



Health system and public health evidence to recommendations framework

Bør fastleger tilby pasienter med alvorlig depresjon, tilbakevendende depresjon, kronisk depresjon og dystymi både antidepressiver og psykologisk behandling?

Problem: Alvorlig depresjon, tilbakevendende depresjon, kronisk depresjon og dystymi hos eldre (over 65 år)

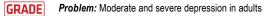
Tiltak: Kombinert behandling med både antidepressiver og psykologisk behandling

Sammenlikning: Monoterapi – enten medikamentell behandling eller psykologisk behandling

Setting: Primærhelsetjenesten

Bakgrunn: Depresjon blant eldre er vanlig, og forårsaker redusert livskvalitet. Somatiske sykdommer, redusert funksjon og tapsopplevelser kan øke risiko for depresjon hos eldre. Depresjon hos eldre har oftere et kronisk forløp og depresjon er ledsaget av økt risiko for somatisk sykdom og dødelighet. Depresjon resulterer i høye utgifter til behandling, og virker negativt inn på både personlige, familiære og sosiale forhold. Diagnosen depresjon blir oftere oversett blant eldre pasienter, og eldre pasienter får oftere mangelfull behandling. Det har vært vanskeligere å få gitt adekvate tilbud i spesialisthelsetjenesten til eldre med depresjon som har behov for vurdering og behandling hos psykolog eller psykiater. Studier viser at pasienter med depresjon ikke alltid behandles i tråd med anbefalinger gitt i kunnskapsbaserte kliniske retningslinjer.

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	ADDITIONAL INFORMATION
	Is the problem a priority?	No Probably Uncertain Probably Yes Varies No Yes 🔲 🔲 🔯 🗀		Alvorlig depresjon innebærer en tung lidelse for den syke og familien, med betydelig funksjonsnedsettelse og risiko for selvmord. Kronisk og tilbakevendende depresjon, og dystymi er også mer belastende enn en enkeltstående episode med mild til moderat depresjon.
PROBLEM	Are a large number of people affected?	No Probably Uncertain Probably Yes Varies No Yes □ 🗓 □ □		Depresjon hos eldre er vanligere enn hos yngre. Mange plages med depressive følelser uten å fylle kravene til diagnosen depresjon. Blant dem som lider av depresjon har de fleste mild til moderat depresjon, slik at alvorlig depresjon er relativt sjelden. Alvorlig depresjon er vanligere hos eldre enn hos yngre voksne. Risiko for residiv (tilbakevendende depresjon) og for et kronisk forløp er større hos eldre enn hos yngre voksne.

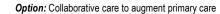


™DECIDE

Option: Collaborative care to augment primary care

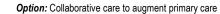
Comparison: Usual care

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	ADDITIONAL INFORMATION
	Are the		Summary of findings:	Både behandling med
	desirable anticipated	No Probably Uncertain Probably Yes Varies No Yes	Antidepressants compared to psychotherapy for elderly with severe depression	antidepressiver og strukturert psykologisk behandling har
	effects large?		Bibliography: Depressive symptoms: ^{1,2} . Hazards/unintended effects: ³	dokumentert klinisk viktig effekt
	-		Outcomes No of Quality of the Relative Participants evidence effect (studies) (GRADE) (95% CI) Follow up Anticipated absolute effects Risk with Risk difference with Psychotherapy Antidepressants (95% CI)	sammenliknet med placebo eller vanlig behandling for pasienter med avlorlig depresjon. Mange pasienter foretrekker psykologisk behandling
			Depressive symptoms 5995 (39 studies¹) ⊕⊕⊕⊕ (39 studies¹) The mean change in depressive symptoms in the intervention groups due to was inconsistency Depression scale inconsistency 0.02 standard deviations higher (0.1 lower to 0.13 higher)	framfor medikamentell behandling ved depresjon. En metaanalyse av 67 studier med pasienter med angst og depresjon, herav 40 studier med pasienter med depresjon, viste ingen
HARMS OF THE OPTIONS			All cause mortality 241757	sikker forskjell i effekt mellom behandling med antidepressiver (AD) og psykoterapi (PT) mht. bedring av symptomer (Cuijpers 2013)¹. Flere metaanalyser viser tilleggseffekt ved å kombinere AD med PT, sammenliknet med enten AD eller PT alene.
BENEFITS & HARMS OF	Are the undesirable anticipated effects small?	No Probably Uncertain Probably Yes Varies No Yes \(\text{Varies} \)	Falls (SSRIs vs no ADs) (1 study) 1-12 years (from 34 more to 42 more) more)	alene.
			CI: Confidence interval; HR: Hazard ratio;	
	What Is the overall certainty of this evidence?	No included studies Very low Low Moderate High	¹ Cuijpers included 67 studies on anxiety and mood disorders. We have used the analyses from 39 studies on major depression. ² Heterogeneity, I ² = 46 %. ³ We did not rate down for indirectness, although studies included all adults, not only elderly with severe depression. ⁴ Adjusted for sex, age (five year bands), year, severity of depression, depression before age 65, smoking status, Townsend deprivation score, coronary heart disease, diabetes, hypertension, cancer, dementia, Parkinson's disease, hypothyroidism, obsessive-compulsive disorder, epilepsy/seizures, statins, non-steroidal anti-inflammatory drugs, antipsychotics, lithium, aspirin, antihypertensive drugs, anticonvulsant drugs,	





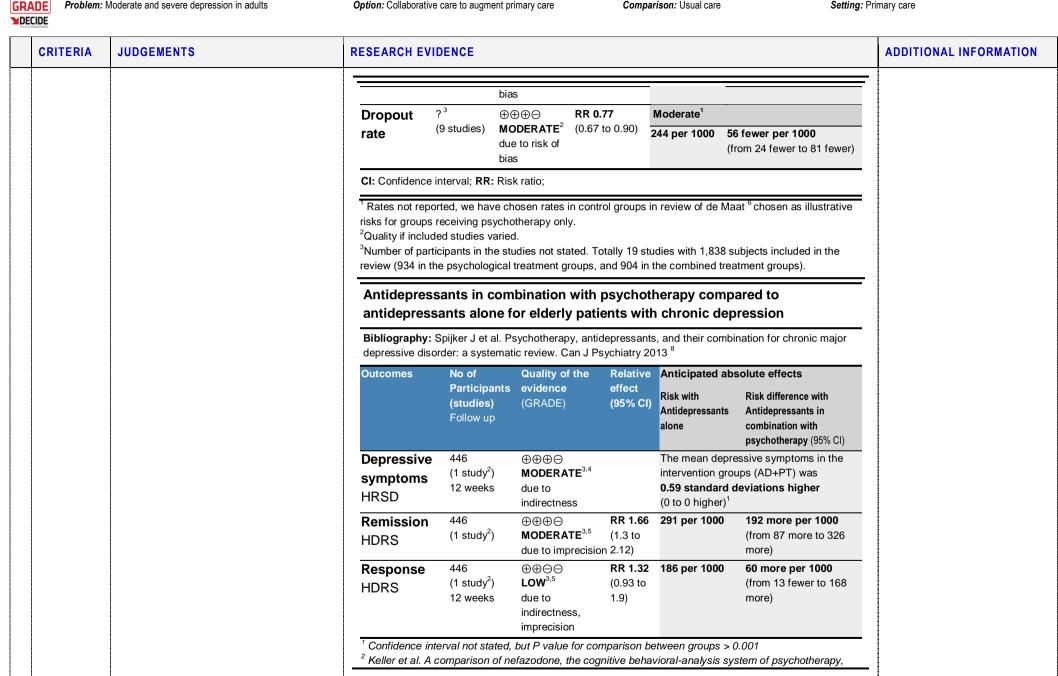
CRITERIA	JUDGEMENTS	RESEARCH EVIDEN	CE				ADDITIONAL INFORMA
		in UK. As this is an obs	patients not currently of arge observational study, it is so differences in charant for some of the ass	on ADs dy based on susceptible acteristics be ociations be	a primary care da to confounding by etween patients pr	atabase from 570 general practices indication, channelling bias, and escribed different antidepressant and the adverse outcomes may	
		Antidepressants antidepressants				-	
		Bibliography: 4,5					
		Outcomes No of Partic (studi	cipants evidence ies) (GRADE)	Relative effect (95% CI)	Antidepressants A	isk difference with ntidepressants in combination ith psychotherapy (95% CI)	
		Symptom 11836 change (25 ²) Scales	⊕⊕⊕⊝ MODERATE³ due to risk of bias	4	groups (AD+PT)	eviations higher	
		Response 1842	⊕⊕⊕⊝	OR 1.86	Moderate ⁵		
		rate (16 °) 12 we			240 per 1000	130 more per 1000 (from 64 more to 203 more)	
		Dropout ?	⊕⊕⊝⊝ LOW ^{3,7}	OR 0.86	Moderate ¹		
		rates all (16 ⁶) studies	due to risk of bias, imprecision	(0.6 to 1.24)	250 per 1000	27 fewer per 1000 (from 83 fewer to 42 more)	
		Dropout ?	⊕⊕⊝⊝ LOW ^{3,7}	OR 1.11	Moderate ¹		
		rates <12 ⁽⁹⁾ weeks	due to risk of bias, imprecision	(0.71 to 1.74)	250 per 1000	20 more per 1000 (from 59 fewer to 117 more)	
i		Dropout ?	⊕⊕⊕⊖	OR 0.59	Moderate ¹		



Comparison: Usual care



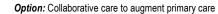
CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	ADDITIONAL INFORMATION
		rates > 12 (6 studies ⁶) MODERATE ^{3,4} (0.39 to due to risk of 0.88) 250 per 1000 86 fewer per 1000 (from 23 fewer to 135 fewer)	
		CI: Confidence interval; OR: Odds ratio;	
		No absolute numbers or data on dropout rates given in review. Control group in systematic review of de Maat et al. used here. Cuijpers et al: Adding psychotherapy to pharmacotherapy in the treatment of depressive disorders in adults: A meta-analysis. Depression and anxiety 2009. Blinding of patients regarding psychotherapy not possible. Methodological quality of several of the included studies not optimal. Effect size in favour of combined treatment with psychotherapy and antidepressives compared with AD alone. Studies on adults with depression, not only older adults with severe depression. Subgroup analysis did not find significant differences in effect size based on patient groups, however, except for lower effect sized in patients with dysthymia. Hence we have chosen not rated down for indirectness. Response rate not stated, 24% in control group in systematic review by Gensichen 2006. Pampallona Arch Gen Psych 2004. Twide confidence interval crossing line of no difference. Antidepressants combined with psychotherapy compared to psychotherapy alone for elderly with severe depression	
		Bibliography: Cuijpers P et al. 2009 ⁴	
		Outcomes No of Quality of the Relative effect Participants evidence (95% CI) (studies) (GRADE) Follow up Anticipated absolute effects Risk with Risk difference with Psychotherapy antidepressants combined with alone psychotherapy (95% CI)	
		Depressive ?³ ⊕⊕⊕⊖ The mean change in depressive symptoms symptoms (19 studies) MODERATE² in the intervention groups (AD + PT) was due to risk of bias 0.35 standard deviations higher (0.24 to 0.45 higher)	
		Recovery rate ?³ ⊕⊕⊕⊕ RR 1.22 Moderate¹ due to risk of (1.14 to 1.29) 344 per 1000 (from 48 more to 100 more)	



GRADE

™DECIDE

CRITERIA	JUDGEMENTS	RESEARCH EVII	DENCE					ADDITIONAL INFOR
		³ Study from US major depressive cognitive behavi ⁴ One study only sizes for studies imprecision, bas ⁵ Wide confidence	on adult with che disorder rando oral-analysis syn t, but effect size on patients with ed on this indire the interval, cross	omly assigned to stem of psychoth of combination of a depression in ge ect evidence from sing line of no diff	essive disord 12 weeks of derapy (16 to 2 FAD + PT co eneral. We had other studies derence.	ler, 681 adults win outpatient treatme 20sessions), or b mpared with AD ave chosen not to 3.	th a chronic nonpsychotic ent with nefazodone, the oth. Mean age 43 years. only is similar to effect o grade down for	
		•	Antidepressants combined with psychotherapy compared to psychotherapy alone for elderly patients with chronic depression				to psychotherapy	
		Bibliography: S						
		Outcomes	No of Participants (studies) Follow up	Quality of the evidence (GRADE)	Relative effect (95% CI)	Anticipated ab Risk with Psychotherapy alone	Risk difference with Antidepressants combined with psychotherapy (95% CI)	
		Depressive symptoms HRSD	442 (1 study ²) 12 weeks	⊕⊕⊖⊖ LOW³ due to risk of bias, indirectness		in the intervention	ge in depressive symptoms on groups (AD+PT) was deviations higher	
		Remission HDRS	442 (1 study ²) 12 weeks	⊕⊕⊕⊖ MODERATE³ due to indirectness	RR 1.45 (1.15 to 1.82)	333 per 1000	150 more per 1000 (from 50 more to 273 more)	
		Response HSRD	442 (1 study²) 12 weeks	⊕⊕⊕⊖ MODERATE³ due to indirectness	RR 1.73 (1.16- 2.57)	144 per 1000	105 more per 1000 (from 23 more to 225 more)	
		CI: Confidence in	*	*				
		adults with a chro	000 ⁹ . US only, mean onic nonpsychot	age 43 years, Sti ic major depressi	udy on adult ve disorder r	with chronic majo andomly assigne	or depressive disorder, 681 d to 2 weeks of outpatient herapy (16 to 20sessions),	



Comparison: Usual care

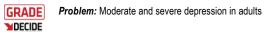


CRITERI	A JUDGEMENTS	RESEARCH EVID	ENCE					ADDITIONAL INFORMATI
		Psychothera	py compar	ed to usual	care for	elderly patier	nts with dysthymia	
		Bibliography: C	uijpers P et al.	2010.10				
		Outcomes	No of Participants (studies) Follow up		effect		Risk difference with Psychotherapy (95% CI)	
		Depressive symptoms Depression scales	0 (3 studies)	⊕⊕⊕⊝ MODERATE¹ due to risk of bias		The mean change in the intervention 0.21 standard dev (0.02 to 0.41 higher	viations higher	
		Adverse events	0 (0)			No information on events with psychological	•	
		CI: Confidence in	terval; RR: Ris	sk ratio;				
		¹ Quality of studie	s varied, lack	of blinding a p	roblem.			
		Psychologic	al treatmer	nt vs antider	ressan	ts for elderly v	vith dysthymia	
		Bibliography: C	uijpers P et al.	2010. 10				
		Bibliography: C	No of	Quality of the		Anticipated abso	olute effects	
				Quality of the	Relative effect (95% CI)	Dick with	Polute effects Risk difference with Psychological treatment (95% CI)	
			No of Participants (studies)	Quality of the evidence	effect	Risk with Antidepressants The mean change symptoms in the	Risk difference with Psychological treatment (95% CI) e in depressive intervention groups (PT) ard deviations lower	
		Depressive symptoms depression	No of Participants (studies) Follow up 0 ³ (3 studies)	Quality of the evidence (GRADE) ⊕⊕⊖⊝ LOW ^{4,5} due to risk of bias, indirectness ⊕⊕⊖⊝	effect (95% CI)	Risk with Antidepressants The mean change symptoms in the was 0.47 standa (0.18 to 0.75 lower Moderate ²	Risk difference with Psychological treatment (95% CI) e in depressive intervention groups (PT) ard deviations lower	
		Depressive symptoms depression scales	No of Participants (studies) Follow up 03 (3 studies)	Quality of the evidence (GRADE) ① ① ② ② ② ② ② ② ② ③ ② ③ ③ ③ ③ ③ ③ ③ ③ ③	effect (95% CI)	Risk with Antidepressants The mean change symptoms in the was 0.47 standar (0.18 to 0.75 lowers)	Risk difference with Psychological treatment (95% CI) e in depressive intervention groups (PT) ard deviations lower	

GRADE



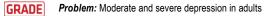
CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	ADDITIONAL INFORMATION
		⁶ This analyses included all studies in the review, patients with different types of chronic depression, not only dysthymia, and not only elderly patients, but we decided not to rate down.	
		Psychotherapy in combination with antidepressants compared to psychotherapy alone for elderly with dysthymia	
		Bibliography: Cuijpers P et al. 2010. ¹⁰	
		Outcomes No of Quality of Relative Participants the evidence effect (studies) (GRADE) (95% CI) Follow up Anticipated absolute effects Risk with Psychotherapy alone in combination with antidepressants (95% CI)	
		Depressive 0 symptoms (4 studies) ⊕⊕⊖ LOW³.4 due to risk of bias, scales LOW³.4 intervention groups was due to risk of bias, imprecision 0.45 standard deviations higher (0.20 to 0.70 higher)	
		Dropout 0 ⊕⊕⊕⊝ RR 1.10 Moderate¹	
		rate (3 studies) VERY (0.79 to LOW ^{3,5,6} 1.52) due to risk of bias, inconsistency, imprecision (3 studies) VERY (0.79 to LOW ^{3,5,6} 1.52) (from 51 fewer to 127 more)	
		CI: Confidence interval; RR: Risk ratio;	
		¹ Rates not reported, we have chosen rates in control groups in review of de Maat ⁶ chosen as illustrative risks for groups receiving psychotherapy only. ² Number of patients not stated. ³ Quality of studies varied. ⁴ Four studies with different patient groups included in the analyses, not only elderly patients, and not only patients with dysthymia, also patients with other form of chronic depression. Too few data to do subgroup based on diagnosis. ⁵ Studies on patients with all types of chronic depression included, not only dysthymia, and not only elderly patients. We decided not to rate down for this, however. ⁶ Wide confidence interval, crossing line of no difference, few observations.	



Option: Collaborative care to augment primary care

Comparison: Usual care

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	ADDITIONAL INFORMATION
VALUES	Are the desirable effects large relative to undesirable effects?	No Probably Uncertain Probably Yes Varies No Yes \(\text{Varies} \)		

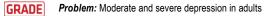


™DECIDE

Option: Collaborative care to augment primary care

Comparison: Usual care

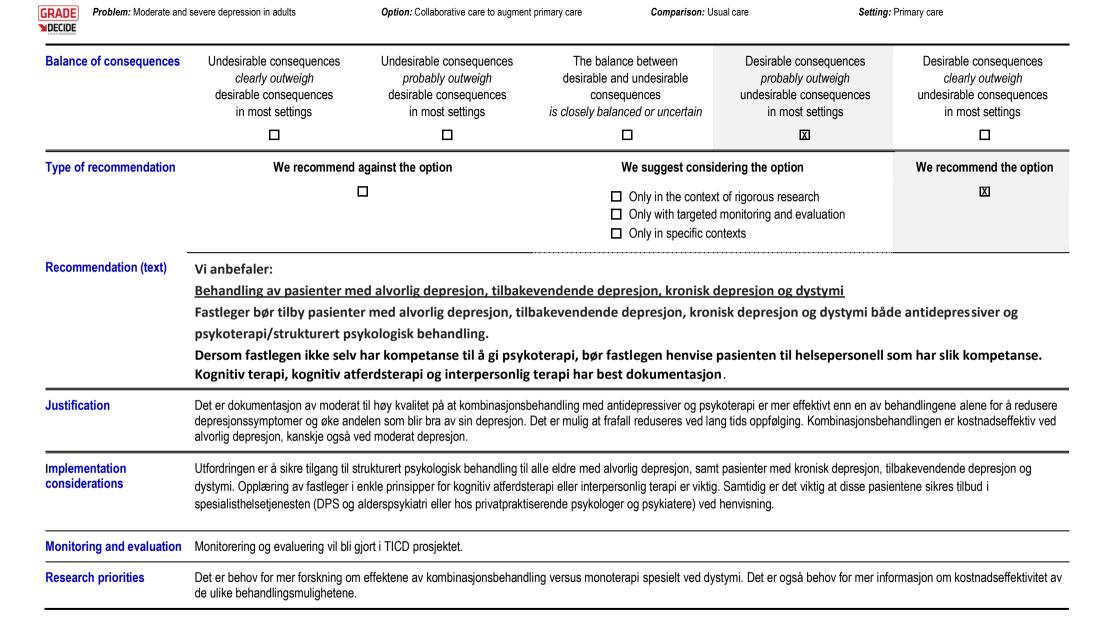
	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	ADDITIONAL INFORMATION
JE USE	Are the resources required small?	No Probably Uncertain Probably Yes Varies No Yes □ □ □ □ □		Kostnadene for pasienten og familien antas å være relativt små. Utgifter til medikamenter er i dag relativt små, mens utgifter til strukturert psykologisk behandling er større. Hovedutfordringen kan være at det er mangel på denne type tilbud, og at eldre med alvorlig depresjon har vanskeligere for å få tilbudet enn yngre med depresjon.
RESOURCE USE	Is the incremental cost small relative to the net benefits?	No Probably Uncertain Probably Yes Varies No Yes \\	Flere kosteffektivitetsanalyser har konkludert med at kombinasjonsbehandling er effektivt ved alvorlig depresjon. Kostnadene for hver pasient som ble vellykket behandlet ble i en engelsk studie beregnet til £ 4056 (95 % CI 1400 -18 300 £); kostnaden per vunnet kvalitetsjusterte leveår var £ 5777 (95 % CI 1900-33 800 £) for alvorlig depresjon (1). Kombinasjonsbehandling ble også vurdert å være kostnadseffektiv i en japansk undersøkelse (2). I disse analysene er også samfunnsmessige tap pga. redusert produktivitet ved sykefravær tatt med i beregningen, slik at kostnadseffektiviteten vil være noe mindre blant eldre som ikke lenger er i arbeid. Fortsatt antar vi imidlertid at kombinasjonsbehandlingen er kostnadseffektiv ved alvorlig depresjon.	
EQUITY	What would be the impact on health inequities?	Increased Probably Uncertain Probably Reduced Varies increased reduced	Vi har ingen dokumentasjon om mulige effecter på ulikheter.	
ACCEPTABILITY	Is the option acceptable to key stakeholders?	No Probably Uncertain Probably Yes Varies No Yes \Boxed{X}	Vi har lite solid dokumentasjon om hvilken behandling eldre med depresjon foretrekker. Erfaringsmessig er både medikamentell og psykologisk behandling akseptabelt for pasienter og familie.	
FEASIBILITY	Is the option feasible to implement?	No Probably Uncertain Probably Yes Varies No Yes X		Det er mangel på tilbud om strukturert psykologisk behandling. Det bør være mulig både å øke kompetansen blant fastleger, samt å sikre at eldre med alvorlig depresjon kan få tilbud om psykologisk behandling i spesialisthelsetjenesten om nødvendig.



MDECIDE

Option: Collaborative care to augment primary care

Comparison: Usual care





Skal antidepressiver vs psykoterapi brukes ved alvorlig depresjon hos eldre, skal kombinasjon av antidepressiver og psykoterapier brukes vs antidepressiver alene, skal kombinasjon av antidepressiver og psykoterapi brukes vs psykoterapi alene

Author(s): Flottorp, Aakhus

Date: 2013-08-25

Question: Should antidepressants vs psychotherapy be used for depression in the elderly?

Settings:

Bibliography: Cuijpers et al. The efficacy of psychotherapy and pharmacotherapy in treating depressive and anxiety disorders: a meta-analysis of direct comparisons. World Psychiatry 2013. Pinquart et al. Treatments for later-life depressive conditions: a meta-analytic comparison of pharmacotherapy and psychotherapy. Am J Psychiatry 2006.

			Quality as	sessment		No of pa	atients		Effect	Quality	Importance	
No of studies	Design	Design Risk of bias Inconsist		Indirectness	Imprecision	Other considerations	Antidepressants		Relative (95% CI)	Absolute		
Depressive	symptoms (m	easured with: D	epression sca	le; Better indicated	by lower values)							
-			no serious imprecision	none	3142 ³	2853 ⁴	-	SMD 0.02 higher (0.1 lower to 0.13 higher)	⊕⊕⊕O MODERATE	CRITICAL		

Both clinical and statistical heterogeneity: studies on depression and anxiety in all adults, not only elderly. 40 studies on depression, 27 on anxiety.

Author(s): Flottorp, Aakhus

Date: 2013-08-25

Question: Should antidepressants in combination with psychotherapy vs antidepressants alone be used for elderly patients with depression?

Settings:

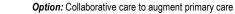
Bibliography: Cuijpers et al. Adding psychotherapy to pharmacotherapy in the treatment of depressive disorders in adults: a meta-analysis. J Clin Psychiatry 2009. Pampallona et al. Combined pharmacotherapy and psychological treatment for depression: a systematic review. Arch Gen Psychiatry 2004.

			Quality ass	essment			No of patier		Effect	Quality	Importance	
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressants in combination with psychotherapy	Antidepressants alone	Relative (95% CI)	Absolute		
Sympton	n change (mea	asured with:	Depression scal	es; Better indica	ted by higher v	alues)						
25 ¹	randomised trials			•	no serious imprecision	none	10818	1018	-	SMD 0.31 higher (0.2 to 0.43 higher)	⊕⊕⊕O MODERATE	CRITICAL

² The 67 studies were on both depression and anxiety, and not only with elderly, But subgroup analysis of 39 studies on MDD showed similar results as all studies.

³ pharmacotherapy

⁴ psychotherapy



Problem: Moderate and severe depression in adults

Comparison: Usual care

Setting: Primary care

Dropout	rate											
19 ¹	randomised trials	serious²	no serious inconsistency	no serious indirectness	no serious imprecision	none	-	0%	OR 0.65 (0.5 to 0.83)	_4	⊕⊕⊕O MODERATE	IMPORTANT
Respons	e rate (follow-	up median	12 weeks)		-				3			
16 ⁵		no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	0/932 (0%)	24% ⁶	OR 1.86 (1.38 to 2.52)	130 more per 1000 (from 64 more to 203 more)	⊕⊕⊕⊕ HIGH	CRITICAL
Dropout	rates all studi	ies (follow-u	p median 12 wee	ks)								
16 ⁵		no serious risk of bias	no serious inconsistency	no serious indirectness	serious ⁷	none	-	25% ⁸	OR 0.86 (0.6 to 1.24)	27 fewer per 1000 (from 83 fewer to 42 more)	0000	IMPORTANT
Dropout	rates <12 wee	ks (follow-u	ıp x-12 weeks)									
9		no serious risk of bias	no serious inconsistency	no serious indirectness	serious ⁷	none	-	25% ⁸	OR 1.11 (0.71 to 1.74)	-	⊕⊕⊕O MODERATE	IMPORTANT
Dropout	rates > 12 we	eks										
6 ⁵	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	-	25% ⁸	OR 0.59 (0.39 to 0.88)	86 fewer per 1000 (from 23 fewer to 135 fewer) ⁴	⊕⊕⊕⊕ HIGH	IMPORTANT

Cuijpers 2009: Adding psychotherapy to pharmacotherapy in the treatment of depressive disorders in adults: A meta-analysis.

Author(s): Flottorp, Aakhus

Date: 2013-08-25

GRADE ▶DECIDE

Question: Should Antidepressants combined with psychotherapy vs psychotherapy alone be used for elderly patients with depression?

Settings: primary care

Bibliography: de Maat et al. Relative efficacy of psychotherapy and combined therapy in the treatment of depression: a meta-analysis. Eur Psychiatry 2007.

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antidepressants combined with psychotherapy	Psychotherapy alone	Relative (95% CI)	Absolute		

² Blinding of patients and not possible. Methodological quality of several of the included studies not optimal.

³ Studies on adults with depression, not only older adults with severe depression. Subgroup analysis did not find significant differences in effect size based on patient groups, however, except for lower effect sized in patients with dysthymia.

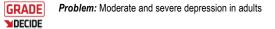
⁴ Dropout rate in control or intervention groups not stated.

⁵ Pampallona Arch Gen Psych 2004

⁶ Response rate not stated in review, 24% in control group in systematic review by Gensichen 2006.

⁷ Wide confidence interval

⁸ No absolute numbers or data on dropout rates given in review. Control group in systematic review of de Maat et al used here



Option: Collaborative care to augment primary care

Comparison: Usual care

Setting: Primary care

Dropout rate (follow-up 8-20 weeks)												
7	randomised	no serious	no serious	no serious	serious ²	none	112/444	112/459	RR 1.03	7 more per 1000	$\oplus \oplus \oplus O$	IMPORTANT
	trials	risk of bias ¹	inconsistency	indirectness			(25.2%)	(24.4%)	(0.82 to 1.3)	(from 44 fewer to 73	MODERATE	
										more)		
Remission (follow-up 8-20 weeks)												
7	randomised	no serious	no serious	no serious	no serious	none	202/444	158/459	RR 1.32	110 more per 1000	$\oplus \oplus \oplus \oplus$	
	trials	risk of bias ¹	inconsistency	indirectness	imprecision		(45.5%)	(34.4%)	(1.12 to	(from 41 more to 193	HIGH	
									1.56)	more)		

¹ Risk of bias in included studies not reported, but we chose not to grade down.
² Wide CI, crossing 1 (line of no difference)

(Return to framework)

References

Option: Collaborative care to augment primary care

¹ Cuijpers et al. The efficacy of psychotherapy and pharmacotherapy in treating depressive and anxiety disorders: a meta-analysis of direct comparisons. World Psychiatry 2013

² Pinquart M et al. Treatments for later-life depressive conditions: a meta-analytic comparison of pharmacotherapy and psychotherapy. Am J Psychiatry 2006;163:1493-501.

³ Coupland C et al. Antidepressant use and risk of adverse outcomes in older people: population based cohort study. BMJ 2011;345:d4551

⁴ Cuijpers P, Dekker J, Hollon SD, Andersson G. Adding psychotherapy to pharmacotherapy in the treatment of depressive disorders in adults: a meta-analysis. J Clin Psychiatry 2009;70:1219-29.

⁵ Pampallona S, Bollini P, Tibaldi G, Kupelnick B, Munizza C. Combined pharmacotherapy and psychological treatment for depression: a systematic review. Arch Gen Psychiatry 2004;61:714-9.

⁶ de Maat SM, Dekker J, Schoevers RA, de JF. Relative efficacy of psychotherapy and combined therapy in the treatment of depression: a meta-analysis. Eur Psychiatry 2007;22:1-8.

⁷ Gensichen J, Beyer M, Muth C, Gerlach FM, Von KM, Ormel J. Case management to improve major depression in primary health care: a systematic review. Psychol Med 2006;36:7-14.

⁸ Spijker J et al. Psychotherapy, antidepressants, and their combination for chronic major depressive disorder: a systematic review. Can J Psychiatry 2013;58:386-92.

⁹ Keller et al. A comparison of nefazodone, the cognitive behavioral-analysis system of psychotherapy, and their combination for the treatment of chronic depression. N Engl J Med 2000;342:1462-70.

¹⁰ Cuijpers P et al. Psychotherapy for chronic major depression and dysthymia: a meta-analysis. Clin Psychol Rev 2010;30:51-62.



Definitions for ratings of the certainty of the evidence (GRADE)

Ratings	Definitions	Implications
⊕⊕⊕⊕ High	This research provides a very good indication of the likely effect. The likelihood that the effect will be substantially different* is low.	This evidence provides a very good basis for making a decision about whether to implement the intervention. Impact evaluation and monitoring of the impact are unlikely to be needed if it is implemented.
⊕⊕⊕ Moderate	This research provides a good indication of the likely effect. The likelihood that the effect will be substantially different ⁴ is moderate.	This evidence provides a good basis for making a decision about whether to implement the intervention. Monitoring of the impact is likely to be needed and impact evaluation may be warranted if it is implemented.
⊕⊕○○ Low	This research provides some indication of the likely effect. However, the likelihood that it will be substantially different ⁴ is high.	This evidence provides some basis for making a decision about whether to implement the intervention. Impact evaluation is likely to be warranted if it is implemented.
⊕OOO Very Low	This research does not provide a reliable indication of the likely effect. The likelihood that the effect will be substantially different ⁴ is very high.	This evidence does not provide a good basis for making a decision about whether to implement the intervention. Impact evaluation is very likely to be warranted if it is implemented.

^{*}Substantially different: large enough difference that it might have an effect on a decision

(Return to framework)