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Closing the Mental Health Treatment Gap Through Field Education: A Call to Action

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Abstract

Seventy-five to ninety percent of individuals affected by mental illness do not receive the treatment they need, largely due to the shortage of mental health professionals. Common Mental Disorders (CMDs) like depression and anxiety constitute a large part of the disease burden of mental illness and can be treated effectively with low-cost, low-resource psychosocial interventions that can be delivered by trained paraprofessionals. Social work education can contribute to closing the treatment gap for mental illness by training Bachelor's of Social Work (BSW) students to deliver evidence-based interventions for CMDs during their field education experience, and thereby meet a critical need in their communities.

Keywords: mental health treatment gap; social work education; evidence-based psychosocial interventions; field education; common mental disorders, task-sharing; social work Grand Challenges; CSWE competencies; Problem Management Plus

An estimated 1.1 billion people globally are affected by mental illness, causing enormous strain on family and social systems, and making it the leading cause of disability worldwide (Vigo, et al., 2016). For the purpose of this article, the term Common Mental Disorders (CMDs) refers to the National Institute of Health's commonly defined neurotic disorders, which "cause marked emotional distress and interfere with daily function, although they do not usually affect insight or cognition"

(Stansfeld et al., 2016, p. 38). These include depression, generalized anxiety disorder, phobias, social anxiety disorder, obsessive-compulsive disorder, and post-traumatic stress disorder (National Collaborating Centre for Mental Health, 2011, p. 13). In the last decade, mental illness topped the list of the costliest medical conditions in the United States (Roehrig, 2016). In developing countries, the economic cost of mental health conditions is estimated to reach trillions of dollars by 2030 (World Health Organization [WHO], 2020). Specifically, by 2030 the global economic cost of mental illness will be $6 trillion (Insel et al., 2015). Although the economic toll of mental illness is higher compared to other health conditions, the funding for research and service delivery for mental illness is significantly lower (Roehrig, 2016). In more affluent countries, only about 4–5% of total health research funding is devoted to mental health research, while it is less than 1% in developing nations (Patel, 2021).

Evidence-based psychosocial interventions are often the first line of treatment for mental illness due to their affordability, scalability, and cost-effectiveness (Singla et al., 2018). Although effective treatment exists, 75% to 90% of those affected by mental illness do not receive the treatment they require (Ngui et al., 2010). In both developing and affluent nations, access to mental health treatment is very limited, partially due to heavy reliance on "specialist mental health professionals" to provide treatment (Rajaraman et al., 2012) and the limited availability of these professionals (Kazdin, 2016; Kohrt et al., 2015; Semrau et al., 2015). For the purpose of this paper, "specialist mental health professionals" and "specialized mental health treatment" refer to licensed mental health providers with a master's degree or higher, such as an LMSW, LCSW, or LPC, and the services provided by these licensed professionals.

There is an urgent need for action to disseminate treatments more widely for people living with CMDs by enabling treatment delivery through nonspecialist personnel, a practice often known as task-sharing or scalability. Task-sharing is a practice in which nonspecialists or paraprofessionals are trained to deliver mental health treatments, making treatments more accessible to communities. Evidence demonstrates improved well-being and alleviation of symptoms for those with a mental illness even when nonspecialists deliver mental health treatment (Singla et al., 2018).

Closing the gap in mental health treatment is a policy, practice, and research priority in social work related to the following Grand Challenges for Social Work (Grand Challenges for Social Work, n.d.): a) close the health gap, and b) ensure healthy development in youth (Williams, 2016). This paper is a call to action describing how social work education can to contribute to closing the mental health treatment gap. This paper will: 1) describe the burden of mental illness and its treatment gap; 2) discuss the research on task-sharing and scaled-up interventions, 3) connect the Grand Challenges for Social Work to closing the mental health treatment gap; and 4) propose a model for how social work field education can contribute to closing this treatment

gap for CMDs (Williams, 2016).

The Burden of Mental Health Disease

Mental illness inflicts a significant burden on individuals, families, and communities. Disability-adjusted life years (DALYs) is a concept developed by the Global Burden of Disease (GBD) study to estimate the disease burden of mental illness to society. Mental disorders account for 37% of all healthy life years lost through disease (GBD 2016 DALYs and HALE Collaborators, 2017; Lopez et al., 2006). Mental illness and CMDs such as depression and anxiety significantly diminish the quality of life of individuals and their families, impacting success in education, negatively affecting social functioning, and influencing employability (Chisholm et al., 2016; Whiteford et al., 2013). Individuals affected by mental health disorders are statistically more likely to be economically disadvantaged (Patel & Kleinman, 2003). Multiple studies have found poverty to be a contributing factor to mental illness; the compounding stressors of poverty can amplify depressive and anxiety disorders, while behavioral health issues can impede one's ability to work and make decisions. This compounding cycle can lead to those living with mental illness becoming increasingly socially and economically marginalized (Knifton & Inglis, 2020; Lund et al., 2011).

Symptoms of depression include feelings of sadness, lack of interest in previously enjoyed activities, persistent feelings of worthlessness and guilt, and impaired sleep and overall functioning (Centers for Disease Control and Prevention, 2021). It is estimated that approximately 280 million people worldwide suffer from depressive disorders, accounting for about 3.8% of the world's population (WHO, 2023). Depression is the leading cause of disability worldwide, with depressive disorders being the third most common cause of hospitalization in the US for both youth and adults (Parks et al., 2006).

Characterized by apprehension, rumination, and fear, anxiety disorders are one of the most prevalent CMDs in the world (Stein et al., 2017). In 2016, approximately 275 million people suffered from anxiety disorders (Flemming, 2019). Anxiety disorders account for 28.68 million DALYs (GBD 2016 DALYs and HALE Collaborators, 2017), especially for adolescents aged 10–24. Anxiety disorders are the sixth leading cause of disability worldwide (Baxter et al., 2014). However, with treatment, individuals with depression and anxiety can live functional, healthy lives.

The Gap in Mental Health Treatment

Individuals living with CMDs can manage their condition effectively with treatment. Clinical treatment and research have shown that individuals' early and ongoing engagement with mental health treatment is effective in managing the condition,

reducing symptoms, strengthening overall functioning, and promoting recovery (Gearing et al., 2014). Early intervention and engagement with treatment are associated with positive outcomes in the following areas: strengthening recovery; changing symptom course; reducing episode recurrence and rehospitalization; and lessening the illness burden, disability, and impairment associated with mental health diagnoses (Dixon et al., 2016). Engagement with psychosocial treatment promotes medication adherence and improves social, psychosocial, and family functioning.

Although there are many benefits to interventions, globally 75 to 90% of individuals with mental illness do not receive the treatment they need (Henderson et al., 2013; Thornicroft, 2007). In the US, only 35% to 40% of individuals with a mental disorder receive treatment (Kessler et al., 2005). Furthermore, an estimated 35% to 70% of individuals who initiate mental health services discontinue treatment after just a few appointments or prior to clinicians' recommendations (Gearing et al., 2014).

Mental health treatment and research are underfunded throughout the world. Lack of investment in the mental health workforce and infrastructure, in addition to limited treatment access for people with a mental illness, exacerbates existing mental health issues and the conditions that contribute to them. Developed nations devote approximately seven percent of their health budget to mental health, while the majority of developing countries devote less than one percent of their health budgets to mental health, most of which is devoted to inpatient neuropsychiatric hospitals rather than primary or community care (WHO, 2009).

Many areas in the US have limited capacity (e.g., infrastructure, workforce, resources) to assess, identify, and treat mental health disorders. Of all those working in healthcare, only one percent of the global health workforce provides mental health care (WHO, 2020). More than 129 million people live in areas with mental health professional shortages, according to the Department of Health and Human Services (Kaiser Family Foundation, 2022; Levine, 2018). In the US, 37% of the population lives in areas identified as mental health professional shortage areas, with some states reporting populations as high as 96% living in identified shortage areas (USA Facts, 2021).

The consequences of untreated mental illness include social and economic inequities, unnecessary suffering, premature deaths, increased stigma, and social and economic marginalization (Ngui et al., 2010). There is an urgent need for multifaceted interventions involving the family, community, and society aimed at rehabilitating and reintegrating those living with mental illness (Murthy, 2011). Within the US, the enormous treatment gap (42–44%) for CMDs is not due to a lack of evidence-based treatments, but rather due to the reliance on "specialist mental health professionals" to deliver mental health treatments, thereby making them inaccessible to the

larger population despite the availability of low-cost, evidence-based psychosocial interventions (Kohn et al., 2004).

Scaled-Up Interventions

Given the severe global shortage of "specialist mental health care providers" and the enormity of the need for mental health treatment, a viable solution to fill the mental health treatment gap is to move from reliance on highly trained mental health care providers to a system that will utilize paraprofessionals trained in evidence-based interventions. To this end, the World Health Organization (WHO) has initiated the Mental Health Global Action Program (mhGAP; WHO, 2008).

The mhGAP was developed for scaling up services for mental, neurological, and substance use (MNS) disorders in low-income contexts and for providing health planners, policy makers, and donors with a set of clear and coherent activities and programs for scaling up care for MNS disorders. A primary objective of the mhGAP is to achieve higher coverage of critical mental health interventions in low-income contexts. This program is grounded in the best available scientific and epidemiological evidence about MNS conditions, and attempts to deliver an integrated package of interventions, including practical solutions to barriers in scaling up services.

The mhGAP package consists of interventions for the prevention and management of CMDs, based on evidence about the effectiveness and feasibility of scaling up these interventions. It provides a template for an intervention package that can be adapted for countries, or regions within countries, based on the local context (WHO, 2008). Advancing the implementation of evidence-based, low-cost mental health treatments to people within their communities is a critical social justice issue supported by a significant research, practice, and policy initiatives, e.g., the Grand Challenges for Social Work.

The Grand Challenges for Social Work

The Grand Challenges for Social Work, initiated by the American Academy of Social Work and Social Welfare, prioritizes and targets 12 areas of focus for practitioners, policymakers, and academics (Grand Challenges for Social Work, n.d.). As a call to action, the social work community is asked to rally around these 12 challenges in moving research, policy, and practice forward toward addressing these grand challenges. Several of the 12 grand challenges remain unmet unless we address the gap in mental health treatment. Specifically, of these 12 grand challenges in social work, closing the treatment gap for mental health relates to the following two challenges described below: a) close the health gap, and b) ensure healthy development for all youth.

Grand Challenge: Close the Health Gap

This challenge relates to the elevated levels of health inequity in the US and globally. People with more resources have better access to healthcare and fewer of the social stressors that exacerbate and create greater risk of illness. Several recommendations pertinent to mental health treatment have been developed from the work around this grand challenge. Specifically, it is recommended that community-based models be utilized to provide treatment access to those who are disadvantaged (Spencer et al., 2016).

Addressing the mental health treatment gap is necessary to close the health gap. Research indicates that individuals with untreated mental illness have shortened lifespans, and people with severe mental disorders have significantly shorter lifespans than the general population (Ilyas et al., 2017). This is referred to as premature mortality. Untreated serious mental illness increases the risk of other chronic medical conditions, and results in a life expectancy that is, on average, 25 years shorter than those without untreated serious mental illness (Parks et al., 2006). Mortality rates among people with schizophrenia are 2 to 2.5 times higher than the general population; among those with bipolar mood disorders, rates are twice as high; and among those with depression, rates are 1.8 times higher than the general population (Scott & Happell, 2011). Thus, individuals with mental illness are much more likely to die prematurely.

Mental health is an essential part of an individual's overall health and functioning. Nevertheless, in the US, treatment for mental health remains less accessible than treatment for physical health conditions (Weil, 2015). Most common mental health disorders (CMDs) can be treated with appropriate interventions, and individuals can have functional and meaningful lives (Prince et al., 2007). Treatment innovations for CMDs, such as Cognitive Behavioral Therapy, Exposure Therapy, Dialectical Behavior Therapy, and appropriate mental health medications, have changed the lives of people for the better (Cuijpers et al., 2020). However, without treatment, there is an increased risk of poor quality of life, including social and economic alienation, resulting in poor educational and employment outcomes.

Grand Challenge: Ensure Healthy Development for All Youth

This challenge relates to behavioral and mental health problems during childhood and adolescence, which create a chain of negative consequences for young people moving into adulthood. Evidence demonstrates that early intervention and prevention are the most effective tools in treating mental illness among children and youth. This challenge seeks to promote early intervention and prevent the development of serious

mental illnesses by reducing the socioeconomic and racial disparities in access to mental healthcare. Specific recommendations seek to provide practical, evidence-based interventions at low cost to families and communities and to reduce the duration of untreated mental illness among young people (Hawkins et al., 2016).

Mental health conditions usually have their onset in the early years of life, and are the leading cause of disability among the adolescent population (Davidson et al., 2015). Most mental health problems diagnosed in adulthood begin in adolescence. Half of lifetime diagnosable mental health disorders start by age 14; this number increases to three-fourths by age 24 (Kessler et al., 2007; Lipari et al., 2016). Approximately 10% of adolescents have a diagnosable mental disorder, with depression and anxiety accounting for 75% of the disease burden (Erskine et al., 2015). In the US, one in five adolescents experience significant symptoms of emotional distress, and one in 10 are emotionally impaired. The most common disorders among adolescents include depression, anxiety disorders, attention-deficit/hyperactivity disorder, and substance use disorders (Knopf et al., 2008).

Mental health problems can have a lasting negative impact on the development of young people, seriously affecting their ability to succeed in education, build social connections, and gain employment in adulthood (Michelson et al., 2019). There is a strong connection between youth mental health problems and suicide, which is the leading cause of premature mortality for young people worldwide (WHO, 2022). Interventions in early childhood and adolescence protect against long-term risks of poor health, low economic status, social exclusion, and other adverse outcomes in adulthood (Michelson et al., 2020). The challenge of ensuring healthy development for all youth necessitates a particular focus on adolescent mental health, with unique solutions for the delivery of services.

Call to Action: Mental Health Training for BSW Students

Social work education is charged with training a workforce to address the Grand Challenges for Social Work as priorities in alleviating human suffering and making progress towards a more just and equitable society. One area of concern is the mental health treatment gap, which relates to several social work Grand Challenges. In the US, most mental health services are provided by social workers (Mendenhall & Frauenholtz, 2013). More social workers provide clinical care than psychiatrists, psychologists, and psychiatric nurses combined (National Association of Social Workers, n.d.). Social workers are more accessible to people needing mental health services than are psychiatrists and other mental health specialists, and they remain the first line of defense for people in distress.

For this reason, as one solution of many, we propose that students training to be future

social workers in BSW programs be intentionally trained and actively employed to contribute to closing the treatment gap for mental illness, specifically CMDs. Specifically, we are advocating for BSW students to be trained to provide evidence-based, nonspecialist-delivered treatments for CMDs during their field education experience. Schools of social work in the US are endowed with a cadre of students in BSW programs who are required to complete 400 hours of fieldwork at an appropriate agency in order to demonstrate competency. Since 2005, the Council on Social Work Education (CSWE) has defined the field education experience as the signature pedagogy of social work education (Smith et al., 2021). Students in BSW programs across the US constitute a sizable nonspecialist workforce that can be employed to provide scalability for evidence-based mental health treatments.

In 2020, there were 61,907 students in BSW programs across the US (CSWE, 2021), and with each of these students completing 400 hours of fieldwork, the social work education community had access to 24,762,800 hours within that school year. Based on this average, and the estimate of one full-time professional working 2,080 hours a year, schools of social work potentially have access to the equivalent of over 11,900 people across the country working full-time in a supervised and standardized environment to provide psychosocial interventions as a front-line response to CMDs. Utilizing this student workforce to provide mental health treatment offers the dual benefits of providing evidence-based psychosocial interventions within communities to help close the treatment gap for mental illness and creating experiential learning for students, providing them with knowledge, skills, and experience for future employment.

The Mental Health Gap Action Program (mhGAP)

The WHO launched the Mental Health Gap Action Program (mhGAP) in 2008 to reduce the burden of mental illness and provide health planners, educators, and policymakers with the tools and resources to scale up mental health treatments and close the treatment gap for mental health (WHO, 2008). As part of the mhGAP's recommendations, psychosocial interventions are considered the first line of treatment for CMDs (WHO, 2008). Psychosocial interventions are widely used in low-income contexts, and there is robust evidence through randomized controlled trials all over the world for their efficacy in alleviating symptoms of mental illness and promoting well-being (Fuhr et al., 2020; Hamdani et al., 2020; Sangruala et al., 2020; Sijbrandij et al., 2015).

Treatment innovations within psychosocial approaches include employing transdiagnostic treatments, which use universally applied therapeutic principles that can be delivered to address a range of problems and psychopathologies (Gutner et al., 2016). Individuals with mental illness usually present with more than one diagnosis, making transdiagnostic treatment approaches efficient and valuable. Transdiagnostic

treatments have demonstrated promising outcomes for common mental disorders in both developing and affluent countries (Bullis et al., 2014).

The mhGAP treatments are developed such that they can be provided by trained personnel who are not mental health specialists. The WHO provides training manuals, teaching materials, PowerPoint slides, guidance, literature, and a clear package of directions for practitioners and researchers to deliver these treatments at community levels, using a cascade model of training. These training models begin with mental health specialists and educators training those with lower levels of expertise, or no expertise, who can then provide treatment delivery to the communities in need. Innovative treatment approaches that use trained community members and the existing infrastructure of community-based agencies could effectively reach more individuals who need mental health treatments in the US and abroad (World Bank Group, 2018).

WHO's *Thinking Healthy* program for perinatal depression and *Problem Management Plus (PM+)* for CMDs are the two most frequently used psychosocial treatments in developing countries. Multiple clinical trials in several countries have demonstrated the effectiveness of these two interventions (Akhtar et al., 2020; Sangraula et al., 2020; Sikander et al., 2015). Trials have demonstrated significant decreases in symptomology for those affected by CMDs, thus establishing promise for cost-effectively closing the treatment gap for mental illness (Chisholm, 2016; Patel et al., 2003; Singla et al., 2018;). The mhGAP treatments have also been used with positive results among refugee populations in humanitarian crises in affluent nations (Sever et al., 2021).

The *mhGAP Intervention Guide (mhGAP-IG)*, developed by the WHO, is a tool for healthcare providers working in nonspecialized healthcare settings, and provides detailed directions for training and supervising personnel to provide specific treatments for certain mental health conditions (WHO, 2021). The theoretical underpinnings, training materials, and guidance on implementation are provided through the *mhGAP-IG*. This curriculum is available for delivering treatments to communities in need and can be taught to social work students.

The Problem Management Plus (PM+) Program

One of the interventions developed by the mhGAP program is the Problem Management Plus (PM+) program. The PM+ program specifically targets adults with CMDs and self-identified practical problems (unemployment, relationship conflicts, etc.). It integrates problem-solving and behavioral treatment techniques that lend themselves to delivery by nonspecialists, while still grounded in evidence-based practices (Bennett-Levy et al., 2010). PM+ uses a transdiagnostic approach to treatment, whereby similar underlying principles are applied to multiple mental

disorders, and treatment protocols are not tailored to specific diagnoses (Reinholt & Krogh, 2014). The PM+ intervention is delivered through five 90-minute, one-on-one sessions with a trained nonspecialist worker, and consists of four core components: a) stress management, b) problem solving, c) behavioral activation, and d) strengthening social support. It also includes a psychoeducation component delivered in the first session. The PM+ intervention can be delivered individually or in a group setting (Dawson et al., 2015).

Students can be taught the underlying therapeutic principles of the PM+ intervention and be trained to apply the specific techniques to deliver the five-session treatment. To comply with field practicum requirements, participating students must engage in activities that meet the nine social work competencies (Council on Social Work Education [CSWE], 2022) at existing social service agencies while delivering the PM+ intervention. Within an already existing agency infrastructure, treatments like the PM+ can be delivered by BSW field students to communities in need. Examples of lay volunteers in communities delivering the PM+ interventions have been found to have statistically significant positive outcomes in many low-income communities around the globe (Sangruala, 2020; Sijbrandij et al., 2016).

Training BSW students to deliver the PM+ interventions as field experience will significantly increase low-income communities' access to evidence-based treatments for CMDs, and will broaden students' learning opportunities. Students will have the opportunity to offer interventions and gain practical experience in providing mental health treatment. Additionally, they will be serving marginalized populations and gaining clinical skills.

Social Work Education and Implications

Social work educators are tasked with preparing students to be proficient social workers within the nine areas of competence defined by the Council on Social Work Education (CSWE, 2022). Training social work students to deliver evidence-based interventions and utilizing the required field education hours as an opportunity for students to deliver these specific interventions in an appropriately supervised setting is the specific call to action in this paper. Given this opportunity, social work students would have the opportunity to meet all nine competencies outlined in the CSWE *Educational Policies and Accreditation Standards* (CSWE, 2022).

Competency 1: Demonstrating Professional and Ethical Behavior

Competency 1 can be achieved when social work students become aware that many individuals living with mental health issues do not get the treatment they need, which poses an ethical issue for the social work community. In learning about

scaling up services for those in need and delivering those services, students meet the requirements for "professional and ethical behavior" in their practice.

Competency 2: Advance Human Rights and Social, Racial, Economic, and Environmental Justice

Competency 2 can be met when students have the opportunity to provide services to individuals and communities from different backgrounds, socioeconomic statuses, racial groups, and lived experiences. In working with individuals and groups who have lived with mental health issues, students will gain an understanding of how one's culture impacts mental health and access to services.

Competency 3: Engage Anti-Racism, Diversity, Equity, and Inclusion (ADEI) in Practice

Competency 3 can be met when students become aware of the large unmet need for mental health care and take concrete steps to meet that need. Students are advancing human rights and social justice by providing a critical service to their communities by delivering much-needed evidence-based mental health treatments.

Competency 4: Research-Informed Practice

Competency 4 can be met when students learn that there is robust evidence worldwide for the efficacy of the interventions they deliver. Also, students can collect data when delivering treatments in field practice, and work collaboratively with supervisors and field educators to analyze the data and findings.

Competency 5: Engage in Policy Practice

Competency 5 can be met as students engage with their client base and gain increased knowledge of the policy issues that affect individuals' access to mental health care. Students can participate in advocacy for the needs of their clients on local, state, and national levels.

Competency 6: Engaging with Individuals, Families, Groups, Organizations and Communities

Competency 6 can be met directly when students are engaged in providing one-on-one mental health treatments to clients.

Competency 7: Assessing Individuals, Families, Groups, Organizations, and Communities

Competency 7 can be met while students are engaged in delivering the PM+ intervention. Each module includes a set of assessments to be administered before, during, or after treatment is provided. Students will have many opportunities to learn about and conduct assessments during their work with clients.

Competency 8: Intervention with Individuals, Families, Groups, Organizations, and Communities

Competency 8 can be met directly by students providing the PM+ intervention for CMDs. Students will become aware of the body of evidence around the mhGAP's treatment packages, and will learn intervention fidelity and concepts of implementation science.

Competency 9: Evaluation with Individuals, Families, Groups, and Communities

Competency 9 can be met by students learning to assess their work during the field experience. Students will have opportunities to reflect on daily service delivery and evaluate client progress within their scheduled supervision, allowing for self-evaluation, evaluation of services, and program evaluation.

Concrete Steps in the Call to Action

There is an urgent need in social work education to consider creative avenues for closing the treatment gap for mental illness. The specific call to action within this paper asks for social work educators, schools of social work, field directors, and social work leaders to use two valuable assets available to them to contribute to a solution for closing this gap. First, there is the availability of PM+, an intervention for CMDs from the mhGAP developed by the World Health Organization and supported by robust evidence for its efficacy throughout the world. The second resource is the enormous number of field hours available that can be leveraged to meet the critical need for the treatment of mental health disorders in our communities. By combining these two resources—social work field students, who are seeking 400 hours of field training, and the PM+, an already-available resource that trains social work students on evidence-based interventions—social work educators can ensure students a quality field experience with opportunities to meet all nine core competencies, while improving mental health outcomes in our communities, as well as address two of the 12 Grand Challenges for Social Work.

Opportunities for action include the following:

- Field offices can study the WHO mhGAP's PM+ in order to be prepared to train BSW students.
- Field office faculty can consider offering PM+ intervention training to students as part of their curriculum in the field seminar class or another related course.
- Field offices can consider coordinating with field sites in assessing the possibility of offering PM+ as a nonspecialist mental health intervention in the communities they serve.
- Field offices can consider informing and partnering with field instructors on supporting BSW students to provide PM+ in their field sites. Through these partnerships, field instructors can develop opportunities for students to provide PM+ interventions formally or informally, monitor treatment fidelity, and offer other support during supervision.
- Social work faculty, field faculty, field office staff, and field site personnel can look for opportunities in their communities for students to deliver the PM+ interventions, and thus attempt to close the treatment gap for mental illness.

Conclusion

The call to action in this paper asks for social work educators, schools of social work, field directors, and social work leaders to use the BSW field requirement to deliver an evidence-based mental health treatment (PM+) and meet the critical need in our communities to close the treatment gap for common mental disorders. Utilizing BSW field education students trained in PM+ to deliver nonspecialist mental health interventions within the community would not only provide substantial movement toward closing the severe mental health treatment gap, but would also give students an opportunity to demonstrate competency within all nine of the social work education competencies outlined by the CSWE. With approximately 1.1 billion people globally who are affected by mental illness, and a global treatment gap estimated at 75 to 90%, the need for intervention is both urgent and critical. Given the resources available to schools of social work and our profession's ethical responsibilities to broader society as defined by our professional code of ethics (National Association of Social Workers, 2021), utilization of scaled-up treatment interventions through student field placement offers an essential and prudent means of alleviating the current mental health treatment gap and furthering the well-being of those with mental illness.

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