**Accuracy of the PHQ-2 Alone and in Combination with the PHQ-9 for Screening to Detect Major Depression: Systematic Review and Meta-analysis**

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**Word count:** 3,495**KEY POINTS**

**Question:** What is the accuracy of the PHQ-2 alone and in combination with PHQ-9 for screening for depression?

**Findings:** In an individual participant data meta-analysis that included 10,627 participants from 44 studies with semi-structured diagnostic interviews, the combination of PHQ-2 (with cutoff ≥2) followed by PHQ-9 (with cutoff ≥10) had a sensitivity of .82, specificity of .87, and area under the ROC of 0.90.

**Meaning:** PHQ-2 followed by PHQ-9 may provide an acceptable accuracy for screening for depression.

**ABSTRACT**

**Importance**: The Patient Health Questionnaire depression module (PHQ-9) is a 9-item self-administered instrument used for detecting depression and assessing severity of depression. The Patient Health Questionnaire-2 (PHQ-2) consists of the first 2 items of the PHQ-9 (which assess the frequency of depressed mood and anhedonia) and can be used as a first step to identify patients for evaluation with the full PHQ-9.

**Objective**: To estimate PHQ-2 accuracy alone and combined with the PHQ-9 for detecting major depression.

**Data Sources**: Medline, Medline In-Process & Other Non-Indexed Citations, PsycINFO, and Web of Science (January 2000-May 2018).

**Study Selection**: Eligible datasets compared PHQ-2 scores to major depression diagnoses from a validated diagnostic interview.

**Data Extraction and Synthesis**: Individual participant data were synthesized with bivariate random-effects meta-analysis to estimate pooled sensitivity and specificity of the PHQ-2 alone among studies using semi-structured, fully structured, or Mini International Neuropsychiatric (MINI) diagnostic interviews, separately, and in combination with the PHQ-9 versus the PHQ-9 alone for studies that used semi-structured interviews. The PHQ-2 score ranges from 0-6, and the PHQ-9 score ranges from 0-27.

**Results:** Individual participant data were obtained from 100 of 136 eligible studies (44,318 participants, 4,572 major depression [10%], mean age 49 years [SD=17], 59% female). Among studies that used semi-structured interviews, PHQ-2 sensitivity and specificity [95% CI] were 0.91 [0.88, 0.94] and 0.67 [0.64, 0.71] for cutoff ≥2 and 0.72 [0.67, 0.77] and 0.85 [0.83, 0.87] for cutoff ≥3. Sensitivity was significantly greater for semi-structured versus fully structured interviews. Specificity was not significantly different across the types of interviews. AUC was 0.88 [0.86, 0.89] for semi-structured interviews, 0.82 [0.81, 0.84] for fully structured interviews and 0.87 [0.85, 0.88] for the MINI. There were no significant subgroup differences.For semi-structured interviews, sensitivity for PHQ-2 ≥2 followed by PHQ-9 ≥10 (0.82 [0.76, 0.86]) was not significantly different than PHQ-9 ≥10 alone (0.86 [0.80, 0.90]); specificity for the combination was significantly but minimally higher (0.87 [0.84, 0.89] versus 0.85 [0.82, 0.87]). AUC was 0.90 [0.89, 0.91]. The combination was estimated to reduce the number of participants needing to complete the full PHQ-9 by 57% [56%, 58%].

**Conclusions and Relevance**: In an individual participant data meta-analysis of studies comparing PHQ scores to major depression diagnoses, the combination of PHQ-2 (with cutoff ≥2) followed by PHQ-9 (with cutoff ≥10) had similar sensitivity but higher specificity compared with PHQ-9 ≥10 alone. Further research is needed to understand the clinical and research value of this combined approach to screening.

**INTRODUCTION**

In depression screening, questionnaires are used to identify patients with scores above a cutoff threshold for evaluation to determine if depression is present.1 One strategy is to administer a brief screening tool followed by a longer tool for positive screens.2-3 The Patient Health Questionnaire-2 (PHQ-2),4 which consists of the first two items (depressed mood and anhedonia) of the Patient Health Questionnaire-9 (PHQ-9),5 has been recommended as a pre-screen prior to administering remaining PHQ-9 items.2,4,6,7 See Box 1.

A 2016 aggregate-data meta-analysis on PHQ-2 accuracy included 21 published studies of the PHQ-2;8 however, it did not include PHQ-2 data from an additional 37 studies of the PHQ-9.9,10 Except for clinical setting, subgroup results were not reported in primary studies and not evaluated; all primary studies were synthesized regardless of the diagnostic interview used, despite differences in their likelihood of classifying major depression;11-13 and PHQ-2 accuracy was not evaluated in combination with the PHQ-9, as typically used in practice. Two primary studies14,15 have evaluated the PHQ-2 and PHQ-9 combination and produced inconsistent results; one examined cutoffs of PHQ-2 ≥2 and PHQ-9 ≥10 in older community-dwelling adults,14 and the other examined cutoffs of PHQ-2 ≥2 and PHQ-9 ≥6 in acute coronary syndrome patients.15

The objectives of this individual participant data meta-analysis were to evaluate PHQ-2 screening accuracy in adults (1) among studies that used different types of reference standards, separately; (2) among participants verified as not diagnosed or in treatment versus all participants and by subgroups based on age, sex, country human development index, and recruitment setting; and (3) alone and in combination with the PHQ-9 versus the PHQ-9 alone.

**METHODS**

We published a protocol16 and registered in PROSPERO (CRD42014010673). Results were reported per PRISMA-DTA17 and PRISMA-IPD.18 Previous publications reported PHQ-819 and PHQ-920 accuracy. Individual prediction models described in the protocol will be developed in future studies. Analysis of the PHQ-2 and PHQ-9 combination was not pre-specified. This study involved analysis of previously collected de-identified data, and included studies were required to have obtained ethics approval and informed consent; thus, the Research Ethics Committee of the Jewish General Hospital determined that ethics approval was not required.

**Study Eligibility**

Studies were sought with datasets that (1) included PHQ-2 scores or item data to calculate PHQ-2 scores; (2) included current Major Depressive Disorder (MDD) or Major Depressive Episode (MDE) classification based on Diagnostic and Statistical Manual of Mental Disorders (DSM)21-23 or International Classification of Diseases (ICD)24 criteria and a validated diagnostic interview; (3) administered the PHQ and diagnostic interview within a two-week period, since diagnostic criteria include only symptoms from the last two weeks; (4) included participants ≥18 years not recruited from school or university settings; and (5) did not recruit participants only from psychiatric settings or with depression symptoms, since screening is done to identify people not suspected of having depression.25 In datasets where only some participants were eligible, we included only those participants. There were no language restrictions.

**Database Searches and Study Selection**

The database search was designed by a medical librarian and peer reviewed26 and included Medline, Medline In-Process & Other Non-Indexed Citations via Ovid; PsycINFO; and Web of Science (January 1, 2000-May 9, 2018) (eMethods1). We searched from 2000 because the PHQ-9 was published in 2001.5 We reviewed review articles and queried contributing authors about non-published studies or studies not identified by the search. We uploaded results into RefWorks (RefWorks-COS, Bethesda, MD, USA), removed duplicates, then uploaded references into DistillerSR (Evidence Partners, Ottawa, Canada).

Titles and abstracts were reviewed independently by varying pairs of two investigators. If one identified a study as potentially eligible, the full text was reviewed by pairs of two investigators, independently. Any differences were resolved by consensus, with a third investigator consulted if necessary.

We conducted a literature search on April 6, 2020 to seek eligible published results that could be included. No studies published since the original search provided results for PHQ-2 and PHQ-9 combined.

**Data Contribution, Extraction, and Synthesis**

We emailed corresponding authors of studies with eligible datasets at least three times, as necessary, to invite them to contribute datasets. If no response, we emailed co-authors and attempted phone contact.

Country, recruitment setting (non-medical, primary care, inpatient, outpatient specialty), and diagnostic interview were extracted from published reports by two investigators independently, with disagreements resolved by consensus. Countries were categorized as “very high”, “high”, or “low-medium” development based on the United Nation’s 2019 Human Development Index.27 Individual participant records included sex, age, major depression status, current mental health diagnosis or treatment, and PHQ-2 and PHQ-9 total and item scores. PHQ-9 items reflect the nine DSM symptoms of major depression; PHQ-2 items reflect depressed mood and anhedonia. We prioritized MDE over MDD, if both were provided, since screening attempts to detect episodes, and DSM over ICD. For four studies with multiple recruitment settings, setting was coded by participant. When primary studies provided sampling weights, we used those weights. If weighting should have been done but was not, we used inverse selection probability weights. If all study participants with scores above a threshold but only a random subset of 50% below the threshold received a diagnostic interview, for instance, those above the threshold received a weight =1 and those below =2.

For each included dataset, we attempted to replicate published participant characteristics and accuracy results. We worked with primary study investigators to resolve any discrepancies.

**Risk of Bias Assessment**

Risk of bias was assessed with the Quality Assessment of Diagnostic Accuracy Studies-2 tool (QUADAS-2; eMethods2).28 This was done by two investigators independently with discrepancies resolved by consensus, involving a third investigator, if necessary.

**Statistical Analyses**

The PHQ-2 score ranges from 0-6, and the PHQ-9 score ranges from 0-27. We estimated sensitivity and specificity for all possible PHQ-2 cutoffs (scores 1-6) by reference standard type, separately: semi-structured diagnostic interviews; fully structured diagnostic interviews, excluding the Mini International Neuropsychiatric Interview (MINI)29,30; and the MINI. We did this because, controlling for depressive symptom scores, the Composite International Diagnostic Interview [CIDI],31 the most commonly used fully structured interview, may classify more participants with low-level symptoms as depressed, but fewer participants with higher-level symptoms, than semi-structured interviews.11-13 The MINI may classify more participants as depressed.11-13 This is consistent with interview designs. Semi-structured interviews are intended for administration by experienced diagnosticians, require clinical judgment, and allow question rephrasing and probes. Fully structured interviews are designed for lay interviewer administration and are fully scripted with no deviation allowed. They are intended to achieve standardization but may sacrifice accuracy.32-35 The MINI was designed for rapid administration and to be over-inclusive.29,30

Within each reference standard category, we conducted subgroup analyses. We estimated sensitivity and specificity among participants who could be verified as not currently diagnosed or receiving mental health treatment versus all participants. This is because some primary studies included people already diagnosed or receiving treatment, but those participants would not be screened in practice. We estimated sensitivity and specificity by age (<60, ≥60 years), sex, country human development index, and recruitment setting.

Among studies that used a semi-structured interview, we evaluated accuracy of the PHQ-2 and PHQ-9 combination based on commonly used cutoffs.8,20 We compared sensitivity and specificity for PHQ-2 ≥2 and ≥3 alone and combined with PHQ-9 ≥10 versus PHQ-9 ≥10 alone. In each scenario, we calculated the number of participants who scored above the PHQ-2 threshold and, in practice, would need to complete the full PHQ-9. For these analyses, we excluded studies and participants without PHQ-9 scores. In additional analyses, we compared sensitivity and specificity for PHQ-2 ≥2 in combination with PHQ-9 cutoffs 5-15 to PHQ-9 alone at cutoffs 5-15.

In all meta-analyses, for all cutoffs separately, we fit bivariate random-effects models using Gauss-Hermite quadrature.36 This two-stage approach models sensitivity and specificity simultaneously, accounting for the correlation between them and within-study precision estimates. Within each reference standard category, we constructed empirical receiver operating characteristic plots and calculated area under the curve (AUC). To compare results between subgroups and for the PHQ-2 and PHQ-2 and PHQ-9 combination versus PHQ-9 alone, we estimated sensitivity and specificity differences and constructed confidence intervals (CIs) for differences via the cluster bootstrap approach,37,38 resampling at study and participant levels. We ran 1000 bootstrap iterations for each comparison, omitting iterations where difference estimates were not produced. We considered differences to be statistically significantly different if their CIs did not include 0.

To evaluate heterogeneity, for each included study, we produced sensitivity and specificity forest plots by reference standard category and for all studies in each subgroup within each category. We quantified heterogeneity by reporting τ2, the estimated variances of the random effects for sensitivity and specificity, and estimating R, the ratio of the estimated standard deviation of pooled sensitivity or specificity from the random-effects model to estimated standard deviation from the corresponding fixed-effects model.39

We generated hypothetical nomograms to illustrate possible positive and negative predictive values of PHQ-2 cutoffs ≥2 and ≥3 alone and in combination with PHQ-9 ≥10 for assumed major depression prevalence of 5-25%. These were based on summary sensitivity and specificity estimates from the analysis of studies that used semi-structured interviews and had PHQ-9 scores available.

In sensitivity analyses, within each reference standard category, we evaluated whether there were accuracy differences by subgroups based on QUADAS-2 items. We did this for all items with at least 100 major depression cases and non-cases rated as “low” versus “unclear” or “high” risk of bias.

For all analyses, we excluded studies with no major depression cases or non-cases, as this did not allow application of the bivariate random-effects model, and participants missing data for a covariate of interest. There was a maximum of 74 participants excluded from any analysis. For clinical setting, we excluded one MINI study (130 participants) that recruited inpatients and outpatients but did not have participant-level setting data.

We did not conduct sensitivity analyses that combined accuracy results with published results from studies that did not contribute data. This is because, among 36 eligible studies that did not contribute data, only two studies with a semi-structured reference standard40,41 (908 participants, 65 cases), one study with a fully structured reference standard42 (201 participants, 42 cases), and four studies using the MINI43-46 (878 participants, 220 cases) published accuracy results eligible for any analyses. The other studies with eligible datasets did not publish eligible accuracy results (eTable1b).

All analyses were run in R (R version R 3.4.1 and R Studio version 1.0.143) using the glmer function within the lme4 package.47 For cutoff ≥1 for fully structured and ≥5 for MINI reference standards, the default optimizer failed to converge, and bobyqa was used. In each analysis, pooled sensitivity and specificity and corresponding 2-sided 95% CIs were estimated.

**RESULTS**

**Search Results and Dataset Inclusion**

The database search identified 9,674 unique citations, of which 9,198 were excluded after title and abstract review and 289 after full-text review, leaving 187 eligible articles with 131 unique datasets. Of these, 100 (76%) contributed datasets with PHQ-9 scores, PHQ-2 scores, or both. Authors of included studies contributed data from five additional unpublished studies, for a total of 105 datasets. Five datasets with PHQ-9 total scores did not have item data necessary to calculate PHQ-2 scores and were excluded. Thus, 100 datasets (44,318 participants, 4,572 cases [10%], mean age 49 years [SD=17], 59% female) were included (Figure1). eTable1 shows study characteristics of included studies and eligible studies that did not provide data. Not counting the five unpublished studies, of 54,633 participants in 131 eligible published studies, we included 43,787 participants (80%) from 95 published studies (73%).

Of the 100 included datasets, 48 were from studies that used semi-structured interviews, 20 from studies that used fully structured interviews (MINI excluded), and 32 from studies that used the MINI. The Structured Clinical Interview for the DSM (SCID)48 (45 studies, 9,713 participants) and CIDI (17 studies, 15,899 participants) were the most common semi-structured and fully structured interviews (Table 1, eTable2).

**PHQ-2 Sensitivity and Specificity**

Among studies with a semi-structured interview, PHQ-2 ≥2 sensitivity and specificity (95% CI) were 0.91 (0.88, 0.94) and 0.67 (0.64, 0.71); PHQ-2 ≥3 sensitivity and specificity were 0.72 (0.67, 0.77) and 0.85 (0.83, 0.87). Across cutoffs, sensitivity (95% CI) with semi-structured interviews was 0.04 (0.01, 0.08) to 0.20 (0.10, 0.28) higher than with fully structured interviews (significantly higher for cutoffs 1-6) and 0.02 (0.00, 0.04) to 0.05 (-0.04, 0.13) higher than with the MINI (not significantly different at any cutoff); specificity was not significantly different across reference standard types (Table 2, eFigure1). AUC (95% CI) was 0.88 (0.86, 0.89) for semi-structured interviews, 0.82 (0.81, 0.84) for fully structured diagnostic interviews, and 0.87 (0.85, 0.88) for the MINI.

There was moderate heterogeneity. For cutoffs 2-3, τ2 values ranged from 0.47-1.29 for sensitivity and 0.27-0.78 for specificity, while R values ranged from 2.22-3.50 for sensitivity and 3.47-9.30 for specificity. Forest plots are shown in eFigure2; τ2 and R values in eTable3.

**Subgroup Analyses**

Sensitivity and specificity estimates were not significantly different for participants verified as not currently diagnosed or receiving mental health treatment compared to all participants across reference standard categories. Among other subgroup comparisons, there were no statistically significant or substantive differences that replicated across cutoffs and reference standard categories (eTable4; forest plots: eFigure2; τ2 and R values: eTable3).

**Comparison of PHQ-2, PHQ-2 in Combination with PHQ-9 ≥10, and PHQ-9 ≥10**

Based on 44 studies that used a semi-structured reference standard and provided both PHQ-2 and PHQ-9 scores, compared to PHQ-9 ≥10 alone, all strategies resulted in substantially reduced sensitivity or specificity, except PHQ-2 ≥2 in combination with PHQ-9 ≥10. For this combination, sensitivity (95% CI) was 0.82 (0.76, 0.86) versus 0.86 (0.80, 0.90) (not statistically significant) and specificity (95% CI) was slightly higher (0.87 [0.84, 0.89] versus 0.85 [0.82, 0.87] (statistically significant; Table 3, eTable5; Figure 2). AUC (95% CI) was 0.90 (0.89, 0.91). Nomograms of positive and negative predictive values are shown in eFigure3. Using PHQ-2 ≥2 in combination with other PHQ-9 cutoffs (5-9, 11-15) resulted in lower combined sensitivity and specificity compared to PHQ-2 ≥2 with PHQ-9 ≥10 (eTable6).

With PHQ-2 ≥2 then PHQ-9 ≥10, 43% (95% CI [42%, 44%]) of participants had positive PHQ-2 screens and would have needed to complete the full PHQ-9 in practice; 23% (95% CI [22%, 24%]) of all participants would have had a positive PHQ-9 screen and needed further mental health assessment, compared to 25% (95% CI [24%, 26%]) for PHQ-9 ≥10 alone and 43% (95% CI [42%, 44%]) for PHQ-2 ≥2 alone.

**Risk of Bias Sensitivity Analyses**

eTable7 shows QUADAS-2 ratings for individual signalling items and risk of bias domains for included primary studies. Among 400 total domain ratings (4 per included study), 131 (33%) were coded as "low" risk of bias; 253 (63%) as "unclear," 11 (3%) as “high”, and 5 (1%) as varying across participants within a study. Three of 48 (6%) studies that used a semi-structured interview, 6 of 20 (30%) studies with a fully structured interview, and 9 of 32 studies (28%) with a MINI reference standard had "low" risk of bias across all four domains.

PHQ-2 accuracy comparisons across QUADAS-2 items within reference standard categories are shown in eTable4. No statistically significant differences were found that replicated across cutoffs for any reference standard category.

**DISCUSSION**

In this individual participant data meta-analysis of 44 studies that used semi-structured diagnostic interviews to classify depression, sensitivity using the combination of PHQ-2 (cutoff ≥2) and PHQ-9 (cutoff ≥10) was not significantly different than using the full PHQ-9 (cutoff ≥10) for all participants. Specificity for the combination was significantly, though minimally, higher. The combination approach was estimated to reduce the number of participants needing to do the full PHQ-9 by 57%. Compared to the PHQ-9 alone, the PHQ-2 alone resulted in statistically significant lower sensitivity or specificity, depending on the cutoff.

Consistent with previous findings with the PHQ-9,20 PHQ-2 sensitivity was highest compared to semi-structured interviews, which most closely replicate clinical interviews by trained professionals, and lower compared to fully structured interviews and the MINI, although differences compared to the MINI were small and not statistically significant. Specificity estimates were not significantly different across reference standards. There were no significant accuracy differences between subgroups that replicated across reference standard categories, although some subgroups had limited numbers of participants and cases.

The finding that PHQ-2 sensitivity was greater when compared to semi-structured rather than fully structured interviews may have occurred because fully structured interviews are designed for reliability at the cost of validity.32-35 Previous studies found that among participants with low-level depressive symptoms, fully structured interviews may classify more participants as having major depression than semi-structured interviews but fewer among participants with high-level symptoms.11-13 In the present meta-analysis, most participants did not have major depression. Thus, misclassification of major depression among participants with sub-threshold depressive symptoms based on fully structured interviews might explain the lower sensitivity compared to semi-structured interviews.

Among studies with semi-structured interviews, PHQ-2 sensitivity and specificity were generally similar to estimates reported in a previous aggregate-data meta-analysis that combined reference standards without adjustment.8 Using individual participant data from 48 studies with semi-structured interviews in the present study, sensitivity and specificity were 0.91 and 0.67 for cutoff ≥2 and 0.72 and 0.85 for cutoff ≥3, compared to 0.91 and 0.70 for cutoff ≥2 (17 studies) and 0.76 and 0.87 for cutoff ≥3 (19 studies) in the previous meta-analysis. This differed from a PHQ-9 individual participant data meta-analysis,20 in which, among studies that used a semi-structured interview, sensitivity at the standard cutoff of ≥10 was substantially greater than reported in a previous aggregate-data meta-analysis that combined reference standards.9,20

No previous meta-analysis and only two primary studies14,15 have evaluated the PHQ-2 in combination with the PHQ-9. The two primary studies, however, reported results using different cutoff combinations and generated estimates of sensitivity and specificity that differed among older community-dwelling adults (N = 378; sensitivity = 0.81, specificity = 0.89) and coronary artery disease patients (N = 1,024, sensitivity = 0.75, specificity = 0.84). Using individual participant data from 44 primary studies with semi-structured interviews in the present study and standard cutoffs, which maximized combined sensitivity and specificity, sensitivity (0.82) for PHQ-2 ≥2 followed by PHQ-9 ≥10 was not significantly different to PHQ-9 ≥10 alone, and specificity (0.87) was significantly better, though minimally. Assuming that screening procedures allow for quick calculation of PHQ-2 scores before presenting remaining PHQ-9 items (e.g., electronic administration), the combination could improve efficiency.

Routine screening for depression in primary care has been recommended in the United States.6 National guidelines from Canada and the United Kingdom, however, recommended against screening due to the lack of direct trial evidence of benefit and concerns about harms and consumption of healthcare resources.49-52 Well-conducted trials that compare screening to no screening are needed to determine if screening improves mental health outcomes. Using the PHQ-2 in combination with the PHQ-9 may be a resource-efficient approach. Many individuals who screen positive, however, will not meet major depression diagnostic criteria and will need to be evaluated by a clinician.

Strengths of the study included the large sample size, inclusion of results from all cutoffs from all studies (rather than just those published), assessment of PHQ-2 accuracy separately across reference standards and by participant subgroups, and evaluation of the PHQ-2 and PHQ-9 combination, which had not been done previously in meta-analyses.

**Limitations**

This study has several limitations. First, primary data from 36 of 131 published eligible datasets (27%) were not included. Second, there was moderate heterogeneity across studies, although it improved in most cases when subgroups were considered. Subgroup analyses based on medical comorbidities, as specified in the study protocol, and on country and language could not be conducted. This is because data on presence of non-psychiatric medical diagnoses were not available for 40% of participants, with higher percentages missing for specific diagnoses, and because many countries and languages were represented in few primary studies. Third, many included studies did not explicitly exclude participants who may have already been diagnosed or receiving care for depression, although there were not statistically significant differences between analyses of participants verified to not currently be diagnosed or receiving treatment and analyses of all participants, including those without this information. Fourth, studies in the individual participant data meta-analysis were categorized based on the interview administered, but it is possible that interviews may not have always been used in the way intended. Among 48 studies that used semi-structured interviews, three used interviewers who did not meet typical standards, and 11 were rated “unclear.” It is possible that use of non-qualified interviewers may have reduced differences in accuracy estimates across reference standard categories. Fifth, few studies were rated as “low” risk of bias across all QUADAS-2 domains; thus, sensitivity analyses using only studies with all “low” ratings were not conducted.

**Conclusions**

In an individual participant data meta-analysis of studies comparing PHQ scores to major depression diagnoses, the combination of PHQ-2 (with cutoff ≥2) followed by PHQ-9 (with cutoff ≥10) had similar sensitivity but higher specificity compared with PHQ-9 ≥10 alone. Further research is needed to understand the clinical and research value of this combined approach to screening.**AUTHOR CONTRIBUTIONS**

BL, AB, and BDT were responsible for the study conception and design. BL, YS, CH, YW, AK, PMB, DN, MI, EB, ZN, and BDT contributed to data extraction, coding, evaluation of included studies, and data synthesis. BL, YS, CH, YW, ZN, FHF, AB, and BDT contributed to data analysis and interpretation. BL, YS, AB and BDT drafted the manuscript. All authors provided a critical review and approved the final manuscript. AB and BDT had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. AB and BDT contributed equally as co-senior authors.

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**DATA SHARING**

Requests to access data should be made to the corresponding author.

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**FIGURES**

**Figure 1. Flow diagram of study selection process**

**Figure 2. Receiver operating characteristic (ROC) plots comparing sensitivity and specificity estimates for the Patient Health Questionnaire-2 (PHQ-2) alone, the Patient Health Questionnaire-9 (PHQ-9) alone, and for the PHQ-2** ≥**2 followed by PHQ-9, among 44 studies (N participants = 10,627; N major depression = 1,361) that used a semi-structured reference standard and had both PHQ-2 and PHQ-9 item scores available**

Among the 48 PHQ-2 studies that used a semi-structured reference standard, 4 studies did not have PHQ-9 item scores available, and thus could not be included in the comparison of screening strategies. The PHQ-2 line has 7 calculated points (inflections), representing possible scores of 0 (right) to 6 (left). The PHQ-9 alone and PHQ-2 ≥2followed by PHQ-9 lines have 28 calculated points (inflections), representing possible scores of 0 (right) to 27 (left). Area under the curve (95% confidence intervals): 0.88 (0.87, 0.89) for PHQ-2 alone, 0.92 (0.91, 0.93) for PHQ-9 alone, and 0.90 (0.89, 0.91) for PHQ-2 ≥2followed by PHQ-9.

**Box 1. Items included in the Patient Health Questionnaire-2 (PHQ-2) and full Patient Health Questionnaire-9 (PHQ-9)a,b,c**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Over the last 2 weeks, how often have you been bothered by any of the following problems? | Not at all | Several days | More than half the days | Nearly every day |
| **1** | Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **2** | Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **3** | Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4** | Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| **5** | Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **6** | Feeling bad about yourself - or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| **7** | Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| **8** | Moving or speaking so slowly that other people could have noticedOr the opposite - being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| **9** | Thoughts that you would be better off dead, or of hurting yourself in some way | 0 | 1 | 2 | 3 |

a Shaded items comprise the PHQ-2. The total score for the PHQ-2 and the PHQ-9 are calculated by summing the items scores for the items included in each.

b The PHQ-9 was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

c The PHQ-2 and PHQ-9 can be found on the internet at <https://www.integration.samhsa.gov/images/res/PHQ>%20-%20Questions.pdf.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Participant Subgroup** | **Semi-Structured Diagnostic Interviews** | **Fully Structured Diagnostic Interviews** | **MINIa** | **All Interviews** |
|  | **N Studies** | **N Participants** | **% of participants in category** | **N (%) Major Depression** | **N Studies** | **N Participants** | **% of participants in category** | **N (%) Major Depression** | **NStudies** | **N Participants** | **% of participants in category** | **N (%) Major Depression** | **N Studies** | **N Participants** | **% of participants in category** | **N (%) Major Depression** |
| **All participants** | 48 | 11,703 | 100 | 1,538 (13) | 20 | 17,319 | 100 | 1,365 (8) | 32 | 15,296 | 100 | 1,669 (11) | 100 | 44,318 | 100 | 4,572 (10) |
| **Subset of participants verified to not currently be diagnosed or receiving treatment for a mental health problemb** | 25 | 3,708 | 32c | 527 (14) | 5 | 4,050 | 23c | 292 (7) | 15 | 8,390 | 55c | 581 (7) | 45 | 16,148 | 36c | 1,400 (9) |
| **Age:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **<60 years** | 46 | 7,767 | 67 | 1,118 (14) | 20 | 13,901 | 80 | 1,097 (8) | 31 | 10,071 | 66 | 1,153 (11) | 97 | 31,739 | 72 | 3,368 (11) |
| ≥**60 years** | 43 | 3,888 | 33 | 415 (11) | 16 | 3,401 | 20 | 268 (8) | 31 | 5,219 | 34 | 515 (10) | 90 | 12,508 | 28 | 1,198 (10) |
| **Sex:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Women** | 48 | 7,287 | 62 | 1,054 (14) | 20 | 9,690 | 56 | 802 (8) | 32 | 9,057 | 59 | 1,138 (13) | 100 | 26,034 | 59 | 2,994 (12) |
| **Men** | 41 | 4,408 | 38 | 484 (11) | 18 | 7,619 | 44 | 561 (7) | 30 | 6,233 | 41 | 530 (9) | 89 | 18,260 | 41 | 1,575 (9) |
| **Country Human Development Indexd:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Very high**  | 37 | 9,156 | 78 | 994 (11) | 16 | 15,574 | 90 | 1,162 (7) | 21 | 10,699 | 70 | 1,141 (11) | 74 | 35,429 | 80 | 3,297 (9) |
| **High**  | 8 | 1,957 | 17 | 356 (18) | - | - | - | - | 9 | 4,352 | 28 | 433 (10) | 17 | 6,309 | 14 | 789 (13) |
| **Low-medium**  | 3 | 590 | 5 | 188 (32) | 4 | 1,745 | 10 | 203 (12) | 2 | 245 | 2 | 95 (39) | 9 | 2,580 | 6 | 486 (19) |
| **Recruitment Setting:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Non-medical caree** | 2 | 567 | 5 | 105 (19) | 4 | 8,316 | 48 | 378 (5) | 8 | 6,792 | 45 | 470 (7) | 14 | 15,675 | 35 | 953 (6) |
| **Primary care** | 15 | 4,569 | 39 | 667 (15) | 7 | 4,789 | 28 | 429 (9) | 9 | 5,092 | 34 | 557 (11) | 31 | 14,450 | 33 | 1,653 (11) |
| **Inpatient specialty care** | 10 | 2,019 | 17 | 184 (9) | 2 | 593 | 3 | 72 (12) | 4 | 619 | 4 | 135 (22) | 16 | 3,231 | 7 | 391 (12) |
| **Outpatient specialty care** | 23 | 4,548 | 39 | 582 (13) | 7 | 3,621 | 21 | 486 (13) | 12 | 2,663 | 18 | 502 (19) | 42 | 10,832 | 25 | 1,570 (14) |

 **Table 1. Participant data by subgroup**

aThe Mini International Neuropsychiatric Interview (MINI) is a very brief fully structured diagnostic interview that was designed for rapid administration by lay interviewers and intended to be over-inclusive.

bThis row contains the subset of participants that could be verified to not currently be diagnosed or receiving treatment for a mental health problem at the time of recruitment. Participants from studies that did not collect data on mental health diagnosis or treatment status were not included. Among studies that did collect this information, participants without a diagnosis or treatment were included, whereas those already diagnosed or receiving treatment were excluded.

cPercentage refers to percent of all participants within semi-structured, fully structured, MINI, or all interviews who could be verified to not be currently diagnosed or receiving treatment.

dBased on Human Development Report 2019.27 The Human Development Index is a composite index comprised of indicators of life expectancy, education, and per capita income. In 2019, very-high human development countries include the top 59 countries, high included countries rated 60-112, medium 113-151, and low 152-189 (http://hdr.undp.org/en/composite/HDI).

eNon-medical care recruitment included general community samples, as well as samples of older adults (2 studies), domestic workers (1 study), individuals in countries exposed to war (1 study), drug users (1 study), and employees on sickness leave (1 study).

**Table 2. Comparison of PHQ-2 sensitivity and specificity estimates among semi-structured, fully structured, and MINI reference standards**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Semi-Structured Reference Standard**N Studies = 48N Participants = 11,703N major depression = 1,538AUC (95% CI) = 0.88 (0.86, 0.89) | **Fully Structured Reference Standard (MINI Excluded)**N Studies = 20N Participants = 17,319N major depression = 1,365AUC (95% CI) = 0.82 (0.81, 0.84) | **MINIa Reference** **Standard**N Studies = 32N Participants = 15,296N major depression = 1,669AUC (95% CI) = 0.87 (0.85, 0.88) | **Differenceb:****Semi-Structured Reference Standard – Fully Structured Reference Standard** | **Differenceb:****Semi-Structured Reference Standard – MINI Reference Standard** |
| **Cutoff** | **Sensitivity****(95% CI)** | **Specificity****(95% CI)** | **Sensitivity****(95% CI)** | **Specificity****(95% CI)** | **Sensitivity****(95% CI)** | **Specificity****(95% CI)** | **Sensitivity****(95% CI)** | **Specificity****(95% CI)** | **Sensitivity****(95% CI)** | **Specificity****(95% CI)** |
| 1 | 0.98(0.96, 0.99) | 0.46(0.42, 0.51) | 0.93(0.88, 0.96) | 0.48(0.38, 0.58) | 0.96(0.94, 0.98) | 0.48(0.43, 0.53) | 0.04(0.01, 0.08) | -0.02(-0.10, 0.08) | 0.02(0.00, 0.04) | -0.01(-0.07, 0.04) |
| 2 | 0.91(0.88, 0.94) | 0.67(0.64, 0.71) | 0.82(0.75, 0.87) | 0.71(0.63, 0.77) | 0.89(0.84, 0.92) | 0.68(0.64, 0.73) | 0.10(0.03, 0.18) | -0.03(-0.09, 0.04) | 0.02(-0.02, 0.09) | -0.01(-0.06, 0.04) |
| 3 | 0.72(0.67, 0.77) | 0.85(0.83, 0.87) | 0.53(0.44, 0.62) | 0.89(0.84, 0.92) | 0.69(0.62, 0.75) | 0.87(0.84, 0.90) | 0.19(0.08, 0.29) | -0.04(-0.07, 0.00) | 0.03(-0.06, 0.11) | -0.02(-0.05, 0.02) |
| 4 | 0.55(0.50, 0.61) | 0.93(0.91, 0.94) | 0.36(0.30, 0.43) | 0.94(0.92, 0.96) | 0.50(0.44, 0.56) | 0.94(0.93, 0.96) | 0.20(0.10, 0.28) | -0.01(-0.03, 0.01) | 0.05(-0.04, 0.13) | -0.01(-0.03, 0.01) |
| 5 | 0.35(0.31, 0.40) | 0.97(0.96, 0.98) | 0.21(0.16, 0.26) | 0.98(0.97, 0.99) | 0.30(0.25, 0.36) | 0.98(0.97, 0.98) | 0.14(0.06, 0.21) | -0.01(-0.02, 0.01) | 0.05(-0.03, 0.13) | -0.01(-0.01, 0.01) |
| 6 | 0.23(0.19, 0.27) | 0.99(0.98, 0.99) | 0.13(0.09, 0.17) | 0.99(0.98, 0.99) | 0.18(0.15, 0.22) | 0.99(0.99, 0.99) | 0.10(0.04, 0.16) | 0.00(-0.01, 0.00) | 0.05(-0.02, 0.10) | 0.00(-0.01, 0.00) |

a The Mini International Neuropsychiatric Interview (MINI) is a very brief fully structured diagnostic interview that was designed for rapid administration by lay interviewers and intended to be over-inclusive.

b Because semi-structured interviews are the type of diagnostic interview that most closely replicates diagnostic procedures, differences are not shown for fully structured reference standards – MINI reference standards.

**Abbreviations**: AUC: area under the curve; CI: confidence interval; MINI: Mini International Neuropsychiatric Interview; PHQ: Patient Health Questionnaire.

**Table 3. Comparison of sensitivity and specificity estimates and number of participants requiring full PHQ-9 for PHQ-2 alone, PHQ-2 in combination with PHQ-9, and PHQ-9 alone among 44 studies (N participants = 10,627; N major depression = 1,361) that used a semi-structured reference standard and had both PHQ-2 and PHQ-9 item scores availablea**

|  |  |
| --- | --- |
|  | **Screening Strategy** |
|  | **PHQ-2 ≥2****alone** | **PHQ-2 ≥3****alone** | **PHQ-2 ≥2 then****PHQ-9 ≥10** | **PHQ-2 ≥3 then****PHQ-9 ≥10** | **PHQ-9 ≥10****alone** |
| **N Administered PHQ-2** | 10,627 | 10,627 | 10,627 | 10,627 | ----- |
| **N (%) Positive PHQ-2 Screens** | 4,529 (42.6) | 2,650 (24.9) | 4,529 (42.6) | 2,650 (24.9) | ----- |
| **N (%) Administered PHQ-9** | ----- | ----- | 4,529 (42.6) | 2,650 (24.9) | 10,627 (100.0) |
| **N (%) Positive PHQ-9 Screens** | ----- | ----- | 2,461 (23.2) | 1,946 (18.3) | 2,655 (25.0) |
| **Sensitivity and Specificity** | **Sensitivity (95% CI)**  | 0.92 (0.88, 0.95) | 0.72 (0.67, 0.77) | 0.82 (0.76, 0.86) | 0.70 (0.64, 0.75) | 0.86 (0.80, 0.90) |
| **Specificity (95% CI)** | 0.67 (0.63, 0.70) | 0.85 (0.83, 0.87) | 0.87 (0.84, 0.89) | 0.91 (0.89, 0.93) | 0.85 (0.82, 0.87) |
| **Difference in accuracy estimates (Each Strategy – PHQ-9 alone)** | **Sensitivity (95% CI)**  | 0.06 (0.01, 0.11) | -0.13 (-0.20, -0.09) | -0.04 (-0.09, 0.01) | -0.16 (-0.23, -0.12) | ----- |
| **Specificity (95% CI)** | -0.18 (-0.21, -0.16) | 0.01 (-0.02, 0.03) | 0.02 (0.00, 0.03) | 0.06 (0.04, 0.08) | ----- |

a Among the 48 PHQ-2 studies that used a semi-structured reference standard, 4 studies did not have PHQ-9 item scores available, and thus could not be included in the comparison of screening strategies.

**Abbreviations**: CI: confidence interval; PHQ: Patient Health Questionnaire.