

Recommendation on screening adults for depression using a screening tool

Eddy Lang MDCM, Casey Gray PhD, John C. LeBlanc MD MSc, Heather Colquhoun PhD, Gregory Traversy MSc; for the Canadian Task Force on Preventive Health Care

■ Cite as: *CMAJ* 2025 October 20;197:E1132-43. doi: 10.1503/cmaj.250237

Abstract

Background: Depression negatively affects how a person feels, thinks, or behaves; is associated with impaired functioning in social and work settings; and can be associated with thoughts of suicide. This update of the 2013 Canadian Task Force on Preventive Health Care guideline provides an evidence-based recommendation about instrument-based screening for depression.

Methods: For this update, we commissioned a systematic review on benefits and harms of instrument-based screening (i.e., using a screening tool) for depression among adults. The systematic review covered relevant literature from October 2018 to May 2020, updated to January 2025 for trials, and to March 2025 for trial registries. We exam-

ined patient values and preferences via patient engagement surveys and focus groups; we engaged content experts and other interest holders at key points throughout the project. We used the Grading of Recommendations, Assessment, Development and Evaluation approach to determine the certainty of evidence for each outcome and strength of the recommendation; adhered to the Guidelines International Network principles of managing competing interests; and followed Appraisal of Guidelines for Research and Evaluation, and Guidance for Reporting Involvement of Patients and the Public reporting guidance.

Recommendations: We recommend against screening all adults aged 18 years and older for depression using

questionnaires (strong recommendation, very low-certainty evidence), based on evidence suggesting that depression screening using a screening tool has little to no effect on health. This recommendation does not apply to adults with a personal history, current diagnosis, or clinical suspicion of a diagnosis of depression or another mental health disorder. It does apply to those who may be at an elevated risk of depression.

Interpretation: The recommendation against screening adults for depression using a screening tool emphasizes the importance of good clinical care, where clinicians ask about their patients' well-being and remain vigilant for symptoms and signs of depression.

Depression is a medical illness that negatively affects how a person feels, thinks, or behaves, and is associated with impaired social and occupational functioning.¹ Depression is common in Canada: the lifetime prevalence of major depressive disorder among people without bipolar disorders was estimated as 9.9% (95% confidence interval [CI] 9.3% to 10.5%) in 2012, and the annual prevalence was estimated as 3.9% (95% CI 3.5% to 4.2%).² The prevalence of Canadians aged 15 years and older experiencing a major depressive episode has risen since 2012. Increases in lifetime prevalence of major depressive episodes from 11.3% (95% CI 10.7% to 11.9%) to 14.0% (95% CI 13.2% to 14.9%) and the 12-month prevalence of major depressive episodes from 4.7% (95% CI 4.3% to 5.1%) to 7.6% (95% CI 6.9% to 8.3%) were observed between 2012 and 2022.³

Social factors — and, to a lesser extent, genetic factors — have been linked to depression.⁴ The annual prevalence of major

depressive disorder in Canada in 2012 was higher in women than in men (4.9% v. 2.8%).² Certain population groups are also at higher risk of developing major depression than others. This includes those who faced childhood adversity (e.g., abuse, neglect);⁴ those living with chronic medical conditions;⁵ First Nations, Métis, and Inuit people (owing to factors such as colonization and forced assimilation, among others);⁶ people with a history of substance use concerns; and 2SLGBTQI+ (Two-Spirit, lesbian, gay, bisexual, transgender, queer, intersex, and additional people who identify as part of sexual- and gender-diverse communities) individuals.⁷ Although reported rates of mental health problems are lower in adults aged 65 years and older than in other age groups in Canada,⁸ research suggests depression in older adults is under-recognized and under-reported, making this another group of potential concern. The consequences of depression can be long term and include reduced quality of

Key messages for the public

- Depression negatively affects how a person feels, thinks, or behaves, results in impaired functioning in social and work settings, and can lead to thoughts of suicide.
- Our systematic review found evidence that using screening questionnaires to identify people who may have depression might not improve their health or well-being.
- It is important to tell your health care provider if you are experiencing symptoms such as a sad mood, difficulty enjoying activities that you usually like to do, feelings of worthlessness or guilt, unexpected fatigue or lack of energy, unexpected changes in your sleep patterns, or thoughts of suicide or self-harm.
- If you are experiencing depressive symptoms or have been diagnosed with depression, a health care provider can discuss support and treatment options with you.

life,^{1,9} increased risk of suicide,^{1,10} increased rates of hospital admission,¹¹ increased prevalence of chronic medical conditions,^{1,12} and stigmatization.¹³

Depression is often diagnosed, managed, and treated in primary care.¹⁴ Major depressive episodes are diagnosed when patients report depressive symptoms that represent a change from previous functioning.¹⁵ Major depressive disorder is diagnosed if a person has reported experiencing 1 or more major depressive episodes, along with other criteria.

Screening for depression involves the systematic administration of a screening tool (e.g., a questionnaire or small set of questions) with a predefined cut-off score to a target population of people who have not reported or are not otherwise suspected of having symptoms of depression.^{16,17} People who meet or exceed the cut-off score are considered “screen positive” and are then further evaluated to see whether they meet diagnostic criteria for depression, whereas those below the cut-off score are “screen negative” and would not receive further evaluation.^{15,16} The goal of screening is to identify people with depression who would otherwise have been identified later in their illness, or not at all.

Without systematic (or routine) screening with questionnaires, people with depression are identified via usual clinical vigilance, or because they report signs, symptoms, or concerns indicative of depression to a primary care provider or mental health services. Once clinicians suspect depression and begin to investigate it, they are engaging in a diagnostic process rather than a screening process.

In 2013, the Canadian Task Force on Preventive Health Care conditionally recommended against screening for depression among adults, given a lack of studies evaluating the benefits and harms of screening; uncertainty about the effectiveness of screening tools in identifying new cases of depression; evidence suggesting that some treatments triggered by screening are unnecessary; and evidence suggesting that some patients will not accept treatment or will stop prematurely.¹⁸

As part of the task force’s ongoing guideline review process, the 2013 guideline was assessed for update.¹⁹ This document updates and replaces the 2013 Canadian Task Force on Preventive Health Care guideline.¹⁸

Scope

This guideline is an update of the task force’s previous recommendation on depression screening in adults aged 18 years and older.¹⁸ The primary audience for this recommendation is clinicians in primary care or other non-mental health clinic settings (e.g., physicians, nurses, or other providers who could serve as first point of contact for care). Secondary audiences for this recommendation are policy-makers and patients. The recommendation is intended to provide clinicians with guidance on whether to screen for depression in adults with no personal history, current diagnosis, or clinical suspicion of a diagnosis of depression or another mental health disorder; and in those who may be at an elevated risk of depression (e.g., trauma in early life, family history of depression). This recommendation does not apply to adults who are already being assessed for mental health disorders or seeking services because of symptoms of depression, or to those already diagnosed with major depressive disorder.

For guidance on screening for depression during the perinatal period (during pregnancy and up to 1 year postpartum), readers may refer to the task force recommendation on screening for depression during pregnancy and the postpartum period.²⁰

Recommendation

The Canadian Task Force on Preventive Health Care recommends against routine instrument-based depression screening (using a questionnaire with a cut-off score to distinguish “screen positive” and “screen negative” status) administered to adults aged 18 years and older (strong recommendation, very low-certainty evidence).

Grading of recommendations is described in Box 1. A summary of the recommendation is available in Box 2. A visual summary of the guideline is available in Figure 1.

To determine whether screening adults for depression is effective in primary care settings, we conducted a systematic review of trials that reported on the benefits and harms of depression screening.²² We found 3 randomized controlled trials (RCTs) that specifically isolated the effects of screening for depression in primary care settings.^{22–25} The first trial was conducted in the United States.²³ Participants were adults aged 21 years or older, diagnosed with acute coronary artery syndrome (ACS) 2–12 months before enrolment ($n = 1001$; mean age about 65.8 yr; about 72% male; race and ethnicity: 72% White, 8.7% Black), randomized at the level of the individual.²³ The second trial was conducted in the United Kingdom.²⁴ Participants were adults aged 45 years or older who consulted for osteoarthritis symptoms ($n = 1412$; mean age 65 yr; 57% female; race and ethnicity: 98% White UK or European), cluster randomized by clinic.²⁴ The third was conducted in Hong Kong.²⁵ Participants were Chinese mothers ($n = 462$; age not reported) at 2 months postpartum, randomized at the level of the individual.²⁵

The intervention in each study was screening for depression using a screening tool with a cut-off score to identify patients

Box 1: Grading of recommendations

Recommendations are graded following the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) system.²¹ Recommendations are graded as strong or conditional depending on certainty in estimated effects of an intervention, estimates of patient values and preferences for outcomes, and resource use, among other considerations.

Strong recommendations

- The task force makes strong recommendations for an intervention when the desirable effects outweigh the undesirable effects. The task force makes strong recommendations against an intervention when the undesirable effects outweigh the desirable effects. A strong recommendation implies that most people will be best served by the recommendation for or against an intervention.
- Strong recommendations are normally made when the task force has high confidence in the estimate of the desirable or undesirable effect of the intervention (high-certainty evidence). Strong recommendations may also be made in other circumstances, as described in the GRADE handbook.

Conditional recommendations

- The task force makes conditional recommendations for an intervention when the desirable effects of an intervention probably outweigh the undesirable effects, but there is appreciable uncertainty. A conditional recommendation against an intervention is made when the undesirable effects probably outweigh the desirable effects, but there is appreciable uncertainty. A conditional recommendation implies that most people will probably be best served by the recommendation for or against an intervention.
- Conditional recommendations are made when the task force has low certainty in the estimate of the effect of the intervention; the balance between desirable and undesirable effects is small and depends on patient values and preferences; there is high variability in the values and preferences of patients; the balance of costs and benefits is unclear; or when acceptability, feasibility, or the effects on health equity are unclear.
- Clinicians may be encouraged to engage in shared decision-making when the task force makes a conditional recommendation for an intervention to help each patient arrive at a management decision consistent with their values and preferences. Knowledge translation tools are available at www.canadiantaskforce.ca to support evidence-informed decision-making in alignment with an individual's priorities.

Evidence is graded as high-, moderate-, low-, or very-low-certainty, based on how likely further research is to change the task force's confidence in the estimate of effect.

who may be depressed. The screening tool and cut-off score differed across studies. In the US ACS study, Kronish and colleagues screened for depression using the Patient Health Questionnaire (PHQ-8) (score of at least 10 considered screen positive).²³ In the UK osteoarthritis trial, Mallen and colleagues used the 2-item Patient Health Questionnaire (PHQ-2) (score of 1 or 2 was considered screen positive), modified to yes or no responses rather than standard scoring (also known as the Whooley questions).^{24,26} In the Hong Kong postpartum study, Leung and colleagues used the 10-item Edinburgh Postnatal Depression Scale (EPDS) (score of at least 10 or suicide ideation considered indicated on item 10), in addition to assessment by a nurse.²⁵

Box 2: Summary of recommendation for clinicians, policy-makers, and patients

The Canadian Task Force on Preventive Health Care recommends against routine instrument-based depression screening (using a questionnaire with a cut-off score to distinguish "screen positive" and "screen negative" status) administered for adults aged 18 years and older (strong recommendation, very low-certainty evidence).

- This recommendation applies to adults with no personal history of depression, and those who are not already receiving assessment or treatment for mental health disorders.
- In the context of this recommendation, screening refers to a process where primary care providers administer a depression-screening instrument in every eligible patient and use a pre-identified cut-off score to classify patients as having positive or negative screening results.
- Health care providers should ask patients about their well-being and be vigilant for signs or symptoms of depression and provide further assessment to those expressing symptoms of depression, as clinically indicated.

In the US ACS trial, treatment decisions for depression were made by treating physicians.²³ In the UK osteoarthritis trial, clinicians were prompted to follow the National Institute for Health and Care Excellence (NICE) guideline recommendations on depression.²⁴ After a positive screen in the Hong Kong postpartum trial, participants were referred for counselling by a nurse.²⁵ The comparator in all studies was described as usual care. In the Hong Kong trial, this consisted of assessment by a nurse for potential depression,²⁵ whereas in the US and UK trials, usual care consisted of no systematic assessment for depression.^{23,24} Importantly, in all studies, screening and usual care groups had access to the same follow-up and treatment options as those identified as potentially depressed,^{23–25} which isolates for the impact of carrying out the screening intervention.

Outcomes examined in the trials were depression (symptoms of depression; depression-free days), health-related quality of life (quality-adjusted life years [QALY]), and harms or adverse events. Outcomes were assessed at baseline and up to 18 months follow-up. The data were not combined for any outcomes because of heterogeneity of participants, interventions, time points, and a high risk of bias.

The US ACS trial found little or no evidence of benefit of screening using standard tools to screen for depression.²³ The UK osteoarthritis and Hong Kong postpartum RCTs found very uncertain evidence about the benefits and harms of screening using standard questionnaires (very serious risk of bias).^{24,25}

Benefits of screening

Symptoms of depression or diagnosis of major depressive disorder

Each of the 3 RCTs examined symptoms of depression (a critical outcome). Evidence from the 3 studies provided very uncertain results or showed little to no difference in symptoms of depression between those who were screened for depression with a screening tool and cut-off score versus those who were not.^{23–25}

Recommendation on screening adults for depression using a screening tool



Depression

- Negatively affects how a person feels, thinks, or behaves
- Is associated with impaired functioning in social and work settings
- Can be associated with thoughts of suicide

RECOMMENDATION

The Canadian Task Force on Preventive Health Care recommends against routine screening for depression using standardized tools like questionnaires in all adults aged 18 years and older.

This guideline does NOT apply to adults with:

- ✗ A history of depression
- ✗ Current depression
- ✗ Symptoms of depression
- ✗ Symptoms of other mental health disorders

This guideline applies to adults with:

- ✓ Normal risk of depression
- ✓ Higher risk of depression (e.g., due to childhood trauma, family history)

Why?

Evidence shows that screening every adult for depression with a questionnaire has little or no effect on health

What does this mean for clinicians?

- Ask patients about their mental health and well-being as part of usual care
- Practise good clinical judgment to detect potential depression
- Don't use a standardized tool to screen every patient
- Be vigilant for depression
- Use clinical judgment to decide on further steps



Figure 1: Summary of the guideline recommendation. See the Related Content tab for accessible version.

In adults with recently documented ACS, screening for depression using the PHQ-8 compared with no screening likely results in little to no difference in symptoms of depression: mean difference (MD) from baseline to 18 months was 0.30 lower (95% CI 0.98 lower to 0.38 higher) using the 10-item Center for Epidemiologic Studies Depression Scale (CESD-10) (score of 0–30, with higher indicating greater severity), and 0.10 lower (95% CI 0.61 lower to 0.41 higher) using the PHQ-8 depression score (score of 0–24, with higher indicating greater severity) (both moderate-certainty evidence).²³ Screening also likely results in little to no difference in change in depressive symptoms at 18 months, assessed using CESD-10, for males (MD 0.30 lower, 95% CI 1.11 lower to 0.51 higher) (moderate-certainty evidence) and may result in little to no difference for females (MD 0.30 lower, 95% CI 0.78 lower to 0.18 higher) (low-certainty evidence).²³

In adults consulting for osteoarthritis, the effect of screening with the PHQ-2 on symptoms of depression, assessed using PHQ-8 (score of at least 10 considered screen positive), was very uncertain at 12 months (MD 0.60 higher, 95% CI 0.18 lower to 1.38 higher).²⁴ The very low certainty was due to serious risk of bias, concern with imprecision (i.e., sample size < 400 for females), and the indirect population, suggesting that the true effect of screening might be substantially different.²¹

In people 6 months postpartum, the effects of screening using the EPDS on the number of patients identified as potentially depressed at 4-month follow-up (91 fewer per 1000, 95% CI 24 fewer to 135 fewer) and EPDS depression scores (0–30, with higher indicating worse) (MD 1.36 lower, 95% CI 0.63 lower to 2.09 lower) is very uncertain.²⁵ The very low certainty was due to very serious risk-of-bias concerns (based on outcome measures used and selective outcome reporting) and an indirect population, suggesting that the true effects of screening might be substantially different.²¹

Health-related quality of life

In adults with recently documented ACS, screening with the PHQ-8 likely results in little to no difference in the change in quality of life (a critical outcome), as measured by mean QALY from baseline to 18 months (MD 0, 95% CI 0.02 lower to 0.02 higher), or quality-of-life utility scores (scale of 0–1, where 1 is perfect health) (MD 0.01 lower, 95% CI 0.04 lower to 0.02 higher) at 18 months (moderate-certainty evidence).²³

For adults consulting for osteoarthritis, evidence points to a very uncertain effect of screening using the PHQ-2 on quality of life assessed using the Medical Outcomes Study Short Form 12 Mental Component score (score from 0 to 100, with lower score indicating worse rating), with an MD 0.40 lower (95% CI 1.87 lower to 1.07 higher) at 12 months.²⁴ There was also a very uncertain effect of screening on quality of life related to physical health assessed using the Medical Outcomes Study Short Form 12 Physical Component score (score from 0 to 100, with lower score indicating worse rating), with an adjusted MD 0.66 lower (95% CI 2.25 lower to 0.93 higher) at 12 months.²⁴

The Hong Kong trial did not report on health-related quality of life.²⁵

Other critical outcomes of interest

The systematic review did not identify any studies reporting on the other critical outcomes of interest categorized as benefits related to depression (i.e., diagnosis of depression using a validated diagnostic interview at a follow-up time point, suicidality).

Important outcomes of interest

The systematic review did not identify any studies reporting on the important outcomes of interest categorized as benefits: day-to-day functionality, time lost at work or at school, or impact on lifestyle behaviour (e.g., alcohol, smoking).

Harms of screening

Harms of treatment

In adults with ACS, evidence suggests screening for depression using the PHQ-8 likely results in little to no difference in harms potentially attributable to the use of antidepressant medications at 18 months, per 1000 patients: bleeding (0 fewer cases of bleeding, 95% CI 36 fewer to 52 more); increased appetite (0 fewer cases, 95% CI 44 fewer to 61 more), decreased appetite (27 fewer, 95% CI 66 fewer to 27 more), drowsiness (28 fewer reports of drowsiness, 95% CI 88 fewer to 42 more), or gastrointestinal upset (30 fewer, 95% CI 78 fewer to 30 more).²³

The Hong Kong trial also collected evidence on adverse events for people in the postpartum period, and reported that none were identified (very low-certainty evidence).²⁵

The UK osteoarthritis trial did not report on adverse events.²⁴

Other important outcomes of interest

No studies were identified that reported on labelling or stigma, or the potential harms of screening including false-positive results, overdiagnosis, or overtreatment.

Patient values and preferences

Patient values and preferences for screening were assessed during patient engagement activities conducted by the knowledge translation team for this guideline.^{27,28} Initially, participants consistently rated the potential benefits of screening (e.g., improvement in depressive symptoms) as more important than the potential harms (e.g., false positives) (Appendix 1, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.250237/tab-related-content). When assessed by survey, most participants indicated a strong preference for screening for depression versus not screening.^{27,28} However, in the second phase of patient engagement, after participants saw the results of the systematic review, variability in responses in the focus groups was greater, with some expressing concerns about the lack of evidence of benefit, given the potential harms (Appendix 2, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.250237/tab-related-content).²⁸

Throughout both phases, it is possible that participants did not fully understand the difference between screening all adults versus usual care (discussions of well-being) or diagnostic testing of adults already experiencing symptoms. Participants interchanged these 2 concepts at several points during the focus-group

discussions, making it difficult to interpret patient perspectives. Nevertheless, participants generally indicated that conversations about mental health with their provider are important, whether this takes the form of screening or other types of discussions.

Resource use

We did not examine cost-effectiveness or resource use in the systematic review. Our ongoing scan of provincial and territorial recommendations (as of March 2025) suggests most provinces and territories do not have a recommendation regarding screening of all adults for depression (Appendix 3, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.250237/tab-related-content). British Columbia has a recommendation regarding “screening” in its provincial primary care guideline; however, this recommendation applies only to those presenting with symptoms of major depressive disorder, whereas we consider screening to be a process to identify unrecognized cases in those not presenting with symptoms.^{29,30}

We are certain there would be costs related to implementing routine screening of all adults for depression where it is not current practice. Costs could include the costs of administering tools, as well as an increase in clinician time associated with triaging and further assessing patients who screen positive, although the exact costs to screen all adults are unknown. Because screening for depression has not been demonstrated to be of greater benefit than usual care (see Rationale section), the additional resource requirements (e.g., time) do not appear to be justified. The resource requirements for following a recommendation against screening are uncertain but would be expected to be none to minimal in jurisdictions where screening is not currently performed.

Feasibility, acceptability, and equity

The task force considers a recommendation against screening to be feasible. Most provinces and territories in Canada do not have a recommendation regarding screening (as of March 2025). Although the task force recommended against screening in 2013,¹⁸ we do not know the degree to which individual health care professionals follow the recommendation.

The task force judges that clinicians who are not currently screening adults for depression are expected to find the recommendation acceptable. For those who are currently systematically screening adults, this would constitute a change in practice (i.e., 1 fewer formal task required). In the US, where a United States Preventive Services Task Force (USPSTF) recommendation to screen has been in place since 2009, just 3% of adult ambulatory care visits included depression screening, supporting the likelihood that maintaining a recommendation against screening would be acceptable in Canada.³¹ The acceptability of the recommendation across all potential interested parties is not known.

Equity could be negatively affected if screening is implemented and resources are redirected away from treatment of patients with known mental health disorders, who often do not receive adequate treatment,^{32–34} and reallocated to universal

screening. The impact of a recommendation against screening on equity is uncertain.

Rationale

In the judgment of the task force, the recommendation against screening of all adults aged 18 years and older for depression using a questionnaire is strong, based on moderate-certainty evidence that screening probably has little to no impact on symptoms of depression or health-related quality of life from 1 trial, and very uncertain evidence on the impact of screening from 2 other trials.

In making this a strong recommendation, the task force considered the resource constraints faced by our primary health care system and the resource burden of engaging in activities that consume scarce resources or limit access to primary care providers,³⁵ particularly when there is no demonstrated evidence of effectiveness or evidence of a lack of effectiveness. Although no trials reported on harms of screening, such as false positives, overdiagnosis, or overtreatment, screening will lead to an increase in false positives and unnecessary treatment, and may lead to unnecessary referrals and diagnostic evaluation for some patients, reducing resources available for those with known mental health concerns.

In rating the certainty of evidence as moderate in the American ACS study, the task force considered the serious indirectness of the included population, as the ACS population did not reflect the general Canadian population.²² In rating the certainty of evidence as very low in the UK osteoporosis trial and the Hong Kong postpartum trial, the task force considered the high risk of bias and serious indirectness of the included study populations (i.e., UK adults consulting for osteoarthritis and Chinese postpartum mothers).²²

A false positive can occur when the patient meets a screening cut-off score and is sent for additional psychiatric evaluation, which finds they do not actually meet the diagnostic criteria for depression.³⁵ A meta-analysis using individual patient data provided accuracy information for a screening tool used in the trials we identified.³⁶ Based on a prevalence of 11%, screening 100 patients with the PHQ-9 using the common cut-off score of 10 would result in 9 true positives, 2 false negatives, 13 false positives, and 76 true negatives.³⁶ This means that some patients who are screened will undergo unnecessary additional assessment.

Overdiagnosis could occur as overdetected in patients with mild, temporary symptoms who might meet a screening cut-off score, leading to further evaluation and possible referral to specialty mental health services, but who would not benefit as the symptoms would subside on their own, or who do not experience functional impairment (e.g., in social or occupational roles) or distress from their symptoms.³⁷ We did not find trials that estimated overdiagnosis, but given the extent of false positives mentioned above, it is likely to occur to some extent, owing to the large number of positive screens using screening instruments.³⁸ The extent of overdiagnosis is unknown and can only be hypothesized. Thombs and colleagues noted the paucity of research on overdiagnosis in mental health more broadly.³⁸

Given the substantial challenges to accessing mental health services in Canada,^{32–34} the unnecessary redirection of resources from the treatment of patients with mental health concerns could be an unintended harm of screening. Spending even 1–2 minutes per clinical encounter reviewing the results of a formal screening instrument with no proven value could consume a substantial amount of time during a 15-minute encounter. As noted above, about 22% of all patients screened using a questionnaire and cut-off score, such as the PHQ-9, would have to receive additional assessment or referrals (most unnecessarily), and thus the resource implications also extend beyond the initial clinical encounter. The task force is mindful of the resource constraints faced by our primary health care system and as such makes recommendations against interventions when the resource implications of a particular health intervention are certain to be important and benefits have not been demonstrated.

Methods

The task force is an independent panel of clinicians and methodologists that makes recommendations on primary and secondary prevention in primary care (www.canadiantaskforce.ca). This recommendation was developed by a working group of 5 task force members (including H.C., J.C.L., and E.L.), with scientific support from Public Health Agency of Canada (PHAC) staff (including C.G. and G.T.) and in consultation with content experts in the area of mental health and depression research.

We used the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) approach to determine the certainty of evidence for each outcome and strength of recommendations;²¹ adhered to the Guidelines International Network (GIN) principles of managing competing interests;³⁹ and followed Appraisal of Guidelines for Research and Evaluation, and Guidance for Reporting Involvement of Patients and the Public reporting guidance.⁴⁰ The protocol has been published.⁴¹ The full methods manual for the task force can be found on the task force website.⁴²

Literature review and quality assessment

The recommendation is based on a systematic review conducted for this guideline on the effectiveness (i.e., benefits and harms) of screening for depression in the general adult population, including in pregnant and postpartum populations, in primary care and other non-mental health clinic settings (see analytic framework in protocol).^{22,41} Information to estimate the number of false positives that would be identified with screening was gathered from a test accuracy review.³⁶

The systematic review was conducted by the Evidence Review and Synthesis Centre at the Ottawa Hospital Research Institute.²² As outlined in the guideline protocol,⁴¹ search strategies were peer reviewed and conducted in MEDLINE, Embase, PsycINFO, CINAHL, and the Cochrane Library, from database inception to May 2020, with supplemental searches for grey literature.²² Before publication, the Evidence Review and Synthesis Centre at the Alberta Research Centre for Health Evidence (Department of

Pediatrics, University of Alberta) updated searches to Jan. 27, 2025, for trials and Mar. 19, 2025, for trial registries. Studies were excluded if recruitment included patients with a recent history or current diagnosis of depression, patients receiving treatment for depression or other mental disorders, or patients receiving services for their mental health symptoms. Studies in which patients were being assessed in psychiatric or mental health settings were also excluded. These populations were excluded because screening is done to attempt to identify people with unrecognized depression. Studies were also excluded if interventions, in addition to screening, included referral for depression care or treatment options that were not available to patients identified as depressed in the nonscreening trial arm. Such studies appear to be common, but they would not allow us to determine whether any accrued benefits or harms were due to the screening intervention or to the added care options being provided only to the intervention arm.

The working group rated outcomes in accordance with the GRADE approach.²¹ Patients also rated outcomes (described in the Patient Engagement section). Outcomes rated as critical or important by working group members and patients were retained to be examined in the systematic review. Reduced symptoms of depression or diagnosis of major depressive disorder, improved health-related quality of life, and lower suicidality (i.e., suicide ideation, attempt, or completion) were rated as critical potential benefit outcomes for assessment in the systematic reviews. Additional clinical outcomes rated as important included improved day-to-day functionality, less time lost at work or school, less impact on lifestyle behaviour (e.g., alcohol abuse, smoking, drugs, gambling), and potential harms of increased false-positive results (i.e., positive screen in absence of a depressive disorder), increased overdiagnosis or overtreatment, increased harms of being labelled or stigma, and increased harms of treatment.

Development of recommendations

We used the GRADE approach to determine the certainty of the evidence and strength of the recommendation (Box 1).²¹ The evidence-to-decision framework captures the benefits and harms, patient values, resource use, feasibility, acceptability, and equity considerations assessed by the task force to develop the recommendation (Appendix 4, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.250237/tab-related-content). The working group developed the draft recommendation. The entire task force reviewed and approved the recommendation, following task force methods.⁴²

Patient engagement

The knowledge translation group at St. Michael's Hospital in Toronto carried out the patient engagement activities for this guideline. Members of the public were recruited to provide input during guideline development (Phase 1; Appendix 1) and during the development of knowledge translation tools (Phase 2; Appendix 2). Eligible participants were members of the target population and those who had already received a diagnosis or were being treated for depression. Participants

were recruited through advertisements on classified advertising websites (e.g., Kijiji) and were each paid \$50 for 2 hours of their time. All participants indicated no competing interests of relevance to the topic.

For phase 1, 16 adults (3 identifying as male, 13 identifying as female; aged 22–63 yr) rated the importance of key harms and benefits of screening for depression and indicated their preference for being screened for depression in an online survey.²⁷ Next, the knowledge translation group held 2 focus groups ($n = 14$; 10 and 4 participants per group) and 2 interviews by teleconference to gather qualitative data regarding the survey question topics.²⁷ The working group considered the input from patients before finalizing the list of outcomes. Outcomes rated as critical or important by both the focus group participants and working group members were considered during guideline development. Based on participant feedback, the working group added harms of being labelled or stigma as an important outcome. We collected data for phase 1 between July 3 and Aug. 22, 2018.²⁷

Phase 2 activities were much the same as phase 1 activities, except that participants in phase 2 received information from the systematic review about the relative likelihood of each outcome.²⁸ Eighteen adults (5 identifying as male, 13 identifying as female; 5 had been diagnosed with or were receiving treatment for depression; aged 22–56 yr; 4 with a high school education, 14 with a postsecondary education) completed the online survey.²⁸ Thereafter, 4 focus group sessions ($n = 18$; 2–7 participants per group) were held via teleconference to gather qualitative data on participants' perceptions of the screening outcomes, and their overall values and preferences for screening.²⁸ The working group considered participants' feedback while developing the final guideline and knowledge translation tools, including suggestions to explain benefits and harms of depression screening clearly and to clarify the distinction between screening and usual care. We collected data for phase 2 between July 16 and Aug. 30, 2019.²⁸

The knowledge translation group developed knowledge translation tools to accompany this guideline, based on feedback from clinicians ($n = 4$) and members of the public ($n = 7$). The tools can be found on the task force website (<https://canadiantaskforce.ca/guidelines/published-guidelines/depression-in-adults-update/>).

External and content expert review

The task force engaged 3 clinical and content experts to provide advice regarding important clinical issues and to address technical concerns. One was a Canada Research Chair with expertise in mental health, including depression screening and the evaluation of depression screening tools. One was a physician–scientist expert in psychiatry, including depression management by primary health care professionals. Finally, one was a physician–scientist expert in psychiatry and epidemiology, including the prevalence of mental disorders, associated risk and prognostic factors, and patterns of morbidity. The experts participated in working group discussions and reviewed the key guideline materials. Review of the guideline manuscript was completed in October 2024. Clinical and content experts engaged by the task force are external to the

task force and do not provide input into or vote on task force recommendations.

The key guideline materials (i.e., the protocol,⁴¹ systematic review,²² and guideline) were externally reviewed by academic peer reviewers and relevant organizations. The draft guideline document was reviewed between Mar. 21, 2023, and July 14, 2023. Twelve peer reviewers and organizational representatives — including researchers in mental health, provincial and territorial health authorities, mental health advocacy groups, and guideline development organizations — provided feedback on a draft of this guideline (see Acknowledgements section). All input received and how it was addressed are available on the task force website (<https://canadiantaskforce.ca/guidelines/published-guidelines/depression-in-adults-update/>).

Management of competing interests

The task force follows GIN principles for disclosure of interests and management of competing interests.³⁹ The task force's oversight committee for evaluating and adjudicating competing interests consists of the task force chair and vice chair and the director of the Global Health and Guidelines Division of PHAC.⁴³ Funding for the task force is provided by PHAC. The task force does not consider the views of the funding body in developing its recommendations.

All task force members are required to disclose financial and other relevant interests, and these are available on the task force website (<https://canadiantaskforce.ca/about/members/>). Clinical and content experts also disclose relevant interests at the outset of their participation and annually thereafter. Information on disclosures and conflicts of interest can be found in Appendix 5 (available at www.cmaj.ca/lookup/doi/10.1503/cmaj.250237/tab-related-content). Scott Klarenbach, who was a task force member but not a member of the topic working group, is the director of the Real World Evidence Unit, University of Alberta, and director and co-chair of the Real World Evidence Consortium (with University of Calgary and Institute of Health Economics). Although he receives no personal honoraria, these 2 groups rely in part on industry funding. This was not judged as a conflict when initially disclosed. However, between recommendation development and submission of this guideline to CMAJ, the task force oversight committee made the decision that Dr. Klarenbach should not vote on the guideline. He did not vote on the draft guideline for submission nor on any changes made in response to peer review, or approve resubmission, and as such is not listed as a contributing author.

No other declared interests affected participation in the guideline development process.

Implementation

Screening in depression in adults is the routine process whereby primary care providers administer an instrument such as a questionnaire to every adult not already reporting symptoms of depression or suspected of having depression, and then use a cut-off score to determine a follow-up action for those at or above the cut-off score.^{16,17} The task force recommends against

Table 1: Recommendations on screening for depression in adults

Organization	Recommendation
Canadian Task Force on Preventive Health Care (current guideline, 2025)	The Canadian Task Force on Preventive Health Care recommends against routine instrument-based depression screening (using a questionnaire with a cut-off score to distinguish “screen positive” and “screen negative” status) administered for adults aged 18 years and older (strong recommendation, very low-certainty evidence).
Canadian Task Force on Preventive Health Care ¹⁸ (2013)	For adults at average risk for depression, the task force recommends not routinely screening for depression (weak recommendation, very low-quality evidence).
National Institute for Health and Care Excellence ⁴⁴ (England)	Does not include a recommendation on screening all adults. Recommends that health and social care professionals be alert to depression and consider asking patients the following depression identification questions if depression is suspected (especially for people with a history of depression or a chronic health problem associated with functional impairment): During the last month, have they often been bothered by feeling down, depressed, or hopeless? During the last month, have they often been bothered by having little interest or pleasure in doing things? Yes to either question triggers additional steps.
UK National Screening Committee ⁴⁵ (United Kingdom)	Screening is not currently recommended.
US Preventive Services Task Force (USPSTF) ⁴⁶ (United States)	The USPSTF recommends screening for depression in the adult population, including pregnant and postpartum people, as well as older adults.

the use of screening owing to the absence of evidence of effectiveness above usual care.

In recommending against screening among adults, the task force emphasizes the importance of good clinical practice whereby clinicians remain alert to patients with risk factors for depression or expressing symptoms of depression, and provide further assessment as clinically indicated.

Most provinces and territories do not have jurisdiction-specific guidance regarding depression assessment for adults (Appendix 3). British Columbia uses the word “screening” to describe a recommendation related to using symptom questionnaires in assessment; however, this guidance is applicable only to patients presenting with symptoms of depression, which is consistent with a diagnostic evaluation rather than screening.

Monitoring and evaluation

Evaluation of the dissemination of this guideline will be carried out as part of the annual evaluation activities of the knowledge translation team. These activities include assessment of awareness of the guideline by interest holders (surveys), reach of knowledge translation materials (number of publications, presentations, dissemination by relevant organizations, website usage measures, media hits), knowledge of guideline recommendations (surveys), and self-reported actual and planned practice change (surveys).

Monitoring of the evidence related to this guideline will be conducted after publication, by the task force’s synthesis and topic prioritization working group. The task force will update the recommendation if new evidence that could inform its direction or strength indicates an update is needed. The detailed methods for the annual evaluation activities of the task force and for assessing the need to update published task force guidelines can be found in the task force methods manual.⁴²

Other guidelines

Table 1 presents other systematically developed provincial and national clinical practice guideline recommendations on screening adults for depression. The current task force recommendation is similar to previous task force guidance.

The UK national screening committee recommends against screening for depression.⁴⁵ Its recommendation is based on its 2020 evidence review,⁴⁵ which found a lack of evidence for longer-term (beyond 2 years) impact of treating milder forms of depression in reducing the likelihood of more severe depression; uncertainty about whether depression screening reduces the risk of mortality and morbidity; and uncertainty about whether the clinical management of depression is optimized in the UK. The committee recommends being alert to possible depression and describes steps to take to investigate suspected depression.⁴⁴

In contrast, the USPSTF recommends screening based on indirect evidence of benefit.⁴⁷ Of the 17 trials included in the systematic review on which the recommendation was based,⁴⁸ most enrolled participants who had already screened positive, and included other care management components. In our evidence assessment of the trials in which screening was compared with no screening, we excluded 1 trial because it included a treatment intervention in the experimental group that was unavailable to the no-screening arm;⁴⁶ another because it was not randomized;⁴⁹ and a third that concluded that screening does not have consistently positive effects on patient outcomes, which we excluded because the usual care case-finding comparator group included a screening question and was not a true no-screening comparison group.⁵⁰ As noted in the Methods section, we excluded studies in which both study arms did not have the same access to follow-up and treatment, as these studies do not allow us to draw conclusions about the benefits of adding the screening intervention specifically.⁴² Among the 3 trials directly comparing screening to no screening included in our review, the

USPSTF systematic review included the Hong Kong study²⁵ but did not include the US study (2020) or the UK trial (2017).^{23,24} The USPSTF examined test accuracy for screening tools but did not evaluate the extent of false positives, which were an outcome of concern for the task force.

Gaps in knowledge

The 3 trials identified for inclusion in the systematic review that informed this guideline were conducted with specific clinical populations with differences in their control group interventions.^{23–25} No studies were identified that compared screening to usual clinical care in a broad general adult population representative of the Canadian population. No trials reported on harms of screening such as false positives, overdiagnosis, or overtreatment, although we were able to gather evidence on false positives from a test accuracy review.³⁶

Limitations

Patient values and preferences for screening were assessed through patient engagement activities conducted by our knowledge translation team. Given the small ($n = 16$ and $n = 18$) sample, with limited representativeness (e.g., age, race and ethnicity) and potential misunderstanding regarding what constitutes screening, results may not be generalizable to the wider population of adults in Canada. Assessment of current practices in Canada (Appendix 3) is based on publicly available documents, and actual current practices may vary.

Furthermore, included trials reported on specific clinical populations.^{23–25} Although these clinical populations do not reflect the makeup of the general population, they are included in and are reasonably well represented in the general population. We acknowledge this potential generalizability issue and considered the generalizability of the included evidence under the “indirectness” domain of GRADE. Thus, the applicability of the evidence is factored into our certainty ratings. As noted, we had moderate-certainty evidence from 1 trial, which suggests the evidence likely reflects the true effect of screening, and very low certainty from 2 others, which suggests the evidence may reflect the true effect of screening.

The time since the completion of the external review of the guideline by academic peer reviewers and relevant organizations (2023), the review by working group clinical and content experts (2024), and the knowledge translation activities (2018 and 2019) was longer than anticipated. We cannot be sure whether updating that work would affect the outcome of those processes; however, our updated search for new evidence did not identify any new findings beyond those considered in these processes.

Conclusion

Overall, the effect of screening adults for depression was either very uncertain or suggested little to no benefit across 3 trials. In the judgment of the task force, there are also important

resource implications to screening using an unproven screening instrument (i.e., there is an absence of evidence of effectiveness above usual care). For these reasons, the task force strongly recommends against screening for depression using questionnaires with cut-off scores among adults without a personal history of depression, and who are not already being assessed or treated for other mental disorders. Health care providers should ask patients about their well-being and be vigilant for symptoms or signs of depression as part of good clinical care.

References

1. Bains N, Abdijadid S. Major depressive disorder. In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2025. Available: <https://www.ncbi.nlm.nih.gov/books/NBK559078/> (accessed 2025 Aug. 8).
2. Patten SB, Williams JVA, Lavorato DH, et al. Descriptive epidemiology of major depressive disorder in Canada in 2012. *Can J Psychiatry* 2015;60:23–30.
3. Stephenson E. *Insights on Canadian Society: Mental disorders and access to mental health care*. Cat no 75-006-X. Ottawa: Statistics Canada; 2023:1–15. Available: https://publications.gc.ca/collections/collection_2023/statcan/75-006-x/75-006-2023-11-eng.pdf (accessed 2025 Aug. 8).
4. Otte C, Gold SM, Pennix BW, et al. Major depressive disorder. *Nat Rev Dis Primers* 2016;2:16065.
5. Evans DL, Charney DS, Lewis L, et al. Mood disorders in the medically ill: scientific review and recommendations. *Biol Psychiatry* 2005;58:175–89.
6. Bellamy S, Hardy C. *Understanding depression in aboriginal communities and families*. Prince George (BC): National Collaborating Centre for Aboriginal Health; 2015:1–24. Available: <https://www.nccih.ca/docs/emerging/RPT-UnderstandingDepression-Bellamy-Hardy-EN.pdf> (accessed 2025 Aug. 8).
7. Hall WJ. No psychosocial risk and protective factors for depression among lesbian, gay, bisexual and queer youth: a systematic review. *J Homosex* 2018; 65:263–316.
8. Suicide Surveillance Indicator Framework Quick Statistics, 2023 Edition: quick stats overview. Ottawa: Public Health Agency of Canada; 2013. Available: https://health-infobase.canada.ca/ssif/PDFs/Quick_Stats_Infobase_Ssif_2023.pdf (accessed 2025 Aug. 8).
9. Tang AL, Thomas SJ. Relationships between depressive symptoms, other psychological symptoms, and quality of life. *Psychiatry Res* 2020;289: 113049.
10. Hawton K, Comabella CCI, Haw C, et al. Risk factors for suicide in individuals with depression: a systematic review. *J Affect Disord* 2013;147:17–28.
11. Frank P, Batty GD, Pentti J, et al. Association between depression and physical conditions requiring hospitalization. *JAMA Psychiatry* 2023;80:690–9.
12. Read JR, Sharpe L, Modini M, et al. Multimorbidity and depression: a systematic review and meta-analysis. *J Affect Disord* 2017;221:36–46.
13. Dubreucq J, Plasse J, Franck N. Self-stigma in serious mental illness: a systematic review of frequency, correlates, and consequences. *Schizophr Bull* 2021;47:1261–87.
14. El-Den S, Chen TF, Gan Y-L, et al. The psychometric properties of depression screening tools in primary healthcare settings: a systematic review. *J Affect Disord* 2018;225:503–22.
15. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)*. Washington: American Psychological Association; 2022.
16. Thombs BD, Coyne JC, Cuijpers P. Rethinking recommendations for screening for depression in primary care. *CMAJ* 2012;184:413–8.
17. Thombs BD, Markham S, Rice DB, et al. Does depression screening in primary care improve mental health outcomes? *BMJ* 2021;374:n1661.
18. Joffres M, Jaramillo A, Dickinson J, et al.; Canadian Task Force on Preventive Health Care. Recommendations on screening for depression in adults. *CMAJ* 2013;185:775–82.
19. *Updating, reaffirmation and sunseting clinical practice guidelines: methods from the Canadian Task Force on Preventive Health Care*. Ottawa: Canadian Task Force on Preventive Health Care; 2024:1–8. Available: <https://canadiantaskforce.ca/methods/updating-reaffirmation-and-sunseting-clinical-practice-guidelines-methods-from-the-canadian-task-force-on-preventive-health-care/> (accessed 2025 Mar. 20).
20. Lang E, Colquhoun H, LeBlanc J, et al.; Canadian Task Force on Preventive Health Care. Recommendation on instrument-based screening for depression during pregnancy and the postpartum period. *CMAJ* 2022;194:E981–9.

21. Schünemann H, Brozek J, Guyatt GH, et al. GRADE handbook for grading quality of evidence and strength of recommendations; 2013. Available: <https://gdt.gradeapro.org/app/handbook/handbook.html> (accessed 2019 Dec. 20).
22. Beck A, Hamel C, Thuku M, et al. Screening for depression among the general adult population and in women during pregnancy or the first year postpartum: two systematic reviews to inform a guideline of the Canadian Task Force on Preventive Health Care. *Syst Rev* 2022;11:176.
23. Kronish IM, Moise N, Cheung YK, et al. Effect of depression screening after acute coronary syndromes on quality of life: the CODIACS-QoL randomized clinical trial. *JAMA Intern Med* 2020;180:45-53.
24. Mallen CD, Nicholl BI, Lewis M, et al. The effects of implementing a point-of-care electronic template to prompt routine anxiety and depression screening in patients consulting for osteoarthritis (the Primary Care Osteoarthritis Trial): a cluster randomised trial in primary care. *PLoS Med* 2017;14:e1002273.
25. Leung SS, Leung C, Lam TH, et al. Outcome of a postnatal depression screening programme using the Edinburgh Postnatal Depression Scale: a randomized controlled trial. *J Public Health (Oxf)* 2011;33:292-301.
26. Whooley MA, Avins AL, Miranda J, et al. Case-finding instruments for depression. Two questions are as good as many. *J Gen Intern Med* 1997;12:439-45.
27. Burnett L, Einarson K, Mascarenhas AS, et al. *Patient preferences for depression screening among adults: data summary*. Toronto; 2018.
28. Burnett L, Silveira K, Stein S, et al. *Patient preferences for depression screening among adults: Phase 2 data summary*. Toronto: Knowledge Translation Program Li Ka Shing Knowledge Institute St. Michael's Hospital; 2019.
29. Information on screening. Ottawa: Canadian Task Force on Preventive Health Care; 2022. Available: <https://canadiantaskforce.ca/tools-resources/information-on-screening/> (accessed 2025 July 7).
30. Disease screening: statistics teaching tools. New York State, Department of Health; 1999. Available: <https://www.health.ny.gov/diseases/chronic/discreen.htm> (accessed 2025 July 7).
31. Bhattacharjee S, Goldstone L, Vadieli N, et al. Depression screening patterns, predictors, and trends among adults without a depression diagnosis in ambulatory settings in the United States. *Psychiatr Serv* 2018;69:1098-100.
32. Moroz N, Moroz I, D'Angelo MS. Mental health services in Canada: barriers and cost-effective solutions to increase access. *Health Manage Forum* 2020;33:282-7.
33. Gratz D. Improving access to evidence-based mental health care. *CMAJ* 2020;192:E342-3.
34. Kurdyak P, Zaheer J, Carvalho A, et al. Physician-based availability of psychotherapy in Ontario: a population-based retrospective cohort study. *CMAJ Open* 2020;8:E105-15.
35. Thombs BD, Straus S, Moore A; Canadian Task Force on Preventive Health Care; Collaborating Members of the Canadian Task Force on Preventive Health Care. Update on task force terminology and outreach activities: advancing guideline usability for the Canadian primary care context. *Can Fam Physician* 2019;65:12-3.
36. Levis B, Benedetti A, Thombs BD; DEPRESSion Screening Data (DEPRESSD) Collaboration. Accuracy of Patient Health Questionnaire-9 (PHQ-9) for screening to detect major depression: individual participant data meta-analysis. *BMJ* 2019;365:l1476.
37. Brodersen J, Schwartz LM, Heneghan C, et al. Overdiagnosis: what it is and what it isn't. *BMJ Evid Based Med* 2018;23:1-3.
38. Thombs B, Turner KA, Shrier I. Defining and evaluating overdiagnosis in mental health: a meta-research review. *Psychother Psychosom* 2019;88:193-202.
39. Schünemann HJ, Al-Ansary LA, Forland F, et al.; Board of Trustees of the Guidelines International Network. Guidelines International Network: principles for disclosure of interests and management of conflicts in guidelines. *Ann Intern Med* 2015;163:548-53.
40. Brouwers MC, Kho ME, Browman GP, et al.; AGREE Next Steps Consortium. AGREE II: advancing guideline development, reporting and evaluation in health care. *CMAJ* 2010;182:E839-42.
41. Hamel C, Lang E, Morissette K, et al. Screening for depression in women during pregnancy or the first year postpartum and in the general adult population: a protocol for two systematic reviews to update a guideline of the Canadian Task Force on Preventive Health Care. *Syst Rev* 2019;8:27.
42. Methodology. Ottawa: Canadian Task Force on Preventive Health Care; 2022. Available: <https://canadiantaskforce.ca/methods/> (accessed 2025 Jan. 16).
43. Policy on disclosures of interests and management of conflict of interest. Ottawa: Canadian Task Force on Preventive Health Care; 2020. Available: <https://canadiantaskforce.ca/about/conflict-of-interest-policy/> (accessed 2020 Nov. 24).
44. Depression in adults: treatment and management [NICE guideline]. Paris (FR): National Institute for Health and Care Excellence (NICE); 2022. Available: <https://www.nice.org.uk/guidance/ng222/chapter/recommendations#recognition-and-assessment> (accessed 2022 Nov. 16).
45. Adult screening programme: depression. London (UK): UK National Screening Committee; 2020. Available: <https://view-health-screening-recommendations.service.gov.uk/depression/> (accessed 2022 Nov. 18).
46. MacArthur C, Winter HR, Bick DE, et al. Effects of redesigned community postnatal care on women's health 4 months after birth: a cluster randomised controlled trial. *Lancet* 2002;359:378-85.
47. Final recommendation statement: depression and suicide risk in adults — screening. Rockville (MD): US Preventive Services Task Force; 2023. Available: <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-depression-suicide-risk-adults#fullrecommendationstart> (accessed 2023 June 30).
48. O'Connor E, Henninger M, Perdue LA, et al. Screening for depression, anxiety, and suicide risk in adults: a systematic evidence review for the U.S. Preventive Services Task Force. Report No 22-05295-EF-1. Rockville (MD): Agency for Healthcare Research and Quality (US); 2023. Available: <https://www.ncbi.nlm.nih.gov/books/NBK592805/> (accessed 2025 June 30).
49. van der Zee-van den Berg AL, Boere-Boonekamp MM, Groothuis-Oudshoorn CGM, et al. Post-up study: postpartum depression screening in well-child care and maternal outcomes. *Pediatrics* 2017;140:e20170110.
50. Williams JW Jr, Mulrow CD, Kroenke K. Case-finding for depression in primary care: a randomized trial. *Am J Med* 1999;106:36-43.

Competing interests: Casey Gray and Gregory Traversy report that they are employed full time by the Public Health Agency of Canada, which funds the task force (compensation does not depend on the content of the manuscript, and the task force does not consider the funding body's views in developing recommendations). No other competing interests were declared.

This article has been peer reviewed.

Affiliations: Department of Emergency Medicine (Lang), University of Calgary; Alberta Health Services (Lang), Calgary, Alta.; Public Health Agency of Canada (Gray, Traversy) Ottawa, Ont.; Department of Pediatrics (LeBlanc), Dalhousie University, Halifax, NS; Department of Occupational Science and Occupational Therapy (Colquhoun), University of Toronto, Toronto, Ont.

Guideline Writing Group: Eddy Lang (voting task force member), Heather Colquhoun (voting task force member), John C. LeBlanc (voting task force member), Casey Gray (nonvoting science team member), and Gregory Traversy (nonvoting science team member).

Collaborating Members of the Canadian Task Force on Preventive Health Care: Jennifer Flemming, Patricia Li, Gail Macartney, Kate Miller, Donna L. Reynolds, Ashraf Sefin, Henry Yu-Hin Siu, Nathalie Slavtcheva, Guylène Thériault, and Keith Jeffrey Todd. The complete list of all current members of the Canadian Task Force on Preventive Health Care is available at <http://canadiantaskforce.ca/about/members>.

Contributors: Eddy Lang, John C. LeBlanc, Heather Colquhoun, and Gregory Traversy contributed to the conception and design

of the work. All of the authors contributed to the acquisition, analysis, and interpretation of data. Eddy Lang, John C. LeBlanc, and Heather Colquhoun drafted the recommendation. Eddy Lang, Casey Gray, John C. LeBlanc, Heather Colquhoun, and Gregory Traversy drafted the guideline statement. All of the authors drafted the manuscript. Eddy Lang, Heather Colquhoun, and John C. LeBlanc revised the manuscript critically for important intellectual content. All of the authors gave final approval of the version to be published and agreed to be accountable for all aspects of the work. All collaborating members of the Canadian Task Force on Preventive Health Care also made contributions to the development of the guideline and all gave final approval of the version to be published.

Content licence: This is an Open Access article distributed in accordance with the terms of the Creative Commons Attribution (CC BY 4.0) licence, which permits use others to distribute, remix, adapt and build upon this work, for commercial use, provided the original work is properly cited. See: <https://creativecommons.org/licenses/by/4.0/>

Funding: Funding for the Canadian Task Force on Preventive Health Care is provided by the Public Health Agency of Canada. The task force does not consider the views of the funding body in developing its recommendations. The views expressed in this article are those of the task force and do not necessarily represent those of the Public Health Agency of Canada.

Acknowledgements: The authors thank previous task force members Stéphane Groulx, Ahmed M. Abou-Setta, Roland Grad, Tina Korownyk, Emily G. McDonald, Navindra Persaud, and Brenda Wilson, who were present during the early development of the guideline. In particular, the authors thank Scott Klarenbach, Ainsley Moore, and John Riva for their contributions to the development of the study concept and design during

their tenure with the task force. The authors thank the University of Ottawa Evidence Review and Synthesis Centre team for the evidence reviews that supported this guideline and Lindsay Gaudet from the University of Alberta Evidence Review and Synthesis team for the update of the evidence review; Marc Avey, Eva Graham, Kate Morissette, Rachel Rodin, Elizabeth Rolland-Harris, and Melissa Subnath of the Global Health and Guidelines Division at the Public Health Agency of Canada, who supported the development of the guideline; and the Knowledge Translation Program, Li Ka Shing Knowledge Institute, St. Michael's Hospital for their contributions to patient engagement and knowledge translation work related to this guideline. The authors also thank Bianca Lauria-Horner (Dalhousie University), Scott Patten (University of Calgary), and Brett D. Thombs (Jewish General Hospital and McGill University; a task force member during study conception), for assisting as clinical or content experts during the development of this guideline. Clinical and content experts who have assisted the task force in the guideline process may or may not agree with the task force recommendations. Additionally, the authors thank peer

reviewers and organizational interest holders who provided feedback on the draft guideline, including David Conn (Canadian Coalition for Seniors Mental Health), Sabrina Guzman (Government of Nunavut), Brandon Hey (Mental Health Commission of Canada), John Higenbottam (Psychosocial Rehabilitation Canada), Sandra Lee (British Columbia Ministry of Health), Karen Mason (Saskatchewan Health Authority), Justin A. Mills (US Department of Health and Human Services Agency for Healthcare Research and Quality), Maria Padjen (Canadian Mental Health Association — Ontario Division), Simone Powell (Public Health Agency of Canada Division of Aging, Seniors and Dementia), Chase Simms (BCGuidelines.ca, Medical Services Commission), and Danielle Rice (McMaster University). Peer reviewers and organizational interest holders are invited to provide input on draft guideline documents, which is considered by the task force. They may or may not agree with the task force recommendations.

Correspondence to: Canadian Task Force on Preventive Health Care, info@canadiantaskforce.ca