Global dissemination and implementation of behavioural activation

In The Lancet, David Richards and colleagues present the Cost and Outcome of Behavioural Activation versus Cognitive Behavioural Therapy for Depression (COBRA) trial—one of the largest randomised controlled trials so far of psychotherapy for depression—comparing junior, low-cost mental health workers delivering a simple treatment (behavioural activation [BA]) to experienced psychological therapists delivering the gold-standard treatment (cognitive behavioural therapy [CBT]). Results identified BA as non-inferior to (mean difference 0·1 Patient Health Questionnaire 9 points [95% CI –1·3 to 1·5], p=0·89) and more cost-effective than (incremental cost-effectiveness ratio –£6865) CBT. Both treatments performed well, with responses consistent with those from a previous meta-analysis of treatment efficacy. Therapists in three different routine UK care settings provided treatment, and exclusion criteria were minimal and representative of practice. The study is generalisable to many mental health-care settings in the UK. Countries like the UK, where government-funded health care and clear evidence-based practice guidelines exist, as well as large health-care organisations internationally, should take note.

Stakeholders should understand that the COBRA trial results are not surprising. The promise of BA—that it can produce equivalent if not superior outcomes to more complex treatments and can do so more efficiently and cost-effectively—has been in place since BA’s inception, and results consistent with this promise have been accruing for decades. Findings from several trials show that BA can be applied effectively by providers with low levels of training in low-resource settings, including in India, Iran, and Iraq, with low-income Latinos in the USA, and with old veterans via telemedicine. WHO has identified BA as a recommended treatment for depression in low-resource settings.

Scientific caution is advised, however, when considering large-scale global dissemination of BA. Substantial obstacles to successful international dissemination and implementation of any evidence-based practice exist at multiple provider, patient, organisational, and sociopolitical levels beyond the scope of the COBRA trial. Common obstacles include lack of training and support for providers, patients’ low acceptability of and stigma towards treatment, organisational climates and cultures that are incompatible with evidence-based practices, and an absence of governmental policies and support for mental health service delivery. BA is a promising treatment to consider in international research efforts to overcome these obstacles.

BA’s face validity is crucial and might help it address some implementation obstacles. For example, BA’s cross-cultural fit and adaptability, an issue not addressed in the COBRA trial (the study’s 91% white British sample is representative of the UK, but not the rest of the world), might be strong. The fundamental rationale behind BA—the importance of engagement in value-driven and meaningful activities as a response to adversity and despair—is recognised globally and has been for a long time. We have found BA’s rationale to be easy for culturally diverse patients to accept, including patients for whom a medical model of depression might be incompatible with cultural beliefs. Although rooted in medical science, BA does not need to be explained in such terms to patients. The message from the provider to the patient, simply put, could be: “Life will inevitably throw obstacles at you, and you will feel down. When you do, stay active. Do not quit. I will help you get active again.” When defining activation targets, a patient’s cultural, spiritual, and other personal values could be incorporated into treatment by the provider without compromising BA’s core strategies or mechanism of action. Thus, when the goal is wide dissemination and implementation across cultures and settings, BA might be considered acceptable and appropriate by multilevel stakeholders (eg, patients, providers, and organisational leaders).

The cost-effectiveness of BA in the COBRA trial was driven primarily by the low costs of BA providers. Because BA’s rationale, techniques, and core mechanism are straightforward and face valid, an additional benefit of BA is that costs of training these providers might be low as well. Considering the few financial and human resources available to mental health services in many parts of the world, research into scalable and cost-effective training strategies, such as brief online training, is important.
Antidepressants fail, but no cause for therapeutic gloom

The careful study by Andreas Cipriani and colleagues in The Lancet has disturbing implications for clinical practice, concluding as it does that the risk-benefit profile of antidepressants in the acute treatment of depression does “not seem to offer a clear advantage for children and adolescents”.

The case for antidepressants, including fluoxetine, is, in fact, even weaker than their meta-analysis suggests. The authors do express appropriate scepticism about the quality and potential bias of data analysed. But, they were not able to factor in the additional problems and consequences of probable data misrepresentation by the companies that did the primary studies. While the common manoeuvre of changing nominated primary outcomes would not have an impact on the findings from this meta-analysis, other manipulations will, such as failing to exclude unblinded patients from the efficacy analysis.

Similarly, although discontinuation due to adverse events is a relatively hard outcome, it can be underestimated in published papers and clinical study reports because of miscoding. Furthermore, the suicidal event data available to Cipriani and colleagues are likely to be substantially underestimated in the drug groups. In four trials of paroxetine versus placebo, only 13 (3%) of 413 events were reported in the paroxetine group; this seems implausible when individual patient-level data reanalysis of just one of those studies found ten events in only 93 patients given paroxetine (10.8%).

So what are the implications for clinicians? Every decision about whether and what to prescribe needs a complex and partly intuitive calculation of the balance between harms and benefits according to the patient’s circumstances. With research evidence as an important part of that calculation, we now know that we need to make a conscious correction for favourable misrepresentation of outcomes in published and unpublished study reports. A reduction should be applied to the reported benefit of a drug, while