Annals of Internal Medicine

EDITORIAL

Improving Depression Care

The development of standard diagnostic criteria for mental disorders has a long history. In 1921, the American Psychiatric Association, working with the New York Academy of Medicine, developed mental health classifications that were used in the American Medical Association's Standard Classified Nomenclature of Disease. In 1949, the World Health Organization published the sixth edition of their International Classification of Diseases, which included for the first time a section on mental disorders. This was followed in 1952 by the first edition of the Diagnostic and Statistical Manual of Mental Disorders, which has subsequently undergone regular revisions, most recently in 2013 with its fifth edition (1). This codification helped clarify both research and clinical definitions and has led to significant progress in mental health care assessment and treatment. Regular revision has also allowed changes that reflect better understanding of mental disorders.

Among the various mental health conditions, depression is the most common in both primary care and specialty settings (2). Over the years, numerous instruments have been used to diagnose and monitor depression, many requiring special training or significant time to complete. An important advance in caring for primary care patients with depression was the development of the Patient Health Questionnaire–9 (PHQ-9) (3), a simple instrument for diagnosing depression, assessing its severity, and monitoring response to treatment. The PHQ-9 can be self-administered by patients and takes only a few minutes to complete. It has been incorporated into routine screening and management processes in many large health care systems, including Kaiser Permanente and the Veterans Health Administration.

In their article, Gliklich and colleagues (4) report on a national initiative to develop "harmonized" outcome measures for depression. This is an important next step because, as the authors point out, "a lack of uniformity remains in measurements and monitoring for depression both in clinical practice and research settings" (4). Many registries and systems across the country track patients with depression using various instruments and outcome definitions (5). This variability impairs comparisons across systems and practices. The depressive outcomes Gliklich and colleagues selected include survival, clinical response, events of interest, quality of life, resource use, and work productivity. In addition, the authors provide specific measures within each of these domains. Moving toward common definitions, measures, and outcomes will significantly improve depression management as well as assessment of treatment effectiveness. It will also help guide clinicians and researchers to focus on the full breadth of clinical outcomes at both patient and systems levels. In addition to improving patient care, standardization of outcomes will help in developing and assessing strategies to improve quality and efficiency as the health care system moves toward increased accountability. In many ways, this is an application to depression care of the concept behind the Patient-Reported Outcomes Measurement Information System, an initiative by the National Institutes of Health that developed standardized outcomes across common medical conditions (6).

An important next step is to better standardize management of depression in primary care. Other disease conditions, such as hypertension, have well-defined targets, outcomes, and management approaches. For example, providers starting patients on medication for blood pressure management measure blood pressure after an initial treatment period, assess side effects, and modify treatment to achieve the blood pressure target. Too often in depression care, after being diagnosed and starting treatment, patients have no formal assessment of the effect of treatment other than to be asked if they feel better. The PHQ-9 provides a ready tool to assess the adequacy of response; after 4 to 6 weeks of treatment, changes of less than 5 points suggest a need to modify treatment. Just as in hypertension care, providers can increase the dose, change medications, or combine medications. Unlike in hypertension care, studies have found that all of the potential pharmacologic and psychologic therapies have similar efficacy (7). Hence adding psychotherapy is another option. Monitoring and adjusting therapy on the basis of response is important because relapse rates are substantially lower for patients who achieve remission and are treated for at least 6 months (8).

Using a standardized approach to measuring outcomes in both clinical and research settings has the promise to significantly improve the quality of depression care. Researchers, clinicians, and health systems should adopt these measures as soon as possible.

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Disclosures: The author has disclosed no conflicts of interest. The form can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M20-1993.

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Ann Intern Med. doi:10.7326/M20-1993

This article was published at Annals.org on 12 May 2020.

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