| Author, Year  and Quality | Group | Intervention Name | DetailedDescription | Provider |
| --- | --- | --- | --- | --- |
| **General Adults** | | | | |
| Williams, 1999162  Fair | IG1 | Case-finding (Combined) | Case-finding interventions (single question and 20-item CES-D instrument) were similar, therefore, groups combined | Physician |
| IG2 | Case-finding (20-item) | CES-D validated questionnaire w/ 20-items that focuses on depressive symptoms in the last week; scores ≥ 16 identify people w/ probable depression; self-administered unless pt could not read or requested it be read to them | Physician |
| IG3 | Case-finding (1 item) | Single question: "Have you felt depressed or sad much of the time in the past year?"; self-administered unless pt could not read or requested it be read to them | Physician |
| CG | Usual Care | No case-finding | Physician |
| Bergus, 200572  Fair | IG | Screening results to provider | Providers asked to review patient's PHQ-9; providers educated about PHQ-9 but were not otherwise influenced to change their practices | Medical provider |
| CG | Usual Care | Providers not informed of PHQ-9 results | Medical provider |
| Jarjoura, 2004165  Fair | IG | Screening results + treatment protocol | Screening nurse gave residents screening results and provided treatment protocol outline asking them to: (1) explore sx with the pt to affirm screen results; (2) attempt to rule out physical conditions, medications, or other primary psychiatric dx that could explain the results; and (3) do the following if a depression diagnosis was appropriate: (a) educate pt about depression, (b) give pt materials, (c) encourage behavioral treatment at partner agency, (d) discuss antidepressants and decide if appropriate, (e) schedule appt in 4 wks, and (f) ensure pts sees nurse for referral info/help. Nurse arranged behav tx appointment if desired, or instructions to make an appointment. Nurse faxed pt information to behavioral tx provider. All residents were trained to follow AHRQ depression tx guidelines. Meds provided for free. | Resident physicians |
| CG | Usual Care | Nurses screened pts, but did not inform residents of results. Pts screening positive told by nurse that they may have a problem with depression and that tx is effective for depression. Pts could discuss depression w/ provider during subsequent visit. All residents were trained to follow AHRQ depression tx guidelines. Meds provided for free. | Resident physicians |
| Rost, 200173  Good | IG | Screening results + provider training & supports | Physicans and nurses in intervention sites participated in a series of 4 1.5 hours conference calls. Calls reviewed study protocol, went over guideline for detection and evaluation of depression in primary care, and provided training on pharmacological therapy and referral to mental health specialists. One nurse in each site also completed an 8-hour training session plus 1 phone call to: 1) review current clinical issues in detection and management of major depression in PC settings; 2) used manual and videotapes to train nurses in treatment protocol, and 3) use role playing and written test to ensure nurses mastery of material. Admin staff training in study protocol, including 2-stage depression screening. Once the intervention began, physicians in enhanced care practices were informed of their enrolled positive screening resutls, and told to evaluate the depression diagnosis, give the patient a copy of the AHCPR's Patient Guide to Depression, and ask the patient to return in 1 week to meet with the nurse and see the physician again. At the 1-week visit, the nurse assessed the nine criteria for major depression, evaluated the patient's treatment preferences (drugs, CBT, watchful waiting) and identified barriers to care. Nurses provided physicians with a description of the patients' symptoms and treatment preferences for their review before seeing the patient on that same day. Phone and in-person followup took place for the next 5-8 weeks. Nurses prepared monthly patient summaries for providers | Physician, nurse |
| CG | Usual Care | CG physicians were not informed which patients were participating in the study, nor did CG nurses meet on a regular basis with depressed patients. | Physician, nurse |
| Wells, 2000163  Fair | IG1 | Screening results, provider training & support (combined) | QI-Med Support and QI-CBT groups analyzed together | Psychotherapists, nurse specialists, physicians |
| IG2 | Screening results, provider training & support, CBT | In both IGs, practices provided in-kind resources; training provided to PCP, nursing supervisor, and MH specialist to implement the interventions, including a 2-day workshop to review depression treatment and principals of collaborative care. Trained 'leaders' distributed clinician manuals, initiated monthly lectures, and provided academic detailing prior to pt recruitment. Monthly team mtgs held where leaders provided audit+feedback on the clinic or clinician level. Nurses also received 1-day workshop on how to condcut brief clinical assessments, patient education, and behavioral activiation based on study manual/video. Monthly phone calls held btw leaders and study team to review study progress.Other materials provided to sites (slides, pocket cards, videos, study charts, etc.). IG provided list of enrolled patients. QI-Therapy- PCC used nurse asst to formulate treatment plan with patient and referred, as appropriate, to CBT-available in English and Spanish. Study-trained psychotherapists provided individual and group CBT for a reduce co-pay ($0-10); patients could access other therapy for the usual co-pyaments ($20-35). Brief (4-session) CBT recommended for patients with minor depression. Medication treatment from regular PCP was available if preferred by patient, but nurse specialists did not provide monthly medication management followup. | Psychotherapists, nurse specialists, physicians |
| IG3 | Screening results, provider training & support, medication support | In both IGs, practices provided in-kind resources; training provided to PCP, nursing supervisor, and MH specialist to implement the interventions, including a 2-day workshop to review depression treatment and principals of collaborative care. Trained 'leaders' distributed clinician manuals, initiated monthly lectures, and provided academic detailing prior to pt recruitment. Monthly team mtgs held where leaders provided audit+feedback on the clinic or clinician level. Nurses also received 1-day workshop on how to condcut brief clinical assessments, patient education, and behavioral activiation based on study manual/video. Monthly phone calls held btw leaders and study team to review study progress.Other materials provided to sites (slides, pocket cards, videos, study charts, etc.). IG provided list of enrolled patients. In QI-Meds, nurse specialist peformed initial patient assessment, PCP used that assessment to formulate a treatment plan with the patient. Nurses supported med adherence through monthly visits or calls. QI-Meds patients able to access counseling via usual options with usual co-pay. | Nurse specialists, physicians |
| CG | Usual Care | UC practices received a mailed copy of the Agency for Healthcare Policy Research practice guidelines. Usual care patients were told they could inform their provider that they screened for depression, but the study did not notify the clinic. Usual care practice includes options for medication and behavioral treatment through normal PC channels, but no extra efforts to manage depression in UC. | Physicians |
| **Older Adults** | | | | |
| van der Weele, 2012166  Good | IG | Screening results + referral for stepped care | PCPs instructed to inform screen-positive pts about their result and motivate them for referral to Community Mental Health Clinic for a stepped care intervention which included: 1) individual counseling about treatment needs and motivation of the patient during 1 or 2 home visits by a community psychiatric nurse; 2) coping with depression course; 3) referral back to GP to discuss further treatment. The Coping with Depression course was based on CBT and consists of 10 weekly group meetings with 2 course instructors and 6-10 participants. If patients could not attend, they were offered the course in-home. | General practitioner, mental health professional |
| CG | Usual Care | GPs in control practices were not informed about screen-positive pts in their practice before the end of the study, except in case of severe depression symptoms MADRS score >30 pts and/or suicidal ideation. Patients in control practices were not individually informed about being screen-positive and treatment allocation. | General practitioner |
| Whooley, 2000164  Fair | IG | Screening results + provider training + psychoed course | 1 hour education session for all PCPs on depression assessment and management skills. PCPs notified of participant's GDS score on the day of their visit to the clinic and given an instruction sheet indicating the range of scores associated with depression. For scores >=11, referral to psychiatry recommended. Patients, and families invited to attend 6 weekly group education sessions, followed by a booster session 4-6 months later. Sessions covered nature and course of depression, physical and emotional manifestations, relation to other medical conditions, treatment alternatives, medications and side effects, coping mechanisms, and preventive strategies. | Primary care physician, psychiatric nurse |
| CG | Usual Care + provider education | 1 hour education session for all PCPs on depression assessment and management skills. PCPs not notified of their patients' GDS scores or advised of the availability of a patient education program. GDS scores for patients with appts in control clinics were not calculated until the time of the followup interview. | Primary care physicians |
| Bijl, 2003167  Fair | IG | Screening results + provider training | 4 hour training session covering screeing, diagnosis, and treatment of depression. GPs instructed to provide education, information, drug therapy, and supportive contact to patient. Based on Dutch depession guideline (van Marwijk, 1994). GPs completed diagnostic interview using PRIME-MD when notified patient had screened positive on GDS. Patient enrolled and treated if GP assigned MDD diagnosis. | General practitoners |
| CG | Usual Care | Treatment of depression in the usual care group depended on whether the GP recognized the patient as being depressed and was not restricted in any way. | General practitioners |
| Callahan, 1994161  Fair | IG | Screening results + provider support | PC providers received the following feedback: a letter specific to the individual patient with HAM-D score and interpretation, previous HAM-D scores (if applicable), a list of currently prescribed medications that have been associated with depression, a reminder that psychiatric consultation is available, an educational flyer on depression, an algorithm for initiating/managing antidepressant treatment of patients. Three additional appointments were scheduled for each patient over 3-month period, where PCP determined if a patient would benefit from therapy. General recommendations included 1) Record diagnosis of depression 2) Discontinue medications that might be causing depression, and substitute drug (if possible) 3) review education flyer and give it to patient at each visit, if appropriate 4) consider antidpressant initiation, using treatment algorithm. 5) After the 3 visits PCPs asked to complete brief questionnaire concerning their clinical decision-making for each patient. | Physicians |
| CG | Usual Care | PCPs received no feedack of depression scores or treatment suggestions, and there were no additional appointments scheduled with PCP. | Physicians |

**Abbreviations:** AHCPR/AHRQ = Agency for Healthcare Research and Quality/Agency for Healthcare Policy Research; asst = assistant; CBT = cognitive behavioral therapy; CES-D = Center for Epidemiologic Studies Depression; CG = control group; dx = diagnosis; GDS = Geriatric Depression Scale; GP = general practitioner; HAM-D = Hamilton Rating Scale for Depression; IG = intervention group; MADRS = Montgomery Asberg Depression Rating Scale; MDD = major depressive disorder; med = medication; mtg = meeting; PCP = primary care physician; PHQ = Patient Health Questionnaire; PRIME-MD = Primary Care Evaluation of Mental Disorders; pt(s) = patient(s); QI = quality improvmenet; sx = symptoms; tx = treatment; UC = usual care; w/ =with; wk(s) = week(s).