Health Technology Assessment 2000; Vol. 4: No. 36

Executive summary

A randomised controlled trial to evaluate the effectiveness and cost-effectiveness of counselling patients with chronic depression

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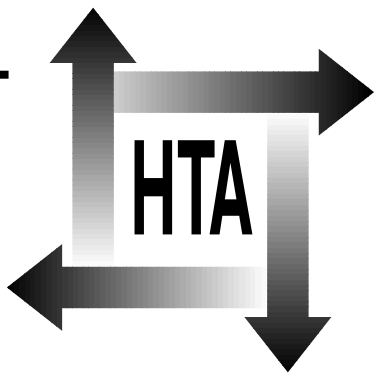
Health Technology Assessment
NHS R&D HTA Programme



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Objectives

To examine the effectiveness and cost-effectiveness of short-term counselling in general practice for patients with chronic depression or combined depression and anxiety, compared with general practitioner (GP) care alone.

Design

A randomised controlled trial and economic evaluation with an initial assessment at randomisation and follow-ups at 6 and 12 months.

Setting

Nine general practices that were well-established participants of the Derbyshire counselling in general practice scheme, and already had a counsellor in the practice team.

Subjects

Patients were screened at GP practices, and asked to participate if they scored ≥ 14 on the Beck Depression Inventory (BDI), had suffered depression or depression/anxiety for 6 months or more, were aged 18–70 and had no history of drug or alcohol abuse, psychoses or suicidal tendencies.

Interventions

The experimental group received usual GP treatment and were also referred to an experienced, well-qualified counsellor attached to their general practice. Of the eight counsellors, two practiced cognitive behavioural therapy (CBT) and six had a psychodynamic approach. The controls were referred back to their GP for routine treatment. There were no restrictions regarding the treatment that could be used, except that GPs could not refer controls to practice counsellors.

Outcome measures

The main outcome measure was the BDI. Others included the Brief Symptom Inventory, the Inventory of Interpersonal Problems and the Social Adjustment Scale. All tests were given at initial, 6- and 12-month assessments. Comprehensive costs were also estimated, and combined with changes in outcomes to examine between-group differences and whether counselling was more cost-effective than standard GP care.

Results

The trial recruited 181 patients. There was an overall significant improvement in the actual scores over time but no difference between groups or between CBT and psychodynamic counselling approaches at either 6 or 12 months. However, fewer experimental group patients were still 'cases' on the BDI than controls. This difference was statistically significant at 12 months and neared significance at 6 months (using logistic regression with the initial score as a covariate). In addition, most patients were very positive about the counselling and considered it helpful. Visual inspection of the outcomes suggested that more patients with mild or moderate depression at study entry had improved and ceased to be cases, and that more of these patients had become 'non-cases' in the experimental than the control group. However, a multiple regression analysis indicated no significant interactions between group and initial severity of depression. This could be partly due to there being no difference in outcome between the experimental and control group patients who were initially severely depressed and few of these patients ceasing to be cases at follow-up.

There were no significant differences in the mean total costs, aggregate costs of services, or any of the service-group costs, except for primary care, between the experimental and control groups over time. The cost-burden to GP practices was significantly higher in the experimental than the control group at 6 months.

Conclusions

Although patients were generally appreciative of the counselling received, there was only limited evidence of improved outcomes in those referred to counselling. Stricter referral criteria to exclude the severely depressed may have yielded more conclusive results. It is also difficult to estimate the effect of recruitment by screening rather than GP referral, which may limit the applicability of the results to routine clinical practice, and may have interfered with the normal working alliance established between the GP, patient and counsellor. A patient preference trial may, therefore, have been more appropriate.

The results indicated that there were similar improvements for both CBT and psychodynamic counselling, but a larger population may have shown different results. The same results between experimental and control groups were found when analyses were conducted on those referred to the psychodynamic counsellors only. The lack of improvement in the initially severely depressed patients may have been due to the chronicity of their problems, and investigation into treatment for these patients remains important. The therapy in this study tended to be short term, which is typical of most general practice counselling, but longer-term and more intensive therapy might possibly result in added benefits above GP care for the more severely depressed. It might be advisable to conduct a further trial of counselling in mildly depressed patients to investigate whether the findings of this study are confirmed. In the meantime, patients in this study are being followed up for 3 years to examine the long-term outcomes and between-group differences.

The primary care costs during the intervention period were significantly higher in the experimental than the control group and this was directly due to the costs of the counselling. This additional cost was not offset by subsequent reduced service use and costs, and did not appear to result in cost-savings at 12 months.

Publication

Simpson S, Corney R, Fitzgerald P, Beecham J. A randomised controlled trial to evaluate the effectiveness and cost-effectiveness of counselling patients with chronic depression. *Health Technol Assess* 2000;**4**(36).

NHS R&D HTA Programme

The NHS R&D Health Technology Assessment (HTA) Programme was set up in 1993 to ensure that high-quality research information on the costs, effectiveness and broader impact of health technologies is produced in the most efficient way for those who use, manage and provide care in the NHS.

Initially, six HTA panels (pharmaceuticals, acute sector, primary and community care, diagnostics and imaging, population screening, methodology) helped to set the research priorities for the HTA Programme. However, during the past few years there have been a number of changes in and around NHS R&D, such as the establishment of the National Institute for Clinical Excellence (NICE) and the creation of three new research programmes: Service Delivery and Organisation (SDO); New and Emerging Applications of Technology (NEAT); and the Methodology Programme.

This has meant that the HTA panels can now focus more explicitly on health technologies ('health technologies' are broadly defined to include all interventions used to promote health, prevent and treat disease, and improve rehabilitation and long-term care) rather than settings of care. Therefore the panel structure has been redefined and replaced by three new panels: Pharmaceuticals; Therapeutic Procedures (including devices and operations); and Diagnostic Technologies and Screening.

The HTA Programme will continue to commission both primary and secondary research. The HTA Commissioning Board, supported by the National Coordinating Centre for Health Technology Assessment (NCCHTA), will consider and advise the Programme Director on the best research projects to pursue in order to address the research priorities identified by the three HTA panels.

The research reported in this monograph was funded as project number 93/07/68.

Criteria for inclusion in the HTA monograph series
Reports are published in the HTA monograph series if (1) they have resulted from work commissioned for the HTA Programme, and (2) they are of a sufficiently high scientific quality as assessed by the referees and editors.

Reviews in *Health Technology Assessment* are termed 'systematic' when the account of the search, appraisal and synthesis methods (to minimise biases and random errors) would, in theory, permit the replication of the review by others.

The editors and publisher have tried to ensure the accuracy of this report but do not accept liability for damages or losses arising from material published in this report. They would like to thank the referees for their constructive comments on the draft document.

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http://www.ncchta.org ISSN 1366-5278