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Screening for depression and anxiety in general practice

New US screening recommendations will expose patients to unnecessary harm

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The United States Preventive Services Task Force (USPSTF) recently recommended that all adults in general practice be screened for major depressive disorder and that everyone aged 19-64 be screened for anxiety disorders, including disorders not common in general practice.[1 2] This would involve administering depression and anxiety symptom questionnaires to all patients without a psychiatric diagnosis, classifying positive and negative results, providing comprehensive assessments to those with positive results, and discussing and implementing any indicated treatment.[3]

Decisions to initiate screening programmes should be based on high quality evidence of sufficient benefits to justify the harms that might be experienced by those who are screened and the consumption of resources that would be unavailable for other healthcare services.[4] An effective mental health screening programme would require that patients agree to be screened; receive a screening test; get an accurate diagnosis if they have a positive result; and can then access treatments they agree to undertake. Furthermore, treatments must reduce symptoms more than no treatment, which may not be the case for people with mild or transient symptoms detected through screening.[3]

The USPSTF said that it considered 17 trials of depression screening[1] and two of anxiety screening.[2] Few of these trials, however, directly tested screening. Instead, almost all enrolled participants with positive screening results. Some trials then randomised participants with positive results to either have those results provided to their healthcare providers or not. Others randomised participants to receive enhanced multidisciplinary mental healthcare not otherwise available in general practice, or standard care.

The two included trials that directly tested depression screening were small and had other serious methodological limitations.[5 6] However, the USPSTF did not review three large, well conducted randomised trials that directly tested mental health screening[7-9]: a 2017 UK cluster trial randomising 44 general practices to screen patients with osteoarthritis for major depressive disorder and anxiety or offer usual care (n=1402)[7]; a 2019 US trial comparing screening for major depressive disorder with usual care in 1500 general practice patients who had had acute coronary syndrome in the past 2-12 months[8]; and a 2017 UK cluster randomised trial comparing screening for major depressive disorder, anxiety, and other psychosocial problems with general mental health advice in military platoons after deployment (10 190 personnel in total).[9] All found that screening did not improve participants' mental health.

Harms and opportunity costs

Most mental health treatment in general practice entails prescription medication.[10] Screening would increase the number of patients prescribed antidepressants or anxiolytics, exposing them to potential side effects, adverse events, and polypharmacy risks.[11] Median duration of antidepressant use is more than two years in the UK and five years in the US,[12] and even benzodiazepines are used long term by many general practice patients.[13] These medications can cause longlasting and severe discontinuation symptoms and be difficult to deprescribe.[14-16] Most people who receive prescriptions in general practice do not meet criteria for any psychiatric disorder.[11 17 18] Screening would exacerbate the risk of overtreatment.

Routine screening would result in an unknown number of extra patients being diagnosed with major depressive disorder and anxiety disorders. Some of these patients would accurately be diagnosed, and others would be diagnosed despite not meeting criteria for a disorder. Many with a positive screening result would be offered pharmacotherapy without further mental health assessment. Indeed, instructions for the depression screening tool used most commonly in general practice, the Patient Health Questionnaire-9 (PHQ-9), propose treatment based on the PHQ-9 score alone.[19] In a typical general practice with 10% prevalence of depression and half of cases recognised before screening, 18% of patients could have positive results from depression screening alone, although almost 80% of these might be false positive.[20 21] Screening for anxiety disorders as well would add to the number of patients with false positive results.

Diagnosing mental health conditions and deciding whether to recommend treatment is challenging in short general practice visits with many competing demands on a clinician's time. If routine mental health screening were implemented, clinician time and other resources would be diverted from other critical services, including providing advice and treatment to patients seeking help for mental health symptoms, many of whom are already unable to access timely and adequate care.[22] Screening is not justifiable given the lack of evidence of benefit and the associated increased risk of overdiagnosis and overtreatment.

The provision of low value health services with minimal or no benefit is one of the reasons the US spends more on healthcare than other high income countries and achieves worse outcomes.[23] USPSTF recommendations to screen for major depressive disorder and anxiety disorders put patients in harm's way without direct evidence of mental health

benefits. The UK Quality and Outcomes Framework included incentives for depression screening from 2006 to 2013 but discontinued them because screening did not appear to increase access to mental health services meaningfully.[24] National guidelines from the UK and Canada do not recommend screening.[3] Patients with mental health concerns would be better served by timely access to caring health professionals with time to talk through their concerns, understand them as a person, and work with them to identify the best way forward.[25 26]

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