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VIEWPOINT

Democratizing Access to Psychological Therapies: Innovations and the Role of Psychologists

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Psychological therapies are highly effective interventions for a range of mental health conditions and often preferred by many patients over medication. Unfortunately, most people who could benefit from these therapies do not receive them. This is true even in the United States, which enjoys relatively high numbers of mental health professionals. The lack of access is further compounded by structural inequities, such as income, geography, and race. The low and inequitable access to one of the most effective interventions for mental health conditions is, arguably, one of the most significant barriers to addressing the growing burden of mental health conditions globally.

There are several reasons which might contribute to this inequity, notably the historical reliance on complex treatment protocols designed in settings which serve a nonrepresentative group of persons with mental health problems and, consequently, an emphasis on specialist providers and in-person protocols. These factors lead to long and expensive training, variable quality of delivery, and enhanced costs and challenges to patient engagement. In contrast to medication, the lack of a commercial incentive to promote psychological therapies means that there are no market forces which fuel their scaling up. Given there will never be enough psychologists to serve the large unmet and growing mental health needs in the population, we consider stepped and collaborative models that leverage the range of expertise offered by diverse providers, to offer a pathway to scale up a person-centered approach for psychological treatments. In this article, we highlight three innovations that address some barriers and the potential roles of clinical psychologists to broaden the reach of psychological therapies.

Simplifying the Treatment

Low-intensity psychotherapies are brief (as brief as a single session and rarely exceeding 10) and focus on transdiagnostic treatment elements such as behavioral activation rather than complex treatment packages. To serve diverse populations, these treatments are often culturally adapted to use metaphors and techniques that are relevant for the populations served and address the wider concerns of the patient beyond a narrow focus of clinical symptoms to consider socioeconomic factors such as loneliness (e.g., by including social work elements). Low-intensity interventions are delivered at times and in settings that are convenient for the patient (e.g., on the weekends or at home). Perhaps most importantly, and in line with the construct of patient empowerment, the treatments are developed and evaluated in collaboration with the communities served.

One example is single-session interventions (SSIs). SSIs are defined as "structured programs that intentionally involve only one encounter with a provider or intervention; they may serve as stand-alone or adjunctive services" (Schleider et al., 2020). Many are self-guided (online) or deliverable by lay providers; they are less than 60 min in length, are associated with fewer dropouts by virtue of their design, and may accessed either once or many times, with each session designed to yield meaningful change—regardless of whether further sessions are possible. SSIs are highly effective, with >70 trials demonstrating their capacity to reduce diverse forms of psychopathology (Schleider et al., 2020). SSIs have reached >40,000 users (mostly youth) via social media, nonprofit partnerships, primary care, and via waiting lists for longer term treatment, across the United States (Schleider et al., 2022). To date, >40% of these SSI users have identified as racial or ethnic minorities, >50% as sexual or gender minorities, and >15% live in rural U.S. counties, supporting SSIs' capacity to promote equity in access to support within and beyond formal systems of care. Initial studies have demonstrated that SSIs can be effective for patients with high levels of symptom severity and acuity, including patients experiencing self-injurious thoughts and

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behavior, with sustained effects across 3 to 9-month follow-ups and equivalent acceptability and utility across diverse demographic groups (Schleider et al., 2022). Moving ahead, additional work is required to further unpack "what works for whom"—to determine which types of patients may benefit from longer protocols rather than single-session treatments (e.g., baseline severity, clinical complexity, comorbidity, age) which will need trials comparing single-session treatments to multisession treatment protocols.

Diversifying the Workforce

One of the key benefits of brief treatments is that they are easier to learn and master. This enables *task sharing*—the "rationale distribution" of tasks to nonspecialist providers or NSPs (World Health Organization, 2008) to individuals with no formal degree or training in implementing mental health care. Task sharing has been one of the key innovations for improving access to evidence-based psychological therapies in low-resource settings. In the Global South, there is now a robust evidence base, exceeding 100 randomized controlled trials to support the effectiveness of this delivery strategy (Barbui et al., 2020). Task sharing has been implemented with a wide range of nonspecialist providers (NSPs), including laypeople, community health workers, and nurses and peer support workers, depending on the specific context. The cadre of provider is organized around their availability, cost-effectiveness, and access to the population they serve. The success of task sharing relies on attention to competency-based training followed by supervision, including peer group supervision, to assure continuing quality.

One local example is the ongoing *S*caling *U*p *M*aternal *M*ental health care by *I*ncreasing access to *T*reatment (SUMMIT) trial (Singla et al., 2021; https://www.thesummittrial.com). SUMMIT is a noninferiority randomized controlled trial of pregnant and postpartum women (n = 1,226), comparing two delivery modes (telemedicine vs. in person) provided by two different delivery agents (mental health specialists vs. trained NSPs) in three North American sites. All participants receive an adapted version of the Health Activity Program—a brief, eight-session behavioral activation treatment that was originally implemented by lay counsellors in India (Patel et al., 2017). This represents a unique example of reverse engineering (i.e., use of a "developing world" intervention manual in a "developed world" settings). Trained NSPs (e.g., nurses, midwives, and doulas) deliver the treatment from a patient-empowered lens and eventually engage in measurement-based peer supervision. Almost 50% of participants self-identify as Black, Indigenous, or persons of color (BIPOC) and report high satisfaction rates that are no different than White counterparts (Singla et al., 2022).

Deploying Digital Tools

A range of digital technologies have been deployed to improve access to psychological therapies, the majority of which target the person with a mental health problem. The most common of these tools train and support person to manage their symptoms by using techniques derived from evidence-based psychological therapies, such as psychoeducation and problem solving. Another type of tool deploys conversational agents (or chatbots) which mimic a therapist engaging with the person in an interactive exchange of written text, programmed to follow an evidence-based protocol. While there is an emerging body of empirical evidence testifying to the effectiveness of these approaches (Vaidyam et al., 2019), especially when supported by a remote therapist/coach (e.g., Karyotaki et al., 2021), the evidence base is still inconclusive. Moreover, neither approach has been successfully scaled up in any population despite significant commercial investments in these technologies. Designing patient-facing tools that are more engaging is a critical challenge for the sector. One strategy might be to deploy such tools as an adjunct to therapist-delivered interventions, for example, to amplify practice of newly learned skills for individuals on waiting lists for treatment (Sung et al., 2023). In this context, a new range of technologies is being developed which targets to the building of a frontline workforce to deliver evidence-based psychological therapies.

One example is EMPOWER—an initiative which deploys a range of digital tools and methods, from the design of competency-based digital curricula to the remote assessment of competencies, peer supervision of therapy quality, and data science-driven methods to evaluate and improve the effectiveness of scaling up psychological therapies. The overall goal is to enable frontline NSPs to learn how to assess mental health, match patient assessments with specific treatment decisions, learn a range of evidence-based therapies, complete a competency assessment, and receive supervision and support to assure quality of care (Patel et al., 2022). EMPOWER is currently in the process of scaling up behavioral activation treatment for depression through community health workers in Madhya Pradesh (India) and Texas (United States). In Texas, EMPOWER has piloted its training of a behavioral activation curriculum with 77 frontline health workers, including community health workers, nurses, medical assistants, and other nonspecialist frontline providers, of which 51 fully completed the training. In Madhya Pradesh, EMPOWER has completed the training of 976 Accredited Social Health Activitists (India's version of a community health worker) of whom 467 are actively delivering the treatment in their communities. Several other treatment programs are under development for autism, emotional disorders in adolescents, and psychosocial support for persons with severe mental illness.

The Role of Psychologists to Democratize Access to Psychological Therapies

Given the wide range of expertise, psychologists can play key roles in the emergence of these innovations to improve equitable access to psychological therapies.

As *scientists*, psychologists possess the unique expertise to design, adapt, and evaluate psychological therapies and to study their wider dissemination and implementation at scale. This may include the selection of active ingredients to simplify traditional treatment packages for specific mental health conditions and the design and conduct of pragmatic, real-world clinical trials for their evaluation. This may also include partnering with other disciplines, such as health economics to evaluate the cost-effectiveness of these novel strategies or data scientists to develop algorithms to automate the assessment of therapy quality.

As *practitioners*, psychologists play a critical role in training and supervising nonspecialist providers, conducting fidelity assessments to facilitate measurement-based care, and serve as referral pathways if additional or alternative treatments are required. Stepped and

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collaborative care models are ideally suited to deploy the full range of providers, from frontline providers to psychologists. As *advocates*, psychologists can adopt a population health perspective which emphasizes our collective responsibility to ensure that everyone, everywhere, can benefit from psychological science and that the structural barriers which lead to mental health disparities are addressed. This includes championing the evidence-based approaches highlighted in this article, implementing a culturally sensitive framework in training and supervision, and partnering with various stakeholders (communities, government, industry, and underserved populations) to build and test sustainable strategies for deploying interventions that are designed to scale.

The time has come to democratize access to psychological therapies. Clinical and counseling psychologists have the potential to transform the scalability and reach of effective psychological therapies worldwide.

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