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1.1 ACCESS TO HEALTHCARE

1.1.1 Included studies characteristics (systematic reviews of factors that affect access to healthcare)

Study ID	COCHRANE2007
Bibliographic reference	Cochrane, L. J., Olson, C. A., Murray, S., <i>et al.</i> (2007) Gaps between knowing and doing: understanding and assessing the barriers to optimal health care. <i>Journal of Continuing Education in the Health Professions</i> , 27(2), 94-102.
Participant characteristics	General population
Method used to synthesise evidence	Qualitative thematic analysis
Design of included studies	Qualitative, surveys and mixed-model
Dates searched	1998-2007
No. of included studies	256
Source of funding	Not reported

Study ID	DAS2006
Bibliographic reference	Das, A. K., Olfson, M., McCurtis, H. L., <i>et al.</i> (2006) Depression in African Americans: breaking barriers to detection and treatment. <i>Applied Evidence</i> , 55(1), 30-39.
Participant characteristics	African-Americans
Method used to synthesise evidence	Narrative
Design of included studies	Qualitative and quantitative studies
Dates searched	1966-2004
No. of included studies	24
Source of funding	Columbia Center for the Health of Urban Minorities (NCMHHD MD000206-019006) (Drs. Olfson and Weissman), an unrestricted grant from Eli Lilly & Company (Dr. Weissman) and a NIMH National Service Research Award Institutional Research Training Grant 5T32MH015144 (Dr. Das).

Study ID	DENNIS2006
Bibliographic reference	Dennis, C. & Chung-Lee, L. (2006) Postpartum depression help-seeking barriers and maternal treatment preferences: a qualitative systematic review. <i>Birth</i> , 33(4), 323-331.
Participant characteristics	Postpartum depression only (does not include other perinatal mood disorders)
Method used to synthesise evidence	Narrative
Design of included studies	Qualitative
Dates searched	1966-2005
No. of included studies	40
Source of funding	Not reported

Study ID	DIXON-WOODS2005
Bibliographic reference	Dixon-Woods M., Kirk D., Agarwal S., <i>et al.</i> (2005) Vulnerable groups and access to health care: a critical interpretive synthesis (Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation Research and Development). London. National Co-ordinating Centre for NHS Service Delivery and Organisation.
Participant characteristics	General population; BME groups; older people
Method used to synthesise evidence	Meta-ethnography (critically interpretive synthesis)
Design of included studies	Qualitative
Dates searched	1985-2005
No. of included studies	General population n = 253; BME groups n = 103; Older people n = 111
Source of funding	Not reported

Study ID	JUNG2003
Bibliographic reference	Jung, H.P., Baerveldt, C., Olesen, F., <i>et al.</i> (2003) Patient characteristics as predictors of primary health care preferences: a systematic literature analysis. <i>Health Expectations</i> , 6(2), 160-181
Participant characteristics	Older patients
Method used to synthesise evidence	Narrative
Design of included studies	Not specified
Dates searched	1963-2001
No. of included studies	145

Source of funding	Not reported
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Study ID	PRINS2008
Bibliographic reference	Prins, M. A., Verhaak, P. F. M., Bensing, J. M., <i>et al.</i> (2008) Health beliefs and perceived need for mental health care of anxiety and depression- the patients' perspective explored. <i>Clinical Psychology Review</i> , 28(6), 1038-1058.
Participant characteristics	Patients with anxiety or depression
Method used to synthesise evidence	Narrative
Design of included studies	Qualitative and quantitative studies
Dates searched	1995-2006
No. of included studies	71
Source of funding	Not reported

Study ID	RODRIGUEZ2009
Bibliographic reference	Rodriguez, M., Valentine, J.M., Son, J.B., <i>et al.</i> (2009) Intimate partner violence and barriers to mental health care for ethnically diverse populations of women. <i>Trauma Violence Abuse</i> , 10, 358-374.
Participant characteristics	Women who have suffered domestic violence
Method used to synthesise evidence	Narrative
Design of included studies	Qualitative, quantitative, and reviews
Dates searched	1996-2008
No. of included studies	55

Source of funding	National Institute of Mental Health -fundedUCLA Center for Culture, Trauma, and Mental Health Disparities (1P50MH073453) and NIH/National Center on Minority Health UCLA/DREW Project Export (P20 MD000148)
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Study ID	SCHEPPERS2006
Bibliographic reference	Scheppers, E., van Dongen, E., Dekker, J., <i>et al.</i> (2006). Potential barriers to the use of health services among ethnic minorities: a review. <i>Family Practice</i> , 23(3), 325-348.
Participant characteristics	General population
Method used to synthesise evidence	Narrative
Design of included studies	Qualitative, quantitative, combined
Dates searched	1990-2003
No. of included studies	54
Source of funding	ZON-MW, The Netherlands Organisation for Health Research and Development. Grant number 14350023

Study ID	VANVOORHES2007
Bibliographic reference	Van Voorhees, B. W., Walters, A. E., Prochaska, M., <i>et al.</i> (2007) Reducing health disparities in depressive disorders outcomes between non-Hispanic whites and ethnic minorities: a call for pragmatic strategies over the life course. <i>Medical Care Research and Review</i> , 64(5), 157S-194S.
Participant characteristics	BME groups
Method used to synthesise evidence	Narrative
Design of included studies	Interventions studies
Dates searched	1995-2006
No. of included studies	73
Source of funding	Robert Wood Johnson Foundation through Finding Answers: Disparities Research for Change, the Department of Medicine at

	The University of Chicago, and the National Institute of Diabetes and Digestive and Kidney Diseases Diabetes Research and Training Center (P60 DK20595). Dr. Van Voorhees is supported by a NARSAD Young Investigator Award, a Robert Wood Johnson Foundation Depression in Primary Care Value Grant, and a Career Development Award from the National Institutes of Mental Health (NIMH K-08 MH 072918-01A2).
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1.1.2 Included studies characteristics (systematic reviews evaluating adapting models of service delivery and therapeutic interventions to improve access)

Study ID	BALAS1997
Bibliographic reference	Balas, E. A., Jaffrey, F., Kuperman, G. J., <i>et al.</i> (1997) Electronic communication with patients evaluation of distance medicine technology. <i>Journal of the American Medical Association</i> , 278(2), 152-159.
Method used to synthesise evidence	Narrative
Design of included studies	RCTs
Dates searched	1966-1996
Review quality	Adequate
Model / method evaluated	Electronic Communication (telephone or computer)
Comparison	Control
Outcome	* Service user satisfaction * Appointments keeping
Participant characteristics	General Population
Pooled effect sizes or summary of findings	Inteventions resulted in:- * higher service user satisfaction * fewer unkept appointments * higher utilistaion of preventative healthcare by elderly individuals keeping rates

Source of funding	National Library of Medicine' (LM05545) and by a grant from the Center for Health Management Research of the National Science Foundation and Arizona State University, Tempe

Study ID	BEE2008
Bibliographic reference	Bee, P. E., Bower, P., Lovell, K., <i>et al.</i> (2008) Psychotherapy mediated by remote communication technologies: a meta-analytic review. <i>BMC Psychiatry</i> , 8, 60.
Method used to synthesise evidence	Meta-analysis
Design of included studies	RCTs
Dates searched	1980-2006
Review quality	Adequate
Model / method evaluated	Psychological intervention delivered via remote communication
Comparison	Control; conventional face-to-face therapy; different types of remote therapy
Outcome	* Ability to increase access to services
Participant characteristics	ICD-10 or DSM diagnoses of mood or functional (non-organic) mental health problem – that is, depression, anxiety or anxiety-related disorders
Pooled effect sizes or summary of findings	Verses control:- * Depression: 0.44 (95% CI 0.29 to 0.59; 7 comparisons, n=726) * Anxiety-related disorders: 1.15 (95% CI 0.81 to 1.49; 3 comparisons, n=168)
Source of funding	Not reported

Study ID	CHAPMAN2004
Bibliographic reference	Chapman, J. L., Zechel, A., Carter, Y. H., <i>et al.</i> (2004) Systematic review of recent innovations in service provision to improve access to primary care. <i>British Journal of General Practice</i> , 54(502), 374-381.
Method used to synthesise evidence	Narrative
Design of included studies	RCTs, systematic reviews, analytical intervention, observational studies
Dates searched	1984-2004
Review quality	Adequate
Model / method evaluated	Personal medical services, GP-led telephone consultations, Nurse-led telephone consultations/triage in general practice, Nurse-led care in general practice, Walk-in centres, NHS Direct, Pharmacist-led care in the community
Comparison	No direct comparison
Outcome	* Use of healthcare services
Participant characteristics	Vulnerable groups (BME groups; older people)
Pooled effect sizes or summary of findings	Overall evidence is insufficient to make recommendations but first-wave personnel medical services pilots how show evidence of improved access to primary care in under-served areas/populations
Source of funding	The Greater London Authority funded the original review on which this paper is based.

Study ID	GRILLI2009
Bibliographic reference	Grilli, R., Ramsay, C. & Minozzi, S. (2002) Mass media interventions: effects on health service utilisation. <i>Cochrane Database of Systematic Reviews</i> , Issue 1, Art. No. CD000389.
Method used to synthesise evidence	Narrative
Design of included studies	RCTs, controlled clinical trials, controlled before and after trials, interrupted time series analyses

Dates searched	Database inception to 1999
Review quality	Adequate
Model / method evaluated	Mass media (for example, radio, television, newspapers, leaflets)
Comparison	No direct comparison
Outcome	* Objective (not self-reported) utilisation of healthcare services by healthcare practitioners and individuals
Participant characteristics	General Population
Pooled effect sizes or summary of findings	Mass media can have an impact on healthcare service utilisation but evidence is methodologically flawed and should be viewed with caution
Source of funding	Internal sources <ul style="list-style-type: none"> • Agenzia Sanitaria Regionale Emilia-Romagna, Bologna, Italy. • Health Services Research Unit, University of Aberdeen, UK External sources <ul style="list-style-type: none"> • NHS Research & Development Programme, UK

Study ID	KAIRY2009
Bibliographic reference	Kairy, D., Lehoux, P., Vincent, CF., <i>et al.</i> (2009) A systematic review of clinical outcomes, clinical process, healthcare utilization and costs associated with telerehabilitation. <i>Disability and Rehabilitation</i> , 31, 1-21.
Method used to synthesise evidence	Narrative
Design of included studies	Experimental or observational intervention studies including cross-over designs
Dates searched	Database inception to 2007

Review quality	Included study quality is assessed but not reported
Model / method evaluated	Telerehabilitation
Comparison	Control (face-to-face or usual care)
Outcome	<ul style="list-style-type: none"> * Attendance and adherence to progreammes * Service user accessability to programme * Service user satisfaction * Healthcare utilisation
Participant characteristics	General Population
Pooled effect sizes or summary of findings	<p>Inteventions resulted in:-</p> <ul style="list-style-type: none"> * greater attendance * greater adherence * higher service user satisfaction * healthcare utilisation was rarely measured in included studies and the results are inconclusive
Source of funding	Not reported

Study ID	KINNERSLEY2007
Bibliographic reference	Kinnersley, P., Edwards, A., Hood, K., <i>et al.</i> (2008) Interventions before consultations to help patients address their information needs by encouraging question asking: systematic review. <i>British Medical Journal</i> , 337, A485-A494.
Method used to synthesise evidence	Meta-analysis
Design of included studies	RCTS
Dates searched	1966-2006
Review quality	Adequate

Model / method evaluated	Information giving prior to consultation
Comparison	Control (for example, usual care, leaflets, general discussion)
Outcome	<ul style="list-style-type: none"> * Question asking * Individuals' anxiety * Service user knowledge and satisfaction
Participant characteristics	General Population
Pooled effect sizes or summary of findings	<p>Inteventions resulted in:-</p> <ul style="list-style-type: none"> * significant increase in question asking (0.27, 95% CI 0.19 to 0.36) * individuals' satisfaction (0.09, 0.03 to 0.16) * non-significant changes in individuals' anxiety before and after consultation, individuals' knowledge, length of consultation
Source of funding	This research received no specific grant from any funding agency in the public, commercial, or not for profit sectors.

Study ID	PIGNONE2005
Bibliographic reference	Pignone, M., DeWalt, D. A., Sheridan, S., <i>et al.</i> (2005) Interventions to improve health outcomes for patients with low literacy: a systematic review. <i>Journal of General Internal Medicine</i> , 20(2), 185-192.
Method used to synthesise evidence	Narrative
Design of included studies	Controlled and uncontrolled trials
Dates searched	1980-2003
Review quality	Adequate
Model / method evaluated	Easy-to-read written material, videotapes, CD-ROM, computer programs, interactive videodisks, in-person instruction
Comparison	No intervention. literature at a standard level

Outcome	* Health knowledge * Health behaviours * Use of healthcare services
Participant characteristics	Persons with low literacy skills
Pooled effect sizes or summary of findings	Effectiveness of interventions inconclusive
Source of funding	Supported by a contract to the Agency for Healthcare Research and Quality (290-02-0016), Rockville, MD.

1.1.3 Included studies characteristics (studies evaluating service developments and interventions which are specifically designed to promote access)

Study ID	ANDERSON2003
Bibliographic reference	Anderson, L. M., Scrimshaw, S. C., Fullilove, M. T., <i>et al.</i> (2003) Culturally competent healthcare systems: a systematic review. <i>American Journal of Preventative Medicine</i> , 24(3), 68-79.
Method used to synthesise evidence	Narrative
Design of included Studies	Not specified
Dates searched	1965-2001
Review quality	The design and the quality of the included studies was unspecified
No. of included studies	6
Targeted vulnerable group	BME groups
Model/ method evaluated	* Recruit members of staff who reflect the community culturally * Use of interpreter or bilingual practitioners

	<ul style="list-style-type: none"> * Cultural competence training * Linguistically and culturally appropriate health education materials * Cultural specific healthcare settings
Comparison	No exposure to intervention
Outcome	<ul style="list-style-type: none"> * Client satisfaction * Racial/ethnic differentials in utilisation of healthcare services
Results	<ul style="list-style-type: none"> * Insufficient evidence to evaluate effectiveness of culturally diverse staff reflecting the local community * Use of bilingual practitioner resulted in patient being more likely to get a follow-up appointment than if interpreter used (OR=1.92, 95% CI=1.11 to 3.33). * Interpreter not used – service user less likely to be given a follow-up appointment than those with language-concordant physician (OR=1.79, 95% CI = 1.00 to 3.23). No difference in uptake of treatment. * Staff training about cultural awareness resulted in greater client satisfaction in African-American individuals (standard effect size = 1.6, p<0.001). Also more likely to return for more sessions (absolute difference=33%, p<0.001) * Only one out of four studies reported change in health behaviour due to use of signage and literature in individuals' language. Three out of four studies reported greater client satisfaction. Overall evidence is weak.
Source of funding	Robert Wood Johnson Foundation

Study ID	BEACH2006
Bibliographic reference	Beach, M. C., Gary, T. L., Price, E. G., <i>et al</i> (2006) Improving health care quality for racial/ethnic minorities: a systematic review of the best evidence regarding provider and organization interventions. <i>BMC Public Health</i> , 6, 104.
Method used to synthesise evidence	Narrative
Design of included Studies	RCTs
Dates searched	1980-2003
Review quality	Adequate
No. of included studies	27

Targeted vulnerable group	BME groups
Model/ method evaluated	<ul style="list-style-type: none"> * Tracking/reminder systems * Multifaceted Interventions * Bypass the physician * Practitioner education * Structured questionnaire * Remote simultaneous translation * Culturally tailored interventions
Comparison	No exposure to intervention
Outcome	<ul style="list-style-type: none"> * Use of services * Appropriateness of care * Quality of practitioners * Service user adherence * Service user satisfaction * Individual/practitioner communication
Results	<ul style="list-style-type: none"> * Strong evidence to support the use of tracking/reminder systems * Evidence is generally positive (but inconsistent across outcomes) for multi-faceted interventions * Evidence supporting bypassing the physician for preventative services is fair * Evidence supports practitioner education as it had a positive effect on counselling behaviours * Insufficient evidence to support the use of structured questionnaires in assessment * Evidence for remote simultaneous translation shows favourable outcomes for accuracy of translation and practitioner/service user satisfaction; improved communication * Evidence was weak and inconclusive for culturally tailored interventions to improve quality of depression care
Source of funding	Under contract to the Agency for Healthcare Research and Quality (Contract No. 290-02-0018), Rockville, MD

Study ID	FISHER2007
Bibliographic reference	Fisher, T. L., Burnet, D. L., Huang, E. S., <i>et al.</i> (2007) Cultural leverage: interventions using culture to narrow racial disparities in health care. <i>Medical Care Research Review</i> , 64 (5), 243S-282S.
Method used to synthesise evidence	Narrative
Design of included Studies	Various (not restricted to RCTs)

Dates searched	1985-2006
Review quality	Adequate
No. of included studies	38
Targeted vulnerable group	BME groups
Model/ method evaluated	<ul style="list-style-type: none"> * Individual level interventions to modify existing behaviour * Interventions that increase access to existing healthcare environments * Interventions that modify healthcare interventions
Comparison	No exposure to intervention; pre- and post- intervention
Outcome	<ul style="list-style-type: none"> * Use of services * Service user understanding * Service user satisfaction
Results	<ul style="list-style-type: none"> * Individual level interventions resulted in general improvement in health but no evidence for access outcomes * Access level interventions did not show any significant improvements in improving healthcare for BME groups * Healthcare interventions (such as staff training in culturally specific interventions) showed some evidence of improved service user understanding of disease, satisfaction, and some trends for improving behaviour
Source of funding	Robert Wood Johnson Foundation through Finding Answers: Disparities Research for Change, the Department of Medicine at the University of Chicago, and the National Institute of Diabetes and Digestive and Kidney Diseases Diabetes Research and Training Center (P60 DK20595). Dr. Fisher is supported by the National Institutes of Health (NIH) Loan Repayment Program. Dr. Burnet is supported by an NIH Career Development Award (K23 DK064073-01). Dr. Huang is supported by an NIH Career Development Award (K23 AG021963). Dr. Chin is supported by an NIH Midcareer Investigator Award in Patient-Oriented Research (K24 DK071933)

Study ID	FLORES2005
Bibliographic reference	Flores, G. (2005) The impact of medical interpreter services on the quality of health care: a systematic review. <i>Medical Care Research Review</i> , 62, 255-299.
Method used to synthesise evidence	Narrative

Design of included Studies	Various (not restricted to RCTs)
Dates searched	1966-2003
Review quality	The quality of the included studies was unspecified
No. of included studies	36
Targeted vulnerable group	Limited English proficiency participants
Model/ method evaluated	<ul style="list-style-type: none"> * Use of professional medical service interpreters * Use of bilingual physicians * Use of ad hoc interpreters
Comparison	Cross-comparisons; use of monolingual interpreter; no interpreter
Outcome	<ul style="list-style-type: none"> * Use of services *Service user satisfaction * Individual-practitioner communication
Results	<ul style="list-style-type: none"> * Service user satisfaction - no difference between interpreter by telephone or in person; those help needed but did not get an interpreter had lowest satisfaction; use of ad hoc interpreter lowest rating than use of professional interpreter * Communication - 'no interpreter'- service user had poor understanding of diagnosis/treatment plan; 'use of interpreter' - service user more likely to incorrectly describe symptoms than those who did not need an interpreter, ad hoc interpreter resulted in individuals not been told medication side effects, misinterpretation and errors in translations, issues of confidentiality; mental health specifically - more open to misinterpretation, 'normalisation' of symptoms by interpreter or ad hoc interpreter such as family member * Use of an interpreter - increase use of healthcare services ; LEP individuals had a greater number of prescriptions written (adjusted mean difference = 1.4) and filled (adjusted mean difference = 1.3) than English proficient (EP) individuals
Source of funding	National Standards for Health Care Language Services project, with support from the Office of Minority Health

Study ID	MEGHANI2009
Bibliographic reference	Meghani, S. H., Brooks, J. M., Gipson-Jones, T., <i>et al.</i> (2009) Patient-provider race-concordance: does it matter in improving

	minority patients' health outcomes? <i>Ethnicity & Health</i> , 14(1), 107-130.
Method used to synthesise evidence	Narrative
Design of included Studies	Qualitative and experimental studies
Dates searched	1980-2008
Review quality	Adequate
No. of included studies	27
Targeted vulnerable group	BME groups
Model/ method evaluated	'Patient-practitioner' 'race-concordance'
Comparison	N/a
Outcome	<ul style="list-style-type: none"> * Utilisation of healthcare * Individual preference (that is, normative expectations) * Provision of healthcare * Individual-practitioner communication * Service user satisfaction * Individual preference * Perception of respect
Results	<ul style="list-style-type: none"> * 'Race-concordance' had a positive impact on utilisation of healthcare * Results for other outcomes are inconclusive
Source of funding	Not reported

Study ID	VANCITTERS2004
Bibliographic reference	Van Citters, A.D. & Bartels, S.J. (2004) A systematic review of the effect of community-based mental health outreach services for older adults. <i>Psychiatric Services</i> , 55(11), 1237-1249
Method used to synthesise evidence	Narrative



Design of included Studies	Various (not restricted to RCTs)
Dates searched	Database inception to 2004
Review quality	The quality of the included studies was unspecified
No. of included studies	14
Targeted vulnerable group	Older individuals
Model/ method evaluated	Gatekeeper Model
Comparison	Traditional referral sources (medical practitioners, family members, informal caregivers)
Outcome	*Use of mental healthcare services
Results	* Gatekeeper model more likely to reach individuals who are less likely to gain access to services (for example, those who live alone, are widowed or divorced, or are affected by economic and social isolation) * At one year follow-up, no difference between two methods in service use or out-of-home placement
Source of funding	Not reported

1.2 CASE IDENTIFICATION

1.2.1 Included studies characteristics

Study ID	BYRNE2010
Bibliographic reference	Byrne, G. J. & Pachana, N. A. (2010) Development and validation of a short form of the Geriatric Anxiety Inventory – the GAI-SF. <i>International Psychogeriatrics</i> , [E-pub ahead of print available on CJO].
Clinical features and settings	Older participants from the community.
Participants	284 participants; 100% women, mean age 72.2 years.
Study design	Cross-sectional.
Target condition and reference standard(s)	GAD by DSM-IV (Mini international neuropsychiatric interview).
Index and comparator tests	GAI-SF (Geriatric Anxiety Inventory - Short Form): a 5-item version of the longer scale; Cut off=3 +
Results	Sensitivity=0.78, Specificity=0.69, LR+=2.52, LR-=0.32
Older adult sample	Yes
Consultation sample	No
Chronic physical health problems	No
Notes	Verification occurred in 242 of the 284 women (85.2%).

Assessment of methodological quality table










Item	Judgement
Representative spectrum?	Yes 
Acceptable reference standard?	Yes 

Acceptable delay between tests?	No
Partial verification avoided?	No
Differential verification avoided?	Yes
Incorporation avoided?	Yes
Reference standard results blinded?	Unclear
Index test results blinded?	Unclear
Relevant clinical information?	Unclear
Uninterpretable results reported?	No
Withdrawals explained?	No
Execution of index test permit replication?	Yes
Selection criteria clearly defined?	Yes
Execution of reference standard permit replication?	Yes

Study ID	CAMPBELL2009
Bibliographic reference	Campbell-Sills, L., Norman, S. B., Craske, M. G., <i>et al.</i> (2009) Validation of a brief measure of anxiety-related severity and impairment: The Overall Anxiety Severity and Impairment Scale (OASIS). <i>Journal of Affective Disorders</i> , 112, 92-101.
Clinical features and settings	Primary care patients referred by their GP into a anxiety treatment study if thought they would benefit.
Participants	1036 patients; 28.8% male, mean age 42.8 years (range 18-75).
Study design	Cross-sectional (participants were taking part in a clinical trial).

Target condition and reference standard(s)	Anxiety by DSM-IV (mini international neuropsychiatric interview).
Index and comparator tests	OASIS (Overall anxiety sensitivity and impairment scale): A 5-item self-report measure. Responses are coded 0-4. Cut off= 8.
Results	Sensitivity=0.89, Specificity=0.71, LR+=3.07, LR-=0.15
Older adult sample	No
Consultation sample	Yes (PC)
Chronic physical health problems	No
Notes	Prevalence of any anxiety disorder: 89.3% (925 of 1036). 60.6% of participants also met criteria for MDD and 4.3% met criteria for dysthymic disorder (DD). Some participants also endorsed alcohol (10.6%) and/or substance use (3.9%) disorders.

Assessment of methodological quality table

Item	Judgement
Representative spectrum?	Yes 
Acceptable reference standard?	Yes 
Acceptable delay between tests?	Yes 
Partial verification avoided?	Unclear 
Differential verification avoided?	Unclear 
Incorporation avoided?	Unclear 
Reference standard results blinded?	Unclear 
Index test results blinded?	Unclear 
Relevant clinical information?	Yes 

Uninterpretable results reported?	Unclear
Withdrawals explained?	Unclear
Execution of index test permit replication?	Yes
Selection criteria clearly defined?	Yes
Execution of reference standard permit replication?	Yes

Study ID	DENNIS2007
Bibliographic reference	Dennis, R. E., Boddington, S. J. & Funnell N. J. (2007) Self-report measures of anxiety: Are they suitable for older adults? <i>Aging & Mental Health</i> , 11, 668-677.
Clinical features and settings	Patients from an NHS mental health trust.
Participants	40 patients (3 dropped out); 27.5% male, mean age 75.5 years. 45% received outpatient treatment, 37.5% received day-hospital care, 17.5% were psychiatric inpatients. Inclusion criteria: Over 65 years old, no organic dementia, observable symptoms of anxiety or in remission from an episode in the past 12 months, no acute psychiatric episode.
Study design	Cross-sectional (MH professionals were asked to identify potential participants from their caseloads).
Target condition and reference standard(s)	Anxiety by DSM-IV (SCID-I).
Index and comparator tests	VAS (Visual Analogue Scale): A 20cm line divided into 10 equal sized parts ranging from 'No anxiety' to 'Most anxiety'. Participants draw a vertical line through where they feel their anxiety over the past week is best represented. Cut off= 10/11cm. HADS-A (Hospital Anxiety and Depression Scale-Anxiety subscale).
Results	VAS: Sensitivity=0.5, Specificity=0.607, LR+=1.27, LR-=0.82 HADS-A: Sensitivity=0.75, Specificity=0.536, LR+=1.62, LR-=0.47




Older adult sample	Yes
Consultation sample	Yes
Chronic physical health problems	No
Notes	Prevalence of anxiety: 30% (12 of 40)












Assessment of methodological quality table

Item	Judgement
Representative spectrum?	No ▼
Acceptable reference standard?	Yes ▼
Acceptable delay between tests?	Yes ▼
Partial verification avoided?	Yes ▼
Differential verification avoided?	Yes ▼
Incorporation avoided?	Yes ▼
Reference standard results blinded?	Yes ▼
Index test results blinded?	Yes ▼
Relevant clinical information?	Yes ▼
Uninterpretable results reported?	Unclear ▼
Withdrawals explained?	Yes ▼
Execution of index test permit replication?	Yes ▼
Selection criteria clearly defined?	Yes ▼
Execution of reference standard permit replication?	Yes ▼

Study ID	EACK2006
Bibliographic reference	Eack, S. M., Greeno, C. G. & Lee, B. (2006) Limitations of the Patient Health Questionnaire in identifying anxiety and depression in community mental health: Many cases are undetected. <i>Research on Social Work Practice</i> , 16, 625-631.
Clinical features and settings	Women seeking psychiatric treatment for their children at two community mental health centres.
Participants	50 participants; 100% female, mean age 39.2 years (range 23-60).
Study design	Cross-sectional (unclear if consecutive sampling was used).
Target condition and reference standard(s)	Any anxiety disorder, not panic by DSM-IV (SCID).
Index and comparator tests	PHQ-A (Patient Health Questionnaire - anxiety module): A brief self-report measure of anxiety symptoms based on DSM-IV. The scale contains a 15-item PD checklist, a 7-item 'other anxiety disorder' checklist and a 9-item depression checklist. Cut off not given.
Results	Sensitivity=0.42, Specificity=0.85, LR+=2.8, LR-=0.68
Older adult sample	No
Consultation sample	No
Chronic physical health problems	No
Notes	Prevalence of at least one anxiety disorder: 50% (panic: 20%; other anxiety: 48% [24 of 50])

Assessment of methodological quality table












Item	Judgement
Representative spectrum?	Yes 
Acceptable reference standard?	Yes 
Acceptable delay between tests?	Unclear 




Partial verification avoided?	Yes 
Differential verification avoided?	Yes 
Incorporation avoided?	Unclear 
Reference standard results blinded?	Unclear 
Index test results blinded?	Unclear 
Relevant clinical information?	Unclear 
Uninterpretable results reported?	Unclear 
Withdrawals explained?	Unclear 
Execution of index test permit replication?	Yes 
Selection criteria clearly defined?	Yes 
Execution of reference standard permit replication?	Yes 

Study ID	GILL2007
Bibliographic reference	Gill, S. C., Butterworth, P., Rodgers, B., <i>et al.</i> (2007) Validity of the mental health component scale of the 12-item Short-Form Health Survey (MCS-12) as measure of common mental disorders in the general population. <i>Psychiatry Research</i> , 152, 63-71.
Clinical features and settings	People selected by telephone screening from the general population.
Participants	10,504 participants (Australians); 44.3% male, mean age 45 years.
Study design	Cross-sectional (stratified sampling procedure).
Target condition and reference standard(s)	Anxiety and/or depression by DSM-IV (CIDI).

Index and comparator tests	MCS-12 (mental health component summary scale of the SF-12). Scores range from 0-100, with lower scores reflecting poorer mental health. Cut off ≤ 50 .
Results	CMHD: Sensitivity=0.84, Specificity=0.74, LR+=3.23, LR-=0.22 Anxiety: Sensitivity=0.81, Specificity=0.73, LR+=3, LR-=0.26
Older adult sample	No
Consultation sample	No
Chronic physical health problems	No
Notes	Prevalence of depression and/or anxiety: 9.0%, Depression: 4.0%, Anxiety: 7.2%















Assessment of methodological quality table

Item	Judgement
Representative spectrum?	Yes 
Acceptable reference standard?	Yes 
Acceptable delay between tests?	Unclear 
Partial verification avoided?	Unclear 
Differential verification avoided?	Yes 
Incorporation avoided?	Yes 
Reference standard results blinded?	Unclear 
Index test results blinded?	Unclear 
Relevant clinical information?	Yes 
Uninterpretable results reported?	Unclear 
Withdrawals explained?	Unclear 

Execution of index test permit replication?	Yes 
Selection criteria clearly defined?	Yes 
Execution of reference standard permit replication?	Yes 

Study ID	HALL1999
Bibliographic reference	Hall, A., A'Hern, R. & Fallowfield, L. (1999) Are we using appropriate self-report questionnaires for detecting anxiety and depression in women with early breast cancer? <i>European Journal of Cancer</i> , 35, 79-85.
Clinical features and settings	Women being treated for early breast cancer that were recruited to a study designed to assess psychological outcomes of different treatment policies.
Participants	266 participants; 100% women, all under 75 years old.
Study design	Cross-sectional (participants were taking part in a clinical trial).
Target condition and reference standard(s)	Anxiety by DSM-III (Present state examination)..
Index and comparator tests	HADS-A (Hospital Anxiety and Depression Scale - Anxiety subscale): A 7 item subscale of the HADS, measuring anxiety symptoms over the previous week on 7 point Likert type scales. Cut off= 7+. RSCL (Rotterdam symptom checklist): A self-report scale to measure symptoms of psychological distress reported by primary care patients. Cut off= 7.
Results	HADS-A: Sensitivity=0.72, Specificity=0.8, LR+=3.6, LR-=0.35 RSCL: Sensitivity=0.85, Specificity=0.67, LR+=2.58, LR-=0.22
Older adult sample	No
Consultation sample	Yes
Chronic physical health problems	Yes
Notes	Prevalence of anxiety: 49.6% (132 of 266)







Assessment of methodological quality table

Item	Judgement
Representative spectrum?	Yes 
Acceptable reference standard?	Yes 
Acceptable delay between tests?	Yes 
Partial verification avoided?	Yes 
Differential verification avoided?	Yes 
Incorporation avoided?	Yes 
Reference standard results blinded?	Unclear 
Index test results blinded?	Yes 
Relevant clinical information?	Yes 
Uninterpretable results reported?	Unclear 
Withdrawals explained?	Unclear 
Execution of index test permit replication?	Yes 
Selection criteria clearly defined?	Yes 
Execution of reference standard permit replication?	Yes 

Study ID	HAWORTH2007
Bibliographic reference	Haworth, J. E., Moniz-Cook, E., Clark, A. L., <i>et al.</i> (2007) An evaluation of two self-report screening measures for mood in an out-patient chronic heart failure population. <i>International Journal of Geriatric Psychiatry</i> , 22, 1147-1153.

Clinical features and settings	Chronic heart failure patients attending an outpatient clinic.
Participants	90 participants; 81% male, mean age 69.9 years (range 56-92). 89% reported co-morbid physical problems, 11% were on anti-depressants, and 1% was on an anxiolytic. Inclusion criteria: symptoms of heart failure for 3+ months. No cognitive impairment (2 excluded for this reason).
Study design	Cross-sectional (consecutive sample)
Target condition and reference standard(s)	Anxiety by DSM-IV (SCID-I)
Index and comparator tests	HADS-A (Hospital Anxiety and Depression Scale - Anxiety subscale): A 7 item subscale of the HADS, measuring anxiety symptoms over the previous week on 7 point Likert type scales. Cut off= 7+
Results	Sensitivity=0.94, Specificity=0.85, LR+=6.27, LR-=0.07
Older adult sample	Yes
Consultation sample	Yes
Chronic physical health problems	Yes
Notes	Prevalence of anxiety: 18%

Assessment of methodological quality table

Item	Judgement
Representative spectrum?	No 
Acceptable reference standard?	Yes 
Acceptable delay between tests?	Unclear 
Partial verification avoided?	Yes 
Differential verification avoided?	Unclear 
Incorporation avoided?	Yes 


Reference standard results blinded?	Unclear
Index test results blinded?	Unclear
Relevant clinical information?	Yes
Uninterpretable results reported?	No
Withdrawals explained?	No
Execution of index test permit replication?	Yes
Selection criteria clearly defined?	Yes
Execution of reference standard permit replication?	Yes

Study ID	KRASUCKI1999
Bibliographic reference	Krasucki, C., Ryan, P., Ertan, T., <i>et al.</i> (1999) The FEAR: A rapid screening instrument for generalized anxiety in elderly primary care attenders. <i>International Journal of Geriatric Psychiatry</i> , 14, 60-68.
Clinical features and settings	Primary care patients.
Participants	88 participants (48 diagnosed using ICD-10). Inclusion criteria: primary care patient, aged 65+. Exclusion criteria: significant cognitive impairment. 47.9% male, mean age 73.2 years.
Study design	Cross-sectional (consecutive sample).
Target condition and reference standard(s)	GAD by ICD-10.
Index and comparator tests	ADS-GA (Anxiety Disorder Scale - Generalised Anxiety subscale): 11 yes/no items, which are added to produce a score from 0-11. in this study, shortened variations of this test were also analysed.
Results	ADS-GA - 3-item version: Sensitivity=0.77, Specificity=0.83, LR+=4.53, LR-=0.28 ADS-GA - 4-item version: Sensitivity=0.77, Specificity=0.83, LR+=4.53, LR-=0.28

	ADS-GA: Sensitivity=0.85, Specificity=0.71, LR+=2.93, LR-=0.21
Older adult sample	Yes
Consultation sample	Yes (PC)
Chronic physical health problems	No
Notes	total GAD 27.1% (13 of 48)



Assessment of methodological quality table













Item	Judgement
Representative spectrum?	Unclear ▼
Acceptable reference standard?	Yes ▼
Acceptable delay between tests?	Unclear ▼
Partial verification avoided?	Yes ▼
Differential verification avoided?	Yes ▼
Incorporation avoided?	No ▼
Reference standard results blinded?	Yes ▼
Index test results blinded?	Yes ▼
Relevant clinical information?	Yes ▼
Uninterpretable results reported?	Yes ▼
Withdrawals explained?	Yes ▼
Execution of index test permit replication?	Yes ▼
Selection criteria clearly defined?	Yes ▼

Execution of reference standard permit replication?	Yes 
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Study ID	KREFETZ2004
Bibliographic reference	Krefetz, D. G., Steer, R. A., Jermyn, R. T., <i>et al.</i> (2004) Screening HIV-infected patients with chronic pain for anxiety and mood disorders with the Beck Anxiety and Depression Inventory-Fast Screens for medical settings. <i>Journal of Clinical Psychology in Medical Settings</i> , 11, 283-289.
Clinical features and settings	Outpatients from a specialist chronic pain in HIV-seropositive clinic.
Participants	63 adult participants, 70% male, mean age 42.0 years (range 24-70).
Study design	Cross-sectional (consecutive sample).
Target condition and reference standard(s)	Anxiety by DSM-IV (AM of the PRIME-MD).
Index and comparator tests	BAI-FS (Beck Anxiety Inventory-Fast Screen): A 7 item scale composed of the subjective, non-somatic symptoms from the BAI. Cut off=4.
Results	Sensitivity=0.82, Specificity=0.59, LR+=2, LR-=0.31
Older adult sample	No
Consultation sample	Yes
Chronic physical health problems	Yes
Notes	Anxiety- 35% (22 of 63)

Assessment of methodological quality table











Item	Judgement
Representative spectrum?	Yes 
Acceptable reference standard?	Yes 





Acceptable delay between tests?	Yes 
Partial verification avoided?	Yes 
Differential verification avoided?	Yes 
Incorporation avoided?	Yes 
Reference standard results blinded?	Unclear 
Index test results blinded?	Unclear 
Relevant clinical information?	Yes 
Uninterpretable results reported?	Unclear 
Withdrawals explained?	Unclear 
Execution of index test permit replication?	Yes 
Selection criteria clearly defined?	Yes 
Execution of reference standard permit replication?	Yes 

Study ID	KROENKE2007
Bibliographic reference	Kroenke, K., Spitzer, R. L., Williams, J. B., <i>et al.</i> (2007) Anxiety disorders in primary care: Prevalence, impairment, comorbidity, and detection. <i>Annals of Internal Medicine</i> , 146, 317-325.
Clinical features and settings	Primary care patients.
Participants	965 patients; 31 % male, mean age 47.1 years (range 18-87).
Study design	Cross-sectional (consecutive sample).
Target condition and reference standard(s)	Any anxiety disorder/ GAD by DSM-IV (SCID, telephone administered).

Index and comparator tests	GAD-2 (Generalised Anxiety Disorder Assessment): Scores range from 0-14. Cut off = 3.
Results	GAD-2 (Anxiety): Sensitivity=0.65, Specificity=0.88, LR+=5.42, LR-=0.4 GAD-2 (GAD): Sensitivity=0.86, Specificity=0.83, LR+=5.06, LR-=0.17 GAD-7 (Anxiety): Sensitivity=0.77, Specificity=0.82, LR+=4.28, LR-=0.28 GAD-7 (GAD): Sensitivity=0.92, Specificity=0.76, LR+=3.83, LR-=0.11
Older adult sample	No
Consultation sample	Yes (PC)
Chronic physical health problems	No
Notes	Prevalence of anxiety: 19.5% (188 of 965); GAD: 7.6% (73 of 965)















Assessment of methodological quality table

Item	Judgement
Representative spectrum?	Yes 
Acceptable reference standard?	Yes 
Acceptable delay between tests?	Yes 
Partial verification avoided?	Yes 
Differential verification avoided?	Yes 
Incorporation avoided?	Yes 
Reference standard results blinded?	Yes 
Index test results blinded?	Yes 
Relevant clinical information?	Yes 
Uninterpretable results reported?	No 

Withdrawals explained?	No 
Execution of index test permit replication?	Yes 
Selection criteria clearly defined?	Yes 
Execution of reference standard permit replication?	Yes 

Study ID	LANG2009
Bibliographic reference	Lang, A., Norman, S., Means-Christensen, A., <i>et al.</i> (2009) Abbreviated Brief Symptom Inventory for use as an anxiety and depression screening instrument in primary care. <i>Depression and Anxiety</i> , 26, 537-543.
Clinical features and settings	Primary care patients.
Participants	158 adults; 48.7% male, mean age 48.4 years; 92% White, 10.1% African-American.
Study design	Cross-sectional (random sample of consenting individuals).
Target condition and reference standard(s)	Anxiety by DSM-IV (CIDI).
Index and comparator tests	BSI (Brief symptom Inventory): Anxiety items. Rated on a 5-point scale of distress, ranging from not at all (0) to extremely (4). Cut off=63.
Results	Sensitivity=0.47, Specificity=0.91, LR+=5.22, LR-=0.58
Older adult sample	No
Consultation sample	Yes (PC)
Chronic physical health problems	No
Notes	Any anxiety disorder (social phobia, n=21; GAD, n=32, PDA, n=17, PTSD, n=23); 23% had more than one diagnosis









Assessment of methodological quality table

Item	Judgement
Representative spectrum?	Yes 
Acceptable reference standard?	Yes 
Acceptable delay between tests?	Unclear 
Partial verification avoided?	Yes 
Differential verification avoided?	Yes 
Incorporation avoided?	Yes 
Reference standard results blinded?	Yes 
Index test results blinded?	Yes 
Relevant clinical information?	Yes 
Uninterpretable results reported?	Yes 
Withdrawals explained?	Yes 
Execution of index test permit replication?	Yes 
Selection criteria clearly defined?	Yes 
Execution of reference standard permit replication?	Yes 

Study ID	LOVE2002
Bibliographic reference	Love, A. W., Kissane, D. W., Bloch, S., <i>et al.</i> (2002) Diagnostic efficiency of the Hospital Anxiety and Depression Scale in women with early stage breast cancer. <i>Australian and New Zealand Journal of Psychiatry</i> , 36, 246-250.
Clinical features and settings	Patients with breast cancer attending a hospital day center.

Participants	303 middle aged women with stage II breast cancer or stage I breast cancer with poor prognostic factors. Exclusion criteria: >65 years, dementia, active psychosis, intellectual disability.
Study design	Cross-sectional (participants were taking part in a clinical trial).
Target condition and reference standard(s)	Anxiety by DSM-IV (MILP).
Index and comparator tests	HADS-A (Hospital Anxiety and Depression Scale - Anxiety subscale): A 7 item subscale of the HADS, measuring anxiety symptoms over the previous week on 7 point Likert type scales. Cut off= 8+.
Results	Sensitivity=0.34, Specificity=0.73, LR+=1.26, LR-=0.9
Older adult sample	No
Consultation sample	Yes
Chronic physical health problems	Yes
Notes	Anxiety- 10.6% (32 of 303) (Adjustment disorders with anxious mood- 5.9%, GAD- 1.6%, PD- 1.3%, PTSD- 1.6%).

Assessment of methodological quality table















Item	Judgement
Representative spectrum?	Yes 
Acceptable reference standard?	Yes 
Acceptable delay between tests?	Yes 
Partial verification avoided?	Unclear 
Differential verification avoided?	Yes 
Incorporation avoided?	Yes 
Reference standard results blinded?	Unclear 
Index test results blinded?	Unclear 

Relevant clinical information?	Yes
Uninterpretable results reported?	Unclear
Withdrawals explained?	No
Execution of index test permit replication?	Yes
Selection criteria clearly defined?	Yes
Execution of reference standard permit replication?	Yes

Study ID	MEANS-C2006
Bibliographic reference	Means-Christensen, A. J., Sherbourne, C. D., Roy-Byrne, P. P., Craske, M. G., & Stein M. B. (2006) Using five questions to screen for five common mental disorders in primary care: diagnostic accuracy of the Anxiety and Depression Detector. <i>Gen Hosp Psychiatry</i> , 28(2), 108-18.
Clinical features and settings	Patients from university-affiliated primary care clinics in Seattle and southern California
Participants	115 patients recruited as part of the Collaborative Care for Anxiety and Panic (CCAP) study
Study design	Cross-sectional
Target condition and reference standard(s)	GAD by DSM-IV (CIDI-Auto)
Index and comparator tests	ADD (GAD item) (Anxiety and Depression Detector): 5 yes/no items, one of which is used to detect GAD.
Results	
Older adult sample	No
Consultation sample	Yes
Chronic physical health problems	No

Notes	Prevalence of GAD = 26%
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Assessment of methodological quality table












Item	Judgement
Representative spectrum?	Yes 
Acceptable reference standard?	Yes 
Acceptable delay between tests?	Yes 
Partial verification avoided?	Yes 
Differential verification avoided?	Yes 
Incorporation avoided?	Yes 
Reference standard results blinded?	No 
Index test results blinded?	Yes 
Relevant clinical information?	Unclear 
Uninterpretable results reported?	Unclear 
Withdrawals explained?	Yes 
Execution of index test permit replication?	Yes 
Selection criteria clearly defined?	Yes 
Execution of reference standard permit replication?	Yes 

Study ID	NEWMAN2002
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Bibliographic reference	Newman, M. G., Zuellig, A. R., Kachin, K. E., <i>et al.</i> (2002) Preliminary reliability and validity of the generalized anxiety disorder questionnaire-IV: A revised self-report diagnostic measure of generalized anxiety disorder. <i>Behavior Therapy</i> , 33, 215-233.
Clinical features and settings	Undergraduate students recruited as part of two separate assessment studies.
Participants	143 undergraduates, 90 of which were interested in being assessed and potentially referred for treatment for an anxiety disorder.
Study design	Cross-sectional
Target condition and reference standard(s)	GAD by DSM-IV (ADIS-IV-L and ADIS-IV)
Index and comparator tests	GAD-Q-IV (Generalised anxiety disorder questionnaire-IV): a 9 item yes/no questionnaire, which gives a total score of 0-12. Cut off= 5.7
Results	Sensitivity=0.83, Specificity=0.89, LR+=7.55, LR-=0.19
Older adult sample	No
Consultation sample	No
Chronic physical health problems	No
Notes	Primary or secondary GAD diagnosis- 21.0% Primary panic disorder diagnosis- 12.6% Primary social phobia diagnosis- 30.0% No anxiety diagnosis- 37.1%

Assessment of methodological quality table

Item	Judgement
Representative spectrum?	Yes 
Acceptable reference standard?	Yes 
Acceptable delay between tests?	No 




Partial verification avoided?	Yes 
Differential verification avoided?	Yes 
Incorporation avoided?	Yes 
Reference standard results blinded?	Unclear 
Index test results blinded?	Unclear 
Relevant clinical information?	Unclear 
Uninterpretable results reported?	No 
Withdrawals explained?	No 
Execution of index test permit replication?	Yes 
Selection criteria clearly defined?	No 
Execution of reference standard permit replication?	Yes 

Study ID	POOLE2006
Bibliographic reference	Poole, N. A. & Morgan, J. F. (2006) Validity and reliability of the Hospital Anxiety and Depression Scale in a hypertrophic cardiomyopathy clinic: The HADS in a cardiomyopathy population. <i>General Hospital Psychiatry</i> , 28, 5-58.
Clinical features and settings	Secondary care (specialist hypertrophic cardiomyopathy clinic).
Participants	115 participants, 56.1% male, median age 43 (range 23-63 years).
Study design	Cross-sectional (consecutive sample).
Target condition and reference standard(s)	Anxiety by DSM-III-R (using SCID-non patient version).

Index and comparator tests	HADS-A (Hospital Anxiety and Depression Scale - Anxiety subscale): A 7 item subscale of the HADS, measuring anxiety symptoms over the previous week on 7 point Likert type scales. Cut off= 8+.
Results	Sensitivity=0.96, Specificity=0.79, LR+=4.57, LR-=0.05
Older adult sample	No
Consultation sample	Yes
Chronic physical health problems	Yes
Notes	Anxiety- 39%

Assessment of methodological quality table















Item	Judgement
Representative spectrum?	Yes ▼
Acceptable reference standard?	Yes ▼
Acceptable delay between tests?	Yes ▼
Partial verification avoided?	Yes ▼
Differential verification avoided?	Yes ▼
Incorporation avoided?	Yes ▼
Reference standard results blinded?	Yes ▼
Index test results blinded?	Yes ▼
Relevant clinical information?	Yes ▼
Uninterpretable results reported?	Unclear ▼
Withdrawals explained?	Unclear ▼

Execution of index test permit replication?	Yes 
Selection criteria clearly defined?	Yes 
Execution of reference standard permit replication?	Yes 

Study ID	SMITH2006
Bibliographic reference	Smith, A. B., Wright, E. P., Rush, R., <i>et al.</i> (2006) Rasch analysis of the dimensional structure of the Hospital Anxiety and Depression Scale. <i>Psycho-Oncology</i> , 15, 817-827.
Clinical features and settings	People with cancer who had participated in studies carried out by Cancer Research - UK's Psychosocial Oncology and Clinical Practice Group.
Participants	381 cancer patients, 49.6% male, mean age 55 (range 21-81).
Study design	Cross-sectional (data were pooled from a number of previous studies).
Target condition and reference standard(s)	Anxiety by ICD-10 (SCAN).
Index and comparator tests	HADS-A (Hospital Anxiety and Depression Scale - Anxiety subscale): A 7 item subscale of the HADS, measuring anxiety symptoms over the previous week on 7 point Likert type scales. Cut off= 8+.
Results	Sensitivity=0.67, Specificity=0.61, LR+=1.72, LR-=0.54
Older adult sample	No
Consultation sample	Yes
Chronic physical health problems	Yes
Notes	Anxiety- 8.4%, Anxiety and depression- 6.3%

Assessment of methodological quality table










Item	Judgement
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Representative spectrum?	Yes 
Acceptable reference standard?	Yes 
Acceptable delay between tests?	Yes 
Partial verification avoided?	Unclear 
Differential verification avoided?	No 
Incorporation avoided?	Yes 
Reference standard results blinded?	Unclear 
Index test results blinded?	Unclear 
Relevant clinical information?	Yes 
Uninterpretable results reported?	Unclear 
Withdrawals explained?	Unclear 
Execution of index test permit replication?	Yes 
Selection criteria clearly defined?	Yes 
Execution of reference standard permit replication?	Yes 

Study ID	STARK2002
Bibliographic reference	Stark, D., Kiely, M., Smith, A., <i>et al.</i> (2002) Anxiety disorders in cancer patients: Their nature, associations, and relation to quality of life. <i>Journal of Clinical Oncology</i> , 14, 3137-3148.
Clinical features and settings	People recruited from a cancer outpatient clinic.
Participants	178 patients with cancer, 60.1% male, mean age 54.89 years (range 22-81).

Study design	Cross-sectional (unclear how sampled).
Target condition and reference standard(s)	Anxiety by SCAN.
Index and comparator tests	HADS-A (Hospital Anxiety and Depression Scale - Anxiety subscale): A 7 item subscale of the HADS, measuring anxiety symptoms over the previous week on 7 point Likert type scales. Cut off= 7+.
Results	Sensitivity=0.81, Specificity=0.6, LR+=2.03, LR-=0.32
Older adult sample	No
Consultation sample	Yes
Chronic physical health problems	Yes
Notes	Anxiety- 17.98% (32 of 178), Panic disorder- 9.0% GAD- 8.4% Phobia- 13.5%.

Assessment of methodological quality table















Item	Judgement
Representative spectrum?	Yes 
Acceptable reference standard?	Yes 
Acceptable delay between tests?	Yes 
Partial verification avoided?	Yes 
Differential verification avoided?	Yes 
Incorporation avoided?	Yes 
Reference standard results blinded?	Unclear 
Index test results blinded?	Yes 
Relevant clinical information?	Yes 

Uninterpretable results reported?	Yes 
Withdrawals explained?	Yes 
Execution of index test permit replication?	Yes 
Selection criteria clearly defined?	Yes 
Execution of reference standard permit replication?	Yes 

Study ID	WEBB2008
Bibliographic reference	Webb, S. A., Diefenbach, G., Wagener, P., <i>et al.</i> (2008) Comparison of self-report measures for identifying late-life generalized anxiety in primary care. <i>Journal of Geriatric Psychiatry and Neurology</i> , 21, 223-231.
Clinical features and settings	Primary care patients.
Participants	191 patients. Exclusion criteria: negative screen for anxiety, < 60 years old.
Study design	Cross-sectional (participants were taking part in a clinical trial).
Target condition and reference standard(s)	GAD by DSM-IV (SCID, GAD subscale).
Index and comparator tests	GAD-Q-IV (Generalized Anxiety Disorders Questionnaire 4th Edition). GAD-Q-IV Item 2 (Is your worry excessive in intensity, frequency, or the amount of distress it causes?). PSWQ-A (Penn State Worry Questionnaire-A), an abbreviated version of the PSWQ developed for older adults: Cut off= 22.
Results	GAD-Q-IV: Sensitivity=0.68, Specificity=0.72, LR+=2.43, LR-=0.44 GAD-Q-IV Item 2: Sensitivity=0.78, Specificity=0.69, LR+=2.52, LR-=0.32 PSWQ-A: Sensitivity=0.79, Specificity=0.63, LR+=2.14, LR-=0.33
Older adult sample	Yes




Consultation sample	Yes (PC)
Chronic physical health problems	No
Notes	58% GAD












Assessment of methodological quality table

Item	Judgement
Representative spectrum?	No 
Acceptable reference standard?	Yes 
Acceptable delay between tests?	Yes 
Partial verification avoided?	Unclear 
Differential verification avoided?	Yes 
Incorporation avoided?	Yes 
Reference standard results blinded?	Unclear 
Index test results blinded?	Unclear 
Relevant clinical information?	Yes 
Uninterpretable results reported?	Yes 
Withdrawals explained?	Yes 
Execution of index test permit replication?	Yes 
Selection criteria clearly defined?	Yes 
Execution of reference standard permit replication?	Unclear 

Study ID	WHELAN2009
Bibliographic reference	Whelan-Goodinson, R., Ponsford, J. & Schonberger, M. (2009) Validity of the Hospital Anxiety and Depression Scale to assess depression and anxiety following traumatic brain injury as compared with the Structured Clinical Interview for DSM-IV. <i>Journal of Affective Disorders</i> , 114, 94-102.
Clinical features and settings	Patients who had been treated at a head injury hospital.
Participants	100 participants with mild-severe traumatic brain injury and 87 informants, 71% male, mean age 37.18 years (range 19-74).
Study design	Cross-sectional (random sampling from database).
Target condition and reference standard(s)	Anxiety, SCID for DSM-IV.
Index and comparator tests	HADS-A (Hospital Anxiety and Depression Scale - Anxiety subscale): A 7 item subscale of the HADS, measuring anxiety symptoms over the previous week on 7 point Likert type scales. Cut off= 7+.
Results	Sensitivity=0.75, Specificity=0.69, LR+=2.42, LR-=0.36
Older adult sample	No
Consultation sample	Yes
Chronic physical health problems	Yes
Notes	Anxiety- 36%

Assessment of methodological quality table









Item	Judgement
Representative spectrum?	Yes 
Acceptable reference standard?	Yes 
Acceptable delay between tests?	Yes 







Partial verification avoided?	Yes 
Differential verification avoided?	Yes 
Incorporation avoided?	Yes 
Reference standard results blinded?	Unclear 
Index test results blinded?	Unclear 
Relevant clinical information?	Yes 
Uninterpretable results reported?	Unclear 
Withdrawals explained?	Unclear 
Execution of index test permit replication?	Yes 
Selection criteria clearly defined?	Yes 
Execution of reference standard permit replication?	Yes 

Study ID	WILLIAMSON2005
Bibliographic reference	Williamson, R. J., Neale, B. M., Sterne, A., <i>et al.</i> (2005) The value of four mental health self-report scales in predicting interview-based mood and anxiety disorder diagnoses in sibling pairs. <i>Twin Research and Human Genetics</i> , 8, 101-107.
Clinical features and settings	Community sample recruited through their GPs.
Participants	469 participants; of the initial sample of 696, 60% were female, 98.5% were Caucasian, had an average age of 43 years (SD = 10, range 20 to 80 years), and all levels of educational attainment and employment status were represented in the sample.
Study design	Cross-sectional (consecutive sample).

Target condition and reference standard(s)	CMHD and GAD; DSM-III-R and ICD-10 (UM-CIDI)
Index and comparator tests	GHQ-12 (General Health Questionnaire-12 item version). EPQ-N (Eysenck Personality Questionnaire-Neuroticism Scale).
Results	GHQ-12 (CMHD): Sensitivity=0.73, Specificity=0.82, LR+=4.06, LR-=0.33 GHQ-12 (GAD): Sensitivity=0.76, Specificity=0.78, LR+=3.45, LR-=0.31 EPQ-N (CMHD): Sensitivity=0.81, Specificity=0.77, LR+=3.52, LR-=0.25 EPQ-N (GAD): Sensitivity=0.82, Specificity=0.8, LR+=4.1, LR-=0.23
Older adult sample	No
Consultation sample	No
Chronic physical health problems	No
Notes	At least one CMHD 38% (179 of 469); GAD 10.7% (50 of 469).

Assessment of methodological quality table

Item	Judgement
Representative spectrum?	Yes 
Acceptable reference standard?	Yes 
Acceptable delay between tests?	Yes 
Partial verification avoided?	Unclear 
Differential verification avoided?	Unclear 
Incorporation avoided?	Yes 
Reference standard results blinded?	Unclear 
Index test results blinded?	Unclear 

Relevant clinical information?	Yes 
Uninterpretable results reported?	Unclear 
Withdrawals explained?	No 
Execution of index test permit replication?	Yes 
Selection criteria clearly defined?	Yes 
Execution of reference standard permit replication?	Unclear 

1.2.2 Excluded studies

Bibliographic reference	Reason for exclusion
Abdel-Khalek, A. & Al-Damaty, A. G. (2003). The Kuwait university anxiety scale: Results for 9,031 Saudi students. [References]. <i>Psychological Reports</i> .93(1), Aug, #203-212.	Non-english version
Abdel-Khalek, A. & Lester, D. (1998). Reliability of the Arabic Obsessive-Compulsive Scale in Kuwaiti and American students. <i>Psychological Reports</i> .83(3, Pt, 2), Dec98, pp, 1470	Non-english version
Abdel-Khalek, A. & Lester, D. (1999). Criterion-related validity of the Arabic Obsessive-Compulsive Scale in Kuwaiti and American students. <i>Psychological Reports</i> .85(3, Pt, 2 [Spec Issue]; Spec Issue), Dec99, pp, 1111-1112.	Non-english version
Abdel-Khalek, A. & Lester, D. (2000). Obsession-compulsion, locus of control, depression, and hopelessness: A construct validity of the Arabic Obsessive-Compulsive Scale in American and Kuwaiti students. <i>Psychological Reports</i> .86(3,Pt2), Jun. pp. 1187-8.	Non-english version
Abdel-Khalek, A. & Lester, D. (2002). Convergent and discriminant validity of the Arabic Obsessive-Compulsive Scale for Kuwaiti and American college students. [References]. <i>Psychological Reports</i> .90(3,Pt2), Jun. pp. 1261-2.	Non-english version
Abdel-Khalek, A. & Lester, D. (2002). Factorial validity of the Arabic Obsessive-Compulsive Scale in two cultures. [References]. <i>Psychological Reports</i> .90(3,Pt1), Jun. pp. 869-70.	Non-english version
Abdel-Khalek, A. & Lester, D. (2004). The Factorial Structure of the Arabic Version of the Revised Collett-Lester Fear of Death Scale. [References]. <i>Death Studies</i> .28(8), Oct. pp. 287-93.	Non-english version

Abdel-Khalek, A. & Maltby, J. (2008). Reliability, factorial validity, and means on the Kuwait University Anxiety Scale: A UK University sample. [References]. <i>Psychological Reports</i> .102(3), Jun. pp. 867-9.	No appropriate gold standard
Abdel-Khalek, A. & Rudwan, S. (2001). The Kuwait University Anxiety Scale: Reliability and criterion-related validity in Syrian college students. <i>Psychological Reports</i> .89(3), Dec. p. 718.	Non-english version
Abdel-Khalek, A. (1997). Death, anxiety, and depression. <i>Omega: Journal of Death and Dying</i> .35(2). pp. 219-229.	No appropriate gold standard
Abdel-Khalek, A. (1997). Two scales of death anxiety: Their reliability and correlation among Kuwaiti samples. <i>Perceptual and Motor Skills</i> .84(3, Pt, 1), Jun97, pp, 921-922.	Non-english version
Abdel-Khalek, A. (1998). Single- versus multi-item scales in measuring death anxiety. <i>Death Studies</i> ., 22, 763-772.	Non-english version
Abdel-Khalek, A. (1998). The development and validation of the Arabic Obsessive Compulsive Scale. <i>European Journal of Psychological Assessment</i> .14(2). pp. 146-158.	Non-english version
Abdel-Khalek, A. (1998). The structure and measurement of death obsession. <i>Personality and Individual Differences</i> .24(2), Feb. pp. 159-165.	Non-english version
Abdel-Khalek, A. (2000). Death, anxiety, and depression in Kuwaiti undergraduates. [References]. <i>Omega: Journal of Death and Dying</i> .42(4). pp. 309-320.	Non-english version
Abdel-Khalek, A. (2000). The Kuwait University Anxiety Scale: Psychometric properties. <i>Psychological Reports</i> .87(2), Oct. pp. 478-92.	Non-english version
Abdel-Khalek, A. (2004). Divergent, criterion-related, and discriminant validities for the Kuwait University Anxiety Scale. [References]. <i>Psychological Reports</i> .94(2), Apr. pp. 572-6.	Non-english version
Abdel-Khalek, A., Tomas-Sabado, J., & Gomez-Benito, J. (2004). Psychometric Parameters of the Spanish Version of the Kuwait University Anxiety Scale (S-KUAS). <i>European Journal of Psychological Assessment</i> ., 20, 349-357.	Non-english version
Abdulmajeed, A., Akram, K., Tareq, H., Gamal, S., Hajar, H., & El-Zean, A. O. (2000). Outcome of a training course in psychiatry for primary health care physicians in Abu Dhabi, UAE. <i>Primary Care Psychiatry</i> .6(2), Jun. pp. 9-16.	Not relevant
Aben, I., Verhey, F., Lousberg, R., Lodder, J., & Honig, A. (2002). Validity of the Beck Depression Inventory, Hospital Anxiety and Depression Scale, SCL-90 and Hamilton Depression Rating Scale as screening instruments for depression in stroke patients. [References]. <i>Psychosomatics: Journal of Consultation Liaison Psychiatry</i> .43(5), Sep-Oct.	Depression
Abiodun, O. A. (1993). A study of mental morbidity among primary care patients in Nigeria. <i>Comprehensive Psychiatry</i> ., 34, pp. 10-13.	Non-english version

Abramowitz, J., Deacon, B., & Valentiner, D. (2007). The short health anxiety inventory: Psychometric properties and construct validity in a non-clinical sample. <i>Cognitive Therapy and Research</i> , 31, 871-883.	Insufficient data
Abramowitz, J., Huppert, J., Cohen, A., Tolin, D., & Cahill, S. (2002). Religious obsessions and compulsions in a non-clinical sample: The Penn Inventory of Scrupulosity (PIOS). [References]. <i>Behaviour Research and Therapy</i> .40(7), Jul. pp. 825-838.	Not relevant
Abrams, M., Carleton, R. N., & Asmundson, G. (2007). An exploration of the psychometric properties of the PASS-20 with a nonclinical sample. <i>The Journal of Pain</i> , 8, 879-886.	Insufficient data
Adoric, V. (2003). Awareness of self and others in social anxiety and self-monitoring: A contribution to validation of Social Awareness Inventory. <i>Suvremena Psihologija</i> , 6. pp. 231-247.	Non-english version
Adrienne, S. & Barna, K. (2006). Characteristics of the Hungarian version of the Perceived Stress Scale (PSS). [Hungarian]. [References]. <i>Mentálhigiéné és Pszichoszomatika</i> .7(3), #203-216.	Non-english version
Agargun, M., Kara, H., Bilici, M., Cilli, A., Telci, M., Semiz, U. et al. (1999). The Van Dream Anxiety Scale: A subjective measure of dream anxiety in nightmare sufferers. <i>Sleep and Hypnosis</i> .1(4). pp. 204-211.	Not relevant
Ailey, S. (2009). The sensitivity and specificity of depression screening tools among adults with intellectual disabilities. <i>Journal of Mental Health Research in Intellectual Disabilities</i> , 2, 45-64.	Depression
Akechi, T., Okuyama, T., Sugawara, Y., Nakano, T., Shima, Y., & Uchitomi, Y. (1915). Major depression, adjustment disorders, and post-traumatic stress disorder in terminally ill cancer patients: associated and predictive factors. <i>Journal of Clinical Oncology</i> , 22, 1957-1965.	Depression
Akechi, T., Okuyama, T., Sugawara, Y., Shima, Y., Furukawa, T., & Uchitomi, Y. (2006). Screening for Depression in Terminally Ill Cancer Patients in Japan. <i>Journal of Pain and Symptom Management</i> .31(1), Jan. pp. 5-12.	Depression
Akin, A. & Cetin, B. (2007). The Depression Anxiety and Stress Scale (DASS): The study of validity and reliability. [References]. <i>Kuram ve Uygulamada Egitim Bilimleri</i> .7(1), Jan. pp. 260-268.	Depression
Al-Adawi, S., Dorvlo, A., Al-Naamani, A., Glenn, M., Karamouz, N., Chae, H. et al. (2007). The ineffectiveness of the Hospital Anxiety and Depression Scale for diagnosis in an Omani traumatic brain injured population. [References]. <i>Brain Injury</i> .21(4), Apr. pp. 385-93.	Non-english version
Aldea, M., Geffken, G., Jacob, M., Goodman, W., & Storch, E. (2009). Further psychometric analysis of the Florida Obsessive-Compulsive Inventory. <i>Journal of Anxiety Disorders</i> , 23, 124-129.	Insufficient data
Alderman, K. J. & et, a. (1983). Factor analysis and reliability studies of the Crown-Crisp Experiential Index (CCEI). <i>British Journal of Medical Psychology</i> .56(4), Dec. pp. 329-45.	No appropriate gold standard

Al-Issa, I., Al, Z., Bakal, D., & Fung, T. (2000). Beck Anxiety Inventory symptoms in Arab college students. <i>Arab Journal of Psychiatry</i> , 11. e 1-7.	Non-english version
Allen, K., Cull, A., & Sharpe, M. (2003). Diagnosing major depression in medical outpatients: Acceptability of telephone interviews. <i>Journal of Psychosomatic Research</i> , 55, 385-387.	Insufficient data
alto-Setälä, T., Haarasilta, L., Marttunen, M., Tuulio-Henriksson, A., Poikolainen, K., Aro, H. et al. (2002). Major depressive episode among young adults: CIDI-SF versus SCAN consensus diagnoses. [References]. <i>Psychological Medicine</i> .32(7), Oct. 1309-14.	Depression
Aluoja, A., Shlik, J., Vasar, V., Luuk, K., & Leinsalu, M. (1999). Development and psychometric properties of the Emotional State Questionnaire, a self-report questionnaire for depression and anxiety. <i>Nordic Journal of Psychiatry</i> .53(6). pp. 443-449.	Depression
Amir, M., Lewin-Epstein, N., Becker, G., & Buskila, D. (2002). Psychometric properties of the SF-12 (Hebrew version) in a primary care population in Israel. <i>Medical Care</i> , 40, 918-928.	Depression
Andersson, G., Käldo-Sandström, V., Ström, L., & Strömgren, T. (2003). Internet administration of the Hospital Anxiety and Depression Scale in a sample of tinnitus patients. [References]. <i>Journal of Psychosomatic Research</i> .55(3), Sep. pp. 259-262.	Depression
Andreescu, C., Belnap, B., Rollman, B., Houck, P., Ciliberti, C., Mazumdar, S. et al. (2008). Generalized Anxiety Disorder Severity Scale validation in older adults. <i>The American Journal of Geriatric Psychiatry</i> , 16, 813-818.	Insufficient data
Andrews, G. & Slade, T. (2002). The classification of anxiety disorders in ICD-10 and DSM-IV: a concordance analysis. <i>Psychopathology</i> , 35, 100-106.	Insufficient data
Angst, J., Merikangas, K. R., & Preisig, M. (1997). Subthreshold syndromes of depression and anxiety in the community. <i>Journal of Clinical Psychiatry</i> , 58 Suppl 8, 6-10.	Not relevant
Antoine, P., Antoine, C., & Nandrino, J. L. (2008). Development and validation of the Cognitive Inventory of Subjective Distress. <i>International Journal of Geriatric Psychiatry</i> , 23, 1175-1181.	Non-english version
Antony, M., Bieling, P., Cox, B., Enns, M., & Swinson, R. (1998). Psychometric properties of the 42-item and 21-item versions of the Depression Anxiety Stress Scales in clinical groups and a community sample. [References]. <i>Psychological Assessment</i> .10(2), Jun. pp. 176-181.	Insufficient data
Antony, M., Coons, M., McCabe, R., Ashbaugh, A., & Swinson, R. (2006). Psychometric properties of the social phobia inventory: Further evaluation. <i>Behaviour Research and Therapy</i> , 44, 1177-1185.	Insufficient data
Apostolo, J., Mendes, A., & Azeredo, Z. (2006). Adaptation to Portuguese of the Depression, Anxiety and Stress Scales (DASS). [References]. <i>Revista Latino-Americana de Enfermagem</i> .14(6), Nov-Dec. pp. 863-71.	Insufficient data

Araya, R., Wynn, R., & Lewis, G. (1992). Comparison of two self administered psychiatric questionnaires (GHQ-12 and SRQ-20) in primary care in Chile. <i>Social Psychiatry & Psychiatric Epidemiology.</i> , 27, 168-173.	Non-english version
Arbisi, P., Ben-Porath, Y., & McNulty, J. (2006). The ability of the MMPI-2 to detect feigned PTSD within the context of compensation seeking. <i>Psychological Services.</i> , 3, 249-261.	Not relevant
Argulewicz, E. & Miller, D. (1984). Self-report measures of anxiety: A cross-cultural investigation of bias. <i>Hispanic Journal of Behavioral Sciences.</i> 6(4), Dec. pp. 397-406.	Non-english version
Argulewicz, E. & Miller, D. (1984). Validity of self-report measures of anxiety for use with Anglo-American, Mexican-American, and Black students. <i>Journal of Psychoeducational Assessment.</i> 2(3), Sep. pp. 233-238.	Young people
Argyle, N., Deltito, J., Allerup, P., Maier, W., & et, a. (1991). The Panic-Associated Symptom Scale: Measuring the severity of panic disorder. <i>Acta Psychiatrica Scandinavica.</i> , 83, 20-26.	Insufficient data
Argyropoulos, S., Ploubidis, G., Wright, T., Palm, M., Hood, S., Nash, J. et al. (2007). Development and validation of the Generalized Anxiety Disorder Inventory (GADI). <i>Journal of Psychopharmacology.</i> , 21, 145-152.	Insufficient data
Armstrong, D. & Earnshaw, G. (2004). What constructs do GPs use when diagnosing psychological problems? <i>British Journal of General Practice.</i> , 54, pp. 580-583.	Insufficient data
Armstrong, K., Khawaja, N., & Oei, T. (2006). Confirmatory factor analysis and psychometric properties of the Anxiety Sensitivity Index--Revised in clinical and normative populations. <i>European Journal of Psychological Assessment.</i> , 22, 116-125.	Insufficient data
Arntz, A., Lavy, E., Van, d., & van, R. (1993). Negative beliefs of spider phobics: A psychometric evaluation of the Spider Phobia Beliefs Questionnaire. <i>Advances in Behaviour Research & Therapy.</i> 15(4), Dec. pp. 257-277.	Insufficient data
Arrindell, W. & Van, d. (1986). Further evidence for cross-sample invariance of phobic factors: Psychiatric inpatient ratings on the Fear Survey Schedule--III. <i>Behaviour Research and Therapy.</i> , 24, 289-297.	Insufficient data
Arrindell, W. A. (2001). Changes in waiting-list patients over time: data on some commonly-used measures. Beware! <i>Behaviour Research & Therapy.</i> , 39, 1227-1247.	Depression
Arrindell, W. A., de, V., I, Eisenhardt, B., van, B., & Kwee, M. G. T. (2002). Cross-cultural validity of the Yale-Brown Obsessive Compulsive Scale. <i>Journal of Behavior Therapy and Experimental Psychiatry.</i> , 33, 159-176.	Non-english version
Arving, C., Glimelius, B., & Brandberg, Y. (2008). Four weeks of daily assessments of anxiety, depression and activity compared to a point assessment with the Hospital Anxiety and Depression Scale. <i>Quality of Life Research.</i> , 17, 95-104.	Insufficient data
Asakura, S., Inoue, S., Sasaki, F., Sasaki, Y., Kitagawa, N., Inoue, T. et al. (2002). Reliability and validity of the Japanese version of the Liebowitz Social Anxiety Scale. <i>Seishin Igaku (Clinical Psychiatry).</i> , 44, pp. 1077-1084.	Non-english version

Asmundson, G., Bovell, C., Carleton, R. N., & McWilliams, L. (2008). The Fear of Pain Questionnaire-- short form (FPQ-SF): Factorial validity and psychometric properties. <i>Pain</i> .134(1-2), Jan. pp. 51-58.	Insufficient data
Asukai, N., Kato, H., Kawamura, N., Kim, Y., Yamamoto, K., Kishimoto, J. et al. (2002). Reliability and validity of the Japanese-language version of the Impact of Event Scale-revised (IES-R-J): Four studies of different traumatic events. [References]. <i>Journal of Nervous and Mental Disease</i> .190(3), Mar. pp. 175-182.	Non-english version
Austin, D., Carlbring, P., Richards, J., & Andersson, G. (2006). Internet administration of three commonly used questionnaires in panic research: Equivalence to paper administration in Australian and Swedish samples of people with panic disorder. <i>International Journal of Testing</i> ., 6, 25-39.	Insufficient data
Avasthi, A., Varma, S. C., Kulhara, P., Nehra, R., Grover, S., & Sharma, S. (2008). Diagnosis of common mental disorders by using PRIME-MD Patient Health Questionnaire. <i>Indian Journal of Medical Research</i> ., 127, pp. 159-164.	Depression, non-english version
Aydin, I. & Ulasahin, A. (2001). Depression, anxiety comorbidity, and disability in tuberculosis and chronic obstructive pulmonary disease patients: Applicability of GHQ-12. [References]. <i>General Hospital Psychiatry</i> .23(2), Mar-Apr. pp. 77-83.	Non-english version
Aylard, P. R., Gooding, J. H., McKenna, P. J., & Snaith, R. P. (1987). A validation study of three anxiety and depression self-assessment scales. <i>Journal of Psychosomatic Research</i> .31(2). pp. 261-8.	No appropriate gold standard
Ayvasik, H. B. & Tutarel-Kislak, S. (2004). Factor Structure and Reliability of the Anxiety Sensitivity Profile in a Turkish Sample. <i>European Journal of Psychological Assessment</i> ., 20, 358-367.	Non-english version
Aziz, M. & Kenford, S. (2004). Comparability of telephone and face-to-face interviews in assessing patients with posttraumatic stress disorder. [References]. <i>Journal of Psychiatric Practice</i> .10(5), Sep. pp. 307-13.	Depression
Baker, S., Heinrichs, N., Kim, H. J., & Hofmann, S. (2002). The Liebowitz social anxiety scale as a self-report instrument: A preliminary psychometric analysis. <i>Behaviour Research and Therapy</i> ., 40, 701-715.	Insufficient data
Balajti, I., Voko, Z., Adany, R., & Kosa, K. (2007). Validation of the Hungarian versions of the abbreviated Sense of Coherence (SOC) scale and the General Health Questionnaire (GHQ-12). <i>Mentálhigiéné és Pszichoszomatika</i> .8(2), Jun.	Non-english version
Baldacchino, D., Bowman, G., & Buhagiar, A. (2002). Reliability testing of the hospital anxiety and depression (HAD) scale in the English, Maltese and back-translation versions. [References]. <i>International Journal of Nursing Studies</i> .39(2), Feb, #207-214.	Insufficient data
Balestrieri, M., Baldacci, S., Bellomo, A., Bellantuono, C., Conti, L., Perugi, G. et al. (2007). Clinical vs. structured interview on anxiety and affective disorders by primary care physicians. Understanding diagnostic discordance. <i>Epidemiologia e Psichiatria Sociale</i> ., 16, pp. 144-51.	No full text

Ballester, D., Hidalgo, M., Ferrao, Y., Salgado, C., Scheidt, J., Godinho, C. et al. (2000). Psychiatric epidemiology: Evaluation instruments in research and clinical practice. [Portuguese]. [References]. <i>Revista de Psiquatria do Rio Grande do Sul</i> .22(2), May-Aug.	Non-english version
Bambauer, K., Locke, S., Aupont, O., Mullan, M., & McLaughlin, T. (2005). Using the Hospital Anxiety and Depression Scale to screen for depression in cardiac patients. [References]. <i>General Hospital Psychiatry</i> .27(4), Jul-Aug, pp. 275-84.	Depression
Bandelow, B. (1995). Assessing the efficacy of treatments for panic disorder and agoraphobia: II. The Panic and Agoraphobia Scale. <i>International Clinical Psychopharmacology</i> ., 10, 73-81.	Non-english version
Bandelow, B., Brunner, E., Broocks, A., Beinroth, D., Hajak, G., Pralle, L. et al. (1998). The use of the Panic and Agoraphobia scale in a clinical trial. <i>Psychiatry Research</i> ., 77, 43-49.	Non-english version
Banos, R. M., Botella, C., Quero, S., & Medina, P. (2007). The Social Phobia and Anxiety Inventory: Psychometric properties in a Spanish sample. <i>Psychological Reports</i> .100(2), Apr. pp. 441-50.	Non-english version
Barbeite, F. & Weiss, E. (2004). Computer self-efficacy and anxiety scales for an Internet sample: Testing measurement equivalence of existing measures and development of new scales. <i>Computers in Human Behavior</i> .20(1), Jan. p. 1-15.	Insufficient data
Barkow, K., Heun, R., Ustun, T. B., Berger, M., Bermejo, I., Gaebel, W. et al. (2005). Identification of somatic and anxiety symptoms which contribute to the detection of depression in primary health care. <i>European Psychiatry: the Journal of the Association of European Psychiatrists</i> .. pp. 250-257.	Depression
Bartlett, C. J. & Coles, E. C. (1998). Psychological health and well-being: why and how should public health specialists measure it? Part 2: Stress, subjective well-being and overall conclusions. <i>Journal of Public Health Medicine</i> ., 20, 281-287.	Review
Basoglu, M., Salcioglu, E., Livanou, M., Ozeren, M., Aker, T., Kilic, C. et al. (2001). A study of the validity of a screening instrument for traumatic stress in earthquake survivors in Turkey. [References]. <i>Journal of Traumatic Stress</i> .14(3), Jul. pp. 491-509.	Specific anxiety disorder (PTSD)
Bates, G., Trajstman, S., & Jackson, C. (2004). Internal Consistency, Test-Retest Reliability and Sex Differences on the Posttraumatic Growth Inventory in an Australian Sample With Trauma. [References]. <i>Psychological Reports</i> .94(3,Pt1), Jun. pp. 793-794.	Insufficient data
Bauermeister, J., Collazo, J., & Spielberger, C. (1983). The construction and validation of the Spanish Form of the Test Anxiety Inventory: Inventario de Auto-Evaluacion Sobre Examenes (IDASE). <i>Series in Clinical & Community Psychology: Stress & Anxiety</i> .2.	Non-english version

bdel-Khalek, A. (1986). Death anxiety in Egyptian samples. <i>Personality and Individual Differences</i> .7(4). pp. 479-483.	Non-english version
Bech, P., Allerup, P., Maier, W., Albus, M., & et, a. (1992). The Hamilton scales and the Hopkins Symptom Checklist (SCL-90): A cross-national validity study in patients with panic disorders. <i>British Journal of Psychiatry</i> .160 Feb. pp. 206-211.	Insufficient data
Beck, A. & Steer, R. (1991). Relationship between the Beck Anxiety Inventory and the Hamilton Anxiety Rating Scale with anxious outpatients. <i>Journal of Anxiety Disorders</i> ., 5, 213-223.	Insufficient data
Beck, A., Epstein, N., Brown, G., & Steer, R. (1988). An inventory for measuring clinical anxiety: Psychometric properties. <i>Journal of Consulting and Clinical Psychology</i> ., 56, 893-897.	Insufficient data
Beck, J. G. & Davila, J. (2003). Development of an interview for anxiety-relevant interpersonal styles: Preliminary support for convergent and discriminant validity. <i>Journal of Psychopathology and Behavioral Assessment</i> ., 25, 1-9.	Insufficient data
Beck, J. G., Coffey, S., Palyo, S., Gudmundsdottir, B., Miller, L., & Colder, C. (2004). Psychometric Properties of the Posttraumatic Cognitions Inventory (PTCI): A Replication With Motor Vehicle Accident Survivors. <i>Psychological Assessment</i> ., 16, 289-298.	Insufficient data
Beck, J. G., Grant, D., Read, J., Clapp, J., Coffey, S., Miller, L. et al. (2008). The Impact of Event Scale-Revised: Psychometric properties in a sample of motor vehicle accident survivors. <i>Journal of Anxiety Disorders</i> ., 22, 187-198.	Insufficient data
Beck, J. G., Stanley, M., & Zebb, B. (1999). Effectiveness of the Hamilton Anxiety Scale with older Generalized Anxiety Disorder patients. <i>Journal of Clinical Geropsychology</i> ., 5, 281-290.	Insufficient data
Beekman, A. T. F., Deeg, D. J. H., Van, L., Braam, A. W., De, V., & Van, T. (1997). Criterion validity of the Center for Epidemiologic Studies Depression scale (CES-D): Results from a community-based sample of older subjects in the Netherlands. <i>Psychological Medicine</i> ., 27, pp. 231-5.	Depression
Beesdo, K., Hoyer, J., Jacobi, F., Low, N. C. P., Hofler, M., & Wittchen, H. U. (2009). Association between generalized anxiety levels and pain in a community sample: Evidence for diagnostic specificity. <i>Journal of Anxiety Disorders</i> ., 23, pp. 684-93.	Insufficient data
Beidel, D., Borden, J., Turner, S., & Jacob, R. (1989). The Social Phobia and Anxiety Inventory: Concurrent validity with a clinic sample. <i>Behaviour Research and Therapy</i> ., 27, 573-576.	Insufficient data
Beidel, D., Turner, S., & Cooley, M. (1993). Assessing reliable and clinically significant change in social phobia: Validity of the Social Phobia and Anxiety Inventory. <i>Behaviour Research and Therapy</i> ., 31, 331-337.	Insufficient data
Beidel, D., Turner, S., Stanley, M., & Dancu, C. (1989). The Social Phobia and Anxiety Inventory: Concurrent and external validity. <i>Behavior Therapy</i> ., 20, 417-427.	Insufficient data

Bell, T., Watson, M., Sharp, D., Lyons, I., & Lewis, G. (2005). Factors associated with being a false positive on the General Health Questionnaire. <i>Social Psychiatry and Psychiatric Epidemiology</i> , 40, 402-407.	Insufficient data
Bendig, A. W. (1960). The factorial validity of items on the IPAT Anxiety Scale. [References]. <i>Journal of Consulting Psychology</i> .24(4), Aug. p. 374.	No appropriate gold standard
Bendig, A. W. (1963). Comparative reliability of Cattell's "covert" and "overt" items as measures of the anxiety factor. <i>Journal of General Psychology</i> .69(2). pp. 175-9.	Insufficient data
Benotsch, E., Lutgendorf, S., Watson, D., Fick, L., & Lang, E. (2000). Rapid anxiety assessment in medical patients: Evidence for the validity of verbal anxiety ratings. <i>Annals of Behavioral Medicine</i> ., 22, 199-203.	Insufficient data
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Weich, S., Morgan, L., King, M., & Nazareth, I. (2007). Attitudes to depression and its treatment in primary care. <i>Psychological Medicine</i> , 37, 1239-1248.	Insufficient data
Weiss, A., Sutin, A. R., Duberstein, P. R., Friedman, B., Bagby, R. M., & Costa, P. T. J. (2009). The personality domains and styles of the five-factor model are related to incident depression in Medicare recipients aged 65 to 100. <i>American Journal of Geriatric Psychiatry</i> , 17, 591-601.	Insufficient data
Weiss, T. & Berger, R. (2001). Reliability and Validity of a Spanish Version of the Posttraumatic Growth Inventory. <i>Research on Social Work Practice</i> .16(2), Mar. pp. 191-199.	Non-english version
Wells, A. (1994). A multi-dimensional measure of worry: Development and preliminary validation of the Anxious Thoughts Inventory. <i>Anxiety, Stress & Coping: An International Journal</i> .6(4), Feb. pp. 289-299.	Insufficient data
Wells, A. (2005). The Metacognitive Model of GAD: Assessment of Meta-Worry and Relationship With DSM-IV Generalized Anxiety Disorder. <i>Cognitive Therapy and Research</i> , 29, 107-121.	Insufficient data
Wells, J., Tien, A. Y., Garrison, R., & Eaton, W. W. (1994). Risk factors for the incidence of social phobia as determined by the Diagnostic Interview Schedule in a population-based study. <i>Acta Psychiatrica Scandinavica</i> .90(2), Aug. pp. 84-90.	Insufficient data
Wenzel, A. & Holt, C. (2003). Validation of the Multidimensional Blood/Injury Phobia Inventory: Evidence for a unitary construct. <i>Journal of Psychopathology and Behavioral Assessment</i> , 25, 203-211.	Insufficient data
Wenzel, A. & Sawchuk, C. (2004). Psychometric properties of the multidimensional blood/injury phobia inventory. <i>the Behavior Therapist</i> , 27.	No full text

Wenzel, A., Sharp, I. R., Brown, G. K., Greenberg, R. L., & Beck, A. T. (2006). Dysfunctional beliefs in panic disorder: The Panic Belief Inventory. <i>Behaviour Research and Therapy</i> , 44, 819-833.	Insufficient data
Weobong, B., Akpalu, B., Doku, V., Owusu-Agyei, S., Hurt, L., Kirkwood, B. et al. (2009). The comparative validity of screening scales for postnatal common mental disorder in Kintampo, Ghana. <i>Journal of Affective Disorders</i> , 131, 109-117.	Insufficient data
Westermeyer, J. (1986). Two self-rating scales for depression in Hmong refugees: Assessment in clinical and nonclinical samples. <i>Journal of Psychiatric Research</i> .20(2). pp. 103-13.	Depression
Wetherell, J. & Arean, P. (1997). Psychometric evaluation of the Beck Anxiety Inventory with older medical patients. <i>Psychological Assessment</i> , 9, 136-144.	Insufficient data
Wetherell, J. & Gatz, M. (2005). The Beck Anxiety Inventory in Older Adults With Generalized Anxiety Disorder. <i>Journal of Psychopathology and Behavioral Assessment</i> , 27, 17-24.	Insufficient data
Wetter, M. & Deitsch, S. (1996). Faking specific disorders and temporal response consistency on the MMPI-2. [References]. <i>Psychological Assessment</i> .8(1), Mar. pp. 39-47.	Not relevant
Wetzel, R., Clayton, P., Cloninger, C. R., Brim, J., Martin, R., Guze, S. et al. (2000). Diagnosis of posttraumatic stress disorder with the MMPI: PK scale scores in somatization disorder. <i>Psychological Reports</i> .87(2), Oct. pp. 535-41.	No full text, insufficient data?
Wetzel, R., Murphy, G., Simons, A., Lustman, P., North, C., & Yutzy, S. (2003). What does the Keane PTSD scale of the MMPI measure? Repeated measurements in a group of patients with major depression. [References]. <i>Psychological Reports</i> .92(3), Jun. pp. 781-6.	Specific anxiety disorder (PTSD)
Whitbeck, L., Adams, G., Hoyt, D., & Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. <i>American Journal of Community Psychology</i> , 33, 119-130.	Insufficient data
Wijma, K., Wijma, B., & Zar, M. (1998). Psychometric aspects of the W-DEQ; a new questionnaire for the measurement of fear of childbirth. <i>Journal of Psychosomatic Obstetrics & Gynecology</i> , 19(2), pp. 84-97.	Insufficient data
Wijngaarden, B., Schene, A., & Koeter, M. (2004). Family caregiving in depression: Impact on caregivers' daily life, distress, and help seeking. [References]. <i>Journal of Affective Disorders</i> .81(3), Sep. pp. 211-22.	Insufficient data
Williams, J. & McCord, D. (2006). Equivalence of standard and computerized versions of the Raven Progressive Matrices Test. [References]. <i>Computers in Human Behavior</i> , 22, 791-800.	Insufficient data
Williams, J. (1994). Anxiety measurement: Construct validity and test performance. <i>Measurement and Evaluation in Counseling and Development</i> .27(1), Apr. pp. 302-07.	Insufficient data
Williams, J., Spitzer, R., & Gibbon, M. (1992). International reliability of a diagnostic intake procedure for panic disorder. <i>American Journal of Psychiatry</i> , 149, 560-562.	Insufficient data

Williams, M., Turkheimer, E., Schmidt, K., & Oltmanns, T. (2005). Ethnic Identification Biases Responses to the Padua Inventory for Obsessive-Compulsive Disorder. <i>Assessment</i> , 12, 174-185.	Insufficient data
Wilson, D., Chibaiwa, D., Majoni, C., Masukume, C., & et, a. (1990). Reliability and factorial validity of the Revised Children's Manifest Anxiety Scale in Zimbabwe. <i>Personality and Individual Differences</i> .11(4). pp. 365-369.	Young people
Winter, W., Ferreira, A., & Ransom, R. (1963). Two measures of anxiety: A validation. <i>Journal of Consulting Psychology</i> .27(6), Dec. pp. 520-524.	Insufficient data
Wisniewski, J., Mulick, J., Genshaft, J., & Coury, D. (1987). Test-retest reliability of the Revised Children's Manifest Anxiety Scale. <i>Perceptual and Motor Skills</i> .65(1), Aug. pp. 67-70.	Young people
Wisocki, P., Handen, B., & Morse, C. (1986). The Worry Scale as a measure of anxiety among homebound and community active elderly. <i>the Behavior Therapist</i> .9(5), May. pp. 91-95.	No full text, insufficient data?
Wittchen, H. U., Kessler, R. C., Zhao, S., & Abelson, J. (1995). Reliability and clinical validity of UM-CIDI DSM-III-R generalized anxiety disorder. <i>Journal of Psychiatric Research</i> ., 29, pp. 95-110.	Insufficient data
Wittchen, H. U., Lieb, R., Pfister, H., & Schuster, P. (2000). The waxing and waning of mental disorders: evaluating the stability of syndromes of mental disorders in the population. <i>Comprehensive Psychiatry</i> ., 41, 122-132.	Depression
Wittchen, H. U., Zhao, S., Abelson, J. M., Abelson, J. L., & Kessler, R. C. (1996). Reliability and procedural validity of UM-CIDI DSM-III-R phobic disorders. <i>Psychological Medicine</i> ., 26, 1169-1177.	Insufficient data
Witteveen, A., Bramsen, I., Hovens, J., & van, d. (2005). Utility of the Impact of Event Scale in screening for posttraumatic stress disorder. <i>Psychological Reports</i> .97(1), Aug. pp. 297-308.	No full text, definitely useful
Wohlfarth, T., van, d., Winkel, F., & ter, S. (2003). Screening for posttraumatic stress disorder: An evaluation of two self-report scales among crime victims. <i>Psychological Assessment</i> ., 15, 101-109.	Non-english version
Woody, S., Steketee, G., & Chambless, D. (1995). Reliability and validity of the Yale-Brown Obsessive-Compulsive Scale. <i>Behaviour Research and Therapy</i> ., 33, 597-605.	Insufficient data
Woody, S., Steketee, G., & Chambless, D. (1995). The usefulness of the obsessive compulsive scale of the Symptom Checklist-90--Revised. <i>Behaviour Research and Therapy</i> ., 33, 607-611.	Insufficient data
Woolrich, R. A., Kennedy, P., & Tasiemski, T. (2006). A preliminary psychometric evaluation of the Hospital Anxiety and Depression Scale (HADS) in 963 people living with a spinal cord injury. <i>Psychology, Health and Medicine</i> ., 11, pp. 80-90.	Insufficient data
Wu, K. & Carter, S. (2008). Further investigation of the Obsessive Beliefs Questionnaire: Factor structure and specificity of relations with OCD symptoms.]. <i>Journal of Anxiety Disorders</i> ., 22, 824-836.	Insufficient data

Wyshak, G. & Barsky, A. J. (1994). Relationship between patient self-ratings and physician ratings of general health, depression, and anxiety. <i>Archives of Family Medicine.</i> , 3, 419-424.	Depression, insufficient data
Wyshak, G., Barsky, A., & Klerman, G. (1991). Comparison of psychiatric screening tests in a general medical setting using ROC analysis. <i>Medical Care.</i> , 29. pp. 775-85.	Insufficient data
Yamamoto, I., Nakano, Y., Watanabe, N., Noda, Y., Furukawa, T., Kanai, T. et al. (2004). Cross-Cultural Evaluation of the Panic Disorder Severity Scale in Japan. <i>Depression and Anxiety.</i> , 20, 17-22.	Non-english version
Yasuda, T., Lubin, B., Kim, J., & Van, W. (2003). The Japanese version of the Multiple Affect Adjective Checklist-Revised: Development and validation. <i>Journal of Clinical Psychology.</i> , 59, 93-109.	Non-english version
Yilmaz, A. E., Gencoz, T., & Wells, A. (2008). Psychometric characteristics of the Penn State Worry Questionnaire and Metacognitions Questionnaire-30 and metacognitive predictors of worry and obsessive-compulsive symptoms in a Turkish sample. <i>Clinical Psychology & Psychotherapy.</i> , 15, 424-439.	Non-english version
Yonkers, K. A., Bruce, S. E., Dyck, I. R., & Keller, M. B. (2003). Chronicity, relapse, and illness--course of panic disorder, social phobia, and generalized anxiety disorder: findings in men and women from 8 years of follow-up. <i>Depression & Anxiety.</i> , 17, 173-179.	Insufficient data
Yoshida, M., Kiriike, N., Nagata, T., Matsunaga, H., & et, a. (1995). The clinical usefulness of the Japanese version of the Maudsley Obsessional-Compulsive Inventory in patients with obsessive-compulsive disorders. [Japanese]. <i>Seishin Igaku (Clinical Psychiatry).</i> , 37.	Non-english version
Young, L. K., Polzin, J., Todd, S., & Simuncak, S. L. (2002). Validation of the nursing diagnosis anxiety in adult patients undergoing bone marrow transplant. <i>International Journal of Nursing Terminologies & Classifications.</i> , 13, 88-100.	Insufficient data
Zajecka, J. (1997). Importance of establishing the diagnosis of persistent anxiety. <i>Journal of Clinical Psychiatry.</i> , 58 Suppl 3:9-13; discussion 14-5.	Review
ZamZam, R., Thambu, M., Midin, M., Omar, K., & Kaur, P. (2009). Psychiatric morbidity among adult patients in a semi-urban primary care setting in Malaysia. <i>International Journal of Mental Health Systems.</i> , 3, Article. p. 13.	Non-english version
Zauszniewski, J. A. & Bekhet, A. K. (2009). Depressive symptoms in elderly women with chronic conditions: Measurement issues. <i>Aging and Mental Health.</i> , 13, 69-72.	Insufficient data
Zauszniewski, J. A. & Graham, G. C. (2009). Comparison of short scales to measure depressive symptoms in elders with diabetes. <i>Western Journal of Nursing Research.</i> , 31, 219-234.	Insufficient data
Zawadzki, B., Strelau, J., Bieniek, A., Sobolewski, A., & Oniszczenko, W. (2002). PTSD Inventory - clinical version (PTSD-C): The development of a questionnaire aimed at assessing post-traumatic stress disorder. [Polish]. [References]. <i>Przegląd Psychologiczny.</i> 45(3).	Non-english version

Zermatten, A., Van, d., Jermann, F., & Ceschi, G. (2006). Validation of a French version of the Obsessive-Compulsive Inventory-Revised in a non-clinical sample. [References]. <i>European Review of Applied Psychology/Revue Europeenne de Psychologie Appliquee.</i> , 56, 151-155.	Non-english version
Zeyrek, E. & Lester, D. (2008). Cronbach Alpha reliability and concurrent validity of the Collett-Lester Fear of Death Scale in a Turkish sample. [References]. <i>Psychological Reports</i> .102(3), Jun. pp. 706-708.	Non-english version
Zgourides, G., Warren, R., & Englert, M. (1989). Further evidence of construct validity for the Agoraphobic Cognitions Questionnaire and the Body Sensations Questionnaire. <i>Psychological Reports</i> .64(2), Apr. p. 590.	No full text
Zigmond, A. S. & Snaith, R. P. (1983). The Hospital Anxiety and Depression Scale. <i>Acta Psychiatrica Scandinavica.</i> , 67, 361-370.	Insufficient data
Zilli, C., Brooke, R. I., Lau, C. L., & Merskey, H. (1989). Screening for psychiatric illness in patients with oral dysesthesia by means of the General Health Questionnaire--twenty-eight item version (GHQ-28) and the Irritability, Depression and Anxiety Scale (IDA). <i>Oral Surgery, Oral Medicine, Oral Pathology.</i> , 67, 384-389.	No appropriate gold standard
Zimmerman, M. & Chelminski, I. (2006). Screening for anxiety disorders in depressed patients. <i>Journal of Psychiatric Research.</i> , 40, 267-272.	>12 items
Zimmerman, M. & Mattia, J.I. (2001). A self-report scale to help make psychiatric diagnoses. The psychiatric diagnostic screening questionnaire. <i>Archives of General Psychiatry</i> , 58, 787-794.	>12 items
Zlotnick, C. & Pearlstein, T. (1997). Validation of the Structured Interview for Disorders of Extreme Stress. <i>Comprehensive Psychiatry</i> , 38, 243-247.	Insufficient data
Zoellner, L. A., Jaycox, L. H., Watlington, C. G., & Foa, E. B. (2003). Are the dissociative criteria in ASD useful? <i>Journal of Traumatic Stress.</i> , 16, 341-350.	Insufficient data
Zoger, S., Svedlund, J., & Holgers, K. M. (2004). The Hospital Anxiety and Depression Scale (HAD) as a screening instrument in tinnitus evaluation. [References]. <i>International Journal of Audiology</i> .43(8), Sep . pp. 458-64.	Non-english version
Zuckerman, M. & Biase, D. V. (1962). Replication and further data on the validity of the Affect Adjective Check List measure of anxiety. [References]. <i>Journal of Consulting Psychology</i> .26(3), Jun. p. 291.	Depression
Zuckerman, M., Lubin, B., & Rinck, C. (1983). Construction of new scales for the Multiple Affect Adjective Check List. <i>Journal of Behavioral Assessment</i> .5(2), Jun. pp. 119-129.	Insufficient data
Zwahlen, D., Hagenbuch, N., Carley, M., Recklitis, C., & Buchi, S. (2008). Screening cancer patients' families with the distress thermometer (DT): A validation study. <i>Psycho-Oncology.</i> , 17, 959-966.	Non-english version

1.3 ASSESSMENT

1.3.1 Included studies characteristics (systematic reviews of formal assessment)

Study ID	NZGG2008
Bibliographic reference	New Zealand Guidelines Group. Identification of Common Mental Disorders and Management of Depression in Primary Care. An Evidence-based Best Practice Guideline. Published by New Zealand Guidelines Group; Wellington: 2008.
Method used to synthesise evidence	Narrative
Design of included studies	Systematic reviews and cohort studies
Evidence search	Details of search reported in appendix which is currently not available from website (awaiting response from developers)
No. of included studies	4 systematic reviews and 27 primary studies
Review quality	Adequate
Instrument/ method of assessment reviewed	Patient Health Questionnaire for Depression (PHQ-9) General Health Questionnaire (GHQ-12) Common Mental Disorder Questionnaire (CMDQ) Center for Epidemiological Studies Depression scale (CES-D) World Health Organization Wellbeing Index (WHO-5) Duke-Anxiety-Depression scale (Duke-AD) Generalised Anxiety Disorder Assessment Tool (GAD-7 & GAD-2) K10 questionnaire
Reference standard used by primary studies	Not reported
Diagnosis of participants included in primary studies	CMHD
Sensitivity and specificity	Not reported
Positive and negative predictive values	Not reported
Source of funding	New Zealand Ministry of Health

1.3.2 Included studies characteristics (systematic reviews of risk assessment)

Study ID	MCMILLAN2007
Bibliographic reference	McMillan, D., Gilbody, S., Beresford, E., et al. (2007) Can we predict suicide and non-fatal self-harm with the Beck Hopelessness Scale? A meta-analysis. <i>Psychological Medicine</i> , 37, 769-778.
Method used to synthesise evidence	Meta-analysis
Design of included studies	Cohort
Evidence search	MEDLINE, CINAHL , Embase and PsycINFO (inception-January 2006)
No. of included studies	19 (10 studies included in the diagnostic accuracy meta-analysis)
Review quality	Poor (quality of included studies not assessed/reported)
Instrument/ method of assessment reviewed	Beck Hopelessness Scale
Reference standard used by primary studies	Number of people with the outcome (suicide or self-harm)
Diagnosis of participants included in primary studies	Depression
Results	<p>Using the BHS to predict suicide Based on four studies, and using a cut off score ≥ 9, the pooled sensitivity of the BHS was 0.80 (95% CI 0.68-0.90, $I^2=57\%$) and specificity was 0.42 (95% CI 0.41-0.44, $I^2=76\%$). Likelihood ratios for positive and negative tests were 1.55 (95% CI 1.31–1.83, $I^2=44\%$) and 0.45 (95% CI 0.20–1.03, $I^2=49\%$) respectively. The pooled diagnostic odds ratio was 3.39 (95% CI 1.29–8.88, $I^2=37\%$). The pooled AUC was 0.70 (95% CI 0.59–0.85).</p> <p>Using the BHS to predict non-fatal self-harm Based on six studies, and using a cut off score ≥ 9, the pooled sensitivity of the BHS was 0.78 (95% CI 0.74-0.82, $I^2=0\%$) and specificity was 0.42 (95% CI 0.38-0.45, $I^2=90\%$). Likelihood ratios for positive and negative tests were 1.29 (95% CI 1.09–1.52,</p>

	I ² =74%) and 0.58 (95% CI 0.47–0.71, I ² =0%) respectively. The pooled diagnostic odds ratio was 2.27 (95% CI 1.53–3.37, I ² =35%), regardless of setting, length of follow-up and baseline risk. The pooled AUC was 0.63 (95% CI 0.57–0.70). After removing a study that used an adolescent population, the results remained similar.
Source of funding	None

1.3.3 Included studies characteristics (systematic reviews of factors that predict treatment response)

Study ID	DODD2004
Bibliographic reference	Dodd, S. & Berk, M. Predictors of antidepressant response: A selective review. <i>International Journal of Psychiatry in Clinical Practice</i> , 8, 91-100.
Method used to synthesise evidence	Narrative
Design of included studies	Preference for clinically relevant primary research articles
Evidence search	Medline (1966 to present) on 'Ovid' (Ovid Technologies, Inc., NY) and hand search of relevant literature
No. of included studies	95
Review quality	High risk bias (only Medline searched, quality of included studies not assessed/reported, poor description of methodology)
Predictor of response	Biological, psychosocial, clinical factors
Outcome measure	Antidepressant response
Diagnosis of participants included in primary studies	Depression
Results	<p>The following non-biological factors predicted better response:</p> <ul style="list-style-type: none"> • moderate depression (compared to severe depression) • endogenous depression (compared to situational/reactive depression) • high autonomy and low sociotropy • high co-operativeness and self-directedness • high reward-dependence and noveltyseeking and low harm-avoidance

	<ul style="list-style-type: none"> • greater non-verbal attunement between patient and interviewer • psychiatrist's initial optimism • strong alliance between therapist and service user • strongly held religious beliefs and activities. <p>The following non-biological factors predicted poor response:</p> <ul style="list-style-type: none"> • comorbidity of generalised anxiety disorder • comorbidity of panic disorder • bipolarity • alcohol abuse and dependance • poor occupational functioning. <p>Biological predictive factors included neuro-endocrine factors, platelet markers, electroencephalographic markers and magnetic resonance markers, but the review authors suggest that while these are useful in research they are of only limited use to the treating clinician.</p>
Source of funding	Eli-Lilly; Novartis; Bristol-Myers-Squibb; Organon

Study ID	FEKADU2009
Bibliographic reference	Fekadu, A., Wooderson, S.C., Markoloulo, K., et al. (2009) What happens to patients with treatment resistant depression? A systematic review of medium to long term outcome studies. <i>Journal of Affective Disorders</i> , 116, 4-11
Method used to synthesise evidence	Narrative
Design of included studies	Observational and longitudinal (minimum follow-up 6 months)
Evidence search	MEDLINE (1960 – June Week 1 2008), EMBASE (1974 – June Week 1 2008), PsycINFO (1967 – June Week 1 2008) and PubMed, and hand search of relevant literature
No. of included studies	9
Review quality	Low risk bias

Predictor of response	Clinical factors
Outcome measure	Treatment response/ readmission
Diagnosis of participants included in primary studies	'Treatment-resistant' depression
Results	<p>The following factors predicted good outcome and recovery:</p> <ul style="list-style-type: none"> • initial responsiveness to lithium • absence of previous history of admission • shorter duration of illness at intake • less severe illness during follow up. <p>The following factors predicted poorer outcome and readmission:</p> <ul style="list-style-type: none"> • prior history of treatment with lithium • presence of delusions and agitation. <p>Age sex and history of dysthymia were not predictive of recovery.</p>
Source of funding	None

Study ID	HARDEVELD2010
Bibliographic reference	Hardeveld, F., Spijker, J., De Graaf, R., <i>et al.</i> (2010) Prevalence and predictors of recurrence of major depressive disorder in the adult population. <i>Acta Psychiatrica Scandinavica</i> , 122, 184–191
Method used to synthesise evidence	Narrative
Design of included studies	Naturalistic, longitudinal study (minimum follow-up 6 months)
Evidence search	PsycINFO and MEDLINE (January 1980 - August 2008)
No. of included studies	27
Review quality	Low risk bias

Predictor of response	Psychosocial and clinical factors
Outcome measure	Recurrence of MDD
Diagnosis of participants included in primary studies	Major depressive disorder
Results	<p>The following factors predicted recurrence of MDD:</p> <ul style="list-style-type: none"> • the number of previous episodes • subclinical residual symptoms after recovery for the last episode. <p>Demographic factors such as gender, civil status and socioeconomic status were not related to the recurrence of MDD.</p> <p>The percentage of recurrence of MDD in specialised mental healthcare settings is high (85% after 15 years) and may be similar in primary care. In general population recurrence of MDD is lower (35% after 15 years).</p>
Source of funding	Netherlands Organisation for Health Research and Development; European Union, Stanley Medical Research Institute; Astra Zeneca; Eli Lilly; GlaxoSmithKline; Wyeth

Study ID	MITCHELL2005
Bibliographic reference	Mitchell, A.J. & Subramaniam, H. (2005) Prognosis of depression in old age compared to middle age: A systematic review of comparative studies. <i>American Journal of Psychiatry</i> , 162, 1588-1601.
Method used to synthesise evidence	Narrative
Design of included studies	Comparative studies of mid- and late-life first episode depression
Evidence search	MEDLINE (1966 - July 2004), PsycINFO (1887 - July 2004), ASSIA (1987 - July 2004), Embase (1980 - July 2004), the National Library of Medicine gateway (accessed July 2004), CINAHL (1982 - July 2004) and full-text collections including Science Direct, Ingenta Select, Ovid (full text), Wiley Interscience and Web of Knowledge (1.2, ISI)
No. of included studies	36
Review quality	Low risk bias

Predictor of response	Age
Outcome measure	Treatment response and remission/ recurrence of depression
Diagnosis of participants included in primary studies	Depression
Results	<p>Response and remission rates to pharmacotherapy and ECT are not significantly different in old-age depression and middle-age depression.</p> <p>The evidence suggests that older patients have a higher risk of further episodes, short intervals to recurrence, and experience more confounding factors, for example medical comorbidity, than younger patients. Therefore, it is important to look at age-related factors, not just age itself, when assessing risk factors for prognosis.</p> <p>Although rates of response are not substantially different between groups, systematic differences in treatment of depression by age exist. In general, the evidence overall supports the notion that depression in the elderly is equally responsive to initial treatment but has a more adverse longitudinal trajectory than depression in middle age.</p>
Source of funding	Not reported

Study ID	NELSON2009
Bibliographic reference	Nelson, J.C., Delucchi, K. & Schneider, L.S. (2009). Anxiety does not predict response to antidepressant treatment in late life depression: results of a meta-analysis. <i>International Journal fo Geriatric Psychiatry</i> , 24, 539-544.
Method used to synthesise evidence	Meta-analysis
Design of included studies	Randomised, double blind placebo controlled trials
Evidence search	The Cochrane Controlled Trials Register (2006, Issue3), MEDLINE (1966 - August 2006), hand search of relevant literature and information retrieved from pharmaceutical manufacturers
No. of included studies	10
Review quality	Low risk bias

Predictor of response	Presence of anxiety
Outcome measure	Response to second generation antidepressant treatment
Diagnosis of participants included in primary studies	Late life depression
Results	There was no evidence that anxiety affected response to second generation antidepressant treatment in placebo-controlled trials of major depression in older adults.
Source of funding	Not reported, but two authors have received funds from pharmaceutical companies

Study ID	POMPILI2009
Bibliographic reference	Pompili, M., Serfini, G., Del Casale, A., <i>et al.</i> (2009) Improving assessment in mood disorders: the struggle against relapse, reoccurrence and suicide risk. <i>Expert Review of Neurotherapeutics</i> , 9(7), 985-1004
Method used to synthesise evidence	Narrative
Design of included studies	Primary research, review articles and descriptive papers that measured adherence
Evidence search	MEDLINE and PsycINFO (1975 – 2009)
No. of included studies	104
Review quality	Poor (quality of included studies not assessed/reported)
Predictor of response	Psychosocial and clinical factors
Outcome measure	Medication adherence
Diagnosis of participants included in primary studies	Unipolar and bipolar depression
Results	Factors that predict medication non-adherence specific to unipolar/ bipolar depression can be categorised as: <ul style="list-style-type: none"> • variables unique to the disorder (early onset, high number of hospitalisations) • treatment issues (complex treatment regimen, medication side effects, delayed onset of action, cost of medication, inadequate medication dosage and inadequate therapy duration)

	<ul style="list-style-type: none"> • patient factors (gender, age, marital status, educational level and social support, ethnicity, cognitive dysfunction, higher level of personality pathology, lack of insight, substance abuse, mood-incongruent psychotic features) • physician factors (poor physician-patient communication). <p>Comorbid symptoms had no effect on adherence.</p>
Source of funding	None

1.3.4 Included studies characteristics (systematic reviews of routine outcome monitoring)

Study ID	KNAUP2009
Bibliographic reference	Knaup, C., Koesters, M., Schoefer, D., et al. (2009) Effect of feedback of treatment outcome in specialist mental healthcare: a meta-analysis. <i>The British Journal of Psychiatry</i> , 195, 15-22.
Method used to synthesise evidence	Meta-analysis
Design of included studies	Controlled trials using outcome management
Evidence search	MEDLINE, PSYINDEX, PsycINFO, the Cochrane Central, Register of Controlled Trials, the Cochrane Database of Systematic, Reviews, the Current Controlled Trials Register, and the world wide web using Google and Google Scholar in November 2006. Search updated in March 2008.
No. of included studies	12
Review quality	Poor (quality of included studies not assessed/reported)
Type of ROM	General
Outcome of ROM	<ul style="list-style-type: none"> • Mental health • Met and unmet needs • Physical impairment • Social functioning • Quality of life • Patient satisfaction • Acceptance or appraisal of feedback

	<ul style="list-style-type: none"> • Rates of significant clinical change • Rates of significant treatment response
Diagnosis of participants included in primary studies	CMHD
Results	<p>ROM often involved standardised assessments of psychological functioning or needs such as the Outcome Questionnaire 4.5.2, Symptom Checklist 11, Camberwell Assessment of Need for the Elderly, Camberwell Assessment of Need Short Appraisal schedule and Cardinal Needs schedule.</p> <p>Feedback mainly comprised information about current treatment status and changes over time.</p> <p>With regard to short-term outcomes, despite moderate between-study heterogeneity ($I^2=31\%$, $p=0.16$), there was a small but statistically significant effect favouring the feedback intervention in 10 studies including a total of 4009 participants (Hedges' $g=0.10$, 95% CI 0.01 to 0.19). For long-term effects of ROM, meta-analysis of 5 studies ($N=573$) demonstrated an unexpected, non-significant trend in favour of the no feedback group ($g=-0.06$, 95% CI -0.22 to 0.11; $I^2=0\%$, $p=0.69$).</p> <p>Routine outcome monitoring was not found to significantly change the length of treatment in the meta-analysis ($g=0.05$, 95% CI -0.05 to 0.15; $I^2=42.03\%$, $p=0.12$).</p>
Source of funding	German Federal Ministry of Education and Research

Study ID	LAMBERT2003
Bibliographic reference	Lambert, M. J., Whipple, J. L., & Hawkins, E. J., (2003) Is it time for clinicians to routinely track patient outcome? A meta-analysis. Clinical Psychology: Science and Practice, 10(3), 288-301.
Method used to synthesise evidence	Meta-analysis
Design of included studies	RCT
Evidence search	No search done as this was a meta-analysis of three RCTs
No. of included studies	3
Review quality	This study did not claim to be a systematic review, but rather was a meta-analysis of three RCTs
Type of ROM	Therapist signal alarm feedback

Outcome of ROM	<ul style="list-style-type: none"> • Psychological dysfunction • Number of sessions of treatment
Diagnosis of participants included in primary studies	CMHD
Results	<p>Following a signal alarm, individuals who were responding poorly to treatment and whose therapist received feedback showed an improvement in functioning, based on the Outcome Questionnaire-45. Conversely, individuals who were responding poorly to treatment but whose therapist was not receiving feedback showed a decrease in functioning. Overall, the effect size was 0.39, which was statistically significant ($F(1,581)=26.15, p<.05$). This difference was maintained at treatment termination. More poorly responding participants whose therapists received no treatment feedback had a clinically significant deterioration (21.3%) in comparison to those whose therapists were receiving feedback (13.4%). This difference was statistically significant ($\chi^2=16.31, p<.001$).</p> <p>For participants who were responding poorly to treatment, those whose therapists received feedback attended about one and half additional sessions than those whose therapists did not receive feedback ($F(1,582)=15.90, p<.05$).</p>
Source of funding	Brigham Young University

1.3.5 Excluded studies

Bibliographic reference	Reason for exclusion
Evans, K., Dougherty, D., Pollack, M., & Rauch, S. (2006). Using Neuroimaging to Predict Treatment Response in Mood and Anxiety Disorders. <i>Annals of Clinical Psychiatry</i> , 18, 33-42.	Review of neuro-imaging
Bagby, R. M., Ryder, A. G., Schuller, D. R., & Marshall, M. B. (2004). The Hamilton Depression Rating Scale: Has the gold standard become a lead weight? <i>American Journal of Psychiatry</i> , 161, 2163-2177.	Instrument reviewed in Depression update guideline
Cepoiu, M., McCusker, J., Cole, M. G., Sewitch, M., Belzile, E., & Ciampi, A. (2008). Recognition of depression by non-psychiatric physicians - A systematic literature review and meta-analysis. <i>Journal of General Internal Medicine</i> , 23,	Non-formal assessment
Cole, M. G. & Dendukuri, N. (2003). Risk factors for depression among elderly community subjects: A systematic review and meta-analysis. <i>American Journal of Psychiatry</i> , 160.	Review of risk factors for developing depression

Cuijpers, P., Li, J., Hofmann, S. G., & Andersson, G. (2010). Self-reported versus clinician-rated symptoms of depression as outcome measures in psychotherapy research on depression: A meta-analysis. <i>Clinical Psychology Review</i> , 30, 768-778.	Review of risk factors for developing depression
Delville, C. & McDougall, G. (2008). A systematic review of depression in adults with heart failure: Instruments and incidence. <i>Issues in Mental Health Nursing</i> , 29(9).	Instruments reviewed in Depression update guideline
Hutton, C. & Gunn, J. (2007). Do longer consultations improve the management of psychological problems in general practice? A systematic literature review. <i>BMC Health Services Research</i> , 7.	Review of consultation length
Lopez-Pina, J., Sanchez-Meca, J., & Rosa-Alcazar, A. (2009). The Hamilton Rating Scale for Depression: A meta-analytic reliability generalization study. <i>International Journal of Clinical and Health Psychology</i> , 9, 143-159.	Instrument reviewed in Depression update guideline
McHugh, R. K. & Behar, E. (2009). Readability of self-report measures of depression and anxiety. <i>Journal of Consulting and Clinical Psychology</i> , 77, 1100-1112.	Not a systematic review
Mitchell, A. J., Vaze, A., & Rao, S. (2009). Clinical diagnosis of depression in primary care: a meta-analysis. <i>The Lancet</i> , 374,	Review of routine clinical diagnosis by GPs
Nichol, M. B. & Zhang, L. (2005). Depression and health-related quality of life in patients with rheumatoid arthritis. <i>Expert Review of Pharmacoeconomics and Outcomes Research</i> , 5, 645-653.	Not a review of formal assessment
Salter, K., Bhogal, S. K., Foley, N., Jutai, J., & Teasell, R. (2007). The assessment of poststroke depression. <i>Topics in Stroke Rehabilitation</i> , 14, 1-24.	Instruments reviewed in Depression update guideline
Wittkamp, K. A., Naeije, L., Schene, A. H., Huyser, J., & van, W. (2007). Diagnostic accuracy of the mood module of the Patient Health Questionnaire: a systematic review. <i>General Hospital Psychiatry</i> , 29.	Instrument reviewed in Depression update guideline
Zimmerman, M., Chelminski, I., & Posternak, M. (2004). A review of studies of the Hamilton Depression Rating Scale in healthy controls: Implications for the definition of remission in treatment studies of depression. <i>Journal of Nervous and Mental Disease</i> , 192, 595-601	Review of HDRS in healthy controls
Colasanti, V., Marianetti, M., Micacchi, F., Amabile, G. A., Mina, C. (2010) Tests for the evaluation of depression in the elderly: a systematic review. <i>Arch Gerontol Geriatr</i> , 50(2), 227-30.	Instruments reviewed in Depression update guideline
Lester, H. & Howe, A. (2008) Depression in primary care: three key challenges. <i>Postgrad Med J</i> . 84(996), 545-8.	Not a systematic review
Lester, H. & Majeed, A. (2008) The future of the quality and outcomes framework. <i>BMJ</i> , 337, a3017.	Not a systematic review

Lester, H. (2007) The UK quality and outcomes framework, <i>BMJ</i> , 337, a2095.	Not a systematic review
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1.4 PATHWAYS

1.4.1 Included studies characteristics

Study ID	ADLER2010
Bibliographic reference	Adler, R., Vasiliadis, A. & Bickell, N. (2010) The relationship between continuity and patient satisfaction: a systematic review. <i>Family Practice</i> , 27, 171-178.
Method used to synthesise evidence	Narrative
Design of included studies	Various
Evidence search	MEDLINE and Cumulative Index to Nursing and Allied Health Literature were searched –2007
No. of included studies	12
Review quality	Poor
Interventions	Continuity of care
Outcome	Patient satisfaction
Diagnosis of participants included in primary studies	Various, medical concerns
Results	In general, continuity of care was associated with overall satisfaction of care. However, results were not always consistent, and varied depending on measures of continuity. Duration of doctor-patient relationship showed no significant effect on satisfaction, whereas subjective measures did.
Source of funding	None

Study ID	ADLI2006
Bibliographic reference	Adli, M., Bauer, M. & Rush, A.J. (2006) Algorithms and collaborative-care systems for depression: are they effective and why? A systematic review. <i>Biological Psychiatry</i> , 59, 1029-1038.

Method used to synthesise evidence	Narrative
Design of included studies	Various
Evidence search	Medline
No. of included studies	Not reported
Review quality	Poor
Interventions	Algorithms
Outcome	Recovery, quality of life, patient satisfaction, remission or response to treatment, treatment adherence, symptom reduction, suicidal ideation, side-effect burden and functional impairment.
Diagnosis of participants included in primary studies	Depression
Results	<p>In clinical practice, treatment algorithms should be embedded in a multi-faceted disease management or collaborative care program. They must be understandable and acceptable, and be capable of overcoming administrative and clinician-related hurdles.</p> <p>Critical decision points can be useful for algorithm implementation, provided that they use objective symptom scales, are based on pre-defined response criteria, include a rigorous assessment of side-effects, are scheduled at appropriate time points and are adaptable to various clinical circumstances.</p> <p>In comparison to treatment as usual, algorithms can help to improve the likelihood of recovery, quality of life and patient satisfaction, to achieve remission or response to treatment, to maintain treatment adherence and to reduce depressive symptoms, suicidal ideation, side-effect burden and functional impairment improve.</p>
Source of funding	German Federal Ministry for Education and Research; Eli Lilly and Company; Janssen-Cilag, Pfizer Inc.; Pharmacia; WyethAyerst Laboratories, Inc.

Study ID	ARGAWAL2008
Bibliographic reference	Agarwal, G. & Crooks, V.A. (2008) The nature of informational continuity of care in general practice. <i>British Journal of General Practice</i> , Nov, e1-e8.

Method used to synthesise evidence	Narrative
Design of included studies	Various
Evidence search	Medline, CINAHL, Embase, PsychInfo and Web of Science were searched -2006.
No. of included studies	34
Review quality	Adequate
Interventions	Informational continuity
Outcome	Accuracy
Diagnosis of participants included in primary studies	Various mental and non-mental health conditions
Results	<p>Duration and depth of the patient-doctor relationship is important, as accurate histories often require a good knowledge base. Doctors were found to rarely ask about social/lifestyle and medical histories on rare occasions, preferring to rely on memory.</p> <p>Around 30% of patients report enjoying discussing what should be entered in their records. However, they can be selective, and often prioritise biomedical issues over socio-contextual or personal ones.</p>
Source of funding	Canadian Institutes of Health Research (CIHR); Canadian Diabetes Association

Study ID	BADAMGARAV2003
Bibliographic reference	Badamgarav, E., Weingarten, S.R., Henning, J.M., et al. (2003) Effectiveness of disease management programs in depression: a systematic review. <i>American Journal of Psychiatry</i> , 160, 2080-2090.

Method used to synthesise evidence	Meta-analysis
Design of included studies	RCTs
Evidence search	Medline, HealthSTAR and Cochrane were searched -2001
No. of included studies	19
Review quality	Adequate
Interventions	Disease management
Outcome	Improvements in symptoms, physical functioning, social and health status and patient satisfaction, impact on health care utilisation, hospitalisations, health care costs, depression detection, referral rates, prescribing adequacy and adherence
Diagnosis of participants included in primary studies	Depression
Results	<p>In comparison to TAU, disease management was significantly better at:</p> <ul style="list-style-type: none"> • Reducing symptoms of depression (effect size=0.33, 95% CI=0.16 to 0.49) • Improving patient satisfaction (effect size=0.51, 95% CI=0.33 to 0.68) • Increasing primary care visits (effect size=-0.1, 95% CI=-0.18 to -0.02) • Detecting depression, but only when programs contained an explicit screening component (effect size=0.18, 95% CI=-0.11 to 0.18) • Improving treatment adequacy (effect size=0.44, 95% CI= 0.30 to 0.59) • Improving patient adherence to treatment (effect size=0.36, 95% CI=0.17 to 0.54) <p>In comparison to TAU, disease management had no effect on:</p> <ul style="list-style-type: none"> • Physical functioning (effect size=-0.05, 95% CI=-0.72 to 0.62) • Social and health status (effect size=0.06, 95% CI=-0.51 to 0.62) • Hospitalisation rates (effect size=-0.2, 95% CI=-0.35 to 0.04) • Health care costs (effect size=-1.03, 95% CI=-2.62 to 0.54) • Outcomes affected by patient and provider adherence to treatment (effect size=0.57, 95% CI=-0.11 to 1.26)Referral to specialist care (effect size=0.13, 95% CI=-0.32 to 0.57)
Source of funding	TAP Pharmaceutical Products Inc.

Study ID	BOWER2006
Bibliographic reference	Bower, P., Gilbody, S., Richards, D., et al. (2006) Collaborative care for depression in primary care. Making sense of a complex intervention: systematic review and meta-regression. <i>British Journal of Psychiatry</i> , 189, 484-493.
Method used to synthesise evidence	Meta-analysis and regression
Design of included studies	RCTs
Evidence search	An update of a published systematic review (-2003) of organisational interventions in primary care mental health. Searches included Medline, EMBASE, CINAHL, PsycINFO, the Cochrane Library and the Database of Abstracts of Reviews f Effectiveness (DARE), and were run -2005.
No. of included studies	28 studies on collaborative care and 34 studies on anti-depressant use
Review quality	Adequate
Interventions	Collaborative care
Outcome	Anti-depressant use and symptom improvement
Diagnosis of participants included in primary studies	Depression or depressive symptoms
Results	<p>Collaborative care had a positive effect on depressive symptom outcomes (SMD= 0.24, 95% CI 0.17-0.32).</p> <p>No intervention content variables predicted anti-depressant use</p> <p>Intervention content variable predicting depressive symptom improvement</p> <ul style="list-style-type: none"> • Recruitment by systematic identification • Case managers with specific mental health backgroundsProvision of regular supervision for case managers
Source of funding	Department of Health

Study ID	BUTLER2007
Bibliographic reference	Butler, R., Hatcher, S., Price, J., et al. (2007) Depression in adults: psychological treatments and care pathways. <i>BMJ Clinical Evidence</i> . Retrieved 12/7/2010 from http://clinicalevidence.bmj.com/ceweb/conditions/meh/1016/1016-get.pdf

Method used to synthesise evidence	Narrative
Design of included studies	Systematic reviews and RCTs
Evidence search	Medline, Embase, PsychInfo, Cochrane, NHS centre of reviews and disseminations, NHS centre for database of abstracts of reviews of effects, Health technology appraisal, Turning research into practice, and NICE guidance were searched -2006.
No. of included studies	10 systematic reviews and 4 RCTs
Review quality	Adequate
Interventions	Care pathways using befriending, cognitive therapy, combining antidepressant drugs and psychological treatments, interpersonal psychotherapy, non-directive counselling, problem-solving therapy or relapse prevention programmes.
Outcome	Effectiveness and safety
Diagnosis of participants included in primary studies	Mild, moderate and severe depression
Results	<p>Compared with usual care:</p> <ul style="list-style-type: none"> • care pathways were more effective at improving symptoms and response rates • recurrence prevention programmes were equally effective at improving relapse rates at 6 months, regardless of specific treatment components • it is unclear what effect care pathways have in the very long term (2+ years) <p>However, much of the evidence was considered to be of low quality</p>
Source of funding	Not reported

Study ID	CALLAGHAN2003
Bibliographic reference	Callaghan, P., Eales, S., Coates, T., et al. (2003) A review of research on the structure, process and outcome of liaison mental health services. <i>Journal of Psychiatric and Mental Health Nursing</i> , 10, 155-165.

Method used to synthesise evidence	Narrative
Design of included studies	Reviews, descriptive studies and evaluative studies
Evidence search	Medline, Assia, Embase, National research register, PsychInfo, Database of abstracts of reviews, British Nursing Index, CINAHL, RCN library, Nursing collection, Cochrane and Best Evidence were searched -2001.
No. of included studies	48
Review quality	Adequate
Interventions	Liaison mental health services
Outcome	Symptom reduction, physician skill improvements, referral rates, acceptability and appointment compliance
Diagnosis of participants included in primary studies	Various mental health problems
Results	<p>Liaison mental health services were found to:</p> <ul style="list-style-type: none"> • Reduce levels of psychological morbidity, cardiac mortality and health care costs • Increase rates of referral for follow up appointments • Be acceptable to clients in terms of the information they received, and overall satisfaction • Have little effect on compliance with psychiatric appointments
Source of funding	Not reported

Study ID	CHANGQUAN2003
Bibliographic reference	Chang-Quan, H., Bi-Rong, D., Zhen-Chan, L., et al. (2009) Collaborative care interventions for depression in the elderly: a systematic review of randomised controlled trials. <i>Journal of Investigative Medicine</i> , 57, 446-455.

Method used to synthesise evidence	Meta-analysis
Design of included studies	RCTs
Evidence search	Medline, Embase and Cochrane were searched -2007
No. of included studies	3
Review quality	Adequate
Interventions	Collaborative care
Outcome	Depression symptoms, response rates, remission, suicidal ideation and treatment seeking
Diagnosis of participants included in primary studies	Depression, older people
Results	At 18 and 24 months, CCIs were superior to usual care in improving depression scores (OR, -0.44, 95% CI -0.55- -0.33 and OR, -0.35, 95% CI -0.46- -0.24 respectively), response rates (OR, 2.38, 95% CI 1.88-3.02 and OR, 1.67, 95% CI 1.63-2.12 respectively) and remission rates (OR, 2.29, 95% CI 1.42-3.10 and OR, 1.83, 95% CI 1.34-1.98 respectively).
Source of funding	Not reported

Study ID	CHRISTENSEN2008
Bibliographic reference	Christensen, H., Griffiths, K., Gulliver, A., et al. (2008) Models in the delivery of depression care: A systematic review of randomised and controlled intervention trials. <i>BMC Family Practice</i> , 9(25).

Method used to synthesise evidence	Statistical (based on counting number of significant findings in primary studies)
Design of included studies	RCT and controlled trials
Evidence search	PubMed, PsychINFO, Cochrane Library were searched (inception to October 2005)
No. of included studies	55 (51 RCTs, 4 controlled trials)
Review quality	Poor
Interventions	Training and feedback, care management, enhancements of extensions to general practice, self-help, teams external to the practice, community based mental health professionals, health maintenance organisation based interventions and broad community based interventions
Outcome	Significant improvement on the key depression measure
Diagnosis of participants included in primary studies	Depression
Results	<p>Treatment monitoring and delivery was best done by a professional with a mental health background ($\chi^2 [2, 22] = 7.558, p = .021$)</p> <p>General practitioner training and clinical practice guideline provision alone were not associated with improved outcomes</p> <p>There was no association between number of treatment components and outcome</p>
Source of funding	Australian Government Department of Health and Ageing; NHMRC

Study ID	CRAVEN2006
Bibliographic reference	Craven, M.A. & Bland, R. (2006) Better practices in collaborative mental health care: an analysis of the evidence base. <i>The Canadian Journal of Psychiatry</i> , 51(Suppl 1), 7S-72S.

Method used to synthesise evidence	Narrative
Design of included studies	Experimental methodology (RCTs and intervention studies with outcome measures)
Evidence search	Medline, Embase, CINAHL, PsychInfo, Eric, Social Science Abstracts, PubMed, Cochrane and Google, -2005
No. of included studies	38
Review quality	Adequate
Interventions	Collaborative care
Outcome	Improved patient response
Diagnosis of participants included in primary studies	Various
Results	<p>Degree of collaboration does not in itself appear to predict clinical outcome.</p> <p>Systematic follow strongly predicts clinical outcome.</p> <p>Enhanced patient education often improved patient outcomes</p> <p>Collaborative interventions took time to establish, and are hard to maintain outside of the study environment.</p> <p>Patient choice is an important factor in treatment engagement in collaborative care.</p>
Source of funding	Health Canada through the Primary Health Care Transitions Fund

Study ID	FOY2010
Bibliographic reference	Foy, R., Hempel, S., Rubenstein, L., et al. (2010) Meta-analysis: effect of interactive communication between collaborating primary care physicians and specialists. <i>Annals of Internal Medicine</i> , 152, 247-258.

Method used to synthesise evidence	Meta-analysis
Design of included studies	RCT
Evidence search	PubMed, PsycInfo, EMBASE, CINAHL, Cochrane Database of Systematic Reviews, Database of Abstracts of Reviews of Effects, and Web of Science -2008
No. of included studies	38
Review quality	Adequate
Interventions	Collaborative care
Outcome	Depression outcomes
Diagnosis of participants included in primary studies	Depression
Results	<p>GP and psychiatrist collaboration led to a significant improvement in depression outcomes (effect size -0.48 95% CI, -0.67 to -0.30).</p> <p>Interventions that improved the quality of information exchange had significantly better outcomes than those with no such focus on information exchange (effect size -0.84 95% CI, -1.14 to -0.55 and -0.27 95% CI, -0.49 to -0.05 respectively)</p> <p>Needs assessment and joint care planning had little effect on outcome</p>
Source of funding	RAND Health's Comprehensive Assessment of Reform Options Initiative, the Veterans Affairs Center for the Study of Provider Behavior, The Commonwealth Fund, and the Health Foundation

Study ID	FREDERICK2007
Bibliographic reference	Frederick, J. T., Steinman, L. E., Prohaska, T. <i>et al.</i> (2007) Community-based treatment of late life depression an expert panel-informed literature review. <i>Am J Prev Med</i> , 33(3), 222-49.

Method used to synthesise evidence	Narrative
Design of included studies	Various
Evidence search	A search of the published scientific literature was conducted through August 2005 using the MEDLINE database of the National Library of Medicine (from 1966), the Cumulative Index to Nursing and Allied Health database (CINAHL, from 1982) and the PsycINFO database of the American Psychological Association (from 1967).
No. of included studies	121
Review quality	Adequate
Interventions	Community-based interventions for depression in older adults
Outcome	Depression outcomes
Diagnosis of participants included in primary studies	Depression in older adults
Results	Depression care management, home or primary care clinics and individual CBT can be strongly recommended.
Source of funding	Dutch Scientific Organization

Study ID	GENSICHEN2005
Bibliographic reference	Gensichen, J., Beyer, M., Muth, C., et al. (2005) Case management to improve major depression in primary health care: a systematic review. <i>Psychological Medicine</i> , 36, 7-14.
Method used to synthesise evidence	Meta-analysis
Design of included studies	RCT
Evidence search	MEDLINE (1966–5.2003), EMBASE (1980–5.2003) and the Cochrane Library (2003, 2nd edition)
No. of included studies	13
Review quality	Adequate
Interventions	Case management

Outcome	Symptom reduction, relative risk reduction, treatment response rate and medication adherence
Diagnosis of participants included in primary studies	Depression
Results	Case management was associated with a significant reduction in depression severity and the relative risk of long lasting depression, and an increase in response rate and medication adherence at 6-12 months in comparison to usual care Simple and complex case management did not differ from each other.
Source of funding	German Ministry for Education and Research (BMBF)

Study ID	GILBODY2003
Bibliographic reference	Gilbody, S., Whitty, P., Grimshaw, J., et al. (2003) Educational and organizational interventions to improve the management of depression in primary care. A systematic review. <i>Journal of the American Medical Association</i> , 289(23), 3145-3152.
Method used to synthesise evidence	Narrative
Design of included studies	RCT, controlled before-and-after design, interrupted timeseries analysis
Evidence search	MEDLINE, PsycLIT, EMBASE, CINAHL, Cochrane Controlled Trials Register, United Kingdom National Health Service Economic Evaluations Database, Cochrane Depression Anxiety and Neurosis Group register, and Cochrane Effective Professional and Organisational Change Group specialist register searched (inception to 2003)
No. of included studies	36 (RCT (29), controlled before-and-after studies (5), interrupted time series analyses (2))
Review quality	Adequate
Interventions	Educational and organisational interventions to improve depression management in primary care
Outcome	Improved patient outcome
Diagnosis of participants included in primary studies	Depression
Results	Effective strategies included collaborative care, stepped collaborative care, quality improvement, case management, pharmacist provided prescribing information and patient educations (medication outcomes only) and guideline implementation strategies when embedded in complex interventions Ineffective strategies included guidelines and educational strategies when not accompanied by organisational support, chronic care clinics for and computer-based decision support systems.

Source of funding	United Kingdom Medical Research Council and Wellcome Health Services Research Fellowship programs, the United Kingdom National Health Service Centre for Reviews and Dissemination, and the United Kingdom Health Technology Assessment Programme (project 94/08/29).
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Study ID	GILBODY2006
Bibliographic reference	Gilbody, S., Bower, P., Fletcher, J., <i>et al.</i> (2006) Collaborative care for depression. A cumulative meta-analysis and review of longer-term outcomes. <i>Archives of General Psychiatry</i> , 166, 2314-2321.
Method used to synthesise evidence	Meta-analysis
Design of included studies	RCT
Evidence search	MEDLINE, EMBASE, CINAHL, PsycINFO, the Cochrane Library, and DARE from inception -2006
No. of included studies	37
Review quality	Adequate
Interventions	Collaborative care
Outcome	Symptom outcomes (6 months and longer term)
Diagnosis of participants included in primary studies	Depression
Results	<p>Collaborative care had a positive effect on depression outcomes at 6 months compared with standard care (SMD, 0.25, 95% CI, 0.18-0.32), which were maintained at 12 months (SMD, 0.31; 95% CI, 0.01 to 0.53), 18 months (SMD, 0.25; 95% CI, 0.03 to 0.46), and 5 years (SMD, 0.15; 95% CI, 0.001 to 0.30)</p> <p>Regular supervision and the mental health background of case managers, were significantly related to study effect size (β 0.15; 95% CI, -0.02-0.31 and β 0.18; 95% CI, 0.04-0.32 respectively)</p> <p>The addition of psychotherapy to medication management in collaborative care was not associated with any significantly increased effect size (β 0.10, 95% CI, -0.05-0.25)</p>

	The number of case management session had no impact on effect size (β , 0.02; 95% CI, -0.008-0.04)
Source of funding	None reported

Study ID	GRIFFITHS2008
Bibliographic reference	Griffiths, K.M., & Christensen, H. (2008) Depression in primary health care: from evidence to policy. <i>Medical Journal of Australia</i> , 188, S81-S83.
Method used to synthesise evidence	Narrative
Design of included studies	Systematic reviews
Evidence search	Discussion of a series of 6 systematic reviews
No. of included studies	6
Review quality	Poor
Interventions	Depression management
Outcome	Depression outcomes
Diagnosis of participants included in primary studies	Depression
Results	<p>The following were associated with improvement depression outcomes relative to treatment-as-usual or control condition</p> <ul style="list-style-type: none"> • Care management • Enhanced/extended care • Guided self-help in general practice • Systematic tracking by a non-doctor • Revision of professional roles • Incorporation of patient preferences into care <p>The following were associated with no improvement in depression outcomes relative to treatment-as-usual or control condition</p> <ul style="list-style-type: none"> • General practitioner training and feedback

	<ul style="list-style-type: none"> • Pharmacist interventions • Community context <p>Telephone interventions, internet support groups and passive education did not have enough evidence to evaluate their effectiveness.</p>
Source of funding	Australian Primary Health Care Research Institute; Australian Government Department of Health and Ageing; National Health and Medical Research Council; NHMRC

Study ID	GUNN2006
Bibliographic reference	Gunn, J., Diggins, J., Hegarty, K., et al. (2006) A systematic review of complex system interventions designed to increase recovery from depression in primary care. <i>BMC Health Services Research</i> , 6(88).
Method used to synthesise evidence	Narrative
Design of included studies	Randomised controlled trials and cluster RCTs
Evidence search	MedLine, PubMed and Cochrane were searched -2004
No. of included studies	11 (5 cluster randomised controlled trials and 6 RCTs)
Review quality	Adequate
Interventions	System level interventions to improve recovery
Outcome	Recovery rates
Diagnosis of participants included in primary studies	Depression
Results	Studies generally favoured the multi-professional intervention groups in comparison to the control groups at varying follow up points for depression outcomes.
Source of funding	Not reported

Study ID	HEIDEMAN2005
Bibliographic reference	Heideman, J., van Rijswijk, E., van Lin, N, et al. (2005) Interventions to improve management of anxiety disorders in general practice. <i>British Journal of General Practice</i> , 55, 867-873.
Method used to synthesise evidence	Meta-analysis
Design of included studies	RCT and controlled before-and-after design
Evidence search	Medline, PsychInfo, Embase and Cochrane searched -2003
No. of included studies	7 (6 RCTs and 1 controlled before-and-after study)
Review quality	Adequate
Interventions	Audit and feedback, brief education and educational outreach
Outcome	Symptom improvement, rates of recognition, correct diagnoses, levels of recovery and appropriate prescriptions.
Diagnosis of participants included in primary studies	Anxiety
Results	<p>Audit and feedback had no effect on the majority of anxiety outcomes, but did lead to significantly higher rates of recognition (RR 1.71, 95% CI 1.27-2.29), treatment, chart notation (RR 1.66, 95% CI 1.23-2.30) and referral in comparison to the control group (RR 2.94, 95% CI 1.33-6.51).</p> <p>Brief education intervention led to significantly higher rates of correct agoraphobia, panic, GAD and adjustment disorder diagnoses than the control group (RR 1.32, 95% CI 1.24-1.42, RR 1.14, 95% CI 1.07-1.21, RR 1.53, 95% CI 1.38-1.69 and RR 1.12, 95% CI 1.04-1.21 respectively)</p> <p>Nurse substitution intervention led to significantly greater improvements in symptoms than the control group</p> <p>Collaborative care led to significantly greater levels of recovery (RR 2.29, 95% CI 1.29-4.06) and more anxiety free days per patient than the control group.</p>
Source of funding	Dutch National Association of General Practitioners (LHV); Dutch College of General Practitioners (NHG)

Study ID	NEUMEYERGROMEN2004
Bibliographic reference	Neumeyer-Gromen, A., Lampert, T., Stark, K., et al. (2004) Disease management programs for depression: a systematic review and meta-analysis of randomized controlled trials. <i>Medical Care</i> , 42(12), 1211-1221.
Method used to synthesise evidence	Meta-analysis
Design of included studies	RCTs
Evidence search	Medline, Psyclit, Psyn dex, Embase, Cochrane, BMJ, Clinical trials, NHS EED, CINAHL and HTA databases were searched - 2002
No. of included studies	10
Review quality	Adequate
Interventions	Disease management programs
Outcome	Depression severity, quality of life, employment status, patient satisfaction, adherence and cost
Diagnosis of participants included in primary studies	Depressive disorders
Results	In comparison to usual care disease management programs significantly improved Health Related Quality of Life Scales at 12 and 24 months (WMD 11.83, 95% CI 7.38-16.28 and WMD 24.42, 95% CI 17.92-30.92 respectively), significantly higher rates of patient satisfaction (RR 0.57, 95% CI 0.37- 0.87; $p= 0.009$) and significantly reduced depression severity in comparison to usual care (RR 0.75, 95% CI 0.70-0.81), although 2 year follow ups showed inconsistent results,.
Source of funding	Not reported

Study ID	SMOLDERS2008
Bibliographic reference	Smolders, M., Laurant, M., Roberge, P., et al. (2008) Knowledge transfer and improvement of primary and ambulatory care for patients with anxiety. <i>Canadian Journal of Psychiatry</i> , 53(5), 277-293.
Method used to synthesise evidence	Meta-analysis
Design of included studies	RCTs and controlled before-and-after studies
Evidence search	Medline, PsychInfo, CINAHL, Embase and Cochrane were searched -2003, and then again -2006
No. of included studies	24 (23 RCTs and one controlled before-and-after study)
Review quality	Adequate
Interventions	Audit and feedback, education and educational outreach
Outcome	Prescription rates, referrals, physician knowledge, anxiety symptom improvement, satisfaction and cost-effectiveness
Diagnosis of participants included in primary studies	Anxiety
Results	<p>Intensive programs that incorporated education and shared care were associated with increased anxiety free days and better employment status.</p> <p>Education and audit and feedback strategies alone were not successful at increasing anxiety outcomes. Brief education was successful at influencing treatment recommendations for panic disorder only and CBT training sessions increased the use of CBT techniques. Studies that used guideline concordant treatment and medication adherence strategies were associated with short-term effects only.</p> <p>Collaborative care improved receipt of adequate medication and medication adherence over 6 months, but not 12 months.</p> <p>Interventions had a high probability of being cost effective</p>
Source of funding	Geestkracht program of the Dutch Scientific Organization (ZON-MW, grant number 10-000-1002) and matching funds from participating universities and mental healthcare organizations.

Study ID	VANHERCK2004
Bibliographic reference	Van Herck, P., Vanhaecht, K., & Sermeus, W. (2004) Effects of clinical pathways: do they work? <i>Journal of Intergrated Pathways</i> , 8(3), 95.
Method used to synthesise evidence	Narrative
Design of included studies	Experimental (18), quasi-experimental (90), observational (35), SRs (9), subjective opinion (20), unclear (33)
Evidence search	Medline, 2000-2002
No. of included studies	200 (one third evaluated the effects of implementing a clinical pathway)
Review quality	Poor (only Medline was searched between 2000-2002, and study quality was not evaluated, although authors acknowledge that it was generally poor).
Interventions	Care pathways (not mental health specific)
Outcome	Clinical outcome, team, process and financial effects
Diagnosis of participants included in primary studies	Various medical and psychiatric conditions
Results	<p>Most studies agreed that pathways had positive effects, and all domains were associated with positive effects more than they were with negative effects.</p> <p>Pathways had stronger positive influence on process, team and financial effects than clinical outcome and service effects.</p> <p>Negative effects were consistently low.</p>
Source of funding	Not reported

1.4.2 Excluded studies

Study	Reason for exclusion
Duncan E, Best C, Hagen S. Shared decision making interventions for people with mental health conditions. <i>Cochrane Database of Systematic Reviews</i> 2010, Issue 1. Art. No.: CD007297. DOI: 10.1002/14651858.CD007297.pub2.	Only one study useable
Ehrlich, C., Kendall, E., Muenchberger, H., <i>et al.</i> (2009) Coordinated care: what does that really mean? <i>Health & Social Care in the Community</i> , 17(6), 619–627,.	Not evaluative
McAdam, M. & Wright, N. (2005) A review of the literature considering the role of mental health nurses in assertive outreach. <i>Journal of Psychiatric and Mental Health Nursing</i> , 12, 648-660.	Serious mental illness, not relevant
Moffat, J., Sass, B., McKenzie, K., <i>et al.</i> (2009) Improving pathways into mental health care for black and ethnic minority groups: a systematic review of the grey literature. <i>International Review of Psychiatry</i> , 21(5), 439-449.	No useable outcomes
Thornicroft, G. & Tansella, M. (2004) Components of a modern mental health service: a pragmatic balance of community and hospital care. <i>British Journal of Psychiatry</i> , 185, 283-290.	Not relevant