Editorials

Anxiety Screening Is Unlikely to Improve Mental Health Outcomes

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See related Putting Prevention Into Practice on page 457 and related U.S. Preventive Services Task Force Clinical Summary in the online version of this issue.

The U.S. Preventive Services Task Force (USPSTF) recommends that adults 19 to 64 years of age be screened for anxiety disorders, which include a number of disorders not commonly treated in primary care.[1] Adding anxiety screening tests, as well as clinician review and interpretation, to an already time-constrained primary care visit takes time away from critical health care tasks, increases administrative burden, and is not likely to benefit patients compared with good standard care.

For anxiety screening to be effective, several elements are required. First, patients must give consent and receive a properly administered screening test; if the result is positive, a diagnostic mental health assessment is required. Then, if a disorder is diagnosed, they must receive treatment that reduces symptoms more effectively than the absence of treatment, with any potential benefit outweighing any treatment-related harms.[2,3]

The USPSTF did not identify any trials that fully tested anxiety screening in primary care.[1] Rather, it cited two randomized controlled trials that tested part of the process by enrolling patients who had already been screened and had positive results; in one group, results were shared with physicians, and in the second group, they were not. Trials that test only part of the screening process should more easily find benefit, but neither randomized controlled trial found evidence of improved mental health.[4,5]

Treatment of generalized anxiety disorder (GAD), the most common anxiety disorder in primary care, mainly involves pharmacotherapy.[6,7] The USPSTF cited two randomized controlled trials that were described as having tested pharmacologic treatment in primary care.[8,9] One (n = 244) reported a small reduction in anxiety symptoms among patients randomized to venlafaxine XL compared with placebo,[8] and the other (n = 177) did not find any difference based on standard intention-to-treat analysis.[9] Neither trial included patients representative of a screened primary care population. GAD detected via screening in real-world primary care settings would presumably be less severe and less amenable to drug treatment than GAD among patients independently reporting symptoms or seeking treatment.[10] One of the trials cited by the USPSTF required participants to have higher levels of anxiety than almost all other GAD treatment trials that have been conducted, even though most of these trials have been completed in specialty mental health settings.[8,11] The other trial also restricted enrollment to patients with high symptom levels, and, contrary to the study's characterization by the USPSTF, most participants were not recruited from primary care settings.[1,9]

The USPSTF downplayed harms from anxiety screening.[1] Increased prescriptions and use of anxiolytic medications can expose patients to adverse effects and drug-drug interactions related to polypharmacy, despite not having evidence of benefit in a screened population.[12] Antidepressants are the most common treatment for GAD, with a mean prescription duration of more than 5 years.[13] Benzodiazepines are also used long term for anxiety by many patients in primary care.[14] Antidepressant and benzodiazepine use can lead to severe discontinuation effects and be difficult to deprescribe.[15,16]

The USPSTF added anxiety screening to other questionnaires it recommends routinely administering to screen for depression, unhealthy drug use, and intimate partner violence. Although these are significant concerns, there is no evidence that they are solvable by administering questionnaires. Neither the U.K. National Screening Committee nor the Canadian Task Force on Preventive Health Care recommends administering questionnaires to screen for these problems[17,18]; there have been at least 20 trials of screening with questionnaires for a range of conditions, and none have shown an improvement in health outcomes.[19] For depression and intimate partner violence screening, several robust trials failed to find benefit.[2,3,19,20]

If implemented as intended, each of the questionnaire-based screening procedures recommended by the USPSTF, including anxiety screening, would substantially increase the time required to provide care and the burden of documenting that care.[21] In addition to administering and scoring

a screening test, anxiety screening would, at a minimum, require an initial evaluation of patients with positive results to evaluate the possible causes of symptoms. Among positive screens, some patients could have mild symptoms reflecting situational stressors or difficult life situations that are not resolvable through a diagnosis and prescription. Others could have symptoms due to a physical condition (e.g., thyroid disease) or lifestyle factor (e.g., caffeine intake).[22] Some patients could have anxiety disorders that are not typically treated in primary care. The amount of time needed for this evaluation could easily fill the allocated visit time for many patients. Some could be referred to a mental health specialist after an initial evaluation is performed, although not enough specialists are available to assess and care for all patients with anxiety disorders, and most patients would require additional time for management in primary care.[22]

Too often, physicians enter the examination room with an ever-increasing checklist of items, making it difficult to hear and address the specific concerns of the patient. Rather than screening everyone with time-consuming questionnaires of unproven benefit, patients would be better served by being able to share their concerns, including those about mental health, with caring clinicians who take the time to talk with them, understand them as people, and help them access care options consistent with their needs, values, and preferences.[3]

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References

1. Barry MJ, Nicholson WK, Silverstein M, et al. Screening for anxiety disorders in adults: US Preventive Services Task Force recommendation statement. *JAMA*. 2023;329(24):2163-2170.
2. Thombs BD, Markham S, Rice DB, et al. Does depression screening in primary care improve mental health outcomes? *BMJ*. 2021;374:n1661.
3. Thombs BD, Markham S, Rice DB, et al. Screening for depression and anxiety in general practice. *BMJ*. 2023;382:1615.
4. Mathias SD, Fifer SK, Mazonson PD, et al. Necessary but not sufficient: the effect of screening and feedback on outcomes of primary care patients with untreated anxiety. *J Gen Intern Med*. 1994;9(11):606-615.
5. Kroenke K, Talib TL, Stump TE, et al. Incorporating PROMIS symptom measures into primary care practice—a randomized clinical trial. *J Gen Intern Med*. 2018;33(8):1245-1252.
6. Olfson M, Marcus SC, Wan GJ, et al. National trends in the outpatient treatment of anxiety disorders. *J Clin Psychiatry*. 2004;65(9):1166-1173.
7. Olfson M. The rise of primary care physicians in the provision of US mental health care. *J Health Polit Policy Law*. 2016;41(4):559-583.
8. Lenox-Smith AJ, Reynolds A. A double-blind, randomised, placebo controlled study of venlafaxine XL in patients with generalised anxiety disorder in primary care. *Br J Gen Pract*. 2003;53(495):772-777.
9. Lenze EJ, Rollman BL, Shear MK, et al. Escitalopram for older adults with generalized anxiety disorder: a randomized controlled trial. *JAMA*. 2009;301(3):295-303.
10. de Vries YA, Roest AM, Burgerhof JGM, et al. Initial severity and antidepressant efficacy for anxiety disorders, obsessive-compulsive disorder, and posttraumatic stress disorder: an individual patient data meta-analysis. *Depress Anxiety*. 2018;35(6):515-522.
11. Slee A, Nazareth I, Bondaronek P, et al. Pharmacological treatments for generalised anxiety disorder: a systematic review and network meta-analysis [published correction appears in *Lancet*. 2019;393(10182):1698]. *Lancet*. 2019;393(10173):768-777.
12. Maust DT, Sirey JA, Kales HC. Antidepressant prescribing in primary care to older adults without major depression. *Psychiatr Serv*. 2017;68(5):449-455.
13. Kendrick T. Strategies to reduce use of antidepressants. *Br J Clin Pharmacol*. 2021;87(1):23-33.
14. Tanguay Bernard MM, Luc M, Carrier JD, et al. Patterns of benzodiazepines use in primary care adults with anxiety disorders. *Heliyon*. 2018;4(7):e00688.
15. Davies J, Read J. A systematic review into the incidence, severity and duration of antidepressant withdrawal effects: are guidelines evidence-based? *Addict Behav*. 2019;97:111-121.
16. Soyka M. Treatment of benzodiazepine dependence. *N Engl J Med*. 2017;376(12):1147-1157.
17. U.K. National Screening Committee. UK NSC recommendations. Accessed December 28, 2023. https://view-health-screening-recommendations.service.gov.uk/
18. Canadian Task Force on Preventive Health Care. Published guidelines. Accessed December 28, 2023. https://canadiantaskforce.ca/guidelines/published-guidelines/
19. Thombs BD, Rice DB, Markham S, et al. Depression screening in pregnancy and postpartum: just do something? *Gen Hosp Psychiatry*. 2023;82:14-18.
20. Worster A, Lang E, Thombs BD, et al. Universal screening in the emergency department for intimate partner violence would consume scarce resources without improving patient well-being. *CJEM*. 2023;25(6):462-464.
21. Simon J, Panzer J, Wright KM, et al. Reduced accuracy of intake screening questionnaires tied to quality metrics. *Ann Fam Med*. 2023;21(5):444-447.
22. Stein MB, Hill LL. Are there reasons to fear anxiety screening? *JAMA*. 2023;329(24):2132-2134. ■