Screening for Depression in Primary Care

Depression is the third most common reason for a consultation in general practice in the UK and was third in the ranking of Disability Adjusted Life Years (DALYs) calculated for all ages in Scotland in 2015\(^1\).

Major depressive disorder is associated with a high degree of personal disability, multiple morbidity, suicide and lost quality of life for patients, families and carers. Patients with chronic depression may also be high service users with significant economic implications.

Depression may not always be recognised by GPs. Each year, about one in twenty adults experience an episode of depression. Approximately one in four people with two or more chronic health problems are depressed, compared to only 3% of people who are physically healthy\(^2\).

This article deals only with screening for depression in primary care. See the separate Depression, Depression in Children and Adolescents and Postnatal Depression articles for details of epidemiology, investigations and management.

Requirements of screening

For a system of screening to be viable it must fulfil certain criteria\(^3\):

- The condition must be sufficiently common to merit screening. This does not necessarily mean common in the whole population unless there is universal screening. It means common in the target group for screening.
- There must be an effective intervention for the condition that is being sought.
- Screening must result in the condition being recognised at an earlier stage when intervention is more effective.
- There must be high specificity (low rate of false positives) and a very high sensitivity (very low rate of false negatives), although this is difficult to assess when evaluating a screening tool for depression.
- The screening test must be relatively cheap or at least the cost per case detected is prohibitively expensive.
- It must be safe, easy to use and acceptable to the patient.

Who should be screened?

Clinicians are obliged to recognise depression at an early stage in any patient. This represents a considerable workload and it may be best to focus one's attentions on patients deemed to be 'at risk'.

National Institute for Health and Care Excellence (NICE) guidelines suggest screening in those with a past history of depression, significant physical illness - especially if it causes disability - and other mental health problems such as dementia. Other situations where the chance of depression is very high include:

- Parkinson's disease where the disease is common but often missed.
- Dementia where the two diseases can easily resemble each other.
- The puerperium - screening may show positive results in as many as 13%.
- Alcohol dependency and drug misuse - it may be difficult to decide if depression is the cause or effect of substance misuse but it may be desirable to treat both.
- Victims of abuse.
- Physical disease like cancer, COPD, cardiovascular disease or diabetes.
- Chronic pain.
- Stressful home environments.
- The elderly.
- Social isolation.
- Unexplained symptoms.

Depression may be more difficult to detect in patients with physical illness because both conditions can have similar symptoms.

Screening and assessment tools

A number of screening and assessment tools have been validated and are generally available.

Initial screening in patients who may have depression

NICE recommends that any patient who may have depression (especially those with a past history of depression or who suffer from a chronic physical illness associated with functional impairment) should be asked the following two questions\(^4\):

- During the last month have you often been feeling down, depressed or hopeless?
- During the last month have you often been bothered by having little interest or pleasure in doing things?
A 'yes' response to one of the two questions has high specificity for depression (0.95, 95% CI 0.91 to 0.97) but low sensitivity (0.66, 95% CI 0.55 to 0.76)\(^2\). The following questions should then be asked:

During the last month, have you often been bothered by:

- Feeling bad about yourself or that you are a failure or have let yourself or your family down?
- Poor concentration?
- Tiredness/low energy levels?
- Changes in appetite (reduced or increased)?
- Changes in your sleep pattern (sleeping too much, problems getting to sleep, waking in the night or waking early)?
- Being so slowed down, or so restless or fidgety, that other people have noticed?
- Thoughts of death?

### Assessing newly diagnosed patients

These tools include:

- **Patient Health Questionnaire (PHQ-9)**: this is a nine-item questionnaire which helps both to diagnose depression and to assess severity. It is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual - Fourth Edition (DSM-IV). It takes about three minutes to complete. Scores are categorised as minimal (1-4), mild (5-9), moderate (10-14), moderately severe (15-19) and severe depression (20-27). It can be downloaded free from the internet.

- **Hospital Anxiety and Depression (HAD) Scale**: despite its name, this has been validated for use in primary care. It is designed to assess both anxiety and depression. It takes about five minutes to complete. The anxiety and depression scales each have seven questions, and scores are categorised as normal (0-7), mild (8-10), moderate (11-14) and severe (15-21).

- **Beck Depression Inventory® - Second Edition (BDI-II)**: this also uses DSM criteria. It takes about five minutes to complete. It is an assessment of the severity of depression and is graded as minimal (0-13), mild (14-19), moderate (20-28) and severe (29-36). It consists of 21 items to assess the intensity of depression in clinical and normal patients. Each item is a list of four statements arranged in increasing severity about a particular symptom of depression. It is also not free but can be purchased from the supplier's website.

Other screening tests may be useful in particular situations. They include:

- Interview-based tools (such as Kiddie-Sads and Child and Adolescent Psychiatric Assessment) can be used for children and young adults suspected of having depressive illness\(^8\). The Center for Epidemiologic Studies Depression (CES-D) Scale and Reynolds’ Adolescent Depression Scale (RADS) are more suitable for adolescents.
- The **Edinburgh Postnatal Depression Scale (EPDS)** - a self-rating scale - is for puerperal depression\(^6\).
- The **Geriatric Depression Scale (GDS)** is suitable for older patients.
- The Cornell Scale for Depression in Dementia (CSDD) is suitable for patients with dementia.

Research has looked at the utility of adding a 'help' question to screening tools\(^7\). A cross-sectional validation study of 1,025 patients showed that adding a single question about desire for treatment (for example, "Is this something with which you would like help?") resulted in similar sensitivities but improved both the diagnostic specificity and patient centredness of depression screening.

Although screening tools are useful, they should not be a substitute for clinical judgement. The patient's history, family history and the existence of comorbidities should be taken into account when diagnosing or assessing depression. It is important to emphasise that screening instruments should be used only to enhance, not replace, the clinical interview.

### Further reading & references

- Depression; Fact Sheet from the World Health Organization (WHO), March 2018
- Scottish Burden of Disease Study, 2015; Depression technical overview, ScotPHO, 2015
- Depression; NICE CKS, October 2015 (UK access only)
- Criteria for appraising the viability, effectiveness and appropriateness of a screening programme; UK Screening Portal
- Depression in adults; recognition and management; NICE Clinical Guideline (April 2018)
- Depression in children and young people: Identification and management in primary community and secondary care; NICE Clinical Guideline (March 2015)
- Depression - antenatal and postnatal; NICE CKS, November 2018 (UK access only)

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