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Telephone-Administered Cognitive-Behavioral Relapse Prevention for Patients with Chronic and Recurrent Depression: The Multicenter NaTel-Trial

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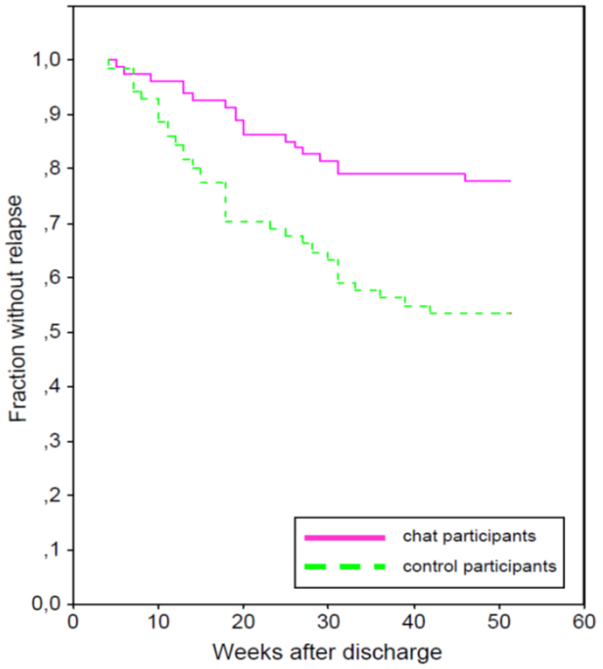
74 NRP Smarter Health Care National Research Programme

SSPH+ SWISS SCHOOL OF PUBLIC HEALTH

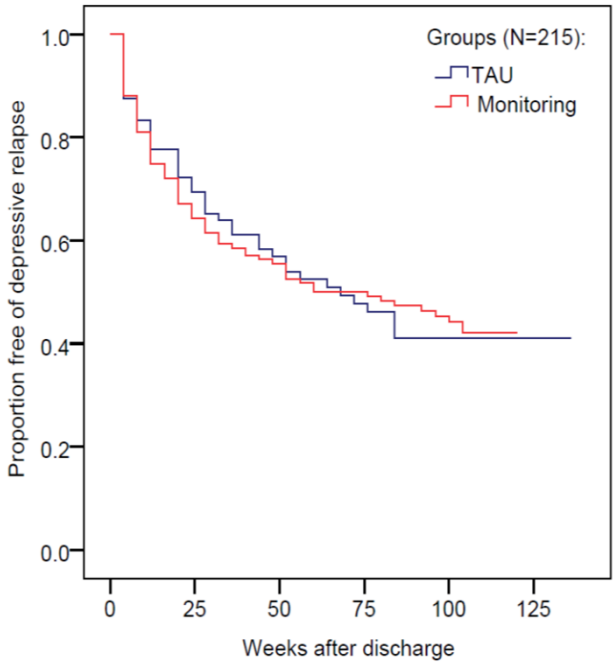
University of Zurich[UZH]

Background: Depression is a chronic condition

- Major depressive disorder is a highly recurrent condition that poses large, potentially life-long burdens on the affected individuals and their families, and causes immense direct and indirect health care costs (Ferrari et al., 2013; Olesen et al., 2012).
- Although the majority of depressed patients benefit from acute treatment, a substantial proportion remains at high risk for relapse or recurrence (e.g. Bauer et al., 2008; Kordy et al., 2016) …
- …with an increasing risk depending on individual risk factors such as number and severity of previous episodes, or residual symptoms (e.g., Judd et al. 2000; Solomon et al., 2000).



Bauer et al. (2008) Psychother Res



Kordy et al. (2016) Psychother Psychosom

Background: Need for systematic relapse prevention

- Accordingly, guidelines strongly recommend psychotherapeutic aftercare and maintenance treatments and/or continuation of antidepressant treatment, particularly for at-risk patients with chronic or recurrent depression (DGPPN et al., 2015).
- Antidepressant continuation treatment can reduce the relapse risk by up to 70% (Geddes et al., 2003), but…
- …adherence to antidepressants often suffers from low compliance and acceptability, with up to 50% discontinuing prematurely, which is why the prevention of depressive relapse remains a major challenge (Sansone & Sansone, 2012).

Empfehlung/Statement	Empfehlungs-grad
3-52 Zur Stabilisierung des Therapieerfolgs sowie zur Senkung des Rückfallrisikos soll im Anschluss an eine Akutbehandlung eine angemessene psychotherapeutische Nachbehandlung (Erhaltungstherapie) angeboten werden. LoE Ia: Metaanalysen [55, 877, 954, 957-959]	**A**

Quelle: S3-NationaleVersorgungsleitlinie Unipolare Depression

Background: Need for systematic relapse prevention

- Fortunately, efficacious (face-to-face) systematic psychological relapse prevention interventions have been developed and well tested in the lab (Biesheuvel-Leliefeld et al., 2015; Vittengl et al., 2007)…
- …but dissemination and systematic uptake of these interventions are challenged by barriers in outpatient service provision and delivery, leaving the majority of depressed patients under-, or wrongly treated (Bockting et al., 2015).
- The use of distance communication (telephone or Internet) has the potential to improve access to evidence-based treatments (e.g., Mohr et al. 2008, 2012; Steinmann et al., 2016), due to its flexible, low-threshold, scalable characteristics, and might, thus, be a promising approach in managing longterm conditions such as recurrent or chronic depression.
- The aims of the current study («NaTel-Study») are to develop, implement, and investigate the effectiveness of a telephone-delivered cognitive-behavioral continuation therapy (T-CT) as an aftercare intervention for patients with chronic or recurrent depression following acute-phase depression treatment.

Background: Lessons learned from our previous research

- Aftercare interventions using distance communication technology such as Internet chat groups, E-mail, and online supportive monitoring, following inpatient treatment were found feasible, acceptable, and effective in terms of relapse prevention and increased well-being in patients with common mental disorders, i.e. depressive and anxiety disorders, compared to TAU-controls (e.g., Bauer et al., 2008; Ceynova et al., 2014; Kordy et al., 2016; Wolf, 2011).
- Telephone-based psychotherapy and case management was found a feasible low-threshold intervention in stepped-care treatment models for patients with depression in routine care (Kivelitz et al., 2017; Watzke et al., 2014; Härter et al., 2015).
- A recent pilot study that tested telephone-based continuation therapy (T-CT) showed that patients preferred longer telephone sessions (50 min) over brief sessions (30 min) (Mahmutow et al, in prep.).

Key lessons learned for successful delivery of psychosocial aftercare:

→ Strong collaboration and alliance with index therapist / institution is crucial!

→ Adequate amount of personal contact!

→ Lowest possible threshold (technical, psychological) to „access“ the intervention!

NaTel-Study («**Na**chsorge per **Tel**efon»)

Aims: To investigate the effectiveness of telephone-delivered cognitive-behavioral continuation therapy (T-CT) as an aftercare intervention for patients with chronic or recurrent depression following acute-phase psychotherapy.

Design: Two-parallel group, multicenter, open-label, rater-blind randomized clinical trial comparing T-CT as an add-on to treatment as usual (TAU) versus TAU alone

Biometry: Institute and Policlinic for Medical Psychology, University Hospital Hamburg-Eppendorf, DE (PD Dr. Levente Kriston)

Clinical monitoring: Clinical Trials Center, UZH

Data and Safety Monitoring Board: Prof. C. Bockting (Univ. Utrecht, NL); Prof. S. Hollon (Vanderbilt Univ., USA); Prof. W. Rössler (UZH, CH)

Trial duration: 2017-2020

Clinicaltrials.gov: NCT03219879

Funding source: SNSF

NaTel-Study

Primary endpoint:

- Depressive relapse or recurrence post-discharge from index depression treatment
- Based on blind evaluation of semi-structured clinical interviews conducted at 6-, 12-, and 18 month follow-up (Longitudinal Interval Follow-Up Evaluation; Keller et al., 1987)

Secondary endpoints:

- Time-to-relapse, well-weeks, self-reported depressive symptoms, health-related quality of life, therapeutic alliance
- Acceptability of the intervention
- Health service utilization
- Safety (SAE)

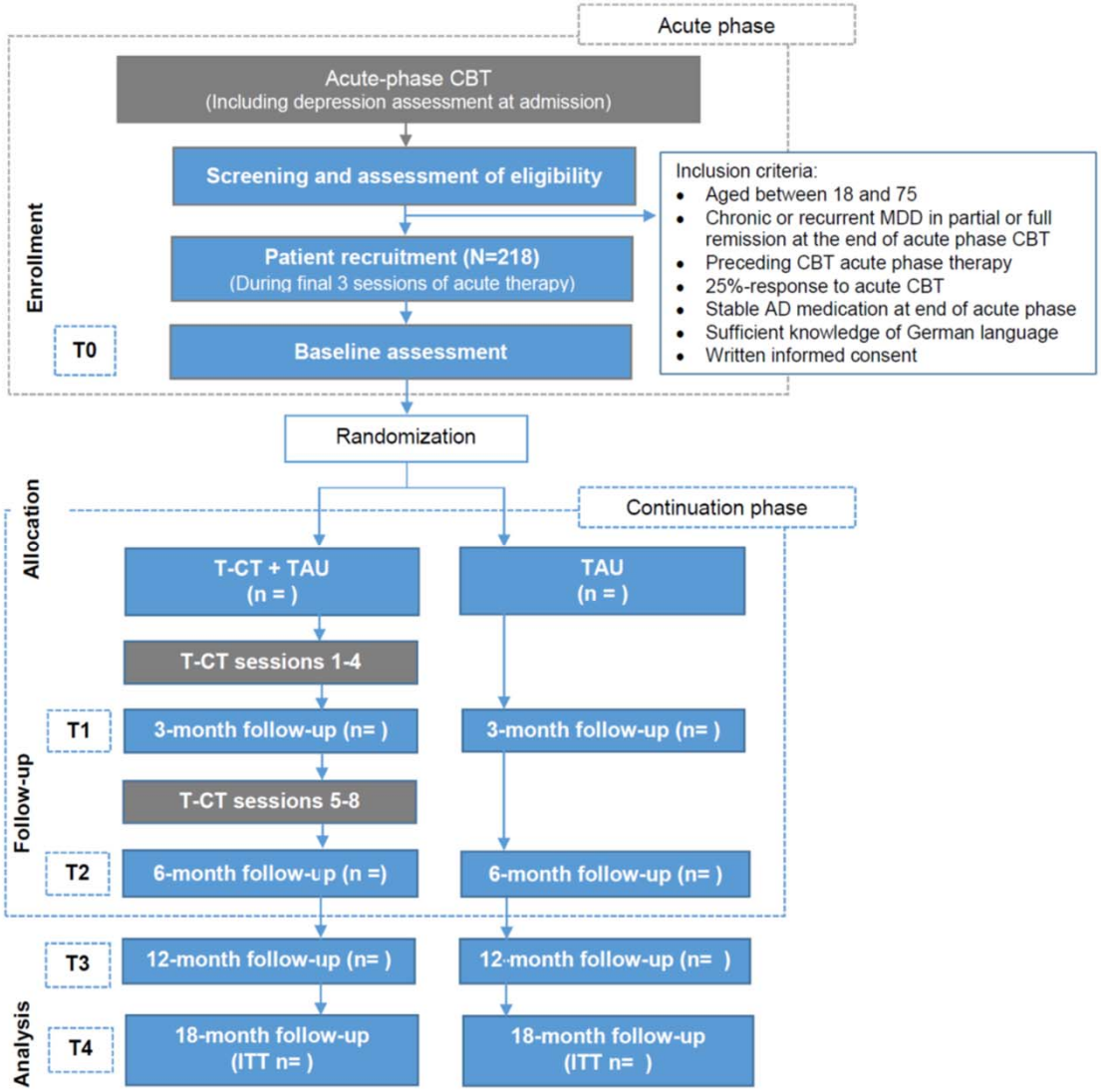


Figure 1. CONSORT flow diagram

Telephone-based continuation therapy

- Telephone-based continuation therapy (T-CT) combines telephone-approaches for the treatment of unipolar depression (Ludman et al., 2007; Mohr et al., 2012; Steinmann et al., 2016) with the principles of CBT relapse prevention protocols (e.g., Bockting et al., 2009; Jarrett et al., 2001; Risch et al., 2012).
- Semi-manualised intervention based on 1-day training
- 8 telephone sessions a 50-min delivered over 6 months post acute-phase CBT
- Conducted by index therapists at the participating hospitals
- Focus of the intervention (see Fig. 2):

  a) To identify preventive strategies learned during index CBT

  b) Support transfer of strategies to daily life

  c) to train general relapse prevention skills

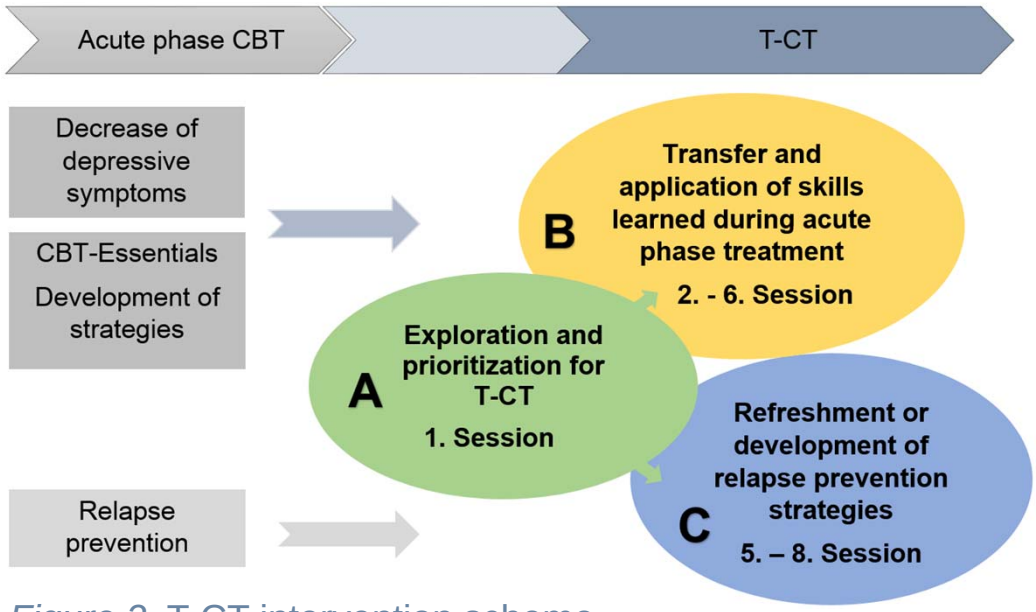


Figure 2. T-CT intervention scheme

Conclusions

- Current trial status:
  - → 8 hospitals and psychotherapy outpatient units in Switzerland and Germany have implemented T-CT and have started recruitment;
  - → >30 therapists trained;
  - → patient recruitment ongoing.
- Major challenges so far:
  - → Staff fluctuations at participating sites require ongoing training efforts;
  - → Recruitment of severely distressed patients into a comprehensive clinical trial with longterm follow-up.
- First experiences: T-CT is well accepted by participating hospitals and therapists, and fits well into their treatment programmes.
- Conclusions: Using telephones increases access to individualysed, evidence-based aftercare treatment due its low-threshold character, its flexibility for tailoring and scheduling the intervention, and its practicability for integration into the patients' everyday lives.

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Thank you for your attention!