The cost-effectiveness of short-term psychodynamic psychotherapy and solution-focused therapy in the treatment of depressive and anxiety disorders during a one-year follow-up


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 compared the cost-effectiveness of two short-term psychotherapies, for the treatment of depressive and anxiety disorders. The authors concluded that the interventions were comparable in effectiveness and cost-effectiveness, but short-term psychodynamic therapy appeared to be more cost-effective than solution-focused therapy. The methods were good, and the results were adequately reported. There were some limitations, and the results may not be generalisable to other settings, but the authors’ conclusions seem appropriate.

Type of economic evaluation
Cost-effectiveness analysis

Study objective
The objective was to evaluate the costs and health outcomes of two short-term psychotherapies, for depressive and anxiety disorders.

Interventions
Short-term psychodynamic psychotherapy was compared with solution-focused therapy. Psychodynamic therapy used a transference-based approach, allowing patients to explore and work through specific conflicts. This was provided in 20-minute, weekly sessions, over five to six months. Solution-focused therapy used a resource-oriented and goal-focused approach, allowing patients to change by constructing solutions. This was provided in 60- to 90-minute sessions, every two or three weeks, over no more than eight months.

Location/setting
Finland/out-patient care.

Methods
Analytical approach:
An economic evaluation, based on one clinical trial, was undertaken. The time horizon was one year. The authors did not explicitly state the perspective.

Effectiveness data:
The effectiveness data were from a randomised trial, the Helsinki Psychotherapy Study (see Other Publications of Related Interest). There were 381 patients who agreed to participate in the trial, with 198 patients randomised to solution-focused or psychodynamic therapy. Some patients withdrew from the trial, and the rest were randomised to a comparator that was not included in this analysis. Patient outcomes were assessed four times in the year of follow-up. A questionnaire and an interview were used to assess some confounding factors, such as demographic characteristics and suitability for psychotherapy. The baseline effectiveness data were analysed using intention-to-treat, and in a secondary analysis the missing values were replaced using multiple imputation. There were four main estimates: depression on the Beck Depression Inventory (BDI), and the Hamilton Rating Scale for Depression (HRSD), and anxiety on the Symptom Checklist-90, Anxiety Scale (SCL-90-ANX), and the Hamilton Anxiety Rating Scale for (HAM-A). The effectiveness of the two treatments was also estimated using the area under the curve.

Monetary benefit and utility valuations:
Not relevant.
Measure of benefit:
The measures of benefit were the main clinical effectiveness estimates: BDI, HRSD, SCL-90-ANX and HAM-A.

Cost data:
The direct and indirect costs of the treatment of mental and non-mental disorders were included. The direct cost categories were intervention therapy session costs, other psychotherapy sessions, out-patient visits and in-patient care for mental disorder, prescribed psychotropic medications, and travel costs for therapy visits. The indirect cost categories were lost productivity due to absence from work, the value of housework neglected, leisure time lost, and unpaid help received for mental disorders. The resources were estimated using a patient register, by direct elicitation from the patients, or using other registers. The unit costs were from insurance registers, a hospital price list, or the unit providing the service. The average productivity figures, used to estimate the human capital value, for the indirect costs, were from the official statistics of Finland. The value of lost leisure time was based on the average net earnings of Finnish employees, and the value of housework neglected was based on the salary of a trained communal helper. All costs were presented in 2006 Euros (EUR).

Analysis of uncertainty:
The unit costs were varied in a sensitivity analysis. An alternative analysis was conducted disregarding the missing observations. The incremental cost-effectiveness ratios, for each of the benefit measures, were varied using 500 bootstrap iterations, and results were presented on incremental cost-effectiveness planes.

Results
All four benefit measures showed a statistically significant reduction, for both interventions, following treatment. There were no statistically significant differences, between the two groups, in the benefit measures or the area under the curve.

The direct cost was EUR 1,791 for psychodynamic therapy, and EUR 2,137 for solution-focused therapy. The indirect cost was EUR 3,276 for psychodynamic therapy, and EUR 1,985 for solution-focused therapy. When including direct costs only, psychodynamic therapy was dominant as it had a lower cost for the same effect.

These results did not change significantly in the sensitivity analyses.

Authors' conclusions
The authors concluded that the interventions were comparable in effectiveness and cost-effectiveness, in reducing the symptoms of depression and anxiety. With bootstrapping, short-term psychodynamic therapy appeared to be more cost-effective than solution-focused therapy.

CRD commentary
Interventions:
The interventions were described and appear to have been appropriate comparators. Short-term psychodynamic psychotherapy was described as the usual practice for this study's population. Another comparator (long-term psychodynamic psychotherapy) was excluded, even though it was assessed within the same trial, because it required long-term follow-up. The scope of this study (short-term therapy) may have excluded some relevant comparators.

Effectiveness/benefits:
The effectiveness data were briefly described. The inclusion and exclusion criteria were clearly reported. The methods of randomisation and whether blinding was undertaken were not described. The original trial report (see Other Publications of Related Interest) should be accessed for a more thorough description of the trial. The reasons for drop-outs were explained, and this may help when replicating the study in other settings. No discounting of the benefits was necessary, as the time horizon was one year. The benefit measures were described, but were not aggregated and not comparable with disorders outside of mental health. This limitation was noted by the authors.

Costs:
The study perspective was not explicitly stated, but all the relevant cost categories for both the payer and societal perspectives appear to have been included. The cost and resource use sources seem appropriate for the Finnish setting. The costs were appropriately adjusted for inflation, and no discounting was necessary.
Analysis and results:
The analysis seems to have been appropriate, and the results were reasonably well reported. Some sensitivity analysis was undertaken, but this was limited and might not have captured all of the uncertainty in the results. The authors acknowledged several limitations to their study. Firstly, the population might not have been representative of the overall Finnish population, as only urban Helsinki patients were included, and they generally had a higher than average health and educational status. This reduces the generalisability of the results to other settings in Finland. Although the study was large for mental health, it had a small sample, which reduces the likelihood of detecting a difference in treatment effect.

Concluding remarks:
The methods were good, and the results were adequately reported. There were some limitations, and the results may not be generalisable to other settings, but the authors’ conclusions seem appropriate.

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