

Research papers

Preventing depression relapse: a primary care approach

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ABSTRACT

- The importance of managing depression as a chronic illness to prevent relapse is established, and models for providing long-term care in the primary care setting are needed.
- There has been very limited research into primary care depression relapse prevention programmes, but there is support for a range of treatment strategies that contribute to relapse prevention.
- Research suggests that a primary care depression relapse prevention programme needs to provide an intensive, multifaceted and integrated approach, and include psychosocial treatments. It may be possible to take components of proven treatments and design novel preventive treatments.
- This paper outlines the development of a primary care depression relapse prevention programme called 'Keeping the blues away'.

The programme involves a multifaceted approach which incorporates a range of evidence-based psychosocial strategies, and enables a novel treatment approach that can be tailored to the individual patient.

- 'Keeping the blues away' is currently undergoing a cluster randomised trial. It is optimally placed within the 'Better Outcomes in Mental Health Care' initiative, and potentially provides a model for delivering accessible long-term depression care in the Australian primary care setting. Research about programmes such as 'Keeping the blues away' is needed to inform practice and policy.

Keywords: chronic, depression, integrated, long-term, multi-faceted, novel prevention, primary care, psychosocial, relapse, recurrence, risk factors

Depression, which is characterized by persistent depressed mood or loss of pleasure or interest in almost all activities, is a relapsing and recurring disorder and is now viewed as a chronic or long-term illness.^{1,2} Relapse is defined as early return of symptoms, and recurrence as later return of symptoms after a period of remission.³ The primary care relapse rate of depression has been reported to be 37–44.5%, and up to 20% of individuals with depression are said to have a chronic course.^{4,5}

Australian government policy addresses important mental healthcare issues, in particular the increasing role of the primary healthcare sector.⁶ The 'Better Outcomes in Mental Health Care' initiative facilitates the management of mental health problems in general practice. The general practice setting is ideal for the delivery of long-term mental

healthcare, but there is a need for general practitioners (GPs) to improve their care of patients with recurrent and chronic psychiatric illness, and to provide longer-term depression care including relapse prevention.^{4,7,8}

Most depression treatment studies have been undertaken in specialist rather than primary care settings, and practical well-researched models for delivering long-term care in the primary care setting are now needed.^{4,9} To address this need, an integrated primary care depression relapse prevention programme called 'Keeping the blues away' has been developed and is undergoing clinical trial in general practice. The programme aims to reduce the relapse rate of depression, reduce the severity of relapses, improve adherence to treatment and improve quality of life. In this paper the evidence informing

the development of the 'Keeping the blues away' programme will be outlined. The rationale for the programme will be discussed, and the programme itself will be outlined.

Primary care relapse prevention literature

A review of the literature was carried out to identify studies of primary care treatment programmes aiming to prevent relapse of depression. The following keywords were used – depressive disorder, family practice, primary health care, outcome, prognosis, prevention, relapse or recurrence. A range of electronic databases including Medline, PsycLit and the Cochrane Library were searched for journals from 1990 onwards in the English language. Bibliographies of identified studies were reviewed and key journals were hand-searched. Leading researchers were contacted to confirm the limited published material available on primary care relapse prevention studies.

The review located one primary care treatment programme aiming to prevent relapse of depression from the US. It consisted of a randomised controlled trial involving 386 patients between 18 and 80 years of age with recurrent depression or dysthymia. The intervention included education, two primary care visits with a depression specialist (such as a psychologist), three telephone consultations over a one-year period with feedback to the GP. It was reported that individuals in the intervention group had significantly greater adherence to adequate dosages of medication and were more likely to refill prescriptions during the 12-months of follow-up. These individuals also had fewer depressive symptoms, but relapse rates were not reduced over the 12-month follow-up period. It was suggested that a more intensive relapse prevention programme might be needed to decrease relapse rates.⁴

Given the limited research published on primary care treatment programmes aiming to prevent relapse of depression, it was necessary to review the general literature on depression management and relapse prevention to inform development of the 'Keeping the blues away' programme.¹⁰

Management of depression

A combination of medication and psychological therapy has been found to be most effective in managing depression.¹¹ A number of studies have

provided Level I evidence for the effectiveness of cognitive-behavioural therapy (CBT) and problem solving.¹²⁻¹⁴ Interpersonal therapy (IPT), which addresses interpersonal functioning (interactions with others, such as family or a partner) and its relationship with the depression, is well supported in the literature.^{15,16} These therapies have been incorporated into evidence-based guidelines, such as the Australian 'beyondblue' guidelines.⁷ Addressing lifestyle factors, developing the sense of well-being and bibliotherapy (working through a treatment book, such as cognitive-behavioural bibliotherapy) have also been reported to be useful strategies.^{10,17,18}

According to current literature, the principles of managing chronic disease can be applied to depression. These include GP and practice staff training, the establishment of case registers, referral and shared care procedures.¹⁹ A study of managed care by practice nurses (telephone monitoring and summaries to GPs) resulted in increased remission rates and level of functioning.²⁰ Randomised controlled trials have shown that education, collaborative models of care, ongoing monitoring or adherence to treatment are effective.²¹⁻²³ A model of care in which patients are followed-up systematically is recommended (such as regular visits or telephone reviews).^{24,25}

Relapse prevention

Risk factors (see Box 1)

The risk factors for relapse of depression are reported to be residual (including subthreshold) symptoms, and a past history of dysthymia or previous episodes of depression.²⁶⁻²⁸ Hospitalisation

Box 1 Risk factors for depression relapse/chronicity

- Continued symptoms
- Past history of dysthymia or depression
- Hospitalisation prior to diagnosis
- Benzodiazepine use
- Early discontinuation of antidepressants
- Psychiatric co-morbidities
- Long duration
- Early onset
- Severe depression
- Negative thinking styles
- Childhood experience of loss or adversity
- Stressful life experiences
- Psychosocial difficulties

in the period prior to relapse, benzodiazepine use, psychiatric co-morbidities (including substance use and panic disorder) and early discontinuation of antidepressants are risk factors.^{5,29,30} Long-term outcome is related to remission status at three months after initiating treatment, and longer duration of illness is predictive of poor recovery.^{20,31} Shorter time to full remission is protective against relapse, and early onset or severe depression with high psychopathology at diagnosis are risk factors for chronicity.^{28,32} Childhood experience of loss or adversity is a risk factor for chronic depression.³³

The literature highlights the potential role of cognitive, psychological and social (psychosocial) factors in depression relapse.^{34,35} There is support for initial depressive episodes being precipitated by stressful life experiences, subsequent episodes by negative thinking styles, and for protracted psychosocial stressors having a role in maintaining depression.^{34,36} It may be that patients who have had depression become sensitised to subsequent episodes.³⁷ It is proposed that cognitions that affect intra and interpersonal communication, or those related to unrealistic goals, perceived lack of control or self-focus influence the chronic nature of depression.³⁸

Treatment strategies to prevent relapse

Depression guidelines support early vigorous treatment to prevent chronicity.³⁹ Duration of therapy will depend on the patient's history, and further studies are needed in this area to establish optimum lengths of therapy.⁴⁰ Continued therapy after the acute phase is critical in the prevention of relapse.^{7,8} For recurrent depression, the 'beyondblue' guidelines recommend maintenance antidepressant therapy and/or a CBT booster and regular monitoring for up to three years. If there has been no prior psychological therapy it is advised that CBT or IPT sessions are added, with regular booster sessions.⁷

There is Level I evidence in the literature for the effectiveness of CBT and IPT in preventing relapse.⁴¹⁻⁴³ A study of relapse rates after patients received continuation CBT found a significantly lower risk of relapse compared to those patients who received no further therapy.⁴² The trend in studies of sequential treatments (antidepressant followed by psychological therapy) has been positive.⁴⁴ A study of preventing recurrent depression with CBT after pharmacotherapy resulted in lower relapse rates persisting for four years.⁴⁵

Studies support the combination or sequential use of different treatments to address different phases of depression, suggesting that multiple interventions may provide more long-term benefit to patients than a single treatment delivered on its

own.⁴⁶ For patients with residual symptoms, combined CBT and medication have been shown to be effective.^{14,47} IPT has been found to be effective in combination with medication in recurrent depression.⁴³ It is suggested that further work is needed to find ways of extending care across the different phases of the disorder, and to tailor treatments to the different needs of depressed patients, for example those with a history of several episodes of depression.⁴⁶

As in the management of other chronic illnesses, the literature recommends identifying risk factors for relapse and minimising them, for example by treatment of co-morbidities.⁴⁸ The general literature emphasises the role of psychosocial difficulties in depression, and it follows that it is important to reduce such difficulties.^{31,34} One study of women suffering from chronic depression found that a reduction in the score for ongoing life difficulties, the presence of social support and a sense of hope for a better future preceded improvement.⁴⁹ Management should also involve the enhancement of protective factors to help reduce the risk of relapse.⁵⁰ The 'beyondblue' guidelines recommend considering increasing social support (for employment and housing, befriending) and teaching problem-solving, and having a plan for managing early relapse symptoms is advised.⁷

Segal suggests that it might be possible to take the active ingredients of proven treatments and design novel preventive treatments that are skills based.⁴⁶ For example, a mindfulness-based cognitive therapy approach that teaches patients core cognitive-behavioural skills and meditation has been developed, and found to reduce relapse in patients with three or more episodes of depression.^{51,52} In mindfulness-meditation patients learn to be aware of their mood becoming more depressed, and to bring their thinking back to the present whenever they are diverted by negative thinking patterns.⁵¹

Discussion

Background research suggests that a primary care depression relapse prevention programme needs to provide an intensive, multifaceted and integrative approach, and include treatments that address psychosocial factors.⁴ It is important to incorporate evidence-based strategies and current management guidelines, and as outlined there is support in the literature for:

- assessment and treatment of co-morbid problems
- early vigorous treatment

- long-term management based on a chronic disease management model
- education about depression and relapse
- encouragement of adherence to medication
- strategies to address risk factors for relapse
- the development of cognitive-behavioural, problem-solving and interpersonal skills
- combined and sequential treatments
- continuation of drug therapy after the acute phase
- addressing psychosocial/interpersonal difficulties
- addressing lifestyle and wellbeing issues
- counselling that fosters hope for a better future
- bibliotherapy
- more intensive follow-up, monitoring and a plan for managing early relapse symptoms.

'Keeping the blues away' (see Box 2)

Given that 75% of patients with depression present to their GP who then continues to play a central management role, it is important that there is access to effective long-term management programmes aiming to prevent relapse.⁷ The 'Keeping the blues away' programme is designed for the general practice setting, but is likely to have application to other primary care settings. It has been developed

Box 2 'Keeping the blues away': ten-step relapse prevention programme

- 1 Medical and psychosocial assessment and goal setting, monitoring progress
- 2 Information about depression and anxiety and relapse prevention
- 3 Healthy lifestyle issues (nutrition, exercise, sleep, managing stress)
- 4 Useful coping skills (mood diary, problem solving, relaxation techniques)
- 5 Helpful thinking or cognitive strategies (thought monitoring, analysis and challenging)
- 6 Dealing with psychological issues (self-esteem, loss and grief, anger and guilt, hopelessness and suicidal thoughts)
- 7 The benefits of activity (activity scheduling, laughter and humour)
- 8 Fostering social support and skills, dealing with relationship issues and unemployment
- 9 Developing a plan to manage early symptoms of relapse
- 10 Reassessment, review and helpful resources

over several years, and is based on literature, current thinking on depression relapse prevention and clinical experience. The preclinical phase, involving development of the programme and extensive materials, and piloting, has been completed. The programme is now undergoing a cluster randomised trial.

GPs are trained to carry out the programme (20 hours). Medication is used as clinically indicated and in accordance with current guidelines. The programme is started once the patient's depression has been stabilised by initial treatment, and involves a multimodal, skills-based treatment approach. It is based on ten steps, incorporating a range of evidence-based psychosocial strategies, and can be tailored to the individual patient. GPs and patients are provided with materials including a GP training manual, patient treatment manual (220 pages), patient journal and relaxation CD.

The 'Keeping the blues away' program is accredited for Level 2 of the 'Better Outcomes in Mental Health Care' initiative. Under this initiative, patients are seen by their GPs for assessment and 6–12 sessions of 'focused psychological strategies'. 'Keeping the blues away' involves regular follow-up for 12 months (visits to the GP and phone calls), including booster treatment sessions. There is the potential for this programme to be carried out in collaboration with allied health professionals, and to be continued over a longer period.

Conclusion

There is a need to develop practical treatment programmes for GPs to use in the long-term management of patients with depression. The current paucity of literature relating to primary care and relapse prevention emphasises the need to develop and research relapse prevention programmes. The literature supports a range of treatment strategies that help prevent depression relapse, and highlights the need for novel, multifaceted, skills-based treatment approaches.

The 'Keeping the blues away' programme which is currently undergoing a cluster randomised trial in the general practice setting involves a multimodal approach, incorporating a range of evidence-based psychosocial strategies. It is optimally placed within the 'Better Outcomes in Mental Health Care' initiative, and potentially provides a model for delivering accessible and acceptable long-term management of depression. Research about programmes such as 'Keeping the blues away' is needed to inform practice and policy.

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CONFLICTS OF INTEREST

None.

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