Non-directive counselling and cognitive behaviour therapy have short-term benefits over usual GP care for depression but are not more cost-effective in the long term


BACKGROUND Short courses of psychotherapy are common in British general practice. Although the effectiveness of these methods has been established in more specialised settings, the efficacy of GP-based psychological depression strategies is less clear. Little is known about their cost-effectiveness.

OBJECTIVE To compare the clinical efficacy and cost-effectiveness of counselling, behaviour therapy and usual GP care for people with depression.

SETTING Thirteen general practices in North London and 11 in greater Manchester; recruitment February 1996–November 1997.

METHOD ‘Patient preference’ controlled trial with one randomised arm.

LITERATURE REVIEW No explicit strategy; 19 references (Bower et al), 25 references (Ward et al).

PARTICIPANTS One hundred and ninety-seven out of 464 eligible adults (mean age 37) presenting to their GP with a Beck depression inventory score of 14+ were fully randomised. One hundred and thirty-seven chose their own treatment and 130 were randomised between the two psychological treatment groups only. Those with a history of psychological therapy; serious suicide attempt; inability to complete questionnaires; restricted mobility; or antidepressant drugs were excluded.

INTERVENTION Usual GP care; 6–12 sessions of non-directive counselling from a specialist counsellor (mean = 6 sessions); or cognitive behavioural therapy with a psychologist (mean = 16.5 sessions).

OUTCOMES Depressive symptoms (Beck depression inventory); health related quality of life; satisfaction with treatment; direct treatment and other costs – all measured after 4 and 12 months. Outcome assessment was not blind to treatment allocation.

ASSUMPTIONS Societal cost-effectiveness perspective; cost data was collected from patient medical records and self-report. Unit costs for 1997–1998 financial year were calculated using the British National Formulary and Personal Social Services Research Unit and Chartered Institute of Public Finance and Accountancy databases. Means and decision rules were used in the case of missing values.

MAIN RESULTS After 4 months, depressive symptoms were lower for those receiving specialist led interventions compared to usual GP care. This difference was not evident after 1 year. After 4 months both intervention groups were more satisfied than the usual GP care group, but after 1 year satisfaction was higher only in the non-directive counselling group. There were no differences between the three groups in direct, societal, or loss of production costs (see Table 1). Those receiving usual care had more consultations; use of antidepressant drugs; and psychiatric referrals. There were no differences in these trends for randomised and non-randomised participants.
Table 1. Mean costs of primary care depression treatment at 4 and 12 months

<table>
<thead>
<tr>
<th>Mean costs per person</th>
<th>Usual GP care</th>
<th>Cognitive behaviour therapy</th>
<th>Non-directive counselling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct costs 4 months</td>
<td>244</td>
<td>216</td>
<td>258</td>
</tr>
<tr>
<td>12 months</td>
<td>473</td>
<td>449</td>
<td>501</td>
</tr>
<tr>
<td>Indirect costs 4 months</td>
<td>384</td>
<td>286</td>
<td>444</td>
</tr>
<tr>
<td>12 months</td>
<td>745</td>
<td>612</td>
<td>897</td>
</tr>
<tr>
<td>Societal costs 4 months</td>
<td>628</td>
<td>502</td>
<td>702</td>
</tr>
<tr>
<td>12 months</td>
<td>1218</td>
<td>1061</td>
<td>1399</td>
</tr>
</tbody>
</table>

Note: All figures are in British Sterling; 1997–1998 financial year.

AUTHORS’ CONCLUSIONS

Psychological therapies based in a general practice setting have short-term clinical benefits over usual GP care, but these may not last. The lack of effect after 1 year may be due to under powering. Variation in treatment costs necessitates further research.

Commentary

Depression is accepted as a major health problem. The World Health Organization predicts that in the next 10 years, depression will become the major health problem in the world, ahead of physical medical problems such as heart attacks and strokes. Evidence based literature has consistently shown that pharmacotherapy and cognitive behaviour therapy are efficacious treatments of choice for the disorder. The effectiveness of non-directive counselling and the use of general practitioners in prescribing pharmacotherapy for depression is not well supported.

In the randomised controlled trial described in these papers, both non-directive counselling and usual general practitioner care were as effective as cognitive behaviour therapy for the treatment of patients with depression or mixed depression and anxiety. While one can always find methodological weaknesses, it must be said that the studies are well conducted and thus the findings are a welcome addition to the literature. The conclusions of these two papers give practitioners of non-directive counselling and general practitioners more confidence in their treatment of depression in community clinics. However, one must still be cautious because the effectiveness evidence produced is limited and cost-effectiveness evidence is preliminary.

In summary, the findings should be welcomed but treated with caution. One or two swallows do not make a spring.

Tian P. S Oei PhD, FAPS
The University of Queensland, Brisbane, Queensland
Australia