UK
National
Screening
Committee

Screening for depression in adults

An evidence map to outline the volume and type of evidence related to screening for depression for the UK National Screening Committee

Version: v1.0

Author: Warwick-Birmingham Screening Evidence Synthesis Group (WeBS-ESG)

Date: January 2026

This report was commissioned by the National Institute for Health and Care Research (NIHR) Evidence Synthesis Programme. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

The UK National Screening Committee secretariat is hosted by the Department of Health and Social Care

Contents

About the UK National Screening Committee (UK NSC) 3

Summary 4

Introduction and approach 5

Background and objectives 5
Previous review on screening for depression in adults 6
Aims of the evidence map 7
Search methods and results 8

Summary of findings 10

Question 1: What is the volume and type of evidence that treatment for people diagnosed with mild or subthreshold depression through screening (population and targeted) leads to better outcomes in the longer term (beyond 2 years) than treatment for people diagnosed with mild or subthreshold depression through other methods? 10
Question 2: What is the volume and type of evidence that screening (population and targeted) adults for depression reduces mortality and morbidity? 11

Conclusions 13

Recommendations 13

Declaration of interests 14

Appendix 1 — Search strategy for the evidence map 15

Databases and platforms searched 15
Search dates 15
Search strategies 15
Numbers of results for each database and question 21
Inclusions and exclusions 21

Appendix 2 – Abstract reporting 25

Question 1 25
Question 2 25

References 28

About the UK National Screening Committee (UK NSC)

The UK National Screening Committee (UK NSC) advises ministers and the NHS in the 4 UK countries about all aspects of population and targeted screening and supports implementation of screening programmes.

Conditions are reviewed against evidence review criteria according to the UK NSC's evidence review process.

Read a complete list of UK NSC recommendations.

UK National Screening Committee, Southside, 39 Victoria Street, London, SW1H 0EU

www.gov.uk/uknsc

Blog: https://nationalscreening.blog.gov.uk/

For queries relating to this document, please contact: uknsc@dhsc.gov.uk.

© Crown copyright 2026

You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence v3.0. To view this licence, visit OGL or email psi@nationalarchives.gsi.gov.uk. Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

Summary

This document discusses the findings of the evidence map on population and targeted screening for depression in adults.

Evidence maps are a way of scanning published literature to look at the volume and type of evidence in relation to a specific topic. They inform whether the evidence is sufficient to commission a more sustained analysis on the topic under consideration.

No evidence was found on whether treatment for people diagnosed with mild or subthreshold depression through screening leads to better outcomes in the longer term (beyond 2 years) than treatment for people diagnosed with mild or subthreshold depression through other methods.

Three studies were found on whether screening adults for depression reduces mortality and morbidity. One study reported a higher rate of diagnosis of depression and a lower risk of psychiatric hospitalisation (but no difference in rates of suicide) in people screened for depression compared to those who were not. Two studies found little to no difference in depression or in quality of life between those who were and were not screened for depression.

Based on the findings of this evidence map, no further evidence synthesis work on screening for depression in adults should be commissioned at the present time. The recommendation is that the UK NSC archive this topic until new evidence becomes available that is likely to have a significant impact on the screening recommendation. Future requests to review the evidence on screening for depression in adults should be submitted through the UK NSC’s open call for topics.

Introduction and approach

Background and objectives

The UK NSC evidence products (for example, evidence maps and evidence summaries) are developed in keeping with the UK NSC evidence review process to ensure that each topic is addressed in the most appropriate and proportionate manner. Further information on the evidence review process can be accessed online.

Screening for depression in adults is a topic currently due for an updated external review.

The Condition

Depression is a mental health condition that can have a serious impact on the affected person and their ability to function (1). It is commonly associated with physical comorbidities (2-4), low mood, fatigue, and sleep disturbances such as insomnia (5-7). It is also linked to reduced quality of life (8), cognitive impairments (9,10), diminished ability to perform daily activities, and poor social functioning (11,12). Depression can impose a substantial burden on health and social care systems (13). Its broader social impact may include greater reliance on welfare and benefits (14), as well as impairments in communication and the ability to maintain relationships throughout the course of the illness (2,15).

Severity of depression is determined by symptoms (which may vary in frequency and intensity), duration and the impact on personal and social functioning (2,5). The National Institute for Health and Care Excellence (NICE) guideline NG222 defines depression as less severe (encompassing subthreshold and mild depression), and more severe (encompassing moderate and severe depression) (2). Even less severe depression can lead to functional impairment, which may in turn predict depressive relapses, and a chronic illness trajectory (16,17).

In 2019 approximately 280 million people in the world were thought to have depression (18) and it is predicted to remain at this level until at least 2030 (13). In autumn 2022 in Great Britain, around 1 in 6 (16%) adults aged 16 years and over reported more severe depressive symptoms (19). The prevalence was highest in the following groups: adult populations who were economically inactive because of long-term sickness (59%), unpaid carers for 35 or more hours a week (37%), disabled adults (35%), young adults aged 16 to 29 years (28%), adults in the most deprived areas of England (25%), and women (19%) (19).

Screening

Recognising depression is often challenging due to patient, provider, and system-level barriers (20). Diagnosis is especially difficult when patients present with somatic or nonspecific symptoms rather than classic signs like low mood (21,22). Primary care providers must assess a combination of somatic complaints, mood changes, and risk factors. This is particularly complex in patients with multiple comorbidities (23). Screening questionnaires have become a useful tool to help identify undiagnosed cases of depression in primary care (20). Screening for depression in primary care may help shorten the time from symptom onset to treatment, potentially preventing the progression from mild to more severe forms with associated adverse outcomes (24).

There are a range of depression screening tools available which vary in length, style, presentation, administration and psychometric properties (25). NICE recommends the use of the Patient Health Questionnaire (PHQ-9), the Hospital Anxiety and Depression Scale, or the Beck Depression Inventory-II to assess individuals for depression, severity of symptoms, functioning, and response to treatment (26). A 2021 systematic review and meta-analysis assessed the performance and accuracy of depression screening tools used in primary care (27). The review included 81 studies reporting on 40 unique depression screening tools. Based on ease of administration, the authors identified 18 screening tools as suitable for use in primary healthcare settings. Among the 6 tools included in the meta-analyses, the PHQ-9 and WHO-5 demonstrated the highest accuracy (as measured by the diagnostic odds ratios, receiver operating characteristic curves, specificity and positive likelihood ratios) and were the easiest to administer (27). The PHQ is the most widely used and studied depression screening tool, with PHQ-9 and PHQ-2 being the most used versions (28). The PHQ-9 is a 9-item self-report scale based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria that rates symptom frequency from 0 (not at all) to 3 (nearly every day), with a maximum score of 27 (26); whereas the PHQ-2 is designed as a rapid tool incorporating only the first 2 questions from the PHQ-9 (29). These tools have sensitivity from 0.77 to 0.81 (PHQ-9) and 0.83 to 0.87 (PHQ-2) and specificity from 0.91 to 0.94 (PHQ-9) and 0.78 to 0.92 (PHQ-2) (30). Evidence suggests that these tests have poor positive predictive value (PPV) when used in the general population (10–32%) (31-37). This means that the tools identify a significant number of false positives and could, therefore, lead to unnecessary follow up in patients who would never go on to develop depression.

Treatment

A variety of approaches for treating depression are recommended in NICE guideline NG222 (2). These include psychological and psychosocial interventions, pharmacological treatments and physical treatments and activities (2). Understanding the relative benefits, harms and costs of these approaches is crucial to making an informed decision on treatment. This is particularly relevant for individuals with subthreshold depression, a condition affecting around 11% of the general population (38). These individuals are approximately 3 times more likely to develop more severe depressive disorder than those without symptoms (39). Early treatment for subthreshold depression, particularly through psychological or behavioural interventions, may help reduce symptom severity and prevent progression to more severe forms of illness (39). However, some studies suggest that only 10 to 12% (40) of people with less severe (subthreshold) depression develop a more severe depressive disorder over time and therefore screening individuals for less severe (subclinical or subthreshold) depression runs the risk of overdiagnosis, leading people who might never experience clinical impairment or morbidity during their lives to be labelled and potentially treated without benefit (41). In a recent cohort study where over 60,000 people were screened for depression, 7% were detected to have elevated depressive symptoms and/or suicidal ideation, and by week 8 after screening 70% had received antidepressant/referral and/or follow-up care (42). This highlights the importance of understanding whether initiating treatment for patients identified through screening leads to improved long-term outcomes.

Previous review on screening for depression in adults

In 2014, the UK NSC commissioned a review to evaluate the evidence for introducing a population screening programme for depression (31). The review assessed the accuracy of questionnaire-based screening tools to detect depression, the effectiveness of early interventions for

mild depression, and the effectiveness of collaborative care models within existing healthcare systems to manage depression. It identified the PHQ as the most commonly used screening tool and noted that its PPV in a general population would likely result in a high number of false positives. Whilst the effectiveness of drug and psychological treatments was well established, evidence on the natural course of the condition and the value of early intervention for mild or subthreshold depression was limited. The review also highlighted a lack of randomised controlled trials (RCTs) showing that screening reduces morbidity or mortality. As a result, the UK NSC did not recommend routine population screening for depression.

In 2020, the UK NSC commissioned an evidence summary (43) to build on the findings of the 2014 review (31). This evidence summary considered 3 key questions exploring the longer term (beyond 2 years) outcomes of interventions to treat milder forms of depression, evidence from RCTs on the effect of screening for depression, and whether the clinical detection and management of depression was currently well implemented in the UK. The review found a lack of evidence on the long-term impact (beyond 2 years) of treating milder forms of depression to prevent progression to more severe illness. Only 3 studies (44-46) reported outcomes beyond 12 months (only one of which had a 2-year follow up (45) and their data were inconsistently reported, with heterogeneous results and no clear evidence that interventions for subthreshold or mild depression reduced the risk of developing more severe depression. The review also identified 2 RCTs that reported on effectiveness of screening for depression on reducing mortality and morbidity (47,48). The studies were small, varied in methods, lacked consistent conclusions, had high risk of bias, and raised concerns about their applicability to UK population screening. Finally, the review found limited and uncertain evidence from 4 UK-based studies (49-52) which were insufficient to determine how well depression is currently detected and managed; overall, they suggested lower-than-expected use of psychological therapies and variable, generally low treatment compliance (43). In response to this review, the UK NSC upheld the recommendations of the previous 2014 review not to introduce a systematic population screening programme for depression.

The UK NSC currently recommends against screening for depression in adults. The Committee based this recommendation on the evidence provided by the 2020 review carried out by Solutions for Public Health.

Aims of the evidence map

Evidence maps are rapid evidence products which aim to gauge the volume and type of evidence relating to a specific topic.

This evidence map has been developed to assess whether further evidence synthesis work on screening for depression in adults should be commissioned and to evaluate the volume and type of evidence on key issues related to screening for depression in adults. The aim of this document is to present the information necessary to inform UK NSC decision-making processes.

The map addressed the following questions:

1. What is the volume and type of evidence that treatment for people diagnosed with mild or subthreshold depression through screening (population and targeted) leads to better outcomes in the longer term (beyond 2 years) than treatment for people diagnosed with mild or subthreshold depression through other methods?

2. What is the volume and type of evidence that screening (population and targeted) adults for depression reduces mortality and morbidity?

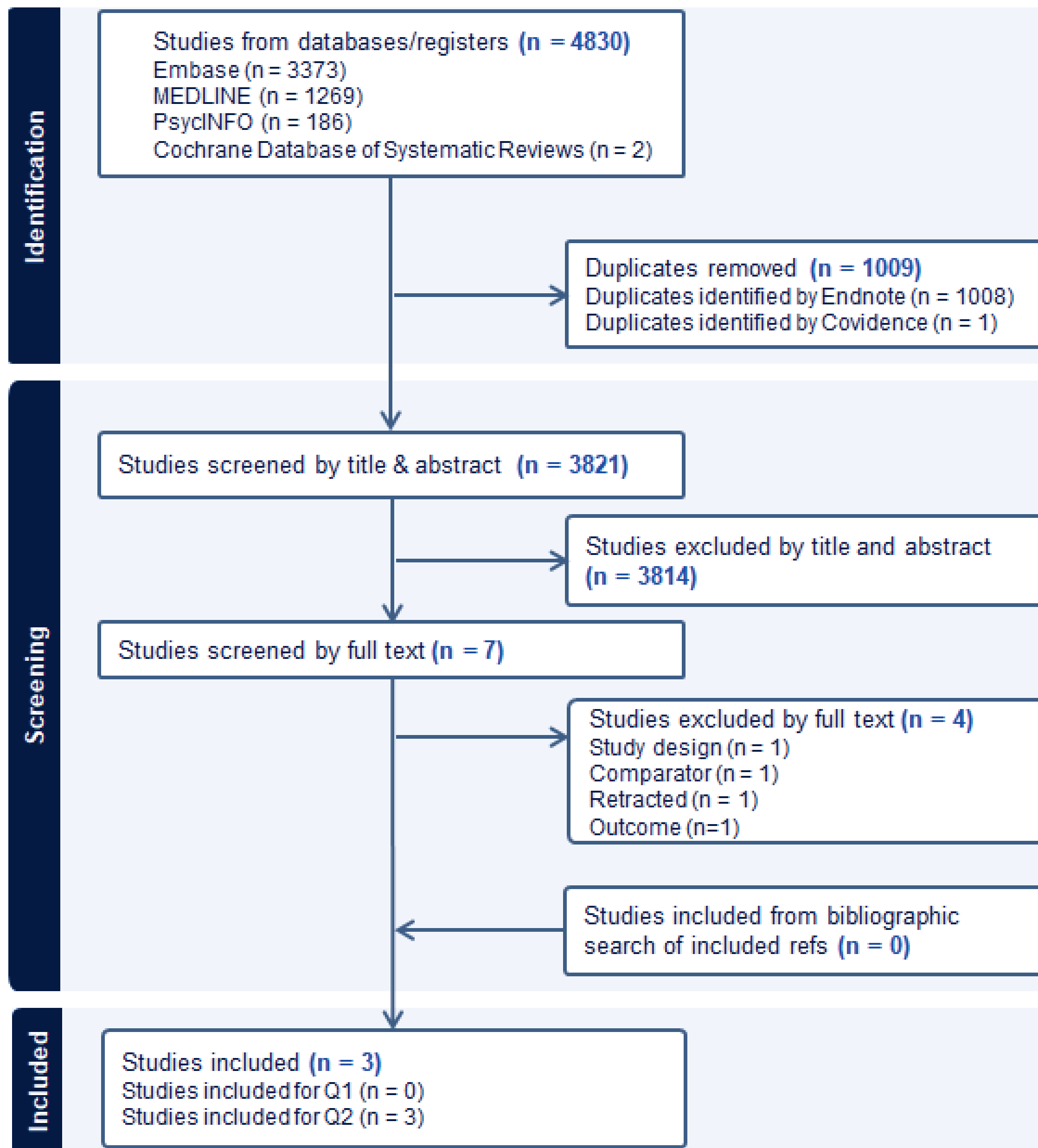
Search methods and results

The searches were conducted on 24 September 2025 using 4 databases: Medline, Embase, PsycInfo and the Cochrane Library (Reviews). Automatic de-duplication was conducted using Endnote v21.4. The search period was restricted to August 2019 to September 2025. The detailed search strategies, including exclusion and inclusion criteria, are available in Appendix 1. Each title and abstract was screened once for eligibility using the Covidence platform (53). All references were reviewed at the title and abstract level. A formal quality appraisal of the evidence was not required, given the remit of the evidence map.

Abstract reporting tables are available in Appendix 2.

The search returned 4830 results. After excluding 152 pre-2019 papers and conducting automatic and manual de-duplication, 3,821 unique references remained for screening. After screening by title and abstract 7 publications remained, and the full texts were accessed to confirm their eligibility. Of these, 4 were excluded and 3 were included in the final evidence map. A Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram summarising the number of studies included and excluded is presented in Figure 1.

Figure 1. PRISMA flow diagram of included and excluded records



Summary of findings

Question 1: What is the volume and type of evidence that treatment for people diagnosed with mild or subthreshold depression through screening (population and targeted) leads to better outcomes in the longer term (beyond 2 years) than treatment for people diagnosed with mild or subthreshold depression through other methods?

Volume of evidence

After screening the titles and abstracts of identified records, 5 studies were identified as being potentially relevant to question 1 and the full texts reviewed (54-58). None met the inclusion criteria for this question. Four studies were ineligible because they did not report outcomes for people with mild or subthreshold depression (54-57), and one study had been retracted (58).

Conclusion

In summary, at present there is insufficient evidence in this key area to justify further evidence synthesis work.

Question 2: What is the volume and type of evidence that screening (population and targeted) adults for depression reduces mortality and morbidity?

Volume of evidence

After screening for eligibility by title and abstract 5 publications appeared to meet the inclusion criteria for this question (54-58). The full texts of these publications were reviewed. Three studies met the inclusion criteria and are described below (54,56,57). Two studies were excluded (55,58). One study, a systematic review and meta-analysis (55), was excluded as only one of the studies included in that review (59) compared a screened with an unscreened population, and this study did not meet our eligibility criteria as the date of publication was 1999 and the length of follow up was 3 months (59). The second study had been retracted (58).

Type of evidence

One study reported the effects of depression screening on the general population (54). The other two studies reported on depression screening in targeted populations, namely survivors of acute coronary syndromes (56) and patients who had suffered ischemic stroke (57).

The study conducted in the general population (54), was a target trial emulation study conducted in Taiwan between 1 January 2013 and 31 December 2019. The study enrolled 4,972,228 adults aged 40 years and over who participated in a health checkup with depression screening and compared outcomes with an equal number of unscreened individuals. Patients were screened using the Whooley questionnaire, which is a 2-question instrument (60) where a yes response to either question was considered to be positive for depression. Individuals were followed up until they reached one of the study outcomes (newly-treated depression, psychiatric hospitalisation, or suicide), death, or end-of-follow-up, whichever occurred first. In relation to the evidence map question, the study outcome “newly treated depression” is used as a proxy for rate of depression, and “psychiatric hospitalisation” and “suicide” to reflect severity of depression. Mean follow-up was 4.1 years for screened individuals and 3.2 years for unscreened subjects. After balancing baseline characteristics using propensity score weighting, the screened group had a higher rate of newly treated depression (hazard ratio (HR) 1.63 [95% confidence intervals (CI) 1.62, 1.64]) and a lower risk of psychiatric hospitalisation (HR 0.93 [95% CI 0.91, 0.95]). There was no association between method of detection and suicide, though risk was higher among adults aged 65 years and over who attended screening than those who did not.

Both studies that were conducted in targeted populations were RCTs which aimed to assess the quality of life of patients in a screened population compared with usual care / no screening (56,57). The first study, the CODIACS-QoL (Comparison of Depression Interventions After Acute Coronary Syndrome: Quality of Life) RCT (56), was conducted in the USA and enrolled patients with acute coronary syndrome with no prior history of depression. Patients were randomised 1:1:1 to one of three groups: a screen, notify, and treat group that received PHQ-8 depression screening, clinician notification, and centralised stepped-care treatment for those who screened positive (n = 499); a screen and notify group that received PHQ-8 screening with clinician notification only (n = 501); or a usual care group that received no depression screening (n = 500). After a follow up of 18 months, there were no differences in mean (standard deviation (SD)) change in quality-adjusted life-years (QALYs) (screen, notify and treat, -0.06 [0.20];

screen and notify, -0.06 [0.20]; no screen, -0.06 [0.18]; p-value = 0.98), or mortality with 4.6%, 5.2% and 3.6% deaths reported respectively. There were also no differences between groups in depression outcomes measured using the CESD-10, including mean (SD) depression-free days (screen, notify and treat 343.1 [179.0]; screen and notify 351.3 [175.0]; no screen 339.0 [176.6]; p = 0.63) or depressive symptom scores at 18 months (PHQ-8: 3.63 [4.40], 3.60 [4.14], and 3.69 [4.21], respectively; p = 0.99).

The second study was a multicentre, patient-masked, cluster RCT conducted in the Netherlands between 2019 and 2022 (57). It enrolled 531 patients who had suffered ischemic stroke from 12 Dutch non-university hospitals. The study assigned clusters (hospitals) to intervention (n = 264) or to usual care / no screening (n = 267). The intervention comprised consultation conducted by a specialised stroke nurse at the outpatient neurology clinics at 6 weeks after stroke and included screening for emotional and cognitive problems, screening for participation restrictions, self-management support, and, if needed, referral to rehabilitation services or usual care. The effect of the intervention on quality of life was mixed. The intervention produced a small, statistically significant improvement on the EQ-5D-5L (mean difference (MD) 0.043; 95% CI 0.021 to 0.064) at 1 year after stroke. There were no statistically significant differences in other quality of life measures; EQ-5D Visual Analog Scale (EQ-VAS) (MD 1.69; 95% CI -0.57 to 3.95), Patient-Reported Outcome Measurement Information System (PROMIS) Global Physical Health T-score (MD 0.51; 95% CI -0.31 to 1.32), PROMIS Global Mental Health T-score (MD 0.74; 95% CI -0.34 to 1.83) 1 year after stroke. There were also no differences between interventions for Hospital Anxiety and Depression Scale-Depression subscale (HADS-D) score at 1 year (MD −0.35; 95% CI −0.85 to 0.14) at the same timepoint.

Conclusion

In summary, at present there is an insufficient volume of evidence in this key area to justify further evidence synthesis work.

Conclusions

The findings of this evidence map are unlikely to impact on current recommendations on screening for depression in adults as no new evidence was identified that would change those conclusions.

Recommendations

Recommendations are developed in collaboration between WeBS-ESG, the Evidence Team (UK NSC Secretariat) and the UK NSC Adult Reference Group (ARG).

Based on the findings of this evidence map, no further evidence synthesis work on screening for depression in adults should be commissioned at the present time. The recommendation is that the UK NSC archive this topic until new evidence becomes available that is likely to have a significant impact on the screening recommendation. Future requests to review the evidence on screening for depression in adults should be submitted through the UK NSC's open call for topics.

Declaration of interests

One of the authors is a member of the UK NSC Adult Reference Group.

Appendix 1 — Search strategy for the evidence map

Databases and platforms searched

Systematic literature searches were undertaken using terms for depression and screening to identify evidence for both review questions simultaneously. The search strategies were developed in MEDLINE (OVID). The search strategies included study design filters to limit the search results to systematic reviews, trials and cohort studies. The search strategies were limited to adults and humans. Search results were limited to those in the English language only and published from August 2019 to date. The search used in the previous UK NSC review on this topic (43) was used as a starting point. After discussion with the Evidence Team (UK NSC Secretariat), it was agreed to run a narrow search. The search was adapted for EMBASE (OVID), PsycInfo (OVID) and The Cochrane Database of Systematic Reviews (Wiley). The retrieved papers were imported into Endnote and deduplicated. The remaining records were uploaded to Covidence (53) for title and abstract screening. One extra duplicate was found by Covidence.

Citation searches were conducted on the 3 included papers. Forward citation searches were conducted on 3 December 2025 in the Web of Science, Scopus, and Citation Chaser. The search retrieved 66 unique references for the Kronish paper (56) and 1 unique reference for the Slender paper (57). One additional reference was found for Chen (54). These were then assessed for eligibility; however, none were relevant.

Search dates

The searches were run on 24 September 2025. The searches were restricted from August 2019 onwards.

Search strategies

Ovid MEDLINE(R) ALL <1946 to September 18, 2025>

1. Depression/ – 173631
2. dysthymic disorder/ – 191
3. depress*.ti,kf. – 258929
4. 1 or 2 or 3 – 329032
5. Mass Screening/ – 122596
6. (screen* or test* or detect*).ti,kf. – 13216
7. 5 or 6 – 1403470
8. 4 and 7 – 1445284
9. (exp Child/ or Adolescent/ or exp Infant/) not exp Adult/ – 2276385
10. 8 not 9 – 12208

11. exp animals/ not humans/ – 5376275
12. 10 not 11 – 11077
13. (201908* or 201909* or 201910* or 201911* or 201912* or 2020* or 2021* or 2022* or 2023* or 2024* or 2025*).ed,dt,da – 10215288
14. 12 and 13 – 3906
15. systematic review*.ti. – 307175
16. systematic review.pt. – 303246
17. 15 or 16 – 384948
18. randomized controlled trial.pt. – 646129
19. exp randomized controlled trial/ – 648172
20. controlled clinical trial.pt. – 95743
21. randomized.ab. – 709265
22. placebo.ab. – 262061
23. clinical trials as topic/ – 205783
24. randomly.ab. – 469021
25. trial.ti. – 346012
26. or/18-25 – 1714368
27. "Epidemiologic Studies"/ – 9704
28. (epidemiologic* adj (studies or study)).ti,ab,kf,kw. – 104202
29. Case-Control Studies/ or Matched-Pair Analysis/ – 356335
30. (case adj2 control).ti,ab,kf,kw. – 182136
31. cohort studies/ or longitudinal studies/ or follow-up studies/ or prospective studies/ or retrospective studies/ – 2792563
32. (cohort or longitudinal or prospective).ti,ab,kf,kw. – 1922481
33. 27 or 28 or 29 or 30 or 31 or 32 – 4023367
34. 17 or 26 or 33 – 5288043
35. 14 and 34 – 1276
36. limit 35 to english language – 1269

Embase Classic+Embase <1947 to 2025 Week 37>

1. recurrent brief depression/ or subsyndromal depression/ or depression/ or minor depression/ – 607993
2. dysthymia/ – 10607
3. depress*.ti,kf. – 354523
4. depression/ – 607377
5. 1 or 2 or 3 or 4 – 739309
6. mass screening/ or screening/ – 289718
7. (screen* or test* or detect*).ti,kf. – 1843554
8. 6 or 7 – 2010355
9. 5 and 8 – 31489
10. exp juvenile/ not exp adult/ – 3245295
11. 9 not 10 – 29179
12. (exp animal/ or exp invertebrate/ or nonhuman/ or animal experiment/ or animal tissue/ or animal model/ or exp plant/ or exp fungus/) not (exp human/ or human tissue/) – 9383029
13. 11 not 12 – 26211
14. (201908* or 201910* or 201911* or 201912* or 2020* or 2021* or 2022* or 2023* or 2024* or 2025*).dc,dd,dp. – 12749448
15. 13 and 14 – 9986
16. systematic review*.ti. – 351837
17. limit 15 to "systematic review" – 480
18. 16 or 17 – 352027
19. exp randomized controlled trial/ – 1103871
20. Controlled clinical trial/ – 460487
21. random$.ti,ab. – 2500033
22. randomization/ – 101595
23. intermethod comp – 316482
24. placebo.ti,ab. – 468374
25. (compare or compared or comparison).ti. – 726377
26. ((evaluated or evaluate or evaluating or assessed or assess) and (compare or compared or comparing or comparison)).ab. – 3337330
27. (open adj label).ti,ab. – 187129
28. ((double or single or doubly or singly) adj (blind or blinded or blindly)).ti,ab. – 372687

29. double blind procedure/ – 310675
30. parallel group$1.ti,ab. – 52739
31. (crossover or cross over).ti,ab. – 157489
32. ((assign$ or match or matched or allocation) adj5 (alternate or group$1 or intervention$1 or patient$1 or subject$1 or participant$1)).ti,ab. – 512400
33. (assigned or allocated).ti,ab. – 609242
34. (controlled adj7 (study or design or trial)).ti,ab.– 636508
35. (volunteer or volunteers).ti,ab. – 328715
36. human experiment/ – 727459
37. trial.ti. – 569452
38. or/19-37 – 7581023
39. (random$ adj sampl$ adj7 ("cross section$" or questionnaire$1 or survey$ or database$1)).ti,ab. not (comparative study/ or controlled study/ or randomi?ed controlled.ti,ab. or randomly assigned.ti,ab.) – 10793
40. Cross-sectional study/ not (exp randomized controlled trial/ or controlled clinical study/ or controlled study/ or randomi?ed controlled.ti,ab. or control group$1.ti,ab.) – 465256
41. (((case adj control$) and random$) not randomi?ed controlled).ti,ab. – 24469
42. Systematic review.ti,ab. not (trial or study).ti. – 421127
43. (nonrandom$ not random$).ti,ab. – 21424
44. "random field$".ti,ab. – 3217
45. (random cluster adj3 sampl$).ti,ab. – 1796
46. (review.ab. and review.pt.) not trial.ti. – 1325128
47. "we searched".ab. and (review.ti. or review.pt.) – 59745
48. "update review".ab. – 154
49. (databases adj4 searched).ab. – 78783
50. (rat or rats or mouse or mice or swine or porcine or murine or sheep or lambs or pigs or piglets or rabbit or rabbits or cat or cats or dog or dogs or cattle or bovine or monkey or monkeys or trout or marmoset$1).ti. and animal experiment/ – 1316579
51. Animal experiment/ not (human experiment/ or human/) – 2784627
52. or/39-51 – 4986197
53. 38 not 52 – 6681889

54. (epidemiologic* adj (studies or study)).ti,ab,kf,kw,hw,sh. – 146203
55. case control study/ – 241743
56. Matched-Pair Analysis.ti,ab,kw,kf,hw,sh. – 2560
57. (case adj2 control).ti,ab,kf,kw,hw,sh. – 341064
58. cohort analysis/ – 1441643
59. longitudinal study/ – 255347
60. follow up/ – 2551500
61. prospective study/ – 1008622
62. (cohort or longitudinal or prospective).ti,ab,kf,kw,hw,sh. – 3728609
63. 54 or 55 or 56 or 57 or 58 or 59 or 60 or 61 or 62 – 5820401
64. 18 or 53 or 63 – 10924665
65. 15 and 64 – 5514
66. limit 65 to (article or article in press) – 3418
67. limit 66 to english language – 3373

APA PsycInfo <1967 to September 2025 Week 2>

1. exp Depression Screening/ – 518
2. depress*.ti,ab,hw. – 392420
3. exp Major Depression/ – 184250
4. 2 or 3 – 393006
5. screen*.ti,hw. – 42538
6. exp Screening/ or exp Screening Tests/ or exp Depression Screening/ – 23369
7. 5 or 6 – 44431
8. 4 and 7 – 5694
9. 1 or 8 – 5694
10. ((child* or adolescen*) not adult*).ag. – 578636
11. 9 not 10 – 5174
12. limit 11 to yr="2019 –Current" – 1821
13. exp Clinical Trials/ or Placebo/ or (random* or sham or placebo* or ((singl* or doubl*) adj (blind* or dumm* or mask*)) or ((tripl* or trebl*) adj (blind* or dumm* or mask*)) or (control*

adj3 (study or studies or trial* or group*)) or Nonrandom* or non random* or non–random* or quasi–random* or quasirandom* or allocated or ((open label or open–label) adj5 (study or studies or trial*)) or ((equivalence or superiority or non–inferiority or noninferiority) adj3 (study or studies or trial*)) or ((pragmatic or practical) adj3 trial*) or ((quasiexperimental or quasi–experimental) adj3 (study or studies or trial*)) or (phase adj3 (III or "3") adj3 (study or studies or trial*))).ti,ab,hw. – 439441

14. exp "Systematic Review"/ – 938
15. 13 or 14 – 440110
16. 12 and 15 – 191
17. limit 16 to english language – 186

The Cochrane Library.

#1. MeSH descriptor: [Depression] explode all trees – 19523

#2. MeSH descriptor: [Dysthymic Disorder] explode all trees – 202

#3. (depress*):ti – 40887

#4. (depress*):kw – 62696

#5. #1 or #2 or #3 or #4 – 77165

#6. MeSH descriptor: [Mass Screening] explode all trees – 6108

#7. (Screen* or test* or detect*):ti – 54061

#8. (Screen* or test* or detect*.):kw – 152842

#9. #6 or #7 or #8 – 188070

#10. #5 and #9 – 8033

Numbers of results for each database and question

Table 1.1 Numbers of records by database searched

Database	**Total no. of references**	**No. of references post-duplication**
Medline All	1269	1225
Embase	3373	2484
The Cochrane Database of Systematic Reviews (Reviews only)	2	1
PsycInfo	186	111
TOTAL	**4830**	**3,821**

Inclusions and exclusions

Studies that satisfied the following criteria listed in the tables were included:

Table 1.2 Question 1. What is the volume and type of evidence that treatment for people diagnosed with mild or subthreshold depression through screening (population and targeted) leads to better outcomes in the longer term (beyond 2 years) than treatment for people diagnosed with mild or sub-threshold depression through other methods?

	Inclusion criteria	**Exclusion criteria**
Population	Adult populations	Groups that would not be within the remit of a nationally organised screening programme (e.g. people who cannot be identified systematically such as those experiencing homelessness) Postnatal and antenatal depression (as they are covered in separate UK NSC reviews)
Target condition	Mild or subthreshold depression*	Moderate / severe depression
Intervention/exposure	Any of the following interventions provided to people diagnosed through screening: • Non-pharmacological interventions (e.g. psychosocial interventions,	Not applicable

	Inclusion criteria	Exclusion criteria
	cognitive behavioural therapy, physical activity) • Pharmacological intervention • Combination of the above	
Comparator	Any of the following interventions provided to people diagnosed through other non-screening methods: • Non-pharmacological interventions (e.g. psychosocial interventions, cognitive behavioural therapy, physical activity) • Pharmacological intervention • Placebo • Combination of the above • No treatment	Not applicable
Outcomes	Severity of depression Resolution of depression (mild, moderate and severe) or only exhibiting subthreshold depressive symptoms Study reported outcomes for interventions Note. Where such data are available, outcomes will be stratified by age, sex, ethnicity and other population or targeted characteristics	Not applicable
Study designs	Systematic reviews** RCTs Prospective observational studies (cohort studies and case control studies) Studies with a follow up of ≥1 year	Studies with a follow up of <1 year Non-English language Published before August 2019 Case series, case reports, retrospective and single-arm studies Conference abstracts/posters Clinical trial registry records
Geographic focus	No restriction	Not applicable

Abbreviations: RCT, randomised controlled trial

* NICE guideline [NG22] noted that the classification of depression severity has moved away from the traditional 4 categories (subthreshold, mild, moderate and severe) to classification as less severe (encompassing subthreshold and mild) or more severe (encompassing moderate and severe) depression

**Systematic reviews were defined as per Centre for Reviews and Dissemination (CDR) Database of Abstract of Reviews of Effects (DARE) criteria (61).

Table 1.3 Question 2. What is the volume and type of evidence that screening (population and targeted) adults for depression reduces mortality and morbidity?

	Inclusion criteria	**Exclusion criteria**
Population	Adult populations	Groups that would not be within the remit of a nationally organised screening programme (e.g. people who cannot be identified systematically such as those experiencing homelessness) Postnatal and antenatal depression (as they are covered in separate UK NSC reviews)
Target condition	Depression	Not applicable
Intervention/exposure	Offer of screening	Not applicable
Comparator	No offer of screening	Not applicable
Outcomes	Depression symptoms, e.g. measures of functionality Severity of depression, e.g. less severe (subthreshold, mild), more severe (moderate, severe) Chronic depression Quality of life measures Mortality Reported rate of depression Note. Where such data are available, outcomes will be stratified by age, sex, ethnicity and other population or targeted characteristics	Not applicable

	Inclusion criteria	**Exclusion criteria**
Study designs	Systematic reviews* RCTs Prospective observational studies (cohort studies and case control studies) Studies with a follow up of ≥1 year	Studies with a follow up of <1 year Non-English language Published before August 2019 Case series, case reports, retrospective and single-arm studies Conference abstracts/posters Clinical trial registry records
Geographic focus	No restriction	Not applicable

Abbreviations: RCT, randomised controlled trial

*Systematic reviews were defined as per Centre for Reviews and Dissemination (CDR) Database of Abstract of Reviews of Effects (DARE) criteria (61).

Appendix 2 – Abstract reporting

Question 1

No citations included for Question 1.

Question 2

Citation 1

Chen et al. (2024) (54)

Study type

This was a target trial emulation study. Specifically, the authors used real-world data from Taiwan to emulate the design of a randomized controlled trial (RCT) comparing adults who received health checkups including depression screening with those who did not.

Objectives

To estimate the effectiveness of health checkup with depression screening on depression treatment and outcomes in middle-aged and older adults compared with those without screening.

Components of the study

Adults aged 40 years and above who participated in a health checkup with depression screening (n = 4,972,228) or age- and sex-matched individuals who had not yet received a checkup served as unscreened controls (n = 4,972,228) between 2013 and 2019. The trial aimed to estimate hazard ratios for newly treated depression, psychiatric hospitalisation, and suicide, and examined how these risks changed over time using interval Cox models.

Outcomes reported

In relation to the eligibility criteria, the outcome "newly treated depression" acts as a proxy for rate of depression, while "psychiatric hospitalisation" and "suicide" reflect severity of depression. A total of 4,972,228 screened individuals and an equal number of comparisons were made. The incidence of newly treated depression was higher among screened individuals compared with unscreened (HR 1.63 [95% CI 1.62, 1.64]). Regarding psychiatric hospitalisations, the incidence rate was slightly lower among screened individuals (HR 0.93 [95% CI 0.91, 0.95]; $p<0.001$). Overall, depression screening was not significantly associated with suicide risk. However, among adults aged ≥65 years, screening was linked to a higher suicide risk.

Conclusions

The authors conclude that health checkups with depression screening increased depression treatment and reduced psychiatric hospitalisation but did not affect suicide mortality. Treatment uptake among screen-positive individuals remained low, highlighting the need to strengthen re-ferral and care pathways.

Citation 2

Kronish et al. (2020) (56)

Study type

This was a 3-group multisite RCT (CODIACS-QoL; NCT01993017) which examined depression screening on patients with ACS.

Objectives

To determine whether systematically screening for depression in survivors of ACS improves quality of life and depression compared with usual care.

Components of the study

Patients with ACS from 4 health care systems (n = 1500) were randomised (1:1:1) to receive (i) systematic depression screening using the 8-item Patient Health Questionnaire, with notification of primary care clinicians and provision of centralised, patient-preference, stepped depression care for those with positive screening results (8-item Patient Health Questionnaire score ≥10; screen, notify, and treat, n = 499); (ii) systematic depression screening, with notification of primary care clinicians for those with positive screening results (screen and notify, n = 501); and (iii) usual care (no screening, n = 500) between 2013 and 2017 (median trial duration 18 months). The primary outcome was change in QALYs, with secondary outcomes including depression-free days, depressive symptom scores, and mortality.

Outcomes reported

There were no differences in mean (SD) change in QALYs (screen, notify and treat, -0.06 [0.20]; screen and notify, -0.06 [0.20]; no screen, -0.06 [0.18]; p-value = 0.98). There were also no differences in depression outcomes, including mean (SD) depression-free days (screen, notify and treat 343.1 [179.0]; screen and notify 351.3 [175.0]; no screen 339.0 [176.6]; p = 0.63) or depressive symptom scores at 18 months (PHQ-8: 3.63 [4.40], 3.60 [4.14], and 3.69 [4.21], respectively; p = 0.99). Harms including death did not differ among groups.

Conclusions

The authors conclude that in patients with ACS without a history of depression, systematic depression screening with or without providing depression treatment did not alter quality-adjusted life-years or harms.

[The full text was accessed to ascertain the depressive symptom scores]

Citation 3

Slenders et al. (2025) (57)

Study type

This was a multicentre, patient-masked, cluster-RCT (Netherlands Trial Register: NL7295) which examined a depression screening and care intervention in patients who had suffered ischemic stroke.

Objectives

The primary objective was to test whether a screening and care intervention targeting emotional and cognitive problems after stroke improved societal participation at 1 year. Secondary objectives were to determine whether the intervention improved emotional and cognitive concerns, anxiety, depression, QoL, self-efficacy, and disability.

Components of the study

Patients with ischemic stroke aged ≥18 years discharged home without inpatient or outpatient rehabilitation (n = 531) were included. Clusters (12 non-university hospitals with a stroke unit) were randomised 1:1 to an intervention (n = 264, consultation conducted by a specialised stroke nurse at the outpatient neurology clinics at 6 weeks after stroke and included screening for emotional and cognitive problems, screening for participation restrictions, self-management support, and, if needed, referral to rehabilitation services) or usual care (n = 267) between 2019 and 2022. The primary outcome was societal participation and included in the secondary outcomes was depression (as measured using HADS-D) and QoL (as measured by EQ-5D-5L, EQ-VAS, PROMIS-10) at 12 months. Continuous outcomes were analysed with mixed models for repeated measures and ordinal outcomes with ordinal mixed-effects models.

Outcomes reported

The primary analysis showed no difference in societal participation at 1 year (p = 0.652). For HADS-D there was no significant differences in scores (4.17 vs 4.52; mean difference (MD) -0.35; 95% CI -0.85 to 0.14) after 1 year. For QoL at 1 year, the intervention produced a small but statistically significant improvement in the EQ-5D-5L index score compared with usual care (0.831 vs. 0.788; MD) 0.043; 95% CI 0.021 to 0.064). Other QoL measures showed no significant differences, including the EQ-VAS (MD 1.69; 95% CI -0.57 to 3.95), PROMIS Global Physical Health T-score (MD 0.51; 95% CI -0.31 to 1.32), and PROMIS Global Mental Health T-score (MD 0.74; 95% CI -0.34 to 1.83). The authors accepted that the effect sizes that were found for the measurement of QoL were small and below minimally important differences.

Conclusions

The authors conclude that that the depression screening and care intervention demonstrated a potential beneficial effect on QoL at 3 months and at 1 year after stroke, which warrants further investigation.

[The full text was accessed to ascertain the QoL and HADS-D data at 1 year]

References

1. World Health Organization. Depressive disorder (depression). 2025. Available from: https://www.who.int/news-room/fact-sheets/detail/depression (Accessed 20 July 2025).
2. National Institute for Health and Care Excellence. Depression in adults: treatment and management, NICE guideline [NG222]. United Kingdom: NICE, 2022. Available from: https://www.nice.org.uk/guidance/ng222 (Accessed 20 July 2025).
3. Lloyd CE, Nouwen A, Sartorius N, Ahmed HU, Alvarez A, Bahendeka S, et al. Prevalence and correlates of depressive disorders in people with Type 2 diabetes: results from the International Prevalence and Treatment of Diabetes and Depression (INTERPRET-DD) study, a collaborative study carried out in 14 countries. Diabetic medicine : a journal of the British Diabetic Association. 2018;35(6):760-9.
4. Thase ME. Managing medical comorbidities in patients with depression to improve prognosis. The Journal of clinical psychiatry. 2016;77(11):22-7.
5. Barlati S, Bulgari V, Calzavara-Pinton I, Nibbio G, Bertoni L, Zardini D, et al. Patient-reported outcomes in the clinical management of depression: current status and future directions. J Ment Health. 2025 Jun 2:1-12. PubMed PMID: 40455689. Epub 20250602.
6. Cui R. Editorial: A Systematic Review of Depression. Current neuropharmacology. 2015;13(4):480-.
7. Pandi-Perumal SR, Monti JM, Burman D, Karthikeyan R, BaHammam AS, Spence DW, et al. Clarifying the role of sleep in depression: A narrative review. Psychiatry research. 2020;291(NA):113239-NA.
8. Lenox-Smith A, Macdonald MTB, Reed C, Tylee A, Peveler R, Quail D, et al. Quality of Life in Depressed Patients in UK Primary Care: The FINDER Study. Neurology and therapy. 2013;2(1):25-42.
9. Barlati S, Lisoni J, Nibbio G, Baldacci G, Cicale A, Ferrarin LC, et al. Current Evidence and Theories in Understanding the Relationship between Cognition and Depression in Childhood and Adolescence: A Narrative Review. Diagnostics (Basel, Switzerland). 2022;12(10):2525-.
10. Kriesche D, Woll CFJ, Tschentscher N, Engel RR, Karch S. Neurocognitive deficits in depression: a systematic review of cognitive impairment in the acute and remitted state. European archives of psychiatry and clinical neuroscience. 2022;273(5):1105-28.
11. IsHak WW, James D, Mirocha J, Youssef H, Tobia G, Pi S, et al. Patient-reported functioning in major depressive disorder. Therapeutic advances in chronic disease. 2016;7(3):160-9.
12. Kennedy N, Foy K, Sherazi R, McDonough M, McKeon P. Long-term social functioning after depression treated by psychiatrists: a review. Bipolar disorders. 2007;9(1-2):25-37.
13. Zhang Y, Jia X, Yang Y, Sun N, Shi S, Wang W. Change in the global burden of depression from 1990-2019 and its prediction for 2030. J Psychiatr Res. 2024 Oct;178:16-22. PubMed PMID: 39106579. Epub 20240802.
14. Cau Q, Gandre C, Lengagne P. Recurrent major depression, employment and transitions to unemployment and disability benefits. Soc Sci Med. 2025 Jul;377:118056. PubMed PMID: 40311499. Epub 20250408.
15. Kirchner L, Kube T, Berg M, Eckert A-L, Straube B, Endres D, et al. Social expectations in depression. Nature Reviews Psychology. 2025 2025/01/01;4(1):20-34.
16. Hardeveld F, Spijker J, de Graaf R, Nolen WA, Beekman ATF. Prevalence and predictors of recurrence of major depressive disorder in the adult population. Acta psychiatrica Scandinavica. 2009;122(3):184-91.

17. Solomon DA, Leon AC, Endicott J, Mueller TI, Coryell W, Shea MT, et al. Psychosocial impairment and recurrence of major depression. Comprehensive psychiatry. 2004;45(6):423-30.
18. Institute of Health Metrics and Evaluation. Global Health Data Exchange (GHDx). Available from: https://vizhub.healthdata.org/gbd-results (Accessed 20 July 2025).
19. Office for National Statistics. Cost of living and depression in adults, Great Britain: 29 September to 23 October 2022. United Kingdom: ONS, 2022. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/mentalhealth/articles/costoflivinganddepressioninadultsgreatbritain/29septemberto23october2022 (Accessed 20 July 2025).
20. Ferenchick EK, Ramanuj P, Pincus HA. Depression in primary care: part 1-screening and diagnosis. BMJ. 2019 Apr 8;365:l794. PubMed PMID: 30962184. Epub 20190408.
21. Herrán A, Vázquez-Barquero JL, Dunn G. Recognition of depression and anxiety in primary care. Patients' attributional style is important factor. BMJ (Clinical research ed). 1999;318(7197):1558-.
22. Jackson JL, O'Malley PG, Kroenke K. Clinical predictors of mental disorders among medical outpatients. Validation of the "S4" model. Psychosomatics. 1998;39(5):431-6.
23. Gold SM, Kohler-Forsberg O, Moss-Morris R, Mehnert A, Miranda JJ, Bullinger M, et al. Comorbid depression in medical diseases. Nat Rev Dis Primers. 2020 Aug 20;6(1):69. PubMed PMID: 32820163. Epub 20200820.
24. O'Connor E, Henninger M, Perdue LA, Coppola EL, Thomas R, Gaynes BN. Screening for Depression, Anxiety, and Suicide Risk in Adults: A Systematic Evidence Review for the U.S. Preventive Services Task Force. Rockville (MD): 2023 22-05295-EF-1. Available from: https://www.ncbi.nlm.nih.gov/pubmed/37406149 (Accessed 10 October 2025).
25. El-Den S, Chen TF, Gan YL, Wong E, O'Reilly CL. The psychometric properties of depression screening tools in primary healthcare settings: A systematic review. J Affect Disord. 2018 Jan 1;225:503-22. PubMed PMID: 28866295. Epub 20170823.
26. National Institute for Health and Care Excellence. Clinical Knowledge Summaries: depression questionnaires. United Kingdom: NICE, 2025. Available from: https://cks.nice.org.uk/topics/depression/diagnosis/assessment/#depression-questionnaires (Accessed 20 July 2025).
27. Miller P, Newby D, Walkom E, Schneider J, Li SC, Evans T-J. The performance and accuracy of depression screening tools capable of self-administration in primary care: A systematic review and meta-analysis. European Journal of Psychiatry. 2021;35(1):1-18.
28. Maurer DM, Raymond TJ, Davis BN. Depression: Screening and Diagnosis. Am Fam Physician. 2018 Oct 15;98(8):508-15. PubMed PMID: 30277728.
29. Levis B, Sun Y, He C, Wu Y, Krishnan A, Bhandari PM, et al. Accuracy of the PHQ-2 Alone and in Combination With the PHQ-9 for Screening to Detect Major Depression: Systematic Review and Meta-analysis. JAMA. 2020 Jun 9;323(22):2290-300. PubMed PMID: 32515813. Pubmed Central PMCID: PMC7284301.
30. Dominguez-Rafer C, Lin S. What are the sensitivity and specificity of the PHQ-2 and the PHQ-9 in screening for depression? Evidence-Based Practice. 2011;14(3):8. PubMed PMID: 00132114-201103000-00009.
31. Allaby M, Pittam G. Appraisal of screening for depression. A report for the UK National Screening Committee. Oxford: Solutions for Public Health, 2014. Available from: https://share.google/LAYGvGGDqEHb39VyZ (Accessed 20 July 2025).
32. Errazuriz A, Beltran R, Torres R, Passi-Solar A. The Validity and Reliability of the PHQ-9 and PHQ-2 on Screening for Major Depression in Spanish Speaking Immigrants in Chile: A Cross-Sectional Study. Int J Environ Res Public Health. 2022 Oct 27;19(21). PubMed PMID: 36360856. Pubmed Central PMCID: PMC9655214. Epub 20221027.

33. Kim M, Jung S, Park JE, Sohn JH, Seong SJ, Kim BS, et al. Validation of the Patient Health Questionnaire-9 and Patient Health Questionnaire-2 in the General Korean Population. Psychiatry Investig. 2023 Sep;20(9):853-60. PubMed PMID: 37794667. Pubmed Central PMCID: PMC10555509. Epub 20230919.
34. Negeri ZF, Levis B, Sun Y, He C, Krishnan A, Wu Y, et al. Accuracy of the Patient Health Questionnaire-9 for screening to detect major depression: updated systematic review and individual participant data meta-analysis. BMJ. 2021 Oct 5;375:n2183. PubMed PMID: 34610915. Pubmed Central PMCID: PMC8491108. Epub 20211005.
35. Gilbody S, Richards D, Brealey S, Hewitt C. Screening for Depression in Medical Settings with the Patient Health Questionnaire (PHQ): A Diagnostic Meta-Analysis. Journal of general internal medicine. 2007;22(11):1596-602.
36. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001 Sep;16(9):606-13. PubMed PMID: 11556941. Pubmed Central PMCID: PMC1495268.
37. Levis B, Benedetti A, Thombs BD, Collaboration DESD. Accuracy of Patient Health Questionnaire-9 (PHQ-9) for screening to detect major depression: individual participant data meta-analysis. BMJ. 2019 Apr 9;365:l1476. PubMed PMID: 30967483. Pubmed Central PMCID: PMC6454318. Epub 20190409.
38. Harrer M, Sprenger AA, Illing S, Adriaanse MC, Albert SM, Allart E, et al. Psychological intervention in individuals with subthreshold depression: individual participant data meta-analysis of treatment effects and moderators. Br J Psychiatry. 2025 May 14:1-14. PubMed PMID: 40365980. Epub 20250514.
39. Zhang R, Peng X, Song X, Long J, Wang C, Zhang C, et al. The prevalence and risk of developing major depression among individuals with subthreshold depression in the general population. Psychol Med. 2023 Jun;53(8):3611-20. PubMed PMID: 35156595. Pubmed Central PMCID: PMC10277767. Epub 20220214.
40. Tuithof M, Ten Have M, van Dorsselaer S, Kleinjan M, Beekman A, de Graaf R. Course of subthreshold depression into a depressive disorder and its risk factors. J Affect Disord. 2018 Dec 1;241:206-15. PubMed PMID: 30130686. Epub 20180809.
41. Degrave A, Silva PRFd. The medicalization of suffering and the overdiagnosis of depression. Saúde em Debate. 2025;49(145).
42. Garcia ME, Ochoa-Frongia L, Neuhaus J, Hong JC, Hinton L, Livaudais-Toman J, et al. Depression Treatment After a Positive Depression Screen Result. JAMA Intern Med. 2025 Feb 1;185(2):221-9. PubMed PMID: 39652335. Pubmed Central PMCID: PMC11791713.
43. Solutions for Public Health. Screening for depression in adults. External review against programme appraisal criteria for the UK National Screening Committee. 2020. Available from: https://view-health-screening-recommendations.service.gov.uk/depression/ (Accessed 20 July 2025).
44. Gilbody S, Lewis H, Adamson J, Atherton K, Bailey D, Birtwistle J, et al. Effect of collaborative care vs usual care on depressive symptoms in older adults with subthreshold depression: the CASPER randomized clinical trial. Jama. 2017;317(7):728-37.
45. van Beljouw IM, van Exel E, van de Ven PM, Joling KJ, Dhondt TD, Stek ML, et al. Does an outreaching stepped care program reduce depressive symptoms in community-dwelling older adults? A randomized implementation trial. The American Journal of Geriatric Psychiatry. 2015;23(8):807-17.
46. Zhang DX, Lewis G, Araya R, Tang WK, Mak WWS, Cheung FMC, et al. Prevention of anxiety and depression in Chinese: A randomized clinical trial testing the effectiveness of a stepped care program in primary care. Journal of Affective Disorders. 2014 2014/12/01/;169:212-20.

47. Oyama H, Sakashita T. Differences in specific depressive symptoms among community-dwelling middle-aged Japanese adults before and after a universal screening intervention. Social psychiatry and psychiatric epidemiology. 2014;49(2):251-8.
48. Silverstone PH, Rittenbach K, Suen VY, Moretzsohn A, Cribben I, Bercov M, et al. Depression outcomes in adults attending family practice were not improved by screening, stepped-care, or online CBT during a 12-week study when compared to controls in a randomized trial. Frontiers in psychiatry. 2017;8:32.
49. Chaplin R, Farquharson L, Clapp M, Crawford M. Comparison of access, outcomes and experiences of older adults and working age adults in psychological therapy. International Journal of Geriatric Psychiatry. 2015;30(2):178-84.
50. Collins N, Corna L. General practitioner referral of older patients to Improving Access to Psychological Therapies (IAPT): an exploratory qualitative study. BJPsych bulletin. 2018;42(3):115-8.
51. Pettit S, Qureshi A, Lee W, Stirzaker A, Gibson A, Henley W, et al. Variation in referral and access to new psychological therapy services by age: an empirical quantitative study. British Journal of General Practice. 2017.
52. Shastri A, Aimola L, Tooke B, Quirk A, Corrado O, Hood C, et al. Recognition and treatment of depression in older adults admitted to acute hospitals in England. Clinical Medicine. 2019;19(2):114-8.
53. Veritas Health Innovation. Covidence systematic review software. Melbourne. Available from: http://www.covidence.org (Accessed 10 December 2025).
54. Chen YL, Wu MS, Wang SH, Lien YJ, Liao SC, Chang CM, et al. Effectiveness of health checkup with depression screening on depression treatment and outcomes in middle-aged and older adults: a target trial emulation study. Lancet Reg Health West Pac. 2024 Feb;43:100978. PubMed PMID: 38076325. Pubmed Central PMCID: PMC10701157. Epub 20231123. eng.
55. O'Connor EA, Perdue LA, Coppola EL, Henninger ML, Thomas RG, Gaynes BN. Depression and Suicide Risk Screening: Updated Evidence Report and Systematic Review for the US Preventive Services Task Force. JAMA. 2023;329(23):2068-85.
56. Kronish IM, Moise N, Cheung YK, Clarke GN, Dolor RJ, Duer-Hefele J, et al. Effect of Depression Screening After Acute Coronary Syndromes on Quality of Life: The CODIACS-QoL Randomized Clinical Trial. JAMA Internal Medicine. 2020;180(1):45-53.
57. Slenders JPL, Van Den Berg-Vos RM, Van Heugten CM, Visser-Meily JMA, van Eijk RPA, Moonen MAA, et al. Screening and Care for Emotional and Cognitive Problems After Ischemic Stroke. Neurology. 2025;105(1):e213774.
58. Saad AA, Rashid MA, Dastgeer S, Iqbal Z, Raza MH, Javaid I, editors. Effects of Depression Screening on Quality of Life after Diagnosis of Acute Coronary Syndrome, Single Center Experience [Retracted]. Medical Forum Monthly; 2022.
59. Williams JW, Jr., Mulrow CD, Kroenke K, Dhanda R, Badgett RG, Omori D, et al. Case-finding for depression in primary care: a randomized trial. The American Journal of Medicine. 1999;106(1):36-43.
60. Whooley MA, Avins AL, Miranda J, Browner WS. Case-finding instruments for depression: two questions are as good as many. Journal of general internal medicine. 1997;12(7):439-45.
61. Centre for Reviews and Dissemination. Database of Abstracts of Reviews of Effects (DARE). York (UK): Centre for Reviews and Dissemination; 1995-2025, Contract No.: 6 June 2025. Available from: https://www.crd.york.ac.uk/CRDWeb/ (Accessed 20 July 2025).