National Depression Screening Day: Educating the Public, Reaching Those in Need of Treatment, and Broadening Professional Understanding

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Depression can negatively impact people's lives, disrupting careers, ruining relationships, aggravating physical health, and sometimes even proving fatal. With a I-year prevalence of 10.3% and a lifetime prevalence of 17.1%,' the illness is quite common. Unfortunately, only about 45% of those who meet the clinical criteria for the disorder receive treatment, and only 20% receive treatment from a mental health care provider.[2]

This disparity between prevalence and diagnosis and treatment led to the creation of National Depression Screening Day (NDSD), which will take place this year on October 5. Health screenings for other illnesses have been commonplace since the mid-1950s. We routinely hear about them for glaucoma, high blood pressure, and various cancers. Until the first NDSD was held in 1991, however, a large-scale screening for a mental disorder had never been attempted, even though depression meets many of the criteria for a large-scale screening as put forth by the World Health Organization.[3] For example, depression is widespread and treatable, and it is often not evident to the affected individual that he or she has an illness. In addition, intervention early in the course of the disorder is advantageous, an appropriate screening instrument with good performance exists; and the cost and burden of conducting the screening are not high.

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NDSD: ITS DEVELOPMENT AND PURPOSE

In the fall of 1990, I held a trial screening for depression at a hospital in the Boston area. This event attracted more than 90 people; 57% scored positive for depression, and of them 79% had never been in treatment. Three people were emergently hospitalized. This trial screening both educated the public and helped many individuals with previously undiagnosed depression to connect with mental health care providers in order to receive treatment.

Using the 1990 trial screening as a model, I submitted a proposal to the American Psychiatric Association suggesting that a free I-day screening program for depression be held during Mental Illness Awareness Week. It was accepted, and NDSD was born. The basic model for this screening is:

- The NDSD Project office recruits mental health facilities nationwide to conduct screening programs locally.
- The NDSD Project office provides each participating site with a detailed procedure manual describing how to conduct a screening,5 and a kit containing screening forms, brochures, videos, posters, and flyers; it also lists participating sites on a toll-free Site Locator Line. (This line is active during the month prior to NDSD and allows people who want to attend a screening to call and locate a site in their area.)
- The NDSD Project office conducts a national publicity campaign; individual facilities are responsible for contacting local media.
- Members of the public arrive on the day of the screening, are greeted, and are given a screening form that contains several demographic questions and a test for depressive symptoms. All screenings are free and anonymous.

- Attendees complete the screening form and give it to screening facility personnel for scoring.
- A mental health professional delivers an educational lecture and answers any questions while the forms are being scored.
- Attendees meet individually with a mental health professional to review the screening form and, if appropriate, to receive referral information about local community resources.
- Videos on depression run continuously while people are waiting to be called for interviews.
- A resource table is available with many different brochures and informational resources.

As a clinical screening event, NDSD aims to identify those individuals who are unaware that they are suffering from a treatable medical illness and to refer them for treatment. Educationally, NDSD serves to call attention to the illness on a national level and to educate the public about its symptoms and treatments. In 1994 nearly 82,000 people attended screenings at more than 2000 sites; 67,000 were individually screened. Sites included private psychiatric hospitals, general hospitals, outpatient medical clinics, libraries, malls, corporations, and military bases. Some 110,000 people called the Site Locator Line. NDSD sponsors now include the American Psychiatric Association, the National Institute of Mental Health, the Harvard Medical School Department of Psychiatry, McLean Hospital, the American Association of Retired Persons, the National Depressive and Manic-Depressive Association, the National Mental Health Association, and the National Alliance for the Mentally **III.**

The media coverage of NDSD has included articles in such publications as *Parade, USA Today,* and the *New York Times* and televised segments on national programs such as *Good Morning America, Today,* and *CBS This Morning.* In 1994 approximately 5000 stories appeared in local and national print media, and millions of people heard about NDSD on radio and television. This extensive coverage has allowed NDSD to fulfill two of its primary goals-to call attention to the illness of depression on a national level, and to educate the public about its signs, symptoms, and treatments.

RESEARCH FINDINGS

Unexpected and exciting by-products of the educational and screening component of NDSD have been the research findings. The National Institute of Mental Health analyzed more than 40,000 screening forms from past NDSDs. The sociodemographic breakdown from 1992 revealed that 66.1 % of those screened were female, 44.2% had at least a high school education, 53.3% were married, 44.4% were employed full time, and 40.3% were not employed at all; 76.6% of those screened scored positive for depression. With respect to treatment history, 61.2% had never been in treatment for depression, 14.9% were in treatment at the time of the screening, and 23.6% had been in treatment in the past.

The most surprising finding emerged from an analysis of the symptoms that the attendees reported. Currently, we know that depression is underdiagnosed for a number of reasons, including the fear of being stigmatized, the difficulty in determining that one is suffering from an illness, and the nature of the illness (e.g., components of self-blame, feelings of worthlessness, and helplessness). Because depression is hard to diagnose, it often goes undetected until it has already caused so much impairment-physical, social, and functional-that the person is somehow brought to the attention of a health care provider. Although most clinicians would certainly recognize a depressive episode at this point in the course of the illness, our results indicate that there are other times when symptoms may not be recognized as clinically significant when, in fact, they are.

The NDSD findings revealed a predominance of psychological symptoms, rather than the typical physical ones, in people who scored positive for depression. The five most frequent symptoms were: having difficulty doing things done in the past, no longer enjoying activities that were once enjoyable, feeling hopeless about the future, having trouble making decisions, and feeling worthless and not needed.[6],7 These symptoms were present in 91% of people whose scores indicated moderate or severe depression. In contrast, only about half said they had ~ll the physical symptoms of depression, including insomnia and loss of appetite. Getting tired for no reason was the number one physical complaint, occurring in 79% of those whose scores indicated moderate or severe depression. A little more than half of those who scored positive for depression reported having trouble sleeping through the night (traditionally a telltale sign of depression) and eating less than they used to. But approximately 44% of the people who reported significant impairment in their daily functioning had little or no trouble sleeping.

These data are important because the psychological symptoms listed above may not elicit the appropriate concern in patients, their health care providers, their family members, or their coworkers because the expected physical symptoms are not sufficiently disabling to warrant attention. They are also important because they remind us that *physical* symptoms need not be present for a diagnosis of major depression.[8] In fact, the most dreaded symptom of depression, thoughts of death or suicide, is psychological.

IMPLICATIONS FOR DIAGNOSIS AND TREATMENT

How do these findings relate to our understanding of the nature of major depression? Our current biological theories stress the significance of somatic symptoms. Hirschfeld and Goodwin[9] noted, "Perhaps the most characteristic abnormalities associated with depression are disturbances in regulation of basic bodily functions. These include problems with sleep, such as difficulty falling asleep and middle-ofthe-night or early-morning awakening .... Changes in appetite are frequent, most often a loss of appetite and weight, but in some forms a substantial increase in both." As the NDSD data demonstrate, this is not always the case.

In our attempt to stress the significance of somatic symptoms when assessing the severity of depressive illness (often in order to convince a skeptical public that depression deserves the label "illness"), we may have lost sight of the significance of psychological symptoms. In fact, we may have discouraged individuals who are plagued primarily with psychological symptoms from self-identifying their illness. This, in turn, may inhibit people from bringing themselves to the attention of a mental health professional, allowing the cycle of hopelessness and apathy to continue. Since our goal is to diagnose and treat all cases and types of depression, we may have to look beyond the common divisions of mild, moderate, and severe-and beyond the common categories of depressive disorders in general. We are investigating the possibility that there are two types of major depression, one with a predominance of physical symptoms and another with a predominance of psychological ones.

FUTURE DIRECTIONS

To address some of these questions, NDSD has started to expand in several directions. One of the most crucial to understanding the effectiveness of a community-based screening such as NDSD is the NDSD Follow-up Study currently under way. One hundred NDSD sites comprising a mixture of academic centers and private psychiatric hospitals were provided with special screening forms that allowed participants to write down their first name and telephone number if they were willing to participate in a brief anonymous follow-up interview by telephone. The interviews are being conducted in the evening by trained research assistants.

The questions are geared toward establishing whether participants who received a referral from a clinician at the screening remember or understood that they had been referred; whether they have followed through on the referral, and if not, why; and whether they were consequently diagnosed with depression or some other disorder. The demographic information collected at the time of the screening is also being confirmed. We hope that this study will provide information about the long-term effectiveness of the program and how well it serves to move people in need into treatment.

Another expansion of community-based screening for depression has been the establishment of the Employee Telephone Access Program. This program, developed for NDSD by the Harvard Medical School Telepsychiatry Project, [10] is an interactive computerized system being marketed to large employers as a way to provide employees and their family members with the opportunity to take a free anonymous screening for depression via touch-tone telephone. The program offers immediate feedback to the caller regarding the results of the screening, with specific referral instructions furnished by the sponsoring company. The service is available 24 hours a day during a 3-month period. Groups of companies working through a single referral source (such as employee assistance programs or managed health care corporations) are also being encouraged to participate. The program is being offered for the first time from October through December 1995.

Yet another direction for NDSD has been the application of its education and screening model to other illnesses. The model has already been successfully applied to anxiety disorders: the second National Anxiety Disorders Screening Day took place on May 3, 1995. A similar education and screening project for eating disorders is scheduled to be implemented on college campuses in February 1996, and a proposal to create a screening program for alcoholism is being developed.

Now that the National Depression Screening Day Project has proven successful and the model is being applied to other disorders, a parent organization has been formed. The National Mental Illness Screening Project is a nonprofit organization developed in an effort to coordinate nationwide mental health screening programs and to ensure cooperation, professionalism, and accountability in these screenings. It has a distinguished board of directors, including Joseph Coyle, MD, Harvard Medical School; Leonard Freedberg, MD, Newton-Wellesley Hospital; Mary Guardino, Project Director, National Anxiety Disorders Screening Day; David Herzog, MD, Harvard Eating Disorders Center; Jerrold Rosenbaum, MD, Massachusetts General Hospital; Sheldon Rutstein, former Chief Financial Officer, Raytheon Corporation; Melvin Sabshin, MD, American Psychiatric Association; and Myrna Weissman, PhD, College of Physicians and Surgeons of Columbia University.

In the future NDSD will have the opportunity to reach even more people and to begin answering some important questions. This October 5, NDSD celebrates its fifth anniversary as mental health professionals and caring volunteers once again join together to educate the public about depression, reach those in need of treatment, and broaden professional understanding.

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