Why Routine Screening for Depression May be Bad for Your Health

Lisa Cosgrove, PhD
University of Massachusetts-Boston
Conflating screening with assessment

Screening differs from clinical assessment in terms of the **intent** (early detection) and in the **mechanization of the process**: A questionnaire score determines the next steps.

Health care provider using clinical skills to *closely observe* and ask *thoughtful, appropriate questions* about a patient’s experience and current situation.
The push for routine screening for depression can be understood in terms of the discourses and practices that

(1) reify depression as a homogeneous “disease” and

(2) reinforce the uncritical exportation of screening into the mental health field
The discourse of “the pharmaceutical imaginary”

• Understanding emotional distress qua mental illness

• Understanding mental illness qua neurotransmitter dysfunction
The discourse of the “Global Health Burden of Depression” and Disability Adjusted Life Years (“DALYs”)

- recent shift from concerns around calculating rates of diseases, deaths to measuring economic costs of living with a disease; we render nonfatal outcomes calculable

I Nkolas Rose
"Depression is a common mental disorder. Globally, more than 300 million people of all ages suffer from depression. Depression is the leading cause of disability worldwide, and is a major contributor to the overall global burden of disease."

Evangelical QualityEthnocentrism
“Political action is required in light of the present high cost of disorders of the brain. Funding of brain research must be increased.

...The current move of the pharmaceutical industry away from brain related indications must be halted and reversed.

It is essential that not only the EU but also the national governments forcefully support these initiatives.”

Cost of disorders of the brain in Europe 2010, emphasis added
Could there be conflicted drivers of the “Global Health Burden of Depression”? 
“Lundbeck puts depression on the global mental health agenda”

On November 25, 2014, Lundbeck is sponsoring a one-day forum along with The Economist Events to examine the burden of depression as well as a variety of national responses to it, bringing in cross-sector stakeholders who are trying to tackle a problem that has become a leading cause of illness.

<table>
<thead>
<tr>
<th>Article</th>
<th>Conflicts</th>
</tr>
</thead>
<tbody>
<tr>
<td>The economic burden of depression and the cost-effectiveness of treatment (2003)</td>
<td>Unrestricted educational grant from Wyeth Pharmaceuticals</td>
</tr>
<tr>
<td>Depression in the workforce: the intermediary effect of medical comorbidity (2010)</td>
<td>Authors received an honorarium from Bristol-Myers Squibb for writing this manuscript.</td>
</tr>
<tr>
<td>Cost of disorders of the brain in Europe (2010)</td>
<td>Unrestricted financial support from the European College of Neuropsychopharmacology, and H. Lundbeck A/S.</td>
</tr>
<tr>
<td>The societal cost of depression: Evidence from 10,000 Swedish patients in psychiatric care (2013)</td>
<td>Written by 3 employees of AstraZeneca. Other co-authors were on AZ board, and one received speakers fees from AZ.</td>
</tr>
</tbody>
</table>
“Global Burden of Disease estimates of depression—how reliable is the epidemiological evidence?”

Journal of the Royal Society of Medicine · January 2011
Conclusions: “Most studies exhibit significant shortcomings and limitations with respect to study design and analysis….Poor quality data limit the interpretation and validity of global burden of depression estimates. The uncritical application of these estimates to international healthcare policy-making could divert scarce resources from other public healthcare priorities.”
What’s the problem?

• Industry is shaping the discussion of the problem and solutions for it

• This undermines a socio-political understanding of distress
The World Health Day - April 7, 2017
Depression: Let's talk about how we address mental health
UN Special Rapporteur on the right to health,
Dainius Pūras, MD

“The longstanding biomedical tradition of medicalizing various forms of psychosocial distress and human suffering has cast a long shadow over the importance of addressing the social and underlying determinants of health.”
There is a need for a shift in investments in mental health, from focusing on ‘chemical imbalances’ to focusing on ‘power imbalances’ and inequalities.

The excessive use of medications and other biomedical interventions, based on a reductive neurobiological paradigm causes more harm than good, undermines the right to health, and must be abandoned.

The dominant biomedical narrative of depression as a "burden" on individuals and societies is shortsighted and insufficient for developing appropriate responses in policy and in practice.”
2016 Donor List for the American Psychiatric Foundation:

$100,000 and above donors
• Alkermes
• Janssen Pharmaceuticals, Inc.
• Otsuka America Pharmaceutical, Inc.
• Sunovion Pharmaceuticals, Inc.

$50,000 - $99,999 donors
• Allergan
• Eli Lilly & Co.
• Lundbeck U.S.
• Takeda Pharmaceuticals U.S.A., Inc.
The **American Psychiatric Association Foundation** would like to thank the following companies for their membership in the 2016 **Corporate Advisory Council**:

<table>
<thead>
<tr>
<th>FOUNDATION PATRON</th>
<th>PATRON</th>
<th>SUSTAINING MEMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alkermes</td>
<td>ACADIA Pharmaceuticals Allergan</td>
<td>Assurex Health</td>
</tr>
<tr>
<td>Janssen Pharmaceuticals, Inc.</td>
<td>FORUM Pharmaceuticals Inc.</td>
<td>Intra-Cellular Therapies Inc.</td>
</tr>
<tr>
<td>GRAND PATRON</td>
<td>Genomind LLC</td>
<td>Lundbeck</td>
</tr>
<tr>
<td>Eli Lilly and Company</td>
<td>Shire US</td>
<td>Merck &amp; Co.</td>
</tr>
<tr>
<td>Otsuka America Pharmaceutical, Inc.</td>
<td>Sunovion Pharmaceuticals, Inc.</td>
<td>NeuroStar TMS Therapy</td>
</tr>
<tr>
<td>PATRON</td>
<td>Takeda Pharmaceuticals US, Inc.</td>
<td>Pfizer Inc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Purdue</td>
</tr>
</tbody>
</table>
• Concerns about overdiagnosis and overtreatment are increasingly prominent across areas of healthcare. These ideas, however, have gained little traction in psychiatry.

• Opinion leaders in psychiatry focus almost exclusively on undertreatment, especially the undertreatment of depression.
Especially in the US we have Pathology without Normality:

“About 25% of all U.S. adults have a mental illness

Nearly 50% of U.S. adults will develop at least one mental illness during their lifetime.”

A CDC mental-health fact sheet—Mental Illness Surveillance Among U.S. Adults

If abnormality is the new norm, we must constantly engage in surveillance
“Mental Illness Surveillance Among Adults in the United States”

“The economic burden of mental illness in the United States is substantial—about $300 billion in 2002.

Mental illness surveillance by organizations such as CDC is a critically important part of disease prevention and control.”
“Future surveillance should pay particular attention to changes in the prevalence of depression both nationwide and at the state and county levels.”

We are all diseased, pre-diseased, or at risk

We have lost a sense of resilience

What an impoverished philosophy of being, of what it means to be human
“I HAVE BEEN IN SORROW’S KITCHEN AND LICKED OUT ALL THE POTS. THEN I HAVE STOOD ON THE PEAKY MOUNTAIN WRAPPED IN RAINBOWS, WITH A HARP AND SWORD IN MY HANDS.”

ZORA NEALE HURSTON
Health screening recommendations have gone beyond programs to detect early-stage, asymptomatic disease to include “screening” for *presently experienced health problems* and symptoms using self-report questionnaires.
## USPTF Recommendations: 2016

### Recommendation Summary

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade (What's This?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General adult population, including pregnant and postpartum women</td>
<td>The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.</td>
<td>B</td>
</tr>
</tbody>
</table>
However....

• Only 38% of participants in a national sample who had been diagnosed with depression by their doctor were judged in the re-evaluation to have had a major depressive episode in the past year.

• Conclusion: Depression overdiagnosis and overtreatment is common in community settings in the USA.

(Mojtabai, 2013)
Canadian Task Force on Preventive Health Care (CTFPHC), United Kingdom National Screening Committee (UKNSC), and United States Preventive Services Task Force (USPSTF)

We reviewed recommendation statements listed on their respective websites to determine:

• consistency of recommendations

• if recommendations included direct evidence from RCTs that questionnaire-based screening improved health outcomes.

Thombs et al 2017
• Only the USPSTF has made any recommendations for screening with questionnaires for presently experienced problems or symptoms.

• The CTFPHC and UKNSC recommended against screening in all of their evaluations.

• No recommendations identified any RCTs that found direct evidence of benefit from screening.
In the 4 cases where the USPSTF recommended screening, either the CTFPHC, the UKNSC, or both recommended against.

Of 6 RCTs that directly evaluated screening interventions, 5 did not report any statistically significant primary or secondary health outcomes in favour of screening, and 1 trial reported equivocal results.
In the US we screen and intervene
“Integrated Behavioral Healthcare”
Clinical Practice Guidelines We Can(?) Trust
Recommendations for Mild Depression: Step 1

*CPG recommends that, “If a patient with mild depression wishes to try exercise alone for several weeks as a first intervention, there is little to argue against it” (p. 30). Exercise is not included in APA’s “Recommended Treatment Modalities” figure. e.g., guided self help; computerized CBT (Wheeler, Kosterina, & Cosgrove, 2013)

<table>
<thead>
<tr>
<th></th>
<th>U.S.</th>
<th>U.K.</th>
<th>SP</th>
<th>ND</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifestyle</strong></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Low-Intensity Psychological</strong></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Psychotherapy</strong></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Antidepressant Medication</strong></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Psychotherapy Plus Medication</strong></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other Somatic Therapies</strong></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
First-Ever Guideline for Mixed Depression Released

Megan Brooks
May 16, 2017

One third or more of adults diagnosed with major depression have depressions with mixed features and probably would do better taking an antipsychotic than an antidepressant, concludes an international panel of experts.
Guidelines for the recognition and management of mixed depression (May 2017)

• “... we have gathered together a panel of experts on mood disorders to develop a set of guidelines for the recognition and treatment of DMX”

• “Controversy exists as to whether the symptoms of DMX are fully captured by the DSM–5 diagnostic Criteria” (so they expand it to include symptoms such as “insomnia” and “rumination”)
Monotherapy with on-patent 2nd generation APs are recommended as the first-line intervention

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Drug Name</th>
<th>Cost per month</th>
<th>Manufacturer</th>
</tr>
</thead>
<tbody>
<tr>
<td>First-Line</td>
<td>Latuda (lurasidone)</td>
<td>$1055</td>
<td>Sunovion (Sumitomo Dainippon Pharma)</td>
</tr>
<tr>
<td></td>
<td>No generic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First-Line</td>
<td>Saphris (asenapine)</td>
<td>$569.28</td>
<td>Merck Sharp &amp; Dohme B.V./Allergan</td>
</tr>
<tr>
<td></td>
<td>No generic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A cursory review of this ‘guideline’

• No systematic review

• Almost all members of the GDG are psychiatrists – no methodologists

• Expands DSM 5 criteria *without adequate support for the expansion*

• 13/20 panel members have multiple ties to the pharmaceutical companies whose products they endorse

• In 4/7 RCTs cited as evidence the PI was a guideline panel member
• 7/7 studies have at least 1 author who is an industry employee

• 5/7 studies have 100% of authors with ties to the drug companies manufacturing the APs

• 3/7 studies acknowledge industry in study design, interpretation of results, and/or writing of the ms

• 4/7 studies are post hoc analyses

• Does not meet even 1 of IOM’s standards for trustworthy guidelines
Lead Author of new “Guideline” on DMX

Serves on Speaker Bureau for drug company

Founds CME company and develops for profit CME about guideline and drug

Founder and Editor of the journal the guideline is published in

Recommends patented drug manufactured by that drug co. (over $1000 per month)
...and that is why in an era of routine depression screening “integrated behavioral healthcare” may inadvertently play handmaiden to industry

And may be bad for your health