GRADE tables for review question 1.1 For adults with depression, what are the relative benefits and harms associated with different models for the coordination and delivery of services?

GRADE tables not provided for subgroup analyses.

Table 29: Clinical evidence profile for Comparison 1: Collaborative care (simple or complex) versus standard care/enhanced standard care.

Quality assessment							Number of participants		Effect			
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Collaborative care	Standard care/enhanced standard care	Relative (95% CI)	Absolute (95% CI)	Quality	Importance
Depression symptomatology at 6 months (assessed with: Hamilton Depression Rating Scale (HAMD)/Patient Health Questionnaire (PHQ-9)/Beck Depression Inventory-II (BDI-II))												
9 (Aragones 2012; Buszewicz 2016; Chen 2015; Curth 2020; Harter 2018; Huang 2018; Landis 2007; Ng 2020; Oladeji 2015)	randomised trials	serious[1]	very serious[2]	not serious	serious[3]	none	1781	1010	-	SMD 0.4 lower (0.71 lower to 0.09)	VERY LOW	CRITICAL
Depression symptomatology at 12 months (assessed with: Hamilton Depression Rating Scale (HAMD)/Patient Health Questionnaire (PHQ-9)/Beck Depression Inventory (BDI/BDI-II))												
13 (Aragones 2012; Bosan	randomised trials	serious[1]	very serious[2]	not serious	serious[3]	none	2957	2451	-	SMD 0.35 lower (0.53 lower to	VERY LOW	CRITICAL

Quality assessment							Number of participants		Effect			
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Collaborative care	Standard care/enhanced standard care	Relative (95% CI)	Absolute (95% CI)	Quality	Importance
quet 2017; Bruce 2004; Buszewicz 2016; Chen 2015; Gensichen 2009; Gilbody 2017/ Lewis 2017; Harter 2018; Holzel 2018; Morriss 2016; Ng 2020; Richards 2013/ 2016; Swindle 2003)										0.16 lower)		
Response at 6 months (assessed with: Number of participants whose scores improved by at least 50% on Hamilton Depression Rating Scale (HAMD)/Patient Health Questionnaire (PHQ-9))												
8 (Aragones 2012; Araya 2003; Berghofer 2012; Chen	randomised trials	serious[1]	serious[4]	not serious	not serious	none	411/885 (46.4%)	198/818 (24.2%)	RR 1.85 (1.34 to 2.56)	206 more per 1,000 (from 82 more to 378 more)	LOW	CRITICAL

Quality assessment							Number of participants		Effect			
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Collaborative care	Standard care/enhanced standard care	Relative (95% CI)	Absolute (95% CI)	Quality	Importance
2015; Huijbregts 2013; Ng 2020; Yeung 2010; Yeung 2016)												
Response at 12 months (assessed with: Number of participants whose scores improved by at least 50% on Hamilton Depression Rating Scale (HAMD)/Patient Health Questionnaire (PHQ-9))												
13 (Aragones 2012; Berghofer 2012; Bruce 2004; Chen 2015; Ell 2007; Gensichen 2009; Harter 2018; Holzel 2018; Huijbregts 2013; Katzelnick 2000; Morriss 2016; Ng 2020; Richards	randomised trials	serious[1]	serious[4]	not serious	not serious	none	984/2744 (35.9%)	535/2166 (24.7%)	RR 1.51 (1.30 to 1.76)	126 more per 1,000 (from 74 more to 188 more)	LOW	CRITICAL

Quality assessment							Number of participants		Effect			
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Collaborative care	Standard care/enhanced standard care	Relative (95% CI)	Absolute (95% CI)	Quality	Importance
2013/ 2016)												
Remission at 6 months (assessed with: Number of participants showing Hamilton Depression Rating Scale (HAMD) score <7 or 8/Patient Health Questionnaire (PHQ-9) score <5/Montgomery-Asberg Depression Rating Scale-self report (MADRS-SR) score <13/Center for Epidemiologic Studies Depression (CES-D) score <20/loss of diagnosis)												
12 (Aragones 2012; Araya 2003; Bjorkelund 2018; Chen 2015; Huijbregts 2013; Jeong 2013; Katon 1999; Ng 2020; Smit 2006; Wells 2000; Yeung 2010; Yeung 2016	randomised trials	serious[1]	serious[4]	not serious	not serious	none	940/2313 (40.6%)	439/1620 (27.1%)	RR 1.63 (1.31 to 2.02)	171 more per 1,000 (from 84 more to 276 more)	LOW	CRITICAL
Remission at 12 months (assessed with: Number of participants showing Hamilton Depression Rating Scale (HAMD) score <7/Patient Health Questionnaire (PHQ-9) score <5 or 10/Center for Epidemiologic Studies Depression (CES-D) score <20/loss of diagnosis)												
14 (Aragones 2012; Bruce 2004; Chen 2015; Ell 2007;	randomised trials	serious[1]	serious[4]	not serious	serious[3]	none	1119/3664 (30.5%)	581/2591 (22.4%)	RR 1.49 (1.23 to 1.8)	110 more per 1,000 (from 52 more to 179 more)	VERY LOW	CRITICAL

Quality assessment							Number of participants		Effect			
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Collaborative care	Standard care/enhanced standard care	Relative (95% CI)	Absolute (95% CI)	Quality	Importance
Gensichen 2009; Harter 2018; Holzel 2018; Huijbregts 2013; Katzelnick 2000; Ludman 2007; Morriss 2016; Ng 2020; Richards 2013/ 2016; Wells 2000												
Antidepressant use at 6 months (assessed with: Number of participants adhering to or in receipt of antidepressants)												
11 (Aragones 2012; Araya 2003; Bjorkelund 2018; Finley 2003; Jeong 2013; Katon 1999; Simon 2004	randomised trials	serious[1]	very serious[2]	not serious	very serious[5]	none	1432/2204 (65.0%)	1007/1818 (55.4%)	RR 1.14 (0.91 to 1.43)	78 more per 1,000 (from 50 fewer to 238 more)	VERY LOW	IMPORTANT

Quality assessment							Number of participants		Effect			
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Collaborative care	Standard care/enhanced standard care	Relative (95% CI)	Absolute (95% CI)	Quality	Importance
(CM); Simon 2004 (CM + psych); Simon 2006; Smit 2006; Unutzer 2002/ Arean 2005)												
Antidepressant use at 12 months (assessed with: Number of participants adhering to or in receipt of antidepressants)												
13 (Aragones 2012; Bosanquet 2017; Bruce 2004; Capoccia 2004; Dobscha 2006; Ell 2007; Fortney 2007; Gensichen 2009; Gilbody 2017/ Lewis 2017; Jarjou	randomised trials	serious[1]	serious[4]	not serious	serious[3]	none	1679/2823 (59.5%)	1433/2843 (50.4%)	RR 1.14 (1.04 to 1.26)	71 more per 1,000 (from 20 more to 131 more)	VERY LOW	IMPORTANT

Quality assessment							Number of participants		Effect			
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Collaborative care	Standard care/enhanced standard care	Relative (95% CI)	Absolute (95% CI)	Quality	Importance
ra 2004; Ludman 2007; Richards 2013/ 2016 Unutzer 2002/ Arean 2005)												
Discontinuation at 6 months (assessed with: Number of participants who dropped out of the study for any reason)												
19 (Aragones 2012; Araya 2003; Bjorkelund 2018; Buszewicz 2016; Chen 2015; Curth 2020; Finley 2003; Harter 2018; Huang 2018; Huijbregts 2013; Jeong 2013; Ng 2020;	randomised trials	not serious	serious[4]	not serious	serious[3]	none	952/5008 (19%)	576/3297 (17.5%)	RR 0.94 (0.77 to 1.15)	10 fewer per 1,000 (from 40 fewer to 26 more)	LOW	IMPORTANT

Quality assessment							Number of participants		Effect			
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Collaborative care	Standard care/enhanced standard care	Relative (95% CI)	Absolute (95% CI)	Quality	Importance
Oladeji 2015; Simon 2004 (CM); Simon 2004 (CM + psych); Simon 2006; Smit 2006; Unutzer 2002/ Arean 2005; Wells 2000)												
Discontinuation at 12 months (assessed with: Number of participants who dropped out of the study for any reason)												
22 (Aragones 2012; Bosanquet 2017; Bruce 2004; Buszewicz 2016; Capoccia 2004; Chen 2015; Dobscha 2006; Ell 2007; Fortne	randomised trials	not serious	serious[4]	not serious	not serious	none	1381/5986 (23.1%)	1015/4930 (20.6%)	RR 1.06 (0.93 to 1.2)	12 more per 1,000 (from 14 fewer to 41 more)	MODERATE	IMPORTANT

Quality assessment							Number of participants		Effect			
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Collaborative care	Standard care/enhanced standard care	Relative (95% CI)	Absolute (95% CI)	Quality	Importance
y 2007; Gensichen 2009; Gilbody 2017/ Lewis 2017; Harter 2018; Holzel 2018; Huijbregts 2013; Katzelnick 2000; Ludman 2007; Morriss 2016; Ng 2020; Richards 2013/ 2016; Swindle 2003; Unutzer 2002/ Arean 2005; Wells 2000)												

CI: Confidence interval; SMD: Standardised mean difference; RR: Risk ratio
1. Risk of bias is high or unclear across multiple domains
2. I-squared>80%
3. 95% CI crosses 1 clinical decision threshold
4. I-squared>50%
5. 95% CI crosses 2 clinical decision thresholds

Table 30: Clinical evidence profile for Comparison 2: Collaborative care for relapse prevention versus standard care

Quality assessment							Number of participants		Effect			
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Collaborative care	Standard care	Relative (95% CI)	Absolute (95% CI)	Quality	Importance
Relapse at 12 months (assessed with: Longitudinal Interval Follow-up Evaluation)												
1 (Katon 2001)	randomised trials	serious[1]	not serious	not serious	very serious[2]	none	68/194 (35.1%)	66/192 (34.4%)	RR 1.02 (0.78 to 1.34)	7 more per 1,000 (from 76 fewer to 117 more)	VERY LOW	CRITICAL
Antidepressant use at 6 months (assessed with: Number of participants receiving antidepressants)												
1 (Katon 2001)	randomised trials	serious[1]	not serious	not serious	serious[3]	none	139/194 (71.6%)	112/192 (58.3%)	RR 1.23 (1.06 to 1.43)	134 more per 1,000 (from 35 more to 251 more)	LOW	IMPORTANT
Antidepressant use at 12 months (assessed with: Number of participants receiving antidepressants)												
1 (Katon 2001)	randomised trials	serious[1]	not serious	not serious	serious[3]	none	123/194 (63.4%)	95/192 (49.5%)	RR 1.28 (1.07 to 1.53)	139 more per 1,000 (from 35 more to 262 more)	LOW	CRITICAL
Discontinuation at 12 months (assessed with: Number of participants who dropped out of the study for any reason)												
1 (Katon 2001)	randomised trials	serious[1]	not serious	not serious	serious[3]	none	20/194 (10.3%)	40/192 (20.8%)	RR 0.49 (0.30 to 0.81)	106 fewer per 1,000 (from 40 fewer to 146 fewer)	LOW	IMPORTANT

CI: Confidence interval; RR: Risk ratio
1. Risk of bias is high or unclear across multiple domains
2. 95% CI crosses 2 clinical decision thresholds
3. 95% CI crosses 1 clinical decision threshold

Table 31: Clinical evidence profile for Comparison 3. Stepped care versus standard care/enhanced standard care

Quality assessment							Number of participants		Effect			
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Stepped care	Standard care/enhanced standard care	Relative (95% CI)	Absolute (95% CI)	Quality	Importance
Depression symptomatology (endpoint score) at 6 months (assessed with: Patient Health Questionnaire (PHQ-9))												
2 (Gureje 2019; Knapstad 2020)	randomised trials	serious[1]	very serious[2]	not serious	not serious	none	959	655	-	SMD 0.36 lower (0.46 to 0.26 lower)	VERY LOW	CRITICAL
Depression symptomatology (change score) at 6 months (assessed with: Montgomery-Asberg Depression Rating Scale (MADRS)/Patient Health Questionnaire (PHQ-9) change from baseline to endpoint)												
2 (Knapstad 2020; Van Der Weele 2012)	randomised trials	serious[1]	very serious[2]	not serious	not serious	none	524	302	-	SMD 0.73 lower (0.89 to 0.58 lower)	VERY LOW	CRITICAL
Depression symptomatology (endpoint score) at 12 months (assessed with: Patient Health Questionnaire (PHQ-9))												
1 (Gureje 2019)	randomised trials	serious[1]	not serious	not serious	not serious	none	542	456	-	SMD 0.02 higher (0.1 lower to 0.15 higher)	MODERATE	CRITICAL
Depression symptomatology (change score) at 12 months (assessed with: Montgomery-Asberg Depression Rating Scale (MADRS) change from baseline to endpoint)												
1 (Van Der Weele 2012)	randomised trials	serious[1]	not serious	not serious	serious[3]	none	101	93	-	SMD 0.24 higher (0.04 lower to 0.53 higher)	LOW	CRITICAL
Response at 6 months (assessed with: Number of participants showing improvement of at least 50% on Montgomery-Asberg Depression Rating Scale (MADRS))												
1 (Van Der	randomised trials	serious[1]	not serious	not serious	very serious[4]	none	17/121 (14.0%)	23/118 (19.5%)	RR 0.72 (0.41 to 1.28)	55 fewer per	VERY LOW	CRITICAL

Quality assessment							Number of participants		Effect			
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Stepped care	Standard care/enhanced standard care	Relative (95% CI)	Absolute (95% CI)	Quality	Importance
Weele 2012)										1,000 (from 115 fewer to 55 more)		
Response at 12 months (assessed with: Number of participants showing improvement of at least 50% on Montgomery-Asberg Depression Rating Scale (MADRS))												
1 (Van Der Weele 2012)	randomised trials	serious[1]	not serious	not serious	serious[3]	none	21/121 (17.4%)	31/118 (26.3%)	RR 0.66 (0.40 to 1.08)	89 fewer per 1,000 (from 158 fewer to 21 more)	LOW	CRITICAL
Remission at 6 months (assessed with: Number of participants showing Hamilton Depression Rating Scale (HAMD) score < 11/ Patient Health Questionnaire (PHQ-9) score < 6)												
2 (Adewuya 2019; Callahan 1994)	randomised trials	serious[1]	serious[5]	not serious	not serious	none	259/556 (46.6%)	126/526 (24%)	RR 2 (1.69 to 2.38)	240 more per 1,000 (from 165 more to 331 more)	LOW	CRITICAL
Remission at 12 months (assessed with: Number of participants showing Patient Health Questionnaire (PHQ-9) score < 6)												
2 (Adewuya 2019; Gureje 2019)	randomised trials	serious[1]	very serious[2]	not serious	very serious[4]	none	756/1087 (69.5%)	502/998 (50.3%)	RR 1.81 (0.45 to 7.28)	407 more per 1,000 (from 277 fewer to 1000 more)	VERY LOW	CRITICAL
Antidepressant use at 6 months (assessed with: Number of participants receiving antidepressants)												
1 (Calla	randomised trials	serious[1]	not serious	not serious	not serious	none	27/100 (27.0%)	7/75 (9.3%)	RR 2.89 (1.33 to 6.28)	176 more per	MODERATE	IMPORTANT

Quality assessment							Number of participants		Effect			
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Stepped care	Standard care/enhanced standard care	Relative (95% CI)	Absolute (95% CI)	Quality	Importance
han 1994)										1,000 (from 31 more to 493 more)		
Discontinuation at 6 months (assessed with: Number of participants who dropped out of the study for any reason)												
5 (Adewuya 2019; Callahan 1994; Gureje 2019; Knapstad 2020; Van Der Weele 2012)	randomised trials	not serious	serious[5]	not serious	serious[3]	none	334/1771 (18.9%)	307/1409 (21.8%)	RR 0.75 (0.6 to 0.94)	54 fewer per 1,000 (from 13 fewer to 87 fewer)	LOW	IMPORTANT
Discontinuation at 12 months (assessed with: Number of participants who dropped out of the study for any reason)												
3 (Adewuya 2019; Gureje 2019; Van Der Weele 2012)	randomised trials	not serious	not serious	not serious	serious[3]	none	154/1208 (12.7%)	195/1116 (17.5%)	RR 0.74 (0.61 to 0.9)	45 fewer per 1,000 (from 17 fewer to 68 fewer)	MODERATE	IMPORTANT

CI: Confidence interval; SMD: Standardised mean difference; RR: Risk ratio
1. Risk of bias is high or unclear across multiple domains
2. I-squared>80%
3. 95% CI crosses 1 clinical decision threshold
4. 95% CI crosses 2 clinical decision thresholds
5. I-squared>50%

Table 32: Clinical evidence profile for Comparison 4. Stepped care for relapse prevention versus standard care

Quality assessment							Number of participants		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Stepped care	Standard care	Relative (95% CI)	Absolute (95% CI)		
Relapse at 12 months (assessed with: Number of participants who relapsed according to Mini-International Neuropsychiatric Interview (MINI))												
1 (Apil 2012)	randomised trials	serious[1]	not serious	not serious	serious[2]	none	19/74 (25.7%)	9/61 (14.8%)	RR 1.74 (0.85 to 3.56)	109 more per 1,000 (from 22 fewer to 378 more)	LOW	CRITICAL
Antidepressant use at 12 months (assessed with: Number of participants receiving antidepressants)												
1 (Apil 2012)	randomised trials	serious[1]	not serious	not serious	very serious[3]	none	25/49 (51.0%)	24/45 (53.3%)	RR 0.96 (0.65 to 1.41)	21 fewer per 1,000 (from 187 fewer to 219 more)	VERY LOW	IMPORTANT
Discontinuation at 12 months (assessed with: Number of participants who dropped out of the study for any reason)												
1 (Apil 2012)	randomised trials	not serious	not serious	not serious	very serious[3]	none	35/74 (47.3%)	30/62 (48.4%)	RR 0.98 (0.69 to 1.39)	10 fewer per 1,000 (from 150 fewer to 189 more)	LOW	IMPORTANT

CI: Confidence interval; RR: Risk ratio
1. Risk of bias is high or unclear across multiple domains
2. 95% CI crosses 1 clinical decision threshold
3. 95% CI crosses 2 clinical decision thresholds

Table 33: Clinical evidence profile for Comparison 5: Pure medication management versus standard care

Quality assessment							Number of participants		Effect			
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Pure medication management	Standard care	Relative (95% CI)	Absolute (95% CI)	Quality	Importance
Depression symptomatology at 6 months (assessed with: Montgomery-Asberg Depression Rating Scale (MADRS)/Patient Health Questionnaire (PHQ-9))												
2 (Aljumah 2015; Rubio-Valera 2013a)	randomised trials	not serious	not serious	not serious	not serious	none	197	202	-	SMD 0.05 higher (0.15 lower to 0.24 higher)	HIGH	CRITICAL
Response at 6 months (assessed with: Number of participants showing improvement of at least 50% on Hamilton Depression Rating Scale (HAMD))												
1 (Sirey 2010)	randomised trials	not serious	not serious	not serious	serious[1]	none	14/33 (42.4%)	8/37 (21.6%)	RR 1.96 (0.94 to 4.08)	208 more per 1,000 (from 13 fewer to 666 more)	MODERATE	CRITICAL
Antidepressant use at 6 months (assessed with: Number of participants adhering to antidepressant medication)												
3 (Akerblad 2003; Rickels 2005; Rubio-Valera 2013a)	randomised trials	serious[2]	not serious	not serious	serious[1]	none	218/441 (49.4%)	183/463 (39.5%)	RR 1.28 (1.10 to 1.49)	111 more per 1,000 (from 40 more to 194 more)	LOW	IMPORTANT
Discontinuation at 6 months (assessed with: Number of participants who dropped out of the study for any reason)												
5 (Akerblad	randomised trials	not serious	not serious	not serious	serious[1]	none	114/596 (19.1%)	133/620 (21.5%)	RR 0.89 (0.71 to 1.11)	24 fewer per	MODERATE	IMPORTANT

Quality assessment							Number of participants		Effect			
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Pure medication management	Standard care	Relative (95% CI)	Absolute (95% CI)	Quality	Importance
2003; Aljumah 2015; Rickles 2005; Rubio-Valera 2013a; Sirey 2010)										1,000 (from 62 fewer to 24 more)		

CI: Confidence interval; SMD: Standardised mean difference; RR: Risk ratio
1. 95% CI crosses 1 clinical decision threshold
2. Risk of bias is high or unclear across multiple domains

Table 34: Clinical evidence profile for Comparison 6: Care coordination versus standard care/enhanced standard care

Quality assessment							Number of participants		Effect			
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Care coordination	Standard care/enhanced standard care	Relative (95% CI)	Absolute (95% CI)	Quality	Importance
Depression symptomatology at 6 months (measured with: Montgomery-Asberg Depression Rating Scale (MADRS))												
1 (McMahon 2007)	randomised trials	serious[1]	not serious	not serious	serious[2]	reporting bias[3]	30	32	-	SMD 0.09 lower (0.59 lower to 0.41 higher)	VERY LOW	CRITICAL
Depression symptomatology at 12 months (measured with: Patient Health Questionnaire (PHQ-9))												
1 (Salisbury 2016)	randomised trials	serious[1]	not serious	not serious	not serious	none	255	261	-	SMD 0.05 lower (0.22 lower to 0.13 higher)	MODERATE	CRITICAL
Remission at 12 months (assessed with: Number of participants showing score < 10 on Patient Health Questionnaire (PHQ-9))												

Quality assessment							Number of participants		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Care coordination	Standard care/enhanced standard care	Relative (95% CI)	Absolute (95% CI)		
1 (Salisbury 2016)	randomised trials	serious[1]	not serious	not serious	serious[2]	none	95/307 (30.9%)	86/302 (28.5%)	RR 1.09 (0.85 to 1.39)	26 more per 1,000 (from 43 fewer to 111 more)	LOW	CRITICAL
Discontinuation at 6 months (assessed with: Number of participants who dropped out of the study for any reason)												
1 (McMahon 2007)	randomised trials	serious[1]	not serious	not serious	very serious[4]	reporting bias[3]	12/30 (40.0%)	16/32 (50.0%)	RR 0.80 (0.46 to 1.40)	100 fewer per 1,000 (from 270 fewer to 200 more)	VERY LOW	IMPORTANT
Discontinuation at 12 months (assessed with: Number of participants who dropped out of the study for any reason)												
1 (Salisbury 2016)	randomised trials	serious[1]	not serious	not serious	serious[2]	none	52/307 (16.9%)	41/302 (13.6%)	RR 1.25 (0.86 to 1.82)	34 more per 1,000 (from 19 fewer to 111 more)	LOW	IMPORTANT

CI: Confidence interval; SMD: Standardised mean difference; RR: Risk ratio
1. Risk of bias is high or unclear across multiple domains
2. 95% CI crosses 1 clinical decision threshold
3. Funding from pharmaceutical company
4. 95% CI crosses 2 clinical decision thresholds

Table 35: Clinical evidence profile for Comparison 7: Attached professional model versus enhanced standard care

Quality assessment							Number of participants		Effect			
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Attached professional model	Enhanced standard care	Relative (95% CI)	Absolute (95% CI)	Quality	Importance
Depression symptomatology at 6 months (measured with: Quick Inventory of Depressive Symptomatology (QIDS))												
1 (Bedoya 2014)	randomised trials	very serious[1]	not serious	not serious	serious[2]	none	63	55	-	SMD 0.36 lower (0.73 lower to 0 higher)	VERY LOW	CRITICAL
Discontinuation at 6 months (assessed with: Number of participants who dropped out of the study for any reason)												
1 (Bedoya 2014)	randomised trials	serious[1]	not serious	not serious	very serious[3]	none	9/65 (13.8%)	11/55 (20.0%)	RR 0.69 (0.31 to 1.55)	62 fewer per 1,000 (from 138 fewer to 110 more)	VERY LOW	IMPORTANT

CI: Confidence interval; SMD: Standardised mean difference; RR: Risk ratio
1. Risk of bias is high or unclear across multiple domains
2. 95% CI crosses 1 clinical decision threshold
3. 95% CI crosses 2 clinical decision thresholds

Table 36: Clinical evidence profile for Comparison 8: Shared care versus standard care

Quality assessment							Number of participants		Effect			
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Shared care	Standard care	Relative (95% CI)	Absolute (95% CI)	Quality	Importance
Depression symptomatology at 6 months (measured with: Montgomery-Asberg Depression Rating Scale (MADRS) change score)												
1 (Banerjee 1996)	randomised trials	not serious	not serious	not serious	not serious	none	33	36	-	SMD 1.03 lower (1.53 lower to 0.52 lower)	HIGH	CRITICAL
Remission at 6 months (assessed with: Number of participants who lost their diagnosis)												

Quality assessment							Number of participants		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Shared care	Standard care	Relative (95% CI)	Absolute (95% CI)		
1 (Banerjee 1996)	randomised trials	not serious	not serious	not serious	serious[1]	none	19/33 (57.6%)	9/36 (25.0%)	RR 2.30 (1.22 to 4.36)	325 more per 1,000 (from 55 more to 840 more)	MODERATE	CRITICAL
Antidepressant use at 6 months (assessed with: Number of participants receiving antidepressants)												
1 (Banerjee 1996)	randomised trials	not serious	not serious	not serious	not serious	none	20/33 (60.6%)	5/36 (13.9%)	RR 4.36 (1.85 to 10.30)	467 more per 1,000 (from 118 more to 1,000 more)	HIGH	IMPORTANT
Discontinuation at 6 months (assessed with: Number of participants who dropped out of the study for any reason)												
1 (Banerjee 1996)	randomised trials	not serious	not serious	not serious	very serious[2]	none	4/33 (12.1%)	4/36 (11.1%)	RR 1.09 (0.30 to 4.01)	10 more per 1,000 (from 78 fewer to 334 more)	LOW	IMPORTANT

CI: Confidence interval; SMD: Standardised mean difference; RR: Risk ratio
1. 95% CI crosses 1 clinical decision threshold
2. 95% CI crosses 2 clinical decision thresholds

Table 37: Clinical evidence profile for Comparison 9: Measurement-based care versus standard care

Quality assessment							Number of participants		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Measurement-based care	Standard care	Relative (95% CI)	Absolute (95% CI)		
Depression symptomatology at 6 months (measured with: Hamilton Depression Rating Scale (HAMD))												

Quality assessment							Number of participants		Effect		Quality	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Measurement-based care	Standard care	Relative (95% CI)	Absolute (95% CI)		
1 (Guo 2015)	randomised trials	serious[1]	not serious	not serious	not serious	none	44	37	-	SMD 1.05 lower (1.51 lower to 0.58 lower)	MODERATE	CRITICAL
Response at 6 months (assessed with: Number of participants showing improvement of at least 50% on Hamilton Depression Rating Scale (HAMD))												
1 (Guo 2015)	randomised trials	serious[1]	not serious	not serious	serious[2]	none	53/61 (86.9%)	37/59 (62.7%)	RR 1.39 (1.11 to 1.73)	245 more per 1,000 (from 69 more to 458 more)	LOW	CRITICAL
Remission at 6 months (assessed with: Number of participants showing score <8 on Hamilton Depression Rating Scale (HAMD))												
1 (Guo 2015)	randomised trials	serious[1]	not serious	not serious	not serious	none	45/61 (73.8%)	17/59 (28.8%)	RR 2.56 (1.67 to 3.93)	449 more per 1,000 (from 193 more to 844 more)	MODERATE	CRITICAL
Discontinuation at 6 months (assessed with: Number of participants who dropped out of the study for any reason)												
1 (Guo 2015)	randomised trials	serious[1]	not serious	not serious	very serious[3]	none	17/61 (27.9%)	22/59 (37.3%)	RR 0.75 (0.44 to 1.26)	93 fewer per 1,000 (from 209 fewer to 97 more)	VERY LOW	IMPORTANT

CI: Confidence interval; SMD: Standardised mean difference; RR: Risk ratio
1. Risk of bias is high or unclear across multiple domains
2. 95% CI crosses 1 clinical decision threshold
3. 95% CI crosses 2 clinical decision thresholds