The Case Against Screening Cancer Patients for Distress

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The push for screening cancer patients for distress is driven by the self interests of professional groups, not the strength of scientific evidence.

Benefits of screening for patient outcomes have not established.

We need to demand evidence, not sloganeering about "emotional distress being the sixth vital sign" or "stamping out distress."
The label "distress" represents Anglo-American linguistic imperialism and will get lost in translation.
Implementing screening for distress involves adopting a distress paradigm for supportive services that will have unintended consequences.
Should cancer patients have access to yoga?

….Even if the average cancer patient does not achieve a reduction in distress from doing yoga?
Should psychiatrists be the ones to offer counseling for spiritual issues?

Should patients who want to talk to clergy first have to go through a mental health specialist or nurse specialist?
Should cancer patients with transportation or parking problems have to be screened by a mental health professional or nurse specialist to get them resolved?
Implementation of screening

Has not been shown to improve patient outcomes.

Involves reworking of pathways from patients to psychosocial services.

Involves reconceptualization of provision of support in terms of billable procedures or “sessions” with professionals.

Has unintended consequences including forcing the cancer experience into the mold of a mental health issue.
Screening for distress defined

- Involves the use of distress thermometer or screening instrument to identify cancer patients who are distressed, but who have not already been recognized by healthcare providers.

- Patients identified as distressed need to be further assessed and, if appropriate, offered treatment.
Screening for distress is potentially useful only to the extent that it improves patient outcomes beyond any detection and treatment that is already provided as part of existing standard care.

To be successful, a screening program must identify a significant number of distressed patients who are not already recognized, engage those patients in treatment, and obtain sufficiently positive treatment results to justify costs and potential harms from screening.
What screening is not

Definition excludes settings in which patients complete screening items or questionnaires and their responses are then used to structure discussions with professionals or peer counselors, regardless of whether the patients meet pre-established thresholds for distress.

Definition excludes situations in which a questionnaire is used to facilitate a conversation independent of patients’ level of distress.
The Basic Comparative Evaluation of Screening

- All patients screened for distress. Patients screening positive according to some set criteria receive a follow up interview, in which nature of distress is evaluated, and a service is provided or a referral is made.

**Versus**

- Patients are informed about same services and have ready access to them by self-referral or clinician referral without regard to level of distress.
No study has ever shown that patients screened for distressed have better outcomes than patients having the same access to discussions with staff and services without being screened.
Proponents of screening make unrealistic claims about

Prevalence of psychiatric disorder among cancer patients
Proponents of screening make unrealistic claims about trajectories of distress.
Proponents of screening make unrealistic claims about Performance of screening instruments
The HADS Should Not Be Used

Coyne JC, van Sonderen E: The Hospital Anxiety and Depression Scale (HADS) is dead, but like Elvis, there will still be citings. Journal of Psychosomatic Research 73:77-78
Depending on the context, mandated screening for distress may

- Increase inappropriate prescription of psychotropic medication in the absence of adequate diagnosis and follow up.
- Disrupt patients readily accessing services on their own by consuming scarce resources and requiring patient psychiatric evaluation for patients who screen positive.
- Increase health disparities.
What we can learn from literature concerning screening for depression in medical settings
Rethinking recommendations for screening for depression in primary care

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Conclusions of Review

- No trials have found that patients who undergo screening have better outcomes than patients who do not when the same treatments are available to both groups.
- Existing rates of treatment, high rates of false-positive results, small treatment effects and the poor quality of routine care may explain the lack of effect seen with screening.
- Developers of future guidelines should require evidence of benefit from randomized controlled trials of screening, in excess of harms and costs, before recommending screening.
Screening must be delivered in a well functioning total system if it is to achieve the best chance of maximum benefit and minimum harm. The system needs to include everything from the identification of those to be invited right through to follow-up after intervention for those found to have a problem.
Evidence whether screening for depression is effective should be distinguished from evidence whether collaborative care depression management interventions improve depression outcomes over routine care.
So far, only one documented attempt to introduce screening *and* provide collaborative care on the basis of screening in a clinical setting.
Screening for depression in high-risk groups: prospective cohort study in general practice

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**Background**
Currently only about half of the people who have major depressive disorder are detected during regular health care. Screening in high-risk groups might be a possible solution.

**Aims**
To evaluate the effectiveness of selective screening for major depressive disorder in three high-risk groups in primary care: people with mental health problems, people with unexplained somatic complaints and people who frequently attend their general practitioner.

**Method**
Prospective cohort study among 2005 people in high-risk groups in three health centres in The Netherlands.

**Results**
Of the 2005 people identified, 1687 were invited for screening and of these 780 participated. Screening disclosed 71 people with major depressive disorder: 36 (60.7%) already received treatment, 14 (19.7%) refused treatment and 4 individuals did not show up for an appointment. As a final result of the screening, 17 individuals (1% of 1687) started treatment for major depressive disorder.

**Conclusions**
Screening for depression in high-risk populations does not seem to be effective, mainly because of the low rates of treatment initiation, even if treatment is freely and easily accessible.

**Declaration of interest**
None.
1,687 primary care patients deemed to be at high risk of depression were sent a screening questionnaire and invited via a letter signed by their GP to participate by completing and returning the questionnaire.

780 returned the screening questionnaire (PHQ-9).

226 screened positive (29%).

Total of 173 positive screens were assessed with a diagnostic interview, and 71 cases of major depression were detected.
Of these 71 cases, 36 were already being treated for depression and 18 declined treatment or did not attend their appointment.

Only 1% (17 of 1,687) of patients eligible for screening initiated depression treatment.
Put another way, the number needed to screen in order to treat one patient was about 100.

Based on a published estimate that approximately 1 in 7 patients treated in primary care will do better than those not being treated, approximately 700 people would need to be approached for screening in order to improve one patient clinically.
Can we assume that screening will benefit patients?

We know of no clinical trial in which patients screened for depression had better depression outcomes than patients who were not screened when the same depression treatment resources were available to both screened and non-screened patients, as would be the case in actual primary care settings.
Dodging the basic question

Increasingly advocates of screening have the resources to test whether it improves outcomes over routine care, but dodge the question by excluding a routine care control.

“Previous work has already established the feasibility of screening in cancer settings, and the superiority of screening with triage to screening without triage (Carlson et al, 2010), so it seemed somewhat unethical not to offer some form of triage” (Carlson et al, BJC, 2012).
American Mandated Screening Practices

A $10 million grant from Pharma to a psychologist financed development of quality indicators to be used to monitor medical records of oncologists.

Oncologists will not be able to close their medical records until they have indicated whether they have queried a patient concerning distress.
American Mandated Screening Practices

If they indicate “yes,” they must indicate what was done to address the distress.

Oncologists can meet standards by simply asking if a patient is distressed and offering a prescription for antidepressants if they get a "yes".

Casual prescription of antidepressants to cancer patients who are not depressed and without patient education or follow-up is already a highly prevalent problem in American cancer care.
Screening for distress should be cautiously recommended for well resourced settings, not mandated!

Be prepared for on intended consequences.
Alternatives to screening

• Enhanced support, access to services, and follow up for patients already known to be distressed or socially disadvantaged.

• Provide ready access for patients to discuss unmet needs with professional and peer counselors regardless of level of distress.

• Increase resources for addressing health disparities in access to psychosocial services.
Give patients time to talk and listen to them, don't let screening for distress get in the way.

Don't require cancer patients to interact through computer touchscreen assessments.

Do give them the opportunity to talk about their experiences, their needs, their concerns, and their preferences regardless of their level of distress.
It's important that policy decisions with significant clinical implications be informed by good evidence, not politics, marketing, sloganeering, and lobbying.
Thank you!