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How to Improve Access to Evidence-Based Psychological Interventions

WHAT'S HINDERING ACCESS TO EVIDENCE-BASED PSYCHOLOGICAL INTERVENTIONS FOR COMMON MENTAL HEALTH DIFFICULTIES? A FOCUS ON ADDRESSING SYSTEMIC LEVEL BARRIERS

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Background

Common mental health difficulties such as depression and anxiety are prevalent, chronic, recurrent, and place a significant burden on the individual, service provider as well as wider society. However, access to evidence-based psychological treatments remains limited worldwide and in order to improve access, the implementation of a new organization of mental health services and innovative delivery strategies is required. Barriers to access occur at the level of the individual (e.g., lack of time, guilt, stigma, symptom recognition), provider (e.g., lack of mental health knowledge, unwillingness to diagnose and treat, stigma) and are related to the organization of service delivery (e.g., limited availability of trained professionals, lack of training in the delivery of evidence-based treatment, poor integration of mental health services in primary care and other health and social care settings).[1]

To address these barriers, a revolution in the organization of mental health service delivery, alongside innovative strategies to deliver psychological interventions, was required. The Improving Access to Psychological Therapies (IAPT) programme implemented across England represented such a revolution, delivering the least restrictive type of evidence-based psychological therapies of the correct treatment intensity at different steps within a mental health stepped care service delivery model.[2] Adopting a stepped care service delivery model facilitated the development of a new 'Practitioner' level psychological workforce that is now gaining interest across the world. This new workforce is trained in competencies to help people to engage in low-intensity cognitive behavioural therapy (LICBT), with the specific intervention techniques delivered through a range of CBT 'self-help' print, e-Mental Health (e.g., internet-administered CBT), and e-Mental Health (e.g., smartphone app) formats.[3] However, despite the success of IAPT in improving the percentage of individuals with depression and anxiety accessing evidence-based psychological therapies per year, significant improvements can still be made.[2,4]

Potential solutions to further reduce the treatment gap may include: (1) ***Rethinking service delivery,*** including exploring ways of delivering mental health services within different sectors. For example, the employment sector, non-governmental organizations, locations commonly used by people with diversity or faith communities; (2) ***Developing new workforces*** beyond the traditional therapist/clinical psychologist role, such as the establishment of new psychological therapies practitioner workforces; and (3) ***Utilizing digital technologies*** (e.g., technologies utilizing the internet) that are facilitating the delivery of healthcare worldwide.[5], with their promise further amplified by the COVID-19 pandemic.[6]

Approach

Objective

The objective of this workshop was to collaborate with members of the public, health and social care professionals, educators, researchers, and policy-makers, to discuss ways in which access to evidence-based psychological interventions could be improved further. Specifically, we explored:

- How to organize the delivery of psychology services to help increase access to psychological therapies;
- The potential for new workforce developments beyond the traditional therapist/clinical psychologist role, and;
- How to utilize e-mental health interventions, such as smartphone applications, to deliver and support psychological interventions.

The workshop was attended by participants from 6 different countries, including Indonesia, Kenya, Saudi Arabia, Sweden, the United Kingdom, and the United States of America. Participants had devise backgrounds including, academia, clinical psychology, primary

healthcare, non-governmental organisations,private e-health providers, and pharmaceutical companies.

The workshop structure encompassed four main parts. First, workshop leader Dr Joanne Woodford welcomed workshop participants and gave an introductory talk on "the Psychological Treatment Gap". This talk was followed by a presentation on "the Stepped Care Model" delivered by workshop co-leader, Professor Paul Farand. Participants were randomly assigned to two breakout groups to discuss the Stepped Care Model. Participants were asked to describe their own country's different mental healthcare systems and explore whether the stepped care model work could work within their country's mental healthcare system. Breakout groups were facilitated by three PhD students from Uppsala University: Oscar Blomberg; Chelsea Coumoundouros; and Frida Svedin. Second, workshop co-leader Professor Paul Farrand gave a talk on "Low-Intensity Cognitive Behavioural Therapy and Psychological Professions". This talk was followed by a presentation from the workshop inspirational speaker, Professor Catherine Gallop (Clinical Education, Development, and Research, University of Exeter, United Kingdom). Professor Gallop provided an over-view of the development, priorities, and implementation of the low-intensity workforce within England for children and young people.

These talks were followed by a further breakout session, whereby participants were encouraged to discuss what types of "intensity" treatments and different psychological professions they currently have within their own mental health care systems, alongside a discussion on barriers and facilitators to the implementation of new psychological workforces. Finally, Dr Joanne Woodford gave a presentation on "e-Mental Health", followed by a third breakout session to explore how the different countries represented used e-Mental Health solutions and what barriers and facilitators existed to implementing e-Mental Health. Towards the end of the workshop, participants took part in a final breakout group whereby they were asked to summarize potential solutions to the challenges discussed during the workshop, including an appreciation of common challenges that exist across the different countries represented in the workshop and recommendations for improving the delivery of psychology therapies.

Recommendations

Challenges discussed relating to the re-organization of psychological service delivery included: many countries represented within the workshop having healthcare systems that were controlled regionally (as opposed to nationally); a lack of collaboration between primary and secondary care; and long treatment waiting lists due to a lack of appropriately trained healthcare professionals. Some countries also experienced challenges pertaining to having insurance-based healthcare systems. Challenges to re-thinking psychological workforces included: countries represented currently having workforces that were predominantly clinical psychology/CBT therapists and thus having only high-intensity CBT provision; the potential for professional "turf wars" should new psychological workforces be developed; and some healthcare contexts represented had preferences for pharmacological interventions. Challenges to implementing e-Mental Health included: a lack of national recommendations, guidance, and regulation of e-Mental Health interventions; a risk of interventions quickly finding themselves in the technological "valley of death" due to rapid technological advances; and both clients' and healthcare professionals' attitudes towards e-Mental Health, e.g., holding preferences for face-to-face contact. Some countries also raised challenges pertaining to low internet access, low smartphone access, and internet access being expensive.

Overall, participants in the workshop concluded that significant changes are required to improve access to psychological interventions, and these changes needed to be driven by governments and healthcare providers. As such, a "call to action" on an individual level was difficult. The workshop concluded that the following recommendations could help improve access to psychological interventions:

- Improving access to psychological interventions requires government level commitment and investment regarding the re-organization of service delivery models and the development of new psychological workforces.
- Should new psychological workforces be developed, there is a need for high-quality accredited higher education training courses with countrywide standardized national curriculums. Specifically, the need for psychological workforces trained in supporting low-intensity CBT was raised as a solution.
- "One size does not fit all" and subsequently there is a need for greater involvement of all key stakeholders (e.g., patients, informal caregivers, healthcare providers, non-governmental organizations, and other community level organizations), to develop and adapt psychological interventions and service delivery models to improve their acceptability and relevancy. A special consideration is required around language, to help overcome stigma related barriers to access.
- There is a need for increased integration of psychological services within community settings and community level organizations, for example, organizations commonly used by people with diversity or faith communities. Acceptability may be improved by reaching people within settings they already engage with and feel more comfortable in, thereby improving access.
- e-Mental Health interventions need to be of high quality, evidence-based, safe, and secure. Psychological workforces supporting e-Mental Health interventions require guidance and training. Organizations implementing e-mental health solutions require national level guidance and recommendations.

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