

Screening for Depression in Adults: Recommendation Statement

► See related Putting Prevention into Practice on page 985.

► See related editorial on page 891.

This summary is one in a series excerpted from the Recommendation Statements released by the U.S. Preventive Services Task Force (USPSTF). These statements address preventive health services for use in primary care clinical settings, including screening tests, counseling, and preventive medications.



This clinical content conforms to AAFP criteria for evidence-based continuing medical education (EB CME). See CME Quiz on page 887.

A collection of USPSTF recommendation statements reprinted in *AFP* is available at <http://www.aafp.org/afp/uspstf>.

The complete version of this statement, including supporting scientific evidence, evidence tables, grading system, members of the USPSTF at the time this recommendation was finalized, and references, is available on the USPSTF Web site at <http://www.uspreventiveservices.org/uspstf/uspstaddepr.htm>.

Summary of Recommendations and Evidence

The U.S. Preventive Services Task Force (USPSTF) recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up (Table 1). **B recommendation.**

The USPSTF recommends against routinely screening adults for depression when staff-assisted depression care supports are not in place. There may be considerations that support screening for depression in an individual patient. **C recommendation.**

Rationale

Importance. Depression is among the leading causes of disability in persons 15 years or older. It affects individuals, families, businesses, and society. It is common in primary care patients.

Detection. The USPSTF found good evidence that screening improves the accurate identification of patients with depression in primary care settings.

Benefits of detection and early intervention. The USPSTF found good evidence that treatment with antidepressants, psychotherapy, or both decreases clinical morbidity in adults and older adults with depression identified through screening in primary care settings.

The USPSTF found good evidence that programs combining depression screening and feedback with staff-assisted depression care supports improve clinical outcomes in adults and older adults.

The USPSTF found fair evidence that screening and feedback alone without staff-assisted care supports does not improve clinical outcomes in adults and older adults.

Harms of detection and early intervention. The USPSTF found no evidence of harms of screening for depression in adults or older adults.

The USPSTF found at least fair-quality evidence that second-generation antidepressants (mostly selective serotonin reuptake inhibitors [SSRIs]) increase suicidal behaviors in adults 18 to 29 years of age, especially those with major depressive disorder and those who receive paroxetine. The USPSTF found at least fair-quality evidence that SSRI use is associated with an increased risk of upper gastrointestinal bleeding in adults older than 70 years, and the risk increases with age.

USPSTF assessment. The USPSTF concludes that for adults who receive care in clinical practices that have staff-assisted depression care supports in place, there is at least moderate certainty that the net benefit of screening for depression is at least moderate.

The USPSTF concludes that for adults who receive care in clinical practices without staff-assisted depression care supports in place, there is at least moderate certainty that the net benefit of screening for depression is small.

Clinical Considerations

Patient population. This recommendation applies to nonpregnant adults, including older adults. It does not apply to children and adolescents, who are considered a separate population.

Assessment of risk. Persons at increased risk of depression are considered at risk throughout their lifetime. Groups at increased risk include persons with other psychiatric disorders, including substance misuse; persons with a family history of depression; persons with chronic medical diseases; and persons who are unemployed or of lower socioeconomic status. Also, women are at increased risk compared with men. Significant depressive symptoms are associated with common life events in older adults, including medical illness, cognitive decline, bereavement, and institutional

Table 1. Screening for Depression in Adults: Clinical Summary of the USPSTF Recommendation

Population	Nonpregnant adults 18 years or older	
Recommendation	Screen when staff-assisted depression care supports* are in place to assure accurate diagnosis, effective treatment, and follow-up Grade: B	Do not routinely screen when staff-assisted depression care supports* are not in place Grade: C
Risk assessment	Persons at increased risk of depression are considered at risk throughout their lifetime. Groups at increased risk include persons with other psychiatric disorders, including substance misuse; persons with a family history of depression; persons with chronic medical diseases; and persons who are unemployed or of lower socioeconomic status. Also, women are at increased risk compared with men. However, the presence of risk factors alone cannot distinguish patients with depression from those without depression.	
Screening tests	Simple screening questions may perform as well as more complex instruments. Any positive screening test result should trigger a full diagnostic interview using standard diagnostic criteria.	—
Timing of screening	The optimal interval for screening is unknown. In older adults, significant depressive symptoms are associated with common life events, including medical illness, cognitive decline, bereavement, and institutional placement in residential or inpatient settings.	—
Balance of harms and benefits	—	Limited evidence suggests that screening for depression in the absence of staff-assisted depression care does not improve depression outcomes.
Suggestions for practice	“Staff-assisted depression care supports” refers to clinical staff that assists the primary care clinician by providing some direct depression care, such as care support or coordination, case management, or mental health treatment.	
Relevant USPSTF recommendations	Related USPSTF recommendations on screening for suicidality, and screening children and adolescents for depression are available at http://www.uspreventiveservicestaskforce.org .	

NOTE: For the full recommendation statement and supporting documents, visit <http://www.uspreventiveservicestaskforce.org>.

USPSTF = U.S. Preventive Services Task Force.

*—See “Suggestions for practice” for further explanation.

placement in residential or inpatient settings. However, the presence of risk factors alone cannot distinguish patients with depression from those without depression.

Screening tests. In 2002, the USPSTF reviewed evidence about the accuracy of screening instruments in identifying depression in adults.¹ Many formal screening tools are available, including instruments designed specifically for older adults. Asking two simple questions about mood and anhedonia (“Over the past two weeks, have you felt down, depressed, or hopeless?” and “Over the past two weeks, have you felt little interest or pleasure in doing things?”) may be as effective as using more formal instruments.² There is little evidence to recommend one screening method over another; therefore, clinicians may choose the method most consistent with

their personal preference, the patient population being served, and the practice setting.

All positive screening tests should trigger full diagnostic interviews that use standard diagnostic criteria (i.e., those from the updated *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed.) to determine the presence or absence of specific depressive disorders, such as major depressive disorder or dysthymia. The severity of depression and comorbid psychological problems (e.g., anxiety, panic attacks, substance abuse) should be addressed.

Treatment. The reviews of evidence on which this recommendation is based cover treatment of adults with antidepressants or psychotherapy¹ and updated evidence on the efficacy of depression treatment in

older adults.³ Treatment may include antidepressants or specific psychotherapeutic approaches (e.g., cognitive behavior therapy, brief psychosocial counseling) alone or in combination. Both are effective in treating adults and older adults.

In treating patients 18 to 29 years of age, clinicians may want to select a psychotherapeutic approach or medications other than SSRIs because of the increased risk of suicidal behavior associated with SSRI use. Similarly, for adults 65 years or older, clinicians may want to select a psychotherapeutic approach or medications other than SSRIs because of the increased risk of upper gastrointestinal bleeding associated with the use of SSRIs. In addition, the concurrent use of SSRIs with a nonsteroidal anti-inflammatory drug or low-dose aspirin increases the risk of upper gastrointestinal bleeding in adults (40 to 79 years of age), although the increase in risk is less with aspirin. The risk of upper gastrointestinal bleeding is greater with medications that feature a moderate to high degree of serotonin reuptake inhibition.

Staff-assisted depression care supports. “Staff-assisted depression care supports” refers to clinical staff that assist the primary care clinician by providing some direct depression care, such as care support or coordination, case management, or mental health treatment.

In the available evidence, the lowest effective level of staff-assisted depression care supports consisted of a screening nurse who advised resident physicians of positive screening results and provided a protocol that facilitated referral to behavior treatment.⁴ At the highest level, staff-assisted depression care supports included screening; institutional monetary commitment; staff and clinician training (one- or two-day workshops); clinician manuals; monthly training lectures; academic detailing; many materials for clinicians, staff, and patients; an initial visit with a nurse specialist for assessment, education, and discussion of patient preferences and goals; a visit with a trained nurse specialist for follow-up assessment and ongoing support for adherence to medication for patients prescribed antidepressant medications; a visit with a trained therapist for cognitive behavior therapy; and a reduced copay for patients referred for psychotherapy.^{5,6}

In a successful study designed for practices without ready access to mental health specialty care, office staff recruited, screened, and enrolled participants who screened positive for depression before a clinic visit.⁷ If the physician confirmed the depression diagnosis, the participant was scheduled for a return visit with the physician and to meet with the nurse specialist in one week. The nurse specialist reassessed the patient’s level of depression, discussed treatment options and preferences, and asked the participant to complete a

homework assignment. Participants completed up to eight additional sessions that followed the same pattern, by phone or in person.

Multidisciplinary team-based primary care that includes self-management support and care coordination has been shown to be effective in management of depression. These components of primary care are detailed in recent recommendations from the Task Force on Community Preventive Services.⁸ It recommends collaborative care for treatment of adults 18 years or older with major depression on the basis of strong evidence of effectiveness in improving short-term treatment outcomes. As defined, collaborative care and disease management of depressive disorders includes a systematic, multi-component, team-based approach that “strengthens and supports self-care ... while assuring that effective medical, preventive, and health maintenance interventions take place” to improve quality and outcome of patient care for treatment of major depressive disorders.⁹

Screening intervals. The optimal interval for screening for depression is unknown. Recurrent screening may be most productive in patients with a history of depression, unexplained somatic symptoms, comorbid psychological conditions (e.g., panic disorder, generalized anxiety), substance abuse, or chronic pain.

Other approaches to prevention. The Task Force on Community Preventive Services also has made several recommendations about depression care in older adults. It recommends clinic-based depression care management to reduce depression in older adults on the basis of sufficient evidence and home-based depression care management on the basis of strong evidence. The Task Force on Community Preventive Services found insufficient evidence to determine the effectiveness of community-based exercise interventions for reducing depression in older adults.

The Task Force on Community Preventive Services makes recommendations on population-based interventions appropriate for use by communities and health care systems to promote health and to prevent disease, injury, disability, and premature death. More information about the task force and its recommendations on depression interventions is available at <http://www.thecommunityguide.org>.

Useful resources. In 2009, the USPSTF updated its recommendation on screening for depression in children and adolescents. The USPSTF recommends screening adolescents (12 to 18 years of age) for major depressive disorder when systems are in place to assure accurate diagnosis, psychotherapy (cognitive behavior or interpersonal), and follow-up (B recommendation). In addition, the USPSTF concluded that the current evidence is insufficient to assess the balance of benefits

and harms of screening children (seven to 11 years of age) for major depressive disorder (I statement).

In 2004, the USPSTF concluded that the evidence is insufficient to recommend for or against routine screening by primary care clinicians to detect suicide risk in the general population (I statement). At that time, the USPSTF found no evidence that screening for suicide risk reduces suicide attempts or mortality. The USPSTF also found limited evidence on the accuracy of screening tools to identify suicide risk in the primary care setting, including tools to identify those at high risk, and found no evidence that directly addressed the harms of screening and treatment of suicide risk. In addition, the USPSTF found insufficient evidence that treatment of persons at high risk reduces suicide attempts or mortality.

For the full recommendation statements and evidence reviews, visit the USPSTF Web site (<http://www.uspreventiveservicestaskforce.org>).

This recommendation statement was first published in *Ann Intern Med*. 2009;151(11):784-792.

The "Other Considerations," "Discussion," and "Recommendations of Others" sections of this recommendation statement are available at [http://www.uspreventiveservicestaskforce.org/uspstf/uspstf/uspstf.htm](http://www.uspreventiveservicestaskforce.org/uspstf/uspstf/uspstf/uspstf.htm).

The U.S. Preventive Services Task Force recommendations are independent of the U.S. government. They do not represent the views of the Agency for Healthcare Research and Quality, the U.S. Department of Health and Human Services, or the U.S. Public Health Service.

REFERENCES

1. Pignone M, Gaynes BN, Rushton JL, et al. Screening for depression: systematic evidence review. Systematic evidence review no. 6. Rockville, Md.: Agency for Healthcare Research and Quality; 2002. AHRQ publication no. 02-S002.
2. Whooley MA, Avins AL, Miranda J, Browner WS. Case-finding instruments for depression. Two questions are as good as many. *J Gen Intern Med*. 1997;12(7):439-445.
3. O'Connor EA, Whitlock EP, Gaynes BN, Beil TL. Screening for depression in adults and older adults in primary care: an updated systematic review. Evidence synthesis no. 75. Rockville, Md.: Agency for Healthcare Research and Quality; 2009. AHRQ publication no. 10-05143-EF-1.
4. Jarjoura D, Polen A, Baum E, Kropp D, Hetrick S, Rutecki G. Effectiveness of screening and treatment for depression in ambulatory indigent patients. *J Gen Intern Med*. 2004;19(1):78-84.
5. Wells KB, Sherbourne C, Schoenbaum M, et al. Impact of disseminating quality improvement programs for depression in managed primary care: a randomized controlled trial [published correction appears in *JAMA*. 2000;283(24):3204]. *JAMA*. 2000;283(2):212-220.
6. Wells K, Sherbourne C, Schoenbaum M, et al. Five-year impact of quality improvement for depression: results of a group-level randomized controlled trial. *Arch Gen Psychiatry*. 2004;61(4):378-386.
7. Rost K, Nutting P, Smith J, Werner J, Duan N. Improving depression outcomes in community primary care practice: a randomized trial of the quEST intervention. Quality Enhancement by Strategic Teaming. *J Gen Intern Med*. 2001;16(3):143-149.
8. Task Force on Community Preventive Services. Guide to Community Preventive Services. Mental health and mental illness. Atlanta, Ga.: Centers for Disease Control and Prevention; 2009. <http://www.thecommunityguide.org/mentalhealth/index.html>. Accessed October 13, 2009.
9. Von Korff M, Gruman J, Schaefer J, Curry SJ, Wagner EH. Collaborative management of chronic illness. *Ann Intern Med*. 1997;127(12):1097-1102. ■

GLOSSARY OF EVIDENCE-BASED MEDICINE AND STATISTICAL TERMS

Term	Abbreviation	Definition
Sensitivity	Sn	Percentage of patients with disease who have a positive test for the disease in question
Specificity	Sp	Percentage of patients without disease who have a negative test for the disease in question
Predictive value (positive and negative)	PV+ PV-	Percentage of patients with a positive or negative test for a disease who do or do not have the disease in question
Pretest probability		Probability of disease before a test is performed
Post-test probability		Probability of disease after a test is performed
Likelihood ratio	LR	LR >1 indicates an increased likelihood of disease, LR <1 indicates a decreased likelihood of disease. The most helpful tests generally have a ratio of less than 0.2 or greater than 5.
Relative risk reduction	RRR	The percentage difference in risk or outcomes between treatment and control groups. Example: if mortality is 30 percent in controls and 20 percent with treatment, RRR is $(30 - 20)/30 = 33$ percent.
Absolute risk reduction	ARR	The arithmetic difference in risk or outcomes between treatment and control groups. Example: if mortality is 30 percent in controls and 20 percent with treatment, ARR is $30 - 20 = 10$ percent.
Number needed to treat	NNT	The number of patients who need to receive an intervention instead of the alternative in order for one additional patient to benefit. The NNT is calculated as: $1/ARR$. Example: if the ARR is 4 percent, the NNT = $1/4$ percent = $1/0.04 = 25$.
Number needed to harm	NNH	The number of patients who need to receive an intervention instead of the alternative in order for one additional patient to experience an adverse event.
95 percent confidence interval	95% CI	An estimate of certainty. It is 95% certain that the true value lies within the given range. A narrow CI is good. A CI that spans 1.0 calls into question the validity of the result.
Systematic review		A type of review article that uses explicit methods to comprehensively analyze and qualitatively synthesize information from multiple studies
Meta-analysis		A type of systematic review that uses rigorous statistical methods to quantitatively synthesize the results of multiple similar studies