Guideline on instrument-based screening for depression in adults – reviewer comments and CTFPHC responses

Reviewer 01 (Stakeholder): David Conn, Canadian Coalition for Seniors Mental health
Disclosure(s):
- Grants/Research Support from CIHR, PHAC, Health Canada, Ontario MOHLTC, CABHI, CSA, MHCC, Private Anonymous Foundation (for a project on social isolation & loneliness).
-Speakers Bureau/Honoraria from Health Canada, PHAC
-Led Update of Canadian Guidelines on Depression among Older Adults (CCSMH, Published 2021)

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**No** As I understand this guideline it does not refer to a patient group but to the general population (screening)	Correct. This guideline applies to adults in the general population.
3. Are the guidelines supported by the evidence?	**Yes** Very limited evidence. Difficult to study!	Thank you.

4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** I believe that it would be helpful for primary care practitioners to add that they should rule out possible depression in high risk groups e.g. those with chronic medical illness, post-partum or recently bereaved. (ref: CCSMH Guidelines on depression in older adults – www.ccsmh.ca) – can use a single screening question!	Thank you for this suggestion. While certain groups are at an elevated risk for depression, our systematic review did not find evidence on screening those at high risk. The Task Force generally does not recommend interventions (e.g., screening) in an absence of supportive evidence. Instead, the Task Force emphasizes that good clinical care should include asking patients about their well-being and being vigilant for signs of depression. Some healthcare providers may choose to use screening questions without the cutoff scores to guide these conversations, but this is not something the task force is specifically advocating for. To emphasize these points, we have revised the key point, "Health care providers should be vigilant for symptoms or signs of depression as part of good clinical care" to read, "Health care providers should ask patients about their well-being and be vigilant for signs and symptoms of depression and provide further assessment to those expressing symptoms of depression as clinically indicated." In addition, we have directed readers to the CTFPHC recommendation on screening for depression during pregnancy and the postpartum period for guidance on post-partum populations in the Scope section.
5. Do you have any comments or suggestions to improve the guideline?	As above. This would be helpful and more useful clinically. It is very important to consider depression in high risk groups. Almost all clinical outcomes are worse in people with co-existing depression. Thanks!	Response provided above.

Reviewer 02 (Stakeholder): Sandra Lee, BC Ministry of Health

Disclosure(s): None

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you
3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** (No comments provided)	Thank you.

5. Do you have any comments or suggestions to improve the guideline?	Page 7 – family physicians would be the ones diagnosing and treating the patients screened positive for depression. Vast majority of patients would not be sent for further psychiatric assessment (I assume this meaning to psychiatrists or mental health specialists). Maybe change this paragraph and it is not the reality of primary care in Canada "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. A recent individual patient data meta-analysis provides accuracy information for a screening tool used in the trials we identified (26). Based on a prevalence of 11%, screening 100 patients with the Patient Health Questionnaire version 9 (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 (26). This means that some patients who are screened will be sent for an	(Guideline pages 8-9) Thank you for raising an important point. We have revised the Rationale section to indicate that there would be further assessment without specifying who would perform the assessment. This leaves the possibility of assessment in primary care and external options (e.g., psychiatric assessment). "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,"

Reviewer 03 (Stakeholder): Sabrina Guzman, Government of Nunavut
Disclosure(s): Active member of the College of Registered Psychiatric Nurses of Alberta
Access to confidential information within the Government of Nunavut, Department of Health, Mental Health and Addictions Division.

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** No comments provided	Thank you.

2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** Excluded groups are also clearly described.	Thank you.
3. Are the guidelines supported by the evidence?	**Yes**	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No**	Thank you.
5. Do you have any comments or suggestions to improve the guideline?	None	Thank you.

Reviewer 04 (Stakeholder): Brandon Hey, Mental Health Commission of Canada
Disclosure(s): None

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes**	Thank you

2. Are the patient groups to whom the guideline is meant to apply clearly described?	**No**	We have reviewed the scope section of the guideline considering comments received from other stakeholders. Others who reviewed indicated that the patient groups were clearly described. Without a comment to clarify the reason you indicated 'no' we are unable to make any changes to improve clarity further.
3. Are the guidelines supported by the evidence?	**Yes**	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** No comment	We have reviewed the guideline based on comments received from other stakeholders and made changes to add additional information to improve clarity for primary practitioners.

5. Do you have any comments or suggestions to improve the guideline?	p.1 key messages “impairment in social and occupational functioning” – is there a more strengths-based way to say that? Can affect social and occupational functioning? Depression can also result from changes in social and occupational functioning – say from the limitations imposed by a chronic disease or injury.	Thank you for your suggestions. We generally agree it is preferable to use strengths-based messaging when making a guideline recommendation. In this instance, we are actively trying to describe the harms associated with depression. Using ‘*can affect* social and occupational functioning’ doesn’t accurately describe the direction of the relationship, which is that depression is the *cause* of the harm. We agree that depression could also result from the changes as well as cause them, but this point is specifically meant to address the symptoms of depression and not the potential causes. To improve clarity around this key message we have revised it to “… results impaired functioning in social and work settings,” (Key messages for the public) The wording of the recommendation and key messages has undergone consultation with a panel to determine patient perspectives and to determine if they are clear and to gather their general feedback.
	p. 1 genetic factors associated with depression are weak, as per GWAS studies. The most robust genetic components are epigenetic and interact with factors such as child adversity. The literature on social factors is far more robust. Predictive models currently show robust associations also with lapses in social support.	Thank you for this suggestion. We have revised this sentence to clarify that social factors are the more robust predictors of depression. The sentence now reads: “Social factors – and, to a lesser extent, genetic factors – have been linked to depression.” (Background)

p.2 – "substance abuse" is a stigmatizing and outdated term. Organizations like CAPSA, the MHCC, and the CCSA highly prefer "substance use concerns" "substance use disorders", "problematic substance use" and "substance use health" – which recognizes that all substance use exists on a continuum and may or may not warrant a formal diagnosis.	Thank you for this suggestion. We have revised this sentence to "substance use concerns" as suggested. (Background)
p.4 – benefits of screening – I would caution discussing this without talking about the need for referral and follow-up support. Many studies have shown that screening without these provide little benefit and can be quite harmful. The lack of changes in depression symptoms (i.e., scrutinized potential benefits) by virtue of using a screener is not surprising at all as its not actually an intervention per se so much as a signpost for it. Are the right outcomes being examined in making a determination of potential benefit?	We agree there needs to be follow up support. This support must be provided equally to people identified in the screening arm and the control arm of studies, in order to properly assess the impacts of screening for depression. In our review, all studies had to include the same follow-up and treatment in both arms. We have now emphasized this in the methods section. The benefits examined in our review would be a result of people being correctly identified as being depressed and receiving follow-up/treatment, thereby impacting the health outcome(s).

	General comment – given that the US Prevention Taskforce recommends screening for depression for those aged 18+, it might be worth talking about some of the reasons for the discrepancy – obviously the Canadian/PHAC taskforce uses different metrics of judgment and methodology, but it might be fruitful to cross-examine recommendation logics.	Thank you for this comment. We have taken your suggestion, which now reads, "Of the 17 trials included in the systematic review the recommendation was based on, 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-screen 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 study (25) but did not include the UK trial 2017) or the US study (2020) (23,24). The USPSTF examined test accuracy for screening tools but did not evaluate the extent of false positives, which were an outcome of interest for

	There are some limitations to only relying on systematic reviews and RCTs, as for public health issues, diverse reputable sources are available and in the literature, a well-designed observational study can trump a RCT. Because there are limited RCTs in this area, there may be value in expanding the search to other types of study designs. (See: v056p00119.pdf (nih.gov))	You have raised an important point. Observational studies can help, particularly when RCTs are lacking or of poor quality. GRADE suggests that observational can help address issues with RCTs (e.g., indirectness). However, in this case, we have at least one RCT with moderate certainty of no effect, and it is unlikely that observational studies would provide stronger evidence than that.

Reviewer 05 (Stakeholder): John Higenbottam, UBC Psychiatry; Psychosocial Rehabilitation Canada (PSR/RPS Canada)
Disclosure(s): None.

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** No comment	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you.
3. Are the guidelines supported by the evidence?	**Yes** Very strong evidence.	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No**	Thank you.

5. Do you have any comments or suggestions to improve the guideline?	No-well written and evidence based.	Thank you.

Reviewer 06 (Stakeholder): Karen Mason, Saskatchewan Health Authority
Disclosure(s): None

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you
3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you
4. Is there any information missing from the guideline that would make it easier to interpret for primary	**No** (No comments provided)	Thank you
5. Do you have any comments or suggestions to improve the guideline?	Page 2, second paragraph. It may be useful to start a new paragraph after the diagnostic critera for MDD is outlined and before the differences between screening and assessment are outlined.	Thank you. This section has seen a major revision following the Task Force's peer and stakeholder review as well as peer review from the CMAJ. Screening is now described in its own paragraph.

Reviewer 07 (Stakeholder): Justin A. Mills, U.S. Department of Health and Human Services Agency for Healthcare Research and Quality

Disclosure(s): I am a member of the American Academy of Pediatrics, however I do not serve on any committees related to this topic.

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** Yes, I think the object of the recommendation is clear to the reader. I appreciate that the recommendation includes language on screening vs. surveillance as well as a note that patients should report symptoms to their health care provider.	Thank you
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** Yes, I believe so.	Thank you.
3. Are the guidelines supported by the evidence?	**Yes** Given the evidence reviewed and presented by the task force, I think the recommendation not to screen is logical and makes sense	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No** Overall, I think the recommendation does a good job of conveying the guidance to clinicians. One thing that might be useful is to reiterate that clinicians remain vigilant for signs and symptoms of depression (i.e. that a recommendation against screening with a questionnaire does not mean not to look for signs of depression or not to treat depression).	Thank you for this suggestion. We have included this suggestion in Box 2: Summary of recommendations for clinicians, policy-makers, and patients: “Healthcare providers should be vigilant for symptoms or signs of depression as part of good clinical care.” To “Healthcare 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.” We have also added this sentence to the end of the guideline *Conclusions* section.

5. Do you have any comments or suggestions to improve the guideline?	In the "Other Guidelines" Section you note "In contrast, the USPSTF recommends screening based on indirect evidence of benefit…."The USPSTF has a draft recommendation statement updating the 2016 recommendation. In this updated recommendation and evidence review, the USPSTF found both direct and indirect evidence of benefit from screening. I don't have a firm timeline for the publication of the final recommendation statement, but we anticipate it happen in the next few months.	We have updated the reference to the final recommendation publication as well as our description of the USPSTF evidence review. This section now reads, "Of the 17 trials included in the systematic review the recommendation was based on, 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-screen 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 study (25) but did not include the UK trial 2017) or the US study (2020) (23,24). The USPSTF examined test accuracy for screening tools but did not evaluate the

Reviewer 08 (Stakeholder): Robert Olson, Centre for Suicide Prevention
Disclosure(s): None.

Question	Reviewer comments	CTFPHC response

1. Is the objective of the guideline clear?	**Yes**	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you.
3. Are the guidelines supported by the evidence?	**Yes**	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No** No comment	Thank you.
5. Do you have any comments or suggestions to improve the guideline?	I think this document presents the position of recommended against universal screening for depression very well. This is especially important as many will be looking for the rationale behind this decision first and foremost.	Thank you.

Reviewer 09 (Stakeholder): Marija Padjen, Canadian Mental Health Association – Ontario Division
Disclosure(s): None.

Question	Reviewer comments	CTFPHC response

1. Is the objective of the guideline clear?	**No** Somewhat. It appears to be a guideline of what not to do and does not appear to show how to move forward. For me any messaging on best practice moving forward was lost. Focus felt that it was saving money and time, rather than providing a true guideline for what physicians could do.	Thank you for this comment. We hope the revisions have made it clear that the recommendation against screening is due to evidence that screening does not improve health. We have included your suggestion to show physicians what they can do instead of screening. Please see Box 2: Summary of recommendations for clinicians, policy-makers, and patients: "Healthcare providers should be vigilant for symptoms or signs of depression as part of good clinical care." To "Healthcare 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." We have also added this sentence to the end of the guideline Conclusions section.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Neither selected.** I struggle with this question as the issue of equity was not addressed to the extent I feel it should be.	Thank you for this comment. Unfortunately, there was minimal evidence available overall, and a particular lack of evidence for various groups that might be disproportionately affected. We found equity to be a gap in the literature. The Task Force recognizes the importance of equity. Prior to the Task Force pause, a methods working group was working to enhance methods related to equity. This work is now being undertaken as part of the effort to modernize the Task Force methods.

3. Are the guidelines supported by the evidence?	**Yes** Yes, though the focus seems to be saving money and physicians time and not how to improve the system for people living with depression.	Thank you for this comment. We would like to point out that *improving the system for people living with depression* is outside of the scope of this guideline. The guideline is intended to provide a recommendation regarding whether or not to regularly screen people who do not have a history of depression, current diagnosis, or clinical suspicion of depression. Nevertheless, the evidence in our systematic review does not show that screening is an effective intervention, and for that reason it is not a good use of resources. Instead, clinicians should focus on asking about patient well-being and being attentive to signs and symptoms of depression. We have attempted to clarify that resource implications are not considered in the direction (for or against) of Task Force recommendations. Rather they are considered in the strength of the recommendation (i.e., strong, moderate). In the Resource Use section: "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
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** Focus appears on what not to do. It would be better to focus on what they should be doing how they should be approaching folks. It appears from the way it is written that it is the responsibility of people with depression to speak up.	Thank you. We have attempted to re-balance the guideline by indicating that providers should ask about well-being during patient visits. "Healthcare 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."

5. Do you have any comments or suggestions to improve the guideline?	-In terms of the public messaging, while of course it is important to encourage folks to bring up depression with their physician many do not feel comfortable doing so. -There needs to be more emphasis on how physicians should approach conversation and this needs to include cultural safety and EDIA principles	Thank you for these suggestions. We agree that these are very important issues and that it would be useful for someone to create guidance to help physicians approach conversations with patients around depression and cultural safety. This guideline was focused on the question of whether or practitioners should screen for depression.

Reviewer 10 (Stakeholder): Simone Powell, Division of Aging, Seniors and Dementia, Public Health Agency of Canada
Disclosure(s): None

Question	**Reviewer comments**	**CTFPHC response**
1. Is the objective of the guideline clear?	**Yes**, **No (selected both)** Suggest that the objective be stated outright at the front end of the guideline (i.e., the objective of this guideline is….), particularly in the upfront summary	Thank you for your comment. Through the CMAJ review process, we have landed on the following wording for the objective in the up front summary: “This document updates and replaces the 2013 Canadian Task Force on Preventive Health Care guideline.” and “This guideline is an update of the task force’s previous recommendation on depression screening in adults aged 18 years and older.” (Scope)
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you

3. Are the guidelines supported by the evidence?	**Yes** The evidence reviewed is clearly noted. However, I did not see reference (for example in Table 1 that lists other guidelines) to https://ccsmh.ca/wp-content/uploads/2021/06/CCSMH_Depression_Guidelines_FINAL_EN.pdf or https://ccsmh.ca/wp-content/uploads/2016/03/2014-ccsmh-Guideline-Update-LTC.pdf The CCSMH guideline on depression Recommends targeted screening of those elderly at higher risk for depression and present with risk factors (eg chronic disabling illness, persistent sleep problems, etc. (pg 15).	Thank you for this comment. The Task Force guidelines listed were based on systematic reviews of the evidence. According to Task Force methods, a review is considered systematic based on the author's report of several criteria, including the author reporting study inclusion and exclusion criteria, conducting quality or risk of bias assessment on included studies, and providing a list and synthesis of included studies. Based on the information we have been able to find, the CCSMH guideline is based on a "systematic search" but there doesn't appear to be any information reported on inclusion/exclusion criteria, risk of bias assessment, or a list or synthesis of included studies other than a brief narrative review of included studies for each recommendation. It may be that this was done but was not made public.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** Suggest providing additional details of the population groups included in the studies reviewed and the patient engagement activities (or to note where such details are lacking re: representation/diversity).	Thank you for your suggestion to provide additional details of the population groups in the SRs and patient engagement activities. We have added to the Gaps in Knowledge section that the participants in the studies were not representative of the Canadian population. We have also added to the Limitations section that the sample of participants in the patient engagement activities were a non-representative sample. "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."

5. Do you have any comments or suggestions to improve the guideline?	The guideline does not include any reference to older adults even though evidence demonstrates that this population group (including those living in long term care) is at risk for depression and are often under-diagnosed and under-treated (see: https://ccsmh.ca/wp-content/uploads/2021/06/CCSMH_Depression_Guidelines_FINAL_EN.pdf https://secure.cihi.ca/free_products/ccrs_depression_among_seniors_e.pdf) Suggest that this population group be noted along side the other at risk population groups noted in the draft guideline.	Thank you for this comment. The search strategy for our systematic review specifically included older adults, and unfortunately, we did not find any eligible evidence on this group. We have added older adults to the background section where we discuss populations at higher risk for depression. "Although reported rates of mental health problems are lower in adults aged 65 years and older than in other age groups in Canada, research suggests depression in older adults is underrecognized and underreported, making this another group of potential concern."
	The patient engagement activities appear to have been lacking in representation from older adults (i.e., phase 1 participants were aged 22 – 63 and phase 2 aged 22 – 56). Given the risk of depression among older adults, it is suggested that that under representation of older adults be noted as a limitation.	Thank you for this comment. We have revised the limitations section to include the lack of representation of age as a limitation. It now reads: "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."
	It is also suggested that the possible under-representation of diverse populations (from either the studies reviewed and/or the patient engagement activities) be noted (e.g., gaps in knowledge and/or limitations).	Along with the revision to age, we also revised the limitations to include potential uncertain representation of race and ethnicity for the patient engagement activities and the systematic review.

	The guideline speaks to “overdiagnosis” however, it does not address the issue of “underdiagnosis” and any potential relationship of “underdiagnosis” to the recommendation of not screening populations at risk for depression.	Thank you for this comment. Early in the guideline development process, the working group voted on outcomes to include in accordance with the GRADE methodology. At that time, the working group did not vote to include underdiagnosis as one of the critical or important outcomes upon which to base the recommendation. Nevertheless, we did not find any studies that examined underdiagnosis in the systematic review. We did find accuracy data and have used it to give an indication of false negative rates.
	It would be useful to include information on other evidence based resources/tools available to support primary care providers who are supporting populations at risk for depression (i.e., given that the guidelines suggests that health care providers “be vigilant for symptoms or signs of depression as part of good clinical care”.	Thank you for this suggestion. As with our guideline on screening for depression during pregnancy and the postpartum period, we are planning to include links to information that can support primary care providers in their provision of good clinical care.

Reviewer 11 (Stakeholder): Chase Simms, BC Guidelines
Disclosure(s): None.

Question	Reviewer comments	CTFPHC response

1. Is the objective of the guideline clear?	**No** The scope on p. 2 states that the guideline is meant for primary care clinicians, but p. 1 addresses members of the public. I suggest potentially separating p. 1 as a supplemental patient summary or re-wording the language to focus on practitioners.	Thank you for this suggestion. We have revised the scope to clarify the primary and secondary audiences: "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." We have key messages for the public as well as key messages for practitioners and these are separate boxes with clear headings to improve clarity for each audience.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes**	Thank you.
3. Are the guidelines supported by the evidence?	**Yes**	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** It would be beneficial to create a care pathway that practitioners could follow. In addition, it would be helpful to include appendices or links on the PHQ-9 instrument/instructions, safety plan, medications including discontinuation of medication (see BC Guideline appendices for reference https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/depression_full_guideline.pdf).	Thank you for this suggestion. We will be developing knowledge translation tools to help patients and providers understand and implement the recommendation. The BC guideline appears to be focused broadly on identification and management of depression, whereas the scope of this Task Force guideline is limited to screening. For this reason, we have chosen not to provide additional materials related to treatment.

5. Do you have any comments or suggestions to improve the guideline?	It would be nice to see resources across the country and broken down by province/territory. Often times our primary care practitioners feel like they do not have a strong grasp of resources available in their area to support their patients post visit.	Thank you for this suggestion. We agree that a compilation of resources across the country could be useful. Unfortunately, at this point in the project we do not have the resources available to conduct an environmental scan to identify such resources. We do plan to highlight and provide links to a few online resources in the knowledge translation tools for this guideline, which practitioners can provide their patients with post visit.
Comment on guideline document, scope section "For guidance on screening for depression during pregnancy and up to 1 year post partum, readers may refer to the CTFPHC recommendation on screening for depression during pregnancy and the postpartum period (13)."	What about perinatal? http://www.perinatalservicesbc.ca/about/news-stories/stories/statement-affirming-the-importance-of-perinatal-depression-screening-in-bc	The Task Force's pregnancy and postpartum depression guideline provides guidance regarding the perinatal period (during pregnancy and up to 1 year after delivery). We have revised the scope to read: 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. (Scope)
	Recommend hyperlinking to all boxes/figures throughout the document for ease of navigating document	Thank you for this suggestion. We are limited to what the Canadian Medical Association Journal allows authors to include. They don't seem to allow hyperlinks to specific boxes and figures, but they do include a "Jump to Section" column alongside articles that hyperlinks to the various sections, including Figures & Tables and Recommendations (where the boxes are located).

Patient Engagement	Compensation and conflict interest statements?	Thank you for this suggestion. We have added information about compensation and conflict of interest statements for the participants in the Patient Engagement section: "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."
Table 1. (strong recommendation, very-low certainty evidence).	Potentially hyperlink to all these resources in the column. Potentially bold these throughout as they become lost in the recommendations	Thank you for this suggestion. CMAJ will hyperlink references within the text of the article (including other guidelines), which will link to the Google Scholar direct link to each resource.
Appendix 1	(added check marks to BC column for recommendations regarding 'Screen patients who present with symptoms for MDD', 'Administer "two-quick question" method', and 'Conduct screening with PHQ-9'	Thank you for this suggestion. The BC guideline recommends screening patients who present with symptoms for MDD. As we understand it, following up with patients who present for MDD would be a diagnostic pathway whereas screening is done with patients who do not present with symptoms. Our recommendation is to follow up with patients who present with symptoms of depression as clinically indicated. (Box 2: Summary of recommendations for clinicians, policy-makers, and patients)
	Noting date of this citation, is there anything newer or will an updated scan be completed?	The systematic review search was updated to January 27, 2025 for trials and March 19, 2025 for trial registries.

Appendix 2: BC Guideline wording	BC Guideline wording: Clinical interview to determine if the patient meets the Diagnostic and Statistical Manual of Mental Disorders (5th editions)5 criteria to diagnose MDD by using S2 IGECAPS and focusing on functional status. Please note that our team will begin revising this guideline later this year. Citation should be: Medical Services Commission of British Columbia, Guidelines and Protocols Advisory Committee. Major Depressive Disorder in Adults – Diagnosis and Management (2013). Available from http://www.bcguidelines.ca/.(accessed Apr 7 2021)	Thank you. We have updated this reference in our guideline.

Reviewer 12 (Reviewer): Danielle Rice, McMaster University
Disclosure(s): None.

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	Yes. The objective of the guideline is clear throughout the document, including the populations included and excluded and the definition of what is (vs isn't) defined as screening. The authors could consider adding the term "objective" for easier skimming if of interest.	Through the CMAJ review process, we have landed on the following wording for the objective in the up front summary: "This document updates and replaces the 2013 Canadian Task Force on Preventive Health Care guideline." and "This guideline is an update of the task force's previous recommendation on depression screening in adults aged 18 years and older." (Scope)

2. Are the patient groups to whom the guideline is meant to apply clearly described?	Yes. Patient groups of interest are clearly defined and reiterated throughout the document. It is unfortunate that the population groups of interest are not included in the research that exists, but this is simply an unfortunate limitation in evidence.	Thank you.
3. Are the guidelines supported by the evidence?	Yes. The recommendations and guidelines overall are supported by the evidence that is available. There is no existing evidence based on the associated systematic review conducted that would support a different set of recommendations. The recommendations and guidelines have been clearly connected to the research/lack of research.	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	No. No, this guidance and the key points are clear.	Thank you.

5. Do you have any comments or suggestions to improve the guideline?	Yes. Please see below a few recommendations that I hope can be considered if helpful. 1. In the "Key Messages for the Public", the last point notes "if you are diagnosed with depression"…, a diagnosis is not/should not be considered a requirement to discuss support and treatment options. Stepped care models for mental health treatment (including depression) would suggest matching the intensity of symptoms (regardless of diagnosis) with support options, for those with depressive symptoms but not meeting criteria for depression they would be great candidates for self-directed support or peer support (freely available from Wellness Together Canada) or treatment such as exercise or increased social connectedness. Could this point be reworded to something like "If you are experiencing depressive symptoms or a diagnosis of depression, your healthcare provider can discuss support and treatment options." 2. Recommended edit on page 1: "Depression is a medical illness that negatively affects how a person feels, thinks, or behaves, and can result in impairment in social and occupational functioning." Depression does not always result in impairments in social or occupational functioning and I think the addition of a word (or an 's' on "result") was needed to improve the readability of the sentence.	Thank you for these suggestions. We have addressed each below: 1. We have revised as suggested to "If you are experiencing depressive symptoms or have been diagnosed with depression, a health care provider can discuss support and treatment options with you." 2. While we had initially worded the description of depression as you suggestion, one of our clinical experts informed us that the diagnostic criteria for depression specifies that the resulting impairment is essential for diagnosis. This may be a difference between clinical and subclinical depression. 3. We have defined all acronyms on first use, as suggested. 4. Timeframes have been added to the Benefits and Harms sections. 5. CSED was revised to CESD. 6. Thank you for pointing this out. We have revised the harms of treatment to clarify that the study by Leung et al. collected information on adverse events and none were reported. 7. We have revised the Patient values and preferences wording as suggested. Following CMAJ review this now reads: "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.