Chapter 4

Care programmes at mental health centres: the degree of adherence in the first phase of treatment

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Abstract

Background: Most mental health care providers in the Netherlands have implemented programs of care. Little is known, however, about the degree to which these programs are used in routine clinical practice.

Methods: For three consecutive years, we randomly selected 100 patients with a unipolar mood, anxiety or somatoform disorder each year and investigated the degree to which programs of care were applied in the first phase of treatment. We used a set of program-derived clinical process indicators. Data were extracted from Routine Outcome Monitoring and patient records. We selected patients from one site of the mental health care provider Rivierduinen.

Results: For most indicators the scores were fair to good over the three years. For the indicators 'follow-up measurements ROM' and 'frequency of psychotherapy', the scores were low. Only ROM of the severity of the psychopathology in the diagnostic phase showed a significant increase over the three years examined.

Conclusion: At this site of Rivierduinen, most elements of the programs of care were well monitored in the first phase of the treatment of unipolar mood, anxiety and somatoform disorders. Follow-up research should focus on the subsequent phases of the treatment. In addition, it is important to relate the extent of application of programs of care in daily practice to the treatment outcomes.

Introduction

Guidelines

In mental health care, treatments that follow guidelines are ubiquitous. Experience and personal preference are no longer major factors determining the correct therapy and have been replaced by treatments with proven effectiveness under controlled treatment conditions. There are high expectations for working according to guidelines: better treatment outcomes, improved cost effectiveness and a reduction in unnecessary variation between treatments. These positive expectations appear to be realised in controlled treatment studies, in which patients treated according to guidelines have better treatment results in terms of various outcome measures, compared with the group undergoing standard treatment. For example, in the US the Texas Medication Algorithm Project compared the commonly used pharmacological treatments of e.g. mood disorders with treatments according to a detailed, evidence-based guideline or algorithm. That prospective study, conducted in 14 different clinics, showed that in the patient group treated according to the algorithm, there was a significantly larger reduction in symptoms and improvement of social functioning. The European counterpart of this study, the Berlin Algorithm Project, found similar results. [1,2] Given these favourable results of controlled studies, the question arises to what extent guidelines are actually applied in daily practice and whether working according to guidelines ultimately leads to better treatment outcomes in daily practice. In the past few years a limited number of studies has appeared that chart the application of guidelines in daily psychiatric practice. It concerns foreign studies exclusively. The majority of these studies use databases of e.g. insurance companies. These databases give limited information about the treatment applied. Often, only the number of prescriptions issued or the number of contacts between practitioners and patients is examined. The outcomes of these studies often contradict each other and show in any case that it is not simple to research clearly the extent of application or compliance. [3-9] According to Weinmann [10] there are no systematic reviews describing the effects of implementation of guidelines in the clinical psychiatric practice.

The Netherlands

Guidelines are mostly embedded in programs of care in the Netherlands, and describe the treatments in greater detail than the 'bare' guidelines. They are also modified to fit the local situation. In the past few years a great deal of energy has been invested in implementing programs of care. In 2004 the Dutch mental health care providers (GGZ) ascertained that the implementation of programs of care was accomplished in the majority of regions (www.ggznederland.nl/zorg/index.html). In that year we sent a questionnaire to the executive boards of 38 GGZ institutions to examine the degree to which programs of care are used in daily practice. Most GGZ institutions informed us that they work with evidence-based programs of care. Many institutions remarked that they did not know the degree to which the programs are used in practice. There was no clarity in these institutions about the systematic measurement of the results of treatments and the application of such outcomes when determining a treatment policy. Various institutions informed us that the percentages they gave were more likely to be based on estimates or predictions for the next few years rather than reliable data from the practice. [11]

As Leentjens and Burgers [12] ascertained in a recent issue of this journal devoted to evidence-based psychiatry, there have not yet been any Dutch studies examining the compliance (or degree of application) with guidelines in the daily psychiatric practice. Insight into the extent of application of programs of care is needed to be able to make reliable statements about the effectiveness and utility of evidence-based psychiatric treatments in daily practice, where patients and their pathology can often be more complex than in controlled treatment studies. In addition, research into the extent of application in routine practice could identify other factors hindering their application that are found on the practitioner and organisation level. Their use could then be improved with targeted interventions. [13]

Because there are hardly any data about the degree of use of programs of care and treatment guidelines in routine psychiatric practice in the Netherlands, we decided to investigate this aspect in one of the outpatient clinics of GGZ Rivierduinen, which started the implementation of programs of care eight years ago. We expected the complexity of the daily clinical GGZ practice would restrict the application of programs of care. We also wanted to explore whether the extent of implementation in routine psychiatric practice, given the ongoing implementation activities, had indeed improved over time. These research

questions were studied on the basis of the treatment used at the start of the treatment program in the GGZ.

Methods

Programs of care at GGZ Rivierduinen

Rivierduinen is a regional GGZ institution with a service area of circa 1 million inhabitants. The programs of care were developed in close collaboration with the Psychiatry Department of Leiden University Medical Centre (LUMC) and gradually implemented starting in 2002 in all sections of Rivierduinen.

Working according to guidelines and the standardised measurement of treatment outcomes (measurement-based care founded on routine outcome monitoring) are now fixed elements of the programs of care at Rivierduinen. [14] The multidisciplinary guidelines are used when designing programs of care, when the sequence and selection of treatment options and measurements are elaborated and determined. The programs of care at GGZ Rivierduinen are designed according to the stepped care principle. As a first step, the form of treatment is used that carries the least burden, is cheap and short. When this step or module is not effective enough, the next module is initiated, usually a more intensive and more expensive form of treatment. In the meantime, programs of care have been developed for unipolar mood, anxiety, and somatoform disorders. GGZ Rivierduinen and LUMC developed the programs of care for somatoform disorders in line with an evidence-based method. Soon there will be programs of care available for the treatment of psychotic and personality disorders.

The different treatment steps in the programs of care are summarised in decision trees, which are available via Internet and intranet for patients and practitioners (www.lumc.nl; see also figure 1). Reference was made to multidisciplinary guidelines when designing the different steps (such as the dosage of a serotonin reuptake inhibitor specified in the treatment step). In 2009 more detailled protocols for pharmacotherapy and psychotherapy, based on the multidisciplinary guidelines, were introduced in the different treatment steps.

Various interventions have been done to ensure the success of the implementation: making the programs of care available online, educational

conferences, participation of the practitioners in modifying and improving the programs of care, auditing and feedback, and extensive support of personnel.

Patients

For this retrospective study over three consecutive years (2004-2006), we included 100 successive patients each year who had been registered by their GP for an outpatient treatment of a unipolar mood, anxiety, or somatoform disorder at Rivierduinen, Rijnveste site (Leiden). Inclusion criteria included a depressive, anxiety, or somatoform disorder, aged between 18 and 65 years old, sufficient mastery of Dutch to be eligible for routine outcome monitoring (ROM), and had visited a practitioner at least once for treatment. The data for the study were then collected and anonymised using a status study. In this study, only the first treatment module applied was examined.

Routine outcome monitoring (ROM)

All patients suffering from a unipolar mood, anxiety, or somatoform disorder and who are able to communicate well in Dutch are eligible for the measurement of treatment outcomes. The effect of the treatment was measured on three levels: improved general well-being, reduction of symptoms, and improved functioning. Measurements were done using self-reporting questionnaires that were completed by the patient, plus rating scales used by specially trained research nurses. These research nurses periodically measured various aspects of the patients' psychological and social behaviour. The questionnaires were classified into generic and disorder-specific instruments. Generic ones, like the BSI [15] were offered to all patients, regardless of their disorder. For each disorder, specific measuring instruments were added, but only if the patient seemed to be suffering from that disorder. During the first measurement the diagnostic status of the patient was ascertained using a standardised interview, the MINI-plus. [16] To administer the questionnaires, calculate the results, report trends over time and manage the data, Questmanager was employed: web-based software that we developed ourselves. ROM was applied to measure the effectiveness of individual treatments and to be able to make statements with the aggregated data about the effectiveness of particular treatments and the quality of care. The data are potentially extremely useful for conducting fundamental scientific research. Currently, the ROM database contains data from over 6000 patients, and 200 more are added each month. [14]

Indicators

To be able to measure the use of programs of care in the first treatment module offered in the GGZ, we developed a number of indicators. We took into account the recommendations in the literature, including the methodology described by Grol et al. [17] We conducted a literature review, held discussions with experts and practitioners, and carried out a pilot study.

The indicators fell into two groups and specify a minimum in a number of cases that must be met according to the guidelines.

Indicators reflecting the implementation of pharmacotherapy and psychotherapy

(i) The combination of a DSM-IV diagnosis and the chosen treatment is dictated by the programs of care. (One treatment is applied that is recommended in the treatment guidelines for this diagnosis.)

(ii) When the patient was treated with *pharmacotherapy:* did the treatment last at least six weeks?

(iii) When the patient was treated with *pharmacotherapy:* was the patient prescribed an adequate dose of the medication (at least the minimal dose specified in the guidelines)?

(iv) When the patient was treated with *psychotherapy:* did the treatment last at least 12 weeks?

(v) When the patient was treated with *psychotherapy:* did the patient have at least one session every week and a half?

Given that therapy sessions are cancelled due to illness, vacations and family circumstances by both practitioners and patients, it was decided in the consensus discussion that a frequency of once per week for psychotherapy was too stringent a criterion and that an average frequency of once per one and a half weeks would be a more realistic minimal criterion.

For the same reason, 12 weeks was chosen as the minimal duration of the psychotherapy given. This was based on the shortest duration of a psychotherapeutic intervention described in the guidelines, namely eight weeks (for example, panic management or exposure in vivo for a panic disorder). Taking into account the realistic minimal frequency of one session

per one and a half weeks, we arrive at a minimal duration of 12 weeks.
The indicators reflecting the implementation of psychotherapy are not applicable to Eye Movement Desensitization and Reprocessing (EMDR). According to the multidisciplinary guideline (and the programs of care for anxiety disorders at Rivierduinen), no frequency has been set for EMDR and only a maximal duration of the intervention period given (8 weeks).

Indicators reflecting specific elements of programs of care in Rivierduinen:

(vi) The principle of stepped care is applied: the patients are treated according to the first step in the programs of care, or the second step in the programs of care if the patient has already had the first treatment from their GP.
(vii) During the diagnostic phase the patient is measured at least once using ROM.
(viii) The progress of the treatment is measured at least once with ROM, after the ROM done in the diagnostic phase.

The indicators are then scored individually for each patient on the basis of the status and the ROM data in a binomial manner: 1 when an indicator was present and 0 when this was not the case.

Statistical analysis
Analyses were conducted with SPSS 14.0. (SPSS Inc., Chigago, IL, USA) Differences between scores on indicators over the three successive years were compared with a chi-square test.

Results

Patients
For each year between January 2004 and January 2007, 100 successive patients were included who met the inclusion criteria. Of the total of 300 patients, 139 (46.3%) had a primary diagnosis of a depressive disorder, 108 (36.6%) an anxiety disorder and 53 (17.7%) a somatoform disorder. The patients' characteristics are given in Table 1. In total, almost 3000 patients were seen for an intake at

the Leiden site of Rivierduinen between January 2004 and January 2007. The characteristics of the patients included in this study did not deviate significantly from those of the other patients with a unipolar mood, anxiety or somatoform disorder who were seen for an intake at the same site.
The number of patients whose GP had started them on a treatment with pharmacotherapy was 112 (37.3% of the total cohort). Of these patients 33.0% were prescribed a SSRI (the majority received paroxetine) and 3.7 % a tricyclic agent.

Scores of indicators

Pharmacotherapy

A majority of the patients received a treatment described in the programs of care: 85 (85%) in 2004, 95 (95%) in 2005 and 93 (93%) in 2006. In total, this was the case for 273 (91%) of the examined patients. There appeared to be a significant difference between the years (p=0.033). The patients who received a treatment from the programs of care were then eligible for the scoring of the indicators, formulated for the specific form of treatment they had received.
The number of patients treated with pharmacotherapy was 20 (23.5%) in 2004, 39 (41.1%) in 2005 and 41 (44.1%) in 2006. This amounted to a total of 100 patients (36.6%).
The number of patients who underwent psychotherapeutic treatment was 44 (51.8%) in 2004, 47 (49.5%) in 2005 and 46 (49.5%) in 2006. This amounted to a total of 137 (50.2%) patients. A combination of pharmacotherapy and psychotherapy was used for 21 (24.7%) patients in 2004, 8 (8.4%) patients in 2005 and 6 (6.5%) patients in 2006. In total, this amounted to 35 (12.8%) patients. For the group of patients who received a combination treatment, the psychotherapy and the pharmacotherapy were evaluated. In 2005 one patient was treated with light therapy ("other" treatment group), and this patient was not included in our study.
A minimal duration of six weeks for pharmacotherapy was reached for 26 (63.4%) patients in 2004, 33 (70.2%) patients in 2005 and 33 (70.2%) patients in 2006. This indicator did not vary significantly from year to year.
An adequate dose of the pharmacon was prescribed for 39 (95.1%) patients with pharmacotherapy in 2004, 40 (85.1%) patients in 2005 and 43 (91.5%) patients in 2006. There were no significant differences between the years for this indicator.

Psychotherapy

The minimal duration of 12 weeks of psychotherapy was realised for 51 patients (85.0%) in 2004, 34 patients (77.3%) in 2005 and 27 patients (61.4%) in 2006. This indicator showed a significant drop over the years (p=0.020).

A frequency of psychotherapeutic sessions of at least once per one and a half weeks was achieved for only 12 patients (20.0%) in 2004, 9 patients (20.5%) in 2005 and 19 patients (43.2%) in 2006 (p=0.016). This indicator showed a significant increase over the three years measured (p=0.016).

The number of patients treated with EMDR was 24. The duration of this treatment varied from 3 to about 70 weeks. The frequency of the sessions varied between once per week and once per month.

ROM and stepped care

During the diagnostic phase all patients were considered for ROM by definition. In 2004, 29 patients (29%) were measured, 52 patients in 2005 (52%) and 69 patients in 2006 (69%). In total, 150 patients were measured in the diagnostic phase (50%). Over the three years there was a significant increase in the number of patients undergoing their first ROM measurement (p<0.000). During the therapeutic phase, patients had to be measured at least once to be able to draw reliable conclusions about the effectiveness of the chosen treatment. Of the 150 patients undergoing their first ROM, 91 patients had a follow-up measurement. In 2004 this occurred in the therapeutic phase in 14 (66.7%) patients, 23 in 2005 (69.7%) and 29 in 2006 (78.4%). In total, 66 (72.5%) of the 91 patients were measured at the right moment. No significant differences were measured for this indicator over the years.

In 2004, 81 (95.3%) patients were treated according to the stepped-care principle, 85 in 2005 (89.5%) and 85 in 2006 (91.4%) . This indicator also did not show any significant increase over the years.

All six indicators were positive for only a limited number of the patients: 3 (1.9%) of the patients undergoing psychotherapy and 16 (10.7%) of the group treated with pharmacotherapy. The majority of the patients had four or five positive process indicators. These suboptimal scores in the group treated with psychotherapy were primarily caused by the frequency of the psychotherapy sessions being too low. In the group treated with pharmacotherapy, the missing indicator appeared to be the ROM during the therapeutic phase.

Discussion and conclusion

This study examined the degree to which programs of care for unipolar mood, anxiety and somatoform disorders in the outpatient psychiatric practice are actually used during the first phase of treatment in the GGZ. Due to the complexity of the daily clinical GGZ practice, our first hypothesis was that programs of care are only applied to a limited extent. Our second hypothesis was that the continuous implementation activities in GGZ Rivierduinen should lead to an increase in the application of programs of care at the site in question over the three successive years of our sample. We used clinically relevant indicators for elements of the pharmacotherapy and psychotherapy and for specific components of the programs of care at Rivierduinen, particularly ROM and the principle of stepped care, to investigate the application.

In contrast to our hypotheses, it appeared that a majority of the patients scored positively for most indicators for the use of pharmacotherapy and psychotherapy, and the scores for most of the indicators were stable over the period examined. In other words, the programs of care often seem to have been followed during the first treatment step in this routine practice. One exception was the frequency of the psychotherapeutic sessions held at least once per one and a half weeks. This indicator only scored positively in a quarter of the patients treated with psychotherapy. The choice for an average frequency of once per one and a half weeks was derived from a consensus discussion and was, taking into account the limitations of the practice, less stringent than specified in guidelines and protocols. The average frequency of psychotherapy during the first module of treatment was one session per 2.3 weeks (± 1.3 weeks). In 45% of the psychotherapy cases, there was a frequency of at least one session per two weeks. We want to emphasise that the low score on the indicator for the frequency of psychotherapy does not reflect on the result of the psychotherapy given. Although most randomised and controlled psychotherapy studies use a weekly frequency, it is possible that a lower frequency in daily practice is more realistic and leads to similar results for psychotherapy. There are indications in the literature that a 'dosage' approach is effective, in which a certain number of sessions must be attended within a set period. [18] This could match what we ascertained in our study, that the frequency of psychotherapy seems to increase over the years, but the minimal duration of psychotherapy actually decreases. Other explanations for this pattern are conceivable, for example involving the

level of organisation of care. We do not know of any other studies looking for a minimal 'dosage' of effective psychotherapy. It is clear that further research into the average frequency and duration of psychotherapy and especially the link with the results in daily practice should be done.

The indicators based more on elements of the programs of care that are specific to Rivierduinen, namely the stepped care and ROM, show that the principle of stepped care is also applied to almost all patients. During the three years we examined, it appeared that only the conduct of ROM in the diagnostic phase increased significantly. In the past few years one of the management's important goals was to ensure that patients were measured as much as possible. This effort bore fruit, even though in the last year around a third of the patients were still not being routinely measured during the intake phase. ROM during the therapeutic phase was less successful; unfortunately, only an extremely limited number of all patients received ROM. Measuring the patient during the therapeutic phase (at its end) is the responsibility of the practitioner, who is sent a reminder after 3 months that patients should be considered for ROM. We got the impression that the second ROM measurement was insufficiently included in a routine, in contrast to the measurement at intake. Logistics factors could be involved, as could non-compliance by the patients (not turning up for appointments).

We expected that the application of the programs of care over the three-year period of our sample would increase. In contrast to our hypothesis, the scores of our chosen indicators generally remained stable over the years examined. As the implementation of the programs of care in this treatment centre began in 2002, this means that it advanced rapidly or that the programs of care suited the standard practice well in terms of design of the direct treatment.

Our study has a number of limitations. The extent of application of programs of care was measured in only one treatment centre, based on a restricted number of indicators and a relatively small number of patients. Also, only the degree of use during the first treatment in the treatment centre was examined. It is still unclear to what extent patients are treated according to the programs of care after the first treatment proves ineffective. Another potential limitation is the fact that relatively little emphasis was given to the special indicators. The indicator measuring whether someone is receiving the correct treatment for his/her diagnosis should perhaps weigh more heavily against the other indicators. We are aware of the fact that the chosen set indicators describe a

restricted, but essential, part of the treatment.

Although a majority of the patients were mostly treated according to programs of care during their first treatment, this was not the case for a considerable proportion of the patients. A logical next step would then be to identify factors at the level of organisation and patient, such as comorbidity or amount of education that could influence the degree of application of programs of care in practice. This would hopefully enable groups of patients to characterise what adjustments of the programs of care are needed, or interventions at the level of practitioners and organisation could be implemented to improve the use of programs of care.

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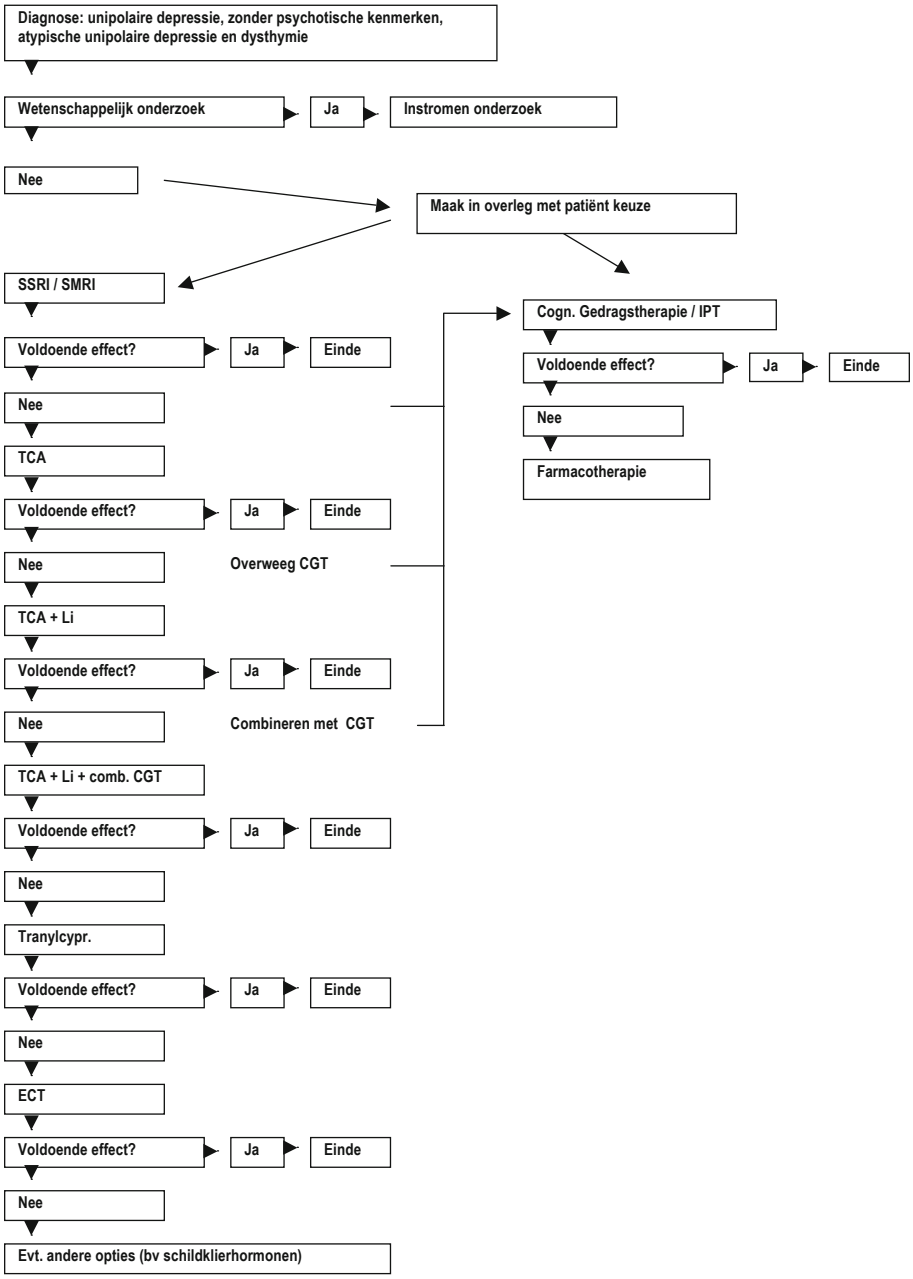
Table 1. Patient Characteristics

	2004	2005	2006	Total
Total - n	100	100	100	300
Age - n	37.4 ± 11.4	37.5 ± 12	36.2 ± 9.8	37.0 ± 11.1
Woman - n	66 (66%)	65 (65%)	68 (68%)	199 (66%)
Mood disorder - n	49 (57%)	42 (48.3%)	48 (56.5%)	139 (46.3%)
Anxiety disorder - n	36 (36.0%)	38 (38.0%)	34 (34.0%)	108 (36.0%)
Somatoform disorder - n	15 (15.0%)	20 (20.0%)	18 (18.0%)	53 (17.7%)

Table 2: Scores of indicators per year.

Process indicators			(N)	2004	2005	2006	Total	Significance*
ROM	ROM during the diagnostic phase		300	29 (29%)	52 (52%)	69 (69%)	150 (50%)	**[χ^2(2)=32.2. P=0.000]**
		ROM during the therapeutic phase	91	14 (66.7%)	23 (69.7%)	29 (78.4%)	66 (72.5%)	[χ^2(2)=1.1. P=0.568]
General	The combination of diagnosis and treatment is according to programmes of care		300	85 (85%)	95 (95%)	93 (93%)	273 (91%)	**[χ^2(2)=6.8. P=0.033]**
		The principle of stepped care is applied	273	81 (95.3%)	85 (89.5%)	85 (91.4%)	251 (91.9%)	[χ^2(2)=2.1. P=0.349]
Pharmacotherapy:		The treatment lasts at least 6 weeks	135	26 (63.4%)	33 (70.2%)	33 (70.2%)	92 (68.1%)	[χ^2(2)=0.61. P=0.738]
		The minimal adequate dose is prescribed	135	39 (95.1%)	40 (85.1%)	43 (91.5%)	122 (90.4%)	[χ^2(2)=2.63. P=0.269]
Psychotherapy:		The treatment lasts at least 12 weeks	148	51 (85.0%)	34 (77.3%)	27 (61.4%)	112 (75.7%)	**[χ^2(2)=7.8. P=0.020]**
		The frequency is at least one session per one and a half weeks	148	12 (20.0%)	9 (20.5%)	19 (43.2%)	40 (27.0%)	**[χ^2(2)=8.3. P=0.016]**

*Differences between years were compared with χ^2-tests; bold-printed values were statistically significant


Diagnose: unipolaire depressie, zonder psychotische kenmerken, atypische unipolaire depressie en dysthymie
Wetenschappelijk onderzoek
Ja
Instromen onderzoek
Nee
Maak in overleg met patiënt keuze
SSRI / SMRI
Voldoende effect?
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TCA
Voldoende effect?
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