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Do We Know Need When We See It?

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In day-to-day practice, we view need for treatment much as former Supreme Court Justice Potter Stewart viewed pornography—we know it when we see it. However, defining need for mental health care can be both complex and politically charged. Many of the major health policy debates in the past quarter century have involved battles over how need for care should be defined and who should get to define it.

The most common method of defining need is based on prevalence of a mental disorder. However, as is often noted, diagnosis is a crude proxy for need. Some people with diagnoses of mental disorders may not need professional care; others without formal diagnoses may benefit from treatment. So, is it possible to devise a simple definition that more closely approximates the concept?

In a study reported in this issue Messias and colleagues sought to address this “need conundrum” by asking psychiatrists to directly assess it. As part of the Baltimore Epidemiologic Catchment Area follow-up study, psychiatrists interviewed each respondent and assessed whether they believed respondents required particular types of treatment. There was a partial, but not complete, concordance between diagnosis and psychiatrist-assessed need. For instance, more than one-quarter of individuals diagnosed as having major depression were not rated by the psychiatrists as having a need for any treatment.

Psychiatrist-based assessments may solve some of the problems created by the use of diagnostic-based evaluations of need. Clinicians can factor severity, treatment effectiveness, and other psychosocial factors into their decisions. However, use of clinician-based assessments also creates some new problems. Left to their own devices, psychiatrists vary widely in how they assess need and deliver care, given their training, organizational factors, local practice patterns, and financial incentives.

Need for mental health treatment is best represented not as a unitary construct but as a series of overlapping circles. The first circle is the level of disease burden, which can be measured as diagnoses, symptomatology, and functional burden. The second circle is availability of treatments, because need for treatment implies the existence of a therapy. The third is consumers’ perspective on need, which may not agree with the first two measures. Finally, as examined by Messias’ team, a clinician’s judgment can add valuable contextual information. When these four definitions overlap, assessing need is easy. When they diverge, it is important to reconcile them through dialogue that allows balancing of competing priorities. Throughout the process, we must recognize the complexity of defining need in mental health and the reality that we may not always know it even when we think we see it.