Antidepressants and cognitive behavioural therapy interventions for major depressive disorder beyond the acute management phase

Report of the Appraisal Committee of the Swiss Medical Board

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Impressum

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Executive Summary

Major depressive disorder (MDD) is one of the most frequent mental health disorders and is associated with a substantial societal and health-economic burden. Around one in three people over age 15 in Switzerland experience mild, moderate or severe MDD during their lifetime. MDD is most often managed using psychotherapy (most commonly cognitive behavioural therapies, CBT) and/or antidepressant medication (ADM). The goals of therapy are remission of depressive symptoms, restoration of normal psychosocial functioning, and prevention of relapse. The management of MDD proceeds over three phases: the acute phase, lasting 6 to 12 weeks, aiming at achieving remission, the continuation phase, lasting 4 to 9 months, aiming at preventing relapse, and the maintenance phase, which may last years, aiming at preventing recurrence or chronic depression. Patients may initially respond to the therapy partially (response) or fully (remission), may subsequently remain in remission (recovery), may suffer a relapse shortly after achieving a response/remission, or may experience a recurrence of MDD. Current treatment recommendations are largely based on short-term randomized controlled trials (RCTs) focused on the acute management phase. Little is known about the benefits and harms of ADM and CBT beyond 12 weeks of treatment.

The Swiss Medical Board evaluated the evidence from RCTs regarding the clinical efficacy, safety and health economic impact of ADM and CBT alone or in combination, in patients over 18 years of age with MDD who were treated beyond the acute management phase. The assessment was based on standard methods for systematic reviews and health economic analysis. Based on this assessment, this Appraisal Report was drafted using the Evidence-to-Decision (EtD) framework.

For the assessment of clinical efficacy and safety, 42 RCTs were identified. Random-effects pairwise meta-analyses and frequentist multivariable random-effects network meta-analyses were conducted when possible, but most data were synthesised using descriptive analysis. Data was not available for many outcomes, comparisons or time periods. The evidence was judged overall to be of low quality. Both ADM and CBT appear to be clinically effective compared to placebo or usual care beyond the acute phase of treatment, however neither was clearly superior to the other. Given that reporting of adverse events was very limited in trials of CBT, much uncertainty remained regarding the safety and differences in the potential benefits and potential harms of ADM compared with CBT. The Appraisal Committee concluded that both ADM and CBT have desirable but variable clinical effects, but the relative effects are unknown.

The therapeutic safety and differences between desirable and undesirable effects of ADM and CBT remain unknown.

The health economic analysis included a systematic review of 33 cost-effectiveness analyses of ADMs and CBT from high income western countries, a cost-adaptation to Switzerland based on 29 of the identified studies, and a budget impact analysis from the Swiss healthcare payer's perspective. The Appraisal Committee determined that the overall cost of treatment for MDD to the Swiss healthcare payer is high, although around 80 percent of the costs are related to hospitalizations. The impact of ADM or CBT on hospitalizations beyond the acute phase of treatment for MDD is not known. Given potential similar clinical effectiveness and higher costs of CBT, if all patients with MDD were to be treated with generic ADM compared with CBT there might be moderate savings for the Swiss healthcare payer. The choice of therapy may however be significantly impacted by multiple factors including severity of symptoms, patient preference, cost, availability and acceptability. As the current distribution of CBT and ADM as therapies for MDD in Switzerland are not known, the actual budget impact of these therapies remains unknown.

The Appraisal Committee concluded that given the burden of MDD there is probably no important uncertainty or variability in how stakeholders value the effects of ADM and CBT. Based on the evidence available, for patients with MDD beyond the acute management phase, the Appraisal Committee issued a recommendation for ADM and a conditional recommendation for CBT +/- ADM, although with the caveat that outcomes and safety data beyond 12 months are particularly scarce.