increase treatment coverage for people in need, but it rarely includes providing evidence-based psychological interventions. Yet research shows that cognitive-behavioral therapy (CBT), on its own or combined with

antidepressants, is the first-line treatment for adult depressive disorders². CBT is also first-line treatment for other conditions, including anxiety disorders. Several other psychological therapies – such as interpersonal, problem solving and behavioral activation therapies – are likely equally effective³.

Many evidence-based psychological interventions are well suited to task-sharing. They can be designed to be safely delivered by supervised non-specialists. They can be adjusted to be briefer and less resource-intensive than conventional psychotherapy, without being less effective¹. And they can be adapted for remote or group delivery or provided through guided or unguided self-help man-

uals, websites and applications. WHO's Problem Management Plus, for example, comprises just five weekly sessions, can be delivered to individuals or groups, and is suitable for many contexts, types of adversity and types of helpers⁴.

Despite their potential, psychological interventions are rarely provided at scale⁵. Yet scale up is possible. The National Mental Health Programme in Lebanon is showing that implementing a nationwide self-help intervention for depression is feasible, even amid multiple crises^{1,6}.

There are many barriers to including psychological interventions in task-sharing:

- *Lack of political support.* Despite the evidence, decision-makers in many countries remain unaware of the effectiveness of psychological interventions and so exclude them from universal health coverage packages of essential services and financial protection schemes.
- *Resistance to change.* Still some psychologists today – including some national psychological associations – are against sharing responsibility for delivering psychological treatments with non-specialists. The reality though is that no society, however rich, will ever have enough specialists to offer more than a fraction of the volume of care required to help the large numbers of people who need mental health interventions.
- *Little commercial incentive.* Despite their cost-effectiveness, there is little commercial incentive to make psychological interventions widely available. By comparison, pharmacological interventions are heavily promoted by pharmaceutical companies, which may influence decision-makers and medical staff to focus on drug treatments⁶.
- *Lack of human resources.* Task-sharing for psychological interventions in primary health care typically means recruiting and retaining additional (non-specialist, community-based) staff to deliver those interventions. This is needed since medical staff in primary health care typically have heavy workloads and, while they can refer people for psychological interventions, they rarely have time to deliver lengthy therapeutic sessions themselves.
- *Lack of financial resources.* Funding a national workforce of providers, trainers and supervisors demands larger mental health budgets than are currently available. This means that more funds must be allocated within health budgets or, importantly, from the state treasury.
- *Lack of access to relevant tools.* Too few proven psychological intervention manuals for non-specialists are freely available (open access)⁷.
- *Lack of operational guidance.* Apart from the Design, Implementation, Monitoring and Evaluation (DIME) manuals⁸, there is little international guidance on how to integrate psychological interventions in primary health care. Even if service planners want to add those interventions to their services, they may not know what steps, service models and resources they need.

Building on the work of many others, the WHO is addressing a range of these barriers. We recommend psychological interven-

tions and promote task-sharing through our *Comprehensive Mental Health Action Plan 2013-2030*, our mhGAP programme, our Universal Health Coverage (UHC) compendium and our *World Mental Health Report*¹. We develop, test and publish open access diverse psychological interventions that are scalable and suit different delivery models. And we support training and supervision tools to help assure a competent non-specialist workforce through our Ensuring Quality in Psychological Support (EQUIP) initiative⁹.

We are also finalizing a new, operational guide – a *Psychological Interventions Implementation Manual* – to help service planners and programmers add psychological interventions to their services. Written for managers and others responsible for planning and implementing services, this manual provides practical guidance on how to plan, prepare and provide psychological interventions within existing services, such as health, social or education services.

This new WHO manual advises service planners on how to: a) choose and adapt psychological interventions to be relevant for their specific settings; b) decide a setting and system for delivery, including linking to associated services; c) develop a competent workforce by selecting, training, assessing and supervising providers; d) identify potential service users, assess their support needs and ensure people get the care they need; and e) use monitoring and evaluation to evaluate and improve the service provided.

The manual marks the latest addition to our toolbox for psychological interventions. After publication, it will be field-tested and refined.

Service planners can now freely access all the resources they need to implement psychological interventions: intervention manuals, tools to support competence, and operational guidance for implementation. The next big step is to get these resources into use. Ultimately, this work is intended to help improve the quality and local availability of evidence-based mental health care, so that millions more people with depression and anxiety will be effectively helped.

Mark van Ommeren, Sian Lewis, Edith van't Hof, Kenneth Carswell
Department of Mental Health and Substance Use, World Health Organization, Geneva, Switzerland

The authors alone are responsible for the views expressed in this paper, and they do not necessarily represent the views, decisions or policies of the WHO. The copyright of this piece belongs to the WHO. This is an open access paper distributed under the terms of the Creative Commons Attribution IGO License.

1. World Health Organization. World mental health report: transforming mental health for all. Geneva: World Health Organization, 2022.
2. Cuijpers P, Miguel C, Harrer M et al. *World Psychiatry* 2023;22:105-15.
3. Cuijpers P, Quero S, Noma H et al. *World Psychiatry* 2021;20:283-93.
4. Rahman A, Khan MN, Hamdani SU et al. *Lancet* 2019;393:1733-44.
5. Patel V. *Lancet* 2022;399:343-5.
6. Cuijpers P, Heim E, Abi Ramia J et al. *PLoS Med* 2022;19:e1004025.
7. Watts S, van Ommeren M, Cuijpers P. *World Psychiatry* 2020;19:251-2.
8. Applied Mental Health Research (AMHR) Group. The DIME Program Research Model: Design, Implementation, Monitoring and Evaluation. Baltimore: Johns Hopkins University, 2018.
9. World Health Organization. Innovations in scalable psychological interventions. Geneva: World Health Organization, 2023.

DOI:10.1002/wps.21114