LETTERS TO THE EDITOR

Re: Using Global Assessment of Functioning to Evaluate an Assertive Community Treatment Program

Dear Editor:

Tibbo and others (1) report significant improvement in functioning in a large cohort of individuals with serious mental illness who received care in an assertive community treatment (ACT) program in Edmonton. They base their conclusions on statistically significant improvement in Global Assessment of Functioning (GAF) scores over a 3-year period following admission to the program. Their results suggest that patients with lower baseline GAF and those with diagnoses of schizophrenia, schizoaffective disorder, and dysthymia are more likely to benefit from ACT than those with diagnoses of delusional disorder, bipolar disorder, and depression.

There are several problems in interpreting these results. GAF is not designed to measure functioning in any domain that is meaningful to individuals living in the community. GAF ratings are influenced more by symptoms than by social and occupational functioning. Several other measures could have more accurately provided information on social, community, and occupational functioning (for example, the Life Skills Profile, several Quality of Life measures, or the Social and Occupational Functioning Assessment Scale). If symptoms did in fact improve, that is significant in itself and needs to be reported as such: controlled ACT trials have generally failed to report any significant improvement in psychopathology. Hopefully, the authors have data on symptom ratings to report such results.

It is unclear whether the raters had received any specific training in the use of GAF. While consensus ratings more likely reflect a true picture of the patient, establishing reliability among raters across teams is essential, because the data reported are being aggregated from disparate sources.

The authors correctly question whether statistical significance is clinically meaningful. The fact that the most significant improvements showed a mean change within the same category (for example, for the schizophrenia group, from 51.4 to 57.9) is particularly important. It would be more meaningful to know what proportion of patients moved from a lower category to a higher category (in units of 10). Further, the results might have been more meaningful if they had been reported for patient clusters based not so much on diagnosis as on other variables known to influence community functioning (for example, sex, length and number of previous hospitalizations, and the severity and type of residual symptoms). A more complex data analysis could have provided more informative results regarding the relative influence of other variables. For example, we do not know whether the patients received different medications (such as novel vs typical antipsychotics) during the ACT phase.

Last, but not least, the results suggest that ACT may be an “overkill” for patients with a higher GAF at baseline, because they do not appear to benefit at any time during the 3 years of treatment. It raises the important question whether a single approach in the form of ACT, with full fidelity to all its components (including a high staff-to-patient ratio of around 1 to 10) may be unnecessary for a substantial proportion of patients with severe mental illness, including those with schizophrenia—as suggested by some recent studies (2). An opportunity exists to design care delivery methods incorporating the elements of intensive and assertive community treatment that are relevant to a particular group of patients with severe mental illness. This would allow a larger number of patients to have greater access to effective methods of care, because the ratio of case managers to patients can be significantly more economical than is the case in a traditional ACT program; there is, indeed, evidence to support this (3).

References

Ashok Malla, MB, FRCP
London, Ontario

Using Global Assessment of Functioning to Evaluate an Assertive Community Treatment Program: Reply

Dear Editor:

Dr Malla correctly observes that Global Assessment of Functioning (GAF) is not the best measure of functional change; however, when our program was originally designed in late 1992, limited resources, together with its already frequent use and familiarity (in hospital discharge summaries, for example) led us to choose it as the primary program outcome measure. We have continued to use GAF in the 6-month comprehensive
client review, but we also use quality of life and functioning measures (though not for all patients). All our raters had received training in the use of GAF, with good interrater reliability within the program. The greatest discrepancies we noted were with respect to discharge GAFs from the referring hospitals, which often had scores that were considerably higher than the GAF scores recorded by our teams at entry into the program.

Given the severity and chronicity of illness in the patients selected for an assertive community treatment (ACT) program, it is certainly true that psychopathology often remains significant—although often more manageable in the community than one might initially expect. Although data concerning the influence of other variables on community functioning were unfortunately tracked much less systematically, they could still be analysed.

The issue of medications is certainly interesting; it is likely influenced by factors such as clozapine use (which still required inpatient starts during the study period) and particularly, medication compliance. Given the nature of the ACT population, pharmacologic treatments tended to involve either conventional depot agents or combinations with novel oral agents or clozapine.

Our results also indicate that the cohort of patients with the highest GAF at baseline had Axis I diagnoses other than schizophrenia and significant Axis II pathology (frequently, borderline personality disorder). This group may comprise individuals with severe mental illness who use psychiatric services heavily; these patients likely benefit more from specific interventions relevant to their diagnoses—such as dialectical behaviour therapy (DBT)—than they do from standard ACT programs. It would be interesting to repeat the study, comparing a cohort derived from the program’s early days with a later cohort. More recently, we have implemented a multidisciplinary intake process that adheres very strictly to the mandate and selects out patients with, for example, primary addiction disorders or significant Axis II pathology. We direct those patients to other programs that have since been developed in Edmonton. Nonetheless, Dr Malla’s comments do highlight the importance of further research in this area, particularly with respect to the outcomes of different community-care levels. It had always been our intention to compare the ACT program with the preexisting case-management program in Edmonton. The latter program had no evaluative measures in place, however, and our request for a comparative study was declined.

Pierre S Chue, MB, BCh, MRCPsych, LMCC, DABPN, FRCP
downtown, Alberta

Re: Clinical Guidelines for the Treatment of Depressive Disorders

Dear Editor:

I was disappointed to find that the Clinical Guidelines for the Treatment of Depressive Disorders (1) rely heavily on so-called controlled studies and metaanalyses. The Guidelines neglect what we all do best: clinical impressions from individual patient contact. Granted, it is hard to quantify these, but they are still the basis for most diagnosis and treatment. The authors also forgot to mention that all antidepressants, particularly the selective serotonin reuptake inhibitors (SSRIs), suppress REM sleep. The net effect is that patients become increasingly agitated and, reflexly, many physicians increase their medication. In doing group psychotherapy (the Hope Alive model), I have found that the patients have been able to gradually wean themselves off 8 to 10 years of antidepressants and resume a reasonably happy conjugal, recreational, and occupational life. They do so, however, with a flood of nightmares representing a backlog of suppressed dreams and unresolved conflicts that at times are terrifying. Have psychiatrists forgotten the long-term impact of REM suppression?

Most patients that are referred to me have been placed on antidepressants by their family doctors, and many of them have been struggling to come off this medication. The patients state, “I don’t feel myself, my thinking is fuzzy, and I don’t know what my real emotions are anymore.” As one patient said, “The pain of my depression and anxiety were awful, but at least the feelings were mine.” It should also be remembered that, when people are grieving, there is no way to avoid the struggles with loss. If antidepressants are given to people who are grieving—as they often are—it prolongs their grief and increases the likelihood of pathological mourning.

Reference


Philip G Ney, MD, FRCPC, MA, FRANZCP, R Psych
Victoria, British Columbia
Worry WARTS have Generalized Anxiety Disorder

Dear Editor:

It has been a long-standing practice in medicine to use memory aids to prompt recognition and diagnosis, and authors have recently proposed mnemonics for the cardinal symptoms of generalized anxiety disorder (GAD). Bohn suggested using the phrase, “Does Mr Fisc worry excessively about minor matters” (1), and Berber proposed “WATCHERS” (2), but the name in the first phrase is forced and we would not automatically link the second mnemonic to GAD. Alternatively, “Worry WARTS” are “ones who are inclined to worry unduly” (3), and if they have GAD, they may be Wound-up, Worn-out, Absent-minded, Restless, Touchy, and Sleepless.

References


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