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Psychological therapies for common mental illness: how effective and equitable is provision?

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ABSTRACT

Objectives To evaluate whether effective psychological therapies are being provided in an inner London population and to describe the ethnicity of clients in relation to estimated need in the population.

Methods A questionnaire survey was sent to 78 providers of structured psychological therapy in the borough.

Results Fifty-nine (76%) providers of structured psychological therapy described the types of therapy they use for each of the common mental illnesses. At least one effective or likely to be effective therapy was used by 70% of voluntary sectors providers, 61% of the primary care team, 59% of the primary care counselling service and 53% of private therapists. Twenty-five percent of the primary care team, 23% of voluntary sector providers and 5% of private therapists only used a therapy that was unlikely to be effective. A validated outcome measure was used by 100% of the primary care counsellors, 67% of the primary care team, 10% of private therapists and none of the voluntary sector providers. Twenty-three percent of the population of Greenwich are from a black and minority ethnic (BME) group. Only 15% of the client group for the primary care counselling service were from BME groups compared with 47% of clients of the private sector and 40% of voluntary sector clients.

Conclusions Levels of use of treatment that is unlikely to be effective are unacceptably high for all provider groups. BME groups are more likely to access voluntary and private sector providers of psychological therapies, and services within the NHS should be developed appropriately to address this inequity of access.

Keywords: effectiveness, equity, psychological therapy

Introduction

Psychological therapy is provided more often outside the state sector by voluntary and private providers than it is within the NHS.[1,2] People accessing therapy therefore often make decisions about the quality and type of therapy without help from the statutory sector. There is a bewildering array of regulatory bodies. In the UK the main ones are the United Kingdom Council for Psychotherapy, the British Association for Counselling and Psychotherapy, the British Psychological Society, the National Council of Psychotherapists and the British Association for Behavioural and Cognitive Psychotherapies. There is no legal requirement for accreditation with any regulatory body and once accredited there is no common standard for ongoing accreditation.[1] This lack of a regulatory framework means that quality

and effectiveness is likely to vary widely.[3] To promote mental wellbeing for all in the population it is important to know how effective psychological therapy provision is to a given population, be it from the NHS-funded primary care counselling scheme, the primary care team members, the voluntary sector or the private sector.[4] It is known that people from black and minority ethnic groups are less likely to be referred to statutory sector providers, but there is no information available about access to private and voluntary provision of psychological therapies for this group. We therefore conducted a postal questionnaire of all potential providers of psychological therapies in one inner city borough, to assess the level of provision of effective therapies and equity of provision of psychological therapies for common mental illness.

Methods

Detailed methods are described in the first paper of this series.[2] From 504 potential providers of psychological therapy or support, a minimum of 78 and estimated maximum of 99 individuals or organisations providing structured psychological therapy to residents of the London Borough of Greenwich were identified. This paper describes the responses of the minimum number of providers (78) to questions about effectiveness and equity.

Effectiveness of structured psychological therapy

There are many different types of psychological therapy. Although the benefit of psychological therapies has been clearly demonstrated, there is also evidence that a client's mental health can deteriorate if therapies are inappropriate or carried out incompetently.[5,6]

Therefore in order to determine the effectiveness of the psychological support being provided in Greenwich, the types of therapy employed by practitioners for a range of conditions were compared with the evidence base.

To make this comparison, an effectiveness grid was created in which psychological therapies for each of the common mental illnesses were categorised by the weight of evidence of their effect (see Table 1). In Table 1, therapies are categorised as having good or some evidence of benefit if their effectiveness has been demonstrated by meta-analysis or at least one quality randomised controlled trial (RCT). Therapies are classified as likely to be ineffective where meta-analysis or at least one RCT demonstrate no benefit from the therapy. Therapies for which there are no meta-analyses or RCTs, or where the results of RCTs are contradictory are categorised as being of unknown effectiveness. The effectiveness grid was created based on published systematic reviews and national guidance.[5,7–9] A multidisciplinary steering group, including representatives from the psychology service, primary care counselling service, voluntary sector, private sector and public health, reviewed and agreed the effectiveness grid. The effectiveness grid is consistent with the recent clinical guidelines from the National Institute for Clinical Excellence (NICE) for the management of anxiety, panic disorder, phobias, mixed anxiety and depression and depression and with the latest version of the BMJ/National electronic Library for Health/DH review of clinical evidence.[10–12]

The questionnaire provided practitioners with a definition of each type of therapy. Practitioners were asked to select from a list the types of psychological therapy they would employ for each of the common mental illnesses (depression, anxiety, mixed anxiety and depression, phobias, obsessive compulsive disorder and panic disorder). The therapies employed were then compared with the evidence base presented in Table 1, and for each condition practitioners were categorised into the following hierarchy:

A those who employed at least one therapy where there is good or some evidence of benefit
B those who employed at least one therapy of unknown effectiveness
C those who only employed a therapy that is likely to be ineffective.

For each provider group (primary care counselling service, the primary care team, the voluntary and private sectors), the number of practitioners in each category for the range of conditions was summed, and the proportion of practitioners in each category calculated.

Treatment length

The issue of optimum treatment length for psychological therapy is complex. Fewer than eight sessions are unlikely to be optimally effective for those who reach the threshold for treatment, with the possible exception of social phobia and uncomplicated panic disorder.[5] Longer treatment length (at least 16 sessions) may be required for more severe mental illnesses including major depressive disorder and for personality disorder.[5] Thus for patients with common mental illness, suitable for management at a primary care level, the optimum treatment length is between 8 and 16 sessions.

Table 1 Effectiveness of psychological therapies[5,7,8,9]

Condition	Good or some evidence of benefit[a]	Unknown effectiveness[b]	Likely to be ineffective[c]
Mixed anxiety and depression	Cognitive, behavioural and cognitive behavioural therapy[5,7] Brief structured psychodynamic therapy[5] Interpersonal psychotherapy[9] Targeted counselling[8] Self-help (book, audio, video and computer)[9]	Generic counselling[5,7,9] Long-term psychodynamic therapy[8] Integrative, eclectic or systemic therapy[8]	
General anxiety disorder	Cognitive behavioural therapy[5] Targeted counselling[8] Self-help (book, audio, video and computer)[9]	Long-term psychodynamic therapy[8] Integrative, eclectic or systemic therapy[8]	Generic counselling
Depression	Cognitive, behavioural and cognitive behavioural therapy[5] Brief structured psychodynamic therapy[5] Targeted counselling[5,8] Problem solving[5,7] Interpersonal therapy[5,7] Brief interpersonal counselling[9] Group therapy[5] Befriending/mentoring[5] Self-help (book, audio, video and computer)[9] Guided self-help, including telephone guidance[9]	Generic counselling[5,9] Long-term psychodynamic therapy[7,8] Integrative, eclectic or systemic therapy[8]	
Phobias	Exposure therapy[5] Cognitive therapy[5] Social skills training[5]	Long-term psychodynamic therapy[8] Integrative, eclectic or systemic therapy[8]	Generic counselling[8]
Obsessive Compulsive Disorder	Cognitive, behavioural and cognitive behavioural therapy[5] Exposure therapy[5]	Long-term psychodynamic therapy[8] Integrative, eclectic or systemic therapy[8]	Generic counselling[8]
Panic disorder	Exposure therapy[5] Cognitive, behavioural and cognitive behavioural therapy[5] Targeted counselling[8]	Long-term psychodynamic therapy[8] Integrative, eclectic, or systemic therapy[8]	Generic counselling[8]

[a]Evidence of effect demonstrated by meta-analysis or at least one quality randomised controlled trial
[b]Therapies whose effectiveness has not been evaluated by meta-analyses or RCT, or where the results of RCTs are contradictory
[c]Therapies where meta-analysis or at least one RCT demonstrate no benefit from the therapy

Practitioners were asked to state the average number of sessions of structured psychological therapy they provide for common mental illness. The overall average, and average for each provider group was calculated.

Use of outcome measures

Practitioners were asked to describe the method by which they assessed client outcome and to state the name of any outcome measures used routinely. The proportion of practitioners using a validated outcome measure was calculated.

Supervision and accreditation

It is recommended that those providing psychological therapy receive a minimum of 1.5 hours of supervision each month from a qualified practitioner (psychiatrist, psychologist or counselling supervisor).[7] The questionnaire asked practitioners to state the number of hours of supervision they received in relation to psychological therapy provision each month, and to state who provided this supervision.

As an additional proxy measure for a therapist's competence to provide psychological therapy, practitioners were asked to list the names of any professional or accrediting bodies with which they were registered.

Ethnicity of clients

The questionnaire asked therapists to state the number of clients in treatment, and the number from black and minority ethnic groups (BME). For each provider group the proportion of clients from a BME group was calculated. The proportion of Greenwich residents from a BME group was estimated from the 2001 census.

Results

Effectiveness of psychological therapy

The effectiveness grid was completed by 59 (76%) of respondents. Table 2 shows that overall only 59% of practitioners offered a therapy that is known to be effective, and 12% only provided a therapy that is likely to be ineffective.

Treatment length

Overall, the average number of sessions of structured therapy provided per client was 11.4. This varied by provider group with the average number of sessions per client being 5.4 for primary care staff, 6.3 for primary care counsellors, 9.8 for voluntary providers and 20.2 for private therapists.

Table 2 Effectiveness of therapies employed, by group[a]

	Primary care counsellor (*n* = 10)	Other primary care staff (*n* = 24)	Private therapists (*n* = 31)	Voluntary providers (*n* = 13)	Total (*n* = 78)
Number who completed the 'effectiveness grid' in the questionnaire (%; those offering 'structured therapy')	9 (90)	17 (71)	25 (81)	8 (62)	59 (76)
Respondents employing at least one therapy with good or some evidence of effectiveness (%)	59	61	53	70	59
Respondents only employing a therapy of unknown effectiveness (%)	41	14	41	7	29
Respondents only employing a therapy unlikely to be beneficial (%)	0	25	5	23	12

[a]This table is hierarchical so that a practitioner is only counted once according to the most effective therapy used

Use of outcome measures

All primary care counsellors and 10% of private therapists reported that they used CORE-OM, a validated outcome measure developed by the Psychological Therapies Research Centre, Leeds.[13] An outcome measure was used by 67% of the primary care team, primarily attributable to use of the Edinburgh Postnatal Depression Scale by health visitors. No other members of the primary care team and no voluntary sector providers used a validated outcome measure.

Supervision and accreditation

All primary care counsellors, voluntary providers and private therapists received adequate supervision from an accredited supervisor (>1.5 hours per month). None of the primary care team providing psychological therapy received supervision in relation to this.

Registration with an accrediting body was reported by 97% of private therapists, 70% of primary care counsellors and 56% of voluntary providers. No members of the primary care team were registered with an accrediting body for psychological therapy provision.

Ethnicity of clients

Table 3 shows the ethnicity of clients receiving psychological therapy by provider group. The primary care team are not included due to low numbers of clients and a low response rate to this question by members of the primary care team. Overall 35% of clients receiving structured psychological therapy are from a BME group. Twenty-three per cent of the Greenwich population are from a BME group.

Discussion

Use of evidence based psychological therapy varied by type of provider, but there was no one overall provider that reliably provided the most effective care. For example in our sample, the voluntary sector providers were most likely to use effective therapies, but a quarter also reported using only therapies that were unlikely to be effective. On the other hand, the private sector was least likely to provide an effective therapy but also least likely to provide an ineffective one. Validated outcome measures were more likely to be used by both of the statutory sector providers, but no member of the primary care team providing structured psychological therapy was accredited with a national body.

Private therapy may be seen as a preserve of the wealthy, but our work has shown that even in a relatively deprived inner city area BME groups are around three times more likely to use private sector psychological therapy than NHS-funded care. Since provision of the most evidence-based therapies was low for all provider groups, the BME population was not more disadvantaged than the general population from higher use of the voluntary and private sectors. However, financially, this group is disadvantaged. They are more likely to live in areas of multiple deprivation, and are disadvantaged both from paying for treatment in the private and voluntary sectors and from paying for inappropriately long treatment in the private sector.[14]

There are many problems with assessing the evidence base for psychological therapies.[1] We ensured that we related evidence of effectiveness to each of the common mental illnesses and used the best current evidence of effectiveness based on independent systematic reviews. The effectiveness grid was approved by a multidisciplinary steering group. We were perhaps over-cautious and labelled many

Table 3 Ethnicity of clients

Provider group	White *n* (%)	Black or ethnic minority *n* (%)	Total
Primary care counselling service	145 (85)	26 (15)	171
Private sector	108 (53)	97 (47)	205
Voluntary sector	84 (60)	56 (40)	140
Total	337 (65)	179 (35)	516
Greenwich population (%; 2001 census)	77.1	22.9	100

treatments for particular disorders as having 'unknown effectiveness' where there were conflicting messages from the summaries of the literature, or there was a lack of research. We only included a therapy as ineffective if there was clear evidence of this in relation to that particular disorder. Our effectiveness grid reflects current knowledge and may change as further evidence emerges.

There is evidence that up to a third of the overall outcome of therapy is dependent on the therapeutic alliance between therapist and client.[8] Therefore, a good therapist from any theoretical background will achieve results with many clients[1]. However there will be good therapists from all backgrounds, and if there is also evidence that the type of therapy has advantages in relation to outcomes then it must be incumbent on health providers and commissioners to choose the most effective therapies. There is now sufficient evidence to show that some types of therapy are more effective for different common mental health problems.[1,5,7–12]

We have no independent assessment of the effectiveness of therapy provided and have relied solely on therapists' own assessments of the treatment type they usually used for each common mental illness. None appeared to have any problems identifying the type of therapy they provided, and since respondents were not aware of the effectiveness grid there were no incentives to record other than their usual practice. We have not been able to show how effective individual practitioners were in providing particular therapies. We sought to determine whether practitioners monitored the effectiveness of their practice by routinely measuring client outcome using validated assessment tools. However, the majority of providers, with the exception of the primary care counselling service, did not do so, hence our assessment of whether practitioners are practising effective therapies is based on the current evidence base as no other measures of effectiveness were available from the majority of providers.

Our results are based on a single inner London borough where nearly a quarter of the population described themselves in non-white categories in the last census. The borough has supported the development of mental health services sensitive to the needs of BME groups and this could explain the higher use of the voluntary sector by these populations. However the higher levels of access of private psychological therapy is unexplained and worryingly suggests lower levels of access to NHS-funded care.

People seeking help for a common mental illness are in a vulnerable position, and few will have knowledge of the current effectiveness literature on which to base rational choice decisions about therapy type and quality. While the lack of a regulatory framework has allowed a great variety of provision to develop and some excellent care to be provided, it also leaves patients at risk. There are disputes about the evidence base, but few therapists are using validated outcome measures and patients will remain at risk of ineffective therapies until outcome measures are more commonly used. Patients are also at risk of costly treatments that are too long.

Nationally there needs to be a shared view about minimum standards of provision of psychological therapies that applies equally to the statutory and non-statutory sectors. Such lack of care for standards for a vulnerable client group is not tolerated for physical interventions (for example provision of abortion services). People with mental health problems should not be subject to second-best care.

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CONFLICTS OF INTEREST

None.

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