Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

EDITORIAL

Check for updates

Editorial: Stepping Up Care to Reach More Families

Eric A. Youngstrom, PhD

There are not enough of us. That was true even before the COVID-19 pandemic, which has only made the need for mental health services more acute.[1,2] There are roughly 30,500 practicing psychiatrists in the United States, and 106,000 licensed psychologists, and perhaps a million mental health practitioners worldwide. That translates to roughly one psychologist per 3,000 persons in the United States, one psychiatrist per 11,000 persons in the United States, and one provider per 8,000 persons globally.[3,4] That is obviously inadequate. Ramping up the training of professionals is not a sufficient solution. Even large percentage increases in the number of freshly minted providers still miss the mark by several orders of magnitude.

We need new models for providing care—methods that will accomplish more with the same resources, or change the scale of services and improve access.[5,6] Salloum *et al.*[7] offer an intriguing model that does that. They present a "stepped care" delivery system for trauma-focused cognitive-behavioral therapy (TF-CBT), comparing it to standard TF-CBT in a carefully designed and analyzed non-inferiority design. They measured symptom reduction, improvement in functioning, changes in diagnostic status, and remission. They also examined treatment cost, acceptability to families, and satisfaction. The stepped model produced non-inferior results on virtually every measure and follow-up period. One exception was baseline acceptability, which was lower among participants randomized to stepped care; however, posttreatment satisfaction levels caught up and were not significantly different, nor were attrition rates. Total costs were 50% lower in stepped care while producing similar outcomes.

What appears to be a statistical "tie" loosely speaking is actually a big win, and not only from a fiscal perspective. Less costly treatment means that the same budget could support more services, which is good news for society. The first step in their stepped care model was a parent-led, therapist-assisted treatment, with traditional TF-CBT held in reserve for nonresponders. The stepped approach combined 3 in-person sessions with a parent workbook, psychoeducation videos and websites, and weekly phone support of up to 15 minutes. The biggest part of the cost savings comes from seeing whether the smaller dose of provider intervention was enough to achieve the desired outcome.

But there is more good news to unpack. The psychoeducation materials also scale much more easily than anything requiring provider time. Websites are not consumable goods; there is no incremental cost for each additional family to access them, once the resources are created and deployed. The workbook could also be used electronically. All of these share the information at much lower marginal costs, and with a far wider reach than our geographic practice catchment area.[5,8]

These are not a replacement for our services, but they are apparently sufficient for some families to achieve satisfactory outcomes. In our own practices and networks, we could potentially not just screen a larger number of persons, but also provide similar materials to teach them about "mental health first aid," along with other strategies that are likely to be low risk and low cost while offering some potential benefit. Far from putting us out of work, it would keep us busy with those who need us most, while also educating and helping a larger swathe of the community.

There are many ways that psychoeducation and self-administered low-risk interventions could be expanded. The randomized controlled trial necessarily had constraints on enrollment that would not have to be maintained in a larger rollout. The initial parent training might be offered in a group format. The study was designed and conducted before the COVID pandemic. We have learned a lot since then about the promise and pitfalls of tele-health delivery of services we would not have considered before. There also is much good that could be accomplished with straight-to-consumer screening, information about treatment alternatives, mental health first aid, and coaching about when and how to access professional care. There is a lot to think through, as well, including how to strike a good balance between empowering patients and the public vs creating risks or unintentionally diverting people from services that they need. The program of work by Salloum *et al.*[7] lays a path toward improved access to care and resource allocation

while preserving outcomes and satisfaction. Although it is not a complete solution, it is a major advance; and there are opportunities for us to apply some of these ideas in our own work, and not wait for other systems to implement stepped care.

Accepted March 7, 2022.

Dr. Youngstrom is with the University of North Carolina at Chapel Hill.

The author has reported no funding for this work.

Disclosure: Dr. Youngstrom has received grant or research support from the National Institute of Mental Health, the American Psychological Association, and the Association for Psychological Science. He has served on the advisory board of the International Bipolar Foundation. He has served as a consultant to Signant Health. He has served as a consulting editor of the *Journal of Clinical Child and Adolescent Psychology* and on the editorial boards of the *Journal of Child and Adolescent Psychopharmacology* and the *WikiJournal of Medicine*. He has received royalties from Guilford Press and the American Psychological Association. He is co-founder and executive director of Helping Give Away Psychological Science (501c3).

Correspondence to Eric A. Youngstrom, PhD, Department of Psychology and Neuroscience, University of North Carolina at Chapel Hill, CB #3270, Davie Hall, Chapel Hill, NC 27514; e-mail: eay@unc.edu

https://doi.org/10.1016/j.jaac.2022.03.006

REFERENCES

1. Taquet M, Luciano S, Geddes JR, Harrison PJ. Bidirectional associations between COVID-19 and psychiatric disorder: retrospective cohort studies of 62 354 COVID-19 cases in the USA. Lancet Psychiatry. 2021;8(2):130-140. https://doi.org/10.1016/s2215-0366(20)30462-4
2. Brooks SK, Webster RK, Smith LE, *et al*. The psychological impact of quarantine and how to reduce it: rapid review of the evidence. Lancet. 2020;395(10227):912-920. https://doi.org/10.1016/S0140-6736(20)30460-8
3. Hawkins Merritt. The silent shortage: a white paper examining supply, demand, and recruitment trends in psychiatry. 2021:1-21. Accessed February 15, 2022. https://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Content/News_and_Insights/Thought_Leadership/mhawhitepaperpsychiatry2018.pdf
4. Youngstrom EA. New ways of sharing one of psychology's best secrets. APA Division 5 Presidential Address. Presented at: Annual meeting of the American Psychological Association; 2021; (virtual). Accessed March 20, 2022. https://bit.ly/D5-HGAPS
5. Susskind R, Susskind D. The Future of the Professions: How Technology Will Transform the Work of Human Experts. Oxford University Press; 2015:346.
6. Kazdin AE, Blase SL. Rebooting psychotherapy research and practice to reduce the burden of mental illness. Persp Psychol Sci. 2011;6(1):21-37. https://doi.org/10.1177/1745691610393527
7. Salloum A, Lu Y, Chen H, *et al*. Stepped care versus standard care for children after trauma: a randomized non-inferiority clinical trial. J Am Acad Child Adolesc Psychiatry. 2022;61:1010-1022. https://doi.org/10.1016/j.jaac.2021.12.013
8. Youngstrom EA, Cotuna A. Helping give away psychological science: putting information and resources where the public and professionals can find and use them. N C Med J. 2020;81(2):117-119. https://doi.org/10.18043/ncm.81.2.117