To screen for depression or not?

Screening may be appropriate to reconsider once we can ensure adequate response to any identified potential cases

Depression presents a significant public health challenge for both the community and the medical profession. In Australia, depression and anxiety affect a substantial proportion of the population (4.8% of men and 10% of women) and is responsible for 8% of the total loss in disability-adjusted life years.[1] It is the top-ranking cause of non-fatal disease in the Australian community for women,[2] and is also associated with an increased risk of ischaemic heart disease and suicide, both causes of early death.

Depressive disorders present diagnostic challenges, not least because in some cases depression is the first presentation of bipolar disorder. Further, treatment may be complicated and limited owing to the symptomatic heterogeneity of depression; complex comorbidities with anxiety, substance abuse, physical health problems or other factors; and the ongoing stigma that hinders many individuals from openly discussing their mood problems. As a result, rates of detection, diagnosis based on clinical presentation, and sufficient intervention remain inadequate. Indeed, a recent meta-analysis from the United Kingdom suggests that the diagnosis was only correct in 47% of cases presenting in primary care.[3] This does not account for those cases that fail to present in the first place, supporting calls to consider widespread screening for depression, especially in primary care settings where the majority of depressive disorders are treated. But is screening for depression in primary care a useful and viable option?

In January 2016, the United States Preventive Services Task Force published its latest recommendation statement in relation to screening for depression in adults.[4] The statement recommended that sufficiently reliable self-report tools are now available to make screening for depression feasible and reliable in primary care. The task force further opined that screening leads to accurate diagnosis and treatment in this setting. Clearly, the latter component is critical to render screening valuable, and the authors drew heavily on the developing evidence around models of collaborative care and depression care management.[5,6] The task force recommended use of the Patient Health Questionnaire-9 (PHQ-9), but as noted in an accompanying editorial,[7] the statement acknowledged that the positive predictive value of the PHQ-9 is only 50%, and that it cannot be considered a replacement for appropriate clinical assessment. In other words, screening is important but it cannot be relied upon.

The idea of screening-led prevention and early intervention is inherently attractive. Within Australia, efforts thus far have focused on high-risk groups such as pregnant or perinatal women and Aboriginal and Torres Strait Islander populations.[8,9] However, a pragmatic perspective that acknowledges the limitations of current mental health service delivery for broader treatment of depression would also have to recognise that international evidence for broad primary care population screening is mixed.

"international evidence for broad primary care population screening is mixed"

After several years of research and development, the Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders were released in late 2015.[10] The guidelines conceptualise both depression and bipolar disorder along a spectrum with considerable overlap, and discuss in detail the diagnosis and management of both conditions. The guidelines do not specifically recommend screening in primary care or other settings. This is because self-assessment via the internet and other self-report screening measures is likely to raise concerns but not necessarily identify those who need help or ensure that they seek proper advice. Once suspicion of depression has been raised by a clinician, the use of a standardised psychiatric measure is preferable but the question remains as to whether general practitioners should initially use their clinical judgement or a screening tool to identify depressive illness. To this end, they can be equipped with measures that corroborate key symptoms but reliance should never rest solely on self-report measures.

Historically, depression has been underdiagnosed, and the stigma of its incidence remains a challenge to encouraging patients to access treatment. We can anticipate increased capacity for the treatment of depression in the new world of integrated mental health service delivery promised in the Australian government's response to the National Mental Health Commission review of mental health programs and services. The stepped care model has the potential to provide optimal support for people with a major depressive disorder. Once these initiatives are established and further data have been gathered as to their suitability and appeal, perhaps then it will be time to revisit the recommendations regarding screening. However, at this point in time there does not appear to be sufficient evidence of pragmatic value to warrant the burden that implementation and continuous screening for depression in primary care would impose.

Malcolm J Hopwood
MB BS, MD, FRANZCP[1,2]

Gin Malhi
FRCPsych, MD, FRANZCP[3,4]

1 Department of Psychiatry, University of Melbourne, Melbourne, VIC.

2 Royal Australian and New Zealand College of Psychiatrists, Melbourne, VIC.

3 Kolling Institute of Medical Research, Sydney, NSW.

4 Northern Clinical School, University of Sydney, Sydney, NSW.

mhopwood@unimelb.edu.au

doi: 10.5694/mja16.00217

Podcast with Professor Malcolm Hopwood available at www.mja.com.au/multimedia/podcasts

Competing interests: No relevant disclosures.

Provenance: Commissioned; externally peer reviewed. ■

References are available online at www.mja.com.au.

1 Australian Bureau of Statistics. National survey of mental health and wellbeing: summary of results, 2007 (ABS Cat. No. 4326.0). Canberra: ABS, 2007. http://www.abs.gov.au/ausstats/abs@.nsf/mf/4326.0 (accessed Feb 2016).

2 Begg SJ, Vos T, Barker B, et al. Burden of disease and injury in Australia in the new millennium: measuring health loss from diseases, injuries and risk factors. *Med J Aust* 2008; 188: 36. https://www.mja.com.au/journal/2008/188/1/burden-disease-and-injury-australia-new-millennium-measuring-health-loss-diseases

3 Mitchell AJ, Vaze A, Rao S. Clinical diagnosis of depression in primary care: a meta-analysis. *Lancet* 2009; 374: 606-619.

4 Siu AL; US Preventive Services Task Force. Screening for depression in adults: US Preventive Services Task Force recommendation statement. *JAMA* 2016; 315: 428.

5 Coventry PA, Hudson JL, Kontopantelis E, et al. Characteristics of effective collaborative care for treatment of depression: a systematic review and meta-regression of 74 randomised controlled trials. *PLoS One* 2014; 9: e108114.

6 Gaynes BN, Rush AJ, Trivedi MH, et al. Primary versus specialty care outcomes for depressed outpatients managed with measurement-based care: results from STAR*D. *J Gen Intern Med* 2008; 23: 551-560.

7 Thase ME. Recommendations for screening for depression in adults. *JAMA* 2016; 315: 349-350.

8 Highet NJ, Purtell CA. The National Perinatal Depression Initiative: a synopsis of progress to date and recommendations for beyond 2013. Melbourne: beyondblue, the national depression and anxiety initiative, 2012. http://cope.org.au/wp-content/uploads/2013/12/Final-Synopsis-Report_PDF.pdf (accessed Mar 2016).

9 Esler D, Johnston F, Thomas D, Davis B. The validity of a depression screening tool modified for use with Aboriginal and Torres Strait Islander people. *Aust N Z J Public Health* 2008; 32: 317-321.

10 Malhi G, Bassett D, Boyce P, et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders. *Aust N Z J Psychiatry* 2015; 49: 1087-1206. ■