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Improving long-term outcome of major depression in primary care

Smit, Jannetje

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Chapter 1

General introduction

Background

The present thesis addresses effectiveness of a new treatment for depression in primary care. This care program is not only concerned with the course and outcome of the current depressive episode, but also with the prevention of it's potential successors.

Major depression is a common mental disorder: lifetime prevalence figures between 14% for men and around 24% for women have been reported in the general population in the Netherlands; 12 month prevalence was almost 8 % (Bijl *et al.* 1998). These findings compare to those reported elsewhere in the western world (Andrews *et al.* 2001; ESEMeD/MHEDEA 2000 consortium 2004, Hasin *et al.* 2005). Depression is a disorder characterized by low mood states and loss of interest or pleasure ; activities normally experienced as pleasurable are not enjoyed anymore. This low mood is accompanied by physical symptoms like trouble sleeping and an overwhelming sense of energy loss, and by a whole range of cognitive connotations such as feelings of guilt and worthlessness, loss of self-confidence and difficulty thinking. Moreover, impairments in social and occupational functioning coincide with the depressive symptoms, which has considerable impact on well-being, relationships and overall quality of life. These adverse consequences are well established (Ormel *et al.* 2004a; 2004b, Űstun *et al.* 2004; Buist–Bouwman *et al.* 2006) . Taken together, these may be defined as ‘the human cost’ of depression (McIntyre & Donovan 2004).

Changed perspective on depression

In the last decades, much progress has been made in the recognition and treatment of depression. Increasingly, it has become clear that depression is often a persistent or recurrent disorder. Longitudinal research has shown that many patients do not fully recover and that those who do run a high risk of experiencing at least one other episode during their lifetime (Belsher & Costello 1988; Mueller *et al.* 1999; Solomon *et al.* 2000). One of the best established risk factors for recurrent depression is the number of previous episodes: the higher that number, the greater the chance that more episodes will follow (Kessing *et al.*

2004). There is also growing evidence for incomplete recovery, marked by residual symptoms following treatment, as an important risk factor for poor long-term outcome (Paykel *et al.* 1995; Judd *et al.* 1998, 2000; Kennedy & Paykel 2003).

The likelihood of depression following a chronic course is considerable. Findings from a Dutch community population study showed that 28% of those depressed at baseline were still, or again, depressed at the assessment one year later; moreover, once depression was still present after 12 months it was also very likely to persist after 24 months (Spijker *et al.* 2000; 2002). These findings add to the growing evidence that increased episode duration has a negative impact on the probability of recovery (McIntyre & Donovan 2004).

Long term prognosis in primary care

Although longitudinal studies in primary care are still scarce, there are many indications that the risk of depression running an unfavourable course is also present in these patients (Simon 2000) . The Groningen Primary Care Study , a naturalistic study in a representative sample of Dutch general practices , found that of the depressive disorders observed in practice attenders only 53% had fully recovered 3,5 years after the index consult (Ormel *et al.* 1991;1993). Lin and colleagues (1998) found relapse rates of 37% within one year in a primary care population. Van Weel *et al* (1998), in a historic cohort study with patients formerly classified as depressive by their primary care physician (PCP) who were followed up for 10 years after this diagnosis, reported recurrence rates of 40%. Brink and co-workers (2002) observed persistent depression in 29% and incomplete recovery in 15% of depressed patients followed for one year. Also, while 39% recovered within six months, episode duration was longer for 17% of the patients included in this study.

Key role for primary care physicians

Primary care is generalist care and accessible to all, irrespective of the exact nature of the health problems. The PCP has a crucial role as gatekeeper in the Dutch health care system, controlling access to specialist healthcare for somatic as well as psychiatric conditions. On a daily basis, PCPs are involved in a huge variety of activities. Thus, they see

the whole range of patients with mental disorders, ranging from patients with a few subthreshold symptoms to those with severe psychopathology. The open access of the system often results in a longitudinal relationship between patients and their PCP.

The fact that many people suffer from depressive disorders, does not necessarily imply that they are (a) in need of treatment or (b) actively seek care or (c) receive adequate treatment when they look for help. In the Dutch population study mentioned before, around half of those diagnosed to be depressed according to a standardized psychiatric interview, had actively sought professional help for their condition. The majority of these individuals went to their PCP, demonstrating the key role fact of these healthcare professionals in the recognition and treatment of depression (Spijker *et al.* 2001; Linden *et al.* 2004). Findings showed that higher levels of care were associated with more severe depression, longer duration of previous episodes and more co morbid anxiety. Next to these clinical characteristics, functional limitations were also of relevance for recognition and treatment.

Implications

It seems clear that to be effective on the longer run, treatment of depression should not only aim at alleviating the acute episode and symptoms but also target probable long-term outcome. For this, further targeting of treatment to individual patients based on their personal history of depression, may be warranted. This would also suggest that including relapse - and recurrence prevention strategies from the start, might be a rational way to improve the bleak long-term prognosis. In addition, like in other chronic conditions, more emphasis on self-care and self-management of depression could make a contribution. In many cases, people prefer to try and sort out their problems themselves. Learning more effective ways of self-care and getting advice and support in using self-management strategies, for example with the aim of recognizing early warning signs of depression recurrence so as to be able to act before this escalates, might therefor be an important element in more effective depression treatment. In order to find out which intervention strategies would work , especially in the primary care context, further research was needed .

Reason for the thesis

The main objective of the study presented in this thesis was to explore the potential of a structured, psycho-educational self-management intervention aimed at the prevention of depression relapse and persistence, and the possibilities of incorporating such an approach in the primary care setting. The intervention consisted of the Depression Recurrence Prevention (DRP-) Program, which included components of chronic disease management programs such as provider-initiated follow-up care, in which self-management and patients' adherence to a treatment- and prevention plan were regularly monitored and reinforced, and an ongoing relationship between patient, prevention specialist and PCP.

The goal of the randomised trial was to compare the treatment effects of this DRP-Program on depression severity, course and outcome over a total of three years with effects of the care that is usually provided for major depression in primary care. In addition, to evaluate whether there were bonus effects of psychiatric consultation or brief Cognitive Behavioral Therapy added to the basic format of the DRP-Program. The focus of the trial was on determining the longer-term benefits of the different treatment strategies, including treatment as usual. Central question to be answered was : which treatment protects best against relapse, recurrence and chronicity of depressive disorders identified in primary care?

Contents and outline of this thesis

Chapter 2 contains a detailed description of the design and implementation of the randomized controlled trial. This chapter describes the design of the trial, gives an overview of the contents and format of the experimental interventions and outlines the procedures and methods used.

Chapters 3 through 6 are concerned with the effects of the Depression Recurrence Prevention Program. In c*hapter 3,* results concerning compliance, contacts with the primary care physician, self-efficacy and patient satisfaction with the DRP-Program are described . Clinical effectiveness of the DRP-Program is the focus of chapters 4 and 5. In c*hapter 4,* short term intervention effects of the enhanced treatment program on depression course and

outcome are examined, while in *chapter 5* the spotlight is on it's long-term effects (up to 36 months). *Chapter 6* concerns the cost-effectiveness of the enhanced treatments.

In *chapter 7* a narrative review based on a sytematic literature search to identify strategies for improvement of routine treatment of major depression in primary care is presented. Included were trials conducted in primary care and reporting at least six months patient outcome data of psychological treatments and supportive interventions for major depression in adults; in addition, literature on patient outcome of educational programs and targeted approaches used in other caresettings were included.

Finally, in *chapter 8* the findings of the study are summarized and their implications for practice and future research discussed.