in health settings in LMICs. For example, to the best of our knowledge, the Thinking Healthy programme[7] – contrary to initial hopes – is not currently being practised in mainstream healthcare in any part of Pakistan. There is a need for researchers in this area to consider the local resources. Otherwise, there is a risk that highly funded programmes will not produce realistic evidence that they can address the treatment gap. We, therefore, believe the paper by Chowdhary *et al* describes a strategy that is not consistent with the current methods of culturally adapting therapy, and one that is too costly to be replicated in LMICs.

1 Chowdhary N, Anand A, Dimidjian S, Shinde S, Weobong B, Balaji M, et al. The Healthy Activity Program lay counsellor delivered treatment for severe depression in India: systematic development and randomised evaluation. *Br J Psychiatry* 2015; **208**: 381–8.

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4 Naeem F, Gul M, Irfan M, Munshi T, Asif A, Rashid S, et al. Brief culturally adapted CBT (CaCBT) for depression: a randomized controlled trial from Pakistan. *J Affect Disord* 2015; **177**: 101–7.

5 Naeem F, Saeed S, Irfan M, Kiran T, Mehmood N, Gul M, et al. Brief culturally adapted CBT for psychosis (CaCBTp): a randomized controlled trial from a low income country. *Schizophr Res* 2015; **164**: 143–8.

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7 Rahman A, Malik A, Sikander S, Roberts C, Creed F. Cognitive behaviour therapy-based intervention by community health workers for mothers with depression and their infants in rural Pakistan: a cluster-randomised controlled trial. *Lancet* 2008; **372**: 902–9.

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Author's reply: Naeem *et al* express two concerns regarding the rationale for the work described in our paper on the development and piloting of the Healthy Activity Program (HAP), a brief psychological treatment that can be delivered by non-specialist workers in primary healthcare settings for adults with severe depression:[1] first, that the methodology adopted was expensive and cumbersome; and second, that the delivery of the intervention is not scalable in terms of human resources.

The goal of the PREMIUM approach was to design a treatment that was based on both contextual as well as global evidence, and that could be delivered by non-specialist workers in routine healthcare settings.[2] In both these ways, the PREMIUM approach is distinct from that adopted by Naeem and colleagues, whose trials adapted an existing psychotherapy package and evaluated the treatment in tertiary facilities or in psychiatric out-patients in large urban settings that cater to an unrepresentative and tiny fraction of the population burden of mental disorders. Our finding that behavioural activation was the most appropriate theoretical approach for treatment was a consequence of our methodology rather than an *a priori* decision and is, in fact, a significant scientific contribution in its own right in two ways: first, in the light of the approach taken, it demonstrates that this theory has cross-cultural validity; and second, it shows that there is no need for the more cumbersome cognitive components of the full package of CBT, a finding that is aligned with the common elements approach being increasingly favoured as a key strategy for the dissemination of psychological treatments.[3] It is true that the methodology we adopted was time-consuming, as we were not to know when we started that our final output would resemble an established psychological treatment; it is as the result of this experience that we have been to identify those steps of the PREMIUM methodology that are crucial to designing scalable treatments, reducing the resource requirements for replicating this approach for other mental health conditions.[2]

With regard to scaling up of empirically supported psychological treatments, it is absolutely correct that the treatments should be designed to be deliverable by existing health personnel. This was precisely the goal of PREMIUM. The problems of scaling up psychological treatments are not unique to LMICs; indeed, there is virtually no country in the world in which it has happened, even those with abundant mental health professionals, barring exceptions such as the UK's Improving Access to Psychological Therapies (IAPT) programme. The human resources that deliver treatments such as HAP and the Thinking Healthy Programme (THP),[4] which Naeem *et al* allude to, are in plentiful supply in all countries, significantly more so than mental health professionals, and the next challenge for our field is to scale up these empirically supported treatments in the real world. This goal is being facilitated by a number of new opportunities, including the collaborative hubs for scaling up evidence-based mental health interventions established by the US National Institute of Mental Health (http://grants.nih.gov/grants/guide/pa-files/PAR-16-174.html) and its ongoing support for evaluating the delivery of the THP through peers in India and Pakistan;[5] the World Health Organization's programme on low-intensity psychological treatments, which has adopted the THP to be scaled up through its Mental Health Gap Action Programme (mhGAP) and is being implemented in dozens of countries around the world; and national policy initiatives, such as in India, to reorient community health workers to deliver mental healthcare. It would be fair to say that it is precisely the systematic development of interventions such as the THP and HAP, with exquisite sensitivity to context and embedding in front-line healthcare delivery platforms, and their subsequent evaluation in definitive trials with impressive clinical results (the HAP definitive trial is currently in review)[6] that has fuelled these initiatives. It remains a mystery why Naeem *et al* believe that their approach, focused on tertiary facilities in urban areas and provision by mental health professionals, is more scalable than the approach of task-sharing by primary and community health workers championed by global mental health, and exemplified by the methodology used to design the THP and HAP.

1 Chowdhary N, Anand A, Dimidjian S, Shinde S, Weobong B, Balaji M, et al. The Healthy Activity Program lay counsellor delivered treatment for severe depression in India: systematic development and randomised evaluation. *Br J Psychiatry* 2016; **208**: 381–8.

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