Appendix 2: Clinician Summary – CTFPHC Recommendation for Screening for Depression in Adults

Population	Recommendations on screening for depression are provided for adults (18 years of age or older) who present at a primary care setting with no apparent symptoms of depression. These recommendations do not apply to people with known depression, with past history of depression, or people in treatment for depression.	
Burden of illness	The 2002 Canadian Community Health Survey[1] reported that 12% of the Canadian population 15 years and older met the criteria for major depression at some point during their lifetime and 5% in the past 12 months (4% of men and 6% of women).	
Intervention	Screening for depression	
Recommendation	For adults at average risk* for depression, we recommend <u>not routinely screening</u> (Weak recommendation, very-low-quality evidence)	For adults in subgroups of the population who may be at increased risk† for depression, we recommend <u>not routinely screening</u> (Weak recommendation, very-low-quality evidence)
Basis of Recommendation	The decision to recommend against screening was based on the lack of evidence on the benefits and harms of routinely screening asymptomatic adults. Despite the lack of evidence, the CTFPHC had concerns about the potential harms of screening (e.g. false positive, unnecessary treatment, labelling and stigma) and appropriate use of limited resources. In the absence of a demonstrated benefit of screening, and considering potential harms, the CTFPHC recommends not routinely screening asymptomatic adults from average- and increased-risk groups. Physicians who believe their patients, or a subset of their patients, place a high value on the potential benefits and are less concerned with potential harms would likely implement screening for these patients.	
Considerations for implementation	**<u>Remain aware to signs and clinical clues of depression</u>** Detecting depression based on clinical symptoms tends to identify patients with more severe depression who may be more likely to benefit from treatment. Clinicians should be alert to the possibility of depression, especially in patients at increased risk, and should look for it when there are clinical clues, such as insomnia, low mood, anhedonia and suicidal thoughts. **<u>Resource implications</u>** Time used by clinicians to screen reduces their availability to deliver other services, which are known to be beneficial. Instead, focusing efforts on effective long-term treatment of patients who have already been identified with depression may be a more efficient use of resources. **<u>Integrated staff-assisted systems</u>** Integrated staff-assisted systems engage nonmedical specialists, such as case managers, care support and coordination staff, or social workers, who play a central role in working with primary care physicians, mental health specialists and nurse practitioners to provide management and follow-up for patients with depression. Clinicians practising in a setting where there are integrated, staff-assisted systems may be more inclined to choose screening given that treatment is more likely to be effective.	

Note: CTFPHC = Canadian Task Force on Preventive Health Care.
*The average-risk population (i.e., general population) includes individuals 18 years of age or older with no apparent symptoms of depression who are not considered at increased risk.
†Subgroups of the population who may be at increased risk for depression include people with: family history of depression, traumatic experiences as a child, recent traumatic life events, chronic health problems, substance misuse, perinatal and postpartum status, and people of Aboriginal origin.

Reference

1. Public Health Agency of Canada. Mood disorders. In: *The human face of mental health and mental illness in Canada 2006*. Ottawa (ON): The Agency; 2006. p. 57-70. Available: www.phac-aspc.gc.ca/publicat/human-humain06/index-eng.php (accessed 2012 Nov. 13).

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