Supplementary Table 1:
Highest Quality of Acute and Continuing-Care to Maximize Remissions While Minimizing Relapse and Dropouts

Descriptor	Explanation
Optimized Sustained Study Participation to Minimize Dropouts [20, p. 473-474]	• Promoted patients' study affiliation via STAR*D-branded brochures, bimonthly newsletters, and an informational video emphasizing STAR*D's public health significance and the critical role played by patients; • Educated patients and families about depression and its treatment using a multi-step educational package. This included teaching the "mechanism of action" for patients' current antidepressant and educating patients that "depression is a disease, like diabetes or high blood pressure" and "can be treated as effectively as other illnesses," etc.; • Used a letter reminder system to alert patients before appointments in those clinics without such systems who had a >15% rate of missed appointments; • Ensured timely follow-up and rescheduling of missed appointments by calling patients on the day of the missed appointment, and again within 24 hours, if there was no response. Patient's physician sent letter within 48 hours if contact was not established; • Used a letter reminder system for all research outcome assessment calls during acute and continuing-care; • In every clinic visit, the Clinical Research Coordinator (CRC) discussed the research outcomes phone calls with the patient to ensure that the calls were completed on schedule and worked to resolve any problematic issues regarding said calls [Clinical Procedures Manual, page 75]; • Paid patients $25.00 for participating in each telephonic research outcomes assessment; • Permitted patients to re-enter acute and/or continuing-care within four weeks after having dropped out [Clinical Procedures Manual, page 80]; • Recommended one-year of continuing-care for all patients who achieved a satisfactory clinical response with the essential goal of preventing relapse [Clinical Procedures Manual, page 15] and • Permitted continuing-care patients to remain in the study if they moved from the area [Clinical Procedures Manual, page 81].
Acute-Care Visits	Physicians met with patients on entry into each new step to initiate drug treatment with follow-up visits scheduled on weeks 2, 4, 6, 9, 12, with an optional week 14 visit.

Measurement-Based Care	Conducted structured evaluations of symptoms and side-effects at each visit and included a centralized treatment monitoring and physician feedback system to ensure consistent implementation of optimal care across research sites.
Aggressive Medication Dosing	Provided aggressive medication dosing with a fully adequate dose for a sufficient duration to "*ensure that the likelihood of achieving remission was maximized and that those who did not reach remission were truly resistant to the medication*". [1, p.30]
Liberal Prescribing of Non-Study Medications	Physicians had great leeway in prescribing non-study medications to treat comorbid symptoms resulting in: • 17.2% taking Trazodone for sleep; • 11.9% taking an anti-anxiety medication; • 16.7% taking either a sedative or hypnotic medication; and • An undisclosed percent taking medications to address side-effects. [2, table 2]
Continuing-Care Visits	Patients saw their physician every 2 months and continued taking their treatment medication(s) at the same doses but their physicians were allowed to make any psychotherapy, medication, and/or medication dose changes to maximize the likelihood of maintaining patients' remission status. [7, p. 1908] Additional continuing-care visits were scheduled when patients began to experience a return of depressive symptoms and/or intolerable side-effects [Clinical Procedures Manual. page 78].
Clinical Research Coordinator (CRC)	Each site had a CRC who: [1, p. 30] • Saw patients before each visit administering multiple measures to them including the QIDS-SR during each acute-care visit; • Assisted physicians in protocol implementation; and • Provided patients support and encouragement in protocol implementation.
Treatment Designed to Enhance Subject Retention	Treatment was designed to minimize drop-outs and/or non-compliance including: • Open label prescribing during acute and continuing-care with no placebo control condition during any study phase; • Patients chose their acceptable treatment assignments for steps two and three to eliminate any concerns they might have about receiving an unacceptable assignment. This resulted in only 21 of 1,439 (1.5%) Step-2 patients making themselves available for random assignment to all treatment options [2, p. 1235] while only 29 of 377 (7.7%) did so in Step-3. [5, p. 1521] • During each step, patients could enroll immediately into the next step if they had intolerable side-effects or had maximized their current medication(s)' dosing without achieving a remission; and • During any step, patients could enter continuing-care directly on their current medication(s) if they were treatment responders even if they had not achieved remission. This was done to minimize responders from dropping out in order to avoid having

	to discontinue their current medication(s) and start a new drug regimen.

***Trivedi MH, Stegman D, Rush AJ, Wisniewski SR, Nierenberg AA: STAR * D clinical procedures manual. July 31, 2002. www.edc.pitt. edu/stard/public/study_manuals.html