Reviewer’s report

Title: Screening of Depression In Primary Care Setting - Prevalence and Instrument

Version: 2 Date: 29 October 2013

Reviewer: Klaas Huijbregts

Reviewer’s report:

Although certainly not without merit I think the paper should not be accepted yet. Some important issues remain.

Major Compulsory Revisions:

*Regarding the methods section:

1. The authors state that ‘Patients who had preexisting depression or on anti-depression medication and/or refused to participate in this study, were excluded.’ Were they counted as having a current depressive disorders, and thus included in the prevalence rate? Otherwise the prevalence estimates could be biased (or the authors should state that they have actually assessed the prevalence of depressive symptoms in patients who are not yet treated for their mental health problems).

2. The cost-analysis procedure appears to be based on quite a few assumptions. Is it possible to ask a random sample of those who filled out the PHQ9-questionnaire to also fill out a questionnaire on direct and indirect medical costs? I would feel reassured about the outcomes if they were replicated by actual data. Another question bout the cost-analysis: psychotherapy was not added to the costs. Does this mean that nobody received psychotherapy? Otherwise it may lead to an underestimation of the costs. At the very least the authors should provide some evidence showing their cost estimates are in line with other studies based on cost questionnaires.

*Regarding the results:

3. A flowchart is lacking showing how many patients were approached to participate, but refused to do so. This figure should also show how many patients were exclude because they were already identified as depressed (and receiving treatment). The ecological validity of the findings might be at stake here.

*Regarding the discussion:

Discussion:

4. In my view the authors should reflect on the following issue: is the PHQ9 or PHQ2 sufficient to diagnose Major Depressive Disorder (MDD)? In my view it is not. It provides useful information that can attract the attention of a clinician to mental health problems that are otherwise easily overlooked. Clinicians will not
always ‘agree with the PHQ9’ that MDD according to DSM IV standards is present. Given the fact that a formal diagnosis by a medical doctor or psychologist is missing we do not know how many patients were actually in need of treatment. More and more data shows that antidepressant medication is particularly effective for patients suffering from relatively severe depressive disorder. Psychotherapy could be particularly beneficial for patients with moderate depression, whereas ‘watchful waiting’ has been proposed as the best strategy for mild depression. Antidepressant medication should probably not be prescribed if a patient does not meet the DSM IV criteria for MDD. Based on the current data of this study we do not know how many patients may meet these criteria. A clinical interview (or a clinical assessment by a clinician blinded to the PHQ9-score) could have helped to circumvent this problem. The actual prevalence of MDD according to the DSM IV criteria will probably be a lot lower than the percentage of patients scoring 10 or higher on the PHQ9, and this is something to take into account when giving advice to screen for depression (and subsequently treat patients). Most interventions were tested in patients who were suffering from MDD according to the DSM IV criteria.

What is the view of the authors on these issues, and can they reflect on them in their discussion section?

Minor Essential Revisions:
5. When using the word ‘prevalence’ please be clear whether you mean the life time prevalence or the point prevalence (at every given moment in time).
6. Furthermore, it would be wise to state somewhere at the beginning of the paper (probably even the abstract) that it is not possible to determine the prevalence of Major Depressive Disorder in DSM IV terms based on your data. Readers should know that you do not mean MDD when you use the word depression.
7. it could be a good idea to send the final manuscript to a native speaker. Some examples:
   - I do not think the sentence ‘Even the prevalence is increasing with time (12)’ I correct. It should be something like ‘the prevalence might even be increasing with time’.
   - The sentence ‘In 2002, depression and anxiety disorder were found around 18.2% among adults in Central of Saudi Arabia (18)’, should be something like ‘In 2002, depression and anxiety disorder prevalence rates were found to be around 18.2% among adults in Central of Saudi Arabia (18).’
   - The sentence ‘In Saudi Arabia, we have one of the highest prevalence rates worldwide and the future figures are expected to increase, worsen, and become costlier, if these figures are linked to country’s GDP per capita, the growth burden of chronic disease, shifting to a modern society in terms of increasing overly-fed, sedentary life style, sunlight-deficient, sleep deprived and the socially isolated become common (26), is too long. Please break it up in separate sentences.
8. In the abstract it is mentioned that a percentage of patients were illiterate. How was the PHQ2/9 administered in these cases?

Discretionary revisions:

9. There is mistake in Table 3 symptom 2 'several days': the percentage between brackets is 3.6, but it should have been 30.6%.

10. Is it possible to provide an exchange rate from SAR to US Dollars or Euros below the cost Table?

11. Could the authors provide some more information about what usual care for mental health problems comprises of in Saudi Arabia. I would find that very interesting!

**Level of interest:** An article of importance in its field

**Quality of written English:** Not suitable for publication unless extensively edited

**Statistical review:** Yes, but I do not feel adequately qualified to assess the statistics.

**Declaration of competing interests:**

I declare that I have no competing interests.