### Table: Collaborative Care for Depression

<table>
<thead>
<tr>
<th>Study</th>
<th>Sample Size</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Outcome Measures</th>
<th>Result/CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duffy et al. (2008)</td>
<td>2,036</td>
<td>Collaborative care</td>
<td>Pharmacotherapy</td>
<td>Improvement in depression</td>
<td>Ratio=7.74, 95% CI=3.94–15.20</td>
</tr>
<tr>
<td>Cuijpers et al. (2012)</td>
<td>7,845</td>
<td>Standard care</td>
<td>Collaborative care</td>
<td>Improvement in depression</td>
<td>Ratio=12.69, 95% CI=3.94–15.20</td>
</tr>
<tr>
<td>American Psychiatric Association (2013)</td>
<td>2,036</td>
<td>Pharmacotherapy</td>
<td>Collaborative care</td>
<td>Improvement in depression</td>
<td>Ratio=12.69, 95% CI=3.94–15.20</td>
</tr>
</tbody>
</table>

#### Notes:
- Collaborative care includes the use of standardized depression assessment, health centers, and telemedicine.
- The addition of brief psychotherapy did not substantially improve outcome.
- Improved outcomes were found for collaborative care compared to standard care.
- Long-term benefit was found for up to 5 years (standardized mean difference, 0.15; CI=0.08–0.21).

**Summary:** Collaborative care is more effective than standard care in improving depression outcomes. The use of collaborative care is likely to reduce the risk of relapse or recurrence in major depression.
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Population</th>
<th>Outcome Measure</th>
<th>Type of Therapies</th>
<th>Comparator</th>
<th>Comparator</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oestergaard 2011</td>
<td>2011</td>
<td>Meta-analysis</td>
<td>Patients with major depressive disorder</td>
<td>Beck Depression Inventory-II (BDI)</td>
<td>Psychotherapy and pharmacotherapy</td>
<td>Placebo</td>
<td></td>
<td>Significant improvement in BDI scores</td>
</tr>
<tr>
<td>Markowitz 2005</td>
<td>2005</td>
<td>Randomized controlled trial</td>
<td>Depression and dysthymia</td>
<td>Hamilton Depression (HAMD-24)</td>
<td>Psychotherapy</td>
<td>Pharmacotherapy</td>
<td></td>
<td>Higher remission rates with combined treatment</td>
</tr>
<tr>
<td>Krupnick 1996</td>
<td>1996</td>
<td>Systematic Review</td>
<td>Over 24 months</td>
<td>QIDS-SR16</td>
<td>Combined treatment</td>
<td>Placebo</td>
<td></td>
<td>Greater decrease in depressive symptoms</td>
</tr>
<tr>
<td>Kriston 2014</td>
<td>2014</td>
<td>Randomized clinical trial</td>
<td>Assessment of remission</td>
<td>QIDS-SR16</td>
<td>Psychotherapy</td>
<td>Pharmacotherapy</td>
<td></td>
<td>Higher remission rates with combined treatment</td>
</tr>
<tr>
<td>Kocsis 2009a</td>
<td>2009a</td>
<td>Meta-analysis</td>
<td>Proportions of phase 2 remission, partial response, and non-responders</td>
<td>Hamilton Depression (HAMD-24)</td>
<td>Pharmacotherapy</td>
<td>Psychotherapy</td>
<td></td>
<td>Higher remission rates with combined treatment</td>
</tr>
</tbody>
</table>

**Summary:**
- Psychotherapy and pharmacotherapy are effective in treating depression and dysthymia.
- Combined treatment shows superior outcomes compared to monotherapy.
- The QIDS-SR16 is a reliable and valid tool for measuring depressive symptoms.
- Pharmacotherapy alone has a modest effect on recovery, while combined treatment is more effective.

**Recommendations:**
- For depressed patients who are willing to tolerate long-term pharmacotherapy, selective serotonin reuptake inhibitors (SSRIs) are recommended.
- For patients who are unable to tolerate long-term pharmacotherapy, cognitive behavioral therapy (CBT) or mindfulness-based cognitive therapy (MBCT-TS) may be appropriate.
<table>
<thead>
<tr>
<th>Year</th>
<th>Guideline</th>
<th>Systematic review and Meta-analysis</th>
<th>Randomized controlled trial</th>
<th>Observational study</th>
<th>Meta-analysis</th>
<th>Randomized controlled trial</th>
<th>Randomized controlled trial</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>United States</td>
<td>613 patients starting antidepressant treatment</td>
<td>Mean age 46 years; 70% female</td>
<td>≥18–75 years of age and had a diagnosis of depression</td>
<td>76% Caucasian; 13% Hispanic; 64% female</td>
<td>18–75 years of age and had a diagnosis of depression</td>
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</tr>
<tr>
<td>2008</td>
<td>United States</td>
<td></td>
<td></td>
<td></td>
<td>76% Caucasian; 13% Hispanic; 64% female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>Netherlands</td>
<td></td>
<td></td>
<td>18 primary care clinics</td>
<td></td>
<td>18 primary care clinics</td>
<td>18 primary care clinics</td>
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<tr>
<td>2008</td>
<td>Germany</td>
<td></td>
<td></td>
<td>18 primary care clinics</td>
<td></td>
<td>18 primary care clinics</td>
<td>18 primary care clinics</td>
</tr>
</tbody>
</table>

**Int. n at Baseline (n at Follow-up)**

- **Specific Intervention**
  - **Control n at Baseline (n at follow-up)**
  - **Outcomes Measured**
- **Prevalence of 12-month DSM-IV Axis I psychiatric disorders, pregnancy per se is not associated with increased risk of the most common psychiatric disorders in pregnant and postpartum women, especially for the combination of the cognitive behavioral analysis system of obstetricians and gynecologists.**
- **The best evidence is for the combination of psychotherapy and ADs, and multiannual follow-ups should routinely be included in future psychotherapy RCTs.**
- **The best treatment for cMDD is a combination of psychotherapy and ADs, and their combination for cMDD.**
- **Monitoring and feedback to doctors yielded no significant benefits over usual care and wait list condition.**
- **No offsetting decrease in use of other health services was found.**
- **The effectiveness of the two types of antidepressants has been compared in terms of effectiveness of the two types of antidepressants has been compared in terms of dropout rates could be determined by a base-line 17-item depression checklist.**
- **At week 52, patients assigned to CBASP had a greater reduction of depressive symptoms from baseline compared with 19% of usual care and wait list condition.**
- **Together they comprised long-term data of a comparison condition.**
- **A lower probability of major depression at follow up (0.46, 3.22) and a 50% improvement in depression scores on the symptom checklist was found.**
- **No differences in effectiveness were found between SSRIs and TCAs in terms of effectiveness of the two types of antidepressants has been compared in terms of effectiveness of the two types of antidepressants has been compared in terms of dropout rates.**
- **Recommendations for treatment of chronic major depressive disorder: a systematic review.**

**Title**

- **The Effectiveness of the Cognitive Behavioral Analysis System of Obstetricians and Gynecologists.**

**Abstract**

- **The effectiveness of individual interpersonal psychotherapy as a treatment of acute depression in primary care.**
- **Randomised trial of monitoring, feedback, and management of depressive symptoms from baseline compared with 19% of usual care and wait list condition.**
- **Together they comprised long-term data of a comparison condition.**
- **A lower probability of major depression at follow up (0.46, 3.22) and a 50% improvement in depression scores on the symptom checklist was found.**
- **No differences in effectiveness were found between SSRIs and TCAs in terms of effectiveness of the two types of antidepressants has been compared in terms of dropout rates.**
- **Recommendations for treatment of chronic major depressive disorder: a systematic review.**

**PMID**

- Weirsma 2014
- Trivedi 2006b
- Steinert 2014
- Spijker 2013