ORGANISATION DE COOPÉRATION ET DE DÉVELOPPEMENT ÉCONOMIQUES

Effective Mental Health Treatment and Services

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April 27, 2010

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Main Messages

- Mental disorders should be understood along a continuum of symptoms and degree of disability, not diagnosis.
- There are effective (and cost-effective) services for treating (common and severe) mental disorders, but they are widely under-used.
- Models of care are available that may improve utilization and outcomes.
- Both supply-side and demand-side interventions are needed to increase utilization of effective treatment for mental disorders.

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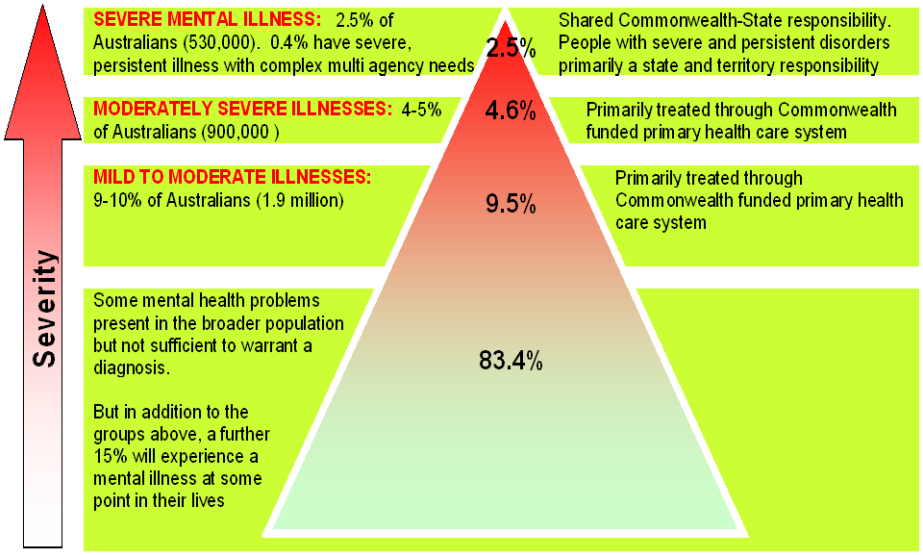
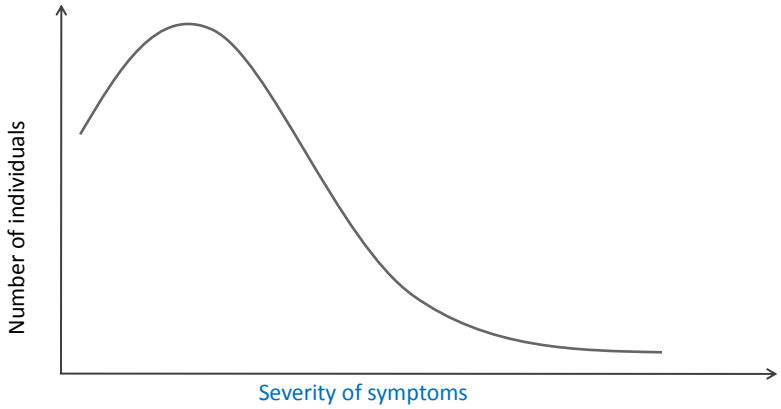
17% of Australians experience a mental disorder each year



Mild or severe conditions?



Knudsen et al. Journal of Psychosomatic Research (in press).
Broadhead et al. JAMA 1990.

For service planning, two broad groups of mental disorder

- Common but mostly less severe mental disorders – e.g. most anxiety and depression
  Treatment is primarily short term psychological and social interventions with pharmacological therapy used where needed. Usually delivered in primary care/referral.
- Severe, often persistent and complex mental disorders – e.g. psychosis
  Treatment is pharmacological, psychological and social, often with multiagency involvement . Usually delivered in specialist care.

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Supply side

Getting the right therapy to the right person at the right time

- therapy =
  - CBT and other psychological therapies
  - Medication
  - Both

If you do this, it will work! (50% of time)

Better than most interventions in medicine for physical illness

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Table 9: Summary of Evidence for the Cost-Effectiveness of Allied Health Provision of Psychological Treatments

Study	Disorder (patient description)	Intervention	Comparator	Study Type and setting	Costs and Outcomes	Results	Q[1]
Antonuccio, Thomas et al., 1997 (106)	Unipolar depression (using several studies)	CBT (15 sessions with unspecified professional + 5 booster sessions) and group CBT	Medication (Prozac)	Modeled No particular setting - stated aim is to do with managed care in US.	Direct health sectors costs, productivity costs and other effects such as multiplier effect due to Outcomes not modeled (but come in via probability of success)	CBT cheaper than drugs (+33%) and combination (+23%)	3
Bower, Byford et al., 2000 (117)	Depression (with and without anxiety as a co-morbidity)	CBT and non-directive counseling by therapists (up to 12 sessions)	Usual GP care	Prospective randomised trial UK study - relatively transferable to Australia	Costs: Health care services and non-treatment costs (e.g. travel and childcare. Lost production Outcomes: BDI and EQ 5D	No differences in outcomes between 2 interventions (at 4 months diffs compared to Usual care observed but disappears by 12 months) No cost diffs observed.	8
Browne, Steiner et al., 2002 (80)	Dysthymia disorder (DSM-IV)	Setraline alone or interpersonal therapy (by 'counsellors') (time limited therapy of 12 sessions alone or combination	All three treatments were compared to each other – No control group	Single blind RCT 6 month & 2 year f'up Canada specifically in primary care setting.	Costs: Health sector costs and production effects including welfare payments. Outcomes: Montgomery Asberg Primary measure: Depression Rating Scale. Secondary measures Social Adjustment Scale, McMaster Family Assessment device, CES-D and VAS to also measure depression	All treatments effective and setraline also cheaper than others	8
Chisholm, Sanderson et. al., 2004 (118)	Depression (not differentiated by co-morbidities .)	Broad range of pharmaceutical and psychotherapeutic interventions	The null (natural course of depression). Plus incremental analysis of the different Treatment options	Modeled using WHO-Choice Generalised Cost-Effectiveness Analysis	Costs: Health sector Outcomes: DALYs modeled from published studies using popmod (Markov model)	All treatment strategies appear cost-effective – particularly Proactive collaborative care strategies	10
Gould, Otto et al., 1995 (119)	Panic Disorder	CBT (psychologist) + drug Treatment	Compared to each other	Meta-analysis USA	Costs- psychology consults Outcomes-effect size	CBT as effective than drugs and group CBT was cheaper	1
Haby, Tonge et al., 2004 (112)	Major depression in children and adolescents (using DSM-IV criteria)	CBT (defined as 12 sessions) by different types of professionals and SSRIs	Current Australian practice (people not receiving effective treatments	Modeled using best available evidence Australia – GP referral to others	Costs: Health sector Outcomes: DALY (modeled from existing literature and the NSMHWB)	CBT by a publicly financed psychologist most cost-effective – SSRIs and other therapists providing CBT (public and private psychiatrists as well as private psychologists) all fall below the threshold of $50,000/DALY	10

Study	Disorder (patient description)	Intervention	Comparator	Study Type and setting	Costs and Outcomes	Results	Q[1]
Heuzenroeder, Donnelly et al., 2004 (113) 8	Generalised Anxiety Disorder and Panic Disorder (using DSM-IV criteria)	CBT and SNRIs	Current Australian practice (people not receiving effective treatments	Modeled using best available evidence Australia – GP referral to others	Costs: Health sector Outcomes: DALY (modeled from existing literature and the NSMHWB)	CBT by a publicly financed psychologist are the most C/E – CBT delivered by various therapists are all more CE than Medication.	10
Issakidis, Sanderson et al., 2004 (114)	Anxiety disorders differentiated by severity	Mild anx: 10% self-help, 60% CBT rest drugs. Mod-severe: 70% CBT mainly (70%) – with some drugs. The remaining 30% - Treatment with meds managed by a GP	Current Australian practice and the null	Modeled using best available evidence Australia	Costs: Govt and health service perspective Outcomes: YLD (as in the DALY)	All modeled interventions appear cost-effective – if we swapped from current care to optimal care the costs would remain similar but the health gains would be markedly increased (to <$20,000/DALY averted	10
Kaltenthaler, Brazier et al., 2006 (107)	anxiety, depression, phobias, panic and obsessive-compulsive behaviour (OCD)	Computerised CBT (4 different products considered) – HTA review	Treatment as usual	Modeled (based on sponsor data) UK – National Health Service	Outcome – depression treated (classified into minimal, mild, moderate and severe) Costs: Intervention costs including license fees, computer hardware, screening, clinical support, capital overheads + other costs (personal communication from McCrone)	All products considered cost-effective with a high probability of the ICER falling below £30,000 (per QALY), When modeling OCD packages, the CE was highly influenced by the assumptions made around licensing	10
King, Sibbald et al., 2000 (120)	depression or mixed depression with anxiety	*Non-directive counselling (provided by counselors) *CBT (provided by clinical psychologists)	Usual GP care –	RCT – 4 and 12 month f'up (not total) however included provisions for patient preferences 24 general practices in the UK	Costs: Health sector costs Outcomes: BDI, Clinical Interview Schedule (ICD-10 Diagnosis), Brief symptom Inventory, modified social adjustment Scale, Satisfaction questionnaire, EuroQol.	The two interventions were more effective at 4 month follow-up but differences disappeared by 12 months. No sig differences in costs were found. Overall conclusion was that psych therapy more C/E in the short-term only.	9
Lave, Frank et al., 1998 (110)	Major Depression (n=276)	*Medication (nortriptyline hydrochloride) *Interpersonal psychotherapy	Usual care – GPs told patient has depression only.	RCT – with up to 12 months follow-up USA	Costs: health sector costs plus time and travel costs Trial costs of interventions, Outcomes: depression free days (measured by the HAM-D), BDI and quality adjusted days (using a conversion methodology from previous research	The ICER for Medication relative to usual care ranges from US$12.66 to $16.87 which translates to direct cost per quality-adjusted year gained from $11270 to $19510 (drugs slightly better than psych	8

Access to effective treatment is important for employment

- Clinical treatment may be a necessary (but not sufficient) condition for some individuals to be able to return to work or keep their jobs
- But under-treatment is widespread (average 40% treatment rate across countries, across disorders)
  - even among those receiving disability benefits for a mental disorder.
  - Effects not sufficiently studied (cost-effectiveness studies do not include employment)

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Evidence from Australia

MILD & MODERATE DISORDERS
14.1%
2.8 million people

Includes:
Common anxiety and depressive disorders
Personality disorder
Eating disorders

Treatment mainly provided through primary health care

- Low treatment rates - only 31% receive treatment by the health system, less than half comparable physical illnesses
- The high level of untreated illness is responsible for $6 billion in lost productivity annually in those who are employed.
- Lost productivity arising from people out of the workforce and on disability pensions is estimated at $9.7 billion per year
- Of the six priority health conditions, mental illness is associated with the lowest likelihood of being in the workforce
- 2003 ABS survey - one third of young people aged 15-29 with a mental illness neither in education nor employment

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Barriers to Treatment

Demand-side

Lack of awareness of effective treatments

Financial barriers

Stigma

Several studies (Australia, Canada, US) suggest demand side barriers are more significant

Supply-side

Not enough trained personnel

Fragmented system/financing

Variable quality

Stigma

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On the supply side, how services are organized matters

- Integrating assessment, diagnosis and treatment into primary care is important for access
- So what does it mean to integrate mental health services into primary care?
- Supply side issues for allied professionals + supervision
  - Effect means replicating good quality psychological services, which are often difficult to scale up.

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