



## editorial

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### Are specialised affective disorder services useful?†

#### SUMMARY

Across the UK there are a number of tertiary level affective disorder services, usually based in academic centres, that provide support for the management of patients with complex and treatment-resistant conditions. Such services play a

potentially important role in instilling hope into patients, carers and healthcare teams in situations where therapeutic nihilism has often developed. They also provide a valuable reservoir of expertise on the use of medications outside of licensed usage, and new and

emerging treatments. To date there is relatively little data regarding patient outcomes after referral to such services; however, what there is does suggest important benefits for both patients and healthcare economies. As ever, more research is needed.

#### What is a specialist service?

The term 'specialised' is a relative one. General practitioners have many specialist skills in the management of common mental illnesses. Secondary care services are 'specialised' in the management of more severe and difficult to treat illnesses. There is a trend towards increasing sub-specialisation within general adult mental health service provision, such as providing functionally delineated services, for example for psychoses or affective disorders. Beyond these secondary care level specialist services sit tertiary level specialist affective disorder services that mainly or wholly take referrals from secondary care. In this review we will focus on these tertiary level services.

The Department of Health has defined specialised services as 'those with low patient numbers but which need a critical mass to make treatment centres cost-effective' (Department of Health, 2007). They highlight training, research and resource allocation as important roles for such services. They have identified 35 'specialised services' and produced definition sets for each of these – definition number 22 covers specialised adult mental health services, identifying ten types of such services. One of these is the service for 'complex and/or treatment-resistant disorders'. This is further divided into 'severe and/or complex affective disorders' and 'psychosis services', and aims to use the best available treatments (pharmacological, psychological, physical and psychosurgery) based on 'rigorous evaluation of the latest research evidence'. The necessity for close links with an academic research centre is emphasised.

There are a variety of different tertiary level specialised affective disorder services in the UK, for example in London, Manchester, Bristol, Southampton, Oxford,

Newcastle and Dundee. A detailed description of the Manchester service is available (Ker & Anderson, 2006). The structure of these services vary from those that provide for out-patients, with input in some cases from psychology, community psychiatric nurses and occupational therapy, to others that comprise both in-patient and out-patient services. These services are notable for their high degree of medical input and close links with universities. Recently, there have been advances in non-pharmacological somatic treatments of mood disorder, for example vagus nerve stimulation (Kennedy & Giacobbe, 2007) and deep brain stimulation. These treatments are in the early stages of development and are a limited resource. In terms of efficient resource management, regional specialised services act as a gateway to such referrals. Assessment of the appropriateness of neurosurgery in treatment-resistant individuals is carried out in the UK by a 'supra-regional service' in Dundee, which currently offers anterior cingulotomy and vagus nerve stimulation (it may in the future be available at other centres). The Bristol service is in the process of selecting patients for a trial of deep brain stimulation.

#### What is the role of specialist services?

The above notwithstanding, what exactly is the role of specialist affective disorder services? Why are tertiary services, in addition to secondary care services, needed? The National Institute for Health and Clinical Excellence (NICE) guideline for depression recommends a stepped care approach to treatment in patients mainly managed in primary care (National Institute for Health and Clinical Excellence, 2004). So, when the patient does not respond to two antidepressants prescribed at an adequate dose

†See invited commentary, p. 44, this issue.



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for an adequate duration, they are referred to secondary care (at level 4 of the stepped care pathway). In level 4 of the guidelines, NICE recommends considering a limited number of treatment strategies for refractory patients (for example, cognitive-behavioural therapy or lithium augmentation of antidepressants, venlafaxine to British National Formulary limits, mirtazapine plus a selective serotonin reuptake inhibitor or phenelzine). Beyond this, it is recommended that 'when a [patient with depression] has failed to respond to various strategies for augmentation and combination treatments, referral to a clinician with a specialist interest in treating depression should be considered' (National Institute for Health and Clinical Excellence, 2004).

Remission rates with each successive treatment trial of depression become lower. In the Star\*D study from the USA, after three failed medication trials, remission rates ranged between 6.9 and 13.7% (McGrath et al, 2006). It is therefore easy to understand why therapeutic nihilism develops. Hopelessness is a core symptom of depression and a major risk factor for suicide. In cases of treatment resistance, if the clinician loses hope as well, malignant psychodynamics can set in, with hopelessness in the patient spiralling downwards. Some clinicians are fearful of giving what they consider being 'false' hope and as a result fail to instil even relative hope for degrees of recovery into their patients. A Delphi consensus study of consumers, carers and clinicians on 'first aid for depression' reported that 80% or more of the panel members rated being given hope for recovery as essential or important (Langlands et al, 2008). The Depression and Bipolar Support Alliance state that 'giving hope to a patient is one of the most powerful things a physician can do'. If a physician believes there is no more that can be done for a treatment-resistant patient, Lewis & Hoofnagle (2003) consider that 'it's time to immediately refer the patient elsewhere' and they emphasise the importance of empowering patients by encouraging second opinions. It has been argued that second opinions be regarded as routine practice in cases of diagnostic and therapeutic difficulty (Nirodi et al, 2003). Thus, an important role of specialised mood disorder services is to collaborate with patients in therapeutic treatment trials with a view to instilling hope and empowering both patient and clinician.

Bipolar disorder is different to unipolar depression in not only its presentation but also patient's needs. Although bipolar disorder is perceived as a severe mental illness, guidance regarding service provision has been lacking (McAllister-Williams & Watson, 2003). In a recent article, Goodwin & Geddes (2007) argued that bipolar disorder should replace schizophrenia as the 'heartland' of psychiatry because it is 'no less debilitating, on comparable measures of morbidity and mortality and is much more common'. Although one might argue about any single disorder being given undue pre-eminence, it is surprising that much less research has been conducted in bipolar disorder than in schizophrenia (Clement et al, 2003), despite the fact that it sits ahead of schizophrenia in the top ten leading causes of disability worldwide (Murray & Lopez, 1997). Specialist services, through their

academic links, can address this deficit and also enhance the profile of affective disorders in general. This is encouraged by NICE guidance for bipolar disorder (National Institute for Health and Clinical Excellence, 2006), which states that '[trusts] providing specialist mental health services should ensure that all clinicians have access to specialist advice from designated experienced clinicians on managing Bipolar Disorder in adults, . . . and on referral to tertiary centres'.

There may be resistance to requesting a second opinion from a specialised service for both unipolar and bipolar disorders. This can relate to the issues of hopelessness described earlier in relation to depression. In addition, the referring clinician may feel discouraged by a negative local environment to help-seeking or a personal sense that they 'should' know what to do. Some clinicians believe that specialised services prioritise academic work over clinical work and have lost touch with the realities of working in a secondary care psychiatric service. It is important to identify and address such reluctance to refer because ultimately this can result in depriving a group of patients who are often at the end of the spectrum of disability and using extensive resources of management options they may benefit from.

Once a person with a mood disorder is on a treatment-resistant trajectory, increasingly complex pharmacotherapy is often necessary. This is coupled with an increased risk of iatrogenic complications. Medications are often used outside of their licenses both in relation to diagnostic indication and dosage level. This can leave the treating clinician feeling medico-legally vulnerable. 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 body of responsible and skilled medical experts'. Such support can be provided by specialised services.

## What do specialist services do?

There is a paucity of data regarding the activities and outcomes of specialist services, especially in the UK. A survey of expert second opinions in a tertiary affective disorder clinic undertaken between 1988 and 2000 reported that 62% of patients were referred due to 'failure to respond to treatment' and 48% due to diagnostic uncertainty. New treatments were recommended in 68% of cases and 31% were offered an alternative diagnosis (Nirodi et al, 2003).

In a mood disorders unit in Sydney, Australia, recovery levels reached two-thirds after a year and were maintained over 3 years later in individuals with moderate to severe depression, including a large number of treatment-resistant individuals (Brodaty et al, 1993). Comparisons between countries, however, are fraught because the model used and patient group provided for a tertiary service are dependent on the models of secondary and primary care in each country.

In another retrospective study of 44 patients with treatment-resistant depression admitted to a specialist



affective disorders service in the UK, most improved substantially (Kennedy & Paykel, 2004). The majority of patients were markedly or severely ill and had long index episodes. Before referral, the mean number of treatment courses was 6.4 (range 2–16), including, in some cases, electroconvulsive therapy (ECT) and lithium augmentation, indicating a high degree of treatment resistance. Nevertheless, after treatment, on global ratings of severity of illness, 86% had shown either a moderate or marked improvement, although no patient became entirely symptom-free. The most effective somatic treatments included very-high dose antidepressants, usually augmented with lithium and often combined with ECT.

Within our own service, an audit of 66 consecutive admissions to our tertiary in-patient unit has shown that a significant improvement in depressive symptoms and functioning (as measured using the Global Assessment of Functioning) at discharge. This is encouraging given that many admissions were of fixed short durations for funding reasons and the purpose of admission is often assessment rather than treatment. It has been possible to follow up 22 of the patients between 1 and 4 years later and there remained a significant improvement compared with ratings on admission. We have also conducted a mirror analysis on 36 patients for a mean duration of 500 days before and after an admission to our unit. This revealed a trend to a decrease in admission rates post-discharge that was significant for the 14 patients with bipolar disorder in the cohort. These data need replication but they are important when considering the potential resource benefits of funding such specialist services.

## Conclusion

Specialist affective disorder services have considerable utility. This is evident clinically in their role in instilling hope into treatment-refractory patients and their clinicians. They provide a reservoir of experience in the use of treatments outwith product licences and treatment guidelines and are able to support the activities of clinicians in secondary services. For these reasons, NICE recommends access to such specialist advice (National Institute for Health and Clinical Excellence, 2004). We believe that specialist services are a cost-effective way of managing complex and difficult to treat patients with affective disorder. However, to date the evidence supporting such a statement is limited. It is beholden on such services to acquire better data so as to justify their funding and continued support.

## Declaration of interest

All authors work in a specialist affective disorders service.

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*Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 583.

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