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Research Article

Mood Disorders Specialized Services: An Overview of Existing Practices and Models

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ABSTRACT

Objective: This paper presents a brief overview of specialized mood disorders centres in North America, shedding light on the type of services it offers and exploring which types of specialized mood disorders service is more efficient. One-time consultation type service, which is the mandate of most specialized mood disorder services in Canada and USA functioning primarily as a consultation clinic in which patients receive an extensive single-visit assessment and recommendations. The other type employed offering short-term follow up. Advantages and disadvantages of each type of services were elaborated.

Method: We searched PubMed, PsycINFO, Ovid Medline, Google Scholar, Cochrane Library and Google search for papers addressing organizational aspects of mood disorders services, systematic reviews and research papers comparing different type of specialized mood disorders services published in the past 10 years. The literature on this topic is sparse.

Results: The available literature on the organizational aspects of specialized mood disorders services is extremely sparse. Based on the review of existing practices, the one-time consultation should be the standard of care in specialized mood disorders programs. Family medicine supported by collaborative mental health and ACTT would be viable follow-up options for patients with treatment resistant mood disorders.

Conclusion: Applying the role of community services, aid moving back to one-time consultation type of mood disorders services, facilitating the access of clients who are most in need of specialized mood disorder programs is fundamental.

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Introduction

It is not uncommon for adults with major depressive disorder (MDD) or bipolar depression to fail achieving remission by complying on indicated pharmacological treatment. Moreover, remission or sustained remission may not be achieved by at least half of the patients following multiple pharmacological interventions [1]. The management of treatment resistant depression has limited guidance, which is reflected by the variation in current treatment practice worldwide. The American

Psychiatric Association guideline recommends increasing the dose of an antidepressant, switching to a different class of antidepressant, employing other modalities such as psychotherapy, augmentation with lithium or other augmenting agents and considering electroconvulsive therapy as possible treatment options for treatment resistant depression [2].

A complex pharmacological regimen is often necessary once a client is diagnosed with treatment resistant mood disorder, which might increase

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the possibility of iatrogenic complications. In such cases, it is more common for medications to be often used outside of their primary indications, the recommended dosages, and using off label medication. Hence medico-legal vulnerability may become a challenge. According to the Bolam test (Bolam v. Friern Hospital Management Committee, 1957), clinicians are protected when it can be shown that they have acted in accordance with a practice expected as proper by a regulatory bodies or expert opinions and consensus statements. Expert opinions may lack specific guidelines in managing treatment resistant mood disorders, in situations like this, support for general psychiatrists can be provided by specialized mood disorders services [3].

The goal of this paper is to review existing models of organizing specialized services for treating resistant mood disorders, to present our organizational model and discuss optimal models with taking into account the access to service, waiting time, and patients' best interest. There are no research studies on this topic, and we were not able to find any published paper on the organizational aspects of the mood disorders specialized services. Since the literature on this topic is extremely sparse, a good quality literature review is barely possible.

General Principles of Organizing Subspecialized Services

The majority of healthcare systems in the Western countries with deinstitutionalized care of patients with severe mental health problems favour the shifting of treatment setting from secondary care into the community. In most instances it has led to substantial reduction in the average length of stay (LOS) [4].

The global burden of disease (GBD) due to psychiatric disorders was estimated 14 % by some, including common and severe mental illnesses and substance misuse, many of which are chronic and enduring in nature. People with mental health problems are widely known to be at a much higher level of risks of physical illnesses, which is further compounded as such population are less likely to access care services. Lack of recognition of the seriousness of mental illness is a barrier to effective treatment of mental illness. The availability of cost-effective treatment for most psychiatric disorders is warranted to ensure most of those affected to become functioning members of society. Alas, policymakers, insurance companies, health and labour policies, and the public at large all have the predilection to discriminate between physical and mental problems [5]. The documented global burden of disease associated with mental disorders is compounded by the widening "mental health treatment gap". In spite of being at a time when evidence-based mental health interventions have been found to be effective in limited resource environments. It's estimated that more than 70 % of people in need of mental health services lack access to care [6].

Primary care is considered less stigmatizing, more accessible, and cost effective compared to specialized healthcare; yet, hospital and psychiatric care continue to be pivotal in the system. A considerable number of people suffering from severe mental disorders (schizophrenia, bipolar disorder) or common mental disorders (anxiety, depression) are still treated primarily by psychiatrists. Some clients are followed by a case manager (nurse or social worker), aiming to reduce hospital admission, promoting community-based services use, and enhancing their clients' quality of life. The burden of mental disorder has prompted various countries to improve their mental healthcare system by

strengthening primary care. Since current mental healthcare reforms aspires to improve primary care and enhance the performance of the healthcare system, more in-depth knowledge is vital on variables associated with primary care and specialized healthcare utilization by persons with mental disorders [7].

The management of common mental illnesses is a specialist skill that general practitioners should have. Secondary care services are 'specialized' in the management of more severe illnesses that are difficult to treat. Beyond these secondary care levels specialty services, there are tertiary level specialty affective disorder services that mainly or wholly take referrals from secondary care. An increase in sub-specialization within general adult mental health service provision has been a trend, such as providing functionally delineated services, for example for psychosis or affective disorders. These services are notable for their high degree of medical input and close links with universities [3].

Mental health services are usually comprised of the community services, general psychiatric clinics in community hospitals or in teaching hospitals and finally specialized clinics at larger university centres. Specialized services are more costly, and these resources should be used reasonably. General psychiatric assessment for newly diagnosed patients is essential and only patients with complex clinical presentations and patients with treatment resistant conditions should be referred to specialized tertiary care services.

Mood Disorders Specialized Services in North America

Early identification of patients with MDD and bipolar disorder who cannot be managed by secondary services and require highly specialized care could enhance need-based patient stratification. This, in turn, may reduce the number of treatment steps needed to achieve and sustain an adequate treatment response, and may subsequently benefit the quality of life of patients. [8].

The outpatient Mood Disorders Centre (MDC) focuses on more complicated cases of depression and bipolar disorders. This service functions primarily as consultation clinics, in which patients receive thorough assessment, diagnosis, and treatment recommendations. A limited number of patients are followed for brief management (typically 2-3 months), usually in clinical research protocols. The focus of expertise in the MDC is on medication management, psychotherapy, and neurostimulation treatments [9]. Some services may also accept tertiary referrals from elsewhere within the province. Occasionally, clients/patients are offered short-term follow-up, sometimes in the context of a research study. These programs are also very involved with teaching medical students and residents in psychiatry [10]. Some services require records summarizing current and past psychiatric treatment prior setting an appointment. If the patient desires a follow-up visit (a new consultation) with the same consulting physician, it can be scheduled within six months to a year after the initial consultation. This consultation is one-and-a-half hours to two hours long. All current records must be received before scheduling the follow-up consultation [11].

Other services may have an emphasis on the inclusion criteria such as, 25 to 65 years old, prominent symptoms of an axis I mood or anxiety

disorder, previous assessment and treatment for mental illness, including previous psychiatric hospitalizations, has previous trials of psychotropic medications demonstrating the signs of treatment resistance and signs of persistent mental illness (present longer than 6 months) with significant functional impairment. The referred patients should be agreeable to attend individual appointments with a psychiatrist or nurse practitioner and a clinician every 1-3 weeks in the first stages of treatment with the goals relating to psychoeducation, treatment, and recovery. Patients may be referred by current psychiatrist or family physician for one-time consultation only. If actively pursuing individual therapy in the community, may be referred for one-time consultation only or shared care [12].

After the consultation in the mood disorders specialized services, a straight-forward treatment recommendation that referring physician can implement are provided. A detailed, type-written evaluation will be sent to the patient and referring physician expeditiously in some services. Such service can also offer an extensive network of referral options for patients requiring ongoing follow-up treatment. Follow-up consultations are offered at six months to one year after the initial evaluation to assess the progress of the treatment recommendations [13].

Our Model of Mood Disorders Specialized Program

Mood Disorders Research and Treatment Service in the Department of Psychiatry at Queen's University offer either one-time consultation or short-term follow-up. This is a modified version of subspecialty service offering follow-up for patients with more complex presentations of mood disorders with significant level of treatment resistance. The lack of community services providing psychiatric follow-up for patients with mood disorders indicates the need for follow-up for unstable mood disorder patients within the Mood Disorders Research and Treatment Service. Community services include mostly assertive community treatment teams and case management programs which accept usually low functioning patients with psychosis, and they are usually not suitable for high functioning mood disorders patients. We are accepting mood patients for a short-term follow-up to help primary care providers with medication adjustment for patients with refractory mood conditions.

However, any longer follow-up at our mood disorders service creates a number of issues such as long waiting time for initial assessment, the lack of follow-up appointments for existing patients, higher need for inpatient treatment in order to adjust medication more efficiently, and as a result the poor quality of care. Therefore, the optimal goal is moving back to the consultation-based concept and keeping with one-time consultation practice which is the mandate of the service. All attempts to change the practice in order to help with systemic issues, such as the lack of community services, end up with decreasing in the quality of provided care. It seems that the community follow-up for patients with mood disorders, including general psychiatrists in the community centres and assertive community treatment teams is essential and should be organized for patients with mood disorders. Providing family physicians with complex treatment recommendations is frustrating for primary care providers and may create a number of issues at different levels. Collaborative mental health care in primary care setting is promising option which could be a golden bridge between highly specialized mental health services and primary care.

What Should Be the Optimal Level of Care for Mood Disorders Patients

Mood disorders specialized services are tertiary care services designated to assess and treat patients with severe and treatment resistant mood disorders warranting subspecialized level of expertise in the management. Specialized mood disorder services mandate is providing a comprehensive and expert opinions and recommendations for patients with treatment resistant conditions. Unfortunately, the literature on this topic is sparse.

There are roughly 2 types of mood specialized services

1) Services functioning primarily as a consultation clinic in which patients receive an extensive single-visit assessment, diagnosis, and treatment recommendations. This type is advantageous as it provides the service it's intended for benefitting as many patients as possible, cutting short wait time.

2) Mood specialized services offering short term follow up after the initial assessment. In this type of services, the patient ensures continuity of care, encouraging the development of therapeutic alliance and rapport, given that it's vital for treatment compliance hence, a better outcome. The disadvantage of such service that it may prolong the waiting time for patients in need of this service and thus the access to service may be very difficult. As other physicians (family physician or general psychiatrist) can provide follow up for patients, ensure the continuity of care and implement treatment recommendations from psychiatrist-consultant, follow-up in subspecialized clinics could be quite redundant.

Mood disorders specialized services accept referrals from general psychiatrists or family physicians and offer assessments of patients with treatment resistant mood disorders. They provide treatment recommendations to referring physicians. As most other consultation-based tertiary care services the majority of these services don't provide any follow-up for patients, but the possibility for repeated consultations is available.

Some of mood disorders services provide short-term follow-up until the patient's condition is more stable but this short-term follow-up may become a longer follow-up if other mental conditions contributing to treatment resistance, particularly comorbid personality disorders are not addressed. This is a common pitfall in the clinical practice as specialized mood disorder services cannot provide evidence-based psychotherapies for personality disorders or comorbid anxiety disorders and thereby patients may end up with a long-term follow-up in the specialized service and having multiple unsuccessful medication trials. If a consultation-based service is providing any type of psychiatric follow-up, waiting time for newly referred patients will gradually increase over time and as a result the service may become dysfunctional. It may reflect on the access to the service and the quality of care.

Another important aspect of specialized services for mood disorders is providing evidence-based psychotherapies. As psychotherapy in most cases is not delivered by psychiatrists and service providers are usually psychologists and social workers, some of the specialized services may face administrative barriers in providing psychotherapy for patients who are discharged by psychiatrist after being seen for one-time consultation.

Obviously, hospital administration should appreciate the patient's need for psychotherapy even if a mood disorders psychiatrist is not actively involved in managing pharmacological treatments.

Since this more flexible system is not always feasible due to the complex relationships between senior hospital management staff, hospital policies and university psychiatry departments, our experience would support different organizational concept of specialized mood disorders services focused more on comprehensive team assessment and treatment recommendations for medication treatment and psychotherapy to the community psychiatrist who is supposed to implement these recommendations. The exception is delivering specialized biological treatments for mood disorders such as electroconvulsive therapy (ECT) and repetitive transcranial magnetic stimulation (rTMS) as these treatments are usually, but not always, provided at mood disorders services.

Relying exclusively on specialty mental health practitioners to solve the problem of improved mental health care access is not the best or most realistic approach. As there is shrinkage in the staffing for psychiatrist and an increasing vacancy in psychiatry residency training programs [14]. Mental health care is under increasing pressure to enhance efficiency due to increasing demands and limited resources. Therefore, high quality short-term treatment is more appealing than ever [15]. Besides limited access to mental health care as a result of scarce mental health resources and financial burden, social stigma pertaining to seeking specialty mental health services prevents many individuals with depressed mood or other severe mental illnesses from seeking and receiving adequate care [14].

In a collaborative model, the primary care provider manages all aspects of patient care, including prevention and screening, early identification and intervention for common mental health problems, and psychopharmacologic treatment for some of these disorders [16]. An essential future strategy for expanding access to mental health care in the US and other developed countries is to train other health care practitioners in basic psychotherapy techniques and prescribing psychopharmacologic regimens for common psychiatric disorders [14].

With regards to the efficiency there are indications that collaborative care is associated with decreased mental health care utilization and a subsequent decrease in costs, even in the longer term [15]. As well as reduced stigma associated with seeking mental health care and enhanced overall health of the population [14]. The first treatment step is increasingly offered in the primary care setting, supported by liaison-consultation functions (i.e. collaborative care), in recent years. Integrating specialized mental health services in primary care was one of the most fundamental recommendations of the World Health Organization in 2001 [15]. Creating an environment that encourages collaboration and supports appropriate care for patients and families is essential to integrate mental health in primary care setting, while offering a full range of services. Sessions on how to build and maintain such a practice along with information on basic mental health competencies should be included in the training programs for primary care practitioners [16].

Assertive community treatment team (ACTT) is perhaps the most studied and well-articulated service model for providing community-

based, comprehensive mental health services to adults with serious mental illnesses, those with bipolar disorder and for more functionally impaired patients, specifically schizophrenia, bipolar disorder, and major depression. The ACT model consists of a multidisciplinary team that maintains a low consumer-to-staff ratio (ideally 10:1). ACTT fidelity standards delineate specific service approaches, such as 24-hour coverage and direct involvement in hospital admissions and discharges, and they require that a majority (75%) of client contacts occur in the community rather than in an office-based setting [17]. ACTT psychiatrist refers patients who are resistant to standard pharmacological treatment to mood disorders specialized services for a consultation and an expert opinion and then implements the provided treatment recommendations. ACTT has been shown to reduce rates of psychiatric hospitalization and improve residential stability for adults with serious mental illness who are living in the community, with better outcomes associated with greater fidelity to the ACT model [17].

On the other hand, the patients with major depressive disorder with no significant level of treatment resistance and patients with a higher functional level are usually under the care of a family physician or general psychiatrist. These patients may also require from time to time a referral to mood disorders specialized services for consult opinion and after this single visit referring psychiatrist or family physician will work on implementing recommended pharmacological treatments and psychotherapy. The role of primary care providers in the treatment of patients with depression and anxiety disorders is essential.

Recommendations

There is no ideal model of organizing specialized mood disorders services, particularly in places where community services are not sufficiently developed. Considering a short-term follow-up for certain categories of patients is sometimes inevitable. Patients receiving highly specialized treatments such as neurostimulation or patients just discharged from mood disorders inpatient units with not yet established community follow-up may need a short-term follow-up with the mood disorders outpatient programs.

However, majority of patients have one-time consultation and after this 1.5-hour visit the patient and referring physician will be provided with treatment recommendations for pharmacological and non-pharmacological treatments. This recommended treatment plan will be implemented by community psychiatrist or primary care provider. The patient could be always referred for a new consultation if needed. More severely impaired mood disorders patients who may need more extensive care should be referred to the ACTT or case management programs. Mood disorders specialized programs should not accept chronic and more impaired patients with mood disorders as these patients usually require long-term follow-up, case management, ACTT and the level of care which subspecialized consultation-based services should not and cannot provide.

Conclusion

Implementing robust community service program for patients with chronic mental illness is aimed at lifting the heavy burden upon the shoulders of specialized mental health services. Therefore, moving back to the consultation-based concept and keeping with one- time

consultation practice which is the mandate of the subspecialized services, will allow to provide the service it's intended for benefitting as many patients as possible cutting the service wait time.

Conflicts of Interest

None.

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