

Counselling and psychotherapy: is there an economic case for psychological interventions?

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Executive summary

Background

The terms counselling and psychotherapy refer to a wide spectrum of talking therapies aimed at supporting individuals with mental and physical health problems in order to promote their health and wellbeing. Clinical research has examined the impact of different therapeutic approaches on wellbeing, symptoms, functioning and quality of life. However, it is abundantly clear that another important dimension comes into play when many policy, practice and commissioning decisions are taken. This is the economic dimension. The British Association for Counselling and Psychotherapy (BACP) therefore commissioned the authors to examine whether there is an economic case for counselling and psychotherapy.

Aim

The aim was to examine the economic evidence about counselling and psychotherapy. We explored what economic evidence could be drawn from completed research studies across a range of mental disorders and some physical health problems. Studies were selected on the basis of the robustness and implementation of their design. Preventive interventions were included, if evidence was available.

Methods

We examined the most significant reviews in the field, sometimes supplemented by a close examination of studies that appeared to be key to the area in question. We were interested in evidence on the total costs of specific disorders, but our primary focus was on economic evaluative evidence on counselling and psychotherapeutic interventions across the lifespan, giving greater emphasis to studies that were both methodologically strong and relevant to the current UK policy and practice contexts (even if some of those studies were conducted outside the UK).

The evidence, reviewed on costs and cost-effectiveness, was organised by age group and type of health need, with almost all the focus being on mental health needs.

Findings for children and adolescents

Half of all lifetime mental illnesses arise by the age of 14, so prevention and promotion interventions during childhood and adolescence have the potential to be highly cost-effective. However, economic evidence in the child and adolescent mental health area is less plentiful when compared to the evidence base for mental health problems in adulthood, and evidence on counselling and psychological interventions is less plentiful than evidence on pharmacological approaches. There is, however, plenty of evidence on the economic consequences of child and adolescent mental health, both in childhood and later in life.

For children with conduct disorder, parenting programmes based on the Incredible Years approach have been shown to be cost-effective, perhaps supplemented with teacher-based and child-based programmes. There is also an economic case for a cognitive-behavioural problem-solving approach, mostly delivered in a school setting in groups of six children. Multi-modal interventions (multi-systemic therapy) have also been shown to be more cost-effective than usual care.

In relation to attention deficit/hyperactivity disorder (ADHD) there is some evidence that the combination of medication with behavioural therapy may be the most cost-effective treatment option. However, the general conclusion from this review is that there is almost a complete absence of studies that have evaluated psychological interventions for ADHD. Similarly, for anxiety disorders and depression the evidence base is thin. For eating disorders, there is some suggestion that a combination of CBT with antidepressant medication would be cost-effective to the NHS. Another study found that CBT was more cost-effective than family therapy for adolescents with bulimia nervosa. CBT-guided self-help may be more effective and less costly than treatment as usual for binge eating. CBT might be cost-effective as an adjunct to antipsychotic medication for children and young people with psychosis or schizophrenia.

Findings for adults

In treating adults with depression, completed studies demonstrate that there is an economic case for some forms of psychological therapy. Combining CBT with antidepressant medication is more costly but also more effective than antidepressant medication alone, and appears to be the more cost-effective option, particularly if impacts on employment are taken into consideration. There is similar evidence on mindfulness-based cognitive therapy, which when added to medication looks cost-effective. An Australian study concluded that bibliotherapy, group CBT and individual CBT were all cost-effective treatments for depression. Brief psychodynamic interpersonal therapy may have better outcomes and lower costs than treatment as usual, although available economic evidence is very limited. The combination of interpersonal therapy and antidepressant medication for dysthymic patients is more cost-effective than either of these treatment approaches delivered singly. Evaluations of the Improving Access to Psychological Therapies (IAPT) pilot programme indicate that the approach is probably cost-effective.

Regarding postnatal depression, the current NICE recommendation is to use antidepressant medication for treating moderate depression in the postnatal period, but a combination of antidepressant medication and CBT for severe or treatment-resistant depression. However, many women are reluctant to take antidepressant medication during the postnatal period; evidence suggests that non-directive counselling is more expensive, more effective and more cost-effective than structured psychological therapy (i.e. CBT, IPT or psychodynamic psychotherapy). There were high discontinuation rates with the latter therapy. Home visits and supportive counselling for women at risk of postnatal depression may be more cost-effective than routine primary care. Preventive counselling (psychological interventions based on either cognitive behavioural or person-centred principles) delivered by specifically trained health visitors is more cost-effective than usual care for women at risk of postnatal depression.

Although anxiety disorders are the most common mental health problems in adulthood, available economic evidence on psychological interventions is scarce. Two NICE reviews of the area were unable to reach conclusions as to the cost-effectiveness of therapies for panic disorder or generalised anxiety disorder. A more recent Dutch study of people with panic disorder with or without agoraphobia concluded that CBT alone was less costly than pharmacotherapy (SSRIs) alone or the two in combination, while CBT alone and in combination with SSRIs generated better outcomes than medication alone.

Therapeutic interventions for schizophrenia can reduce costs by decreasing relapses and thereby reducing the need for in-patient admission, and by maximising function hence improving work-related productivity. Although evidence is not plentiful, there may be an economic case for arts therapies for people with schizophrenia, while CBT is potentially a cost-effective intervention for people with acute psychosis or medication-resistant schizophrenia. Cognitive remediation therapy also looks cost-effective, although the number of studies is small. Family interventions derived from behavioural and systemic ideas, adapted to the needs of families, are more effective than standard care and also potentially cost-saving.

Brief psychological interventions (one or two sessions with a mental health nurse for 30 minutes) are cost-effective when compared to self-help groups for people with drug misuse problems, with the two-session intervention looking more cost-effective than the one-session intervention. Economic evidence on more structured psychological interventions (CBT, interpersonal therapy, behavioural couple therapy, family-based interventions and short-term psychodynamic interventions) is almost completely absent. An American study concluded that behavioural couples therapy for people with addictions was more cost-effective than individual treatment. NICE concluded that CBT is not cost-effective compared to doing nothing (waiting list) for cannabis users.

There is little available evidence on psychological interventions for alcohol-use disorders, but an assisted withdrawal programme and a psychosocial treatment package delivered in a non-residential day hospital or community treatment programme is likely to be more cost-effective than residential treatment.

For the general population, client-centred, psychologically-informed interventions can be effective and cost-effective approaches to smoking cessation. Proactive telephone counselling was found by NICE to be the most cost-effective option. For disadvantaged groups, a range of interventions has been found to be cost-effective, including a series of supportive actions for smokers to be delivered by GPs, nurses and telephone helplines.

Findings for older people

Cognitive stimulation therapy is both effective and cost-effective for people with mild to moderate dementia. No published economic evidence is available on using CBT for treating depression or anxiety when co-morbid with dementia. Cost-effectiveness studies of loneliness among older people are still very rare; however, the few available studies suggest that group interventions can decrease hospitalisations and improve quality of life. A group intervention (therapeutic writing, group psychotherapy, group exercise and art activities) aimed at empowering older people identified as lonely, and to promote their peer support and social integration has been found to improve survival rates at relatively low cost.

Findings for people with chronic physical health problems

Low-intensity psychosocial interventions, delivered to individuals or in groups of five to six people, may be effective in reducing depression symptoms, and cost-effective for people with a long-term condition and co-morbid depression. Psychosocial interventions based on cognitive-behaviour approaches may be cost-effective in alleviating symptoms of anxiety and depression among cancer survivors. Psychosocial support can be effective and cost-effective compared to standard care for women with metastatic breast cancer. Brief CBT is cost-effective for patients undergoing implantation of a cardiac defibrillator. Hostility management group therapy for patients could be cost-effective for patients with coronary artery disease. There is some evidence to suggest that CBT can be more cost-effective than usual care for people with medically unexplained symptoms.

Conclusions

With growing pressures on NHS and other budgets, decision-makers at all levels within health and other systems are increasingly wanting to know whether there is an economic case for particular courses of action, especially when new interventions or arrangements are being proposed. It really is important that evaluations of counselling and psychotherapeutic interventions include an economic dimension, and that individual therapists are in a position to explain how a particular approach can not only improve the wellbeing of the patient but also have economic benefits.

Economic evaluations in the mental health area can only be robust if they stem from multidisciplinary effort, which in turn will require some blending of approaches and study designs. This might not be easy, but there is surely a need for wider investment in generating and using economic evidence in relation to counselling and psychotherapy.

One reason for the small amount of economic evidence is that counselling and psychotherapy are not simple treatments, nor are they distinguishable solely by their theoretical bases. In addition to the view of psychopathology adopted by the therapist, there are many variables (including the training, personality and characteristics of therapists; the characteristics of patients, and the treatment settings), each of which could affect the course of treatment, the outcomes and the costs. Such differences and difficulties might act as a deterrent to the search for evaluative evidence, including economic evidence.

Therapists have duties to their patients and to their profession, but also to the public interest. Counsellors and psychotherapists constantly face the challenge of helping their individual patients achieve better health and wellbeing, while working within and responding to a particular policy environment. One aspect of that environment currently is the tightening of resource availability. The increasingly tough economic situation should not in any way change the commitment of individual therapists to the wellbeing of their patients, but it does change the context within which therapists are working, and indeed the context within which patients are living their lives. For these reasons, it is helpful to understand both how key decision-makers (national and local) are responding, and what evidence there is on the resource consequences of therapeutic and other decisions.

Finally, there is of course a pressing need for more research. It has almost become a cliché to end a research paper with such a plea. In the areas we have reviewed in this paper, however, the gaps in knowledge are often alarmingly wide. If counselling and psychotherapy are to be funded at levels which will allow them to begin to achieve their potential in making key contributions to improved health, wellbeing and quality of life, then it is not just effectiveness but also cost-effectiveness evidence that will need to be marshalled.