Scaling up psychological treatments for common mental disorders: a call to action

Empirically supported psychological treatments – spanning interpersonal, cognitive and behavioural therapies – are recommended as first-line interventions to address the significant burden of depression, anxiety and stress-related disorders worldwide. Nevertheless, they remain inaccessible for the wide majority of the world's population, both in low- and middle-income countries (LMICs), where less than 5% of people with major depressive disorder receive minimally adequate treatment[1], and in high-income countries (HICs), where the corresponding figure reaches only 20%[1].

This massive treatment gap for such effective treatments is unprecedented in medicine and, as the experience of HICs shows, is not simply a challenge which can be addressed by more mental health care providers. Here we summarize a range of potential strategies through which these treatments might be scaled up to achieve their full potential and reduce the global burden of common mental disorders.

Three major barriers prevent delivery of psychological treatments: the lack of skilled providers, limited access, and low demand for mental health care. Each is an obstacle in most countries, but all have viable, evidence-based solutions.

If we assume that a "skilled" provider is a health care professional who has been trained in one of the mental health disciplines (social work, psychology or psychiatry), then there is no chance of overcoming the first barrier. There are large gaps between the required and actual numbers of mental health professionals in all countries. Furthermore, the methods typically used to train these specialized persons are expensive, time-intensive and requiring of another, even more experienced specialist to conduct regular supervision for an extended period of time.

An effective strategy to address this barrier is "task sharing" or training non-specialist providers – i.e., individuals with no formal training or background in mental health care – to deliver brief, low-intensity psychological treatments. The concept of non-specialist providers originated from para-professional movements in the US and UK. They include nurse practitioners, community health workers, teachers and peers, and are selected because of their availability, low cost, access to and close ties with the population they serve[2]. Not only can non-specialist providers in LMICs be trained to deliver treatments (and as effectively as specialists in HICs[2,3]), but recent evaluations demonstrate that they can ensure high quality of therapy through peer-led supervision[4]. This, in turn, addresses the bottleneck of the need for supervision provided by mental health specialists.

Recent evidence also makes clear that utilizing a core set of common treatment "elements" (such as behavioural activation, exposure, problem solving and communication skills) can reduce the complexity of needing to learn diverse psychological treatment packages for specific clinical phenotypes (such as depressive, anxiety and stress-related disorders). For example, the COBRA trial in the UK demonstrated that non-specialist junior mental health workers with no previous professional training in mental health services successfully delivered a treatment package that focused on the core element of behavioural activation. Results showed equivalent effectiveness in reducing depressive symptom severity as specialists delivering longer courses of cognitive behavioural therapy[5]. Similarly, in India, lay counsellors trained over 3 months to deliver a culturally adapted version of behavioural activation attained improved remission rates and sustained outcomes in primary care attenders with moderately severe to severe depression[6].

The second barrier is limited access to psychological treatments. In most countries, psychological treatments are accessible only to a minority of individuals who can afford private treatment or who are supported by generous insurance programs. Furthermore, these provider-centered treatments are typically delivered face-to-face, in urban specialist facilities, and at a time that is most suitable for the provider. In contrast, evidence-based solutions involve the delivery of psychological treatments in settings and at times that are convenient to the patient (for example, at home and during the weekend). In addition, the use of telemedicine and other digital platforms can facilitate this flexibility as well as guided self-care. Delivery of a treatment through a digital platform may be as effective as in-person treatment, but preferred by the recipient and with better sustained outcomes[7]. Moreover, recent evaluations have demonstrated that therapists can be efficiently trained through digital platforms[8].

In all contexts, these feasible and cost-effective solutions may be particularly beneficial for individuals with limited financial, social or physical capacity to travel to health facilities, such as mothers with infants, individuals with physical disabilities, or people who are homebound for various reasons, including due the impact of mental disorders.

Third, there is a low demand for psychological interventions, particularly from lower social classes and ethnic minorities, and treatment retention of most psychological treatments is less than 50% in most patient populations. The solutions to these problems reflect lessons learned from a community engagement model used for psychosis[9]. There is growing evidence of the benefits of: engaging a "grassroots" perspective when developing and designing mental health services; avoiding biomedical labels and using patients' own explanatory models; targeting social determinants concurrently with psychological symptoms; and engaging the individuals' relationships and resources, including their partner and community at large. Furthermore, a common elements approach is also likely to be

more acceptable, as it is brief, focused, and entails mastering only a limited set of skills.

Despite the growing evidence base supporting these exciting innovations, access to psychological treatments remains an exception. One unique exemplar of scaling up these treatments is the UK's Improving Access to Psychological Treatments (IAPT). IAPT services treat more than 537,000 patients with depression and anxiety annually, train non-specialist providers and specialists with brief accredited courses, and assess the progress of almost all (98%) patients using a unique monitoring outcome system[10]. Their results show that stepped care models of delivery are clinically effective, facilitate short wait times to improve patient attendance, and ultimately increase collaboration between therapists and patients.

In order to integrate and optimize new models of delivery beyond a mental health specialist providing individual care, we must develop, implement and evaluate stepped care systems. As demonstrated by IAPT, this model of care would consist of two levels: an entry, low-intensity step (Step 1) for the majority of patients with mild to moderate symptoms; and a high-intensity step (Step 2) for the minority of patients suffering from severe symptoms and those who do not respond to the first step.

Step 1 would involve either guided self-care or non-specialist professionals performing a range of tasks such as screening, delivering brief evidence-based psychological treatments, and acting as case managers to link the patient, family physician and specialists from mental health or other disciplines. In Step 2, mental health specialists would treat the more severe spectrum of these disorders, monitor use and adherence to medication when appropriate, and ensure treatment quality by training and supervising non-specialist professionals.

This stepped care model emphasizes patient-centered approaches and collaboration with local communities. This includes receiving input on how treatment could be best delivered in order to reduce administrative barriers, and engaging patient advocates in planning and improving the navigation of existing systems. In addition, we can target relevant co-occurring risk factors through integrated health programmes such as parenting platforms, chronic disease interventions and community-based care. In doing so, we may also have the opportunity to reach marginalized groups who may not typically seek mental health care.

We call on the mental health community at large to embrace these evidence-based strategies into routine health care delivery platforms, as a cost-effective approach to reducing the astonishingly large treatment gap for common mental disorders worldwide.

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Progress in developing a classification of personality disorders for ICD-11

In appointing a Working Group charged with developing recommendations in the area of personality disorders (PDs) for the ICD-11, the World Health Organization (WHO) Department of Mental Health and Substance Abuse highlighted several problems with the classification of PDs in the ICD-10.

First, PDs appeared to be substantially underdiagnosed relative to their prevalence among individuals with other mental disorders. Second, of the ten specific PDs, only two (emotionally unstable personality disorder, borderline type and dissocial personality disorder) were recorded with any frequency in publicly available databases. Third, rates of co-occurrence were extremely high, with most individuals with severe disorders meeting the requirements for multiple PDs. Fourth, the typical description of PD as persistent across many years was inconsistent with available evidence about its lack of temporal stability.

The WHO, therefore, asked the Working Group to consider changes in the basic conceptualization of PDs and specifically to explore the utility and feasibility of a dimensional approach. At the same time, the WHO emphasized that any classification system of PDs for the ICD-11 must be usable and useful for health care workers in lower-resource settings who are not highly trained specialist mental health professionals[1].

The Working Group, under the leadership of P. Tyrer, took the WHO's requests very seriously in developing its proposal for ICD-11. PD was conceptualized in terms of a general dimension of severity, continuous with normal personality variation and