Organized phone therapy for depression found cost-effective

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When people get brief, structured, phone-based cognitive behavioral psychotherapy soon after starting on antidepressant medication, significant benefits may persist two years after their first session, with only modest rises in cost. Over two years, this treatment is cost-effective, according to a randomized trial in the October 2009 *Archives of General Psychiatry*.

"The most important reason to treat depression is to reduce suffering and improve daily functioning," said Group Health psychiatrist Gregory E. Simon, MD, MPH, also a senior investigator at Group Health Research Institute (formerly called Group Health Center for Health Studies). "But our findings suggest that insurers or health care systems aiming to improve depression treatment in primary care should consider incorporating structured psychotherapy."

The *Journal of the American Medical Association* (*JAMA*) reported earlier results from the same 600-person trial, the largest to date of psychotherapy by phone—and one of the largest studies of psychotherapy ever.

Over two years, phone psychotherapy plus care management led to a gain of 46 depression-free days, with only a $397 increase in outpatient health care costs. The incremental net benefit of phone psychotherapy plus care management was positive, even if a day free of depression was valued as low as $9.

By contrast, phone care management alone, with no phone psychotherapy, led to a gain of only 29 days free of depression, with a $676 rise in outpatient health care costs. The incremental net benefit of phone care management alone was negative, even if a day free of depression was valued up to $20.

The trial enrolled 600 Group Health patients whose primary care doctors diagnosed their depression and (as is usual in primary care) prescribed their antidepressants without psychotherapy.

The patients were randomly assigned to receive either:

- Usual primary care
- Phone care management: usual care plus a phone-based care-management program including three outreach calls from a bachelors-level clinician (assessing patients' symptoms, antidepressant drug use, and side effects and referring to mental health specialty care if needed), with care coordination and feedback to the primary care doctor
- Phone psychotherapy: usual care, plus phone care management, plus eight 30-40 minute sessions of structured cognitive-behavioral psychotherapy delivered by phone by a masters-level mental health clinician

The trial excluded people who were already seeing a therapist or intending to do so. The patients and mental health clinicians never met face to face, only over the phone. The mental health clinicians followed a structured protocol for psychotherapy. They encouraged the patients to identify and counter their negative thoughts (cognitive behavioral therapy), pursue activities they had enjoyed in the past (behavioral

activation), and develop a plan to care for themselves.

Few of the patients who received phone-based therapy—even fewer than those who did not receive it—sought in-person therapy. Phone-based therapy is more convenient and acceptable to patients than in-person psychotherapy, said Dr. Simon.

Depression symptoms, including feeling discouraged and avoiding other people, can prevent people from seeking help, he added. Nationally, only about half of insured patients receiving depression treatment make any psychotherapy visit, and less than a third make four or more visits. By contrast, in this trial, three in four patients completed at least six phone therapy sessions.

Source: Group Health Cooperative Center for Health Studies