Main Submission

Light at the end of the tunnel: A focus on outcomes in mental health services

Isabelle A. Vallerand

University of Calgary

Nearly 1 in 4 people will suffer from a mental disorder in a given year – an estimate that has remained consistent over recent decades.[1] Despite this constant incidence, the rate of treatment appears to be increasing.[2] With the provision of more treatment for mental disorders comes along concerns regarding the quality and outcomes attained through such interventions. As part of a national public health strategy aimed at improving mental health, the Canadian Psychiatric Association (CPA) has issued recommendations to use evidence-based treatments to reduce distress and impairment and to monitor outcomes.[3] Although an emphasis on promoting evidence-based practice is warranted, it is important to consider that such implementation cannot guarantee the eradication of mental disorders. Even though many process measures exist in mental health aimed at ensuring quality in the delivery of services, the majority have not been shown to be related to treatment outcomes.[4] As such, it is entirely possible that efforts being put forth to recognize and treat mental disorders may not ultimately lead towards improved mental health outcomes.

Factors that may undermine improvements in mental disorders include the current lack of rigorous outcome measurement and frequent monitoring in real-world practices.[3] For instance, the inability to follow-up and measure treatment effects over time could result in the failure to detect residual symptoms, recurrences, as well as adverse effects – all important aspects which could influence clinical decision-making towards an alternate and perhaps more appropriate course of treatment. Thus, part of an early intervention strategy for managing mental disorders should include the early identification and management of recurrences of symptoms or adverse effects which may impede reaching the end goal of therapy. Theoretically, the measurement of outcomes in mental health services is in part contingent on the ability to identify goals of treatment and accurately measure well-defined therapeutic outcomes.[5] This then begs an important question: what is the goal of treatment in mental health?

One definition of a treatment goal might be to achieve a state of remission from a mental disorder, whereby patients no longer experience daily impairments. Various disorder-specific definitions of remission exist based on different thresholds of improvement, which can be summarized in three levels: 1) symptomatic, 2) syndromal, and 3) functional remission.[6] For instance, with bipolar disorder, symptomatic remission invokes a loss of partial diagnostic status when the patient has minimal or no symptoms according to measures such as the Young Mania Rating Scale, Hamilton Rating Scale for Depression (HAM-D), or the Scale for the Assessment of Positive Symptoms (SAPS). Syndromal remission may occur when a patient no longer meets the full diagnostic criteria according to the DSM-IV. Concurrently, functional remission can be achieved when a patient has made a functional (full) recovery to pre-morbid levels after 6-12 months, with a quality of life that is acceptable to the patient. Therefore, some definitions of remission as the end goal of treatment have been established and are based on the use of validated instruments for measuring outcomes and engagement by patients in defining their own goals of treatment. Despite this, the extent to which real-world practices are measuring treatment outcomes has not been well-documented. Additionally, a lack of a recommended treatment monitoring schedule may be further hindering efforts to measure remission or recurrences of symptoms over time.

On the other hand, a barrier to the measurement of outcomes may be that clinicians are limited in the time they have to thoroughly follow-up with their patients for mental health difficulties. This may be particularly true for primary care physicians who frequently care for patients with mental health difficulties. For instance, one study ▶

revealed that primary care physicians spend only an average of 10.7 minutes face-to-face with their patients.[7] This does not appear to leave physicians with much time to assess mental health patients for residual symptoms, recurrences, or adverse effects, let alone attend to other medical concerns. Considering the existing workload placed on primary care physicians, it is not surprising that they often experience a lack of time in consultations with patients suffering from mental health difficulties.[8] Therefore, one of the challenges in following-up on mental illness is the perceived threat of increased demand for health services.

When debating the issue of measuring outcomes, it is important to consider that undiagnosed or untreated mental disorders contribute to a tremendous degree of suffering to patients and a financial drain to society due to disability, lost work days, and excessive healthcare use.[9] It is for these reasons that further research is needed to identify strategies or tools that may assist with the measurement of outcomes. At the same time, it is imperative that healthcare professionals be more vigilant in monitoring patients and more aggressive in pursuing better treatment outcomes for millions of individuals suffering from mental disorders worldwide. ■

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Isabelle Vallerand

Isabelle Vallerand is a PhD student studying Epidemiology in the Community Health Sciences Graduate Program at the University of Calgary. Isabelle's research is focused on the morbidity and mortality associated with serious mental disorders and their progression over the lifespan.