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Are brief psychological therapies effective for adults experiencing common mental health difficulties in primary care?

Paul Toner¹, Shehzad Ali², Antonina Mikocka-Walus³

1. Centre for Improving Health-Related Quality of Life, School of Psychology, Queen's University Belfast, UK
2. Schulich School of Medicine & Dentistry, Western University, Canada
3. School of Psychology, Deakin University, Australia

Correspondence concerning this article should be addressed to: Paul Toner, Centre for Improving Health-Related Quality of Life, School of Psychology, Queen's University Belfast, David Keir Building, 18-30 Malone Road, Belfast, BT9 5BN, United Kingdom. Email: p.toner@qub.ac.uk
Introduction

Corpas and colleagues (2021) provide a comprehensive meta-analysis on the clinical effectiveness of brief psychological therapies for adults experiencing common mental health difficulties in primary care. The review focused on the relative effectiveness of psychological therapies in comparison to pharmacological interventions which tend to be usual care in this setting. Brief psychological therapies averaged six but ranged from two to 10 sessions delivered by specialist mental health professionals as opposed to practitioners providing routine healthcare. There were six different types of therapy identified: problem-solving; cognitive behavioral; counseling; mindfulness-based cognitive; interpersonal and psychodynamic. Common mental health difficulties included anxiety, depression, and emotional disorders/mixed diagnoses.

Thirty-four discrete studies from 33 randomised control trials met this inclusion criteria. Studies were conducted in 11 countries, however, the UK (15) and US (6) contributed 62% of the primary studies. In contrast, low- and middle-income countries only provided 17.6% of the studies overall. As is usual in reviews, there was variability in studies contributing to the meta-analysis with samples ranging from 20 to 361 participants, with associated variations in methodological quality and whether all trials were pragmatic was unclear. Also, where data was available the included sample was predominantly female at 73.6%. Further participant characteristics such as ethnicity and other gender identities included were not elaborated on. Notwithstanding these factors, and the high level of heterogeneity found as multiple outcome measures were used to assess symptoms with no standard follow-up timeframe. The meta-analysis indicated a significant moderate effect in favour of brief psychological therapies at post-treatment. However, in the 19 studies which included follow-up assessments taken at 36 weeks on average, this significant effect was not maintained.

The authors also presented extensive subgroup analyses to give further clarity on the main results. Interestingly, there was no significant difference between combined psychological and pharmacological interventions and psychological interventions alone at post-treatment and
follow-up. Cognitive behavioral therapy was found to be superior to problem-solving but only when used with pharmacological interventions and at post-treatment. Unsurprisingly, reported symptoms were better for those diagnosed with anxiety only in comparison with mixed diagnoses post-treatment. However, this finding was based on four studies in total.

This rigorous review by Corpas and colleagues (2021), while addressing salient questions for the field, raises several important areas for discussion.

**Primary Care**

While certainly a crucial setting to intervene with common mental health difficulties based on prevalence, primary care is not uniform across countries and there are important differences in how healthcare is structured. For example, a report from the UK indicated improved waiting times, referrals completion, and recovery using the Improving Access to Psychological Therapies (IAPT), which was introduced in 2008 to ensure better access to psychotherapy for people with anxiety and depression (NHS Digital, 2018). Yet despite these encouraging findings, health inequalities in access to IAPT persist and the majority of people living with anxiety and depression are yet to be offered adequate treatment for these conditions (McManus, Bebbington, Jenkins, & Brugha, 2016). In contrast, the Australian Better Access program provides up to 10 mental health sessions per year (increased to 20 during the COVID-19 pandemic) delivered by mental health practitioners including General Practitioners. Better Access has been found to improve mental health outcomes, in a cost-effective manner, reducing waiting times to 14 days and addressing some inequalities in access to care (Pirkis, Harris, Hall, & Ftanou, 2011).

The review assumes a stepped care model which was developed to limit the use of expensive high-intensity therapies to those who need it. While this model is practiced in some developed countries with a strict gate-keeping system, this is not always feasible in developing countries where healthcare systems tend to be physician-centric and also chronically underfunded. Therefore, it is unsurprising that low- and middle-income countries were underrepresented in
the current review. Task sharing is practiced in many developing countries and therefore it would be important to capture in future evidence reviews whether effectiveness is maintained with non-specialist delivery.

**Brief psychological therapy**

The authors provide clear inclusion criteria that structured psychological treatment was implemented by a specialist mental health professional. Therefore, findings were not conflated with low intensity interventions such as brief advice or psychoeducation delivered by a healthcare practitioner. However, the level of expertise of the therapists delivering the brief psychological interventions was unclear. It would be interesting to know whether this has an impact on effectiveness, as for example, in the UK psychological wellbeing practitioners (PWPs) train for only 45 days to implement structured psychological treatments.

While 10 sessions could certainly be considered brief for some treatment modalities, for example, psychodynamic therapy - it would be important to look at dose response in relation to effectiveness. More structured approaches such as cognitive behavioral therapy lend themselves to a briefer application so it may be appropriate to offer guidance of six sessions as the suggested optimum. However, it is important to be patient-centred and offer a menu of approaches as from the review there are only marginal gains towards therapies more suited to briefer forms. Consideration should also be given to the strong evidence on relapse after brief therapy which often turns these services into a revolving door system. This is partly attributable to early discharge of patients with residual symptoms of depression and anxiety at the end of therapy (Ali et al., 2017). These patients could be offered ongoing post-therapy support to prevent relapse, however, the evidence on the effectiveness of such strategies is currently limited.
Pharmacological interventions

Although the review points to providing psychological therapy as usual care for common mental health difficulties in primary care, we also must consider that there are barriers to implementation especially in developing countries. Relative cost-effectiveness data in comparison with pharmacological interventions would strengthen this argument as well as patient-level data indicating clinical effectiveness for more complex diagnoses/severe symptoms. In addition to clinical and cost-effectiveness, advocates of psychological therapies should consider the challenges of feasibility and acceptability. For instance, these therapies should be provided in a manner that is culturally relevant and appropriate for patients which can be challenging in diverse multi-lingual and multi-ethnic societies. Moreover, ignoring heterogeneity of the patient population is likely to increase inequity in access and outcomes. Alternatively, meta-analytic evidence suggests that a combination of psychopharmacology and psychotherapy may be more effective than either alone (Cuijpers et al., 2014), perhaps because they work on different regions of the brain. For example, psychotherapy acts within the prefrontal cortex, basal ganglia, and limbic areas, while psychopharmacology does so in the limbic areas and frontal cortex (Seminowicz et al., 2004). This information would enable healthcare practitioners to make informed choices on the most appropriate treatment for their patients.

Implications

There is scope for implementing third wave interventions such as Behavioral Activation which has been shown to be as clinically effective and more cost-effective (as can be delivered by PWPs) as cognitive behavioral therapy for treating depression at 12-month follow-up (Richards et al., 2016). In relation to common mental health comorbidity, the authors suggest adapting transdiagnostic interventions in primary care, we concur these interventions could be applied based on clinical effectiveness shown in independent reviews (Andersen, Toner, Bland, & McMillan, 2016). With any innovations in brief psychological therapies, trials should be well-
designed and include a measure of therapeutic alliance. Based on study titles there was at least one study included which used telephone administration. Telehealth-delivered interventions could be particularly useful to increase access to and affordability of psychological therapies as this type of delivery also lends itself well for future pandemic-like events. It has to be acknowledged that in recent years, there has been a significant shift towards computerised cognitive behavioural therapy, with or without therapist support. The goal of this model is also to increase access and reduce cost. Therefore, more high-quality evidence is required to expand and support the findings from the current review especially for longer-term outcomes.
References


