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## 1.1 ACCESS TO HEALTHCARE

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

<b>Study ID</b>	<b>COCHRANE2007</b>
<b>Bibliographic reference:</b>	
Cochrane, L. J., Olson, C. A., Murray, S., <i>et al.</i> (2007) Gaps between knowing and doing: understanding and assessing the barriers to optimal health care. <i>Journal of Continuing Education in the Health Professions</i> , 27, 94–102.	
<b>Participant characteristics</b>	General population
<b>Method used to synthesise evidence</b>	Qualitative thematic analysis
<b>Design of included studies</b>	Qualitative, surveys and mixed-model
<b>Dates searched</b>	1998–2007
<b>Number of included studies</b>	256
<b>Source of funding</b>	Not reported

<b>Study ID</b>	<b>DAS2006</b>
<b>Bibliographic reference:</b>	
Das, A. K., Olfson, M., McCurtis, H. L., <i>et al.</i> (2006) Depression in African Americans: breaking barriers to detection and treatment. <i>Applied Evidence</i> , 55, 30–39.	
<b>Participant characteristics</b>	African Americans
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Qualitative and quantitative studies
<b>Dates searched</b>	1966–2004
<b>Number of included studies</b>	24
<b>Source of funding</b>	Columbia Center for the Health of Urban Minorities (NCMHHD MD000206-019006) (Drs Olfson and Weissman), an unrestricted grant from Eli Lilly & Company (Dr Weissman) and a NIMH National Service Research Award Institutional Research Training Grant 5T32MH015144 (Dr Das)

<b>Study ID</b>	<b>DENNIS2006</b>
<b>Bibliographic reference:</b> Dennis, C. & Chung-Lee, L. (2006) Postpartum depression help-seeking barriers and maternal treatment preferences: a qualitative systematic review. <i>Birth</i> , 33, 323–331.	
<b>Participant characteristics</b>	Postpartum depression only (does not include other perinatal mood disorders)
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Qualitative
<b>Dates searched</b>	1966–2005
<b>Number of included studies</b>	40
<b>Source of funding</b>	Not reported

<b>Study ID</b>	<b>DIXON-WOODS2005</b>
<b>Bibliographic reference:</b> Dixon-Woods, M., Kirk, D., Agarwal, S., <i>et al.</i> (2005) <i>Vulnerable Groups and Access to Health Care: a Critical Interpretive Synthesis</i> . (Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO). London: National Co-ordinating Centre for NHS Service Delivery and Organisation.	
<b>Participant characteristics</b>	General population; BME groups; older people
<b>Method used to synthesise evidence</b>	Meta-ethnography (critically interpretive synthesis)
<b>Design of included studies</b>	Qualitative
<b>Dates searched</b>	1985–2005
<b>Number of included studies</b>	General population: n = 253 BME groups: n = 103 Older people: n = 111
<b>Source of funding</b>	Not reported

<b>Study ID</b>	<b>JUNG2003</b>
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<b>Bibliographic reference:</b>	
Jung, H. P., Baerveldt, C., Olesen, F., <i>et al.</i> (2003) Patient characteristics as predictors of primary health care preferences: a systematic literature analysis. <i>Health Expectations</i> , 6, 160–181.	
<b>Participant characteristics</b>	Older patients
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Not specified
<b>Dates searched</b>	1963–2001
<b>Number of included studies</b>	145
<b>Source of funding</b>	Not reported

<b>Study ID</b>	<b>PRINS2008</b>
<b>Bibliographic reference:</b>	
Prins, M. A., Verhaak, P. F. M., Bensing, J. M., <i>et al.</i> (2008) Health beliefs and perceived need for mental health care of anxiety and depression – the patients’ perspective explored. <i>Clinical Psychology Review</i> , 28, 1038–1058.	
<b>Participant characteristics</b>	Patients with anxiety or depression
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Qualitative and quantitative studies
<b>Dates searched</b>	1995–2006
<b>Number of included studies</b>	71
<b>Source of funding</b>	Not reported

<b>Study ID</b>	<b>RODRIGUEZ2009</b>
<b>Bibliographic reference:</b>	
Rodriguez, M., Valentine, J. M., Son, J. B., <i>et al.</i> (2009) Intimate partner violence and barriers to mental health care for ethnically diverse populations of women. <i>Trauma Violence Abuse</i> , 10, 358–374.	
<b>Participant characteristics</b>	Women who have suffered domestic violence
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Qualitative, quantitative, and reviews
<b>Dates searched</b>	1996–2008
<b>Number of included studies</b>	55
<b>Source of funding</b>	NIMH-funded University of California at Los Angeles Center for Culture, Trauma, and Mental Health Disparities (1P50MH073453) and National Institutes of Health/National Center on Minority Health University of California at Los Angeles/Drew Project Export (P20 MD000148)

<b>Study ID</b>	<b>SCHEPPERS2006</b>
<b>Bibliographic reference:</b>	
Scheppers, E., van Dongen, E., Dekker, J., <i>et al.</i> (2006) Potential barriers to the use of health services among ethnic minorities: a review. <i>Family Practice</i> , 23, 325–348.	
<b>Participant characteristics</b>	General population
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Qualitative, quantitative, combined
<b>Dates searched</b>	1990–2003
<b>Number of included studies</b>	54
<b>Source of funding</b>	ZonMw, The Netherlands Organisation for Health Research and Development. Grant number 14350023



<b>Study ID</b>	<b>VANVOORHES2007</b>
<b>Bibliographic reference:</b>	Van Voorhees, B. W., Walters, A. E., Prochaska, M., <i>et al.</i> (2007) Reducing health disparities in depressive disorders outcomes between non-Hispanic whites and ethnic minorities: a call for pragmatic strategies over the life course. <i>Medical Care Research and Review</i> , 64, 157S–194S.
<b>Participant characteristics</b>	BME groups
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Interventions studies
<b>Dates searched</b>	1995–2006
<b>Number of included studies</b>	73
<b>Source of funding</b>	Robert Wood Johnson Foundation through Finding Answers: Disparities Research for Change, the Department of Medicine at The University of Chicago, and the National Institute of Diabetes and Digestive and Kidney Diseases Diabetes Research and Training Center (P60 DK20595). Dr Van Voorhees is supported by a NARSAD Young Investigator Award, a Robert Wood Johnson Foundation Depression in Primary Care Value Grant and a Career Development Award from NIMH (K-08 MH 072918-01A2)

### 1.1.2 Included studies characteristics (systematic reviews evaluating adapting models of service delivery and therapeutic interventions to improve access)

<b>Study ID</b>	<b>BALAS1997</b>
<b>Bibliographic reference:</b>	Balas, E. A., Jaffrey, F., Kuperman, G. J., <i>et al.</i> (1997) Electronic communication with patients evaluation of distance medicine technology. <i>Journal of the American Medical Association</i> , 278, 152–159.
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	RCTs
<b>Dates searched</b>	1966–1996
<b>Review quality</b>	Adequate
<b>Model /method evaluated</b>	Electronic communication (telephone or computer)
<b>Comparison</b>	Control
<b>Outcome</b>	Service-user satisfaction Appointment-keeping
<b>Participant characteristics</b>	General population
<b>Pooled effect sizes or summary of findings</b>	Inteventions resulted in: <ul style="list-style-type: none"> <li>• higher service user satisfaction</li> <li>• fewer unkept appointments</li> <li>• higher utilistaion of preventative healthcare by elderly individuals keeping rates</li> </ul>
<b>Source of funding</b>	National Library of Medicine (LM05545), and a grant from the Center for Health Management Research of the National Science Foundation and Arizona State University, Tempe

<b>Study ID</b>	<b>BEE2008</b>
<b>Bibliographic reference:</b>	Bee, P. E., Bower, P., Lovell, K., <i>et al.</i> (2008) Psychotherapy mediated by remote communication technologies: a meta-analytic review. <i>BMC Psychiatry</i> , 8, 60.
<b>Method used to synthesise evidence</b>	Meta-analysis

<b>Design of included studies</b>	RCTs
<b>Dates searched</b>	1980–2006
<b>Review quality</b>	Adequate
<b>Model/method evaluated</b>	Psychological intervention delivered via remote communication
<b>Comparison</b>	Control; conventional face-to-face therapy; different types of remote therapy
<b>Outcome</b>	Ability to increase access to services
<b>Participant characteristics</b>	ICD-10 or DSM diagnosis of mood or functional (non-organic) mental health problem – that is, depression, anxiety or anxiety-related disorders
<b>Pooled effect sizes or summary of findings</b>	<p>Verses control:</p> <ul style="list-style-type: none"> <li>• depression: 0.44 (95% CI 0.29 to 0.59; 7 comparisons, n = 726)</li> <li>• anxiety-related disorders: 1.15 (95% CI 0.81 to 1.49; 3 comparisons, n = 168)</li> </ul>
<b>Source of funding</b>	Not reported

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

<b>Source of funding</b>	The Greater London Authority funded the original review on which this paper is based
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<b>Study ID</b>	<b>GRILLI2009</b>
<b>Bibliographic reference:</b>	
Grilli, R., Ramsay, C. & Minozzi, S. (2002) Mass media interventions: effects on health service utilisation. <i>Cochrane Database of Systematic Reviews</i> , Issue 1, CD000389.	
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	RCTs, controlled clinical trials, controlled before and after trials, interrupted time series analyses
<b>Dates searched</b>	Database inception to 1999
<b>Review quality</b>	Adequate
<b>Model/method evaluated</b>	Mass media (for example, radio, television, newspapers, leaflets)
<b>Comparison</b>	No direct comparison
<b>Outcome</b>	Objective (not self-reported) utilisation of healthcare services by healthcare practitioners and individuals
<b>Participant characteristics</b>	General population
<b>Pooled effect sizes or summary of findings</b>	Mass media can have an impact on healthcare service utilisation, but evidence is methodologically flawed and should be viewed with caution
<b>Source of funding</b>	Internal sources: <ul style="list-style-type: none"> <li>• Agenzia Sanitaria Regionale Emilia-Romagna, Bologna, Italy</li> <li>• Health Services Research Unit, University of Aberdeen, UK</li> </ul> External sources: <ul style="list-style-type: none"> <li>• NHS Research &amp; Development Programme, UK</li> </ul>

<b>Study ID</b>	<b>KAIRY2009</b>
<b>Bibliographic reference:</b>	
Kairy, D., Lehoux, P., Vincent, C. F., <i>et al.</i> (2009) A systematic review of clinical outcomes, clinical process, healthcare utilization and costs associated with telerehabilitation. <i>Disability and Rehabilitation</i> , 31, 1-21.	
<b>Method used to synthesise evidence</b>	Narrative

<b>Design of included studies</b>	Experimental or observational intervention studies including cross-over designs
<b>Dates searched</b>	Database inception to 2007
<b>Review quality</b>	Included study quality is assessed but not reported
<b>Model/method evaluated</b>	Telerehabilitation
<b>Comparison</b>	Control (face-to-face or usual care)
<b>Outcome</b>	Attendance and adherence to programmes Service user accessibility to programme Service user satisfaction Healthcare utilisation
<b>Participant characteristics</b>	General population
<b>Pooled effect sizes or summary of findings</b>	Interventions resulted in: <ul style="list-style-type: none"> <li>• greater attendance</li> <li>• greater adherence</li> <li>• higher service user satisfaction</li> <li>• healthcare utilisation was rarely measured in included studies and the results are inconclusive</li> </ul>
<b>Source of funding</b>	Not reported

<b>Study ID</b>	<b>KINNERSLEY2007</b>
<b>Bibliographic reference:</b> Kinnersley, P., Edwards, A., Hood, K., <i>et al.</i> (2008) Interventions before consultations to help patients address their information needs by encouraging question asking: systematic review. <i>British Medical Journal</i> , 337, A485–A494.	
<b>Method used to synthesise evidence</b>	Meta-analysis
<b>Design of included studies</b>	RCTs
<b>Dates searched</b>	1966–2006
<b>Review quality</b>	Adequate
<b>Model/method evaluated</b>	Information giving prior to consultation
<b>Comparison</b>	Control (for example, usual care, leaflets, general discussion)
<b>Outcome</b>	Question-asking Individuals' anxiety

	Service user knowledge and satisfaction
<b>Participant characteristics</b>	General population
<b>Pooled effect sizes or summary of findings</b>	Inteventions resulted in: <ul style="list-style-type: none"> <li>• significant increase in question asking (0.27, 95% CI 0.19 to 0.36)</li> <li>• individuals' satisfaction (0.09, 0.03 to 0.16)</li> <li>• non-significant changes in individuals' anxiety before and after consultation, individuals' knowledge, length of consultation</li> </ul>
<b>Source of funding</b>	This research received no specific grant from any funding agency in the public, commercial, or not for profit sectors

<b>Study ID</b>	<b>PIGNONE2005</b>
<b>Bibliographic reference:</b>	Pignone, M., DeWalt, D. A., Sheridan, S., <i>et al.</i> (2005) Interventions to improve health outcomes for patients with low literacy: a systematic review. <i>Journal of General Internal Medicine</i> , 20, 185–192.
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Controlled and uncontrolled trials
<b>Dates searched</b>	1980–2003
<b>Review quality</b>	Adequate
<b>Model/method evaluated</b>	Easy-to-read written material, videotapes, CD-ROM, computer programs, interactive videodisks, in-person instruction
<b>Comparison</b>	No intervention. literature at a standard level
<b>Outcome</b>	Health knowledge Health behaviours Use of healthcare services
<b>Participant characteristics</b>	Persons with low literacy skills
<b>Pooled effect sizes or summary of findings</b>	Effectiveness of interventions inconclusive
<b>Source of funding</b>	Supported by a contract to the Agency for Healthcare Research and Quality (290-02-0016), Rockville, MD

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

<b>Study ID</b>	ANDERSON2003
<b>Bibliographic reference:</b>	Anderson, L. M., Scrimshaw, S. C., Fullilove, M. T., <i>et al.</i> (2003) Culturally competent healthcare systems: a systematic review. <i>American Journal of Preventative Medicine</i> , 24, 68–79.
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Not specified
<b>Dates searched</b>	1965–2001
<b>Review quality</b>	The design and the quality of the included studies was unspecified
<b>Number of included studies</b>	6
<b>Targeted vulnerable group</b>	BME groups
<b>Model/method evaluated</b>	Recruit members of staff who reflect the community culturally Use of interpreter or bilingual practitioners Cultural competence training Linguistically and culturally appropriate health education materials Cultural specific healthcare settings
<b>Comparison</b>	No exposure to intervention
<b>Outcome</b>	Client satisfaction Racial/ethnic differentials in utilisation of healthcare services
<b>Results</b>	Insufficient evidence to evaluate effectiveness of culturally diverse staff reflecting the local community Use of bilingual practitioner resulted in patient being more likely to obtain a follow-up appointment than if an interpreter was used (OR = 1.92, 95% CI = 1.11 to 3.33) Interpreter not used – service user less likely to be given a follow-up appointment than those with language-concordant physician (OR = 1.79, 95% CI = 1.00 to 3.23). No difference in uptake of treatment Staff training about cultural awareness resulted in greater client satisfaction in African-American individuals (standard effect size = 1.6, $p < 0.001$ ). Also more likely to return for more sessions (absolute difference = 3%, $p < 0.001$ ) Only one out of four studies reported change in health behaviour due to use of signage and literature in individuals' language. Three out of four studies reported greater client satisfaction. Overall evidence is weak
<b>Source of funding</b>	Robert Wood Johnson Foundation

<b>Study ID</b>	<b>BEACH2006</b>
<b>Bibliographic reference:</b>	Beach, M. C., Gary, T. L., Price, E. G., <i>et al.</i> (2006) Improving health care quality for racial/ethnic minorities: a systematic review of the best evidence regarding provider and organization interventions. <i>BMC Public Health</i> , 6, 104.
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	RCTs
<b>Dates searched</b>	1980–2003
<b>Review quality</b>	Adequate
<b>Number of included studies</b>	27
<b>Targeted vulnerable group</b>	BME groups
<b>Model/method evaluated</b>	Tracking/reminder systems Multifaceted Interventions Bypass the physician Practitioner education Structured questionnaire Remote simultaneous translation Culturally tailored interventions
<b>Comparison</b>	No exposure to intervention
<b>Outcome</b>	Use of services Appropriateness of care Quality of practitioners Service user adherence Service user satisfaction Individual/practitioner communication
<b>Results</b>	Strong evidence to support the use of tracking/reminder systems Evidence is generally positive (but inconsistent across outcomes) for multi-faceted interventions Evidence supporting bypassing the physician for preventative services is fair Evidence supports practitioner education because it had a positive effect on counselling behaviours Insufficient evidence to support the use of structured questionnaires in assessment Evidence for remote simultaneous translation shows favourable outcomes for accuracy of translation and practitioner/service-user satisfaction; improved communication



	Evidence was weak and inconclusive for culturally tailored interventions to improve quality of depression care
<b>Source of funding</b>	Under contract to the Agency for Healthcare Research and Quality (Contract No. 290-02-0018), Rockville, MD

<b>Study ID</b>	<b>FISHER2007</b>
<b>Bibliographic reference:</b>	
Fisher, T. L., Burnet, D. L., Huang, E. S., <i>et al.</i> (2007) Cultural leverage: interventions using culture to narrow racial disparities in health care. <i>Medical Care Research Review</i> , 64 (5), 243S–282S.	
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Various (not restricted to RCTs)
<b>Dates searched</b>	1985–2006
<b>Review quality</b>	Adequate
<b>Number of included studies</b>	38
<b>Targeted vulnerable group</b>	BME groups
<b>Model/method evaluated</b>	Individual level interventions to modify existing behaviour Interventions that increase access to existing healthcare environments Interventions that modify healthcare interventions
<b>Comparison</b>	No exposure to intervention; pre- and post- intervention
<b>Outcome</b>	Use of services Service user understanding Service user satisfaction
<b>Results</b>	Individual level interventions resulted in general improvement in health but no evidence for access outcomes Access level interventions did not show any significant improvements in improving healthcare for BME groups Healthcare interventions (such as staff training in culturally specific interventions) showed some evidence of improved service user understanding of disease, satisfaction, and some trends for improving behaviour
<b>Source of funding</b>	Robert Wood Johnson Foundation through Finding Answers: Disparities Research for Change, the Department of Medicine at the University of Chicago, and the National Institute of Diabetes and Digestive and Kidney Diseases Diabetes Research and Training Center (P60 DK20595). Dr Fisher is supported by the National Institutes of Health Loan Repayment Program. Dr Burnet is supported by an National Institutes of Health Career Development Award (K23 DK064073-01). Dr Huang is supported by an National Institutes of Health Career Development Award (K23 AG021963). Dr Chin is supported by an National Institutes of Health Midcareer Investigator Award in Patient-Oriented Research (K24 DK071933)

<b>Study ID</b>	<b>FLORES2005</b>
<b>Bibliographic reference:</b>	Flores, G. (2005) The impact of medical interpreter services on the quality of health care: a systematic review. <i>Medical Care Research Review</i> , 62, 255–299.
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Various (not restricted to RCTs)
<b>Dates searched</b>	1966–2003
<b>Review quality</b>	The quality of the included studies was unspecified
<b>Number of included studies</b>	36
<b>Targeted vulnerable group</b>	Limited English proficiency participants
<b>Model/method evaluated</b>	Use of professional medical service interpreters Use of bilingual physicians Use of ad hoc interpreters
<b>Comparison</b>	Cross-comparisons; use of monolingual interpreter; no interpreter
<b>Outcome</b>	Use of services Service user satisfaction Individual-practitioner communication
<b>Results</b>	Service user satisfaction – no difference between interpreter by telephone or in person; those who needed help but were not given access to an interpreter had the lowest satisfaction; use of an ad hoc interpreter was given a lower rating than use of a professional interpreter Communication – ‘no interpreter’ – service user had poor understanding of diagnosis/treatment plan; ‘use of interpreter’ – service user more likely to incorrectly describe symptoms than those who did not need an interpreter; ad hoc interpreter resulted in individuals not been told medication side effects, misinterpretation and errors in translations, and issues of confidentiality; mental health specifically – more open to misinterpretation, ‘normalisation’ of symptoms by interpreter or ad hoc interpreter such as family member Use of an interpreter – increased use of healthcare services; limited English-proficiency participants had a greater number of prescriptions written (adjusted mean difference = 1.4) and filled (adjusted mean difference = 1.3) than English proficient individuals
<b>Source of funding</b>	National Standards for Health Care Language Services project, with support from the Office of Minority Health

<b>Study ID</b>	<b>MEGHANI2009</b>
<b>Bibliographic reference:</b>	
Meghani, S. H., Brooks, J. M., Gipson-Jones, T., <i>et al.</i> (2009) Patient-provider race-concordance: does it matter in improving minority patients' health outcomes? <i>Ethnicity &amp; Health</i> , 14, 107-130.	
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Qualitative and experimental studies
<b>Dates searched</b>	1980-2008
<b>Review quality</b>	Adequate
<b>Number of included studies</b>	27
<b>Targeted vulnerable group</b>	BME groups
<b>Model/method evaluated</b>	'Patient-practitioner' 'race-concordance'
<b>Comparison</b>	N/A
<b>Outcome</b>	Utilisation of healthcare Individual preference (that is, normative expectations) Provision of healthcare Individual-practitioner communication Service user satisfaction Individual preference Perception of respect
<b>Results</b>	'Race-concordance' had a positive impact on utilisation of healthcare Results for other outcomes are inconclusive
<b>Source of funding</b>	Not reported

<b>Study ID</b>	<b>VANCITTERS2004</b>
<b>Bibliographic reference:</b>	
Van Citters, A. D. & Bartels, S. J. (2004) A systematic review of the effect of community-based mental health outreach services for older adults. <i>Psychiatric Services</i> , 55, 1237-1249	
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Various (not restricted to RCTs)
<b>Dates searched</b>	Database inception to 2004
<b>Review quality</b>	The quality of the included studies was unspecified
<b>Number of included studies</b>	14
<b>Targeted vulnerable group</b>	Older individuals
<b>Model/method evaluated</b>	Gatekeeper model
<b>Comparison</b>	Traditional referral sources (medical practitioners, family members, informal caregivers)
<b>Outcome</b>	Use of mental healthcare services
<b>Results</b>	Gatekeeper model more likely to reach individuals who are less likely to gain access to services (for example, those who live alone, are widowed or divorced, or are affected by economic and social isolation) At one year follow-up, no difference between two methods in service use or out-of-home placement
<b>Source of funding</b>	Not reported

## 1.2 CASE IDENTIFICATION

### 1.2.1 Included studies characteristics

Study ID	BYRNE2011
<b>Bibliographic reference:</b> Byrne, G. J. & Pachana, N. A. (2010) Development and validation of a short form of the Geriatric Anxiety Inventory – the GAI-SF. <i>International Psychogeriatrics</i> , 23, 125-131.	
Clinical features and settings	Older participants from the community
Participants	N = 284 participants; 100% women, mean age 72.2 years
Study design	Cross-sectional
Target condition and reference standard(s)	GAD by DSM-IV (Mini International Neuropsychiatric Interview)
Index and comparator tests	GAI-SF: a five-item version of the longer scale; cut off = $\geq 3$
Results	Sensitivity = 0.78, specificity = 0.69, LR+ = 2.52, LR- = 0.32
Older adult sample	Yes
Consultation sample	No
Chronic physical health problems	No
Notes	Verification occurred in n = 242 of the N = 284 women (85.2%)

### Assessment of methodological quality table

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

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

<b>Study ID</b>	<b>CAMPBELL2009</b>
<b>Bibliographic reference:</b> Campbell-Sills, L., Norman, S. B., Craske, M. G., <i>et al.</i> (2009) Validation of a brief measure of anxiety-related severity and impairment: the Overall Anxiety Severity and Impairment Scale (OASIS). <i>Journal of Affective Disorders</i> , 112, 92–101.	
<b>Clinical features and settings</b>	Primary care patients referred by their GP into an anxiety treatment study if thought they would benefit
<b>Participants</b>	N = 1,036 patients; 28.8% male, mean age 42.8 years (range 18 to 75 years).
<b>Study design</b>	Cross-sectional (participants were taking part in a clinical trial)
<b>Target condition and reference standard(s)</b>	Anxiety by DSM-IV (mini international neuropsychiatric interview)
<b>Index and comparator tests</b>	OASIS: a five-item self-report measure. Responses are coded 0–4. Cut-off = 8
<b>Results</b>	Sensitivity = 0.89, specificity = 0.71, LR+ = 3.07, LR- = 0.15
<b>Older adult sample</b>	No
<b>Consultation sample</b>	Yes (primary care)
<b>Chronic physical health problems</b>	No
<b>Notes</b>	Prevalence of any anxiety disorder: 89.3% (n = 925 of N = 1036). 60.6% of participants also met criteria for MDD and 4.3% met criteria for dysthymic disorder. Some participants also endorsed alcohol (10.6%) and/or substance use (3.9%) disorders

### Assessment of methodological quality table

Item	Judgement
Representative spectrum?	Yes
Acceptable reference standard?	Yes
Acceptable delay between tests?	Yes
Partial verification avoided?	Unclear
Differential verification avoided?	Unclear

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

<b>Study ID</b>	<b>DENNIS2007</b>
<b>Bibliographic reference:</b> Dennis, R. E., Boddington, S. J. & Funnell N. J. (2007) Self-report measures of anxiety: Are they suitable for older adults? <i>Aging &amp; Mental Health</i> , 11, 668-677.	
<b>Clinical features and settings</b>	Patients from an NHS mental health trust.
<b>Participants</b>	N = 40 patients (three dropped out); 27.5% male, mean age 75.5 years, 45% received outpatient treatment, 37.5% received day-hospital care, 17.5% were psychiatric inpatients. Inclusion criteria: over 65 years old, no organic dementia, observable symptoms of anxiety or in remission from an episode in the past 12 months, no acute psychiatric episode
<b>Study design</b>	Cross-sectional (mental health professionals were asked to identify potential participants from their caseloads)
<b>Target condition and reference standard(s)</b>	Anxiety by DSM-IV (SCID-IV)
<b>Index and comparator tests</b>	VAS: a 20-centimetre line divided into ten equal-sized parts ranging from 'No anxiety' to 'Most anxiety'. Participants draw a vertical line through where they felt their anxiety over the past week was best represented. Cut-off = 10/11 centimetres. HADS-A
<b>Results</b>	VAS: sensitivity = 0.5, specificity = 0.607, LR+ = 1.27, LR- = 0.82 HADS-A: sensitivity = 0.75, specificity = 0.536, LR+ = 1.62, LR- = 0.47
<b>Older adult sample</b>	Yes
<b>Consultation sample</b>	Yes
<b>Chronic physical health problems</b>	No
<b>Notes</b>	Prevalence of anxiety: 30% (n = 12 of N = 40)

### Assessment of methodological quality table

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

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



<b>Chronic physical health problems</b>	No
<b>Notes</b>	Prevalence of at least one anxiety disorder: 50% (panic: 20%; other anxiety: 48% [n = 24 of N = 50])

### Assessment of methodological quality table

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

<b>Study ID</b>	<b>GILL2007</b>
<b>Bibliographic reference:</b> Gill, S. C., Butterworth, P., Rodgers, B., <i>et al.</i> (2007) Validity of the mental health component scale of the 12-item Short-Form Health Survey (MCS-12) as measure of common mental disorders in the general population. <i>Psychiatry Research</i> , 152, 63-71.	
<b>Clinical features and settings</b>	People selected by telephone screening from the general population
<b>Participants</b>	N = 10,504 participants (Australians); 44.3% male, mean age 45 years
<b>Study design</b>	Cross-sectional (stratified sampling procedure)
<b>Target condition and reference standard(s)</b>	Anxiety and/or depression by DSM-IV (Composite International Diagnostic Interview [CIDI])
<b>Index and comparator tests</b>	MCS-12 (MCS scale of the SF-12). Scores range from 0 to 100, with lower scores reflecting poorer mental health. Cut-off ≤50

<b>Results</b>	Common mental health disorders: sensitivity = 0.84, specificity = 0.74, LR+ = 3.23, LR- = 0.22 Anxiety: sensitivity = 0.81, specificity = 0.73, LR+ = 3, LR- = 0.26
<b>Older adult sample</b>	No
<b>Consultation sample</b>	No
<b>Chronic physical health problems</b>	No
<b>Notes</b>	Prevalence of depression and/or anxiety: 9.0%; depression: 4.0%; anxiety: 7.2%

### Assessment of methodological quality table

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

<b>Study ID</b>	<b>HALL1999</b>
<b>Bibliographic reference:</b> Hall, A., A'Hern, R. & Fallowfield, L. (1999) Are we using appropriate self-report questionnaires for detecting anxiety and depression in women with early breast cancer? <i>European Journal of Cancer</i> , 35, 79-85.	
<b>Clinical features and settings</b>	Women being treated for early breast cancer who were recruited to a study designed to assess psychological outcomes of different treatment policies
<b>Participants</b>	N = 266 participants; 100% women, all under 75 years old

<b>Study design</b>	Cross-sectional (participants were taking part in a clinical trial)
<b>Target condition and reference standard(s)</b>	Anxiety by DSM-III (Present State Examination)
<b>Index and comparator tests</b>	HADS-A: a seven-item subscale of the HADS, measuring anxiety symptoms over the previous week on seven-point Likert-type scales. Cut-off = 7+ RSCL: a self-report scale to measure symptoms of psychological distress reported by primary care patients. Cut-off = 7
<b>Results</b>	HADS-A: sensitivity = 0.72, specificity = 0.8, LR+ = 3.6, LR- = 0.35 RSCL: sensitivity = 0.85, specificity = 0.67, LR+ = 2.58, LR- = 0.22
<b>Older adult sample</b>	No
<b>Consultation sample</b>	Yes
<b>Chronic physical health problems</b>	Yes
<b>Notes</b>	Prevalence of anxiety: 49.6% (n = 132 of N = 266)

### Assessment of methodological quality table

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

<b>Study ID</b>	<b>HAWORTH2007</b>
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<b>Bibliographic reference:</b>	
Haworth, J. E., Moniz-Cook, E., Clark, A. L., <i>et al.</i> (2007) An evaluation of two self-report screening measures for mood in an out-patient chronic heart failure population. <i>International Journal of Geriatric Psychiatry</i> , 22, 1147-1153.	
<b>Clinical features and settings</b>	Chronic heart failure patients attending an outpatient clinic
<b>Participants</b>	N = 90 participants; 81% male, mean age 69.9 years (range 56 to 92 years). 89% reported co-morbid physical problems, 11% were on antidepressants and 1% was on an anxiolytic. Inclusion criteria: symptoms of heart failure for 3+ months. No cognitive impairment (two participants excluded for this reason)
<b>Study design</b>	Cross-sectional (consecutive sample)
<b>Target condition and reference standard(s)</b>	Anxiety by DSM-IV (SCID-IV)
<b>Index and comparator tests</b>	HADS-A: a seven-item subscale of the HADS, measuring anxiety symptoms over the previous week on seven-point Likert-type scales. Cut-off = 7+
<b>Results</b>	Sensitivity = 0.94, specificity = 0.85, LR+ = 6.27, LR- = 0.07
<b>Older adult sample</b>	Yes
<b>Consultation sample</b>	Yes
<b>Chronic physical health problems</b>	Yes
<b>Notes</b>	Prevalence of anxiety: 18%

### Assessment of methodological quality table

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

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

<b>Study ID</b>	<b>KRASUCKI1999</b>
<b>Bibliographic reference:</b> Krasucki, C., Ryan, P., Ertan, T., <i>et al.</i> (1999) The FEAR: a rapid screening instrument for generalized anxiety in elderly primary care attenders. <i>International Journal of Geriatric Psychiatry</i> , 14, 60–68.	
<b>Clinical features and settings</b>	Primary care patients
<b>Participants</b>	N = 88 participants (n = 48 diagnosed using ICD-10); inclusion criteria: primary care patients, aged >65 years. Exclusion criteria: significant cognitive impairment. 47.9% male, mean age 73.2 years
<b>Study design</b>	Cross-sectional (consecutive sample)
<b>Target condition and reference standard(s)</b>	GAD by ICD-10
<b>Index and comparator tests</b>	ADS-GA: 11 yes/no items, which are added to produce a score from 0 to 11. in this study, shortened variations of this test were also analysed
<b>Results</b>	ADS-GA (three-item version): sensitivity = 0.77, specificity = 0.83, LR+ = 4.53, LR- = 0.28 ADS-GA (four-item version): sensitivity = 0.77, specificity = 0.83, LR+ = 4.53, LR- = 0.28 ADS-GA: sensitivity = 0.85, specificity = 0.71, LR+ = 2.93, LR- = 0.21
<b>Older adult sample</b>	Yes
<b>Consultation sample</b>	Yes (primary care)
<b>Chronic physical health problems</b>	No
<b>Notes</b>	Total GAD: 27.1% (n = 13 of N = 48)

### Assessment of methodological quality table

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

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

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

### Assessment of methodological quality table

Item	Judgement
Representative spectrum?	Yes
Acceptable reference standard?	Yes

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

<b>Study ID</b>	<b>KROENKE2007</b>
<b>Bibliographic reference:</b> Kroenke, K., Spitzer, R. L., Williams, J. B., <i>et al.</i> (2007) Anxiety disorders in primary care: Prevalence, impairment, comorbidity, and detection. <i>Annals of Internal Medicine</i> , 146, 317-325.	
<b>Clinical features and settings</b>	Primary care patients
<b>Participants</b>	N = 965 patients; 31 % male, mean age 47.1 years (range 18 to 87 years)
<b>Study design</b>	Cross-sectional (consecutive sample)
<b>Target condition and reference standard(s)</b>	Any anxiety disorder/ GAD by DSM-IV (SCID, telephone administered)
<b>Index and comparator tests</b>	GAD-2: scores range from 0 to 14. Cut-off = 3
<b>Results</b>	GAD-2 (anxiety): sensitivity = 0.65, specificity = 0.88, LR+ = 5.42, LR- = 0.4 GAD-2 (GAD): sensitivity = 0.86, specificity = 0.83, LR+ = 5.06, LR- = 0.17 GAD-7 (anxiety): sensitivity = 0.77, specificity = 0.82, LR+ = 4.28, LR- = 0.28 GAD-7 (GAD): sensitivity = 0.92, specificity = 0.76, LR+ = 3.83, LR- = 0.11
<b>Older adult sample</b>	No
<b>Consultation sample</b>	Yes (primary care)
<b>Chronic physical health problems</b>	No
<b>Notes</b>	Prevalence of anxiety: 19.5% (n = 188 of 965); GAD: 7.6% (n = 73 of N = 965)

### Assessment of methodological quality table

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

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



<b>Notes</b>	Any anxiety disorder (social phobia, n = 21; GAD, n = 32; panic disorder without agoraphobia and with agoraphobia; n = 17, PTSD, n = 23); 23% had more than one diagnosis
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### Assessment of methodological quality table

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

<b>Study ID</b>	LOVE2002
<b>Bibliographic reference:</b> Love, A. W., Kissane, D. W., Bloch, S., <i>et al.</i> (2002) Diagnostic efficiency of the Hospital Anxiety and Depression Scale in women with early stage breast cancer. <i>Australian and New Zealand Journal of Psychiatry</i> , 36, 246–250.	
<b>Clinical features and settings</b>	Patients with breast cancer attending a hospital day centre
<b>Participants</b>	N = 303 middle-aged women with stage II breast cancer or stage I breast cancer with poor prognostic factors; exclusion criteria: >65 years, dementia, active psychosis, intellectual disability
<b>Study design</b>	Cross-sectional (participants were taking part in a clinical trial)
<b>Target condition and reference standard(s)</b>	Anxiety by DSM-IV (Monash Interview for Liaison Psychiatry)
<b>Index and comparator tests</b>	HADS-A: a seven-item subscale of the HADS, measuring anxiety symptoms over the previous week on seven-point Likert-type scales. Cut-off = <8

<b>Results</b>	Sensitivity = 0.34, specificity = 0.73, LR+ = 1.26, LR- = 0.9
<b>Older adult sample</b>	No
<b>Consultation sample</b>	Yes
<b>Chronic physical health problems</b>	Yes
<b>Notes</b>	Anxiety: 10.6% (n = 32 of N = 303) (adjustment disorders with anxious mood: 5.9%; GAD: 1.6%; panic disorder: 1.3%; PTSD: 1.6%)

### Assessment of methodological quality table

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

<b>Study ID</b>	MEANS-C2006
<b>Bibliographic reference:</b> Means-Christensen, A. J., Sherbourne, C. D., Roy-Byrne, P. P., Craske, M. G. & Stein M. B. (2006) Using five questions to screen for five common mental disorders in primary care: diagnostic accuracy of the Anxiety and Depression Detector. <i>General Hospital Psychiatry</i> , 28, 108-118.	
<b>Clinical features and settings</b>	Patients from university-affiliated primary care clinics in Seattle, WA, and southern California
<b>Participants</b>	N = 115 patients recruited as part of the Collaborative Care for Anxiety and Panic study
<b>Study design</b>	Cross-sectional

<b>Target condition and reference standard(s)</b>	GAD by DSM-IV (CIDI-Auto)
<b>Index and comparator tests</b>	ADD (GAD item): five yes/no items, one of which is used to detect GAD
<b>Results</b>	Sensitivity = 1.00, specificity = 0.56
<b>Older adult sample</b>	No
<b>Consultation sample</b>	Yes
<b>Chronic physical health problems</b>	No
<b>Notes</b>	Prevalence of GAD = 26%

### Assessment of methodological quality table

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

<b>Study ID</b>	NEWMAN2002
<b>Bibliographic reference:</b> Newman, M. G., Zuellig, A. R., Kachin, K. E., <i>et al.</i> (2002) Preliminary reliability and validity of the generalized anxiety disorder questionnaire-IV: a revised self-report diagnostic measure of generalized anxiety disorder. <i>Behavior Therapy</i> , 33, 215-233.	
<b>Clinical features and settings</b>	Undergraduate students recruited as part of two separate assessment studies

<b>Participants</b>	N = 143 undergraduates, n = 90 of whom were interested in being assessed and potentially referred for treatment for an anxiety disorder
<b>Study design</b>	Cross-sectional
<b>Target condition and reference standard(s)</b>	GAD by DSM-IV (ADIS-IV-L and ADIS-IV)
<b>Index and comparator tests</b>	GAD-Q-IV: a nine-item yes/no questionnaire, which gives a total score of 0 to 12. Cut-off = 5.7
<b>Results</b>	Sensitivity = 0.83, specificity = 0.89, LR+ = 7.55, LR- = 0.19
<b>Older adult sample</b>	No
<b>Consultation sample</b>	No
<b>Chronic physical health problems</b>	No
<b>Notes</b>	Primary or secondary GAD diagnosis: 21.0%; primary panic disorder diagnosis: 12.6%; primary social phobia diagnosis: 30.0%; no anxiety diagnosis: 37.1%

### Assessment of methodological quality table

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

<b>Study ID</b>	<b>POOLE2006</b>
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<b>Bibliographic reference:</b>	
Poole, N. A. & Morgan, J. F. (2006) Validity and reliability of the Hospital Anxiety and Depression Scale in a hypertrophic cardiomyopathy clinic: The HADS in a cardiomyopathy population. <i>General Hospital Psychiatry</i> , 28, 5-58.	
<b>Clinical features and settings</b>	Secondary care (specialist hypertrophic cardiomyopathy clinic)
<b>Participants</b>	N = 115 participants; 56.1% male, median age 43 years (range 23 to 63 years)
<b>Study design</b>	Cross-sectional (consecutive sample)
<b>Target condition and reference standard(s)</b>	Anxiety by DSM-III-R (using SCID non-patient version)
<b>Index and comparator tests</b>	HADS-A: a seven-item subscale of the HADS, measuring anxiety symptoms over the previous week on seven-point Likert-type scales. Cut-off = $\geq 8$
<b>Results</b>	Sensitivity = 0.96, specificity = 0.79, LR+ = 4.57, LR- = 0.05
<b>Older adult sample</b>	No
<b>Consultation sample</b>	Yes
<b>Chronic physical health problems</b>	Yes
<b>Notes</b>	Anxiety: 39%

### Assessment of methodological quality table

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

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

### Assessment of methodological quality table

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

Execution of reference standard permit replication?	Yes
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<b>Study ID</b>	<b>STARK2002</b>
<b>Bibliographic reference:</b> Stark, D., Kiely, M., Smith, A., <i>et al.</i> (2002) Anxiety disorders in cancer patients: their nature, associations, and relation to quality of life. <i>Journal of Clinical Oncology</i> , 14, 3137-3148.	
<b>Clinical features and settings</b>	People recruited from a cancer outpatient clinic
<b>Participants</b>	N = 178 patients with cancer; 60.1% male, mean age 54.89 years (range 22 to 81 years)
<b>Study design</b>	Cross-sectional (unclear how sampled)
<b>Target condition and reference standard(s)</b>	Anxiety by Specialist Clinical Addiction Network
<b>Index and comparator tests</b>	HADS-A: a seven-item subscale of the HADS, measuring anxiety symptoms over the previous week on seven-point Likert-type scales. Cut-off = >7
<b>Results</b>	Sensitivity = 0.81, specificity = 0.6, LR+ = 2.03, LR- = 0.32
<b>Older adult sample</b>	No
<b>Consultation sample</b>	Yes
<b>Chronic physical health problems</b>	Yes
<b>Notes</b>	Anxiety: 17.98% (n = 32 of N = 178); panic disorder: 9.0%; GAD: 8.4%; phobia: 13.5%

### Assessment of methodological quality table

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

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

<b>Study ID</b>	<b>WEBB2008</b>
<b>Bibliographic reference:</b> Webb, S. A., Diefenbach, G., Wagener, P., <i>et al.</i> (2008) Comparison of self-report measures for identifying late-life generalized anxiety in primary care. <i>Journal of Geriatric Psychiatry and Neurology</i> , 21, 223-231.	
<b>Clinical features and settings</b>	Primary care patients
<b>Participants</b>	N = 191 patients; exclusion criteria: negative screen for anxiety, age <60 years
<b>Study design</b>	Cross-sectional (participants were taking part in a clinical trial)
<b>Target condition and reference standard(s)</b>	GAD by DSM-IV (SCID, GAD subscale)
<b>Index and comparator tests</b>	GAD-Q-IV GAD-Q-IV Item 2 (Is your worry excessive in intensity, frequency, or the amount of distress it causes?) PSWQ-A an abbreviated version of the PSWQ developed for older adults. Cut-off = 22
<b>Results</b>	GAD-Q-IV: sensitivity = 0.68, specificity = 0.72, LR+ = 2.43, LR- = 0.44 GAD-Q-IV Item 2: sensitivity = 0.78, specificity = 0.69, LR+ = 2.52, LR- = 0.32 PSWQ-A: sensitivity = 0.79, specificity = 0.63, LR+ = 2.14, LR- = 0.33
<b>Older adult sample</b>	Yes
<b>Consultation sample</b>	Yes (primary care)
<b>Chronic physical health problems</b>	No
<b>Notes</b>	58% GAD

### Assessment of methodological quality table

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



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

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

### Assessment of methodological quality table

Item	Judgement
Representative spectrum?	Yes

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

<b>Study ID</b>	<b>WILLIAMSON2005</b>
<b>Bibliographic reference:</b> Williamson, R. J., Neale, B. M., Sterne, A., <i>et al.</i> (2005) The value of four mental health self-report scales in predicting interview-based mood and anxiety disorder diagnoses in sibling pairs. <i>Twin Research and Human Genetics</i> , 8, 101-107.	
<b>Clinical features and settings</b>	Community sample recruited through their GPs
<b>Participants</b>	N = 469 participants; of the initial sample of 696, 60% were female, 98.5% were Caucasian, had an average age of 43 years (standard deviation = 10, range 20 to 80 years), and all levels of educational attainment and employment status were represented in the sample
<b>Study design</b>	Cross-sectional (consecutive sample)
<b>Target condition and reference standard(s)</b>	Common mental health disorder and GAD; DSM-III-R and ICD-10 (University of Michigan CIDI)
<b>Index and comparator tests</b>	GHQ-12 EPQ-N
<b>Results</b>	GHQ-12 (common mental health disorder): sensitivity = 0.73, specificity = 0.82, LR+ = 4.06, LR- = 0.33 GHQ-12 (GAD): sensitivity = 0.76, specificity = 0.78, LR+ = 3.45, LR- = 0.31 EPQ-N (common mental health disorder): sensitivity = 0.81, specificity = 0.77, LR+ = 3.52, LR- = 0.25 EPQ-N (GAD): sensitivity = 0.82, specificity = 0.8, LR+ = 4.1, LR- = 0.23

<b>Older adult sample</b>	No
<b>Consultation sample</b>	No
<b>Chronic physical health problems</b>	No
<b>Notes</b>	At least one common mental health disorder: 38% (n = 179 of N = 469); GAD: 10.7% (n = 50 of N = 469)

### Assessment of methodological quality table

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

### 1.2.2 Excluded studies

[The titles of articles whose *Reason for exclusion* is 'Non-English version' are shown in their English translation, not their original published language.]

Bibliographic reference	Reason for exclusion
Abdel-Khalek, A. & Al-Damaty, A. G. (2003) The Kuwait university anxiety scale: results for 9,031 Saudi students. <i>Psychological Reports</i> , 93, 203–212.	Non-English version
Abdel-Khalek, A. & Lester, D. (1998) Reliability of the Arabic Obsessive-Compulsive Scale in Kuwaiti and American students. <i>Psychological Reports</i> , 83, 1470.	Non-English version

Abdel-Khalek, A. & Lester, D. (1999) Criterion-related validity of the Arabic Obsessive-Compulsive Scale in Kuwaiti and American students. <i>Psychological Reports</i> , 85, 1111-1112.	Non-English version
Abdel-Khalek, A. & Lester, D. (2000) Obsession-compulsion, locus of control, depression, and hopelessness: a construct validity of the Arabic Obsessive-Compulsive Scale in American and Kuwaiti students. <i>Psychological Reports</i> , 86, 1187-1188.	Non-English version
Abdel-Khalek, A. & Lester, D. (2002) Convergent and discriminant validity of the Arabic Obsessive-Compulsive Scale for Kuwaiti and American college students. <i>Psychological Reports</i> , 90, 1261-1262.	Non-English version
Abdel-Khalek, A. & Lester, D. (2002) Factorial validity of the Arabic Obsessive-Compulsive Scale in two cultures. <i>Psychological Reports</i> , 90, 869-870.	Non-English version
Abdel-Khalek, A. & Lester, D. (2004) The factorial structure of the Arabic version of the revised Collett-Lester Fear of Death Scale. <i>Death Studies</i> , 28, 287-293.	Non-English version
Abdel-Khalek, A. & Maltby, J. (2008) Reliability, factorial validity, and means on the Kuwait University Anxiety Scale: a UK University sample. <i>Psychological Reports</i> , 102, 867-869.	No appropriate gold standard
Abdel-Khalek, A. & Rudwan, S. (2001) The Kuwait University Anxiety Scale: reliability and criterion-related validity in Syrian college students. <i>Psychological Reports</i> , 89, 718.	Non-English version
Abdel-Khalek, A. (1997) Death, anxiety, and depression. <i>Omega: Journal of Death and Dying</i> , 35, 219-229.	No appropriate gold standard
Abdel-Khalek, A. (1997) Two scales of death anxiety: their reliability and correlation among Kuwaiti samples. <i>Perceptual and Motor Skills</i> , 84, 921-922.	Non-English version
Abdel-Khalek, A. (1998) Single- versus multi-item scales in measuring death anxiety. <i>Death Studies</i> , 22, 763-772.	Non-English version
Abdel-Khalek, A. (1998) The development and validation of the Arabic Obsessive Compulsive Scale. <i>European Journal of Psychological Assessment</i> , 14, 146-158.	Non-English version
Abdel-Khalek, A. (1998) The structure and measurement of death obsession. <i>Personality and Individual Differences</i> , 24, 159-165.	Non-English version
Abdel-Khalek, A. (2000) Death, anxiety, and depression in Kuwaiti undergraduates. <i>Omega: Journal of Death and Dying</i> , 42, 309-320.	Non-English version
Abdel-Khalek, A. (2000) The Kuwait University Anxiety Scale: psychometric properties. <i>Psychological Reports</i> , 87, 478-492.	Non-English version
Abdel-Khalek, A. (2004) Divergent, criterion-related, and discriminant validities for the Kuwait University Anxiety Scale. <i>Psychological Reports</i> , 94, 572-576.	Non-English version
Abdel-Khalek, A., Tomas-Sabado, J. & Gomez-Benito, J. (2004) Psychometric parameters of the Spanish version of the Kuwait University Anxiety Scale (S-KUAS). <i>European Journal of Psychological Assessment</i> , 20, 349-357.	Non-English version

Abdulmajeed, A., Akram, K., Tareq, H., <i>et al.</i> (2000) Outcome of a training course in psychiatry for primary health care physicians in Abu Dhabi, UAE. <i>Primary Care Psychiatry</i> , 6, 9–16.	Not relevant
Aben, I., Verhey, F., Lousberg, R., <i>et al.</i> (2002) Validity of the Beck Depression Inventory, Hospital Anxiety and Depression Scale, SCL-90 and Hamilton Depression Rating Scale as screening instruments for depression in stroke patients. <i>Psychosomatics: Journal of Consultation Liaison Psychiatry</i> , 43, 386–393.	Depression
Abiodun, O. A. (1993) A study of mental morbidity among primary care patients in Nigeria. <i>Comprehensive Psychiatry</i> , 34, 10–13.	Non-English version
Abramowitz, J., Deacon, B. & Valentiner, D. (2007) The short health anxiety inventory: psychometric properties and construct validity in a non-clinical sample. <i>Cognitive Therapy and Research</i> , 31, 871–883.	Insufficient data
Abramowitz, J., Huppert, J., Cohen, A., Tolin, D. & Cahill, S. (2002) Religious obsessions and compulsions in a non-clinical sample: The Penn Inventory of Scrupulosity (PIOS). <i>Behaviour Research and Therapy</i> , 40, 825–838.	Not relevant
Abrams, M., Carleton, R. N. & Asmundson, G. (2007) An exploration of the psychometric properties of the PASS-20 with a nonclinical sample. <i>The Journal of Pain</i> , 8, 879–886.	Insufficient data
Adoric, V. (2003) Awareness of self and others in social anxiety and self-monitoring: a contribution to validation of Social Awareness Inventory. <i>Suvremena Psihologija</i> , 6, 231–247.	Non-English version
Adrienne, S. & Barna, K. (2006) Characteristics of the Hungarian version of the Perceived Stress Scale (PSS). <i>Mentalhigiene es Pszichoszomatika</i> , 7, 203–216.	Non-English version
Agargun, M., Kara, H., Bilici, M., <i>et al.</i> (1999) The Van Dream Anxiety Scale: a subjective measure of dream anxiety in nightmare sufferers. <i>Sleep and Hypnosis</i> , 1, 204–211.	Not relevant
Ailey, S. (2009) The sensitivity and specificity of depression screening tools among adults with intellectual disabilities. <i>Journal of Mental Health Research in Intellectual Disabilities</i> , 2, 45–64.	Depression
Akechi, T., Okuyama, T., Sugawara, Y., <i>et al.</i> (1995) Major depression, adjustment disorders, and post-traumatic stress disorder in terminally ill cancer patients: associated and predictive factors. <i>Journal of Clinical Oncology</i> , 22, 1957–1965.	Depression
Akechi, T., Okuyama, T., Sugawara, Y., <i>et al.</i> (2006) Screening for depression in terminally ill cancer patients in Japan. <i>Journal of Pain and Symptom Management</i> , 31, 5–12.	Depression
Akin, A. & Cetin, B. (2007) The Depression Anxiety and Stress Scale (DASS): the study of validity and reliability. <i>Kuram ve Uygulamada Egitim Bilimleri</i> , 7, 260–268.	Depression
Al-Adawi, S., Dorvlo, A., Al-Naamani, A., <i>et al.</i> (2007) The ineffectiveness of the Hospital Anxiety and Depression Scale for diagnosis in an Omani traumatic brain injured population. <i>Brain Injury</i> , 21, 385–393.	Non-English version
Aldea, M., Geffken, G., Jacob, M., <i>et al.</i> (2009) Further psychometric analysis of the Florida Obsessive-Compulsive Inventory. <i>Journal of Anxiety Disorders</i> , 23, 124–129.	Insufficient data

Alderman, K. J., Mackay, C. J., Lucas, E. G., <i>et al.</i> (1983) Factor analysis and reliability studies of the Crown-Crisp Experiential Index (CCEI). <i>British Journal of Medical Psychology</i> , 56, 329–345.	No appropriate gold standard
Al-Issa, I., Al, Zubaidi, A., Bakal, D., <i>et al.</i> (2000) Beck Anxiety Inventory symptoms in Arab college students. <i>Arab Journal of Psychiatry</i> , 11, 41–47.	Non-English version
Allen, K., Cull, A. & Sharpe, M. (2003) Diagnosing major depression in medical outpatients: acceptability of telephone interviews. <i>Journal of Psychosomatic Research</i> , 55, 385–387.	Insufficient data
Aalto-Setälä, T., Haarasilta, L., Marttunen, M., <i>et al.</i> (2002) Major depressive episode among young adults: CIDI-SF versus SCAN consensus diagnoses. <i>Psychological Medicine</i> , 32, 1309–1314.	Depression
Aluoja, A., Shlik, J., Vasar, V., <i>et al.</i> (1999) Development and psychometric properties of the Emotional State Questionnaire, a self-report questionnaire for depression and anxiety. <i>Nordic Journal of Psychiatry</i> , 53, 443–449.	Depression
Amir, M., Lewin-Epstein, N., Becker, G. & Buskila, D. (2002) Psychometric properties of the SF-12 (Hebrew version) in a primary care population in Israel. <i>Medical Care</i> , 40, 918–928.	Depression
Andersson, G., Käldo-Sandström, V., Ström, L., <i>et al.</i> (2003) Internet administration of the Hospital Anxiety and Depression Scale in a sample of tinnitus patients. <i>Journal of Psychosomatic Research</i> , 55, 259–262.	Depression
Andreescu, C., Belnap, B., Rollman, B., <i>et al.</i> (2008) Generalized Anxiety Disorder Severity Scale validation in older adults. <i>The American Journal of Geriatric Psychiatry</i> , 16, 813–818.	Insufficient data
Andrews, G. & Slade, T. (2002) The classification of anxiety disorders in ICD-10 and DSM-IV: a concordance analysis. <i>Psychopathology</i> , 35, 100–106.	Insufficient data
Angst, J., Merikangas, K. R. & Preisig, M. (1997) Subthreshold syndromes of depression and anxiety in the community. <i>Journal of Clinical Psychiatry</i> , 58 (Suppl. 8), 6–10.	Not relevant
Antoine, P., Antoine, C. & Nandrino, J. L. (2008) Development and validation of the Cognitive Inventory of Subjective Distress. <i>International Journal of Geriatric Psychiatry</i> , 23, 1175–1181.	Non-English version
Antony, M., Bieling, P., Cox, B., <i>et al.</i> (1998) Psychometric properties of the 42-item and 21-item versions of the Depression Anxiety Stress Scales in clinical groups and a community sample. <i>Psychological Assessment</i> , 10, 176–181.	Insufficient data
Antony, M., Coons, M., McCabe, R., <i>et al.</i> (2006) Psychometric properties of the social phobia inventory: further evaluation. <i>Behaviour Research and Therapy</i> , 44, 1177–1185.	Insufficient data
Apostolo, J., Mendes, A. & Azeredo, Z. (2006) Adaptation to Portuguese of the Depression, Anxiety and Stress Scales (DASS). <i>Revista Latino-Americana de Enfermagem</i> , 14, 863–871.	Insufficient data
Araya, R., Wynn, R. & Lewis, G. (1992) Comparison of two self administered psychiatric questionnaires (GHQ-12 and SRQ-20) in primary care in Chile. <i>Social Psychiatry &amp; Psychiatric Epidemiology</i> , 27, 168–173.	Non-English version

Arbisi, P., Ben-Porath, Y. & McNulty, J. (2006) The ability of the MMPI-2 to detect feigned PTSD within the context of compensation seeking. <i>Psychological Services</i> , 3, 249–261.	Not relevant
Argulewicz, E. & Miller, D. (1984) Self-report measures of anxiety: a cross-cultural investigation of bias. <i>Hispanic Journal of Behavioral Sciences</i> , 6, 397–406.	Non-English version
Argulewicz, E. & Miller, D. (1984) Validity of self-report measures of anxiety for use with Anglo-American, Mexican-American, and Black students. <i>Journal of Psychoeducational Assessment</i> , 2, 233–238.	Young people
Argyle, N., Deltito, J., Allerup, P., <i>et al.</i> (1991) The Panic-Associated Symptom Scale: Measuring the severity of panic disorder. <i>Acta Psychiatrica Scandinavica</i> , 83, 20–26.	Insufficient data
Argyropoulos, S., Ploubidis, G., Wright, T., <i>et al.</i> (2007) Development and validation of the Generalized Anxiety Disorder Inventory (GADI). <i>Journal of Psychopharmacology</i> , 21, 145–152.	Insufficient data
Armstrong, D. & Earnshaw, G. (2004) What constructs do GPs use when diagnosing psychological problems? <i>British Journal of General Practice</i> , 54, 580–583.	Insufficient data
Armstrong, K., Khawaja, N. & Oei, T. (2006) Confirmatory factor analysis and psychometric properties of the Anxiety Sensitivity Index – revised in clinical and normative populations. <i>European Journal of Psychological Assessment</i> , 22, 116–125.	Insufficient data
Arntz, A., Lavy, E., Van den Berg, G., <i>et al.</i> (1993) Negative beliefs of spider phobics: a psychometric evaluation of the Spider Phobia Beliefs Questionnaire. <i>Advances in Behaviour Research &amp; Therapy</i> , 15, 257–277.	Insufficient data
Arrindell, W. & van der Ende, J. (1986) Further evidence for cross-sample invariance of phobic factors: psychiatric inpatient ratings on the Fear Survey Schedule – III. <i>Behaviour Research and Therapy</i> , 24, 289–297.	Insufficient data
Arrindell, W. A. (2001) Changes in waiting-list patients over time: data on some commonly-used measures. Beware! <i>Behaviour Research &amp; Therapy</i> , 39, 1227–1247.	Depression
Arrindell, W. A., de Vlam, I. H., Eisenhardt, B., <i>et al.</i> (2002) Cross-cultural validity of the Yale-Brown Obsessive Compulsive Scale. <i>Journal of Behavior Therapy and Experimental Psychiatry</i> , 33, 159–176.	Non-English version
Arving, C., Glimelius, B. & Brandberg, Y. (2008) Four weeks of daily assessments of anxiety, depression and activity compared to a point assessment with the Hospital Anxiety and Depression Scale. <i>Quality of Life Research</i> , 17, 95–104.	Insufficient data
Asakura, S., Inoue, S., Sasaki, F., <i>et al.</i> (2002) Reliability and validity of the Japanese version of the Liebowitz Social Anxiety Scale. <i>Seishin Igaku (Clinical Psychiatry)</i> , 44, 1077–1084.	Non-English version
Asmundson, G., Bovell, C., Carleton, R. N., <i>et al.</i> (2008) The Fear of Pain Questionnaire – short form (FPQ-SF): factorial validity and psychometric properties. <i>Pain</i> , 134, 51–58.	Insufficient data
Asukai, N., Kato, H., Kawamura, N., <i>et al.</i> (2002) Reliability and validity of the Japanese-language version of the Impact of Event Scale-revised (IES-R-J): four studies of different traumatic events. <i>Journal of Nervous and Mental Disease</i> , 190, 175–182.	Non-English version

Austin, D., Carlbring, P., Richards, J., <i>et al.</i> (2006) Internet administration of three commonly used questionnaires in panic research: equivalence to paper administration in Australian and Swedish samples of people with panic disorder. <i>International Journal of Testing</i> , 6, 25–39.	Insufficient data
Avasthi, A., Varma, S. C., Kulhara, P., <i>et al.</i> (2008) Diagnosis of common mental disorders by using PRIME-MD Patient Health Questionnaire. <i>Indian Journal of Medical Research</i> , 127, 159–164.	Depression, non-English version
Aydin, I. & Ulasahin, A. (2001) Depression, anxiety comorbidity, and disability in tuberculosis and chronic obstructive pulmonary disease patients: Applicability of GHQ-12. <i>General Hospital Psychiatry</i> , 23, 77–83.	Non-English version
Aylard, P. R., Gooding, J. H., McKenna, P. J., <i>et al.</i> (1987) A validation study of three anxiety and depression self-assessment scales. <i>Journal of Psychosomatic Research</i> , 31, 261–268.	No appropriate gold standard
Ayvasik, H. B. & Tutarel-Kislak, S. (2004) Factor structure and reliability of the Anxiety Sensitivity Profile in a Turkish sample. <i>European Journal of Psychological Assessment</i> , 20, 358–367.	Non-English version
Aziz, M. & Kenford, S. (2004) Comparability of telephone and face-to-face interviews in assessing patients with posttraumatic stress disorder. <i>Journal of Psychiatric Practice</i> , 10, 307–313.	Depression
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Koksal, F. & Power, K. (1990) Four Systems Anxiety Questionnaire (FSAQ): a self-report measure of somatic, cognitive, behavioral, and feeling components. <i>Journal of Personality Assessment</i> , 54, 534–545.	Insufficient data
Komiti, A. A., Jackson, H. J., Judd, F. K., <i>et al.</i> (2001) A comparison of the Composite International Diagnostic Interview (CIDI-Auto) with clinical assessment in diagnosing mood and anxiety disorders. <i>Australian and New Zealand Journal of Psychiatry</i> , 35, 224–230.	More than 12 items
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Kotov, R., Schmidt, N., Zvolensky, M., <i>et al.</i> (2005) Adaptation of Panic-Related Psychopathology Measures to Russian. <i>Psychological Assessment</i> , 17, 242–246.	Non-English version
Kovess, V. & Fournier, L. (1990) The DISSA: an abridged self-administered version of the DIS: approach by episode. <i>Social Psychiatry and Psychiatric Epidemiology</i> , 25, 179–186.	Insufficient data
Kramer, T. L., Owen, R. R., Wilson, C., <i>et al.</i> (2003) Relationship between self-report and clinician-rated impairment in depressed outpatients. <i>Community Mental Health Journal</i> , 39, 299–307.	Depression
Krause, E. D., Kaltman, S., Goodman, L. A., <i>et al.</i> (2002) Longitudinal factor structure of posttraumatic stress symptoms related to intimate partner violence. <i>Psychological Assessment</i> , 19, 165–175.	Insufficient data
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Kubany, E., Abueg, F., Kilauano, W., <i>et al.</i> (1997) Development and validation of the Sources of Trauma-Related Guilt Survey – War-Zone Version. <i>Journal of Traumatic Stress</i> , 10, 235–258.	Insufficient data
Kubany, E., Haynes, S., Abueg, F., <i>et al.</i> (1996) Development and validation of the Trauma-Related Guilt Inventory (TRGI). <i>Psychological Assessment</i> , 8, 428–444.	Insufficient data
Kubany, E., Leisen, M., Kaplan, A., <i>et al.</i> (2007) Validation of a brief measure of posttraumatic stress disorder: the Distressing Event Questionnaire (DEQ). <i>Psychological Assessment</i> , 12, 197–209.	Specific anxiety disorder (PTSD)
Kubany, E., Leisen, M., Kaplan, A., <i>et al.</i> (2000) Development and preliminary validation of a brief broad-spectrum measure of trauma exposure: The Traumatic Life Events Questionnaire. <i>Psychological Assessment</i> , 12, 210–224.	Insufficient data
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Lobo, A., Chamorro, L., Luque, A., <i>et al.</i> (2002) Validation of the Spanish versions of the Montgomery-Asberg Depression and Hamilton Anxiety Rating Scales. <i>Medicina Clinica</i> , 118, 493–499.	Insufficient data
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Lynch, S., Curran, S., Montgomery, S., <i>et al.</i> (2000) The Brief Depression Scale – reliability and validity of a new self-rating depression scale. <i>Primary Care Psychiatry</i> , 6, 111–118.	Depression
Lyness, J. M., Chapman, B. P., McGriff, J., <i>et al.</i> (2009) One-year outcomes of minor and subsyndromal depression in older primary care patients. <i>International Psychogeriatrics</i> , 21, 60–68.	Insufficient data
Lyness, J. M., Kim, J., Tang, W., <i>et al.</i> (2007) The clinical significance of subsyndromal depression in older primary care patients. <i>American Journal of Geriatric Psychiatry</i> , 15, 214–223.	Insufficient data
Lyons, J., Caddell, J., Pittman, R., <i>et al.</i> (1994) The potential for faking on the Mississippi Scale for Combat-Related PTSD. <i>Journal of Traumatic Stress</i> , 7, 441–445.	Not relevant
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Malasi, T. H., Mirza, I. A. & El-Islam, M. F. (1991) Validation of the Hospital Anxiety and Depression Scale in Arab patients. <i>Acta Psychiatrica Scandinavica</i> , 84, 323–326.	Depression, non-English version
Manne, S., Du Hamel, K., Gallelli, K., <i>et al.</i> (1998) Posttraumatic stress disorder among mothers of pediatric cancer survivors: Diagnosis, comorbidity, and utility of the PTSD Checklist as a screening instrument. <i>Journal of Pediatric Psychology</i> , 23, 357–366.	Specific anxiety disorder (PTSD)

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Mantani, T., Sasaki, T., Akechi, T., <i>et al.</i> (1998) Are self-rating scales useful for the prediction and the screening of IFN-induced psychiatric disorders? <i>Seishin Igaku (Clinical Psychiatry)</i> , 40, 157–161.	Non-English version
Marchevsky, D. (1999) Quick rating of depressed mood. <i>British Journal of Psychiatry</i> , 175, 289–290.	Not relevant
Margraf, J., Ehlers, A., Taylor, C. B., <i>et al.</i> (1990) Guttman scaling in agoraphobia: cross-cultural replication and prediction of treatment response patterns. <i>British Journal of Clinical Psychology</i> , 29, 37–41.	No full text
Marmar, C. R., Weiss, D. S., Schlenger, W. E., <i>et al.</i> (1994) Peritraumatic dissociation and posttraumatic stress in male Vietnam theater veterans. <i>American Journal of Psychiatry</i> , 151, 902–907.	Insufficient data
Marshall, M. & Bagby, R. M. (2006) The incremental validity and clinical utility of the MMPI-2 Infrequency Posttraumatic Stress Disorder Scale. <i>Assessment</i> , 13, 417–429.	Not relevant
Marshall, S. C., Gray, D., Wilson, K. G., <i>et al.</i> (2007) A prospective study to validate an impairment questionnaire for major trauma survivors. <i>American Journal of Physical Medicine and Rehabilitation</i> , 86, 114–124.	Insufficient data
Martin, C. R. & Jomeen, J. (2003) Is the 12-item General Health Questionnaire (GHQ-12) confounded by scoring method during pregnancy and following birth? <i>Journal of Reproductive and Infant Psychology</i> , 21, 267–278.	Not relevant
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Martin, C. R., Tweed, A. E. & Metcalfe, M. S. (2004) A psychometric evaluation of the Hospital Anxiety and Depression Scale in patients diagnosed with end-stage renal disease. <i>British Journal of Clinical Psychology</i> , 43, 51–64.	Insufficient data
Martin, C., Bonner, A., Brook, A., <i>et al.</i> (2000) Factor structure and use of the Hospital Anxiety and Depression Scale in the homeless and socially marginalized. <i>Psychology, Health and Medicine</i> , 11, 190–197.	Insufficient data
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Martinsen, E., Friis, S. & Hoffart, A. (1989) A factor analytical study of the Comprehensive Psychopathological Rating Scale among patients with anxiety and depressive disorders. <i>Acta Psychiatrica Scandinavica</i> , 80, 492–428.	Insufficient data

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Mason, S., Farrow, T. F. D., Fawbert, D., <i>et al.</i> (2009) The development of a clinically useful tool for predicting the development of psychological disorder following injury. <i>British Journal of Clinical Psychology</i> , 48, 31–45.	Insufficient data
Mastro, J., French, R., Henschen, K., <i>et al.</i> (1985) Use of the State-Trait Anxiety Inventory for visually impaired athletes. <i>Perceptual and Motor Skills</i> , 61, 775–778.	Not relevant
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Mataix-Cols, D., Fullana, M., Alonso, P., <i>et al.</i> (2000) Convergent and discriminant validity of the Yale-Brown obsessive-compulsive scale symptom checklist. <i>Psychotherapy and Psychosomatics</i> , 73, 190–196.	Non-English version
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Matarazzo, J. (1955) MMPI validity scores as a function of increasing levels of anxiety. <i>Journal of Consulting Psychology</i> , 19, 213–217.	Insufficient data
Matarazzo, J., Guze, S. & Matarazzo, R. (1955) An approach to the validity of the Taylor Anxiety Scale: scores of medical and psychiatric patients. <i>The Journal of Abnormal and Social Psychology</i> , 51, 276–280.	Insufficient data
Matson, J. & Nieminen, G. (1987) Validity of measures of conduct behavior, depression, and anxiety. <i>Journal of Clinical Child Psychology</i> , 16, 151–157.	Insufficient data
Matsumaru, K., Otsubo, T., Tanaka, K., <i>et al.</i> (2003) The construct of Maudsley Obsessional-Compulsive Inventory (MOCI): a study of Japanese female nurses. <i>Seishin Igaku (Clinical Psychiatry)</i> , 45, 825–833.	Non-English version
Matthey, S. (2008) Using the Edinburgh Postnatal Depression Scale to screen for anxiety disorders. <i>Depression and Anxiety</i> , 25, 926–931.	Depression
Matthey, S., Barnett, B., Howie, P., <i>et al.</i> (2003) Diagnosing postpartum depression in mothers and fathers: whatever happened to anxiety? <i>Journal of Affective Disorders</i> , 74, 139–147.	Insufficient data
Matthey, S., Barnett, B., Kavanagh, D., <i>et al.</i> (2001) Validation of the Edinburgh Postnatal Depression Scale for men, and comparison of item endorsement with their partners. <i>Journal of Affective Disorders</i> , 64, 175–184.	Depression
Mattick, R. & Clarke, J. C. (1998) Development and validation of measures of social phobia scrutiny fear and social interaction anxiety. <i>Behaviour Research and Therapy</i> , 36, 455–470.	Insufficient data
Mavissakalian, M. (1986) The Fear Questionnaire: a validity study. <i>Behaviour Research and Therapy</i> , 24, 83–85.	Insufficient data
McCaffrey, R. & Bellamy-Campbell, R. (1989) Psychometric detection of fabricated symptoms of combat-related post-traumatic stress disorder: a systematic replication. <i>Journal of Clinical Psychology</i> , 45, 76–79.	Insufficient data

McCall, L., Clarke, D. M. & Rowley, G. (2002) A questionnaire to measure general practitioners' attitudes to their role in the management of patients with depression and anxiety. <i>Australian Family Physician</i> , 31, 299–303.	Depression
McCracken, L. & Dhingra, L. (2002) A short version of the Pain Anxiety Symptoms Scale (PASS–20): preliminary development and validity. <i>Pain Research &amp; Management</i> , 7, 45–50.	No full text, insufficient data
McCracken, L., Zayfert, C. & Gross, R. (1992) The Pain Anxiety Symptoms Scale: development and validation of a scale to measure fear of pain. <i>Pain</i> , 50, 67–73.	Insufficient data
McCue, P., Buchanan, T. & Martin, C. (2006) Screening for psychological distress using internet administration of the Hospital Anxiety and Depression Scale (HADS) in individuals with chronic fatigue syndrome. <i>British Journal of Clinical Psychology</i> , 45, 483–498.	Insufficient data
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McDevitt-Murphy, M., Weathers, F., <i>et al.</i> (2007) The utility of the PAI and the MMPI-2 for discriminating PTSD, depression, and social phobia in trauma-exposed college students. <i>Assessment</i> , 14, 181–195.	Insufficient data
McFall, M., Smith, D., Roszell, D., <i>et al.</i> (1990) Convergent validity of measures of PTSD in Vietnam combat veterans. <i>American Journal of Psychiatry</i> , 147, 645–649.	Insufficient data
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McKenzie, N. & Marks, I. (1999) “Quick rating of depressed mood”: Reply. <i>British Journal of Psychiatry</i> , 174, 266–269.	Not relevant
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Moody, D. & Kish, G. (1989) Clinical meaning of the Keane PTSD Scale. <i>Journal of Clinical Psychology</i> , 45, 542–546.	Insufficient data
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Morel, K. & Marshman, K. (2008) Critiquing symptom validity tests for posttraumatic stress disorder: a modification of Hartman's criteria. <i>Journal of Anxiety Disorders</i> , 22, 1542–1550.	Review
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Munley, P., Bains, D., Bloem, W., <i>et al.</i> (1995) Posttraumatic stress disorder and the MCMI-II. <i>Psychological Reports</i> , 76, 939–944.	Depression
Muris, P. & Merckelbach, H. (1996) A comparison of two spider fear questionnaires. <i>Journal of Behavior Therapy and Experimental Psychiatry</i> , 27, 241–244.	Insufficient data
Muszbek, K., Szekely, A., Balogh, E., <i>et al.</i> (2006) Validation of the Hungarian translation of hospital anxiety and depression scale. <i>Quality of Life Research</i> , 15, 761–766.	Non-English version
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Mykletun, A., Stordal, E. & Dahl, A. (2001) Hospital Anxiety and Depression (HAD) scale: factor structure, item analyses and internal consistency in a large population. <i>British Journal of Psychiatry</i> , 179, 540–544.	Insufficient data
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Nease, D. E. J. & Aikens, J. E. (2001) DSM depression and anxiety criteria and severity of symptoms in primary care: cross sectional study. <i>British Medical Journal</i> , 327, 1030–1031.	Insufficient data
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Nelson, C. J. (2006) An argument to screen for distress in men diagnosed with early-stage prostate cancer: commentary. <i>Nature Clinical Practice Urology</i> , 3, 586–587.	Not relevant
Nelson, W. A. & Clum, G. A. (2002) Assessment of panic frequency: reliability and validity of a time-line follow-back method. <i>Journal of Psychopathology and Behavioral Assessment</i> , 24, 47–54.	Insufficient data
Nesselroade, J., Pruchno, R. & Jacobs, A. (1986) Reliability vs. stability in the measurement of psychological states: an illustration with anxiety measures. <i>Psychologische Beitrage</i> , 28, 255–264.	Insufficient data
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Ni, M., Butler, J. S., Magill, P. F., <i>et al.</i> (2008) The increased need for liaison psychiatry in surgical patients due to the high prevalence of undiagnosed anxiety and depression. <i>Irish Journal of Medical Science</i> , 177, 211–215.	Insufficient data
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Nortvedt, M., Riise, T. & Sanne, B. (2005) Are men more depressed than women in Norway? Validity of the Hospital Anxiety and Depression Scale. <i>Journal of Psychosomatic Research</i> , 60, 195–198.	Depression
Novovic, Z., Selakovic-Bursic, S., Misic-Pavkov, G., <i>et al.</i> (2004) Discriminative ability of Hamilton's measures of depression and anxiety: proposal for reconstruction of Hamilton scales. <i>Psijatrija Danas</i> , 36, 227–242	Non-English version; insufficient data
Novy, D., Stanley, M., Averill, P., <i>et al.</i> (2001) Psychometric comparability of English- and Spanish-language measures of anxiety and related affective symptoms. <i>Psychological Assessment</i> , 13, 347–355.	Non-English version
Nuevo, R., Dunn, G., Dowrick, C., <i>et al.</i> (2009) Cross-cultural equivalence of the Beck Depression Inventory: a five-country analysis from the ODIN study. <i>Journal of Affective Disorders</i> , 114, 156–162.	Non-English version
Nuevo, R., Mackintosh, M. A., Gatz, M., <i>et al.</i> (2007) A test of the measurement invariance of a brief version of the Penn State Worry Questionnaire between American and Spanish older adults. <i>International Psychogeriatrics</i> , 19, 89–104.	Insufficient data
Nye, E., Qualls, C. & Katzman, J. (2006) The Trauma Symptom Inventory: factors associated with invalid profiles in a sample of combat veterans with post-traumatic stress disorder. <i>Military Medicine</i> , 171, 857–891.	Insufficient data
Nyunt, M., Chiam, P., Kua, E., <i>et al.</i> (2009) Determinants of mental health service use in the National Mental Health Survey of the elderly in Singapore. <i>Clinical Practice and Epidemiology in Mental Health</i> , 5, 2.	Non-English version
O'Donnell, M. L., Creamer, M. C., Parslow, R., <i>et al.</i> (2008) A predictive screening index for posttraumatic stress disorder and depression following traumatic injury. <i>Journal of Consulting and Clinical Psychology</i> , 76, 923–932.	Specific anxiety disorder (PTSD)
Oei, T., Kenna, D. & Evans, L. (1991) The reliability, validity and utility of the SAD and FNE scales for anxiety disorder patients. <i>Personality and Individual Differences</i> , 12, 111–116.	Depression
Oei, T., Moylan, A. & Evans, L. (1991) Validity and clinical utility of the Fear Questionnaire for anxiety-disorder patients. <i>Psychological Assessment: a Journal of Consulting and Clinical Psychology</i> , 3, 391–397.	Insufficient data
O'Hare, T., Shen, C. & Sherrer, M. (2007) Validating the Posttraumatic Stress Disorder Symptom Scale with persons who have severe mental illnesses. <i>Research on Social Work Practice</i> , 17, 720–728.	SMI
Ohlde, C., Schauer, A., Garfield, N., <i>et al.</i> (1987) Preliminary steps in the development of a screening instrument to assess posttraumatic stress disorder. <i>Journal of Counseling &amp; Development</i> , 66, 104–106.	Insufficient data
Ohman, S. G., Grunewald, C. & Waldenstrom, U. (2003) Women's worries during pregnancy: testing the Cambridge Worry Scale on 200 Swedish women. <i>Scandinavian Journal of Caring Sciences</i> , 17, 148–152.	Non-English version
Okun, A., Stein, R., Bauman, L., <i>et al.</i> (1996) Content validity of the Psychiatric Symptom Index, CES-Depression Scale, and State-Trait Anxiety Inventory from the perspective of DSM-IV. <i>Psychological Reports</i> , 79, 1059–1069.	Insufficient data

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Olatunji, B., Deacon, B., Abramowitz, J., <i>et al.</i> (2006) Dimensionality of somatic complaints: factor structure and psychometric properties of the Self-Rating Anxiety Scale. <i>Journal of Anxiety Disorders</i> , 20, 543–561.	Insufficient data
Olatunji, B., Schottenbauer, M., Rodriguez, B., <i>et al.</i> (2007) The structure of worry: relations between positive/negative personality characteristics and the Penn State Worry Questionnaire. <i>Journal of Anxiety Disorders</i> , 21, 540–553.	Insufficient data
Olde, E., Kleber, R., van der Hart, O., <i>et al.</i> (2006) Childbirth and posttraumatic stress responses: a validation study of the Dutch Impact of Event Scale-Revised. <i>European Journal of Psychological Assessment</i> , 22, 259–267.	Non-English version
Olden, M., Rosenfeld, B., Pessin, H., <i>et al.</i> (2009) Measuring depression at the end of life: is the Hamilton Depression Rating Scale a valid instrument? <i>Assessment</i> , 16, 43–54.	Depression
Olivares, J., Garcia-Lopez, L. & Hidalgo, M. (2001) The Social Phobia Scale and the Social Interaction Anxiety Scale: factor structure and reliability in a Spanish-speaking population. <i>Journal of Psychoeducational Assessment</i> , 19, 69–80.	Non-English version
Olsson, I., Mykletun, A. & Dahl, A. (2005) The Hospital Anxiety and Depression Rating Scale: a cross-sectional study of psychometrics and case finding abilities in general practice. <i>BMC Psychiatry</i> , 5, 46.	No appropriate gold standard, non-English version
Onelov, E., Steineck, G., Nyberg, U., <i>et al.</i> (2007) Measuring anxiety and depression in the oncology setting using visual-digital scales. <i>Acta Oncologica</i> , 46, 810–816.	No appropriate gold standard, insufficient data
Oner, N. (1983) State and trait anxiety in Turkish patients and normals. <i>Series in Clinical &amp; Community Psychology: Stress &amp; Anxiety</i> , 2, 107–119.	Non-English version
Opolot, J. (1983) The development and validation of the experimental Lugandan Form of the State-Trait Anxiety Inventory. <i>Series in Clinical &amp; Community Psychology: Stress &amp; Anxiety</i> , 2, 53–65.	Non-English version
Opolot, J. (1983) The development and validation of the Kiswahili Form of the State-Trait Anxiety Inventory. <i>Series in Clinical &amp; Community Psychology: Stress &amp; Anxiety</i> , 2, 41–45.	Non-English version
Oppo, A., Mauri, M., Ramacciotti, D., <i>et al.</i> (2009) Risk factors for postpartum depression: The role of the Postpartum Depression Predictors Inventory-Revised (PDPI-R): results from the Perinatal Depression-Research Screening Unit (PNDReScU) study. <i>Archives of Women's Mental Health</i> , 12, 239–249.	Non-English version
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Orme, J. G., Reis, J. & Herz, E. J. (1986) Factorial and discriminant validity of the center for epidemiological studies depression (CES-D) scale. <i>Journal of Clinical Psychology</i> , 42, 28–33.	Not relevant

Orr, S. P., Claiborn, J. M., Altman, B., <i>et al.</i> (1990) Psychometric profile of posttraumatic stress disorder, anxious, and healthy vietnam veterans: correlations with psychophysiologic responses. <i>Journal of Consulting and Clinical Psychology</i> , 58, 329–335.	Insufficient data
Osman, A., Barrios, F., Aukes, D. & Osman, J. (1995) Psychometric evaluation of the Social Phobia and Anxiety Inventory in college students. <i>Journal of Clinical Psychology</i> , 51, 235–243.	Insufficient data
Osman, A., Barrios, F., Aukes, D., Osman, J., <i>et al.</i> (1993) The Beck Anxiety Inventory: Psychometric properties in a community population. <i>Journal of Psychopathology and Behavioral Assessment</i> , 15, 287–297.	Insufficient data
Osman, A., Barrios, F., Gutierrez, P., <i>et al.</i> (2003) The Pain Distress Inventory: development and initial psychometric properties. <i>Journal of Clinical Psychology</i> , 59, 767–785.	Not relevant
Osman, A., Barrios, F., Haupt, D., <i>et al.</i> (1996) The Social Phobia and Anxiety Inventory: further validation in two nonclinical samples. <i>Journal of Psychopathology and Behavioral Assessment</i> , 18, 35–47.	Insufficient data
Osman, A., Barrios, F., Osman, J., <i>et al.</i> (1994) The Pain Anxiety Symptoms Scale: psychometric properties in a community sample. <i>Journal of Behavioral Medicine</i> , 17, 511–522.	Insufficient data
Osman, A., Breitenstein, J., Barrios, F., <i>et al.</i> (2002) The fear of pain questionnaire-III: further reliability and validity with nonclinical samples. <i>Journal of Behavioral Medicine</i> , 25, 155–173.	Insufficient data
Osman, A., Kopper, B., Barrios, F., <i>et al.</i> (1997) The Beck Anxiety Inventory: reexamination of factor structure and psychometric properties. <i>Journal of Clinical Psychology</i> , 53, 7–14.	Insufficient data
Ost, L. G. (1990) The Agoraphobia Scale: An evaluation of its reliability and validity. <i>Behaviour Research and Therapy</i> , 28, 323–329.	Non-English version
Ost, L. G. (2007) The Claustrophobia Scale: a psychometric evaluation. <i>Behaviour Research and Therapy</i> , 45, 1053–1064.	Non-English version
Ownsworth, T., Little, T., Turner, B., <i>et al.</i> (2008) Assessing emotional status following acquired brain injury: the clinical potential of the depression, anxiety and stress scales. <i>Brain Injury</i> , 22, 858–869.	Insufficient data
Paci, E. (1992) Assessment of validity and clinical application of an Italian version of the Rotterdam Symptom Checklist. <i>Quality of Life Research</i> , 1, 129–134.	Insufficient data and non-English version
Pais-Ribeiro, J., Silva, I., Ferreira, T., <i>et al.</i> (2007) Validation study of a Portuguese version of the Hospital Anxiety and Depression Scale. <i>Psychology, Health &amp; Medicine</i> , 12, 235–237.	Not relevant
Pallanti, S., DeCaria, C., Grant, J., <i>et al.</i> (2005) Reliability and validity of the pathological gambling adaptation of the Yale-Brown Obsessive-Compulsive Scale (PG-YBOCS). <i>Journal of Gambling Studies</i> , 21, 431–443.	Not relevant
Papassotiropoulos, A. & Heun, R. (1999) Detection of subthreshold depression and subthreshold anxiety in the elderly. <i>International Journal of Geriatric Psychiatry</i> , 14, 643–650.	Non-English version
Paradis, C., Friedman, S., Lazar, R., <i>et al.</i> (1992) Use of a structured interview to diagnose anxiety disorders in a minority population. <i>Hospital &amp; Community Psychiatry</i> , 43, 61–64.	Insufficient data

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Pasquini, M., Biondi, M., Costantini, A., <i>et al.</i> (2006) Detection and treatment of depressive and anxiety disorders among cancer patients: Feasibility and preliminary findings from a liaison service in an oncology division. <i>Depression and Anxiety</i> , 23, 441–448.	Insufficient data
Patel, V., Araya, R., Chowdhary, N., <i>et al.</i> (2008) Detecting common mental disorders in primary care in India: a comparison of five screening questionnaires. <i>Psychological Medicine</i> , 38, 221–228.	Non-English version
Paulsen, A., Crowe, R., Noyes, R., <i>et al.</i> (1988) Reliability of the telephone interview in diagnosing anxiety disorders. <i>Archives of General Psychiatry</i> , 45, 62–63.	Insufficient data
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Wetter, M. & Deitsch, S. (1996) Faking specific disorders and temporal response consistency on the MMPI-2. <i>Psychological Assessment</i> , 8, 39–47.	Not relevant
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Whitbeck, L., Adams, G., Hoyt, D., <i>et al.</i> (2004) Conceptualizing and measuring historical trauma among American Indian people. <i>American Journal of Community Psychology</i> , 33, 119–130.	Insufficient data
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Zeyrek, E. & Lester, D. (2008) Cronbach Alpha reliability and concurrent validity of the Collett-Lester Fear of Death Scale in a Turkish sample. <i>Psychological Reports</i> , 102, 706–708.	Non-English version
Zgourides, G., Warren, R. & Englert, M. (1989) Further evidence of construct validity for the Agoraphobic Cognitions Questionnaire and the Body Sensations Questionnaire. <i>Psychological Reports</i> , 64, 590.	No full text
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Zilli, C., Brooke, R. I., Lau, C. L., <i>et al.</i> (1989) Screening for psychiatric illness in patients with oral dysesthesia by means of the General Health Questionnaire – twenty-eight item version (GHQ-28) and the Irritability, Depression and Anxiety Scale (IDA). <i>Oral Surgery, Oral Medicine, Oral Pathology</i> , 67, 384–389.	No appropriate gold standard
Zimmerman, M. & Chelminski, I. (2006) Screening for anxiety disorders in depressed patients. <i>Journal of Psychiatric Research</i> , 40, 267–272.	More than 12 items
Zimmerman, M. & Mattia, J.I. (2001) A self-report scale to help make psychiatric diagnoses. The psychiatric diagnostic screening questionnaire. <i>Archives of General Psychiatry</i> , 58, 787–794.	More than 12 items
Zlotnick, C. & Pearlstein, T. (1997) Validation of the Structured Interview for Disorders of Extreme Stress. <i>Comprehensive Psychiatry</i> , 38, 243–247.	Insufficient data
Zoellner, L. A., Jaycox, L. H., Watlington, C. G., <i>et al.</i> (2003) Are the dissociative criteria in ASD useful? <i>Journal of Traumatic Stress</i> , 16, 341–350.	Insufficient data
Zoger, S., Svedlund, J. & Holgers, K. M. (2004) The Hospital Anxiety and Depression Scale (HAD) as a screening instrument in tinnitus evaluation. <i>International Journal of Audiology</i> , 43, 458–464.	Non-English version
Zuckerman, M. & Biase, D. V. (1962) Replication and further data on the validity of the Affect Adjective Check List measure of anxiety. <i>Journal of Consulting Psychology</i> , 26, 291.	Depression
Zuckerman, M., Lubin, B. & Rinck, C. (1983) Construction of new scales for the Multiple Affect Adjective Check List. <i>Journal of Behavioral Assessment</i> , 5, 119–129.	Insufficient data
Zwahlen, D., Hagenbuch, N., Carley, M., <i>et al.</i> (2008) Screening cancer patients' families with the distress thermometer (DT): a validation study. <i>Psycho-Oncology</i> , 17, 959–966.	Non-English version

## 1.3 ASSESSMENT

### 1.3.1 Included studies characteristics (systematic reviews of formal assessment)

<b>Study ID</b>	NZGG2008
<b>Bibliographic reference:</b>	New Zealand Guidelines Group. <i>Identification of Common Mental Disorders and Management of Depression in Primary Care. An Evidence-based Best Practice Guideline.</i> Wellington: New Zealand Guidelines Group, 2008.
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Systematic reviews and cohort studies
<b>Evidence search</b>	Details of search reported in appendix, which was not available from the New Zealand Guidelines Group website at the time of development
<b>Number of included studies</b>	Four systematic reviews and 27 primary studies
<b>Review quality</b>	Adequate
<b>Instrument/ method of assessment reviewed</b>	PHQ-9 GHQ-12 CMDQ CES-D WHO-5 Duke-Anxiety-Depression scale GAD-2 and GAD-7 Kessler-10 questionnaire
<b>Reference standard used by primary studies</b>	Not reported
<b>Diagnosis of participants included in primary studies</b>	Common mental health disorder
<b>Sensitivity and specificity</b>	Not reported
<b>Positive and negative predictive values</b>	Not reported
<b>Source of funding</b>	New Zealand Ministry of Health



### 1.3.2 Included studies characteristics (systematic reviews of risk assessment)

Study ID	MCMILLAN2007
Bibliographic reference:	McMillan, D., Gilbody, S., Beresford, E., <i>et al.</i> (2007) Can we predict suicide and non-fatal self-harm with the BHS? A meta-analysis. <i>Psychological Medicine</i> , 37, 769–778.
Method used to synthesise evidence	Meta-analysis
Design of included studies	Cohort
Evidence search	CINAHL, EMBASE, MEDLINE and PsycINFO (inception to January 2006)
Number of included studies	19 (10 studies included in the diagnostic accuracy meta-analysis)
Review quality	Poor (quality of included studies not assessed/ reported)
Instrument/ method of assessment reviewed	BHS
Reference standard used by primary studies	Number of people with the outcome (suicide or self-harm)
Diagnosis of participants included in primary studies	Depression
Results	<p><b>Using the BHS to predict suicide</b> Based on four studies, and using a cut off score <math>\geq 9</math>, the pooled sensitivity of the BHS was 0.80 (95% CI 0.68-0.90, <math>I^2 = 57\%</math>) and specificity was 0.42 (95% CI 0.41-0.44, <math>I^2 = 76\%</math>). Likelihood ratios for positive and negative tests were 1.55 (95% CI 1.31–1.83, <math>I^2 = 44\%</math>) and 0.45 (95% CI 0.20–1.03, <math>I^2 = 49\%</math>) respectively. The pooled diagnostic odds ratio was 3.39 (95% CI 1.29–8.88, <math>I^2 = 37\%</math>). The pooled AUC was 0.70 (95% CI 0.59–0.85)</p> <p><b>Using the BHS to predict non-fatal self-harm</b> Based on six studies, and using a cut off score <math>\geq 9</math>, the pooled sensitivity of the BHS was 0.78 (95% CI 0.74 to 0.82, <math>I^2 = 0\%</math>) and specificity was 0.42 (95% CI 0.38 to 0.45, <math>I^2 = 90\%</math>). Likelihood ratios for positive and negative tests were 1.29 (95% CI 1.09 to 1.52, <math>I^2 = 74\%</math>) and 0.58 (95% CI 0.47 to 0.71, <math>I^2 = 0\%</math>) respectively. The pooled diagnostic odds ratio was 2.27 (95% CI 1.53 to 3.37, <math>I^2 = 35\%</math>), regardless of setting, length of follow-up and baseline risk. The pooled AUC was 0.63 (95% CI 0.57 to 0.70). After removing a study that used an adolescent population, the results remained similar</p>

Source of funding	None
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### 1.3.3 Included studies characteristics (systematic reviews of factors that predict treatment response)

Study ID	DODD2004
Bibliographic reference:	Dodd, S. & Berk, M. Predictors of antidepressant response: a selective review. <i>International Journal of Psychiatry in Clinical Practice</i> , 8, 91-100.
Method used to synthesise evidence	Narrative
Design of included studies	Preference for clinically relevant primary research articles
Evidence search	MEDLINE (1966 to present) on Ovid (Ovid Technologies, Inc., New York, NY) and hand-search of relevant literature
Number of included studies	95
Review quality	High risk of bias (only MEDLINE searched, quality of included studies not assessed/reported, poor description of methodology)
Predictor of response	Biological, psychosocial, clinical factors
Outcome measure	Antidepressant response
Diagnosis of participants included in primary studies	Depression
Results	<p>The following non-biological factors predicted better response:</p> <ul style="list-style-type: none"> <li>• moderate depression (compared with severe depression)</li> <li>• endogenous depression (compared with situational/reactive depression)</li> <li>• high autonomy and low sociotropy</li> <li>• high co-operativeness and self-directedness</li> <li>• high reward-dependence and novelty-seeking and low harm-avoidance</li> <li>• greater non-verbal attunement between patient and interviewer</li> <li>• psychiatrist's initial optimism</li> <li>• strong alliance between therapist and service user</li> <li>• strongly held religious beliefs and activities</li> </ul> <p>The following non-biological factors predicted poor response:</p> <ul style="list-style-type: none"> <li>• comorbidity of generalised anxiety disorder</li> </ul>

	<ul style="list-style-type: none"> <li>• comorbidity of panic disorder</li> <li>• bipolarity</li> <li>• alcohol abuse and dependance</li> <li>• poor occupational functioning</li> </ul> <p>Biological predictive factors included neuro-endocrine factors, platelet markers, electroencephalographic markers and magnetic resonance markers, but the review authors suggest that while these are useful in research they are of only limited use to the treating clinician</p>
<b>Source of funding</b>	Eli-Lilly; Novartis; Bristol-Myers-Squibb; Organon

<b>Study ID</b>	<b>FEKADU2009</b>
<b>Bibliographic reference:</b>	
Fekadu, A., Wooderson, S. C., Markouloulo, K., <i>et al.</i> (2009) What happens to patients with treatment resistant depression? A systematic review of medium to long term outcome studies. <i>Journal of Affective Disorders</i> , 116, 4–11.	
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Observational and longitudinal (minimum follow-up 6 months)
<b>Evidence search</b>	EMBASE (1974 to June 2008), MEDLINE (1960 to June 2008), PsycINFO (1967 to June 2008), PubMed and hand-search of relevant literature
<b>Number of included studies</b>	9
<b>Review quality</b>	Low risk of bias
<b>Predictor of response</b>	Clinical factors
<b>Outcome measure</b>	Treatment response/readmission
<b>Diagnosis of participants included in primary studies</b>	'Treatment-resistant' depression
<b>Results</b>	<p>The following factors predicted good outcome and recovery:</p> <ul style="list-style-type: none"> <li>• initial responsiveness to lithium</li> <li>• absence of previous history of admission</li> <li>• shorter duration of illness at intake</li> <li>• less severe illness during follow-up</li> </ul>

	<p>The following factors predicted poorer outcome and readmission:</p> <ul style="list-style-type: none"> <li>• prior history of treatment with lithium</li> <li>• presence of delusions and agitation</li> </ul> <p>Age, sex and history of dysthymia were not predictive of recovery</p>
<b>Source of funding</b>	None

<b>Study ID</b>	<b>HARDEVELD2010</b>
<b>Bibliographic reference:</b>	
Hardeveld, F., Spijker, J., De Graaf, R., <i>et al.</i> (2010) Prevalence and predictors of recurrence of major depressive disorder in the adult population. <i>Acta Psychiatrica Scandinavica</i> , 122, 184–191	
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Naturalistic, longitudinal study (minimum follow-up 6 months)
<b>Evidence search</b>	MEDLINE (January 1980 to August 2008) and PsycINFO
<b>Number of included studies</b>	27
<b>Review quality</b>	Low risk of bias
<b>Predictor of response</b>	Psychosocial and clinical factors
<b>Outcome measure</b>	Recurrence of MDD
<b>Diagnosis of participants included in primary studies</b>	MDD
<b>Results</b>	<p>The following factors predicted recurrence of MDD:</p> <ul style="list-style-type: none"> <li>• the number of previous episodes</li> <li>• subclinical residual symptoms after recovery for the last episode</li> </ul> <p>Demographic factors such as sex, civil status and socioeconomic status were not related to the recurrence of MDD</p> <p>The percentage of recurrence of MDD in specialised mental healthcare settings is high (85% after 15 years) and may be similar in primary care. In the general population, recurrence of MDD is lower (35% after 15 years).</p>
<b>Source of funding</b>	Netherlands Organisation for Health Research and Development; European Union; Stanley Medical Research Institute; Astra Zeneca; Eli Lilly; GlaxoSmithKline; Wyeth

<b>Study ID</b>	<b>MITCHELL2005</b>
<b>Bibliographic reference:</b>	Mitchell, A. J. & Subramaniam, H. (2005) Prognosis of depression in old age compared to middle age: a systematic review of comparative studies. <i>American Journal of Psychiatry</i> , 162, 1588–1601.
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Comparative studies of mid- and late-life first episode depression
<b>Evidence search</b>	ASSIA (1987 to July 2004), CINAHL (1982 to July 2004), EMBASE (1980 to July 2004), MEDLINE (1966 to July 2004), the National Library of Medicine gateway (accessed July 2004), Ovid (full text), PsycINFO (1887 to July 2004), and full-text collections including Science Direct, Ingenta Select, Wiley Interscience and Web of Knowledge (1.2, ISI)
<b>Number of included studies</b>	36
<b>Review quality</b>	Low risk of bias
<b>Predictor of response</b>	Age
<b>Outcome measure</b>	Treatment response and remission/recurrence of depression
<b>Diagnosis of participants included in primary studies</b>	Depression
<b>Results</b>	<p>Response and remission rates to pharmacotherapy and ECT are not significantly different in old-age depression and middle-age depression</p> <p>The evidence suggests that older patients have a higher risk of further episodes and short intervals to recurrence, and experience more confounding factors, for example medical comorbidity, than younger patients. Therefore, it is important to look at age-related factors, not just age itself, when assessing risk factors for prognosis</p> <p>Although rates of response are not substantially different between groups, systematic differences in treatment of depression by age exist. In general, the evidence overall supports the notion that depression in the elderly is equally responsive to initial treatment but has a more adverse longitudinal trajectory than depression in middle age</p>
<b>Source of funding</b>	Not reported

<b>Study ID</b>	<b>NELSON2009</b>
<b>Bibliographic reference:</b>	
Nelson, J. C., Delucchi, K. & Schneider, L. S. (2009). Anxiety does not predict response to antidepressant treatment in late life depression: results of a meta-analysis. <i>International Journal of Geriatric Psychiatry</i> , 24, 539–544.	
<b>Method used to synthesise evidence</b>	Meta-analysis
<b>Design of included studies</b>	Randomised, double blind placebo controlled trials
<b>Evidence search</b>	The Cochrane Controlled Trials Register (2006, Issue 3), MEDLINE (1966 to August 2006), hand-search of relevant literature and information retrieved from pharmaceutical manufacturers
<b>Number of included studies</b>	10
<b>Review quality</b>	Low risk of bias
<b>Predictor of response</b>	Presence of anxiety
<b>Outcome measure</b>	Response to second generation antidepressant treatment
<b>Diagnosis of participants included in primary studies</b>	Late life depression
<b>Results</b>	There was no evidence that anxiety affected response to second-generation antidepressant treatment in placebo-controlled trials of major depression in older adults
<b>Source of funding</b>	Not reported, but two authors received funds from pharmaceutical companies

<b>Study ID</b>	<b>POMPILI2009</b>
<b>Bibliographic reference:</b>	
Pompili, M., Serfini, G., Del Casale, A., <i>et al.</i> (2009) Improving assessment in mood disorders: the struggle against relapse, reoccurrence and suicide risk. <i>Expert Review of Neurotherapeutics</i> , 9, 985–1004.	
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Primary research, review articles and descriptive papers that measured adherence
<b>Evidence search</b>	MEDLINE and PsycINFO (1975 to 2009)
<b>Number of included studies</b>	104
<b>Review quality</b>	Poor (quality of included studies not assessed/ reported)

<b>Predictor of response</b>	Psychosocial and clinical factors
<b>Outcome measure</b>	Medication adherence
<b>Diagnosis of participants included in primary studies</b>	Unipolar and bipolar depression
<b>Results</b>	<p>Factors that predict medication non-adherence specific to unipolar/ bipolar depression can be categorised as:</p> <ul style="list-style-type: none"> <li>• variables unique to the disorder (early onset, high number of hospitalisations)</li> <li>• treatment issues (complex treatment regimen, medication side effects, delayed onset of action, cost of medication, inadequate medication dosage and inadequate therapy duration)</li> <li>• patient factors (gender, age, marital status, educational level and social support, ethnicity, cognitive dysfunction, higher level of personality pathology, lack of insight, substance abuse, mood-incongruent psychotic features)</li> <li>• physician factors (poor physician-patient communication).</li> </ul> <p>Comorbid symptoms had no effect on adherence.</p>
<b>Source of funding</b>	None

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

<b>Study ID</b>	KNAUP2009
<b>Bibliographic reference:</b> Knaup, C., Koesters, M., Schoefer, D., <i>et al.</i> (2009) Effect of feedback of treatment outcome in specialist mental healthcare: a meta-analysis. <i>The British Journal of Psychiatry</i> , 195, 15–22.	

<b>Method used to synthesise evidence</b>	Meta-analysis
<b>Design of included studies</b>	Controlled trials using outcome management
<b>Evidence search</b>	CDSR, MEDLINE, PSYINDEX (German and English psychological literature database), PsycINFO, the Cochrane Central Register of Controlled Trials, the Current Controlled Trials Register and the World Wide Web using Google and Google Scholar in November 2006. Search updated in March 2008
<b>Number of included studies</b>	12
<b>Review quality</b>	Poor (quality of included studies not assessed/reported)
<b>Type of ROM</b>	General
<b>Outcome of ROM</b>	<ul style="list-style-type: none"> <li>• Mental health</li> <li>• Met and unmet needs</li> <li>• Physical impairment</li> <li>• Social functioning</li> <li>• Quality of life</li> <li>• Patient satisfaction</li> <li>• Acceptance or appraisal of feedback</li> <li>• Rates of significant clinical change</li> <li>• Rates of significant treatment response</li> </ul>
<b>Diagnosis of participants included in primary studies</b>	Common mental health disorder
<b>Results</b>	<p>ROM often involved standardised assessments of psychological functioning or needs such as the Outcome Questionnaire 4.5.2, Symptom Checklist 11, Camberwell Assessment of Need for the Elderly, Camberwell Assessment of Need Short Appraisal schedule and Cardinal Needs schedule</p> <p>Feedback mainly comprised information about current treatment status and changes over time</p> <p>With regard to short-term outcomes, despite moderate between-study heterogeneity (<math>I^2 = 31\%</math>, <math>p = 0.16</math>), there was a small but statistically significant effect favouring the feedback intervention in ten studies including a total of 4,009 participants (Hedges' <math>g = 0.10</math>, 95% CI 0.01 to 0.19). For long-term effects of ROM, meta-analysis of five studies (<math>N = 573</math>) demonstrated an unexpected, non-significant trend in favour of the 'no feedback' group (<math>g = -0.06</math>, 95% CI -0.22 to 0.11; <math>I^2 = 0\%</math>, <math>p = 0.69</math>)</p> <p>Routine outcome monitoring was not found to significantly change the length of treatment in the meta-analysis (<math>g = 0.05</math>, 95% CI -0.05 to 0.15; <math>I^2 = 42.03\%</math>, <math>p = 0.12</math>)</p>



<b>Source of funding</b>	German Federal Ministry of Education and Research
<b>Study ID</b>	LAMBERT2003
<b>Bibliographic reference:</b>	
Lambert, M. J., Whipple, J. L. & Hawkins, E. J., (2003) Is it time for clinicians to routinely track patient outcome? A meta-analysis. <i>Clinical Psychology: Science and Practice</i> , 10, 288–301.	
<b>Method used to synthesise evidence</b>	Meta-analysis
<b>Design of included studies</b>	RCT
<b>Evidence search</b>	No search done as this was a meta-analysis of three RCTs
<b>Number of included studies</b>	3
<b>Review quality</b>	This study did not claim to be a systematic review, but rather was a meta-analysis of three RCTs
<b>Type of ROM</b>	Therapist signal alarm feedback
<b>Outcome of ROM</b>	<ul style="list-style-type: none"> <li>• Psychological dysfunction</li> <li>• Number of sessions of treatment</li> </ul>
<b>Diagnosis of participants included in primary studies</b>	Common mental health disorder
<b>Results</b>	<p>Following a signal alarm, individuals who were responding poorly to treatment and whose therapist received feedback showed an improvement in functioning, based on the Outcome Questionnaire-45. Conversely, individuals who were responding poorly to treatment but whose therapist did not receive feedback showed a decrease in functioning. Overall, the effect size was 0.39, which was statistically significant (<math>F [1,581] = 26.15, p &lt; 0.05</math>). This difference was maintained at treatment termination. Participants responding more poorly whose therapists received no treatment feedback had a clinically significant deterioration (21.3%) in comparison with those whose therapists were receiving feedback (13.4%). This difference was statistically significant (<math>\chi^2 = 16.31, p &lt; 0.001</math>)</p> <p>For participants who were responding poorly to treatment, those whose therapists received feedback attended about 1.5 sessions than more than those whose therapists did not receive feedback (<math>F [1,582] = 15.90, p &lt; 0.05</math>)</p>
<b>Source of funding</b>	Brigham Young University

### 1.3.5 Excluded studies

Bibliographic reference:	Reason for exclusion
Bagby, R. M., Ryder, A. G., Schuller, D. R., <i>et al.</i> (2004) The Hamilton Depression Rating Scale: has the gold standard become a lead weight? <i>American Journal of Psychiatry</i> , 161, 2163–2177.	Instrument reviewed in Depression update guideline
Cepoiu, M., McCusker, J., Cole, M. G., <i>et al.</i> (2008) Recognition of depression by non-psychiatric physicians - A systematic literature review and meta-analysis. <i>Journal of General Internal Medicine</i> , 23, 25–36.	Non-formal assessment
Cole, M. G. & Dendukuri, N. (2003) Risk factors for depression among elderly community subjects: a systematic review and meta-analysis. <i>American Journal of Psychiatry</i> , 160, 1147–1156.	Review of risk factors for developing depression
Colasanti, V., Marianetti, M., Micacchi, F., <i>et al.</i> (2010) Tests for the evaluation of depression in the elderly: a systematic review. <i>Archives of Gerontology and Geriatrics</i> , 50, 227–230.	Instruments reviewed in Depression update guideline
Cuijpers, P., Li, J., Hofmann, S. G., <i>et al.</i> (2010) Self-reported versus clinician-rated symptoms of depression as outcome measures in psychotherapy research on depression: a meta-analysis. <i>Clinical Psychology Review</i> , 30, 768–778.	Review of risk factors for developing depression
Delville, C. & McDougall, G. (2008) A systematic review of depression in adults with heart failure: instruments and incidence. <i>Issues in Mental Health Nursing</i> , 29, 1001–1017.	Instruments reviewed in Depression update guideline
Evans, K., Dougherty, D., Pollack, M., <i>et al.</i> (2006) Using neuroimaging to predict treatment response in mood and anxiety disorders. <i>Annals of Clinical Psychiatry</i> , 18, 33–42.	Review of neuro-imaging
Hutton, C. & Gunn, J. (2007) Do longer consultations improve the management of psychological problems in general practice? A systematic literature review. <i>BMC Health Services Research</i> , 7, 71.	Review of consultation length
Lester, H. (2007) The UK quality and outcomes framework. <i>British Medical Journal</i> , 337, a2095.	Not a systematic review
Lester, H. & Howe, A. (2008) Depression in primary care: three key challenges. <i>Postgraduate Medical Journal</i> , 84, 545–548.	Not a systematic review
Lester, H. & Majeed, A. (2008) The future of the quality and outcomes framework. <i>British Medical Journal</i> , 337, a3017.	Not a systematic review
Lopez-Pina, J., Sanchez-Meca, J. & Rosa-Alcazar, A. (2009) The Hamilton Rating Scale for Depression: a meta-analytic reliability generalization study. <i>International Journal of Clinical and Health Psychology</i> , 9, 143–159.	Instrument reviewed in Depression update guideline
McHugh, R. K. & Behar, E. (2009) Readability of self-report measures of depression and anxiety. <i>Journal of Consulting and Clinical Psychology</i> , 77, 1100–1112.	Not a systematic review
Mitchell, A. J., Vaze, A. & Rao, S. (2009) Clinical diagnosis of depression in primary care: a meta-analysis. <i>The Lancet</i> , 374, 609–619.	Review of routine clinical diagnosis by GPs

Nichol, M. B. & Zhang, L. (2005) Depression and health-related quality of life in patients with rheumatoid arthritis. <i>Expert Review of Pharmacoeconomics and Outcomes Research</i> , 5, 645–653.	Not a review of formal assessment
Salter, K., Bhogal, S. K., Foley, N., <i>et al.</i> (2007) The assessment of poststroke depression. <i>Topics in Stroke Rehabilitation</i> , 14, 1–24.	Instruments reviewed in Depression update guideline
Wittkamp, K. A., Naeije, L., Schene, A. H., <i>et al.</i> (2007) Diagnostic accuracy of the mood module of the Patient Health Questionnaire: a systematic review. <i>General Hospital Psychiatry</i> , 29, 388–395.	Instrument reviewed in Depression update guideline
Zimmerman, M., Chelminski, I. & Posternak, M. (2004) A review of studies of the Hamilton Depression Rating Scale in healthy controls: Implications for the definition of remission in treatment studies of depression. <i>Journal of Nervous and Mental Disease</i> , 192, 595–601.	Review of HDRS in healthy controls

## 1.4 PATHWAYS

### 1.4.1 Included studies characteristics

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

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

<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Various
<b>Evidence search</b>	MEDLINE
<b>Number of included studies</b>	Not reported
<b>Review quality</b>	Poor
<b>Interventions</b>	Algorithms
<b>Outcome</b>	Recovery, quality of life, patient satisfaction, remission or response to treatment, treatment adherence, symptom reduction, suicidal ideation, side-effect burden and functional impairment
<b>Diagnosis of participants included in primary studies</b>	Depression
<b>Results</b>	<p>In clinical practice, treatment algorithms should be embedded in a multi-faceted disease-management or collaborative-care program. They must be understandable and acceptable, and be capable of overcoming administrative and clinician-related hurdles</p> <p>Critical decision points can be useful for algorithm implementation, provided that they use objective symptom scales, are based on pre-defined response criteria, include a rigorous assessment of side-effects, are scheduled at appropriate time points and are adaptable to various clinical circumstances</p> <p>In comparison with treatment as usual, algorithms can help to: improve the likelihood of recovery, quality of life and patient satisfaction; achieve remission or response to treatment; maintain treatment adherence; reduce depressive symptoms, suicidal ideation, side-effect burden; improve functional impairment</p>
<b>Source of funding</b>	German Federal Ministry for Education and Research; Eli Lilly and Company; Janssen-Cilag, Pfizer Inc.; Pharmacia; WyethAyerst Laboratories, Inc.

<b>Study ID</b>	<b>ARGAWAL2008</b>
<b>Bibliographic reference:</b>	
Agarwal, G. & Crooks, V. A. (2008) The nature of informational continuity of care in general practice. <i>British Journal of General Practice</i> , 58, e17–e24.	

<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Various
<b>Evidence search</b>	CINAHL, EMBASE, MEDLINE, PsycINFO and Web of Science were searched up to 2006
<b>Number of included studies</b>	34
<b>Review quality</b>	Adequate
<b>Interventions</b>	Informational continuity
<b>Outcome</b>	Accuracy
<b>Diagnosis of participants included in primary studies</b>	Various mental and non-mental health conditions
<b>Results</b>	<p>Duration and depth of the patient-doctor relationship was important, because accurate histories often require a good knowledge base</p> <p>Doctors were found to rarely ask about social/lifestyle and medical histories, preferring to rely on memory</p> <p>Around 30% of patients report enjoying discussing what should be entered in their records. However, they can be selective and often prioritise biomedical issues over socio-contextual or personal ones</p>
<b>Source of funding</b>	Canadian Institutes of Health Research (CIHR); Canadian Diabetes Association

<b>Study ID</b>	<b>BADAMGARAV2003</b>
<b>Bibliographic reference:</b>	
Badamgarav, E., Weingarten, S. R., Henning, J. M., <i>et al.</i> (2003) Effectiveness of disease management programs in depression: a systematic review. <i>American Journal of Psychiatry</i> , 160, 2080–2090.	
<b>Method used to synthesise evidence</b>	Meta-analysis
<b>Design of included studies</b>	RCTs
<b>Evidence search</b>	Cochrane Library, HealthSTAR and MEDLINE were searched up to 2001
<b>Number of included studies</b>	19
<b>Review quality</b>	Adequate
<b>Interventions</b>	Disease management

<b>Outcome</b>	Improvements in symptoms, physical functioning, social and health status, and patient satisfaction; impact on healthcare utilisation, hospitalisations, healthcare costs, depression detection, referral rates, prescribing adequacy and adherence
<b>Diagnosis of participants included in primary studies</b>	Depression
<b>Results</b>	<p>In comparison with treatment as usual, disease management was significantly better at:</p> <ul style="list-style-type: none"> <li>• reducing symptoms of depression (effect size = 0.33, 95% CI = 0.16 to 0.49)</li> <li>• improving patient satisfaction (effect size = 0.51, 95% CI = 0.33 to 0.68)</li> <li>• increasing primary care visits (effect size = -0.1, 95% CI = -0.18 to -0.02)</li> <li>• detecting depression, but only when programs contained an explicit screening component (effect size = 0.18, 95% CI = -0.11 to 0.18)</li> <li>• improving treatment adequacy (effect size = 0.44, 95% CI = 0.30 to 0.59)</li> <li>• improving patient adherence to treatment (effect size = 0.36, 95% CI = 0.17 to 0.54)</li> </ul> <p>In comparison with treatment as usual, disease management had no effect on:</p> <ul style="list-style-type: none"> <li>• physical functioning (effect size = -0.05, 95% CI = -0.72 to 0.62)</li> <li>• social and health status (effect size = 0.06, 95% CI = -0.51 to 0.62)</li> <li>• hospitalisation rates (effect size = -0.2, 95% CI = -0.35 to 0.04)</li> <li>• healthcare costs (effect size = -1.03, 95% CI = -2.62 to 0.54)</li> <li>• outcomes affected by patient and provider adherence to treatment (effect size = 0.57, 95% CI = -0.11 to 1.26)</li> <li>• referral to specialist care (effect size = 0.13, 95% CI = -0.32 to 0.57)</li> </ul>
<b>Source of funding</b>	TAP Pharmaceutical Products Inc.

<b>Study ID</b>	<b>BOWER2006</b>
<b>Bibliographic reference:</b>	
Bower, P., Gilbody, S., Richards, D., <i>et al.</i> (2006) Collaborative care for depression in primary care. Making sense of a complex intervention: systematic review and meta-regression. <i>British Journal of Psychiatry</i> , 189, 484-493.	

<b>Method used to synthesise evidence</b>	Meta-analysis and regression
<b>Design of included studies</b>	RCTs
<b>Evidence search</b>	An update of a published systematic review (up to 2003) of organisational interventions in primary-care mental health. Searches included CINAHL, Cochrane Library, DARE, EMBASE, MEDLINE and PsycINFO, and were carried out from inception up to 2005
<b>Number of included studies</b>	28 studies on collaborative care and 34 studies on antidepressant use
<b>Review quality</b>	Adequate
<b>Interventions</b>	Collaborative care
<b>Outcome</b>	Antidepressant use and symptom improvement
<b>Diagnosis of participants included in primary studies</b>	Depression or depressive symptoms
<b>Results</b>	<p>Collaborative care had a positive effect on depressive symptom outcomes (SMD = 0.24, 95% CI 0.17 to 0.32)</p> <p>No intervention content variables predicted antidepressant use</p> <p>Intervention content variables predicting depressive-symptom improvement:</p> <ul style="list-style-type: none"> <li>• recruitment by systematic identification</li> <li>• case managers with specific mental health backgrounds</li> <li>• provision of regular supervision for case managers</li> </ul>
<b>Source of funding</b>	Department of Health

<b>Study ID</b>	<b>BUTLER2007</b>
<b>Bibliographic reference:</b>	
Butler, R., Hatcher, S., Price, J., <i>et al.</i> (2007) Depression in adults: psychological treatments and care pathways. <i>BMJ Clinical Evidence</i> , 8, 1016.	



<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Systematic reviews and RCTs
<b>Evidence search</b>	Cochrane Library, MEDLINE, EMBASE, HTA database, NICE guidance, NHS centre for Reviews and Disseminations, NHS centre for Database of Abstracts of Reviews of Effects, PsycINFO and Turning Research Into Practice were searched from inception up to 2006.
<b>Number of included studies</b>	10 systematic reviews and 4 RCTs
<b>Review quality</b>	Adequate
<b>Interventions</b>	Care pathways using befriending, cognitive therapy, combining antidepressant drugs and psychological treatments, interpersonal psychotherapy, non-directive counselling, problem-solving therapy or relapse-prevention programmes
<b>Outcome</b>	Effectiveness and safety
<b>Diagnosis of participants included in primary studies</b>	Mild, moderate and severe depression
<b>Results</b>	<p>Compared with usual care:</p> <ul style="list-style-type: none"> <li>• care pathways were more effective at improving symptoms and response rates</li> <li>• recurrence prevention programmes were equally effective at improving relapse rates at 6 months, regardless of specific treatment components</li> <li>• it is unclear what effect care pathways have in the very long term (2 years or more)</li> </ul> <p>However, much of the evidence was considered to be of low quality</p>
<b>Source of funding</b>	Not reported

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

<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Reviews, descriptive studies and evaluative studies
<b>Evidence search</b>	MEDLINE, ASSIA, EMBASE, National Research Register, PsycINFO, DARE, British Nursing Index, CINAHL, Royal College of Nursing Library, Nursing Collection, Cochrane Library and Best Evidence were searched up to 2001
<b>Number of included studies</b>	48
<b>Review quality</b>	Adequate
<b>Interventions</b>	Liaison mental health services
<b>Outcome</b>	Symptom reduction, physician skill improvements, referral rates, acceptability and appointment compliance
<b>Diagnosis of participants included in primary studies</b>	Various mental health problems
<b>Results</b>	<p>Liaison mental health services were found to:</p> <ul style="list-style-type: none"> <li>• reduce levels of psychological morbidity, cardiac mortality and healthcare costs</li> <li>• increase rates of referral for follow up appointments</li> <li>• be acceptable to clients in terms of the information they received and overall satisfaction</li> <li>• have little effect on compliance with psychiatric appointments</li> </ul>
<b>Source of funding</b>	Not reported

<b>Study ID</b>	<b>CHANGQUAN2003</b>
<b>Bibliographic reference:</b>	
Chang-Quan, H., Bi-Rong, D., Zhen-Chan, L., <i>et al.</i> (2009) Collaborative care interventions for depression in the elderly: a systematic review of randomised controlled trials. <i>Journal of Investigative Medicine</i> , 57, 446-455.	
<b>Method used to synthesise evidence</b>	Meta-analysis
<b>Design of included studies</b>	RCTs
<b>Evidence search</b>	EMBASE, MEDLINE and Cochrane Library were searched up to 2007
<b>Number of included studies</b>	3
<b>Review quality</b>	Adequate
<b>Interventions</b>	Collaborative care
<b>Outcome</b>	Depression symptoms, response rates, remission, suicidal ideation and treatment seeking

<b>Diagnosis of participants included in primary studies</b>	Depression, older people
<b>Results</b>	At 18 and 24 months, collaborative care interventions were superior to usual care in improving depression scores (OR, -0.44, 95% CI -0.55 to -0.33 and OR, -0.35, 95% CI -0.46 to -0.24, respectively), response rates (OR, 2.38, 95% CI 1.88 to 3.02 and OR, 1.67, 95% CI 1.63 to 2.12, respectively) and remission rates (OR, 2.29, 95% CI 1.42 to 3.10 and OR, 1.83, 95% CI 1.34 to 1.98, respectively)
<b>Source of funding</b>	Not reported

<b>Study ID</b>	<b>CHRISTENSEN2008</b>
<b>Bibliographic reference:</b> Christensen, H., Griffiths, K., Gulliver, A., <i>et al.</i> (2008) Models in the delivery of depression care: a systematic review of randomised and controlled intervention trials. <i>BMC Family Practice</i> , 9, 25.	
<b>Method used to synthesise evidence</b>	Statistical (based on counting the number of significant findings in primary studies)
<b>Design of included studies</b>	RCT and controlled trials
<b>Evidence search</b>	PubMed, PsycINFO, Cochrane Library were searched (inception to October 2005)
<b>Number of included studies</b>	55 (51 RCTs, 4 controlled trials)
<b>Review quality</b>	Poor
<b>Interventions</b>	Training and feedback, care management, enhancements of extensions to general practice, self-help, teams external to the practice, community-based mental health professionals, health maintenance organisation based interventions and broad community-based interventions
<b>Outcome</b>	Significant improvement on the key depression measure
<b>Diagnosis of participants included in primary studies</b>	Depression
<b>Results</b>	Treatment monitoring and delivery was best done by a professional with a mental health background ( $\chi^2 [2, 22] = 7.558, p = .021$ )  General practitioner training and clinical practice guideline provision alone were not associated with improved outcomes  There was no association between number of treatment components and outcome
<b>Source of funding</b>	Australian Government Department of Health and Ageing; National Health and Medical Research Council

<b>Study ID</b>	<b>CRAVEN2006</b>
<b>Bibliographic reference:</b>	
Craven, M.A. & Bland, R. (2006) Better practices in collaborative mental health care: an analysis of the evidence base. <i>The Canadian Journal of Psychiatry</i> , 51 (Suppl. 1), 7S-72S.	
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Experimental methodology (RCTs and intervention studies with outcome measures)
<b>Evidence search</b>	MEDLINE, EMBASE, CINAHL, PsycINFO, Education Resources Information Center, Social Science Abstracts, PubMed, Cochrane and Google up to 2005
<b>Number of included studies</b>	38
<b>Review quality</b>	Adequate
<b>Interventions</b>	Collaborative care
<b>Outcome</b>	Improved patient response
<b>Diagnosis of participants included in primary studies</b>	Various
<b>Results</b>	<p>Degree of collaboration does not in itself appear to predict clinical outcome</p> <p>Systematic follow strongly predicts clinical outcome</p> <p>Enhanced patient education often improved patient outcomes</p> <p>Collaborative interventions took time to establish, and are hard to maintain outside of the study environment</p> <p>Patient choice is an important factor in treatment engagement in collaborative care</p>
<b>Source of funding</b>	Health Canada through the Primary Health Care Transitions Fund
<b>Study ID</b>	<b>FOY2010</b>

<b>Bibliographic reference:</b>	
Foy, R., Hempel, S., Rubenstein, L., <i>et al.</i> (2010) Meta-analysis: effect of interactive communication between collaborating primary care physicians and specialists. <i>Annals of Internal Medicine</i> , 152, 247–258.	
<b>Method used to synthesise evidence</b>	Meta-analysis
<b>Design of included studies</b>	RCT
<b>Evidence search</b>	CINAHL, Cochrane Database of Systematic Reviews, DARE, EMBASE, PubMed, PsycINFO and Web of Science up to 2008
<b>Number of included studies</b>	38
<b>Review quality</b>	Adequate
<b>Interventions</b>	Collaborative care
<b>Outcome</b>	Depression outcomes
<b>Diagnosis of participants included in primary studies</b>	Depression
<b>Results</b>	<p>GP and psychiatrist collaboration led to a significant improvement in depression outcomes (effect size -0.48 95% CI, -0.67 to -0.30)</p> <p>Interventions that improved the quality of information exchange had significantly better outcomes than those with no such focus on information exchange (effect size -0.84 95% CI, -1.14 to -0.55 and -0.27 95% CI, -0.49 to -0.05, respectively)</p> <p>Needs assessment and joint care planning had little effect on outcome</p>
<b>Source of funding</b>	RAND Health's Comprehensive Assessment of Reform Options Initiative, the Veterans Affairs Center for the Study of Provider Behavior, The Commonwealth Fund and the Health Foundation

<b>Study ID</b>	<b>FREDERICK2007</b>
<b>Bibliographic reference:</b>	
Frederick, J. T., Steinman, L. E., Prohaska, T. <i>et al.</i> (2007) Community-based treatment of late life depression an expert panel-informed literature review. <i>American Journal of Preventive Medicine</i> , 33, 222–249.	

<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Various
<b>Evidence search</b>	A search of the published scientific literature was conducted through August 2005 using the MEDLINE database of the National Library of Medicine (from 1966), CINAHL (from 1982) and the PsycINFO database of the American Psychological Association (from 1967)
<b>Number of included studies</b>	121
<b>Review quality</b>	Adequate
<b>Interventions</b>	Community-based interventions for depression in older adults
<b>Outcome</b>	Depression outcomes
<b>Diagnosis of participants included in primary studies</b>	Depression in older adults
<b>Results</b>	Depression care management, home or primary care clinics and individual CBT can be strongly recommended
<b>Source of funding</b>	Dutch Scientific Organization

<b>Study ID</b>	<b>GENSICHEN2005</b>
<b>Bibliographic reference:</b> Gensichen, J., Beyer, M., Muth, C., <i>et al.</i> (2005) Case management to improve major depression in primary health care: a systematic review. <i>Psychological Medicine</i> , 36, 7–14.	
<b>Method used to synthesise evidence</b>	Meta-analysis
<b>Design of included studies</b>	RCT
<b>Evidence search</b>	The Cochrane Library (2003, 2nd edition), MEDLINE (1966 to May 2003) and EMBASE (1980 to May 2003)
<b>Number of included studies</b>	13
<b>Review quality</b>	Adequate
<b>Interventions</b>	Case management
<b>Outcome</b>	Symptom reduction, relative risk reduction, treatment response rate and medication adherence
<b>Diagnosis of participants included in primary studies</b>	Depression
<b>Results</b>	Case management was associated with a significant reduction in depression severity and the relative risk of long lasting

	depression, and an increase in response rate and medication adherence at 6 to 12 months in comparison with usual care Simple and complex case management did not differ from each other
<b>Source of funding</b>	German Ministry for Education and Research (BMBF)

<b>Study ID</b>	<b>GILBODY2003</b>
<b>Bibliographic reference:</b>	Gilbody, S., Whitty, P., Grimshaw, J., <i>et al.</i> (2003) Educational and organizational interventions to improve the management of depression in primary care: a systematic review. <i>Journal of the American Medical Association</i> , 289, 3145–3152.
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	RCT, controlled before-and-after design, interrupted time-series analysis
<b>Evidence search</b>	Cochrane Depression Anxiety and Neurosis Group register, Cochrane Effective Professional and Organisational Change Group specialist register, Cochrane Controlled Trials Register, CINAHL, EMBASE, MEDLINE, PsycLIT and UK NHS EED searched (inception to 2003)
<b>Number of included studies</b>	36 (29 RCTs, five controlled before-and-after studies, two interrupted time series analyses)
<b>Review quality</b>	Adequate
<b>Interventions</b>	Educational and organisational interventions to improve depression management in primary care
<b>Outcome</b>	Improved patient outcome
<b>Diagnosis of participants included in primary studies</b>	Depression
<b>Results</b>	Effective strategies included collaborative care, stepped collaborative care, quality improvement, case management, pharmacist provided prescribing information and patient educations (medication outcomes only), and guideline implementation strategies when embedded in complex interventions  Ineffective strategies included guidelines and educational strategies when not accompanied by organisational support, chronic care clinics and computer-based decision support systems
<b>Source of funding</b>	United Kingdom Medical Research Council and Wellcome Health Services Research Fellowship programs, the United Kingdom National Health Service Centre for Reviews and Dissemination, and the United Kingdom HTA Programme (project 94/08/29)

<b>Study ID</b>	<b>GILBODY2006</b>
<b>Bibliographic reference:</b>	
Gilbody, S., Bower, P., Fletcher, J., <i>et al.</i> (2006) Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. <i>Archives of General Psychiatry</i> , 166, 2314–2321.	
<b>Method used to synthesise evidence</b>	Meta-analysis
<b>Design of included studies</b>	RCT
<b>Evidence search</b>	The Cochrane Library, CINAHL, DARE, EMBASE, MEDLINE and PsycINFO searched from inception to 2006
<b>Number of included studies</b>	37
<b>Review quality</b>	Adequate
<b>Interventions</b>	Collaborative care
<b>Outcome</b>	Symptom outcomes (6 months and longer term)
<b>Diagnosis of participants included in primary studies</b>	Depression
<b>Results</b>	<p>Collaborative care had a positive effect on depression outcomes at 6 months compared with standard care (SMD, 0.25, 95% CI, 0.18 to 0.32), which were maintained at 12 months (SMD, 0.31; 95% CI, 0.01 to 0.53), 18 months (SMD, 0.25; 95% CI, 0.03 to 0.46), and 5 years (SMD, 0.15; 95% CI, 0.001 to 0.30)</p> <p>Regular supervision and the mental health background of case managers, were significantly related to study effect size (<math>\beta</math> 0.15; 95% CI, -0.02 to 0.31 and <math>\beta</math> 0.18; 95% CI, 0.04 to 0.32, respectively)</p> <p>The addition of psychotherapy to medication management in collaborative care was not associated with any significantly increased effect size (<math>\beta</math> 0.10, 95% CI, -0.05 to 0.25)</p> <p>The number of case management session had no impact on effect size (<math>\beta</math>, 0.02; 95% CI, -0.008 to 0.04)</p>
<b>Source of funding</b>	None reported

<b>Study ID</b>	<b>GRIFFITHS2008</b>
<b>Bibliographic reference:</b>	
Griffiths, K. M. & Christensen, H. (2008) Depression in primary health care: from evidence to policy. <i>Medical Journal of Australia</i> , 188, S81-S83.	



<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Systematic reviews
<b>Evidence search</b>	Discussion of a series of 6 systematic reviews
<b>Number of included studies</b>	6
<b>Review quality</b>	Poor
<b>Interventions</b>	Depression management
<b>Outcome</b>	Depression outcomes
<b>Diagnosis of participants included in primary studies</b>	Depression
<b>Results</b>	<p>The following were associated with an improvement in depression outcomes relative to treatment as usual or control condition:</p> <ul style="list-style-type: none"> <li>• Care management</li> <li>• Enhanced/extended care</li> <li>• Guided self-help in general practice</li> <li>• Systematic tracking by a non-doctor</li> <li>• Revision of professional roles</li> <li>• Incorporation of patient preferences into care</li> </ul> <p>The following were associated with no improvement in depression outcomes relative to treatment-as-usual or control condition:</p> <ul style="list-style-type: none"> <li>• General practitioner training and feedback</li> <li>• Pharmacist interventions</li> <li>• Community context</li> </ul> <p>Telephone interventions, internet support groups and passive education did not have enough evidence to evaluate their effectiveness</p>
<b>Source of funding</b>	Australian Primary Health Care Research Institute, Australian Government Department of Health and Ageing, National Health and Medical Research Council and the National Health and Medical Research Council

<b>Study ID</b>	<b>GUNN2006</b>
<b>Bibliographic reference:</b> Gunn, J., Diggins, J., Hegarty, K., <i>et al.</i> (2006) A systematic review of complex system interventions designed to increase recovery from depression in primary care. <i>BMC Health Services Research</i> , 6, 88.	

<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Randomised controlled trials and cluster RCTs
<b>Evidence search</b>	MedLine, PubMed and Cochrane were searched to 2004
<b>Number of included studies</b>	11 (five cluster randomised controlled trials and six RCTs)
<b>Review quality</b>	Adequate
<b>Interventions</b>	System level interventions to improve recovery
<b>Outcome</b>	Recovery rates
<b>Diagnosis of participants included in primary studies</b>	Depression
<b>Results</b>	Studies generally favoured the multi-professional intervention groups in comparison with the control groups at varying follow up points for depression outcomes
<b>Source of funding</b>	Not reported

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

<b>Study ID</b>	<b>NEUMEYERGROMEN2004</b>
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<b>Bibliographic reference:</b>	
Neumeyer-Gromen, A., Lampert, T., Stark, K., <i>et al.</i> (2004) Disease management programs for depression: a systematic review and meta-analysis of randomized controlled trials. <i>Medical Care</i> , 42, 1211-1221.	
<b>Method used to synthesise evidence</b>	Meta-analysis
<b>Design of included studies</b>	RCTs
<b>Evidence search</b>	BMJ, CINAHL, Clinical trials, Cochrane, EMBASE, HTA databases, MEDLINE, PsycLIT, PsyINDEX and NHS EED were searched to 2002
<b>Number of included studies</b>	Ten
<b>Review quality</b>	Adequate
<b>Interventions</b>	Disease management programs
<b>Outcome</b>	Depression severity, quality of life, employment status, patient satisfaction, adherence and cost
<b>Diagnosis of participants included in primary studies</b>	Depressive disorders
<b>Results</b>	In comparison with usual care, disease management programs significantly improved health-related quality of life scores at 12 and 24 months (weighted MD 11.83, 95% CI 7.38 to 16.28 and weighted MD 24.42, 95% CI 17.92 to 30.92, respectively), resulting in significantly higher rates of patient satisfaction (RR 0.57, 95% CI 0.37 to 0.87; $p = 0.009$ ) and significantly-reduced depression severity in comparison with usual care (RR 0.75, 95% CI 0.70 to 0.81), although 2-year follow-ups showed inconsistent results
<b>Source of funding</b>	Not reported

<b>Study ID</b>	<b>SMOLDERS2008</b>
<b>Bibliographic reference:</b>	Smolders, M., Laurant, M., Roberge, P., <i>et al.</i> (2008) Knowledge transfer and improvement of primary and ambulatory care for patients with anxiety. <i>Canadian Journal of Psychiatry</i> , 53, 277–293.
<b>Method used to synthesise evidence</b>	Meta-analysis
<b>Design of included studies</b>	RCTs and controlled before-and-after studies
<b>Evidence search</b>	MEDLINE, PsycINFO, CINAHL, EMBASE and Cochrane were searched up to 2003, and then again up to 2006
<b>Number of included studies</b>	24 (23 RCTs and one controlled before-and-after study)
<b>Review quality</b>	Adequate
<b>Interventions</b>	Audit and feedback, education and educational outreach
<b>Outcome</b>	Prescription rates, referrals, physician knowledge, anxiety symptom improvement, satisfaction and cost-effectiveness
<b>Diagnosis of participants included in primary studies</b>	Anxiety
<b>Results</b>	<p>Intensive programs that incorporated education and shared care were associated with increased anxiety-free days and better employment status</p> <p>Education and audit and feedback strategies alone were not successful at increasing anxiety outcomes. Brief education was successful at influencing treatment recommendations for panic disorder only and CBT training sessions increased the use of CBT techniques. Studies that used guideline concordant treatment and medication adherence strategies were associated with short-term effects only</p> <p>Collaborative care improved receipt of adequate medication and medication adherence over 6 months, but not 12 months</p> <p>Interventions had a high probability of being cost effective</p>
<b>Source of funding</b>	Geestkracht program of the Dutch Scientific Organization (ZON-MW, grant number 10-000-1002) and matching funds from participating universities and mental healthcare organisations

<b>Study ID</b>	<b>VANHERCK2004</b>
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<b>Bibliographic reference:</b>	
Vanherck, P., Vanhaecht, K. & Sermeus, W. (2004) Effects of clinical pathways: do they work? <i>Journal of Intergrated Pathways</i> , 8, 95.	
<b>Method used to synthesise evidence</b>	Narrative
<b>Design of included studies</b>	Experimental (18), quasi-experimental (90), observational (35), SRs (nine), subjective opinion (20), unclear (33)
<b>Evidence search</b>	MEDLINE, 2000 to 2002
<b>Number of included studies</b>	200 (one third evaluated the effects of implementing a clinical pathway)
<b>Review quality</b>	Poor (only MEDLINE was searched between 2000-2002, and study quality was not evaluated, although authors acknowledge that it was generally poor).
<b>Interventions</b>	Care pathways (not mental-health specific)
<b>Outcome</b>	Clinical outcome, team, process and financial effects
<b>Diagnosis of participants included in primary studies</b>	Various medical and psychiatric conditions
<b>Results</b>	<p>Most studies agreed that pathways had positive effects, and all domains were associated with positive effects more than they were with negative effects</p> <p>Pathways had stronger positive influence on process, team and financial effects than clinical outcome and service effects</p> <p>Negative effects were consistently low</p>
<b>Source of funding</b>	Not reported

### 1.4.2 Excluded studies

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