

This is a repository copy of *Association Between Chronic Physical Conditions and the Effectiveness of Collaborative Care for Depression:An Individual Participant Data Meta-analysis*.

White Rose Research Online URL for this paper:

<https://eprints.whiterose.ac.uk/104235/>

Version: Published Version

---

**Article:**

Panagioti, Maria, Bower, Peter, Kontopantelis, Evangelos et al. (24 more authors) (2016) Association Between Chronic Physical Conditions and the Effectiveness of Collaborative Care for Depression:An Individual Participant Data Meta-analysis. *JAMA Psychiatry*. pp. 978-989. ISSN 2168-6238

<https://doi.org/10.1001/jamapsychiatry.2016.1794>

---

**Reuse**

Items deposited in White Rose Research Online are protected by copyright, with all rights reserved unless indicated otherwise. They may be downloaded and/or printed for private study, or other acts as permitted by national copyright laws. The publisher or other rights holders may allow further reproduction and re-use of the full text version. This is indicated by the licence information on the White Rose Research Online record for the item.

**Takedown**

If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing [eprints@whiterose.ac.uk](mailto:eprints@whiterose.ac.uk) including the URL of the record and the reason for the withdrawal request.

JAMA Psychiatry | Original Investigation | META-ANALYSIS

# Association Between Chronic Physical Conditions and the Effectiveness of Collaborative Care for Depression

## An Individual Participant Data Meta-analysis

Maria Panagioti, PhD; Peter Bower, PhD; Evangelos Kontopantelis, PhD; Karina Lovell, PhD; Simon Gilbody, DPhil; Waqas Waheed, MD; Chris Dickens, PhD; Janine Archer, PhD; Gregory Simon, MD; Kathleen Ell, PhD; Jeff C. Huffman, MD; David A. Richards, PhD; Christina van der Feltz-Cornelis, MD; David A. Adler, MD; Martha Bruce, PhD; Marta Buszewicz, MD; Martin G. Cole, MD; Karina W. Davidson, PhD; Peter de Jonge, PhD; Jochen Gensichen, MD; Klaas Huijbregts, PhD; Marco Menchetti, MD; Vikram Patel, PhD; Bruce Rollman, PhD; Jonathan Shaffer, PhD; Moniek C. Zijlstra-Vlasveld, PhD; Peter A. Coventry, PhD

 Supplemental content at [jamapsychiatry.com](http://jamapsychiatry.com)

**IMPORTANCE** Collaborative care is an intensive care model involving several health care professionals working together, typically a physician, a case manager, and a mental health professional. Meta-analyses of aggregate data have shown that collaborative care is particularly effective in people with depression and comorbid chronic physical conditions. However, only participant-level analyses can rigorously test whether the treatment effect is influenced by participant characteristics, such as chronic physical conditions.

**OBJECTIVE** To assess whether the effectiveness of collaborative care for depression is moderated by the presence, type, and number of chronic physical conditions.

**DATA SOURCES** Data were obtained from MEDLINE, EMBASE, PubMed, PsycINFO, CINAHL Complete, and Cochrane Central Register of Controlled Trials, and references from relevant systematic reviews. The search and collection of eligible studies was ongoing until May 22, 2015.

**STUDY SELECTION** This was an update to a previous meta-analysis. Two independent reviewers were involved in the study selection process. Randomized clinical trials that compared the effectiveness of collaborative care with usual care in adults with depression and reported measured changes in depression severity symptoms at 4 to 6 months after randomization were included in the analysis. Key search terms included *depression, dysthymia, anxiety, panic, phobia, obsession, compulsion, posttraumatic, care management, case management, collaborative care, enhanced care, and managed care*.

**DATA EXTRACTION AND SYNTHESIS** Individual participant data on baseline demographics and chronic physical conditions as well as baseline and follow-up depression severity symptoms were requested from authors of the eligible studies. One-step meta-analysis of individual participant data using appropriate mixed-effects models was performed.

**MAIN OUTCOMES AND MEASURES** Continuous outcomes of depression severity symptoms measured using self-reported or observer-rated measures.

**RESULTS** Data sets from 31 randomized clinical trials including 36 independent comparisons (N = 10 962 participants) were analyzed. Individual participant data analyses found no significant interaction effects, indicating that the presence (interaction coefficient, 0.02 [95% CI, -0.10 to 0.13]), numbers (interaction coefficient, 0.01 [95% CI, -0.01 to 0.02]), and types of chronic physical conditions do not influence the treatment effect.

**CONCLUSIONS AND RELEVANCE** There is evidence that collaborative care is effective for people with depression alone and also for people with depression and chronic physical conditions. Existing guidance that recommends limiting collaborative care to people with depression and physical comorbidities is not supported by this individual participant data meta-analysis.

JAMA Psychiatry. doi:10.1001/jamapsychiatry.2016.1794  
Published online August 17, 2016. Corrected on August 24, 2016.

**Author Affiliations:** Author affiliations are listed at the end of this article.

**Corresponding Author:** Peter A. Coventry, PhD, Mental Health and Addiction Research Group, Department of Health Sciences, University of York, York YO10 5DD, England  
([peter.coventry@york.ac.uk](mailto:peter.coventry@york.ac.uk)).

Depression is the leading global cause of disease burden accounting for most disability-adjusted life years.<sup>1,2</sup> The combination of depression with a chronic physical condition (hereinafter termed *physical condition*), such as cardiovascular diseases, respiratory diseases, and diabetes, is associated with the greatest decrements in quality of life, years lost owing to disability,<sup>3</sup> patient safety failures, and unscheduled care.<sup>4-8</sup>

A promising intervention for depression in primary care is collaborative care,<sup>9</sup> which involves the use of a case manager (usually nonmedical but also medical; eg, clinical social workers) working with primary care professionals, often supervised by a mental health specialist and supported by care management systems. A Cochrane review<sup>10</sup> showed that collaborative care is more effective than usual care for depression.

Finding feasible and effective ways of integrating care for patients with depression and comorbid physical conditions remains a critical goal for health systems worldwide. There has been significant interest in the ability of collaborative care to improve care for people with depression and physical conditions.<sup>11,12</sup> In the United States, the Community Preventive Services Task Force<sup>13,14</sup> recommends collaborative care for the treatment of major depression in adults but concedes that there are evidence gaps about the effectiveness of this approach in people with comorbid physical conditions. In the United Kingdom, the English organization responsible for clinical guidelines (National Institute for Health and Care Excellence)<sup>15</sup> recommends that collaborative care should be considered only for people with depression and comorbid physical conditions based on results from aggregate-data meta-analyses of 2 sets of trials: collaborative care for patients with depression and collaborative care for patients with depression and physical conditions. Although these recommendations were based on the best available evidence at the time, conducting 2 separate meta-analyses means that any differences in effectiveness may be confounded by differences between the trials (eg, location, quality, and intervention format) and may not be due to physical conditions.<sup>16</sup> In addition, some collaborative care trials that recruited people with depression would not necessarily have excluded those with physical conditions, especially trials conducted in older populations in whom such conditions are highly prevalent.<sup>17-25</sup>

To reach international consensus about the most effective ways to manage depression it is critical that guidelines reflect the most robust analysis of the most current data. There is increasing recognition that individual participant data (IPD) meta-analysis is a better basis for modeling treatment effects than are aggregate data meta-analyses.<sup>26</sup> Individual participant data meta-analysis is more precise because it involves the application of standardized analyses across multiple data sets, overcomes sample size and reporting issues, and allows more sophisticated modeling of moderator effects.<sup>26-28</sup> In this context, IPD allows for more accurate coding of comorbidity based on actual patient health.

In the present study, we used IPD meta-analysis to test whether physical conditions moderate the effectiveness of collaborative care for depression outcomes. First, we examined

## Key Points

**Question** Is collaborative care more effective for patients with depression and chronic physical conditions compared with patients with depression alone?

**Findings** This meta-analysis of individual participant data from 10 960 patients found no significant differences in the treatment effects of collaborative care between patients with depression alone and patients with depression and chronic physical conditions.

**Meaning** Collaborative care is an equally effective way to deliver depression care for patient with and without comorbid chronic physical conditions; existing guidance that recommends limiting access to collaborative care for patients with depression and chronic physical conditions should be updated.

whether studies that recruited individuals with physical conditions as part of inclusion criteria demonstrated greater effect of collaborative care on depression outcomes (ie, a study-level moderator analysis). Subsequently, we examined whether the effectiveness of collaborative care on depression outcomes was moderated by the presence, number, and type of physical conditions reported by individual participants within trials (ie, participant-level moderator analyses). The results will provide a rigorous basis for recommendations about the types of people most likely to benefit from collaborative care and contribute to the wider debate about how multimorbidity influences treatment effectiveness.<sup>29,30</sup>

## Methods

This IPD meta-analysis was conducted and reported according to published methodological guidelines.<sup>31,32</sup> The PRISMA-D was completed (eTable 1 in the [Supplement](#)).

### Information Sources

The published Cochrane review<sup>10</sup> of collaborative care was used to identify eligible randomized clinical trials (RCTs). The Cochrane review searches were updated in March 2014 (MEDLINE, EMBASE, PsycINFO, Cochrane Central Register of Controlled Trials, and CINAHL Complete) but search and collection of eligible studies was ongoing until May 22, 2015. Key search terms included *depression, dysthymia, anxiety, panic, phobia, obsession, compulsion, posttraumatic, care management, case management, collaborative care, enhanced care, and managed care*. The reference lists of reports of all included studies were screened for additional studies. We also asked authors of studies reviewed to identify additional published studies and trials in progress.

### Eligibility Criteria

We used the same inclusion criteria reported by the Cochrane review,<sup>10</sup> except we excluded studies conducted in adolescents and studies that did not report a depression outcome (eMethods in the [Supplement](#)). The following factors were evaluated in study selection:

1. Adults (age  $\geq 18$  years) with depression or mixed anxiety and depressive disorder,
2. Collaborative care interventions (multiprofessional approach to patient care, structured management plan, scheduled patient follow-ups, and enhanced interprofessional communication),
3. Comparison (usual or enhanced usual care),
4. Outcome (continuous depression scores), and
5. Research design (RCTs or cluster RCTs).

### Measuring Depression and Physical Conditions

All studies provided continuous depression scores measured using validated scales, including the Beck Depression Inventory,<sup>33</sup> the Center for Epidemiologic Studies Depression Scale,<sup>34</sup> the Hamilton Rating Scale for Depression,<sup>35</sup> and the Patient Health Questionnaire-9.<sup>36</sup> We focused on short-term depression outcomes reported between 4 and 6 months after randomization. Depression scores were standardized within each study, using the baseline SD and the follow-up mean score.

At study level, 9 of the 36 comparisons recruited participants with a physical condition. Thirty of the 36 comparisons reported data on the presence and number of physical conditions at individual participant level. Of these, most comparisons (21 [58%]) used validated comorbidity indices, such as the Charlson Comorbidity Index,<sup>37</sup> and 6 (17%) used empirical lists of physical conditions. Seventeen comparisons (47%) identified the type of physical conditions among participants. Based on these data, we were able to create 5 categories of physical conditions: cancer (10 comparisons), cardiac disease (16 comparisons), diabetes (17 comparisons), hypertension (11 comparisons), and respiratory disease (11 comparisons).

### Data Extraction and Preparation

We contacted the study authors to obtain primary data sets for the following data: treatment group, age, sex, baseline and follow-up depression scores, and number and types of physical conditions (eTable 2 in the [Supplement](#)). Received data were cleaned, converted into the same reporting format, and aggregated into a single data set. Initial separate analyses on depression outcomes were conducted for each study to ensure that our analyses were consistent with those reported in the original study. We extracted data from the published reports of all the eligible studies using a standardized Excel (Microsoft Inc) data extraction form. Data on populations, interventions, chronic conditions (used as moderator in the analyses), risk of bias, and outcome effect sizes were also extracted. Studies with data available to us were compared with studies with unavailable data in terms of outcome effect sizes and moderator analyses.

### Missing Data

Multiple imputation techniques were used to obtain more complete data sets and to better protect against bias due to data missing at random mechanisms. Missing values for age and depression scores at follow-up were imputed with a multivariate imputation algorithm (*mi impute mvn* in

Stata, version 14; StataCorp LP) using Markov chain Monte Carlo.<sup>38,39</sup> This process produces several data sets, each of which is analyzed separately using the prespecified model; the results are then combined using Rubin's rules,<sup>40</sup> which account for uncertainty in imputed values. A total of 1000 new data sets with the observed and imputed scores for age and depression at follow-up were generated based on values obtained from study identification number, treatment group, baseline depression score, and sex. The range of imputed values was limited to the range of observed values of the variables. Time series and autocorrelation plots of the worst linear function were performed to monitor the convergence of the generated imputation algorithms.<sup>41,42</sup> We examined whether baseline variables (study, treatment group, age, sex, and baseline depression scores) predicted missing data to confirm that the assumptions underlying imputations were met. Sensitivity analyses were performed using only cases with available data; no significant differences were detected in any of the reported results.

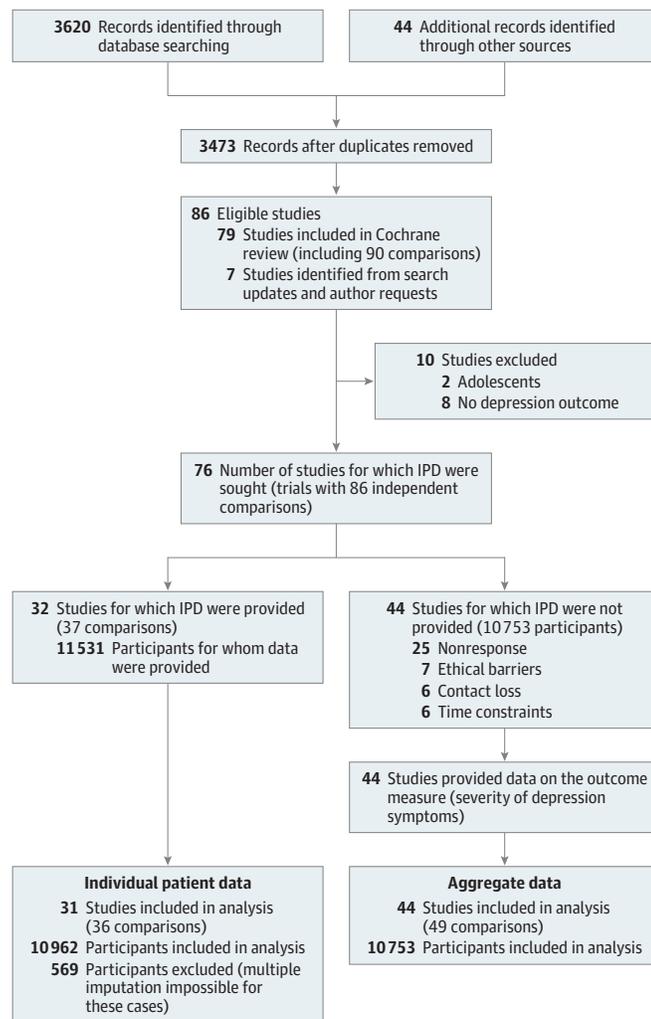
### Statistical Analysis

One-step meta-analysis was undertaken because it is less susceptible to bias, is most efficient in terms of power, and allows for sophisticated modeling of covariates (age, sex, and baseline depression scores in the present study).<sup>43,44</sup> A 1-step IPD meta-analysis constructs a model for the hypothesized treatment-covariate associations across all IPD sets while statistically accounting for clustering at the level of each included data set.<sup>28,45</sup>

Appropriate mixed-effects models (fixed study-specific intercepts, random treatment effect, and fixed study-specific effects for baseline depression) were used to meta-analyze the participant-level data and estimate the between-study and within-study variances and the effects of covariates.<sup>46</sup> Clustered RCTs were statistically accounted for in the model by adhering to the methodologic recommendations of Sutton et al.<sup>47</sup> The Stata, version 14, command *mixed* was used through the *ipdforest* command to summarize the evidence by study and obtain forest plots.<sup>48,49</sup> A 1-stage meta-analysis variant of the  $I^2$  statistic was used to assess heterogeneity.<sup>50</sup> We examined the impact of covariates separately, building a model based on both statistical and theoretical criteria. If studies included multiple treatment groups and a single control group, the treatment groups were treated as separate comparisons in the analyses, whereas, the control groups were halved at random to avoid double counting in the analyses. In accordance with published guidelines,<sup>51</sup> funnel plots were constructed to assess the potential for publication bias.

Several prespecified primary analyses were performed. One analysis examined a study-level moderator (binary variable; participants with physical conditions as part of the study's inclusion criteria: yes, 1; no, 0). The other analyses examined moderators at patient level including the presence (binary variable; present, 1; absent, 0), number (continuous variable), and types of physical conditions (binary variables for each condition; present, 1; absent, 0).

Figure 1. PRISMA Flowchart



Flowchart of the inclusion of studies in the review. IPD indicates individual participant data.

We conducted 2 secondary analyses to examine the robustness of the results and assessed whether the results remained the same after controlling for the risk of bias scores of the studies (based on allocation concealment item). Allocation concealment was selected as an indicator of risk of bias because it is the most sensitive item to changes in the treatment effect, especially when based on self-reported outcomes.<sup>52-54</sup> We also explored whether the main effects were influenced by the measure used to assess physical conditions (use of validated comorbidity severity indices).

## Results

Figure 1 presents the flowchart of the study selection process. A total of 76 RCTs (22 284 patients) including 86 independent comparisons were eligible for inclusion in the IPD meta-analysis. We found no evidence of asymmetry in the funnel plot for these studies (Egger regression test intercept [SE],  $-0.54$  [0.42];  $P = .21$ ) (eFigure 1 in the Supplement). We

collected data from 32 trials (11 531 [51.7%] of the total number of participants) that included 37 comparisons. One RCT<sup>55</sup> (a pilot study based on 49 participants) was excluded from the analyses because it did not include data on age and sex, leaving 36 comparisons. A total of 569 individual cases (4.9%) were excluded from the analyses because of missing baseline values on depression or age, leaving 10 962 unique cases (of which 1819 [16.6%] were imputed using multiple imputations).

### Baseline Characteristics and Comparisons Between Available and Unavailable Data

Eighteen studies were conducted in the United States, 11 in Europe, 1 in Canada, and 1 in India. Most participants were women (7749 [70.7%]); mean (SD) age was 51 (15) years (range, 17-97 years). Most participants (8099 [78.1%]) had at least 1 physical condition with a mean of 2.5 (2.3) conditions. We identified no important issues while checking the IPD. Details on the characteristics of the studies are presented in eTable 3 and eTable 4 in the Supplement.

**Table. Comparison of Studies Providing Data for the IPD Analyses and Those Not Providing Data**

Variable	Data Unavailable (n = 49)	Data Available (n = 36)	Statistical Test	P Value
Country, United States	36 (78)	23 (62)	$\chi^2_{1,85} = 3.17$	.08
Publication date, y				
Mean (SD)	2006 (4.03)	2007 (5.29)	$t_{83} = 1.01$	.32
Median (range)	2007 (1995-2013)	2008 (1995-2015)		
Systematic recruitment method, No. (%)	41 (84)	31 (84)	$\chi^2_{1,85} = 0.01$	.98
Chronic physical condition present, No. (%)	12 (24)	9 (24)	$\chi^2_{1,85} = 0.01$	.97
Intervention content psychological or both, No. (%)	20 (41)	28 (76)	$\chi^2_{1,85} = 12.79$	<.01
Frequency of scheduled supervision, mean (SD)	1.64 (0.82)	1.76 (0.91)	$t_{83} = 0.65$	.52
Allocation concealment low risk, No. (%)	30 (61)	18 (49)	$\chi^2_{1,85} = 3.17$	.24
Sample size				
Mean (SD)	220 (305)	292 (192)	$t_{83} = 1.63$	.11
Median (range)	165 (23 to 1570)	227 (64 to 783)		
Effect size				
SMD (SE)	-0.32 (0.31)	-0.24 (0.30)	$t_{83} = 1.22$	.23
SMD (95% CI)	(-0.40 to -0.23)	(-0.29 to -0.10)		

Abbreviations: IPD, individual participant data; SMD, standardized mean difference.

Available and unavailable studies were compared in terms of population, intervention, and risk of bias characteristics, as well as outcome data. We selected these specific characteristics based on the results of 2 previous reviews<sup>12,16</sup> that applied meta-regression analyses to identify moderators of the main effect of collaborative care interventions. As reported in the **Table**, the only statistically significant difference identified was for the intervention content; a larger proportion of trials that incorporated psychological interventions made data available.

#### Effects of Collaborative Care on 3 Depressive Symptoms at 4- to 6-Month Follow-up

Collaborative care was associated with a small but significant effect on depression outcomes compared with usual care (standardized mean difference [SMD], -0.22 [95% CI, -0.25 to -0.18];  $I^2 = 0.8\%$ ; 0.3%-3.5%) (eFigure 2 in the **Supplement**) equal to a drop of approximately 2 points on the Patient Health Questionnaire-9 above the change in the controls. This effect size was smaller but not significantly different from the effect size reported in a Cochrane review<sup>10</sup> (-0.28 [95% CI, -0.31 to -0.25];  $P = .227$ ) (**Table**).

#### Association Between Systematic Identification of Patients with Chronic Physical Conditions and the Effectiveness of Collaborative Care on Depression Scores

A statistically significant interaction was found between systematic identification of participants with physical conditions in the study and treatment effect (interaction coefficient, -0.12 [95% CI, -0.23 to -0.02]) (**Figure 2**).<sup>12,19,21,24,56-82</sup> Randomized clinical trials that explicitly recruited people with physical conditions were associated with significantly larger treatment effects for depression (SMD, -0.29 [95% CI, -0.37 to -0.21]) compared with RCTs that did not explicitly recruit

people with physical conditions (SMD, -0.19 [95% CI, -0.23 to -0.15]). The moderating effect of inclusion of physical conditions was even larger in trials with adequate concealment of allocation (interaction coefficient, -0.14 [95% CI, -0.26 to -0.02]).

#### Association Between Presence of Chronic Physical Conditions and the Effectiveness of Collaborative Care on Depression Scores

When we compared the effects of collaborative care in participants with and without physical conditions, the interaction term with the treatment effect was nonsignificant (interaction coefficient, 0.02 [95% CI, -0.10 to 0.13]) (**Figure 3**) (References 12, 19, 21, 24, 56, 57, 59, 60, 63, 65-72, 74-82). We could not demonstrate any statistically significant moderating effect of the presence of physical conditions on depression outcomes at follow-up (effect in those with physical conditions: SMD, -0.21 [95% CI, -0.27 to -0.15], in those without physical conditions: SMD, -0.23 [95% CI, -0.32 to -0.12]) (**Figure 3**).

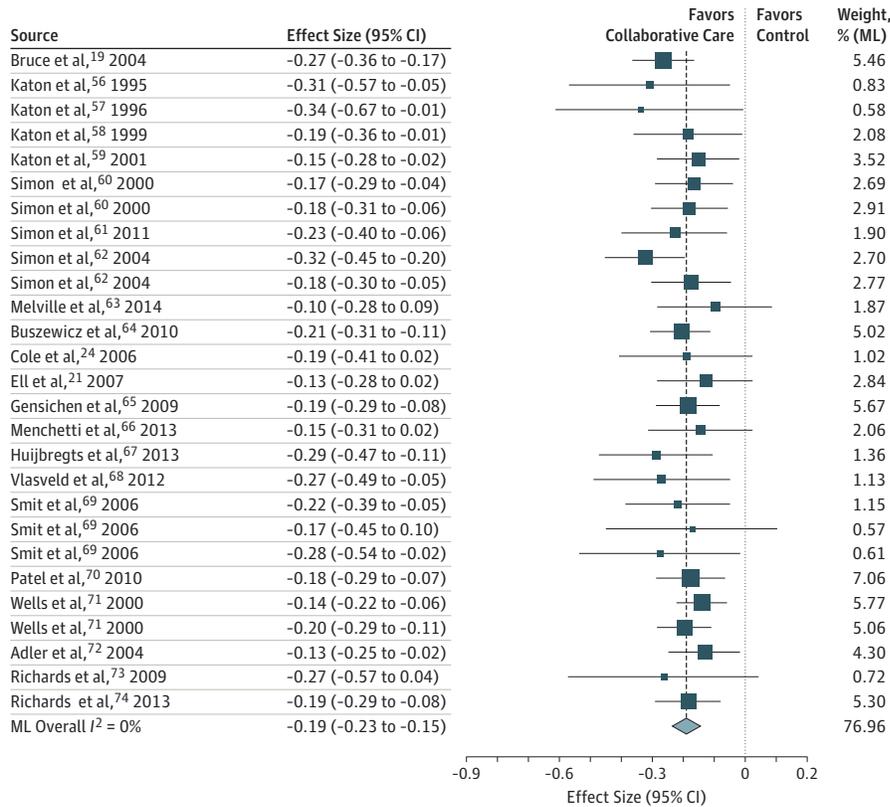
This result was not sensitive to allocation concealment ratings (adequate: interaction coefficient, -0.06 [95% CI, -0.04 to 0.02]) or to the measure used to assess physical conditions (validated: 0.05 [95% CI, -0.08 to 0.10]).

#### Association Between Number of Chronic Physical Conditions and the Effectiveness of Collaborative Care on Depression Scores

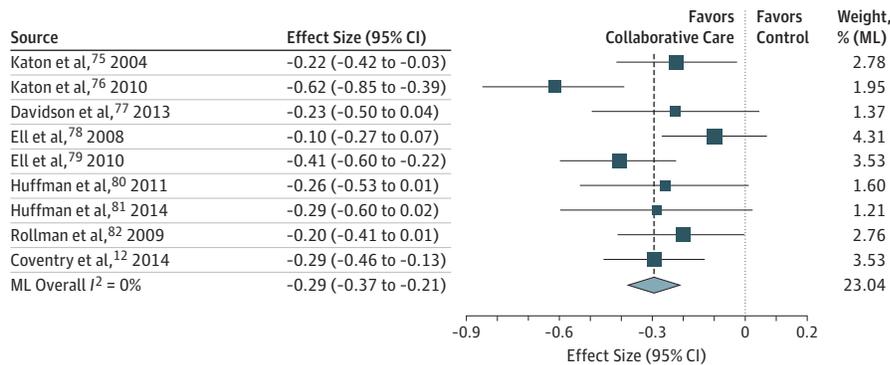
The interaction term between number of physical conditions and treatment effect was nonsignificant (interaction coefficient, 0.00 [95% CI, -0.01 to 0.02]) (**Figure 4**) (References 12, 19, 21, 24, 56, 57, 59, 60, 63, 65-72, 74-82). This finding suggests that the improvement of depression scores at follow-up does not differ according to the number of physical condi-

Figure 2. Study-Level Analysis Examining the Effect of the Presence Chronic Physical Conditions on the Effectiveness of Collaborative Care

**A** Studies did not explicitly recruit patients with chronic physical conditions



**B** Studies explicitly recruited patients with chronic physical conditions



Study-level data and pooled effects across 36 comparisons. A, Studies that did not explicitly recruit patients with chronic physical conditions. B, Studies that explicitly recruited patients with chronic physical conditions; mixed-effects model used. Weights are from random-effects analysis. ML indicates maximum likelihood.

tions. The interaction effect was not significantly affected by the allocation concealment rating (interaction coefficient, -0.00 [95% CI, -0.03 to 0.03]) or by the measure used to assess physical conditions (interaction coefficient, -0.01 [95% CI, -0.04 to 0.02]).

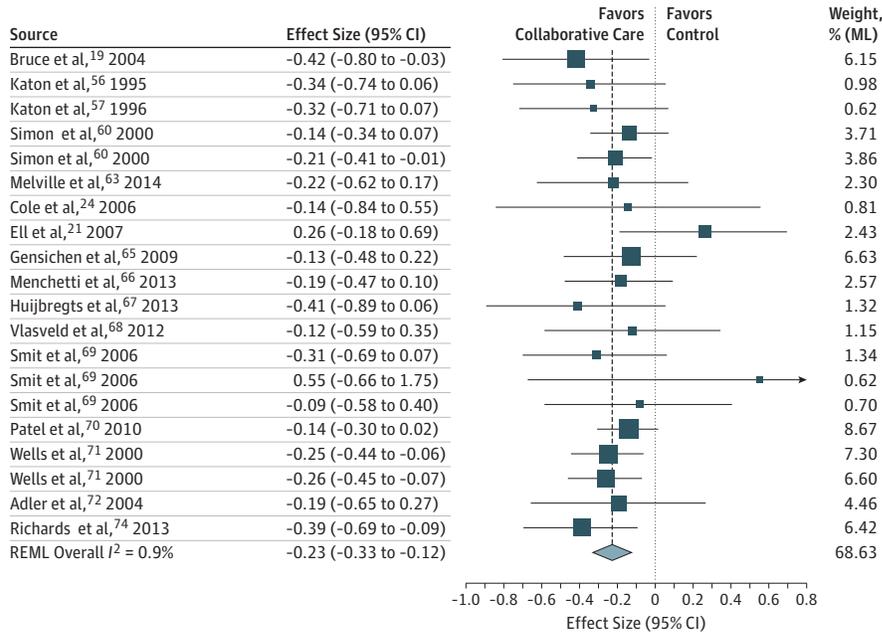
**Association Between Types of Chronic Physical Conditions and the Effectiveness of Collaborative Care on Depression Scores**

We found no evidence that the effects of collaborative care on depression outcomes are moderated by the types of physical

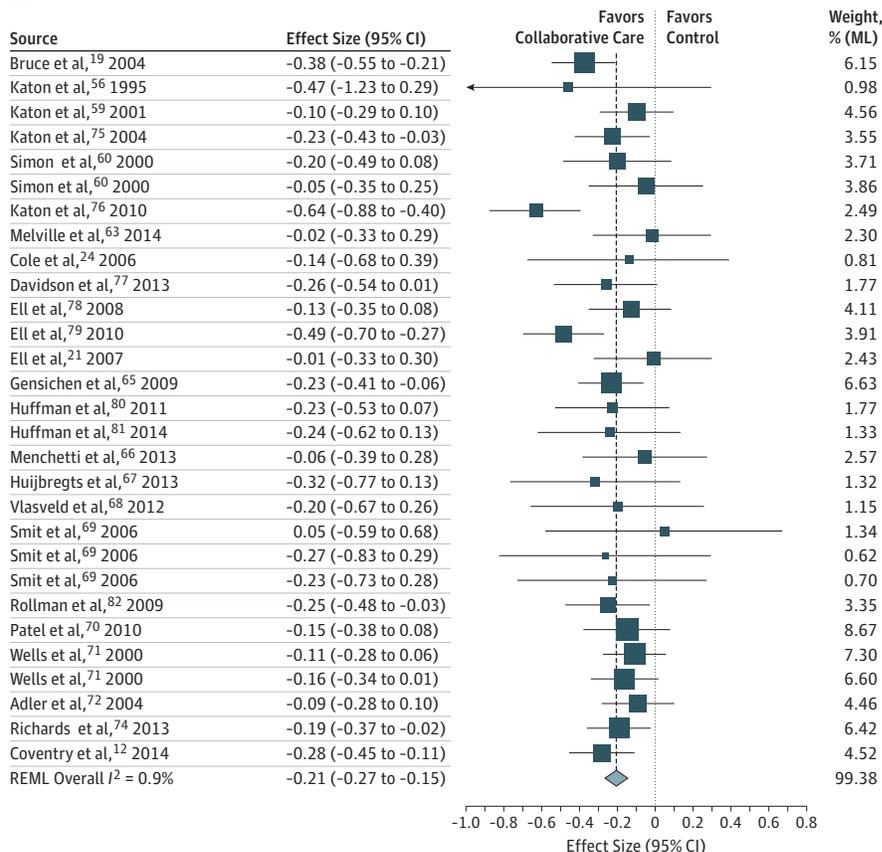
conditions among participants. None of the interaction effects between treatment effect and types of physical conditions were significant: cancer (interaction coefficient, -0.11 [95% CI, -0.02 to 0.09]), cardiac disease (interaction coefficient, -0.02 [95% CI, -0.14 to 0.09]), diabetes (interaction coefficient, -0.02 [95% CI, -0.08 to 0.09]), hypertension (interaction coefficient, -0.09 [95% CI, -0.21 to 0.03]), and respiratory disease (interaction coefficient, -0.08 [95% CI, -0.21 to 0.07]). These findings suggest that the benefits derived by collaborative care do not differ significantly across subgroups of people with certain types of physical conditions. None of the interaction effects were

**Figure 3. Individual Participant–Level Analysis Examining the Effect of the Presence of Chronic Physical Conditions on the Effectiveness of Collaborative Care**

**A** Participants did not have chronic physical conditions

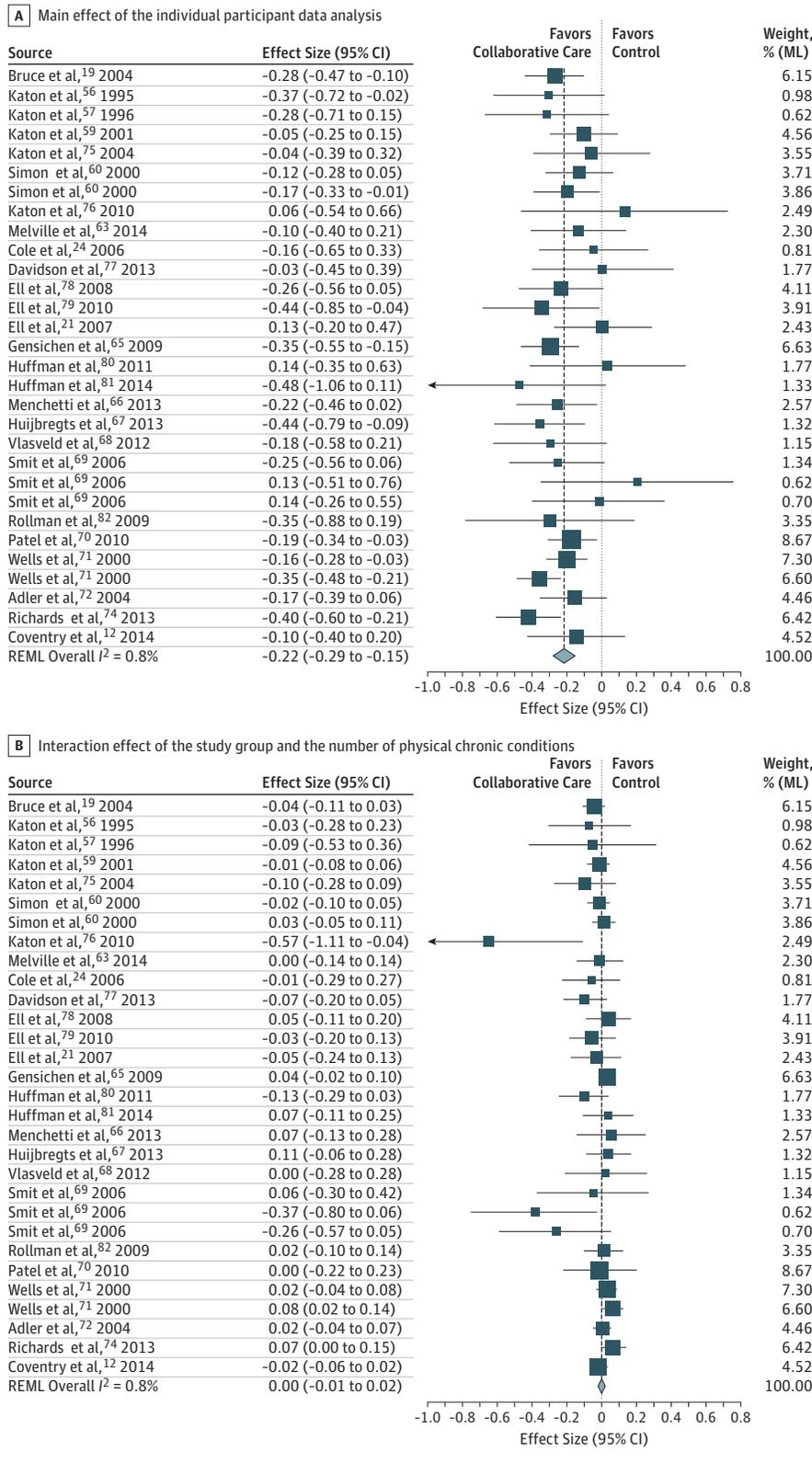


**B** Participants had a chronic physical condition



Individual participant data and pooled effects across 30 comparisons. A, Studies in which participants did not have a chronic physical condition. B, Studies in which participants had a chronic physical condition. Mixed-effects model used. Weights are from random-effects analysis. REML indicates restricted maximum likelihood.

Figure 4. Individual Participant–Level Analysis Examining the Effect of the Number of Chronic Physical Conditions on the Effectiveness of Collaborative Care



affected by allocation concealment or by the measure used to assess physical conditions.

## Discussion

Analyzing data from 36 comparisons of collaborative care and 10 962 participants, this IPD meta-analysis showed that collaborative care is associated with significant short-term improvements in depression outcomes across all people with or without comorbid physical conditions. At study level, trials that recruited only participants with comorbid physical conditions were associated with larger treatment effects compared with trials that did not include those with comorbid conditions, confirming previous findings.<sup>12,15</sup> However, when a more accurate analysis at the individual participant level was undertaken, the presence, number, and type of physical conditions did not moderate the main effect of collaborative care on depression outcomes. Overall, the findings of this IPD meta-analysis do not support existing recommendations based on meta-analyses of aggregate data that collaborative care should be considered only for patients with comorbid depression and physical conditions. Our findings highlight the importance of undertaking IPD analyses in developing rigorous recommendations, especially for subgroups of complex patients.

### Strengths and Limitations

To our knowledge, this study is the most methodologically rigorous test of the influence of physical conditions on the effects of collaborative care on depression outcomes.<sup>26,83</sup> However, there are several limitations. Individual participant data meta-analysis remains vulnerable to important sources of bias, including publication, study or reviewer selection, and data availability bias.<sup>51</sup> No funnel plot asymmetry was detected, suggesting that publication bias is not likely to be present in the overall data set. Study selection bias was minimized by including studies through multiple sources (ie, an existing standard Cochrane review,<sup>10</sup> top-up database searches, and author requests) using strict prespecification of trial eligibility criteria. These efforts facilitated access to data from approximately half of the participants included in published RCTs of collaborative care for depression, which is below the recommended recruitment target (80% of data requested).<sup>51</sup> We observed some differences between available and unavailable studies, but these differences rarely reached statistical significance. For example, the overall effect size was smaller than that found in the previous Cochrane review.<sup>10</sup> This difference is likely to be explained by the fact that less than half of all collaborative care trials were included in this IPD analysis, and these trials were generally larger than those that were not included. It is important to continue to develop effective methods and agreements about data sharing to ensure that future analyses have better access to data.

Another limitation of the study is that the evaluation of physical conditions was not pursued in an entirely consistent manner across trials. Most of the trials assessed the

number of physical conditions using validated comorbidity indexes that contain extensive lists of physical conditions, but some trials used less-comprehensive lists of physical conditions that were empirically devised.<sup>37</sup> Although we separately examined the influence of 5 common physical conditions, participants could have more than 1 of these conditions. The experience and interactions of multiple concordant or discordant conditions<sup>84</sup> is another possible factor to recognize why people might respond differently to depression treatment.

The use of multiple mixed-effects regression analyses of IPD and controlling for covariates significantly reduces the possibility of bias present in aggregate data meta-analyses (eg, ecologic fallacy or Simpson paradox).<sup>26,83,85-87</sup> However, we recommend interpreting these findings cautiously since some of these biases might still operate.

Finally, there were important between-study variations, including intervention content (collaborative care is generally heterogeneous)<sup>10</sup> and depression measures. However, these study-level variations are unlikely to influence the participant-level analyses that showed that chronic physical conditions do not moderate the effectiveness of collaborative care. A post hoc sensitivity analysis indicated that the results were similar regardless of using self-reported or observer-rated measures for depression.

### Comparison With Previous Systematic Reviews

Previous systematic reviews<sup>12,16</sup> have examined moderators of the effect of collaborative care on depression outcomes but were based on aggregate data and used meta-regressions. Improved depressive outcomes were predicted by the inclusion of psychological interventions, and the use of antidepressant medication was predicted by recruiting people with physical conditions.<sup>12</sup> Based on these findings, it was proposed<sup>12</sup> that patients with physical conditions may derive greater benefits from collaborative care compared with patients without physical conditions. As noted above, these analyses are a less-robust basis for decision making because they are insensitive to variation in physical conditions at the level of individual patients. In this IPD meta-analysis, we found no support for this hypothesis.

### Implications for Clinicians, Policymakers, and Researchers

This study suggests that depressed patients with and without comorbid physical conditions gain important improvements in depression outcomes from collaborative care. As such, our findings do not support the recommendation by the National Institute for Health and Care Excellence that collaborative care should be considered only for people with depression and comorbid physical conditions with functional impairment.<sup>15</sup> Limiting collaborative care to people with depression and comorbid physical conditions does not appear to be a reasonable policy recommendation with important implications for patient benefit. Individual participant data meta-analyses are underused in the development of clinical guidelines, and the next iteration of guidelines for depression could be improved by using the most-reliable evidence available.<sup>88</sup>

Given that the effectiveness of collaborative care is confirmed, future research should focus on understanding how to optimize the delivery and outcomes of collaborative care. For instance, based on recent published evidence,<sup>89</sup> the systematic measurement and management of physical health outcomes along with mental health outcomes has the potential to boost the effectiveness of collaborative care in people with physical comorbidities. However, the overall treatment benefits associated with collaborative care are modest.<sup>10</sup> It is therefore legitimate to suggest that future treatment policy guidelines should also be grounded on the comparative cost-effectiveness of collaborative care to other types of interventions.

## Conclusions

To our knowledge, this IPD meta-analysis represents the most rigorous and precise analysis to date on the extent to which physical conditions influence the effectiveness of collaborative care on depression outcomes. People with depression derive significant benefits from collaborative care regardless of the presence, number, or type of comorbid physical conditions. The core challenge now is to understand how to deliver these interventions at scale in routine settings and to better operationalize the treatment outcomes to maximize patient benefits.

### ARTICLE INFORMATION

**Accepted for Publication:** June 14, 2016.

**Correction:** This article was corrected on August 24, 2016, to fix the byline and Author Affiliations.

**Accepted for Publication:** June 14, 2016.

**Published Online:** August 17, 2016.  
doi:10.1001/jamapsychiatry.2016.1794.

**Author Affiliations:** National Institute of Health Research School for Primary Care Research, Centre for Primary Care, Institute of Population Health, University of Manchester, Manchester, England (Panagioti, Bower, Kontopantelis, Waheed); School of Nursing, Midwifery and Social Work, University of Manchester, Manchester, England (Lovell, Archer); Mental Health and Addiction Research Group, Department of Health Sciences, Hull York Medical School, University of York, York, England (Gilbody); Institute of Health Research, University of Exeter Medical School, Exeter, England (Dickens, Richards); National Institute of Health Research Collaboration for Leadership in Applied Health Research and Care for the South West Peninsula, University of Exeter, Exeter, England (Dickens); Group Health Research Institute, Seattle, Washington (Simon); Ethnicity and Poverty, School of Social Work, University of Southern California, Los Angeles (Ell); Harvard Medical School, General Hospital/Blake 11, Boston, Massachusetts (Huffman); Department of Psychiatry and Behavioral Sciences, Faculty of Social and Behavioral Sciences, Tilburg University, the Netherlands (van der Feltz-Cornelis); Department of Psychiatry, Tufts Medical Center, Boston, Massachusetts (Adler); Department of Psychiatry, Weill Cornell Medical College, White Plains, New York (Bruce); Institute of Epidemiology and Health, Faculty of Population and Health Sciences, University College London, London, England (Buszewicz); Department of Psychiatry, St. Mary's Hospital Center, McGill University, Montreal, Quebec, Canada (Cole); Center for Behavioral Cardiovascular Health, Department of Medicine, Columbia University, New York, New York (Davidson); Interdisciplinary Center Psychopathology and Emotion Regulation, University Medical Center Groningen, Groningen, the Netherlands (de Jonge); Institute of General Practice, Friedrich-Schiller-University, School of Medicine, University Hospital, Jena, Germany (Gensichen); Netherlands Institute of Mental Health and Addiction, Trimbos Institute, Utrecht, the Netherlands (Huijbrechts, Zijlstra-Vlasveld); Department of Medical and Surgical Sciences, University of Bologna, Bologna, Italy (Menchetti); Public Health Foundation of India, Gurgaon, India

(Patel); Psychiatry, Biomedical Informatics, and Clinical and Translational Science, Department of Biomedical Informatics, University of Pittsburgh, Pittsburgh, Pennsylvania (Rollman); Department of Psychology, University of Colorado, Denver (Shaffer); Mental Health and Addiction Research Group, Department of Health Sciences, University of York, York, England (Coventry); Centre for Reviews and Dissemination, University of York, York, England (Coventry).

**Author Contributions:** Dr Coventry had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

**Concept and design:** Bower, Kontopantelis, Lovell, Gilbody, Waheed, Dickens, Archer, Coventry.

**Acquisition, analysis, or interpretation of data:** Panagioti, Bower, Kontopantelis, Lovell, Dickens, Simon, Huffman, Richards, van der Feltz-Cornelis, Adler, Bruce, Buszewicz, Cole, Davidson, de Jonge, Gensichen, Menchetti, Patel, Rollman, Shaffer, Coventry.

**Drafting of the manuscript:** Panagioti, Bower, Kontopantelis, Coventry.

**Critical revision of the manuscript for important intellectual content:** Bower, Kontopantelis, Gilbody, Lovell, Waheed, Dickens, Archer, Simon, Ell, Huffman, Richards, van der Feltz-Cornelis, Adler, Buszewicz, Cole, Davidson, de Jonge, Gensichen, Menchetti, Patel, Rollman, Shaffer, Zijlstra-Vlasveld, Coventry.

**Statistical analysis:** Panagioti, Kontopantelis.

**Obtaining funding:** Bower, Kontopantelis, Lovell, Gilbody, Waheed, Dickens, Archer, Coventry.

**Administrative, technical, or material support:** Panagioti, Bower, Lovell, Dickens, Huffman, van der Feltz-Cornelis, de Jonge, Huijbrechts, Menchetti, Rollman, Shaffer, Zijlstra-Vlasveld.

**Study supervision:** Bower, Kontopantelis, Coventry.

**Conflict of Interest Disclosures:** Dr Bower is a paid consultant to the British Association of Counselling and Psychotherapy. The authors have been or are involved in the conduct of trials of collaborative care in the United Kingdom funded by the Medical Research Council and the National Institute for Health Research. No other disclosures were reported.

**Funding/Support:** This study was funded by grant 212 from the UK National Institute of Health Research (NIHR) School for Primary Care Research. The research team members were independent from the funding agency.

**Role of the Funder/Sponsor:** The NIHR had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

**Disclaimer:** The views expressed in this publication are those of the authors and not necessarily those of the National Health Service, the National Institute for Health Research, or the Department of Health.

**Additional Contributions:** We acknowledge the important contribution of Wayne Katon, MD, who died in March 2015 before approving this manuscript; he provided us access to 6 datasets of collaborative care trials. Harm van Marwijk, MD (National Institute of Health Research School for Primary Care Research, Centre for Primary Care, Institute of Population Health, University of Manchester), and Penny Bee, PhD (School of Nursing, Midwifery and Social Work, University of Manchester) provided comments on drafts of this manuscript. There was no financial compensation.

### REFERENCES

- Murray CJL, Vos T, Lozano R, et al. Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet*. 2012;380(9859):2197-2223.
- Whiteford HA, Degenhardt L, Rehm J, et al. Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *Lancet*. 2013;382(9904):1575-1586.
- Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V, Ustun B. Depression, chronic diseases, and decrements in health: results from the World Health Surveys. *Lancet*. 2007;370(9590):851-858.
- Freedland KE, Carney RM. Depression as a risk factor for adverse outcomes in coronary heart disease. *BMC Med*. 2013;11:131.
- Carney RM, Blumenthal JA, Catellier D, et al. Depression as a risk factor for mortality after acute myocardial infarction. *Am J Cardiol*. 2003;92(11):1277-1281.
- Panagioti M, Stokes J, Esmail A, et al. Multimorbidity and patient safety incidents in primary care: a systematic review and meta-analysis. *PLoS One*. 2015;10(8):e0135947.
- Dickens C, Katon W, Blakemore A, et al. Does depression predict the use of urgent and unscheduled care by people with long term conditions? a systematic review with meta-analysis. *J Psychosom Res*. 2012;73(5):334-342.
- Naylor C, Parsonage M, McDaid D, Knapp M, Fossey M, Galea A. *Long-term Conditions and Mental Health: The Cost of Co-morbidities*. London, England: King's Fund and Centre for Mental Health; 2012.
- Gunn J, Diggins J, Hegarty K, Blashki G. A systematic review of complex system

interventions designed to increase recovery from depression in primary care. *BMC Health Serv Res*. 2006;6:88.

10. Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. *Cochrane Database Syst Rev*. 2012;10:CD006525.

11. Katon W, Von Korff M, Lin E, Simon G. Rethinking practitioner roles in chronic illness: the specialist, primary care physician, and the practice nurse. *Gen Hosp Psychiatry*. 2001;23(3):138-144.

12. Coventry PA, Hudson JL, Kontopantelis E, 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.

13. Community Preventive Services Task Force. Recommendation from the Community Preventive Services Task Force for use of collaborative care for the management of depressive disorders. *Am J Prev Med*. 2012;42(5):521-524.

14. Thota AB, Sipe TA, Byard GJ, et al; Community Preventive Services Task Force. Collaborative care to improve the management of depressive disorders: a community guide systematic review and meta-analysis. *Am J Prev Med*. 2012;42(5):525-538.

15. NICE. *Depression in Adults With a Chronic Physical Health Problem: Treatment and Management*. Leicester, England: British Psychological Society; 2010.

16. Bower P, Gilbody S, Richards D, Fletcher J, Sutton A. Collaborative care for depression in primary care: making sense of a complex intervention: systematic review and meta-regression. *Br J Psychiatry*. 2006;189:484-493.

17. Bartels SJ, Coakley EH, Zubritsky C, et al; PRISM-E Investigators. 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. *Am J Psychiatry*. 2004;161(8):1455-1462.

18. Blanchard MR, Waterreus A, Mann AH. The effect of primary care nurse intervention upon older people screened as depressed. *Int J Geriatr Psychiatry*. 1995;10(4):289-298.

19. Bruce ML, Ten Have TR, Reynolds CF III, et al. Reducing suicidal ideation and depressive symptoms in depressed older primary care patients: a randomized controlled trial. *JAMA*. 2004;291(9):1081-1091.

20. Ciechanowski P, Wagner E, Schmalting K, et al. Community-integrated home-based depression treatment in older adults: a randomized controlled trial. *JAMA*. 2004;291(13):1569-1577.

21. Ell K, Unützer J, Aranda M, Gibbs NE, Lee PJ, Xie B. Maaging depression in home health care: a randomized clinical trial. *Home Health Care Serv Q*. 2007;26(3):81-104.

22. McCusker J, Cole M, Yaffe M, et al. Project Direct: pilot study of a collaborative intervention for depressed seniors. *Can J Commun Ment Health*. 2008;27(2):201-218.

23. Unützer J, Katon W, Callahan CM, et al; IMPACT Investigators. Improving mood-promoting access to collaborative treatment: collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *JAMA*. 2002;288(22):2836-2845.

24. 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. *CMAJ*. 2006;174(1):38-44.

25. Chew-Graham CA, Lovell K, Roberts C, et al. A randomised controlled trial to test the feasibility of a collaborative care model for the management of depression in older people. *Br J Gen Pract*. 2007;57(538):364-370.

26. Stewart GB, Altman DG, Askie LM, Duley L, Simmonds MC, Stewart LA. Statistical analysis of individual participant data meta-analyses: a comparison of methods and recommendations for practice. *PLoS One*. 2012;7(10):e46042.

27. Clarke MJ, Stewart LA. Obtaining data from randomised controlled trials: how much do we need for reliable and informative meta-analyses? *BMJ*. 1994;309(6960):1007-1010.

28. Riley RD, Lambert PC, Abo-Zaid G. Meta-analysis of individual participant data: rationale, conduct, and reporting. *BMJ*. 2010;340:c221.

29. Harrison M, Reeves D, Harkness E, et al. A secondary analysis of the moderating effects of depression and multimorbidity on the effectiveness of a chronic disease self-management programme. *Patient Educ Couns*. 2012;87(1):67-73.

30. Fried TR, O'Leary J, Towle V, Goldstein MK, Trentelange M, Martin DK. The effects of comorbidity on the benefits and harms of treatment for chronic disease: a systematic review. *PLoS One*. 2014;9(11):e112593.

31. Stewart LA, Clarke M, Rovers M, et al; PRISMA-IPD Development Group. Preferred Reporting Items for Systematic Review and Meta-analyses of Individual Participant Data: the PRISMA-IPD statement. *JAMA*. 2015;313(16):1657-1665.

32. Tierney JF, Vale C, Riley R, et al. Individual participant data (IPD) meta-analyses of randomised controlled trials: guidance on their use. *PLoS Med*. 2015;12(7):e1001855.

33. Beck AT, Steer RA. Internal consistencies of the original and revised Beck Depression Inventory. *J Clin Psychol*. 1984;40(6):1365-1367.

34. Radloff LS. The CES-D scale: a self-report depression scale for research in the general population. *Appl Psychol Meas*. 1977;1(3):385-401.

35. Hamilton M. Rating depressive patients. *J Clin Psychiatry*. 1980;41(12, pt 2):21-24.

36. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med*. 2001;16(9):606-613.

37. Charlson ME, Pompei P, Ales KL, MacKenzie CR. A new method of classifying prognostic comorbidity in longitudinal studies: development and validation. *J Chronic Dis*. 1987;40(5):373-383.

38. Gadbury GL, Coffey CS, Allison DB. Modern statistical methods for handling missing repeated measurements in obesity trial data: beyond LOCF. *Obes Rev*. 2003;4(3):175-184.

39. Donders AR, van der Heijden GJ, Stijnen T, Moons KG. Review: a gentle introduction to imputation of missing values. *J Clin Epidemiol*. 2006;59(10):1087-1091.

40. Rubin DB. *Multiple Imputation for Nonresponse in Surveys*. New York, NY: Wiley & Sons; 1987.

41. Schafer J. *Analysis of Incomplete Multivariate Data*. Boca Raton, FL: Chapman & Hall; 1997.

42. Stata Press. *Multiple-Imputation Reference Manual*. College Station, TX: Stata Press; 2014.

43. Stewart LA, Parmar MK. Meta-analysis of the literature or of individual patient data: is there a difference? *Lancet*. 1993;341(8842):418-422.

44. Vickers AJ, Cronin AM, Maschino AC, et al; Acupuncture Trialists' Collaboration. Acupuncture for chronic pain: individual patient data meta-analysis. *Arch Intern Med*. 2012;172(19):1444-1453.

45. Simmonds MC, Higgins JP. Covariate heterogeneity in meta-analysis: criteria for deciding between meta-regression and individual patient data. *Stat Med*. 2007;26(15):2982-2999.

46. Whitehead A. *Meta-analysis of Controlled Clinical Trials*. New York, NY: John Wiley & Sons; 2002.

47. Sutton AJ, Kendrick D, Coupland CA. Meta-analysis of individual- and aggregate-level data. *Stat Med*. 2008;27(5):651-669.

48. StataCorp. *Stata Statistical Software: Release 12*. College Station, TX: StataCorp LP; 2011.

49. Kontopantelis E, Reeves D. A short guide and a forest plot command (ipdforest) for one-stage meta-analysis. *Stata J*. 2013;13(3):574-587.

50. Higgins JP, Thompson SG. Quantifying heterogeneity in a meta-analysis. *Stat Med*. 2002;21(11):1539-1558.

51. Ahmed I, Sutton AJ, Riley RD. Assessment of publication bias, selection bias, and unavailable data in meta-analyses using individual participant data: a database survey. *BMJ*. 2012;344:d7762.

52. Higgins JPT, Altman DG, Gøtzsche PC, et al; Cochrane Bias Methods Group; Cochrane Statistical Methods Group. The Cochrane Collaboration's tool for assessing risk of bias in randomised trials. *BMJ*. 2011;343:d5928.

53. Schulz KF, Chalmers I, Hayes RJ, Altman DG. Empirical evidence of bias: dimensions of methodological quality associated with estimates of treatment effects in controlled trials. *JAMA*. 1995;273(5):408-412.

54. Pildal J, Hróbjartsson A, Jørgensen KJ, Hilden J, Altman DG, Gøtzsche PC. Impact of allocation concealment on conclusions drawn from meta-analyses of randomized trials. *Int J Epidemiol*. 2007;36(4):847-857.

55. McMahon L, Foran KM, Forrest SD, et al. Graduate mental health worker case management of depression in UK primary care: a pilot study. *Br J Gen Pract*. 2007;57(544):880-885.

56. Katon W, Von Korff M, Lin E, et al. Collaborative management to achieve treatment guidelines. Impact on depression in primary care. *JAMA*. 1995;273(13):1026-1031.

57. Katon W, Robinson P, Von Korff M, et al. A multifaceted intervention to improve treatment of depression in primary care. *Arch Gen Psychiatry*. 1996;53(10):924-932.

58. Katon W, Von Korff M, Lin E, et al. Stepped collaborative care for primary care patients with persistent symptoms of depression: a randomized trial. *Arch Gen Psychiatry*. 1999;56(12):1109-1115.

59. Katon W, Rutter C, Ludman EJ, et al. A randomized trial of relapse prevention of

- depression in primary care. *Arch Gen Psychiatry*. 2001;58(3):241-247.
60. 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):550-554.
61. Simon GE, Ralston JD, Savarino J, Pabiniak C, Wentzel C, Operskalski BH. Randomized trial of depression follow-up care by online messaging. *J Gen Intern Med*. 2011;26(7):698-704.
62. 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):935-942.
63. Melville JL, Reed SD, Russo J, et al. Improving care for depression in obstetrics and gynecology: a randomized controlled trial. *Obstet Gynecol*. 2014;123(6):1237-1246.
64. Buszewicz M, Griffin M, McMahon EM, 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.
65. Gensichen J, von Korff M, Peitz M, et al; PRO-MPT (Primary care Monitoring for depressive Patients Trial). Case management for depression by health care assistants in small primary care practices: a cluster randomized trial. *Ann Intern Med*. 2009;151(6):369-378.
66. Menchetti M, Sighinolfi C, Di Michele V, et al. Effectiveness of collaborative care for depression in Italy. A randomized controlled trial. *Gen Hosp Psychiatry*. 2013;35(6):579-586.
67. Huijbregts KM, de Jong FJ, van Marwijk HW, 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. *J Affect Disord*. 2013;146(3):328-337.
68. Vlasveld MC, van der Feltz-Cornelis CM, Adèr HJ, et al. Collaborative care for major depressive disorder in an occupational healthcare setting. *Br J Psychiatry*. 2012;200(6):510-511.
69. Smit A, Kluiters H, Conradi HJ, et al. Short-term effects of enhanced treatment for depression in primary care: results from a randomized controlled trial. *Psychol Med*. 2006;36(1):15-26.
70. Patel V, Weiss HA, Chowdhary N, 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):2086-2095.
71. Wells KB, Sherbourne C, Schoenbaum M, et al. Impact of disseminating quality improvement programs for depression in managed primary care: a randomized controlled trial [published correction appears in *JAMA*. 2000;283(24):3204]. *JAMA*. 2000;283(2):212-220.
72. Adler DA, Bungay KM, Wilson IB, et al. The impact of a pharmacist intervention on 6-month outcomes in depressed primary care patients. *Gen Hosp Psychiatry*. 2004;26(3):199-209.
73. Richards DA, Lovell K, Gilbody S, et al. Collaborative care for depression in UK primary care: a randomized controlled trial: Corrigendum. *Psychol Med*. 2009;39(4):701.
74. Richards DA, Hill JJ, Gask L, et al. Clinical effectiveness of collaborative care for depression in UK primary care (CADET): cluster randomised controlled trial. *BMJ*. 2013;347:f4913.
75. Katon WJ, Von Korff M, Lin EH, et al. The Pathways Study: a randomized trial of collaborative care in patients with diabetes and depression. *Arch Gen Psychiatry*. 2004;61(10):1042-1049.
76. Katon WJ, Lin EH, Von Korff M, et al. Collaborative care for patients with depression and chronic illnesses. *N Engl J Med*. 2010;363(27):2611-2620.
77. Davidson KW, Bigger JT, Burg MM, et al. Centralized, stepped, patient preference-based treatment for patients with post-acute coronary syndrome depression: CODIACS vanguard randomized controlled trial. *JAMA Intern Med*. 2013;173(11):997-1004.
78. 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. *J Clin Oncol*. 2008;26(27):4488-4496.
79. Ell K, Katon W, Xie B, 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):706-713.
80. 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*. 2011;52(1):26-33.
81. Huffman JC, Mastromauro CA, Beach SR, 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 Intern Med*. 2014;174(6):927-935.
82. Rollman BL, Belnap BH, LeMenager MS, et al. Telephone-delivered collaborative care for treating post-CABG depression: a randomized controlled trial. *JAMA*. 2009;302(19):2095-2103.
83. Tierney JF, Pignon J-P, Gueffier F, et al; Cochrane IPD Meta-analysis Methods Group. How individual participant data meta-analyses have influenced trial design, conduct, and analysis. *J Clin Epidemiol*. 2015;68(11):1325-1335.
84. Piette JD, Kerr EA. The impact of comorbid chronic conditions on diabetes care. *Diabetes Care*. 2006;29(3):725-731.
85. Simmonds MC, Higgins JPT, Stewart LA, Tierney JF, Clarke MJ, Thompson SG. Meta-analysis of individual patient data from randomized trials: a review of methods used in practice. *Clin Trials*. 2005;2(3):209-217.
86. Altman DG, Deeks JJ. Meta-analysis, Simpson's paradox, and the number needed to treat. *BMC Med Res Methodol*. 2002;2:3.
87. Kievit RA, Frankenhuis WE, Waldorp LJ, Borsboom D. Simpson's paradox in psychological science: a practical guide. *Front Psychol*. 2013;4:513.
88. Vale CL, Rydzewska LH, Rovers MM, Emberson JR, Gueffier F, Stewart LA; Cochrane IPD Meta-analysis Methods Group. Uptake of systematic reviews and meta-analyses based on individual participant data in clinical practice guidelines: descriptive study. *BMJ*. 2015;350:h1088.
89. McGregor M, Lin EH, Katon WJ. TEAMcare: an integrated multicondition collaborative care program for chronic illnesses and depression. *J Ambul Care Manage*. 2011;34(2):152-162.