Canadian Task Force on Preventive Health Care:
Screening for Depression in Adults 2013
Slide Deck Notes

Slide Number 1: TITLE PAGE

In May 2013 the Canadian Task Force on Preventive Health Care (CTFPHC) updated their guidelines on screening for depression in adults. This presentation will provide review the guidelines and the scientific methods used to develop the guidelines.

Slide Number 2: Overview

Today we will review the following:

- The background on The Canadian Task Force on Preventive Health Care
- An overview of current Breast Cancer screening practices
- The scientific methods used by CTFPHC to develop their guidelines
- An overview and details of CTFPHC's Depression Screening Recommendations

Slide Number 3: CTFPHC Background

Slide Number 4: WHO IS THE CTFPHC?

CTFPHC (originally known as The Canadian Task Force on Periodic Health Examination) was originally established in 1976 by the Canadian Government.

The mandate of the CTFPHC was and is to act as an independent body to weigh scientific evidence and make recommendations for or against including preventive measures in the periodic health examination of asymptomatic people.

The CTFPHC also identifies gaps in evidence that need to be filled and provides guidance documents for each topic.

The original CTFPHC was disbanded in 2005.

In 2010 the CTFPHC was re-established with the support of the Public Health Agency of Canada (PHAC) with a renewed commitment and vision to continue it's 25+ year history of excellence.

The current CTFPHC is comprised of 14 primary care and prevention experts from across Canada. CTFPHC members service is voluntary – they are only reimbursed for their expenses to attend meetings.

Additional CTFPHC background information:
The Canadian Task Force on Preventive Health Care (CTFPHC), previously known as the Canadian Task Force on Periodic Health Examination, was established in September 1976 by the Conference of Deputy Ministers of Health of the ten Canadian provinces. From 1976–1979, a methodology was developed for

weighing scientific evidence to make recommendations for or against including preventive manoeuvres in the periodic health examination of asymptomatic people.

The CTFPHC recognized then, as it does now, that in clinical practice, caregivers dealing with individual patients must make binary decisions–"do it" or "don't do it". It also recognizes, however, that for many preventive interventions, the scientific evidence does not lend itself to such simple two-dimensional alternatives. The particular characteristic that distinguishes the CTFPHC methodology from traditional approaches to decision-making on prevention issues is that **evidence takes precedence over consensus**.

The first CTFPHC report, published in 1979, reviewed the scientific evidence for the preventability of 78 conditions and arrived at an important central recommendation, namely that the undefined "annual check-up" should be abandoned and replaced with a series of age-specific "health protection packages" implemented during the course of medical visits for other purposes.

From 1979 to 1994, the CTFPHC published 9 updates evaluating the preventability of 19 conditions not considered previously, and revising 28 earlier reports in the light of new evidence. In 1994, it published a landmark compilation of recommendations for 81 conditions, called The Canadian Guide to Clinical Preventive Health Care. This 1009-page volume, known as "the red brick", has become a standard reference tool for Canadian primary care clinicians. In 1995, the French version of the "red brick" won the prestigious Prix Prescrire, awarded annually by the Paris-based journal Prescrire, to a medical/pharmaceutical publication.

In the 1980s the CTFPHC methodology was adopted, with minimal modification, by the United States Preventive Services Task Force (USPSTF). It has now been applied successfully by the both the Canadian and U.S. Task Forces to evaluate the preventability of over 200 conditions and has achieved international recognition as a basis for developing guidelines for clinical practice and public health policy. The Canadian and U.S. Task Forces continue to enjoy a close, constructive collaboration. Canadian, along with U.S. Preventive Services, Task Force recommendations are currently being used by the U.S. Department of Health and Human Services' "Put Prevention into Practice" initiative to create a resource for clinicians to use when considering preventive care.

In 2005, the Canadian Task Force on Preventive Health Care was disbanded.

In 2010, the CTFPHC was re-established with the support of the Public Health Agency of Canada (PHAC) and a renewed commitment and vision to continue its 25-year tradition of excellence.

Slide Number 5: SCREENING FOR DEPRESSION: OVERVIEW

Slide Number 6: BACKGROUND

This guideline updates the previous CTFPHC 2005 guidelines.

The 2005 guidelines recommended screening adults in the general population for depression in primary care settings that have integrated programs for feedback to patients and access to case management or mental health care.

Slide Number 7: THE GOAL OF THE 2013 GUIDELINE

CTFPHC selected this topic for update for the following reasons:

1. To address a disease with high prevalence in Canada
2. To address discrepancies between recommendations from industrialized nations
3. To ensure the guidelines align with the most recent evidence from systematic review.

Slide Number 8: SCIENTIFIC METHODS

Slide Number 9: METHODS OF CTFPHC

1. Work on each recommendation is led by a work group of 2 – 6 members of the CTFPHC. The Depression Screening Guideline Working Group was comprised of 6 CTFPHC members.
2. The working group creates key and contextual research questions and an analytical framework.
3. A team of methodologists from the Evidence Review and Synthesis Center (ERSC) at McMaster University reviews the analytical framework and then summarizes the evidence using a systematic review and quantitative summary of relevant available evidence.
4. The Working Group then independently conducts a detailed review of the evidence and develops recommendations by consensus.

When formulating recommendations, the working group considered:

- The benefits and harms associated with a screening test
- Patient values and preferences
- The quality of evidence

The recommendations developed by the workgroup are then reviewed and approved by the entire Task Force and reviewed by external experts and stakeholders in the field.

Detailed information on CTFPHC procedures can be found at: www.canadiantaskforce.ca/methods/methods_manual.

Slide Number 10: ELIGIBLE STUDIES FOR CLINICAL PRACTICE GUIDELINES

Eligible Studies

The population assessed for these recommendations was:

Asymptomatic adults over the age of 18 years from the general population who are not at high risk for depression, or who are at high risk for depression.

The following study designs were included in the systematic review:

For: Effectiveness of screening on preselected outcomes.

Study designs included systematic reviews, randomized controlled trials and observational studies with comparison groups.

The CTFPHC decided to concentrate on clinically relevant outcomes including:

- quality-of-life
- suicidality rate (real or ideation)
- all-cause mortality
- depression related mortality
- hospitalization rates
- symptoms of depression

For: Harms of screening

Studies of various designs and multiple data sources were included.

Harms included:

- Psychological stress (labelling, anxiety, stigma)
- false positives
- false negatives
- decreased day-to-day functioning
- increased symptoms of depression

For: Contextual questions

Studies of various designs

Contextual questions included:

- Effect of depression
- Screening in subgroups
- Resource implications
- Values and preferences of individuals
- Outcome performance measurements

Slide Number 11: GRADE: HOW IS EVIDENCE GRADED?u

Using GRADE (Grading of Recommendations Assessment, Development and Evaluation), evidence was deemed to be of either High, Moderate or Low quality.

Evidence was judged as **high quality** when there was high confidence that the true effect lies close to that of the estimate of the effect.
For example, evidence is judged as high quality if all of the following apply:

- there is a wide range of studies included in the analyses with no major limitations.
- there is little variation between studies, and the summary estimate has a narrow confidence interval.

Evidence was judged as **moderate quality** when it was considered that the true effect was likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
For example, evidence might be judged as moderate quality if any of the following applies:

- there are only a few studies and some have limitations but not major flaws
- there is some variation between studies
- the confidence interval of the summary estimate is wide.

Evidence was judged to be **low quality** when it was deemed that the true effect may have been substantially different from the estimate of the effect.
For example, evidence might be judged as low quality if any of the following applies:

- the studies have major flaws
- there is important variation between studies
- the confidence interval of the summary estimate is very wide.

Evidence was judged to be **very low quality** when it was deemed that any estimate of effect is very uncertain.

Slide Number 12: GRADE: HOW IS THE STRENGTH OF THE RECOMMENDATIONS GRADED?

After review of the evidence the Working Group developed their recommendations. The recommendations are graded as either strong or weak.

The strength of the recommendations is based on 4 factors:

- The quality of the supporting evidence
- The degree of uncertainty about the balance between desirable and undesirable effects
- The uncertainty or variability in values and preferences of citizens

1. Uncertainty about whether the intervention represents a wise use of resources****Strong recommendations are more likely when:**

   there is a large difference between the benefits and harms and certainty around that difference

   there is greater certainty or similarity in values and preferences

   when the evidence quality is higher.

2. **Weak recommendations indicate that greater uncertainty exists.**

Strong recommendations can be made even with low quality evidence assuming that the balance between benefits and harms is clear and values and preferences are consistent while weak recommendations can be made based on high quality evidence.

As an example, although only anecdotal evidence (low quality) suggests that parachutes are an effective intervention to reduce morbidity and mortality associated with jumping from an airplane, the recommendation to use a parachute would be classified as strong.

***Bell N, Connor Gorber S, Shaw L, et al. From ABCs to GRADE: The Canadian Task Force on Preventive Health Care's New Rating System for Clinical Practice Guidelines. Canadian Family Physician.*

Slide Number 13: INTERPRETATIONS OF THE RECOMMENDATIONS

How does the strength of the recommendation translate into clinical practice?

Ŧ **Strong recommendations** are those for which ***we are confident*** that the desirable effects of an intervention outweigh its undesirable effects (strong recommendation **for** an intervention) ***or*** that the undesirable effects of an intervention outweigh its desirable effects (strong recommendation **against** an intervention).

A strong recommendation implies that most individuals will be best served by the recommended course of action.

Weak recommendations are those for which the desirable effects ***probably*** outweigh the undesirable effects (weak recommendation **for** an intervention) ***or*** undesirable effects probably outweigh the desirable effects (weak recommendation **against** an intervention) but uncertainty exists.

A weak recommendation implies that we believe most people would want the recommended course of action but that many would not.

For clinicians, this means they must recognize that different choices will be appropriate for different individuals, and they must support each person in reaching a management decision consistent with his/her values and preferences.

Ŧ GRADES of Recommendation, Assessment, Development, and Evaluation (GRADE) Working Group, 2011

It should be noted that preferences and values, and resource allocation may also play a role in determining certainty and may impact the strength of the recommendation.

≠The more values and preferences vary, or the greater the uncertainty in values and preferences, the higher the likelihood that a weak recommendation is warranted.
The higher the cost of treatment, the less likely a strong recommendation.

≠Guyatt G, Oxmann A, Kinz R, et al. GRADE: going from evidence to recommendations.

Slide Number 14: SCREENING FOR DEPRESSION – RECOMMENDATIONS

Slide Number 15: DEFINITION OF SCREENING

For these guidelines screening is defined as:

- methods used to identify only new cases of depression. (**Screening does not apply to patients who are known to have depression, have a history of depression or are receiving treatment for depression.)**
- performed in individuals with no apparent symptoms, with the aim of detecting those individuals with a high probability of having a disease before the disease manifests itself (early identification)

Those identified through screening would undergo further testing to confirm the presence of the disease (i.e. diagnostic testing). If confirmed, they may be offered disease treatment.

The net benefit of screening depends on early identification and successful treatment, and requires that the benefits of such treatment outweigh any harm, such as side effects of medication

Slide Number 16: CONSIDERATIONS

These recommendations apply to adults who:

- are 18+ years of age
- with no apparent symptoms of depression
- are at average risk or increased risk for depression

These recommendations *do not* apply to people:

- with known depression
- with past history of depression
- or people in treatment for depression

Clinicians can use symptoms of depression (for example, insomnia, low modd, anhedonia and suicidal thoughts) to identify patients with potential depression. Evidence suggests that 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 in patients with clinical clues, especially those at increased risk of depression and implement treatment as appropriate when depression is diagnosed.

Slide Number 17: AVERAGE AND INCREASED RISK POPULATIONS

For the purpose of these guidelines:

The **Average Risk** population is the general population including all individuals 18 years of age and older with no apparent symptoms of depression.

Population at **Increased Risk** of depression include:

- family history of depression
- traumatic experiences as a child
- recent traumatic life events
- chronic health problems
- substance misuse
- perinatal and post-partum status
- aboriginal origin

Slide Number 18: CTFPHC RECOMMENDATIONS: AVERAGE RISK POPULATION

For adults at average risk for depression we recommend not routinely screening for depression.
This is a weak recommendation based on very low quality evidence.

Slide Number 19: RECOMMENDATION: AVERAGE RISK POPULATION

This recommendation is based on:

- the lack of direct evidence on the benefits of screening the average risk population
- the lack of evidence on harms of screening
- Concerns about the potential harms of screening

This recommendation places a relatively high value on the importance of demonstrating a clear net benefit before recommending routine screening for an entire population and on the potential harms that may result from screening

The recommendation places a relatively low value on the unproven likelihood that early identification and subsequent treatment of people with depression may lead to better health outcomes.

Slide Number 19: RECOMMENDATION: HIGH RISK POPULATION

For adults in subgroups of the population who may be at increased risk of depression we recommend not routinely screening for depression.

Slide Number 21: RECOMMENDATION: HIGH RISK POPULATION

This recommendation is also based on:

- the lack of direct evidence on the benefits of screening in populations who may be at increased risk population
- the lack of evidence on harms of screening
- Concerns about the potential harms of screening

The incidence of depression (and prevalence of undetected depression) may be higher in populations at increased risk, which in theory would be expected to favourably influence the potential benefit of screening.

However the efficacy and adverse effects of treatment, the performance of screening tools and the possibility of harms likely also differ among subgroups of the population who may be at increased risk of depression.

Therefore one cannot assume that screening will benefit people at increased risk simply because they may have a higher incidence and prevalence of depression.

Slide Number 22: FINDINGS: AVERAGE AND HIGH RISK POPULATION (1)

The evidence review found 5 quasi-experimental studies examined community-based depression screening in Japanese elderly adults in rural communities.

These studies showed a reduction in the number of completed suicides (RRR=0.51, 95% CI, 0.34 to 0.75; p=0.0008) All of the studies showed a statistically significant reduction in the number of completed suicides after implementation of the program.

However the studies were considered as very low quality of evidence due to methodological and generalizability concerns including:

- It was uncertain what portion of the reported outcomes involved people who actually received the intervention. The number of suicides (before and after the intervention) was based on independent statistics reported by the local health agency, not a follow up of people who were screened.
- Because of the community-based nature of the intervention, there is a particularly high risk of bias, because the people classifying the deaths as suicides were not blinded to the group assignments. Given that the studies compared a small number of suicides in both the intervention and control groups, any influence on even a few classifications could have affected the results.
- The generalizability of these results to the Canadian population is uncertain given that:

the prevalence of depression in Japanese rural elders is 5 times higher than the elderly Canadian population as a whole (10.4% versus 2% respectively)

the suicide rate for elderly Japanese women 7 times higher than in Canadian women 75 - 84 years of age (23.4 versus 3.3 per 100,000 respectively)

Slide Number 23: FINDINGS: AVERAGE AND HIGH RISK POPULATION (2)

Evidence of harms of screening

No eligible studies measuring the harms of screening for depression were identified in the systematic review.

However potential harms of depression include:

- false positive diagnosis with subsequent unnecessary treatment
- adverse effects of medical therapy among people correctly identified as having depression
- consequences of labeling and stigma

Evidence on patient preferences and values

Although there was a high variability in patient preferences and values, patients generally consider screening for depression to be important and the screening tools to be acceptable. However most studies of the acceptability of screening for depression that were identified in the systematic review focused on perinatal women.

There was some evidence that any treatment in identified cases should be culturally sensitive and that matching treatment to patient preferences improves outcomes.

Evidence on resource implications

Evidence from a modeling study in the United States suggested that one-time screening for depression may be cost-effective. However this conclusion was based on a low-cost screening approach (maximum $6 per person) and on high remission rates associated with treatment (settings that can achieve full remission in 45% of patient and partial remission in an additional 25%). Given the lack of support for these assumptions, the validity of this conclusion is uncertain.

The time clinicians take to screen for depression reduces their availability to deliver other services of known clinical benefit (opportunity cost.

Evidence from a Canadian modeling study suggests that routine screening to identify new cases of depression, resulting in increased rates of treatment may not reduce the burden of depression. Instead, focusing efforts on reducing episodes of relapse (e.g. through long-term treatment in patients with known depression) may be a more efficient use of resources.

Slide Number 24: RATIONALE FOR LIMITING REVIEW TO DIRECT EVIDENCE (SCREEN VS. NO-SCREEN CONTROL GROUP)

Other reviews[+] ** have included multiple studies in which both the treatment and control groups were screened, with only the former receiving treatment if depression was found. Rather than studying the effect of screening, such studies actually compared the addition of treatment to screening alone.

In addition, screening all participants may increase awareness of depressive symptoms, which can either overestimate or underestimate any benefits.

- If participants in the control group are more aware of their symptoms, they may present themselves as more depressed, inflating apparent differences between groups.
- If, on the other hand, screening leads to participants in the control group to engage in some form of treatment (this could be as simple as exercise or self care) the apparent differences between the 2 groups may be reduced.

Studies that include people with known depression, with past history of depression, or people on treatment for depression, may bias the effect of screening in either direction depending on the impact of treatment in this group. Screening does not apply to people who already have known disease.

[+]O'Conner et al. *Screening for depression in adults and older adults in primary care: an updated systematic review*

[**] Gilbody et al. *Screening and case finding instruments for depression: a meta-analysis*

Slide Number 25: DIFFERENCES WITH THE CTFPHC 2005 GUIDELINES

These recommendations are a change from the 2005 CTFPHC guideline, which recommended screening adults for depression in primary care settings where integrated staff-assisted systems are in place to manage treatment.

The 2005 recommendation was based on an analysis of a literature review done for the US Preventive Services Task Force in 2002 which showed that screening improved the accuracy of diagnosis of depression and that benefit was more likely in settings where screening was linked to effective follow-up and treatment.

Many trials included in the 2002 literature review did not exclude people with prior or known depression, which may have overestimated the benefits of screening.

Slide Number 26: 2009 USPSTF REVIEW

Several key differences exist between the 2009 USPSTF review on depression screening and the latest review conducted for the CTFPHC. The research questions and study selection criteria were different due to differing standards of admissible evidence.

The USPSTF identified one RCT that addressed the effectiveness of screening. This RCT was not eligible for inclusion in the CTFPHC's evidence review because all participants underwent a diagnostic interview (i.e. all were screened for depression). At 3 months, only depressed patients and a random sample of non depressed patients were reassessed for DSM-III-R disorders and symptoms of depression. The study concluded that case finding leads to a modest increase in rates of recognized depression and recovery from depression, but does not have consistently positive effects on patient outcomes.

The USPSTF used 8 studies to address the question on the effectiveness of screening with feedback and support systems. These studies were excluded from the CTFPHC evidence review for several reasons:

- First, the studies did not meet inclusion criteria due to a lack of an unscreened comparison group (all patients in the intervention and control groups were screened).
- Second, the CTFPHC recommendations do not apply to people with known depression, with past history of depression, or people on treatment for depression. This is particularly relevant given that 4 out of the 8 studies cited in the USPSTF review included patients who were currently being treated for depression or had been recently treated. As stated in our guideline, the recommendations do not apply to people with known depression since "screening" does not apply to people who already have known disease. Including people with known depression when evaluating the effectiveness of screening can produce a bias in favor of the screening intervention. One study included patients that had a history of depression, and 2 studies did not report the percentage of patients currently or recently treated.
- Third, among the 8 studies included in the USPSTF review, there was substantial variability in the interventions delivered to participants with screen-detected depression – making it difficult to determine what portion of the benefit observed is attributed solely to screening and how clinicians should use the results of screening tools in practice.

Slide Number 27: GILBODY REVIEW

As suggested by several external reviewers of the guideline, the 2008 Gilbody review was examined to determine whether it could provide any additional data on benefits and harms of screening. The results of our analysis were as follows:

The Gilbody review examined indirect evidence. Gilbody et al. analyzed 16 randomized controlled trials conducted in non-mental health settings that used case-finding or screening instruments for depression and assessed their impact on clinical outcomes. The review found no evidence that screening instruments have an effect on depression clinical outcomes (standardized mean difference –0.02, 95% CI –0.25 to 0.2).

Nineteen papers were published on the 16 randomized controlled trials included in the Gilbody review. Sixteen of the nineteen papers were not considered further due to the following reasons:

Published before 1994, which is the start date of the CTFPHC search – meaning relevant publications prior to 1994 would have been in our search.

- The population being studied included people with known depression, with past history of depression, or people in treatment for depression, which is contrary to the objective of screening: an intervention meant to be used to identify new cases of depression in an asymptomatic population.
- The outcome or setting was outside of the scope of the guideline.
- The interventions delivered included management and treatment of depression, not only screening (e.g. case management support, training for clinicians, educational sessions for patients, scheduled follow-up visits, etc), which made it difficult to draw any particular conclusion about the impact that screening had on the outcomes.

Three RCTs included by Gilbody et al merited further analysis.

1. One RCT showed higher recovery rates at 3 months in depressed participants who were screened (48% intervention vs. 27% control, *P*=0.03), but the mean improvement of depression symptoms was similar to those that were not screened (1.6 intervention vs. 1.5 control, *P*= 0.21). One limitation of this study is that all participants underwent a diagnostic interview at baseline, which raised awareness amongst participants about depression symptoms and are therefore, more likely to report symptoms at later stages of the study. Put differently, this trial compared screening with intervention to screening without intervention. Also, the analysis of clinical outcomes was only calculated for patients that were depressed at baseline and a random sample of non-depressed participants, and one site did not participate in the follow-up.
2. Another RCT showed that providing the results of screening to clinicians without any further instructions did not influence depression scores. At 6 weeks the mean GHQ score was higher in the group where screening results were provided to the clinician (27.2 disclosed results vs. 26.6

withheld results, *P*=0.04). There were no statistically significant differences between groups at 3 months and 6 months. An important limitation of this study is that all participants were screened with the GHQ-12 at baseline before the consultation with their clinician, which could have led to bias: all screened subjects, whether part of the intervention or control groups, are more aware of depression symptoms and are more likely to report them if asked to complete a screening questionnaire.

3. The third RCT showed that disclosing cases of unrecognized depression to general practitioners had no effect on clinical outcomes at 6 or 12 months. Again, an important limitation of this study is that all participants completed the Beck Depression Inventory before the consultation with their clinician, which could have led to bias.

Evidence from these 3 randomized controlled trials suggests that routine screening does not lead to improved clinical outcomes in the average risk population. These results led us to conclude that even if these 3 RCTs would have been included in the literature review our recommendations would not have changed.

Slide Number 28: REASSESSING STUDIES MISSING A NO-SCREEN COMPARATOR

The systematic review on depression screening examined only direct evidence on the effectiveness of screening. Yet, after the external review process, the McMaster Evidence Review and Synthesis Center (i.e. ERSC) independently re-examined the 144 studies that were excluded due to the lack of an unscreened comparison group and to identify those that could provide high quality indirect evidence.

Only 1 RCT that could provide high quality indirect evidence was identified. The study evaluated the effectiveness of a postnatal screening programme using the Edinburgh Postnatal Depression Scale (EPDS).

At 6 months, fewer participants in the intervention group had EPDS scores above the cut-off (EPDS scores >10) than the control group (13% vs 22%; risk ratio: 0.59; 95% CI: 0.39–0.89). However, at 18 months there were no significant differences in EPDS scores >10 between the intervention and control groups (RR = 1.10, 95% CI: 0.70–1.73) but this may be due to the treatment delivered to all patients with EPDS>10 in both intervention and control groups.

The long-term effect of screening post-natal women is therefore uncertain. It is unlikely that the inclusion of this study would have changed the CTFPHC recommendation not to screen groups of the population thought to be at higher risk for depression.

Slide Number 29: CONSIDERATIONS FOR IMPLEMENATION OF RECOMMENDATIONS

Screening for depression refers to the detection of depression among patients with no apparent symptoms. However clinicians can use symptoms of depression (e.g. insomnia, low mood, anhedonia and suicidal thoughts) to identify patients with potential depression.

Evidence suggests that 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 in patients with clinical clues, especially those at increased risk of depression and implement treatment as appropriate when depression is diagnosed.

Slide Number 30: IMPLEMENTING A WEAK RECOMMENDATION

The recommendations for this guideline are Graded as 'weak' meaning the undesirable effects probably outweigh the desirable effects but appreciable uncertainty exists.

A weak recommendations implies that most people would want the recommended course of action, in this case not screening, but many would not.

Clinicians 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

Slide Number 31: CONSIDERATIONS FOR IMPLEMENTATION OF RECOMMENDATIONS

Integrated staff-assisted systems engage 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 depression management and follow up.

Evidence suggests that such integrated systems may be more effective than usual care in increasing the likelihood of successful treatment of depression.

However, it is unclear whether screening is a necessary component of these programs.

Nevertheless, clinicians practicing 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 in this setting.

Slide Number 32: RECOMMENDATIONS FROM OTHER INDUSTRIALIZED COUNTRIES

The following table displays recommendations from the National Institute for Health and Care Excellence (NICE) in the UK and the USPSTF.

NICE
2004 (updated) 2009 Clinical Practice Guidelines for adults
NICE recommended that rather then general population screening, practitioners perform targeted case identification in people with:

- a history of depression
- current chronic physical health problems and/or associated functional impairment

The screening tool of choice was the 'Whooley' questions.

NICE
2007 Clinical Practice Guidelines for perinatal women
NICE recommended screening perinatal women with

- past or present severe mental illness, including schizophrenia, bipolar disorder, psychosis in the postnatal period and severe depression
- previous treatment by a psychiatrist/specialist mental health team including inpatient care
- a family history of perinatal mental illness

The screening tool of choice was the 'Whooley' questions plus a third 'help' question.

USPSTF 2009 Guidelines
USPSTF recommended routinely screening adults for depression in clinical practices when systems are in place to ensure accurate diagnosis and effective treatment & follow up.

No screening tool was specifically identified.

Slide Number 33: SCREENING FOR DEPRESSION: CONCLUSIONS

Slide Number 34: KEY POINTS

1) The evidence review did not identify high quality evidence on the effectiveness of screening for depression.
2) The evidence review did not identify direct evidence on the harms of screening but we remain concerned about false positives, unnecessary or inappropriate treatment, labeling and stigma, and appropriate use of limited resources.
3) For adults with no apparent symptoms of depression, who are at average or high risk for depression, we recommend not routinely screening for depression in primary care settings.

Slide Number 34: KEY POINTS: CONTINUATION

4) Clinicians should be alert to the possibility of depression, especially in individuals with characteristics that may increase the risk for depression. Clinicians should look for depression when there are clinical clues, such as insomnia, low mood, anhedonia, lack of motivation, and suicidal thoughts.

5) Randomized controlled trials with unscreened controls, evaluating the effect of screening for depression on clinically relevant outcomes should be a high research priority, especially in populations at higher risk of depression.

Slide Number 36: KNOWLEDGE TRANSLATION TOOLS

Slide Number 37: CLINICIAN DECISION TOOL WITH PATIENT SCENARIOS AND CORRESPONDING ACTIONS

This tool is available in English and French and can be downloaded from the CTFPHC website: http://canadiantaskforce.ca/resources/tools/

Slide Number 38: CLINICIAN FAQ

This tool is available in English and French and can be downloaded from the CTFPHC website: http://canadiantaskforce.ca/resources/tools/