Adult Depression – Clinician Summary

This guideline on screening adults for depression provides guidance to 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.

Population

The target population is adults aged 18 years and older. This guideline applies to those who may be at an elevated risk of depression. It does not extend to adults who are already being assessed for mental health disorders, who are seeking services because of symptoms of depression, or to those already diagnosed with major depressive disorder.

Recommendation

The Canadian Task Force on Preventive Healthcare 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 for depression (strong recommendation, very-low certainty evidence).

This recommendation emphasizes the importance of good clinical care, where clinicians ask about their patients’ well-being and remain vigilant for symptoms and signs of depression.

Putting into Practice

The term ‘screening’ in this recommendation refers to a routine process in which primary care providers administer an **instrument such as a questionnaire to every adult not already reporting symptoms of depression and then use a cut-off score** to determine a follow-up action for those at or above the cut-off score.

Clinicians in primary care or other non-mental health clinic settings are advised:

- To remain alert to patients with risk factors for depression or expressing symptoms of depression, and provide further assessment as clinically indicated.
- The task force does not recommend 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 for depression.

Most provinces and territories do not have jurisdiction-specific guidance regarding depression assessment for adults.

Burden of Illness

The lifetime prevalence of major depressive disorder among people without bipolar disorders was estimated as 9.9% in 2012, and the annual prevalence was estimated as 3.9%. 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% to 14.0% and the 12-month prevalence of major depressive episodes from 4.7% to 7.6% were observed between 2012 and 2022.

Potential consequences of depression

- Lower quality of life
- Suicidal ideation
- Chronic medical conditions
- Increased rates of hospital admission
- Stigmatization

Basis of Recommendation

Evidence

Our systematic review included 3 randomized controlled trials that specifically isolated the effects of screening for depression in three primary care settings. Participants were adults in the United States who were recently diagnosed with acute coronary artery syndrome (ACS), adults in the United Kingdom consulting for osteoarthritis symptoms (OSA), and Chinese mothers at 2 months postpartum.

The three studies provided very uncertain results or showed little to no difference in symptoms of depression between those who were screened and those who were not.

Two trials reported on health related quality of life. The ACS trial showed little to no differences in the change in quality of life (QALY) from baseline to 18 months or quality of life utility scores at 18 months. The OSA study reported a very uncertain effect of screening on quality of life at 12 months.

Two studies reported on harms of screening. The ACS trial reported little to no difference between screening and not screening for harms potentially attributable to the use of antidepressant medications at 18 months. The postpartum trial reported that no adverse events were identified (very-low certainty evidence).

No studies reported directly on diagnosis of depression using a validated diagnostic interview at a follow-up time point or suicidality, day-to-day functionality, time lost at work or at school, impact on lifestyle behaviour, labelling or stigma, false-positive results, overdiagnosis, or overtreatment.

Rationale

This strong recommendation is based on moderate-certainty evidence that screening probably has little to no impact on symptoms of depression or health-related quality of life from one trial, and very uncertain evidence on the impact of screening from two other trials.

While no trials reported on harms of screening such as false positives, overdiagnosis, or overtreatment, screening will lead to an increase in false positives, and may lead to unnecessary referrals and diagnostic evaluation, and overdiagnosis for some patients, reducing resources available for those with known mental health concerns. A meta-analysis using individual patient data gave accuracy information about a screening tool used in the trials we identified. The analysis estimates that 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.

Given the significant challenges to accessing mental health services in Canada, the unnecessary redirection of resources from the treatment of patients with mental health concerns could be an unintended harm of screening. 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 implication of a particular health intervention are certain to be important and benefits have not been demonstrated.