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Routine Depression Screening for Patients With Diabetes

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In Reply

Dr Thombs provides an opportunity to further clarify the consensus in the field of type 1 diabetes for routine depression screening of patients, especially in pediatrics. We share Thombs' commitment to RCTs, especially RCTs to provide evidence-based treatments for conditions such as depression. Thombs is correct; neither our Viewpoint nor the ADA guidelines¹ that recommend depression screening are based on RCT evidence.

Meta-analyses across studies of patients with type 1 and type 2 diabetes have documented that depression is consistently associated with increased risk of poor self-management, poor glycemic control, and diabetes complications.² Furthermore, Roy et al³ have demonstrated that black patients with type 1 diabetes who had elevated depressive symptom scores were 3 times as likely to progress to proliferative diabetic retinopathy during 6 years of follow-up compared with those with low depressive symptom scores. There is strong and consistent evidence that depression is an important risk factor for poor health outcomes in patients with diabetes.⁴

Given this well-documented association between depression and poor diabetes outcomes, we are concerned about the ethics of RCT designs used in screening for diabetes-associated depression. How would an RCT of depression screening be carried out? Would one enroll patients who first had to consent to be randomized to a depression-screening condition or to a no-depression-screening condition? Given the well-documented association between depression and poor diabetes outcomes, is this ethical? Thombs asserts that depression screening would "unintentionally harm some patients"; however, though we understand the nocebo effect is always a risk in any screening project, it is not clear to us how this risk would outweigh the benefits of depression screening.

We emphasize that there are effective, evidence-based treatments from RCTs for clinical depression and for subclinical "diabetes distress"⁵ when detected, and treatment is associated with improved outcomes. Thombs raises the question of the cost of depression screening. A short survey (or even a single question⁵) has minimal cost compared with the

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complications of diabetes associated with untreated clinical depression or subclinical distress, but we would welcome such a study. With respect to cost, data document that depression among people with diabetes is associated with increased health care use and expenditures, irrespective of age, sex, race/ethnicity, and health insurance status.⁶

In summary, we find that data clearly show that mental health comorbidities are a serious risk to poor health outcomes in diabetes, yet screening for depression and appropriate referral are far from the norm. We suggest that psychological screening, especially for depression, is important for optimal health and quality of life among patients with diabetes.

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