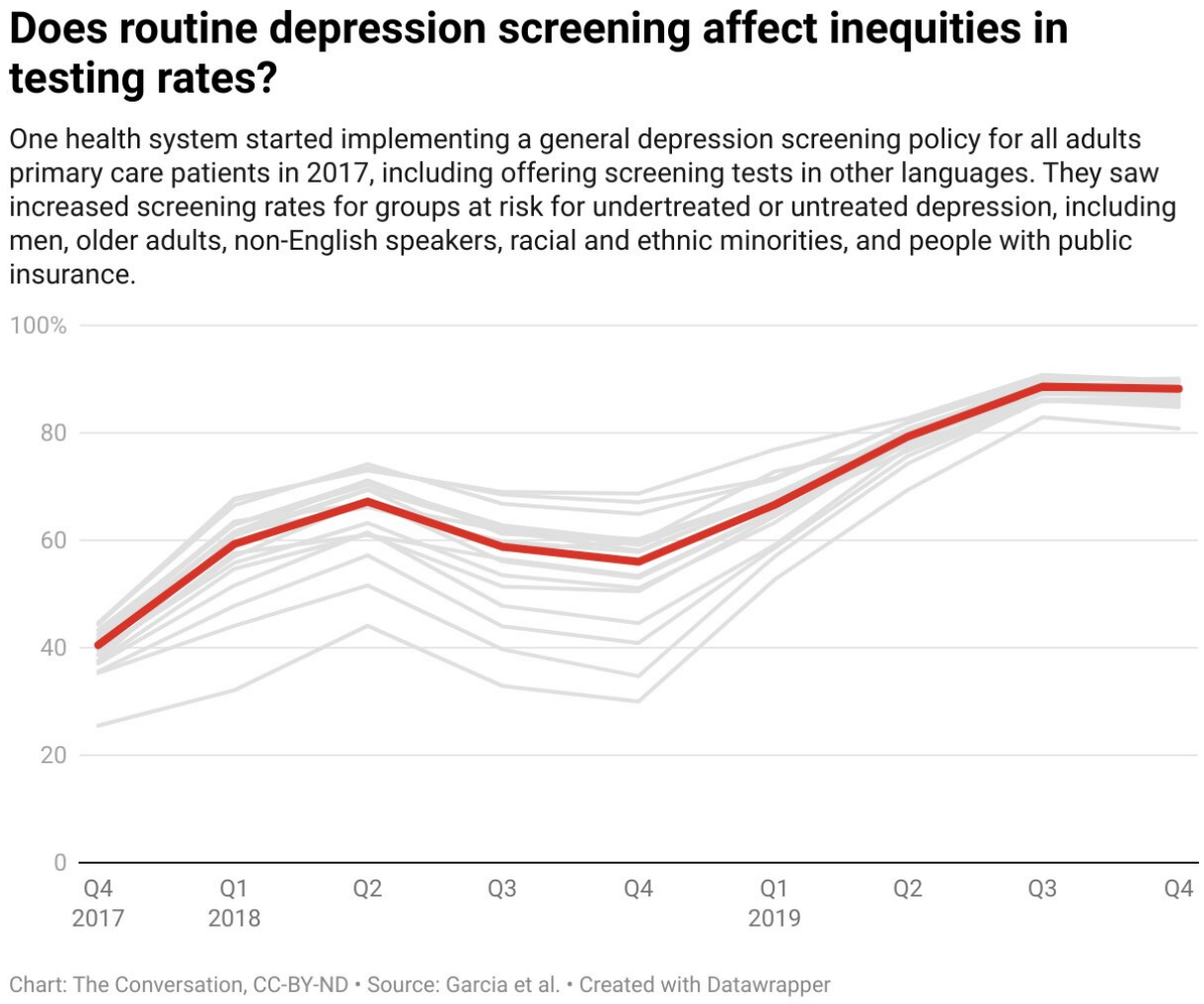
Medical Xpress

Routine screening policy for all adult primary care patients could significantly improve depression diagnosis

November 21 2022, by Maria Garcia



Credit: The Conversation

Depression is a costly and debilitating condition that profoundly influences a person's quality of life. In 2020, more than 21 million adults in the U.S. reported having at least one major depressive episode in the previous year. Depression symptoms increased dramatically during the COVID-19 pandemic, and now affect nearly 1 in 3 American adults.

There are also many disparities in access to depression treatment. Clinicians are less likely to recognize and treat depressive symptoms in certain groups, including racial and ethnic minorities, men, older adults and people with language barriers. These disparities may be driven by poor patient-physician communication about mental health, cultural differences in discussing depressive symptoms, stigma around mental illness and limited available treatment options.

Limited time to discuss mental health symptoms in depth in primary care settings may also contribute to the depression treatment gap. As a researcher and primary care physician focused on improving access to mental health treatment, I have seen many patients struggle to have their depressive symptoms recognized by their clinicians and access quality care. Depression screening often only occurs when a clinician suspects the patient may have depression or when the patient specifically requests mental health care.

But making depression screening a routine practice could help reduce treatment disparities. In January 2016, the U.S. Preventive Services Task Force began recommending depression screening for all adults. In October 2022, given the mental health effects of the pandemic, it extended the recommendation to include screening all adolescents age 12 and up for depression and suicide risk during routine wellness checkups.

In our recent study, my team and I found that implementing universal, routine depression screening for adults in primary care is one way to make detection more equitable.

Depression screening in one large health system

The goal of our study was to evaluate whether the six primary care practices in the University of California, San Francisco health system had adopted routine depression screening for all their adult patients, and whether traditionally undertreated or untreated groups were being screened.

Medical assistants were asked to administer the screening test before patients saw their clinician. The clinician, after reviewing and discussing the results with the patient, could then arrange a follow-up appointment, prescribe a depression medication or submit a referral to a behavioral health specialist.

After two years, we analyzed data for 52,944 adult patients who had an appointment at one of the primary care clinics in that period. Screening rates were initially low—only 40.5% of patients were screened. Furthermore, men, older adults, racial and ethnic minorities, those with public health insurance, and those with language barriers were all less likely to be screened. For example, patients who spoke a Chinese language were almost half as likely to be screened as patients who spoke English.

However, with the UCSF health system's coinciding focus on equity, screening rates increased to 88.8% by 2019. UCSF Health established a task force that met over the course of the project to discuss its progress, share best practices across primary care clinics and actively make adjustments to address screening disparities.

Overall, screening rates dramatically increased over those two years for all groups at risk of having their depression go unrecognized and untreated.

Improving depression care for all patients

Depression is a leading cause of disability worldwide. It can affect a person's ability to manage other chronic conditions, and can lead to worsened disability and earlier death.

Our research found that increasing universal screening efforts can help reach groups that are less likely to be screened and treated for depression. We ensured that screening tools were available in other languages, clinical staff were periodically trained, and screening was integrated with routine clinical tasks. We also made sure that our efforts were aligned with the UCSF health system's priorities, quality improvement efforts and reimbursement policies to reduce the burden of implementation and ensure sustainability.

While depression screening is necessary, it is not sufficient on its own to decrease care disparities for depression. Additional research is needed to see whether improved screening will lead to increased treatment and care engagement among at-risk groups.

Our team's next steps are to evaluate whether a positive screen led to initiation of treatment for depression, and whether all patient groups were equally likely to engage in treatment. Our hope is that the lessons we learned from implementing routine depression screening in our primary care practices can encourage other health care systems around the country to do the same, and help better serve diverse patient populations.

Provided by The Conversation