GAF is scored on the basis of diagnosis and symptom severity rather than on social and occupational disability and that these ratings are of questionable value in predicting treatment outcome (2). This problem is ameliorated by the use of separate subscales for these domains in the MIRECC GAF and the Kennedy Axis V. Therefore, it is puzzling that Dr. Kennedy and Dr. Aas advocate the use of a global score, which, even with good training and accurate scoring, tells us nothing about why a patient is doing poorly, getting better, or getting worse, because symptoms and disabilities do not predictably covary (3).

The *DSM-5* cross-cutting symptom assessments and the World Health Organization Disability Assessment Schedule (WHODAS) represent efforts to "unpack" the elements of the axis V global score for users of *DSM-5*. These measures represent good targets for assessing treatment outcomes. They can be used across diagnostic categories, require no formal training, and have demonstrated reliability (4,5). The domains measured in the cross-cutting symptom assessments, such as depression, anxiety, sleep disturbance, somatic symptoms, suicidal ideation, and substance misuse, may be a part of the clinical presentation of virtually any patient, regardless of diagnosis. The WHODAS, based on the WHO International Classification of Functioning, Disability, and Health, is applicable across all health conditions. These are patient-completed instruments, although the assessment procedure used in the *DSM-5* Field Trials specified clinical review and interpretation of patient responses.

There is no arguing that the GAF has been widely used clinically and in research and has been emulated by several other measures. However, in a health care climate that increasingly emphasizes patient-reported outcomes, measurement-based treatment decisions, and quality-of-care metrics, the use of axis V global measures of "functioning" for our patients is outdated and was properly abandoned by the *DSM-5* Task Force.

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References

1. Vatnaland T, Vatnaland J, Friis S, et al: Are GAF scores reliable in routine clinical use? Acta Psychiatrica Scandinavica 115:326–330, 2007
2. Moos RH, Nichol AC, Moos BS: Global Assessment of Functioning ratings and the allocation and outcomes of mental health services. Psychiatric Services 53:730–737, 2002
3. Israel JA: Remission in depression: definition and initial treatment approaches. Journal of Psychopharmacology (Oxford, England) 20(Suppl):5–10, 2006
4. Narrow WE, Clarke DE, Kuramoto SJ, et al: DSM-5 field trials in the United States and Canada, Part III: development and reliability testing of a cross-cutting symptom assessment for DSM-5. American Journal of Psychiatry 170:71–82, 2013
5. Ustün TB, Chatterji S, Kostanjsek N, et al: WHO/NIH Joint Project: Developing the World Health Organization Disability Assessment Schedule 2.0. Bulletin of the World Health Organization 88:815–823, 2010

A Personalized Patient Page

To the Editor: A patient page is a document describing a disease in easy-to-understand, layperson's terms. It is considered important in motivating patients and their relatives to engage in treatment (1). Patient pages are distributed widely in many areas of health care, but as Thomas Goetz (2) suggested in his recent book, their value would be greatly improved if the information was placed in the context of the patient's personal clinical data. As such, patients would arguably become more engaged in their own treatment, more motivated to take responsibility, and more satisfied with doctor-patient communication.

The idea of a personalized patient page is fairly new, and until now it has not been applied to the treatment of persons with mental illness. With this in mind, we developed an example of a personalized patient page for a fictional patient with depression. [The sample page is available as an online data supplement to this letter.] When the page is implemented in the clinic, we envisage that it would be generated automatically when results from an examination are recorded in the patient's file. Furthermore, the page could be delivered to the patient's e-mail inbox or smartphone application, and the page could have an interactive design. For example, if the patient wishes to clarify or know more about "minor depression," he or she would click on that term and the relevant information would be displayed. We expect that the main barrier to implementation will be the development of software that can find information in the patient file and copy it to the appropriate places on the patient page.

We believe that this personalized patient page will empower and motivate patients to take control of their mental health. According to Daniel Pink (3), motivation comes with autonomy, mastery, and purpose. The personalized patient page that we have designed will contribute to the goal of motivating patients by helping them understand the severity of their depression, what it means to them, and what they can do to combat it. Making the patient's health profile more individual, present, tangible, and straightforward will clarify the purpose of treatment. Second, providing patients and their relatives with information that they understand and will remember provides a foundation for engaging in treatment. Third, as health care professionals encourage patient autonomy by relinquishing part of their sovereignty in regard to treatment, patients are more likely to take control of their own health. Finally, a patient page may prevent misunderstandings during doctor-patient communications and provide needed additional information.

In conclusion, we predict that implementing a personalized patient page in the treatment of persons with mental illness will promote patient engagement in treatment, motivate patients to take responsibility, and lead to greater satisfaction with patient-doctor communication.

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References

1. Hong J, Nguyen TV, Prose NS: Compassionate care: enhancing physician-patient communication and education in dermatology: part II. patient education. Journal of the American Academy of Dermatology 68: 353e1–353e8, 2013
2. Goetz T: The Decision Tree: Taking Control of Your Health in the New Era of Personalized Medicine. New York, Rodale, 2010
3. Pink DH: Drive: The Surprising Truth About What Motivates Us. New York, Penguin, 2009

Low Depression Screening Rates in U.S. Ambulatory Care

To the Editor: Depression is an important public health problem with significant costs both to individuals and society. In 2003, the U.S. lifetime prevalence of major depressive disorder was 16.2% (1). Depression is the leading cause of disability (2), with an estimated cost of $83.1 billion in the United States in 2000 (3). As of 2009, the U.S. Preventive Services Task Force (USPSTF) recommends "screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up" (4). In light of these recommendations, the primary aim of the study reported here was to estimate the rate of depression screening in the U.S. outpatient office setting.

The National Ambulatory Medical Care Survey (NAMCS) is an annual cross-sectional survey of visits to office-based physicians across the United States, stratified by physician specialty (5). Approximately two of three sampled physicians participate in the survey. Depression screening at sampled visits is ascertained and recorded by the responding physician, a member of his or her staff, or a U.S. Census Bureau field representative who reviews medical records for documentation of the screening performed. Because information on depression screening was first collected in 2005, data from 2005 to 2010 were analyzed. The USPSTF does not support screening for children 11 years and younger. Therefore, only visits for patients 12 years and older were included. Visits to psychiatrists were excluded from the analysis.

SAS version 9.2 was used to analyze the data; SAS SVY PROCS was used to account for the complex survey design. Sampled visit weights were applied, which produced unbiased national estimates. The percentage of visits, overall and with primary care physicians (general and family practitioners, internists, pediatricians, and obstetricians-gynecologists), linked with depression screenings are reported with 95% confidence intervals (CIs).

Over the period, the average number of annual visits was estimated to be 947 million, and the average annual frequency of documented depression screening was 1.3% (CI=1.1%–1.5%). For visits to primary care physicians, the rate was 1.8% (CI=1.5%–2.1%). Screening was most common among internists (2.8%, CI=1.8%–3.8%), followed by gynecologists (2.4%, CI=1.3%–3.4%), family physicians (1.9%, CI=1.6%–2.2%), pediatricians (1.8%, CI=1.0%–2.6%), and other specialists (.5%, CI=.2%–.7%). Among visits for which no screening was documented, 7.7% (CI=7.2%–8.2%) were for patients who already had a diagnosis of depression.

The NAMCS has several limitations. It does not record whether sampled offices have adequate staff for screening and follow-up care. To our knowledge, the accuracy of NAMCS methods for identifying depression screening through chart review has not been confirmed. Because visits were the unit of analysis and physicians may screen patients only annually, the period prevalence of screening for patients over a year cannot be estimated.

Ultimately, depression screening rates are quite low and further steps are required for improvement. Depression screening itself can be as simple as asking two questions. Thus it is likely that screening may not be performed because the necessary follow-up care resources are not available at some offices. It is therefore important to develop a plan that improves access to depression management resources for outpatient offices.

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References

1. Kessler RC, Berglund P, Demler O, et al: The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). JAMA 289:3095–3105, 2003
2. Murthy R, Bertolote J, Epping-Jordan J, et al: Mental Health: New Understanding, New Hope. Geneva, World Health Organization, 2001
3. Greenberg PE, Kessler RC, Birnbaum HG, et al: The economic burden of depression in the United States: how did it change between 1990 and 2000? Journal of Clinical Psychiatry 64:1465–1475, 2003
4. US Preventive Services Task Force: Screening for depression in adults: US Preventive Services Task Force recommendation statement. Annals of Internal Medicine 151: 784–792, 2009
5. Ambulatory Health Care Data. Atlanta, National Center for Health Statistics, Centers for Disease Control and Prevention. Available at www.cdc.gov/nchs/ahcd.htm. Accessed Feb 2, 2013

The Pedagogy of Recovery

To the Editor: In 2009, the United Kingdom's first Recovery Colleges