UK National Screening Committee

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UK National Screening Committee

Screening for Depression

19 March 2015

Aim

1. This document provides background on the item addressing screening for depression.

Current policy

2. The UK National Screening Committee reviewed screening for depression in 2010, recommending against routine screening of the population or subsets of the population.

Current review

3. This current review is an update of the 2010 review, both of which have been undertaken by Dr Martin Allaby from Solutions for Public Health.

4. The conclusion of the current review is that population screening for depression should not be recommended. The key reasons relates to the test, and the lack of evidence and RCTs to demonstrate improved long-term outcomes from screening:

    - The questionnaire-based tests included in the studies offer moderate-good sensitivity, but when used in the general population have poor positive predictive values, resulting in a high number of false positives.
    - There is insufficient evidence to show that early intervention of subthreshold depression will reduce the likelihood of major depression in the long term after two years.

- Further research is needed to be able to be able to identify which screen positive patients will recover without substantial intervention, and which will need more intensive intervention.

Consultation

5. A five month consultation was hosted on the UK NSC website and additionally promoted through the PHE Screening Twitter platform. The following organisations were contacted directly: British Association of counselling and Psychotherapy, British Psychological Society, Depression Alliance, Mental Health Foundation, Mind.org, National Collaborating Centre for Mental Health, NHS England, Royal College of GPs, and Royal College of Psychiatrists.

6. Responses were received from the Royal College of Psychiatrists, British Association of counselling and Psychotherapy, and Action on Hearing Loss. There is agreement with the recommendation to not screen the general population.

7. The main concern raised in the responses is that this review focussed too much on the general population, rather than on subsets where there is a higher prevalence of depression, such as among people older people suffering hearing loss. In this regard the responses were also concerned that the current recommendation not to screen or test in high risk groups may contradict national guidance.

Some additional references were submitted in relation to this issue but they do not appear to impact on the review's content as high risk groups and subsets of the population were excluded from the review as being outside the NSC's remit.

The full consultation responses can be found in Annex A.

Recommendation

8. It is proposed that the recommendation statement separates whole population screening and management of high risk groups and subsets of the population. The committee is asked to approve the following:

   "The UK NSC does not recommend a population screening programme for Depression.

   National clinical guidance is available to inform practice in high risk groups and subsets of the population."

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UK National Screening Committee
Screening for Depression- an evidence review

Consultation comments pro-forma

Name:	Nancy Rowland	**Email address:**	**xxxx xxxx**
Organisation (if appropriate):	British Association for Counselling and Psychotherapy (BACP)		
Role:	Director of Research, Policy and Professional Practice		

Do you consent to your name being published on the UK NSC website alongside your response?

Yes X **No** ☐

Section and / or page number	**Text or issue to which comments relate**	**Comment** *Please use a new row for each comment and add extra rows as required.*
Overall document	General comment	The British Association for Counselling and Psychotherapy (BACP) welcomes this opportunity to comment on the consultation of the UK National Screening Committee's recommendation on Screening for Depression in adults.
Page 4	Introduction, point 2: 'The current NSC policy is that "routine screening of the population or subsets of the population for depression is not recommended" (NSC, 2014).'	BACP acknowledges that the research referenced in this draft report does not provide definitive evidence to support a recommendation for routine screening of the population for depression. However, there are research findings which suggest that routine screening of subsets of the population

		may have beneficial patient outcomes for groups known to be at increased risk of common mental disorder. For example, routine screening of general hospital patients may support identification of need and inform care and treatment (Rayner et al., 2014); findings from a study of patients with type 2 diabetes indicated an incremental relationship between symptoms of depression and poorer diabetes self-care (Gonzalez et al., 2007), suggesting that screening for depression in this patient group may support better management of the physical health condition through early identification of symptomology which may impact on self-care. Research into addiction treatment services suggests that mental health screening can help identify co-morbid disorders in order to provide appropriate support and treatment, and is generally accepted by service users (Delgadillo et al., 2012). In addition, the recommendation regarding screening of subsets of the population somewhat contradicts clinical guidelines from the National Institute for Health and Care Excellence (NICE), which recommend practitioners be alert to depression in adults with a chronic physical health problem, and to consider asking further screening questions (NICE, 2009). References: Delgadillo, J., Gore, S., Jessop, D., Payne, S., Singleton, P.

		and Gilbody, S. (2012). Acceptability of mental health screening in routine addictions treatment. *General Hospital Psychiatry, 34,* 415-422. Gonzalez, J.S., Safren, S.A., Cagliero, E., Wexler, D.J., Delahanty, L, Wittenberg, E. et al. (2007). Depression, Self-Care, and Medication Adherence in Type 2 Diabetes. *Diabetes Care, 30*(9), 2222-2227. National Institute for Health and Care Excellence. (2009). *Depression in adults with a chronic physical problem: Treatment and management. NICE guidelines [CG91].* London: NICE. http://www.nice.org.uk/guidance/cg91 Rayner, L., Matcham, F., Hutton, J., Stringer, C., Dobson, J., Steer, S. et al. (2014). Embedding integrated mental health assessment and management in general hospital settings: feasibility, acceptability and the prevalence of common mental disorder. *General Hospital Psychiatry, 36,* 318-324.
Page 9	Test criterion: 'There should be a simple, safe, precise and validated screening test. The distribution of test values in the target population should be known and a suitable cut-off level defined and agreed.' Additional information.	Whilst routine screening for depression is not recommended under current NSC policy, BACP would like to highlight for any future work the findings of a systematic review of meta-analyses and systematic reviews reporting on the diagnostic accuracy of screening tools for depression. This research found that less than 5% of studies appropriately excluded patients who already have a diagnosis of depression, or are in receipt of treatment for depression, which may lead to

		inaccurate estimates of the accuracy of screening tools (Thombs et al., 2011). **Reference:** Thombs, B.D., Arthurs, E., El-Baalbaki, G., Meijer, A., Ziegelstein, R.C. and Steele, R.J. (2011). Risk of bias from inclusion of patients who already have diagnosis of or are undergoing treatment for depression in diagnostic accuracy studies of screening tools for depression: systematic review. *British Medical Journal, 343,*
Page 11	Point 43: 'did not identify any studies assessing the acceptability of screening tests in a UK population.'	Two of the above cited research studies (Delgadillo et al., 2012; Rayner et al., 2014) were undertaken with UK populations, although these were specific subsets of the general population.
Page 12	Point 49. Additional information.	A meta-analysis of studies examining psychological treatment of depression in primary care (Cuijpers et al., 2009) found significantly higher effect sizes in studies in which patients were referred for treatment by their GP than in studies where systematic screening was used to recruit patients. Reference: Cuijpers, P., van Straten, A., van Schaik, A. and Andersson, G. (2009). Psychological treatment of depression in primary care: a meta-analysis. *British Journal of General Practice, 59,* e51-60.
Page 17	Point 75. Additional information.	Thombs et al (2012) also identify the possibility of a 'nocebo effect', whereby "verbal suggestions of a negative outcome

		can lead to the development or worsening of symptoms" (p.416). Reference: Thombs, B.D., Coyne, J.C., Cuijpers, P., de Jonge, P., Gilbody, S., Ioannidis, J.P.A. et al. (2012). Rethinking recommendations for screening for depression in primary care. *Canadian Medical Association Journal, 184*(4), 413-418.
Page 18	Implications for research	BACP supports the recommendations outlined by NSC for future research, based on gaps and inconsistencies within the current evidence base.

Name:	Chris Wood	**Email address:**	**xxxx xxxx**
Organisation (if appropriate):	Action on Hearing Loss		
Role:	**Senior Research and Policy Officer**		

Do you consent to your name being published on the UK NSC website alongside your response?

Yes ☒ **No** ☐

Section and / or page number	Text or issue to which comments relate	Comment *Please use a new row for each comment and add extra rows as required.*
Page 4, paragraph 5	"This review does not include…	The National Screening Committee and Public Health England should not exclude groups with other conditions, particularly very common conditions such

	groups identified as being at high risk of depression, for example people with pre-existing long term medical or mental health conditions"	as hearing loss. They should consider the links between hearing loss and mental health problems such as depression, and how important properly diagnosing and managing hearing loss can be to reducing the incidence of depression, particularly given that the criterion on testing for depression is not met, but the test for hearing loss is good value, acceptable and easy to administer, and would reduce the incidence of depression as a result of proper management of hearing loss. One in six people have hearing loss across the UK, and this incidence increases to 71% of over 70 year olds, meaning most older people are affected by hearing loss and its negative impacts. However, people wait on average ten years before they seek help for their hearing loss, and only one third of people who could benefit from hearing aids have them – four million people across the UK, most of whom are older, have not sought help for their hearing loss[1]. The evidence is clear that unaddressed hearing loss leads to communication difficulties, hindering an individual's interaction with friends, family, and colleagues and often resulting in social isolation[2]. Gopinath et al (2012)

[1] Action on Hearing Loss (2011) Hearing Matters, available at: www.actiononhearingloss.org.uk/hearingmatters

[2] Herbst et al (1990) Implications of hearing impairment for elderly people in London and in Wales. Acta Oto-laryngologica. 476: 209-214; Du Feu and Fergusson (2003) Sensory impairment and mental health. Advances in psychiatric treatment. 9: 95-103; Monzani et al (2008) Psychological profile and social behaviour of working adults with mild or moderate hearing loss. Acta Otorhinolaryngologica Italica. 28(2): 61-6; Barlow et al (2007) Living with late deafness: insight from between worlds. International Journal of Audiology. 46(8):442-8; Hétu et al (1993). The impact of acquired hearing loss on intimate relationships: Implications for rehabilitation. Audiology 32(3): 363–81; Gopinath et al (2012) Hearing-impaired adults are at increased risk of experiencing emotional distress and social engagement restrictions five years later. Age and Ageing 41(5): 618–623; Echalier (2010) In it together – the impact of hearing loss on personal relationships. Available at:

		examined more than 800 older hearing impaired people over five years and found that older, hearing-impaired adults were "significantly more likely to experience emotional distress and reduced social engagement restrictions (self-perceived hearing handicap) directly due to their hearing impairment"[3]. As summarised in Arlinger's review of the literature on the negative consequences of uncorrected hearing loss, unaddressed hearing loss "gives rise to disabilities of various kinds" and can "often lead to withdrawal from social activities... this, in turn, leads to reduced intellectual and cultural stimulation, and an increasingly passive and isolated social citizen"[4]. From a study of 73 hearing-impaired subjects and 96 controls, Monzani et al (2008) concluded that "sensory impairment, with its associated disability, may discourage hearing-impaired individuals from exposing themselves to socially challenging situations, producing isolation that leads to depression, irritability, feelings of inferiority"[5]. Extensive research shows that, if it is not addressed effectively, the communication difficulties, isolation and other negative impacts of hearing loss

www.hearingloss.org.uk/~/media/Documents/Policy%20research%20and%20influencing/Research/Previous%20research%20reports/2010/In%20it%20together/In%20it%20Together.ashx National Council on the Aging. (2000) The consequences of untreated hearing loss in older persons. Head & Neck Nursing. 18(1): 12-6;

[3] Gopinath et al (2012) Hearing-impaired adults are at increased risk of experiencing emotional distress and social engagement restrictions five years later. Age and Ageing 41(5): 618–623

[4] Arlinger (2003) Negative consequences of uncorrected hearing loss – a review. International Journal of Audiology 42(2): 17-20

[5] Monzani et al (2008) Psychological profile and social behaviour of working adults with mild or moderate hearing loss. Acta Otorhinolaryngologica Italica. 28(2): 61-6

		lead to an increase in the risk of developing mental health problems, particularly depression[6]. Key evidence shows that older people with hearing loss are 2.5 times as likely to develop depression as their peers without hearing loss[7]. Given the high prevalence of hearing loss, it is therefore a major contributor to depression in older adults. Furthermore, extensive evidence shows that the main way to manage hearing loss, the provision of hearing aids, reduces the risk of developing and the symptoms of depression[8]. One study found that when compared with those who did not wear hearing aids, hearing aid wearers reported benefits that include less sadness, depression, paranoia, worry and anxiety; more social activity and better relationships with their families; better feelings about themselves; improved mental health; greater independence and security[9]. Providing hearing

[6] Eastwood et al (1985) Acquired hearing loss and psychiatric illness: an estimate of prevalence and co-morbidity in a geriatric setting. British Journal of Psychiatry 147: 552–556; Saito et al (2010) Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese. Journal of the American Geriatrics Society 58(1): 93-7; National Council on the Aging. (2000) The consequences of untreated hearing loss in older persons. Head & Neck Nursing. 18(1): 12-6; Cacciatore et al (1999) Quality of life determinants and hearing function in an elderly population: Osservatorio Geriatrico Campano Study Group. Gerontology 45:323-323; Genther et al (2013) Association of Hearing Loss With Hospitalization and Burden of Disease in Older Adults- Journal of the American Medical Association 309(22): 2322; Monzani et al (2008) Psychological profile and social behaviour of working adults with mild or moderate hearing loss- Acta Otorhinolaryngol Ital. 28(2): 61–66

[7] Saito et al (2010) Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese. Journal of the American Geriatrics Society 58(1): 93-7

[8] See for example National Council on the Aging. (2000) The consequences of untreated hearing loss in older persons. Head and Neck Nursing 18(1): 12-6; Acar et al (2011) Effects of hearing aids on cognitive functions and depressive signs in elderly people, Archives of Gerontology and Geriatrics, 52(3): 250-2; Mulrow et al (1992) Sustained benefits of hearing aids. Journal of Speech & Hearing Research 35(6): 1402-5; Goorabi et al (2008) Hearing aid effect on elderly depression in nursing home patients. Asia Pacific Journal of Speech, Language and Hearing 11(2): 119-123; Mulrow et al (1990) Quality-of-life changes and hearing impairment. A randomized trial. Annals of Internal Medicine. 113(3): 188-94; Cacciatore et al (1999) Quality of life determinants and hearing function in an elderly population: Osservatorio Geriatrico Campano Study Group. Gerontology 45: 323-323

[9] National Council on the Aging. (2000) The consequences of untreated hearing loss in older persons. Head & Neck Nursing 18(1): 12-6

		tests and appropriate management, such as through a universal hearing screening programme for adults, would significantly reduce the risk of people developing depression, particularly among older adults.
Page 4, paragraph 6	NICE guidelines on depression	NICE guidelines on depression and public health initiatives, information and guidance should make clear the points raised above on the links between hearing loss and depression, and the impact that improving diagnosis and management of hearing loss could make on the prevalence of depression in older adults.

The following comments have been provided for specific sections of the document.

Royal College of Psychiatrists Consultation Response

DATE: February 13, 2015

Submission of: THE ROYAL COLLEGE OF PSYCHIATRISTS

Submission to: The UK NSC recommendation on Screening for depression in adults

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

The College aims to improve the outcomes of people with mental illness, and the mental health of individuals, their families and communities. In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. Nationally and internationally,the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

We are pleased to respond to this consultation.

For further information please contact the Policy Unit on 0203 701 2541 or e-mail hphillips@rcpsych.ac.uk 2

The following comments have been provided for specific sections of the document.

Royal College of Psychiatrists
Response to: The UK NSC recommendation on Screening for Depression in adults

Thank you for the opportunity to comment on the document appraisal of screening for depression.

Our main concern with this report is that it a priori focuses on general population, which may exclude the groups where screening would have a major clinical impact on NHS care and function. This focus is premature as we are not yet achieving good enough detection in at risk groups.
These groups are in addition to people presenting with symptoms of depression or anxiety disorders, where there is another psychiatric disorder, including learning disability. A high prevalence of depression is common in these groups.

The groups are:

1. People with chronic physical health problems (physical illness), including cancer and neurological, cardiovascular, endocrine and inflammatory conditions.

2. Specific screening in the acute presentation of some conditions such as myocardial infarction and stroke.

3. Any elderly person presenting to A&E or who becomes an inpatient (in addition to a dementia screen).

4. Any repeated attender to general practice.

5. Adolescents presenting to general practice or voluntary sector counselling organisations for nonspecific symptoms related to motivation or cognitive performance.

6. Adolescents who underperform in school compared with their 'usual' standard.

7. NHS staff.

We therefore recommend that the above be taken into account when the research priorities are determined. We would be happy to provide names of UK experts that have a great deal of clinical as well as academic experience in the specified fields.
There is of course an issue with screening instruments in some of the above as symptoms can overlap. However there are some instruments available, and this is an issue that clinicians have contended with for a number of years.3

The following comments have been provided for specific sections of the document.

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We also recommend the insertion of the following clarifications:
Some people do not recognise depressed mood as such and may try to focus on the few hedonic responses that are still present. Since these are two fundamental questions, other questions should also be asked if clinical suspicion is high.

Moderate depression can have a big functional impact. The Patient Health Questionnaire (PHQ -9) is a screening instrument and is not particularly good as a measure of clinical and functional severity.

There needs to be a clear understanding of the difference between comorbid depression and anxiety disorders versus mixed anxiety depression. The first means that the person has diseases that cross the threshold for both anxiety and depressive disorders. The second means that the person has a collection of symptoms whereby s/he would not meet diagnostic criteria for either depressive or anxiety disorders. In the first case prognosis is poorer and people are more likely to have a treatment refractory or a chronic course. We do not know the long term prognosis in the second but at present it generates as much disability as depressive disorder on its own.

The following comments have been provided for specific sections of the document.

Section and / or page number	Text or issue to which comments relate	Comment Please use a new row for each comment and add extra rows as required.
3	The 2010 NSC review focused on a combination of three elements...clinical management of depression was not optimised in the UK in terms of prescribing	Why did the 2010 NSC review not also consider clinical management in terms of psychological treatment? It should also highlight that access to CBT and other psychological treatments is still poor in some areas and for some populations (such as the over 65), despite the introduction of the IAPT program
3	Screening would detect cases at the milder end of the spectrum but it was uncertain whether treatment would prevent progression to more severe depression	Screening would detect cases at the milder end of the spectrum but it was uncertain whether treatment would prevent progression to more severe depression
6		We would like to have seen some mention of other populations at high risk of depression such as older adults in nursing or residential settings where the point prevalence of depression is thought to be at least 40% (Evers et al., 2002).
8-9	The condition should be an important health problem?	The condition should be an important health problem?
13	Estimated point prevalences for depression	Please include point prevalences in older people in non-community settings such as hospital (28%) and residential care (42%) (Gould et al., 2012).
16	Meta-analysis results suggest that many cases of mild depression and any-severity depression are not detected by GPs during routine clinical care. This criterion is met.	Meta-analysis results suggest that many cases of mild depression and any-severity depression are not detected by GPs during routine clinical care. This criterion is met.
20		Older people are particularly vulnerable to incomplete recovery and a chronic course.

		(Mitchell and Subramaniam, 2005)
37-38		Please see WHO-Five Well-being Index as a valid screening tool for depression in nursing homes alongside the GDS (Allgaier et al., 2013).
48-64		There should be an explicit mention of treatment of older adults in a subheading. In particular, that there is emerging evidence that treatments used in younger adults work for older patients but that modification of both pharmacological and psychological approaches may be needed. Also, that cognitive impairment should not preclude treatment (as MMSE is a poor indicator of treatment response (Caudle et al., 2007)).
		Cohen suggests that depression screening in residential homes 'can significantly increase the proportion of depressed dementia patients receiving antidepressants, lead to dose adjustments, diminish potential ethnic biases in treatment, and affect the depressive symptoms of treated individuals' (Cohen et al., 2003). Bern-Klug also suggests that social care practitioners should have a role in residential home screening (Bern-Klug et al., 2010).