

Section W: Depression Screenings in Dental Programs

Preface

Over the past 20 years, dental healthcare professionals have increasingly participated in an integrated delivery system consisting of primary care providers, pharmacists, behavioral health providers, and other health care professionals. In Indian Health Service (IHS) and IHS-funded tribal programs, such an integrated delivery model is even more necessary due to the co-location of health services and the multiple co-morbidities of our patients. This clinical guideline provides recommendations for IHS, Tribal, and Urban (I/T/U) dental programs in screening patients for depression in a dental setting.

Background

Depression (major) is a significant and debilitating disorder that is present in up to 10% of all patients in a primary care condition and perhaps in as many as 20% of patients with chronic illness.¹ Depression is a major contributor of suicide, and at a rate of 16.93 per 100,000, the suicide rate for American Indians/Alaska Natives of all ages is 33% more than the overall U.S. rate and even more significant in adults and adolescents under the age of 24 years.² Dental health professionals, as primary care providers, may be the first providers in a health system to identify depression. In one study in 2002, approximately 45% of individuals who later committed suicide made contact with a primary care provider in the month preceding their death.³ Major Depressive Disorder (MDD) may affect as many as 20.9 million adults per year in the U.S. and up to 25% of people will experience MDD in their lifetime.⁴

Not only should dental health care professionals worry about depression from an overall health perspective, but also because mental health has a direct relationship with oral health status and oral health outcomes. The presence of uncomfortable chewing problems or speaking difficulties associated with poor oral health are associated with stress, depression, and even suicidal ideation.⁵ Similarly, the more depressed patients were, the more decayed teeth they had, the fewer restored teeth they had, the less saliva they had, the worse poor oral hygiene they reported, and the worse self-reported oral health status they reported, all conditions that led to even more disease.⁶ These physiological consequences of depression – leading to xerostomia, cariogenic diet, impaired immune function, increased oral infections – start a cascade of events that results in further detriment in the oral cavity.⁷

U.S. Preventive Services Task Force (USPSTF)

The USPSTF recommends that providers, including dental providers, screen both adults⁸ and adolescents⁹ for depression, providing an overall grade of “B” for this recommendation. Below is an explanation of the recommendations used by USPSTF.

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	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.	Offer or provide this service.
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer or provide this service for selected patients depending on individual circumstances.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
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.	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

In making these recommendations, the USPSTF notes risk factors in adults including “disability and poor health status related to medical illness, complicated grief, chronic sleep disturbance, loneliness, and history of depression. Risk factors during pregnancy and postpartum include poor self-esteem, childcare stress, prenatal anxiety, life stress, decreased social support, single/unpartnered relationship status, history of depression, difficult infant temperament, previous postpartum depression, lower socioeconomic status, and unintended pregnancy.”⁸ For

children and adolescents, some of the risk factors noted by the USPSTF include “female sex; older age; family (especially maternal) history of depression; prior episode of depression; other mental health or behavioral problems; chronic medical illness; overweight and obesity; and, in some studies, Hispanic race/ethnicity. Other psychosocial risk factors include childhood abuse or neglect, exposure to traumatic events (including natural disasters), loss of a loved one or romantic relationship, family conflict, uncertainty about sexual orientation, low socioeconomic status, and poor academic performance.” It is important to note, according to the USPSTF, that the evidence on depression screenings in children ≤ 11 years is insufficient.

Depression Screening Tool

The Patient Health Questionnaire – 9 (PHQ-9) is a nine-question depression screening tool created in 2001, with a sensitivity and specificity of 88%.¹⁰ The PHQ-2, comprising the first 2 items of the PHQ-9, asks about the degree to which an individual has experienced depressed mood and anhedonia over the past two weeks. Its purpose is not to establish final diagnosis or to monitor depression severity, but rather to screen for depression. Patients who screen positive should be further evaluated by a primary care provider (medical provider) and/or behavioral health provider with the PHQ-9 to determine whether they meet criteria for a depressive disorder.¹¹

The tool itself is as follows:

(Adults): Over the last 2 weeks, how often have you been bothered by any of the following problems? (use “X” to indicate your answer)

	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

(Adolescents/note slight change in the second question): Over the last 2 weeks, how often have you been bothered by any of the following problems? (use “X” to indicate your answer)

	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, irritable , or hopeless	0	1	2	3

IHS Dental Depression Screening Pilot Project

From September 2016 to April 2017, 12 IHS and Tribal dental programs representing nine of the 12 IHS Areas participated in a demonstration project to assess the viability of conducting depression screenings in a dental setting. These facilities were nominated by Area Dental Officers for inclusion in the project and received no funding for their voluntary participation. While three of the facilities already had some type of depression screening already in place, the results of this six-month project were overwhelming: over a 1,200% increase in the number of patients screened in a dental setting for depression (from 1,064 to 14,536), and a 382% increase in the number of patients referred from a dental setting to a primary care or behavioral health provider due to a positive depression screening (from 23 to 111).

Recommendations

The IHS Division of Oral Health recommends that IHS, Tribal, and Urban dental programs screen all patients ≥ 12 years for depression at least once annually using the scored PHQ-2 form.

- Frequency: Annually
- Ages: 12 years and over
- Form: PHQ-2 Scored, Adult & Adolescent versions
- Referral: When the patient has an overall score of 3 or higher

Communicating with Behavioral Health & Primary Care

Prior to commencing depression screenings, it is imperative that the dental team communicate intentions with behavioral health program and primary care to discuss the implementation of depression screenings in dental, the referral process, and the anticipated additional workload for behavioral health or primary care. With our demonstration sites, some programs preferred an initial referral from dental to the primary care provider, while others opted for a referral directly from dental to behavioral health providers. In either case, a warm handoff from dental, where the dental staff walks the patient over to medical/behavioral health, seems to have the highest probability for further evaluation.

Communicating with Patients

In many facilities, patients are accustomed to dental providers asking questions related to overall health, medication history, and even sometimes behavioral health (alcohol and substance abuse, domestic violence, etc.) history. However, in other facilities, such questions may seem to be

intrusive to the patient and community. Dental providers should inform patients (and the community) that, in an effort to work in the health care team and provide optimal health care to the patient, they will screen the patient for depression. Most patients will allow the PHQ-2 to be administered by the dental provider or dental assistant/receptionist.

Who Should Administer the PHQ-2 in Your Clinic?

Each program must determine the responsibilities of each dental staff related to depression screenings. In some of the demonstration sites, the screening form was handed to the patient along with the patient health questionnaire (and in several instances, the two questions were actually added to the IHS 42-1, Dental Patient Medical History Form) by the dental receptionist or dental assistant, and the dental provider (dentist or dental hygienist) would evaluate the form, ask any follow-up questions of the patient, and make a determination as to whether or not the patient should be referred to a primary care provider and/or behavioral health provider (for scores 3 and over on the scored PHQ-2). It is up to each clinic to determine who will ask the patient the questions, whether it will only be through a written self-reported form or be asked verbally, and how a positive response will be followed. Dental providers should seek assistance from the primary care and behavioral health providers in setting up depression screenings initially.

Documentation and Coding

Each program in the demonstration pilot project documented and coded depression screenings slightly different from one another. Several programs documented depression screenings in both the dental record (electronic or paper) as well as the IHS Electronic Health Record, while others utilized a paper Government Performance and Results Act (GPRA) Screening Form to document depression screenings in addition to the dental record, while others utilized a “user-defined” tracking code in the Electronic Dental Record (currently IH33-IH49) to track depression screenings and referrals. At a minimum, dental programs should document the depression screening, which can be done as part of a regular dental examination or at any dental visit, in the patient’s dental record (clinical note/progress note), and the dental providers should seek assistance from primary care, behavioral health, or administration to determine what other documentation is preferred at their particular facility.

References

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