Introduction

Approximately half of patients will experience relapse or recurrence after their first episode of depression and this risk increases to 70% and 90% after a second and third episode respectively (Tylee et al., 2007). There is evidence that the severity of depression and resistance to treatment increases with each successive episode of depression (Kendler et al., 2000), highlighting the potential benefits of intervening early to prevent relapse and improve the overall trajectory of depression.

Relapse and recurrence are both terms used to describe the reemergence of depression symptoms following some level of improvement and to better conceptualise the distinction between the two, we will first discuss the definitions of some other key terms: response, remission and recovery. *Response* is a reduction in symptom severity (usually 50%) relative to baseline, usually as a result of initial treatment. *Remission* can be thought of as a period of time (usually 2 months or longer), following a response to treatment, during which patients can be thought of as well but still "in episode". *Recovery* follows an extended period of remission (6-12 months) and at this point, patients are said to be no longer in episode (Bockting et al., 2015). *Relapse* has been defined as the reemergence of depressive symptoms following remission but preceding recovery and *recurrence* as the onset of a new episode of depression after recovery (Frank et al., 1991). These definitions provide a useful theoretical framework, although evidence for their clinical utility is lacking. They are helpful, however, when considering the trajectory of depression and its treatment phases: those implemented before any symptomatic improvement with a view to achieving remission (acute phase), those employed after symptomatic improvement but before recovery (continuation phase) and those that extend past the point of recovery (maintenance phase) (Bockting et al., 2015).

Given the wide variability in the way in which these terms relapse and recurrence have been operationalized by researchers, Bockting et al. (2015) recommended using the terms interchangeably to describe the "reemergence of symptoms following a period of relative wellness". Relapse prevention interventions, therefore, can be thought of as those aimed at people with depression who have had symptomatic improvement and have entered the continuation or maintenance phases or those applied during the acute phase with the intention of exerting a protective effect against relapse or recurrence in the future (Bockting et al., 2015). Most commonly they constitute a combination of continuation antidepressant medication and psychological therapies. There have been only a small number of studies exploring which relapse prevention interventions are most effective, particularly in a primary care context (Gili et al., 2015; Rodgers et al., 2012).

Collaborative care is a framework, originally developed for chronic disease management, and successfully used to optimise the provision and delivery of depression care. As such, it is best thought of as a system level intervention rather than as a therapeutic intervention in and of itself. Collaborative care incorporates the following four constituent parts to support the delivery of depression interventions: i) multidisciplinary working with input from two or more health care professionals, ii) structured evidenced-based case management, iii) proactive and scheduled patient follow-up, and iv) enhanced inter-professional communication systems (Gunn et al., 2006).

A Cochrane review of 79 RCTs showed that, compared with usual care or active control groups, collaborative care is more effective for treating depression and anxiety in the short-term (6 months or less) and that these effects persist into the longer term (13-24 months) (Archer et al,, 2012). Improvements in social functioning outcomes have also been demonstrated in patients treated using a collaborative care approach compared with those

receiving usual care (Hudson et al., 2016). Further work has explored study-level factors, and participant-level factors moderating treatment outcomes in the short term, for example depression outcomes are improved where a psychological treatment was included in the intervention (Coventry et al., 2014) and collaborative care has been shown to be effective for patients with isolated depression as well as those with depression and chronic physical conditions (Panagioti et al., 2016) As such, we have a good understanding of the components driving acute phase response (up to 6 months in the case of these reviews).

It is important to be mindful of the risk of relapse and recurrence associated with depression when developing and implementing interventions for people with depression. While the long-term beneficial effects of collaborative care are well evidenced (Camacho et al., 2018), it is unclear whether a focus on relapse prevention might account for this. We are now well positioned, with a large number of trials of collaborative care, to identify and characterise relapse prevention strategies to gain a better understanding of how these approaches might be used in the context of implementing collaborative care.

In this review, we aim to better understand whether relapse prevention is a common and key component of collaborative care. We describe the means by which relapse prevention has been addressed in trials of collaborative care and how the principles of collaborative care have been utilised to optimise the delivery of relapse prevention strategies.

Methods

This systematic review is reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Statement (PRISMA) and was produced according

the Centre for Reviews and Dissemination guidance on systematic reviews for healthcare (Centre for Reviews and Dissemination, 2009).

Literature search

The literature search was originally conducted for a Cochrane review (Archer et al., 2012) and has been subsequently updated in December 2013, October 2016 and May 2017. This last update added 1 study to the review.

The original review (Archer et al., 2012) searched the Cochrane Collaboration Depression, Anxiety and Neurosis (CCDAN) group (now Common Mental Disorders group) trial register on 9th February 2012. The CCDAN trial register comprehensively indexed trials registered to MEDLINE, EMBASE, PsychINFO, CENTRAL, World Health Organisation's trials portal, Clinicaltrials.gov, and CINAHL. The search was updated using the CENTRAL database in December 2013 and to inform a subsequent meta-regression (Coventry et al., 2014). For the current review, we updated the search using the CENTRAL database in October 2016 and in May 2017. This method is considered a sufficient and cost-effective approach for the systematic detection of RCTs of health care interventions (Royle and Waugh, 2005).

Inclusion criteria

We kept to the same inclusion criteria used in previous systematic reviews and meta-regression analyses of collaborative care (Archer et al., 2012; Coventry et al., 2014). RCTs were included if they met the following criteria:

Participants: Adults (aged 18 years or over) who met criteria (self-report or diagnostic interview) for a diagnosis of depression or who had mixed anxiety and depression.

Intervention: Collaborative care must include all of the following four components (Gunn et al., 2006):

a. A multidisciplinary approach to care delivery, defined as two or more health care professionals, of which one must include a primary care provider.
b. A structured treatment plan delivered by a health care professional/case manager who is not the patient's primary care provider. Treatment plans could include pharmacotherapy and/or psychotherapy.
c. Scheduled and proactive patient follow-up consisting of one or more planned sessions.
d. Enhanced inter-professional communication/support, for example: team meetings, supervision from a senior health care professional/mental health specialist.

Comparator: Usual care or enhanced usual care.

Outcome: Measured change in depression end of treatment outcomes using self-report measures or diagnostic clinical interviews. Binary self-report depression outcomes may have included either remission or reduction in depression symptoms according to a priori defined threshold (e.g. ≥50%).

Study Design: Individual or cluster RCT, in primary or community setting. The original trial report paper was in the English language.

Study Selection

For this review, eligible studies were identified for inclusion from a previous meta-regression of 84 collaborative care RCTs for depression (Coventry et al., 2014). In addition, 3 authors (JH, PC, RC) screened potentially eligible studies identified from CENTRAL search updates against the above inclusion criteria, as described above.

Other sources

In addition to using the RCT report papers for details of intervention content, we contacted the authors to request that they share any additional trial materials, particularly manuals used to train the professionals implementing the intervention (provider manuals) and materials given to patients to guide their self-management (patient workbooks). The aim was to optimise the amount of information available for deriving a description of relapse prevention strategies. We attempted to contact corresponding or other appropriate authors to request materials up to a maximum of 3 times. In the absence of materials or where authors did not reply, we accessed publically available protocols and companion papers that provided more information on intervention content.

Data extraction and synthesis

We extracted data about intervention content (i.e. the commonly used relapse prevention strategies and approaches reported by trialists) and intervention delivery (i.e. the ways in which collaborative care facilitated the delivery of intervention content).

In terms of intervention content, we defined relapse prevention components as any that are introduced after acute treatment has been successfully completed (once patients had reached remission and entered the continuation phase, as defined by the investigators of the individual trials), or that were applied during the acute phase with the intention of exerting a protective effect against relapse in the future (Bockting et al., 2015). We identified four common relapse prevention components *a priori*, on pragmatic grounds:

1. Formal relapse prevention planning: taking place either during the acute or continuation phase;
2. Proactive symptom monitoring and follow-up beyond the acute phase;
3. Strategies to promote continuation medication adherence: occurring during the acute or continuation phase, as long as focus was on long-term medication adherence and relapse prevention rather than initial symptom improvement;
4. Psychological or psycho-educational treatments: again, these could be implemented during the acute phase with a focus on strategies for relapse prevention or could be implemented during the continuation phase (e.g. "booster" sessions).

Each trial was reviewed for information about the intervention content. We reviewed the materials for each RCT and identified the components used in the intervention. Where relapse prevention components were present, a descriptive paragraph was written on the approach taken for each trial.

The intervention content was mapped to the four key components of collaborative care, as described by Gunn et al. (2006), to better understand how collaborative care facilitates the delivery of intervention content aimed at relapse prevention. By definition, all four components were present in each trial and so we have recorded specifically where these

components have been used to facilitate relapse prevention. Results were validated and coded by two independent reviewers per paper (AM, NC and OJF) and any disagreements were referred to a third reviewer (DM).

Risk of bias

Risk of bias assessment has been undertaken and reported elsewhere for all included trials using the Cochrane Collaboration's tool for assessing risk of bias in randomised trials (Higgins et al., 2011).

Results

Study selection

In total, 93 RCTs of collaborative care for depression were identified for inclusion in this review (see Figure 1 for PRISMA flow diagram outlining search). See Appendix 1 for relevant study characteristics. 79 of these were identified for the original Cochrane review (Archer et al., 2012), 5 were added in updated search in 2014 (Coventry et al., 2014), 8 were added in the CENTRAL search update in October 2016 and 1 study was added during the updated search in May 2017.

[Figure 1: PRISMA Flow chart of included studies]

After collating responses from authors and accessing materials online where they were available, we identified additional trial materials for 44 (47.3%) of the 93 trials identified. Of these 13 had a provider manual, 2 had a patient workbook and the remainder (n=29) had both. For the trials where there were no materials available, we were able to gain further information regarding intervention content from email correspondence with the authors of 7 of the trials and from reference to the original programme grant application for 1.

For the remaining trials (n=49), we consulted the main trial papers and any associated publications.

Data synthesis

The relapse prevention components identified were: presence of a formal relapse prevention plan (31 out of 93, 33.3%), active monitoring and follow up after the acute phase (42 out of 93, 45.2%), focus on medication adherence beyond the acute phase (39 out of 93, 41.9%) and psychological therapies beyond the acute phase (20 out of 93, 21.5%).

RCTs of collaborative care for depression have addressed relapse prevention to varying degrees. Table 1 maps the relapse prevention components used across trials. Table 2 provides a description of the relapse prevention approach taken and how the collaborative care framework has facilitated the delivery of these.

8 studies (Bogner and de Vries, 2008, 2010; Bogner et al., 2012; Dwight-Johnson et al., 2010; Lerner et al., 2015; McCusker et al., 2008; McMahon et al., 2007; Menchetti et al., 2013) focussed on acute-phase treatment and recovery, with very short-term follow-up and no emphasis on relapse prevention. 2 studies (Adler et al., 2004; Finley et al., 2003) focussed

entirely on pharmacological interventions with medication maintenance primarily aimed at short-term improvement and only indirectly targeted at relapse prevention.

Only 1 of the 93 trials (Katon et al., 2001) tested a collaborative care relapse prevention intervention. In this trial, patients who had recovered after 8 weeks of antidepressant treatment were randomised to usual care or a relapse prevention intervention, which consisted of two primary care visits with a depression specialist and three telephone calls over a one-year period. The intervention aimed to monitor symptoms, increase medication adherence and involved the writing of a personalised relapse prevention plan. The usual care and intervention groups had similar rates of relapse, although medication adherence was significantly improved in the intervention group.

Others reported a significant focus on relapse prevention while primarily focussing on acute treatment outcomes. Notably, the inclusion of relapse prevention in CADET (Clinical effectiveness of collaborative care for treatment of depression in UK primary care), the largest UK-based collaborative care trial, came directly from qualitative and public involvement findings in the original development and feasibility trial. The original pilot trial did not address relapse prevention until analysis of the acceptability data and subsequent change to the protocol to account for the findings (Richards et al., 2009; 2013).

30 trials had no reported approach to relapse prevention, 21 had one approach only, 25 reported using two approaches, 5 reported three and 12 reported using all 4 relapse prevention components. 9 studies (9.6%) reported outcomes beyond 12 months and only one study (Katon et al., 2001) reported relapse data (Table 2).

[Table 1: Summary of relapse prevention components used in each RCT]

[Table 2: Description of relapse prevention approaches used in RCTs of collaborative care]

Intervention content: Relapse prevention components

Relapse prevention plan

One third of the studies (n=31) reported that the professional administering the intervention was trained to develop a formal relapse prevention plan with patients. All of the studies reporting a relapse prevention plan went on to provide further details of what this entailed (Bartels et al., 2004; Buszewicz et al., 2010, 2016; Ciechanowski et al., 2004, 2010; Coventry et al., 2015; Datto et al., 2003; Davidson et al., 2013; Ell et al., 2008; Gilbody et al., 2017; Grote et al., 2015; Huijbregts et al., 2013; Johnson et al., 2014; Katon et al., 1996, 2001, 2004, 2010; Ludman et al., 2007, 2016; Mavandadi et al., 2015; Oslin et al., 2003, Piette et al., 2011; Richards 2008, 2012; Rollman et al., 2009; Ross et al., 2008; Salisbury et al., 2015; Simon et al., 2004; Smit et al., 2005; Unutzer et al., 2002; Vlasveld et al., 2011). 5 of the included studies used the Foundations for Integrated Care manuals (US Department of Veterans Affairs, 2017) to guide the delivery of their intervention (Bartels et al., 2004; Datto et al., 2003; Mavandadi et al., 2015; Oslin et al., 2003; Ross et al., 2008). The manuals advise that patients are educated about risk of relapse and to make a plan for "relapse prevention treatment", including "reinforcing self-monitoring skills for signs of recurrence". Patients are encouraged to identify "personal" early warning signs of recurrence and individual triggers. Self-care skills in the event of recurrence may include "calling friends or relatives, preparing for stressful events by writing down a coping plan, pursuing interests, and continuing to take medication as prescribed". Patients are also given written instructions on when they should

consult a doctor (worsening PHQ-9 or GAD-7 scores, especially if scoring 14 or above, unable to perform daily activities or thoughts of suicide).

The Collaborative Interventions for Circulation and Depression (COINCIDE) trial instructed professionals and patients on following a "staying well" (Coventry et al., 2015) plan that encouraged patients to identify protective factors and behaviours to implement these on a long-term basis. Buszewicz et al. (2012, 2016) similarly advised professionals on the importance of discussing relapse prevention with patients and identifying triggers, which would put patients in "a better position to avoid relapse in the future or to seek help at an early stage". Ciechanowski et al. (2004, 2010) and Richards et al. (2009, 2013) gave patients a written relapse prevention plan template with headings including "personal warning signs" and "things that make me feel better".

Proactive monitoring and follow-up

A number of the trials used proactive symptom monitoring and proactive follow-up, ranging from informal follow-up to regular use of psychometric tools for tracking deterioration. The Foundations for Integrated Care manuals (US Department of Veterans Affairs, 2017) strategy was to follow up with the patient once a month, until they had gone for 3 months without depressive symptoms, to obtain a PHQ-9 or GAD-7 score. There are specific instructions within the healthcare professional manual that if a patient becomes symptomatic (defined as a score above 10), they should then be reassessed in one week to determine if relapsing. If the score remains elevated at that point, the treatment plan will be reassessed, including discussion regarding adding pharmacological treatment if the patient is not already on this.

Ciechanowski et al., (2004, 2010) also had provision for monthly phone calls after the acute phase with administration of the PHQ-9.

Coventry et al. (2015) made use of a RAG (Red, Amber, Green) system wherein patients were encouraged to self-administer psychometric tools (in this case, the PHQ-9 or GAD-7) and the score would correspond to traffic lights system. This would prompt the patient to take no action, use the "action plan" and monitor their mood more closely or consider contacting a health worker if above a specified threshold ("red"). The action plan recapped signs and triggers of depression and reminded patients of details of their support network. Pyne et al. (2011) used regular telephone monitoring once remission had been reached, although the details of these were not reported. Others such as Ell et al. (2008) provided a robust monitoring system with proactive telephone follow-up to monitor symptoms and in-person visits if needed.

In the True Blue trial, conducted in Australian general practices, patients were monitored and completed a PHQ-9 at 13-week intervals for 12 months. The authors of this trial explained that the intervention was designed to be feasible in the Australian Medicare system and so the follow-up periods were not "unrealistically regular" (Morgan et al., 2009).

Medication maintenance

Notable methods of ensuring medication maintenance were asking patients and reassuring about side effects (Landis et al., 2007), ensuring longer term medication in those at higher risk of relapse (Davidson et al., 2013) and offering an alternative antidepressant in the case of relapse or where the medication is poorly tolerated (Kroenke et al., 2010). Capoccia et al. (2014) and Finley et al. (2003) both trialled pharmacist-led collaborative care-based

interventions to promote medication adherence and address medication-related issues arising throughout the maintenance and continuation phases.

Again, the Foundations for Integrated Care manuals (US Department of Veterans Affairs, 2017) had detailed information about the specific medication maintenance strategies used in their trial. The manuals advise that if patients are assessed to be at low risk of relapse (fewer than two prior episodes of depression and no history of dysthymia), they should complete 6 to 9 months and if at high risk (more than 2 episodes or history of dysthymia), they should complete at least two years of antidepressant therapy. Katon et al. (1995, 1999) used active monitoring of automated pharmacy data to monitor medication adherence during the continuation phase (3-7 months) without monitoring for depressive symptoms.

Psychological or psycho-educational treatments

The final intervention component noted was the provision of psychotherapeutic or psycho-educational approaches. Araya et al. (2003) provided a psycho-educational group as part of a multi-component programme of treatment and these included "booster" sessions occurring during the continuation phase at weeks 9 and 12 with a focus on relapse prevention techniques. It was unclear from the trial paper what these techniques were. Oladeji et al. (2015) similarly provided a programme consisting of psycho-education, problem-solving therapy and activity scheduling and patients who improved (as measured by PHQ-9 scores) were offered four fortnightly "top up talking therapies" for a period of 8 weeks.

Simon et al. (2004) offered an 8-session manualized cognitive behavioural therapy (CBT)-based programme followed by three to four telephone relapse prevention sessions. Ludman et al. (2007) similarly offered acute and "booster" psychotherapy sessions, focussing on

behavioural activation and identification and interruption of automatic negative thoughts. Piette et al. (2011) offered counselling sessions monthly for nine months following the acute phase to "minimize relapse". Ell et al. (2008) provided on-going psychotherapeutic approaches (behavioural activation and problem solving therapy) extending beyond the acute phase.

Intervention delivery: Collaborative care components

Gunn et al. (2006) outlined the four key characteristics of a collaborative care intervention: a multidisciplinary approach to care delivery; structured treatment plan delivered by a health care professional/case manager who is not the patient's primary care provider; scheduled and proactive patient follow-up consisting of one or more planned sessions; and enhanced inter-professional communication/support.

Where collaborative care appears to be particularly well placed to address relapse prevention is through its use of structured management plans, including an organised approach to providing evidence-based treatments. Whether these are pharmacological or psychological or a combination of both, they can be tailored to address relapse prevention in a standardised and consistent manner and implemented either during the continuation phase or during the acute phase with a view to maintaining longer-term health. The other key and recurring area in which collaborative care seems to confer a particular benefit is its focus on scheduled patient follow-up, particularly in the form of symptom monitoring and facilitating treatment adherence.

Multi-professional approach and enhanced inter-professional communication have been less explicitly employed as a means of facilitating the delivery of relapse prevention intervention

content. A multi-professional approach is key feature of collaborative care interventions, but the way in which this has been used to optimise relapse prevention is not well documented. Enhanced inter-professional communication includes strategies such as team meetings and shared medical notes. The only trial to report using it in a way that facilitated relapse prevention was Katon et al. (1999) which used the collaborative care framework to implement a system wherein the psychiatrist reviewed monthly automated pharmacy data on antidepressant refills to monitor the patient's adherence to the acute and continuation phases of treatment and was able to alert the primary care physician if premature discontinuation of medication occurred. It is possible and perhaps likely, however, that systems to facilitate multi-professional working and enhanced communication have been a feature of relapse prevention provision in collaborative care trials but have not been reported.

Discussion

This is the first systematic review to map the relapse prevention content of trials of collaborative care for depression and to provide a description of the different strategies employed. Overall, researchers have been inconsistent in their approaches and in the way that interventions are reported and described in the literature. We identified 4 recurring relapse prevention strategies or components across two thirds of the trials identified. The established key features of collaborative care, particularly structured management plans and scheduled patient follow-up, facilitated the delivery of these relapse prevention strategies.

Implications for research and policy

With its focus on multi-professional approach, proactive and structured follow-up and enhanced inter-professional communication, collaborative care has potential advantages over other methods for providing relapse prevention in depression. There are now a significant number of collaborative care trials and the evidence base is such that new trials may not be an efficient use of resources. The effectiveness of collaborative care on depression outcomes is well established. However, relapse is an important issue and we need innovative research to explore the impact of relapse prevention content. This might involve embedding studies of relapse prevention in ongoing implementation of collaborative care.

Novel trial methods offer opportunities to trial the effectiveness of relapse prevention components without the need for a conventional RCT. The Cohort Multiple Randomised Controlled Trial (cmRCT) allows pragmatic trials of interventions on large numbers of patients at a lower cost with more detail on longer-term outcomes derived from patients within routine practice. The relapse prevention components of the interventions reported in this review are of low intensity and are likely to be desirable to patients and well accepted, overcoming the risk of patient non-compliance or refusal to accept interventions, which is one of the key limitations of cmRCTs (Relton et al., 2010). The cmRCT model itself has been shown to be acceptable to patients with depression (Richards et al., 2014). We recommend that this approach be considered to enable to researchers to better assess the effectiveness of the components described here in practice. For example, if patients with depression consented to being in an "observational cohort", they could then be randomised, once they have reached remission, to receive a relapse prevention intervention (for example, a self-monitoring system such as the Red, Amber, Green (RAG) system or maintenance phase booster psychotherapeutic sessions) or indeed combinations of interventions. Routine outcome data

could be used to assess the effectiveness of different interventions over the long-term and this evidence could be used to guide implementation in practice.

We have described the difficulty in extracting a description of the intervention content pertaining to relapse prevention from the trial publications alone. The Template for Intervention Description and Replication (TIDieR) checklist provides a framework for reliably reporting intervention content (Hoffman et al., 2014). We recommend that researchers use the TIDieR checklist when reporting intervention content, which would better enable researchers to understand what was done. In the case of this review, more consistent reporting and describing of interventions would enable researchers to adopt and incorporate common intervention components when developing novel relapse prevention interventions for implementation in practice.

Implications and challenges for clinical practice

If effectiveness of particular relapse prevention strategies can be demonstrated, then these should be incorporated into collaborative care models in practice. Implementing these in, for example a primary care setting, would require several key challenges to be addressed. Whitebird et al. (2015) reported several key factors as being essential for successful implementation of primary care models in practice. Several of these, such as the need for strong leadership, a strong primary care physician champion and working with specialist mental health teams, could involve the training and engagement of professionals already in post, but others would involve increased upfront financial costs, such as the employment of an on-site and accessible care manager. These costs could be commissioned at an individual provider level or the costs of additional staff could be shared between providers. Cost-

effectiveness evaluation during trials could be used support and reinforce the longer-term financial benefits of taking this approach. This is particularly important as "not seeing operating costs as a barrier to participation" was another of Whitebird's key factors driving successful implementation of collaborative care and was associated with improved remission rates at 6 months (Whitebird et al., 2015).

There is a growing role for digital health interventions in the treatment of depression, which could provide an opportunity to support self-monitoring. Mobile apps exist which allow patients to record and monitor their scores on validated tools such as the PHQ-9 and then share the results with clinicians. However, there is as yet little evidence for the effectiveness of these approaches (Hollis et al., 2017) and, while one can envisage versions of these apps that would flag patients and allow them to re-enter the acute phase treatment early, they would require formal assessment of clinical and cost-effectiveness in practice and would need to be standardised and integrated into existing systems in order to be successfully implemented.

Cross-sectorial working is also likely to be key, given that patients will leave therapy services to be monitored in primary care and one of the challenges will be setting up lines of communication between providers to track patient recovery (Winters et al., 2016). Collaborative care is well placed to support enhanced modes of communication across disciplines and sectors to facilitate more coordinated follow-up and it is important that we evaluate how best to maintain such communication models after the acute phase of treatment. We recommend that work be done around understanding how monitoring and recall can be built into collaborative care protocols to ensure that interventions are more responsive to patients at risk of relapse.

Limitations

A limitation of this work is that we did not receive manuals for the majority of trials and, as such, were limited to describing the intervention components as published and supplemented by accessory materials which were freely available online. Furthermore, of the trials reviewed, most had at best medium term (12 month) follow-up and only a small number reported longer-term (n=9; 9.6%) or relapse data (n=1). We have therefore been unable to perform a quantitative analysis to explore the effectiveness of the relapse prevention intervention components described in this review.

Declaration of interest

None

References

Adler DA, Bungay KM, Wilson IB, Pei Y, Supran S, Peckham E, et al. The impact of a pharmacist intervention on 6-month outcomes in depressed primary care patients. General Hospital Psychiatry. 2004. 26(3), 199-209.

Araya R, Rojas G, Fritsch R, Gaete J, Rojas M, Simon G, et al. Treating depression in primary care in low-income women in Santiago, Chile: a randomised controlled trial. Lancet. 2003. 361(9362), 995-1000.

Aragones E, Pinol JL, Caballero A, Lopez-Cortacans G, Casaus P, Hernandez JM, et al. Effectiveness of a multi-component programme for managing depression in primary care: a cluster randomized trial. The INDI project. Journal of Affective Disorders. 2012. 142, 297-305

Archer J, Bower P, Gilbody S, Lovell K, Richards D, et al. Collaborative care for depression and anxiety problems. Syst Rev. 2012. 10: CD006525.

Bartels SJ, Coakley EH, Zubritsky C, Ware JH, Miles KM, Areán PA, et al. Improving access to geriatric mental health services: a randomized trial comparing treatment engagement with integrated versus enhanced referral care for depression, anxiety, and at-risk alcohol use. American Journal of Psychiatry. 2004. 61(8), 1455-62.

Blanchard M, Waterreus A, Mann A. The effect of primary care nurse intervention upon older people screened as depressed. International Journal of Geriatric Psychiatry 1995. 10(4), 289-98.

Bockting CL, Hollon SD, Jarrett RB, Kuyken W, Dobson K. A lifetime approach to major depressive disorder: The contributions of psychological interventions in preventing relapse and recurrence. Clinical Psychology Review. 2015. 41, 16e26.

Bogner HR, de Vries HF. Integration of depression and hypertension treatment: a pilot, randomized controlled trial. Annals of Family Medicine. 2008. 6(4), 295-301.

Bogner HR, de Vries HF. Integrating type 2 diabetes mellitus and depression treatment among African Americans a randomized controlled pilot trial. The Diabetes Educator. 2010. 36(2), 284-92.

Bogner HR, Morales KH, de Vries HF, Cappola AR. Integrated management of type 2 diabetes mellitus and depression treatment to improve medication adherence: a randomized controlled trial. Annals of Family Medicine. 2012. 10(1), 15-22.

Bruce ML, Ten Have TR, Reynolds III CF, Katz II, Schulberg HC, Mulsant BH, et al. Reducing suicidal ideation and depressive symptoms in depressed older primary care patients. JAMA. 2004. 291(9), 1081-91.

Bruce ML, Raue PJ, Reilly CF, Greenberg RL, Meyers BS, Banerjee S, et al. Clinical effectiveness of integrating depression care management into medicare home health: the Depression CAREPATH Randomized trial. JAMA Internal Medicine. 2015. 175, 55-64.

Buszewicz M, Griffin M, McMahon E, Beecham J, King M. Evaluation of a system of structured, pro-active care for chronic depression in primary care: a randomised controlled trial. BMC Psychiatry. 2010. 10(1), 61.

Buszewicz M, Griffin M, McMahon EM, Walters K, King M. Practice nurse-led proactive care for chronic depression in primary care: a randomised controlled trial. The British Journal of Psychiatry. 2016. 208, 374-80.

Camacho E, Davies L, Hann M, Small N, Bower P, Chew-Graham C, Coventry P. Long-term clinical and cost-effectiveness of collaborative care (versus usual care) for people with mental–physical multimorbidity: Cluster-randomised trial. The British Journal of Psychiatry, 2018. 213(2), 456-463. doi:10.1192/bjp.2018.70

Capoccia KL, Boudreau DM, Blough DK, Ellsworth AJ, Clark DR, Stevens NG, et al. Randomized trial of pharmacist interventions to improve depression care and outcomes in primary care. American Journal of Health-System Pharmacy. 2004. 61(4), 364-72.

Centre for Reviews and Dissemination. Systematic Reviews. 2009

Chaney EF, Rubenstein LV, Liu C-F, Yano EM, Bolkan C, Lee M, et al. Implementing collaborative care for depression treatment in primary care: a cluster randomized evaluation of a quality improvement practice redesign. Implementation Science. 2011. 6(1), 121 doi:10.1186/1748-5908-6-121.

Chen S, Conwell Y, He J, Lu N, Wu J. Depression care management for adults older than 60 years in primary care clinics in urban China: a cluster-randomised trial. The Lancet Psychiatry 2015. 2, 332-9.

Chew-Graham CA, Lovell K, Roberts C, Baldwin R, Morley M, Burns A, et al. A randomised controlled trial to test the feasibility of a collaborative care model for the management of depression in older people. The British Journal of General Practice. 2007. 57(538), 364-70.

Ciechanowski P, Wagner E, Schmaling K, Schwartz S, Williams B, Diehr P, et al. Community-integrated home-based depression treatment in older adults. JAMA 2004. 291(13),1569-77.

Ciechanowski P, Chaytor N, Miller J, Fraser R, Russo J, Unutzer J, et al. PEARLS depression treatment for individuals with epilepsy: a randomized controlled trial. Epilepsy & Behavior. 2010. 19(3), 225-31.

Cole MG, McCusker J, Elie M, Dendukuri N, Latimer E, Belzile E. Systematic detection and multidisciplinary care of depression in older medical inpatients: a randomized trial. Canadian Medical Association Journal 2006. 174(1), 38-44.

Coventry PA, Hudson JL, Kontopantelis E, Archer J, Richards DA, et al. Characteristics of Effective Collaborative Care for Treatment of Depression: A Systematic Review and Meta-Regression of 74 Randomised Controlled Trials. PLOS ONE. 2014. 9(9):e108114. doi: 10.1371/journal.pone.0108114.

Coventry P, Lovell K, Dickens C, Bower P, Chew-Graham C, McElvenny D, et al. Integrated primary care for patients with mental and physical multimorbidity: cluster randomised controlled trial of collaborative care for patients with depression comorbid with diabetes or cardiovascular disease. BMJ. 2015. 350:h638

Datto CJ, Thompson R, Horowitz D, Disbot M, Oslin DW. The pilot study of a telephone disease management program for depression. General Hospital Psychiatry 2003. 25(3), 169-77.

Davidson KW, Bigger JT, Burg MM, Carney RM, Chaplin WF, Czajkowski S, et al. Centralized, stepped, patient preference-based treatment for patients with post-acute coronary syndrome depression: CODIACS vanguard randomized controlled trial. JAMA Internal Medicine. 2013. 173(11), 997-1004.

Dietrich AJ, Oxman TE, Williams JW, Schulberg HC, Bruce ML, Lee PW, et al. Re-engineering systems for the treatment of depression in primary care: cluster randomised controlled trial. BMJ. 2004. 329(7466), 602.

Dwight-Johnson M, Lagomasino I, Hay J, Zhang L, Tang L, Green J, et al. Effectiveness of collaborative care in addressing depression treatment preferences among low-income Latinos. Psychiatric Services. 2010; 61(11), 1112-8.

Ell K, Unützer J, Aranda M, Gibbs NE, Lee P-J, Xie B. Managing depression in home health care: a randomized clinical trial. Home Health Care Services Quarterly. 2007. 26(3), 81-104.

Ell K, Xie B, Quon B, Quinn DI, Dwight-Johnson M, Lee P-J. Randomized controlled trial of collaborative care management of depression among low-income patients with cancer. Journal of Clinical Oncology. 2008. 26(27), 4488-96.

Ell K, Katon W, Xie B, Lee P-J, Kapetanovic S, Guterman J, et al. Collaborative Care Management of Major Depression Among Low-Income, Predominantly Hispanic Subjects With Diabetes A randomized controlled trial. Diabetes Care 2010;33(4):706-13.

Engel CC, Jaycox LH, Freed MC, Bray RM, Brambilla D, Zatzick D, et al. Centrally Assisted Collaborative Telecare for Posttraumatic Stress Disorder and Depression Among Military Personnel Attending Primary Care: A Randomized Clinical Trial. JAMA Internal Medicine. 2016. 176(7), 948-56.

Finley PR, Rens HR, Pont JT, Gess SL, Louie C, Bull SA, et al. Impact of a collaborative care model on depression in a primary care setting: a randomized controlled trial. Pharmacotherapy. 2003. 23(9), 1175-85.

Fortney JC, Pyne JM, Edlund MJ, Williams DK, Robinson DE, Mittal D, et al. A randomized trial of telemedicine-based collaborative care for depression. Journal of General Internal Medicine. 2007. 22(8),1086-93.

Frank E, Prien RF, Jarrett RB, et al. Conceptualization and Rationale for Consensus Definitions of Terms in Major Depressive Disorder. Remission, Recovery, Relapse, and Recurrence. Arch Gen Psychiatry.1991. 48(9), 851–855.

Fritsch R, Araya R, Solis J, Montt E, Pilowsky D, Rojas G. A randomized trial of pharmacotherapy with telephone monitoring to improve treatment of depression in primary care in Santiago, Chile. Revista Médica de Chile. 2007. 135(5), 587-95.

Gensichen J, vonKorff M, Peitz M, Muth C, Beyer M, Guthlin C, et al. Case management for depression by health care assistants in small primary care practices: a cluster randomized trial. Annals of Internal Medicine. 2009. 151(6), 369–78.

Gilbody S, Lewis H, Adamson J, Atherton K, Bailey D, Birtwistle J, et al. Effect of Collaborative Care vs Usual Care on Depressive Symptoms in Older Adults With Subthreshold Depression: The CASPER Randomized Clinical Trial. JAMA. 2017. 317(7), 728-37.

Gili M, Vicens C, Roca M, Andersen P, McMillan D. Interventions for preventing relapse or recurrence of depression in primary health care settings: A systematic review. Preventive Medicine. 2015. 76 Suppl:S16-21.

Grote NK, Katon WJ, Russo JE, Lohr MJ, Curran M, Galvin E, et al. Collaborative Care for Perinatal Depression in Socioeconomically Disadvantaged Women: A Randomized Trial. Depress Anxiety. 2015. 32(11), 821-34.

Gunn J, Diggens J, Hegarty K, Blashki G. A systematic review of complex system interventions designed to increase recovery from depression in primary care. BMC Health Servs Res. 2006. 6(1), 88. doi: 10.1186/1472-6963-6-88.

Hedrick SC, Chaney EF, Felker B, Liu CF, Hasenberg N, Heagerty P, et al. Effectiveness of collaborative care depression treatment in Veterans' Affairs primary care. Journal of General Internal Medicine. 2003. 18(1), 9-16.

Higgins Julian P T, Altman Douglas G, Gøtzsche, Peter C, Jüni Peter, Moher David, Oxman Andrew Det al. The Cochrane Collaboration's tool for assessing risk of bias in randomised trials *BMJ*2011; 343 :d5928

Hoffmann TC, Glasziou PP, Boutron I, Milne R, Perera R, et al. Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. BMJ. 2014. 348. doi: 10.1136/bmj.g1687.

Hollis, C., Morriss, R., Martin, J., Amani, S., Cotton, R., Denis, M., & Lewis, S. Technological innovations in mental healthcare: Harnessing the digital revolution. British Journal of Psychiatry. 2015. 206(4), 263-265. doi:10.1192/bjp.bp.113.142612

Hollis C, Falconer CJ, Martin JL, Whittington C, Stockton S, Glazebrook C, Davies EB. Annual Research Review: Digital health interventions for children and young people with mental health problems – a systematic and meta-review. J Child Psychol Psychiatr. 2017. 58: 474-503. doi:10.1111/jcpp.12663

Hudson JL, Bower P, Archer J, Coventry PA. Does collaborative care improve social functioning in adults with depression? The application of the WHO ICF framework and meta-analysis of outcomes. J Affect Disord. 2016. 189:379-91. doi: http://dx.doi.org/10.1016/j.jad.2015.09.034.

Huffman JC, Mastromauro CA, Sowden GL, Wittmann C, Rodman R, Januzzi JL. A collaborative care depression management program for cardiac inpatients: Depression characteristics and in-hospital outcomes. Psychosomatics: Journal of Consultation Liaison Psychiatry 2011. 52(1), 26–33.

Huffman JC, Mastromauro CA, Beach SR, Celano CM, DuBois CM, Healy BC, et al. Collaborative care for depression and anxiety disorders in patients with recent cardiac events: the Management of Sadness and Anxiety in Cardiology (MOSAIC) randomized clinical trial. JAMA Internal Medicine. 2014. 174, 927-35

Huijbregts KM, de Jong FJ, van Marwijk HW, Beekman AT, Adèr HJ, Hakkaart-van Roijen L, et al. A target-driven collaborative care model for Major Depressive Disorder is effective in primary care in the Netherlands. A randomized clinical trial from the depression initiative. Journal of Affective Disorders. 2013. 146(3), 328-37.

Hunkeler EM, Meresman JF, Hargreaves WA, Fireman B, Berman WH, Kirsch AJ, et al. Efficacy of nurse telehealth care and peer support in augmenting treatment of depression in primary care. Archives of Family Medicine. 2000. 9(8), 700–8.

Johnson JA, Al Sayah F, Wozniak L, Rees S, Soprovich A, Qiu W, et al. Collaborative care versus screening and follow-up for patients with diabetes and depressive symptoms: results of a primary care-based comparative effectiveness trial. Diabetes Care. 2014. 37:3220-6.

Katon W, Von Korff M, Lin E, Walker E, Simon GE, Bush T, et al. Collaborative management to achieve treatment guidelines impact on depression in primary care. JAMA. 1995. 273(13), 1026-31.

Katon W, Robinson P, Von Korff M, Lin E, Bush T, Ludman E, et al. A multifaceted intervention to improve treatment of depression in primary care. Archives of General Psychiatry 1996. 53(10), 924.

Katon W, Von Korff M, Lin E, Simon G, Walker E, Unutzer J, et al. Stepped collaborative care for primary care patients with persistent symptoms of depression: a randomized trial. Archives of General Psychiatry 1999;56(12):1109-15.

Katon W, Rutter C, Ludman E J, Von Korff M, Lin E, Simon G, et al. A randomized trial of relapse prevention of depression in primary care. Archives of General Psychiatry. 2001, 58(3):241–7.

Katon WJ, Von Korff M, Lin EH, Simon G, Ludman E, Russo J, et al. The Pathways Study: a randomized trial of collaborative care in patients with diabetes and depression. Archives of General Psychiatry 2004. 61(10), 1042–9.

Katon WJ, Lin EH, Von Korff M, Ciechanowski P, Ludman EJ, Young B, et al. Collaborative care for patients with depression and chronic illnesses. New England Journal of Medicine. 2010. 363(27):2611–20.

Katon WJ, Lin EH, Von Korff M, Ciechanowski P, LudmanEJ,YoungB,et al. Collaborative care for patients with depression and chronic illnesses. New England Journal of Medicine. 2010. 363(27), 2611–20.

Katzelnick DJ, Simon GE, Pearson SD, Manning WG, Helstad CP, Henk HJ, et al. Randomized trial of a depression management program in high utilizers of medical care. Archives of Family Medicine. 2000. 9(4), 345–51.

Kendler KS, Thornton LM, Gardner CO. Stressful life events and previous episodes in the etiology of major depression in women: An evaluation of the 'kindling' hypothesis. American Journal of Psychiatry. 2000. 157: 1243e1251.

Kroenke K, Theobald D, Wu J, Norton K, Morrison G, Carpenter J ,et al. Effect of telecare management on pain and depression inpatients with cancer. JAMA. 2010. 304(2), 163–71.

Landis SE, Gaynes BN, Morrissey JP, Vinson N, Ellis AR, Domino ME. Generalist care managers for the treatment of depressed medicaid patients in North Carolina: A pilot study. BMC Family Practice. 2007. 8(1), 7.

Lerner D, Adler DA, Rogers WH, Chang H, Greenhill A, Cymerman E, et al. A randomized clinical trial of a telephone depression intervention to reduce employee presenteeism and absenteeism. Psychiatric services. 2015. 66(6), 570-7

Ludman E, Simon G, Grothaus L, Luce C, Markley D, Schaefer J. A pilot study of telephone care management and structured disease self-management groups for chronic depression. Psychiatric Services. 2007. 58(8), 1065-72.

Ludman EJ, Simon GE, Grothaus LC, Richards JE, Whiteside U, Stewart C. Organized Self-Management Support Services for Chronic Depressive Symptoms: A Randomized Controlled Trial. Psychiatric services. 2016. 67, 29-36.

Mann A, Blizard R, Murray J, Smith J, Botega N, MacDonald E, et al. An evaluation of practice nurses working with general practitioners to treat people with depression. The British Journal of General Practice. 1998. 48(426), 875.

Mavandadi S, Benson A, DiFilippo S, Streim JE, Oslin D. A Telephone-Based Program to Provide Symptom Monitoring Alone vs Symptom Monitoring Plus Care Management for Late-Life Depression and Anxiety: A Randomized Clinical Trial. JAMA Psychiatry. 2015. 72, 12118.

McCusker J, Cole M, Yaffe M, Cappeliez P, Dawes M, Sewitch M, et al. Project DIRECT: Pilot study of a collaborative intervention for depressed seniors. Canadian Journal of Community Mental Health. 2008. 27(2), 201-18.

McMahon L, Foran KM, Forrest SD, Taylor ML, Ingram G, Rajwal M, et al. Graduate mental health worker case management of depression in UK primary care: a pilot study. The British Journal of General Practice. 2007. 57(544), 880-5.

Melville JL, Reed SD, Russo J, Croicu CA, Ludman E, LaRocco-Cockburn A, et al. Improving care for depression in obstetrics and gynecology: a randomized controlled trial. Obstetrics and Gynecology. 2014. 123, 1237-46.

Menchetti M1, Sighinolfi C, Di Michele V, Peloso P, Nespeca C, Bandieri PV, et al. Effectiveness of collaborative care for depression in Italy. A randomized controlled trial. General Hospital Psychiatry 2013. 35(6), 579-86.

Morgan MA, Coates MJ, Dunbar JA, Reddy P, Schlicht K, Fuller J. The TrueBlue model of collaborative care using practice nurses as case managers for depression alongside diabetes or heart disease: a randomised trial. BMJ Open. 2013. 3(1).

Oladeji BD, Kola L, Abiona T, Montgomery AA, Araya R, Gureje O. A pilot randomized controlled trial of a stepped care intervention package for depression in primary care in Nigeria. BMC Psychiatry. 2015. 15:96

Oslin DW, Sayers S, Ross J, Kane V, Ten Have T, Conigliaro J, et al. Disease management for depression and at-risk drinking via telephone in an older population of veterans. Psychosomatic Medicine. 2003. 65(6), 931-7.

Panagioti M, Bower P, Kontopantelis E, et al. Association Between Chronic Physical Conditions and the Effectiveness of Collaborative Care for Depression: An Individual Participant Data Meta-analysis. JAMA Psychiatry. 2016. 73(9), 978–989. doi:10.1001/jamapsychiatry.2016.1794

Patel V, Weiss HA, Chowdhary N, Naik S,Pednekar S, Chatterjee S, et al. Effectiveness of an intervention led by lay health counsellors for depressive and anxiety disorders in primary care in Goa, India(MANAS):A cluster randomised controlled trial. Lancet. 2010. 376(9758), 2086–95.

Piette JD, Richardson C, Himle J, Duffy S, Torres T, Vogel M, et al. A randomized trial of telephonic counseling plus walking for depressed diabetes patients. Medical Care. 2011. 49(7), 641–8.

Pyne JM, Fortney JC, Curran GM, Tripathi S, Atkinson JH, Kilbourne AM, et al. Effectiveness of collaborative care for depression in human immunodeficiency virus clinics. Archives of Internal Medicine. 2011. (1), 23–31

Relton Clare, Torgerson David, O'Cathain Alicia, Nicholl Jon. Rethinking pragmatic randomised controlled trials: introducing the "cohort multiple randomised controlled trial" design. BMJ. 2010, 340:c1066

Richards DA, Lovell K, Gilbody S, Gask L, Torgerson D, Barkham M, et al. Collaborative care for depression in UK primary care: A randomized controlled trial: Corrigendum. Psychological Medicine. 2009. 39(4), 701.

Richards DA, Hill JJ, Gask L, Lovell K, Chew-Graham C, Bower P, et al. Clinical effectiveness of collaborative care for depression in UK primary care (CADET): cluster randomised controlled trial. BMJ. 2013. 347: f4913

Richards DA, Ross S, Robens S, Borglin G. The DiReCT study - improving recruitment into clinical trials: a mixed methods study investigating the ethical acceptability, feasibility and recruitment yield of the cohort multiple randomised controlled trials design. 2014. Trials. 15:398. https://doi.org/10.1186/1745-6215-15-398

Rodgers M, Asaria M, Walker S, McMillan D, Lucock M, Harden M. 2012. The clinical effectiveness and cost- effectiveness of low-intensity psychological interventions for the secondary prevention of relapse after depression: a systematic review. Health Technology Assessment. 16(28), 1-130.

Rojas G, Fritsch R, Solis J, Jadresic E, Castillo C, Gonzalez M, et al. Treatment of postnatal depression in low income mothers in primary-care clinics in Santiago, Chile: a randomised controlled trial. Lancet. 2007. 370(9599), 1629–37.

Rollman BL, Herbeck Belnap B, LeMenager MS, Mazumdar S, Houck PR, Counihan PJ, et al. Telephone delivered collaborative care for treating post-CABG depression: a randomized controlled trial. JAMA. 2009. 302(19), 2095–103.

Ross JT, Eakin AC, Suzanne Difilippo RN C, Oslin DW. A randomized controlled trial of a close monitoring program for minor depression and distress. Journal of General Internal Medicine 2008. 23(9), 1379-85.

Rost K, Nutting P, Smith JL, Elliott CE, Dickinson M. Managing depression as a chronic disease: a randomised trial of ongoing treatment in primary care. BMJ. 2002. 325(7370), 934.

Royle P, Waugh N. A simplified search strategy for identifying randomised controlled trials for systematic reviews of health care interventions: a comparison with more exhaustive strategies. BMC Med Res Methodol. 2005. 5(1), 23. doi: 10.1186/1471-2288-5-23.

Rubenstein LV, Parker LE, Meredith LS, Altschuler A, dePillis E, Hernandez J, et al. Understanding team-based quality improvement for depression in primary care. Health Services Research. 2002. 37(4), 1009–29.

Salisbury C, O'Cathain A, Edwards L, Thomas C, Gaunt D et al. Effectiveness of an integrated telehealth service for patients with depression: a pragmatic randomised controlled trial of a complex intervention. The Lancet Psychiatry. 2016. 3 (6), 515-525

Sharpe M, Walker J, Holm Hansen C, Martin P, Symeonides S, Gourley C, et al. Integrated collaborative care for comorbid major depression in patients with cancer (SMaRT Oncology-2): a multicentre randomised controlled effectiveness trial. Lancet. 2014. 384, 1099-108

Simon GE, VonKorff M, Rutter C, Wagner E. Randomised trial of monitoring, feedback, and management of care by telephone to improve treatment of depression in primary care. BMJ. 2000. 320(7234), 550–4.

Simon GE, Ludman EJ, Tutty S, Operskalski B, Von Korff M. Telephone psychotherapy and telephone care management for primary care patients starting antidepressant treatment: a randomized controlled trial. JAMA. 2004. 292(8), 935–42.

Simon GE, Ralston JD, Savarino J, Pabiniak C, Wentzel C, Operskalski BH. Randomized trial of depression follow-up care by online messaging. Journal of General Internal Medicine 2011. 26(7), 698–704.

Smit A, Kluiter H,Conradi HJ, van der Meer K, Tiemens BG, Jenner JA, et al. Short-term effects of enhanced treatment for depression in primary care: Results from a randomized controlled trial. Psychological Medicine. 2006. 36(1), 15–26.

Strong V, Waters R, Hibberd C, Murray G, Wall L, Walker J, et al. Management of depression for people with cancer (SMaRToncology 1): a randomised trial. Lancet. 2008. 372(9632), 40–8.

Swindle RW, Rao JK, Helmy A, Plue L, Zhou XH, Eckert GJ, et al. Integrating clinical nurse specialists into the treatment of primary care patients with depression. International Journal of Psychiatry in Medicine. 2003. 33(1), 17–37.

Tylee A, Walters P. We need a chronic disease management model for depression in primary care. Br J Gen Pract. 2007. 57(538), 348-350.

Whitebird RR, Solberg LI, Jaeckels NA, Pietruszewski PB, Hadzic S, Unützer J, Ohnsorg KA, Rossom RC, Beck A, Joslyn KE, Rubenstein LV. Effective Implementation of collaborative care for depression: what is needed? *Am J Manag Care*. 2014 Sep;20(9):699-707. PMID: 25365745; PMCID: PMC4270471.

Winters S, Magalhaes L, Kinsella EA, Kothari A. Cross-sector Service Provision in Health and Social Care: An Umbrella Review. International Journal of Integrated Care. 2016. 16(1), 10. DOI: http://doi.org/10.5334/ijic.2460

Uebelacker LA, Marootian BA, Tigue P, Haggarty R, Primack JM, Miller IW. Telephone Depression Care Management for Latino Medicaid Health Plan Members: A Pilot Randomized Controlled Trial. The Journal of Nervous and Mental Disease. 2011. 199(9), 678-83.

Unutzer J, Katon W, Callahan CM, Williams JW Jr, Hunkeler E, Harpole L, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA. 2002. 288(22): 2836–45

US Department of Veterans Affairs. Foundations for Integrated Care. Last updated April 21 2017. Available: https://www.mirecc.va.gov/visn4/BHL/BHLresources3.asp

Vlasveld M, Van der Feltz-Cornelis C, Adèr H, Anema J, Hoedeman R, Van Mechelen W, et al. Collaborative care for major depressive disorder in an occupational healthcare setting. The British Journal of Psychiatry. 2012. 200(6), 510-1.

Wells KB, Sherbourne CD, Schoenbaum N, Duan N, Meredith LS, Unutzer J, Miranda J, Carney M, Rubenstein LV. Impact of disseminating quality improvement programs for depression in managed primary care: a randomized controlled trial. JAMA 2000. 283(2), 212–20.

Walker J, Hansen CH, Martin P, Symeonides S, Gourley C, Wall L, et al. Integrated collaborative care for major depression comorbid with a poor prognosis cancer (SMaRT Oncology-3): a multicentre randomised controlled trial in patients with lung cancer. The Lancet Oncology. 2014. 15(10), 1168-76.

Williams LS, Kroenke K, Bakas T, Plue LD, Brizendine E, Tu W, et al. Care management of poststroke Depression a randomized, controlled trial. Stroke. 2007. 38(3), 998-1003.

771 Yeung A, Shyu I, Fisher L, Wu S, Yang H, Fava M. Culturally sensitive collaborative
772 treatment for depressed Chinese Americans in primary care. American Journal of Public Health. 2010.
773 100(12), 2397-40.