Is Questionnaire-Based Screening for Depression Worthwhile in Primary Care?

Yes: It Improves Clinical Outcomes

James J. Stevermer, MD, MSPH, and Nikole Cronk, PhD

Depression is a common issue with significant morbidity and disease burden.[1,2] We believe that screening for depression provides health benefit for adolescents, adults (including those older than 65), and people who are pregnant or postpartum. These benefits include decreased prevalence of depression with improved remission rates. Both the Canadian Task Force on Preventive Health Care (CTFPHC) and the US Preventive Services Task Force (USPSTF) use methods that are transparent, structured, and rigorous for the development of clinical guidelines to support patient care. However, in the past several years, CTFPHC upheld its recommendation against screening, and the USPSTF renewed its long-standing recommendation for screening, resulting in potential uncertainty for clinicians.[3,4]

The CTFPHC has never recommended screening for depression. Their strong recommendation reflects the high confidence of the CTFPHC that screening has little to no impact on depression symptoms or health-related quality of life. This conclusion was based on a systematic review of three randomized controlled trials (n = 3,804) that met their criteria for inclusion, with one study having moderate-certainty evidence and two studies having very low-certainty evidence. Each of these trials offered treatment for patients who screened positive for depression, while the control group received usual care. The review found a nonsignificant decrease in General Health Questionnaire-12 score (standardized mean difference = −0.16; 95% CI, −0.35 to 0.02). There was no change in mean quality-adjusted life-year (standardized mean difference = 0; 95% CI, −0.12 to 0.12).[1]

In contrast, the USPSTF has recommended screening for depression in adults.[4] Its 2023 update concluded with moderate certainty that there is a moderate net benefit to screening based on 17 randomized trials (n = 18,437). The meta-analysis of these studies reported a decreased prevalence of depression (odds ratio = 0.6; 95% CI, 0.50 to 0.73) and increased rate of remission (odds ratio = 1.58; 95% CI, 1.0. to 2.02).[2] In addition, the USPSTF found 14 primary studies and 10 systematic reviews supporting the accuracy of screening tests to detect major depression. They also reviewed 50 existing systematic reviews supporting psychological and pharmacologic therapy for depression, although most of these studies were not limited to people identified by screening, resulting in a spectrum of depression severity that was potentially different than a screened population.

So how did the CTFPHC and USPSTF, using similar rigorous methodologies, end up on opposite sides of this question? It is likely that this difference largely relates to which studies were included in the respective evidence reviews. Only one study, which enrolled postpartum women in Hong Kong, was included in both evidence bases.[5] The USPSTF did not include the other two studies used by the CTFPHC because the USPSTF excluded studies with populations that were not broadly generalizable to primary care; all patients in the two studies had osteoarthritis or acute coronary syndrome.[6,7]

On the other hand, the USPSTF used 16 studies the CTFPHC excluded from their database to answer the primary question. Of the 17 studies the USPSTF included, only four had an unscreened control group. However, the other 13 studies screened all participants but released the screening results only to clinicians caring for people in the intervention group. The effect of this minor broadening of inclusion criteria slightly modifies the key question from "Does screening for depression in primary care improve health outcomes?" to "Does sending depression screening test results to clinicians (with or without additional care management supports) improve health outcomes?"[2] The USPSTF posited that this change does not likely reduce the certainty of evidence.

Guideline-making bodies must consider the clinical and social contexts in which their recommendations will be

JAMES J. STEVERMER, MD, MSPH, and NIKOLE CRONK, PhD, University of Missouri Family and Community Medicine, Columbia

Author disclosure: No relevant financial relationships.

Address correspondence to James J. Stevermer at stevermerj@health.missouri.edu.

This is one in a series of pro/con editorials discussing controversial issues in family medicine.

See related editorial on page 18.

A collection of Editorials: Controversies in Family Medicine published in *AFP* is available at https://www.aafp.org/afp/pro-con.

implemented. Although there are many similarities between the United States and Canada, the level of function and penetration of primary care is clearly different, and there appears to be a minor difference in the prevalence of depression. The annual prevalence of major depression was 8.3% in 2021 in the United States and 7.6% in 2022 in Canada.[8,9]

Screening for depression should routinely be performed in patients 12 years and older, based on the USPSTF recommendations. The a priori setting of criteria for medical literature selection for clinical practice recommendations can be challenging, but we agree that the pragmatic approach of the USPSTF to literature selection was reasonable. The USPSTF found moderate evidence that screening reduced prevalence and improved remission. These key improvements in patient-oriented outcomes underlie our affirmation of whether questionnaire-based screening for depression is worthwhile in primary care.

Editor's Note: At the time this editorial was written, Dr. Stevermer was a member of the USPSTF.

Disclaimer: This article does not necessarily represent the views and policies of the USPSTF.

REFERENCES

1. 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(1):176.
2. 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. Evidence Synthesis No. 223. Agency for Healthcare Research and Quality; 2023.
3. Lang E, Gray C, LeBlanc JC, et al.; Canadian Task Force on Preventive Health Care. Recommendation on screening adults for depression using a screening tool. *CMAJ*. 2025;197(35):E1132-E1143.
4. Barry MJ, Nicholson WK, Silverstein M, et al. Screening for depression and suicide risk in adults: US Preventive Services Task Force recommendation statement. *JAMA*. 2023;329(23):2057-2067.
5. Leung SSL, 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(2):292-301.
6. 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(4):e1002273.
7. 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(1):45-53.
8. Substance Abuse and Mental Health Services Administration. 2021 NSDUH Annual National Report. January 4, 2023. Accessed March 9, 2026. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report
9. Stephenson E. Mental disorders and access to mental health care. September 22, 2023. Accessed March 9, 2026. https://www150.statcan.gc.ca/n1/pub/75-006-x/2023001/article/00011-eng.htm ■