CD Summary

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Telephone 971-673-1111
Fax 971-673-1100

cd.summary@state.or.us
http://oregon.gov/dhs/ph/cdsummary

OREGON PUBLIC HEALTH DIVISION • DEPARTMENT OF HUMAN SERVICES

TIME TO SCREEN FOR DEPRESSION

The need to screen and treat depression is gaining a sense of urgency on the national level. While we have not yet reached consensus on universal screening, there are many reasons to consider it. Depression is associated with increased risk for suicide; depression can impede self-management of other chronic diseases. Depression destroys relationships and impedes the ability to work. Populations of special interest include seniors, whose depression is often seen as a "normal part of aging" and returning veterans who are likely to have high rates of depression. *(See below for details on how you can obtain assistance treating veterans.)* Should screening be universal? This *CD Summary* reviews the evidence supporting screening and provides examples of screening resources for use in the primary care setting.

DEPRESSION IS A MAJOR PUBLIC HEALTH PROBLEM

Depression is the second most common chronic disorder seen by primary care physicians; on average, 12 percent of patients have major depression.[1] Depression is the leading cause of disability in the U.S. for ages 15–44.[2] Depression, formally called major depressive disorder, affects approximately 14.8 million American adults, or about 6.7 percent of the U.S. population age 18 and older in a given year.[2] When extrapolated to Oregon, this means that approximately 187,000 Oregon adults have depression. In 2005 almost 5 percent of adult Oregonians reported symptoms consistent with a major depressive episode, and over 20 percent of adult Oregonians noticed feeling down, depressed or hopeless on several days or nearly every day in the preceding two weeks.*

More than half of suicides in Oregon were reported to have been depressed.[3] The lifetime risk of suicide among people with depression is as high as 15 percent. In addition, all cause mortality rate is two to three fold higher among those with depression. Depression is estimated to cost the U.S. $65 billion annually.[4]

Depression also is seen commonly among patients with chronic diseases. The prevalence of depression as a comorbidity for these diseases ranges from 20 percent to nearly 50 percent.[5] Nearly 30 percent of Oregon adults with chronic diseases including arthritis, cardiovascular diseases, and diabetes reported having had depression in the last year. Oregonians with comorbid depression were less likely to have confidence in their ability to self-mange their underlying chronic disease and to engage in several key self-management and health behaviors. They also were more likely to smoke and to be obese which can exacerbate chronic diseases.[3] Depressive disorders also often co-occur with anxiety disorders and substance abuse.[2]

SCREENING

Studies indicate that up to 50 percent of depressed patients are undetected in primary care settings.[6] High risk indicators with depression are summarized in the Table.[1]

A variety of screening instruments are available to detect depression.[1,6] The most common instruments used for adults include the Beck Depression Inventory Scales, the Center for Epidemiological Studies Depression, Geriatric Depression Scales and the Zung self–rating Depression Scales. Each of those instruments contains 20 to 30 questions and usually takes 5 to 15 minutes for patients to complete. Although not sufficient to diagnose depression on their own, these instruments have a sensitivity of 80–90 percent and a specificity of 70–85 percent.

Several variations on these scales exist for specific populations. The Geriatric Depression Scale is specifically developed for use in people older than 60 years. Both the Beck Depression Inventory and the Geriatric Depression Scale have a shorter version. Beck Depression Inventory–PC has only seven items and takes less than five minutes to complete. For those providers looking for a really brief instrument, a simple question, such as "Do you often feel sad or depressed?" may identify a substantial number of depressed patients. For the patients with cognitive deficits, the Cornell Scale for Depression in Dementia or Hamilton Rating Scale for Depression is preferred.

High risk indicators with depression

Adults	Children and adolescents
First degree biologic relative with history of depression	Antisocial behavior
Two or more chronic diseases	Diminished school performance
Obesity	
Chronic pain (e.g. backache, headache)	Excessive weight gain or loss
Experience of trauma or violence	Experience of trauma or violence
Impoverished home environment	Impoverished home environment
Traumatic brain injury	Traumatic brain injury
Financial strain	Aggression
Experiencing major life changes	Agitation or irritability
Pregnant or postpartum	
Socially isolated	
Multiple vague symptoms (e.g. gastrointestinal, cardiovascular, neurologic)	Withdrawal from friends or social activities
Fatigue or sleep disturbance	Fatigue or sleep disturbance
Substance abuse	Substance abuse
Loss of interest in sexual activity	
Elderly age	

*http://www.dhs.state.or.us/dhs/ph/chs/brfs/05/depression.pdf/

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The U.S. Preventive Services Task Force suggests that clinicians screen in ways that best fits their personal preferences, the patient population, and the practice.

Is there a downside to screening? Although there are no empirical data on the harm of screening, potential harms include mislabeling transient distress as depression, the inconvenience of further diagnostic workup following a false-positive test, and the increasing time of consultation in primary care settings.[6]

OTHER ISSUES

There is insufficient evidence to support or argue against routine screening for depression among children and adolescents. The American Academy of Pediatrics recommends that pediatricians ask adolescents questions regarding depression routinely as part of history taking. The American Medical Association recommends screening for depression among adolescents at risk of using drug or alcohol, having family problems, and other risk indicators.[6]

In conclusion, depression should be taken seriously as a disease. Screening and proper care can free patients from a serious and persistent disability that causes great suffering and harm.

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Oregon Veteran Benefits

Depression is common among veterans. It can undermine their transition into civilian life. Veterans have increased health care needs and low paying benefits. Governor Kulongoski recently signed HB 3201, a tax incentive package aimed at providing better health care for Oregon National Guard soldiers and their families. The bill offers a tax credit of $2,500 the first year doctors expand their TRICARE patient load and a $1,000 credit each year thereafter. Contact Linda Peppler at OHSU Office of Rural Health for more information: pepplerl@ohsu.edu, or 503-494-4450.

New Public Health Practices for HIV Reporting

In April 2006, HIV infection became reportable ***by name*** in Oregon. Most reports come from laboratories with only minimal information. Follow-up with physician offices is necessary to get complete case information. In the past, this had been done by state public health staff. In November, local public health departments will begin making these calls. In addition, similar to other reportable diseases, someone from the local health department or the state HIV Program will routinely attempt to interview all patients with newly reported cases of HIV/AIDS to verify case report details and offer services such as partner counseling and referrals to health care.

HOW WILL THIS AFFECT YOU?

This change will primarily affect those clinicians who see many patients with HIV/AIDS in their practice. These physicians may want to work with their local health department staff to develop procedures to minimize reporting burden, such as provision of on-site medical record access to public health staff for purposes of collecting case reports, or designating a single point of contact for calls about HIV/AIDS case reporting.

WHY THESE CHANGES?

We hope to improve timeliness and quality of case reports. The current system of case reporting directly to the State Public Health Division has led to a median reporting delay of more than two months. Because of these delays, offers and acceptance of important public health services such as partner counseling and referral are low. In addition, many local health departments are unfamiliar with the circumstances of incident HIV/AIDS cases in their own jurisdictions.

Please contact your local health department or the state HIV Program at 971-673-0153 for more information.