WHO recommendations on psychological interventions for mental disorders

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We thank Falk Leichsenring and colleagues[1] for their Comment on the compilation of WHO recommendations for psychological interventions for mental disorders in the WHO manual on integrating psychological interventions into existing services.[2] They note that the recommendations primarily endorse behavioural therapy and cognitive behavioural therapy (CBT), while other therapeutic approaches are mostly not discussed. Leichsenring and colleagues correctly state that CBT is not the only evidence-based psychotherapeutic approach and advocate for a wider range of therapies, including psychodynamic therapy. The authors' concerns and arguments will be considered during future guideline updates. In this Comment, we provide more information on the development of WHO guidelines and the prominence of CBT within these guidelines.

With, on average, only 2% of global health budgets allocated to mental health and 82% of people experiencing mental disorders living in low-income and middle-income countries (LMICs), effective yet scalable mental health care is urgently needed.[3] Lower-intensity psychological interventions, including interventions that are brief and delivered by non-specialists or use guided self-help, have been successfully delivered at scale in LMICs.[3] These interventions alone are not a solution: with a substantial shortage or absence of a specialist psychological workforce worldwide, a public health approach that considers the feasibility, affordability, and cost-effectiveness of delivery is required. The development of a sizeable specialist workforce for referral care and supportive supervision remains crucial but will not address the gaps in treatment coverage in the near term.

Following WHO's mandate of supporting member states, the WHO manual is written with the aim of increasing access to psychological interventions delivered by trained and supervised non-specialist workers. All recommendations are contained in WHO's mental health gap action programme (mhGAP) guidelines.[4] mhGAP has been used in more than 100 countries, mostly in primary health care.[3] While almost all physicians and nurses in primary health care are too busy to offer multi-session psychological interventions, research has repeatedly shown that such interventions can be offered by other staff attached to primary health care, such as counsellors or community health workers.

The guideline development process follows WHO's rigorous guideline methodology.[5] Formulation of guidelines involves agreement on recommendations by an independent Guideline Development Group of experts, with diverse demographics and expertise across the domains of implementation and research, including meta-analysis, across different mental, neurological, and substance use disorders. The process includes a systematic appraisal of evidence, which is summarised in evidence profiles,[6] covering evidence retrieval, synthesis, and grading of evidence. Recommendations are based on the WHO-INTEGRATE evidence-to-decision framework, which considers the effectiveness of an intervention in the context of other factors that would influence a public health recommendation: the certainty of the evidence; balance between desirable and undesirable effects; values and preferences of intended intervention users; resource requirements and cost-effectiveness; health equity, equality, and non-discrimination; feasibility; and human rights and sociocultural acceptability.[7]

Based on this approach, the Guideline Development Group made recommendations for interventions for different disorders that cover CBT (including third-wave CBT approaches) and interpersonal psychotherapy, in addition to some interventions that can be suitable for delivery by personnel with more extensive training as part of referral care. To facilitate access to non-CBT interventions, WHO has published an open access manual on interpersonal psychotherapy for delivery by non-specialists,[8] which was informed by trials in Uganda.[9]

The prominence of CBT recommendations in WHO guidelines is due to more extensive evidence available for CBT compared with other approaches, particularly from LMICs. An estimated 7% of global health research funding goes to mental health, but only 5% of this funding is focused on LMICs.[3] LMIC psychological

interventions research has predominantly been based on CBT, which might be due to the relative ease with which non-specialists can be trained in CBT, and its popularity with researchers. As an example of this relative popularity, the METAPSY database of psychotherapy trials shows that for trials of therapies for people with depression compared with control groups, there is only one trial on psychodynamic therapy outside of high-income countries, whereas there are 56 trials for CBT, most of which involve delivery by non-specialists.

For more on **METAPSY database** see https://www.metapsy.org/

In our *World Mental Health Report*,[3] we identify some of the biggest challenges affecting the worldwide gap in access to affordable, effective mental health care. Two challenges are particularly relevant: the absence of a sufficient workforce, including for psychological interventions, and the information gap in research. To help to address these challenges and to promote access to a wider range of effective psychological interventions, we encourage researchers and their funders to continue to develop evidence for psychological interventions for delivery by non-specialists under specialist supervision, with the use of innovative and widely scalable formats, with manuals being made available open access to allow further research of promising interventions.[10] When this goal is achieved, future iterations of the WHO guidelines will probably include a wider range of intervention approaches to increase access to evidence-based mental health care, including in places where this care is urgently needed.

We declare no competing interests.

The authors alone are responsible for the views expressed in this Comment and they do not necessarily represent the views, decisions, or policies of the institutions with which they are affiliated.

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