CMAJ OPEN HIGHLIGHTS

Poor quality evidence supports latest depression guideline

The Canadian Task Force on Preventive Health Care has a guideline on screening for depression among adults 18 years of age or older at average or high risk for depression. This systematic review provides the evidence used to update this guideline and evaluates the literature on the effectiveness of screening for depression in adults.

The search covered the period 1994 to May 23, 2012, using several electronic databases. Randomized controlled trials, observational studies and systematic reviews with evidence for the benefits or harms of screening for depression were eligible for inclusion. Two people screened articles for relevance, extracted data, analyzed risk of bias and assessed quality. Meta-analysis was carried out using the generic inverse variance method. The authors used the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system to determine confidence in the effect.

Five quasi-experimental studies (before–after design with a nonrandomized control group) met the inclusion criteria for this review. These studies reported on the effect of community-based screening for depression, with follow-up on the risk of suicide completion, for older residents in regions of rural Japan with high suicide rates. Meta-analysis showed that the screening program had a protective effect on the overall incidence of suicide completion (ratio of rate ratios [RRR] 0.50, see Figure 1). The overall GRADE rating applied to this evidence indicated very low quality.

The authors concluded that there is very limited research evidence about the effectiveness of screening for depression in either average-risk or high-risk populations. **See *CMAJ Open* 2013. DOI:10.9778/cmajo.20130030**

Study	Log RRR	SE	Weight (%)	RRR (95% CI)
Oyama et al.[17]	–1.23	0.43	21.5	0.29 (0.13–0.68)
Oyama et al.[19]	–0.31	0.41	23.2	0.73 (0.33–1.64)
Oyama et al.[20]	–0.19	0.38	26.0	0.83 (0.39–1.74)
Oyama et al.[18]	–0.99	0.68	9.9	0.37 (0.10–1.41)
Oyama et al.[21]	–1.07	0.46	19.4	0.34 (0.14–0.84)
Overall (I^2 = 21%)			100.0	0.50 (0.32–0.78)

Test for overall effect: $Z = 3.06$ ($p = 0.002$)

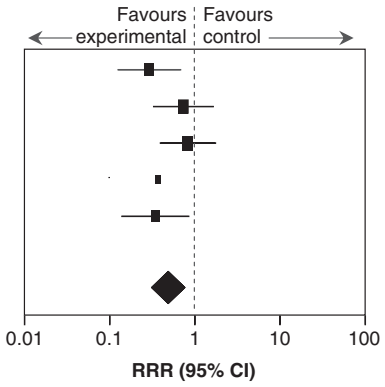

Figure 1: Meta-analysis of the effect of community-based suicide prevention programs, including screening for depression, on suicide rates reported in cohort studies. CI = confidence interval; RRR = ratio of rate ratios (rate ratio for intervention divided by rate ratio for control), where RRR less than 1.0 indicates a benefit of suicide prevention programs; SE = standard error.

Building the BETTER trial

In this article, the authors describe how they collected and harmonized guidelines to help design the intervention to be used in the Building on Existing Tools to Improve Chronic Disease Prevention and Screening in Family Practice (BETTER) randomized controlled trial. The aim of the BETTER trial is to improve the primary prevention of and screening for multiple conditions (diabetes, cardiovascular disease, cancer) and some of the associated lifestyle factors (tobacco use, alcohol overuse, poor nutrition, physical inactivity).

The authors identified clinical practice guidelines and tools through a structured literature search. From these guidelines, recommendations were extracted for use in the BETTER trial. End-users (family physicians, nurse practitioners, nurses and dieticians) were engaged in reviewing the recommendations and tools, as well as tailoring the content to the needs of the BETTER trial and family practice.

In total, three to five high-quality guidelines were identified for each condition; from these, high-grade recommendations for the prevention of and screening for chronic disease were identified. The guideline recommendations were limited by conflicting recommendations, vague wording and different taxonomies for strength of recommendation. There was a lack of quality evidence for manoeuvres to improve the uptake of guidelines among patients with depression. The authors developed the BETTER clinical algorithms for the implementation plan. Although it was difficult to identify high-quality tools, 180 tools of interest were identified.

The results of the trial, published in the journal *BMC Family Practice* showed that a prevention practitioner using the BETTER tools improved the number of preventive actions patients received. **See *CMAJ Open* 2013. DOI:10.9778/cmajo.20130040**