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Management of recurrent depression

Background
Depression is a potentially recurring or chronic disorder. The provision of evidence based treatment and effective practice organisation is central to chronic disease management, and these principles can be applied to managing depression.

Objective
This article outlines the principles of chronic disease management, including the use of management plans and a team care approach, and their application to the management of depression.

Discussion
Treatment approaches that systematically assist patients in managing their chronic disease are more effective than those based on acute care. Depression treatment guidelines are available, as well as primary care initiatives which facilitate comprehensive and long term mental health care, including relapse prevention strategies. A number of risk factors for depression relapse have been identified, and research has recommended that novel intensive relapse prevention programs need to be developed.

Depression is a disorder in which both relapse (the early return of symptoms) and recurrence (the later return of symptoms after a period of remission) are common.[1,2] It is reported that the majority (77.5%) of patients with depression will relapse or have a chronic course, and it is therefore desirable that a long term approach to care is taken.[3,4]

Chronic disease management and depression

Principles of CDM

Patients with chronic disease have different needs to individuals with acute illness, and approaches that systematically assist patients in managing their chronic condition are reported to be more effective than those based on acute care.[5] A chronic care model, developed by Wagner,[6] focuses on improving health outcomes through:[6]

- reorientation of the health service to provide planned care
- evidence based practice
- patient centred support including management planning[7]
- clinical information systems to organise patient information
- teamwork[8,9]
- the use of community resources.[10]

Table 1 highlights important systems related to chronic disease management (CDM) in the general practice setting.

It is also reported that patients who are more active in the health care process have better outcomes.[11,12] Self management involves managing symptoms of illness and its impacts on functioning, adhering to treatment regimens, and engaging in activities that promote health.[7]

Chronic disease management involves the development of a management plan (in collaboration with the patient) based on a comprehensive assessment and including:

- a list of problems to be addressed
- strategies to be used
- referral and longer term management plans.[13]

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A team approach to CDM

Chronic disease management involves practice based teamwork which may involve the general practitioner, practice manager, practice nurse and administration staff. Strategies for building teamwork in general practice include having good leadership and shared goals, defining staff roles and ensuring good communication within practices.[8,9]

Mental health care also involves a multidisciplinary team approach to enable patients to benefit from the different skills and knowledge available from practitioners in different professions. Potential mental health team members may include GPs, psychiatrists, practice nurses, clinical psychologists and psychologists, social workers, mental health nurses, occupational therapists, personal helpers and mentors, and Aboriginal and Torres Strait Islander health workers. Consumers and carers also provide essential input.[14,15]

Current treatment of depression

What do treatment guidelines recommend?

Depression treatment guidelines recommend maintaining a treatment regimen for as long as is necessary to allow the person to stabilise. This will be at least 1 year, and where there is a history of recurrence, or significant risk of recurrence, the person should be monitored and treated actively for 3 years.[16] *Table 2* outlines recommended depression treatment guidelines.

Potential barriers to depression care

Potential barriers to care include social stigma related to depression, the GP's limited time or training, and not having systems in practices for CDM.[17] Possible solutions involve the development of registers and reminder systems to ensure active follow up of patients with depression, and providing greater support from mental health professionals.[9] Campaigns to reduce depression related stigma, such as those by *beyondblue*, are vital, as is the dissemination of interventions that empower patients managing depression.[18]

Depression in the Australian primary care setting

In 2001–2002 the Australian Commonwealth Government established the Better Outcomes in Mental Health Care initiative (BOMHCi) to train GPs to undertake a mental health assessment, management plan and review process, and focused psychological strategies (FPS). It also included programs to enable patients with mental health disorders to access allied psychological services (via divisions of general practice) and psychiatric support.[19]

Table 1. Important systems for quality CDM

- Information management systems – appointments, disease registers, reminders/recalls and treatment guidelines
- Practice governance and business management
- Teamwork with delineation of roles and responsibilities
- Linkages with other providers and community agencies
- Patient education, including access to resources, education programs and self management
- Staffing – incorporating practice nurses and allied health practitioners
- Support from divisions of general practice
- A multidisciplinary team approach including referral and shared care practices between GPs and other mental health professionals
- Clinical support systems (eg. templates and guidelines)
- Staff training
- Focus on patient centeredness and long term care
- Quality improvement practises (eg. audits)
- Physical infrastructure appropriate for chronic care

Table 2. Recommendations from depression treatment guidelines[16]

- Mild depression should be managed within primary care and should include psycho-education, lifestyle changes, supportive monitoring and the use of strategies such as problem solving. If symptoms persist then brief CBT, IPT, or selective serotonin reuptake inhibitors (SSRIs) should also be used
- For moderately severe depression, an antidepressant or brief psychological therapy is recommended, with regular progress monitoring
- For moderately severe depression with comorbid substance use or physical disorders, concurrent treatment of the physical disorders and substance use will be required
- Severe depression is treated with an antidepressant and once there has been a response, psychological therapy may be added
- For recurrent depression or failure to respond to first line treatment through an SSRI or psychological therapy, swapping to another class of antidepressant should be considered or combination therapy
- Psychotic depression or severe depression with suicide risk should be managed by specialist mental health services

In 2006, the Better Access to Mental Health Care initiative was established to enable individuals with mental health issues to access the services of GPs, psychiatrists and mental health professionals. It encourages GPs to work more collaboratively with psychiatrists, clinical psychologists and other health professionals to achieve improved patient outcomes.[19] All GPs are now able to undertake a patient assessment, develop a management plan, and refer to a mental health professional.

Table 3 lists current Medicare Benefits Schedule (MBS) item numbers available to GPs undertaking patient mental health care planning. In addition, there are item numbers allowing suitably trained GPs working in accredited practices to deliver FPS. A mental health issue may also be addressed as part of a CDM GP Management Plan and Team Care Arrangement (item numbers 721 and 723) if the mental health issue is one of several chronic or terminal conditions and better addressed as part of these plans.

Relapse and recurrence of depression

What are the risk and protective factors for depression relapse?

Identifying and minimising risk factors for depression relapse is recommended (*Table 4*).[20] The potential role of cognitive, psychological and social factors in depression relapse is highlighted in the literature.[21] Methods for enhancing protective factors for patients include teaching them problem solving and having a plan for managing early relapse symptoms.[22] Research has suggested that the use of medication to treat depression leads to a more rapid recovery, but that patients do better in the long term with additional psychological therapy.[23]

Table 3. GP Mental Health Care Plan Medicare item numbers[36]

- Item 2710 – Mental Health Assessment and Plan (GP Mental Health Care Plan): preparation by a medical practitioner of a GP Mental Health Care Plan for a patient
- Item 2712 – Review of the Mental Health Assessment and Plan: review by a medical practitioner of a GP Mental Health Care Plan (Item 2710) or a Psychiatrist Assessment and Management Plan (Item 291)
- Item 2713 – Mental Health Consult: attendance by a medical practitioner on a patient in relation to a mental health issue, involving taking relevant history, identifying presenting problems, providing treatment, advice, and/or referral for other services or treatments, lasting 20 minutes or more

Table 4. Risk factors for recurrent depression

- Genetic vulnerability[37]
- Past history of dysthymia or previous episodes of depression[38]
- Hospitalisation in the period before relapse
- Benzodiazepine use
- Psychiatric comorbidities such as substance use and panic disorder
- Early discontinuation of antidepressants[3]
- Longer illness duration[39]
- Early onset or severe depression at diagnosis
- Residual (including sub-threshold) symptoms[38]
- Childhood experience of loss or trauma[38]
- Psychosocial stressors and negative thinking styles[21]
- Lower self efficacy to manage depression[40]

Relapse prevention strategies

Treatment guidelines for depression support both early vigorous treatment, and continued therapy after the acute phase.[24] In recurrent depression, maintenance antidepressant therapy and regular monitoring is advised, and in addition cognitive behavioural therapy (CBT) or interpersonal psychotherapy (IPT).[22] There is evidence that CBT has an enduring effect that assists in preventing the recurrence of depression.[25]

Segal[26] suggests that it might be possible to take the active ingredients of proven treatments and design novel preventive treatments that are skill based.[26] For example, a mindfulness based cognitive therapy approach that teaches patients cognitive behavioural skills and meditation has been found to reduce relapse in patients with three or more episodes of depression.[26,27]

Why use a relapse prevention plan?

Relapse prevention involves putting supports in place to help the patient stay well and to reduce the likelihood of future illness. It includes developing personal strategies to cope with stressors, and recognising early warning signs of illness and responding to them.[28] Having a plan for managing early relapse symptoms assists the person to identify their particular symptoms at an early stage, and to identify potential high risk situations (such as during times of stress).[29] The plan involves recording what the patient should do and who they might contact if symptoms appear (*Figure 1*).

Are there relapse prevention programs for the primary care setting?

One primary care treatment program, developed by Katon in the United States, aimed to prevent depression relapse by improving medication adherence, increasing early help seeking behaviours, and increasing the use of depression treatment techniques. The intervention involved psycho-education, several visits with a depression specialist, and three telephone consultations with a nurse over a 1 year period. A well designed randomised controlled trial to evaluate this program found that individuals in the intervention group had significantly improved medication adherence and fewer depressive symptoms, though relapse rates were not reduced. The study concluded that primary care requires organisational change to improve chronic illness management, and that a more intensive relapse prevention program might be needed to decrease relapse rates.[30]

'Keeping the blues away' (KBA) is a treatment program designed to reduce the severity and relapse of depression. It incorporates evidence based depression treatment and relapse prevention strategies such as cognitive behavioural skills and having a relapse prevention plan. The development of the KBA program and results of a pilot study have been published elsewhere.[31,32] 'Keeping the blues away' uses a 10 step approach to treatment that incorporates assessment and treatment planning (*Table 5*). The program is delivered during regular appointments over a 3 month period, and is followed by regular patient

Figure 1. Developing a plan for managing relapse[33–35]

1. Identify early warning symptoms of depression, eg. difficulty sleeping, tearfulness, loss of interest in usual activities, or increased irritability.

Early warning symptoms of depression
1.
2.
3.
4.
5.

2. Identify possible high risk situations for relapse, eg. times of stress, times related to relationship difficulties or becoming less involved with activities. Consider strategies cope with high risk situations, eg. relaxation techniques.

Possible high risk situations and strategies to cope
1.
2.
3.
4.
5.

3. Prepare an emergency plan to put into action when the depression is relapsing, such as monitoring and challenging thinking, taking some time out, getting support from friends or family, making an earlier or urgent, appointment with the GP, using medication (under the guidance of the GP), talking with the GP or mental health professional.

Emergency plan
1.
2.
3.
4.
5.

review for the remainder of the 12 month period. The program is presented as a treatment manual that serves as a guide for the GP or health professional, and a separate workbook and relaxation CD for patients. A training program has been developed for practitioners.

The results of a pilot study of KBA (involving 110 patients) found no significant differences between the intervention (KBA) and control groups in terms of relapse rates. However, there was a nonsignificant tendency for relapse to be reduced in the KBA group (RR intervention = 0.77; 95% CI: 0.5–2.05). Age was found to be protective of relapse, with older participants (50+ years) in the KBA group showing a significantly lower probability of relapse than those in the control group (p=0.018). There was an overall decrease in depression scores in the intervention and control groups.

Participants in the intervention group had more severe depression at the outset of the study, and the reduction in severity in participants

Table 5. 'Keeping the blues away': 10 step relapse prevention program

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

in the KBA group who had been experiencing depression symptoms for more than 6 months was nearly significant (p=0.06). The KBA program was positively received by GPs and their patients, and the study concluded that the program was particularly promising for both older patients and for those with more severe or persistent symptoms.[32] A computer assisted version of KBA has now been developed and will be evaluated in 2008–2009.

Conclusion

Depression is a potentially recurrent or chronic condition and therefore requires a long term management approach.[4] Practices can apply CDM principles and systems to improve their organisational capacity to manage depression and help prevent relapse. Primary care relapse prevention strategies draw on CDM principles, such as ensuring follow up, monitoring progress and adherence to treatment. Utilising these strategies, as well as management and relapse prevention plans, can assist GPs in improving health outcomes for their patients.

Resources

- BOMHCi and other commonwealth initiatives: www.health.gov.au
- Information on mental health training for GPs: www.racgp.org.au
- Information on team work in primary care: http://notes.med.unsw.edu.au/cphceweb.nsf/page/CD-Current-Teamwork
- The KBA program: www.keepingthebluesaway.com.

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