**EDITORIAL**

## Treating recurrent mood disorders seriously

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The current model of health service for people with moderate to severe recurrent mood disorders in New Zealand usually involves referral from primary care to specialty mental health services (or in some cases direct referral) and referral back to primary care following stabilisation of the acute phase of the episode. Despite its limitations in relation to sample size, and the representativeness of its sample, the Stangroom, Morriss and Soosay study\(^1\) (in this issue of the *NZMJ*) has identified that 72% of people discharged from community mental health services, most of who had a mood disorder diagnosis (60%), make contact with their GP at least 3–4 months. They found that low engagers and high engagers had readmission rates of 21.4% and 23.5% respectively. Another interesting finding was that one-third of those discharged to GP care did not have their medications renewed. These are not particularly reassuring results.

There are problems with this silo approach to care delivery for those experiencing recurrent mood disorders. This model may meet the fiscal accounting requirements of the New Zealand health system but it can be argued that it fails those with recurrent mood disorders. This approach does not take treatment of recurrent of mood disorders seriously and it can lead to fragmented and poorly co-ordinated care. The World Health Organization\(^2\) has identified that most health systems need to redesign their current models of health care delivery which focus on acute care to address the very different ongoing needs of those with long-term conditions including recurrent mood disorders.

Depression is the leading cause of disability as measured by the World Health Organization’s Years Lived with Disability and the fourth leading contributor to the global burden of disease (based on Disability Adjusted Life Years [DALY]) in 2000. By the year 2017, depression is projected to reach second place of the ranking of DALYs calculated for all ages and both sexes.\(^3\) The disability associated with depression is related to it being a recurrent disorder with a 50% risk of relapse.\(^4\) Only 20–25% of people diagnosed with major depressive episode have a sustained recovery. Each additional episode increases the risk of recurrence by 18% and for the majority of people with major depressive disorder, recurrence after recovery is the rule.\(^5\)

The more complex recurrent mood disorder, bipolar disorder, is ranked as the sixth leading cause of disability and contrary to the notion that patients return to their premorbid level of functioning, residual symptoms and a lack of sustained recovery are common. Few patients with bipolar disorder experience a simple trajectory of clear-cut episodes, with complete recovery. Judd et al\(^4\) found that patients with bipolar I disorder were symptomatically ill on average 47.3% of weeks throughout a mean of 12.8 years’ follow-up. Depressive symptoms are predominant and subsyndromal symptoms are nearly three times more frequent than syndromal-level major depressive and manic symptoms. The current model of acute care delivery in New Zealand (admission to specialty mental health services for mood stabilisation and discharge following the acute phase) fails to address the chronic and relapsing nature of bipolar disorder, in particular, and for many people who experience recurrent depression. The GP model is not resourced to undertake this role and specialty services are not resourced for treatment unless it is an acute episode. Many patients continue to have syndromal relapses and subsyndromal, fluctuating symptoms that impact on social, interpersonal, occupational and daily functioning and there is evidence that GPs are not always able to diagnose or treat these symptoms.\(^6\)–\(^8\)

Both the current acute care model and the primary care model have an almost exclusive reliance on medication. This is despite a lack of evidence that pharmacological treatments have resulted in an improvement in the long-term outcome of patients with mood disorders.\(^9\) Given the issues related to the efficacy of antidepressants; recurrence; a lack of evidence for the long-term use of
antidepressants; and an estimated non-adherence rate of 50%; there is a need to examine alternative models of care.

A collaborative care model that bridges the primary and specialty care silos is one possible model. Most collaborative care models talk of integrating mental health care into primary care but there is another model that sits at the interface of the two. One example of this type of specialist care model has been described by Kessing et al.\textsuperscript{10} It would be an interdisciplinary specialty service that recognises the unique complexities of recurrent mood disorders and does not leave the management of these to generalist practitioners. The interface model would have specialist practitioners delivering specialist care in a primary health care model that emphasises long-term continuity of care not just while mood symptoms are sub-syndromal (GP) or until the mood disorder is no longer acute (specialty mental health services).

People with recurrent mood disorders experience persistent mood symptoms, functional deficits and cognitive impairment that leave them more vulnerable to recurrence of full mood episodes. There is good evidence that recurrence occurs as a result of life adversities. There is strong and increasing evidence\textsuperscript{12,13} that the combination of medication and disorder-specific psychotherapy improves functioning, relapse, treatment adherence and is also more cost effective in the long-term for recurrent mood disorders. The specialty interface model would need to address mood management strategies alongside interventions to improve coping strategies and day to day social, interpersonal, occupational and cognitive functioning. One possible solution is a model that integrates specialist medication management from psychiatrists with extensive psychopharmacological experience, and both intensive and maintenance psychotherapy delivered by experienced mental health nurses, social workers or psychologists. Generalist practitioners could be integrated into this interface model to monitor the physical health care needs prevalent among those with mood disorders. People with recurrent mood disorders would be enrolled in this clinic on discharge from specialty mental health services and may become part of a registry of recurrent mood disorders similar to those used internationally.\textsuperscript{11}

This interface collaborative model would require re-thinking how funding is allocated as it would need to be funded from both silos. It is envisaged that this model would eliminate structural service delivery impediments such as the need for referrals and wait-lists. Implementation requires a more responsive health system design that can incorporate flexible models of patient-centred service delivery that can provide quality care. While this may have short-term financial and resource implications it is likely to be more cost-effective in the long-term.

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**References**


