

Pharmacotherapy for schizophrenia and depression

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One of the great challenges facing mental health care in the near future is the need to increase its effectiveness. This challenge involves different aspects. Many believe that the care utilisation for psychiatric problems will continue to increase. Since Health Care is confronted for many years with a restricted growth of finances, the increasing care utilisation can no longer be met by supplying more and more of the same care. Another question pertains the definition of effectiveness in mental health care. The question is intimately related to the tasks and aims of mental health care. The discussion about the domain of mental health care has been an emotional and difficult discussion, which has so far not resulted in a satisfactory answer. The definition of effectiveness of mental health care comprises different dimensions. At the one end the aim is humane care, which perhaps could even be called palliative care, for chronic psychiatric patients whose perspectives on a bearable existence outside intramural care facilities are quite limited. An adjacent question is the organisation of care for those who deliberately avoid psychiatric care: what are reasonable and desirable goals for these patients? Only after agreement on treatment goals one can start to measure the effectiveness of care provision. On the other extreme of mental health care the aim is complete abolition of symptoms and ultimately of disorders. Effectiveness of care in this context is measured in terms of the degree of recovery achieved, a recovery which is economically sound and is as fast and complete as is reasonable. Between both extremes is a large population of patients for whom intermediate goals apply. For those the highest attainable goals should be formulated clearly. Those goals should be realised by responsible and qualitatively sound care. Such care is defined in the 'Quality of Care Institutions Act' ('Kwaliteitswet') to be effective, efficient and patient-centred. Straight short and long-term goals are often difficult to formulate in the grey area between cure and care. It requires a certain mind-set, which has not yet become widely accepted. Steering mental health care based on pre-set goals is in progress in some areas, but is no common practice.

The present report is a future scan on the possibilities to optimise care and pharmacotherapy for schizophrenia and depression. It is envisioned that optimising care and pharmacotherapy could significantly increase the effectiveness of mental health care.

After a short introduction on the applied scenario methodology, two chapters are devoted to the analysis of information basic to the disorders schizophrenia and major depression. This analysis comprises a selection from the vast amount of available literature. The aim is not to be comprehensive. The focus is on those developments in the epidemiology and diagnosis, on the potential causes, the current treatment and the demand and utilisation of care. Changes in these four areas, which may be relevant for the future, have been investigated and have been ordered regarding their potential impact.

The two disorders chosen for this study differ in nature, in incidence and in prevalence. The treatment and organisation of the care diverge as well. Through the comparison of two different disorders, we have attempted to articulate both the similarities in treatment concepts as well as the bottlenecks in care and pharmacotherapy. The changing medical and societal context of mental health care affects the treatment of schizophrenia and depression. In chapter 5 eight trends are analysed and described that may crucially change mental health care. The potential

influences of these trends, the uncertainties and possible alternative developments have been mapped. In a nutshell the following can be stated.

The increasing utilisation of mental health care appears to be a realistic development. A number of (societal) factors can lead to maximisation of mental health care. In the case of unchanged effectiveness and capacity, a congestion of the system of mental health care is likely to occur. One of the consequences is the urgent need to reconsider the domain of mental health care. Questions regarding the domain and the goals of mental health care are unfortunately often not sufficiently interconnected.

The developments in evidence-based medicine (EBM) also become mature in psychiatry. The results form a strong support for the evolvement of consensus documents, multidisciplinary guidelines and protocols. Under the condition that this approach does not induce a deindividualisation, it could lead to improved transparency and quality of care. Moreover, for non-professionals the notion of the contents of care will increase.

The regional indication procedures for admission to mental health services could have profound effects on health care provision. An increased bureaucracy might result from this attempt to harmonise all provisions under the 'Exceptional Medical Expenses Act' ('AWBZ'), effectively reducing the finances for mental health care. On the other hand, a certain formalisation of the indicated care might facilitate a better coupling of diagnosis and adequate treatment. With regard to the latter, the (r)evolution in evidence-based psychiatry seems invaluable.

The effectiveness of the care could also be influenced by professional changes among psychiatrists. Psychiatry has to stand for its profession and make clear what the society may expect from this medical specialisation. Psychiatry is no panacea for societal problems, but has more to offer than ever before in humane and effective care for the ill. A specialised, quality-driven discipline can develop the most strong force in those areas that require integrated medical attention. This will undoubtedly lead to a higher appreciation of the psychiatric specialism and increase the potential to deliver effective care.

The potential significance of predictive medicine, early diagnosis and prevention has been discussed from different perspectives. The breakthrough chances of molecular biology and the human genome project seem unrivalled. However, the coupling between genetics and psychiatric no-so-logical entities is still troublesome. The relation between genetic traits and (patho)physiological functions opens promising perspectives. Many issues concerning early diagnosis, prevention programmes and psychiatric interventions at a young age, are still in debate because of ethical dilemmas.

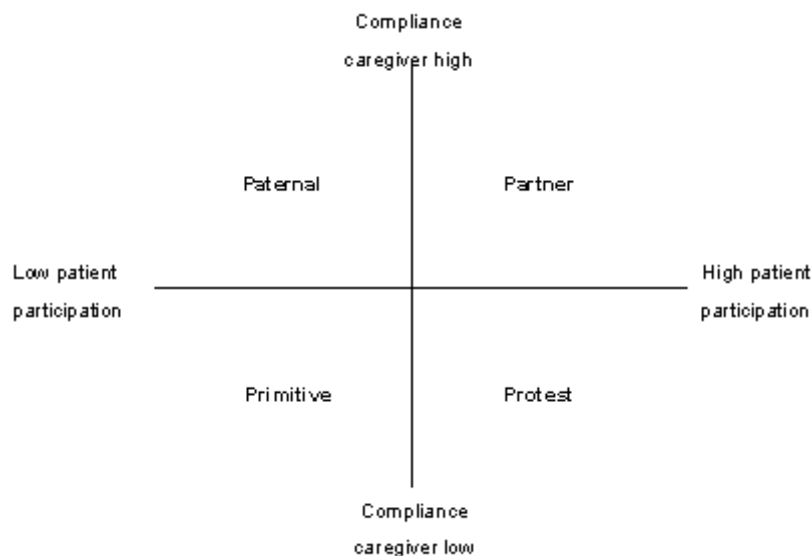
Pharmacological progress seems to enter new dimensions. New molecular biological techniques and concepts offer a different view on pathological changes and henceforth on other targets for drug development. Neurobiological findings will also form a strong impetus to alternative treatment strategies for cognitive disorders. Different experts, however, rate the speed with which these developments will become reality, quite variably.

The role of patient interest groups and parent organisations is rapidly growing. The autonomy of the patient is considered of high importance, but strong patient interest groups require professional organisations that combine knowledge and political power on the one hand, with facilities for mutual support groups on the other hand. Such organisations and groups may strongly influence the processes of information dissemination, proto-professional attitudes and stigmatisation. They

are likely to become a stable factor with increasing influence on the quality and transparency of mental health care.

The 'deinstitutionalization' of mental health care in favour of transmural, extramural community mental health services is strongly supported by the national government. Not only by the Dutch government, but worldwide strong emphasis is given to comprehensive community mental health services. These structural changes in care provision could work out for good, but it is fair to conclude that the evaluation of this policy still lags behind. Without a number of essential conditions psychiatric care can drop below acceptable levels. The coming years will reveal the degree of acceptance and tolerance of psychiatric patients by the society.

These aforementioned trends affect the level of interaction of the patient and his environment and the caregiver. They act upon the margins and possibilities of the patient. They limit the perception of professional standards and the context in which patient and professional interact with each other and with the disease. Optimising care and pharmacotherapy is vitally dependent on the very nature of the therapeutical relationship. Within the doctor-patient relationship we have formulated two scenario-axes or critical uncertainties, that will determine this optimisation. The first axis is the participation of the patient and his environment. This may vary from resignation or passive resistance to strong co-operation and involvement. The second axis regards the compliance of the caregivers (chain). This axis comprises both the compliance of individual professionals in mental health care to current best practices as well as the guaranteed continuity in care provision. Care for chronic patients often involves many different professionals and a bad co-ordination results in unnecessary suffering and a low quality of care. Based on these axes four quadrants have been constructed (see figure):



In chapter 7 the four scenario's Partner, Protest, Primitive and Paternal are described in more detail. In chapter 8 and 9 the consequences of each of the scenarios is discussed for patients, (medical) professionals, government and insurance companies. Moreover, the organisation of care-supply chains, the significance for pharmaceutical industries and society values and visions are worked out in more detail. Although the impetus for different parties varies, the conceptual model appeared a useful tool for discussing the future. The frame of reference appears feasible to anticipate threats and promises for the future, both for depression and for schizophrenia.

The Partner scenario offers the best possibilities to arrive at a shared responsibility in terms of pharmacotherapy and with regard to care in general. In reality the participation of the patient and his environment will not always be optimal. The Paternal scenario is therefore a plausible picture of the future as well, in which care is mainly optimised by the professionals that deliver mental health care. When professionals in mental health care offer insufficient dedication or quality a countervailing power will emerge in the Protest scenario, possibly leading to consumerism. If indeed the pressure on the mental health care system becomes huge, and quality and co-ordination fail, care might deteriorate to the situation described in the Primitive scenario.

The report started with addressing questions around the effectiveness of mental health care. Inhibiting and facilitating factors have been mapped and appeared of relevance in the four plausible scenarios. The question that remains is: what may be expected from mental health care in the future?

At any rate mental health care will be more evidence-based, more transparent and verifiable. The tuning between different occupational groups might result in a functional and satisfying positioning of individual professionals. It can also be expected that the role of patient interest groups and parent organisations will increase and hence the quality of care, of pharmacotherapy and the relationship between patient and caregiver will improve. Finally, although the chances of a breakthrough are judged differently, it is expected that minor or major steps in biotechnological or pharmacological respect will find more rapid and adequate implication to reduce suffering and increase the autonomy of the patient and his environment.

Expanding possibilities to increase the effectiveness of mental health care are realised by making flexible transitions between the Partner and the Paternal scenario. The way in which this could be realised best was not the scope of the scenario discussions. Initiatives and decisiveness of the field parties will determine the speed of implementation.