

**Economic evidence tables for review question 1.1 For adults with depression, what are the relative benefits and harms associated with different models for the coordination and delivery of services?**

**Table 42: Economic evidence table for simple collaborative care**

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost- effectiveness	Comments
Bosanquet 2017 UK Cost-utility analysis	Interventions: Simple collaborative care (SCC), using behavioural activation, designed specifically for people aged ≥ 65 with depression, delivered over 8 sessions by a case manager (a primary care mental health / IAPT worker) for an average of 6 sessions over 7-8 weeks. SCC included telephone support, medication management, symptom monitoring and active surveillance, facilitated by a computerised case management. The first session was delivered face-to-face and subsequent sessions via telephone. SCC was provided in	Adults aged ≥ 65 years with major depressive disorder. Exclusion criteria: alcohol dependency; psychotic symptoms; recent suicidal risk/self-harm; significant cognitive impairment Pragmatic, multi-centre open RCT (N=485) Source of efficacy and resource use data: RCT (Bosanquet 2017); (N=485; at 18 months n=344; cost data available for n=447) Source of unit costs: national sources	Costs: intervention (case manager's time and supervision, as well as training including manual, supervision, travel and accommodation) and usual primary care (GP appointment, home visits and telephone consultation; practice nurse appointments and telephone consultations) Mean total cost per person (95% CI): SCC: £1,171 (£1,167 to £1176); TAU: £654 (£651 to £658) Adjusted difference £480 (£381 to £579). Primary outcome measure: QALY based on SF-6D ratings (UK tariff) Mean number of QALYs per person (SD): SCC: 0.900 (0.241); TAU: 0.889 (0.224) Adjusted difference 0.019 (95% CI -0.020 to 0.057, p=0.338)	ICER of SCC vs TAU: £26,010/QALY Probability of SCC being cost-effective: 0.39 and 0.55 at WTP £20,000 and £30,000/QALY, respectively. Sensitivity analysis: Including only participants who engaged with 5 or more sessions in the analysis: ICER £9,876/QALY	Perspective: NHS/PSS (intervention and primary care exclusively considered) Currency: GBP£ Cost year: 2012/13 Time horizon: 18 months Discounting: NA Applicability: directly applicable Quality: potentially serious limitations

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost-effectiveness	Comments
	addition to usual GP care. Treatment as usual, comprising GP care alone (TAU)				
Green 2014 UK Cost-utility analysis	Interventions: Simple collaborative care in addition to usual primary care (SCC), comprising care managers making 6-12 contacts with service users over 14 weeks; contacts involved education about depression, medication management, behavioural activation and relapse prevention instructions. Care managers provided GPs with advice on medication and regular updates on service user progress including medication adherence. Treatment as usual (TAU), defined as GP care that includes antidepressant treatment and referral for other treatments, including Improving Access to Psychological	Adults with depression Multi-centre cluster RCT (N=581) Source of efficacy data: RCT (Richards 2013); (data available for n=466) Source of resource use data: RCT (data available for n=447) Source of unit costs: national sources	Costs: intervention (care manager's time and supervision by specialists), staff time (GP, mental health nurse, practice nurse, counsellor, mental health worker, social worker, home care worker, occupational therapist, psychiatrist, psychologist, psychiatric nurse/care coordinator), walk-in-centre, voluntary group, inpatient psychiatric and general stay, A&E, day hospital, other outpatient contact, day care centre, drop-in club; informal care and service user expenses in sensitivity analysis Mean NHS/PSS cost per person (SD): SCC: £1,887 (£3,714); TAU: £1,571 (£2,442) Unadjusted difference: £316 Adjusted difference: £271 (95%CI: -£203 to £886) Primary outcome measure: QALY based on EQ-5D ratings (UK tariff); SF-6D (UK tariff) used in sensitivity analysis Mean number of QALYs per person (SD):	ICER of SCC vs TAU: £14,248/QALY Probability of SCC being cost-effective: 0.58 and 0.65 at WTP £20,000 and £30,000/QALY, respectively. Results robust to multiple imputation of missing data, use of SF-6D utility values, use of alternative SCC costs; SCC dominant using a broader perspective; excluding one participant with an extremely high level of self-reported resource use, ICER became £3,334/QALY and probability of cost effectiveness 0.76 and 0.79 at WTP £20,000 and £30,000 /QALY, respectively	Perspective: NHS/PSS; broader perspective (informal care costs and service user expenses) considered in sensitivity analysis Currency: GBP£ Cost year: 2011 Time horizon: 12 months Discounting: NA Applicability: directly applicable Quality: minor limitations

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost-effectiveness	Comments
	Therapies (IAPT) services		SCC: 0.605 (0.261); TAU: 0.554 (0.286) Unadjusted difference: 0.051 Adjusted difference: 0.019 (95%CI: -0.019 to 0.06)		
Lewis 2017  UK  Cost-utility analysis	<u>Interventions:</u> Simple collaborative care (SCC), which included behavioural activation delivered by a case manager (a primary care mental health worker / Improving Access to Psychological Therapies (IAPT) worker) for an average of 7 sessions over 8–10 weeks, in addition to usual GP care. Collaborative care included telephone support, symptom monitoring and active surveillance, facilitated by computerised case management.  Treatment as usual, comprising GP care alone (TAU)	Older adults who screened positive for subthreshold depression ( $\geq 75$ years old during the pilot phase and $\geq 65$ years old during the main trial)  Pragmatic, multi-centre RCT (N=705)  <u>Source of efficacy and resource use data:</u> RCT (Gilbody 2017); (N=705; complete data used in base-case economic analysis n=448)  <u>Source of unit costs:</u> national sources	Costs: intervention (case manager's time and supervision, as well as training including manual, supervision, travel and accommodation) and usual primary care (GP appointment, home visits and telephone consultation; practice nurse appointments and telephone consultations)  <u>Mean NHS/PSS cost per person (SD):</u> SCC: £894 (£391); TAU: £450 (£393) Unadjusted difference: £444 for n=620 Adjusted bootstrapped difference for n=448 sample included in economic analysis: £421 (95%CI: £348 to £494)  <u>Primary outcome measure:</u> QALY based on EQ-5D ratings (UK tariff)  <u>Mean number of QALYs per person (SD):</u> SCC: 0.756 (0.246); TAU: 0.660	ICER of SCC vs TAU: £9,633/QALY  Probability of SCC being cost-effective: 0.92 and 0.97 at WTP £20,000 and £30,000/QALY, respectively.  Sensitivity analysis: Accounting for the true observed SCC contact rate (rather than the expected SCC contact rate that was used in the base-case analysis), ICER became £3,328/QALY	<u>Perspective:</u> NHS/PSS (intervention and primary care exclusively considered) <u>Currency:</u> GBP£ <u>Cost year:</u> 2012/13 <u>Time horizon:</u> 12 months <u>Discounting:</u> NA <u>Applicability:</u> directly applicable <u>Quality:</u> potentially serious limitations

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost-effectiveness	Comments
			(0.247) Unadjusted difference: 0.096 Adjusted difference: 0.044 (95%CI: 0.015 to 0.072, p=0.003)		
Simon 2002 US Cost effectiveness analysis	Interventions: Simple collaborative care comprising an educational book and videotape on effective management of depression; 2 visits to a depression prevention specialist including shared decision making on maintenance antidepressant treatment; plus 3 scheduled telephone contacts and 4 personalised mailings for monitoring depressive symptoms and treatment adherence (SCC) Treatment as usual (TAU), including primary care and referral to specialty mental health care	Adults with a history of either recurrent major depression (i.e. at least 3 depressive episodes in the previous 5 years) or dysthymia (depressive symptoms present continuously for the past 2 years) that had recovered from a depressive episode following antidepressant treatment in primary care RCT (Katon 2001) Source of efficacy and resource use data: RCT; N=386, n=315 (82%) completed all follow-up assessments; n=377 (98%) remained enrolled throughout the follow-up period Source of unit costs: local data	Costs: medication, staff time, any inpatient and outpatient services for mental health or general medical care Mean total cost cost per person: SCC: \$2,691 (95%CI \$2,320 to \$3,062) TAU: \$2,619 (95%CI \$2,139 to \$3,099) Incremental \$13 (95%CI -\$584 to \$511), after adjustment for gender, age, baseline Hopkins Symptoms Checklist (HSCL) depression score and chronic disease score Primary outcome measure: number of depression-free days, defined as days with a HSCL depression score ≤ 0.5; days with a HSCL score above 0.5 but < 2 were considered 50% depression free Number of depression-free days: SCC: 253.2 (95% CI 241.7 to 264.7) TAU: 239.4 (95% CI 227.3 to 251.4) Incremental 13.9 (95%CI -1.5 to 29.3, p=0.078), after adjustment for gender, age, baseline SCL	ICER of SCC vs. TAU \$1 per depression-free day (95%CI -\$134 to \$344)	Perspective: 3rd party payer Currency: US\$ Cost year: 1998 Time horizon: 12 months Discounting: NA Applicability: partially applicable Quality: potentially serious limitations

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost- effectiveness	Comments
			depression score and chronic disease score		

**Table 43: Economic evidence table for complex collaborative care**

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost- effectiveness	Comments
Morriss 2016 UK Cost-utility analysis	Interventions: Complex collaborative care, comprising secondary outpatient specialist depression services offering tailored integrated pharmacological and psychological (CBT, MBCT and compassion focused therapy, as appropriate) treatment within a collaborative care approach for 12-15 months (CCC) Usual secondary mental health care (TAU)	Adults with persistent unipolar moderate or severe depression, with HDRS total $\geq 16$ , GAF $\leq 60$ , that have received treatment for depression for at least 6 months and are currently receiving secondary mental healthcare Multi-site single-blind RCT (N=187) Source of efficacy and resource use data: RCT (Morriss 2016, N=187; 84% completed at 6 months, 72% at 12 months and 59% at 18 months) Source of unit costs: national sources	Costs: primary care (GP surgery and home attendances), practice / district / community psychiatric nurse, psychotherapist, inpatient and outpatient (psychiatric or other) care, A&E attendances, medication Mean total cost per person (95% CI): CCC: £9,315 (£7,547 to £11,084) TAU: £5,869 (£4,501 to £7,238) Incremental total cost (bias-corrected bootstrapped): £3,446 (£1,915 to £5,180) Primary outcome measure: QALYs based on EQ-5D-3L ratings (UK tariff) Mean QALYs per person (95% CI): CCC: 0.753 (0.659 to 0.847) TAU: 0.646 (0.538 to 0.754) Incremental QALYs (bias-corrected bootstrapped): 0.079 (0.007 to 0.149)	ICER of CCC vs. TAU £43,603/QALY Controlling for baseline differences and cluster effects: probability of CCC being cost-effective exceeds 0.50 at WTP of £42,000/QALY	Perspective: NHS and personal social services Currency: GBP£ Cost year: 2014 Time horizon: 18 months Discounting: NA Applicability: directly applicable Quality: minor limitations

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost-effectiveness	Comments
Goorden 2015 The Netherlands Cost-utility analysis	Interventions: Complex collaborative care (CCC) provided by a depression care manager, usually a qualified nurse, who collaborated with a GP and a liaison psychiatrist in order to provide and guide more structured and adherent depression treatment in primary care. Treatment consisted of problem solving, manual guided self-help (both provided by the care manager), and, if necessary, antidepressants (prescribed by the GP). Care managers and GPs received training in CCC. Treatment as usual (TAU) in primary care, comprising prescription of antidepressants or referral to psychotherapy	People aged $\geq 17$ years with major depression according to the MINI. Exclusion criteria: being suicidal, psychotic symptoms, dementia, drug or alcohol dependence, already under specialty mental health treatment RCT (N=150; 93 identified by screening and 47 by GP referral) Source of efficacy and resource use data: RCT (Huijbregts 2013, n=93 identified by screening) Source of unit costs: national sources	Costs: GP, psychiatric / mental health care practice nurse, psychiatric inpatient care, specialist outpatient care, private psychologist / psychiatrist, occupational physician, other specialist, paramedic, social worker, counselling centre for drugs, alcohol, etc, alternative medicine, self-help group, day care, psychotropic medication Mean total healthcare cost per person: CCC €4,011 (95% CI €2,679 to €5,513) TAU €2,838 (95% CI €2,463 to €3,244) Difference: €1,173 (95% CI, -€216 to €2726) Primary outcome measure: QALYs based on EQ-5D ratings (Dutch tariff) Mean total number of QALYs gained per person: CCC 0.07 (95% CI 0.05 to 0.09) TAU 0.05 (95% CI 0.03 to 0.06) Difference: 0.02 (95% CI -0.004 to 0.04)	ICER of TAU vs CCC €53,717/QALY Probability of CCC being cost-effective: 0.20 and 0.70 at WTP €20,000 and €80,000/QALY, respectively.	Perspective: healthcare system; productivity losses reported separately Currency: Euro (€) Cost year: 2013 Time horizon: 12 months Discounting: NA Applicability: partially applicable Quality: potentially serious limitations
Grochtdreis 2019 Germany	Interventions: Complex collaborative care (CCC) formed around a primary care physician (PCP);	Adults aged $\geq 60$ years with moderate depressive symptoms; PHQ-9 score 10-14.	Costs: outpatient physician (e.g. PCP, specialist physician, psychotherapy) and non-physician services (e.g. physiotherapy, occupational therapy, massage), inpatient care,	ICER of CCC vs TAU €26.07/DFD €55,800/QALY	Perspective: healthcare system (informal care reported separately) Currency: Euro (€)

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost-effectiveness	Comments
Cost effectiveness	<p>treatment evaluation occurred every 8 weeks. Intervention consisted of a patient manual, an initial face-to-face session and ongoing telephone sessions between the care manager and the patient every other week. Patients' depressive symptom severity was regularly assessed by the PHQ-9. Problem-solving techniques were optionally held.</p> <p>Treatment as usual (TAU) comprising regular PCP visits without involvement of a care manager. Depressive symptom severity not routinely assessed.</p>	<p>Exclusion criteria: alcohol/drug abuse, severe cognitive impairment, severe psychological disorders, suicidal ideation, active depression treatment</p> <p>Cluster RCT (N=246 from 71 clusters; ITT analysis)</p> <p>Source of efficacy and resource use data: RCT (Hölzel 2018)</p> <p>Source of unit costs: national sources</p>	<p>rehabilitation, formal nursing care (professional nurse or housekeeper), informal nursing care (family or friends), medication and medical devices.</p> <p>Mean total healthcare cost per person: CCC €6155; TAU €5674 Adjusted difference: €558; p = 0.532</p> <p>Primary outcome measure: depression-free days (DFDs), based on PHQ-9 scores. PHQ-9 &lt;5: depression-free; PHQ-9 ≥15: depressed; linear interpolation used for calculations.</p> <p>Secondary outcome measure: QALYs based on EQ-5D ratings (UK tariff)</p> <p>Mean total DFDs per person: CCC 207.1; TAU 185.8 Adjusted difference: 21.4; p = 0.022</p> <p>Mean total QALYs per person: CCC 0.57; TAU 0.56 Adjusted difference: 0.01; p = 0.701</p>	<p>Probability of CCC being cost-effective: 0.95 for WTP of €200/DFD; 0.45 for WTP of €50,000/QALY</p>	<p>Cost year: 2013</p> <p>Time horizon: 12 months</p> <p>Discounting: NA</p> <p>Applicability: partially applicable</p> <p>Quality: minor limitations</p>

**Table 44: Economic evidence table for stepped care**

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost-effectiveness	Comments
Mukuria 2013 UK Cost effectiveness and cost-utility analysis	Interventions: Stepped care approach: Improving Access to Psychological Therapies (IAPT) service comprising: Step 1 watchful waiting; Step 2 guided self-help including bibliotherapy with support, computerised CBT (cCBT) with support and CBT-based telephone support for problem-solving; Step 3 CBT ± medication. IAPT was provided in addition to treatment as usual (TAU) TAU alone, comprising GP care, primary care counselling and referral to mental health professionals in secondary care. IAPT was evaluated in Doncaster demonstration site. Comparator sites were selected to match IAPT site regarding size & type of population served based on	People 16-64 years old with a new or recurrent episode of depression or anxiety, who were likely to benefit from psychological therapies. More than 95% of people in IAPT had a primary diagnosis of depression by their GP. Prospective cohort study with matched sites (N=403) Source of efficacy and resource use data: cohort study (N=403; available 8-month cost and QALY data for n=297) Source of unit costs: IAPT data and national sources	Costs: intervention (staff time, training, equipment, facilities and overheads), other mental healthcare (psychiatrist, psychologist, community psychiatric nurse, psychotherapist/ counsellor, other mental health professionals and voluntary sector services), primary and secondary care, social care; medication costs not considered Mean total cost per person (SD): IAPT: £1,190 (£2,193); TAU: £934 (£1,666) Unadjusted difference: £256 (95% CI: -£266 to £779) Adjusted difference: £236 (95%CI: -£214 to £689) Primary outcome measures: proportion of people with a reliable and clinically significant (RCS) improvement on the PHQ-9; QALY based on SF-6D ratings (UK tariff); QALYs based on predicted EQ-5D ratings (UK tariff), estimated from SF-6D using an empirical mapping function were used in sensitivity analysis Proportion of people with a PHQ-9 RCS significant improvement (95% CI):	ICER of IAPT vs. TAU £9,440 per participant with RCS improvement £29,500/QALY using SF-6D £16,857/QALY using predicted EQ-5D scores Probability of IAPT being cost-effective using SF-6D QALYs: <0.40 at WTP £30,000/QALY; using EQ-5D QALYs: 0.38 and 0.53 at WTP £20,000 and £30,000 / QALY, respectively. Using national unit costs instead of IAPT financial data resulted in an ICER of £3,800 per participant achieving RCS improvement and £11,875/QALY using SF-6D	Perspective: NHS and social services; productivity losses estimated separately Currency: GBP£ Cost year: 2008/09 Time horizon: 8 months Discounting: NA Applicability: directly applicable Quality: potentially serious limitations



Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost- effectiveness	Comments
	deprivation, ethnicity and age; geographical location; local implementation of 'pathways to work'; ethnic diversity; recent changes in organisational structure. Also, comparator sites were selected based on how well they performed according to average Quality and Outcomes Framework points, a voluntary annual reward and incentive programme for all GPs in England that assesses areas of clinical care, organisation, patient experience & other services.		IAPT: 0.221 (0.164 to 0.278) TAU: 0.205 (0.116 to 0.293) Unadjusted difference: 0.016 (-0.089 to 0.122) Adjusted difference: 0.025 (-0.078 to 0.127) Mean number of SF-6D QALYs per person (95% CI): IAPT: 0.026 (0.018 to 0.033) TAU: 0.018 (0.007 to 0.029) Unadjusted difference 0.007 (-0.006 to 0.021) Adjusted difference 0.008 (-0.005 to 0.021) Mean number of EQ-5D QALYs per person (95% CI): IAPT: 0.038 (0.027 to 0.049) TAU: 0.025 (0.009 to 0.040) Unadjusted difference: 0.013 (-0.007 to 0.033) Adjusted difference: 0.014 (-0.005 to 0.032)		
Meeuwissen 2019 The Netherlands Cost-utility analysis	Interventions: Stepped care (SC) comprising a standardised stepwise treatment algorithm for mild or moderate/severe depression; basic interventions (psychoeducation, active monitoring, structuring of the day) offered to all; self-help	Adults with mild, moderate or severe major depression without psychotic symptoms. Decision-analytic modelling Source of efficacy data: literature review Source of resource use data: published literature	Costs: health professional time (GP, psychologist, psychiatrist, psychotherapist, social worker, nurse), antidepressants, telephone consultation, self-help book or information leaflet, group therapy, crisis intervention, inpatient care, day care, homecare, other out-patient care  Mean incremental cost/person:	ICER: Mild depression: SC dominant Moderate/severe depression: €3,166/QALY  Probability of SC being dominant: Mild depression: 0.67	Perspective: healthcare Currency: Euro (€) Cost year: 2017 Time horizon: 5 years Discounting: 4% or costs, 1.5% for outcomes Applicability: partially applicable

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost-effectiveness	Comments
	<p>may be added according to patient preference</p> <p>Treatment as usual (TAU) comprising all commonly available treatments in the health care system, often delivered in a mix of care</p>	<p>(clinical trials and empirical studies)</p> <p>Source of unit costs: possibly national sources</p>	<p>Mild depression: -€36.72</p> <p>Moderate/severe depression: €46.96</p> <p>Primary outcome measure: QALY; effect size transformed into a utility increment.</p> <p>Mean incremental QALY/person: Mild depression: 0.014 Moderate/severe depression: 0.015</p>	<p>Moderate/severe depression: 0.33</p> <p>Probability of SC being cost-effective at €20,000/QALY: &gt;0.95 for both mild and moderate/ severe depression</p>	<p>Quality: minor limitations</p>
<p>Van Der Weele 2012</p> <p>The Netherlands</p> <p>Cost effectiveness and cost-utility analysis</p>	<p>Interventions: Stepped care (SC) comprising step 1 individual counselling concerning treatment needs and motivation of the subjects during 1-2 home visits by a community psychiatric nurse; step 2 'Coping with Depression' course, based on CBT, by trained mental health professionals; if indicated, step 3 referral back to GP to discuss further treatment.</p> <p>Treatment as usual (TAU); GPs and participants in control</p>	<p>Adults ≥75 years old who screened positive for depressive symptoms in general practice, according to a ≥5 points score on an interviewer-administered 15-item version of the Geriatric Depression Scale (GDS-15)</p> <p>Exclusion criteria: current treatment for depression, clinical diagnosis of dementia or a Mini-Mental State Examination (MMSE) score &lt;19, loss of partner or child in the preceding 3 months, life expectancy ≤3 months and not speaking Dutch.</p>	<p><u>Costs:</u> intervention (individual consultation, course sessions, course instructors, room rental, refreshments, course materials), staff time (psychiatrist, psychologist, GP, physiotherapist), medication, hospitalisation (psychiatric &amp; general), hospital day care, specialist care, paramedical care; service user costs (time &amp; travel), informal care</p> <p><u>Mean healthcare cost per person:</u> 75-79 years: SC €10,199, TAU €7,816 ≥80 years: SC €14,097, TAU €14,518</p> <p><u>Mean total cost per person:</u></p>	<p>Under a healthcare perspective:</p> <p><u>75-79 years:</u> SC dominated using EQ-5D QALY ICER of SC vs. TAU €297,838/QALY using SF-6D</p> <p><u>≥80 years:</u> SC dominant using either EQ-5D or SF-6D QALY</p>	<p><u>Perspective:</u> healthcare plus service user and informal care costs considered <u>Currency:</u> Euro (€) <u>Cost year:</u> likely 2004 <u>Time horizon:</u> 12 months <u>Discounting:</u> NA <u>Applicability:</u> partially applicable <u>Quality:</u> potentially serious limitations</p>

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost-effectiveness	Comments
	arm were not informed about screen-positive results before the end of the study, except in case of a MADRS score >30 and/or suicidal ideation	Pragmatic cluster RCT (N=239)  <u>Source of efficacy and resource use data:</u> RCT (Van Der Weele2012, N=239; completers n=194)  <u>Source of unit costs:</u> national sources	75-79 years: SC €14,026, TAU €9,353; p=0.10 ≥80 years: SC €16,087, TAU €16,661; p=0.87  <u>Primary outcome measures:</u> MADRS change score, QALY based on EQ-5D and SF-6D ratings (UK tariff)  <u>Mean MADRS change score (SE):</u> SC -3.1 (0.61); TAU: -4.6 (0.64); p=0.084  <u>Mean EQ-5D QALYS per person:</u> 75-79 years: SC 0.404; TAU 0.429; p=0.66 ≥80 years: SC 0.350; TAU 0.303; p=0.36  <u>Mean SF-6D QALYs per person:</u> 75-79 year: SC 0.624; TAU 0.616; p=0.78 ≥80 years: SC 0.588; TAU 0.568; p=0.46		
Health Quality Ontario 2019  Cost-utility analysis	Analysis A: Stepped care (SC1) comprising computerised CBT (cCBT) with support followed by individual CBT	Analysis A: adults with mild to moderate major depression Analysis B: adults with mild to moderate major depression who are likely to drop out of treatment	Costs: intervention (health professional time, training and supervision, equipment), assessment, medication, follow-up care with GP, psychiatrist time  Mean cost/person:	Analysis A: SC dominant over TAU. ICER of SC1 vs SC2: \$1,098/QALY. Results robust to change in efficacy, dropout rates, utilities,	Perspective: healthcare and long term care Currency: Can\$ Cost year: 2018 Time horizon: Analysis A: lifetime

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost- effectiveness	Comments
	<p>Stepped care (SC2) comprising cCBT with support followed by group CBT Treatment as usual (TAU)</p> <p>Analysis B: Stepped care (SC) comprising cCBT without support followed by cCBT with support Individual CBT Group CBT TAU</p>	<p>Decision-analytic modelling Source of efficacy data: systematic literature review Source of resource use data: published literature and expert opinion</p>	<p>Analysis A: SC1: \$280,538; SC2: \$280,498 TAU: \$283,651</p> <p>Analysis B: SC \$715; group CBT \$1,690; individual CBT \$2,654; TAU \$409</p> <p>Primary outcome measure: QALY; utility data from literature review, ratings of various scales.</p> <p>Mean QALY/person: Analysis A: SC1: 18.33; SC2: 18.30; TAU: 18.09</p> <p>Analysis B: SC 0.80; group CBT 0.82; individual CBT 0.83; TAU 0.79</p>	<p>medication costs, time horizon. Probability of SC1 being cost-effective at \$50,000/QALY: 0.60</p> <p>Analysis B ICERs: Indiv CBT vs group CBT: \$100,316/QALY Group CBT vs SC: \$67,161/QALY SC vs TAU: \$19,454/QALY Probability of SC being cost-effective at \$50,000/QALY: 0.48</p>	<p>Analysis B: 1 year Discounting: 1.5% for costs and outcomes Applicability: partially applicable Quality: minor limitations</p>

**Table 45: Economic evidence table for medication management**

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost- effectiveness	Comments
Rubio-Valera 2013 Spain Cost effectiveness and cost-utility analysis	Interventions: Medication management (MM), comprising an educational intervention provided by the pharmacist, focusing on improving service users' knowledge of antidepressant medication, making them aware of the importance of compliance to the medication, reassuring them about possible side-effects, and stressing the importance of carrying out GPs' advice. In service users with a sceptical attitude towards antidepressants, the intervention aimed to reduce stigma. Pharmacists were trained for the intervention. Treatment as usual from GP and pharmacist (TAU), comprising filling the	Adults aged 18-75 years initiating treatment with antidepressants because of depression RCT (N=179) Source of efficacy and resource use data: RCT (Rubio-Valera 2013, N=179; 71% completed at 6 months; n=151 received intervention as allocated) Source of unit costs: regional sources	Costs: intervention (pharmacist time, pharmacist training), publicly funded healthcare services (GP, nurse, psychologist, psychiatrist, other medical specialists, social worker, hospital emergency visits, hospital stay, diagnostic tests, medication), privately funded healthcare services (psychiatrist, psychologist, medical specialist, GP), absenteeism from paid labour. Mean societal cost per person: MM: €1,091; TAU: €767 Mean difference €324 (95%CI – €97 to €745). Mean direct cost per person: MM: €444; TAU: €425 Mean difference €49 (95%CI not reported). Primary outcome measures: adherence to antidepressant treatment measured using electronic pharmacy records; remission of depressive symptoms defined as a reduction in the Patient Health Questionnaire 9-item (PHQ-9) of at least 50%; QALYs based on EQ-5D ratings (Spanish tariff)	Under a healthcare perspective: ICER of MM vs. TAU €962 per extra adherent service user €3,592/QALY TAU dominant in terms of remission Probability of MM being cost-effective 0.71 and 0.76 for WTP €6,000 /adherent service user and €30,000 /QALY, respectively. Using remission, maximum probability of MM being cost-effective 0.46. Results robust to per protocol or complete case analysis, use of DSM-IV criteria for depression, intervention costs or method for estimating indirect costs.	Perspective: societal and healthcare Currency: Euro (€) Cost year: 2009 Time horizon: 6 months Discounting: NA Applicability: partially applicable Quality: potentially serious limitations

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost-effectiveness	Comments
	prescriptions, addressing service users' questions about medication and giving basic advice about how to take the antidepressant.		Incremental probability of adherence per person: 0.04 (95%CI -0.2 to 0.1) Incremental probability of remission per person: -0.01 (95%CI -0.2 to 0.1) Incremental QALYs per person: 0.01 (95%CI -0.02 to 0.03)		

**Table 46: Economic evidence table for shared care**

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost-effectiveness	Comments
Wiley-Exley 2009  US  Cost effectiveness and cost-utility analysis	<u>Interventions:</u> Integrated (shared) care (IC) comprising collaboration between primary and specialty mental health care; a behavioural health professional was co-located in the primary care setting and the primary care provider continued involvement in the mental health care of the service user  Primary care with a specialty referral system (SRS) for referral to a behavioural	Adults above 65 years of age with depression (major or minor)  Multi-site pragmatic RCT (N=840)  <u>Source of efficacy and resource use data:</u> RCT (populations with various conditions. Subgroup with depression: N=840; within VA n=365, outside VA n=475; individuals with major depression within VA n=214, outside VA n=302)  <u>Source of unit costs:</u> national sources	<u>Costs:</u> outpatient visits, inpatient care, nursing home, rehabilitation, emergency room, medication, service users' and caregivers' time and travel costs.  <u>Adjusted incremental total cost per person:</u> All: VA: -\$651, p=ns; Non-VA: \$46, p=ns Major depression: VA: \$877, p=ns; Non-VA: -\$380, p=ns  <u>Primary outcome measures:</u> Center for Epidemiologic Studies Depression Scale (CES-D) score; number of depression-free days (DFD) derived from the 20-item CES-D (score =0 indicated depression-free day, ≥ 16 full	Full VA sample: IC is dominant  Probability of IC being cost-effective >0.70 for any WTP/QALY-SF  Full non-VA sample: IC is dominated when using CES-D, DFD, QALY-DFD. When using QALY-SF, ICER of IC vs. SRS was \$94,929/QALY  Probability of IC being cost-effective <0.40 for any WTP/QALY-SF	<u>Perspective:</u> healthcare & service users' and carers' time and travel costs <u>Currency:</u> US\$ <u>Cost year:</u> 2002 <u>Time horizon:</u> 6 months <u>Discounting:</u> NA <u>Applicability:</u> partially applicable <u>Quality:</u> potentially serious limitations

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	<p>health provider outside the primary care setting, who had primary responsibility for the mental health needs of the service user.</p> <p>Both service delivery models were assessed within and outside the Veteran Affairs (VA) system.</p>		<p>symptoms and intermediate severity scores were assigned a value between depression-free and fully symptomatic by linear interpolation); QALYs estimated based on depression-free days (QALY-DFD), using utility weights of health=1, depression=0.59); QALYs estimated based on SF-36 (QALY-SF), using preferences for matched vignettes created following cluster analysis of SF-12 mental and physical component scores, elicited by US service users with depression using SG</p> <p><u>Adjusted incremental CES-D score per person:</u> All: VA: -1.3, p=ns; Non-VA: 2.9, p&lt;0.01 Major depression: VA: -2.8, p&lt;0.05; Non-VA: 3.45, p&lt;0.05</p> <p><u>Adjusted incremental DFDs per person:</u> All: VA: 3.89, p=ns; Non-VA: -5.73, p=ns Major depression: VA: 9.29, p=ns; Non-VA: -5.20, p&lt;0.05</p> <p><u>Adjusted incremental QALY-DFD per person:</u> All: VA: 0.005, p=ns; Non-VA: -0.016, p&lt;0.05 Major depression: VA: 0.019,</p>	<p>Major depression VA sample: ICER of IC vs. SRS:</p> <ul style="list-style-type: none"> <li>• \$322/CES-D point change</li> <li>• \$94/DFD</li> <li>• \$45,965/QALY-DFD</li> <li>• \$58,815/QALY-SF</li> </ul> <p>Probability of IC being cost-effective &lt;0.50 for WTP of \$40,000/QALY-SF and above</p> <p>Major depression non-VA sample: SRS is dominant in terms of CES-D ICER of SRS vs. IC:</p> <ul style="list-style-type: none"> <li>• \$73/DFD</li> <li>• \$34,167/QALY-DFD</li> <li>• \$79,590/QALY-SF</li> </ul> <p>Probability of IC being cost-effective &gt;0.50 for WTP \$50,000/QALY-SF and above</p>	

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			<p>p=ns; Non-VA: -0.011, p&lt;0.05</p> <p><u>Adjusted incremental QALY-SF per person:</u>                      All: VA: 0.007, p=ns; Non-VA: 0.0004, p=ns                      Major depression: VA: 0.015, p=ns; Non-VA: -0.005, p=ns</p>		