Whom to screen for anxiety and depression: Updated USPSTF recommendations

New guidance is offered concerning anxiety in children, adolescents, and adults. Advantages of particular screening tests are reviewed.

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In September 2022, the US Preventive Services Task Force (USPSTF) released 2 sets of draft recommendations on screening for 3 mental health conditions in adults: anxiety, depression, and suicide risk.[1,2] These draft recommendations are summarized in **TABLE 1**[1-4] along with finalized recommendations on the same topics for children and adolescents, published in October 2022.[3,4]

The recommendations on depression and suicide risk screening in adults are updates of previous recommendations (2016 for depression and 2014 for suicide risk) with no major changes. Screening for anxiety is a topic addressed for the first time this year for adults and for children and adolescents.[1,3]

The recommendations are fairly consistent between age groups. A "B" recommendation supports screening for major depression in all patients starting at age 12 years, including during pregnancy and the postpartum period. (See **TABLE 1** for grade definitions.) For all age groups, evidence was insufficient to recommend screening for suicide risk. A "B" recommendation was also assigned to screening for anxiety in those ages 8 to 64 years. The USPSTF believes the evidence is insufficient to make a recommendation on screening for anxiety among adults ≥ 65 years of age.

The anxiety disorders common to both children and adults included in the USPSTF recommendations are generalized anxiety disorder, social anxiety disorder, panic disorder, separation anxiety disorder, phobias, selective mutism, and anxiety type not specified. For adults, the USPSTF also includes substance/medication-induced anxiety and anxiety due to other medical conditions.

Adults with anxiety often present with generalized complaints such as sleep disturbance, pain, and other somatic disorders that can remain undiagnosed for years. The USPSTF cites a lifetime prevalence of anxiety disorders of 26.4% for men and 40.4% for women, although the data used are 10 years old.[5] The cited rate of generalized anxiety in pregnancy is 8.5% to 10.5%, and in the postpartum period, 4.4% to 10.8%.[6]

The data on direct benefits and harms of screening for anxiety in adults through age 64 are sparse. Nevertheless, the USPSTF deemed that screening tests for anxiety have adequate accuracy and that psychological interventions for anxiety result in moderate reduction of anxiety symptoms. Pharmacologic interventions produce a small benefit, although there is a lack of evidence for pharmacotherapy in pregnant and postpartum women. There is even less evidence of benefit for treatment in adults ≥ 65 years of age.[1]

How anxiety screening tests compare

Screening tests for anxiety in adults reviewed by the USPSTF included the Generalized Anxiety Disorder (GAD) scale and the Edinburgh Postnatal Depression Scale (EPDS) anxiety

TABLE 1

Mental health screening: Summary of USPSTF recommendations[1-4]

	Children/adolescents	Adults (19-64 y)	Older adults (≥ 65 y)	Pregnancy and postpartum
Anxiety	8-18 y B recommendation ≤ 7 y I statement	B recommendation	I statement	B recommendation
Suicide risk	I statement	I statement	I statement	I statement
Depression	12-18 y B recommendation ≤ 11 y I statement	B recommendation	B recommendation	B recommendation

USPSTF, US Preventive Services Task Force.

B recommendation: The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

I statement: The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

TABLE 2

Generalized Anxiety Disorder 2-item (GAD-2)[8,9a]

Over the past 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	+1	+2	+3
Not being able to stop or control worrying	0	+1	+2	+3

If the score is 2 or greater, the patient should be evaluated further.

[a] Based on the original screening tool developed by Spitzer et al. *Arch Intern Med*. 2006.[9]

subscale.[1] The most studied tools are the GAD-2 and GAD-7.

The sensitivity and specificity of each test depends on the cutoff used. With the GAD-2, a cutoff of 2 or more resulted in a sensitivity of 94% and a specificity of 68% for detecting generalized anxiety.[7] A cutoff of 3 or more resulted in a sensitivity of 81% and a specificity of 86%.[7] The GAD-7, using 10 as a cutoff, achieves a sensitivity of 79% and a specificity of 89%.[7] Given the similar performance of the 2 options, the GAD-2 (**TABLE 2**[8,9]) is probably preferable for use in primary care because of its ease of administration.

The tests evaluated by the USPSTF for anxiety screening in children and adolescents ≥ 8 years of age included the Screen for Child Anxiety Related Disorders (SCARED) and the Patient Health Questionnaire–Adolescent (PHQ-A).[3] These tools ask more questions than the adult screening tools do: 41 for the SCARED and 13 for the PHQ-A. The sensitivity of SCARED for generalized anxiety disorder was 64% and the specificity was 63%.[10] The sensitivity of the PHQ-A was 50% and the specificity was 98%.[10]

Various versions of all of these screening tools can be easily located on the internet. Search for them using the acronyms.

Screening for major depression

The depression screening tests the USPSTF examined were various versions of the Patient Health Questionnaire (PHQ), the Center

TABLE 3

Patient Health Questionnaire-2 (PHQ-2)[11]

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	+1	+2	+3
Feeling down, depressed, or hopeless	0	+1	+2	+3

If the score is 3 or greater, the patient should be evaluated further.

for Epidemiologic Studies Depression Scale (CES-D), the Geriatric Depression Scale (GDS) in older adults, and the EPDS in postpartum and pregnant persons.[7]

A 2-question version of the PHQ was found to have a sensitivity of 91% with a specificity of 67%. The 9-question PHQ was found to have a similar sensitivity (88%) but better specificity (85%).[7] **TABLE 3**[11] lists the 2 questions in the PHQ-2 and explains how to score the results.

The most commonly studied screening tool for adolescents is the PHQ-A. Its sensitivity is 73% and specificity is 94%.[12]

The GAD-2 and PHQ-2 have the same possible answers and scores and can be combined into a 4-question screening tool to assess for anxiety and depression. If an initial screen for anxiety or depression (or both) is positive, further diagnostic testing and follow-up are needed.

Frequency of screening

The USPSTF recognized that limited information on the frequency of screening for both anxiety and depression does not support any recommendation on this matter. It suggested screening everyone once and then basing the need for subsequent screening tests on clinical judgment after considering risk factors and life events, with periodic rescreening of those at high risk. Finally, USPSTF recognized the many challenges to implementing screening tests for mental health conditions in primary care practice, but offered little practical advice on how to do this.

Suicide risk screening

As for the evidence on benefits and harms of screening for suicide risk in all age groups, the USPSTF still regards it as insufficient to make a recommendation. The lack of evidence applies to all aspects of screening, including the accuracy of the various screening tools and the potential benefits and harms of preventive interventions.[2,7]

Next steps

The recommendations on screening for depression, suicide risk, and anxiety in adults have been published as a draft, and the public comment period will be over by the time of this publication. The USPSTF generally takes 6 to 9 months to consider all the public comments and to publish final recommendations. The final recommendations on these topics for children and adolescents have been published since drafts were made available last April. There were no major changes between the draft and final versions. JFP

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