Clinical outcomes and cost-effectiveness of brief guided parent-delivered cognitive behavioural therapy and solution-focused brief therapy for treatment of childhood anxiety disorders: a randomised controlled trial

Cathy Creswell*, Mara Violato*, Hannah Fairbanks, Elizabeth White, Monika Parkinson, Gemma Abitabile, Alessandro Leidi, Peter J Cooper

Summary

Background Half of all lifetime anxiety disorders emerge before age 12 years; however, access to evidence-based psychological therapies for affected children is poor. We aimed to compare the clinical outcomes and cost-effectiveness of two brief psychological treatments for children with anxiety referred to routine child mental health settings. We hypothesised that brief guided parent-delivered cognitive behavioural therapy (CBT) would be associated with better clinical outcomes than solution-focused brief therapy and would be cost-effective.

Methods We did this randomised controlled trial at four National Health Service primary child and mental health services in Oxfordshire, UK. Children aged 5–12 years referred for anxiety difficulties were randomly allocated (1:1), via a secure online minimisation tool, to receive brief guided parent-delivered CBT or solution-focused brief therapy, with minimisation for age, sex, anxiety severity, and level of parental anxiety. The allocation sequence was not accessible to the researcher enrolling participants or to study assessors. Research staff who obtained outcome measurements were masked to group allocation and clinical staff who delivered the intervention did not measure outcomes. The primary outcome was recovery, on the basis of Global Impressions of Improvement (CGI-I). Parents recorded patient-level resource use. Quality-adjusted life-years (QALYs) for use in cost-utility analysis were derived from the Child Health Utility 9D. Assessments were done at baseline (before randomisation), after treatment (primary endpoint), and 6 months after treatment completion. We did analysis by intention to treat. This trial is registered with the ISRCTN registry, number ISRCTN07627865.

Findings Between March 23, 2012, and March 31, 2014, we randomly assigned 136 patients to receive brief guided parent-delivered CBT (n=68) or solution-focused brief therapy (n=68). At the primary endpoint assessment (June, 2012, to September, 2014), 40 (59%) children in the brief guided parent-delivered CBT group versus 47 (69%) children in the solution-focused brief therapy group had an improvement of much or very much in CGI-I score, with no significant differences between groups in either clinical (CGI-I: relative risk 1·01, 95% CI 0·86–1·19; p=0·95) or economic (QALY: mean difference 0·006, −0·009 to 0·02; p=0·42) outcome measures. However, brief guided parent-delivered CBT was associated with lower costs (mean difference $448; 95% CI $334 to 37; p=0·070) and, taking into account sampling uncertainty, was likely to represent a cost-effective use of resources compared with solution-focused brief therapy. No treatment-related or trial-related adverse events were reported in either group.

Interpretation Our findings show no evidence of clinical superiority of brief guided parent-delivered CBT. However, guided parent-delivered CBT is likely to be a cost-effective alternative to solution-focused brief therapy and might be considered as a first-line treatment for children with anxiety problems.

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Introduction

Anxiety disorders are among the most common mental health disorders and, because of their high prevalence, persistence, and associated impairment, have a greater economic burden than any other mental health condition.1 Half of all lifetime cases emerge before age 12 years.2 Effective treatments for anxiety disorders in children exist,3 however, fewer than a third of children with an anxiety disorder access professional help.4 Both parental preferences5 and treatment side-effect profiles6 indicate the use of psychological treatments as the first-line treatment, yet evidence-based psychological treatments are typically lengthy (eg, 14–16 h-long sessions)7 and studies have mainly been done in specialist settings. Cost-effective psychological treatments suitable for routine clinical practice are needed.

Systematic evaluations of psychological interventions for childhood anxiety disorders have been limited to cognitive behavioural therapy (CBT).8 Although good evidence exists for the efficacy of CBT compared with...
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Evidence before this study
Anxiety disorders are among the most common mental health disorders. Half of all lifetime cases emerge before age 12 years, affecting a substantial proportion of children worldwide. Good evidence exists to show that cognitive behavioural therapy (CBT) is an effective treatment for childhood anxiety, compared with waiting-list controls, with recovery rates around 60%. However, how CBT compares with other psychological therapies that are used in child mental health services remains unclear. Furthermore, most trials of CBT involve at least nine face-to-face treatment sessions, although this is not always practical in routine health settings in which resources are often scarce. We searched PsycINFO and MEDLINE from Jan 1, 2000, to April 1, 2016, with the search terms “anxi*”, “child”, “adolescent”, “paediatric”, “pediatric”, “youth”, “treatment”, “intervention”, “therapy”, “psychotherapy”, “bibliotherapy”, “computer*”, “technology”, and “randomi*” controlled trial”, “clinical trial” to identify brief psychological interventions for childhood anxiety disorders. The most frequently evaluated treatment for childhood anxiety disorders was guided parent-delivered CBT (four studies) in which parents are supported by a therapist in working through a book that provides strategies to help them implement CBT strategies in their child’s day-to-day life; however, none of the studies compared a brief psychological intervention with a credible control treatment, and none included an economic analysis.

Added value of this study
In this study, we compared the effect of two brief psychological interventions on both clinical and economic outcomes in children referred for problems with anxiety. 40 (59%) children in the brief guided parent-delivered CBT group versus 47 (69%) children in the solution-focused brief therapy group had an improvement of much or very much in Clinical Global Impression of Improvement score at the assessment after treatment, and 45 (66%) versus 49 (72%) children had an improvement at the 6 month follow-up assessment, with no significant differences between groups across both timepoints (relative risk 1·01, 95% CI 0·86–1·19; p=0·95). We did not find a significant difference in costs of providing the two therapies, both delivered with 5 h of therapist contact; however, when we considered the joint distribution of incremental mean costs and effects, brief guided parent-delivered CBT was likely to be cost-effective compared with solution-focused brief therapy.

Implications of all the available evidence
To our knowledge, this randomised controlled trial is the first to provide data for the outcomes of brief guided parent-delivered CBT compared with solution-focused brief therapy for childhood anxiety disorders in routine clinical practice. Although previous studies have shown that guided parent-delivered CBT is an effective treatment for childhood anxiety disorders compared with waiting-list controls, our findings show that it is no better than an alternative brief psychological treatment, solution-focused brief therapy, in terms of children’s outcomes. Nonetheless, brief guided parent-delivered CBT might be a more cost-effective approach, building on previous studies that support its use as a low-intensity intervention to improve access to evidence-based treatments for childhood anxiety. Further studies are needed to examine how effective psychological treatments can be delivered at reduced costs without negatively affecting clinical outcomes and to establish the longer-term cost-benefits of intervention for children with these common, debilitating, and often chronic difficulties.

Methods

Study design and participants
We did this randomised controlled trial in children referred to four NHS primary child and adolescent mental health services in Oxfordshire, UK. Families were invited to participate if the child was aged 5–12 years with anxiety associated with clinical impairment as the primary presenting problem. We excluded children prescribed psychotropic medication, and parents or children with little understanding of English or with physical or intellectual impairment (including autism spectrum disorder) that would interfere with their ability to participate.

Waiting-list controls, few studies have compared this therapy with an active comparator and, when this has been done, the comparator has most commonly been an attention control condition rather than an established treatment. CBT can be effectively delivered in a brief form, whereby parents are supported in applying CBT principles. This approach is superior to a waiting-list comparison, with similar outcomes to CBT delivered in a more intensive traditional form. Indeed, brief guided parent-delivered CBT might be a cost-effective first-line treatment for childhood anxiety disorders. However, whether this therapy would be superior to a credible, alternative, brief psychological treatment remains unclear. We therefore aimed to compare the effectiveness and cost-effectiveness of two brief psychological treatments for childhood anxiety. We selected solution-focused brief therapy as the usual-care comparator because it is widely used in National Health Service (NHS) mental health settings, in which only a few sessions can be provided. Although this approach has not been evaluated with children with anxiety disorders specifically, our consultations revealed that it was the most commonly used approach for working with children with a range of difficulties, including anxiety, in the NHS services participating in this trial.

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