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Scaling up person-centered psychosocial interventions: Global mental Health's next challenge

I have spent much of my recent career struggling to bridge the apparent chasm between two visions of mental health care which lie at the heart of global mental health: how can we deliver mental health care at scale in a way which is sensitive not only to the ecological context, but also the unique characteristics of each individual? While global mental health interventions have always explicitly acknowledged the central role of context, for example in designing interventions which are culturally sensitive, the enormous diversity of individuals, their lived experiences and needs *within* a context has been much harder to attend to.

The terms 'scaling up' and 'person-centred care' may seem incompatible as they are often interpreted to describe fundamentally different perspectives in mental health care. On the one hand, scaling up emphasizes the need to standardize interventions through protocols which can be delivered with a high degree of fidelity. Such protocols are launched by the identification of a particular type of mental health problem (for e.g. depression) which triggers an algorithmic step-wise approach to deliver specific clinical interventions for that problem. The classic example of this approach is the WHO's mhGAP initiative which prescribes particular protocols for care for specific mental health problems (Dua et al., 2011).

Global mental health innovators have sought to reframe this reductionist, diagnosis-driven, approach with an emphasis on medication delivery (which was the major thrust of the first avatar of mhGAP) through interventions which primarily focused on building psychological skills or addressed social determinants, which embraced a dimensional perspective of psychopathology (for example, delivering interventions based on self-reported symptom severity or functional impairment), and which were designed to optimise acceptability to target populations, for example by being delivered in routine care settings by non-specialist providers (NSPs) who are embedded in the communities they serve (Singla et al., 2017). Still, even with these significant innovations, the reality remained that these psychosocial interventions targeted specific clinical phenotypes of mental health problems and individuals' needs were largely determined by categories based on clinical characterization.

On the other hand, person-centred care emphasizes interventions which are tailored to meet the needs of or address the outcomes prioritized by the person with a mental health problem. Such an approach should not be confused with personalized or precision medicine, the beating heart of a biological model of medicine, where treatment decisions are tailored to an individual's biological predictors of treatment response. Rather, person-centred care highlights client preferences and treatment goals and engages with aspects important to the client's identity. Person-centred care "transforms what had been primarily viewed as a bureaucratic requirement, taking time away from the practitioner's clinical responsibilities, into what may be regarded as the essence of the work of recovery: that is, creating, implementing and modifying in an ongoing manner the person's roadmap to a fulfilling life" (Davidson & Tondora, 2022). Person-centred care also acknowledges that the identity of the provider shapes their relationship with the client.

Person-centred care is the hall-mark of the care of persons with chronic conditions which, unlike infectious diseases, involve the use of a more varied set of interventions tailored to the specific 'stages' of an illness and which can be dynamically modified according to response of both clinical and person-centred outcomes. Person-centred outcomes typically extend beyond symptomatic recovery; for example, we observed that a range of social and functional goals like having a friend to talk to or being able to work were the most important outcomes for people with chronic psychoses in India (Balaji et al., 2012). Indeed, some patients may not even conceptualize symptomatic recovery as independent from social or functional priorities.

Moreover, person-centred care should also tailor interventions to be sensitive to the diversity of personal characteristics which may moderate the effectiveness of interventions (for example, gender, social circumstances, sexual orientation, ethnicity or race). This is the most expansive interpretation of person-centred care, which is care that is exquisitely sensitive to *both* felt needs and priorities *and* personal characteristics. Put another way, to understand and address mental health problems, one needs as much attention to the specific clinical condition as to the individual's personal history, illness narratives and social circumstances. While person-centred outcomes and personal characteristics are not an infinite list (though the permutations of these variations, along with clinical variations, can become daunting), they are much more varied than symptom-based categories and often require strategies which fall outside a narrowly defined clinical delivery model, and are thus much harder to 'standardize' and 'protocolize'. Such care is, inevitably, much harder to learn, master and deliver with fidelity.

Global mental health practitioners have made significant strides in accommodating the diversity of personal needs within their treatment protocols. One example is recognizing the diversity of mental health problems experienced by different individuals in a community which requires mastery of a range of interventions and skills on how to select the most appropriate intervention for the mental health problem prioritized by the patient. This is best illustrated by the Common Elements Treatment Approach (CETA) protocol which comprises a suite of 'active ingredients' tailored to a range of specific types of mental health problems (for example, behavioral activation for depression and exposure for severe anxiety)(Murray et al., 2014). Another example is the addition of social work components to address the social problems which often co-occur with mental health problems. Such intervention protocols not only deliver the psychological skill ingredients but also attempt to address commonly co-occurring social determinants. Two examples from my own work are the incorporation of specific strategies to address

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intimate partner violence in the Healthy Activity Program, a brief behavioral activation treatment for depression (Chowdhary et al., 2016) and the identification of practical problems in older adults with chronic health problems and supporting them to navigate health and social services for the prevention of depression (Dias et al., 2019). This is why such psychological interventions are better described as psychosocial interventions.

But these approaches still fall short of care which address the unique personal stories which distinguish the needs and outcomes of individuals with seemingly similar clinical conditions. Consider a few examples which a community based NSP may encounter in a program aimed at scaling up a behavioral activation treatment for depression. Individuals with histories of trauma, in particular those related to early life neglect and maltreatment, often respond less well to protocolized interventions. Addressing psychological distress without collective engagement to address structural violence may be unable to lead to sustained recovery of hope and purpose in individuals belonging to sub-groups who have faced historic discrimination, such as LGBTQ+ and indigenous peoples. Individuals who have personality traits which interfere with adaptive coping and inter-personal relationships may need longer-term therapies requiring mastery of skills which go beyond the basket of competencies common to task-shared psychosocial interventions. And then there are individuals who are simply struggling with long-standing life difficulties for whom only direct actions addressing those difficulties (for example, cash transfers or better housing or, in the case of young people in conservative societies such as India, the freedom to love a person of their choice) will offer relief from distressing emotional experiences. Scaling up this expansive definition of person-centred care is, in my reckoning, beyond the scope of what most efforts in global mental health have sought to do so far.

In recent years, I have begun to refocus my efforts towards the scaling up of the task-sharing of psychosocial interventions, buoyed by the robust evidence of its effectiveness, especially for mood and anxiety conditions (van Ginneken et al., 2021). A key hurdle I have had to tackle is the training of the large number of NSPs needed, the assessment of their competencies and their supervision to assure the quality of the therapy they deliver. The existing approaches, essentially an imitation of the practices in trials which evaluated the task-sharing of these interventions, comprise expert-led workshops (ranging from a few days to several weeks) followed by regular, expert-led, in-person supervision (for example, of audio-recorded therapy sessions or case note records), are simply not scalable because of significant barriers, for example the limited availability and cost of specialists, the burden of time for NSPs already engaged with other tasks, and the logistical arrangements for in-person interactions (such as the hiring of class-rooms).

My colleagues and I have designed and evaluated a number of strategies to address these barriers. We developed a methodology to produce a competency based digital curriculum derived from the manuals of evidence based psychosocial interventions (Khan et al., 2020). We designed scalable approaches to assess competencies (Restivo et al., 2020). We designed two formats of digital learning (one format supplemented by remote coaching) and compared them with the gold-standard of expert-led in-person training (Naslund et al., 2021). We designed tools which can be used by NSPs to rate therapy sessions generating quantitative metrics of quality (Kohrt et al., 2015). We designed and evaluated the use of peer supervision using these tools to replace expert supervision (Singla et al., 2014). This suite of innovations has been brought together under the umbrella of the EMPOWER program (www.empower.care/) which seeks to use digital tools to build the capacity of a community based NSP workforce to deliver evidence based psychosocial interventions (Patel, 2021). Led by Harvard Medical School in the US and Sangath in India, this program has initiated our first steps towards implementing the Healthy Activity Program for depression in the US (in Texas) and India (in Madhya Pradesh).

As I embark on this new ambitious phase of my work, I have begun to explore how, in scaling up brief psychosocial interventions, we incorporate skills for person-centred care. The first step of this effort must be the explicit recognition of the individual diversities which need to be embraced in formulating a mental health care plan. To this end, we are designing a 'person-centred' curriculum whose key domains include: (i) an overview of person-centred care, (ii) interpersonal reflexivity for providers and persons in distress, "How we see each other", (iii) aspects of identity and cultural humility on the part of providers, "Getting to know the person", (iv) explanatory models of distress, "How a person in distress sees their problem", and (v) structural competency and context, "Getting to know their world." These lessons aim to assure that NSP have the appropriate understanding and skills related to cultural competency, cultural humility, structural competency, explanatory models, and reflexivity, with reflexivity recommended as the key entry-point.

But, even with this additional training, it is highly unlikely that any mental health provider, and here I also include those who have received specialised training, can comprehensively address the entire range of personal characteristics, needs and outcome alone. At the heart, then, of the balance between scaling up and person-centred care is that mental health care is always designed around a team-based approach ("collaborative care"). Such an approach not only involves front-line NSP providing first-level care for specific clinical conditions but also a team of other providers who have expertise in supporting needs that NSPs cannot address (such as housing). If there are known predictors of poor response to first-line treatment which can be assessed in routine settings, for example a trauma history, then stratified care based on the principles of precision medicine, may be countenanced. In places where such team-based approaches are not be feasible due to the lack of resources and providers for addressing diverse needs, some NSPs can be 'up-skilled' to deliver a wider range of strategies for such patients and, as they master these skills through real-world practice, they can contribute to building skills for person-centred care in other NSPs in targeted supervision (for example, of sessions with patients who are not responding despite good engagement).

There has never been a greater need and a more opportune moment for scaling up the task-sharing of psychosocial interventions: in the shadow of the pandemic, there is significant political will and demand (even in high-income countries endowed with far greater numbers of mental health professionals) and the clinical and implementation science is robust. As we do so, we must constantly endeavour to bring the person (with a mental health problem) to the centre of the mental health care plan, for only then will we be able to realize person-centred care, embracing the diversity of humanity and the lived experiences we wish to serve and making the task of mental health care ever more enriching.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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