Clinical and Community Prevention and Treatment Service for Depression

A Whole Greater Than the Sum of Its Parts

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To capitalize on all the health benefits of providing evidence-based preventive services to individuals, there must be strategies that promote the delivery of these services at the population level. This is a critical underlying concept for the interaction between two distinct but interrelated working groups, well described by Fielding and Teustch,[1] and acknowledged and supported by Congress in the Affordable Care Act: the U.S. Preventive Services Task Force (USPSTF) hosted by the Agency for Health Research and Quality (AHRQ), and the *Guide to Community Preventive Services* (the *Community Guide*) hosted by the CDC. For example, the USPSTF clinical recommendation supports colorectal cancer screening[2] and the *Community Guide* recommends a number of health systems and community-based interventions designed to increase participation in colorectal cancer screening in the community.[3] To maximize the health improvements associated with the early detection of colorectal cancer in the population, the service should be available, offered, and used by as many individuals in the appropriate age groups as possible.

The release of the *Community Guide*'s recommendation supporting multi-component collaborative care for depression treatment represents a truly remarkable different interaction with the USPSTF.[4–6] Here, the healthcare system–level intervention actually improves the response rate of the clinical intervention beyond that achieved by the traditional healthcare delivery system.

The USPSTF concluded with at least moderate certainty that screening adults for depression in the primary care setting provided at least a moderate net health benefit (benefits minus harm), in the setting of sufficient diagnosis, treatment, and follow-up, resulting in a Grade B recommendation.[7] For this recommendation to affect the health of patients, it requires uptake and implementation in primary care offices and other health systems as well as the development of adequate treatment and follow-up resources. To maximize the benefit at the population level, it will require spread across health systems and potentially application in nontraditional healthcare settings; interventions that would support this spread would be the usual role of the *Community Guide*.

However, the review of collaborative care interventions[5] for depression revealed a different interaction: These services, when provided to individuals diagnosed with and treated for depression, provide a significant and substantial increase in clinical response to therapy. Consider the health benefit of taking a clinical response rate of 46%–48% with usual medical and/or behavioral treatment and increasing it 92%. This remarkable synergy between clinical and community services for a common and serious health condition deserves notice and consideration from policymakers, providers, care systems, and payers. This may well represent the Holy Grail of healthcare delivery across the care setting spectrum.

The challenge again becomes the development and deployment of the necessary resources to make these community services available to as many individuals and communities as is feasible. It will be interesting to watch the response to an intervention that requires perhaps a different delivery and funding scheme and yet almost doubles the effectiveness of a medical service representing a current standard in medical care. Here is an opportunity to link the healthcare and public health sectors in addressing a very important condition and make a remarkable contribution to the health of our communities.

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