



AMERICAN
PSYCHOLOGICAL
ASSOCIATION

Written Statement of

Amalia Corby-Edwards, MS

On behalf of the

American Psychological Association

**RE: U.S. Preventive Services Task Force DRAFT Research Plan
Primary Care Screening for Depression in Adults**

April 23, 2014

The American Psychological Association (APA) is pleased to have the opportunity to submit comments on the draft research plan for primary care screening of depression in adults. APA supports the U.S. Preventive Services Task Force's (USPSTF) goal to identify the impact of depression screening in primary care settings on mental health outcomes among adults including older adults in the general population and among pregnant and post-partum women. Studies have shown that screening in primary care settings improves the detection of depression among adults, and if appropriately treated after diagnosis, depression related morbidity is reduced (Feinberg, Smith, Naik, 2009).

We are encouraged by this important comprehensive update to depression screening for adults and are gratified that this draft incorporates additional key questions regarding pregnant and postpartum women. Numerous studies have shown that depression is a serious and prevalent health problem amongst adult populations, yet the considerations for screening certain populations may vary. Our comments below provide context for populations in need of additional consideration, and the concluding sections provide specific recommendations for the research plan.

Regarding people of color:

Considering that people of color, particularly African Americans, are more likely to use general medical services (e.g. physicians, nurses) for mental health care (Neighbors, et al. 2007), improving the accurate identification of depression in primary care is particularly important for this population. Understanding the barriers to appropriate treatment for identified depressed patients is of particular importance for populations of color. There is growing evidence that even among those with identified depression, people of color are more likely to experience delays in obtaining treatment or fail to receive treatment at all (Wang, Berglund, Olfson, et al., 2005).

As currently stated, the key questions do not examine the mechanism through which detection in primary care leads to appropriate treatment. Moreover, it is the adequate treatment of depression, once it is diagnosed, that ultimately leads to improved outcomes. Examining the link between screening and outcomes without a systematic investigation of the mechanisms through which screening leads to treatment assumes that the link between screening and treatment is a given, which will provide an incomplete picture, particularly for populations of color.

Regarding older adults:

Studies from Alexopoulos and Steffens and their colleagues have noted that “of the roughly 35 million Americans aged 65 and older, an estimated two million have a major depressive illness and another five million may have subsyndromal depressive symptoms” (as cited in Delano-Wood & Abeles, 2005). Thus, about 20 percent of older Americans struggle with depressive disorder or its associated symptoms. Depression is under-treated in older adults and rates of suicide are highest in older adults as compared to other age groups across the lifespan. Therefore, primary care screening for depression is critical for older adults.

The rate of depressive symptoms in older adults increases for those with chronic physical disorders and disabilities, and “the presence of comorbid medical illness can have an extensive impact on morbidity, mortality, and quality of life” (Delano-Wood & Abeles, 2005). Existing research suggests that medical professionals are less likely to refer older adults for treatment, and older adults are less likely to accept or follow through on referrals due to a host of factors including stigma, ageism, inadequate workforce, low rates of Medicare acceptance, and transportation barriers.

Evidence has shown depression to be associated with many chronic disorders, such as endocrine disorders, cancer, and arthritis, and depression has a strong relationship with cardiovascular disease in older patients (Delano-Wood & Abeles, 2005). USPSTF reported in its 2009 recommendation statement that appropriate treatment of depressed older adults identified through screening in primary care settings decreases clinical morbidity and improves clinical outcomes (USPSTF, 2009).

Regarding pregnant and postpartum women:

Depression is common during pregnancy and in the postpartum period. Although screening pregnant women for depression is not universal, estimates of depression during pregnancy range from 14% to 23%; estimates of maternal depression in the first year postpartum range from 5% to 25% (ACOG, June 2010). There are many programs at the federal, state, and local levels that support maternal and child health; these programs may indirectly contribute to maternal mental well-being. However, these programs do not have depression screening requirements or built-in support for mental health services.

The inclusion of pregnant and postpartum women in depression screening is particularly important given the psychological vulnerability of women in the perinatal period, and the effect of depression on pregnancy outcomes. Perinatal depression is associated with negative pregnancy outcomes such as preeclampsia, preterm birth, and low birth weight. It is also associated with negative effects on children, including discontinuation of breastfeeding, family dysfunction, and child abuse and neglect (AAP 2010). We suggest that, when considering the potential harms of screening pregnant and postpartum women, that the potential harms of not screening are also weighed.

Specific recommendations:

1. In Key Question 1.a., care management supports need to include provider information about appropriate referrals for psychotherapy and other interventions. Will the results of screening be reviewed with additional supports, and a separate review occur for screening when additional care management supports are not available?
2. We contend that proposed Contextual Question 3 should be added to the analytic framework and systematically reviewed.
3. Regarding Key Questions 2 and 4 for pregnant and postpartum women--unless USPSTF believes they have sufficient information regarding common depression screening

instruments in primary care as well as treatment outcomes post screening, it would seem important to ask those questions for the general primary care population as well.

4. In Section IV, the proposed study characteristics and criteria should provide more information about the “harms of screening” that will be considered. How is treatment avoidance to be measured? How was it determined that “deterioration in patient-provider relationship” occurs as a result of screening? How will that be measured?
5. Also in Section IV, we suggest clarifying which child outcomes you are planning to assess. The factors suggested by AAP are listed in the previous paragraph; however, one could also consider functioning of the mother-child dyad or achievement of recognized child developmental milestones as potential measures.
6. Given that research has found postpartum depression has differential effects on certain populations, we also suggest including studies that examine the effects of culture, Socio-Economic Status, employment status and other characteristics.
7. We are concerned about the notation to exclude adults with comorbid conditions. Does this apply to psychiatric comorbid conditions, medical comorbid conditions, or both? Since nearly all older adults have comorbid chronic medical illness, it would not be possible to include older adults while excluding those with medical comorbidities, and subsequently suppress evidence of screening effectiveness in this population.
8. If possible, it would be useful to add rates of referral and rates of referral acceptance as outcome variables of interest.

Conclusion

In closing, the current USPSTF recommendation to screen only “when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up” does not universally facilitate the identification of individuals with depression and access to care. There is inherent harm for individuals with a mental health disorder being undiagnosed and therefore uninformed of their condition. Depression is a mental disorder for which effective treatments are available; yet such treatments cannot be delivered unless efforts are made to appropriately screen and refer those in need.

The lack of treatment resources in the primary care setting should not serve as a disincentive for depression screening. Even in the absence of such primary care services, the patient could be referred for treatment to psychologists and other qualified mental health professionals in the community. It is important to note that depression screening will yield objective data to help determine whether or not the primary care services should be expanded to offer depression treatment, particularly when such treatment is not available in the surrounding community.

We are hopeful that the USPSTF will soon lift the requirement that staff-assisted depression care supports be in place in the primary care setting for such screening to be recommended. Depression is a common, costly, and debilitating condition for adults if left unrecognized and untreated. However, depression is treatable, and treatment can improve quality of life and clinical outcomes. It is imperative that universal depression screening be used to identify

depression in primary care patients. For reasons stated above, the APA strongly supports annual depression screening for all adults in primary care settings and looks forward to the results of your review.

References

American Academy of Pediatrics (AAP). (2010). Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. *Pediatrics*, 126(5), 1032-1039.

Delano-Wood, L., & Abeles, N. (2005). Late-life depression: Detection, risk reduction, and somatic intervention. *Clinical Psychology: Science and Practice*, 12(3), 207-217.

Feinberg, E., Smith, M.P., & Naik, R. (2009). Ethnically diverse mothers' views on the acceptability of screening for maternal depressive symptoms during pediatric well-child visits. *Journal of Health Care Poor Underserved*, 20(3), 780-797.

Neighbors, H. W., Caldwell, C., Williams, D. R., Nesse, R., Taylor, R. J., et. al. (2007). Race, ethnicity, and the use of services for mental disorders: Results from the National Survey of American Life. *Archives of General Psychiatry*, 64(4),485-494.

U.S. Preventive Services Task Force. Screening for Depression in Adults: Recommendation Statement. AHRQ Publication No. 10-05143-EF-2, December 2009. <http://www.uspreventiveservicestaskforce.org/uspstf09/adultdepression/addeprss.htm>.

Wang, P.S., Berglund, P., & Kessler, R.C. (2000). Recent care of common mental disorders in the United States: Prevalence and conformance with evidence-based recommendations. *Journal of General Internal Medicine*, 15(5):284-292.