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Screening adults for depression in primary care: A position statement of the American College of Preventive Medicine

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Position statement

The American College of Preventive Medicine (ACPM) maintains that primary care providers should screen all adults for depression and that all primary care providers should have systems in place, either within the primary care setting itself or through collaborations with mental health professionals, to ensure the accurate diagnosis and treatment of this condition. The earliest and best opportunities to identify depression are in the clinics of primary care providers. Thus, the ACPM supports the recommendations of the US Preventive Services Task Force (USPSTF), and further suggests that *all* primary care practices should have such systems of care in place.

Why a position statement? The rationale

Primary care physicians have already been urged by the USPSTF and other authorities to consider screening adults for depression an essential aspect of care.[1-5] So why is the ACPM issuing a new position statement on the subject? Because, the College believes, controversy over how to apply this mandate in the primary care setting is ongoing. Primary care providers—whether they practice family medicine, internal medicine, obstetrics/gynecology, or are in general practice—need to know what role they should play in screening adults for depression and ensuring adequate diagnosis and treatment.

The USPSTF recommendation

In May 2002, the USPSTF made a category B recommendation (high certainty of moderate net benefit) that adults should be screened for depression in "clinical practices *that have systems in place to assure accurate diagnosis, effective treatment, and follow-up" of depression*[1] (emphasis added). The less-than-clear aspect of this recommendation is italicized: Just what constitutes the "system" that primary care providers, the first and often the only point of contact adults have with the health care system, are told to have "in place"? And how can they go about providing such systems? That's what the College has set out to elucidate.

The toll depression takes

Depression is a potentially life-threatening disorder that affects up to 6.7% of the population 18 years of age and older, or approximately 14.8 million Americans, in a given year.[6] Many people younger than age 18 are also affected. The extensive STAR*D (Sequenced Treatment Alternatives to Relieve Depression) study of outpatients with depression found that nearly 40% of respondents had their first depressive episode before the age of 18.[7,8]

The ripple effects

Depression is the leading cause of disability in the United States for individuals between the ages of 15 and 44 years.[9] But the burden of this illness is not borne only by those diagnosed with the disorder; depression has a serious impact on the patient's family, caregivers, colleagues, and society at large.

Medical costs. Depression contributes to a higher morbidity and mortality of other medical conditions. For example, people who have a myocardial infarction (MI) with comorbid depression have worse outcomes

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than those having an MI without depression. However, if the depressive episode is treated successfully, medical and surgical outcomes improve.[10] Furthermore, studies documenting increased cardiovascular morbidity and mortality in patients with depressive symptoms or major depression suggest that depression is an independent risk factor in the pathophysiologic progression of cardiovascular disease, not just a secondary emotional response to the illness.[11]

Economic costs. Depression is a leading contributor to lost productivity, not only from worker absenteeism, but also from what is known as "presenteeism"—being physically at work but not fully engaged. Thus, depression may be a leading cause of poor organizational performance. Further, employees diagnosed with depression have a higher incidence and longer duration of both work-related and non-work-related disabilities.

Depression is an independent risk factor in cardiovascular disease.

Screening: Easier than you think

Screening instruments with acceptable sensitivity and specificity are available. These brief, paper-and-pencil instruments can be quickly completed by patients in your waiting room. Some of the most commonly used self-administered measures are the Beck Depression Inventory (BDI), the Center for Epidemiologic Studies Depression Scale, Revised (CES-DR), the Zung Self-Rating Depression Scale, and the Patient Health Questionnaire (PHQ-9).[12-16] These tools take approximately 5 to 10 minutes for patients to complete and do not interfere with clinical practice. You can choose the tests that are appropriate for screening your patient population, and you can also use the same instruments for ongoing monitoring of patients receiving treatment for depression.

Two questions. For an even briefer screen, ask your patients these 2 questions:

- Over the past month, have you felt down, depressed, or hopeless?
- Over the past month, have you felt little interest or pleasure in doing things?

Patients who answer Yes may need more in-depth screening and clinical assessment.

When these 2 questions were tested in a primary care setting with patients not receiving psychotropic drugs, they had a sensitivity of 97% and a specificity of 67%.[17] Other research also shows that simple questions about depression perform as well as longer questionnaires, further proof that screening for depression need not add undue length to the clinical assessment in primary care.[18]

Which instrument is best? Selection of a screening measure, whether it be the 2 simple questions noted above or a longer, more comprehensive tool, is the first step in the process of detecting depression in primary care settings. In making your choice, consider characteristics of the population being screened, psychometric properties of the instrument, time required to complete the measure, time required to score the measure, ease of use, and cost. A review of available screening instruments suitable for use by primary care physicians has been published in *American Family Physician*.[19] The review includes screening measures developed specifically for adolescents, such as the Reynolds Adolescent Depression Scale, and those developed for older adults, such as the Geriatric Depression Scale.

What comes next? Making the diagnosis

Screening tools provide only a preliminary assessment. Elevated scores must be confirmed with diagnostic interviewing. Without proper follow-up, false-positive scores can lead to harmful labeling, unnecessary additional testing, and inappropriate treatment.

The diagnostic interview. Primary care physicians may feel competent to perform the diagnostic interview themselves, or they may refer patients identified by screening to a mental health professional. The interview should determine whether a patient meets the diagnostic criteria for a depressive disorder—including major depressive disorder or dysthymic disorder—found in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR).[20] Bear in mind that criteria important for diagnosis, such as duration of symptoms, degree of impairment, and comorbid psychiatric or substance use disorders, are not revealed in the screening instruments.

Differential diagnosis. Depressive symptoms often overlap with medical conditions, such as hypothyroidism, and with other psychiatric illnesses, such as generalized anxiety disorder. That's why the differential diagnosis is crucial.

Screen for bipolar disorder. Patients meeting criteria for a depressive disorder should be screened for bipolar disorder, because the 2 conditions are managed differently. Screening instruments for bipolar disorder have been less extensively studied than the depression screening instruments described earlier. The Mood Disorder Questionnaire is a brief, easy-to-use, self-report screening instrument for bipolar-spectrum disorders.[21] This single-page measure screens for a lifetime history ("has there ever been a period of time") of manic or hypomanic symptoms using 13 yes/no items, as well as 2 items assessing whether several symptoms were experienced during the same time period, and the level of functional impairment associated with such symptoms. As noted earlier, elevated scores on this and other screening instruments must be confirmed with diagnostic interviewing.

Use DSM criteria. Because of the varying clinical manifestations of depression, clinical judgment sometimes must supersede strict adherence to DSM-IV-TR criteria. Nevertheless, reliance on these well-established criteria is generally recommended as the best way to avoid over- or underdiagnosis, billing problems, and legal problems arising from an inaccurate diagnosis or inappropriate use of medications.

Treating depression

Depression is a highly treatable condition with generally good outcomes.[22] A variety of antidepressant medications and psychotherapeutic modalities are available. Consensus-based guidelines have been developed to guide clinicians in the evaluation and treatment of depression.[23] Remission—not simply treatment response or an improvement in symptoms—should be the targeted endpoint. STAR*D data revealed that "better but not remitted" patients consistently have a worse prognosis and higher relapse rates than those achieving full remission.[8,24]

Why me?

The answer: Primary care providers are the principal contacts for more than 50% of patients with mental illnesses. Approximately 35% of patients seen in primary care meet criteria for some form of depression and 10% suffer from major depression.[25,26] Because individuals with depression use health care more frequently, the prevalence of major depression is 2 to 3 times higher in primary care settings than in the general population.[27] Yet, a substantial proportion of primary care patients with major depression go undiagnosed, leading to a dangerous situation in which symptoms may worsen and suicidal ideation can develop.[28] That's why you, as a primary care practitioner, have such an important role to play in assessing, diagnosing, and treating depression.

Making a difference. Interventions initiated in the primary care setting have been shown to be effective for the treatment of depression.[29] Findings of the STAR*D study confirm that primary care providers, when given the time, staffing, and reimbursement support, can provide high-quality, appropriate care for patients with depression, especially in uncomplicated cases.[8]

Simple questions about depression perform as well as longer questionnaires.

What you need are "systems in place"

The USPSTF recommended screening for depression in "clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up." Given the prevalence and gravity of the problem, the ACPM recommends that *all* primary care practices have such systems in place. These systems may be either:

- within your own practice, using clinical guidelines for the diagnosis and treatment of depression, or
- within an established system of referral to mental health professionals.

If you treat patients with depression within your own practice, keep in mind that using standardized treatments with established efficacy in psychiatric patients has been shown to be more effective than "usual care."[30] If you choose to partner with mental health professionals, you can employ various levels of collaboration. Depending on the size of your

practice, you may want to include a mental health professional as an integral part of your staff, or you may prefer to hire a part-time consultant. Another alternative is to establish an ongoing, collaborative relationship with a mental health provider in private practice. In some instances, working with a patient's employee assistance program may be the best way to ensure that he or she receives treatment and follow-up. Primary care practices serving disadvantaged or impoverished communities may need to develop partnerships with public-sector community mental health centers.

Whatever setup works best for you, the goal is to make sure that your patients with depression have access to ongoing screening, diagnostic, and treatment services. That goal is worthy of your best efforts. JFP

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