**Introduction**

Approximately half of patients will experience relapse or recurrence after their first episode of depression and this risk increases to 70% and 90% after a second and third episode respectively (Tylee et al., 2007). There is evidence that the severity of depression and resistance to treatment increases with each successive episode of depression (Kendler et al., 2000), highlighting the potential benefits of intervening early to prevent relapse and improve the overall trajectory of depression.

Relapse and recurrence are both terms used to describe the re-emergence of depressive symptoms following some level of improvement (Frank et al., 1991). The definitions of relapse and recurrence are dependent on first defining three further terms: response, recovery and remission. *Response* is a reduction in symptom severity (usually 50%) relative to baseline, usually as a result of initial treatment. *Remission* is a period of time (usually 2 months or longer), following a response to treatment, during which patients can be thought of as well but still “in episode”. *Recovery* follows an extended period of remission (6-12 months) and at this point, patients are said to be no longer in episode (Bockting et al., 2015). *Relapse* has been defined as the re-emergence of depressive symptoms following remission but preceding recovery whereas *recurrence* is the onset of a new episode of depression after recovery (Frank et al., 1991). These definitions provide a useful theoretical framework and may be of clinical relevance. They are particularly helpful when considering the trajectory of depression and its treatment phases: those implemented before any symptomatic improvement with a view to achieving remission (acute phase), those employed after symptomatic improvement but before recovery (continuation phase) and those that extend past the point of recovery (maintenance phase) (Bockting et al., 2015).

Given the wide variability in the way in which the terms relapse and recurrence have been operationalized by researchers, Bockting et al. (2015) recommended using the terms interchangeably to describe the “re-emergence of symptoms following a period of relative wellness”. Relapse prevention interventions, therefore, can be thought of as those aimed at people with depression who have had symptomatic improvement and have entered the continuation or maintenance phases or those applied during the acute phase with the intention of exerting a protective effect against relapse or recurrence in the future (Bockting et al., 2015). Most commonly they constitute a combination of continuation antidepressant medication and psychological therapies. There have been only a small number of studies exploring which relapse prevention interventions are most effective, particularly in a primary care context (Gili et al., 2015; Rodgers et al., 2012).

Collaborative care is a framework, originally developed for chronic disease management, which has been successfully used to optimise the provision and delivery of depression care. As such, it is best thought of as a system level intervention rather than as a therapeutic intervention in and of itself. Collaborative care incorporates the following four constituent parts to support the delivery of depression interventions: i) multidisciplinary working with input from two or more health care professionals, ii) structured evidenced-based case management, iii) proactive and scheduled patient follow-up, and iv) enhanced inter-professional communication systems (Gunn et al., 2006).

A Cochrane review of 79 RCTs showed that, compared with usual care or active control groups, collaborative care is more effective for treating depression and anxiety in the short-term (6 months or less) and that these effects persist into the longer term (13-24 months) (Archer et al,, 2012). Improvements in social functioning outcomes have also been demonstrated in patients treated using a collaborative care approach compared with those receiving usual care (Hudson et al., 2016). Further work has explored study-level factors, and participant-level factors moderating treatment outcomes in the short term. For example, depression outcomes are improved where a psychological treatment was included in the intervention (Coventry et al., 2014) and collaborative care has been shown to be effective for patients with isolated depression as well as those with depression and chronic physical conditions (Panagioti et al., 2016) As such, we have a good understanding of the components driving acute phase response (up to 6 months in the case of these reviews).

It is important to be mindful of the risk of relapse and recurrence associated with depression when developing and implementing interventions for people with depression. While the long-term beneficial effects of collaborative care are well evidenced (Camacho et al., 2018), it is unclear whether a focus on relapse prevention might account for this. We are now well positioned, with a large number of trials of collaborative care, to identify and characterise relapse prevention strategies to gain a better understanding of how these approaches might be used in the context of implementing collaborative care.

In this review, we aim to better understand whether relapse prevention is a common and key component of collaborative care. We describe the means by which relapse prevention has been addressed in trials of collaborative care and how the principles of collaborative care have been utilised to optimise the delivery of relapse prevention strategies.

**Methods**

This systematic review is reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Statement (PRISMA) and was produced according the Centre for Reviews and Dissemination guidance on systematic reviews for healthcare (Centre for Reviews and Dissemination, 2009).

**Literature search**

The literature search was originally conducted for a Cochrane review (Archer et al., 2012) and has been subsequently updated in December 2013, October 2016 and May 2017. This last update added 1 study to the review.

The original review (Archer et al., 2012) searched the Cochrane Collaboration Depression, Anxiety and Neurosis (CCDAN) group (now Common Mental Disorders group) trial register on 9th February 2012. The CCDAN trial register comprehensively indexed trials registered to MEDLINE, EMBASE, PsychINFO, CENTRAL, World Health Organisation’s trials portal, Clinicaltrials.gov, and CINAHL. The search was updated using the CENTRAL database in December 2013 and to inform a subsequent meta-regression (Coventry et al., 2014). For the current review, we updated the search using the CENTRAL database in October 2016 and in May 2017. This method is considered a sufficient and cost-effective approach for the systematic detection of RCTs of health care interventions (Royle and Waugh, 2005).

**Inclusion criteria**

We kept to the same inclusion criteria used in previous systematic reviews and meta-regression analyses of collaborative care (Archer et al., 2012; Coventry et al., 2014). RCTs were included if they met the following criteria:

*Participants:* Adults (aged 18 years or over) who met criteria (self-report or diagnostic interview) for a diagnosis of depression or who had mixed anxiety and depression.

*Intervention:* Collaborative care must include all of the following four components (Gunn et al., 2006):

* 1. A multidisciplinary approach to care delivery, defined as two or more health care professionals, of which one must include a primary care provider.
	2. A structured treatment plan delivered by a health care professional/case manager who is not the patient’s primary care provider. Treatment plans could include pharmacotherapy and/or psychotherapy.
	3. Scheduled and proactive patient follow-up consisting of one or more planned sessions.
	4. Enhanced inter-professional communication/support, for example: team meetings, supervision from a senior health care professional/mental health specialist.

*Comparator:* Usual care or enhanced usual care.

*Outcome:* Measured change in depression end of treatment outcomes using self-report measures or diagnostic clinical interviews. Binary self-report depression outcomes may have included either remission or reduction in depression symptoms according to a priori defined threshold (e.g. ≥50%).

*Study Design:* Individual or cluster RCT, in primary or community setting. The original trial report paper was in the English language.

**Study Selection**

For this review, eligible studies were identified for inclusion from a previous meta-regression of 84 collaborative care RCTs for depression (Coventry et al., 2014). In addition, 3 authors (JH, PC, RC) screened potentially eligible studies identified from CENTRAL search updates against the above inclusion criteria, as described above.

**Other sources**

In addition to using the RCT report papers for details of intervention content, we contacted the authors to request that they share any additional trial materials, particularly manuals used to train the professionals implementing the intervention (provider manuals) and materials given to patients to guide their self-management (patient workbooks). The aim was to optimise the amount of information available for deriving a description of relapse prevention strategies. We attempted to contact corresponding or other appropriate authors to request materials up to a maximum of 3 times. In the absence of materials or where authors did not reply, we accessed publically available protocols and companion papers that provided more information on intervention content.

**Data extraction and synthesis**

We extracted data about intervention content (i.e. the commonly used relapse prevention strategies and approaches reported by trialists) and intervention delivery (i.e. the ways in which collaborative care facilitated the delivery of intervention content).

In terms of intervention content, we defined relapse prevention components as any that are introduced after acute treatment has been successfully completed (once patients had reached remission and entered the continuation phase, as defined by the investigators of the individual trials), or that were applied during the acute phase with the intention of exerting a protective effect against relapse in the future (Bockting et al., 2015). We identified four common relapse prevention components *a priori*, on pragmatic grounds:

1. Formal relapse prevention planning: taking place either during the acute or continuation phase;
2. Proactive symptom monitoring and follow-up beyond the acute phase;
3. Strategies to promote continuation medication adherence: occurring during the acute or continuation phase, as long as focus was on long-term medication adherence and relapse prevention rather than initial symptom improvement;
4. Psychological or psycho-educational treatments: again, these could be implemented during the acute phase with a focus on strategies for relapse prevention or could be implemented during the continuation phase (e.g. “booster” sessions).

Each trial was reviewed for information about the intervention content. We reviewed the materials for each RCT and identified the components used in the intervention. Where relapse prevention components were present, a descriptive paragraph was written on the approach taken for each trial.

The intervention content was mapped to the four key components of collaborative care, as described by Gunn et al. (2006), to better understand how collaborative care facilitates the delivery of intervention content aimed at relapse prevention. By definition, all four components were present in each trial and so we have recorded specifically where these components have been used to facilitate relapse prevention. Results were validated and coded by two independent reviewers per paper (AM, NC and OJF) and any disagreements were referred to a third reviewer (DM).

**Risk of bias**

Risk of bias assessment has been undertaken and reported elsewhere for all included trials using the Cochrane Collaboration’s tool for assessing risk of bias in randomised trials (Higgins et al., 2011).

**Results**

**Study selection**

In total, 93 RCTs of collaborative care for depression were identified for inclusion in this review (see Figure 1 for PRISMA flow diagram outlining search). See Table 2 for relevant study characteristics. 79 of these were identified for the original Cochrane review (Archer et al., 2012), 5 were added in updated search in 2014 (Coventry et al., 2014), 8 were added in the CENTRAL search update in October 2016 and 1 study was added during the updated search in May 2017.

**[Figure 1: PRISMA Flow chart of included studies]**

After collating responses from authors and accessing materials online where they were available, we identified additional trial materials for 44 (47.3%) of the 93 trials identified. Of these 13 had a provider manual, 2 had a patient workbook and the remainder (n=29) had both. For the trials where there were no materials available, we were able to gain further information regarding intervention content from email correspondence with the authors of 7 of the trials and from reference to the original programme grant application for 1.

For the remaining trials (n=49), we consulted the main trial papers and any associated publications.

**Data synthesis**

The relapse prevention components identified were: presence of a formal relapse prevention plan (31 out of 93, 33.3%), active monitoring and follow up after the acute phase (42 out of 93, 45.2%), focus on medication adherence beyond the acute phase (39 out of 93, 41.9%) and psychological therapies beyond the acute phase (20 out of 93, 21.5%).

RCTs of collaborative care for depression have addressed relapse prevention to varying degrees. Table 1 maps the relapse prevention components used across trials. Table 2 provides a description of the relapse prevention approach taken and how the collaborative care framework has facilitated the delivery of these.

8 studies (Bogner and de Vries, 2008, 2010; Bogner et al., 2012; Dwight-Johnson et al., 2010; Lerner et al., 2015; McCusker et al., 2008; McMahon et al., 2007; Menchetti et al., 2013) focussed on acute-phase treatment and recovery, with very short-term follow-up and no emphasis on relapse prevention. 2 studies (Adler et al., 2004; Finley et al., 2003) focussed entirely on pharmacological interventions with medication maintenance primarily aimed at short-term improvement and only indirectly targeted at relapse prevention.

Only 1 of the 93 trials (Katon et al., 2001) tested a collaborative care relapse prevention intervention. In this trial, patients who had recovered after 8 weeks of antidepressant treatment were randomised to usual care or a relapse prevention intervention, which consisted of two primary care visits with a depression specialist and three telephone calls over a one-year period. The intervention aimed to monitor symptoms, increase medication adherence and involved the writing of a personalised relapse prevention plan. The usual care and intervention groups had similar rates of relapse, although medication adherence was significantly improved in the intervention group.

Others reported a significant focus on relapse prevention while primarily focussing on acute treatment outcomes. Notably, the inclusion of relapse prevention in CADET (Clinical effectiveness of collaborative care for treatment of depression in UK primary care), the largest UK-based collaborative care trial, came directly from qualitative and public involvement findings in the original development and feasibility trial. The original pilot trial did not address relapse prevention until analysis of the acceptability data and subsequent change to the protocol to account for the findings (Richards et al., 2009; 2013).

30 trials had no reported approach to relapse prevention, 21 had one approach only, 25 reported using two approaches, 5 reported three and 12 reported using all four relapse prevention components. 9 studies (9.6%) reported outcomes beyond 12 months and only one study (Katon et al., 2001) reported relapse data (Table 2).

**[Table 1: Summary of relapse prevention components used in each RCT]**

**[Table 2: Description of relapse prevention approaches used in RCTs of collaborative care]**

***Intervention content: Relapse prevention components***

*Relapse prevention plan*

One third of the studies (n=31) reported that the professional administering the intervention was trained to develop a formal relapse prevention plan with patients. All of the studies reporting a relapse prevention plan went on to provide further details of what this entailed (Bartels et al., 2004; Buszewicz et al., 2010, 2016; Ciechanowski et al., 2004, 2010; Coventry et al., 2015; Datto et al., 2003; Davidson et al., 2013; Ell et al., 2008; Gilbody et al., 2017; Grote et al., 2015; Huijbregts et al., 2013; Johnson et al., 2014; Katon et al., 1996, 2001, 2004, 2010; Ludman et al., 2007, 2016; Mavandadi et al., 2015; Oslin et al., 2003, Piette et al., 2011; Richards 2008, 2012; Rollman et al., 2009; Ross et al., 2008; Salisbury et al., 2015; Simon et al., 2004; Smit et al., 2005; Unutzer et al., 2002; Vlasveld et al., 2011). 5 of the included studies used the Foundations for Integrated Care manuals (US Department of Veterans Affairs, 2017) to guide the delivery of their intervention (Bartels et al., 2004; Datto et al., 2003; Mavandadi et al., 2015; Oslin et al., 2003; Ross et al., 2008). The manuals advise that patients are educated about risk of relapse and to make a plan for “relapse prevention treatment”, including “reinforcing self-monitoring skills for signs of recurrence”. Patients are encouraged to identify “personal” early warning signs of recurrence and individual triggers. Self-care skills in the event of recurrence may include “calling friends or relatives, preparing for stressful events by writing down a coping plan, pursuing interests, and continuing to take medication as prescribed”. Patients are also given written instructions on when they should consult a doctor (worsening PHQ-9 or GAD-7 scores, especially if scoring 14 or above, unable to perform daily activities or thoughts of suicide).

The Collaborative Interventions for Circulation and Depression (COINCIDE) trial instructed professionals and patients on following a “staying well” (Coventry et al., 2015) plan that encouraged patients to identify protective factors and behaviours to implement these on a long-term basis. Buszewicz et al. (2012, 2016) similarly advised professionals on the importance of discussing relapse prevention with patients and identifying triggers, which would put patients in “a better position to avoid relapse in the future or to seek help at an early stage”. Ciechanowski et al. (2004, 2010) and Richards et al. (2009, 2013) gave patients a written relapse prevention plan template with headings including “personal warning signs” and “things that make me feel better”.

*Proactive monitoring and follow-up*

A number of the trials used proactive symptom monitoring and proactive follow-up, ranging from informal follow-up to regular use of psychometric tools for tracking deterioration. The Foundations for Integrated Care manuals (US Department of Veterans Affairs, 2017) strategy was to follow up with the patient once a month, until they had gone for 3 months without depressive symptoms, to obtain a PHQ-9 or GAD-7 score. There are specific instructions within the healthcare professional manual that if a patient becomes symptomatic (defined as a score above 10), they should then be reassessed in one week to determine if relapsing. If the score remains elevated at that point, the treatment plan will be reassessed, including discussion regarding adding pharmacological treatment if the patient is not already on this. Ciechanowski et al., (2004, 2010) also had provision for monthly phone calls after the acute phase with administration of the PHQ-9.

Coventry et al. (2015) made use of a RAG (Red, Amber, Green) system wherein patients were encouraged to self-administer psychometric tools (in this case, the PHQ-9 or GAD-7) and the score would correspond to traffic lights system. This would prompt the patient to take no action, use the “action plan” and monitor their mood more closely or consider contacting a health worker if above a specified threshold (“red”). The action plan recapped signs and triggers of depression and reminded patients of details of their support network. Pyne et al. (2011) used regular telephone monitoring once remission had been reached, although the details of these were not reported. Others such as Ell et al. (2008) provided a robust monitoring system with proactive telephone follow-up to monitor symptoms and in-person visits if needed.

In the True Blue trial, conducted in Australian general practices, patients were monitored and completed a PHQ-9 at 13-week intervals for 12 months. The authors of this trial explained that the intervention was designed to be feasible in the Australian Medicare system and so the follow-up periods were not “unrealistically regular” (Morgan et al., 2009).

*Medication maintenance*

Notable methods of ensuring medication maintenance were asking patients and reassuring about side effects (Landis et al., 2007), ensuring longer term medication in those at higher risk of relapse (Davidson et al., 2013) and offering an alternative antidepressant in the case of relapse or where the medication is poorly tolerated (Kroenke et al., 2010). Capoccia et al. (2014) and Finley et al. (2003) trialled pharmacist-led collaborative care-based interventions to promote medication adherence and address medication-related issues arising throughout the maintenance and continuation phases.

Again, the Foundations for Integrated Care manuals (US Department of Veterans Affairs, 2017) had detailed information about the specific medication maintenance strategies used in their trial. The manuals advise that if patients are assessed to be at low risk of relapse (fewer than two prior episodes of depression and no history of dysthymia), they should complete 6 to 9 months and if at high risk (more than 2 episodes or history of dysthymia), they should complete at least two years of antidepressant therapy. Katon et al. (1995, 1999) used active monitoring of automated pharmacy data to monitor medication adherence during the continuation phase (3-7 months) without monitoring for depressive symptoms.

*Psychological or psycho-educational treatments*

The finalintervention component noted was the provision of psychological or psycho-educational approaches. Araya et al. (2003) provided a psycho-educational group as part of a multi-component programme of treatment and these included “booster” sessions occurring during the continuation phase at weeks 9 and 12 with a focus on relapse prevention techniques. It was unclear from the trial paper what these techniques were. Oladeji et al. (2015) similarly provided a programme consisting of psycho-education, problem-solving therapy and activity scheduling and patients who improved (as measured by PHQ-9 scores) were offered four fortnightly “top up talking therapies” for a period of 8 weeks.

Simon et al. (2004) offered an 8-session manualized cognitive behavioural therapy (CBT)-based programme followed by three to four telephone relapse prevention sessions. Ludman et al. (2007) similarly offered acute and “booster” psychotherapy sessions, focussing on behavioural activation and identification and interruption of automatic negative thoughts. Piette et al. (2011) offered counselling sessions monthly for nine months following the acute phase to “minimize relapse”. Ell et al. (2008) provided on-going psychological approaches (behavioural activation and problem solving therapy) extending beyond the acute phase.

***Intervention delivery: Collaborative care components***

Gunn et al. (2006) outlined the four key characteristics of a collaborative care intervention: a multidisciplinary approach to care delivery; structured treatment plan delivered by a health care professional/case manager who is not the patient’s primary care provider; scheduled and proactive patient follow-up consisting of one or more planned sessions; and enhanced inter-professional communication/support.

Where collaborative care appears to be particularly well placed to address relapse prevention is through its use of structured management plans, including an organised approach to providing evidence-based treatments. Whether these are pharmacological or psychological or a combination of both, they can be tailored to address relapse prevention in a standardised and consistent manner and implemented either during the continuation phase or during the acute phase with a view to maintaining longer-term health. The other key and recurring area in which collaborative care seems to confer a particular benefit is its focus on scheduled patient follow-up, particularly in the form of symptom monitoring and facilitating treatment adherence.

Multi-professional approach and enhanced inter-professional communication have been less explicitly employed as a means of facilitating the delivery of relapse prevention intervention content. A multi-professional approach is key feature of collaborative care interventions, but the way in which this has been used to optimise relapse prevention is not well documented. Enhanced inter-professional communication includes strategies such as team meetings and shared medical notes. The only trial to report using it in a way that facilitated relapse prevention was Katon et al. (1999) which used the collaborative care framework to implement a system wherein the psychiatrist reviewed monthly automated pharmacy data on antidepressant refills to monitor the patient’s adherence to the acute and continuation phases of treatment and was able to alert the primary care physician if premature discontinuation of medication occurred. It is possible and perhaps likely, however, that systems to facilitate multi-professional working and enhanced communication have been a feature of relapse prevention provision in collaborative care trials but have not been reported.

**Discussion**

This is the first systematic review to map the relapse prevention content of trials of collaborative care for depression and to provide a description of the different strategies employed. Overall, researchers have been inconsistent in their approaches and in the way that interventions are reported and described in the literature. We identified 4 recurring relapse prevention strategies or components across two thirds of the trials identified. The established key features of collaborative care, particularly structured management plans and scheduled patient follow-up, facilitated the delivery of these relapse prevention strategies.

*Implications for research and policy*

With its focus on multi-professional approach, proactive and structured follow-up and enhanced inter-professional communication, collaborative care has potential advantages over other methods for providing relapse prevention in depression. There are now a significant number of collaborative care trials and the evidence base is such that new trials may not be an efficient use of resources. The effectiveness of collaborative care on depression outcomes is well established. However, relapse is an important issue and we need innovative research to explore the impact of relapse prevention content. This might involve embedding studies of relapse prevention in ongoing implementation of collaborative care.

Novel trial methods offer opportunities to trial the effectiveness of relapse prevention components without the need for a conventional RCT. The Cohort Multiple Randomised Controlled Trial (cmRCT) allows pragmatic trials of interventions on large numbers of patients at a lower cost with more detail on longer-term outcomes derived from patients within routine practice. The relapse prevention components of the interventions reported in this review are of low intensity and are likely to be desirable to patients and well accepted, overcoming the risk of patient non-compliance or refusal to accept interventions, which is one of the key limitations of cmRCTs (Relton et al., 2010). The cmRCT model itself has been shown to be acceptable to patients with depression (Richards et al., 2014). We recommend that this approach be considered to enable researchers to better assess the effectiveness of the components described here in practice. For example, if patients with depression consented to being in an “observational cohort”, they could then be randomised, once they have reached remission, to receive a relapse prevention intervention (for example, a self-monitoring system such as the Red, Amber, Green (RAG) system or maintenance phase booster psychotherapeutic sessions) or indeed combinations of interventions. Routine outcome data could be used to assess the effectiveness of different interventions over the long-term and this evidence could be used to guide implementation in practice.

We have described the difficulty in extracting a description of the intervention content pertaining to relapse prevention from the trial publications alone. The Template for Intervention Description and Replication (TIDieR) checklist provides a framework for reliably reporting intervention content (Hoffman et al., 2014). We recommend that researchers use the TIDieR checklist when reporting intervention content, which would better enable researchers to understand what was done. In the case of this review, more consistent reporting and describing of interventions would enable researchers to adopt and incorporate common intervention components when developing novel relapse prevention interventions for implementation in practice.

*Implications and challenges for clinical practice*

If the effectiveness of particular relapse prevention strategies is demonstrated, then these should be incorporated into collaborative care models in practice. Implementing these in, for example, a primary care setting would require several key challenges to be addressed. Whitebird et al. (2015) reported the key factors essential for successful implementation of primary care models in practice. Several of these, such as the need for strong leadership, a strong primary care physician champion and working with specialist mental health teams, could involve the training and engagement of professionals already in post, but others would involve increased up-front financial costs, such as the employment of an on-site and accessible care manager.

Pincus et al. (2015) conducted a similar review of factors supporting the successful implementation of new care models for integrated care across different countries and healthcare systems. The factors reported in this review including a cultural shift towards more holistic care, which is dependent on strong leadership and interdisciplinary training. The authors noted that, while “integrated care programs built around the chronic care model” result in improved clinical and economic outcomes for patients, the initial investment and identification of previously unmet needs associated with such models mean that overall health care costs may not actually be reduced. The authors therefore recommended changes to payment models and incentives to promote shared accountability across all providers. This would be an important consideration if commissioning the provision of new collaborative care-based relapse prevention strategies to ensure that no individual provider feels disproportionately burdened with the associated costs. This is particularly important as “not seeing operating costs as a barrier to participation” was another of Whitebird’s key factors driving successful implementation of collaborative care and was associated with improved remission rates at 6 months (Whitebird et al., 2015).

There is a growing role for digital health interventions in the treatment of depression, which could provide an opportunity to support self-monitoring. Mobile apps exist which allow patients to record and monitor their scores on validated tools such as the PHQ-9 and then share the results with clinicians. However, there is as yet little evidence for the effectiveness of these approaches (Hollis et al., 2017) and, while one can envisage versions of these apps that would flag patients and allow them to re-enter the acute phase treatment early, they would require formal assessment of clinical and cost-effectiveness in practice and would need to be standardised and integrated into existing systems in order to be successfully implemented.

Cross-sectorial working is also likely to be key, given that patients will leave therapy services to be monitored in primary care, and one of the challenges will be setting up lines of communication between providers to track patient recovery (Winters et al., 2016). Collaborative care is well placed to support enhanced modes of communication across disciplines and sectors to facilitate more coordinated follow-up and it is important that we evaluate how best to maintain such communication models after the acute phase of treatment. The bridging of technology gaps will be an essential part of ensuring effective information sharing and collaborative working (Pincus et al., 2015). We recommend that work be done around understanding how monitoring and recall can be built into collaborative care protocols to ensure that interventions are more responsive to patients at risk of relapse.

*Limitations*

A limitation of this work is that we did not receive manuals for the majority of trials and, as such, were limited to describing the intervention components as published and supplemented by accessory materials which were freely available online. Furthermore, of the trials reviewed, most had at best medium term (12 month) follow-up and only a small number reported longer-term (n=9; 9.6%) or relapse data (n=1). We have therefore been unable to perform a quantitative analysis to explore the effectiveness of the relapse prevention intervention components described in this review.

**Declaration of interest**

None

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