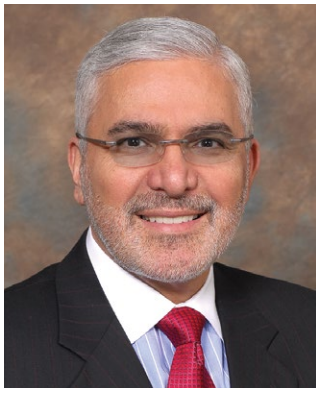

Henry A. Nasrallah, MD
Editor-in-Chief

It's time to implement measurement-based care in psychiatric practice

In an editorial published in Current Psychiatry 10 years ago, I cited a stunning fact based on a readers' survey: 98% of psychiatrists did not use any of the 4 clinical rating scales that are routinely used in the clinical trials required for FDA approval of medications for psychotic, mood, and anxiety disorders.[1]

As a follow-up, Ahmed Aboraya, MD, DrPH, and I would like to report on the state of measurement-based care (MBC), a term coined by Trivedi in 2006 and defined by Fortney as "the systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient."[2]

We will start with the creator of modern rating scales, Father Thomas Verner Moore (1877-1969), who is considered one of the most underrecognized legends in the history of modern psychiatry. Moore was a psychologist and psychiatrist who can lay claim to 3 major achievements in psychiatry: the creation of rating scales in psychiatry, the use of factor analysis to deconstruct psychosis, and the formulation of specific definitions for symptoms and signs of psychopathology. Moore's 1933 book described the rating scales used in his research.[3]

Since that time, researchers have continued to invent clinician-rated scales, self-report scales, and other measures in psychiatry. The *Handbook of Psychiatric Measures*, which was published in 2000 by the American Psychiatric Association Task Force chaired by AJ Rush Jr., includes >240 measures covering adult and child psychiatric disorders.[4]

Recent research has shown the superiority of MBC compared with usual standard care (USC) in improving patient outcomes.[2,5-7] A recent well-designed, blind-rater, randomized trial by Guo et al[8] showed that MBC is more effective than USC both in achieving response and remission, and reducing the time to response and remission. Given the evidence of the benefits of MBC in improving patient outcomes, and the plethora of reliable and validated rating scales, an important question arises: Why has MBC not yet been established as the standard of care in psychiatric clinical practice? There are many barriers to implementing MBC,[9] including:

- time constraints (most commonly cited reason by psychiatrists)
- mismatch between clinical needs and the content of the measure (ie, rating scales are designed for research and not for clinicians' use)

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• measurements produced by rating scales may not always be clinically relevant

• administering rating scales may interfere with establishing rapport with patients

• some measures, such as standardized diagnostic interviews, can be cumbersome, unwieldy, and complicated

• the lack of formal training for most clinicians (among the top barriers for residents and faculty)

• lack of availability of training manuals and protocols.

Clinician researchers have started to adapt and invent instruments that can be used in clinical settings. For more than 20 years, Mark Zimmerman, MD, has been the principal investigator of the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) Project, aimed at integrating the assessment methods of researchers into routine clinical practice.[10] Zimmerman has developed self-report scales and outcome measures such as the Psychiatric Diagnostic Screening Questionnaire (PDSQ), the Clinically Useful Depression Outcome Scale (CUDOS), the Standardized Clinical Outcome Rating for Depression (SCOR-D), the Clinically Useful Anxiety Outcome Scale (CUXOS), the Remission from Depression Questionnaire (RDQ), and the Clinically Useful Patient Satisfaction Scale (CUPSS).[11-18]

We have been critical of the utility of the existing diagnostic interviews and rating scales. I (AA) developed the Standard for Clinicians' Interview in Psychiatry (SCIP) as a MBC tool that addresses the most common barriers that clinicians face.[9,19-23] The SCIP includes 18 clinician-rated scales for the following symptom domains: generalized anxiety, obsessions, compulsions, posttraumatic stress, depression, mania, delusions, hallucinations, disorganized thoughts, aggression, negative symptoms, alcohol use, drug use, attention deficit, hyperactivity, anorexia, binge-eating, and bulimia. The SCIP rating scales meet the criteria for MBC because they are efficient, reliable, and valid. They reflect how clinicians assess psychiatric disorders, and are relevant to decision-making. Both self-report and clinician-rated scales are important MBC tools and complementary to each other. The choice to use self-report scales, clinician-rated scales, or both depends on several factors, including the clinical setting (inpatient or outpatient), psychiatric diagnoses, and patient characteristics. No measure or scale will ever replace a seasoned and experienced clinician who has been evaluating and treating real-world patients for years. Just as thermometers, stethoscopes, and laboratories help other types of physicians to reach accurate diagnoses and provide appropriate management, the use of MBC by psychiatrists will enhance the accuracy of diagnoses and improve the outcomes of care.

On a positive note, I (AA) have completed a MBC curriculum for training psychiatry residents that includes 11 videotaped interviews with actual patients covering the major adult psychiatric disorders: generalized anxiety, panic, depressive, posttraumatic stress, bipolar, psychotic, eating, and attention-deficit/hyperactivity. The interviews show and teach how to rate psychopathology items, how to score the dimensions, and how to evaluate the severity of the disorder(s). All of the SCIP's 18 scales have been uploaded into the Epic electronic health record (EHR) system at West Virginia University hospitals. A pilot project for implementing MBC in the treatment of adult psychiatric disorders at the West Virginia University residency program and other programs is underway. If we

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If we instruct residents in measurement-based care during their psychiatric training, they will likely practice it for the rest of their clinical careers

instruct residents in MBC during their psychiatric training, they will likely practice it for the rest of their clinical careers. Except for a minority of clinicians who are involved in clinical trials and who use rating scales in practice, most practicing clinicians were never trained to use scales. For more information about the MBC curriculum and videotapes, contact Dr. Aboraya at aborayascip@gmail.com or visit www.scip-psychiatry.com.

Today, some of the barriers that impede the implementation of MBC in psychiatric practice have been resolved, but much more work remains. Now is the time to implement MBC and provide an answer to AJ Rush, who asked, "Isn't it about time to employ measurement-based care in practice?"[24] The 3 main ingredients for MBC implementation—useful measures, integration of EHR, and health information technologies—exist today. We strongly encourage psychiatrists, nurse practitioners, and other mental health professionals to adopt MBC in their daily practice.

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