National Institute for Health and Care Excellence

FINAL

Depression in adults

[H] Access to services

NICE guideline NG222

Evidence review underpinning recommendations 1.16.1 to 1.16.5 and research recommendations in the NICE guideline June 2022

Final



May 2024: We have simplified the guideline by removing recommendations on general principles of care that are covered in other NICE guidelines (for example, the NICE guideline on service user experience in adult mental health).

This is a presentational change only, and no changes to practice are intended.

Disclaimer

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Local commissioners and/or providers have a responsibility to enable the guideline to be applied when individual health professionals and their patients or service users wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.

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ISBN: 978-1-4731-4622-8

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Access

Review question

For adults (18 years and older) at risk of depression (or anxiety disorders) from particular vulnerable groups (older people, BME groups, LGBT groups and men) do service developments and interventions which are specifically designed to promote access, increase the proportion of people from the target group who access treatment, when compared with standard care?

Introduction

Improving access to health and social care should enable people with depression to obtain the help, treatment and support they need in order to preserve and improve their health and wellbeing. Poor access to services may be a greater problem for some groups than others, and equity of access is a particular concern for black minority ethnic (BME) groups, older people, and men, with these groups known to access help less frequently. Lesbian, gay, bisexual and transgender (LGBT) groups may also be more socially excluded and less likely to access support or treatment.

The aim of this review is to determine if service developments which are specifically designed to promote access for these groups, increase access to, and the uptake of, treatments.

Summary of the protocol

See Table 1 for a summary of the Population, Intervention, Comparison and Outcome (PICO) characteristics of this review.

Population	 Adults (18 years and older) identified as at risk of depression (or anxiety disorders*) from the following vulnerable groups: Older adults (mean age of 60 years or older) BME groups LGBT groups Men *due to limited depression-specific evidence, a broader evidence base (including anxiety disorders) was used. An update of the review conducted for the Common Mental Health Disorders NICE guideline was undertaken.
Intervention	 Service developments or changes which are specifically designed to promote access. Specific models of service delivery (that is, community-based outreach clinics, clinics or services in non-health settings). Methods designed to remove barriers to access (including stigma, misinformation or cultural beliefs about the nature of mental disorder)
Comparison	Standard care
Outcomes	 Critical: Proportion of people from the target group who access treatment Uptake of treatment Important: Satisfaction, preference

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Table 1: Summary of the protocol (PICO table)

Anxiety about treatment

BME: black minority ethnic; LGBT: lesbian, gay, bisexual, transgender

For further details see the review protocol in appendix A.

Methods and process

This evidence review was developed using the methods and process described in <u>Developing NICE guidelines: the manual</u>. Methods specific to this review question are described in the review protocol in appendix A.

Declarations of interest were recorded according to NICE's 2014 conflicts of interest policy until 31 March 2018. From 1 April 2018, declarations of interest were recorded according to NICE's 2018 <u>conflicts of interest policy</u>. Those interests declared until April 2018 were reclassified according to NICE's 2018 conflicts of interest policy (see Register of Interests).

Clinical evidence

Included studies

Eighteen randomised controlled trials (RCTs) are included in this review.

Seven RCTs include interventions to promote access for older adults, with 3 comparisons:

- Tele-problem solving therapy versus in-person problem solving therapy (Choi 2014)
- Co-located services versus geographically separate service (Bartels 2004)
- Collaborative care versus standard care/enhanced standard care (Callahan 1994; Chen 2015; Ciechanowski 2004; Gilbody 2017; Unutzer 2002).

Six RCTs include interventions to promote access for BME groups, with 6 comparisons:

- Culturally sensitive telepsychiatry versus treatment as usual (Chong 2012)
- Culturally-adapted CBT versus treatment as usual (Naeem 2015)
- Culturally adapted motivational enhancement therapy for antidepressants versus usual care (Interian 2013)
- Telephone CBT versus enhanced usual care (Dwight-Johnson 2011)
- Collaborative care versus enhanced standard care (Lagomasino 2017)
- Culturally sensitive collaborative care versus standard collaborative care (Cooper 2013).

No evidence was identified for interventions to promote access for LGBT groups.

Five RCTs included interventions to promote access for men, with 2 comparisons:

- Remote treatment versus face-to-face treatment (Luxton 2016; Yuen 2015)
- Collaborative care versus standard care/enhanced standard care (Dobscha 2006; Fortney 2007; Hedrick 2003).

The included studies are summarised in Table 2 to Table 12.

See the literature search strategy in appendix B and study selection flow chart in appendix C.

Excluded studies

Studies not included in this review with reasons for their exclusions are provided in appendix K.

Summary of clinical studies included in the evidence review

Summaries of the studies that were included in this review are presented in Table 2 to Table 12.

Table 2: Summary of included studies for Comparison 1: Tele-problem solving
therapy versus in-person problem solving therapy for older adults

therapy versus in-person problem solving therapy for order addits					
Study	Population	Intervention	Comparison	Comments	
Choi 2014	N=85	Problem solving therapy delivered	Problem solving therapy delivered	Length of follow- up (in weeks): 12	
RCT	Targeted group: Older adults	by telephone	face-to-face (in participants' home)	Outcomes:	
US	(inclusion criteria 50+ homebound)	Intensity: 6x 1- hour sessions	nome)	• Satisfaction (scores obtained in a	
	Disorder: Depression (HAMD score ≥15)			treatment acceptance tool)	
	Mean age (years): 65.2				
	Sex (% female): 22				
	Ethnicity (% BME): 59				

BME: black minority ethnic; HAMD: Hamilton depression rating scale; RCT: randomised controlled trial

Table 3: Summary of included studies for Comparison 2: Co-located services versus geographically separate services for older adults

Study		Population	Intervention	Comparison	Comments
Bartels 20		N=1309 (depression	Integrated care model (mental	Enhanced referral model (referral in	Length of follow- up (in weeks): 26
RCT	:	subgroup)	health [& substance abuse]	2-4 weeks; treatment in	Outcomes:
US		Targeted group: Older adults (inclusion criteria ≥65 years) Disorder: Depression (primary mental health diagnosis) Mean age (years): NR (≥65) Sex (% female): 74 Ethnicity (%	services co- located in primary care setting) Intensity: Variable	separate location)	 Accessing treatment (number of participants who attended an appointment with a mental health provider following randomization at the index primary care visit) Uptake of treatment (number of treatment visits)
		BME): 48			

BME: black minority ethnic; NR: not reported; RCT: randomised controlled trial

	care/enhanced s			
Study	Population	Intervention	Comparison	Comments
Callahan 1994	N=175	Simple collaborative care	Standard care	Length of follow- up (in weeks): 13
RCT US	Targeted group: Older adults (inclusion criteria ≥60 years)	Specialist advice (3 additional GP visits, with instructions on	TAU (no additional visits or feedback on depression scores, referral	Outcomes: • Accessing treatment (number of
	Disorder: Depression (above clinical threshold on CES-D and HAMD)	referral and suggested clinical actions including suggestions about providing basic psychoeducation to the patient in	pathways etc)	 patients using antidepressants Accessing treatment (number of patients for whom a
	Mean age (years): 65.1 Sex (% female):	the intervention letter from the study team)		psychiatric consultation was sought)
	76 Ethnicity (%	Intensity: 3 sessions within 3 months		
	BME): 51			
Chen 2015	N=326	Simple collaborative care	Enhanced standard care	Length of follow- up (in weeks): 52
RCT	Targeted group: Older adults (inclusion criteria	Collaborative- care depression		Outcomes: • Accessing
Crimita	≥60 years) Disorder: Depression (DSM-IV major depressive episode)	care management (included: training for physicians in use of treatment guidelines; medication algorithm; training for primary care		treatment (number of patients for whom a psychiatric consultation was sought)
	Mean age (years): NR (median 70)	nurses to function as care managers; consultation with		
	Sex (% female): 37	psychiatrists as support)		
	Ethnicity (% BME): NR	Intensity: 16 weekly sessions		
Ciechanowski 2004	N=138	Simple collaborative care	Standard care	Length of follow- up (in weeks): 26
RCT	Targeted group: Older adults (inclusion criteria	Program to Encourage		Outcomes: • Uptake of
US	≥60 years) Disorder:	Active, Rewarding Lives for Seniors		treatment (number of participants
	Depression	(PEARLS).		starting

Table 4: Summary of included studies for Comparison 3: Collaborative care versus standard care/enhanced standard care for older adults

Study	Population	Intervention	Comparison	Comments
	(DSM-IV minor depression or dysthymia) Mean age (years): 73 Sex (% female): 79 Ethnicity (% BME): 42	Intervention included problem- solving treatment, social and physical activation, and potential recommendations to patients' physicians regarding antidepressant medications. All intervention cases were reviewed weekly or biweekly by the study psychiatrist during depression management team sessions.		antidepressant treatment)
Gilbody 2017 RCT UK	N=705 Targeted group: Older adults (inclusion criteria ≥65 years) Disorder: Depression (DSM-IV subthreshold depression) Mean age (years): 77.3 Sex (% female): 42 Ethnicity (% BME): 1	Simple collaborative care Collaborative care Positive Elders (care consisted of telephone support and session-by- session symptom monitoring to track treatment response; offer of BA; encouragement to continue medication [for participants already prescribed antidepressants]; primary care physicians encouraged to initiate medication only in response to increasing	Standard care	Length of follow- up (in weeks): 8 Outcomes: • Accessing treatment (number of patients using antidepressants)

Study	Dopulation	Intervention	Comparison	Commonto
Study	Population	Intervention depressive symptoms) Intensity: 8 weekly sessions (first session delivered face-to- face and subsequent sessions delivered via telephone)	Comparison	Comments
Unutzer 2002 RCT US	N=1901 Targeted group: Older adults (inclusion criteria ≥60 years) Disorder: Depression (DSM-IV major depression or dysthymia) Mean age (years): 71.2 Sex (% female): 35 Ethnicity (% BME): 23	Complex collaborative care Improving Mood- Promoting Access to Collaborative Treatment (IMPACT) collaborative case management program (included: access to a depression care manager who was supervised by a psychiatrist and a primary care expert and who offered education, care management, and support of antidepressant management by the patient's primary care physician or PST- PC; individualized treatment plan including algorithm).	Standard care	Length of follow- up (in weeks): 52 Outcomes: • Accessing treatment (number of patients using antidepressants) • Satisfaction (number of patients rating depression care as 'excellent/very good')
BA: behavioural activati	on [.] BMF [.] black minorit	v ethnic: CES-D: center	r for enidemiologic stud	lies depression [.]

BA: behavioural activation; BME: black minority ethnic; CES-D: center for epidemiologic studies depression; DSM: diagnostic statistical manual; HAMD: Hamilton depression rating scale; NR: not reported; PST-PC: problem solving treatment in primary care; RCT: randomised controlled trial; TAU: treatment as usual

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Study	Population	Intervention	Comparison	Comments
Chong 2012 RCT	N=197 Targeted group:	Culturally sensitive telepsychiatry	TAU (care received from usual providers)	Length of follow- up (in weeks): 26
NOT	BME (Hispanic)		, ,	Outcomes:
US	Disorder: Depression (inclusion criteria: PHQ-9≥10 & MINI diagnosis of MDD; Baseline mean PHQ-9 = 17.8) Mean age (years): 43 Sex (% female): 11 Ethnicity (% BME): 100	Clinic-based telepsychiatry using an online virtual meeting programme (addressed following factors to target access: language and cultural concerns [Hispanic psychiatrists provided intervention]; cost [patients were not asked to pay for any MH services provided in the clinic]) Intensity: Monthly sessions for 6 months (4 hours [1 hour for intake + 6 x 30-min follow-ups])		 Accessing treatment (number of patients who made a mental health appointment) Accessing treatment (number of patients who made a primary care appointment) Accessing treatment (number of patients who used antidepressants) Uptake of treatment (mean number of completed mental health appointments) Uptake of treatment (mean number of completed mental health appointments) Uptake of treatment (mean number of completed primary care appointments) Satisfaction (Visit Specific Satisfaction Questionnaire [VSQ-9])

Table 5: Summary of included studies for Comparison 4: Culturally sensitive telepsychiatry versus treatment as usual for a BME population

BME: black minority ethnic; MDD: major depressive disorder; MH: mental health; MINI: mini-international neuropsychiatric interview; NR: not reported; PHQ-9: patient health questionnaire-9 item; RCT: randomised controlled trial; TAU: treatment as usual

Table 6: Summary of included studies for Comparison 5: Culturally-adapted CBT versus treatment as usual for a BME population

Study	Population	Intervention	Comparison	Comments
Naeem 2015	N=137	Culturally- adapted CBT	TAU (typically medication and	Length of follow- up (in weeks): 13
RCT	Targeted group:		hospital visits)	
	BME (Pakistani)	Cultural		Outcomes:
Pakistan		adaptations included family		 Satisfaction (number of

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Study	Population	Intervention	Comparison	Comments
	Disorder: Depression (ICD- 10 F32 or F33) Mean age (years): 31.7 Sex (% female): 40 Ethnicity (% BME): 100	member involvement, initial focus on physical symptoms, Urdu translations of jargon, culturally appropriate homework assignments, use of folk stories and examples relevant to local religious beliefs.		participants 'very satisfied' with treatment)
		Intensity: 6 individual sessions + 2 family session		

BME: black minority ethnic; ICD: international classification of diseases; NR: not reported; RCT: randomised controlled trial; TAU: treatment as usual

Table 7: Summary of included studies for Comparison 6: Culturally adaptedmotivational enhancement therapy for antidepressants versus usual care for
a BME population

Study	Population	Intervention	Comparison	Comments
Interian 2013	N=50	Culturally adapted	Usual care (delivered in	Length of follow- up (in weeks): 22
RCT	Targeted group: BME (Latino)	motivational enhancement therapy for	community mental health centre, this	Outcomes:
US	Disorder: Depression (DSM-IV depression or dysthymia) Mean age (years): 40.6 Sex (% female): 24 Ethnicity (% BME): 94	antidepressants (META) Focus groups explored Latino antidepressant adherence issues and reasons for nonadherence, and META adapted to account for identified cultural values.	approach included psychotherapy and pharmacotherapy in a naturalistic framework)	 Uptake of treatment (antidepressant adherence score on medication event monitoring system [MEMS])
		hour sessions		

BME: black minority ethnic; DSM: diagnostic statistical manual; NR: not reported; RCT: randomised controlled trial

Table 8: Summary of included studies for Comparison 7: Telephone CBT versus enhanced usual care for a BME population (living in rural areas)

Study	Population	Intervention	Comparison	Comments
Dwight-Johnson 2011	N=101	Telephone CBT	Enhanced usual care (any typically available	Length of follow- up (in weeks): 26

Study	Population	Intervention	Comparison	Comments
Study RCT US	Population Targeted group: BME (Latino patients living in rural areas) Disorder: Depression (PHQ-9 score ≥ 10) Mean age (years): 39.8 Sex (% female): 22 Ethnicity (%	Intervention CBT, translated into the Spanish language and checked for relevance to the local Latino context and culture. Intensity: 8x 45- 50min sessions	Comparison care for depression, patients were encouraged to talk with their primary care provider about depression)	Comments Outcomes: • Satisfaction (number reporting they were satisfied with the treatment provided)
	BME): 100			

BME: black minority ethnic; NR: not reported; PHQ-9: patient health questionnaire – 9 item; RCT: randomised controlled trial

Table 9: Summary of included studies for Comparison 8: Collaborative care versus enhanced standard care for BME population

Study	Population	Intervention	Comparison	Comments
Lagomasino 2017 RCT US	Population N=400 Targeted group: BME (Latino) Disorder: Depression (PHQ-9 score ≥ 10) Mean age (years): 49.6 Sex (% female): 17 Ethnicity (% BME): 97	InterventionTailored collaborative care interventionIncludes: bilingual case managers; culturally-adapted CBT, available in Spanish, and 	Comparison Enhanced usual care (patients received information about depression and primary care provider informed of diagnosis)	Comments Length of follow- up (in weeks): 16 Outcomes: • Accessing treatment (number of patients receiving antidepressants) • Accessing treatment (number of patients receiving minimally adequate treatment [counselling or medications]) • Satisfaction (number of patients satisfied or very satisfied with emotional health care)
RME: black minority eth	nia: ND: not reported: I	240 0: notiont boolth a	unationnaire Oitami	,

BME: black minority ethnic; NR: not reported; PHQ-9: patient health questionnaire – 9 item; RCT: randomised controlled trial

conaborative care versus standard conaborative care for BME population				
Study	Population	Intervention	Comparison	Comments
Cooper 2013	N=132	Culturally sensitive	Standard collaborative care	Length of follow- up (in weeks): 52
RCT	Targeted group: BME (African	collaborative care	intervention for patients (disease	Outcomes:
US	American) Disorder: Depression (DSM-IV MDD) Mean age (years): 46.5 Sex (% female): 21 Ethnicity (% BME): 100	Patient-centred and culturally tailored collaborative care intervention for patients (care management focused on access barriers, social context, and patient– provider relationships) and clinicians (participatory communication skills training and mental health consultation)	management) and clinicians (review of guidelines and mental health consultation) Intensity: Variable	 Accessing treatment (number of patients taking any antidepressant) Accessing treatment (number of patients receiving any counselling) Accessing treatment (number of patients receiving guideline-
		Intensity: Variable		concordant depression treatment)

Table 10: Summary of included studies for Comparison 9: Culturally sensitive collaborative care versus standard collaborative care for BME population

BME: black minority ethnic; DSM: diagnostic statistical manual; MDD: major depressive disorder; NR: not reported; RCT: randomised controlled trial

Table 11: Summary of included studies for Comparison 10: Remote treatment versus face-to-face treatment for a predominantly male population

		Intervention		Commonto
Study	Population	Intervention	Comparison	Comments
Luxton 2016	N=121	Behavioural activation in- home via	Behavioural activation in-	Length of follow- up (in weeks): 8
RCT	Targeted group: Men (veterans)	videoconferencin g	person	Outcomes:
US	Disorder: Depression (DSM-IV minor or major depressive disorder) Mean age (years): NR Sex (% female): 82 Ethnicity (%	Intensity: 8x 50- 60-min weekly sessions	Intensity: 8x 50- 60-min weekly sessions	 Satisfaction (Client Satisfaction Questionnaire [CSQ])
	BME): 30			
Yuen 2015 RCT	N=52	Prolonged exposure through home-based telehealth	Prolonged exposure through standard in-	Length of follow- up (in weeks): 12

Study	Population	Intervention	Comparison	Comments
US	Targeted group: Men (veterans)	Intensity: 8-12 sessions	person office- based care	Outcomes: • Satisfaction (number of
	Disorder: PTSD & depression symptoms (inclusion criteria DSM-IV-TR PTSD; 42% comorbid depression diagnosis, and mean depression symptoms above clinical cut-off) Mean age (years): 44.0 Sex (% female): 98 Ethnicity (% BME): 46		Intensity: 8-12 sessions	patients satisfied/very satisfied with treatment)

BME: black minority ethnic; DSM: diagnostic statistical manual; NR: not reported; PTSD: post-traumatic stress disorder; RCT: randomised controlled trial

Table 12: Summary of included studies for Comparison 11: Collaborative care versus standard care/enhanced standard care for a predominantly male population

Study	Population	Intervention	Comparison	Comments
Dobscha 2006	N=375	Collaborative care	Standard care	Length of follow- up (in weeks): 52
RCT US	Targeted group: Men (veterans) Disorder: Depression (inclusion criteria: PHQ-9 = 10-25 or SCL-20 score≥1.0; baseline mean PHQ-9 = 13.8; 49% MDD diagnosis criteria and 47% dysthymia) Mean age (years): 56.8 Sex (% female): 93 Ethnicity (% BME): 3	Depression decision support team (1 psychiatrist + 1 nurse care manager) provided 1 early patient educational contact and depression monitoring with feedback to clinicians (includes the following add-ons to usual care: care manager makes telephone call to patient and patient encouraged to attend depression education class;		Outcomes: • Accessing treatment (number who attended ≥1 appointment with mental health specialist) • Accessing treatment (number of participants using antidepressants)

Study	Population	Intervention	Comparison	Comments
		review of patient progress by depression decision support team; feedback or suggestions to primary care clinician or nurse; psychiatrist consultation actively offered or suggested; facilitated referral to other mental health services when indicated) Intensity: Monitoring with feedback to clinicians over 12 months (1 psychiatrist assigned up to 4 hours/week and 1 nurse care manager		
		assigned up to 8 hours/week)		
Fortney 2007	N=395	Collaborative care	Enhanced standard care	Length of follow- up (in weeks): 52
RCT US	Targeted group: Men (veterans) Disorder: Depression (PHQ 9 score ≥ 12) Mean age (years): 59.2 Sex (% female): 92 Ethnicity (% BME): 25	Telemedicine Enhanced Antidepressant Management (TEAM), a telemedicine- based collaborative care model adapted for small clinics without onsite psychiatrists. Included a stepped-care model of depression treatment. Intensity: 14 sessions (follow- up encounters to monitor symptoms, medication adherence, and side effects were scheduled every		Outcomes: • Accessing treatment (number of participants using antidepressants) • Satisfaction (number of patients satisfied with care)

Study	Population	Intervention	Comparison	Comments
		2 weeks during acute treatment and every 4 weeks during watchful waiting or continuation treatment)	Companion	
Hedrick 2003 RCT US	N=354 Targeted group: Men (veterans) Disorder: Depression (DSM-IV current MDD episode, dysthymia or both) Mean age (years): 57.2 Sex (% female): 95 Ethnicity (% BME): 20	Collaborative care Mental health team: provided a treatment plan to the primary care provider; telephoned patients to support adherence to the plan; reviewed treatment results; suggested modifications to the provider. Intensity: 3-month study period (collaborative care team met weekly to develop treatment plans and to conduct a 6- and 12-week progress evaluation for each patient; patients were discussed in the team meeting on an average of 3 occasions)	Consultant-liaison care (study clinicians informed the primary care provider of the diagnosis and facilitated referrals to psychiatry residents practicing in the primary care clinic)	Length of follow- up (in weeks): 13 Outcomes: • Accessing treatment (number who attended ≥1 appointment with mental health specialist) • Accessing treatment (number who have had a depression- related primary care visit) • Accessing treatment (number of participants using antidepressants)

BME: black minority ethnic; DSM: diagnostic statistical manual; MDD: major depressive disorder; NR: not reported; PHQ-9: patient health questionnaire – 9 item; RCT: randomised controlled trial; SCL-20: symptom checklist depression scale

See the full evidence tables in appendix D and the forest plots in appendix E.

Quality assessment of clinical outcomes included in the evidence review

See the clinical evidence profiles in appendix F.

Economic evidence

Included studies

A single economic search was undertaken for all topics included in the scope of this guideline but no economic studies were identified which were applicable to this review question. See the literature search strategy in appendix B and economic study selection flow chart in appendix G.

Excluded studies

A list of excluded economic and utility studies, with reasons for exclusion, is provided in supplement 3 - Health economic included & excluded studies

Economic model

No economic modelling was undertaken for this review because the committee agreed that other topics were higher priorities for economic evaluation.

Evidence statements

Clinical evidence statements

Interventions to promote access for older adults

Comparison 1. Tele-problem solving therapy versus in-person problem solving therapy for older adults

Important outcomes

Satisfaction

• Low quality evidence from 1 RCT (N=85) shows a clinically important and statistically significant benefit of tele-problem solving therapy, relative to in-person problem solving, on treatment acceptance scores for older adults with depression.

Comparison 2. Co-located services versus geographically separate services for older adults

Critical outcomes

Proportion of people from the target group who access treatment

 Moderate quality evidence from 1 RCT (N=1297) shows a clinically important and statistically significant benefit of co-located services, relative to geographically separate services, on the number of people who attended an appointment with a mental health provider for older adults with depression.

Uptake of treatment

• Moderate quality evidence from 1 RCT (N=1390) shows a statistically significant but not clinically important benefit of co-located services, relative to geographically separate services, on the number of treatment visits for older adults with depression.

Comparison 3. Collaborative care versus standard care/enhanced standard care for older adults

Critical outcomes

Proportion of people from the target group who access treatment

- Very low quality evidence from 3 RCTs (N=2449) shows a clinically important but not statistically significant benefit of collaborative care, relative to standard care, on the number of older adults with depression who were using antidepressants.
- Very low quality evidence from 2 RCTs (N=501) shows a clinically important but not statistically significant benefit of collaborative care, relative to standard care or enhanced standard care, on the number of older adults with depression for whom a psychiatric consultation was sought.

Uptake of treatment

• Very low quality evidence from 1 RCT (N=138) shows a clinically important but not statistically significant benefit of collaborative care, relative to standard care, on the number of older adults with depression starting antidepressant treatment.

Important outcomes

Satisfaction

 Moderate quality evidence from 1 RCT (N=1364) shows a clinically important and statistically significant benefit of collaborative care, relative to standard care, on the number of older adults with depression who rated depression care as 'excellent/very good'.

Interventions to promote access for BME groups

Comparison 4. Culturally sensitive telepsychiatry versus treatment as usual for a BME population

Critical outcomes

Proportion of people from the target group who access treatment

- Moderate quality evidence from 1 RCT (N=167) shows a clinically important and statistically significant benefit of culturally sensitive telepsychiatry, relative to treatment as usual, on the number of Hispanic people with depression who made a mental health appointment.
- Low quality evidence from 1 RCT (N=167) shows a clinically important and statistically significant benefit of treatment as usual, relative to culturally sensitive telepsychiatry, on the number of Hispanic people with depression who made a primary care appointment.
- Low quality evidence from 1 RCT (N=167) shows a clinically important and statistically significant benefit of culturally sensitive telepsychiatry, relative to treatment as usual, on the number of Hispanic people with depression who used antidepressants.

Uptake of treatment

- Low quality evidence from 1 RCT (N=106) shows neither a clinically important nor statistically significant benefit of culturally sensitive telepsychiatry, relative to treatment as usual, on the mean number of completed mental health appointments for Hispanic people with depression.
- Moderate quality evidence from 1 RCT (N=132) shows neither a clinically important nor statistically significant benefit of culturally sensitive telepsychiatry, relative to treatment as

usual, on the mean number of completed primary care appointments for Hispanic people with depression.

Important outcomes

Satisfaction

• Moderate quality evidence from 1 RCT (N=167) shows neither a clinically important nor statistically significant benefit of culturally sensitive telepsychiatry, relative to treatment as usual, on satisfaction scores for Hispanic people with depression.

Comparison 5. Culturally-adapted CBT versus treatment as usual for a BME population

Important outcomes

Satisfaction

• Very low quality evidence from 1 RCT (N=137) shows a clinically important and statistically significant benefit of culturally-adapted CBT, relative to treatment as usual, on the number of Pakistani people with depression who were 'very satisfied' with treatment.

Comparison 6. Culturally adapted motivational enhancement therapy for antidepressants versus usual care for a BME population

Critical outcomes

Uptake of treatment

• Moderate quality evidence from 1 RCT (N=50) shows a clinically important and statistically significant benefit of culturally adapted motivational enhancement therapy for antidepressants, relative to usual care, on the antidepressant adherence score for Latino people with depression.

Comparison 7. Telephone CBT versus enhanced usual care for a BME population (living in rural areas)

Important outcomes

Satisfaction

 Very low quality evidence from 1 RCT (N=101) shows a clinically important and statistically significant benefit of telephone CBT, relative to enhanced usual care, on the number of Latino people with depression (living in rural areas) who reported that they were satisfied with the treatment provided.

Comparison 8. Collaborative care versus enhanced standard care for BME population

Critical outcomes

Proportion of people from the target group who access treatment

- Moderate quality evidence from 1 RCT (N=329) shows a clinically important and statistically significant benefit of collaborative care, relative to enhanced standard care, on the number of Hispanic people with depression who were receiving antidepressants.
- Moderate quality evidence from 1 RCT (N=327) shows a clinically important and statistically significant benefit of collaborative care, relative to enhanced standard care, on the number of Hispanic people with depression who were receiving minimally adequate treatment (counselling or medications).

Important outcomes

Satisfaction

 Moderate quality evidence from 1 RCT (N=330) shows a clinically important and statistically significant benefit of collaborative care, relative to enhanced standard care, on the number of Hispanic people with depression who were satisfied or very satisfied with emotional health care.

Comparison 9. Culturally sensitive collaborative care versus standard collaborative care for BME population

Critical outcomes

Proportion of people from the target group who access treatment

- Very low quality evidence from 1 RCT (N=113) shows a clinically important but not statistically significant benefit of standard collaborative care, relative to culturally sensitive collaborative care, on the number of African American people with depression who were taking any antidepressant.
- Very low quality evidence from 1 RCT (N=113) shows a clinically important but not statistically significant benefit of standard collaborative care, relative to culturally sensitive collaborative care, on the number of African American people with depression who were receiving any counselling.
- Very low quality evidence from 1 RCT (N=113) shows a clinically important and statistically significant benefit of standard collaborative care, relative to culturally sensitive collaborative care, on the number of African American people with depression who were receiving guideline-concordant depression treatment.

Interventions to promote access for LGBT groups

No evidence was identified for interventions to promote access for LGBT groups.

Interventions to promote access for men

Comparison 10. Remote treatment versus face-to-face treatment for a predominantly male population

Important outcomes

Satisfaction

- Low quality evidence from 1 RCT (N=52) shows neither a clinically important nor statistically significant difference between remote and face-to-face prolonged exposure treatment on the number of people who were satisfied/very satisfied with treatment, amongst a predominantly male (veteran) population with PTSD and depression symptoms.
- Very low quality evidence from 1 RCT (N=87) shows neither a clinically important nor statistically significant difference between remote and face-to-face behavioural activation, on treatment satisfaction scores for a predominantly male (veteran) population with depression.

Comparison 11. Collaborative care versus standard care/enhanced standard care for a predominantly male population

Critical outcomes

Proportion of people from the target group who access treatment

- Very low quality evidence from 2 RCTs (N=729) shows neither a clinically important nor statistically significant benefit of collaborative care, relative to standard care or consultantliaison care, on the number of people who attended at least 1 appointment with a mental health specialist for a predominantly male (veteran) population with depression.
- Very low quality evidence from 1 RCT (N=354) shows a clinically important and statistically significant benefit of collaborative care, relative to consultant-liaison care, on the number of people who had a depression-related primary care visit for a predominantly male (veteran) population with depression.
- Very low quality evidence from 3 RCTs (N=868) shows a statistically significant but not clinically important benefit of collaborative care, relative to standard care or enhanced standard care, on the number of people using antidepressants for a predominantly male (veteran) population with depression.

Important outcomes

Satisfaction

• Very low quality evidence from 1 RCT (N=325) shows neither a clinically important nor statistically significant benefit of collaborative care, relative to enhanced standard care, on the number of people satisfied with care for a predominantly male (veteran) population with depression.

Economic evidence statements

No economic evidence was identified which was applicable to this review question.

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

As this question was about improving access to services and treatment for certain groups of people with depression, the committee identified that the proportion of people from the target groups who access treatment, and the uptake of treatment were the critical outcomes. This was measured in most studies as the number of people who attended appointments (either any appointment, a minimum number, or if they completed a series of sessions), or who commenced treatment such as antidepressants.

As satisfaction with treatment is likely to lead to improved uptake and adherence, satisfaction with treatment (or preference), and anxiety about treatment were identified by the committee as important outcomes.

The quality of the evidence

The quality of evidence for outcomes was assessed using GRADE and ranged from moderate to very low.

The evidence for this review generally came from single RCTs, some of which had small sample sizes. The evidence was generally directly applicable to the groups of interest (BME,

male, older people) with depression. Some of the evidence relevant to promoting access for men was conducted in predominantly male veteran populations who have specific healthcare provision, and issues relating to access may not be applicable to the UK setting, and this was reflected in the indirectness ratings.

There was no evidence identified for interventions to promote access for LGBT groups.

Benefits and harms

Although the subject of the review had been focused on improving access for specific groups who may find obtaining treatment more difficult, the committee agreed that it was important to ensure good access for all people with depression. The committee therefore drew on their own knowledge and experience and the successes of the national roll out of the Improving Access to Psychological Therapies (IAPT) programme. The IAPT programme had shown that the development of accessible systems for the delivery of care are associated with improved uptake of services. The committee therefore agreed that treatment pathways should be accessible to people with depression, with multiple entry points (for example, self-referral, GP referral), allow for prompt assessment and be integrated across primary and secondary care, to share information and so provide a coordinated service.

The committee noted that such systems, based on models such as stepped care, would promote effective access to and delivery of treatment for people with depression and therefore developed recommendations that specified what the care pathways should include and achieve. The committee were aware of work emanating from the NHS long-term plan which suggested that care should be locality-based and integrated across all aspects of health and social care, as well as with other agencies such as education, housing and the voluntary and social enterprise sector, and so made recommendations to advise this. The committee also agreed that in order to ensure that these pathways worked as intended it was necessary to monitor access, uptake and outcomes. The committee also recognised that mental health services for people with depression were delivered by a wide range of practitioners in a wide range of settings, but that integration between these services and settings was essential, and so made a recommendation to state this.

There was no evidence from this review for stepped care, but the committee agreed that this model was well accepted and understood and so included it as an option. They also discussed that in light of the additions to the guideline about taking into account patient choice, patient preferences and other factors that may influence the choice of treatment such as severity of depression and previous treatment history, a preferred term may be 'matched care'. There was, however, evidence for the benefits of collaborative care in terms of uptake of treatment and satisfaction with care for older adults, black, Asian and minority ethnic groups and men. Based on this evidence, and the evidence for clinical benefits associated with collaborative care (see Evidence review A), the committee recommended that services should be delivered using collaborative care, but noted that separate recommendations on collaborative care had already been made, based on the evidence review on service delivery.

The committee were aware that access to services could be hindered by a lack of appropriate and accessible information, and so, based on their own awareness of accessibility issues, they made a separate recommendation to highlight that information to help people access services should be available in a variety of formats, languages and culturally adapted where necessary.

The committee agreed that the symptoms of depression itself and the impact of stigma can make it difficult for people with depression to access mental health services or take up offers of treatment, and recommended that steps are taken locally to reduce stigma, discrimination and barriers to access for individuals seeking help for depression. The committee agreed that this was such an important principle that they included this in the amended recommendations at the very beginning of the guideline which covers over-arching principles of care.

The committee discussed the evidence from this review and noted that a number of the interventions reviewed may have clinical benefits both directly, in terms of increased uptake of treatment, and indirectly in terms of greater satisfaction, which may in turn lead to better ongoing engagement with services. There was evidence for benefits, in terms of uptake and acceptance of treatment, associated with delivering interventions using different methods in order to promote access, for example using telephone delivery of treatment or services to older adults or black, Asian or minority ethnic groups. The committee discussed that, in addition to the telephone, there is now an increased use of other methods of communication in the NHS, particularly since the Covid-19 pandemic. This can include text messages, emails or video consultations. While this is welcomed by many people, the committee also discussed the importance of patient choice and problems associated with digital exclusion or digital poverty: some people may prefer a face-to-face intervention either because they are not comfortable using technology, because they lack the appropriate device or internet connection, lack a private and confidential space, or because of wider issues associated with difficulties in accessing services that intersect with the vulnerable groups identified in this review. The committee therefore recommended interventions be available via a range of different methods, and the methods of delivery should be guided by patient choice, with remote consultations only being used for people who wish to access and are able to access services in this way.

There were also benefits associated with culturally adapted interventions or services on treatment uptake, engagement, and satisfaction for black, Asian and minority ethnic groups, and the committee agreed to recommend that services be delivered in culturally appropriate or culturally adapted language and formats, and that access to bilingual therapists or independent translators is available. However, the committee noted the importance of not being overly prescriptive in terms of the specific nature of adaptations so that the specific access needs of the local population could be most appropriately identified and addressed.

The committee discussed the current drive within the NHS to provide services outside of standard working hours. The committee noted the absence of evidence included in this review for potential clinical benefits or cost-effectiveness of this modification, and were aware that service-level data on uptake is mixed. However, practitioners have found evening appointments to be popular with patients, and based on consensus opinion the committee recommended that services should be available outside normal working hours in order to promote access and increased uptake of services for people with depression.

For older people, there was evidence that co-locating mental health services with physical health services in a primary care setting improved engagement with depression treatment. Based on their knowledge and experience the committee also noted that providing services at home or in community centres or care homes could promote access to services for older adults and other groups of people with depression. The committee agreed that services should be provided in community-based settings where appropriate, and integrated services that are designed to meet the needs of the local population should be available.

The committee reflected on the limited evidence base for interventions to promote access for the target groups identified in this review, particularly for LGBT groups, and highlighted the importance of the third sector in promoting access. Based on their expert opinion, the committee recommended that services be delivered jointly with charities or the voluntary sector.

The committee discussed whether it was possible to make recommendations tailored specifically to each of the target groups (identified in the review) that would improve access to treatment and services for depression. However, given the limited evidence available and the overarching themes and principles, the committee thought it more appropriate to make general recommendations on what should be done to promote access and increased uptake

of services. The committee did, however, highlight particular groups who may have difficulty in accessing, or face stigma when taking up, some or all mental health services including the target groups from the evidence review (men; older people; LGBT people; people from Black, Asian and minority ethnic communities) and other groups that the committee were aware may face particular issues with access (people with learning disabilities or acquired cognitive impairments; people with physical or sensory disabilities; people who have conditions which compromise their ability to communicate; asylum seekers). The committee recognised that religion and faith cannot be conflated with culture or ethnicity but did not have any evidence about the impact of depression or lack of access to services for any particular religious or faith groups. They therefore agreed to keep broader recommendations about avoiding discrimination and promoting access that would apply to all minority groups.

The committee noted, despite concerns about depression and suicide in younger men, that no evidence had been identified for interventions to increase access for this particular group. In the absence of evidence about what may be effective for this group the committee were wary of making specific recommendations for practice using consensus. They agreed, however, that the recommendations made should improve access for younger men too.

In light of the limited evidence the committee decided to make a research recommendation to help identify the most effective and cost-effective methods to promote increased access to, and uptake of, interventions for people with depression who are under-served and under-represented in current services.

Cost effectiveness and resource use

No evidence on the cost-effectiveness of service developments and interventions that have been specifically designed to promote access to services for vulnerable groups of adults with, or at risk of, depression was identified and no further economic analysis was undertaken.

The committee acknowledged that enhanced accessibility to services and integrated delivery of services for people with depression across primary and secondary care are likely to have considerable resource implications. The committee noted, however, that facilitating timely access to effective and cost-effective NICE-recommended treatments for depression results in more efficient use of resources and better outcomes for service users; moreover, there may be significant cost-savings for the NHS and social care as delayed or poorly co-ordinated treatment may negate the need for more costly intensive treatments for entrenched or chronic depressive symptoms. The committee noted that availability of services outside normal hours (evenings/weekends) is already established and would not entail significant resource implications.

The committee also acknowledged that routine collection of data on access to, uptake of, and outcomes of the interventions in the pathway is likely to have moderate resource implications. However, they expressed the opinion that routine collection of such data will allow more effective planning, delivery and evaluation of services, leading to more efficient use of resources and enhanced equality within and across services.

Other factors the committee took into account

In developing the recommendations to promote access for these target groups, the committee also took into account the qualitative evidence from the review on treatment choice (Evidence review I). This increased the confidence in the recommendations as these were supported by themes arising from the experiences of people with depression in terms of accessing treatment and services.

Recommendations supported by this evidence review

This evidence review supports recommendations 1.16.1 to 1.16.6 and research recommendations in the NICE guideline.

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Appendices

Appendix A – Review protocols

Review protocol for review question: For adults at risk of depression (or anxiety disorders) from particular vulnerable groups (older people, black minority ethnic groups, lesbian, gay bisexual, transgender groups and men) do service developments and interventions which are specifically designed to promote access, increase the proportion of people from the target group who access treatment, when compared with standard care?

Field (based on PRISMA-P)	Content
Review question	RQ3.0 For adults (18 years and older) at risk of depression (or anxiety disorders) from particular vulnerable groups (older people, BME groups, LGBT groups and men) do service developments and interventions which are specifically designed to promote access, increase the proportion of people from the target group who access treatment, when compared with standard care?
Type of review question	Intervention review
Objective of the review	To identify the most effective service developments and interventions which are specifically designed to promote access
Population	 Adults (18 years and older) identified as at risk of depression (or anxiety disorders*) from the following vulnerable groups Older adults BME groups LGBT groups Men *Note: due to limited depression specific evidence, a broader evidence base (including anxiety disorders) will be used. An update of the review conducted for the Common Mental Health Disorders NICE guideline will be undertaken
Exclude	 Trials of people with depression where the population does not fall into one of the particular vulnerable groups that are the focus of this review (older people, BME groups, LGBT groups and men)

Field (based on <u>PRISMA-P)</u>	Content
	Trials of women with antenatal or postnatal depression
	 Trials of children and young people (mean age under 18 years)
	Trials of people with learning disabilities
	 Trials of adults in contact with the criminal justice system (not solely as a result of being a witness or victim) Trials that specifically recruit participants with a physical health condition in addition to depression (e.g. depression in people with diabetes)
Intervention	 Service developments or changes which are specifically designed to promote access. Specific models of service delivery (that is, community-based outreach clinics, clinics or services in non-health settings).
	 Methods designed to remove barriers to access (including stigma, misinformation or cultural beliefs about the nature of mental disorder)
Comparison	Standard care
Outcomes and prioritisation	Critical outcomes:
	 Proportion of people from the target group who access treatment
	Uptake of treatment
	Important but not critical outcomes:
	Satisfaction, preference
	Anxiety about treatment
Study design	• RCTs
	Systematic reviews of RCTs
Include unpublished data?	Conference abstracts, dissertations and unpublished data will not be included unless the data can be extracted from elsewhere (for instance, from the Common Mental Health Disorders guideline)
Restriction by date	All relevant studies from existing reviews from the Common Mental Health Disorders guideline and from previous searches (pre-2016) will be carried forward. No restriction on date for the updated search (due to the addition of the LGBT groups since the original search was run), studies published between database inception and the date the searches are run will be sought.
Minimum sample size	N = 10 in each arm

Field (based on PRISMA-P)	Content
Study setting	Primary, secondary, tertiary and social care settings. Non-English-language papers will be excluded (unless data can be obtained from an existing review).
The review strategy	Data Extraction (selection and coding) Citations from each search will be downloaded into EndNote and duplicates removed. Titles and abstracts of identified studies will be screened by two reviewers for inclusion against criteria, until a good inter-rater reliability has been observed (percentage agreement =>90%). Initially 10% of references will be double-screened. If inter-rater agreement is good then the remaining references will be screened by one reviewer. All primary-level studies included after the first scan of citations will be acquired in full and re-evaluated for eligibility at the time they are being entered into a study database (standardised template created in Microsoft Excel). At least 10% of data extraction will be double-coded. Discrepancies or difficulties with coding will be resolved through discussion between reviewers or the opinion of a third reviewer will be sought.
	Data Analysis A meta-analysis using a random-effects model will be conducted to combine results from similar studies. An intention to treat (ITT) approach will be taken where possible.
	Risk of bias will be assessed at the study level using the Cochrane risk of bias tool. This assessment includes: adequacy of randomisation (sufficient description of randomisation method, allocation concealment and any baseline difference between groups); blinding (of participants, intervention administrators and outcome assessors); attrition ('at risk of attrition bias' defined as a dropout of more than 20% and completer analysis used, or a difference of >20% between the groups); selective reporting bias (is the protocol registered, are all outcomes reported); other bias (for instance, conflict of interest in funding).
	Risk of bias will also be assessed at the outcome level using GRADE. For heterogeneity, outcomes will be downgraded once if $l^2>50\%$, twice if $l^2>80\%$. For imprecision, outcomes will be downgraded using rules of thumb. If the 95% CI is imprecise i.e. crosses the line of no effect and the threshold for clinical benefit/harm, 0.8 or 1.25 (dichotomous) or -0.5 or 0.5 SMD (for continuous), the outcome will be downgraded. Outcomes will be downgraded one or two levels depending on how many lines it crosses. If the 95% CI is not imprecise, we will consider whether the criterion for Optimal Information Size is met (for dichotomous outcomes, 300 events; for continuous outcomes, 400 participants), if not we will downgrade one level.
Heterogeneity	Where possible, the influence of the following subgroups will be considered:

Field (based on PRISMA-P)	Content
(sensitivity analysis and subgroups)	Different subgroups within the LGBT category
	Different subgroups within the BME category
Data management (software)	Endnote was used to sift through the references identified by the search, and Excel for data extraction Pairwise meta-analyses and production of forest plots was done using Cochrane Review Manager (RevMan5). 'GRADEpro' was used to assess the quality of evidence for each outcome.
Information sources – databases and dates	Databases: Embase 1980 to 2019 Week 13, Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily 1946 to April 02, 2019, PsycINFO 1806 to March Week 4 2019 The Cochrane Library: Cochrane Database of Systematic Reviews, Issue 4 of 12, April 2019; Cochrane Central Register of Controlled Trials, Issue 4 of 12, April 2019 HE - Database(s): Embase 1980 to 2019 Week 08, Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily 1946 to February 26, 2019, PsycINFO 1806 to February Week 1 2019 NIHR Centre for Reviews and Dissemination: Health Technology Assessment Database (HTA)
	CINAHL Plus (Cumulative Index to Nursing and Allied Health Literature) 1937-current, EBSCO Host
Identify if an update	Update of CG90 (2009)
Author contacts	For details please see the guideline in development web site.
Highlight if amendment to previous protocol	For details please see section 4.5 of <u>Developing NICE guidelines: the manual 2014</u>
Search strategy – for one database	For details please see appendix B.
Data collection process – forms/duplicate	A standardised evidence table format will be used, and published as appendix D (clinical evidence tables) or H (economic evidence tables).
Data items – define all variables to be collected	For details please see evidence tables in appendix D (clinical evidence tables) or H (economic evidence tables).
Methods for assessing bias at outcome/study level	Standard study checklists were used to critically appraise individual studies. For details please see section 6.2 of <u>Developing NICE guidelines: the manual 2014.</u>
	The risk of bias across all available evidence was evaluated for each outcome using an adaptation of the 'Grading of Recommendations Assessment, Development and Evaluation (GRADE) toolbox' developed by the international GRADE working group <u>http://www.gradeworkinggroup.org/.</u>
Criteria for quantitative synthesis	For details please see section 6.4 of Developing NICE guidelines: the manual 2014

Field (based on <u>PRISMA-P)</u>	Content
Methods for quantitative analysis – combining studies and exploring (in)consistency	For details please see the methods chapter
Meta-bias assessment – publication bias, selective reporting bias	For details please see section 6.2 of <u>Developing NICE guidelines: the manual 2014</u> .
Confidence in cumulative evidence	For details please see sections 6.4 and 9.1 of Developing NICE guidelines: the manual 2014
Rationale/context – what is known	For details please see the introduction to the evidence review.
Describe contributions of authors and guarantor	A multidisciplinary committee developed the evidence review. The committee was convened by the National Guideline Alliance (NGA) and chaired by Dr Navneet Kapur in line with section 3 of <u>Developing NICE</u> guidelines: the manual 2014.
	Staff from the NGA undertook systematic literature searches, appraised the evidence, conducted meta-analysis and cost effectiveness analysis where appropriate, and drafted the guideline in collaboration with the committee. For details please see the methods chapter.
Sources of funding/support	The NGA is funded by NICE and hosted by the Royal College of Obstetricians and Gynaecologists.
Name of sponsor	The NGA is funded by NICE and hosted by the Royal College of Obstetricians and Gynaecologists.
Roles of sponsor	NICE funds NGA to develop guidelines for those working in the NHS, public health and social care in England
PROSPERO registration number	Not applicable

BAME/BME: black, Asian, minority, ethnic; CI: confidence interval; GRADE: Grading of Recommendations Assessment, Development and Evaluation; ITT: intention to treat; LGBT: lesbian, gay, bisexual, transgender/transsexual; MID: minimally important difference; NGA: National Guideline Alliance; N: number of participants; NHS: National health service; NICE: National Institute for Health and Care Excellence; RCT: randomised controlled trial; RoB: risk of bias; SD: standard deviation; SMD: standardised mean difference

Appendix B – Literature search strategies

Literature search strategies for review question: For adults at risk of depression (or anxiety disorders) from particular vulnerable groups (older people, black minority ethnic groups, lesbian, gay bisexual, transgender groups and men) do service developments and interventions which are specifically designed to promote access, increase the proportion of people from the target group who access treatment, when compared with standard care?

Clinical search

Database(s): Embase 1974 to 2019 Week 13, Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily 1946 to April 02, 2019, PsycINFO 1806 to March Week 4 2019

Date of search: 03/04/2019

Search updated: 03/03/2021

#	Searches		
1	(exp anxiety disorders/ or body dysmorphic disorder/ or exp depression/ or mental stress/) use oemezd		
2	(anxiety/ or exp anxiety disorders/ or body dysmorphic disorders/ or exp compulsive behavior/ or depression/ or exp depressive disorder/ or panic/ or stress, psychological/) use ppez		
3	(anxiety/ or anxiety management/ or exp anxiety disorders/ or panic attack/ or performanice anxiety/ or social anxiety/ or speech anxiety/ or test anxiety/ or body dysmorphic disorder/ or panic/ or exp depression/ or atypical depression/ or "depression (emotion)"/ or psychological stress/) use psyh		
4	(anxiet* or anxious* or body dysmorphi* or dysmorphophobi* or (combat adj (disorder* or fatigue or neuros* or syndrome*)) or concentration camp syndrome or torture syndrome or war neuros* or (rape adj2 trauma*) or flash back* or flashback* or posttrauma* or post trauma* or ptsd or railway spine or re experienc* or reexperienc* or (trauma* and (avoidance or grief or horror or death* or nightmare* or night mare* or emotion*)) or depress* or dysphori* or dysthymi* or melanchol* or seasonal affective disorder* or clean response* or compulsi* or obsession* or obsessive* or ocd or recur* thought* or panic* or agoraphobi* or claustrophobi* or phobi* or ((extreme or trauma*)) or psychotrauma* or stress disorder* or ((acute or chronic* or extreme or incessant* or intense* or persistent* or serious* or sever*) adj2 (apprehens* or doom or fear* or terror*)) or hypervigil*).tw.		
5	(healthcare or health care or (mental adj (disorder* or health)) or primary care).tw.		
6	or/1-5		
7	(health care access/ or health disparity/ or health care utilization/) use oemezd or (health promotion/ use oemezd and (access* or barrier* or disparit* or equity or inequit* or inequalit*)).tw.		
8	(health services accessibility/ or healthcare disparities/ or health status disparities/) use ppez or (exp health promotion/ use ppez and (access* or barrier* or disparit* or equity or inequit* or inequalit*).tw.) or (ut.fs. and (care or health care or healthcare or service*).hw.)		
9	(health care delivery/ or treatment barriers/ or health care utilization/ or health disparities/) use psyh or (health promotion/ use psyh and (access* or barrier* or disparit* or equity or inequit* or inequalit*).tw.)		
10	((access* or barrier* or disparit* or equity or inequit* or inequalit*) adj4 (care or clinical practice or detect* or diagnos* or health* or interven* or medication* or medicine* or program* or psychotherap* or recogni* or referral* or service* or therap* or treat*)).tw.		
11	(((health adj (care or service)) or healthcare) adj2 (need*1 or use*1 or using or utilis* or utiliz*)).tw.		
12	((barrier* or disparit* or equity or hinder* or hindran* or hurdle* or imped* or improv* or inequit* or inequalit* or obstacle* or obstruct* or prevent* or promot* or reluctan* or restrict* or uptake or utiliz* or utilis* or vulnerable) adj3 access*).tw.		
13	((access or barrier) adj research*).tw.		
14	((behavio?r* or helpseek* or help seek* or system*) adj2 barrier*).tw.		
15	or/7-14		
16	"translating (language)"/ use oemezd or translating/ use ppez or foreign language translation/ use psyh or (translate* or translating or translator*).tw.		
17	15 or 16		
18	(exp african/ or exp aged/ or ancestry group/ or exp asian/ or asian american/ or asian continental ancestry group/ or exp black person/ or british asian/ or exp *"caribbean (person)"/ or exp central american/ or cultural anthropology/ or cultural competence/ or cultural deprivation/ or exp elderly care/ or exp "ethnic or racial aspects"/ or exp ethnic group/ or ethnology/ or geriatric*.hw. or gerontology/ or exp hispanic/ or exp immigration/ or exp indigenous people/ or exp migrant/ or minority group/ or mongoloid/ or exp multiracial person/ or multilingualism/ or nursing home/ or exp oceanian/ or exp oceanic ancestry group/ or prejudice/ or exp religion/ or exp religious group/ or residential home/ or social problem/ or exp south american/ or superstition/ or *taboo/ or *"translating (language)"/) use oemezd		
19	(exp african continental ancestry group/ or exp aged/ or exp american native continental/ or "emigration and immigration"/ or ancestry group/ or exp asian continental ancestry group/ or "emigrants and immigrants"/ or "health services for the aged"/ or "homes for the aged"/ or "transients and migrants"/ or cross-cultural comparison/ or cultural characteristics/ or cultural competency/ or cultural deprivation/ or cultural diversity/ or culture/ or exp ethnic groups/		

 or ethnology or minority groups or multilingualism or nursing homes or oceanic ancestry group or exp perialical or translating) use ppez or genitaric ", w. or eth.s. (african culture groups or to freque in quage translation" or patistic patients of translating or translating or access cultural communication or exp cross cultural iseration of or taxes in the investigation of translating or translating or translating or translating and the investigation of translating or exp religious beliefs' or exp religious practices' or residential care or translating or culture (chines and translating) or translating or culture (chines and translating) or translating or culture (chines and translating) or translating or culture (chines and translating or cultural translating or cultural translating or transl	#	Searches		
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43	((cd or communication or digital or electronic* or mobile or net or pc*1 or pda or phone* or phoning or tablet* or technolog* or telephon* or web or www) adj3 (aid* or assist* or based or deliver* or diary or diaries)).tw.		
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45	((vr or virtual reality) adj2 (advocacy or application* or approach* or coach* or educat* or exchang* or exposure or feedback* or guide*1 or help* or instruct* or interact* or interven* or learn* or manag* or meeting* or module* or network* or package* or participat* or prevent* or program* or psychoanaly* or psychotherap* or rehab* or retrain* or re train* or self guide* or self help or selfguide* or selfhelp or session* or skill* or strateg* or support* or teach* or technique* or therap* or train* or treat* or work shop* or workshop*)).tw.		
46	(caccbt or ccbt or ccbt or call in or (caller*1 adj3 (interven* or program* or therap* or treat*)) or callline* or call line* or ediar* or ehealth or emediat* or elearn* or etherap* or (e adj (diar* or learn or health or mediat* or therap*)) or help line* or helpline* or hotline* or hot line* or outreach* or phone in or phonein or telecare or telecommunication or teleconsult* or telehealth or telemedicine or telement* or telepsychology or telepsychiatry or teletherap* or (tele adj (care or communication or consult* or health or medicine or mental* or psychology or psychiatry or therap*)) or videocam* or video cam* or webcam* or web cam*).tw.		
47	(alles onder controle or autism xpress or autismexpress or avatars programme or (beating adj2 blues) or big white wall or blue pages or bluepages or (brave program and anxiet*) or (camp cope adj2 lot) or (catch it and depres*) or cool teens or coping cat or crufadschools or (e couch and depres*) or fearfighter or ff education or ffeducation or grip op je dip or internet psychiatri or internet psykiatri or leap project or linden method or (little prince and depres*) or (living life adj2 full) or mind your*1 mind or mood gym or mood helper or moodgym or moodhelper or my*1 body my*1 life or net ff or netcope or netff or co fighter or offighter or pix talk or pixtalk or (restoring adj2 balance) or sparx or standalone ff or standaloneff or student bodie or student bodies prevention program* or studentbodie or ((the*1 adj lowdown) and depres*) or the*1 journey or therapeutic learning program* or trouble on*1 the*1 tightrope or think feel do or whiz kid games or (youth mental health adj2 parent* guide)).tw.		
48	(ecological momentary assessment* or mhealth or (mobile adj2 (app or apps or application*)) or virtual reality or wearable*).tw.		
49	or/39-48		
50	49 and (17 or (access* or barrier* or disparit* or equity or inequit* or inequalit*).tw.)		
51 52	6 and (17 and (or/22,27,38) and 50) limit 51 to dc=20160601-20190403 use oemezd [Limit not valid in PsycINFO; records were retained]		
53	limit 51 to ed=20160601-20190403 use ppez [Limit not valid in Embase,PsycINFO; records were retained]		
54	limit 51 to up=20160601-20190403 use psyh		
55	or/52-54		
56	6 and (17 and 33 and 50)		
57	55 or 56		
58 59	limit 57 to english language Letter/ use ppez		
60	letter.pt. or letter/ use oemezd		
61	note.pt.		
62	editorial.pt.		
63	Editorial/ use ppez		
64 65	News/ use ppez exp Historical Article/ use ppez		
66	Anecdotes as Topic/ use ppez		
67	Comment/ use ppez		
68	Case Report/		
69	case study/ use oemezd		
70	(letter or comment*).ti.		
71 72	or/59-70 randomized controlled trial/		
72	randomized controlled that/		
74	72 or 73		
75	71 not 74		
76	(animals/ not humans/) use ppez		
77	(animal/ not human/) use oemezd		
78	nonhuman/ use oemezd		
79 80	exp animals/ use psyh "primates (nonhuman)"/ use psyh		
81	exp Animals, Laboratory/ use ppez		
82	exp Animals, Euserimentation/ use ppez		
83	exp animal experiment/ use oemezd		
84	exp experimental animal/ use oemezd		
85	exp Models, Animal/ use ppez		
86 87	animal model/ use oemezd		
07	animal models/ use psyh		

#	Searches		
88	animal research/ use psyh		
89	exp Rodentia/ use ppez		
90	exp rodent/ use oemezd		
91	exp rodents/ use psyh		
92	(rat or rats or mouse or mice).ti.		
93	or/75-92		
94	58 not 93		
95	clinical Trials as topic.sh. or (controlled clinical trial or pragmatic clinical trial or randomized controlled trial).pt. or (placebo or randomi?ed or randomly).ab. or trial.ti.		
96	95 use ppez		
97	(controlled clinical trial or pragmatic clinical trial or randomized controlled trial).pt. or drug therapy.fs. or (groups or placebo or randomi?ed or randomly or trial).ab.		
98	97 use ppez		
99	crossover procedure/ or double blind procedure/ or randomized controlled trial/ or single blind procedure/ or (assign* or allocat* or crossover* or cross over* or ((doubl* or singl*) adj blind*) or factorial* or placebo* or random* or volunteer*).ti,ab.		
100	99 use oemezd		
101	clinical trials/ or (placebo or randomi?ed or randomly).ab. or trial.ti.		
102	101 use psyh		
103	96 or 98		
104	100 or 102 or 103		
105	Meta-Analysis/		
106	exp Meta-Analysis as Topic/		
107	systematic review/		
108	meta-analysis/		
109	(meta analy* or metanaly* or metaanaly*).ti,ab.		
110	((systematic or evidence) adj2 (review* or overview*)).ti,ab.		
111	((systematic* or evidence*) adj2 (review* or overview*)).ti,ab.		
112	(reference list* or bibliograph* or hand search* or manual search* or relevant journals).ab.		
113	(search strategy or search criteria or systematic search or study selection or data extraction).ab.		
114	(search* adj4 literature).ab.		
115	(medline or pubmed or cochrane or embase or psychlit or psyclit or psychinfo or psycinfo or cinahl or science citation index or bids or cancerlit).ab.		
116	cochrane.jw.		
117	((pool* or combined) adj2 (data or trials or studies or results)).ab.		
118	(or/105-107,109,111-116) use ppez		
119	(or/107-110,112-117) use oemezd		
120	or/118-119		
121	104 or 120		
122	94 and 121		
123	remove duplicates from 122		

The Cochrane Library: Cochrane Database of Systematic Reviews, Issue 4 of 12, April 2019; Cochrane Central Register of Controlled Trials, Issue 4 of 12, April 2019

Date of search: 03/04/2019

Search updated: 09/03/2021

ID	Search		
#1	MeSH descriptor: [Depression] this term only		
#2	MeSH descriptor: [Depressive Disorder] explode all trees		
#3	MeSH descriptor: [Anxiety] this term only		
#4	MeSH descriptor: [Anxiety Disorders] explode all trees		
#5	MeSH descriptor: [Body Dysmorphic Disorders] this term only		
#6	MeSH descriptor: [Compulsive Behavior] this term only		
#7	MeSH descriptor: [Panic] this term only		
#8	MeSH descriptor: [Panic] this term only (anxiet* or anxious* or "body dysmorphi*" or dysmorphophobi* or (combat near/1 (disorder* or fatigue or neuros* or syndrome*)) or "concentration camp syndrome" or "torture syndrome" or "war neuros*" or (rape near/2 trauma*) or "flash back*" or flashback* or posttrauma* or "post trauma*" or ptsd or "railway spine" or "re experienc*" or reexperienc* or (trauma* and (avoidance or grief or horror or death* or nightmare* or "night mare*" or emotion*)) or depress* or dysphori* or dysthymi* or melanchol* or "seasonal affective disorder*" or "clean response*" or compulsi* or obsession* or obsessive* or ocd or recur* thought* or panic* or agoraphobi* or claustrophobi* or (psych* near/1 (stress or trauma*)) or psychotrauma* or "stress disorder*" or ((acute or chronic* or extreme or incessant* or intense* or persistent* or serious* or sever*) near/2 (apprehens* or doom or fear* or terror*)) or hypervigil*):ti,ab		
#9	(healthcare or "health care" or (mental near/1 (disorder* or health)) or "primary care"):ti,ab		
#10	{or #1-#9}		
#11	MeSH descriptor: [Health Services Accessibility] this term only		
#12	MeSH descriptor: [Healthcare Disparities] this term only		

ID	Search		
#13	MeSH descriptor: [Health Status Disparities] this term only		
#14	MeSH descriptor: [Health Promotion] this term only		
#15	((access* or barrier* or disparit* or equity or inequit* or inequalit*) and (care or "clinical practice" or detect* or diagnos* or health* or interven* or medication* or medicine* or program* or psychotherap* or recogni* or referral* or service* or therap* or treat*)):ti.ab		
#16 #17	(((health near/1 (care or service)) or healthcare) near/2 (need* or use* or using or utilis* or utiliz*)):ti,ab ((barrier* or disparit* or equity or hinder* or hindran* or hurdle* or imped* or improv* or inequit* or inequalit* or obstacle* or obstacle* or operative or prevent* or promot* or reluctan* or restrict* or uptake or utiliz* or utilis* or vulnerable) and access*):ti,ab		
#18	((access or barrier) near/1 research*):ti,ab		
#19	((behavior* or behaviour* or helpseek* or "help seek*" or system*) and barrier*):ti,ab		
#20	MeSH descriptor: [Translating] this term only		
#21	(translate* or translating or translator*):ti,ab		
#22	{or #11-#21}		
#23 #24	MeSH descriptor: [Communication Barriers] explode all trees MeSH descriptor: [Health Education] this term only		
#24 #25	MeSH descriptor: [Health Literacy] this term only		
#26	MeSH descriptor: [Health Promotion] this term only		
#27	MeSH descriptor: [Literacy] this term only		
#28	MeSH descriptor: [Socioeconomic Factors] this term only		
#29 #30	((health near/2 (educat* or promot*)) or ((client* or patient*) near/2 (educat* or information)) or literac*):ti, ab ((((computer* or electronic* or technolog*) near/2 (communication* or mediat*)) or etherap* or "e therap*" or (remote* near/2 (communic* or deliver* or therap*)) or ((distance or remote*) near/2 (communication* or technolog* or electronic*)) or internet or telecommunicat* or "tele communicat*" or telemedicine or "tele medicine" or telephone* or telepsychiatr* or videoconf* or "video conf*") and (access* or barrier* or disparit* or ((enter* or entry) near/2 service*) or equity or inequit* or inequalit* or (receipt near/2 service*) or utilisation or utilization) and (intervention* or etherap* or program* or psychotherap* or therap* or treat*)):ti,ab		
#31	{or #23-#30}		
#32	MeSH descriptor: [African Continental Ancestry Group] explode all trees		
#33	MeSH descriptor: [Aged] explode all trees		
#34 #25	MeSH descriptor: [American Native Continental Ancestry Group] explode all trees		
#35 #36	MeSH descriptor: [Emigration and Immigration] this term only MeSH descriptor: [Asian Continental Ancestry Group] explode all trees		
#30	MeSH descriptor: [Emigrants and Immigrants] explode all trees		
#38	MeSH descriptor: [Health Services for the Aged] this term only		
#39	MeSH descriptor: [Homes for the Aged] this term only		
#40	MeSH descriptor: [Transients and Migrants] this term only		
#41	MeSH descriptor: [Cross-Cultural Comparison] this term only		
#42	MeSH descriptor: [Cultural Characteristics] this term only		
#43	MeSH descriptor: [Cultural Competency] this term only		
#44 #45	MeSH descriptor: [Cultural Deprivation] this term only MeSH descriptor: [Cultural Diversity] this term only		
#43 #46	MeSH descriptor: [Culture] this term only		
#47	MeSH descriptor: [Ethnic Groups] explode all trees		
#48	MeSH descriptor: [Ethnology] this term only		
#49	geriatric*:kw		
#50	MeSH descriptor: [Minority Groups] this term only		
#51	MeSH descriptor: [Multilingualism] this term only		
#52	MeSH descriptor: [Nursing Homes] explode all trees		
#53 #54	MeSH descriptor: [Oceanic Ancestry Group] this term only		
#54 #55	MeSH descriptor: [Prejudice] this term only MeSH descriptor: [Race Relations] explode all trees		
#55	MeSH descriptor: [Refugees] this term only		
#57	MeSH descriptor: [Religion] explode all trees		
#58	MeSH descriptor: [Superstitions] this term only		
#59	MeSH descriptor: [Taboo] this term only		
#60	MeSH descriptor: [Translating] this term only		
#61	((aged or ageism or agism or aging or aging or elder* or ((frail or old or older) near/1 (adult* or men or people or person* or women)) or geriatric* or gerontology or "nursing home*" or "residential care" or african or asian* or bangladesh* or bengali or (black* near/2 (communit* or famil* or people or person*)) or blacks or (bme near/2 (communit* or group* or people or person*)) or caribbean* or (chinese near/2 (adult* or communit* or famil* or people or person*)) or cultur* or disadvantaged or disparities or ethnic* or ethnic* or ethnic* or gujurati or hindu or hispanic* or imigrant* or immigrant* or inequalit* or interpret* or latino* or migrant* or multi lingual*" or multicultur* or multilingual* or muslim* or "pacific islander*" or translation or urdu or vulnerable) and (access* or barrier* or disparit* or ((enter* or entry) near/2 service*) or equity or inequalit* or inequalit* or (receipt near/2 service*) or utilisation or utilization)):ti,ab		
#62	MeSH descriptor: [Male] explode all trees		
#63	MeSH descriptor: [Men] explode all trees		
#64	((boy or boys or brother* or father* or husband* or male* or men or son or sons or widower*) and (access* or barrier* or disparit* or equity or inequit* or inequalit*)):ti,ab		
#65	{or #32-#64}		

ID	Search		
#66			
#67	MeSH descriptor: [Sexual and Gender Minorities] explode all trees		
	MeSH descriptor: [Gender Dysphoria] this term only		
#68 #69	MeSH descriptor: [Gender Identity] explode all trees MeSH descriptor: [Bisexuality] this term only		
#09	MeSH descriptor: [Homosexuality] explode all trees		
#70	MeSH descriptor: [Transsexualism] this term only		
#71	MeSH descriptor: [Health Services for Transgender Persons] this term only		
#72			
#73	(bigender* or bi-gender* or bisexual* or bi-sexual* or gay or gender minorit* or gender neurtral or glbt or glbtq* or lbg or lgbt or lgbtq* or homosexual* or homo-sexual* or lesbian* or lesbigay* or non-heterosexual* or nonheterosexual* or queer* or sexual dissident* or sexual minorit*):ti,ab		
#74	(transgender* or trans-gender* or gender diverse or gender varian* or genderqueer* or intersex* or non-binary or nonbinary or transexual* or transsexual* or trans-sexual* or transvestite*):ti,ab		
#75	{or #66-#74}		
#76	MeSH descriptor: [Attitude to Computers] this term only		
#77	MeSH descriptor: [Audiovisual Aids] explode all trees		
#78	MeSH descriptor: [Cell Phone] explode all trees		
#79	MeSH descriptor: [Communications Media] this term only		
#80	MeSH descriptor: [Computer Literacy] this term only		
#81	MeSH descriptor: [Computer User Training] this term only		
#82	MeSH descriptor: [Computing Methodologies] this term only		
#83	MeSH descriptor: [Computer Systems] explode all trees		
#84	MeSH descriptor: [Decision Making, Computer-Assisted] this term only		
#85	MeSH descriptor: [Decision Support Systems, Clinical] this term only		
#86	MeSH descriptor: [Electronic Mail] this term only		
#87	MeSH descriptor: [Hotlines] this term only		
#88	MeSH descriptor: [Multimedia] this term only		
#89	MeSH descriptor: [Optical Storage Devices] explode all trees		
#90	MeSH descriptor: [Programmed Instruction as Topic] explode all trees		
#91	MeSH descriptor: [Social Networking] explode all trees		
#92	MeSH descriptor: [Software] explode all trees		
#93	MeSH descriptor: [Telecommunications] this term only		
#94	MeSH descriptor: [Telemedicine] explode all trees		
#95	MeSH descriptor: [Telemetry] this term only		
#96	MeSH descriptor: [Telephone] explode all trees		
#97	MeSH descriptor: [Therapy, Computer-Assisted] this term only		
#98	MeSH descriptor: [Video Recording] explode all trees		
#99	((cd or communication or digital or electronic* or mobile or net or pc or pda or phone* or phoning or tablet* or technolog* or telephon* or web or www) near/3 (aid* or assist* or based or deliver* or diary or diaries)):ti,ab		
#100	((cd or communication or digital or electronic* or mobile or net or pc or pda or phone* or phoning or tablet* or technolog* or telephon* or web or www) near/7 (advocacy or application* or approach* or coach* or educat* or exchang* or guide* or help* or instruct* or interact* or interven* or learn* or manag* or meeting* or module* or network* or package* or participat* or prevent* or program* or psychoanaly* or psychotherap* or rehab* or retrain* or "re train*" or "self guide*" or "self help" or selfguide* or selfhelp or session* or skill* or strateg* or support* or teach* or technique* or therap* or train* or "work shop*" or workshop*)):ti,ab		
#101	((vr or virtual reality) near/2 (advocacy or application* or approach* or coach* or educat* or exchang* or exposure or feedback* or guide* or help* or instruct* or interact* or interven* or learn* or manag* or meeting* or module* or network* or package* or participat* or prevent* or program* or psychoanaly* or psychotherap* or rehab* or retrain* or "re train*" or "self guide*" or "self help" or selfguide* or selfhelp or session* or skill* or strateg* or support* or teach* or technique* or therap* or train* or "re train*" or "work shop*" or workshop*)):ti,ab		
#102	(caccbt or ccbt or "c cbt" or "call in" or (caller* near/3 (interven* or program* or therap* or treat*)) or callline* or "call line*" or ediar* or ehealth or emediat* or elearn* or etherap* or (e near/1 (diar* or learn or health or mediat* or therap*)) or "help line*" or helpline* or hotline* or "hot line*" or outreach* or "phone in" or phonein or telecare or telecommunication or teleconsult* or telehealth or telemedicine or telement* or telepsychology or telepsychiatry or teletherap* or (tele near/1 (care or communication or consult* or health or medicine or mental* or psychology or psychiatry or therap*)) or videocam* or "video cam*" or webcam* or "web cam*"):ti,ab		
#103	("alles onder controle" or "autism xpress" or autismexpress or "avatars programme" or (beating near/2 blues) or "big white wall" or "blue pages" or bluepages or ("brave program" and anxiet") or ("camp cope" near/2 lot) or ("catch it" and depres*) or "cool teens" or "coping cat" or crufadschools or ("e couch" and depres*) or fearfighter or "ff education" or ffeducation or "grip op je dip" or "internet psychiatri" or "internet psykiatri" or "leap project" or "linden method" or ("little prince" and depres*) or ("living life" near/2 full) or "mind your* mind" or "mood gym" or "mood helper" or moodgym or moodhelper or "my body my life" or "net ff" or netcope or netff or "oc fighter" or ocfighter or "online anxiety prevention" or "overcoming bulimia online" or ("overcoming depression" and program*) or "panic online" or "pix talk" or pixtalk or (restoring near/2 balance) or sparx or "standalone ff" or standaloneff or "student bodie" or "therapeutic learning program*" or strudentbodie or ((the near/1 lowdown) and depres*) or "the journey" or "therapeutic learning program*" or "trouble on the tightrope" or "think feel do" or "whiz kid games" or ("youth mental health" near/2 parent* guide)):ti,ab		
#104	("ecological momentary assessment*" or mhealth or (mobile near/2 (app or apps or application*)) or "virtual reality" or wearable*):ti,ab		
#105 #106	{or #76-#104} (access* or barrier* or disparit* or equity or inequit* or inequalit*):ti,ab		
#100	#105 and (#22 or #106)		
#108	(#10 and (#22 or #31 or #65) and #107) with Cochrane Library publication date Between Jun 2016 and Apr 2019		

ID	Search
#109	#75 and (#22 or #31 or #106)
#110	#10 and #109
#111	#108 or #110

Health Economics search

Database(s): Embase 1974 to 2019 Week 08, Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily 1946 to February 26, 2019, PsycINFO 1806 to February Week 1 2019

Date of search: 27/02/2019

Search updated: 02/03/2021

#	Searches
1	(depression/ or agitated depression/ or atypical depression/ or depressive psychosis/ or dysphoria/ or dysthymia/ or
	endogenous depression/ or involutional depression/ or late life depression/ or major depression/ or masked
	depression/ or melancholia/ or "mixed anxiety and depression"/ or "mixed depression and dementia"/ or
	premenstrual dysphoric disorder/ or reactive depression/ or recurrent brief depression/ or seasonal affective
	disorder/ or treatment resistant depression/) use oemezd
2	((Depression/ or exp Depressive Disorder/ or Adjustment Disorders/ or Affective Disorders, Psychotic/ or Factitious
	Disorders/ or Premenstrual Dysphoric Disorder/) use ppez
3	("depression (emotion)"/ or exp major depression/ or affective disorders/ or atypical depression/ or premenstrual
	dysphoric disorder/ or seasonal affective disorder/) use psyh
4	(depress* or dysphori* or dysthym* or melanchol* or seasonal affective disorder* or ((affective or mood) adj
	(isorder*)).tw.
5	or/1-4
6	Letter/ use ppez
7	
8	letter.pt. or letter/ use oemezd
	note.pt.
9	editorial.pt.
10	Editorial/ use ppez
11	News/ use ppez
12	exp Historical Article/ use ppez
13	Anecdotes as Topic/ use ppez
14	Comment/ use ppez
15	Case Report/
16	case study/ use oemezd
17	(letter or comment*).ti.
18	or/6-17
19	randomized controlled trial/
20	random*.ti,ab.
21	19 or 20
22	18 not 21
23	(animals/ not humans/) use ppez
24	(animal/ not human/) use penezd
25	nonhuman/ use oemezd
26	exp animals/ use psyh
27	"primates (nonhuman)"/ use psyh
28	exp Animals, Laboratory/ use ppez
20	exp Animals, Laboratory use ppez
30	exp animal experimentation/ use ppez
31	exp experimental animal/ use oemezd
32	exp Models, Animal/ use ppez
33	animal model/ use oemezd
34	animal models/ use psyh
35	animal research/ use psyh
36	exp Rodentia/ use ppez
37	exp rodent/ use oemezd
38	exp rodents/ use psyh
39	(rat or rats or mouse or mice).ti.
40	or/22-39
41	5 not 40
42	Economics/
43	Value of life/
44	exp "Costs and Cost Analysis"/
45	exp Economics, Hospital/
46	exp Economics, Medical/
47	Economics, Nursing/
48	Economics, Pharmaceutical/

#	Searches		
49	exp "Fees and Charges"/		
50	exp Budgets/		
51	(or/42-50) use ppez		
52	health economics/		
53	exp economic evaluation/		
54	exp health care cost/		
55	exp fee/		
56	budget/		
57	funding/		
58	(or/52-57) use oemezd		
59	exp economics/		
60	exp "costs and cost analysis"/		
61	cost containment/		
62	money/		
63	resource allocation/		
64	(or/59-63) use psyh		
65	budget*.ti,ab.		
66	cost*.ti.		
67	(economic* or pharmaco?economic*).ti.		
68	(price* or pricing*).ti,ab.		
69	(cost* adj2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)).ab.		
70	(financ* or fee or fees).ti,ab.		
71	(value adj2 (money or monetary)).ti,ab.		
72	or/65-70		
73	51 or 58 or 64 or 72		
74	Quality-Adjusted Life Years/ use ppez		
75	Sickness Impact Profile/		
76 77	quality adjusted life year/ use oemezd		
77	"quality of life index"/ use oemezd		
78	(quality adjusted or quality adjusted life year*).tw.		
79	(qaly* or qal or qald* or qale* or qtime* or qwb* or daly).tw.		
80 81	(illness state* or health state*).tw. (hui or hui2 or hui3).tw.		
82	(multiattibute* or multi attribute*).tw.		
83	(utilit* adj3 (score*1 or valu* or health* or cost* or measur* or disease* or mean or gain or gains or index*)).tw.		
84	utilities.tw.		
85	(eq-5d* or eq5d* or eq-5* or eq5* or euroqual* or euro qual* or euroqual 5d* or euro qual 5d* or euro qol* or euroqol*or euro quol* or euroquol* or euro quol5d* or euroquol5d* or eur qol* or eurqol* or eur qol5d* or eurqol5d* or eur?qul* or eur?qul5d* or euro* quality of life or european qol).tw.		
86	(euro* adj3 (5 d* or 5d* or 5 dimension* or 5dimension* or 5 domain* or 5domain*)).tw.		
87	(sf36 or sf 36 or sf thirty six or sf thirtysix).tw.		
88	(time trade off*1 or time tradeoff*1 or tto or timetradeoff*1).tw.		
89	Quality of Life/ and ((quality of life or qol) adj (score*1 or measure*1)).tw.		
90	Quality of Life/ and ec.fs.		
91	Quality of Life/ and (health adj3 status).tw.		
92	(quality of life or qol).tw. and Cost-Benefit Analysis/ use ppez		
93	(quality of life or qol).tw. and cost benefit analysis/ use oemezd		
94	(quality of life or qol).tw. and "costs and cost analysis"/ use psyh		
95	((qol or hrqol or quality of life).tw. or *quality of life/) and ((qol or hrqol* or quality of life) adj2 (increas* or decreas* or improv* or declin* or reduc* or high* or low* or effect or effects or worse or score or scores or change*1 or impact*1 or impacted or deteriorat*)).ab.		
96	Cost-Benefit Analysis/ use ppez and cost-effectiveness ratio*.tw. and (cost-effectiveness ratio* and (perspective* or life expectanc*)).tw.		
97	cost benefit analysis/ use oemezd and cost-effectiveness ratio*.tw. and (cost-effectiveness ratio* and (perspective* or life expectanc*)).tw.		
98	"costs and cost analysis"/ use psyh and cost-effectiveness ratio*.tw. and (cost-effectiveness ratio* and (perspective* or life expectanc*)).tw.		
99	*quality of life/ and (quality of life or qol).ti.		
100	quality of life/ and ((quality of life or qol) adj3 (improv* or chang*)).tw.		
101	quality of life/ and health-related quality of life.tw.		
102	Models, Economic/ use ppez		
103	economic model/ use oemezd		
104	or/74-101		
105	73 or 104		
106	41 and 105		
107 108	limit 106 to english language limit 107 to yr="2016 -Current"		
100			

Database(s): NIHR Centre for Reviews and Dissemination: Health Technology Assessment Database (HTA)

Date of search: 26/02/2019

- #
 Searches

 #1
 MESH DESCRIPTOR: depressive disorder EXPLODE ALL TREES

 #2
 ((depres* or dysphori* or dysthymi* or melancholi* or seasonal affective disorder* or affective disorder* or mood disorder*))
- #3 #1 or #2 IN HTA FROM 2016 TO 2019

Database(s): CINAHL Plus (Cumulative Index to Nursing and Allied Health Literature) 1937current, EBSCO Host

Date of search: 26/02/2019

Search updated: 02/03/2021

	upualeu. 02/03/2021	
#	Query	Limiters/Expanders
S31	S4 AND S30	Limiters - Publication Year: 2016-2019;
		Exclude MEDLINE records; Language:
		English
		Search modes - Boolean/Phrase
S30	S10 OR S29	Search modes - Boolean/Phrase
S29	S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR	Limiters - Exclude MEDLINE records;
025	S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR	Language: English
	S27 OR S28	Search modes - Boolean/Phrase
S28	(MH "Quality of Life") AND TX (health-related quality of life)	Search modes - Boolean/Phrase
S27	(MH "Quality of Life") AND TI (quality of life or qol)	Search modes - Boolean/Phrase
S26	AB ((qol or hrqol or quality of life) AND ((qol or hrqol* or quality of life) N2	Search modes - Boolean/Phrase
	(increas* or decreas* or improv* or declin* or reduc* or high* or low* or	
	effect or effects or worse or score or scores or change*1 or impact*1 or	
	impacted or deteriorat*)))	
S25	(MH "Cost Benefit Analysis") AND TX ((quality of life or qol) or (cost-	Search modes - Boolean/Phrase
	effectiveness ratio* and (perspective* or life expectanc*))	
S24	(MH "Quality of Life") TX (health N3 status)	Search modes - Boolean/Phrase
S23	(MH "Quality of Life") AND TX ((quality of life or qol) N (score*1 or	Search modes - Boolean/Phrase
	measure*1))	
S22	TX (time trade off*1 or time tradeoff*1 or tto or timetradeoff*1)	Search modes - Boolean/Phrase
S21	TX (sf36 or sf 36 or sf thirty six or sf thirtysix)	Search modes - Boolean/Phrase
S20	TX (euro* N3 (5 d* or 5 d* or 5 dimension* or 5 dimension* or 5 domain*	Search modes - Boolean/Phrase
520	or 5domain*))	Search modes - Boolean/Phrase
0.40		
S19	TX (eq-5d* or eq5d* or eq-5* or eq5* or euroqual* or euro qual* or	Search modes - Boolean/Phrase
	euroqual 5d* or euro qual 5d* or euro qol* or euroqol*or euro quol* or	
	euroquol* or euro quol5d* or euroquol5d* or eur qol* or europt or eur	
	qol5d* or eurqol5d* or eur?qul* or eur?qul5d* or euro* quality of life or	
	european qol)	
S18	TI utilities	Search modes - Boolean/Phrase
S17	TX (utilit* N3 (score*1 or valu* or health* or cost* or measur* or disease*	Search modes - Boolean/Phrase
	or mean or gain or gains or index*))	
S16	TX (multiattibute* or multi attribute*)	Search modes - Boolean/Phrase
S15	TX (hui or hui2 or hui3)	Search modes - Boolean/Phrase
S14	TX (illness state* or health state*)	Search modes - Boolean/Phrase
S13	TX (quality adjusted or quality adjusted life year*or qaly* or qal or qald*	Search modes - Boolean/Phrase
010	or qale* or qtime* or qwb* or daly)	
S12	(MH "Sickness Impact Profile")	Search modes - Boolean/Phrase
S12	· · · ·	
	(MH "Quality-Adjusted Life Years")	Search modes - Boolean/Phrase
S10	S5 OR S6 OR S7 OR S8 OR S9	Limiters - Exclude MEDLINE records;
		Language: English
		Search modes - Boolean/Phrase
S9	TX (value N2 (money or monetary))	Search modes - Boolean/Phrase
S8	TX (cost* N2 (effective* or utilit* or benefit* or minimi* or unit* or estimat*	Search modes - Boolean/Phrase
	or variable*))	
S7	TI cost* or economic* or pharmaco?economic*	Search modes - Boolean/Phrase
S6	TX budget* or fee or fees or finance* or price* or pricing	Search modes - Boolean/Phrase
S5	(MH "Fees and Charges+") OR (MH "Costs and Cost Analysis+") OR	Search modes - Boolean/Phrase
	(MH "Economics") OR (MH "Economic Value of Life") OR (MH	
	"Economics, Pharmaceutical") OR (MH "Economic Aspects of Illness")	
	OR (MH "Resource Allocation+")	
S4	S1 OR S2 OR S3	Limiters - Exclude MEDLINE records;
34	51 OK 32 OK 33	Language: English
		Search modes - Boolean/Phrase
60	TY (depress* or dysphori* or dysthym* or malanabal* or accessed	Search modes - Boolean/Phrase
S3	TX (depress* or dysphori* or dysthym* or melanchol* or seasonal affective disorder)	Search modes - Doolean/Phrase
00		Counch modes - Declass /Dhreet
S2	(MH "Adjustment Disorders+") OR (MH "Factitious Disorders") OR (MH	Search modes - Boolean/Phrase
	"Affective Disorders, Psychotic")	

#	Query	Limiters/Expanders
S1	(MH "Depression+") OR (MH "Premenstrual Dysphoric Disorder") OR (MH "Seasonal Affective Disorder")	Search modes - Boolean/Phrase

Appendix C – Clinical evidence study selection

Clinical study selection for review question: For adults at risk of depression (or anxiety disorders) from particular vulnerable groups (older people, black minority ethnic groups, lesbian, gay bisexual, transgender groups and men) do service developments and interventions which are specifically designed to promote access, increase the proportion of people from the target group who access treatment, when compared with standard care?

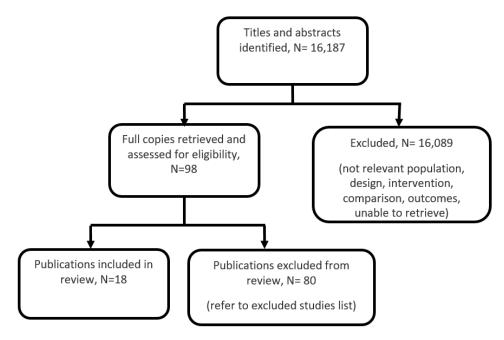


Figure 1: Study selection flow chart

Appendix D – Clinical evidence tables

Clinical evidence tables for review question: For adults at risk of depression (or anxiety disorders) from particular vulnerable groups (older people, black minority ethnic groups, lesbian, gay bisexual, transgender groups and men) do service developments and interventions which are specifically designed to promote access, increase the proportion of people from the target group who access treatment, when compared with standard care?

Please refer to the clinical evidence tables in supplement H – Clinical evidence tables for review 3.0

Appendix E – Forest plots

Forest plots for review question: For adults at risk of depression (or anxiety disorders) from particular vulnerable groups (older people, black minority ethnic groups, lesbian, gay bisexual, transgender groups and men) do service developments and interventions which are specifically designed to promote access, increase the proportion of people from the target group who access treatment, when compared with standard care?

Interventions to promote access for older adults

Comparison 1. Tele-problem solving therapy versus in-person problem solving therapy for older adults

Figure 2: Satisfaction (scores obtained in a treatment acceptance tool)

	Experimental		tal	Control				Std. Mean Difference	Std. Mean Difference			
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI	IV, Fixed, 95% CI			
Choi 2014	72.14	6.64	43	68.08	8.27	42	100.0%	0.54 [0.10, 0.97]	_			
Total (95% CI)			43			42	100.0%	0.54 [0.10, 0.97]	•			
Heterogeneity: Not ap Test for overall effect:	•).02)						-10 -5 0 5 10 Favours in-person PST Favours tele-PST			

Comparison 2. Co-located services versus geographically separate services for older adults

Figure 3: Accessing treatment (number of participants who attended an appointment with a mental health provider following randomization at the index primary care visit)

	Experimental		Control		Risk Ratio			Risk Ratio			
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% CI		M-H, Fixe	ed, 95% CI		
Bartels 2004	481	640	338	657	100.0%	1.46 [1.34, 1.59]					
Total (95% CI)		640		657	100.0%	1.46 [1.34, 1.59]			•		
Total events	481		338								
Heterogeneity: Not a Test for overall effect		P < 0.00	001)				0.01	0.1 Favours separate	1 10 Favours co-located	100	

Figure 4: Uptake of treatment (number of treatment visits)

	Expe	Experimental Co						Std. Mean Difference			Std. Mean Difference		
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI		IV,	Fixed, 95% C	I	
Bartels 2004	3.5	3.9	687	2.22	3.9	703	100.0%	0.33 [0.22, 0.43]					
Total (95% CI)			687			703	100.0%	0.33 [0.22, 0.43]			•		
Heterogeneity: Not a Test for overall effect).00001	1)					-10	-5 Favours sep	0 arate Favours	5 s co-locate	10 ed

Comparison 3. Collaborative care versus standard care/enhanced standard care for older adults

Figure 5: Accessing treatment (number of patients using antidepressants)

	Experim	ental				Risk Ratio	Risk Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Random, 95% Cl	M-H, Random, 95% Cl
Callahan 1994	26	100	6	75	24.5%	3.25 [1.41, 7.50]	_ _
Gilbody 2017	23	234	44	281	34.0%	0.63 [0.39, 1.01]	
Unutzer 2002	649	889	497	870	41.5%	1.28 [1.19, 1.37]	-
Total (95% CI)		1223		1226	100.0%	1.26 [0.66, 2.40]	•
Total events	698		547				
Heterogeneity: Tau ² =	= 0.26; Chi ^a	²= 13.46	6, df = 2 (P = 0.0	01); I^z = 89	5%	
Test for overall effect	: Z = 0.71 (P = 0.48)				Favours standard care Favours CC

Figure 6: Accessing treatment (number of patients for whom a psychiatric consultation was sought)

	Experim	ental	Cont	rol		Risk Ratio	Risk Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Random, 95% Cl	M-H, Random, 95% Cl
Callahan 1994	12	100	11	75	51.6%	0.82 [0.38, 1.75]	
Chen 2015	17	164	7	162	48.4%	2.40 [1.02, 5.63]	
Total (95% CI)		264		237	100.0%	1.38 [0.48, 3.97]	
Total events	29		18				
Heterogeneity: Tau ² =				= 0.06); I² = 71 %	ò	
Test for overall effect:	Z = 0.59 (F	P = 0.55)				Favours standard care Favours CC

Figure 7: Uptake of treatment (number of participants starting antidepressant treatment)

	Experim	ental	Cont	ol		Risk Ratio	Risk Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% Cl	M-H, Fixed, 95% CI
Ciechanowski 2004	7	72	4	66	100.0%	1.60 [0.49, 5.23]	
Total (95% CI)		72		66	100.0%	1.60 [0.49, 5.23]	
Total events	7		4				
Heterogeneity: Not ap Test for overall effect:	•	= 0.43)					0.01 0.1 1 10 100 Favours standard care Favours CC

Figure 8: Satisfaction (number of patients rating depression care as 'excellent/very good')

	Experim	ental	Control			Risk Ratio	Risk F	latio	
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% Cl	M-H, Fixed	I, 95% CI	
Unutzer 2002	597	790	272	574	100.0%	1.59 [1.45, 1.75]			
Total (95% CI)		790		574	100.0%	1.59 [1.45, 1.75]		•	
Total events	597		272						
Heterogeneity: Not a Test for overall effect	••	⊃ < 0.00	001)				0.01 0.1 1 Favours standard care	10 Favours CC	100

Interventions to promote access for BME groups

Comparison 4. Culturally sensitive telepsychiatry versus treatment as usual for a BME population

Figure 9: Accessing treatment (number of patients who made a mental health appointment)

	Experim	ental	Control			Risk Ratio	Risk Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% Cl	M-H, Fixed, 95% CI
Chong 2012	77	80	29	87	100.0%	2.89 [2.14, 3.90]	
Total (95% CI)		80		87	100.0%	2.89 [2.14, 3.90]	•
Total events	77		29				
Heterogeneity: Not ap	oplicable						
Test for overall effect:	Z = 6.92 (F	P < 0.00	001)				0.01 0.1 1 10 100 Favours TAU Favours CS-telepsychiatry

Figure 10: Accessing treatment (number of patients who made a primary care appointment)

	Experim	ental	Contr	rol		Risk Ratio	Risk Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% Cl	I M-H, Fixed, 95% CI
Chong 2012	56	80	76	87	100.0%	0.80 [0.68, 0.94]]
Total (95% CI)		80		87	100.0%	0.80 [0.68, 0.94]	ı ◆
Total events	56		76				
Heterogeneity: Not ap Test for overall effect:	•	P = 0.00	8)				0.01 0.1 1 10 100 Favours TAU Favours CS-telepsychiatry

Figure 11: Accessing treatment (number of patients who used antidepressants)

	Experim	ental	Control			Risk Ratio	Risk Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% Cl	I M-H, Fixed, 95% Cl
Chong 2012	56	80	40	87	100.0%	1.52 [1.16, 1.99]]
Total (95% CI)		80		87	100.0%	1.52 [1.16, 1.99]	ı ◆
Total events	56		40				
Heterogeneity: Not a Test for overall effect		P = 0.00	2)				0.01 0.1 1 10 100 Favours TAU Favours CS-telepsychiatry

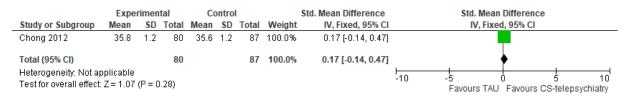
Figure 12: Uptake of treatment (mean number of completed mental health appointments)

	Experimental		Experimental Control				Std. Mean Difference		Std. Mean Difference			
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI		IV, Fixed	, 95% CI	
Chong 2012	4.8	2.7	77	4.3	3.6	29	100.0%	0.17 [-0.26, 0.59]				
Total (95% CI)			77			29	100.0%	0.17 [-0.26, 0.59]		•	•	
Heterogeneity: Not a Test for overall effect		(P = 0).44)						-10	-5 C Favours TAU	Favours CS-	5 10 telepsychiatry

Figure 13: Uptake of treatment (mean number of completed primary care appointments)

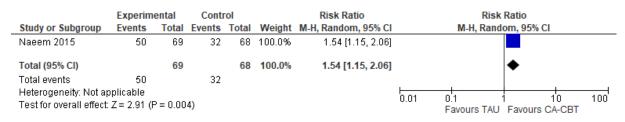
	Expe	rimen	tal	Co	ontro	I		Std. Mean Difference		Std. Mean	Difference		
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI		IV, Fixe	d, 95% CI		
Chong 2012	3.2	3.8	56	3.2	2.7	76	100.0%	0.00 [-0.35, 0.35]					
Total (95% CI)			56			76	100.0%	0.00 [-0.35, 0.35]			•		
Heterogeneity: Not a Test for overall effect			.00)						-10	-5 Favours TAU	l 0 Favours CS	5 -telepsyc	10 chiatry

Figure 14: Satisfaction (Visit Specific Satisfaction Questionnaire [VSQ-9])



Comparison 5. Culturally-adapted CBT versus treatment as usual for a BME population

Figure 15: Satisfaction (number of participants 'very satisfied' with treatment)



Comparison 6. Culturally adapted motivational enhancement therapy for antidepressants versus usual care for a BME population

Figure 16: Uptake of treatment (antidepressant adherence score on medication event monitoring system [MEMS])

	Experimental Control						Std. Mean Difference	Std. Mean Difference	
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Interian 2013	59.81	6.51	26	33.57	6.78	24	100.0%	3.89 [2.92, 4.86]	
Total (95% CI)			26			24	100.0%	3.89 [2.92, 4.86]	•
Heterogeneity: Not ap Test for overall effect:	•		0.00001)					-10 -5 0 5 10 Favours usual care Favours CA-META

Comparison 7. Telephone CBT versus enhanced usual care for a BME population (living in rural areas)

Figure 17: Satisfaction (number reporting they were satisfied with the treatment provided)

	Experim	ental	Contr	rol		Risk Ratio	Risk Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Random, 95% CI	M-H, Random, 95% Cl
Dwight-Johnson 2011	24	50	12	51	100.0%	2.04 [1.15, 3.62]	
Total (95% CI)		50		51	100.0%	2.04 [1.15, 3.62]	
Total events	24		12				
Heterogeneity: Not appl Test for overall effect: Z		0.01)					0.1 0.2 0.5 1 2 5 10 Favours enhanced TAU Favours tele-CBT

Comparison 8. Collaborative care versus enhanced standard care for BME population

Figure 18: Accessing treatment (number of patients receiving antidepressants)

	Experim	ental	Contr	rol		Risk Ratio	Risk Rati	0	
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% Cl	M-H, Fixed, 9	5% CI	
Lagomasino 2017	77	171	41	158	100.0%	1.74 [1.27, 2.37]			
Total (95% CI)		171		158	100.0%	1.74 [1.27, 2.37]	•		
Total events	77		41						
Heterogeneity: Not a Test for overall effect	••	P = 0.00	05)				0.01 0.1 1 Favours standard care Fav	10 rours CC	100

Figure 19: Accessing treatment (number of patients receiving minimally adequate treatment [counselling or medications])

	Experim	Experimental Control			Risk Ratio	Risk Ratio	
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% Cl	M-H, Fixed, 95% CI
Lagomasino 2017	131	170	33	157	100.0%	3.67 [2.68, 5.02]	
Total (95% CI)		170		157	100.0%	3.67 [2.68, 5.02]	◆
Total events	131		33				
Heterogeneity: Not ap Test for overall effect:		0.00 × 0	001)				0.01 0.1 1 10 100 Favours standard care Favours CC

Figure 20: Satisfaction (number of patients satisfied or very satisfied with emotional health care)

	Experimental Control			Risk Ratio	Risk Ratio			
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% Cl	M-H, Fixed, 95% Cl	
Lagomasino 2017	145	170	90	160	100.0%	1.52 [1.30, 1.76]		
Total (95% CI)		170		160	100.0%	1.52 [1.30, 1.76]	•	
Total events	145		90					
Heterogeneity: Not a Test for overall effect		0.00 × 0	001)				0.01 0.1 1 10 11 Favours standard care Favours CC	00

Comparison 9. Culturally sensitive collaborative care versus standard collaborative care for BME population

Figure 21: Accessing treatment (number of patients taking any antidepressant)

	Experim	ental	Contr	rol		Risk Ratio	Risk Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% Cl	M-H, Fixed, 95% CI
Cooper 2013	17	59	25	54	100.0%	0.62 [0.38, 1.02]	
Total (95% CI)		59		54	100.0%	0.62 [0.38, 1.02]	•
Total events	17		25				
Heterogeneity: Not applicable Test for overall effect: Z = 1.88 (P = 0.06)							0.01 0.1 1 10 100 Favours standard CC Favours cultural CC

Figure 22: Accessing treatment (number of patients receiving any counselling)

	Experim	ental	Cont	rol		Risk Ratio	Risk Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% Cl	M-H, Fixed, 95% Cl
Cooper 2013	11	59	13	54	100.0%	0.77 [0.38, 1.58]	
Total (95% CI)		59		54	100.0%	0.77 [0.38, 1.58]	-
Total events	11		13				
Heterogeneity: Not a Test for overall effect		^D = 0.48)				0.01 0.1 1 10 100 Favours standard CC Favours cultural CC

Figure 23: Accessing treatment (number of patients receiving guideline-concordant depression treatment)

	Experim	ental	Control			Risk Ratio	Risk Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% Cl	M-H, Fixed, 95% CI
Cooper 2013	17	59	28	54	100.0%	0.56 [0.35, 0.89]	
Total (95% CI)		59		54	100.0%	0.56 [0.35, 0.89]	◆
Total events	17		28				
Heterogeneity: Not a Test for overall effect		P = 0.02)				0.01 0.1 1 10 100 Favours standard CC Favours cultural CC

Interventions to promote access for men

Comparison 10. Remote treatment versus face-to-face treatment for a predominantly male population

Figure 24: Satisfaction (number of patients satisfied/very satisfied with treatment)

	Experim	ental	Contr	ol		Risk Ratio	Risk Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% CI	M-H, Fixed, 95% CI
Yuen 2015	29	29	23	23	100.0%	1.00 [0.93, 1.08]	•
Total (95% CI)		29		23	100.0%	1.00 [0.93, 1.08]	•
Total events	29		23				
Heterogeneity: Not a Test for overall effect		P = 1.00)				0.01 0.1 1 10 100 Favours face-to-face Favours remote

Figure 25: Satisfaction (Client Satisfaction Questionnaire [CSQ])

	At home B	At home BA (web-based) In			In person BA (control)			Std. Mean Difference	Std. Mean Difference			
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI	IV, Fixed, 95% CI			
Luxton 2016	28.76	3.41	45	29.29	3.98	42	100.0%	-0.14 [-0.56, 0.28]				
Total (95% CI) Heterogeneity: Not ap Test for overall effect:	•	0.51)	45			42	100.0%	-0.14 [-0.56, 0.28]	-10 -5 0 5 10 Favours face-to-face Favours remote			

Comparison 11. Collaborative care versus standard care/enhanced standard care for a predominantly male population

Figure 26: Accessing treatment (number who attended ≥1 appointment with mental health specialist)

	Experim	ental	Contr	ol		Risk Ratio	Risk Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Random, 95% Cl	M-H, Random, 95% Cl
Dobscha 2006	78	189	51	186	49.5%	1.51 [1.13, 2.01]	
Hedrick 2003	60	168	69	186	50.5%	0.96 [0.73, 1.27]	+
Total (95% CI)		357		372	100.0%	1.20 [0.77, 1.86]	◆
Total events	138		120				
Heterogeneity: Tau² = Test for overall effect:				= 0.03)	; I² = 79%	5	0.01 0.1 1 10 100 Favours standard care Favours CC

Figure 27: Accessing treatment (number who have had a depression-related primary care visit)

	Experim	ental	Cont	ol		Risk Ratio	Risk R	latio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% Cl	M-H, Fixed	I, 95% CI
Hedrick 2003	141	168	106	186	100.0%	1.47 [1.28, 1.70]		
Total (95% CI)		168		186	100.0%	1.47 [1.28, 1.70]		•
Total events	141		106					
Heterogeneity: Not ap	pplicable							10 100
Test for overall effect	: Z = 5.37 (F	• < 0.00	001)				Favours standard care	

Figure 28: Accessing treatment (number of participants using antidepressants)

	Experim	ental	Cont	rol		Risk Ratio	Risk Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Random, 95% Cl	M-H, Random, 95% CI
Dobscha 2006	150	189	129	186	48.0%	1.14 [1.01, 1.29]	
Fortney 2007	84	110	88	133	27.1%	1.15 [0.98, 1.35]	
Hedrick 2003	108	135	71	115	24.9%	1.30 [1.10, 1.53]	-
Total (95% CI)		434		434	100.0%	1.18 [1.09, 1.29]	•
Total events	342		288				
Heterogeneity: Tau ² =	= 0.00; Chi ^a	= 1.54,	df = 2 (P	= 0.46)); I ^z = 0%		
Test for overall effect:	Z = 3.96 (F	P < 0.00	01)				0.01 0.1 1 10 100 Favours standard care Favours CC

Figure 29: Satisfaction (number of patients satisfied with care)

	Experim	ental	Cont	rol		Risk Ratio	Risk F	latio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% Cl	M-H, Fixed	I, 95% CI
Fortney 2007	100	141	113	184	100.0%	1.15 [0.99, 1.35]		
Total (95% CI)		141		184	100.0%	1.15 [0.99, 1.35]		•
Total events	100		113					
Heterogeneity: Not a Test for overall effect	••	P = 0.07)				0.01 0.1 1 Favours standard care	10 100 Favours CC

Appendix F – GRADE tables

GRADE tables for review question: For adults at risk of depression (or anxiety disorders) from particular vulnerable groups (older people, black minority ethnic groups, lesbian, gay bisexual, transgender groups and men) do service developments and interventions which are specifically designed to promote access, increase the proportion of people from the target group who access treatment, when compared with standard care?

Interventions to promote access for older adults

Table 14: Clinical evidence profile for Comparison 1. Tele-problem solving therapy versus in-person problem solving therapy for older adults

Quality	Quality assessment							Number of participants		Effect		
№ of studie s	Study design	Risk of bias	Inconsistenc y	Indirectnes s	Imprecisio n	Other considerations	Tele- problem solving	In-person problem solving	Relative (95% Cl)	Absolute (95% Cl)	Quality	Importance
Satisfac	tion (follow-u	up 3 months	; measured with	: Scores obtai	ned in a treati	ment acceptance to	ol)					
1 (Choi 2014)	randomise d trials	serious ¹	no serious inconsistency	no serious indirectness	serious ²	none	43	42	-	SMD 0.54 higher (0.1 to 0.97 higher)	LOW	IMPORTANT

CI: Confidence interval; SMD: standardised mean difference

1. Risk of bias is high or unclear across multiple domains

2. 95% CI crosses 1 clinical decision threshold

Quality	Quality assessment						Number of pa	rticipants	Effect			
№ of studie s	Study design	Risk of bias	Inconsistenc y	Indirectnes s	Imprecisio n	Other considerations	Co-located services	Geographi cally separate services	Relative (95% Cl)	Absolute (95% Cl)	Quality	Importance
	Accessing treatment (follow-up 6 months; measured with: Number of participants who attended an appointment with a mental health provider following randomization at the index primary care visit)											
1 (Bartel s 2004)	randomise d trials	serious ¹	no serious inconsistency	no serious indirectness	no serious imprecision	none	481/640 (75.2%)	338/657 (51.4%)	RR 1.46 (1.34 to 1.59)	237 more per 1000 (from 175 more to 304 more)	MODERA TE	CRITICAL
Uptake	of treatment	(follow-up 6	months; measu	red with: Num	ber of treatme	ent visits)						

Quality	Quality assessment							rticipants	Effect			
№ of studie s	Study design	Risk of bias	Inconsistenc y	Indirectnes s	Imprecisio n	Other considerations	Co-located services	Geographi cally separate services	Relative (95% Cl)	Absolute (95% Cl)	Quality	Importance
1 (Bartel s 2004)	randomise d trials	serious ¹	no serious inconsistency	no serious indirectness	no serious imprecision	none	687	703	-	SMD 0.33 higher (0.22 to 0.43 higher)	MODERA TE	CRITICAL

CI: Confidence interval; RR: relative risk; SMD: standardised mean difference

1. Risk of bias is high or unclear across multiple domains

Table 16: Clinical evidence profile for Comparison 3. Collaborative care versus standard care/enhanced standard care for older adults

Quality	assessment						Number of pa	rticipants	Effect			
№ of studie s	Study design	Risk of bias	Inconsistenc y	Indirectnes s	Imprecisio n	Other considerations	Collaborativ e care	Standard care/enha nced standard care	Relative (95% Cl)	Absolute (95% CI)	Quality	Importance
						ients using antidep						
3 (Calla han 1994; Gilbod y 2017; Unutz er 2002)	randomise d trials	serious ¹	very serious ²	no serious indirectness	very serious ³	none	698/1223 (57.1%)	547/1226 (44.6%)	RR 1.26 (0.66 to 2.4)	116 more per 1000 (from 152 fewer to 625 more)	VERY LOW	CRITICAL
Accessi	ing treatment	t (follow-up	3-12 months; me	asured with: N	Number of pat	ients for whom a ps	ychiatric consu	ltation was s	ought)			
2 (Calla han 1994; Chen 2015)	randomise d trials	serious ¹	serious ⁴	no serious indirectness	very serious ³	none	29/264 (11%)	18/237 (7.6%)	RR 1.38 (0.48 to 3.97)	29 more per 1000 (from 39 fewer to 226 more)	VERY LOW	CRITICAL
Uptake	of treatment	(follow-up 6	months; measu	red with: Num	ber of particip	ants starting antide	pressant treatm	nent)				
1 (Ciech anows ki 2004)	randomise d trials	very serious ¹	no serious inconsistency	no serious indirectness	very serious ³	none	7/72 (9.7%)	4/66 (6.1%)	RR 1.6 (0.49 to 5.23)	36 more per 1000 (from 31 fewer to 256 more)	VERY LOW	CRITICAL

Quality	uality assessment						Number of pa	rticipants	Effect			
№ of studie s	Study design	Risk of bias	Inconsistenc y	Indirectnes s	Imprecisio n	Other considerations	Collaborativ e care	Standard care/enha nced standard care	Relative (95% Cl)	Absolute (95% Cl)	Quality	Importance
1 (Unutz er 2002)	randomise d trials	serious ¹	no serious inconsistency	no serious indirectness	no serious imprecision	none	597/790 (75.6%)	272/574 (47.4%)	RR 1.59 (1.45 to 1.75)	280 more per 1000 (from 213 more to 355 more)	MODERA TE	IMPORTANT

CI: Confidence interval; RR: relative risk

1. Risk of bias is high or unclear across multiple domains

2. I-squared>80%

3. 95% CI crosses 2 clinical decision thresholds

4. I-squared>50%

Interventions to promote access for BME groups

Table 17: Clinical evidence profile for Comparison 4. Culturally sensitive telepsychiatry versus treatment as usual for a BME population

Quality	uality assessment						Number of pa	rticipants	Effect			
Nº of studie s	Study design	Risk of bias	Inconsistenc y	Indirectnes s	Imprecisio n	Other considerations ts who made a men	Culturally sensitive telepsychiat ry tal health appoi	TAU	Relative (95% Cl)	Absolute (95% Cl)	Quality	Importance
1 (Chon g 2012)	randomise d trials	serious ¹	no serious inconsistency	no serious indirectness	no serious imprecision	none	77/80 (96.3%)	29/87 (33.3%)	RR 2.89 (2.14 to 3.9)	630 more per 1000 (from 380 more to 697 more)	MODERA TE	CRITICAL
Accessi	ng treatment	(follow-up	6 months; meas	ured with: Nun	nber of patien	ts who made a prim	ary care appoir	ntment)				
1 (Chon g 2012)	randomise d trials	serious ¹	no serious inconsistency	no serious indirectness	serious ²	none	56/80 (70%)	76/87 (87.4%)	RR 0.8 (0.68 to 0.94)	175 fewer per 1000 (from 52 fewer to 280 fewer)	LOW	CRITICAL
Accessi	ng treatment	(follow-up	6 months; meas	ured with: Nun	nber of patien	ts who used antide	oressants)					
1 (Chon	randomise d trials	serious ¹	no serious inconsistency	no serious indirectness	serious ²	none	56/80 (70%)	40/87 (46%)	RR 1.52 (1.16 to 1.99)	239 more per 1000 (from 74	LOW	CRITICAL

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Quality	assessment						Number of pa	rticipants	Effect			
№ of studie s	Study design	Risk of bias	Inconsistenc y	Indirectnes s	Imprecisio n	Other considerations	Culturally sensitive telepsychiat ry	TAU	Relative (95% Cl)	Absolute (95% Cl)	Quality	Importance
g 2012)										more to 455 more)		
Uptake	of treatment	(follow-up 6	months; measu	red with: Mear	number of co	ompleted mental he	alth appointme	nts)				
1 (Chon g 2012)	randomise d trials	serious ¹	no serious inconsistency	no serious indirectness	serious ²	none	77	29	-	SMD 0.17 higher (0.26 lower to 0.59 higher)	LOW	CRITICAL
Uptake	of treatment ((follow-up 6	months; measu	red with: Mear	number of co	ompleted primary c	are appointmen	ts)				
1 (Chon g 2012)	randomise d trials	serious ¹	no serious inconsistency	no serious indirectness	no serious imprecision	none	56	76	-	SMD 0 higher (0.35 lower to 0.35 higher)	MODERA TE	CRITICAL
Satisfac	tion (follow-ເ	up 6 months	; measured with	: Visit specific	satisfaction of	questionnaire (VSQ	-9))					
1 (Chon g 2012)	randomise d trials	serious ¹	no serious inconsistency	no serious indirectness	no serious imprecision	none	80	87	-	SMD 0.17 higher (0.14 lower to 0.47 higher)	MODERA TE	IMPORTANT

BME: Black minority ethnic; CI: Confidence interval; RR: relative risk; SMD: standardised mean difference; TAU: treatment as usual

1. Risk of bias is high or unclear across multiple domains

2. 95% CI crosses 1 clinical decision threshold

Table 18: Clinical evidence profile for Comparison 5. Culturally-adapted CBT versus treatment as usual for a BME population

Quality	assessment		•	-		, ,	Number of pa	rticipants	Effect			
№ of studie s	Study design	Risk of bias	Inconsistenc y	Indirectnes s	Imprecisio n	Other considerations	Culturally- adapted CBT	TAU	Relative (95% Cl)	Absolute (95% Cl)	Quality	Importance
Satisfac	tion (follow-u	up 3 months	; measured with	: Number of p	articipants 've	ery satisfied' with tre	eatment)					
1 (Naee m 2015)	randomise d trials	very serious ¹	no serious inconsistency	no serious indirectness	serious ²	none	50/69 (72.5%)	32/68 (47.1%)	RR 1.54 (1.15 to 2.06)	254 more per 1000 (from 71 more to 499 more)	VERY LOW	IMPORTANT

BME: Black minority ethnic; CI: Confidence interval; RR: relative risk; TAU: treatment as usual

1. Risk of bias is high or unclear across multiple domains

2. 95% CI crosses 1 clinical decision threshold

Quality	Quality assessment							rticipants	Effect			
Nº of studie s	Study design	Risk of bias	Inconsistenc y	Indirectnes s	Imprecisio n	Other considerations	Culturally- adapted motivationa I enhanceme nt therapy for antidepress ants	Usual care	Relative (95% Cl)	Absolute (95% Cl)	Quality	Importance
Uptake	of treatment	(follow-up 5	months; measu	red with: Antic	lepressant ad	herence score on n	nedication even	t monitoring s	ystem (MEMS	5))		
1 (Interi an 2013)	randomise d trials	serious ¹	no serious inconsistency	no serious indirectness	no serious imprecision	none	26	24	-	SMD 3.89 higher (2.92 to 4.86 higher)	MODERA TE	CRITICAL

Table 19: Clinical evidence profile for Comparison 6. Culturally adapted motivational enhancement therapy for antidepressants versus usual care for a BME population

BME: Black minority ethnic; CI: Confidence interval; SMD: standardised mean difference

1. Risk of bias is high or unclear across multiple domains

Table 20: Clinical evidence profile for Comparison 7. Telephone CBT versus enhanced usual care for a BME population (living in rural areas)

Quality	assessment					Number of participants		Effect				
Nº of studie s	Study design	Risk of bias	Inconsistenc y	Indirectnes s	Imprecisio n	Other considerations	Telephone CBT	Enhanced usual care	Relative (95% Cl)	Absolute (95% Cl)	Quality	Importance
Satisfac	Satisfaction (follow-up 6 months; measured with: Number reporting they were satisfied with t							vided)				
1 (Dwig ht- Johns on 2011)	randomise d trials	very serious ¹	no serious inconsistency	no serious indirectness	serious ²	none	24/50 (48%)	12/51 (23.5%)	RR 2.04 (1.15 to 3.62)	245 more per 1000 (from 35 more to 616 more)	VERY LOW	IMPORTANT

BME: Black minority ethnic; CI: Confidence interval; RR: relative risk

1. Risk of bias is high or unclear across multiple domains

2. 95% Ci crosses 1 clinical decision threshold

		•••••								• · • · • · · · - •		
Quality	assessment						Number of pa	rticipants	Effect			
№ of studie s	Study design	Risk of bias	Inconsistenc y	Indirectnes s	Imprecisio n	Other considerations	Collaborativ e care	Enhanced standard care	Relative (95% Cl)	Absolute (95% Cl)	Quality	Importance
Accessi	ng treatment	(follow-up	4 months; meas	ured with: Nun	nber of patient	ts receiving antidep	pressants)					
1 (Lago masin o 2017)	randomise d trials	serious ¹	no serious inconsistency	no serious indirectness	no serious imprecision	none	77/171 (45%)	41/158 (25.9%)	RR 1.74 (1.27 to 2.37)	192 more per 1000 (from 70 more to 356 more)	MODERA TE	CRITICAL
Accessi	ng treatment	(follow-up	4 months; meas	ured with: Nun	nber of patient	ts receiving minima	Illy adequate tre	eatment (coun	selling or med	lications))		
1 (Lago masin o 2017)	randomise d trials	serious ¹	no serious inconsistency	no serious indirectness	no serious imprecision	none	131/170 (77.1%)	33/157 (21%)	RR 3.67 (2.68 to 5.02)	561 more per 1000 (from 353 more to 845 more)	MODERA TE	CRITICAL
Satisfac	tion (follow-u	up 4 months	; measured with	: Number of p	atients satisfie	ed or very satisfied	with emotional	health care)				
1 (Lago masin o 2017)	randomise d trials	serious ¹	no serious inconsistency	no serious indirectness	no serious imprecision	none	145/170 (85.3%)	90/160 (56.3%)	RR 1.52 (1.3 to 1.76)	292 more per 1000 (from 169 more to 428 more)	MODERA TE	IMPORTANT

Table 21: Clinical evidence profile for Comparison 8. Collaborative care versus enhanced standard care for BME population

BME: Black minority ethnic; CI: Confidence interval; RR: relative risk

1. Risk of bias is high or unclear across multiple domains

Table 22: Clinical evidence profile for Comparison 9. Culturally sensitive collaborative care versus standard collaborative care for BME population

Quality	Quality assessment							Number of participants		Effect		
№ of studie s	Study design	Risk of bias	Inconsistenc y	Indirectnes s	Imprecisio n	Other considerations	Culturally sensitive collaborativ e care	Standard collaborati ve care	Relative (95% Cl)	Absolute (95% Cl)	Quality	Importance
Accessi	ng treatment	(follow-up	12 months; mea	sured with: Nu	mber of patie	nts taking any antid	lepressant)					
1 (Coop er 2013)	randomise d trials	very serious ¹	no serious inconsistency	no serious indirectness	serious ²	none	17/59 (28.8%)	25/54 (46.3%)	RR 0.62 (0.38 to 1.02)	176 fewer per 1000 (from 287 fewer to 9 more)	VERY LOW	CRITICAL

Quality	Quality assessment						Number of pa	rticipants	Effect			
№ of studie s	Study design	Risk of bias	Inconsistenc y	Indirectnes s	Imprecisio n	Other considerations	Culturally sensitive collaborativ e care	Standard collaborati ve care	Relative (95% Cl)	Absolute (95% Cl)	Quality	Importance
1 (Coop er 2013)	randomise d trials	very serious ¹	no serious inconsistency	no serious indirectness	very serious ³	none	11/59 (18.6%)	13/54 (24.1%)	RR 0.77 (0.38 to 1.58)	55 fewer per 1000 (from 149 fewer to 140 more)	VERY LOW	CRITICAL
Accessi	ing treatment	(follow-up	12 months; mea	sured with: Nu	mber of patie	nts receiving guide	ine-concordant	t depression t	reatment)			
1 (Coop er 2013)	randomise d trials	very serious ¹	no serious inconsistency	no serious indirectness	serious ²	none	17/59 (28.8%)	28/54 (51.9%)	RR 0.56 (0.35 to 0.89)	228 fewer per 1000 (from 57 fewer to 337 fewer)	VERY LOW	CRITICAL

BME: Black minority ethnic; CI: Confidence interval; RR: relative risk

1. Risk of bias is high or unclear across multiple domains

2. 95% CI crosses 1 clinical decision threshold

3. 95% CI crosses 2 clinical decision thresholds

Interventions to promote access for men

Table 23: Clinical evidence profile for Comparison 10. Remote treatment versus face-to-face treatment for a predominantly male population

Quality	assessment						Number of pa	rticipants	Effect			
Nº of studie s	Study design	Risk of bias	Inconsistenc y	Indirectnes s	Imprecisio n	Other considerations	Remote treatment	Face-to- face treatment	Relative (95% Cl)	Absolute (95% Cl)	Quality	Importance
Satisfac	tion (follow-u	up 3 months	; measured with	: Number of p	atients satisfi	ed/very satisfied wit	th treatment)					
1 (Yuen 2015)	randomise d trials	serious ¹	no serious inconsistency	serious ²	no serious imprecision	none	29/29 (100%)	23/23 (100%)	RR 1 (0.93 to 1.08)	0 fewer per 1000 (from 70 fewer to 80 more)	LOW	IMPORTANT
Satisfac	tion (follow-u	up 2 months	; measured with	: Client Satisfa	action Questic	onnaire (CSQ))						
1 (Luxto n 2016)	randomise d trials	serious ¹	no serious inconsistency	serious ²	serious ³	none	45	42	-	SMD 0.14 lower (0.56 lower to 0.28 higher)	VERY LOW	IMPORTANT

CI: Confidence interval; RR: relative risk; SMD: standardised mean difference

1. Risk of bias is high or unclear across multiple domains

2. Sample of veterans accessing treatment through Veteran Affairs services which may limit generalisability 3. 95% CI crosses 1 clinical decision threshold

Table 24: Clinical evidence profile for Comparison 11. Collaborative care versus standard care/enhanced standard care for a
predominantly male population

Quality	assessment						Number of pa	rticipants	Effect			
№ of studie s	Study design	Risk of bias	Inconsistenc y	Indirectnes s	Imprecisio n	Other considerations	Collaborativ e care	Standard care/enha nced standard care	Relative (95% Cl)	Absolute (95% CI)	Quality	Importance
Accessi	ng treatment	(follow-up	3-12 months; me	asured with: N	Number who a	ttended ≥1 appoint	ment with ment	al health spec	ialist)			
2 (Dobs cha 2006; Hedric k 2003)	randomise d trials	very serious ¹	serious ²	serious ³	very serious ⁴	none	138/357 (38.7%)	120/372 (32.3%)	RR 1.2 (0.77 to 1.86)	65 more per 1000 (from 74 fewer to 277 more)	VERY LOW	CRITICAL
Accessi	ng treatment	(follow-up	8 months; meas	ured with: Nun	nber who have	e had a depression-	related primary	care visit)				
1 (Hedri ck 2003)	randomise d trials	very serious ¹	no serious inconsistency	serious ³	no serious imprecision	none	141/168 (83.9%)	106/186 (57%)	RR 1.47 (1.28 to 1.7)	268 more per 1000 (from 160 more to 399 more)	VERY LOW	CRITICAL
Accessi	ng treatment	(follow-up	3-12 months; me	asured with: N	Number of par	ticipants using anti	depressants)					
3 (Dobs cha 2006; Fortne y 2007; Hedric k 2003)	randomise d trials	very serious ¹	no serious inconsistency	serious ³	serious ⁵	none	342/434 (78.8%)	288/434 (66.4%)	RR 1.18 (1.09 to 1.29)	119 more per 1000 (from 60 more to 192 more)	VERY LOW	CRITICAL
Satisfac	tion (follow-u	up 12 month	s; measured wit	h: Number of	patients satisf	ied with care)						
1 (Fortn ey 2007)	randomise d trials	very serious ¹	no serious inconsistency	serious ³	serious⁵	none	100/141 (70.9%)	113/184 (61.4%)	RR 1.15 (0.99 to 1.35)	92 more per 1000 (from 6 fewer to 215 more)	VERY LOW	IMPORTANT

CI: Confidence interval; RR: relative risk

1. Risk of bias is high or unclear across multiple domains

2. I-squared>50%

3. Sample of veterans accessing treatment through Veteran Affairs services which may limit generalisability 4. 95% CI crosses 2 clinical decision thresholds

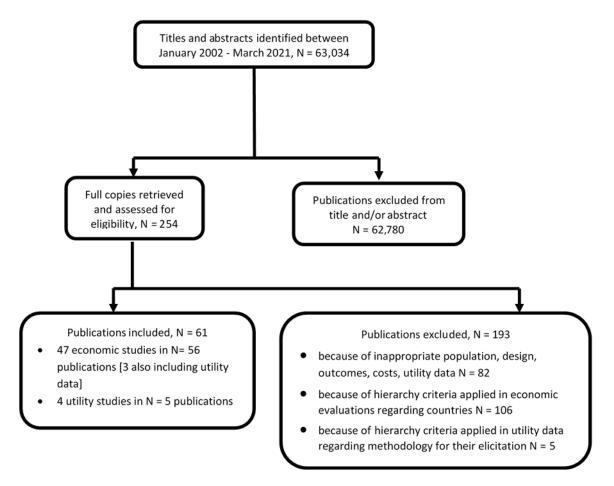
5. 95% CI crosses 1 clinical decision threshold

Appendix G – Economic evidence study selection

Economic evidence study selection for review question: For adults at risk of depression (or anxiety disorders) from particular vulnerable groups (older people, black minority ethnic groups, lesbian, gay bisexual, transgender groups and men) do service developments and interventions which are specifically designed to promote access, increase the proportion of people from the target group who access treatment, when compared with standard care?

A global health economics search was undertaken for all areas covered in the guideline. Figure 30 shows the flow diagram of the selection process for economic evaluations of interventions and strategies for adults with depression and studies reporting depressionrelated health state utility data.

Figure 30. Flow diagram of selection process for economic evaluations of interventions and strategies for adults with depression and studies reporting depression-related health state utility data.



Appendix H – Economic evidence tables

Economic evidence tables for review question: For adults at risk of depression (or anxiety disorders) from particular vulnerable groups (older people, black minority ethnic groups, lesbian, gay bisexual, transgender groups and men) do service developments and interventions which are specifically designed to promote access, increase the proportion of people from the target group who access treatment, when compared with standard care?

No economic evidence was identified which was applicable to this review question.

Appendix I – Economic evidence profiles

Economic evidence profiles for review question: For adults at risk of depression (or anxiety disorders) from particular vulnerable groups (older people, black minority ethnic groups, lesbian, gay bisexual, transgender groups and men) do service developments and interventions which are specifically designed to promote access, increase the proportion of people from the target group who access treatment, when compared with standard care?

No economic evidence was identified which was applicable to this review question.

Appendix J – Economic analysis

Economic evidence analysis for review question: For adults at risk of depression (or anxiety disorders) from particular vulnerable groups (older people, black minority ethnic groups, lesbian, gay bisexual, transgender groups and men) do service developments and interventions which are specifically designed to promote access, increase the proportion of people from the target group who access treatment, when compared with standard care?

No economic analysis was conducted for this review question.

Appendix K – Excluded studies

Excluded clinical and economic studies for review question: For adults at risk of depression (or anxiety disorders) from particular vulnerable groups (older people, black minority ethnic groups, lesbian, gay bisexual, transgender groups and men) do service developments and interventions which are specifically designed to promote access, increase the proportion of people from the target group who access treatment, when compared with standard care?

Clinical studies

Please refer to the excluded studies in supplement H – Clinical evidence tables for review 3.0

Economic studies

Please refer to supplement 3 - Economic evidence included & excluded studies.

Appendix L – Research recommendations

Research recommendations for review question: For adults at risk of depression (or anxiety disorders) from particular vulnerable groups (older people, black minority ethnic groups, lesbian, gay bisexual, transgender groups and men) do service developments and interventions which are specifically designed to promote access, increase the proportion of people from the target group who access treatment, when compared with standard care?

Research question

What are the most effective and cost effective methods to promote increased access to, and uptake of, treatments for people with depression who are under-represented in current services?

Why this is important

There is general under-recognition of depression but the problem is more marked in certain populations. In addition, even where depression is recognised by the person with depression or by health professionals, access to treatment can still be difficult. A number of factors may relate to this limited access including a person's view of their problems, the information available on services and the location, design and systems for referral to services. The aim of this research would be to identify methods to increase access to and uptake of treatment in these hard-to-reach groups, and so improve outcomes.

Research question	What are the most effective and cost effective methods to promote increased access to, and uptake of, treatments for people with depression who are under-represented in current services?
Importance to 'patients' or the population	There are groups within the population who find it more difficult than others to access treatment for depression, for example those from minority ethnic communities, those with disabilities or older people. Identifying how interventions can be targeted or adapted to meet the needs of these people and enable them to access services can lead to effective treatment of their depression, improved quality of life and improved functioning.
Relevance to NICE guidance	The NICE guideline on depression recommends treatments for first-line treatment, further-line treatment, relapse prevention and chronic depression, but these treatments will not be effective if they cannot be accessed. As there is evidence that certain sections of the population find it more difficult to access treatment for depression, it is important to improve access to ensure that the treatment recommendations are available all those who suffer from depression.
Relevance to the NHS	Failure to treat depression in marginalised groups may to lead to a greater impact on NHS resources in the long-term,
National priorities	The NHS Five Year Forward plan makes access to mental health services a key national priority
Current evidence base	A number of studies have addressed reduced access to treatment for depression, and a number of strategies have been developed to address it but no consistent picture has emerged from the research which can inform the design and delivery of services to promote access. Little is also known about how these systems might be tailored to the needs of particular groups such as older people, people from black, Asian and minority ethnic communities, and people with disabilities who may have additional difficulties in accessing services.
Equality	All sections of the population should have equal access to services for the treatment of depression

Table 25: Research recommendation rationale

Criterion	Explanation
Population	 Adults (18 years and older) identified with or at risk of depression from the following vulnerable groups: BME groups Older adults LGBT groups Men People with disabilities
Intervention	 Service developments or changes which are specifically designed to promote access. Specific models of service delivery (that is, community-based outreach clinics, clinics or services in non-health settings). Methods designed to remove barriers to access (including stigma, misinformation or cultural beliefs about the nature of mental disorder)
Comparator (without the risk factor)	Standard care
Outcome	 Critical: Proportion of people from the target group who access treatment Uptake of treatment Symptomatology, response, remission and relapse Important: Satisfaction, preference Anxiety about treatment Cost-effectiveness to be included as an outcome as well.
Study design	Randomised controlled trials
Timeframe	6 to 12 months; ideally follow-up study to assess remission/relapse

Table 26: Research recommendation modified PICO table