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Open Pilot Trial of a Single Session Consultation Service for Clients at StrongMinds Uganda

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ABSTRACT

The need for mental health services in Sub-Saharan Africa far exceeds the availability of support, creating long waitlists for the few services that are in place. To address this crisis, implementing evidence-based, single-session interventions for individuals seeking treatment may provide timely relief. StrongMinds—a mental health charity organization serving youth and adults in Uganda—piloted a Single-Session Consultation (SSC) service for new treatment-seekers with elevated depressive symptoms, as indicated by a score on a screener survey suggesting the presence of at least mild depression. To optimize its reach and fit with StrongMinds' service delivery model, the SSC was delivered by trained lay providers in both individual and group-based formats. Within 2 months (September–October 2023), the SSC was delivered to 200 Ugandan adults with elevated depression symptoms (ages 16–86; 73% female) upon initial outreach for StrongMinds' group psychotherapy services. SSC clients reported significant improvements in hopelessness and depression symptoms at 2-week ($ds = -0.73, -1.12$) and 1-month follow-ups ($ds = -0.96, -1.44$), while waiting for group psychotherapy. SSC clients reported high SSC satisfaction ($M = 4.47/5$), and intervention effects did not significantly differ by delivery format (i.e., individual vs. group format). Results suggest the SSC's acceptability, feasibility, and utility as a low-intensity, scalable intervention for adolescents and adults in Uganda on waiting lists for longer-term psychotherapy.

1 | Introduction

The majority of people living in low- and middle-income countries (LMICs) have no access to mental health services (World Health Organization 2014; Lopes et al. 2016), and this lack of access is especially pronounced throughout countries in Africa, like Uganda (Iversen et al. 2021). Depression is a particularly burdensome mental health concern in African countries. It has long remained the leading cause of morbidity in both adolescents and adults (GBD Causes of Death 2024; GBD 2019 Mental Disorders Collaborators 2022), and the prevalence of depression throughout African countries is 9%–10%, compared to 4%–5% for the global population (Esan and Esan 2016; Gbadamosi et al. 2022). In Uganda, access to mental health treatment is particularly low (Iversen et al. 2021), creating an

urgent need for innovative service delivery models that can sustainably address the country's crisis of untreated depression. StrongMinds is a charity organization that was founded in the United States of America (US) with a vision to treat depression among people throughout Africa, with a special focus on women (www.strongminds.org), and with services currently provided in Uganda and Zambia. Historically, StrongMinds' model of treatment has involved the provision of Group Interpersonal Psychotherapy (IPT-G), an evidence-based treatment for depression (MacKenzie and Grabovac 2001), delivered by trained, nonprofessional (lay) providers to adolescents and adults. StrongMinds is one of a handful of organizations working to rapidly scale a solution to the burden of depression in Africa. By training lay providers to deliver mental health

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services through IPT-G therapy sessions, StrongMinds aims to provide depression treatment to the most underserved populations in Sub-Saharan Africa. Since it was founded, 543,181 people have been served by StrongMinds, with a goal to treat over 350,000 people in 2024 alone (StrongMinds 2024).

Although StrongMinds' group-based treatments benefit those who access them, many people seeking these services face delays before connecting with their care. For people seeking services at StrongMinds, those who miss out on a new group enrollment window may wait up to two and a half months for care, if not longer. These treatment delays can cause harm. The longer individuals spend on waitlists, the more likely they are to experience further declines in symptoms, lose motivation for change, develop negative perceptions and distrust in mental health services, and drop out early once treatment starts (Punton et al. 2022; Reitzel et al. 2006; Steinert et al. 2017). Indeed, individuals placed on waitlists may fare worse, in terms of their symptoms and difficulties, than those told that no

treatment is available at all (Furukawa et al. 2014). As such, there is a pressing need to identify brief, evidence-based interventions that may bridge gaps in mental health services in low-resource settings, such as those that StrongMinds Uganda seeks to serve. Thus, the goal of the current study was to assess the acceptability and effectiveness of integrating an evidence-based single-session intervention (SSI)—the Single-Session Consultation—into the StrongMinds treatment model in Uganda (Figure 1).

1.1 | Single-Session Interventions

SSIs are defined as structured programs that intentionally involve one visit or encounter with a clinic, provider, or program (Schleider et al. 2020). They are a “one-at-a-time” approach to intervention designed to mitigate symptoms of mental health distress (Harper-Jaques and Foucault 2014). SSIs are designed to be singular, discrete interventions; however,

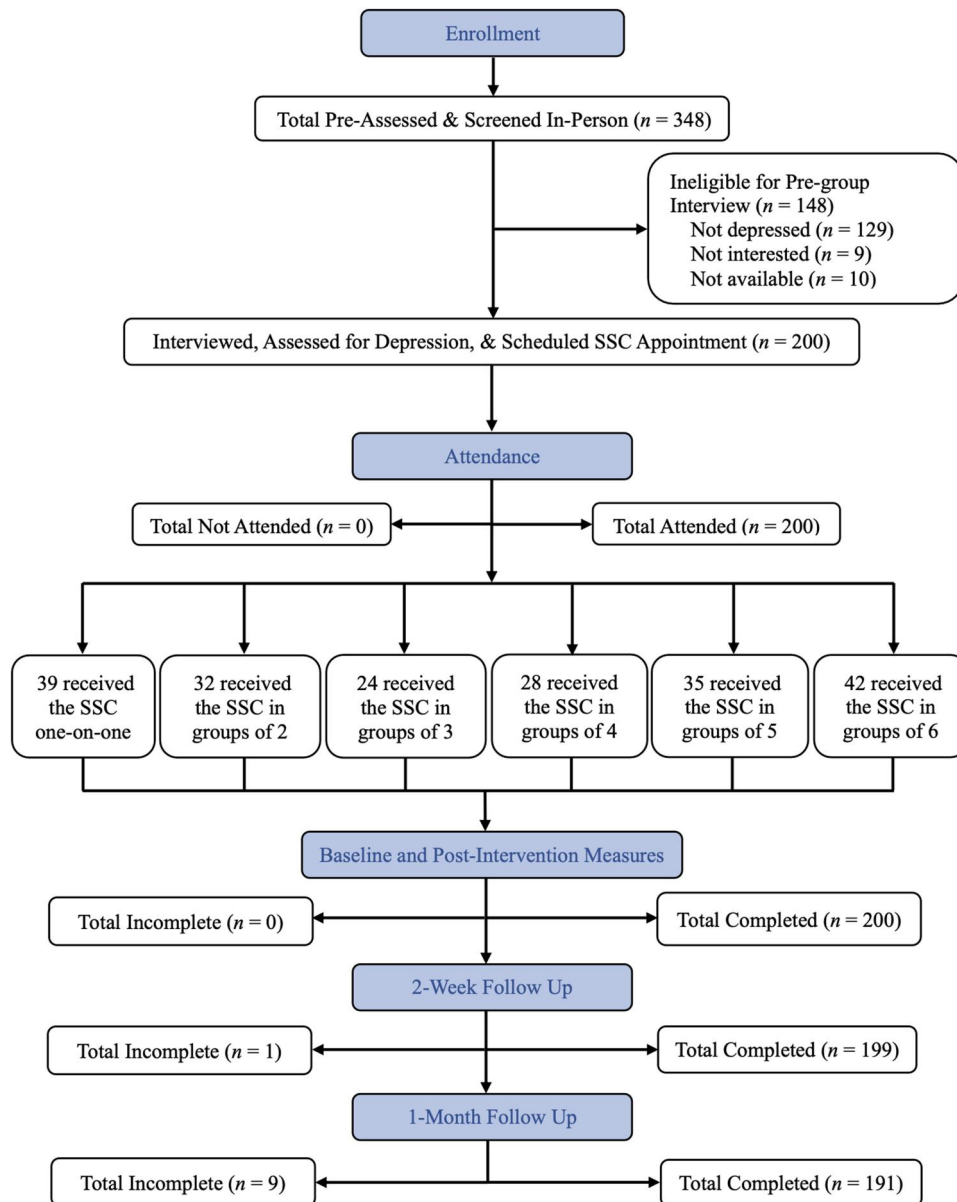


FIGURE 1 | CONSORT diagram.

they can also be used as adjuncts to more traditional treatment (Young and Dryden 2019). There is no assumption within the SSI framework that individuals can or should address all their concerns within one session; at the same time, each SSI holds potential to yield some degree of positive, meaningful clinical change (per recent trials, up to 12 months later; Schleider et al. 2025). SSIs acknowledge the reality that any given clinical encounter could be someone's last (especially in low-resource contexts where clients face barriers to consistent treatment), and that any single-session can nonetheless yield meaningful benefit (Young et al. 2012).

Several SSIs have proven effective for reducing depression in adolescents and adults. In a recent umbrella review synthesizing 24 systematic reviews, including 415 unique clinical trials of SSIs for mental health problems (> 300 focused on youth and young adults), 20 reviews (83.33%) reported significant, clinically meaningful effects of SSIs for > 1 outcomes (e.g., depression; anxiety). Across 12 reviews that examined SSIs' effectiveness relative to active controls, SSIs showed a positive effect across outcomes and age groups, Standardized Mean Difference (SMD) = -0.25 at 2–12-month follow-up, with low to moderate heterogeneity across studies. Notably, a meta-analysis of 50 SSI trials found that SSIs evaluated outside of North America—mostly in low- and middle-income countries (LMICs)—were significantly more effective in reducing youth mental health problems than SSIs evaluated within North America ($g = 0.48$ vs. $g = 0.17$; Schleider and Weisz 2017). This result suggests utility for underserved populations in resource limited settings. Regarding SSIs for depression, five systematic reviews have reported positive effects compared to control conditions up to 12 months post-intervention (Schleider et al. 2025). Across trials, depression-focused SSIs grounded in solution-focused therapy, an evidence-based treatment for depression, show especially consistent promise.

Although multiple studies have demonstrated that SSIs are effective (Schleider and Weisz 2017), there is a knowledge gap in their implementation and feasibility in low-resource settings, like Uganda. Researchers in LMICs have made efforts to evaluate SSIs in their local contexts, and findings demonstrate the potential for SSIs to meaningfully benefit youth in LMICs, like their counterparts in high-income countries (e.g., the US; Ghosh et al. 2023). Nevertheless, research is needed to verify the extent of SSIs' effects for Ugandans, especially in identifying scalable solutions to severely limited mental health care access. Research on the advantages of SSIs for addressing mental disorders and their role in waitlist management within Uganda and LMICs has yet to be extended (Schleider et al. 2021; Sung et al. 2023). By filling this knowledge gap, SSIs can be assimilated into existing mental health frameworks throughout LMICs and thus provide timely and effective assistance to those who are struggling. The incorporation of SSIs into models of care can bridge the gap between the enormous demand for mental health treatment and the limited resources available to deliver it by providing a quick and focused response.

The integration of SSIs into current mental healthcare frameworks, such as within the StrongMinds treatment model, is one viable approach to the pervasive problem of restricted access to mental health services (Singla et al. 2023). SSIs offer evidence-

based care both as stand-alone support and as adjuncts to other clinical services (e.g., SSIs instead of *and* in addition to standard IPT-G sessions offered by StrongMinds). Following an internal review, StrongMinds identified a sizable demand for solutions addressing milder emotional discomfort and social isolation, beyond more serious difficulties associated with Major Depressive Disorder (MDD). To close this gap, StrongMinds redesigned their pre-treatment options and integrated an SSI, the *Single Session Consultation* (SSC), alongside their current service options to provide a more practical and accessible option for people who were feeling emotionally distressed and socially isolated. StrongMinds began offering the SSC to both individuals already on their waitlist for traditional services (i.e., IPT-G) and individuals who did not want to pursue longer treatment. The SSC is especially equipped to supplement StrongMinds' services, due to its established evidence-base in the use of the SSC for clients on waitlists at mental health clinics. Offering support that minimizes time waited until treatment is accessed is crucial to avoiding the “nocebo” effect, or the reduced impact of treatment once mental health care is accessed, due to long waiting times (Steinert et al. 2017).

1.2 | The Single-Session Consultation (SSC)

The SSC is well-suited for integration into StrongMinds Uganda, specifically as a “just-in-time” support for individuals placed on waitlists for services. The SSC is a provider-delivered, strengths-based, and person-centered SSI inspired by the principles of Solution Focused Brief Therapy (SFBT; Bannink 2007; de Shazer 1985) that encourage individuals to create and strive towards highly-specific, concrete goals in a single, 30–90 min session (Sung et al. 2023; full SSC delivery protocol: <https://osf.io/xnz2t>). In the SSC model, a provider sees a client within ~5 days of initial outreach for support, dramatically reducing wait times for services and capitalizing on motivation for treatment. Using a semi-structured protocol that yields a personalized action plan for each client, the SSC helps clients identify the strengths they already possess to solve a problem at hand and to take steps, however small, toward a future in which that problem is less influential. Across two evaluations including adolescents and young adults in the U.S., a single SSC significantly decreased hopelessness ($ds = 0.72$ – 0.90), increased problem-solving ability and autonomy ($ds = 0.82$ – 1.11), enhanced motivation for change ($d = 0.49$), and reduced depressive symptoms across 2-week follow-up periods ($ds = 0.21$ – 0.91 ; Schleider et al. 2021; Sung et al. 2023). Further, SSC recipients reported high levels of therapeutic alliance with their providers that were indistinguishable from those observed in trials of multi-session therapy (Sung et al. 2023).

Three features of the SSC warrant mention, given their relevance to sustainable deployment within low-resource contexts such as StrongMinds Uganda. First, in these past trials, the SSC was provided to all clients with elevated symptoms of anxiety or depression (i.e., a score on a screening survey suggesting at least mild levels of depressive symptoms) in these studies, regardless of their specific symptom profile; thus, the SSC can function as a problem-agnostic intervention that can flexibly address challenges that clients view as important. Second, also in both trials, non-professional providers delivered the SSC to fidelity—including

bachelor-level trainees with no formal mental health training. Indeed, the SSC was intentionally created to be easily delivered by providers with diverse levels of training (from secondary education to doctoral-level training), to optimize sustainment within low-resource settings (Sung et al. 2015, 2023). As such, the SSC is designed to be feasible for StrongMinds' trained lay providers to deliver. Third, provider training for the SSC itself is very brief, comprising one 90-min training workshop and as-needed follow-up consultations with SSC trainers. Given the SSC's flexibility and the brevity of its training, the SSC can offer mental health clinics like StrongMinds Uganda a low-cost, scalable option for meeting the needs of individuals on their waitlists. Together, these features highlight the suitability of the SSC for StrongMinds Uganda's current operations, and they motivated the selection of the SSC for this pilot study. While StrongMinds would typically deliver IPT-G in its full extent, the SSC served as a bridge to care for individuals who would not have been able to access the full IPT-G service, due to being located outside of StrongMinds' zone of service.

The SSC is well positioned for large-scale dissemination and adaptation to the needs of diverse cultures. SSC training for lay providers lasts 90 min on average, with no prior qualifications needed. Thus, the current study examined immediate improvements in clients' proximal clinical outcomes (i.e., hopelessness, perceived agency) after SSC completion, gauged clients' opinions of the SSC's acceptability and utility, and examined changes in depressive symptom levels from before the SSC to both the 2-week and 1-month follow-ups. These goals worked together to create a thorough framework for assessing the SSC's capacity to meet the urgent mental health needs of people from Uganda.

1.3 | Present Study

This pilot trial examined the acceptability, feasibility, and effectiveness of the SSC offered to individuals in community settings on waitlists for StrongMinds' services (i.e., group interpersonal psychotherapy, or IPT-G) in Uganda. The pilot trial initiated and concluded recruitment from September 2023 to December 2023, and SSCs were delivered in community settings (e.g., in local churches, schools). The hypotheses were as follows:

- Hypothesis 1: Receiving the SSC would be associated with decreased symptoms of depression (i.e., primary outcome) at the 2-week and 1-month follow-ups and improved proximal targets (i.e., hopelessness and perceived agency; secondary outcomes) immediately post-intervention and at the 2-week and 1-month follow-ups. Further, we explored the clinical significance of change scores based on the Brief Symptom Inventory 18-item (BSI-18) depression subscale at the 2-week and 1-month follow-ups.
- Hypothesis 2: Immediately post-intervention, participants would perceive the SSC as acceptable and useful in addressing their clinical needs.
- Hypothesis 3: The relative benefits of receiving the SSC on primary (i.e., depression) and secondary (i.e., hopelessness and perceived agency) outcomes would not significantly differ by delivery method (i.e., individual vs. group format

at StrongMinds), per baseline, post-SSI, 2-week, and 1-month follow-up client-report data.

In addition to the above hypotheses, we planned to benchmark SSC effects observed in this study against those observed in previous, U.S. based SSC trials (Schleider et al. 2021; Sung et al. 2023) to gauge whether the SSC service was similarly acceptable, and yielded similar benefits, across cultures and contexts (i.e., an American context vs. a Ugandan context, comparing lay provider delivery to delivery by psychology trainees).

2 | Methods

2.1 | Procedure

Ethical approval for the study to be conducted through StrongMinds Uganda was received from Makerere University, School of Health Sciences REC, prior to client recruitment. Once enrolled in the SSC, clients were non-randomly allocated to either an individual or a group SSC session, depending on the provider's and the client's availability. In their session, clients completed a screening that encompassed informed consent, a discussion on confidentiality, and an introduction to the SSC's objectives. Although adolescents were eligible for inclusion in the study, all participants identified as adults or as the head of household; therefore, only consent and no assent procedures were used. The screening was followed by baseline questionnaires to assess levels of depression, hopelessness, and agency. All assessments were administered in-person, and individual items from all scales were verbally read out loud to each participant to compensate for varying literacy levels among the community; thus, approximately 40 min were allotted for lay providers to collect baseline data prior to beginning the SSC. The introduction phase lasted about 5 min and focused on explaining the structure components and purpose of the SSC. The SSC core session (approximately 45–90 min long) was administered by a trained lay provider in a local community setting once baseline assessments were completed. Four lay providers at StrongMinds delivered the SSC, in individual and group sessions, for this pilot trial. Lastly, post-session assessments were administered to gauge the impact of the intervention. Follow-up assessments were scheduled to track progress and ensure continued support 2 weeks and 1 month after the administration of the SSC. Assessments at the 2-week and 1-month follow-ups were administered by the same lay providers who delivered the SSCs, although participants did not necessarily complete follow-ups with the lay provider who delivered their specific SSC.

2.2 | Clinical Setting

StrongMinds delivers mental health services through non-professional lay providers, with educational attainment ranging from high school through bachelor's degrees. Opportunities to become a StrongMinds lay provider were advertised through community leaders, and applicants were screened for motivation and literacy. Successful candidates were then trained in helping skills, identifying mental health conditions, and interpersonal psychotherapy for groups. In this pilot study, lay

providers with bachelor's degrees were taken through a foundational helping skills workshop and completed a 90-min SSC training conducted by the senior author (J.L.S.) before they began administering the SSC to waitlisted clients. In the present pilot, SSC individual sessions and groups were conducted in community settings, such as schools and prisons. The lay providers delivering the SSC received weekly supervision and quality assurance support by StrongMinds staff, as well as 2 h-long group clinical consultation sessions led by the senior author (J.L.S.)

The study was conducted in several small rural communities throughout the central and eastern regions of Uganda, including the towns of Nakede, Nakitokolo, Gvulvi, and Buvembo, and some groups near the district of Wakiso. These communities are located outside major urban centers, with Wakiso located northwest of Kampala, the capital and largest city of Uganda, and are primarily characterized by rural and agriculturally-based populations with limited access to specialized health and mental health services. Individuals recruited in the present study varied in their experiences of living in proximity to urban settings (e.g., Buvembo, closer to Kampala) and living in more rural places (e.g., Nakitokolo, further east or north).

2.3 | Inclusion Criteria

All adolescent and adult clients who presented for treatment at StrongMinds Uganda operation sites were offered the opportunity to receive the SSC. A screening survey was administered to assess eligibility, and individuals with total scores above 23 on the PHQ-9, and/or who endorsed active suicidal ideation were immediately referred to a higher level of care, according to policies implemented by StrongMinds to minimize risks of harm; thus, these individuals were excluded from participation to avoid delay until treatment or services were received. In addition, children younger than 11 years old were not included in the study as the SSC was tailored to adolescent and adult populations. Individuals with elevated depressive symptoms, as indicated by a PHQ-9 total score of ≥ 10 , were considered eligible for the study. Importantly, the PHQ-9 has been translated and cross-culturally validated among Ugandans and demonstrates reliable rates for detecting depressive episodes (Nakku et al. 2016; Kaggwa et al. 2022). Individuals who qualified were then enrolled in the study and received the same therapeutic intervention (i.e., the SSC). Informed consent was obtained prior to study initiation with each participant. Through our convenience sampling approach to recruitment, only adults were recruited, with the exception of two individuals under the age of 18, both of whom self-identified as the heads of their households and were therefore treated as adults. Though adolescents as young as 11 were eligible, none were screened or enrolled in the study.

2.4 | Intervention

The SSC is an evidence-based SSI lasting 45–90 min that is grounded in solution-focused brief therapy (SFBT). After assessing readiness to engage in the SSC, the lay provider

introduced the purpose of the SSC, set expectations, and shared the Action Plan, which guides the session's structure. The client (or clients, if delivered in a group setting) was asked to identify their top struggle related to their mental health, along with their hope for the consultation. Next, the lay provider posed the “miracle question,” a canonical SFBT technique: “Imagine that a miracle occurs overnight; while you are sleeping, your top struggle has completely disappeared. When you wake up, how will you know that there has been a miracle? What will you do, think, or feel differently?” The lay providers asked the client to rate, on a 1–10 scale, “how close they are to [their] miracle day” now, with “10” representing their problem having disappeared entirely, and “1” representing their problem being at its worst. The rest of the SSC was dedicated to crafting a personalized Action Plan, geared towards helping the client “move up by just one point on your Miracle Day scale”—for instance, if a client rates themselves at a 4/10, their plan supports them in reaching a 5/10. The Action Plan included 3 concrete things the client can do to increase their miracle day scale rating by one point. Lay providers encouraged client(s) to choose strategies reflecting small steps they have taken before, drawing on existing strengths, connections, and coping skills. Clients also identified two people or resources that can help them use their plan. Once the Action Plan was constructed, the client was asked to identify an important inner obstacle (thought, feeling, or bad habit) that may keep them from following through with their plan. The client was asked to generate a “phrase, thought, or action to help them overcome their inner obstacle,” with guidance from the lay provider. At the end of the SSC, the lay provider wrote a personalized note to the client that was shared with them on the Action Plan worksheet, identifying two specific reasons why the lay provider personally believed the client was capable of following through on their Action Plan. The client then received a copy of the Action Plan to take home; another copy was stored at the clinic for record-keeping, fidelity coding, and to guide consultation.

Within this pilot trial, SSC delivery differed slightly between individual and group contexts. Individual SSCs were strictly limited to 45–60 min, while group SSCs lasted 90 min or longer, depending on the number of participants. Time restrictions were disregarded for groups of three and above to allow group attendees to share and offer feedback to one another with enough time for all questions raised by the group to be discussed. Within individually delivered SSCs, participants identified solutions to their top problems with only the lay provider offering feedback. Participants within group-delivered SSCs received feedback and sometimes collaboratively brainstormed solutions to top problems, often before the lay provider made any suggestions. The primary difference reported by lay providers in format delivery was that community members worked to collaboratively resolve top problems and offered social support in real time during group SSCs, compared to participants in individual SSCs occasionally struggling to identify solutions to their top problems without assistance from the lay provider.

2.5 | Provider Training, Supervision, and Fidelity

To ensure fidelity, the four lay providers at StrongMinds involved in the open pilot clinical trial participated in a 2-h

training, followed by two consultation calls with the last author (JLS) and weekly supervision from StrongMinds. The training provided background information on single-session and solution-focused therapeutic techniques, a step-by-step walk-through of the SSC program protocol, an overview of potential challenges (and recommended solutions) faced by SSC providers, and guidelines for addressing imminent risk during an SSC session. Lay providers in this study were advised to utilize standard clinic procedures to assess risk in participants reporting non-zero suicidal ideation at pre-intervention. To promote delivery fidelity, lay providers received a step-by-step guide to delivering the SSC in its intended format (see Schleider et al. 2021) and an “Action Plan” worksheet to be completed jointly with clients during the SSC. The Action Plan is designed to impose a uniform, linear structure into each SSC while generating a personal coping plan for each client. After this initial, single session of training, all providers received structured weekly supervision from StrongMinds staff throughout the implementation period, followed by two 1-h group consultations with the last author (JLS) to review challenges in SSC delivery, review selected action plans from sessions, and to support fidelity to the SSC structure. Importantly, supervision was not considered a “post-training add-on” but a structured component of implementation, to align with prior research on task-shared mental health care in low-resource settings that emphasize the need for effective systems of ongoing supervision and mentorship (Kemp et al. 2019). Furthermore, prior SSC trials (Schleider et al. 2021; Sung et al. 2023) established that non-professional providers, including bachelor-level trainees with no formal mental health training or licensure, delivered the SSC to fidelity with this training structure. The SSC was intentionally designed for deployment in this context. In the present study, Action Plans were successfully completed at or above the 80% threshold for all sessions, providing an objective indicator of delivery fidelity and suggesting high fidelity among providers trained for this study.

2.6 | Measures

2.6.1 | Brief Symptom Inventory-18—Depression Subscale and Overall Score (BSI-18)

The BSI-18 (Derogatis 2001) assesses self-reported psychopathology and distress. It was selected as the primary outcome measure for this study because it is brief, normed on samples of adults, and inclusive of multiple domains of psychopathology (e.g., depressive symptoms, anxiety symptoms, somatic symptoms). Respondents rate endorsement of 18 physical and emotional complaints on a 0–4 Likert scale. The total sum score yields an additional total distress score (range: 0–72). Higher scores indicate higher levels of overall psychological distress. The BSI-18 was administered at baseline, 2-week follow-up, and the 1-month follow-up. The depression subscale was used in the current study. For the overall BSI-18 measure, the internal consistency was $\alpha = 0.83$ at baseline, $\alpha = 0.90$ at the 2-week follow-up, and $\alpha = 0.87$ at the 1-month follow-up. For the BSI-18 depression subscale, the internal consistency was $\alpha = 0.67$ at baseline, $\alpha = 0.80$ at the 2-week follow-up, and $\alpha = 0.73$ at the 1-month follow-up. The BSI-18 has also demonstrated good reliability and validity in prior research conducted in East

African (Shacham et al. 2008) and Ugandan (Vancampfort et al. 2019) settings, including with Ugandan adolescents (Moscardino et al. 2012).

2.6.2 | Patient Health Questionnaire-9 Item Version (PHQ-9)

The Patient Health Questionnaire, 9-item version (Kaggwa et al. 2022) was used as a screening tool for study eligibility among individuals presenting to StrongMinds Uganda for treatment, already incorporated into their organizational policies for service delivery. People who expressed interest in study participation were administered the PHQ-9, and total scores of ≥ 10 were deemed eligible, due to having mild or greater depressive symptoms. Beyond screening, data from the PHQ-9 were not further used in analysis. As mentioned above, our primary outcome, depression, was measured and tracked using the BSI-18.

2.6.3 | State Hope Scale (Pathways Subscale)

The State Hope Scale (Snyder et al. 1996) was used to measure perceived agency and asked participants to rate three statements based on how they think about themselves right now. Participants rated the three statements on an 8-point scale ranging from 1 (Definitely False) to 8 (Definitely True). The resulting total score ranged from 3 to 24, with higher scores representing higher levels of perceived agency. There are two subscales in the State Hope Scale, one for pathway thinking and another for agency thinking. Only the “pathways” subscale was used to assess agency in this study, immediately pre- and immediately post-SSI and at a 2-week follow-up. At baseline, the Cronbach's alpha was $\alpha = 0.55$, and immediately post-intervention, the Cronbach's alpha was $\alpha = 0.69$. We address the limitations of this lower internal consistency in the discussion. The State Hope Scale has also been used in prior research studying hope among Ugandan populations (Evangeli et al. 2024) and has previously been translated into Luganda (Barnett et al. 2015).

2.6.4 | Beck Hopelessness Scale-4 Item Version (BHS-4)

The BHS-4 (Perczel Forintos et al. 2013) was used to measure hopelessness and asks participants to rate four statements based on their sense of hopelessness. Participants rate the four statements on a 4-point scale ranging from 0 (Absolutely Disagree) to 3 (Absolutely Agree). Total score ranges from 0 to 12, with a higher score indicating greater levels of hopelessness. This was assessed pre- and immediately-post SSI, at 2-week follow-up, and at the 1-month follow-up. The Cronbach's alpha ranged from $\alpha = 0.83$ at baseline to $\alpha = 0.82$ immediately post-intervention. For the follow-ups, internal consistency was $\alpha = 0.84$ at 2 weeks and $\alpha = 0.81$ at 1 month. The Beck Hopelessness Scale has also been used in prior research with East African (Kagotho et al. 2018) and Ugandan (Cavazos-Rehg et al. 2021) populations.

2.6.5 | Consultation Feedback Form

The consultation feedback form, designed for SSC trials and administered at post-SSC, contained five items rated on a 0 (“Not at all”) to 4 (“Very much”) Likert scale, reflecting

endorsement of a series of statements about the SSC (e.g., “Did you find the consultation helpful in addressing your concerns?” and “How hopeful are you that the action plan will be useful?”). Higher scores indicated greater perceived usefulness of the SSC. The Consultation Feedback Scale was administered immediately post-SSI, and the Cronbach’s alpha was $\alpha = 0.76$.

2.6.6 | Demographic Questions

Participants were asked to report demographic information including age, district, sex assigned at birth, nationality, marital status, cohabitation status, number of children, and the location where they received the SSC.

2.7 | Sample Size Justification

StrongMinds’ ongoing services included a significant level of integration for the evaluation of the SSC. To monitor and assess the SSC program’s efficacy for the client group, we conducted an open evaluation of the program within a 3-month data collection period with no upper limit to participant engagement following IRB approval. To achieve a good balance between the study’s objectives, feasibility, and practicality, and to deepen the organization’s dedication to evidence-based practice and continuous improvement in delivering effective mental health support, a minimum sample size of 30 individuals was recruited for the study. A sample of 30 participants was sufficient to obtain a stable estimate of the trial’s effects, per guidelines for pilot study-planning proposed by Julious (2005) and Whitehead et al. (2016). Further, it was expected that a larger sample size would be achieved based on treatment-seeking patterns among StrongMinds clients.

2.8 | Analytic Plan

For hypothesis 1, we ran a series of linear regression models to test whether the SSC predicted (1) improvements in proximal targets at post-SSI (perceived agency; hopelessness), and (2) future reductions in adolescent depressive symptom severity (primary study outcome) from pre-SSI to 2-week and 1-month follow-up. Potential covariates included age, sex, gender, race, and time (baseline, post-SSI where relevant, and follow-up); covariates were included if they were significantly related to a model outcome at pre-SSI or follow-up. Changes in outcomes of interest were also evaluated by computing within-group effect sizes using the R package Measure of Effect (MOTE; Buchanan et al. 2019). Similar to previous trials (Buchlmayer et al. 2024), we calculated both Cohen’s d_{av} (which provides difference scores as a ratio of the average standard deviation of the outcome at both timepoints) and Cohen’s d_z (which provides difference scores as a ratio of the standard deviation of change scores), including 95% confidence intervals (Lakens 2013) to maximize transparency:

$$\text{Cohen } d_{av} = M_{\text{diff}} / ((SD_1 + SD_2) / 2) \quad (1)$$

$$\text{Cohen } d_z = M_{\text{diff}} / \sqrt{(\sum ((x_{\text{diff}} - M_{\text{diff}})^2 / (N - 1)))} \quad (2)$$

These calculations were completed with participants who completed a given measure at both the initial and secondary timepoint (i.e., immediately post-intervention, 3-month follow up).

For hypothesis 2, we examined the mean scores of acceptability as measured by the Consultation Feedback Form, both across individual items and for items combined.

For hypothesis 3, we ran a linear regression to test whether delivery method (i.e., individual vs. group delivery) predicted (1) improvements in proximal targets at post-SSI (perceived agency; hopelessness), and (2) future reductions in depressive symptom severity (primary study outcome) from pre-SSI to 2 week and 1-month follow-up, relative to each other.

We examined descriptive statistics, means, and frequencies to assess client ratings of SSC usefulness and the percentage of eligible participants electing to participate in the SSC. We conducted repeated-measures t-tests to determine whether proximal outcomes (e.g., hopelessness, agency) improved from immediately before to immediately after the SSI (within-subjects), and whether depressive symptom outcomes improved from immediately before to 1 month after the SSC (also within-subjects). The primary goal of these analyses was to determine the preliminary utility of this new service at StrongMinds and to identify areas for future research.

2.8.1 | Missing Data

One participant dropped out before completing their 2-week follow up, and eight additional participants failed to complete the 1-month follow up. Listwise deletion was used for all missing data from these nine participants as required by computing packages in R.

3 | Results

3.1 | Sample Characteristics

Participants ($N = 200$) were 16–86 years old ($M = 41.68$, $SD = 17.38$), 73% were assigned female at birth, and all participants (100%) identified as Ugandan. When asked, 5.5% of participants reported they were married, 14.0% were single, 14.5% were widowed, 26% were separated, and 40% reported cohabiting. All participants reported that they were from the district of Wakiso. Most participants (30%) reported that they were in Nakedde, 26.5% were in Nakitokolo, 25.5% were in Ggulwe, 17.5% were in Buwembo, and one participant (0.5%) was in Jesa. See Table 1 for all demographic statistics characterizing the sample. At baseline, the average score for the depression subscale on the BSI-18 was about 10 out of 24 ($M = 10.50$, $SD = 4.30$). Participants overall reported low scores of hopelessness ($M = 4.81$, $SD = 3.49$). A full breakdown of means and standard deviations for all measures at all time points are listed in Table 2.

3.2 | Did Clients Who Received the SSC Report Improvements in Primary and Secondary Outcomes From Baseline to Post-Intervention, 2-Week, and 1-Month Follow Ups?

3.2.1 | Did Hopelessness and Agency Change Immediately Post-Intervention?

Participants who received the SSC service, and provided pre- and post-SSC data, reported significant reductions in hopelessness

TABLE 1 | Demographic characteristics of the sample.

Demographic Variables	N = 200; M (SD) or n (%)
Age	41.68 (17.38)
District	
Wakiso	200 (100%)
Sex at Birth	
Female	146 (73.0%)
Male	54 (27.0%)
Location	
Buwembo	35 (17.5%)
Ggulwe	45 (22.5%)
Ggurwe	6 (3.0%)
Jesa	1 (0.5%)
Nakedde	60 (30.0%)
Nakitokolo	53 (26.5%)
Nationality	
Ugandan	200 (100%)
Marital Status	
Cohabiting	80 (40.0%)
Married	11 (5.5%)
Separated	52 (26.0%)
Single	28 (14.0%)
Widowed	29 (14.5%)
Number of Children	
1–3	57 (28.5%)
4–6	90 (45.0%)
7 and above	34 (17.0%)
None	18 (9.0%)
No Response	1 (0.5%)

from baseline ($M = 4.81$, $SD = 3.49$) to immediately post-intervention ($M = 2.21$, $SD = 2.38$), $d_z = -0.91$, $t(199) = 12.83$, $p < 0.001$. A common language effect size was also calculated, otherwise known as the probability of superiority or greater likelihood (Lakens 2013). Immediately after the SSC, participants had an 89% chance of having a lower score of hopelessness than they did before the intervention. SSC recipients also reported significant increases in perceived agency from before ($M = 16.32$, $SD = 3.82$) to immediately after the intervention ($M = 18.90$, $SD = 3.76$) the SSC, $d_z = 0.82$, $t(199) = -11.53$, $p < 0.001$. In other words, immediately after the SSC, participants had a 68.0% chance of reporting greater perceived agency.

3.2.2 | Did Depression Change at the 2-Week Follow Up?

At the 2-week follow up, participants who received the SSC service reported significant reductions in depressive symptoms from baseline ($M = 10.42$, $SD = 4.27$) to the 2-week follow up ($M = 4.93$, $SD = 4.32$), $d_z = -1.12$, $t(198) = 15.80$, $p < 0.001$. At the 2-week follow up after receiving the SSC service, participants had a 128% of reporting a lower score of depressive symptoms than before the SSC. Participants also reported significant decreases in hopelessness from baseline ($M = 4.80$, $SD = 3.49$) to the 2-week follow up ($M = 2.03$, $SD = 2.52$),

$d_z = -0.73$, $t(198) = 10.28$, $p < 0.001$. At the 2-week follow up, participants had a 92% chance of having a lower score of hopelessness than before the SSC.

3.2.3 | Any Change at the 1-Month Follow-Up?

At the 1-month follow-up, SSC recipients reported significant decreases in their depressive symptoms from baseline ($M = 10.41$, $SD = 4.28$) to the 1-month follow-up ($M = 3.16$, $SD = 3.15$), $d_z = -1.52$, $t(197) = 21.33$, $p < 0.001$. One month after receiving the SSC, participants had a 97% chance of having a lower score of depressive symptoms than before the SSC. Participants also reported significant decreases in hopelessness from baseline ($M = 4.79$, $SD = 3.50$) to the 1-month follow up ($M = 1.08$, $SD = 1.78$), $d_z = -1.06$, $t(197) = 14.85$, $p < 0.001$. At the 1-month follow-up, participants had a 93% chance of having a lower score of hopelessness than before the SSC.

3.3 | Was the SSC Rated Acceptable?

Overall, participants who completed the SSC ($N = 200$) found the intervention to be highly acceptable. On average, participants rated a satisfaction rating of 4.47 out of 5 ($SD = 0.42$), which is higher than previously used acceptability benchmarks of 3 out of 5 (Schleider et al. 2021) and 3.5 out of 5 (Sung et al. 2023) on this measure. On an item-by-item level, using a scale from 1 (not at all) to 5 (very much), participants typically reported that: (1) the SSC was helpful in addressing their concerns ($M = 4.67$, $SD = 0.50$); (2) the SSC helped them develop an action plan to address their concerns ($M = 4.35$, $SD = 0.63$); (3) they were hopeful that the action plan would be useful ($M = 4.37$, $SD = 0.69$); (4) they felt motivated to use the action plan ($M = 4.27$, $SD = 0.63$); and that (5) they would recommend the consultation service to others ($M = 4.70$, $SD = 0.49$). Participants also provided written feedback at the end of the consultation feedback form, mostly positive (e.g., “Thank you I have benefitted, learnt a lot and become strong”).

3.4 | Did Individual Versus Group Delivery of the SSC Affect Outcomes?

Among all participants ($N = 200$), 19.5% ($n = 39$) of participants received the SSC individually (i.e., their lay provider delivered the SSC one-on-one), and 80.5% ($n = 161$) of participants received the SSC in a group setting, ranging from two to six clients and a lay provider (see Table 3). All lay providers delivered the SSC individually, and three out of four lay providers each facilitated an SSC group with six clients. Intervention effects did not differ due to delivery format; participants experienced comparable benefits following the SSC, regardless of whether they received the SSC service in an individual or group format. After running a series of z-tests to examine if effect sizes significantly differed based on delivery format for each outcome (see Table 2 for all effect sizes), no significant differences were detected between effect sizes calculated from participants who received the SSC individually or in groups, indicating that format (i.e., individual vs. group delivery) did not predict SSC effectiveness.

TABLE 2 | Means, standard deviations, effect sizes, and confidence intervals for all measures at all time points.

Measure and Format	Baseline			Post-SSC			2-Week Follow Up			1-Month Follow Up		
	M (SD)	d _z	[95% CI]	M (SD)	d _z	[95% CI]	M (SD)	d _z	[95% CI]	M (SD)	d _z	[95% CI]
BSI-18	Total	29.30 (11.90)		NA		NA	16.80 (12.30)	-0.94 [-1.11, -0.77]		9.52 (8.47)	-1.49 [-1.70, -1.28]	
	Individual	25.20 (10.20)		NA		NA	15.20 (12.20)	-0.84 [-1.21, -0.47]		10.10 (10.30)	-1.54 [-2.00, -1.06]	
	Group	30.40 (12.00)		NA		NA	17.20 (12.30)	-0.97 [-1.15, -0.78]		9.38 (7.99)	-1.52 [-1.75, -1.28]	
BSI-18 Depression Sub-Scale	Total	10.50 (4.30)		NA		NA	4.93 (4.32)	-1.12 [-1.30, -0.94]		3.16 (3.17)	-1.44 [-1.64, -1.23]	
	Individual	8.38 (3.96)		NA		NA	3.95 (4.39)	-0.88 [-1.24, -0.50]		2.84 (3.48)	-1.20 [-1.62, -0.78]	
	Group	11.00 (4.24)		NA		NA	5.18 (4.28)	-1.19 [-1.39, -0.98]		3.24 (3.10)	-1.51 [-1.74, -1.28]	
BHS-4	Total	4.81 (3.49)		2.20 (2.38)		-0.91 [-1.07, -0.74]	2.03 (2.52)	-0.73 [-0.88, -0.57]		1.10 (1.80)	-0.96 [-1.13, -0.78]	
	Individual	4.18 (3.18)		2.36 (2.80)		-0.76 [-1.11, -0.40]	1.46 (2.32)	-0.76 [-1.12, -0.40]		0.84 (1.35)	-1.00 [-1.38, -0.60]	
	Group	4.96 (3.55)		2.17 (2.27)		-0.95 [-1.13, -0.76]	2.17 (2.55)	-0.72 [-0.89, -0.54]		1.17 (1.89)	-0.95 [-1.14, -0.75]	
Agency	Total	16.30 (3.82)		18.90 (3.76)		0.82 [0.65, 0.97]	NA	NA		NA	NA	
	Individual	16.20 (4.24)		18.40 (4.11)		0.66 [0.31, 1.00]	NA	NA		NA	NA	
	Group	16.30 (3.72)		19.00 (3.67)		0.86 [0.67, 1.04]	NA	NA		NA	NA	
CFF*	Total	NA		4.47 (0.42)		NA	NA	NA		NA	NA	
	Individual	NA		4.52 (0.39)		NA	NA	NA		NA	NA	
	Group	NA		4.45 (0.43)		NA	NA	NA		NA	NA	

Note: Effect sizes were calculated from baseline to the given time point. CFF* indicates that the mean and standard deviation shown reflect the mean and standard deviation of all items (not the total score) of the CFF; BSI-18 represents the Brief Symptom Inventory 18-item measure; BHS-4 represents the Beck Hopelessness Scale 4-item measure; Agency was measured using the State Hope Scale Pathways subscale (questions 1, 3, and 5); CFF represents the Consultation Feedback Form measure.

TABLE 3 | Number of participant per SSC delivery format.

Delivery format	Number of clients who received this format
Individual (one-on-one)	39
Group (2+ clients present)	161
Two clients	32
Three clients	24
Four clients	28
Five clients	35
Six clients	42
Total Sample Size	200
Total Individual Sessions	39
Total Group Sessions	45

4 | Discussion

The present study evaluated the acceptability and short-term clinical effects of the Single-Session Consultation (SSC), delivered by lay providers in both individual and group formats, as a service for adolescents and adults on waitlists for longer-term psychotherapy from StrongMinds Uganda presenting with elevated depressive symptoms, as indicated by at least mild levels of depressive symptoms. Results suggested that the SSC was associated with high acceptability and large, significant improvements in depression symptoms, hopelessness, and agency across a 1-month follow-up period, when delivered by lay providers to SSC clients within StrongMinds Uganda. The positive outcomes associated with the SSC did not significantly differ across clients who received the SSC individually or in a group of two to six other clients. The improvements observed among SSC clients in depression symptoms, hopelessness, and perceived agency are consistent with previous studies of single-session interventions broadly (Schleider et al. 2025); of solution-focused brief therapy approaches (Bannink 2007); and of the SSC in particular (Schleider et al. 2021; Sung et al. 2023).

This study is the first to observe the SSC's acceptability and short-term utility among individuals seeking depression treatment in Uganda, suggesting the intervention's potential to help bridge gaps in mental health services for Ugandan adolescents and adults experiencing depression. Results suggest several next steps for future research on the SSC in low-resource contexts, particularly across Sub-Saharan Africa.

First, this study demonstrates that the SSC is acceptable and linked with symptom reductions when delivered by lay providers within community settings. The study also suggests that lay providers can achieve fidelity in delivering the SSC, consistent with prior studies of the SSC delivered by non-professional providers (see Sung et al. 2024). This set of results is highly pertinent to SSC delivery in low-resource contexts, such as Uganda and other LMICs, where barriers to evidence-based care are copious (e.g., stigma; mental health provider shortages; limited funds). Further, training to deliver SSC to high fidelity consists of a single, 90-min training, a supervised

mock session, and ongoing supervision). Thus, may circumvent organization-level and provider-level implementation barriers linked with longer-term psychotherapies, such as high training and consultation costs and limited provider time. Further trials evaluating cost are needed to quantify the SSC's potential impacts on organizational scalability, and in turn, the intervention's sustainability for clinics to deliver in the longer-term.

Second, this study establishes an evidence base of preliminary findings prompting further investigation into the acceptability and effectiveness of the SSC delivered in group settings. Notably, in both individual and group settings, all SSC recipients received psychoeducation and an individualized, completed Action Plan. Within group sessions ($n = 45$, see Table 3), SSC providers focused on using a strengths-based approach to guide participants and provide insights that would help them create an individualized Action Plan (i.e., one that works for *them*). These findings highlight the importance and potential benefits of further studying the acceptability of a group-based SSC for individuals with at least mild levels of depression in Uganda. Participants in the current study rated both the individual and group-based SSC as highly acceptable, and exploratory analyses did not suggest differences in clinical outcomes by delivery format for participants within the present trial. Cultural factors may have contributed to the high rates of acceptability of the group-delivered SSC, given the salience of community support and relatedness within Ugandan research (Mbalinda et al. 2011; Mburu et al. 2013). Further research is needed to gauge whether group-based SSCs are similarly acceptable across diverse cultural contexts.

Compared to previous US-based SSC trials, the SSC was associated with numerically larger depression symptom reductions in the current study (see Table 4). This result is consistent with previous meta-analytic work, which has found that SSI effects on mental health are significantly larger when delivered in low- and middle-income countries (LMICs) compared to those delivered in the United States and Canada (Schleider and Weisz 2017). This pattern may stem from the scarcity of mental health care options in resource-limited settings like Uganda, where the need for effective interventions is especially urgent. The treatment gap between people who need mental health care and people who receive it is most severe in LMICs, where up to 90% of people do not receive any mental health services at all (Docherty et al. 2017). Researchers have documented various reasons for the severity of the treatment gap in LMICs, including a lack of trained mental health professionals (Clausen and Skokauskas 2018), limited funding for mental health initiatives (Ghosh et al. 2023), and difficulty accessing evidence-based treatment options (Patel et al. 2013). These shortages in access may lead individuals from LMICs to experience greater improvements in their mental health following the completion of an SSI. Thus, benefits from the SSC delivered in LMICs may be twofold: (1) they address clinical symptoms directly (e.g., depression, hopelessness) with effectiveness and scalability, and (2) they help bridge the treatment gap by providing brief and accessible training to lay providers on the delivery of evidence-based treatments, extending the reach of effective interventions to those in need.

Results suggest some effect sizes (e.g., for depression symptoms) may have increased over time for participants in this study

TABLE 4 | SSC effect sizes across trials.

SSC trial	Symptom scale	Post-SSC d_z	Follow-Up d_z
Pilot Trial (Schleider et al. 2021)	Agency	1.43	N/A
	Hopelessness	1.11	N/A
	Distress	N/A	0.72 ^a
Telehealth Trial (Sung et al. 2023)	Readiness for Change	−0.49	N/A
	Hopelessness	0.91	N/A
	Depression	N/A	0.21 ^a
	Anxiety	N/A	0.40 ^a
StrongMinds Trial (current study)	Agency	0.82	N/A
	Hopelessness	−0.91	−0.73 ^a
			−0.96 ^b
	Depression	N/A	−1.12 ^a
			−1.44 ^b

Note: Table represents data collected over three different trials. Superscript indicated follow-up time period (i.e., ^aTwo-week follow-up period, ^bOne-month follow-up period).

(see Table 2). However, the precise mechanisms of change underlying the SSC's longitudinal impacts have not been formally tested, and the duration of SSC effects beyond 1 month remains unknown. Future research may formally examine mechanisms of change underlying the SSC's short and sustained impacts on symptoms. One potential mechanism, which was not evaluated here, is post-SSC skill rehearsal, operationalized as clients' post-SSC use of their personalized Action Plan. Perhaps regular use of Action Plan skills and strategies relates to larger symptom reductions or more sustained improvements. Another potential mechanism for the SSC's impacts—specifically for group-based SSC delivery—is social or community support. Clients who received in the SSC in a group may have benefited from the validation, understanding, or accountability gleaned from sharing their problems and Action Plan with others, in turn leading to increased Action Plan use, decreased hopelessness, or increased wellbeing. As both skill rehearsal and social support have been identified as a possible mechanism for longer-term psychotherapies, evaluating these factors as mediators of longer-term SSC outcomes remains an important direction for future work.

4.1 | Limitations

Findings must be interpreted in the context of several limitations. Most importantly, conclusions drawn from the study are limited by the lack of a control group. Although an open trial was deemed the most ethical approach to study design for prioritizing support delivery to people seeking care, the absence of a control group limited comparisons which may have provided evidence for claiming the SSC alone was responsible for improvements following treatment. Thus, we were unable to rule out the possibility that these results are not simply attributable to regression to the mean or demand characteristics (Nichols and Maner 2008), and larger-scale randomized trials are needed. Another limitation included a lack of independent assessors to administer measures, which can lessen pressure on participants to report improvement directly to their providers, leading to desirability effects. Participants recruited for this

study lived outside the zone of services typically covered by StrongMinds Uganda. In response, StrongMinds created a waitlist for individuals in case opportunities, like a research study, materialized to facilitate service delivery. Therefore, although we lacked independent assessors, participants had not yet encountered StrongMinds and were unlikely to access services after receiving the SSC. Relatedly, all measures except the Consultation Feedback Form have previously been used with Ugandan research participants. Thus, our interpretation of our findings on the perceived acceptability of the SSC is limited by the lack of cross-cultural validation in our measure assessing participants' perceptions of the helpfulness, usefulness, hope-inspiring, and motivating aspects of the SSC. Findings were further limited by the small sample size, especially for participants who received the SSC individually ($n = 39$) compared to in groups ($n = 161$; see Table 3). Randomization of participants to solo SSCs, group SSCs, or a control condition would extend evidence on SSC outcomes by isolating effects through analyses examining between-group differences. Additionally, it is notable that study participants were majority female, which may limit the generalization of findings to people assigned female at birth. Lastly, it warrants mention that the internal consistency for the perceived agency measure was low (i.e., the State Hope Scale, Pathways subscale; $\alpha < 0.70$), suggesting a need to validate culturally appropriate assessments for this construct. Due to the lack of internal consistency on the State Hope Scale across timepoints and of the BSI-18 at baseline, we advise caution when interpreting study results on perceived agency and depression.

4.2 | Conclusion

Study results support the acceptability and likely effectiveness of the SSC, when delivered by lay providers, for depression symptoms and hopelessness among clients served by StrongMinds in Uganda. This was the first study to explore the impacts of the SSC in Uganda, and its acceptability for delivery in small group settings. Critical next steps to extend these findings include a larger-scale randomized-trial of the SSC,

comparing individual and group-delivered SSC to an active control, and formal investigation of possible change mechanisms (skill rehearsal; social support) underlying longer-term effects. Further testing and deployment of the lay provider-delivered SSC may help reduce the treatment gap in LMICs, equipping global communities with tools to overcome structural barriers to mental health care.

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Ethics Statement

Ethical approval for the study to be conducted through StrongMinds Uganda was received from Makerere University, School of Health Sciences REC. (IRB: MAKSHSREC-2024-695).

Conflicts of Interest

JLS serves on the Scientific Advisory Board for Walden Wise and the Clinical Advisory Board for Koko; has received consulting fees from United Health and Woebot; and receives book royalties from New Harbinger, Oxford University Press, and Little Brown Book Group. RK and PB are employees of StrongMinds. The authors report no other potential financial conflicts or competing interests.

Data Availability Statement

The data that support the findings of this study are openly available in Open Science Framework at <https://osf.io/kxn6z/>. All de-identified data and the R script of code used for the statistical analyses, along with other project materials, are available on the Open Science Framework: <https://osf.io/kxn6z/>.

Peer Review

For transparency, the peer review documents associated with this article are available at <https://doi.org/10.1002/mhs2.70056>.

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