

Empowering the (Extra)Ordinary

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Psychological treatments are among the most effective interventions for a wide range of mental health conditions but remain inaccessible to most people who could benefit from them, including in many high-income countries. We describe two case studies from South Asia that demonstrate innovatively designed psychological treatments addressing many of the barriers that limit their scalability. The treatments are brief, less complex, and delivered by frontline providers, such as peer counselors in community settings. These case studies, alongside a large and growing literature from around the world, provide the foundation for a paradigm shift in mental health care by rejecting the nihilistic notion that communities do not have enough resources to address mental health problems or that these problems are too complex to address. Central to this notion is the recognition that mental health problems can be addressed effectively with resources that every community possesses: people who care for others in their communities.

Mental health conditions are not only among the leading causes of the burden of health-related suffering globally, but their contribution to the burden of disease has been rising inexorably in all world regions over the past two decades. This increase is fueled in part by the relative success in the reduction of other burdensome conditions (such as childhood infections and cardiovascular diseases), as well as the absence of effective mental health prevention and care programs. The latter may be explained by two interacting factors. First, the failure to address social determinants that both fuel the onset of mental health problems and their persistence, and second, the failure to improve the effective coverage of the interventions that have been shown to improve the chances of recovery. The key words here are *effective*, indicating the interventions are backed by evidence and must be delivered with adequate quality, and *coverage*, indicating that the entire population is covered, in particular the groups who bear a disproportionate burden of mental health conditions. This essay focuses specifically on the goal of realizing effective coverage of one of the most effective interventions for mental health conditions: psychological treatments.

Psychological treatments (“talking” treatments) have been around for over a century, though their shape and form have changed significantly over this period, from the long-term (sometimes, lifelong) therapies founded on the principles of

psychoanalysis to the more recent emergence of treatments based upon cognitive, behavioral, and interpersonal theories. The latter have been shown to have effects on improving outcomes in a wide range of mental health conditions. Indeed, psychological treatments are the first-line and most effective interventions for most child and adolescent mental health problems, anxiety disorders, and post-traumatic stress disorder (PTSD). In the case of depression, there have been two primary approaches to the treatment of an acute depressive episode: namely, antidepressant medication and psychological treatments. While antidepressant medication is an effective treatment, two recent systematic reviews have shown that psychological treatments outperform medication on the important outcome of keeping people well in the longer term after an initial episode.¹ Thus, psychological treatment is the best choice for the management of depression. For other mental health conditions for which medication has robust effects (for example, psychotic disorders), psychological treatments, typically combined with social work components, improve the odds of better clinical and social outcomes.

Given this robust evidence, one might expect that psychological treatments would be widely available globally. In fact, the reality is the opposite: in the countries where we have worked for much of our careers (India and Pakistan), and countries in other parts of Asia and Africa where we have collaborated with colleagues, the effective coverage of psychological treatments is probably not even 1 percent of the population. Alarming, even in wealthy countries like the United States, which has among the highest numbers of mental health practitioners per capita in the world, for patients who do receive treatment for depression, the vast majority – approaching 90 percent – are prescribed antidepressant medications, while only about one-quarter receive psychological treatment.² Despite this imbalance, the overwhelming majority of patients, in particular those from racial and ethnic minority groups, express a preference for psychological treatments. Those who do receive psychological treatments report greater satisfaction, higher rates of treatment completion, and superior clinical outcomes.³ This is the heart of the global mental health crisis: the most effective treatments and those preferred by patients are not accessible to the vast majority of the world's population.

The barriers are formidable. The historic divisions in mental health practitioner disciplines and the implicit hierarchies that position psychiatry over the other disciplines play a significant role in the privileging of “biomedical” interventions over psychological treatments. On the other hand, psychological treatments have become increasingly complex with multiple components that require years of expensive training and present licensing hurdles, greatly limiting the numbers of providers who are permitted to deliver them. The high costs of training psychologists and their deployment means that there is not only a great shortage of skilled providers, but an extreme maldistribution across geographical and population contexts. Within the camps of psychological therapists, there is

reluctance to widen the pool of providers to include a more diverse workforce or to adopt the simpler, briefer versions of psychotherapy that are distilled from the traditional complex packages. Reimbursements or public financing for psychotherapy typically lag behind, or are completely absent, compared with medication, making psychotherapy more expensive for patients than medication. Then there is the concern that psychological treatments are based on observations made in relatively homogenous, white, affluent patients who are seeking care from academic mental health centers, and that these principles and assumptions may not generalize to more diverse populations. Finally, another barrier lies in the lack of any commercial backing for psychotherapies, typically developed by scientists in university settings who are brilliant designers of theoretically informed interventions but are no match for pharmaceutical corporations in terms of marketing. In a health care landscape where profits drive what is made available to patients, psychotherapies cannot compete with pills, even when they outperform them.

In this context, we describe two case studies initiated in the Global South with the shared goal of designing psychological treatments for depression that were acceptable and feasible in the communities where they were intended to be delivered. We will describe each study in turn, and then consider the lessons from these cases for the future of global mental health.

In 1988, Atif Rahman, the founder of the Human Development Research Foundation in Pakistan, began his medical career at what was then the Rawalpindi General Hospital. Situated in the historic garrison city of Rawalpindi, the hospital was a typical busy, overcrowded, tertiary health facility catering to a population of over ten million. Working in the neonatal and pediatrics wards, Rahman very quickly realized that the journey to good health began very early in life. Humans were shaped in the mother's womb, and this process, along with the environment of the first three thousand days of life, laid down the template for what was to follow. In these busy wards, one of Rahman's duties was to provide instructions to mothers of infants with diarrhea about the use of oral rehydration. He was struck by the inability of some mothers to follow these simple instructions – they seemed distant, lacking self-confidence, and were emotionally unavailable. In his next job at the psychiatry department, he came across patients with the same presentation, and learned they suffered from a disabling disorder: depression. The condition was important from a public health perspective because of its associations with infant growth and development. Medication was not indicated due to the risk of harm to fetuses and breastfeeding infants. The psychiatry department only catered to the tip of the iceberg: millions of women were suffering from depression in silence, especially in rural areas where trained mental health care practitioners were nonexistent. Learning from approaches to tackle the HIV epidemic in Africa, the field of global mental health was fast adopting the strat-

egy of “task-shifting” or “task-sharing,” which involved the rational redistribution of tasks among health workforce teams. Where appropriate, tasks once only entrusted to highly qualified health workers were moved to those with shorter training and fewer qualifications to make more efficient use of the available human resources for health. Could task-sharing be applied to a complex task such as the delivery of cognitive behavior therapy (CBT) to depressed, mostly nonliterate women in rural areas of Pakistan?

Now working at the University of Liverpool, Rahman and his team at the Human Development Research Foundation developed the Thinking Healthy Programme (THP), a CBT-based intervention that could be delivered by frontline providers, such as community health workers in primary and secondary care settings. A key feature in the development of this intervention was that it took into account the voices of the women from low-income rural settings who would receive the intervention.⁴ The formative research showed that the word *depression* was not widely recognized, and mental health problems carried a stigma. The intervention therefore focused on mobilizing family support around the agenda of the child (rather than addressing maternal depression directly, which is often met with resistance) and individual counseling for mothers using CBT techniques that addressed not only the mother’s mood state but also her interactions with her infant. The mothers were provided health education in a manner that built up their self-confidence and belief in their parenting abilities. The community health workers were encouraged to assist the mother in problem-solving: for example, helping nonliterate mothers negotiate the health care system. The workers were able to titrate and tailor the intervention according to the individual needs of each family and in the process target those with the greatest needs. The use of narratives and pictures to deliver the intervention to nonliterate women made the intervention feasible and acceptable.

Starting from pregnancy to one year postnatal, mothers received eight to sixteen sessions of psychological treatment. The approach in the THP included simplified CBT strategies to achieve three main goals: 1) to identify and modify maladaptive styles of thinking and behaving – in particular those leading to poor self-esteem, inability to care for their infants, and disengagement from social networks – and to substitute these with more adaptive ways of thinking and behaving; 2) behavioral activation to rehearse the more adaptive behaviors, such as self-care, attention to diet, and positive interactions with the infant between sessions; and 3) problem-solving to overcome barriers to practicing such strategies. The program was fully manualized, and included instructions for the delivery of each session with culturally appropriate pictorial illustrations aimed at helping mothers reflect on their thinking process and encouraging family involvement. There were five modules: preparing for the baby, the baby’s arrival, and early, mid, and late infancy. The intervention was designed to be delivered in home visits by supervised community

health workers who had received a brief five-day training, strengthened by experiential learning and monthly half-day facilitated group supervision.

The Thinking Healthy Programme was integrated into primary health care, which, in Pakistan, is organized around Basic Health Units (BHUs) catering to a population of between thirty thousand and fifty thousand. Each BHU has a doctor, a midwife, and about twenty-five frontline providers called Lady Health Workers (LHWs). These village-based LHWs deliver maternal and child health care services in the communities. The LHWs were trained to deliver the treatment to mothers in their care. A cluster randomized controlled trial was conducted with nine hundred mothers experiencing perinatal depression.⁵ The intervention more than halved the rate of perinatal depression in the intervention group, compared to the control group. In addition to symptomatic relief, the women receiving the intervention had less disability and improved social functioning. Infants of treated women had fewer episodes of diarrhea and were more likely to be immunized, treated women were more likely to use contraception, and both parents reported spending more time playing with their infants. An independent group of health economists conducted a long-term follow-up of the original research and found that the impacts on women's mental health had persisted, with a 17-percent reduction in depression rates after seven years. The intervention also improved women's financial empowerment and increased both time- and money-intensive parental investments by between 0.2 and 0.3 standard deviations.⁶

Expanding the THP nationally and globally presented another set of challenges. Rahman's team collaborated with several groups to explore strategies for such scale-up. In urban India (in collaboration with Patel), they found that peers (lay women from the community) were effective in delivering the program.⁷ Peer-delivered THP cost only 1 USD per intervention recipient, which was negligible compared to the benefits. To meet the challenge of a lack of staff to scale up training and supervision, a single specialist instructed and managed a group of frontline trainers, who in turn cascaded the training to peers.⁸ The peers were able to achieve and sustain the required competency to deliver the intervention. As peers became more competent, they could become peer-supervisors, thus adding to the pool of trainers and supervisors. This cascaded model could potentially be scaled up with only a few specialist trainers nationally. In Vietnam, Peru, and China, researchers found that the translated and adapted versions of the THP were acceptable and appropriate for delivery by frontline providers, demonstrating the transferability of the intervention across cultures and health systems.⁹ In Pakistan, Rahman's group developed a software application for the training and supervision of community health workers remotely without the need for in-person instruction.¹⁰ In Kenya, researchers piloted the delivery of the THP through mobile phones.¹¹ In 2015, the THP became the first completely manualized evidence-based intervention to be incorporated in the WHO's flagship mental health Gap

Action Programme (mhGAP), with step-by-step instructions for implementation by frontline providers.¹² In 2019, the THP received a boost from the highest office in Pakistan when it was included in the President's Plan to Promote Mental Health of Pakistanis: an ambitious program to scale up selected interventions, including the THP, to the entire country.¹³

Perhaps the best testament to the utility of these approaches comes from the patients themselves who have received the intervention, and the “barefoot therapists” who delivered it to them.

“My [health worker] helped me take care of myself . . . when there was nobody . . . when she started working with me I realised I have to look after myself . . . for my child.”
(a mother in Goa, India)

“I am learning new things every day, which are beneficial for me.” (a mother in Rawalpindi, Pakistan)

“What could be more rewarding than to see a mother smiling again and playing joyfully with her baby. I feel proud of my work as it is bringing positive changes in the lives of many mothers.” (a frontline provider in Rawalpindi, Pakistan)¹⁴

What is the way forward for the THP? Clearly, in Pakistan, scale-up from a few hundred health workers to one hundred fifty thousand health workers nationally is a giant leap and requires further research and innovation to assure both the quality and sustainability of delivery. While randomized controlled trials show that the THP is effective, cost-effective, and less stigmatizing than other treatments for depression, efforts to scale up at this level are hampered by issues of quality control, and what has been described by implementation scientists as “voltage drop” (meaning the intervention loses some degree of its potency or fidelity when moving from efficacy to effectiveness in the real world) and “programme drift” (in other words, the intervention deviates from its manualized or implementation protocols).¹⁵ Applying a technological solution to this challenge and working with the local community, Rahman and his team have developed an app that allows frontline providers to deliver the intervention sustainably without the need for extensive training and supervision.¹⁶ A frontline provider delivers the cognitive-therapy components through a virtual “avatar” therapist incorporated into the app. Using automated cues from the app, the peer reinforces key therapeutic messages, helps with problem-solving, and provides the nonspecific but essential therapeutic elements of empathy and support. The peer and app therefore act as cotherapists in the delivery of the intervention. The peer can deliver the intervention with good fidelity after brief automated training. This approach has the potential to be applied to other areas of mental health and help bridge the care gap, especially in resource-poor settings. Currently, a randomized controlled trial is underway to test the effectiveness and cost-effectiveness of the app.

A tech-assisted peer-delivered intervention that improves mental health will have several implications for practice and research, especially in low- and middle-income countries. From a practice perspective, the innovation offers a unique model of service delivery, with peers working in partnership with the health system to provide care for depression as the first step in a tiered model of care. In addition, the technology has the potential to assist peers in triaging the target population according to symptom severity and other risks, such as suicidal ideation and interpersonal violence at an early stage, allowing these to be managed at a specialist facility, optimizing the efficiency of this expensive and scarce resource. The technology also has the potential to provide more personalized therapy by developing algorithms that direct the peer toward automated therapy sessions tailored to the needs of individual patients. Analytic methods using machine learning can be employed in future versions of the app to help peers take clinical decisions. Finally, the app has the potential to collect data about anxiety and depression at a population-level. This can assist with planning for future services, and research into the mechanism of action of the intervention in various demographic groups, as well as providing data on implementation outcomes, contributing to reducing the global burden from depression.

The origin site of the Healthy Activity Program case study is the state of Goa in India. The huge land size and population of India have resulted in wide differences between its thirty-odd states, and Goa is a unique example of this diversity. Unlike the rest of the country, Goa was colonized by Portugal. It is among the most literate and wealthiest states of the country as well as one of the smallest. Despite being relatively well-resourced, most of Goa's population has no access to evidence-based psychological treatments, as mental health practice is dominated by pharmacological interventions.

Vikram Patel led the program of work in this study, which was implemented by Sangath, a nonprofit mental health organization he cofounded in 1996, shortly after returning to India upon completing his psychiatric residency in England, and two formative years of working in Zimbabwe, where he was first exposed to the challenges of meeting mental health needs in contexts with very few specialized providers and pervasive social determinants of poor mental health. Patel began by documenting the burden of depression, reporting that the condition was very common (as many as one in five adults attending primary care were affected by distressing depressive symptoms), that it was strongly linked to social deprivation (such as poverty and gender-based violence), and that it was associated with disability and a higher risk of suicidal behaviors. The studies also reported that many of those affected by depression (more than 95 percent) did not have their mental health problem recognized.¹⁷ The few who were able to access care typically received a cocktail of medications targeting specific symptoms (such as

benzodiazepines for insomnia, analgesics for pain, and vitamins for fatigue), prescribed by poorly trained medical practitioners.

This led to the evolution of Sangath's work in extending mental health care away from hospitals to community settings. Preliminary work highlighted the challenges of integrating psychological therapies within existing health systems steeped in the biomedical models of mental health care.¹⁸ It was also clear that psychological treatments developed in high-income countries could not simply be transposed in low-income settings. Researchers in low-income countries were now trying to develop culturally appropriate psychological treatments. Psychologist Paul Bolton and his colleagues' work in Uganda and psychiatrist Ricardo Araya and his colleagues' work in Chile provided the early breakthroughs in the field, demonstrating the effectiveness of task-sharing to frontline providers.¹⁹ This inspired Patel, now working for the London School of Hygiene & Tropical Medicine, to undertake a major program in India called MANAS (Manshanti Sudhar Shodh, which means "Project to Improve Mental Health" in the local Konkani language). MANAS was ambitious. It involved designing and evaluating a collaborative care intervention for integrating the treatment of depression and anxiety in routine primary care. A brief psychological treatment (interpersonal therapy) delivered by frontline counselors was a core element of the intervention. While the results were promising, the uptake of the psychological treatment was still low and further work was required to make the treatments acceptable in the community.²⁰

Inspired by the landmark publication of the THP findings described earlier, Patel launched PREMIUM (PRogram for Effective Mental health Interventions in Under-resourced health systems), whose goal was to develop and implement a systematic methodology to design effective psychological treatments for mental disorders that were affordable, culturally acceptable, and feasible for delivery by frontline providers.²¹ After careful study of other successful approaches to adapt psychological interventions to varied cultural contexts, a systematic methodology was applied to the design of a psychological treatment for depression. The treatment development phase lasted about three years and involved a series of studies aimed at addressing two key objectives: 1) designing the structure of the intervention (for example, its "active ingredients," based on global evidence and/or local practice) and 2) evaluating its delivery in routine health care settings to maximize its acceptability to the target population and its feasibility for delivery by nonspecialist providers. The resulting treatment was called the Healthy Activity Program (HAP), which centers on behavioral activation, a course of treatment supplemented by problem-solving and other simple techniques to address challenges faced by patients in achieving and/or maintaining activation targets, and to respond to other common complaints such as rumination, relationship difficulties, and sleep difficulties. The HAP was delivered in a face-to-face format over five to eight sessions, each lasting up to forty minutes, with initial sessions taking

place weekly. Sessions were delivered at the Primary Health Center (PHC) or patient's home, but telephone sessions were used when necessary and feasible.

The HAP was evaluated in a randomized controlled trial in ten PHCs in which the new treatment was compared with enhanced usual care.²² Ultimately, 495 primary care attenders with moderately severe to severe depression took part in the study. The HAP was designed to be delivered by frontline health workers who were recruited through a process that began with advertising these positions in local newspapers. Selected applicants were then invited for the training, which was delivered over two weeks, covering both general counseling skills and techniques specific to the HAP. Supervision was an essential process to assure the quality of health care delivery for all cadres of providers. The traditional approach to supervising frontline counselors has been to use "experts" (typically mental health professionals) to observe sessions or discuss cases. This approach is simply not feasible in the real world. We demonstrated that peer supervision (in which a group of frontline counselors would listen to, rate [on a therapy-quality scale], and then discuss audiotaped sessions of one of the counselors) was acceptable and effective. Peers met in groups of three to four participants each week, in which two to three audiotaped sessions were rated and discussed. Over time, each counselor had the opportunity for a number of their sessions to be rated, with average to good quality across the trial period for all the counselors.

A major lesson from previous trials was that many patients found it hard to visit the clinic regularly for sessions (typically because of poor transportation facilities and high costs, including the time required to travel to the clinic), which led to high attrition rates. In the trial, while most patients received the first session in the clinic (where their depression was detected through routine screening), 91 percent of follow-up sessions were delivered at home. Thanks to this delivery strategy, we observed high treatment completion rates of 69 percent. The trial results unequivocally demonstrated a moderate effect at three months (patients who received the treatment were 61 percent more likely to remit). These effects were sustained at the end of one year. Notably, the effect of the HAP on depression outcomes at twelve months was mediated by patient-reported behavioral activation levels at three months, confirming the theory that underpinned the intervention. Economic analyses reported that the HAP is cost-effective, with a high probability that the HAP could be cost saving. Like the long-term follow-up of the THP, a recently completed follow-up observed significantly better mood scores and decreased rates of depression five years later.

As with the experiences of patients in the THP studies in Pakistan, patients who received the HAP often attributed improvement to the interpersonal relationship with the counselor, in particular their perception of the counselor as being sincere and committed, providing enough time to discuss all their concerns, and a feeling of being listened to and understood.

“I found it easy to talk to her. She helped me understand my health problem. You immediately felt like there was all the time in the world to talk, which of course you never feel at the PHC. The fact that she was looking at me intensely, listening, and writing down what I was saying made me feel like she was interested in what I had to say.” (45-year-old woman)

“She seemed very honest and sincere. She was interested in what I used to tell her. I felt, she genuinely wanted to help me. She would ask about my financial situation and about my relationship with my family members. I thought somebody is interested in listening to my story.” (58-year-old man)

“I felt completely comfortable telling her everything. I could share all my problems. I could trust her. I could feel that she cared about me and that helped me . . . it made me feel stronger because she was there to support me.” (50-year-old woman)

“She helped me understand my health problem. I feel calmer. She taught me how to relax. The strategies she suggested were useful and helped me, I would say it helped me more than the medicines.” (40-year-old man)²³

Beyond the impact on patients, the counselors also reported a sense of enhanced confidence and satisfaction in their work. They thought the experience of delivering the HAP had also offered benefits to their own well-being. One counselor narrated her learning experience: “This experience has helped us to learn how to deal with and cope in such situations [depression].” Another shared her intentions of using her skills to help people within her intimate social circle: “Personally this will also help us in the future. . . . We can use these skills to help friends and neighbors.”

The unique sociocultural context of Goa where the HAP was developed may limit the generalizability of the experiences in its implementation. Thus, its utility in the wider global health context required its evaluation in diverse contexts. There are now several such examples of adaptation and evaluation from diverse contexts. The HAP was adapted for use in a very rural and impoverished region of central India for Sangath’s VISHRAM (Vidarbha Stress and Health Programme) project, a population-based initiative with the goal of implementing a coordinated multi-component program to increase demand for care (largely through community-based strategies), and to improve supply of care (largely through community-based counselors delivering the HAP). The program led to a sixfold increase in the demand for mental health care among people with depression in the community.²⁴ The HAP was adapted for use in Nepal and evaluated in randomized controlled trials, which reported its effectiveness in reducing the severity of depression and disability compared with the WHO’s mhGAP package training (including nonspecific psychosocial counseling).²⁵ The HAP has been adapted for depression care for patients with tuberculosis in Nepal and with HIV in Uganda.

Given the large unmet needs for care for depression even in well-resourced countries (like the United States), a key question is the extent to which the evidence generated in these studies may be relevant to those contexts. This has been greatly facilitated by the fact that the active ingredient of the HAP is behavioral activation, a component of CBT that studies have shown is just as effective as the full CBT package, and which has evolved into a standalone psychological treatment in its own right.²⁶ The key innovation in the HAP was to make the treatment brief and feasible for frontline providers. The SUMMIT (Scaling Up Maternal Mental Healthcare by Increasing Access to Treatment) project adapted the HAP for perinatal women with depressive and anxiety symptoms and launched a trial comparing nonspecialist with specialist delivery models in sites in Toronto, Chapel Hill, and Chicago – cities with large, ethnically diverse, urban, and rural populations.²⁷ Our efforts to scale up the HAP has led us to address the barrier of training and supervision through the use of digital curricula, scalable approaches to assess competencies, and tools that can be used by frontline providers to rate therapy sessions generating quantitative metrics of quality.²⁸

When seen alongside the wider literature on psychological treatments for mood, anxiety, and trauma-related disorders (which together account for at least two-thirds of the global burden of mental disorders), these two studies demonstrate how the challenges to scaling up psychological treatments can be addressed through innovations in their design and delivery.²⁹ First, the treatments combine established principles of psychological science with factors that enhance their acceptability in the sociocultural contexts of their delivery, such as minimizing the number of components, delivering them in relatively few sessions and in settings that are convenient to the patient (typically in their own homes), and incorporating social care (for example, in the THP, addressing mother-child interaction; and in the HAP, addressing determinants like interpersonal violence). Second, the studies demonstrate that the fundamental principles of the most dominant theories underpinning psychological treatments (namely, cognitive, behavioral, and interpersonal principles) are just as potent in these diverse populations as they were originally shown to be in samples drawn from high-income countries. This is a singularly important affirmation of the universal applicability of psychological science, once considered its Achilles' heel when compared with the presumed universal applicability of medications for mental health problems. Third, simplification of the treatment procedures makes it easier for frontline providers to learn the core principles underpinning psychological treatments and for patients to understand and incorporate behavioral change in their daily lives, providing an explanation for their impressive long-term effects. Fourth, these studies emphatically demonstrate how the competency-based training of the providers followed by continuing peer supervision and sup-

port, and the use of appropriate technology, can enable them to deliver these treatments with a high degree of fidelity and impact. Finally, it would be incorrect to interpret this large body of evidence to suggest that the only value of task-sharing is to address access to evidence-based interventions as a stop-gap measure for contexts where there are insufficient specialist providers. The evaluations of task-sharing have demonstrated many other benefits too, including empowerment of the providers themselves with heightened self-efficacy and purpose, the reduction of stigmas attached to mental health care, and improved engagement with mental health care consequent to the comfort that patients have talking to providers from their own communities who also address their other health and social concerns.

This body of evidence is central for reimagining how the crisis of lack of access to evidence-based psychological treatments can be addressed globally. The global impact of this work is evidenced by the acknowledgment of the critical role of task-sharing of brief psychosocial interventions not only for low- and middle-income countries but also in high-income countries. There is now a robust body of evidence evaluating this approach in these countries, and the academic and policy communities have called to embrace this approach to transform mental health care.³⁰ It is important to note this innovation represents an extension of the existing mental health care system, not a replacement, expanding its footprint deep into the community to reach those whose needs have been unmet while ensuring coordination so that those who require more specialized care can easily access it. Most important, task-sharing of these carefully designed interventions intended to optimize acceptability and feasibility not only increases their coverage but also reaches those who cannot otherwise access care, reducing disparities. Yet apart from small islands of successful scale-up at a national level, notably the Improving Access to Psychological Treatments program in England, there is no visible effort to scale up psychological treatments in most countries.³¹

A major challenge is finding a way to enable providers on the scale needed to address the vast unmet needs for care. The traditional models of face-to-face training and supervision are not feasible, and digital platforms and peer-led capacity building will need to be used to achieve this goal, as have been tested for both the THP and the HAP. EMPOWER is a program led by Harvard Medical School and Sangath that is deploying a suite of digital methods and tools to efficiently train and support a wide range of frontline providers in learning, mastering, and delivering evidence-based psychosocial interventions. The first offering, the scale-up of the HAP, is now underway in the central state of Madhya Pradesh, one of the least-resourced states in India. The program is being implemented in partnership with the state government's health department and involves the training and support of a cadre called Accredited Social Health Activists (ASHA), who serve as the frontline providers of the country's National Health Mission. Building on this ex-

perience in India, we are now extending this work to Texas. Over 80 percent of the state's 254 counties are designated as "mental health professional shortage areas."³² In partnership with the Meadows Mental Health Policy Institute and the UT Southwestern Medical Center, we aim to scale up depression care in under-resourced communities in Texas by training and supporting frontline providers to deliver the treatment. We have completed the tailoring of the program content for the U.S. context and are currently engaged in culturally adapting the content so that it will also be available in Spanish to meet the needs of the significant Hispanic population in the state. This effort is a rare example of reverse engineering innovations developed in low-resource countries for delivery in wealthy countries.

This body of science, much of it led from the Global South with generous funding from Northern donors and collaboration with psychological and implementation scientists in Northern universities, is an exemplar of both the value of global partnerships and the decolonization of global health, creating novel interventions and delivery approaches that can transform policy and practice in all countries. Our experiences, along with those of the thriving global mental health research and practitioner community, emphasize the need for paradigm shifts in the architecture and principles of the mental health care system. At its heart is the reduced medicalization of mental health problems that privileges a narrow biomedical paradigm dominated by doctors, diagnoses, and drugs. A critical goal of all mental health care systems is both the recognition that mental health care must address psychosocial needs (which will always involve a team of community-based frontline providers) and the admission that adequate resources and support are needed to empower these extraordinary persons. Moreover, this reimagination radically revises the widely prevalent nihilistic notion that most communities in the world do not have enough resources to address mental health problems or that these problems are too complex to address. Instead, we must recognize that every community has resources, and mental health problems can be addressed effectively with a resource every community possesses: people who care for others in their communities.

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ENDNOTES

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