Outcome, costs and patient engagement for group and individual CBT for depression: a naturalistic clinical study


Record Status
This is a critical abstract of an economic evaluation that meets the criteria for inclusion on NHS EED. Each abstract contains a brief summary of the methods, the results and conclusions followed by a detailed critical assessment on the reliability of the study and the conclusions drawn.

CRD summary
This study assessed the clinical and economic impact of individual versus group cognitive-behavioural therapy (CBT) for the treatment of depression in adults. The authors concluded that group CBT could reduce symptoms, without reducing satisfaction or take-up, at a lower cost, compared with individual therapy, but a large randomised controlled trial was needed. There were some methodological limitations that might affect the validity of the authors’ conclusions.

Type of economic evaluation
Cost-effectiveness analysis

Study objective
This study assessed the clinical and economic impact of individual versus group cognitive-behavioural therapy (CBT) for the treatment of depression in patients over 17 years old.

Interventions
Individual was compared with group CBT. Individual CBT consisted of six to 18 sessions and group CBT consisted of 10 to 12 weekly sessions, with eight to 12 patients in each group.

Location/setting
UK/secondary care.

Methods
Analytical approach:
The analysis was based on one study, with a follow-up of three months. The authors did not state the perspective adopted.

Effectiveness data:
The clinical analysis was based on a prospective observational study carried out at five psychology services, provided by a large mental health trust. There were 130 eligible patients; 44 were allocated to group CBT and 49 to individual CBT. Power calculations showed that 26 patients in each arm were required to detect a large effect size in the outcomes. Therapists allocated patients to individual or group therapy. Patients were followed-up for three months. A number of endpoints were used, including scores on the Beck Depression Inventory II (BDI-II), other depression scales, the Client Satisfaction Questionnaire (CSQ-8), and a treatment preference scale. The endpoints were compared between groups, using statistical analyses, to assess bias due to attrition and other factors.

Monetary benefit and utility valuations:
Not considered.

Measure of benefit:
No summary benefit measure was used. Several clinical endpoints were reported.

Cost data:
The economic analysis included staff time, non-staff costs, organisational overheads, and capital. The resource quantities were from the clinical study, with data available for 45 individual-therapy patients and 40 group-therapy
patients. The costs were in UK pounds sterling (£) at 2006 to 2007 prices.

Analysis of uncertainty:
Not considered.

Results
No statistically significant differences were found between groups in the depression measures. For example, the BDI-II score improved from 29.49 to 18.97 with individual therapy and from 29.14 to 21.50 with group therapy (p=0.23). Patients were equally satisfied with treatment whether they received individual or group CBT.

The mean costs from baseline to three-month assessment were £246.33 for group CBT and £375.32 for individual CBT (p=0.001).

Authors’ conclusions
The authors concluded that group CBT could reduce symptoms, without reducing satisfaction or take-up, at a lower cost, compared with individual therapy. A larger trial was needed, but group therapy should be considered more often.

CRD commentary
Interventions:
The selection of the comparators was appropriate because it included the two available delivery methods for CBT; individual or group therapy.

Effectiveness/benefits:
The clinical data were from a naturalistic study, which as the authors stated was not ideal. The allocation procedure was by therapist preference rather than random, which could have reduced any selection bias. At baseline, the group-therapy patients were older, less educated, and had a longer history of depression, but their depression scores were comparable to those of individual-therapy patients. Statistical analysis was conducted to control for baseline differences, but the authors acknowledged that confounding could not be ruled out. The outcome measures were specific to depression.

Costs:
The perspective was not reported, but the categories of costs appear to have reflected the viewpoint of the mental health institutions. The authors reported the categories that were considered, but they gave no unit costs and resource quantities. The resource use was from the clinical study, which should have ensured satisfactory data collection. The authors acknowledged that there was considerable variation in treatment duration, which might have affected the costs. No sensitivity analysis of the costs was conducted. The price year was reported, but the sources for the unit costs were not.

Analysis and results:
The results were clearly presented, with the total costs and outcomes for each strategy. No incremental ratios were calculated as a cost-consequences analysis was conducted. The uncertainty was not investigated; no sensitivity analysis was carried out. The authors acknowledged that the main limitation of their study was the naturalistic nature of the clinical analysis. The results appear to be specific to the authors’ setting and cannot be transferred to other settings.

Concluding remarks:
There were some methodological limitations that might affect the validity of the authors’ conclusions. As the authors stated, a large randomised controlled trial is needed.

Funding
Funded by the South London and Maudsley NHS Foundation Trust.

Bibliographic details